

COVID-19 AND GENDER BEST PRACTICES, CHALLENGES, AND LESSONS FOR FUTURE PANDEMICS

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MATAHARI



THE
PEOPLE'S
VACCINE



IMPRESSUM AND ACKNOWLEDGMENTS

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Matahari Global Solutions is a global health consultancy firm focusing on global health solutions with local relevance. Registered in Kuala Lumpur and with consultants based globally, our work has covered a wide range of global health issues, including pandemic response, [affordability and accessibility to COVID-19 and MPOX diagnostics in LMICs](#), [transgender legal recognition](#) and impact on access to healthcare, [paediatric TB](#) and impacts of advocacy, and the evaluation of multi-country HIV projects, across Africa, Asia, Eastern Europe and Central Asia, and Latin America.

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ABBREVIATIONS

AMC	Advance Market Commitment
CHWs	Community Health Workers
CSOs	Civil Society Organisations
DART	Development and Reproductive Toxicology
DRC	Democratic Republic of the Congo
FMoH	Federal Ministry of Health
FPV	Feminists for a People's Vaccine Campaign
GBV	Gender-Based violence
ICU	Intensive Care Units
IIGH	International Institute of Global Health, United Nations University
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual People
LMICs	Low- and Middle-Income Countries
NDVPs	National Deployment and Vaccination Plans
NGOs	Non-Governmental Organisations
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SAGE	Strategic Advisory Group of Experts COVID-19 Working Group (WHO)
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health and Research
SOGIE	Sexual Orientation and Gender Identity and Expression



DEFINITIONS¹

Cisgender/Cis

A person whose sense of gender identity correlates with the sex that they were assigned at birth.

Gender

Gender can be understood as the social and cultural construction of norms and behaviours attributed to people differently on the basis of their sex assigned at birth. Gender can also be understood as an identity. A person's innate sense of their own gender may or may not correspond to the sex they were assigned at birth, for example, trans men and women and non-binary people, and people of other genders as differently expressed in the different contexts and cultures in which we work.

Gender non-conforming

People who do not conform to the social norms associated with the gender that correlates with their sex assigned at birth.

Intersectionality

Intersectionality recognises how various parts of our identity – like race, sex, gender, sexuality, class and ability – overlap to create unique experiences of oppression and privilege. The term was created to reflect how Black women face both racism and sexism. Nowadays, it's applied more widely to other aspects of identity, and it's vital that we start but do not stop with race.

Non-binary

Non-binary refers to a spectrum of gender identities that are not exclusively masculine or exclusively feminine, i.e. identities that are outside the gender binary.

Transgender/Trans

People whose gender identity differs from their sex assigned at birth.



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EXECUTIVE SUMMARY

This report aims to highlight several structural barriers that women in all their diversity and gender non-conforming people face in accessing COVID-19 vaccines and therapeutics. While the report brings attention to these issues, more research is warranted for each of these barriers evident in pandemic preparedness and response. These were the documented barriers:

Gendered Social Norms/Traditional Roles. Gendered norms often result in women taking a disproportionate burden of domestic work, care for children, seek permission from male relatives to access healthcare, or present at vaccination centres with a male guardian.

Transportation and a Lack of Finances. With gendered roles comes limited access to transportation, with male partners more likely to have full-time use of owned vehicles, and a lack of access to financial means for public transport to travel to COVID-19 vaccination or treatment centres.

Health Systems Factors, including Digitalisation of COVID-19 Tools. Many governments rolled out digital-first tools for vaccine registration, leaving out elderly populations, disabled populations, and populations with less digital literacy. In LMICs, 165 million less women have access to mobile phones compared to men. In addition, the COVID-19 response did not take into account the need to deploy vaccines and treatments in safe environments for LGBTQIA+ people.

Exclusion from Clinical Trials. Pregnant and lactating people were left out of clinical trials for vaccines and for the novel antivirals, despite pregnant people having higher COVID-19 risk. This resulted in delays of lifesaving interventions, and increased misinformation.

Limited Gender-Disaggregated Data. Countries did not initially collect sex- and gender-disaggregated data on COVID-19 deaths, hospitalisation rates, and infections. In addition, there was poor sex- and gender-based analyses of clinical trial results.²

Literacy. Regardless of education levels, overall literacy has been cited as key for vaccination uptake. In some environments, low literacy of female community health workers meant that innovative approaches to vaccine uptake training had to be employed.

Right to Information, Digital Divide, and Community Engagement/Communications Strategies.

The pandemic failed to include gender-sensitive messaging and community engagement at inception, including via messaging that accounted for the roles that women had as primary caretakers in families, that used media channels most used by women, and by communicators that were most trusted by women.

Unpaid Labour and Compromised Income Generation During the Pandemic. The pandemic disproportionately impacted income generation for women and LGBTQIA+ people. In addition, women's workloads due to unpaid labour (childcare and other unpaid labour, such as on family farms, as community health workers, and as contract hospital cleaners) put them at increased COVID-19 risk.

Corruption. Corruption in PPE procurement was a contributing factor in driving up prices up for PPE. Given that the majority of healthcare workers were women, this created artificial scarcity for PPE and resulted in less protection for women. In addition to this, PPE often were not developed with women in mind.



Despite these documented barriers and their far-reaching impacts, our findings illustrate that in most scenarios gender-responsive interventions were only adopted reactively; for example, only when country-level data emerged showing a disparity in uptake of vaccines among women versus men in certain contexts, rather than at inception of pandemic plans.

An intersectional lens to the gendered impacts of pandemics should be the norm rather than the exception. Based on this, we conducted research towards this project objective: to document and expose gender inequalities faced by women and girls, transgender people, non-binary people and other marginalised groups, people with disabilities, and refugees, migrants, and other displaced populations in accessing COVID-19 vaccines and therapeutics, via the examination of prior and current vaccination rollout as well as rollout of novel antivirals for COVID-19. We also examined whether other forms of inequity such as racism, colonialism, ableism, and economic marginalisation have contributed to the gender inequalities.

Based on the analysis in this report, we make several recommendations. Below is a top line summary. For full recommendations see [here](#):



To Governments

- To report publicly sex disaggregated data and gender data on pandemic tools uptake, and include further disaggregation such as age, race/ethnicity, migration status, and disability, among other variables.³ In addition, there should be regular analysis, sensemaking, discussions in parliament and public communications around this data. Governments should also set targets and publish milestones towards achieving these targets.
- Co-creating this process with representatives of at-risk communities. To invest in social listening and focus groups with communities: community expertise and community-led solutions leads to more gender-responsive programming.
- To proactively include an intersectional gender perspective at the beginning of pandemic planning. This can be done by recognising and remedying the specific barriers women and gender diverse people face in access and distribution of vaccines and other diagnostics and treatments. This includes the following:
 - a) Providing access to pandemic tools where women and gender diverse people are during the daytime – this includes safe spaces, markets, churches, LGBTQIA+ NGO facilities, associations for persons with disabilities, and other spaces depending on local context.
 - b) To account for undocumented migrants, refugees, and ethnic minority women – including in terms of information about the pandemic pathogen and availability in local languages.
 - c) To provide travel reimbursements and direct cash support for communities of women and gender non-conforming people who need to take time off childrearing and informal work to be able to access vaccines.
- To invest in robust communications and community engagement strategies through the predominant mode of media that women get information from, as well as through all available channels, using communicators that are trusted by communities (these may not be doctors or the lead medical officer of government entities – this may be influencers, religious leaders, community health workers).



- To invest in community health workers/mobile services/door-to-door services from the outset, including to ensure uptake among elderly communities, individuals who have childrearing duties, persons with disabilities, and migrant populations.



To Global Health Agencies/Donors

- To ensure that commitments to gender-sensitive programming remain during crisis/pandemic periods. Women and gender non-conforming people are disproportionately impacted by poor pandemic responses and this means that reducing focus on gender and gender-related project indicators during a pandemic result in poor uptake and access among these populations.
- To adapt the COVID-19 gender checklist⁴ for future pandemics and to require applicants to complete it, and validate it with community groups, as a prerequisite of grant approval.
- In patriarchal societies, to ensure that community engagement and advocacy targets male partners and guardians.
- To expand definitions beyond a binary view of gender, i.e., programming only for cis-men and women. A gender inclusive lens must include gender non-conforming people and an intersectional gender lens must include these populations in all their diversity, including migrants, refugees, elderly people, people with disabilities, people of diverse sexual orientation and minority ethnic persons.



To Scientists/Biomedical Researchers

- In line with international guidance and informed by animal studies, to ensure that clinical trials involving new pandemic technologies include pregnant and breastfeeding girls, women, and people.
- Clinical trials also need to account for responsiveness for global applicability including skin colour⁵ and genetic diversity, intersectionality and gender, and hormone treatment for transgender people.



