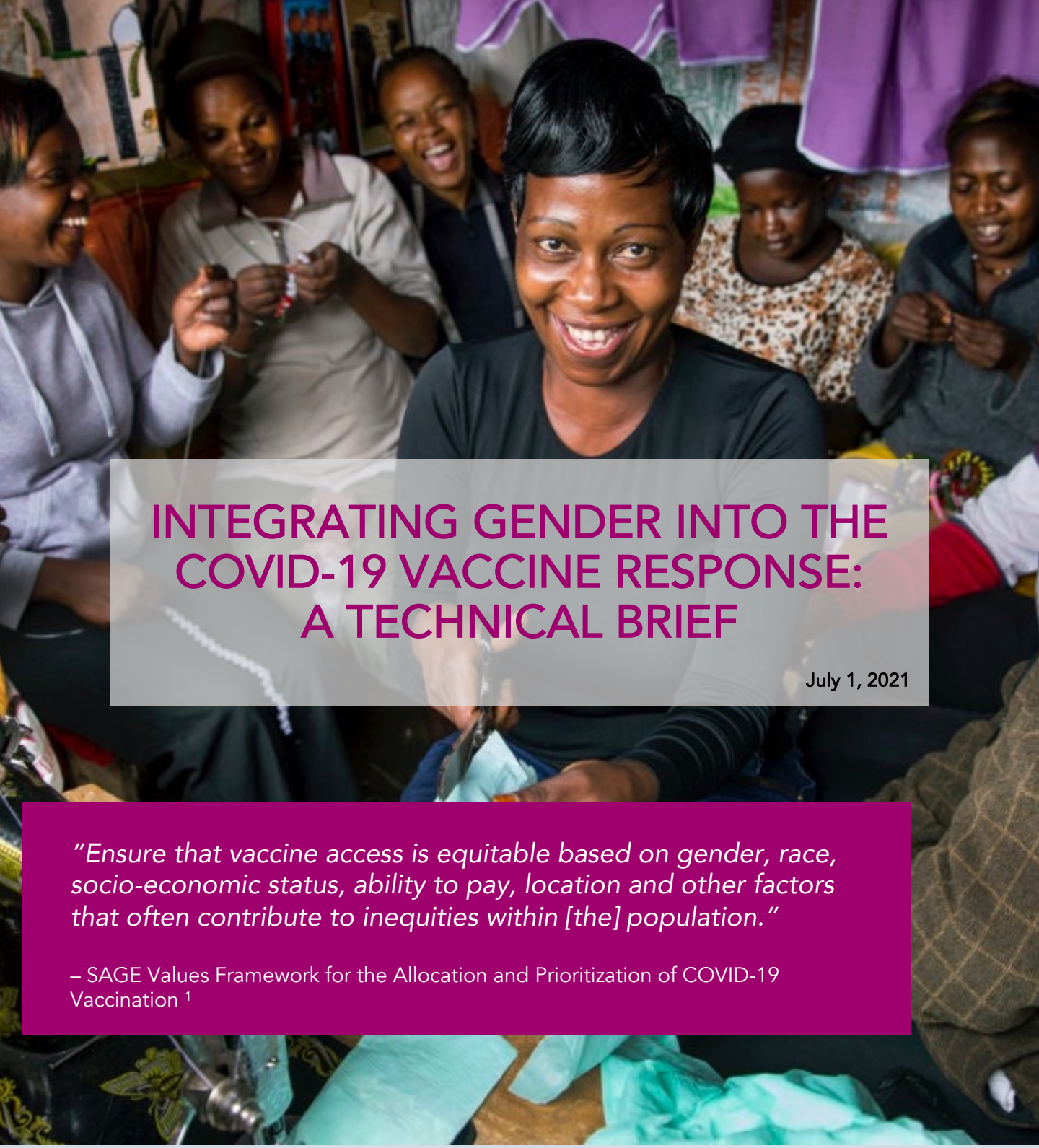

INTEGRATING GENDER INTO THE COVID-19 VACCINE RESPONSE: A TECHNICAL BRIEF

July 1, 2021

"Ensure that vaccine access is equitable based on gender, race, socio-economic status, ability to pay, location and other factors that often contribute to inequities within [the] population."

