



The Global  
Alliance  
for Vitamin A



# GENDER EQUALITY AND VITAMIN A SUPPLEMENTATION (VAS)

## HOW GENDER MAINSTREAMING CAN IMPROVE CHILD SURVIVAL AND PROMOTE GENDER EQUALITY

### WHAT DO GENDER EQUITY AND GENDER EQUALITY HAVE TO DO WITH VAS PROGRAMS?

VAS programs have traditionally been gender-unaware. Door-to-door campaigns, where VAS was co-delivered along with essential childhood vaccinations, were able to achieve high coverage across both sexes by reducing barriers to accessing VAS. As the need for mass immunization campaigns decreases, many countries are transitioning to delivering VAS through facility-based campaigns and routine health services.

This shift in delivery platforms increases the burden placed on caregivers and health workers, causing VAS programs to increasingly intersect with gender dynamics. Although the goal of VAS programs remains the same—to reach all children—they often do not consider how gender inequality may affect the outcome of coverage or the burden of participation on caregivers or providers.

Given the increasing body of literature demonstrating the impacts of gender inequality and restrictive gender norms on health and well-being, including nutrition, it is important to look at

nutrition programs through a broad gender lens [1,2,3]. This means considering how interventions might impact—and be impacted by—gender inequity, and how programs can become more gender responsive or gender transformative in the future.

A program that demonstrates gender equity ensures that women, men, boys and girls all have equal opportunities to achieve their full health potential – while considering the intersection of additional vulnerabilities [4]. It involves treating girls and boys, and women and men fairly according to their respective needs. Often, it involves taking special measures to compensate for historical discrimination based on gender roles that benefit men and boys, or in some cases, to compensate for increased biological needs.

This brief was developed by the Global Alliance for Vitamin A (GAVA) to help countries identify and address gender equity and equality issues that often go unrecognized in VAS programs.



## KEY MESSAGES

1. Gender equity and promotion of gender equality actions in VAS programs must go far beyond the collection of sex-disaggregated VAS coverage.
2. A sex- and gender-based analysis (SGBA) can provide the necessary insight to design gender-responsive VAS programs that consider gender dynamics.
3. Changes in recruitment and training are needed to rebalance women's under-representation in leadership and decision-making positions and recognize their high levels of participation in service delivery jobs.
4. Communication and messaging for VAS programs may have potential to challenge gender norms and be tailored to female and male caregivers with the intention of shifting the division of labour in childcare and increasing gender balance in access to resources and decision-making.
5. Innovations are needed in the timing, delivery and structure of VAS services to reduce the physical and time-related barriers experienced by caregivers. These barriers are often exacerbated by the socio-cultural context, including gender norms, social position, and socioeconomic status.
6. When monitoring and evaluating VAS programs, include gender-responsive indicators and collect sex-disaggregated data at multiple levels (community to national) and from multiple stakeholders and program participants. Also, consider intersectionality of other vulnerabilities (e.g. race, caste, SES, religion).

## KEY TERMS:

**Gender-unaware programs:** programs that do not consider gender norms, roles and relations and overlook differences in opportunities and resource allocation between men and women. These programs are often designed following the principle of being “fair” by treating everyone the same.

**Gender-responsive programs:** programs where gender norms, roles and inequalities have been considered, and measures have been taken to actively address the different needs of girls, boys, men and women to promote equal outcomes.

**Gender-transformative programs:** programs that seek to redefine gender roles, transform unequal gender relations and provide support for women's empowerment to promote shared power, control of resources, and decision-making.

**Gender equality:** a broad concept and a Sustainable Development Goal (SDG). Gender equality is achieved when everyone, regardless of gender, has equal rights, freedoms, conditions, and

opportunities for realizing their full potential and for contributing to—and benefiting from—economic, social, cultural and political development.

**Gender equity:** the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on an equitable basis, or a “level playing field.”