INTRODUCTION

The COVID-19 pandemic was marked by vaccines, therapeutics, and diagnostics apartheid,⁶ as well as the decimation of health systems. Within the rollout of medical technologies and crisis response, several gendered impacts of COVID-related measures emerged. As countries instituted lockdowns, countries began reporting an increase in gender-based violence, with countries like Cyprus and Singapore reporting an increase in helpline calls by 30% and 33% respectively,⁷ and another study noting an increase of up to 131% of domestic violence complaints in districts in India with most stringent lockdown measures.⁸

The care economy came sharply into focus during the COVID-19 pandemic – with a disproportionate amount of frontline health care workers and community health workers being women, and jointly having care responsibilities at home. In the words of Dr Sameera Al Tuwaijri from the World Bank:

“

This is a huge gender issue, how women are a majority of frontline health care workers and having to simultaneously care for people at home during the pandemic.⁹

”

The pandemic also saw the reduction in access to health services for women, with data from 63,000 health facilities showing reduced accessibility for reproductive health and family planning services, with one example from Nigeria showing a more than 10% decrease in April 2020 and in May 2020 a 15% decrease in family planning services.¹⁰ Another study inferred an overlap between predictors that women, immigrants, racialised minorities and minority ethnic people would die differentially from COVID-19, and existing data that women and girls with lower socioeconomic status experience greater SRH disparities even pre-pandemic – drawing an outline of how overlapping comorbidities could be affected by COVID.¹¹ Another survey across Marie Stopes International-affiliated health facilities in 37 countries estimated that COVID-related service disruptions could result in 1.3 million unintended pregnancies, 1.2 million unsafe abortions, and 5000 pregnancy-related deaths.¹² LGBTQIA+ people across multiple geographies reported shrinking personal spaces, poorer access to LGBTQIA-sensitive health services, and declining mental health during the COVID-19 pandemic.¹³

There was also a delay in pregnant and lactating girls, women, and people accessing COVID-19 vaccinations due to concerns over safety. Initial clinical trials with COVID-19 vaccine candidates excluded pregnant people, with development and reproductive toxicology (DART) animal data slow to emerge in 2021.¹⁴ The result of this delay, according to gender experts Shirin Heidari and colleagues: ‘the failure to collect timely pregnancy-specific data denies pregnant women timely access to vaccines that could protect them and their infants from severe disease and death.’¹⁵ This is especially pertinent given the risk of COVID-19 complications pregnant people face due to other comorbidities such as gestational diabetes.



In El Salvador, 38% of the Salvadoran population is rural, out of a total population of 6,704,864 people,¹⁶ with women playing a key role in the rural sector, including in care and upbringing as well as production, supply, and marketing of food. Despite this contribution, according to a People's Vaccine Alliance, their 'unique needs are nullified in the design of public policies'.¹⁷ Salvadoran women living in rural areas reported key barriers in accessing vaccines, including distance of vaccination centres to their homes, the lack of public transport serving their neighbourhoods and villages, a lack of funds to take any available transport, and fear of being infected with COVID by crowds at vaccination centres.¹⁸ It is precisely due to unique circumstances like these that not only should a gender-sensitive approach be the norm, but that any gender-sensitive approaches be intersectional, and account for rural/urban location, as well as other factors like disability, race/ethnicity, and income levels.

The leadership of the global response to the pandemic was dominated by males. This is problematic because it excludes diverse perspectives and expertise, resulting in poorly contextualised interventions and support mechanisms. In the words of Kim Robin van Daalen and colleagues:



Men dominating leadership positions in global health has long been the default mode of governing. This is a symptom of a broken system where governance is not inclusive of any type of diversity, be it gender, geography, sexual orientation, race, socio-economic status, or disciplines within and beyond health – excluding those who offer unique perspectives, expertise and lived realities. This not only reinforces inequitable power structures but undermines an effective COVID-19 response – ultimately costing lives.¹⁹



Despite these and more far-reaching impacts, based on our findings, in most scenarios gender-responsive interventions were only adopted reactively; for example, only when country-level data emerged showing a disparity in uptake of vaccines among women versus men in certain contexts. In addition, the majority of practices and documents we examined – whether documenting work of global health agencies or countries – the tendency was to define gender in binary terms of 'men' and 'women', rather than as Kim Robin van Daalen describes as 'non-binary, socially produced, self-identified and complex'.²⁰ CSOs interviewed for this report, however, were more likely to include trans or gender non-conforming individuals within gender-responsive programming.

COVID restrictions and COVID-related impacts such as job redundancies mean that many trans people were confined to non-affirming environments,²¹ meaning that trans people were at higher risk of overlapping comorbidities of mental health and COVID-19. In addition, according to trans people we interviewed for this report, due to criminalisation of gender identity in Malaysia, police presence at vaccination centres (for crowd control) led to fears that trans people would be arrested at vaccination centres.²² In Bangladesh, vaccination queues separated by binary genders meant that trans people were subjected to harassment and bullying while queuing for vaccinations.²³ In South Africa, women in sex work, transgender women, and lesbians suffer discrimination while accessing healthcare, as Sibongile Tshabalala, National Chairperson, Treatment Action Campaign illustrates:



“

Women in sex work, transgender women and lesbians have often come through to say they're not able to access services due to discrimination from healthcare workers. The complaints include being disrespected, ridiculed about their gender, and being turned away and refused care. Behaviour of healthcare workers is an access issue. We believe it discourages many of these groups from making the decision to access care in future. Being mistreated at the clinic obviously means you won't be coming back for your preventive care, whether it's COVID-19 vaccines, HIV drugs, or treatment of COVID-19 and other ailments.²⁴

”

These all point to the need for government strategies to provide vaccines in safe and supportive environments for gender non-conforming individuals, women in sex work, and lesbian women.

An essential therapeutic for moderate- to serious- COVID illness is oxygen. A literature search for gender and oxygen supply during COVID-19 returned no relevant results. Leith Greenslade, an expert on oxygen access and Coordinator at Every Breath Counts, told us:

“

Nobody has done a gender analysis of oxygen access during the pandemic. It's uncharted territory. While we do know that the responsibility for caring for COVID-19 patients needing oxygen - in hospitals and at home - fell largely to women, there is a shocking lack of data on that heavy burden or its impact on women. And there is nothing that looks at the particular needs of women in low-resource settings, women from minority communities, or women with disabilities or any other intersectional data really. This is a gap that needs addressing so we do a much better job of protecting women next time around.²⁵

”

Over and above these, data indicates that mid-adult women are more likely to suffer from post-COVID-19 condition, more widely known as Long COVID,²⁶ suggesting the need for specific interventions for this target population. These examples and others in this report illustrate how closely sex and gender impacts uptake, access to COVID-19 tools, and experience of disease. As gender experts Heidari and colleagues illustrate:

“

Sex and gender shape risk of infection, vulnerability to disease and experience of ill health, and socioeconomic disparities. Important interplays between biological sex and gender, as a social construct, and other variables such as age, race and ethnicity, and other health conditions, have demonstrated differential risks of COVID-19 exposure, acquisition and outcomes... it is imperative that sex and gender be meaningfully considered alongside other intersecting dimensions when developing and deploying COVID-19 vaccines.²⁷

”



An intersectional gender lens to the impacts of pandemics should be the norm rather than the exception. Based on this, we conducted research towards this project objective: to document and expose gender inequalities faced by women and girls, transgender people, non-binary people and other marginalised genders, and people with disability in accessing COVID-19 vaccines and therapeutics, via the examination of prior and current vaccination rollout as well as rollout of novel antivirals for COVID-19. We also examined whether other forms of inequity such as racism, colonialism, ableism, and economic marginalisation have contributed to the gender inequalities.





METHODOLOGY

Desk review began with reviewing key documents – including the 2021 SDG 3 Global Action Plan and IIGH gender checklist²⁸ on equitable COVID-19 vaccine deployment. A Google Scholar search was then conducted using the term “COVID-19 and gender” – with key documents forming the basis of and informing the structure of a semi-structured questionnaire to be deployed among key identified informants. These included publications in *The Lancet*²⁹ and in *BMJ Global Health*.³⁰ WHO COVID-19 guidelines were reviewed for mentions of pregnant and lactating persons. Desk review was then suspended until after the bulk of interviews, during which interviewees shared documents that they had created and compiled as part of their work to address gender inequalities. This included UNICEF documents on using social listening to increase vaccine uptake among women,³¹ and Parliamentary documents³² showing key gender-related arguments made by civil society. After identifying key themes, a further in-depth search was conducted to find triangulating and corroborating documents and studies.