– SAGE Values Framework for the Allocation and Prioritization of COVID-19 Vaccination [1]

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Why is gender an important consideration in the COVID-19 vaccine response?

Many gender-related barriers impact immunization services, including access to, and uptake of, COVID-19 vaccination. These barriers can include social norms; access to education; ability to make decisions and control resources; health provider attitudes, biases, and preferences; inequitable policies, laws, and regulations; and governance and stakeholder engagement. Failure to address these factors will impede achieving widespread vaccine uptake and greater community protection. However, focusing on gender should not be seen as identifying which group is most affected or at risk, and therefore deserves greater attention, but rather recognizing the different and disproportional ways gender norms and barriers affect women, men, and gender minorities at different life stages.[2]

This technical brief focuses on recommendations to integrate gender perspectives in COVID-19 vaccine promotion efforts as part of the overall risk communication and community engagement (RCCE) response. For guidance and considerations on gender in the COVID-19 prevention response, please see Integrating Gender in the COVID-19 RCCE Response: Technical Brief.

How do gender inequalities impact COVID-19 vaccination access and uptake?

Examining COVID-19 vaccination through a gender lens includes the following considerations:

Gender and COVID-19 risk:

Women hold the majority of both frontline health worker jobs and informal caregiving roles globally, which increases their risk of exposure to COVID-19. In contrast, death rates from COVID-19 among men appear higher than for women in multiple settings, likely due to a combination of biological susceptibility and gender norms influencing care-seeking and behavioral risk factors such as smoking.

Gender digital divide:

Women are 20% less likely than men to use mobile internet and 8% less likely than men to own a mobile phone.[3] While narrowing, the gender digital divide in low- and middle-income countries remains substantial. RCCE programs have widely used digital channels during the COVID-19 response due to physical distancing restrictions; this, combined with gender inequity in technology access and use, may restrict women's access to information on COVID-19 and vaccination options. Therefore, women may have less exposure to campaigns disseminating essential messages. In some countries, vaccine registration is required online or via smartphone apps, limiting women's access to vaccines.

How do gender inequalities impact COVID-19 vaccination access and uptake? (continuation)

Variations in vaccine hesitancy and acceptability:

Lower formal educational levels—typically experienced by women—reduces access to accurate vaccine information and results in less vaccine confidence.[4] However, gender differences in COVID-19 vaccine hesitancy vary by country, which can be influenced by gender norms as well as other gender-based factors. For example, as of end of March 2021, according to data from a global multi-wave survey looking at COVID-19 knowledge, attitudes, and practices, women were less likely than men to "definitely" or "probably" accept a vaccine in 17 out of 23 (74%) countries. However, in six countries (Argentina, United States, Bangladesh, Indonesia, Brazil, and the United Kingdom), women were more likely or equally likely as men to say they would accept a vaccine.[5]

Unique needs of pregnant and lactating women:

Pregnant women are at higher risk of severe COVID-19 (especially those who are older, overweight, or have pre-existing medical conditions), and pregnant women with COVID-19 are more likely to deliver preterm.[6] However, initial vaccine trials excluded pregnant and lactating women, and very little data on vaccine safety in pregnancy and while breastfeeding is available. A study from the United States shows that the two COVID-19 mRNA vaccines now available in that country (Pfizer and Moderna) appear to be safe for pregnant women.[7] Pfizer, Moderna, and Jannsen are planning further vaccine studies among pregnant women, but no studies of the AstraZeneca vaccine in pregnant women exist, and plans for clinical trials are uncertain.[8] The World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention recommend that pregnant and lactating women get vaccinated *when the benefits outweigh the risk*[9]; however, the limited data available means that pregnant and lactating women may be left out as vaccine recipients in national policies. Current data shows that 41 countries do not recommend the COVID-19 vaccine for pregnant women, while 88 countries have no clear policy position.[10] Effective RCCE projects need to tailor information to pregnant and lactating women so that they may better understand the risks and benefits during pregnancy. Messaging should also advise continued breastfeeding after vaccination.

Low representation of women in leadership:

While women are at the frontlines of the COVID-19 response throughout the world, women are underrepresented in decision-making and leadership, from politics to business. This pattern likely extends to national, community, and local level responses to COVID-19, all of which may leave women out of leadership and decision-making roles.[11] Not having women's voices at the table when RCCE programs make critical decisions makes it less likely that their needs will be addressed.

