



GENDER AND COVID-19 VACCINES

Listening to women-focused organizations
in Asia and the Pacific

MAY 2021



**COVID-19
RESPONSE**



**GENDER
IN HUMANITARIAN ACTION**
Asia and the Pacific

AMPLIFYING WOMEN AND GIRLS IN CRISES
voice



Gender-Based Violence Aor
Global Protection Cluster

INTRODUCTION

More than a year into the coronavirus pandemic, COVID-19 vaccines are being distributed across at least 176 countries, with over 1.7 billion doses administered worldwide.¹ Combatting the pandemic requires equitable distribution of safe and effective vaccines, however, women and girls² are impacted by gaps both in the supply side and the demand side that hamper equitable distribution of the vaccine.³ Evidence reveals that 75 per cent of all vaccines have gone to just 10 countries, and only 0.3 per cent of doses have been administered in low-income countries.⁴ Very few of COVID-19 vaccines are going to those most vulnerable (figure 1).

The vaccine rollout in Asia and the Pacific has been relatively slow and staggered amid secondary waves of the virus. India, despite being the largest vaccine developer, has only vaccinated 3 per cent of the population and continues to battle a variant outbreak that, at its peak, was responsible for more than half of the world's daily COVID-19 cases and set a record-breaking pace of about 400,000 cases per day.⁵ However, the small Pacific nation of Nauru, reported a world record administering the first dose to 7,392 people, 108 per cent of the adult population within four weeks.⁶ Bhutan also set an example by vaccinating 93 per cent of its eligible

population in less than two weeks.⁷ That success could be at risk, given the situation in India and the suspended export of vaccines.⁸

The region faces many challenges in delivering vaccines, particularly in humanitarian emergencies in Afghanistan⁹, Timor-Leste¹⁰ and Myanmar¹¹. The Asia-Pacific region is the most disaster-prone region in the world, with rapidly escalating complex humanitarian emergencies and systems for delivering relief measures that have become increasingly fragile in the context of COVID-19.¹² As women and marginalized populations are often disproportionately affected by humanitarian emergencies, it is essential that national vaccination strategies and policies are inclusive and non-discriminatory with a tailored gender-responsive and intersectional approach to ensure those who are most vulnerable are not left behind. Women tend to be more exposed to infection, and they are likely to occupy high-risk roles, such as family caregivers and frontline health workers, thus multi-sectoral responses with targeted and protected funding for women-focused organizations and programmes are required to reach those most in need. Vaccine programmes also present an opportunity to provide otherwise neglected services to women and vulnerable or hard to reach populations. Finally, engaging women-focused and youth/girl-centred organizations can maximize the reach of prevention efforts so that women and girls can access immunization services and the information they need.

1 New York Times (2021) [Tracking Coronavirus Vaccinations Around the World](#).

2 The term "women" in the report recognizes the diversity of women's representation and expression, and that the life cycle of girls and adolescents, youth and women is interlinked.

3 United Nations (2021) [Secretary-General Calls Vaccine Equity Biggest Moral Test for Global Community, as Security Council Considers Equitable Availability of Doses](#).

4 New York Times (2021) [Tracking Coronavirus Vaccinations Around the World](#).

5 New York Times (2021) [What to Know About India's Coronavirus Crisis](#); CNN (2021) [India's COVID-19 crisis is a problem for the world](#).

6 ABC News (2021) [Nauru gives first COVID vaccine shot to entire adult population in four-week campaign](#).

7 Ministry of Health, Royal Government of Bhutan, Thimphu, Bhutan (2021) [Key highlights from the press brief dated 08.04.2021](#).

8 BBC (2021) [India Coronavirus: Vaccine makers are prioritising local needs](#); Gyeltshen, N. and Wangdi, P. (2021) [India's COVID chaos puts Bhutan's vaccine success at risk](#).

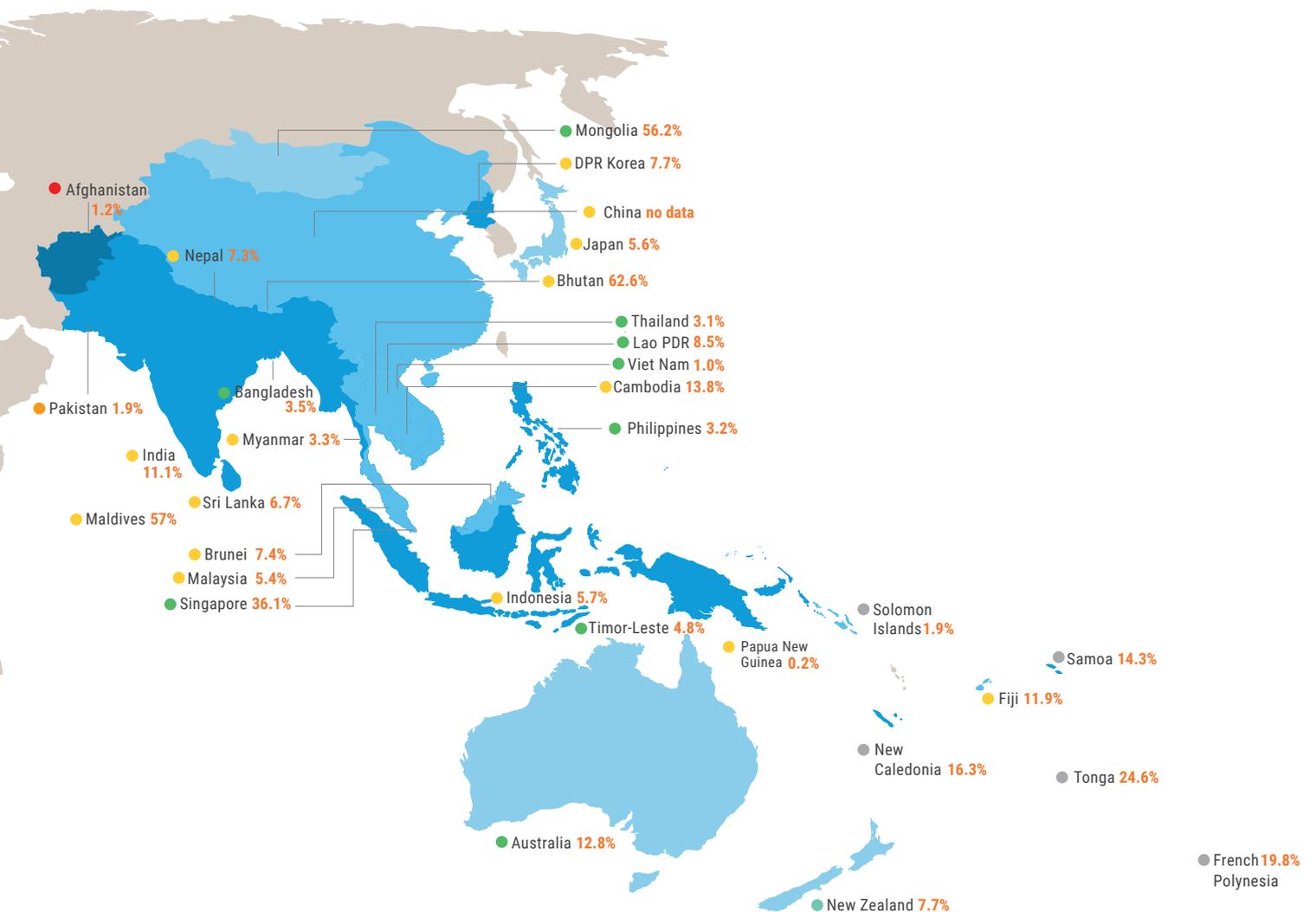
9 WHO/OCHA (2021) [Afghanistan Strategic Situation Report: COVID-19 No. 95](#).