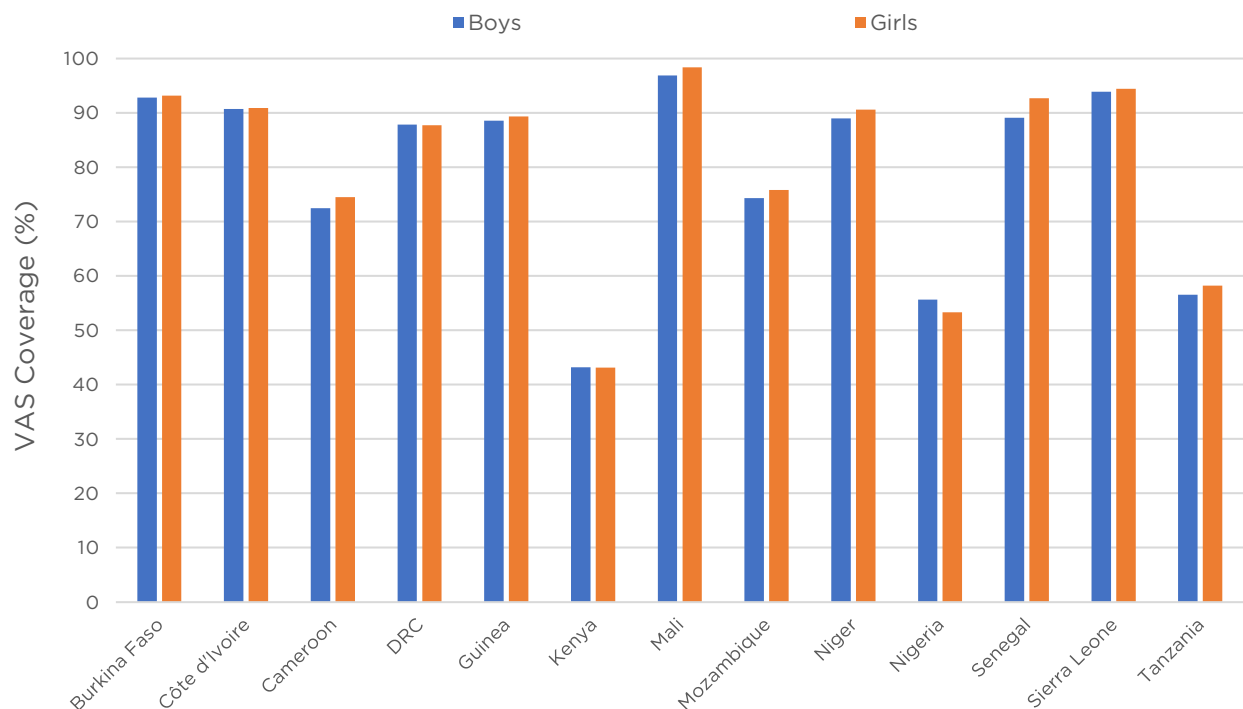
**Gender mainstreaming:** a globally accepted strategy for promoting gender equality that involves assessing the implications for women and men of any legislation, policy or program. It requires that women's and men's concerns and experiences are an integral dimension of the design, implementation, monitoring and evaluation of policies and programs so that women and men benefit equally and inequality is not perpetuated.

## INVESTIGATING THE INTERSECTION OF VAS AND GENDER

To explore the intersections between VAS and gender, we conducted a literature review on terms related to gender equality, gender equity, health services, VAS, vitamin A deficiency and immunization. The review revealed that VAS coverage does not differ significantly between boys and girls [5]. In fact, an analysis of VAS coverage data in sub-Saharan Africa found that the


average difference in VAS coverage between boys and girls was less than 1% (**Figure 1**) [5]. Any consideration of gender in VAS programming must therefore go beyond simply looking at sex-disaggregated coverage and examine other pieces of program data through a gender lens.

