

UPDATED

GENDER AND COVID-19 VACCINE POLICY DEVELOPMENT

KEY BARRIERS AND OPPORTUNITIES



SEPTEMBER 2022

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We interviewed 17 COVID-19 vaccination experts about why COVID-19 vaccine policies developed did not consider gender and explored opportunities to strengthen the gender-responsiveness of vaccination efforts.

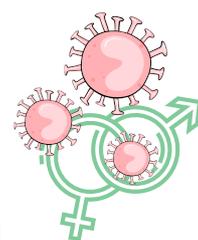
Methodology

This policy brief is based on the views of 17 experts in the fields of immunization, communicable diseases, public health, and gender, working in France, India, Kenya, Malaysia, Norway, South Africa, Switzerland, and the US. All experts were involved in COVID-19 vaccine policy development globally or at the national level, and were interviewed in July 2021. These findings represent the views of two or more experts and are indicative of common issues and suggestions. The study aimed to understand why gender did not feature in COVID-19 vaccination development and was commissioned as part of the The Global Health 50/50 Sex, Gender and COVID-19 Project.

We are grateful to Spark Street Advisors for their support and expertise.

FIVE ACTIONS TO PROMOTE INCLUSION OF GENDER IN VACCINE POLICIES

1. Demand sex disaggregation of vaccine coverage data
2. Push for gender as core to country vaccine policies
3. Collect evidence in real-time
4. Use existing evidence more effectively to reach policy-makers
5. Speak out on gender issues



See page 5 for detail

THE ISSUE: COVID-19 VACCINE POLICIES INITIALLY IGNORED GENDER

1. The COVID-19 pandemic has aggravated existing inequities

The pandemic has particularly affected people who face multiple forms of vulnerability and discrimination — poverty, gender, ethnicity, occupation, migration, or healthcare access.

2. The consequences of the pandemic are gendered

Reported severe cases and deaths are higher in men. Differences in morbidity and mortality are associated with sex-based differences in immunology as well as gendered social norms and behaviors. Indirect effects of the pandemic have included rising financial hardship, domestic unpaid work burden, mental health issues, and gender-based violence — all of which have disproportionately affected women as a result of existing gender inequalities.

3. COVID-19 has reinforced the importance of vaccines

Global health organizations including WHO and its Strategic Advisory Group of Experts (SAGE) and UNICEF supported countries to plan for vaccine approval, deployment, and demand generation by developing guidance and recommendations on immunization.

4. There was a lack of clear guidance on actionable interventions and strategies on how to address gender in vaccine deployment

COVID-19 guidelines frequently recognised gender as one variable that can affect COVID-19 health risks and health inequities, in particular in relation to men, health care workers, and pregnant and lactating women. They further recognised the need to include gender as a factor for planning, surveillance, and programme performance. However, they did not provide guidance on concrete interventions or strategies.

5. COVID-19 vaccine policies set in the first 18 months of the pandemic ignored gender norms, roles, and relations as drivers of health outcomes

The Sex, Gender and COVID-19 Health Policy Portal revealed that only a fraction of national COVID-19 policies addressed gender despite the recognition of gender issues in the pandemic more broadly. More than 90% of the vaccine policies reviewed were gender-blind.



BARRIERS TO FOCUSING ON GENDER IN COVID-19 VACCINE POLICY-MAKING

1. Vaccine policymakers focused on issues of supply and distribution and neglected sex/gender

While recognition of sex/gender as a key determinant of COVID-19 health outcomes grew as the pandemic continued, sex/gender was mentioned only as a socio-demographic element in vaccine policies. Sex/gender featured primarily in recognition of the need for sex-disaggregated data on vaccine coverage and clinical trials. Vaccine policymakers mainly focused on the inequities of supply and distribution and neglected to analyse access issues, including from a sex/gender perspective.

