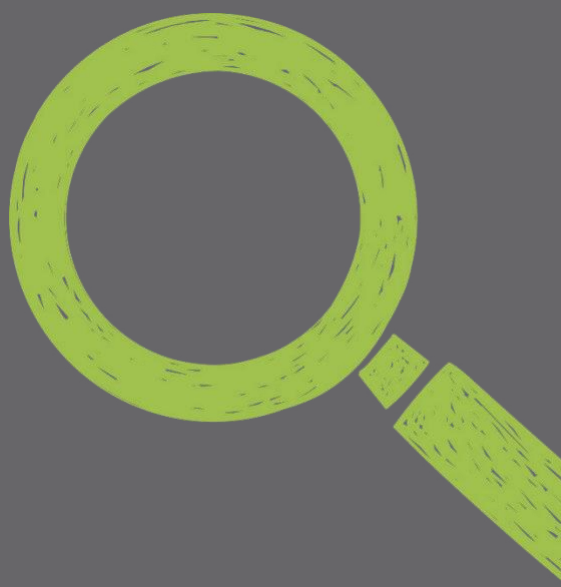
ARIA-RISE and AETAP-PPI

Gender, Disability and Social Inclusion Analysis Report

January 2023



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L4D would also like to acknowledge the traditional custodians of the lands on which this knowledge was shared and pay our respects to elders past and present.

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1	19/10/22	NCIRS	For initial review
2	16/11/22	NCIRS	With revisions.
3	02/12/22	Partners and DFAT	For review and comments.
4	13/01/23	DFAT and NCIRS	Amended to incorporate DFAT feedback.

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ACRONYMS

AETAP-PPI	Australian Expert Technical Assistance Program for Regional COVID-19 Access: Policy, Planning and Implementation
ARIA	Australian Regional Immunisation Alliance
ARIA-RISE	Australian Regional Immunisation Alliance - Regional Immunisation Support and Engagement
BeSD	Behavioural and Social Drivers
DFAT	Australian Government Department of Foreign Affairs and Trade
DFAT HSI	Health Security Initiative, Australian Government Department of Foreign Affairs and Trade
EOPOs	End of program outcomes
FGDs	Focus group discussions
GAVI	Gavi, the Vaccine Alliance
GEDSI	Gender, disability and social inclusion
IA2030	Immunization Agenda 2030
MEL	Monitoring, evaluation and learning
NCIRS	National Centre for Immunisation Research and Surveillance
OPD	Organisation of persons/people with disabilities
PICs	Pacific Island Countries
SDGs	Sustainable Development Goals
VAHSI	Vaccine Access and Health Security Initiative
WG-SS	The Washington Group Short Set on Functioning
WHO	World Health Organization
WPRO	World Health Organization Regional Office for the Western Pacific

EXECUTIVE SUMMARY

This Gender, Disability, and Social Inclusion (GEDSI) Analysis Report was commissioned by the Australian Regional Immunisation Alliance (ARIA) Secretariat, based at the National Centre for Immunisation Research and Surveillance (NCIRS). The Report is an important step in supporting implementing partners in the ARIA network to meet good GEDSI practice across their programming in two Australian Government Department of Foreign Affairs and Trade (DFAT) investments: the Australian Expert Technical Assistance Program for Regional COVID-19 Vaccine Access: Policy, Planning, and Implementation (AETAP-PPI) and ARIA–Regional Immunisation Support and Engagement (ARIA-RISE)

The ARIA-RISE and AETAP-PPI programs were designed to contribute to more equitable health outcomes in the Pacific and Southeast Asia. Reflecting DFAT's strong commitment to GEDSI, AETAP-PPI and ARIA-RISE end-of-program outcomes explicitly reference gender, disability, vulnerable groups, underserved populations and inclusion.[1] This provides a sound basis for project design and implementation that is GEDSI responsive.

Project document review and focus groups undertaken for this Report affirm that ARIA-RISE programs and partners are contributing to more equitable health outcomes in the Pacific and Southeast Asia, including in health systems resource development (ARIA 1, 2, 3, 8 and 11), improving vaccination coverage for children (ARIA 9, 10 and 12), contributing to local capacity-building (ARIA 4, 5 and 6), and engaging people with disabilities (ARIA 4 and 7). Overall, a key strength of ARIA-RISE projects is that they seek to build local capacity for evidence-generating research and activities, and support partner countries to generate their own evidence and data to inform local public health policies and introduce new vaccines.

There is substantial variability, however, in how successfully GEDSI is approached across ARIA-RISE and AETAP-PPI programs. This is primarily because the stakeholders involved in the network have different levels of familiarity and experience with GEDSI approaches to health research and health programming, as well as DFAT funding requirements. As outlined in the Diversity, Equity and Inclusion Action Plan that accompanies this report, the Secretariat and Steering Committees will need to play a greater role in supporting funding partners to ensure that all programs are meeting minimum standards and good practice in GEDSI and safeguarding (Child Protection and Preventing Sexual Exploitation, Abuse and Harassment) in both activity design, implementation and reporting.

[1] AETAP-PPI EOPO2: Citizens, including women and other vulnerable groups, in partner countries have increased confidence and demand for vaccines and EOPO3: AETAP-PPI support to COVID-19 vaccination programs is valued by the region. ARIA-RISE EOPO1: Improved information systems and immunisation data for tracking and addressing coverage gaps with a focus on gender, disability and inclusion and EOPO3: Tailored immunisation program guidance adopted into policy and practice ensuring reach to vulnerable and underserved populations. More information on DFAT GEDSI program design requirements can be found at: https://www.dfat.gov.au/about-us/publications/gender-equality-in-investment-design-good-practice-note

1. INTRODUCTION

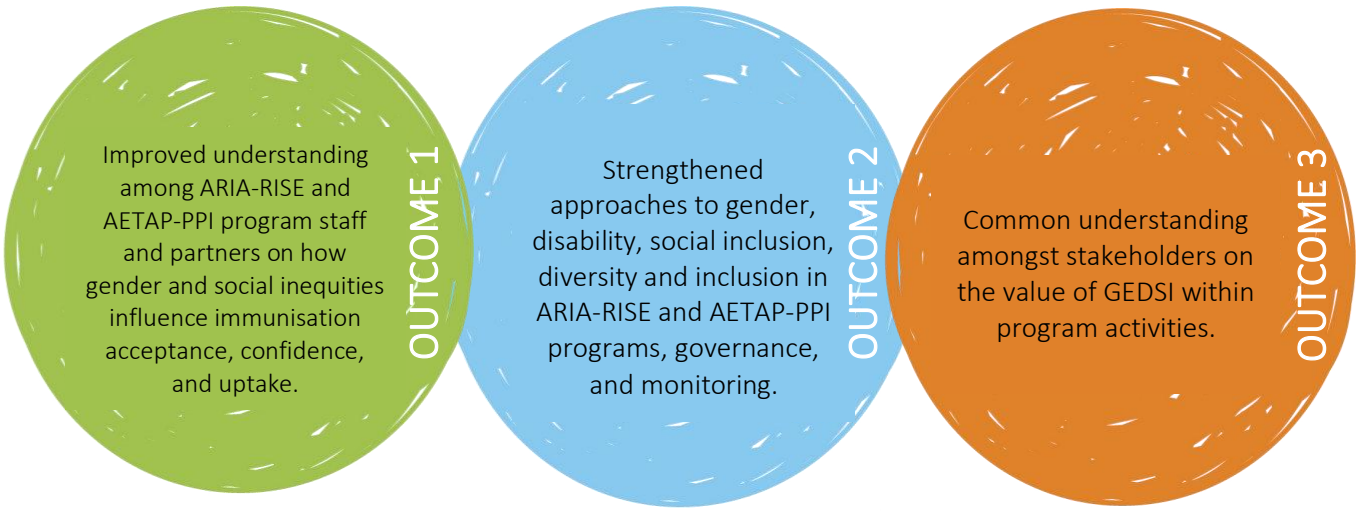
Immunisation rates are affected by the interplay between age, disability, culture, ethnicity, gender, linguistics, nationality, physically isolation and socioeconomic status.[2] Where these characteristics intersect, vulnerability and exclusion can be exacerbated, e.g., rural women with disability. Marginalised and/or hard-to-reach individuals may be overlooked in immunisation campaigns and activities, reducing the overall impact and effectiveness of vaccination initiatives and interventions.

The Australian Expert Technical Assistance Program for Regional COVID-19 Vaccine Access: Policy, Planning, and Implementation (AETAP-PPI) and ARIA–Regional Immunisation Support and Engagement (ARIA-RISE) investments from DFAT have a critical role in building and maintaining trust and confidence in immunisation; encouraging health communication that promotes community confidence in immunisation; and supporting behavioural and social interventions to help communities actively demand immunisation. Both programs aim to prioritise and mainstream GEDSI into these activities, build capacity and contribute to positive immunisation outcomes. To effectively nurture an inclusive and enabling environment within the AETAP-PPI and ARIA-RISE programs, two key activities were commissioned by the ARIA & AETAP-PPI Secretariat, based at NCIRS ('the Secretariat'):

1) Conduct a GEDSI analysis of ARIA-RISE and AETAP-PPI programs and current projects.
2) In consultation with ARIA-RISE partners, develop a Diversity and Inclusion Action Plan to inform future delivery of immunisation support and engagement as part of broader CHS projects.

1.1 Parameters of this report

The GEDSI analysis of the AETAP-PPI and ARIA-RISE programs and projects was commissioned to provide the following three mutually reinforcing outcomes:



The GEDSI Analysis and the Diversity, Equity and Inclusion (DEI) Action Plan reflect DFAT's broader strategy to advance gender equality, women's empowerment, and disability and social inclusion and are in line with Australian Government values, strategies, and commitments.

[2] Vaccine Access and Health Security Initiative Gender Equality, Disability and Social Inclusion Strategy, p. 1

The GEDSI Analysis and the DEI Plan are designed to support the ARIA-RISE and AETAP-PPI Secretariat (referred to below as the 'Secretariat'), currently based at NCIRS, to support AETAP-PPI and ARIA-RISE partners to promote GEDSI efforts across all their engagements and meet end-of-program outcomes (EOPOs), particularly:

AETAP-PPI EOPOs

EOPO2: Citizens, including women and other vulnerable groups, in partner countries have increased confidence and demand for vaccines.
EOPO3: AETAP-PPI support to COVID-19 vaccination programs is valued by the region.

ARIA-RISE EOPOs

EOPO1: Improved information systems and immunisation data for tracking and addressing coverage gaps with a focus on gender, disability and inclusion.
EOPO3: Tailored immunisation program guidance adopted into policy and practice ensuring reach to vulnerable and underserved populations.

The DEI Plan will support partner teams to report on GEDSI, in alignment with the AETAP-PPI and revised ARIA-RISE Monitoring, Evaluation and Learning Framework,[3] which asks implementing partners to:

- Outline how the project has supported and promoted equity, accessibility and participation in vaccine programs. Where relevant, how the project has identified and addressed barriers to vaccine information and services and promoted the safety for target populations. Include evidence and references to how gender equality has been promoted and where people with disabilities and other target populations have been actively included in vaccine roll-out; and
- Outline the challenges and risks to achieving equity and inclusion in vaccine programs, and how they will be addressed.

An enhanced focus on GEDSI will enable AETAP-PPI and ARIA-RISE projects to create spaces for new conversations with implementing partners and target communities about GEDSI practice, and set project expectations upfront to drive more inclusive outcomes. This enhanced GEDSI focus will also provide opportunities for developing stronger relationships with in-country partners in line with Australia's Partnerships for Recovery policy, which promotes strengthened partnerships in the region, and DFAT's forthcoming Development Policy and the Disability Inclusion Strategy, in which we expect gender equality, disability inclusion and First Nations to be strongly embedded. Improving GEDSI performance by ARIA-RISE and AETAP-PPI will also enable the programs to meet DFAT's commitments that:

- 80 percent of development investments effectively address gender equality in implementation; and

[3] Following discussions between DFAT and the ARIA-RISE Secretariat, the MELF will be further revised and updated during the next reporting period to refine some of the outcome indicators.

- New ODA investments over $3 million have a gender equality objective as their End of Program Outcome or Intermediate Outcome.[4]

1.2 Methodology

The Secretariat developed the terms of reference for the GEDSI Analysis. The methodology was developed in collaboration with the Secretariat and presented to DFAT, NCIRS and ARIA project partners during the ARIA-RISE Symposium on July 8, 2022. The GEDSI Analysis was conducted from July – early September 2022, after an initial meeting with Professor Kristine Macartney, Director of NCIRS on July 11, 2022.

