

GUIDANCE NOTE AND CHECKLIST FOR TACKLING GENDER-RELATED BARRIERS TO EQUITABLE COVID-19 VACCINE DEPLOYMENT

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Developed by the **SDG3 Global Action Plan For Healthy Lives and Well-Being: Gender Equality Working Group**



and the **Gender and Health Hub, United Nations University International Institute for Global Health**



THE WHAT

- The goal is to safely vaccinate as many women, men, and gender-diverse people as possible, equitably, efficiently, and effectively, to maximize the protective benefits of COVID-19 vaccines.
- Achieving this goal requires addressing gender-related barriers to vaccine access, information, uptake, and effectiveness.
- This checklist provides a set of practical actions for countries to implement and ensure gender equality and equity in the deployment of COVID-19 vaccines towards the aim of “leaving no one behind”.

THE WHY

Gender-related barriers and inequities in communities and health systems negatively affect access to health services, including vaccination.¹

The consequences of neglecting these barriers in COVID-19 vaccine deployment include:

- insufficient or fragmented vaccination delivery, demand, and access, resulting in gaps in vaccination coverage and hindering the achievement of population-level immunity needed to curb the pandemic.
- increased burden of preventable morbidity and premature mortality from COVID-19 and other conditions that are exacerbated by gender-related barriers and inequities in accessing health services.^{2 3 4}
- delayed economic recovery, particularly among people who experience multiple intersecting forms of disadvantage and marginalization (e.g., based on geographic location, socio-economic status, ethnicity, and disability) and who experience loss of employment, decreasing income and savings, and increased burden of unpaid care.^{5 6}
- widened gender inequities and inequalities and violations of rights in society and in the economy by hindering access to economic resources, formal employment, and care services.⁵

THE HOW

- **Consider and implement the priority actions in this checklist** to address specific gender-related barriers in COVID-19 vaccine deployment.
- **Identify and act on the known and context-specific barriers** that are influenced by gender inequalities to achieve the highest level of population coverage possible.
- **Prioritize targeted outreach to vulnerable and disadvantaged groups^a** within each priority population eligible for vaccination, and address the additional gender-related barriers they face.
- **Partner with women's organizations and other community-based groups** to ensure accurate information is available to communities, and gender perspectives are considered in planning, design, and monitoring.

The target audience for this checklist

- Both COVAX-supported⁷ and self-financing countries
- COVID-19 vaccine deployment Coordinating Committees and National Immunization Programme managers
- Country stakeholders^b responsible for planning, implementing, and monitoring COVID-19 vaccine deployment
- Reviewers of COVID-19 National Deployment and Vaccination Plans (NDVPs)
- Multilateral development partners supporting vaccine deployment

a These vulnerable groups may include: people with disabilities; people living with HIV; indigenous people; rural or hard-to-reach populations; people living in institutional setting, such as in shelters, detention centers or prisons; ethnically, racially and sexually diverse groups; marginalized occupational groups with high exposure to SARS-CoV-2; migrants; refugees; indigeneous people; people living in humanitarian conditions or conflict zones.

b Country stakeholders who should be consulted in vaccine deployment planning and implementation, including civil society, health workers, employer and trade unions, religious and traditional leaders, the private sector, gender experts, representatives of women and gender-diverse people, and groups with intersecting marginalized status.

THE CHECKLIST



1

Regulatory preparedness

Make sex and age disaggregated data on pre- and post-market vaccine trials an essential requirement for expedited approval and emergency regulatory approval procedures.



2

Planning and coordination

Ensure gender balance and representation from women's groups and marginalized high-risk groups in coordination and decision-making bodies responsible for COVID-19 vaccine deployment.



3

Costing and funding

Mobilize and allocate sufficient resources to implement the gender-related actions described in this checklist at scale.



6

Human resource management and training

- Value and remunerate the work and time of women healthcare workers and volunteers.
- Put in place mechanisms to ensure the safety of all in the vaccine deployment workforce.
- Incorporate gender considerations when planning for human resources in the vaccine deployment and in-service training to reach priority populations. This may require task-shifting, surge recruiting, and tailored trainings.