Figure 1. VAS Coverage by Sex for 13 Countries in Africa [5]



The evidence also indicates that gender inequalities exist on both the supply side and demand side of health services in sub-Saharan Africa. On the supply side, the literature shows imbalanced gender representation in human resources, with women under-represented at decision-making levels [6] and highly-represented at the level of service delivery [7]. Female health workers often experience poor working conditions

characterized by harassment and discrimination, making career advancement difficult as well as hampering their ability to provide quality services to beneficiaries [8]. Qualitative data suggests that gender also affects the acceptability of community health workers (CHW). Individuals seeking care from CHWs were more comfortable disclosing health-related information to CHWs of the same gender, and both women and men experienced



discomfort discussing sexual and reproductive health issues with CHWs of the opposite sex. As such, the evidence emphasizes the importance of having both female and male CHWs to reach and engage women and men – and children via their caregivers – with health services [9].

On the demand side, the burden of maternal and child healthcare is often placed on women. Their time is often not given equal value to that of men, especially in the case of lost time for unpaid labour at the household level. VAS is provided free of charge, but indirect costs such as transportation and time often fall on women as the primary caregivers of young children [10], even though they may not have control over or access to resources. Travel to health clinics for VAS services may also increase women's exposure to harassment and violence, especially in contexts where gender-based violence and informal drinking establishments for men are common [10].

Gender also plays an important role in intra-household decision-making regarding VAS. Although mothers are often expected to carry out activities related to child health and nutrition, cultural gender roles and generational power dynamics may limit their power to influence healthcare-related decision-making [10]. In Mali, 77% of survey respondents reported that the father decides whether or not a child should receive VAS [11], and a survey in Nigeria showed that the most common barrier to a child receiving VAS was the disapproval of the father [12]. In communities where healthcare decision-making is a collective process, politically motivated resistance to child immunization is often summoned by male leaders but enacted by women when they refuse to immunize their children during interactions with health workers [13]. Health services are often targeted to mothers who may have limited bargaining power within the household, which can be problematic. This bias neglects the limited access to resources and decision-making often felt by mothers, and results in placing blame on mothers who may be publicly shamed for their

inability to overcome structural constraints. Conversely, the father's role in denying immunization services to the child is often not challenged [13].

Gender norms that place unjust burden on mothers may also contribute to lower levels of paternal involvement in accessing child preventive services such as VAS. The literature review revealed that health services are often managed and organized in ways that target mothers, including the type of information they provide [10]. Health facilities are often perceived as feminized spaces [13], and the current health system context in many communities may discourage fathers from sharing the responsibility of accessing health care for their children [10]. For example, it may be difficult for fathers to seek care for their children when health services are only offered during typical working hours for men.

Lastly, the literature search revealed a lack of data available on sex-disaggregated prevalence of VAD, as well as the gender of caregivers or distributors involved in VAS programs. The availability of sex-disaggregated VAS coverage was variable, and often the disaggregation at the local level was not retained as it rolled up to the national level [14].



## I'M CONVINCED GENDER EQUITY MATTERS FOR MY VAS PROGRAM. NOW WHAT?

There are four major areas where VAS programs can address gender inequity: planning and training, awareness raising and demand generation, service delivery, and monitoring and evaluation (M&E).

The first key area for gender action, **planning and training (Figure 2)** involves thinking about how the selection, support, and training of managers, supervisors and CHWs reinforces or challenges gender inequities and inequalities in communities. Staff should be selected to represent different genders and ethnicities where possible, as women and men often feel more comfortable interacting with a healthcare provider of the same sex. The staff selection criteria should consider the different barriers and challenges often experienced by women and minorities. It is essential to engage women and men in this step.