This report's methodology included:

- a literature review of the barriers to immunisation in Pacific and Southeast Asian countries included in sampled ARIA-RISE Projects and AETAP-PPI deployments (Cook Islands, Fiji, Nauru, Niue, Papua New Guinea, Samoa, Solomon Islands, Timor-Leste, Tonga, Tuvalu, and Vanuatu); and
- semi-structured interviews and focus group discussions with AETAP-PPI and ARIA-RISE partner representatives.

The full list of interviewees and focus group participants is included in Annex A, and the abridged methodology is in Annex B. An overview of the AETAP-PPI and ARIA-RISE programs is summarised in Annex C, and the list of materials reviewed is provided in Annex D.

1.3 Limitations

Table 1: Review limitations and mitigation strategies

Category	Limitation description	How these limitations were mitigated
Data limitations	Quality of GEDSI data and reporting by AETAP-PPI and ARIA-RISE programs was poor. Different documents were available for each program, making systematic analysis and comparisons challenging.	Limitations of evidence is clearly communicated where relevant in this report. NCIRS Program Manager provided continuous support to ensure review team had access to relevant documentation.
Number of stakeholders	The nature of the ARIA-RISE and AETAP-PPI programs means that over a dozen primary stakeholders were included in document collection, focus groups and interviews.	

The project partners interviewed for this GEDSI analysis fell into two groups - those with projects currently being implemented or recently completed, and those with projects not yet implemented or in the early stages of implementation. Some of the representatives from the latter category felt that it was too early to share any learnings with the review team, but still had contributions in terms of their project planning. Regardless of the different stages of project implementation, the focus group discussions provided an

[4] See Gender Equality in Investment Design: Good Practice Note for further information.

opportunity to deepen understandings of inclusion and reflections on marginalisation, disability, and social norms in different country contexts, to achieve greater project impact and social benefit.

1.4 Partners and Policy Context

In May 2020, DFAT launched Partnerships for Recovery to guide Australia's development response to COVID-19. The strategy seeks to ensure Australia is at the forefront of responses to COVID-19 in Australia's region, focusing on four investment priorities: health security, stability, and economic recovery, and is underpinned by a commitment to upholding the rights of those who experience greatest vulnerability, including women and girls, people with disabilities, and those living in poverty. A sustained focus on gender equality and disability-inclusive development directly contributes to DFAT's commitments under Partnerships for Recovery in the Pacific and Southeast Asia and contributes to the achievement of the health goals set out in partner countries' strategies and plans on health and those related to GEDSI .

This GEDSI Analysis has been developed with reference to the following policy and guidance documents:

- Immunization Agenda 2030 (IA2030): a global strategy to leave no one behind (2021)
- Why Gender Matters: Immunization Agenda 2030 (2021)
- Implementing the Immunization Agenda 2030 (2021)
- Partnerships for Recovery: Australia's COVID-19 Development Response (2020)[5]
- Disability-Inclusion in the DFAT Aid Program: Good Practice Note (2021)
- Development for All 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program (extended to 2021)
- Gender Equality and Women's Empowerment Strategy (2016)
- Vaccine Access and Health Security Initiative (VAHSI) Gender Equality, Disability and Social Inclusion Strategy
- Health Security Initiative Gender Guidance Note (DFAT)
- Health Security Initiative Disability Guidance Note (DFAT)
- Gender Equality in Investment Design Good Practice Note (DFAT)
- Gender Equality in Monitoring and Evaluation Good Practice Note (DFAT)
- Reaching Indigenous People in the Australian Aid Program Guidance Note (DFAT)
- Health Security Initiative for the Indo-Pacific Region: Provisional Strategic Framework 2019-2022

The following regional and national policies and plans have also informed this GEDSI Analysis Report:

- Pacific Platform for Action on Gender Equality and Women's Human Rights 2018-2030
- Pacific Framework for the Rights of Persons with Disabilities 2016-2025
- Papua New Guinea National Health Plan 2021-2030: "leaving no one behind is everybody's business"
- Papua New Guinea National Policy on Disability 2015-2025
- National Gender Equality Plan for Solomon Islands 2020-2022
- Timor-Leste National Health Sector Strategic Plan 2011-2030

Together, these policies and the guidelines below provide the framework and principles for addressing GEDSI in this Report.

[5] Partnerships for Recovery will be superseded by DFAT's forthcoming International Development Policy.

Indo-Pacific Centre for Health Security

The Indo-Pacific Centre for Health Security was established in 2017 to lead implementation of the Australian Government's Health Security Initiative for the Indo-Pacific region. The Centre is part of the Global Health Division in the Department of Foreign Affairs and Trade. It contributes to the avoidance and containment of infectious disease threats with the potential to cause social and economic harms on a national, regional or global scale.

As outlined above, DFAT's organisational GEDSI policies, including the Gender Equality and Women's Empowerment Strategy (2016), the Development for All Strategy (2015), and Partnerships for Recovery (2020), provide a strong institutional grounding for GEDSI in DFAT's development work. In 2023, we anticipate this focus will be strongly embedded in DFAT's forthcoming Development Policy and in its Disability Inclusive Development Strategy. In addition, the Health Security Initiative (HSI) for the Indo-Pacific Region Provisional Strategic Framework 2019-22 highlights gender as a cross-cutting theme for selecting, implementing, and evaluating investments under HSI.

HSI has developed resources for partners to apply an institutional approach to GEDSI, which should be a key resource for AETAP-PPI and ARIA-RISE partners moving forward. The Centre for Indo-Pacific Health Security also maintains an online Monitoring, Evaluation and Learning Resources Hub, which also has potential for greater access and engagement by the Secretariat and implementing partners. The Hub includes a Health Security Initiative Disability Guidance Note and a Health Security Initiative Gender Guidance Note, both of which provide highly relevant guidance for ARIA-RISE projects. The Hub also includes templates for program reporting, which could be leveraged to strengthen ARIA-RISE GEDSI reporting, and a Health Security Initiative Partner Risk and Safeguards Tool, which would also serve as a useful resource for implementing ARIA-RISE and AETAP-PPI partners.

Vaccine Access and Health Security Initiative Gender, Disability and Social Inclusion Strategy

AETAP-PPI is an investment under the Vaccine Access and Health Security Initiative (VAHSI). The VAHSI GEDSI Strategy commits to working with partners to implement contextual GEDSI approaches to enhance vaccine acceptance, confidence and uptake and to improve access to vaccine programs.[6] VAHSI's approach to GEDSI is underpinned by four pillars:

- Equity: we recognise that vaccine prioritisation processes and the delivery of vaccination programs need to consider and be responsive to the increased vulnerabilities, risks and needs that certain groups face on account of underlying socio-economic, geographic and biomedical factors. We recognise the need to monitor for situations of inequitable vaccine access and to use our advocacy and policy engagement efforts to ensure at-risk groups are not left behind.
- Rights: we recognise the importance of supporting partner governments to ensure vaccination services are safe and that programs take a 'do no harm' approach, safeguarding those at increased risk of violence, abuse and harassment. We recognise the need to ensure informed consent processes are accessible to all, vaccination acceptance is free of coercion, services do not discriminate against at-risk groups and privacy of information is protected.
- Accessibility: we recognise the importance of supporting partner governments to ensure vaccination programs are accessible to diverse groups, in particular those at increased risk of vulnerability and disadvantage. This acknowledges the need to address those barriers that limit equitable access to vaccination information and services.

[6] Vaccine Access and Health Security Initiative Gender Equality, Disability and Social Inclusion Strategy, p.2

- Participation: we recognise that community engagement and meaningful participation of a diverse range of stakeholders within COVID-19 vaccine-related programming and decision-making will enhance vaccine acceptance, confidence and access, contribute to and strengthen resilisnce, and support inclusive recovery.

ARIA-RISE and AETAP-PPI programs can contribute to four of the five VAHSI GEDSI Strategy focus areas: accessibility of vaccine delivery and communications, monitoring and reporting on vaccine access, community engagement, and workforce development.

Australian Regional Immunisation Alliance (ARIA)

Supported through the Indo-Pacific Centre for Health Security, ARIA is a consortium of immunisation and vaccine preventable disease experts from Australian universities and research institutes. It was first established in April 2019. with the support of National Centre for Immunisation Research and Surveillance (NCIRS). ARIA membership includes representation from the University of Sydney, the Murdoch Children's Research Institute and the University of Melbourne, the Burnet Institute, the Menzies School of Health Research of Curtin University, the Australian National University, Telethon Kids Institute and the Kirby Institute of the University of New South Wales.

ARIA is governed by a steering committee, which provides strategic leadership and is responsible for ensuring ARIA's guiding principles underpin its work and that ARIA achieves its goals. As a membership body, ARIA does not have its own policies and procedures. NCIRS advised that each ARIA member has its own policies and procedures relating to gender equality, disability and social inclusion, and safeguarding, although these were not reviewed in this GEDSI Analysis. Those partners who have previously partnered with DFAT, such as the Burnet Institute, expressed more familiarity with DFAT policy expectations.

Through a competitive tender process. ARIA was successful in securing funding for the ARIA-RISE project from the Indo-Pacific Centre for Health Security through its Pacific Infectious Disease Prevention (PIDP) Program.

National Centre for Immunisation Research and Surveillance (NCIRS)

The National Centre for Immunisation Research and Surveillance (NCIRS) is the leading immunisation research organisation in Australia. It provides independent expert advice on all aspects of vaccine preventable diseases, and other issues related to immunisation, to inform policy and planning for immunisation services in Australia.

NCIRS' 2019-2023 Strategic Plan has a clear focus on social inclusion, identifying domestically appropriate focus groups for disease prevention, including culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people, refugees, and older persons.[7] NCIRS aims to increase its reach to strengthen immunisation uptake by strengthening equity in immunisation in Australia and assisting in strengthening health security in the region through immunisation.

NCIRS' governance and infrastructure support is provided to NCIRS by Sydney Children's Hospitals Network NSW Health. This means that NCIRS is bound by the NSW Health Code of Conduct, Responding To Sexual Assault (Adult And Child) Policy, and Child Wellbeing and Child Protection Policy. NCIRS promotes gender equality in its internal corporate and human resource policies and practices, including through the NSW Health Workplace Gender Equality Action Plan.

NCIRS operates the Secretariat for ARIA and is the overall contract holder for the ARIA-RISE and AETAP-PPI programs. In addition to having a management and coordination role, NCIRS also participates in the

delivery of technical assistance. Interviews with the Secretariat, based at NCIRS, demonstrated capacity and interest in promoting GEDSI approaches to ARIA-RISE partners.

As a DFAT partner, NCIRS continues to develop its understanding of DFAT policy and requirements and align its policies to improve social inclusion and address discrimination. This report, when combined with the Diversity, Equity, and Inclusion (DEI) Action Plan, will provide the foundational framework for NCIRS to strengthen its approach to GEDSI at an institutional level, and programmatically.

2. AETAP-PPI AND ARIA-RISE STEERING COMMITTEES

AETAP-PPI and ARIA-RISE Steering Committees are advisory boards with members who are experts, authority figures, and senior stakeholders in global health and development. These committees have a significant influence in how AETAP-PPI and ARIA-RISE programs and projects are managed.

The steering committees are responsible for providing oversight to the direction, scope, budget, timeliness of projects, and methods used to achieve project outcomes. Discussion with steering committee members during the GEDSI Analysis acknowledged that while improved health outcomes underpin program design documents and end-of-program outcomes for ARIA-RISE and AETAP-PPI, the committees have not dedicated sufficient attention to gender, disability, or approaches to social inclusion. This is partly due to AETAP-PPI and ARIA-RISE proposal and appraisal templates not specifically addressing GEDSI considerations.

However, the extensive experience of AETAP-PPI and ARIA-RISE Steering Committee Members in global health and immunisation programming, advocacy and research provides an opportunity for steering committee members to become effective champions for GEDSI approaches at a program level. With overlapping responsibilities on global health committees, governance boards and research institutions, the AETAP-PPI and ARIA-RISE steering committee members are exceptionally well placed to facilitate knowledge exchange, collaboration, and peer-to-peer learning between Program partners and institutions, thereby promoting and strengthening GEDSI practice. For example, ARIA-RISE project leads, such as Professor Julie Leask, also contribute significantly to identifying social and behavioural drivers of vaccination through their contributions to WHO. Notably, members of the AETAP-PPI and ARIA-RISE steering committees and projects are also on the Collaboration of Social Science and Immunisation (COSSI) Committee. Integrating GEDSI into key project architecture, such as the project appraisal criteria and interim reporting tools, will assist the Steering Committee to elevate discussion and consideration of GEDSI issues.

