



**RESEARCH BRIEF**

**VACCINATION AND GENDER: CHALLENGES AND WAYS FORWARD**

**This paper is one of a series of research elements produced by the European Union funded AHA! Awareness with Human Action project that seeks to contribute to the response efforts of the COVID-19 pandemic by preventing conflict and building social cohesion in Pakistan, Sri Lanka, Bangladesh and broader South Asia. The AHA! project is implemented by a consortium of project partners, including the Network for Religious and Traditional Peacemakers/Finn Church Aid, World Faiths Development Dialogue, the Center for Peace and Justice – Brac University, the Center for Communication and Development of Bangladesh, Islamic Relief Worldwide, the Youth Development Foundation, and Sarvodaya.**

**This publication was produced with the financial support of the European Union. Its contents are the sole responsibility of the World Faiths Dialogue and the Network for Religious and Traditional Peacemakers and do not necessarily reflect the views of the European Union.**

## EXECUTIVE SUMMARY

With the world's largest vaccination campaign underway, a clear understanding of gendered experiences during the COVID-19 pandemic is critical for a successful, equitable and universal vaccination campaign. Evidence on sex-based differences in vaccine response can help to dispel some myths around why males and females experience the vaccines differently. It can also help in framing appropriate messages to prepare communities for the vaccination campaign.

Since the global COVID-19 pandemic began, gender (alongside other identities notably class and race/ethnicity) has been a major factor determining who is at risk of infection, severe illness, and death from COVID-19. As vaccination campaigns are implemented, identifying and reaching priority groups among women who are vulnerable and at particular risk demands a special focus.

Global COVID-19 data disaggregated by sex shows that while both men and women are infected by the virus at similar rates (50.9% and 49.1% respectively), casualty rates are higher for men (60.2%) compared to women (39.8%).<sup>1</sup> Sex disaggregated COVID-19 infection and fatality data is helpful in determining risk factors; however, it can obscure the important roles that social environments, structures, values, and norms play to privilege or obfuscate certain gendered groups in society. Sex-disaggregated data is also limited in its explanatory capacity since it does not consider gender identities, such as transgender and non-binary people.<sup>2</sup>

Community specific vulnerabilities for women within religious minorities, including specific concerns facing those susceptible to trafficking, and LGBTQ populations, thus call for special focus. This review highlights South Asian specific experience to date, with a particular focus on information and misinformation issues that have been the focus of the AHA! Project.

<sup>1</sup> "COVID-19 and Gender Monitor | UN Women Data Hub." Accessed March 1, 2021. <https://data.unwomen.org/resources/covid-19-and-gender-monitor>.

<sup>2</sup> "The Sex, Gender and COVID-19 Project | Global Health 50/50." Accessed March 1, 2021. <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/>.

## SEX-BASED VACCINE RESPONSE

A sex-based vaccine response is usually measured by the immune response and the likelihood of adverse events that are influenced by sex.<sup>3,4</sup> Epidemiological research generally shows that vaccine response differs by sex across the entire lifespan—while women exhibit a greater immune response and vaccine efficacy, men face less adverse effects of the vaccination process itself. Some specific findings from clinical research on past vaccines show the following patterns<sup>5</sup>:

- Women generally have stronger immune responses to foreign antigens than men;
- Girls and women tend to report greater pain at the injection site during and post vaccination than male children and adults; and
- Women report more "immediate hypersensitivity reactions" at the injection site than men.

## GENDER-BASED VACCINE RESPONSE

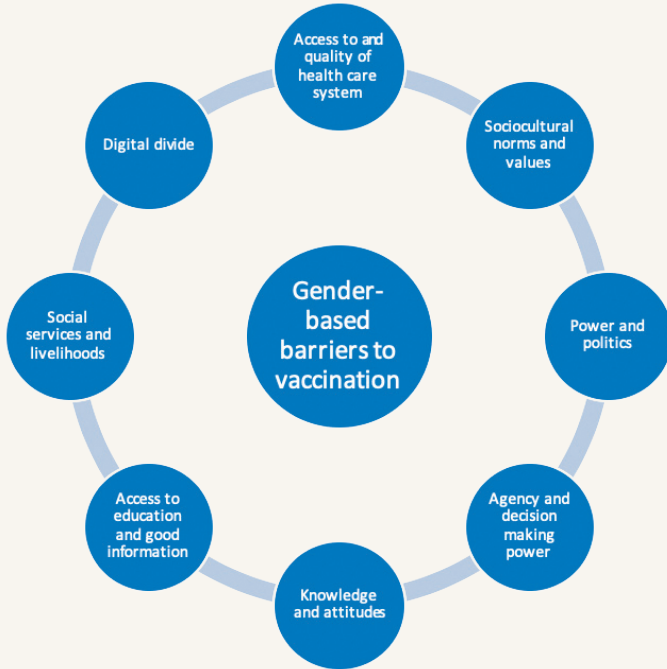
Gender refers to socially constructed norms, values, roles, behaviors, activities, and attributes that a given society considers appropriate for men, women, and non-binary people. Gender-based factors and their impact on vaccination are well documented from previous immunization experiences, including in South Asia. Marginalizing factors such as access to education and healthcare are also gendered. Thus, cumulative gender-based vulnerability can be significant factors to consider during a global crisis, such as the COVID-19 pandemic. Reports show a clear divide among those who are getting the vaccine by gender: of those who had received the COVID-19 vaccine in Bangladesh as of February 19, 2021, only 33% were women.<sup>6</sup> The Immunization Agenda 2030 as well as the GAVI 2021-2025 work plan recognize the critical role that societal expectations for men and women play in shaping access to vaccines among all age groups.