How can we integrate gender into the RCCE COVID-19 vaccination response?

The six pillars of comprehensive RCCE are the foundation of the current COVID-19 response. All pillars present opportunities to integrate gender considerations and address gender inequalities. This technical brief provides recommendations for each pillar, as well as overarching actions RCCE programs can take to increase gender equity in the COVID-19 response*.

Overarching recommendations

The COVID-19 vaccination response can engage in several cross-cutting actions to integrate gender considerations:

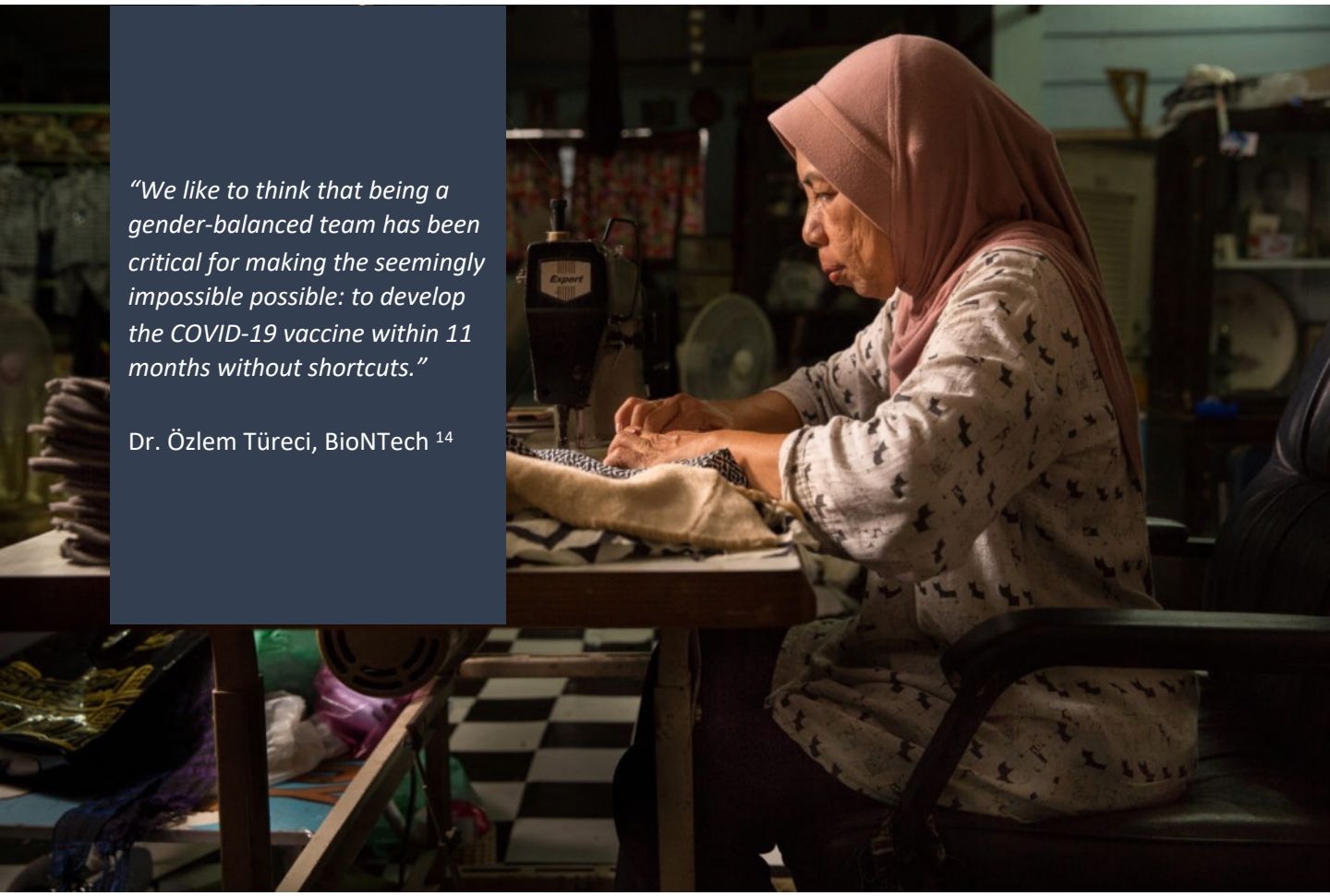
- Include gender-related questions in any rapid formative research, social listening, or rumor tracking efforts. Such efforts should include tailored questions that look at different impacts of the pandemic—and the factors contributing to vaccine uptake and hesitancy—for women, men, girls, boys, and gender minorities.[+] If RCCE teams are unable to collect first-hand data, they should review local, relevant, and existing literature on how gender dynamics and differences in power influence access, decision-making, and agency to practice positive health seeking behaviors, including vaccination for self, children, or other family members. Such research should include, for example, questions that address women's and men's specific perceptions, attitudes, norms, and abilities to get vaccinated. It should also consider how women and gender minorities are able to participate given inequitable access to technology.
- Ensure that all data collection plans and monitoring systems allow for sex and age disaggregation. Any data analysis should take both these factors and existing health disparities, into account. Where possible, go beyond sex and age to disaggregate data on COVID-19 vaccination by other socioeconomic factors.
- Consider the different needs of male and female frontline public and private health care and social workers involved in the COVID-19 vaccine response. For example, gender-based power dynamics influence decision-making and agency, and family care responsibilities may be greater for female staff, adding additional pressure and demands to their existing workload.