5

Vaccine delivery strategies

- Use differentiated vaccine delivery strategies to effectively reach women, men and gender-diverse people.
- Address gender-related barriers to vaccine enrolment/registration and follow-up.



4

Priority populations for vaccination

- Organize the delivery of vaccinations across and within prioritized population groups considering gender and intersecting inequalities that hinder access to services.
- Plan to offer vaccination to pregnant and lactating women in priority target groups.



7

Vaccine acceptance and uptake

Address gender-related barriers to vaccine information and uptake through tailored messages and communication channels that address the specific concerns of different sub-groups of women, men and gender-diverse people, including health and social workers, people with pre-existing illnesses and compromised immunity, pregnant and lactating women.



8

Vaccine safety

Mechanisms for both active and passive reporting should capture sex and age disaggregated data, pregnancy/lactating status, frequency, and severity of adverse events following immunization.



9

Monitoring and evaluation systems

Monitor vaccine implementation progress and equitable access through selected priority indicators that include national and subnational data disaggregated by sex and age (and race, income level, migrant status, and other contextually relevant factors).

The checklist aligns with:

- the **United Nations equality principle**⁸ and the equal respect principle of the **WHO SAGE Values Framework**⁹, which underscores that immunization delivery systems place equal focus on reaching everyone in every COVID-19 vaccination priority group.
- existing international guidelines, including **WHO and UNICEF's National Deployment Vaccination Plan (NDVP) guidance**,¹⁰ and lessons learned on gender, immunization and COVID-19.¹¹⁻¹⁵

Tactical principles for addressing intersectional gender barriers and implementing the checklist:

- Apply an approach that upholds **human rights** and the principles of '**do no harm**' and '**leave no one behind**'.
- **Address gender power inequalities** in accessing vaccination, including women's limited mobility, decision-making power, access to resources and their risks of experiencing sexual harassment, exploitation, and other forms of gender-based violence.
- **Address stigma and discrimination** as key barriers in accessing vaccination, linked to age, gender identity, sexual orientation, occupation, citizenship status, or other factors.
- **Collaborate with a range of stakeholders** and draw on the lived knowledge, experience and trust-relationships of community and civil society groups for effective vaccine deployment.
- **Actively engage non-traditional stakeholders** in vaccine deployment planning and decision-making processes, such as women's, ethnic and indigenous organizations and community-based groups, as well as government departments that coordinate gender equality and human rights.
- **Hold all implementers and stakeholders accountable** throughout vaccine deployment.
- Be **responsive to new evidence**, evolving lessons, and emerging gender considerations in real-time, through iterative planning, social listening, learning, and adaptation in consultation with key stakeholder groups.

KEY SEX AND GENDER CONSIDERATIONS FOR EQUITABLE DEPLOYMENT OF VACCINES

Domain	Examples of biological differences and gender-related barriers, inequalities and inequities
 <p>Regulatory preparedness and vaccine safety</p>	<ul style="list-style-type: none"> ● With the COVID-19 vaccines, initial data suggests that while very rare, more adverse events are being reported among women.¹⁶ This underscores the importance of rigorous sex-disaggregated data in post-marketing monitoring of adverse events.
 <p>Coordination, decision-making, and planning</p>	<ul style="list-style-type: none"> ● Women continue to be under-represented in leadership roles and decision-making bodies leading COVID-19 responses.¹⁷ ● There is even lower representation of and engagement with women with intersecting identities or statuses that are often marginalized in society (including race, ethnicity, migration status, disability, HIV status.); sexual orientation and gender identities and expressions.¹⁸
 <p>Priority populations for vaccination</p>	<ul style="list-style-type: none"> ● Men, women and gender-diverse groups experience different forms of risk to COVID-19 and its consequences. While men have more severe complications and higher mortality in acute COVID-19 infections, evidence suggests that women are more likely to suffer from long-term symptoms of COVID ('post COVID condition').^{19 20} ● The WHO SAGE Roadmap for prioritizing uses of COVID-19 vaccines underscores the importance of ensuring that immunization delivery systems place equal focus on reaching both men and women in every priority group. This requires acting on gender-related barriers and inequities. ● The socio-economic impact of the COVID-19 pandemic is high among women, due to preexisting inequalities, such as their limited financial security, their over-representation in the informal sector, frontline occupations and economic sectors most affected by the economic downturn, their burden of unpaid care and home-schooling, and their increased experience of gender-based violence.⁵ <p>²¹ Although the priority populations for vaccination are defined based on risk and exposure, these indirect impacts should be considered in the sequencing of the vaccine roll-out within each priority group.</p>