10 UN RCO (2021) [Timor-Leste Floods – Situation Report No. 7](#).

11 UN News (2021) [Myanmar: Attacks on healthcare jeopardizing COVID-19 response, UN team says](#).

12 ESCAP (2019) [Summary of the Asia Pacific Disaster Report 2019](#).

Figure. 1. Comparing vaccination rates, gender equality, and humanitarian emergency risk in Asia and the Pacific



Vaccine Rate (%)
share of people who have received at least one dose of the COVID-19 vaccine
Source: Our World in Data (May 25, 2021)

OCHA Focus Score
(Source: OCHA Regional Focus Model 2021)

- Very high (>7.5)
- High (0.5-7.5)
- Medium (2.5-4.9)
- Low (<2.5)

Gender Gap Index
(Source: Global Gender Gap Report 2021 WEF)

- <0.5
- 0.5-0.59
- 0.6-0.69
- 0.7-0.79
- >0.8
- No data

COVAX

The COVAX platform, co-led by Gavi, the World Health Organization (WHO), the Coalition for Epidemic Preparedness Innovations (CEPI), and the United Nations Children's Fund (UNICEF), supports the development of and equal access to COVID-19 vaccines across all participating countries. Providing doses for at least 20 per cent of countries' populations and guided by an [allocation framework](#), COVAX also ensures access to vaccines for high-risk populations in humanitarian settings through the 'COVAX Buffer'.¹³

In Asia and the Pacific, COVAX has started rolling out vaccines in Cambodia, Fiji, Indonesia, Kiribati, the Lao People's Democratic Republic, Malaysia, Mongolia, Nepal, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Timor-Leste, Tonga, Tuvalu and Viet Nam.¹⁴ However, with the suspension of vaccine exports from India, rollouts across low- and lower-middle-income countries are jeopardized at a time when COVID-19 cases are escalating in the region, particularly in South Asia.¹⁵

However, with the suspension of vaccine exports from India, rollouts across low- and lower-middle-income countries are jeopardized at a time when COVID-19 cases are escalating in the region, particularly in South Asia.¹⁶ Limited vaccine supply is not the only challenge. Countries with low resource settings may also be dealing with unpredictable impacts of humanitarian crises that exacerbate logistical issues to deliver vaccines requiring strict cold chain management. Many issues related to uptake of the vaccine also exist around access to vaccines and response services, as well as vaccine hesitancy.

13 Gavi (2021) [The COVAX Humanitarian Buffer Explained](#).

14 Gavi (2021) [COVAX has so far shipped over 72 million COVID-19 vaccines to 126 participants](#).

15 Wall Street Journal (2021) [Why a Grand Plan to Vaccinate the World Against COVID Unraveled](#).

16 UN News (2021) [COVID-19: Wealthy nations urged to delay youth vaccines, donate to solidarity scheme](#).

AVAILABILITY OF DATA

More than a year into the crisis, there remains a limited understanding of the differentiated impacts of COVID-19 on men and women, including youth and children, due to the lack of comprehensive sex-, age- and disability-disaggregated data (SADDD) on testing, cases, mortality and vaccines.¹⁷ Understanding the contribution of sex, age and gender to the COVID-19 pandemic and identifying opportunities for reducing health inequities requires SADDD that can be analysed to explain gendered inequalities and yield important evidence on both the biological mechanisms that underlie differences in illness outcomes and the social and structural dynamics that influence individuals' risk and vulnerability.¹⁸ Many governments have not prioritized SADDD, providing inconsistent accounts of COVID-19 deaths and infection rates, and, in some cases, initial SADDD reporting has declined.¹⁹ At the global level, slightly more than half of countries have reported any sex-disaggregated data on COVID-19, and the rate declined from 54 per cent in October 2020 to 51 per cent in April 2021. Some countries in the region, such as Sri Lanka, have reportedly never provided any sex-disaggregated data on COVID-19.²⁰

Of the 11 countries in the Asia-Pacific region that are included in the [COVID-19 Sex-Disaggregated Data Tracker](#), only India and Bangladesh are consistently reporting sex-disaggregated data on COVID-19 vaccinations. As of April 2021, men received 63 per cent of vaccines in India, and 52 per cent of vaccines in Bangladesh. This is in contrast to the global average where women received 53 per cent of total vaccines.²¹

17 Seck et al. (2021) [Gendered Impacts of COVID-19 in Asia and the Pacific: Early Evidence on Deepening Socioeconomic Inequalities in Paid and Unpaid Work](#).

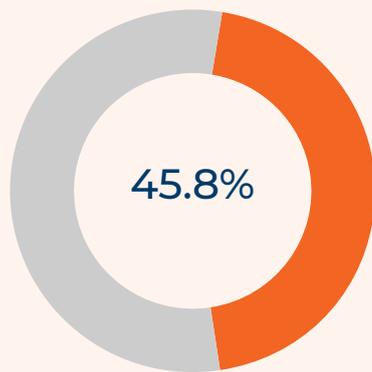
18 Sarah Hawkes et al. (2021) Recorded but not revealed: exploring the relationship between sex and gender, country income level, and COVID-19, in *Correspondence* Vol. 9, issue 6, E751-E752, 1 June. Available at [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(21\)00170-4/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00170-4/fulltext).

19 Global Health 50/50 (2021) [The COVID-19 Sex-Disaggregated Data Tracker February Update Report](#).

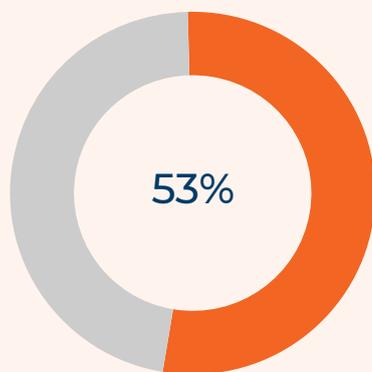
20 Global Health 50/50 (2021) [The COVID-19 Sex-Disaggregated Data Tracker April Update Report](#).