A semi-structured questionnaire was designed based on the key themes. 17 audio recorded interviews were carried out with 25 individuals from global health agencies, UN agencies, civil society organisations (including feminist and LGBTQIA+ organisations, and academic/research institutions). Written feedback was provided by several respondents, including Jean Munro and Alex Beecher from Gavi, and Sibongile Tshabalala from the Treatment Action Campaign. Interviews were transcribed using Otter.ai and analysed using Jhpiego’s gender analysis framework.³³

Case studies were selected through a snowball sample, following leads from desk research and qualitative interviews for documented practices that had the potential to highlight neglected areas of a global gender-sensitive COVID-19 response. Potential case studies were assessed for availability of data, consent of program implementers, and correlation to research findings.



FINDINGS

Definitions of Gender in Global Health: How Inclusive Are They?

Definitions are an important contribution to human interactions. They aid us in understanding the precise meaning of words, finding common understanding and a means for communication. Finding a joint basis for communication is of particular importance when we communicate across different languages, cultures, and countries. In global health, cross-cultural communication and working with translations or in a language other than our mother tongue is a regular occurrence. Definitions are supposed to carry across our meaning, our intention, and give direction to our actions. It is not surprising, then, that there are articles contemplating the different definitions of global health being used, and assessing them in terms of focus, ability to inspire etc. Definition, it becomes clear, can be challenging.

Challenges also appear when considering who gets to define a term or concept? When and by which process does a definition count as accepted? And accepted by whom? And what do we do when we have contradictory definitions in use by stakeholders in the same discussion? These are important considerations because definitions demarcate concepts and thereby influence identities. They can govern who is included, and in turn, who is excluded. Gender – both in a global health context but also in other social contexts – is such a term.

During the research for this Report, interviewees were asked if and how they defined gender in the context of their work, and what communities were at the centre of their work. The research also asked to reflect on the current state of gender analyses by global health stakeholders. Of the 15 organisations that participated in our research, seven explicitly used gender in the women and men binary, excluding gender-nonconforming or trans individuals. One organisation took a decided intersectional approach centering women living with HIV/AIDS, and six organisations included LGBTQIA+ communities in their gender analysis. Interestingly, the latter six and the intersectionality-focused organisation were all community-based civil society organisations.

With regard to the current depth of gender analysis in global health, some respondents utilising a feminist framework stated that the analyses go neither deep nor far enough, citing likely political reasons. Without a strong analysis, they continued, the existing funding allocations do not sufficiently support policy implementation and programmes. In the words of one feminist campaigner, Dr Lesley Ann Foster, Masimanyane Women's Rights International:

“

The 27 global health institutions pay lip service to addressing gender equality in any of the initiatives. I think if we look at the policies and so forth, they talk about it, but they don't actually think through how that access needs to be created.³⁴

”



Dr Foster continued by saying that the Sustainable Development Goals (SDG) create a clear expectation of necessary steps but concluded that “the actual investment is very weak and that is problematic.” Correspondingly, during the early phase of the COVID-19 pandemic, large international organisations such as the World Bank adjusted their grant making process to drastically shorten the project approval timeline. Unfortunately, as retold in an interview on the subject, that meant that the usual prescriptions for gender-inclusive programs were suspended and replaced by less-strong gender sensitivity requirements, despite early analysis by the World Bank that gender issues including gender-based violence, domestic violence, and adolescent pregnancies would likely increase during the pandemic in part due to a rollback of routine services and adolescents not physically going to school. It also stated that women comprising the majority of the health workforce but also the main caregivers in their homes would be at a higher risk and with limited support. The World Bank Guidance concludes that “when women are underrepresented in decision making for outbreak prevention and response, their needs are less likely to be met.”³⁵ The reality of many of these expected issues are documented in this report.

In a similar vein on gender and global health, one commentator stated that more “theoretical and conceptual thinking” is needed to fully understand gender in the context of global health to be able to better utilise and apply these theoretical concepts, because “[a]s a concept of power, gender operates everywhere; it is pervasive; it is one of the ways by which we organise societies and therefore also our health and medical systems. And as such, gender is by definition a determinant of health, even if gender equality were achieved.”³⁶

On a theoretical level, gender in global health “refers to the socially constructed norms that impose and determine roles, relationships and positional power for all people across their lifetime. Gender interacts with sex, the biological and physical characteristics that define women, men and those with intersex identities.”³⁷ Political and social realities across the world merit the following reinforcement:

“

Gender is different from biological sex. It is not equivalent to women and girls, or men and boys, but encompasses people of all genders and sexual orientations. It is socially constructed and influenced by laws, politics, policies, communities, families and individuals. It shapes how we behave, act and feel. Gender determines our positions and roles in society. It impacts health and wellbeing, influencing both our own individual behaviours (what risks we take with our health, what risks we face and whether or not we seek health care), and how the health system responds to our needs when we are sick or need care and support.³⁸

”

Because the colloquial use of ‘gender equality’ all-too-often refers to the equality of women and girls vis-à-vis men, rather than taking on the inclusive lens of gender identity vs biological sex, we want to make clear that for the purposes of this report, we aim to be inclusive of women, men, transgender and non-binary people, rather than a focus on (biological) women and girls juxtaposed to men. We feel this is necessary because we are faced with articles from global health institutions that when writing about gender and the impact of COVID-19, more often than not the focus is solely on women and girls in the biological sense, leaving transgender and non-binary persons out of their



analysis.³⁹ Focus on women and girls is of course warranted. But we also know from other research that COVID-19 has had tremendous impact on all marginalised people across the gender spectrum, including gender-based violence, economic power, and access to sexual and reproductive health services.⁴⁰ Similarly, when it comes to COVID-19 vaccine distribution, anecdotal evidence from communication during the research for this report suggests that people experiencing multiple layers of marginalisation, e.g., Roma in Eastern Europe and Romania; and trans people in Ecuador, are at a great disadvantage in terms of access to COVID-19 vaccination.⁴¹

Integrating and systematising abundant anecdotal evidence that the rollout of COVID-19 vaccines and therapeutics affected transgender and non-binary people as it did women and girls is essential to creating a clearer roadmap of what gender-sensitive COVID-19 policies must include.

An inclusive focus on gender equality becomes more urgent when we consider that we have ongoing consecutive pandemics, including HIV/AIDS, tuberculosis (TB) that have made progress on their gender-based approaches, but whose lessons were largely disregarded during the responses to COVID-19. At the same time, the global conversation has moved on to preventing the next pandemic, with the negotiation of a new pandemic instrument at the WHO INB and a new pandemic fund at the World Bank. It is important that all global health stakeholders recognise that every human experience along the gender and sexuality spectrum must be taken into account to achieve gender equality and health for all.

The spectrum of inequalities that exists within the broad categories of women and girls, transgender and non-binary persons must be understood and taken into account for an equitable, gender-sensitive response to COVID-19. Oxfam America recognises that:

“

[u]nequal systems of power built upon patriarchy create gender discrimination that keeps women and gender non-conforming people in poverty. Around the world, the systems underpinning our society— including laws and the enforcement of them—have been built in ways that deny women and individuals along gender identity and sexual orientation spectrums the same rights as cisgender, heterosexual men.⁴²

”

Communities, academics, global health institutions, and practitioners have documented that “[t]he systemic neglect of gender norms and inequalities in programme design, implementation, monitoring, and evaluation undermine the health of everyone—women and girls, boys and men, and gender minorities.”⁴³ But evidence and recognition are not sufficient. The COVID-19 pandemic has demonstrated that as new health challenges emerge, political leaders and health policymakers need to be reminded of what we know about the importance of including gender considerations into health strategies.



Key Gender-Related Structural Barriers

Gendered Social Norms/Traditional Roles

Multiple interviewees spoke about gendered social norms that required women to stay at home, seek permission from male relatives to access healthcare, or present at vaccination centres with a male guardian. Dr Sagri Singh, Chief of Gender & Health at the International Institute of Global Health in Kuala Lumpur stated that these gendered social norms and the lack of decision-making power about health preceded the pandemic. In Dr Sagri's own words:

“

Women don't have decision making power. Women don't have the ability, therefore, to either make choices or decisions for themselves or their children, or even if they are able to, they don't have access to transport, they don't have access to funds that could facilitate the transport, etcetera. These are all really well documented.⁴⁴

”

Women were also more likely to have food insecurity because of their gendered roles of childrearing and giving up food to ensure children were fed, raising questions as to risk of nutritional deficiency comorbidities alongside COVID-19 risk, but also the need for women to focus jointly on raising money and raising children – making it difficult for women to prioritise travelling for COVID-19 vaccinations or to access treatments. In the words of Dr Lesley Ann Foster from Masimanyane Women's Rights International in South Africa:

“

Food insecurity was higher for women (during COVID), because they had to provide for children on an ongoing basis, so that also affected women's ability to go and seek help or support for themselves, because they were scrounging for whatever they could afford.⁴⁵

”

In Mozambique, Sharon Truzão, Program Officer at Muleide, an organisation working on women's rights, stated that traditional norms and power dynamics were a key barrier for access to vaccines for subsistence farmer⁴⁶ women, and especially women living with HIV:



“

Power dynamics (were a big factor) – where the woman needs to stay at home and take care of the children. The vaccination campaigns were held in other districts, and for her to go and get vaccinated was difficult. In addition, a majority of these women were peasant women or farmers and they had to work to produce what they eat and provide for their families. And their husbands were going to work. And (during the pandemic) many women stopped their ART treatment and weren't targeted by vaccination campaigns on COVID-19. It was really hard for us to engage this group and spread the message that they should be included.⁴⁷

”

In some contexts, 'sociocultural and/or religious norms and practices restrict women's mobility and social and physical contact between men and women',⁴⁸ therefore restricting ability of women to access healthcare services. This was observed in Afghanistan, where women needed to be accompanied by a *mahram*⁴⁹ to access health and other basic services, or health services would be refused. According to one interviewee:

“

For a woman to access health or any other basic services, presence of female frontline workers is critical. Otherwise, women will not access COVID vaccinations. If (a woman) doesn't have a *mahram* who is a chaperone to escort her, it is a stumbling block to access services.⁵⁰

”

The situation in Afghanistan worsened in the acute phase of the pandemic with the country coming under Taliban control in early 2021⁵¹ – and while health services provided by female health workers have resumed,⁵² at time of writing women are highly invisible with restricted movement.

In South Sudan, women still need to ask for permission from male guardians to visit healthcare services, and indeed for most situations involving leaving the house. According to UNICEF South Sudan, through the COVID pandemic advocacy and engagement was conducted with men to sensitise them about women's healthcare autonomy – and while gains were made, further work is needed. This is described in more detail in the South Sudan vaccination uptake case study contained [elsewhere in this report](#).



These social norms were rooted in deep-seated patriarchal beliefs that were difficult to address. In the words of Sharon Truzão from women's rights organisation Muleide in Mozambique:

“

We were fighting traditional beliefs and it is deeply rooted – it's a culture. And it is very difficult to address these gender issues, even though Muleide is an organisation that has been working with gender for over 30 years. So even though we are experienced working on this matter, we still have the same gaps, and we find it difficult to overcome these issues, because of the slow progress. It has been very frustrating implementing this project (a test and treat project in collaboration with the Aurum Institute) especially because the pandemic has just enhanced the gender differences and inequalities, and access to commodities, services, and jobs.⁵³

”

Transportation and a Lack of Access to Finances for Transport

Hand in hand with gendered social norms is a lack of access to household assets, including income and transportation. As Tracey Goodman and colleagues describe:

“

Although immunisation services are usually free of charge, transportation adds to a “hidden” cost in many settings. In poor areas, mothers need to raise the necessary resources, or mobilise means of transport to take her child to vaccination.⁵⁴

”

These pre-existing barriers for child immunisation remained the same in the COVID-19 pandemic for adult vaccinations. Charlotte Baker, Director of Small Steps for Africa, a community-based organisation based in the semi-rural town of Ambohidratimo in Madagascar, described how the cost of bus fares resulted in a major barrier for access to COVID-19 vaccinations:

“

We have observed that one barrier for the parents we support in the community of Ambohidratimo was the cost of the bus fare to attend a vaccination clinic, especially for those living in more remote areas. Bus fare prices in Antananarivo increased by 20% in 2022, reflecting the rising cost of fuel, which only made this more difficult. It's also worth factoring in the working time lost in travelling there and back, given the heavy traffic at certain times of day. Some people told us it took nearly the whole working day to get their vaccine. We heard anecdotally that some of those who had got their vaccine, received it when they attended the health clinic for another reason e.g., immunisation for their children.⁵⁵

”



This quote illustrates the value of integrating adult COVID-19 vaccinations with routine child immunisations or essentially providing COVID-19 vaccinations where women will already be or are likely to frequent, to reduce transportation costs that they might incur from two separate trips. Offering vaccinations at markets, churches, and women's associations such as in [DRC](#) and [South Sudan](#) is also an example of meeting women with vaccinations and vaccination resources as they go about their daily lives. Initially in South Sudan, the vaccination rollout occurred in large health facilities and hospitals in urban settings, and UNICEF South Sudan realised that mainly males were attending health services, precipitating a change in approach.⁵⁶

In addition to not having access to transportation or funds for transportation, in Madagascar, floods and poor road maintenance was a compounding factor preventing vaccination access. As Charlotte Baker described:

“

At a meeting with partners working in a remote area of Ranomafana (a town 400 kms South of the capital Antananarivo), one issue that was flagged was the fact that some health centres simply aren't reachable at certain times of year, due to flooding and poorly maintained roads. People aren't always familiar with where else they should go for healthcare more generally, so this extended to COVID-19 vaccination.⁵⁷

”

Health Systems Factors – Including Digitisation of COVID-19 Tools

Gender-responsive health systems can be a major factor influencing COVID-19 vaccines and therapeutics uptake. As the World Health Organization describes: Health systems are not gender neutral; structures and processes of oppression and discrimination that exist in society are reproduced in health systems.⁵⁸

The COVID-19 pandemic saw a proliferation of digital applications and tools used to register for COVID-19 vaccinations. In Malaysia, the MySejahtera application was used to register for vaccinations and to display vaccination certificates. Online systems were also deployed in El Salvador, India, and numerous other countries. Given that 165 million fewer women in LMICs own a mobile phone compared to men,⁵⁹ this approach, while demonstrating the technological proficiency of governments and growing middle classes, was not progressive from a gender-, income- and disability- standpoint.

In El Salvador, the electronic system was used to verify if an individual was eligible for vaccinations and to schedule vaccination appointments. According to a 2022 People's Vaccine Alliance report, this mechanism constituted 'a barrier for women with a low level of formal education'.⁶⁰ These same women, usual women living in rural areas, also had difficulties accessing testing 'both due to the difficulty of obtaining timely information about the place where the mobile booth will be located that day and the economic cost'.⁶¹ Due to the barriers that these women faced in accessing COVID-19 services, 47.59% of vaccinated rural women did not use technology to make their appointments online – instead they looked for alternatives to register for the vaccines, such as making their



appointments directly at the Health Unit or through promoters and community health workers who make home visits.⁶²

In India, the government rolled out a digital application for vaccine registration – leaving out rural populations, persons with disabilities, women and trans people with less technological literacy, and minority ethnic people who did not speak the major languages. According to Dr Sarojini Nadimpally, Executive Director at Sama Resource Group for Women and Health, a feminist organisation in India, this approach ‘magnified the effects of isolation’ and was ‘gendered, ableist, and inequitable’. In her own words:

“

Technology has contributed to navigating these responses through online schooling, remote work, online shopping. But it didn’t acknowledge the digital divide because it’s not very common in rural areas or tribal areas, particularly women and young people and people with disability, then not they neither have access to mobile phones, or laptops or internet connectivity, not have the wherewithal of other language skills to manoeuvre the complex tools. Digital technology has magnified the effects of isolation for many, given the growing emphasis on the access and connectivity for economic survival and access to social and support networks, but at the same time, not having the infrastructure and knowledge production. It is also gendered, ableist, and inequitable.⁶³

”

In commentary on this digital-first approach to vaccine rollout in India, feminist scholars Tiffany Nassiri-Ansari and colleagues (2022) stated:

“

Had this approach been augmented by an analysis of the country’s gendered digital divide in terms of technological literacy, access, and usage, a more inclusive delivery campaign to reach women could have been delivered.⁶⁴

”

In Tanzania, we spoke to Member of Parliament Dr Faustine Ndugulile, formerly Minister of Health, about whether vaccine rollout was sufficiently gender inclusive. Ndugulile detailed an online registration system where tickets for vaccinations were issued through the online system. In November 2022, however, a community-based approach was instituted to ‘drive up numbers’. In Ndugulile’s own words:

“

The community-based approach involved vaccinators going to the community and registering them with tablets.⁶⁵

”



This illustrates how a digital-only approach leaves out key populations, and that an inclusive approach necessitates community health worker support and alternative routes of registration for vaccines.