* The recommendations include those relevant from the earlier *Integrating Gender into the COVID-19 RCCE Response*[13] brief and draw on those made in other publications, including WHO's *Critical Sex and Gender Considerations for Equitable Research, Development and Delivery of COVID-19 Vaccines*4 and the SDG3 Global Action Plan, *Guidance Note and Checklist for Tackling Gender-related Barriers to Equitable COVID-19 Vaccine Deployment*.[14]

[+] Gender, race, ethnicity, and class are intersectional; gender can be non-binary; and the experiences of women, men, and gender minorities vary by age, location, and other demographic and psychosocial factors. For the sake of this broad guidance, this brief refers globally to "women and men" but encourages implementers to unpack the multifaceted aspects of gender in their response.

Overarching recommendations (continuation)

- Consider the different needs of women, men, girls, boys in vulnerable populations, including orphans and vulnerable children, those living in informal settlements, refugees, migrants, sex workers, men who have sex with men, transgender men and women, and people with disabilities, among others. These populations may be more vulnerable to stigma and may avoid vaccination services because of mistrust. Any response plan should be sensitive to these factors and propose approaches that will reach, include, and protect vulnerable populations.



"We like to think that being a gender-balanced team has been critical for making the seemingly impossible possible: to develop the COVID-19 vaccine within 11 months without shortcuts."

Dr. Özlem Türeci, BioNTech [14]

Photo credit: Paula Bronstein/Getty Images/Images of Empowerment. Viboonsri Wongsangiym and her husband, Bang Aree, produce Muslim garments in their home in suburban Bangkok. https://www.imagesofempowerment.org/pa0050681-63

Risk Communication Systems

This pillar includes strengthening risk communication systems by providing support to RCCE teams, including secondment of staff with RCCE and social and behavior change (SBC) expertise.

Recommendations:

- Advocate for RCCE teams (or other supported bodies) to include an equitable balance of women and men at the national and local levels, as well as representation from community groups for women, men, youth, and marginalized populations. If seconding staff to RCCE teams, consider the gender balance of the group in making staffing decisions.
- Encourage the RCCE team (or other supported bodies) to include at least one person with gender expertise, including someone knowledgeable about the national and sub-national gender-based violence (GBV) policies and services.
- Examine gender-based power dynamics when establishing Standard Operating Procedures and roles and responsibilities of the RCCE team, ensuring female members have equitable decision-making power when determining strategic priorities and budgets, and have the agency to exercise that power in mixed-sex groups. This includes appointing women as leads on various teams and sub-committees, ensuring women are asked directly to express their viewpoints, and not exclusively assigning women tasks that are based on gender stereotypes (e.g., taking minutes or serving tea/coffee).
- Consider differing needs of women, men, girls, boys, and gender minorities when developing vaccine strategies. For example, ensure these groups play a role in strategy development and pose explicit questions around gender that guide strategy development and review.
- Develop gender-related indicators teams can track and report to measure actions in national and/or sub-national vaccine strategies.