21 Ibid.

Figure 2. Vaccination rate by sex (first dose)



Asia-Pacific average,



Global average,

MALE FEMALE

Source: [Global Health 50/50](#)

While Timor-Leste has not regularly reported sex-disaggregated data, a singular report indicated that women received only 33 per cent of vaccines distributed in April.²² Additionally, women in Cambodia and Hong Kong, China, have received 45 per cent and 51.6 per cent of vaccines, respectively.²³ Samoa, a country not included in the tracker, reported on 22 May that

22 Government of Timor-Leste (2021) [Meeting of the Council of Ministers on April 14th, 2021](#).
 23 WHO (2021) [Cambodia COVID-19 Situation Report #45](#); The Government of Hong Kong Special Administrative Region (2021) [Hong Kong Vaccination Dashboard](#).

only 45 per cent of vaccines so far had gone to women.²⁴ New Zealand, a notable anomaly in the region, tracks gender, age and ethnicity data, and the country has vaccinated significantly more females (62 per cent) than males (38 per cent) or individuals identifying as “other” (0.1 per cent).²⁵ In a region where women make up the majority of frontline workers, it seems a disproportionate number of men are receiving the vaccine before women.

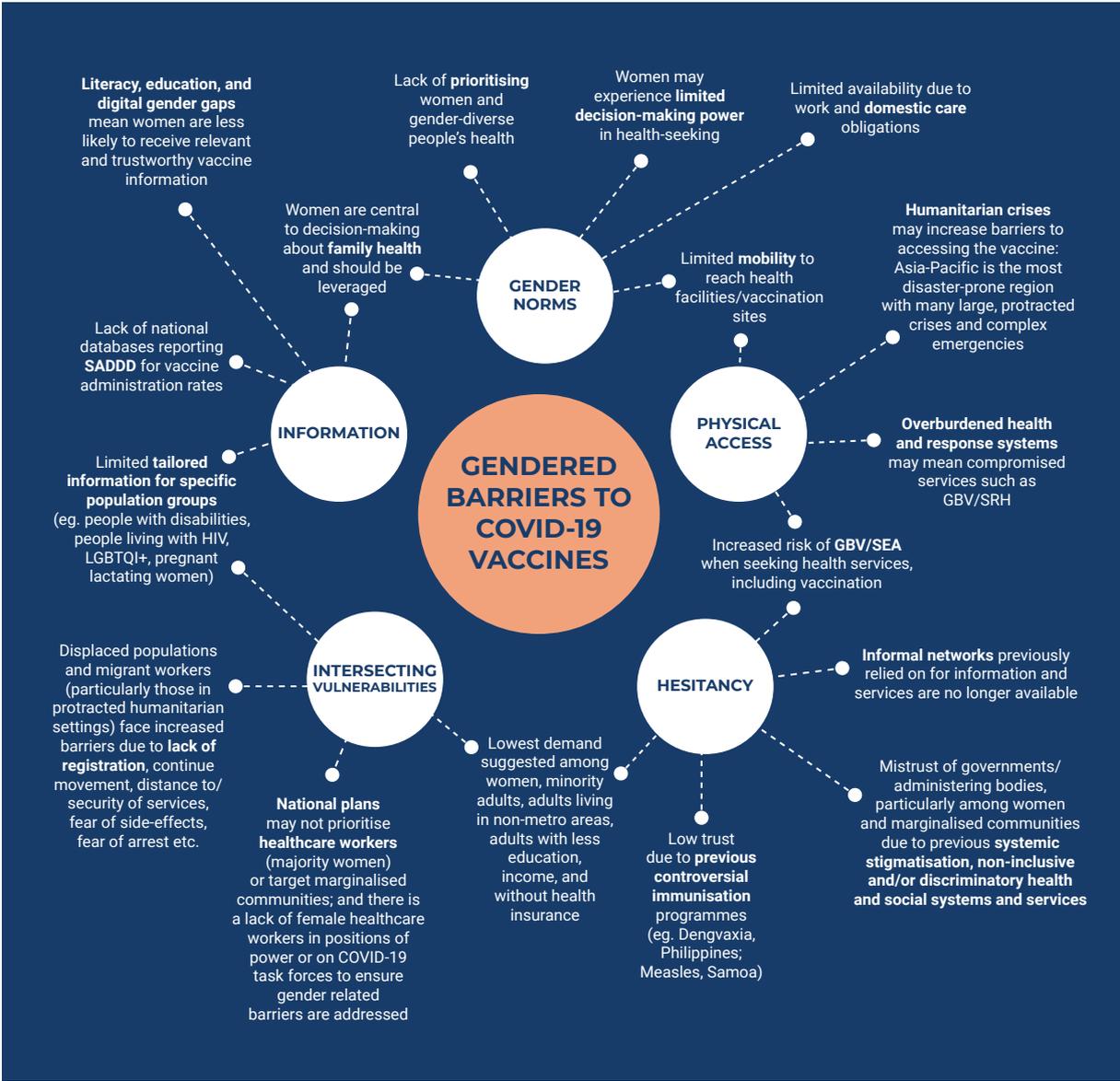
EMERGING GENDER BARRIERS

Biologically, women and men respond differently to many vaccines due to a mix of factors including genes, hormones and dosage. Emerging evidence indicates more men are dying both globally and regionally from COVID-19, but women are more likely to report experiencing long-term symptoms from COVID-19 infections and worse side effects from the vaccines.²⁶

In addition to biological differences, the burden of diseases is influenced by social factors. It is imperative to explore gender barriers in access to COVID-19 vaccines (figure 3) in order to identify effective response strategies and address existing disparities and health inequities.²⁷ For example, immunization campaigns in Asia and the Pacific should include teachers – many of whom are women – and this will support the continuity of learning during the pandemic.²⁸ Providing women with easy and reliable access to COVID-19 vaccines is paramount to ensuring communities achieve herd immunity and have the resilience to recover from the wider social and economic impacts.

24 Ministry of Health Samoa (2021) [Samoa Total Vaccination Count May 22, 2021](#).
 25 Ministry of Health New Zealand (2021) [COVID-19: Vaccine Data](#).
 26 The Wall Street Journal (2021) [COVID-19 Vaccines and Rare Blood Clots: Are Women at Greater Risk?](#); New York Times (2021) [Women Report Worse Side Effects After a COVID Vaccine](#); Global Health 50/50 (2021) [The Sex-Gender COVID-19 Project](#).
 27 UNICEF (2020) [Gender Equality During COVID-19](#).
 28 UNICEF (2021) [COVAX COVID-19 Vaccine Deliveries Make Schools Safer in Afghanistan](#).