Domain	Examples of biological differences and gender-related barriers, inequalities and inequities
 <p>Vaccination delivery strategies</p>	<ul style="list-style-type: none"> ● Structural gender-related barriers, such as social, cultural, financial and legal inequalities create critical challenges to meet the health needs of women, men and gender-diverse people, including vaccinations.²² ● In many settings women have limited autonomy and decision-making power, even over their own health care needs – and limited time to seek services because of their caring responsibilities.^{23 24} With service disruptions and school closures, women are shouldering the brunt of unpaid care work, which can affect their the access to vaccination information and services.¹³ ● The opening times and location of services, and how women and gender non-conforming people are treated when receiving health services, such as vaccinations, can impact uptake.²⁵ ● In certain settings, engagement with men on women’s right to vaccination can address some of the social barriers for women’s uptake of the vaccine, but should recognise women’s agency and not reinforce power imbalances.²⁶
 <p>Human resource management and training</p>	<ul style="list-style-type: none"> ● Globally, women account for 70% of the health and social workforce delivering care to around 5 billion people²⁷, but are poorly represented in managerial and decision-making positions, including in the COVID-19 vaccine roll-out.²⁷ ● Existing power imbalances, wage gaps, irregular salaries and non-financial compensation (e.g., for community health workers), lack of formal employment, and exclusion from leadership and decision-making can result in limited access to vaccines, and increased vulnerability to infection from lack of protective structures and resources (including personal protective equipment).²⁷ ● Vaccine shortages and rationing can contribute to the perpetration of sexual harassment (including sex for vaccines), abuse, mistreatment and corruption in the health sector. These abuses have been previously reported in multiple settings in health programmes, including in humanitarian settings.
 <p>Vaccine acceptance and uptake</p>	<ul style="list-style-type: none"> ● Gender-related factors can influence vaccine confidence and hesitancy.^{28 29} In some settings, women’s limited access to trustworthy information, previous experiences, limited decision-making power and dependence on men in their households and those in perceived positions of power (e.g., teachers, local healers, religious leaders) can negatively influence their uptake of vaccinations.
 <p>Monitoring and evaluation system</p>	<ul style="list-style-type: none"> ● To date only 54% of countries have reported sex-disaggregated data on confirmed cases.³⁰ ● Only a handful of countries are reporting coverage of vaccinations, and even less by sex and age.³⁰

CHECKLIST

This checklist provides priority actions and examples to address gender-related barriers and inequities in COVID-19 vaccine deployment. The domains and actions are not necessarily chronological and may take place concurrently.



Regulatory preparedness

- Make sex and age disaggregated data on pre- and post-market vaccine trials an essential requirement for expedited approval and emergency regulatory approval procedures.**

Approval should not be delayed if disaggregated data is not available immediately, but agree on a timeframe for its provision and consider imposing penalties if this data is not provided within the agreed time period.^{c31}



Planning and coordination

- Ensure gender balance and representation from women's groups and marginalized high-risk groups in coordination and decision-making bodies^d responsible for COVID-19 vaccine deployment.³²**

Include meaningful involvement of gender experts (particularly with expertise in immunization and development), and representation from two or more of the following groups:

- Women-led organisations at the national and community level.³³
- Civil society organisations representing the rights of gender-diverse people, and groups who face other forms of discrimination, including migrants and refugees, ethnically and racially diverse groups, people living with disability, people living with HIV.
- Workers in frontline occupations that are dominated by women or men, including health (nurses, midwives), social care (community workers), and other sectors (school staff, food retail workers, cleaning staff, firefighters, law enforcement, service industry).