3. GEDSI ISSUES RELATING TO IMMUNISATION

AETAP-PPI and ARIA-RISE projects and partnerships are supporting countries in the Pacific and Southeast Asia to achieve better health outcomes through technical and policy advice, developing norms and standards, and generating and sharing knowledge. As noted above, several AETAP-PPI and ARIA-RISE experts are members of peak global advisory groups to WHO and others on COVID-19 vaccines, and a number have expertise in social and behavioural elements of vaccine uptake and strategies to build vaccine confidence.

Applying an intersectionality focus to immunisation programs is useful for understanding how barriers on the basis of ethnicity, age, gender, sexual orientation, socioeconomic status, and disability compound and impact vaccine access and reduce take-up and access in different contexts. Public health scholars and

practitioners are increasingly using intersectionality to conceptualise and address disparities and social inequality in health.[8]

3.1 Barriers for Women and Girls

Gender-related norms and barriers operate at multiple levels, from the individual and the household to the community and health systems. Often, these norms and barriers are underpinned by inequitable power relations, and lead to different opportunities, limitations, challenges, needs and vulnerabilities, especially for women and girls, which affect their access to health information and vaccines. For instance, in some cultural contexts it is customary for women to visit female health workers, but if the only people trained to deliver certain vaccines for adults are male, then women may not be able to access those vaccines. Addressing gender-related barriers and the specific needs of girls and boys – and gender-diverse people - women and men in accessing health services and increasing women's meaningful participation in the design and delivery of health services will contribute to advancing gender equality and social inclusion.

3.2 Barriers for Children

Children in lower and middle-income countries often don't receive basic vaccines each year, which has been further exacerbated through the COVID-19 pandemic and associated disruptions. For example, in 2021, the number of completely unvaccinated children globally increased by 5 million since 2019 (WHO, July 2022); and the number of girls not vaccinated against human papillomavirus (HPV) increased by 3.5 million, compared to 2019. Childhood immunisation is hindered by multiple factors, such as parental fear and health system barriers, including distance to clinics and a lack of health care knowledge and awareness.

3.3 Barriers for People with Disabilites

People with disabilities face multiple barriers and unfair conditions which affect access to equitable health outcomes. The rates of disability are increasing globally due to ageing populations, an increase in chronic health conditions, and improved identification of disability. In the Western Pacific region, around 15.3% of people have a disabilitty (WHO Global report on health equity for persons with disabilities, 2022). Disability is not a gender-neutral experience. It impacts women, men, girls, boys and people of other gender identities differently. Women and girls with disabilities often face additional, severe disadvantage due to discriminatory social norms and perceptions of their value and capacity. Barriers to full social and economic inclusion of persons with disabilities include inaccessible physical environments and transportation, the unavailability of assistive devices and technologies, non-adapted means of communication, gaps in service delivery, and discriminatory prejudice and stigma in society and from healthcare providers. Additionally, people with disabilities experience barriers accessing health services and public health information and are often at a higher risk of acquiring infectious disease due to living arrangements, a lack of adequate or accessible water, sanitation (WASH) and hygiene infrastructure, lower access to vaccines, and challenges in infection prevention and control, including for those relying on personal assistance or sign language interpretation.[9]

Understanding how these barriers manifest in practice is essential for developing interventions that seek to in build and maintain trust and confidence in immunisation; encourage health communication that promotes community confidence in immunisation; and support behavioural and social approaches to help communities actively demand immunisation. The following list is a compilation of known barriers to

[8] See, for example, Heidari et al. (2021), *Time for action: towards an intersectional gender approach to COVID-19 vaccine development and deployment that leaves no one behind*

[9] Health Security Initiative Guidance Note: Supporting disability inclusion through DFAT health security investments, p.1

immunisation globally, supplemented by research generated within ARIA-RISE, as well as insights shared by ARIA-RISE partners based on experience.

Drivers of challenges and barriers to inclusive vaccine processes identified in the focus groups and interviews for the GEDSI Analysis include:

- Health Service Access: Distance to the nearest clinic, the clinic's opening hours, and the availability of vaccines at the local clinic are key factors that influence access to immunisation services. Door-to-door implementation is a strategy implemented by some governments to overcome this barrier. Poor access to health information – such as what vaccinations are recommended, safety information about vaccinations, and when they should be received, is also a barrier to immunisation.
- Health Care Capacity: Lack of healthcare workers, or healthcare workers who are not confident in taking gender sensitive, inclusive and accessible approaches in health clinics and facilities also compromises the availability of immunisation services.
- Geography and Seasonal Factors: A range of geographical and seasonal factors can impede access. For example, in some rural areas, families may not be able to reach health clinics during the rainy season due to rising rivers or poor road conditions. This may have particular impacts for women who often travel with young children. These barriers are also amplified for anyone already facing physical barriers that limit their mobility, e.g. wheelchair and mobility aid users, older persons, etc.
- Economic: Lack of available funds to cover the costs of travelling to clinics can also impact access, particularly for women who typically have less access to discretionary funds or economic decision making at the household level. Additionally, women may be reluctant to give up their market day or an income earning opportunity to go to the clinic.
- Gender Norms: Although it is highly contextual, women are generally less engaged in making health-care decisions because of limited household decision-making power and have greater difficulty reaching vaccination sites due to limited mobility and access to transport, particularly in remote regions. Workload, household, and care commitments for women can mean that visits to health clinics are not prioritised or supported by family members.
- Sexual-harassment and violence: Women and gender-diverse groups are also often at risk of experiencing sexual harassment and other forms of gender-based violence when travelling to health clinics.
- Beliefs: Distrust about the vaccine messages from community and scepticism about the vaccines and their side effects. Misinformation about vaccines and their impact in fertility or disability has direct impact on access by women and people with disabilities.
- Access to Information: Limited and uneven access to information about vaccines, their benefits and their risks can lead to low knowledge of the vaccine or distrust in the efficacy or need for the vaccine. For example, one ARIA-RISE partner shared their experience of communities asking why the cervical cancer vaccine is only for girls and not boys.
- Communication: Key messaging must be accessible to all and culturally sensitive. In the absence or delay of accurate information from good sources, misinformation can spread quickly. Ensuring that the materials are appropriate to the level of health literacy in communities is critical to promote vaccination.
- Misinformation and disinformation: Misinformation and disinformation about vaccines via social media, social networks and, in some cases, community leaders has led to vaccine hesitancy. In some cases, communities expressed fear that if they took their child to be vaccinated, the adult would receive the COVID-19 vaccination.
- Cultural Norms: There is some anecdotal evidence that males may be prioritised to receive immunisation.

Specific drivers of challenges and barriers for people living with disability identified in the focus groups and interviews for the GEDSI Analysis, include:

- Lower levels of representation of OPDs in community meetings and lower levels of representation in heath policy, planning and delivery, including health-related research.
- Accessibility for people with disabilities, including women and girls with disabilities, to health services.
- People with physical disabilities may have trouble taking children to immunisation clinics. Anecdotally, instances of people caring for people with complex health needs are concerned that a previous vaccine may have caused the disability impairment.
- A sense of shame or stigma for people with disabilities, especially around children, and parents often won't bring them to the clinic. Families of children often don't want to disclose this and will hide it if they can. People with disabilities also face attitudinal barriers from some healthcare workers and other community members.
- Communication channels to reach families with children with disabilities may not be known or used by health interventions

Insights for inclusive and participatory project implementation identified in the focus groups and interviews for the GEDSI Analysis include:

- Healthcare workers have deep knowledge of their communities and are able to provide contextual knowledge about social groups and marginalised people, in partnership with representative groups (including OPDs) and people from diverse and marginalised groups.
- The views of healthcare workers have a strong influence on attitudes towards vaccines
- The role of religious and community leaders in telling people to get vaccines is incredibly influential. Church groups often also provide influential support and encouragement for vaccine uptake.
- The importance of having local project managers and teams involved who can use their social connections and experience to communicate with target communities. Local project managers and project coordinators can also assist project teams to connect with Health Centres.
- Working closely with community leaders and the health municipality to share project information helps facilitate community participation.

These qualitative insights from interviews and focus group discussions highlight the value of close coordination with key partners, in conjunction with close collaboration with religious, family and community networks, particularly OPDs and other representative groups. In addition to contributing to sustainable and equitable impact, these networks can provide contextual advice on managing the design of inclusive immunisation programs and implementing social protection initiatives the Pacific and Southeast Asia.

4. AETAP-PPI APPROACH TO GEDSI

AETAP-PPI supports Pacific and Southeast Asian countries to plan, implement and monitor COVID-19 vaccination rollout programs. It provides remote and in-country technical assistance across five key thematic areas relevant to country COVID-19 vaccination programs, with a coordinated delivery approach that leverages existing ARIA member resources, capabilities, and engagement.

Based on the review of three in-country progress reports for the Solomon Islands deployment in March – September 2022, AETAP-PPI has largely supported the Ministry of Health and Medical Services (MHMS) with:

- Technical and management expertise for key immunisation program staff and groups/committees: including the implementation of training on AEFI (Adverse Events Following Immunisation) developed

by NCIRS, TGA and WHO; and contributing to a public media response for addressing misinformation about the COVID-19 vaccination circulating within the Solomon Islands medical establishment.
- Strengthening of planning, monitoring and supervision of vaccine rollouts in provinces, including assisting DFAT in the organisation of a school vaccination clinic for the rollout of paediatric vaccine doses donated by Australia.
- Highlighting to the Technical Working Group on Immunisation the need for rebooting human papillomavirus (HPV) vaccination, which currently has a coverage of less than 7% of the targeted adolescent girl population and integrating HPV with the COVID-19 vaccine rollout.
- Complementing assistance delivered through key partners and donors, such as DFAT, WHO, UNICEF and Gavi partners, to promote good coordination and efficient use of resources, including contributing to Gavi's Targeted Country Assistance (TCA) implementation plan.

It is important to note that these placements are demand driven, and as such there is less scope for AETAP-PPI partners to design the intervention. However, under the defined program objectives, there is scope for the AETAP-PPI to contribute to GEDSI outcomes through:

- Strengthening coordination and microplanning to generate demand and improve access. The AETAP-PPI deployee has recommended following up on the MHMS Health Promotion Unit offer of a behavioural and social drivers of vaccination (BeSD) advisor to assist in risk communication on the Expanded Programme on Immunization. This relationship could be leveraged to contribute to a deeper understanding of the cultural and social barriers and dynamics of immunisation access for targeting AETAP-PPI technical assistance. Similarly, deployee meetings held with the MHMS Director of Reproductive, Maternal and Child Health provide an opportunity to identify priority and targeted support for women and girls. The value of these relationships for strengthening GEDSI outcomes is already evidenced in the recommendation for rebooting the HPV vaccination programme.

- Strengthening digital heath data systems and supporting the collection, disaggregation, and dissemination of health reporting data. This could include supporting the MHMS Health Information Unit to effectively utilise tools such as the WHO digital health data toolkit for District Health Information Software (DHIS2). The AETAP-PPI deployee has initiated discussions with the MHMS Health Information Unit on EPI data issues and the Oslo University's help to upgrade DHIS2 to accommodate EPI modules.

AETAP-PPI project documents reviewed also include three in-country progress reports for Timor-Leste. The deployment period from May 2022-May 2023 involves technical advice to support the Ministry of Health (MoH) with:
- policy and planning
- program design and planning, including monitoring and evaluation
- monitoring immunisation coverage and disease outbreaks
- safety surveillance and response.

In addition to providing technical advice on vaccine delivery, AETAP-PPI's deployee in Timor-Leste has met with the USAID Health Systems Strengthening Activity staff who are working with MoH to improve data issues. The AETAP-PPI deployee provided valuable insights about inefficiencies with municipal health services that can assist the USAID Health Systems Strengthening Activity staff to identify more efficient processes. In terms of GEDSI contributions, there is potential to leverage existing AETAP-PPI partner relationships with the Ministry of Social Solidarity and Inclusion (MSSI) to support strengthening services for immunisation access and information at the municipal level, increasing community engagement and

linking civil society to decision makers to improve access to services. AETAP-PPI technical assistance is well placed to support the government of Timor-Leste in strengthening the social strategy, programmes and delivery systems in line with Timor-Leste's Disability National Action Plan (2021-2031).