The second area for gender programming is in **awareness raising and demand generation (Figure 3)**. Good communication and messaging can improve awareness and generate demand for VAS services, while challenging gender norms and promoting gender equality. This requires applying a gender lens when looking at targeting, delivering and framing of messaging. A gender-responsive awareness campaign will challenge gender norms through messaging and will work with key trusted community leaders to spread information that promotes gender equality and equity. For example, a gender-responsive message could encourage fathers to take their child to the health facility for routine, preventive services such as VAS. Or, messaging could be used to acknowledge the current burden of care of females and recognize the valuable role they play in the family. However, careful consideration must be taken to ensure that behaviour change campaigns do not unintentionally reinforce gender inequity and jeopardize women's empowerment. Merten et al. explain that interventions designed at increasing male

### FIGURE 2: GENDER MAINSTREAMING IN PLANNING AND TRAINING

- Conduct a SGBA to identify existing gender-related and socioeconomic barriers that influence VAS outcomes and affect the potential to participate in—or benefit from—interventions.
- Try to hire diverse staff, including both men and women, as well as individuals from different ethnic and socioeconomic backgrounds.
- Be sensitive to gendered barriers that may favour hiring men over women. For example, women may be more likely to lack employment history or education.
- Provide support to staff to overcome access barriers (e.g. provide stipends for transport or childcare).
- Showcase images and examples of gender equity during training (e.g. images of men helping with childcare and housework).
- Use training as an opportunity to educate health workers on the principles of gender equity and how to promote gender equity through their work and influence in the community. Presenting the results of the SGBA during training may help important stakeholders understand issues of gender equity in their community.
- Ensure that the voices of male and female clients and service providers (healthcare workers) are brought into the design, delivery and M&E of programs.

involvement in child health care may also support the legitimacy of male decision-making power within the family, which may reinforce gender inequalities and compromise the intended efforts of the intervention [13].



### FIGURE 3: GENDER MAINSTREAMING IN AWARENESS-RAISING AND DEMAND GENERATION

- Use images and messages that depict equitable gender roles instead of reinforcing inequitable gender roles or stereotypes (e.g. use images of fathers helping with housework or childcare, use language that includes fathers and mothers in decision-making around child health).
- Use knowledge about trusted sources of information for men and women when disseminating messaging. Studies in Nigeria showed that men and women often look to different community leaders or types of media for information on health.
- Use both male and female community leaders to publicize information.
- Ensure that messages, materials and channels are appropriate for the needs of women and men, considering differences in workload, access to information and services, and mobility.
- In messages and materials, include positive role models that appeal to both men and women.
- Use modeling of men in leadership roles who express benefits from increased engagement in child's care and sharing of household labour.
- Acknowledge current burden of care of females and recognize the valuable role they are playing.
- Target men's groups as well as women's groups to improve knowledge on VAS and encourage caregivers to access VAS services for their children.
- Consider the services being offered and opportunities to decrease burden on caregivers through hours of operation, decreased wait times and quality of care.

The third area for gender action is **service delivery**, which considers the timing, location, and structure of VAS campaigns and routine delivery, as well as the quality of service (**Figure 4**). Different types of VAS delivery platforms create distinct barriers for women and men, which has implications for VAS coverage and equity of access to VAS services. For example, fixed-point programming can be more costly for caregivers in terms of the time and resources required for transportation, while community-based programs and outreach services can reduce some of this burden. Programs should be designed to reduce the amount of time and resources required for caregivers to seek VAS for their children, and to reduce caregiver exposure to violence and harassment. Bundling VAS with other services may in some cases increase coverage and empower women [15, 16], and efforts to make health facilities welcoming to both men and women may support increased involvement of fathers in child health programs. By adjusting different aspects of service delivery to meet the needs of caregivers, program managers can ensure that VAS services are acceptable and accessible to mothers and fathers of young children. It would also be valuable to consider a woman's level of empowerment and how her agency and empowerment may impact her potential to participate, depending on how programs are delivered. Programs may need specific strategies to reach less-empowered women.

The design of VAS programs also has implications for the safety of health workers. Special provisions should be made to ensure that health workers—especially women—feel safe when conducting outreach or after-hours services.