<sup>3</sup> It is an umbrella term for biological characteristics of genetics, reproductive organs, and sex hormones.

<sup>4</sup> McCartney, Patricia Robin. "Sex-Based Vaccine Response in the Context of COVID-19." *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 49, no. 5 (September 2020): 405–8. <https://doi.org/10.1016/j.jogn.2020.08.001>.

<sup>5</sup> *ibid*

<sup>6</sup> The Daily Star. "Covid-19 Vaccine: Only a Third of the Recipients Women," February 19, 2021. <https://www.thedailystar.net/frontpage/news/covid-19-vaccine-only-third-the-recipients-women-2047253>.



of earning and taking care of the family. Therefore, factors such as unpredictability of vaccination services, distance from the household, a lack of privacy at the centers, the sexual orientation of the service providers, and availability of childcare can lead to discriminatory vaccine response from women. Gender non-binary populations are often deprived of minimum civic rights. Social stigma, economic hardship due to the pandemic and fear of persecution might discourage them from participating in mass vaccination programs. For instance, in Bangladesh, the Hijra community is hit disproportionately hard by the effects of the pandemic with many losing their livelihoods and therefore also access to healthcare.

Global immunization data show that women with the lowest education levels and women with less educated partners often miss out on vaccination. **Education level** is often considered as a proxy for poverty, lack of access to social services, and inability to access and understand written communication methods. Low literacy rates of household leaders are also correlated with negative attitudes towards vaccines.

Most immunization services, globally, have been built around maternal and child health (MCH) services. Immunization services are generally feminized in terms of who are employed, how interactions and dissemination of information is done, and how services are delivered at the health care centers.<sup>7</sup> Data shows that 69.9% of global health service workers are women.<sup>8</sup> In addition, vaccination campaigns often predominantly target women where men are left out of vaccine messaging. This **gender bias** must be addressed during COVID-19 vaccination campaigns, because of the high casualty rate among men. On the other hand, since women are disproportionately working as front-liners in the health sector during this pandemic, their health needs must also be addressed.

Immunization strategies and services that fail to recognize and consider **socio-cultural constraints** women face in accessing and utilizing vaccination services can contribute to gender inequality in the vaccine response. Women often have limited access to household financial resources. They are often the caregivers for the whole family, limiting their time to engage with the topic or be able to travel to a vaccination site. Working women often have a double burden



<sup>7</sup> World Health Organization, GENDER AND IMMUNISATION Summary report for SAGE, November 2010. Available at [https://www.who.int/immunization/sage/1\\_immunization\\_gender\\_reports\\_without\\_graphics.pdf](https://www.who.int/immunization/sage/1_immunization_gender_reports_without_graphics.pdf)

<sup>8</sup> “COVID-19 and Gender Monitor | UN Women Data Hub.” Accessed March 1, 2021. <https://data.unwomen.org/resources/covid-19-and-gender-monitor>.

Women's **agency in the decision-making processes** in households often determines whether they or their dependents get vaccinated or not. Existing socio-cultural norms that disempower one gender over the other create significant gender-based discrimination in vaccine access. Disagreeing with a male partner's vaccine preference is often chastised in patriarchal societies. Women bear more responsibilities for family members' well-being yet may hesitate to jeopardize the family's health if influenced by rampant vaccine misinformation. Gender-based violence and child marriage have also increased significantly during the COVID-19 pandemic, highlighting why women's agency to choose for themselves is even more restricted than during non-pandemic times. For example, in Bangladesh, child marriage rose by 44% in 2020.<sup>9</sup> In Pakistan, 2,297 cases of violence against women were reported in 25 districts in 2020.<sup>10</sup>

**The digital divide**, defined as the gap in access to and quality of usage of technology and internet, works to discriminate against women and other gender-based minorities. Global data show that girls and women have less access to technology and the internet compared to boys and men. This is problematic because in the context of COVID-19 vaccination efforts, most countries have opted for online registration processes. This policy is necessarily discriminatory because of the limited access and use of technology among women of all ages.