The review of in-country progress reports highlights that AETAP-PPI partnerships have the potential to strengthen GEDSI outcomes through leveraging and supporting in-country partnerships, which can and should include:

- Encouraging incremental improvements to GEDSI mainstreaming by collaborating with Ministries of Health in a range of initiatives, including developing/revising training modules, guides, and vaccination management and surveillance protocols. The Secretariat could consider producing resources (one-pagers) on the DEI-related services and capacities available to partner countries under AETAP-PPI.
- Including a preparatory assistance budget for conducting situation analyses with partner country requests to identify under-represented groups and analyses of social roles, relations, norms and inequalities in relation to disability, gender, and other relevant dimensions of health inequity.

Areas for strengthening

While the AETAP-PPI considered disability inclusion in its initial design, activities under this project to date have not reflected specific details of disability inclusion approaches. As a first step, the AETAP-PPI technical assistance form (TA Request Form) should be revised to include a more specific GEDSI focus. This will also strengthen the quality of AETAP-PPI GEDSI reporting. The current AETAP-PPI TA Request Form requests details about how GEDSI principles are being addressed under 'Impact': Does the TA provide/encourage/support gender equality and social and disability inclusion principles? Apart from an overall assessment, none of the activities undertaken during the six-month reporting period (Jan-June 2022) detailed their specific consideration to GEDSI.

To align the program's implementation to the MELF and ensure a stronger GEDSI focus, the Secretariat acknowledges that future AETAP-PPI activities will need to incorporate tracking and reporting of GEDSI indicators on an ongoing basis (AETAP-PPI Annual Report Milestone 4, February 2022). Joint mid-term and/or end cycle reports should also be prepared with partner countries to assess progress against outcomes.

5. ARIA-RISE APPROACH TO GEDSI

The ARIA-RISE projects aspire to enable and promote opportunities for inclusive approaches to immunisation for women, men, girls, boys, and people with disability.

Summary

The analysis found that ARIA-RISE partners have differing levels of comfort, understanding and attention to terminology and principles relating to GEDSI. While all AETAP-PPI and ARIA-RISE projects seek to contribute to positive public health outcomes, there are differing levels of analysis among partners of the barriers that women, girls, men, boys, gender diverse people, people with disabilities and other groups may have in contributing to and benefiting from programs and projects. This translates in practice to some ARIA-RISE projects taking a generic approach to project design and implementation, and other projects having explicitly GEDSI-sensitive outcomes, such as the community-based intervention to improve immunisation coverage among children with disability in Fiji, which takes a very purposeful approach to ensuring inclusion,

equity, and balanced representation in its activities. Other examples of good practice are outlined in the following section.

Disability Inclusion

In general, there has not been an explicit disability inclusion lens applied to project design in AETAP-PPI and ARIA-RISE projects, with the exception of ARIA-RISE projects that focus on disability as the primary target population. There is an opportunity for AETAP-PPI and ARIA-RISE partners to actively work to improve access and participation in immunisation programs for people with disabilities by engaging with disability people's organisations during the design and implementation phases, determining coverage gaps and actively addressing gaps among target groups. While discussions indicated that this has happened on a couple of projects underway, there is significantly more opportunity for partners to engage with DPOs and design strategies that enable people with disability to participate directly in projects.

Anecdotal reports of inclusive practices more generally in project implementation involve the engagement of in-country project managers and project coordinators who utilise their social networks to access at-risk populations, communicate with local communities to get balanced representation in workshops, and help project teams connect with the district Municipalities and Health Centres. By working closely with community leaders and the health municipality, information and objectives are shared with the community, who are encouraged by trusted sources to participate in the project. This encourages social inclusion and GEDSI outcomes through bottom-up participatory processes. These strategies for enhancing meaningful participation and representation support the principle that consulting people on programming decisions is greatly enhanced through their representative organisations and directly.

Overall, the GEDSI Analysis found that ARIA-RISE is well placed to make meaningful contributions to GEDSI, supported by committed and experienced ARIA partners. In order to fully realise the program's ability to achieve equitable and inclusive outcomes, however, the following observations are made with respect to strengthening intentional approaches to gender equality, disability, and social inclusion in design and implementation:

- An explicit focus on GEDSI throughout the project management cycle would assist partners to more intentionally integrate good practice in project design, implementation, monitoring and learning. Like AETAP-PPI, this will require changes to the project adjudication process. It would also provide a mandate for partners to discuss GEDSI issues with overseas partner institutions and promote equal representation, access, and opportunities within local health systems.

- Projects would be further strengthened by partners conducting a disability and gender analysis to ensure that program designs take into account barriers to participation and access and integrate approaches that overcome these barriers and achieve inclusive outcomes.

- Projects would benefit from deeper investments in collecting and analysing data that is disaggregated by sex, age, and disability to understand the program's reach and impact.

- There is an opportunity to deepen partners' institutional approaches to gender equality, disability, and social inclusion, through building GEDSI skills and capacities of ARIA-RISE project staff at all levels. ARIA-RISE partners were selected for the strong technical expertise and experience they could bring to the program. In most cases, project staff who participated in FGDs were familiar with key GEDSI

concepts and able to identify examples of how their project had sought to advance GEDSI. However, many acknowledged that training, tools and guidance would support their attention to GEDSI.

- As suggested by ARIA-RISE project teams at interview and in focus groups, a GEDSI focal point for each ARIA-RISE activity would create a network of practitioners who could lead and participate in GEDSI trainings, connect their teams to the resources that already exist, share examples of practice from the field, and support each other to incorporate a GEDSI lens to every aspect of programming. They would need to be supported with appropriate resourcing.

- For longer projects, a project specific GEDSI Strategy overseen by the GEDSI focal point may be the most effective way of ensuring consistent and good practice application of GEDSI principles. GEDSI focal points could also provide inputs and/or oversight to GEDSI reporting to the Secretariat. The Diversity, Equity, and Inclusion Action Plan provides more information on this recommendation.

- ARIA-RISE programs could learn a lot about GEDSI from each other. Utilising and adapting GESDI responsive design and insights from completed ARIA-RISE projects that successfully facilitated social inclusion, safety, and/or equitable and meaningful participation of at-risk groups would help inform the future design of program activity. The key focus of ARIA learning exchanges should be best practices, lessons learned, and stories of successful and unsuccessful GEDSI approaches and implementation. These exchanges would seek to intentionally consider and draw on DFAT strategies and good practices. Partners with experience in gender equality, disability and social inclusion domains are well placed to share research and project approaches with other partners and collaborate to strengthen End of Program Outcomes. Approaches should be adaptive and iterative in response to monitoring, evaluation, and learning.

- There is opportunity for the Secretariat to review and revise the program architecture for AETAP-PPI and ARIA-RISE projects; specifically, the guidance material and project templates (proposal, appraisal, reporting and monitoring and evaluation templates), and project learning mechanisms.

The DEI Plan responds to these observations with practical recommendations. To mainstream GEDSI into already funded projects (at possible entry points), there is a need to strengthen a common understanding amongst partners on the value of GEDSI within program activities and address challenges for projects and partnerships in achieving the cross-cutting priorities and end-of-program outcomes. Partners could be provided with the opportunity to opt into a GEDSI self-assessment process. Partners undertaking the self-assessment process should be provided with support for retrofitting, strengthening, or expanding their GEDSI approaches in future programs to meet minimum standards and good practice. In addition, ARIA-RISE partners should be encouraged to consider reallocations of forecasted underspends to strengthen their GEDSI approaches (within project scope), including by engaging external GEDSI Advisers. Partners should also be encouraged to identify and improve their GEDSI practice and resourcing prior to any new ARIA contracting periods or extensions, where relevant and feasible, so that all future projects meet minimum standards and good practice.

5.1 Successes so far

ARIA-RISE has developed a portfolio of projects that have strong pathways to equity and inclusion. Project document review and focus groups highlighted the many different ways that ARIA-RISE programs are making GEDSI contributions, including in health systems resource development (ARIA 1, 2, 3, 8 and 11),

improving vaccination coverage for children (ARIA 9, 10 and 12), contributing to local capacity-building (ARIA 4, 5 and 6), and engaging people with disabilities (ARIA 4 and 7).

Examples of the ways in which projects have sought to address equity and inclusion are highlighted below:

Community-based intervention to improve immunisation coverage among children with disability in Fiji, is generating evidence to promote the uptake of vaccine preventable diseases, with a key focus on children with disabilities. This has potential to make a strong contribution to Fiji as there is currently so little data on the accessibility of immunisation among children with disability in Fiji. One key challenge for people with disability in the Western Pacific is accessing quality primary health care services, compounded by the additional accessibility barriers to access existing services.

The COSSI Vaccine Champions and vaccine communication program: building confidence in the Western Pacific region, which focuses on local capacity building and was adapted to the local context through co-design and community engagement approaches. The project intentionally engaged a wide range of community stakeholders in the early stages of the project, including women's leaders, women's groups, a local disabled people's organisation, and local organisations. The Vaccine Champions program supports opportunities for women, girls, and marginalised groups to be in leadership or representative roles. It also engages male leaders, who are key stakeholders in influencing community sentiment towards vaccination.

The Rapid Formative Assessment and the EPI Mid-Level Management Education Training Program projects established all-female working groups. The Rapid Formative Assessments in Cook Islands, Nauru, Niue, Samoa, Tonga, Tuvalu, and Vanuatu (now complete) improved project staff and partners' understanding of how gender and social inequalities influence immunisation acceptance, confidence, and uptake. Through an inclusive sampling process, which incorporated the WHO behavioural and social drivers (BeSD) tools, the survey found that mothers are the predominant decision-makers for childhood vaccination, leading to a recommendation to work with mothers to develop communications strategies. This approach's impact, the collection of disaggregated data on sex and disability, and country-specific gender-sensitive immunisation uptake results are expected to continue to inform and improve future vaccine delivery in partner countries. Similarly, the Immunisation Refresher Training Program Development and Delivery for Pacific Island Countries seeks to ensure that public health information and communications produced by ARIA-RISE projects are in formats that are accessible to all.

The Regional Guidelines for Measles and Rubella Outbreak Preparedness and Response in the Western Pacific promotes equity, accessibility, and inclusion through its development and content. The project working group collaborated on a co-design model with experts from the region, including women, to ensure peer mentoring and capacity development. The guidelines address management and preparedness of outbreaks in special risk groups. The development of the guidelines incorporated a peer review process with select ARIA members and the WHO Pacific Regional Office (WPRO). An external consultant reviewed the module on community and community engagement, which specifically addresses gender equity, disability, accessing hard to reach groups, and effective communication strategies. The guidelines also include management and preparedness of outbreaks in special risk groups.

Overall, a key strength of ARIA-RISE projects from an equity and inclusion perspective is that they consistently seek to build local capacity for evidence-generating research and activities (such as the sero-surveillance projects), and support partner countries to generate their own evidence and data to inform local public health policies and introduce new vaccines. Capacity building is an ongoing outcome of the ARIA-

RISE Program. For example, the Immunisation Refresher Training Program Development and Delivery project will continue to strengthen the capacity of immunisation managers; the Vaccine Champions and Vaccine Communication program is building the skills and confidence gained by participants and will support them to have conversations with impact for other recommended vaccine initiatives in the future; and the data from Rapid formative assessment survey including sex and disability disaggregated data can be used by partner countries, where feasible, to inform and improve vaccine service delivery. The community-based intervention to improve immunisation coverage among children with disability in Fiji can guide the development/adaptation of similar programs in other Pacific Island countries; and the vaccination behavioural insights research will inform tailored resources and strategies to improve immunisation uptake.

Interviews and discussions undertaken during the GEDSI analysis also revealed that some of the project teams are actively collaborating with a range of stakeholders to draw on the lived knowledge, experience and trust-relationships of community and civil society groups for inclusive and effective vaccine research, education, training, and deployment. Many projects link with national, regional, and local networks and influence others to fulfil their roles and responsibilities. Comments from focus group discussions and interviews emphasise the value of local and regional networks in programs taking inclusive approaches and understanding and reaching local communities:

- It is important to have local project managers involved who can use their social connections and ability to communicate with local communities to get the right people involved in workshops.
- Engage project managers and project coordinators who know the layout and can help project teams to connect with the district municipalities and Health Centres. We can then engage with local village leaders and hold discussions prior to arriving, so they are aware that the teams are coming.
- We utilise existing models such as familiar or primary care programs involving doctors, nurses, midwives and public health themes that cover the municipality and rural hamlets and involve health consultation. Engage the right leaders, local communities, villagers, and everybody comes and that's how we were able to collect as many samples as we did.
- We work closely with community leaders and the health municipality – we first talk to the municipal president and administrator, and they share the project information (communicated in clear terms) and encourage the community to participate in our study.
- Most healthcare work is done by nurses with the help of extension officers, who predominantly tend to be women. The local nurses, healthcare workers etc, are incredibly good at knowing their communities and that is the kind of knowledge that we rely on.