^c WHO stipulates that 'rolling reviews' of evidence may be acceptable, and calls for sex-disaggregated clinical efficacy in: Considerations for Evaluation of Covid19 Vaccines. Points to consider for manufacturers of COVID19 vaccines. WHO Switzerland, November 2020. Accessed February 19, 2021. https://www.who.int/docs/default-source/in-vitro-diagnostics/covid19/considerations-who-evaluation-of-covid-vaccine_v25_11_2020.pdf?sfvrsn=f14bc2b1_3&download=true

^d Including but not limited to the National Coordinating Committee (NCC), National Immunization Technical Advisory Group (NITAG) and technical working groups (TWGs)



Costing and funding

- Mobilize and allocate sufficient resources to implement the gender-related actions described in this checklist at scale.**

Including, but not limited to:

- Collecting, analyzing, and disseminating national and subnational sex and age-disaggregated data, and conduct qualitative research.
- Human resources, logistics, communication.
- Implementing rights-based demand generation strategies to address knowledge and information barriers to vaccine uptake.
- Rolling out community-based service delivery models.
- Integrating modules on gender equality, rights and prevention and protection of sexual harassment, abuse and exploitation in trainings of COVID-19 vaccine deployment for the health workforce.



Priority populations for vaccination

- Organize the delivery of vaccinations across and within prioritized^e population groups considering gender and intersecting inequalities that hinder access to services.¹¹⁻¹³**

For example:

- Apply needs and risk-based analysis for vaccine prioritization of health workers (including community health workers) that identifies those who are most exposed, irrespective of their gender, positions, race or ethnicity and establish mechanisms of redress and accountability for preferential vaccinations.
- Once frontline health personnel and nationally identified high-risk populations are vaccinated, consider the unequal impacts of the pandemic measures and school closures on women's unpaid care burden and labour force participation, and the benefits of prioritizing the vaccination of teachers to support the safe reopening and functioning of schools, as well as women in other occupations on the frontline (such as pharmacists, grocery clerks, markets, restaurants, cleaning staff, etc.).

- Plan to offer vaccination to pregnant and lactating women in priority target groups.**

Provide training and evidence updates to vaccinators on how to discuss risks and benefits with clients and answer questions, to enable informed decision-making by pregnant and lactating women.

^e Prioritization strategies should be aligned with recommendations from the WHO SAGE values framework and based on evidence that identifies specific populations at greater risk for infection, morbidity and mortality



Vaccine delivery strategies

- Use differentiated vaccine delivery strategies to effectively reach women, men and gender-diverse people.**

For example:

- 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, occupation, criminalized status, and tailor strategies accordingly.
- Community and periphery health centers are known to be more accessible for women.
- On-site workplace vaccination (e.g., construction sites and truck stops, garment factories) can increase access for occupational groups that face gender-related and other barriers to access health services.
- Mass vaccination campaigns with women vaccinators to ensure social acceptability of services for women in communities with gender segregation.

- Address gender-related barriers to vaccine enrolment/registration and follow-up.**

For example:

- Design enrolment and registration to be inclusive and accessible to all, and limit contingencies that exclude some people in the population (e.g. national identity cards prevents vaccine access for stateless or undocumented migrants; women's more limited access to smartphones or internet will constrain their digital registration through websites or government apps).
- Integrate vaccine delivery into settings where the community has trust, such as community-based programmes; and/or mobilize trusted community health and social workers to provide outreach and assist groups who face enrolment challenges.
- Identify channels of communication and influencers to reach older adults and people with comorbidities, and those with special needs.
- Adjust service logistics that accommodate the differing needs of women, men and gender-diverse people: women with young children, and single parents need child-friendly and safe spaces; privacy considerations; extended and flexible vaccination hours to accommodate working hours and caregivers' responsibilities; where gender-segregated spaces are culturally required, options should be provided for people whose gender does not match their ID, etc.
- Integrate COVID-19 vaccinations into existing service delivery that responds to gender-specific needs, such as community-based sexual and reproductive health services and antenatal care.



Human resource management and training

Value and remunerate the work and time of women healthcare workers and volunteers.