There are other health system factors that affected women's access to the COVID-19 vaccine, notably the fact that it is the mothers that were more used to engaging with the healthcare system for their children's routine immunisations. In the words of Charlotte Baker, Director of Small Steps for Africa:

“

In urban and semi-urban settings in Madagascar, I think overall women were more open to being ok with the vaccine, because they were used to engaging with the health system for routine immunisation for their children... Whereas for many men, they would perhaps not have even been to their local health centre for years.⁶⁶

”

In South Africa, Sibongile Tshabalala stated that the quality of public healthcare facilities and services deterred communities for seeking treatment for COVID-19. One May 2021 report on the state of healthcare facilities in Mpumalanga, in eastern South Africa, found that 92.7% of facility managers said their facilities didn't have enough staff, 4 hours and 41 minutes was the average waiting time reported by patients, and 11% of patients left the clinics without the medicines they needed.⁶⁷ As Tshabalala described:

“

The quality of services in public healthcare facilities is a big issue here. Challenges such as long waiting times, negative staff attitudes and poor filing systems discourage our community from seeking treatment for COVID19 and other ailments, we tend to avoid clinics and hospitals completely even when we really need them.⁶⁸

”

Exclusion from Clinical Trials

There was also a delay in pregnant and lactating persons accessing COVID-19 vaccinations due to concerns over safety. Initial clinical trials with COVID-19 vaccine candidates excluded pregnant women, with DART animal data slow to emerge in 2021.⁶⁹ The result of this delay, according to gender experts Shirin Heidari and colleagues was: 'the failure to collect timely pregnancy-specific data denies pregnant women vaccines that could protect them and their infants from severe disease and death.'⁷⁰ This is especially pertinent given that pregnant people have higher risk of COVID-19 complications due to risk of other comorbidities such as gestational diabetes.



These exclusions also applied to the emerging novel antivirals such as Paxlovid (nirmatrelvir/ritonavir), meaning that at the acute phase of the pandemic, novel antivirals were not recommended for use by pregnant and breastfeeding women, even though they were at higher risk of COVID-19 complications. Dr Janet Diaz, Team Lead (Clinical Management, Infectious Hazard Management, World Health Emergency Programme), World Health Organization, explained:

“

The inequities were around a lot of the evidence that was emerging and what continues to emerge on the efficacy of these drugs in COVID-19, as many trials don't enrol pregnant women, breastfeeding women, or children. And there are obviously reasons for that. But over time, there's got to be a mechanism where, structurally, there could be a recommendation for earlier involvement of women into clinical trials, and pregnant women specifically, into clinical trials. Because in this pandemic when the evidence emerged, we've had to just stick with the evidence and make recommendations for use of drug X for COVID and say that it is not recommended for pregnant women or breastfeeding, because we don't know (what the effects would be). And in some drugs, there is proper concern for potentially some negative effects. But for others, maybe it's more just that they weren't tested. And so, we don't know whether they could be used safely and effectively in pregnant women. And that (scenario) applies a lot to the novel antivirals, like nirmatrelvir/ritonavir, which is one that we just recently authorised the application of the drug to pregnant women and breastfeeding women. When we first made the recommendation, we weren't able to do that (and the evidence has now improved). So, I do find that as a structural problem.⁷¹

”

Crucially, Dr Diaz stated that safety studies done in animals/non-human models to look at heterogeneity in pregnant women, looking at exposures in breast milk “need to continue to be done, done well, and be made public as early as possible.”⁷²

Literacy

Literacy, regardless of level of education, has been cited as a key predictor of vaccination uptake.⁷³ Women have been cited as less likely than men to receive relevant or trustworthy vaccine information ‘because of literacy, education, and digital gaps.’⁷⁴ The relationship between mothers’ education and childhood immunisation is well documented, although this is also linked with ‘socioeconomic status and contextual factors, since more educated mothers tend to live in more affluent households and in areas with better access to healthcare and services’.⁷⁵



Literacy was also cited as barrier in engaging community health workers in South Sudan, however with innovative approaches with non-traditional methods of training, these CHWs were able to effectively be deployed in communities who trust them and were able to act as reference points and drivers for vaccinations among women. In the words of Aping Kuluel Machoul, Social and Behaviour Change Officer at UNICEF South Sudan:

“

That has been a key challenge we faced when recruiting female community mobilisers, and this was even worse in rural villages where the level of education is even lower compared to cities. But through some networks of women and engagement with community leaders, we were able to help the community leaders understand the whole process, and they even recruited women who were not formally educated but were able to be trained on skills like talking to and engaging the communities on COVID-19 vaccinations.⁷⁶

”

Right to Information, Digital Divide, and Community Engagement/Communications Strategies

Gender-responsive communications is an essential component of pandemic response and uptake of health technologies. As gender analysis expert Sini Ramo describes: “Gender-responsive communications is based on the understanding that people experience health emergencies, like COVID-19, differently - and this difference is shaped by gendered norms and roles in societies, embedded in unequal power relations.”⁷⁷ Ramo describes, for example, that health promotion materials during the West African Ebola outbreak was limited by a lack of understanding⁷⁸ of local gender norms and women’s caretaking responsibilities. Posters and radio spots advised against touching and cleaning up after those who appeared ill - messaging that was ignorant to the responsibilities women had as primary caretakers in families.⁷⁹

Likewise, communications guidance documents issued by WHO and WHO regional offices either did not mention gender⁸⁰ or mentioned gender only briefly (i.e., that ‘messages from policy makers and communicators should be evidence-based, clear, easy to understand, gender-sensitive and culturally acceptable’)⁸¹ and that helpful approaches including using communication channels that communities regularly use and trust and to perform social listening to analyse data around perceptions, attitudes, and behaviours.⁸² These latter considerations, for example, were employed in the use of radio programmes (the main form of communication in South Sudan), social listening to understand what community-led interventions would work the best, and female influencers and church leaders to deliver vaccination messaging.

In Zimbabwe, Michelle Ruhonde from GALZ, Zimbabwe’s main LGBTI+ support organisation, and who herself was pregnant during the COVID-19 pandemic, illustrated how conflicting messaging around whether pregnant people could in fact get vaccinated, was juxtaposed with disinformation through social media. This resulted in anxiety and uncertainty among pregnant people. In Ruhonde’s own words:



“

(The conflicting messages) prompted a lot of anxiety. Because at first, they said pregnant women couldn't get the vaccine. And then it was later changed to everyone can get the vaccine. So, it prompted a lot of questions around 'Okay, is it safe?' And you know, the one thing that kills us as Zimbabweans is social media. A lot of information that was being shared was how you could give birth to a child with a disability due to the vaccine. And I feel there wasn't adequate information around pregnant women, lactating mothers, on the facts around the COVID-19 vaccine.⁸³

”

Trusted sources and messengers were key to delivering COVID-19 information, especially in areas where trust in the state and medical professionals is low. According to Charlotte Baker, Director of Small Steps for Africa, a Madagascan community-based organisation:

“

People I know told me they only got the (COVID-19) vaccine because Ankizy Gasy (trusted community NGO) or their church minister advised them it was safe. They didn't accept the message from other sources as easily, for example radio ads from the government, because trust in the state is low in some communities.⁸⁴

”

As described in the UNICEF South Sudan case study [elsewhere in this report](#), in South Sudan, trusted female influencers and church leaders effectively helped to increase vaccine uptake. Listening circles and focus group discussions were effective because they were community-led and -formulated. In the words of Dr Sagri Singh, Gender and Health Chief at the International Institute of Global Health:

“

UN Women (Asia Pacific) and partners convened some of these listening circles to really understand and to really engage women's organisations on the barriers that they have identified for access – and then to overcome those through whatever means necessary. And this is the other point that often comes up in broader health interventions and particularly immunisation, that tapping (into) local knowledge and experience to overcome barriers is one of the best approaches.⁸⁵

”

Social listening was also used by the UNICEF Jordan office, where the role of Community Engagement officers was to 'gather community questions, concerns, complaints and demands, counter rumours and misinformation about the Coronavirus, and encourage people to get vaccinated'.⁸⁶ As a result of the campaign, cases reduced, and vaccination rates increased. More on UNICEF's social listening approaches are elaborated in the UNICEF section below.



Rural and remote communities were also excluded because of COVID-19 information being predominantly digital or online. In India, where information about COVID-19 largely occurred through digital applications such as WhatsApp, Telegram, and Twitter, specific rural communities experiencing poverty struggled to get up-to-date accurate information about COVID-19. Neelanjana Das from Sama Resource Group for Women and Health described an anecdote of widespread misinformation about vaccines through remote villages:

“

In terms of information (about the vaccines), take the example of a remote village near here which is inhabited by a particularly vulnerable tribal group, and they are usually quite secluded from (the outside world). They stay at the top of the mountain, they are a very small community, and they don't have access to much information. There was one person who died after (getting vaccinated). It could have been due to other health reasons, or it could be related to a lack of support, but this news went around the entire village and nearby villages. And that would be misinformation, but the people did not know whom to clear this up with and there was not much clarity even with the health system. So, I think the misinformation and rumours and not being able to access information from a trusted source in the language that they can understand as a massive problem. Information was predominantly in English on Twitter or Telegram. And this was a major concern.⁸⁷

”





Vanita Nayak Mukherjee (DAWN & Feminists for a People's Vaccine, India) corroborated this, stating that while middle class and educated communities had 'excellent information', this was less so in communities experiencing poverty. It became necessary to leverage ad hoc community support systems and doctors within communities to increase the quality of COVID-19 information being accessed by communities, and to do so in language and terminology that is easily understood by all. In Vanita's own words:

“

WhatsApp is very, very widespread in India and messaging through WhatsApp has been very effective. But information was very minimal in poorer communities. Every community has kind of a community network that had been activated during COVID, just to help each other out. I have even heard that in the slums of Delhi there were some kind of support systems that came into place. Questions then emerged as to who is (in charge) of the administration for these WhatsApp groups and where are they getting the information from? In our colony, which is middle class and highly educated, everyone can read English, so we had excellent information. Doctors in the community who were living here started actively putting out information and holding talks with the communities, including online webinars for the community for questions and answers. This included people giving testimonies of their experience, including on effects of the first doses of the vaccinations. There was so much discussion in these WhatsApp groups, and (the quality) of information depended on where you're located, whether things are organised in your community, whether there is someone taking the lead, and then there's an issue of language. Language becomes so important, because how do you put things in a very simple way for people to understand the information?⁸⁸

”

The approach in India, while technologically progressive, was not progressive from a gender perspective. The opinion of feminist scholars Nassiri-Ansari and colleagues are worth repeating; that 'had this approach been augmented by an analysis of the country's gendered digital divide in terms of technological literacy, access, and usage, a more inclusive delivery campaign to reach women could have been delivered'.⁸⁹

This blind spot was not exclusive to the approaches of governments but was also represented in the approaches of international agencies. In Afghanistan, one expert told us that despite poor digital access among women, international agencies still deployed COVID-19 messaging through unsuitable digital means:



“

The whole issue of digital access – during COVID, there was an RCCE study conducted on the context in Afghanistan, where less than 35% of women said they have access to digital skills, even access to radio, TV, and access to phones. Yet, most of the messaging that Social and Behaviour Change colleagues, including from WHO, UNICEF and the rest, (was through) massive awareness campaigns on COVID using digital platforms, radio, TV, and SMS through phones. While the statistics were telling us otherwise in terms of where women are, and what gadgets do they use in terms of accessing messages. As a result, many women within the Afghanistan context were left behind.⁹⁰

”

Paxlovid, the novel antiviral consisting of drugs nirmatrelvir and ritonavir, came to market in the Global North in 2021 to much fanfare over clinical trial data that showed a reduction of nearly 90% in the risk of severe COVID-19.⁹¹ However, the drug has been slow to reach countries in the Global South. In one example from Somalia, in mid-2022, the WHO office requested 3000 courses of Paxlovid but only received 300.⁹² In India, generic versions of the drug began to be marketed in September 2022,⁹³ a full nine months after the pill was made available to consumers in the United States.⁹⁴ Despite this amount of time between launch in the United States and inevitable release in the Global South, information about how to access the antiviral, and indeed whether it could be used to treat COVID-19 in pregnant and breastfeeding persons, was halting. In the words of Vanita Nayak Mukherjee from DAWN and Feminists for a People's Vaccine in India, interviewed for this report in February 2023:

“

This magic drug Paxlovid which is supposedly highly effective, we have local manufacturers that are producing it at minimal prices compared to global prices. But it's not yet that accessible even though it was introduced (in) September (2021) – everyone is very confused about how to access it and whether it is accessible only by prescription, because it is possible to buy many drugs over the counter. Our pharmacists know what drugs work and there's a lot of faith in what a pharmacist prescribes. Paxlovid is something that we are hearing about, but I feel like I'm hearing about because I work in this area. Lots of other people don't even know about it. And while it is relatively cheap compared to the rest of the world at \$50 per course, this is quite expensive for us. So, unless one can access a hospital and a doctor can give you a prescription, it's one of those things that we do not have a full sense about.⁹⁵

”

These speak to the need for specific community engagement and robust communications strategies on Paxlovid and on test-and-treat initiatives. When asked about the role of WHO in communicating the specific safety and efficacy profiles of Paxlovid for pregnant and breastfeeding persons, Dr Janet Diaz, Team Lead on Clinical Management in WHO's Emergencies Programme stated:



“

I think we can do better. At the Geneva level we have infographics,⁹⁶ and community engagement strategies get worked on more at the region and in the country level, but I am not sufficiently sure what we have, for example, with the new update of what we just did for nirmatrelvir a week ago – i.e., the launch of a big database and we did a press release on what we’ve done, but did we make additional dissemination products that would target pregnant women and clinicians taking care of pregnant women in primary care? Our simplified infographic that’s been published in the BMJ is maybe going to catch the eye of clinicians – I hope. But did we do something that would maybe catch people aside from the press, which does get people informed? I think we could probably do better.⁹⁷

”

In one August 2022 report, health workers in rural areas in Haiti, Madagascar, and Nigeria all reported never having heard of Paxlovid nor any other novel antiviral for COVID-19.⁹⁸ These quotes illustrate the gap in communications and community engagement strategies and collaborative at the local, regional, and global levels respectively on the COVID-19 novel antivirals.

Unpaid Labour and Compromised Income Generation During the Pandemic

Women’s livelihoods and unpaid workload were disproportionately affected by the COVID-19 pandemic and compromised their access to COVID-19 tools. The lack of social safety nets meant that some communities lost significant proportions of income during the COVID-19 pandemic. As a result, the key focus and priorities for families was to generate income – and all other priorities, including COVID vaccinations were deprioritised. In the words of Dr Sarojini Nadimpally, Executive Director of Sama Resource Group for Women and Health:

“

I think one of the important things is to understand how the lockdown impacted the communities and that is across various vulnerable and marginalised communities. Even when the vaccine came, it was not in a vacuum. People were already under a lot of distress, because their livelihood options had been compromised. Before the pandemic they were earning for a whole month, then (during the pandemic) this was reduced to maybe 10-12 days for example, and they were struggling to cope with the basic essential services. And for them that was prioritised over the need to get a vaccine.⁹⁹

”



Patriarchal norms influence the roles that everyone in the household holds. As described in one report:

“

Girls' preparation for and socialisation with their future household responsibilities starts early and often takes preference over her education and aspirations. Learning how to be a good future 'housewife' is passed on from mothers to daughters... Boys are raised with the perception that their future wives will take care of them and do the household duties... This means that they carry the burden of all the unpaid work that is necessary to run a household.¹⁰⁰

”

Women as the main caregivers have been under an unprecedented workload, either working from home or working in essential jobs while providing care labour for children who were home from school. This fact meant that many women found it difficult to find time and financing to travel to vaccination centres. In Mozambique, Sharon Truzão told us how vaccination campaigns were held in other districts and because of women's childrearing roles and patriarchal norms requiring women to stay at home, it was difficult for women to access vaccines.¹⁰¹ This was also evident in our interviews in the Madagascan context, where some women maintained hawker stalls while caring for children,¹⁰² making sacrificing a day to access COVID-19 vaccinations particularly cumbersome.





Women also had less access to accurate, reliable, and timely COVID-19 information due to multiple factors both due to their multiple roles taking up time, but also due to 165 million less women having access to mobile phones compared to men, described in more depth [elsewhere](#) in this report. This link between access to information and unpaid labour has been documented elsewhere, for example in one report on women cocoa farmers usually working as unpaid family labour and were reliant on their husbands or male relatives for access to training, inputs, and information.¹⁰³

In Cambodia, India, Indonesia, and Kenya, community health workers working predominantly in TB continued working through the COVID-19 pandemic to collect sputum samples, provide nutrition to TB patients for TB medication adherence, and to disseminate COVID-19 information.¹⁰⁴ The majority of these workers were women, and the great majority worked without salaries in risky environments, at risk of arrest and police harassment due to breaches of PPE and lockdown regulations and having to dip into their own pockets to support patient nutrition.¹⁰⁵

COVID-19 also disproportionately affected women and gender minorities in exploitative labour – such as frontline workers under insecure contracts, including contract nurses and hospital cleaners, usually from migrant populations. During the COVID-19 lockdowns these workers still had to go to work, were subject to increased COVID-19 risk due to insufficient PPE, and at the same time were stuck in exploitative and unstable contract roles. Chee Yoke Ling described the precise situation vis-à-vis these women working in Malaysia:

“

In Malaysia the majority of frontline workers are women, (and) I'm not talking just about nurses, but also those who are cleaning the hospitals and clinics. When everybody was locked down, they had to go to work. And a company was contracted to go and bring in these people who will do like the cleaning of the hospitals. These people are mostly women and they are treated really badly (by companies who) don't comply with the labour laws. A lot of this has come out (in the open). There had been movements and support groups, but during COVID, these came out a lot more because (these women) had to keep going to work and they were also getting sick. They also come from lower income backgrounds and had to simultaneously take care of their kids, and were still having to go to work. So that's a lot and (on top of that), husbands were losing their jobs and they were subject to domestic violence.¹⁰⁶

”

This quote highlights the interlinked syndemics caused by exploitative and unpaid labour and childcare, gendered roles, pandemic-related unemployment, and gender-based violence.