These learnings reflect strong experience and expertise among existing project partners and provide a sound basis for further extending GEDSI practice, particularly through engaging with more people with lived experience of exclusion and marginalisation.

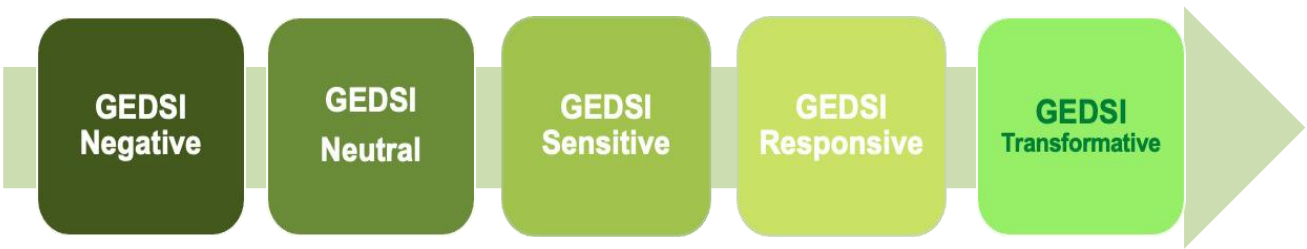
5.2 Review of GEDSI Practice

ARIA-RISE and AETAP-PPI's approach to GEDSI was reviewed using Learning4Development's GEDSI domains of practice – a framework that allows cross-cutting and program-specific analysis. Our analysis is structured against seven key domains, shown below in the GEDSI Domains of Practice Framework (Figure 1). Some domains are more relevant (and possible) in some programs than others.

Learning4Development GEDSI Domains of Practice (Thomson and Lucas, 2019)

Once GEDSI has been integrated more intentionally into all ARIA-RISE programming, each domain can be assessed and tracked along the GEDSI spectrum.

GEDSI Spectrum



5.2.1 Institutional policies and practices

This domain recognises that laws, policies, institutional practices, and processes can inadvertently discriminate against disadvantaged or marginalised groups. This is highly relevant to working with partner governments, who may not always consider and address inequalities related to gender, disability, and marginalisation in immunisation planning and implementation.

In the context of AETAP-PPI and ARIA-RISE, program partners can support partner governments to deliver health policies and strategies that consider barriers and inequalities experienced by different genders, people with disability, and marginalised people. Lack of policies, strategies and data on gender and disability inclusiveness is often compounded by lack of training on gender and disability issues, and by attitudes, awareness, and norms. An example of how this has been addressed under ARIA-RISE includes the seroprevalence surveys in PNG and Solomon Islands (ARIA 6), which seek to increase the capacity of local health systems and improve country-specific data on population immunity. Through supporting a range of

countries to collect data, ARIA-RISE is supporting local institutions to be in a position to design and implement of a range of vaccination campaigns that target susceptible and underserved populations.

To meet good practice standards, AETAP-PPI and ARIA-RISE implementing partners and programs should support institutional policies and practices that prioritise GEDSI, including by:

- Working with partner governments to build awareness of, and commitment to, principles of gender equality, disability, and social inclusion throughout immunisation programs and projects.
- Supporting partner governments in the implementation of associated GEDSI commitments as they relate to health (such as UN human rights treaties, Sustainable Development Goals, and universal health coverage priorities)
- Aligning with other DFAT health investments to support partner governments to collect appropriate information, including statistical and research data, to formulate and implement inclusive programs and services.
- Supporting partner institutions to disaggregate health data by sex, age, and disability, and determine the implications, impacts, and opportunities for women, girls, and persons with disabilities.
- Encouraging partner government health services to improve access to inclusive feedback mechanisms between communities and local health centres/workers to identify and address barriers to equitable access to health services and immunisation programs.

5.2.3 Access to information, resources and services

This domain considers the barriers to equitable access to information, education, services and resources. In the context of immunisation, limited and uneven access to information about vaccines, their benefits and their risks can lead to low knowledge of the vaccine or distrust in the efficacy or need for the vaccine. Similarly, in the absence or delay of accurate information from good sources, misinformation can spread quickly. In addition, there are multiple barriers to accessing immunisation services, which are compounded by intersecting factors including gender, age, disability, ethnicity, location, stigma, and poverty. People living with disability often face a range of barriers including both attitudinal and infrastructure barriers that make getting to and around health facilities inaccessible.

A number of ARIA-RISE projects are aimed at increasing access to immunisation through equipping local health systems with data about populations with low vaccine coverage rates. Projects contributing to reaching underserved communities most at-risk of vaccine preventable outbreaks include ARIA-RISE projects that have undertaken sero-prevalence studies in partnership with local health ministries. These studies seek to identify populations with particularly low vaccine coverage rates, which will in turn support activities to strengthen national vaccine infrastructure and may lead to supplementary immunisation activities which are targeted to specific demographic groups. These are important initiatives from a social inclusion perspective and provide partners with the opportunity to make significant contributions to disaggregated sex and disability data, while encouraging incremental improvements in GEDSI mainstreaming. These projects include:

The sero-surveillance for Vaccine Preventable Diseases in East New Britain, PNG (ARIA 8) seeks to contribute to reaching zero-dose children and under-immunised communities. By identifying populations with particularly low vaccine coverage rates, the project promotes highly targeted and effective interventions and, more broadly, critical surveillance data for vaccine preventable diseases. The project is also working to embed the Washington Group questions to support data disaggregation by disability.

The seroprevalence of SARS-CoV-2 and select vaccine-preventable diseases in Timor-Leste (ARIA 2) supports a National Survey to provide epidemiological information which is representative of the whole population in Timor-Leste, which will, in turn, support activities to strengthen the national vaccine infrastructure and may lead to supplementary immunisation activities which are targeted to specific demographic groups.

The seroprevalence survey in Timor-Leste (ARIA 5) is partnering with and training local researchers in epidemiology, survey design, and other diagnostic and management skills. The project will investigate a novel method for performing serological surveillance of dengue (using RDTs), which has the potential to increase the reach of serological surveillance into remote areas.

Following technical support from DFAT, the seroprevalence project in Fiji (ARIA 9) involves engagement with a representative from an organisation of persons of disabilities and service provider, and is developing a community-based program to improve immunisation coverage for higher risk groups of children with disability with the potential that this may be able to be adapted and used in other Pacific Island countries.

To meet good practice, AETAP-PPI and ARIA-RISE partners and programs should promote equitable access to information, resources and service by:

- Routinely collecting disaggregated data to know whether women, girls, and people with disabilities (including women and girls with disabilities) are accessing information and services (a minimum standard for projects funded by DFAT).[10]
- Including people with disabilities as members of research teams
- Supporting the collection and analysis of feedback from women and girls, and people with disabilities as service users.
- Encouraging locally driven approaches which engage representative organisations to increase access to quality and integrated essential services by women and girls, people with disabilities, and marginalised populations.

5.2.4 Skills and capacities

This domain is about strengthening skills and capacities to enable women and girls and people with disabilities to participate equitably, fulfil their potential, and influence others. While this domain is often considered in the context of the skills and capacities of local community members, it also encompasses community leader and representatives, business leaders and employees.

Upskilling local health workers is especially relevant to effective immunisation, which was the main objective of the Immunisation Refresher Training Program Development and Delivery project (ARIA 4). This project builds local capacity through targeting mid-level healthcare managers. By providing participants with tailored education materials, guides, and vaccination management and surveillance protocols based on local program delivery, the program aims to improve vaccine coverage and strengthen immunisation services. The vaccination behavioural insights research (ARIA 11) project will also contribute by contribute knowledge for developing tailored resources and strategies to improve immunisation uptake.

[10] See, for example, Gender Equality in Investment Design: Good Practice Note, section 5.3.5 on monitoring and evaluation, and the Gender Equality in Monitoring and Evaluation and Reporting: Good Practice Note.

As healthcare workers are often women, AETAP-PPI and ARIA-RISE initiatives also have the potential to increase their individual skills, capacities, and leadership skills, consistent with DFAT's Gender Equality and Women's Empowerment Strategy. For example, the Seroprevalence of SARS-CoV-2 and select vaccine-preventable diseases in Timor-Leste project (ARIA 2) provides training to in-country technical teams that are comprised primarily of female scientists (although this was not a design element). The design of the project uses Menzies' established model of mentoring. This entails hands-on in-country technical laboratory support and mentoring to the serology scientist/s, contributing to improved staff expertise, confidence and capabilities. There may be further opportunities for Mezies to look at pathways to leadership for women scientists.

Another example of ARIA-RISE's efforts to build skills and capacities is demonstrated in the Vaccine Champions project (ARIA 7), which bolsters the skills and confidence of community participants, including women and disability groups, and supports them to have conversations with impact for other recommended vaccine initiatives in the future. The vaccine champions provide training and advocacy in their own communities and workplaces to build vaccine confidence, guide individuals towards trustworthy sources of information and encourage vaccine uptake. The project was reported to be "incredibly successful in terms of building confidence in these communities and empowering advocates in the community" and is now being adapted in Vietnam and the Philippines, with another two Pacific Island countries to be included as part of the ARIA-RISE program. ARIA 7's consultation and including representative community groups is a good model of baseline participation, and could provide a useful model for other ARIA partners.

To meet good practice, AETAP-PPI and ARIA-RISE partners and programs should prioritise strengthening skills, capacities and leadership of women and people with disabilities, including by:

- Consulting health-workers and researchers on their skills needs.
- Identifying training (providing, designing and receiving) opportunities for local community representatives such as young men and women, older men and women, men and women with disabilities.
- Promoting pathways to leadership for women researchers and health care workers
- Ensuring that any training provided is sensitive to the needs of women and people with disabilities in terms of transport, accommodation, location and timing.

5.2.5 Agency and decision making

This domain recognises the importance of being able to make and execute decisions about one's own life, free of violence, retribution, or fear. In many contexts, women's success in negotiating decisions and resources that affect themselves and their children depends on their bargaining position in the gendered hierarchies of the community and household. For example, women may not have the freedom or confidence to decide to get vaccinated if there are strong family or community views against vaccination. Similarly, women and people with disability may not have the agency to access family income needed to make the trip a health centre where vaccinations are available; and women caregivers are often time-poor which limits their capacity to act in their own interests when it comes to accessing health services. Intersecting barriers related to disadvantage such as limited negotiating power, remoteness, and low literacy levels can also lead to lower agency to access immunisation services.

The Rapid Formative Assessment in Pacific Island Countries (ARIA 1) collated information on awareness and potential barriers to vaccination and vaccination acceptance which can contribute baseline information for future immunisation projects in Western Pacific countries. The development of a community-based

intervention to improve immunization coverage among children with disability in Fiji (ARIA 9), generating data on underlying reasons for non-uptake or incomplete vaccination also contributes to developing bespoke community-based awareness raising and tailored advocacy programs to improve vaccination uptake among children with disability in Fiji, with potential to scale-up in other contexts.

To meet good practice and DFAT minimum standards, ARIA-RISE and AETAP-PPI partners and programs can promote agency and decision making by:

- Support women's organisations, networks and coalitions and organisations of persons with disabilities wherever possible, particularly those giving a voice to marginalised groups particularly women with disabilities, and young women and girls.
- Promote women's decision-making, by seeking to ensure equal participation by women and men, and people with disabilities, on community committees supporting ARIA-RISE programs.
- Providing training to men, alongside women, in families, communities, and institutions on women's rights and gender equity.
- Provide access to information that equips women and girls and people with disabilities to make choices in their own best interests
- Form and sustain partnerships with local women's groups, women leaders, women service providers, informal community networks and associations, organisations of people with disabilities.
- Work with community networks, particularly women's groups and organisations of persons with disabilities, to provide entry points to increasing both the demand for and addressing equity issues in accessing health services.

Strengthen response driven ARIA-RISE and AETAP-PPI investment models by increasing local partner agency within ARIA partner decision making platforms, such as through a country partner reference group and/or improved inclusion in activity planning meetings.