For example:

- Remunerate health workers in an equal and timely manner for any overtime during vaccination campaigns; and provide additional flexibility to enable them to balance their responsibilities outside of work.
- Professionalize and remunerate volunteers – vaccination campaigns should not exploit unpaid volunteers as this perpetuates women’s unpaid work and the gender pay gap.

Put in place mechanisms to ensure the safety of all in the vaccine deployment workforce.

For example:

- Consult with staff and community organizations to identify the types of safety issues that affect women, men and gender-diverse staff, and design potential mitigation strategies.
- Address menstrual health and hygiene needs by ensuring adequate rest and changing times for shifts, and safe, well-located, lit, hygienic washing and changing facilities that are accessible, including for people with disabilities.
- Implement safety measures to protect vaccinators, particularly women frontline workers that may be targets of harassment/ violence (confidential complaints system, ensuring lighted areas, accompanied travel to and from sites, law enforcement accompanying mass vaccinations).
- Implement a “zero tolerance” policy on discrimination, harassment, and exploitation reinforced through periodic trainings and implementing redress measures that provide reporting and support for victims of gender-based violence and recourse for perpetrators.

Incorporate gender considerations when planning for human resources in the vaccine deployment and in-service training to reach priority populations. This may require task-shifting, surge recruiting, and tailored trainings.

For example:

- Increase the number of vaccinators and social mobilizers at the community level where women access health services the most, particularly in settings where facility-based health services are not easily accessible.
- Pursue gender balance of vaccinators and social mobilizers to allow for women-to-women and men-to-men services in communities that practice gender segregation.
- In-service COVID-19 vaccine deployment trainings should cover: respectful patient communication and pre-vaccination communication on risks and benefits sensitive to the needs of women, men, and gender-diverse people, including survivors of violence and discrimination; codes of conduct for vaccinators to prevent and combat sexual exploitation, harassment and abuse; and how to refer survivors of gender-based violence safely and appropriately to specialized services.



Vaccine acceptance and uptake

- Address gender-related barriers to vaccine information and uptake through tailored messages and communication channels** that address the specific concerns of different sub-groups of women, men and gender-diverse people, including health and social workers, people with pre-existing illnesses and compromised immunity, pregnant and lactating women.

For example:

- Develop targeted communication messages that are evidence-based, culturally-sensitive, inclusive, in simple language to empower women, men, and gender-diverse people with information, vaccine literacy and address the different ways in which they access and respond to messages.
- Co-create messaging with stakeholders, including women's groups, indigenous communities, religious leaders, and ensure that messages are rights-based and do not reinforce **gender stereotypes** or any stigma, such as that encountered by people living with HIV, TB, mental health conditions and other disabilities, sex workers, prisoners.
- Leverage diverse communication channels to reach different sub-groups of women, men and gender-diverse people (e.g., where they are located, through community leaders, community-based women's and minority groups, young people's groups, primary health care workers, mass media, social media, mobile apps, informational websites, couple discussions to promote joint decisions)
- Use other culturally-sensitive and inclusive approaches, such as communication in different languages to reach migrant populations, and braille and sign language to reach persons with disabilities.
- Address doubts regarding efficacy and safety due to the rapid development of vaccines; and myths and misinformation relating to impotence, infertility, etc.
- Communicate evidence as it becomes available to support informed decision-making by pregnant and lactating women, and sub-populations.



Vaccine safety surveillance

- Mechanisms for both active and passive reporting should capture sex and age disaggregated data, pregnancy/lactating status, frequency, and severity of adverse events following immunization.**

- Refer to the **WHO COVID-19 Safety Surveillance Manual** for further guidance
- Collect and report sex-disaggregated data on all local and systemic adverse events



Monitoring and evaluation systems

- Monitor vaccine implementation progress and equitable access through selected priority indicators that include national and subnational data disaggregated by sex and age** (and race, income level, migrant status, and other contextually relevant factors)

Specifically:

- Vaccine uptake and coverage (including 1st dose, 2nd dose, drop-out, and full completion of schedule).
- Ensure full confidentiality of data and records.
- Conduct prospective surveys, qualitative analyses, and case studies that can inform, and document the gender dimensions that were identified and addressed in the vaccine deployment.^{33 34}

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