Internal Partner Coordination

This pillar includes supporting the large-scale, multi-sectoral coordination and collaboration of partners needed to establish RCCE strategies and approaches, ensure effective knowledge management, and harmonize messaging.

Recommendations:

- Ensure partner mapping includes groups working with and led by women and marginalized populations and that opportunities exist for RCCE teams to meaningfully engage these groups in vaccine roll-out.
- Encourage partners to agree upon harmonized messaging related to the gender-based factors influencing COVID-19 vaccination, including messaging around vaccines for pregnant and lactating women.
- Promote the establishment of clear referral systems between COVID-19-related health services and other health and social services for people of all genders. This can include maternal care, sexual and reproductive healthcare, child healthcare, and GBV support services.

Public Communication

This pillar includes developing and implementing mass and social media campaigns, message guides, RCCE toolkits, and other activities to reach the general public and specific audiences.

Recommendations:

- Ensure that the team developing RCCE guidelines for matters including vaccine rollout, promotion, and message guides has a gender-equitable balance of members and includes experts in gender perspectives. If the composition of the design team is already fixed, consider ways the team can get input from underrepresented voices, including women and youth, in campaign design, pre-testing, and dissemination of materials.
- Ensure messages are rights-based; model gender-equitable roles and do not reinforce gender stereotype.
- Incorporate specific gender-related barriers to vaccine uptake in public communication approaches, messages, and materials, such as promoting equitable household decision-making, encouraging all family members to be vaccinated. For example, design strategies to promote women's access to vaccination sites in contexts where women have reduced autonomy around their mobility.
- Ensure public communication around vaccine distribution and demand generation is sensitive and responsive to different trusted sources of information for women, men, and gender minorities. Do not rely only on men as gatekeepers of information.
- Understand the gender digital divide in the local context; consider who has access to digital communication channels, how devices are being used or shared within a family, and whether social norms will prevent women and girls from accessing digital content. Consider leveraging alternative communication channels to reach different sub-groups of women, men, girls, boys, and gender minorities, such as informal networks, women's groups, and TV or radio programs popular with different populations.
- Incorporate evidence-based messaging around vaccination for pregnant and lactating women. This should include guidance to health care providers for discussing risks and benefits with their clients and promoting informed decision-making. Update messages with new evidence as it becomes available and ensure they are in line with local government policies (see http://www.comitglobal.org/pregnancy).

Questions to consider when designing a communication response

1. Who has access to the communication channels being used to disseminate information, considering the differences in women's and men's access to media, the digital divide and other barriers that may exist?

2. Are preferred and trusted sources for women, men, and gender minorities being used to convey vaccine uptake messages?

3. How do social networks play a role in reaching women, men, girls, boys, and gender minorities?

4. Who is the voice of authority in the messaging? Employ the voices and images of women and men from different socioeconomic and ethnic groups equally to talk about COVID-19 vaccination. Position both women and men as authoritative, trusted sources of information.

5. Are visual portrayals of women, men, girls, boys, and gender minorities reinforcing harmful gender stereotypes or promoting equitable gender roles? For example, are women only being shown in the home? Are men being portrayed as caretakers?

6. Do messages promote women and men making joint decisions about how to protect themselves and their families? Consider how messages can be reframed to further promote couples working together and support women's agency; address aspects of traditional masculinities that may prevent men and boys from accessing healthcare.

7. How is the team tailoring messages for women, men, and gender minorities?

8. How are stakeholders using social media tools, like paid advertising, to reach sub-groups, and what metrics are used to capture reach for these sub-groups?

9. How is the team measuring message efficacy within sub-groups?

Community Engagement

Community engagement is particularly challenging in a context where governments have mandated stay-at-home orders, quarantines, or restrictions on gatherings. RCCE programs may need to adapt such approaches based on local prevention measures and/or the rate of COVID-19 infections in a given location.