**The politicization** of vaccination by local faith and political leaders often contributes to rumors and fears that manipulate both men and women. Some male religious and political leaders resist and prohibit vaccination, though there are many examples of religious actors, such as Islamic clerics in Indonesia or Pakistan, who have spoken out in favor of vaccinations. In some Muslim communities, concerns focus on whether or not vaccines are haram. Authoritarian government policies often demand vaccination as opposed to relying on persuasion and individual choice. Top-down approaches often fail to understand socio-cultural and practical barriers to vaccination.

<sup>9</sup> Dhaka Tribune. "Post-Economic Burden of Covid-19 Pandemic Continues to Drive Child Marriage," March 2, 2021. <https://www.dhakatribune.com/bangladesh/2021/03/02/post-economic-burden-of-covid-19-pandemic-continues-to-drive-child-marriage>.

<sup>10</sup> "Over 2,000 Cases of Violence against Women Reported in 2020." Accessed March 3, 2021. <https://www.thenews.com.pk/print/789297-over-2-000-cases-of-violence-against-women-reported-in-2020>.

**Safety concerns** about side effects and other perceived health impacts of vaccines, accentuated by rumors and misinformation, hinder equitable participation in the vaccination processes. Fear of inoculation looms large in many communities. A major concern has been whether the COVID-19 vaccines are dangerous for pregnant women and breastfeeding mothers. Rumor and disinformation about the COVID-19 vaccine causing impotency among men and infertility among women has gained media attention.<sup>11</sup> Since COVID-19 casualty rates show disparities among men and women, women may feel they are invincible and may reject vaccination.

**Personal security concerns** of women and girls may discourage them to vaccinate, especially if the vaccination centers require travel. Attacks on health care workers and social stigma against the vaccinated are real concerns in different parts of the world, as seen during previous Polio and Ebola inoculation programs. Since most of the COVID-19 vaccines require two doses timed apart, as well as boosters, the risk factors increase.



<sup>11</sup> "India Covid-19: Misleading Claims Shared about Vaccines." BBC News, January 31, 2021, sec. Reality Check. <https://www.bbc.com/news/55768656>.

## MEASURES TO ENSURE GENDER-SENSITIVE AND EQUITABLE COVID-19 VACCINATION

- ■ Targeted communication strategies (print, radio, and graphic communications, and social media messaging) should consider contextual information about gender roles, norms, and power relations in the selected communities. Due to the existing digital divide among male and female users of technology, communication strategies should also consider alternatives such as direct collaboration with religious and men/women/youth leaders and cooperatives.
- ■ A rigorous data collection mechanism needs to be in place to gather data about both sex-based and gender-based COVID-19 vaccine responses and their impacts on public health. Availability of good data would help the policymakers to better know and understand “where, and for whom, the need for a vaccine is the greatest, which social sectors are most vulnerable, and how to prioritize the distribution of a vaccine [...]”.<sup>12</sup>
- ■ Since the scale of COVID-19 vaccination is enormous compared to previous vaccination drives, it is important to strengthen the overall immunization system’s capacity for universal and equitable vaccination. Vaccine administrators and related health professionals should be aware of gender dynamics of vaccination processes.
- ■ In cases of countering mis/disinformation, rumor, and hesitation related to COVID-19 vaccines, safe spaces need to be created where people feel comfortable to share their concerns and feel that their concerns are heard with care. Vaccine hesitancy should be countered through accessible scientific information and good data, not with top-down mandatory vaccination policies.
- ■ Discriminatory social norms and practices should be addressed through both short- and long-term policy interventions. The rule of law should be enforced with deliberate measures to protect children and women from child marriage and gender-based violence. Directed education and social campaigns can change discriminatory practices against women and gendered minorities.
- ■ Local, national, and regional level coalitions and agreements should recognize gender-based barriers to vaccinations and ensure affordable, consistent, and the best quality vaccines to the lower- and middle-income countries. In the long term, countries should invest in technical and gender educational components to vaccine delivery that can address the gender-based constraints and social norms that prevent women from accessing and benefiting from vaccination.

<sup>12</sup> “Gender and Immunizations within the Covid-19 Landscape.” Accessed February 25, 2021. <https://www.csis.org/analysis/gender-and-immunizations-within-covid-19-landscape>.