Figure 3. Gendered barriers to COVID-19 vaccines



Women at the centre of the response

During the COVID-19 pandemic, women health-care workers have been at the forefront of the response, and they were often underprotected and overexposed. Women make up around 80 per cent of frontline health-care workers in the Asia-Pacific region, and they still face notable differences in the conditions in which they operate compared with men.²⁹ This includes the gender pay gap, long-existing inequities in women’s access to leadership and decision-making roles, lack of gender transformative policies, and barriers to full-time employment.³⁰ The pattern of

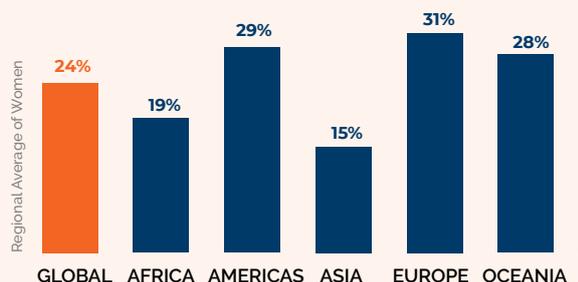
underprioritizing the needs and voices of female health-care workers during the pandemic has already led to instances of inadequate access to personal protective equipment, increased rates of infection among women health-care workers compared to their male counterparts, neglected menstrual hygiene needs in the workplace, and a lack of psychosocial support.³¹ Asia has the lowest proportion of women on COVID-19 task forces globally (figure 4). The low representation

29 UN Women (2020) *The First 100 Days of the COVID-19 Outbreak in Asia and the Pacific: A Gender Lens*.

30 Ibid.

31 UN Women (2020) *The First 100 Days of the COVID-19 Outbreak in Asia and the Pacific: A Gender Lens*; WHO (2021) *Weekly Operational Update on COVID-19, 16 March 2021*; Bandyopadhyay, S. (2020) *Infection and mortality of healthcare workers worldwide from COVID-19: a systematic review*; Rodriguez, L. (2020) *Health Workers Around the World Are Calling Period Products to be Considered Essential PPE*.

Figure 4. Proportion of women on COVID-19 task forces globally and by region



Source: [UNDP COVID-19 Global Gender Response Tracker](#)

of women in leadership roles in health and care weakens health systems and global health security, and like gaps in vaccination rates, the leadership gap in health can only be closed by addressing the systemic barriers women face.³² Solutions need to be implemented to ensure women and men health-care workers receive equal access to vaccines and to ensure women are included in COVID-19 task forces and positions of leadership so that vaccine distribution is gender-responsive and intersectional.

Existing and exacerbated gender gaps

The most common barriers that prevent women from receiving vaccinations are a lack of information, social norms that are discriminatory toward women and decisions that fail to prioritize women’s health. Gender gaps in literacy, education and technology mean women are less likely to receive relevant and trustworthy information about COVID-19 vaccinations. Additionally, the face-to-face informal networks women relied on before COVID-19 have been limited by lockdown measures. Evidence suggests fewer women than men in Bangladesh and Pakistan are likely to receive information about COVID-19.³³ Bangladesh has a 29 per cent gender gap in the ownership of mobile phones, and a 52 per cent gap in the use of mobile

Internet.³⁴ A survey among rural households in Bangladesh revealed an even larger gap – only 37 per cent of households identified women among the most digitally able members of the households.³⁵ In Pakistan, similar gaps are seen, as its rank is among the lowest in the world on the Global Gender Gap Index.³⁶ Only 46.5 per cent of women are literate, 61.6 per cent attended primary school, 34.2 per cent attended high school, and 8.3 per cent enrolled in tertiary education.

Gender gaps in the literacy rate persist across the region, and there is a risk of increased illiteracy given the impacts of COVID-19 restrictions on school closures. In Myanmar, the literacy rate among women is 71.8 per cent, in Timor-Leste it is 64.2 per cent and in Papua New Guinea it is 57.9 per cent.³⁷ In Papua New Guinea, over 50 per cent of surveyed individuals reported being either against or unsure of accepting COVID-19 vaccines, the leading reason stated “they did not know enough about the vaccine”.³⁸ South Asia has the largest gender gap (17 percentage points) with an adult male literacy rate of 79 per cent and adult female literacy rate of 62 per cent.³⁹ These indicators highlight the impact of restrictive gender norms and barriers women face in limiting women’s access to information about COVID-19 vaccines and response efforts. If these structural injustices are addressed not only would COVID-19 vaccine information be more widely accessible, but a foundation would be in place a more equitable digital future with opportunities for women in a growing digital economy.

While COVID-19 vaccine information is difficult for many populations to access and navigate, there are further challenges for vulnerable and marginalized populations with many intersecting identities, such as indigenous and minority populations, people with disabilities, people living with HIV; lesbian, gay, bisexual, transgender, queer, intersex and other (LGBTQI+) people; and pregnant or lactating women. Inclusive information and data about the vaccine

32 WHO (2021) *Closing the Leadership Gap: Gender Equity and Leadership in the Global Health and Care Workforce*.
 33 UN Women (2020) *Surveys show COVID-19 has gendered effects in Asia and Pacific*; UNICEF (2020) *Amplifying immunization efforts during the COVID-19 pandemic*.

34 Janah, N. and Zahan, I. (2021) *The widening gender gap in digital era: A rural Bangladesh scenario*.
 35 Ibid.
 36 World Economic Forum (2021) *Global Gender Gap Report*.
 37 Ibid.
 38 UNICEF (2021) *EAPRO Humanitarian Situation Report No 1*.
 39 World Bank (2019) *More men than women are literate*.

are extremely limited. Some vulnerable and marginalized population groups were excluded from or underrepresented in clinical trials for COVID-19 vaccines, creating a gap in trustworthy information.⁴⁰

Emergency contexts

Key population groups, including recently displaced populations and migrant workers, particularly those traveling to and from settings with protracted humanitarian challenges, face increased barriers to obtaining vaccination due to factors, such as difficulty registering due to lack of national identity cards, continued movement, distance to and security of immunization services, fear of side-effects (particularly fever), fear of arrest, difficulty keeping immunization appointments, and work and domestic care obligations.⁴¹ Widespread conflict and long and protracted crises in the region also amplify challenges for supply chains and health-care workers. In Afghanistan, in March, three female polio vaccinators were shot dead in Jalalabad, as the COVID-19 vaccine rollout unravelled in areas controlled by the Taliban or local militias, and critical levels of food insecurity threatened more than 40 per cent of the population.⁴² Given the feminized nature of the health-care workforce and vaccination teams, security concerns for women are amplified. In many settings, women and gender-diverse groups are also at risk of experiencing sexual harassment, exploitation, disrespect and other forms of gender-based violence (GBV) when seeking health services, including vaccination.⁴³ Vaccine rollouts need to be supported by policies that protect people from sexual exploitation and abuse. During

40 Kramer, J. (2021) In COVID Vaccine Data, LGBTQ People fear Invisibility; Gregory, M. (2021) Why It's Harder For Many Transgender People to Access (and trust) COVID-19 Vaccines; Rubin, R. (2021) Pregnant People's Paradox – Excluded from Vaccine Trials Despite Having a Higher Risk of COVID-19 Complications.