#### FIGURE 4: GENDER MAINSTREAMING IN SERVICE DELIVERY

- Consider offering mobile services, outreach and after-hours or weekend services to ensure that caregivers engaging in both paid and unpaid labour can access services.
- Ensure that service providers are well-trained, respectful and empathetic to the needs of caregivers.
- Ensure that health spaces are welcoming to all genders. This could be accomplished by employing a gender-balanced staff ratio in clinics, or by providing VAS services bundled with other services that men and women want.
- Offer a fast-track lane at clinics so that caregivers who come in for simple VAS services do not spend hours waiting.
- Work with women's groups to identify marginalized families and help health workers reach these marginalized groups.
- Encourage policy-makers to provide more support for women and provide this support whenever possible (e.g. have a zero-tolerance policy for sexual harassment at work and towards clients at facilities).

**Monitoring and evaluation (Figure 5)** is the fourth area to consider gender dynamics. This includes considering who is selected to monitor and evaluate VAS programs, the type of data that are collected, and the methods used to collect data. Sex-disaggregated data on coverage, and gender-disaggregated data on caregivers and health workers who participate in VAS programming should be collected at all levels and discussed regularly during review meetings. Qualitative data collection methods can be helpful to try to identify

local gender roles and inequities, in order to understand the different experiences of females and males. Protocols for data collection on sensitive issues should protect participants from any possible harm derived from their contribution to data collection. By employing a gender specialist as part of the planning team, managers can help ensure that a gender perspective is integrated into all stages of the data production process [17].





## FIGURE 5: GENDER MAINSTREAMING IN MONITORING AND EVALUATION

- Conduct a SGBA at the beginning of new programs to better understand gender dynamics and how they might influence caregivers' potential to benefit from the program, and the demands of participating in the program.
- Target women when recruiting for M&E positions.
- Include indicators that monitor important gender-related inequalities and barriers that influence VAS coverage.
- Report sex-disaggregated data at all levels (community to national) and for multiple categories (coverage, caregivers seeking VAS services, health workers distributing VAS).
- Disaggregate data by sex as well as other characteristics to understand the intersecting inequalities faced by the most vulnerable groups.
- Employ mixed methods during M&E to understand gender-related barriers and underlying causes of gender-based health inequities and increase opportunities for women's participation.
- Incorporate sex-disaggregated data and data on gender dynamics into feedback loops and post-event review meetings.
- Collect data from mothers and fathers, as well as female and male health workers to ensure that the voices of diverse men and women from multiple levels (community to national) and sectors (healthcare workers, clients, etc.) are heard.
- Ensure that data collection methods do not support gender bias (e.g. in some communities, women may not be comfortable sharing their views in mixed-gender groups; separate men and women during focus groups to allow all voices to be heard).

## AT A CROSSROADS: OPPORTUNITY FOR GENDER MAINSTREAMING IN VAS PROGRAMS

Recent reports have argued that VAS is at a crossroads as traditional campaigns give way to integration with routine services [18]. Door-to-door campaigns can achieve high coverage by reducing barriers to accessing VAS, but as VAS programs shift to facility-based campaigns and routine services, the burden placed on caregivers and health workers changes, and coverage tends to drop. While this transition is challenging, it presents an exciting opportunity for countries to design programs that are sensitive to gender norms, roles and relations. By considering gender dynamics during all stages of programming—program planning, training, awareness-raising, service delivery and M&E—program managers can design VAS programs that reduce the gender-related barriers that impede positive health outcomes for children.

Gender equity is a cross-cutting issue that is relevant to how health systems function and how programs are designed. For VAS programming, the issue of gender equity extends far beyond sex-disaggregation of coverage. By addressing the causes of gender-based health inequities and including strategies to respond to unequal gender norms, VAS programs can potentially increase coverage of the life-saving intervention while promoting gender equality.





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## ADDITIONAL RESOURCES

### **Gender equity in VAS programs:**

Nordhagen S, Bauck A, Dolodec D. Gender equity and vitamin A supplementation: moving beyond equal coverage. *Food Nutr Bull* 2019;17:379572119860310. doi: 10.1177/0379572119860310. [Epub ahead of print].