Corruption

While not related to vaccines and therapeutics, the already existing supply shortages of PPE were compounded in Kenya, among others, by corruption,¹⁰⁷ South Africa,¹⁰⁸ the United Kingdom,¹⁰⁹ and numerous other countries around the globe. Dr Lesley Ann Foster from Masimanyane Women's Rights International described how corruption led to higher prices for PPE, which in turn increased scarcity of PPE and the inability to protect women health workers as well as they should have been:



“

There were huge levels of corruption related to the pandemic in the procurement of PPE. And that was mostly men (that perpetrated it) and women that suffered, because they were not given the correct PPE to carry out the work. But the corruption was men, from the minister downwards and many benefiting from (corruption). And as a result of corruption, there was overcharging for PPE, which of course impacted on women a lot.¹¹⁰

”

Accounting for Intersectional Identities and Gender in Pandemic Preparedness and Response

“Centering marginalised groups is what will save us. It is unfortunate that we still have to debate this.”

Figure 1: Extract from interview with gender and SRHR expert (via Zoom, 7 February 2023)

Alongside inequalities resulting from their gender and gender expression, women, girls, transgender people, and non-binary people may experience additional inequalities that are linked to other denominators of their social power. In 1989, Kimberlé Crenshaw devised the term intersectionality to describe how these people, for example Black women in the United States of America, face discrimination based on their multidimensionality. Multidimensionality refers to the reality that some people live with multiple burdens, i.e., being Black while also being a woman (aka multiple societal marginalisations), which leads to a specific type of discrimination that cannot be ameliorated by addressing either of the identities separately from the other.¹¹¹ Instead of centring responses according to the perceived large single disadvantages, Crenshaw suggests that:

“

[If] efforts instead began with addressing the needs and problems of those who are most disadvantaged and with restructuring and remaking the world where necessary, then others who are singularly disadvantaged would also benefit. In addition, it seems that placing those who currently are marginalised in the center is the most effective way to resist efforts to compartmentalise experiences and undermine potential collective action.¹¹²

”

The following chapter highlights some of the intersectional challenges that came to the forefront throughout the COVID-19 pandemic. While some are immediately related to (physical) access of COVID-19 vaccines and therapeutics, i.e., transportation for people with mobility issues, some challenges are buried deeper in society through the legacies of colonialism and racism that underpin the power structure of global public health, and as derivatives the national systems of power that shape societal values.



Two interviewees, Vanita Nayak Mukherjee (DAWN & Feminists for a People's Vaccine, India) and Sibongile Tshabalala (Treatment Action Campaign, South Africa), illustrate:

“

Women, people with disabilities, those who are poor, those who are migrants - all of them have very specific problems. You need a very sensitive government to understand these problems in their various dimensions that raise barriers for Access to Vaccines, Diagnostics and Therapeutics. Only then, can you create solutions and universal access is possible.¹¹³

”

“

Poorer women have more problems with access, similarly to the very old. Transgender women have more barriers compared to cisgender women, similarly to lesbian women who are in sex work, who have more problems than heterosexual women. Women in urban areas have better access because there are more sites in urban areas, particularly places like malls, which rural communities have no access to.¹¹⁴

”

Given the role that intersectionality plays in placing a particular individual in policy areas which are more neglected, Dr Sagri Singh, Chief of Gender and Health at the International Institute for Global Health (IIGH) emphasised that engaging communities at these intersections and valuing their expertise should be the primary approach in addressing interactional barriers to health services:

“

If you start to put the intersectionality together, i.e., if you're less educated, if you're from a lower ethnic group, or a minority group, or a particular caste that is considered lower, you automatically start going down the chain. And at every point, if you are a woman with all those factors, you are probably at the bottom of the chain. And if you're a trans woman, you're even further at the bottom. The point I'm trying to make is that the decolonial feminist approach very much speaks to tapping experiences and valuing experiences as much as academic research that, in some cases, doesn't always capture all the nuance.¹¹⁵

”

Colonial legacies, patriarchal structures, and racism

Deep rooted societal attitudes and traditions can tend to marginalise women and gender diverse people. Colonialisation has also left a legacy of discrimination against gender diverse people. Many respondents noted that the structural barriers outlined in the previous chapter are rooted in deep societal structures and legacies that date back to colonial times. For example, Section 377 of the British colonial penal code has been contributing to the discrimination against LGBTQIA+ people for



over 160 years. Mitch Yusof, Executive Director of SEED Malaysia, an organisation working on the rights and welfare of transgender people in Malaysia stated:

“

When we talk about intersecting challenges, the situation of transgender people is just like in many other countries. We are more bound by the indoctrination of religion. We know that the laws that we have in Malaysia right now came from British colonial law, penal code 377. And people's understanding of it is related to the beliefs in the religion with regards to LGBT. The fact is that we are not okay in many aspects. What is considered easy for you is not easy for us. When we talk about for example, loans, it all boils down to the identity card.¹¹⁶

”

Even where the legal status has been repealed, the social-formative effects of the law still reverberate in societal attitudes, stigma, and discrimination. As Sibongile Tshabalala, National Chairperson, Treatment Action Campaign described:

“

Women in sex work, transgender women and lesbians have often come through to say they're not able to access services due to discrimination from healthcare workers. The complaints include being disrespected, ridiculed about their gender, and being turned away and refused care. Behaviour of healthcare workers is an access issue. We believe it discourages many of these groups from making the decision to access care in future. Being mistreated at the clinic obviously means you won't be coming back for your preventive care, whether it's COVID-19 vaccines, HIV drugs, or treatment of COVID-19 and other ailments.¹¹⁷

”

Also evident through the interviews were that those who were in pre-existing positions of privilege (such as being a middle-class cis woman) generally fared better than individuals with less social and economic mobility. The latter group of women and gender non-conforming people had worse outcomes. Essentially, challenges for access to COVID-19 tools followed social patterns that had existed before the pandemic.

Racism and casteism resulted in some communities feeling marginalised and as a result deterred from going to vaccination centres. This particularly applied with communities from the Northeast of India, but also with individuals from certain castes. As Dr Sarojini Nadimpally, Executive Director of Sama Resource Group for Women and Health elaborated:



“

The racism is always there – like in early 2020 Muslims were blamed for the pandemic. There were people who have been discriminated very badly during the pandemic period. It’s not just the race but the religion and caste, but also having certain features coming from the northeast part of India and being labelled as Chinese and being accused of bringing the virus. We are all part of the same country, but they were discriminated.¹¹⁸

”

Feminist and other civil society activists mentioned that the experience from the COVID-19 pandemic presents a “massive opportunity to bring justice and gender into the distribution,” foremost with regards to production capacities and the health system, pointing out that countries must build resilient health systems not as a favour but as a fundamental understanding of what justice looks like.¹¹⁹

COVID-19 revealed existing inequities within health systems, not new limitations. To a certain degree, health systems were described in our interviews as reflecting longstanding patriarchal structures, both in the ways in which diseases and financial allocations are prioritised. In the words of one gender and SRHR expert:

“

Women are being considered more resilient when it serves the system, and weak when it serves otherwise.¹²⁰

”

This differential treatment of gender-specific health issues showed in several ways. Interviewees pointed out that especially early in the pandemic, there were no vaccination protocols on pregnant and lactating people yet, in large part because the WHO had not yet communicated guidance. The expedited nature of vaccine trials excluded pregnant and lactating people from being among the study population, turning every individual into a clinical experiment, a situation that has been lamented for other infectious diseases, e.g., tuberculosis and HIV/AIDS.¹²¹

A lack of disaggregated data preventing a true intersectional response

One challenge for ameliorating the limited access for women, girls, transgender, and nonbinary people is the lack of disaggregated data available from national sources. In the words of Vanita Nayak Mukherjee:

“

There is a lack of disaggregated data. And without that data there is a limit to what you can actually design. If you don’t have the proper information about what is happening vis-a-vis men and women and marginalised communities, how can you actually design interventions?¹²²

”



Efforts have been made to increase country reporting of sex disaggregated data, as described in the WHO section below. In addition, in a joint effort by Global Health 50/50, the International Center for Research on Women, and the African Population and Health Research Centre, sex disaggregated trackers on, inter alia, ICU admissions, testing, vaccinations, and confirmed cases among healthcare workers, were developed as a response to the fact that only a handful of countries were reporting sex-disaggregated data and there was no single database consolidating all the data. A March 2023 snapshot of the tracker indicates the following:



Figure 2: Global Health 50/50 Sex-Disaggregated COVID-19 Tracker (current to 17 March 2023)

The graphic shows that out of 206 countries, 114 countries (55.3%) have ever reported sex-disaggregated data on vaccinations, only 20 countries (9.7%) ever reported sex-disaggregated data on ICU admissions, and only 18 countries (8.7%) reported sex disaggregated data on testing. While this dashboard provides a starting point for more gender-inclusive pandemic response, a more intersectional approach would require data disaggregation by age, disability, migration status, health comorbidities, race/ethnicity, among others. In addition, the tracker only interprets gender from a binary view of male and female.