41 Zakaria, R. (2021) IDs and Vaccines.

42 UNICEF (2021) Statement by UNICEF Executive Director Henrietta Fore on killing of polio workers in Afghanistan; Gliński, S. (2021) Afghanistan's COVID-19 vaccine rollout plans cross conflict front lines.

43 SDG3 Global Action Plan for Healthy Lives and Well-Being: Gender Equality Working Group (2021) Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable COVID-19 Vaccine Deployment.

GBV AoR Helpdesk (2021) COVID-19 Vaccine Rollout – What do we know from past public health emergencies about gender-based violence risks and gender-related barrier to vaccine access?



“Vaccine promotion has been exclusionary for transgender and refugee populations, and these populations lack access to national ID cards.”

**- Manasa Vasudevan,
YuWaah**

Photo: UN Women/Fahad Kaizer

previous vaccination programmes, for example during Ebola, there were reports of alleged sexual abuse by male health-care workers and aid workers.⁴⁴ During the pandemic the risk of GBV has increased immensely and disproportionately for women and girls at the community level and among female health-care workers.⁴⁵ The same factors that underlie the increase in GBV during COVID-19 may not only prevent women and girls from accessing vaccines in many settings but may also create additional risks of GBV linked to vaccine distribution if GBV risk mitigation measures are not put in place. It is of vital importance that all agencies involved in rolling out vaccines recognize that GBV and the gender inequality that drives it are fundamental issues that will directly undermine the effectiveness of their vaccination campaigns.⁴⁶

As the most disaster-prone region in the world, Asia and the Pacific faces the pandemic and vaccine rollouts amid calamitous and unpredictable threats. In April, Timor-Leste, dealt with the dual crises of rapidly rising COVID-19 cases and Tropical Cyclone Seroja. The cyclone left in its wake torrential rainfall, flooding, landslides, increased risks of waterborne and vector-borne diseases, and overall damage estimated at \$300 million, equivalent to almost 20 per cent of non-oil GDP.⁴⁷ These impacts compound challenges that disproportionately impact women, girls, gender diverse groups and other marginalized populations and make it more difficult for them to access vaccines. For instance, women tend to have limited mobility to reach health facilities or vaccination sites, limited decision-making power in their health-seeking, and limited access to health resources, including evidence-based information on vaccine safety (especially among pregnant and lactating women), all of which is compromised in humanitarian scenarios.⁴⁸

Vaccine hesitancy

Vaccine hesitancy needs to be addressed in the context of COVID-19. Misinformation has fuelled the COVID-19 pandemic, and many governments in the region, including in Australia and Hong Kong, China, have expressed safety concerns over existing vaccines, impeding public uptake of COVID-19 vaccines and leading to sluggish vaccine rollouts.⁴⁹ A nationally representative survey in the Philippines found one third of Filipinos demonstrated COVID-19 vaccine hesitancy, and only 66 per cent of Filipinos were willing to get a COVID-19 vaccine.⁵⁰ A more recent survey conducted in the Manila metropolitan area indicated only 25 per cent of respondents were willing to get a COVID-19 vaccine, and 47 per cent were undecided.⁵¹ These low rates followed public controversy in 2016 and 2017 related to the dengue vaccine, Dengvaxia.⁵² Prior to this in 2015, the Philippines had ranked in the top 10 countries worldwide for vaccine confidence. Similar declines in confidence were noted in Afghanistan, Indonesia, Pakistan and the Republic of Korea.⁵³ In Samoa, public mistrust of vaccines existed prior to COVID-19 and re-emerged during the 2019 measles outbreak following medical malpractice that led to low vaccination rates and a resurgence of measles cases in the Pacific.⁵⁴ Additionally, marginalized communities, such as women and girls; LGBTIQ+ people, people with disabilities, people living with HIV, ethnic and/or religious minorities, refugees, migrants and internally displaced people, who may have experienced systemic stigmatization or encountered non-inclusive and/or discriminatory health and social systems and services may have greater distrust of vaccination campaigns. Transgender communities in India, totalling 0.013 per cent of the vaccinated population, have reported COVID-19 vaccine hesitancy due to mistrust of the medical industry, exclusion from vaccine

44 Harman, S., et al. (2021) [COVID-19 Vaccines and Women's Security](#).

45 GBV AoR Helpdesk (2021) [COVID-19 Vaccine Rollout – What do we know from past public health emergencies about gender-based violence risks and gender-related barrier to vaccine access?](#)

46 Ibid.

47 The Diplomat (2021) [Why Humanitarian Assistance Matters: The Case of Climate Disaster and COVID-19 in Timor-Leste](#).

48 SDG3 Global Action Plan for Healthy Lives and Well-Being: Gender Equality Working Group (2021) [Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable COVID-19 Vaccine Deployment](#).

49 Time (2021) [Asia Was a Model for How to Deal With COVID-19. Why Is It Lagging in Vaccine Rollouts?](#)

50 Social Weather Stations (2020) [SWS September 17-20, 2020 National Mobile Phone Survey](#).

51 CNN Philippines (2021) [OCTA survey: Only 25% of Metro Manila respondents willing to get COVID-19 Vaccine](#).

52 Alfonso, C., et al. (2021) [From Dengvaxia to Sinovac: Vaccine Hesitancy in the Philippines](#).

53 De Figueiredo, A., et al. (2020) [Mapping global trends in vaccine confidence and investigating barriers to vaccine uptake: a large-scale retrospective temporal modelling study](#).