### **Gender equity in immunization programs:**

Feletto M, Sharkey A, Rowley E, Gurley N, Sinha A. *A gender lens to advance equity in immunization*. Equity Reference Group for Immunisation; 2018.

### **Integrating gender data into child health programming:**

UNICEF, “Every child counts: Using gender data to drive results for children,” UNICEF, New York, 2020.

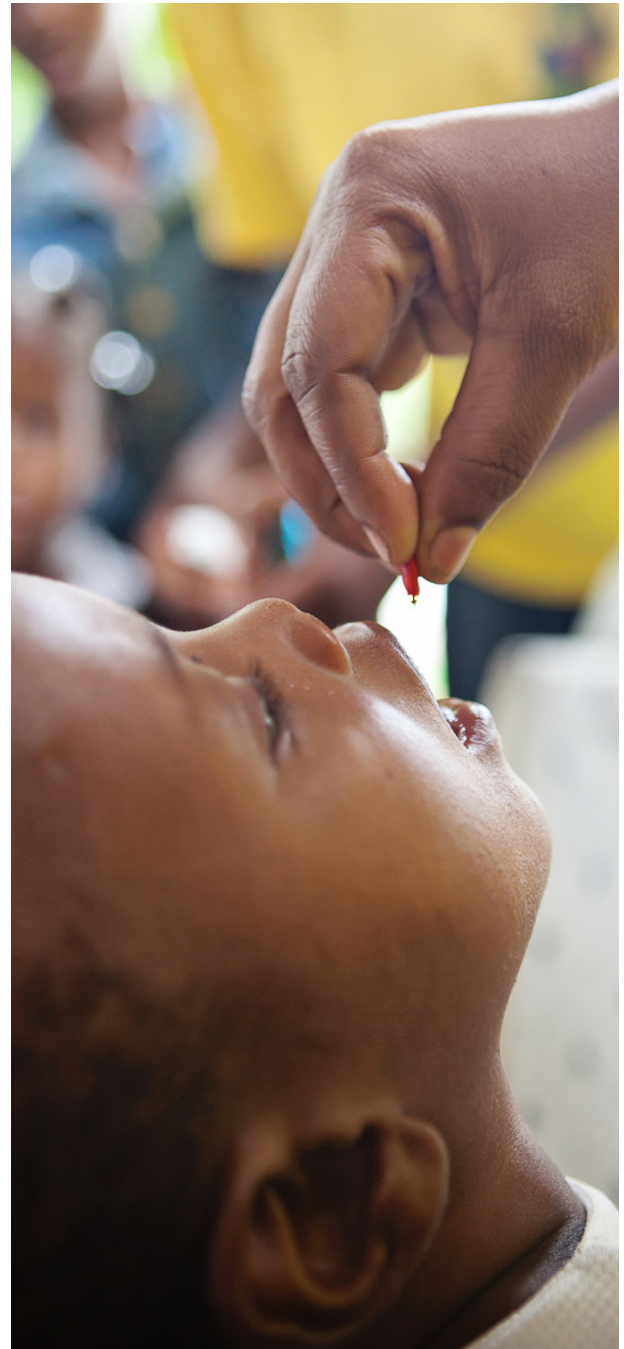
### **Considering gender equity in neglected tropical disease programs:**

Theobald S, MacPherson EE, Dean L, et al. Twenty years of gender mainstreaming in health: lessons and reflections for the neglected tropical diseases community. *BMJ Glob Health*. 2017;2(4):e000512. doi:10.1136/bmjgh-2017-000512.

### **Conducting a gender analysis:**

<https://gender.jhpiego.org/analysistoolkit/gender-analysis/>

Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do)...gender analysis in health systems research. *Health Policy Plan*. 2016;31(8):1069-78. doi: 10.1093/heapol/czw037.





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