2. COVID-19 vaccine policy development leadership lacked representation from gender experts

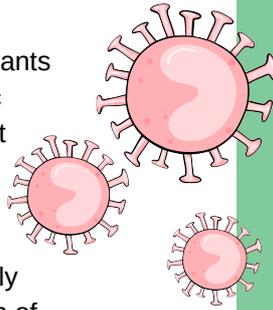
- Global vaccine policy-making structures were separate from dedicated gender expertise within global health organisations.
- Technical advisory groups and other relevant committees consisted mainly of experts with biomedical or public health backgrounds and, while some of them were strong gender advocates, gender aspects remained under-prioritised.
- Key ministries responsible for gender issues were not part of the core COVID-19 policy-making structure.



“There probably wasn't any leadership on integrating a gender approach [into COVID-19 vaccination policies] at any level from the beginning”

3. Preconceptions around data with no sex-disaggregation slowed down the identification of gender as a key area for vaccine development and deployment

- Early data and evidence did not indicate gender as a risk factor, including how gender intersected with other determinants such as age, ethnicity, socio-economic background, housing status, or migrant status.
- Lack of data and evidence hindered pregnant and lactating women from receiving the COVID-19 vaccine in early phases, which resulted in the exclusion of frontline workers and people with higher-risk conditions from vaccine trials and immunisation protocols. Vaccine rates for this group lagged for several months due to risk-averse policies until a strong push by advocates based on growing evidence led to their inclusion.



4. Existing decision-making mechanisms did not require a gender focus

Vaccine research and development did not emphasise gender, nor was it required to, as regulatory approval processes do not demand sex-based data for decision-making. Countries do not analyse sex/gender-based data collected through health management information systems.

"Gender is not a criteria for vaccine allocation"

5. Gender guidance tools often did not reach vaccine decision-makers

Developing effective strategies require dedicated resources. While several gender guidance tools have been developed over the years, these are often developed by gender experts through parallel processes. Consequently, such guidance did not reach vaccine and immunisation decision-makers during the COVID-19 pandemic. This gap has, however, triggered the development of hundreds of policy briefs and guides on a range of gender-related topics.

6. Time Pressure

Gender was not an integral part of policy-making before the pandemic and, due to the workload and time pressure, gender considerations were post-facto.

7. Gender-focused guidance was developed after policy formulation and implementation

Vaccination plans were initiated in Fall 2020, and gender guides with evidence and recommendations were finalised later, in early 2021. The Gender Equality Working Group of the SDG3 Global Action Plan for Healthy Lives and Wellbeing (the GAP) and the United Nations University International Institute for Global Health (UNU-IIGH) guidance note and checklist was published in March 2021, and the WHO SAGE evidence review with recommendations in April 2021.

8. Advocacy groups for gender were missing from COVID-19 vaccine development which was led by technical groups with limited broader input

Neither global organizations [WHO, UNICEF, UNDP] nor private sector entities initially emphasised gender as part of vaccine initiatives. While advocating for COVID-19 more broadly, civil society was not particularly active around vaccine access outside of the issue of intellectual property rights and decisions on allocations.

9. Policy-making during COVID-19 reflects the existing disconnect between health and gender paradigms

- The language of gender advocates is disconnected from the expectations of the vaccine community leading to the perception that recommendations are not concrete and instrumental enough.
- Gender is considered siloed across equity and rights areas and is often misunderstood as a synonym for women's empowerment excluding men and other gender identities.

10. The lack of gender consideration in vaccination policies reflects wider structural inequalities that disadvantage women

Women are less represented in decision-making bodies, have poorer access to health services and education, and less in the political and public domain.

"The only time you start to see a woman is when she's the vaccinator and she has absolutely no say in the delivery"

OPPORTUNITIES TO INTEGRATE GENDER INTO COVID-19 VACCINATION POLICIES

1. Use data and evidence to demonstrate how gender influences immunisation programme outcomes:

- Reporting and analysis of risk groups, drivers of the coverage, adverse events following immunisation, vaccine confidence and hesitancy, and access overall will make gender perspectives more meaningful.
- Scientific research on biological sex could inform discussions and policy development.
- More analysis and clearer evidence on the return on investment in gender policies and programs is required.