54 BBC (2019) [How a wrong injection helped cause Samoa's measles epidemic](#).

trials, lack of inclusive registration standards and challenges with valid photo identity cards.⁵⁵ Some studies have found the highest estimates of non-intent to receive COVID-19 vaccination among women, adults from ethnic minority groups, adults living in non-metropolitan areas and adults with less education and income who lack health insurance.⁵⁶

Overburdened health systems

While COVID-19 has challenged even countries with the most prepared health systems, overwhelming barriers are seen in lower income economies. In lower resource settings, such as Vanuatu, only 85 registered nurses are available across the country's 60 islands.⁵⁷ With declining projections of health workers globally (shortfalls are estimated around 18 million by 2030, particularly in low- and middle-income countries), COVID-19 response requires a multifaceted approach, including public education, training of health-care professionals and appropriate vaccine administration infrastructure and venues. Significant resources are required to deal with the increased pressure that will be on health systems that are currently fragile.⁵⁸ In previous outbreaks, such as Ebola, health systems were overburdened and governments diverted essential resources from other departments, such as sexual and reproductive health services, to deal with the outbreak. As a result, significant regional increases in maternal mortality and morbidity were recorded.⁵⁹ This is further complicated by recent increases in rates of adolescent pregnancy during the pandemic, which were exacerbated by school closures.⁶⁰ As a result of COVID-19, fewer women are accessing routine and essential primary care and sexual and reproductive health services for themselves and fewer children are accessing primary care, as shown in decreased rates of childhood vaccinations, including the

MMR vaccination.⁶¹ Safe and effective vaccine and COVID-19 response services need to reach these population groups so that gains toward gender equality will not be reversed.

Conclusion

Women, especially those with intersecting vulnerabilities, need to be targeted in vaccine outreach and delivery to improve overall health outcomes for communities. Recognizing and resolving gender-based barriers to vaccination is particularly critical because women are often tasked with caring for family members, and women play a central role in health and immunization decisions.⁶² That role should be leveraged to benefit the equitable distribution of vaccines and overall uptake within communities. Gender equity in vaccinations will not only improve public health outcomes but also mitigate GBV and protection risks, including sexual exploitation and abuse.

PERSPECTIVES FROM WOMEN FOCUSED ORGANIZATIONS

The Gender in Humanitarian Action Working Group (GiHA WG), VOICE and the Gender Based Violence Area of Responsibility (GBV AoR), convened a 'Listening Session for Women-Focused Organizations on the COVID-19 Vaccine Rollout in Asia and the Pacific' on 25 May 2021 with representatives from the following organizations and networks serving diverse women who shared their views: Philippines Federation for the Deaf, YuWaah Youth Warriors Coalition, HomeNet International, Fiji Women's Rights Movement, Ekjut India, Maldives Red Crescent, and ActionAid Afghanistan. Some participants also facilitated breakout sessions that provided a platform for discussion on issues related to COVID-19 vaccine supply and demand. In addition, speakers from Gavi, The Vaccine Alliance, and UNICEF were represented to participate and listen.

55 Choudhary, P. (2021) *Less than 4% vaccinated – Transgender Indians have been 'othered' by vaccines and forms.*

56 MMWR/CDC (2021) *COVID-19 Vaccination Intent, Perceptions, and Reasons for Not Vaccinating Among Groups Prioritized for Early Vaccination – United States, September and December 2020.*

57 The Pacific Project (2021) *Vanuatu coronavirus vaccine rollout to take until end of 2023.*

58 WHO (2021) *Weekly Operational Update on COVID-19, 16 March 2021.*

59 Gavi (2020) *Why a gender lens is needed for the COVID-19 response.*

60 UNICEF (2020) *COVID-19 and Girls' Education in East Asia and Pacific.*

61 Obasanjo Afolabi Bolarinwa et al. (2021) *Mapping Evidence of impacts of COVID-19 outbreaks on sexual and reproductive health: A scoping review, in Healthcare (Basel).* April; 9(4): 436.

62 Gavi (2021) *Gender and Immunisation.*

The following graphic rendering captured the listening session.

LISTENING SESSION WITH WFOs ON COVID-19 VACCINE ROLLOUT IN ASIA AND THE PACIFIC: PANELISTS SHARING SESSION

ORGANISED by:



COMMUNICATION IS THE MAIN BARRIER FOR THE DEAF COMMUNITY

- IN PHILIPPINES, PEOPLE MAKE DECISIONS FOR US!
- E.G. HEALTH: "I HAD A CESAREAN SECTION, BUT IT WAS THE DOCTOR'S CHOICE"
- MOST OF MY INFORMATION COMES FROM FB, TV, & MY DEAF FRIENDS. WE LIVE IN A REMOTE WORLD.



YOUTH WARRIORS COALITION:

- MOBILISING YOUTH: CALL FOR VOLUNTEERS TO JOIN ACROSS SOCIAL MEDIA & NETWORKS
- YOUTH ENGAGEMENT ON LOW TECH PLATFORMS: REGISTER ON WHATSAPP TO PROMOTE VERIFIED COVID-19 INFORMATION
- COMMUNICATION ON CAMPAIGN: PROMOTE POSITIVE STORIES OF YOUTH ACTION THROUGH PARTNERS & INFLUENCERS
- KNOWLEDGE HUB: VIRTUAL LIBRARY WITH STATE SPECIFIC INFO, TOOLS & LEARNING MODULES
- MENTAL HEALTH HELPLINE: SPECIAL HELPLINE FOR YOUTH & OTHER FRONTLINE VOLUNTEERS WITH SUPPORT OF CSOs



COVID-19 HAS MOVED TO RURAL AREAS. WHERE DEATH RATES ARE RISING

THERE'S A LOT OF FAKE NEWS & MISINFORMATION

YOUTH ADVISORY LEADERS ARE ACTIVELY PROMOTING VACCINATION IN THEIR LOCAL COMMUNITIES

EXPLAIN WHY VACCINE IS ESSENTIAL

MITIGATE ACCURATE INFORMATION AND NEWS

WORKING ON SOCIAL MEDIA & ON THE GROUND

THERE'S RESTRICTED ACCESS TO THE VACCINE FOR WOMEN, GIRLS & THE DIFFERENTLY ABLED

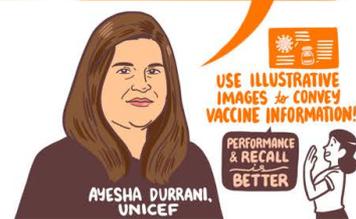


VACCINATION ISSUES:

- LOW LITERACY LEVEL OF MOTHERS
- SOCIO-CULTURAL BARRIERS
- MOBILITY ISSUES-DAILY WAGE EARNERS FROM URBAN SLUMS
- MISINFORMATION AROUND VACCINES
- LIMITED ACCESS TO DIGITAL INFORMATION SERVICES
- MALE VACCINATORS FOR VACCINATING FEMALES
- ONLY FEMALE SOCIAL MOBILISERS: FACE HARASSMENT FROM COMMUNITIES

VACCINATION HESITANCY IN PAKISTAN IS DUE TO...