5.2.6 Leadership and Representation

This domain recognises the importance of having people of all genders, ages, disabilities, socio-economic experience, locations and ethnicities represented in consultation and decision making forums. There are, however, many barriers to equitable representation, including social norms, awareness of forums, and confidence to attend forums.

The Vaccine Champions and Communication project (ARIA 7) is an example of an ARIA-RISE project actively recruiting community vaccine champions from a broad range of social groups, including highly trained and skilled healthcare workers, faith workers, industry, leaders, and community workers. In doing so, it aims to ensure that the voices of all stakeholders of different ages, abilities, socio-economic, rural/urban and ethnic groups are equitably represented.

Similarly, the Regional Guidelines for Measles and Rubella Outbreak Preparedness and Response in the Western Pacific Region (ARIA 3), commissioned by the Western Pacific Regional office of the WHO, adopts a co-design approach model with experts from the region, especially women. Such learning processes can promote positive social modelling and mentoring among women's peer networks.

To meet good practice, ARIA-RISE and AETAP-PPI partners and programs can promote leadership and representation by:

- Developing initiatives and activities that promote women and people with disabilities in decision-making bodies and leadership roles.
- Identifying and supporting role models who can represent and highlight the capacities of people with disabilities, including women with disabilities in health delivery.
- Encouraging and supporting women to take up leadership roles in health delivery so they become active participants in health systems, and not only health system users. Provide leadership training to women and girls and people with disabilities.
- Encouraging and incentivising women and girls, including women and girls with disabilities, to participate in decision making bodies and advisory committees so they have opportunities to share their experiences and to advocate for their needs.

5.2.7 Social norms

This domain recognises that some attitudes, behaviours and practices limits equitable access to accessing services and opportunities. It is therefore important to find ways to identify social norms and understand how these impact and affect access to immunisation services in a particular context.

In terms of promoting positive social norms, several ARIA-RISE project teams are working with local stakeholders to develop good practices and knowledge to progress this agenda sensitively. For example, the Development of a community-based intervention to improve immunization coverage among children with disability in Fiji (ARIA 9) works with a representative from the national organisation of persons with disabilities to promote vaccination of children with disabilities in local communities.

To meet good practice, programs can promote positive social norms and overcome negative prejudices, stigma and behaviours by:

- Encouraging availability of female health professionals where sociocultural and/or religious norms and practices restrict social and physical contact between men and women.
- Modelling positive social norms through leadership teams and workplace practices
- Sensitising communities on the value and importance of immunization for girls and boys, and people with disabilities including children with severe disabilities.
- Promoting the benefits of effectively targeted and equitable health protection programs.
- Awareness raising with front line staff and service providers on the rights of women and girls and people with disabilities and the impact of social norms
- Prioritising targeted outreach to vulnerable and disadvantaged groups, working alongside representative groups to support this outreach were possible .
- Communication material that promotes positive gender and inclusion norms and that is accessible, consulting with people with disabilities and those from linguistically diverse groups.

5.2.8 Safeguarding

This domain recognises that there are a range of risks facing women and girls and people with disabilities (including women and girls with disabilities) due to discrimination, exploitation, and abuse. If these risks are not identified and actively managed / mitigated, AETAP-PPI and ARIA-RISE projects may unintentionally create harm for people in vulnerable situations.

Safeguarding policies and procedures will better support partners delivering effective immunisation programs with a commitment to gender equality and social inclusion. Due to the high-risk contexts that some ARIA-RISE and AETAP-PPI projects operate in and close work with groups of people who may experience greater vulnerability, the Secretariat is required to ensure that ARIA partners and their personnel comply with DFAT's Preventing Sexual Exploitation, Abuse and Harassment (PSEAH) Policy and Child Protection Policy. In practice, the Secretariat relies on partners having their own safeguarding policies and practices in place. although these may not fully reflect DFAT minimum standards. All program partners should adopt a regular review of DFAT's PSEAH policy to ensure that personnel are aware of their reporting obligations and are equipped to take the necessary steps to minimise the risk of harm to communities. The Secretariat should continue to apply safeguards such as the AETAP-PPI Code of Conduct and ARIA Steering Committee Guidelines Document which cover expected behaviours around safeguarding and PSEAH. This could be further strengthened by requiring that these declarations are signed by all incoming Project personnel. As the Secretariat convenes each of the different organisations that make up ARIA-RISE and AETAP-PPI, it should also consider additional PSEAH onboarding and training initiatives or providing resources for partners to conduct their own training.

To meet safeguarding minimum standards, ARIA-RISE partners and programs should:

- Review and or/develop safeguarding policies and procedures that comply with DFAT PSEAH and CP policy requirements
- Undertake assessments of the safeguarding risks facing women and girls, boys, Indigenous People and ethnic minorities and people with disabilities in the contexts of proposed work
- Support the establishment and/or use of sensitive and accessible safeguarding reporting mechanisms at the community level

5.3 Project Management

ARIA-RISE Project Management architecture would benefit from some adaptions to better support cross-cutting GEDSI priorities and ARIA-RISE' end-of-program outcomes[11] that explicitly commit ARIA-RISE programs to GEDSI goals. Suggested adaptions and improvements are outlined below:

5.3.1 Project design

The ARIA-RISE Country Project Proposal Template for the selection of activities (Component 1-Phase 2) does not include criteria corresponding to the Approved ARIA-RISE Program Logic 2020-2022 and therefore did not require partners to address GEDSI in their proposals. As a result, GEDSI considerations were not adequately addressed for many ARIA-RISE projects during the design phase. Two projects, the Vaccine Champions Project (ARIA 7) and the Immunisation Refresher Training Program (ARIA 4) included GEDSI as an integral part of the project design. Other projects, including the Development of Regional Guidelines for Measles and Rubella Outbreak Preparedness and Response (ARIA 3) have included a co-design approach with stakeholder groups.

Engagement with community organisations (including women-led networks and organisations of persons with disabilities) at the design stage will also help to further identify vaccine access barriers by gender,

[11] EOPO 1 (Improved information systems and immunisation data for tracking and addressing coverage gaps with a focus on gender, disability, and inclusion) and EOPO 3 (Improved information systems and immunisation data for tracking and addressing coverage gaps with a focus on gender, disability, and inclusion).

disability and intersecting factors such as age, ethnicity, language, income level, etc., and better assist project teams to tailor strategies accordingly. A stronger focus on gender and disability analysis and representative consultation with communities will contribute to improved project design as well as ARIA's internal governance and project implementation. Consistent with a twin-track approach, AETAP-PPI and ARIA-RISE project designs should involve (wherever possible) specific activities or interventions to support empowering networks of diverse women, people with disability, and others at risk of exclusion, while enhancing individual capacities for agency and decision-making.

The ARIA-RISE Review Committee Adjudication Report Template does not include gender equality, disability, and social inclusion criteria in the assessment weighting and this addition would strengthen the overall appraisal of projects regarding their attention to GEDSI.

5.3.2 Project reporting

Ongoing attention is required to improve the quality and consistency of project reporting and identify how GEDSI could be better addressed and monitored. There is also an opportunity for partners to develop methods to monitor changes in attitudes and empowerment, thereby developing a more comprehensive understanding of a project's impact. Reporting should also demonstrate that ARIA-RISE projects have considered safeguarding risks to women and girls and marginalised groups and have developed strategies to address those risks.

Reporting on GEDSI and cross-cutting issues are now included in the annual ARIA-RISE report template (based on the revised MELF), however the 'Information Required' for periodic reports (3 months and 6 months) requires only summary project updates without specific details about GEDSI performance. This means that GEDSI is only being reported on in Annual Reports rather than continuously throughout project implementation.

Ensuring that ARIA-RISE projects routinely collect disaggregated GEDSI data in all activities will also improve information systems and immunisation tracking data (EOPO1), as well as monitor unintended consequences of participation for women and people with disabilities.

5.3.3 Program Guidance

DFAT resources and policies on gender and disability provide clear guidance on GEDSI indicators that can be easily incorporated into project reporting to prompt analysis of gender, disability and social inclusion so that it is explicitly described and considered. These resources should be socialised more broadly across the full suite of partners. It would be especially beneficial to ensure the DFAT HSI Guidance Notes for supporting gender equality and disability inclusion are provided by the Secretariat during the project design phase and reporting periods to ensure a rigorous GEDSI process is not only integrated into project methodology and implementation, but also substantially outlined in progress reports.

5.3.6 Peer-to-peer learning and GEDSI focal points

The interviews and focus groups highlighted diverse elements and degrees of successful gender and disability mainstreaming in specific country contexts, but it is evident that there is a need for success examples from completed (or nearly completed) projects to assist those designing new proposals to integrate GEDSI within project cycles. Guidance for incorporating GEDSI strategies into an integrated

project cycle approach is provided in the Health Security Initiative (HSI) learning tools for inclusive design[12], and these should be widely socialised among ARIA-RISE and AETAP-PPI partners.

6. KEY GEDSI RECOMMENDATIONS

The following recommendations are made to strengthen GEDSI integration:

1. The Secretariat has continued opportunity to strengthen GEDSI capacity building for all AETAP-PPI and ARIA-RISE partners in current and potential future projects. As a start, an online GEDSI Hub could share and socialise GEDSI resources to all program partners, including, but not limited to:

    a. DFAT Gender and Disability Guidance notes
    b. DFAT's Gender Equality and Women's Empowerment Strategy[13]
    c. Development for All: Strategy for disability-inclusive development in Australia's aid program and the Indigenous Diplomacy Agenda.
    d. Indigenous Diplomacy Agenda
    e. DFAT Environmental and Social Safeguard Policy
    f. Research for All: Making Research Inclusive of People with Disabilities (Research for Development Impact Network)
    g. IA2030 resources, particularly at design phase and reporting periods, highlighting the importance of GEDSI to good project outcomes and community benefit.

2. Engage a twin track approach to promoting an intentional approach to inclusiveness and representation for better GEDSI outcomes by all ARIA partners. This involves mainstreaming and integrating GEDSI across all program activities and operations - including the Secretariat's ways of working - as well as specific interventions to improve access and the participation of individuals and groups with particular immunisation barriers and requirements.

3. Include GEDSI from the design stage, specifically in the Project Proposal and Adjudication Templates for new ARIA-RISE Projects.

4. Continuing to facilitate knowledge exchange, collaboration, and peer-to-peer learning between AETAP-PPI and ARIA-RISE partners, specifically celebrating and strengthening GEDSI practice in programming. Consider appointing a GEDSI focal point for each program and within the Secretariat, to lead on collaboration and to report GEDSI progress and needs to Project Leads.

5. Encourage incremental improvements to GEDSI mainstreaming across the project management cycle. Utilise BeSD studies conducted in partner countries by ARIA members for situational analysis of GEDSI dynamics in project design phase, e.g. partner country reports from the RFA on BeSD in 9 Pacific Island countries inform strategies.

6. Strengthen networks for collaboration with local groups, including womens groups and organisations of people with disabilities, to advance inclusiveness in rural communities. Include a strong multi-directional mentoring component in all project activities to ensure skills transfer and knowledge sharing between ARIA members, partner countries, and organisational representatives including in decision making around future projects.

7. For large and ongoing programs, consider creating a program specific GEDSI Strategy, accompanied by a GEDSI outcome. This will require resourcing, both human and financial.

[12] Including guidance notes on supporting gender equality and disability inclusion through health security investments.
[13] These resources will require continual update with forthcoming stratefis, including the disability inclusion strategy and the First Nations Foreign Policy.

The Diversity, Equity and Inclusion Action Plan includes more detail about how to action these recommendations.