Recommendations:

- Engage with community organizations to identify vaccine access barriers by gender and intersecting factors such as age, ethnicity, race, disability, HIV status, language, religion, income level, refugee/migrant status, and occupation. Then tailor strategies accordingly.
- Partner with community organizations in the design, implementation, and monitoring of COVID-19 vaccination interventions, leveraging their knowledge of local contexts and care practices whenever possible.
- Customize strategies to reach women and men, including when working in gender-segregated contexts.
- Ensure community engagement teams are gender-balanced and promote women's leadership within the team, including those from marginalized groups.
- Provide information to community, religious, and other formal and informal leaders that includes gender perspectives in promoting COVID-19 vaccination, such as equitable decision-making among couples.
- Encourage workplaces to offer staff flexible time, opportunities, and support for getting vaccinations, especially for women who may face additional time burdens.
- Help community radio stations report on women's and men's opinions and experiences related to COVID-19 vaccination. Encourage the stations to push for a gender balance on call-in programs and set aside specific time slots to hear from women, youth, and other groups that may be marginalized.
- Equip frontline health care workers going door-to-door with information about COVID-19 that highlights the different needs of women, men, and gender minorities related to vaccination, including common and adverse side effects. They should be able to provide referral services for GBV, family planning/reproductive health, and other essential services. Be sure these frontline healthcare workers also possess masks and hand-washing/sanitizing options to keep them COVID-safe.

Addressing Uncertainty and Perceptions and Managing Misinformation

Tracking and addressing rumors to curb misinformation about vaccination is an essential component of RCCE in the COVID-19 outbreak, and aids in the reduction of stigma and discrimination.

Recommendations:

- Ensure rumor tracking systems for COVID-19 vaccination are tapping into communication channels used by women, men, gender minorities, and youth.
- Analyze rumors to assess whether they are fueling gender-based inequalities, stigma, and discrimination. Design responsive messaging.
- Consider the gender digital divide when analyzing data on rumors and misinformation, recognizing that rumors identified through social media listening may be skewed towards men.
- Identify influencers of different genders who can amplify correct information about COVID-19 vaccination in their communities or social circles, including those who can reach marginalized populations.

Capacity Building

Training and other capacity strengthening activities for health care workers, journalists, hotline counselors, RCCE technical working groups, and others may be in-person or virtual depending on local physical distancing mandates.

Recommendations:

- Ensure at least some members of the RCCE team for COVID-19 vaccination have received training in gender integrated programming. If they have not, consider sharing this guidance with them or adapting it as necessary for the local context and audience.
- Make certain in-service COVID-19 vaccine deployment trainings cover the following:

- Respectful and gender-sensitive patient communication,[15] pre-vaccination communication on risks and benefits, and post-vaccination counseling on side effects. Messages should be sensitive to the needs of women, men, and gender minorities, including survivors of violence and discrimination
- Codes of conduct for vaccinators to prevent and combat sexual exploitation, harassment, and abuse
- Probing for—and responding to—reports of GBV, using standards such as those set forth by the United Nations Population Fund (UNFPA)

- Ensure COVID-19 vaccine job aides and trainings for healthcare workers cover communication on risks and benefits sensitive to the needs of women, men, and gender minorities.
- Include training for hotline counselors on gender differences in gender-related barriers to vaccination. Inform trainees how common side effects and adverse reactions to COVID-19 vaccination may differ for women and men.
- Equip journalists to report ethically on how women and men differ in opinions and experiences related to the COVID-19 vaccination and to include a diversity of voices in their reporting.

Recommended resources

- SDG3 Global Action Plan for Healthy Lives and Well-Being Gender Equality Working Group & the Gender and Health Hub, United Nations University International Institute for Global Health. (2021 Mar 26). *Guidance Note and Checklist for Tackling Gender-related Barriers to Equitable COVID-19 Vaccine Deployment* [policy brief]. Gender & Health Hub. https://www.genderhealthhub.org/articles/guidance-note-and-checklist-for-tackling-gender-related-barriers-to-equitable-covid-19-vaccine-deployment/

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Resource Persons at the Johns Hopkins Center for Communication Programs

Name	E-mail
Joanna Skinner	joanna.skinner@jhu.edu
Zoé Hendrickson (francophone)	zhendri1@jhu.edu
Jane Brown	jane.brown@jhu.edu

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Cover photo credit: Jonathan Torgovnik/Getty Images/Images of Empowerment. Woman that are members of the Nairobi Young and Old cooperative group.
https://www.imagesofempowerment.org/full_release_dsw_nairobi_githurai_young___old_group_0080