- WORRIED ABOUT SIDE EFFECTS (E.G. FERTILITY ISSUES)
- WAIT & SEE EFFICACY
- BELIEF OTHERS NEED THE VACCINE MORE THAN THEY DO



LISTENING SESSION WITH WFOs ON COVID-19 VACCINE ROLLOUT IN ASIA AND THE PACIFIC: SUPPLY AND DEMAND BREAKOUT SESSIONS

ORGANISED by:



SUPPLY

EASIER VACCINE ACCESS FOR THE RICH!

DIGITAL REGISTRATION IS A BARRIER FOR THOSE WITH NO ACCESS TO WIFI...

LACK OF STOCK HAS ALSO PREVENTED SOME FROM RECEIVING THEIR 2ND DOSE

INVISIBLE DISCRIMINATION

- RURAL COMMUNITY & THE POOR
- LESS DIGITIZED COMMUNITIES
- TRANSGENDER COMMUNITY FEARING VIOLENCE & DISCRIMINATION
- REFUGEES WITHOUT IDENTIFICATION WHO CAN'T REGISTER FOR VACCINATION

MOBILE VACCINATIONS ESP FOR WOMEN WITH LIMITED MOBILITY!

IT IS THE DUTY OF THE GOVERNMENT TO ACQUIRE VACCINES FOR ALL. THIS IS A RIGHT! NOT A PRIVILEGE.

NEPAL
IMPUNITY & CORRUPTION PREVENTING VACCINE ROLLOUT

DEMAND

ISSUES FOR VACCINE ROLL OUTS:

- LACK OF DOCTORS DURING CONDUCT
- FAKE NEWS REGARDING VACCINES' EFFECTS
- PREFERENCE FOR VACCINES WITH HIGH EFFICACY RATES
- REFUSING TO USE BRANDS AVAILABLE

LACK OF VACCINATIONS FOR:

- WOMEN MIGRANTS
- THOSE IN RURAL AREAS

THIS IS DUE TO...

- UNABLE TO TAKE TIME OFF WORK
- STIGMA
- LANGUAGE BARRIERS

GOVERNMENTS LACK VACCINE INFORMATION IN VARIOUS LANGUAGES FOR MIGRANT WORKERS

URDU BAHASA INDONESIA TAGALOG

PHYSICAL ACCESSIBILITY:

- WOMEN'S MOBILITY ISSUES
- LACK OF TIME TO GO TO VACCINATION SITES

MOST REGISTRATION MODALITIES ARE:

- ONLINE
- DIGITAL

NOT EVERYONE CAN ACCESS!

SECURING A TIME SLOT FOR VACCINATION IS DIFFICULT

SUGGESTIONS:

- ADVOCATE FOR DIFFERENT APPROACHES FOR LOGISTICS DISTRIBUTION:
 - MOBILE SERVICE DELIVERY TO REACH MARGINALISED GROUPS WHO MAY NOT BE ABLE TO GO TO VACCINATION CENTERS
- ENSURE SMOOTH SUPPLY OF VACCINES
- FREE FOR ALL:
 - PRIORITISE THOSE WITH DISABILITIES & MENTAL HEALTH ISSUES
- STOP STIGMATISING MIGRANT WORKERS
 - CREATE A SPACE FOR PEOPLE TO ASK QUESTIONS
- CLEARER INFORMATION TO BE CONVEYED TO EVERYONE!
- ENGAGE COMMUNITY-LEVEL ORGANISATIONS OF WOMEN; HOME-BASED WORKERS; COMMUNITY HEALTH WORKERS; ORGANISATION OF PERSONS WITH DISABILITIES

Breakout sessions focused on gendered barriers to COVID-19 vaccine demand and vaccine supply. The discussions and recommendations of those sessions are summarized below. Implementing these recommendations can lead to a range of positive outcomes across multiple sectors of development and humanitarian action – health, protection, education, livelihoods, etc.

Gendered barriers to COVID-19 vaccine uptake

Women-focused organizations expressed the following gender-related barriers in accessing COVID-19 vaccines.

Key examples of physical accessibility issues experienced by women:

- Heightened **mobility** issues
- Limited **availability** to go to vaccination sites within given hours
- **Long distances** to vaccination centres, and due to imposed lockdowns transport is either limited or non-existent
- **Rural/urban divide:** COVID-19 vaccine is not reaching rural parts of countries, despite second waves of COVID-19 affecting these areas

Key examples of administrative accessibility issues experienced by women:

- Registration modalities are **online or digital**, requiring Internet access or smartphones, without these resources or digital competence, securing a time slot for vaccination is challenging
- Vaccination may not yet be available for **specific groups**, e.g., pregnant or lactating women
- **Vulnerable populations**, including the severely ill, persons with disabilities, persons with mental illness, and homeless, experience heightened difficulty in accessing vaccination centers and are dependent upon others to access
- In some cases, vaccines are **for sale**, increasing the barriers faced by women and vulnerable groups in accessing the vaccine

Key examples of social accessibility issues experienced by women:

- Limited availability due to **domestic care** obligations
- Hesitant to experience side-effects/fear of getting sick due to fear of missing work/paid home-based work, care, or domestic obligations: *“cannot afford to get sick”*
- **Deprioritized** within household; with limited supplies of vaccines the preference may be provided to the male earning member of the household
- Lack of **translated information** (in Urdu, Bahasa Indonesia, or Tagalog) on vaccination programmes, particularly impacting women migrant workers
- **Discrimination** and **stigma** related to COVID-19 particularly experienced by women migrant workers

Key examples of information accessibility issues experienced by women:

- Lack of **demand generating** and **awareness raising** activities for vaccine rollouts, possibly due to scarce vaccine supplies; marginalized populations are especially impacted
- **Vaccine hesitancy** is hampering the vaccine rollout
 - » Social media fuelling **misinformation**
 - » **Myths** related to risks of infertility in women, impotency in men, or risk of death
 - » **Myths** based on religious grounds are common in the Pacific, an opportunity for faith-based organizations to play a crucial role in guiding trustworthy information in communities
 - » Fear of **side effects** (including fever, chills, body ache, vomiting) without counselling on what to expect or medical follow-up if treatment needed

Recommendations

- Given the already devastating socioeconomic impacts of COVID-19, imposed lockdowns, and restrictions on communities:
 - » Vaccines should be available for everyone, free of cost (this may also mitigate GBV risks, including prevention of sexual exploitation and abuse)
 - » Vaccination rollouts should specifically target hard to reach populations
- Ensure national vaccine prioritization strategies account for overlapping vulnerabilities and intersecting identities of women and girls who are most exposed and vulnerable to COVID-19:
 - » Good practices identified: Fiji is using mobile service delivery in addition to static vaccination sites to reach marginalized groups
 - » Prioritize market vendors in fruit and vegetable markets as frontline workers for vaccinations, given many countries in the region face challenges around food insecurity, which has been exacerbated during the pandemic
- Promote women's voices and leadership in all levels of decision-making during the COVID-19 response to ensure equitable distribution of the vaccine
- Engage community-level organizations of women-focused and youth-centred organizations that engage girls in community outreach and participation (home-based workers, community health workers, organizations representing persons with disabilities, faith-based groups, etc.) to support the vaccination campaign and delivery
- Amplify efforts to ensure timely and accurate information on COVID-19 vaccines is disseminated in accessible formats and various languages with an intersectional approach, to specifically reduce the spread of misinformation, vaccine hesitancy and discrimination and stigma associated with COVID-19:

- » Engage faith-based organizations to counter and dispel myths and address vaccine hesitancy⁶³
- » Specific recommendations for people with disabilities:
 - Provide sign language interpreters for deaf people receiving the vaccine
 - Develop targeted and inclusive communication outreach and materials for people with disabilities on COVID-19 vaccines
 - Create open and inclusive spaces for people with disabilities to engage questions and responses related to COVID-19 vaccine rollouts (for example, online discussions that can be recorded and shared to organizations representing people with disabilities)



Photo: UN Women/Louie Pacardo

63 WHO (2021) WHO Director-General and global faith leaders high-level dialogue on COVID-19.

Gendered challenges in COVID-19 vaccine supply

Women-focused organizations expressed the following gender-related challenges in supplying COVID-19 vaccines equitably.

- Vaccine inequity widens social inequities and disparities, and the reversal of gains toward gender equality
- Poor management of vaccine supply chain:
 - » Disrupted and uncertain supplies of vaccines are concerning and present challenges for delivery of the **second dose** within the proper timeframe
 - » Instances of vaccine **doses damaged** and wasted due to lack of information to providers on management
 - » Instances of **political disturbance, impunity and corruption** delay vaccine rollout to wider population
 - » Countries struggle to deal with dual crises and **collapsed health infrastructure** or minimal health facilities that impede rollout (e.g., Myanmar, Nepal)
- Inequitable distribution of vaccines occurring across demographic groups (including gender, class, caste, rural/urban):
 - » Notable trends reported mostly from South Asian countries
 - » Large **rural/urban divide** in vaccine distribution; rural areas experience increased barriers due to unreachable terrain in many parts of the region (e.g., Nepal), urban poor experience additional barriers as well
 - » Women and youth are being excluded from priority groups eligible for vaccination
 - Women are struggling to access the vaccine due to **care giving obligations, cost of transport, hard-to-access centres and increased risk of GBV**
 - In India the **age group 18–45** was reportedly excluded from vaccine provisions despite making up significant portions of frontline workers

- Youth, particularly girls, are reporting high levels of anxiety and strains on mental health in relation to vaccine promotion in communities
- » Vulnerable populations are being left behind
 - **Migrant workers**, especially the **undocumented**, face barriers in registering for the COVID-19 vaccine and accessing trustworthy information
 - **Transgender populations** experience barriers in accessing the vaccine due to stigma, discrimination and reported levels of violence; communication efforts are not targeting or engaging transgender communities (who have some of the lowest vaccine acceptance rates) to transform behaviours for adoption of vaccinations
 - **Refugee communities** lack access to national identity cards, required for accessing vaccines or response services; urgency was noted for vaccination rollouts in camp settings, such as Cox's Bazaar
 - **Dalit women** lack access to the vaccine and medical services in Nepal, and face multiple additional risks, such as poverty and food insecurity
- Exclusively **digitized vaccine information and registration systems** are perpetuating the exclusion of marginalized communities and leaving behind those most vulnerable:
 - » Gaps in literacy, digital literacy and access to the Internet/smartphones, mean women, especially those living in rural areas, are less likely to access trustworthy information about COVID-19 vaccines
 - » Many are reporting that registration processes are unclear, presenting challenges for rural people and marginalized communities, particularly women
- Despite increased reports of **GBV** during the pandemic, **sexual and reproductive health and rights and emergency contraception services** are not being prioritized in overburdened health systems, where resources are instead diverted to the COVID-19 response

Recommendations

- ➔ Provide vaccination openly as a duty of State, not as a privilege:
 - » Ensure equitable and free access to vaccines for all population groups
 - » Given supply shortages, women focused organizations recommend waiving intellectual property protection on coronavirus vaccines to allow wider production and larger global output for the high demand
 - » Advocate for different approaches for logistics distribution; provide logistical support to women and groups, who experience barriers due to care giving obligations and cost of transport, through cash provision or household visits
- ➔ Ensure inclusive and diverse representation of women and marginalized groups in national COVID-19 task forces, including for vaccine distribution
- ➔ Improve the work environment for frontline workers:
 - » Ensure all frontline workers are prioritized and eligible to receive COVID-19 vaccination, despite demographic differences:
 - Connect and engage youth volunteers
 - » Invest in mental health support and services for frontline workers
- ➔ Develop strong platforms and action plans for Risk Communication and Community Engagement to ensure people are receiving the necessary information on COVID-19 vaccines:
 - » Develop targeted and inclusive materials for key population groups, such as transgender populations, to transform behaviours for adoption of the vaccine
- ➔ Ensure life-saving services, such as sexual and reproductive health and rights and GBV services, remain prioritized, available and accessible for those most in need

We thank those who participated in the virtual listening session with women-focused and youth/girl-centred organizations on gender and the COVID-19 vaccine rollout, in particular the speakers and organizers from the Voice of Women Organization, Philippines Federation for the Deaf, YuWaah Youth Warriors Coalition, HomeNet International, Fiji Women's Rights Movement, Ekjut India, Maldives Red Crescent, ActionAid Afghanistan, VOICE, Gavi The Vaccine Alliance, United Nations Children Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the Gender-Based Violence Area of Responsibility (GBV AoR – Asia and the Pacific), the World Health Organization (WHO), CARE, and the International Federation of Red Cross and Red Crescent.

Key resources for addressing gender barriers in the COVID-19 vaccine rollout:

- [Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable COVID-19 Vaccine Deployment](#) (SDG3 Global Action Plan for Healthy Lives and Well-Being: Gender Equality Working Group)
- [Proposed Actions vis-à-vis Emerging GBV Risks in relation to the deployment and vaccination plan for COVID-19 vaccines](#) (GBV AoR)
- [Gavi Guidance to Address Gender-Related Barriers to Maintain, Restore and Strengthen Immunisation in the Context of COVID-19](#) (Gavi The Vaccine Alliance)
- [WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply](#) (WHO)
- [Gender and Immunization Toolkit; Immunization and Gender](#) (UNICEF ROSA)

For access to more resources and information, please visit our [Resource Repository](#)



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**From
the People of Japan**