ANNEX A: List of interviewees and focus group participants

Date	Organisation/Institution	Participants
Interviews		
11/07/22	NCIRS	Kristine Macartney
08/08/22	Kirby Institute/Chair of ARIA-RISE Steering Committee	John Kaldor
08/08/22	ARIA-RISE SC Member	Josh Francis
10/08/22	University of Sydney/RFA Project Lead	Julie Leask
10/08/22	ANU/AETAP-PPI Steering Committee	Meru Sheel
11/08/22	Burnet/AETAP-PPI Steering Committee	Milena Dalton
17/08/22	Jhpiego/AETAP-PPI Steering Committee	Chris Morgan
19/08/22	NCIRS Secretariat	Karina Stamef, Michael Wong, Kidest Nadew, Shiva Shrestha
22/08/22	DFAT	Andrew Everett, Larissa Burke and Karina Stamef
Focus Groups	Project Title	Participants
10/08/22	Rapid Formative Assessment Prior to New Vaccine Introductions in Nine Pacific-Island Countries	Kylie Jenkins
	COSSI Vaccine Champions and Vaccine Communication program: building confidence in COVID-19 vaccination in the Western Pacific Region AND Vaccination behavioural insights research to inform tailored resource development in three Pacific Island Countries	Belle Overmars
16/08/22	Determining Streptococcus pneumoniae carriage in children under five in Timor-Leste: A cross-sectional pre-vaccination survey.	Nevio Sarmento
	Reaching Zero-Dose children in the Solomon Islands: Technical assistance for Solomon Islands Ministry of Health and Medical Services Extended Program on Immunisation	Stefanie Vaccher
16/08/22	Development of a community-based intervention to improve immunization coverage among children with disability in Fiji	Dr Gulam Khandaker, Dr Israt Jahan, Meru Sheel
17/08/22	Seroprevalence of SARS-CoV-2 and select vaccine-preventable diseases in Timor-Leste	Maria Tanesi, Nevio Sarmento and Debbie Hall
25/08/22	Immunisation Refresher Training Program Development and Delivery	Aditi Dey and Janet Forber
23/08/22	Serological Surveillance for Vaccine Preventable Diseases in the Western Pacific Region	Dorothy Machalek, Fiona Angrisano and Paul Daly

ANNEX B: Methodology (Abridged)

Utilising a strengths-based approach that is consultative and formational rather than instructional we invited project partners to share experiences about how they have confronted gender equality, disability and social inclusion (GEDSI) challenges and implemented GEDSI solutions, with consideration of different (contextual) lens of intersectional discrimination or disadvantage.

An analysis of GEDSI at the project level included:

- a review of AETAP-PPI and ARIA-RISE project designs (funded projects only), reporting templates, progress reports.
- a review of AETAP-PPI and ARIA-RISE annual and milestone reports.

The literature review sought information on:

- how gender, disability and social differences may impact vaccine hesitancy, and how this may impact take-up and access in different contexts.
- how activities address the specific gender-barriers, including disability and social inclusion barriers within the sector.

There is rich and deep GEDSI knowledge in the ARIA-RISE and AETAP-PPI projects, which the GEDSI analysis captured in a detailed and systematic way. Methods of primary data collection included focus group discussions and reflective partner workshops with project leads or nominated representatives of twelve approved ARIA- RISE programs, to discuss and analyse how GEDSI is addressed in the management of ARIA-RISE and AETAP-PPI programs, and how partners have considered GEDSI in the design and implementation of projects.

The focus group discussions were recorded with the permission of participants. Interviews were conducted with a sample of ARIA-RISE Project Leads, NCIRS (AETAP-PPI Secretariat), and AETAP-PPI Steering Committee.

The reflective Focus Group Discussions and Interviews sought to understand how project design and implementation can meaningfully engage with partner countries and be intersectional and effective. The participatory analysis actively engaged with ARIA-RISE and AETAP-PPI committee members and project partners to develop an understanding of the context and different lenses to intersectionality. The questions in the Focus Group Discussions and in individual interviews were designed to learn more about challenges and opportunities in each of the seven GEDSI domains below. Flexible and open-ended questions were included to explore the participant's own accounts of the drivers and barriers, as well as to yield narrative summaries with key themes and indicative quotes.

Key findings from the document review and the consultations were synthesised to develop preliminary findings for the GEDSI Analysis Report. Preliminary findings and recommendations were presented to partners at a reflection workshop, and a draft Diversity, Equity and Inclusion and Action Plan provided to partners for comment. The development of the Diversity, Equity and Inclusion Action Plan will support project partners to achieve ARIA-RISE and AETAP-PPI end-of-program reporting outcomes (EOPOs) below:

ARIA-RISE EOPOS

EOPO 1	Improved information systems and immunisation data for tracking and addressing coverage gaps with a focus on gender, disability, and inclusion.

EOPO 2	Increase in quality and uptake of immunisation services within selected partner countries.
EOPO 3	Tailored immunisation program guidance adopted into policy and practice and ensure equity of access to vaccines, with specific consideration of gender, disability, and social inclusion.
EOPO 4	ARIA-RISE Program has contributed to improved human resource capacity in routine immunisation delivery services.

AETAP-PPI EOPOS

EOPO 1	Partner governments have increased capacity to deliver safe, effective, and efficient COVID-19 vaccination programs.
EOPO 2	Citizens, including women and other vulnerable groups, in partner countries have increased confidence and demand for vaccines.
EOPO 3	AETAP-PPI support to COVID-19 vaccination programs is valued by the region.

ANNEX C: AETAP-PPI and ARIA-RISE Program Overview

Overview of DFAT's Australia's Health Security Initiative

The Strategic Framework for the Australian Government's Health Security Initiative (HSI) for the Indo-Pacific region (the Initiative) guides the investment of resources and a linked suite of programs to contribute to the avoidance and containment of infectious disease threats with the potential to cause social and economic harms on a national, regional, or global scale. In line with Immunisation Agenda 2030 program performance assessment arrangements for the Initiative seek to measure Australia's contribution to the achievement of partner country progress towards sustainable infectious disease prevention, as well as detection and response capacity relative to the core capacities described in the World Health Organisation's International Health Regulations 2005 and related capability assessment frameworks.

GOVERNANCE OF AETAP-PPI

AETAP-PPI provides technical assistance across five key thematic areas relevant to country COVID-19 vaccination programs under two core activities. Activities with specific relevance to GEDSI outcomes are outlined below (see text with emphasis added):

Activity 1: Specialist technical support for vaccine delivery, surveillance, and safety:

- 1A. Immunisation Service Delivery and Coordination: Support countries in the monitoring of progress of NITAG working groups (and/or other relevant instruments) on COVID-19 vaccines and interim recommendations focusing on prioritisation, equity and inclusion; in identifying and enlisting the breadth of service platforms and health provider partnerships needed to reach priority populations; in the development of sub-national vaccination plans and planning for other related components such as blanket and targeted demand generation, risk communications and safety surveillance including reviewing and adapting NDVPs in accordance with phased delivery approaches; through mentoring and shadowing, including technical and planning support for key COVID-19 focal point staff and structures; and working with a broad range of stakeholders involved in the planning and coordination of the national COVID-19 response and advocating for the meaningful participation of all sectors of the community.

- 1B. Coverage, Surveillance and Epidemiology: Support countries in collecting data on COVID-10 vaccination including doses delivered and coverage. Where feasible, reviewing and strengthening local health information systems for recording COVID-19 vaccination and COVID19 disease, as well as other VPDs where relevant, feasible and efficient. This may include supporting Ministry staff to develop or adapt equitable vaccination recording and monitoring tools, such as vaccination cards, facility-based registers and/or tally sheets, vaccination reports (paper and/or electronic); using analytical tools to monitor immunisation progress and coverage among all target populations, including disadvantaged communities, and its impact on COVID-19 disease, in line with international standards; and developing and distributing vaccine recording/monitoring tools to vaccination providers; to develop, test and roll-out any changes to electronic systems; and to provide training in the use of these tools to vaccine providers.

- 1C. Vaccine Safety: In collaboration with the TGA where relevant, support countries undertake timely and comprehensive reviews of and responses to safety data in coordination with local AEFI review working groups and/or Australian TGA staff when relevant. Related activities may include planning for active surveillance of COVID-19 vaccine related adverse events, including those of special interest. If this is not possible, developing provisions that allow reliance on active surveillance data, decisions, and information from other countries or regional or international bodies; supporting AEFI causality assessments (of serious AEFI), identification of clusters of AEFI at a sub-national level and identifying related and emerging safety concerns and intersectionality (gender, age, ethnic group, co-morbidity).

- 1D. Social and Behavioural Insights: Support countries in designing an equitable demand plan (including advocacy, social mobilisation, risk and safety communications, community engagement, and training) to generate confidence, acceptance and demand for COVID-19 vaccines across diverse communities, including training and mentoring for crisis communications preparedness planning; establishing comprehensive disaggregated (gender, sex, age, location, co-morbidity, disability) data management information systems, including 1) social media listening and misinformation management, and 2) assessing and responding to diverse behavioural and social data; and developing key messages and materials for public communications and advocacy, in alignment with demand planning.

Activity 2: Generalist support for technical coordination, public health risk communication, and education and training: AETAP-PPI will provide support for coordination, public health risk communication, and education and training related to immunisation program delivery in low- and middle-income settings:

- 2A. Communications Support: Support countries in planning and delivery of communications campaigns in countries in scope, with the aim of promoting public health risk communications and lessons learnt from the project across regional and global networks; and coordinating communications support regionally, including: co-development of communications materials and messaging through existing peak vaccine communications networks, including the ARIA member platform, DFAT Partner Forums and others; and to exchange communications materials and messaging and documentation of lessons learned through existing peak vaccine communications networks.

- 2B. Education and Training Support: Develop and implement training modules, guides, and vaccination management and surveillance protocols based on local program conditions related to COVID-19 vaccine introduction. Where possible AETAP-PPI personnel will support local facilitation and institutional program delivery. AETAP-PPI will also offer hands-on training opportunities related to technical areas, including: capacity building for in-country mid-level immunisation program managers; and potentially engaging Master of Applied Epidemiology Fellows (both Australian and international cohort members) and other practitioners to enable: highly specialised professional development; and strengthening the long-term skills and expertise of mid-level managers supporting immunisation service delivery at a subnational (provincial/district) level.

GOVERNANCE OF ARIA-RISE

The National Centre for Immunisation Research and Surveillance (NCIRS) works closely with the Indo-Pacific Centre for Health Security of the Australian Government Department of Foreign Affairs and Trade (DFAT) and the Therapeutic Goods Administration (TGA) on the Australian Expert Technical Assistance Program for Regional COVID-19 Vaccine Access: Policy, Planning, and Implementation (AETAP-PPI) as part of the Centre's Vaccine Access and Health Security Initiative (VAHSI). This partnership allows countries in Southeast Asia and the Indo-Pacific to access technical advice from Australian immunisation experts to support planning, implementation, and monitoring of COVID-19 vaccination rollout programs. Countries can request different levels and types of technical assistance, depending on their need. Requests may be of any nature - from simple queries to longer term commitments like training packages or technical twinning arrangements.

Hosted by NCIRS, the Australian Regional Immunisation Alliance (ARIA), involves a consortium of experts in immunisation and vaccine preventable diseases from Australian universities and research institutes[14] with experience in communicable disease in the Indo-Pacific. NCIRS operates the Secretariat for ARIA. The goal of ARIA members is to come together to work collaboratively with governments, global immunisation partners, non-government organisations and other partners to strengthen and to expand immunisation to reduce the impact of vaccine preventable diseases (VPDs) in our region.

[14] ARIA membership includes representation from the University of Sydney, the Murdoch Children's Research Institute and the University of Melbourne, the Burnet Institute, the Menzies School of Health Research of Curtin University, the Australian National University, Telethon Kids Institute and the Kirby Institute of the University of New South Wales.

ARIA members work with partners in the Indo-Pacific to strengthen immunisation programs, providing independent expert advice on all aspects of vaccine preventable diseases, and other issues related to immunisation, to inform policy and planning for immunisation services. Requests for technical assistance from Partner governments and regional bodies (such as WHO, UNICEF) have included advice and training related to:

- vaccine safety pharmacovigilance (monitoring/adverse event reporting systems)
- vaccine program planning support immunisation service delivery and coordination
- surveillance and epidemiology
- social and behavioural insights

ARIA-RISE Project Governance

The governance process of assessing and approving proposed projects is required to consider the appropriateness of the interventions and their alignment with the ARIA-RISE project's end of program outcomes (EOPOs) and intermediate outcomes (IOs). The ARIA Secretariat gathers and compiles evidence of progress against EOPOs and IOs. Progress towards IOs is reported periodically, while EOPOs progress will be reported at the end of the ARIA-RISE project cycle (30 June 2023). These project outcomes are expected to contribute towards ARIA-RISE program-level goals, which will further contribute to the overarching health security initiative goal.