2. Demystify gender with measurable goals and concrete actions:

- Present data with actionable items to speak to the biomedical and public health communities while maintaining the common objective of increasing vaccine coverage overall.
- Present concrete country examples specific to immunisation that clarify why gender matters, and minimise use of generic terms like “gender-responsive,” “cross-cutting,” or “integrated” that are perceived as too abstract.

“If messages are evidence-based and packaged in the right way, then decision-makers listen”

3. Use funding to incentivise the inclusion of gender:

- Funders should request that WHO and other databases include sex-disaggregation.
- A requirement of allocating 25 percent of grants to gender can incentivise the development and integration of gender-responsive approaches.

“The most powerful tool would be sex-disaggregated numbers”

4. Support inclusive policy-making processes:

- Increase women’s and other underrepresented groups’ share in research and leadership positions in vaccine policy-making.
- Design more inclusive policy development processes that involve health and gender experts, social scientists and civil society organisations.

5. Include amendments and gender guidance in existing vaccine policy guidance, funding cycles, and processes rather than additional guidance:

- Sex-disaggregated data should be a requirement for vaccine regulatory approval.
- Policies should include at least one priority gender-focused indicator as a performance metric for vaccine deployment to direct policy change.
- Require differentiated approaches to address context-specific barriers at the country level and at the state and district levels in large countries.

“We don't want to see gender as separate. We want to see it as part of a programme's efforts to address issues of equity”



Explore all our COVID-19 data and analysis on our website

KEY ADVOCACY MESSAGES

The lessons learned from COVID-19 are applicable to broader health policymaking on the global, national and subnational levels, including for other vaccines and health interventions. Here are some ideas of what you can do to change how gender is considered in COVID-19 and other vaccination policies and deployment.



Who can take action



Policymakers



Government



Academia



Gender experts



Civil society

Demand sex disaggregation of vaccine coverage data.

While countries collect national data, global health organisations and funders can support countries to ensure reporting is sex-disaggregated, both at national and sub-national (state, district) levels. To this end, WHO and other major databases (e.g. Our World in Data) should publish real time data on pandemics and other health conditions by sex. Likewise, at the national level, governments should require, publish, and analyse disaggregated data to inform responses.



Push for gender as core to country vaccine policies.

Vaccine policies should be improved with a gender lens, to ensure that gender is reflected in the selection of target populations, vaccination strategies, demand generation, and monitoring. Given the context-specificity of gender issues, implementation strategies should likely be developed for state or sub-state levels. Any new vaccination policies should be further reviewed and gender aspects flagged if required.

Collect evidence in real-time.

Research should continue to examine the interplay between gender and risk groups, vaccine coverage, adverse events following immunisation as well as vaccine confidence and hesitancy. While there has been more focus on pregnant and lactating women, women's high share in the frontline health care workforce and consequently, high risk of infection, was a missed advocacy opportunity at the country level. Likewise, the role of women as primary caregivers in the family was not emphasized in supporting immunization.



Use existing evidence more effectively to reach policy-makers.

Currently, gender policies, guidance, and messages are developed within parallel structures, often based on language that does not resonate among the policy-makers. To convince, more "user-friendly" communications should be developed with experts from the biomedical and public health communities, grounded in scientific research on biological sex, cost-benefit analyses, evidence-based interventions and lessons learned from countries.

Speak out on gender issues.

Gender was not adequately brought up within the COVID-19 vaccine context. Evidence on inequities in vaccination access and demand helps advocate for broader societal inequities that determine health outcomes and agency more broadly. Collaborate with governments and different stakeholders to support the integration of gender into COVID-19 and other vaccine policies.



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