Annex D: Documents Reviewed

ARIA-RISE

- ARIA Member Map - Updated country list where partners work
- Multi-Institutional Agreement for Commonwealth of Australia Represented by the Department of Foreign Affairs and Trade (DFAT).
- ARIA-RISE - Risk and Safeguard Tool (Excel Spreadsheet)
- ARIA-RISE Risk and Safeguard Screening Tool (Excel Spreadsheet)
- ARIA-RISE Country Project template for selection of ARIA-RISE activities
- ARIA-RISE Proposal Reviewer Guide Template
- Reporting Guide – ARIA-RISE Project Updates
- ARIA-RISE Six monthly Progress Report August 2022
- Rapid Formative Assessment Reports for 7 Western Pacific Countries
- ARIA-RISE Solomon Islands – Equity Accelerator Fund (EAF) Narrative Report

AETAP-PPI

- Partner-led Design – NCIRS: Investment Design Title: Australian Expert Technical Assistance Program for Regional COVID-19 Vaccine Access: Policy, Planning and Implementation (AETAP- PPI) 2021-2023
- AETAP-PPI in-country Progress Reports for Solomon Islands
- AETAP-PPI in-country Progress Reports for Timor-Leste
- AETAP-PPI in country Position Description for PNG deployment submitted by Kirby Institute
- AETAP-PPI Technical Assistance Request Form
- AETAP-PPI Annual Report Milestone 7 August 2022
- Health Security Initiative AETAP-PPI Annual Report Milestone 4 February 2022

Other

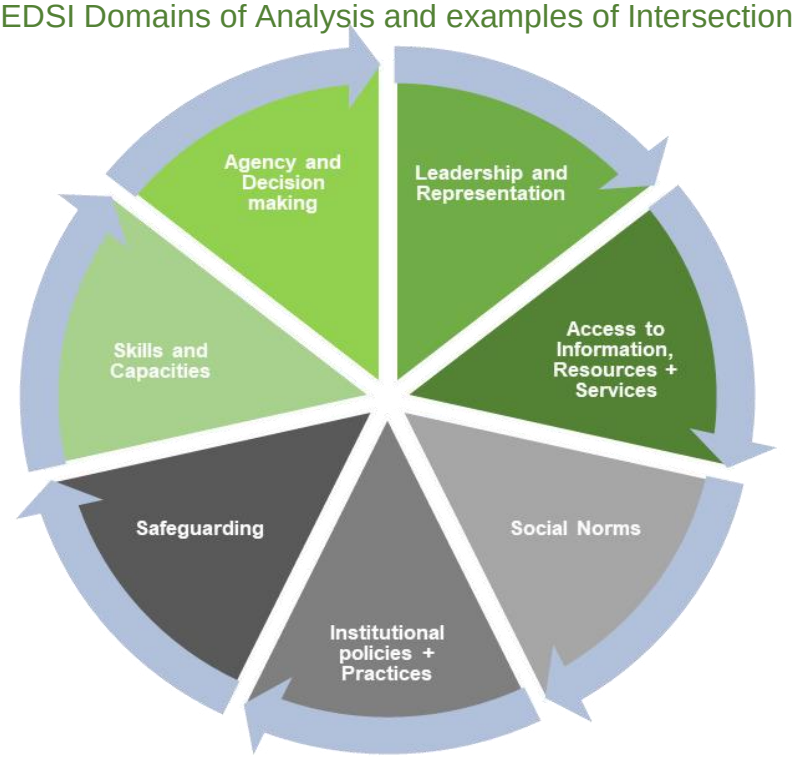
- NCIRS Concept Note (draft version 02.12.2020)
- Health Security Initiative Mid-Term Progress Report 2017-2019: Management Actions and Response

Immunisation Literature and Guidance Notes

- Immunization Agenda 2030: Why Gender Matters
- Implementing the Immunization Agenda 2030: A Framework for Action through Coordinated Planning, Monitoring & Evaluation, Ownership & Accountability.
- Development of tools to measure behavioural and social drivers (BeSD) of vaccination: Progress Report (WHO, 2020)
- Shifting gender barriers in immunisation in the COVID-19 pandemic response and beyond.
- The Global Vaccine Action Plan 2011-2020: Review and Lessons Learned
- The influence of gender on immunisation: using an ecological framework to examine intersecting inequities and pathways to change
- The Association between Childhood Immunization and Gender Inequality: A Multi-Country Ecological Analysis of Zero-Dose DTP Prevalence and DTP3 Immunization Coverage
- Gender equity in the health workforce: analysis of 104 countries
- Towards the Healthiest and Safest Region: A vision for WHO work with Member States and partners in the Western Pacific
- Shifting gender barriers in immunisation in the COVID-19 pandemic response and beyond
- Gender And Immunisation Abridged Report: A Knowledge Stocktaking Exercise and an Independent Assessment of the GAVI Alliance
- Overcoming Gender-Related Barriers to Immunization Services
- Disability in the Western Pacific

- Improving health services for people with disability
- Vaccination in people with disability: a review
- Disability considerations for COVID-19 vaccination: WHO and UNICEF policy brief, 2021
- Behavioural and social drivers of vaccination: Tools and practical guidance for
- achieving high uptake
- Guidance note and checklist for tackling gender-related barriers to equitable COVID-19 vaccine deployment' (WHO)
- Immunization and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes (2019, UNICEF Regional Office for South Asia)
- A Toolkit for Integrating Gender Equality and Social Inclusion in Design Monitoring and Evaluation (2020, World Vision)
- Immunization and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes (2019, UNICEF)
- Vaccine Access and Health Security Initiative (VAHSI) Gender Equality, Disability and Social Inclusion Strategy
- Health Security Initiative Gender Guidance Note (DFAT)
- Health Security Initiative Disability Guidance Note (DFAT)
- Gender Equality in Investment Design Good Practice Note (DFAT)
- Gender Equality in Monitoring and Evaluation Good Practice Note (DFAT)
- Reaching Indigenous People in the Australian Aid Program Guidance Note (DFAT)

ANNEX E: GEDSI Domains of Analysis and examples of Intersectional Barriers



	GEDSI BARRIERS	INTERSECTIONALITY	EXAMPLES OF STRATEGIES
Geographical Context	Geographical and seasonal variations in livelihood systems may conflict with health intervention delivery schedules. In some rural areas, families may not be able to reach health clinics during the rainy season due to rising rivers or poor road conditions.	The intersections between individual capabilities, access to resources, and geographical and seasonal factors can significantly impede access. People with physical disabilities may have additional trouble taking children to immunisation clinics. Women may not be allowed to travel alone due to cultural norms and safety reasons.	• Schedule immunisation services in convenient locations. Tailor location of outreach services to meet the needs of caregivers and ensure acceptability of services among both mothers and fathers. • Ensure that the location for mobile outreach services is accessible to disability groups as well as women and men at times that enable equal access. • Open vaccination sessions at more appropriate/flexible times, such as earlier or later to accommodate women and men's work hours and include measure to ensure women's safety.
		Single mothers, people living with disability, and those in low-income households in rural areas are marginalised through	• Bundle services so that caregivers can access child immunization services and sexual and reproductive health, nutrition services and/or other services at the same time and place.

		high costs of transportation to access health services, especially with seasonal challenges.	
GEDSI DOMAINS	GEDSI BARRIERS	INTERSECTIONALITY	EXAMPLES OF STRATEGIES
Skills & Capacities	People living with disabilities have greater barriers to participate in initiatives to strengthen their capacities, skills, and confidence.	Women and girls and people with disabilities are less represented in communication strategies to inform planning and project implementation, which further limits their capacity to negotiate choices and build skills and capacities. Lower literacy levels as well as lack of negotiating power can lead to lower motivation to vaccinate women, children, and disability groups.	• Incorporate targeted communications for disability groups and activities that bolsters the skills and confidence of women and disability groups. • Consult women, girls, and people with disabilities (including women and girls with disabilities) on skills needs. • Set targets for participation in training opportunities for women and people with disabilities (including women with disabilities) • Tackle barriers to equitable participation in training opportunities.
	Women and girls with disabilities are most vulnerable to exclusion from health care.	People living with disability often face both attitudinal and infrastructure barriers that make health facilities inaccessible.	• Support disability inclusion through the lens of participation and accessibility. • Encourage locally driven approaches that increase access to quality and integrated essential services by women and girls, people with disabilities, and marginalised populations. Support women's organisations, networks and coalitions wherever possible, particularly those giving a voice to marginalised groups such as women with disabilities, or young women and girls. Promote women's decision-making, by seeking to ensure equal participation by women and men on community committees supporting ARIA-RISE programs.
Agency & Decision making	Women and vulnerable	Women and vulnerable groups' unequal	• Include measures to support the meaningful participation of women

	populations often lack the opportunity to engage in the design of training and monitoring programs.	participation in national immunisation bodies and advisory groups further limits their capacities to inform project design.	and disability groups in all decision-making processes. • Support women's equal participation in relevant structures in the development of local capacity for delivering health programs. • Advocate for women to be better represented in advisory bodies and health providers. • Coordinate with local and provincial partners on gender-based violence (GBV), including Family Support Centres and referral pathway service providers.
	In many contexts, women's success in negotiating decisions and resources that affect their children partly depends on their bargaining position in the gendered hierarchies of the community and household.	Intersecting barriers of gender and corresponding limited negotiating power, along with lower literacy levels can lead to lower motivation to vaccinate families and children.	• Form and sustain partnerships with local women's groups, women leaders, women service providers, informal community networks and associations, and groups representing marginalised communities. • Community networks provide entry points to increasing both the demand for and addressing equity issues in accessing health services.
Leadership & Representation	Women and disability groups tend to have lower levels of representation and greater barriers in leadership roles. Gender norms create significant barriers to women's leadership.	Women with disabilities face greater challenges in equitable representation and leadership positions due to the intersection of gender and disability discrimination. In contexts of limited social services available to families, women caregivers are more time-poor with significant constraints on their capacity to represent their own interests in health systems.	• Develop initiatives and activities that promote women and people with disabilities in decision-making bodies and leadership roles. • Identify and support role models who can represent and highlight the capacities of women with disabilities in health delivery. • Encourage and support women to take up leadership roles in health delivery so they become active participants in health systems, and not only beneficiaries. Provide leadership training to women and girls. • Encourage and incentivise women and girls to participate in decision

			making bodies and advisory committees so they have opportunities to share their experiences and to advocate for their needs.
Social norms	Workload and household and care commitments for women can mean that visits to health clinics are not prioritised or supported by family members.	Women in more traditional societies may not seek care for themselves or even for their children unless they have access to a female provider. 'Son preference' may be perpetuated in some contexts. Some women and girls with disabilities are at higher risk of violence depending on the nature of their disability.	• Availability of female health professionals is particularly important where sociocultural and/or religious norms and practices restrict social and physical contact between men and women. • Sensitize community on the value of immunization for girls and boys. Promote the benefits of effectively targeted and equitable health protection programs. • Prioritize targeted outreach to vulnerable and disadvantaged groups. Communication material should promote positive gender and inclusion norms. • Feedback from women, girls and disability groups as service users should be systematically collected and analysed to ensure that the allocation of resources is based on needs of women and girls, men and boys, and people with disability.
Access to Information, Resources and Services.	Women, girls, and people with disabilities have less equitable access to information, education, services and resources.	Limited and uneven access to information about vaccines, their benefits and their risks can lead to low knowledge of the vaccine or distrust in the efficacy or need for the vaccine. In the absence or delay of accurate information from good sources, misinformation can spread quickly.	• Communication material must be accessible for persons with disabilities to ensure they can access immunisation information. • Sex-disaggregated data should be routinely collected to know whether women, girls, and people with disabilities (including women and girls with disabilities) are accessing information and services.
Institutional Policies and Practices	Health policies and strategies of partner governments often do not consider	Lack of policies, strategies and data on gender and disability inclusiveness is compounded by lack of training on gender and	• Embed GEDSI in all program initiatives and activities including operations, and organisational culture. • Build awareness of, and commitment to, principles of gender equality, disability, and social

	inequalities (gender, disability, and marginalised people) in immunisation planning and implementation.	disability issues in the health sector.	inclusion throughout immunisation programs and projects. • Disaggregate data in all activities, by sex, age, and disability, and determine the implications, impacts, and opportunities for women, girls, and persons with disabilities. • Improve feedback mechanisms between communities and local health workers and project teams to identify and address barriers to equitable access. • Analysis of unintended consequences of participation for women will assist to understand how ARIA-RISE projects are influencing norms and systems in different social and cultural contexts.
Safeguarding	If risks are not being actively managed / mitigated to avoid impacts to achieving intended outcomes, ARIA-RISE projects may unintentionally contribute negative impacts to people, the, environment and resources.	Weak GEDSI safeguarding policies and procedures will prevent partners delivering effective immunisation programs with a commitment to gender equality and social inclusion. Failure to consider and address gender and social inequalities will affect vaccination upta ke and coverage.	• Develop safeguarding policies and procedures. • Undertake assessments of the safeguarding risks facing women and girls. • Establish sensitive safeguarding reporting mechanisms.