(Dis)Ability

“Intersectionality plays such a big role. If we talk about women and women with disability, it is a very different picture from women without disability.”

Figure 3: Extract from interview with Vanita Nayak Mukherjee, Executive Committee Member, DAWN and FVP, India

Throughout the interviews for this report, it was clear that disability was largely overlooked in vaccination and treatment strategies for COVID-19. While prioritisation for vaccine access especially at the beginning of the pandemic included age and underlying conditions, disability was not readily understood to be an underlying condition that needed to be addressed.¹²³

The rush to integrate technology as an enabler for a population that in early pandemic stages was under stay-at-home orders, did not account for the challenges that people with disabilities faced with the new technologic tools such as apps for scheduling appointments. In the example of India, an app was introduced to introduce safety and equity into getting vaccine appointments. However, as Vanita Nayak Mukherjee of DAWN highlighted:



“

There are very specific barriers for people with disabilities... there are different kinds of disabilities. You have people who cannot see, who cannot hear and those who have motor disabilities. Now, can you imagine, for someone who cannot see, none of the apps were with audio. They were all visual. How can those who cannot see register for a vaccine appointment? How are they even going to get a slot? “Access” acquires a whole new dimension and meaning for people with disabilities.¹²⁴

”

Of course, the whole premise of apps as an enabler is built on the idea that everyone has equal access to the internet and the devices needed. And while some people with disabilities have specialised tools and technologies such as screen-readers that allow them to utilise internet applications, these are largely available to an urban, financially able population. Scheduling online vaccine appointments in many countries, including in high-income countries such as the USA, was also a game of timing. Even for those who were able to use appointment apps with the help of additional tools, these tools add an additional time barrier, meaning their user speed is a little slower, resulting in a disadvantage in signing up for limited appointment slots. For people with motor disabilities, some are unable to operate the apps making them dependent on others. Mukherjee described these as “layers and intangible things that need to be addressed.” The exclusive rather than the inclusive nature of mainly app and internet-based access procedures presents similarly to rural, urban-poor, and other economically marginalised communities, including transgender people as described below.

Chee Yoke Ling of Third World Network noted:

“

[In Malaysia] we went down the age groups, then all young people would get vaccinated. There was no differentiation in terms of disability, or gender. There was no conscious policy to include everyone. It was up to a lot of the civil society groups and those working with these different communities to ensure that they will not be left behind.¹²⁵

”

For many countries, respondents observed the same prioritisation criteria. Especially in the first one or two years of the pandemic, “people with disabilities just did not appear on that list” [of people with priority access to vaccinations in India]. However, with delay, India instituted walk-in appointments, and later on-call transportation services for those with mobility challenges; or on-call paramedics and nurses that could provide vaccinations via home visits. Mukherjee stated that India did not experience extensive vaccine shortages that other countries had, lowering the first barrier to access.



LGBTQIA+

LGBTQIA+ people have a built a tenuous recognition among infectious disease circles in global and national health settings. Now understood as so-called key populations, people living with HIV, men who have sex with men, and transgender persons have found representation on committees of donor agencies, international organisations, and government departments, e.g., the Ministry of Health. This change has been accompanied by the tacit acknowledgement of many global health stakeholders that community participation must be part of the approach not only for outreach purposes. However, representation does not always come with due recognition. This can in part be linked back to colonial legacy, conservative religious values, and patriarchal norms. One respondent commented that especially the transgender community continues to experience devaluation of their expertise. Even when their representatives are official appointees of committees, they may not always be allowed to speak, provide their expertise, or question those of high government office.¹²⁶



We still have constraints from the religious departments, because we enforce Islam at the individual state level in Malaysia. Indonesia doesn't have state enforcing Islam, but the conservative forces have grown in recent years, right. In a way the COVID-19 response is also linked to how much we have come along in HIV etc. to recognise that these are the voices that should be heard, and they are the communities that can reach out to those who for all the reasons that we know will not come forward when they need treatment.¹²⁷



In India and Nepal, due to (sometimes unplanned) lockdowns some LGBTQIA+ people were stuck in the cities where they work while some were able to return to their – often rural – hometowns. In both contexts as previously marginalised communities, they largely experienced social stigma within their families, making many vulnerable to domestic violence, similar to women and girls. Many transgender people are in precarious labour situations which were largely inaccessible during lockdowns, impacting their livelihood options. In India, a respondent recounted the appearance of stigmatising posters blaming the transgender community for spreading COVID-19. Not only were some transgender persons unable to afford basic testing services due to lack of income, but many were also too scared to appear in public for fear of violence.¹²⁸ An increase in domestic violence, stigma and discrimination including from their birth families whom they were forced to live in close quarters with during the pandemic contributed greatly to increased mental health needs.¹²⁹

Transgender people were also negatively impacted by the discontinuation of specific health services especially in the early part of the pandemic. Highly affected appear to have been those undergoing hormone replacement therapy and antiretroviral therapy for HIV/AIDS, both essential services that community-based organisations in India and Nepal advocated strongly for becoming accessible again through mobile services. In the case of Nepal, Blue Diamond Society was able to negotiate through the Ministry of Health that their staff receive special approval from the public security forces to deliver essential medications during lockdowns.¹³⁰



The lack of mobility during lockdowns combined with lack of livelihoods therefore compounded a range of equality issues that transgender people face. In India, respondents discussed that their research documented a significant number of transgender persons that did not have identity cards and were without income or livelihood during the pandemic. They observed that livelihood and food security took precedence over vaccination access once vaccine rollout started.¹³¹

In Malaysia, SEED connected the inability of transgender persons to gain legal gender recognition on identity cards to the limited access in vaccination. As Mitch Yusof, Executive Director at SEED, describes:

“

It is all interconnected. When we speak about legal gender recognition, it boils down to access to education, and when we talk about access to education, they may not have higher education. When they do not have a great education, they may not be working or being employed. So, what kind of income can they have? And would that income be used for transportation [to a vaccination site]? Or would it be used for food because remember that at that point in time, we were all in lockdown and even sex work was rarely done or not existent at all. It was all about which is a priority at that point in time, food or getting the vaccination.¹³²

”

The lack of legal gender recognition means it is unlikely that transgender people have an outward appearance that is considered by society to be in line with their documented sex. This leads to stigma and discrimination in housing, employment, social services etc. Transgender people can experience stigma and discrimination both from members of the public as well as officials and service representatives. COVID-19 vaccinations became overall available without large scarcity in Malaysia. However, long queues and presence of police and other security forces checking identification during wait times were strong deterrents for the transgender community. In Kuala Lumpur, SEED Malaysia was able to collaborate with another civil society organisation to initiate targeted outreach to transgender individuals to inform them about COVID-19 vaccinations, support them in navigating the online registration process, and have support staff present during the vaccination, all to facilitate greater access to COVID-19 vaccination.

When transgender people had to go to COVID-19 quarantine centres or seek inpatient treatment, they were placed in wards according to the sex on their ID card. Quarantine centres in Malaysia are designed dormitory style with sex segregated communal showers and bathrooms, inhibiting transgender people's ability to go about their daily needs in a safe manner. During non-COVID times, hospitals in some areas such as Kuala Lumpur provide individual rooms for transgender women in the men's ward and vice versa, allowing for a degree of privacy and security. However, these policies were rolled back during COVID-19. Thus, while treatment was generally available, fear of discrimination and violence in congregate settings led many transgender persons to not seek it.¹³³



Discriminatory behaviours were also present in India and were a deterrent for accessing vaccinations from public facilities. According to Neelanjana Das, then-Research Coordinator at Sama Resource Group for Women and Health:

“

For trans persons, there is a lot of apprehension to go to a public health facility. From our experience, they like to go to a private sector clinic so they can avoid the discriminatory behaviour and intrusive questions.¹³⁴

”

In South Africa, trans women in rural areas also experienced great difficulties in accessing healthcare. With reduced protection from community services and support, physical and mental attacks on transgender people increased. Civil society organisations also reported a spike in sexually transmitted infections and repeat infections due to the unavailability of protective technologies especially during lockdowns.¹³⁵

Migration status

Within the transgender and people with disabilities (communities), there are also families (who) have been migrant workers for at least one or two generations. And Malaysia has quite a large number of undocumented workers. A lot of the workers in the service industry and in the plantations came illegally, but then they stayed on. When COVID hit, these people became really vulnerable. And by law, when the health workers go in, and they have to get information from a person, and when you find that the person doesn't have any documentation, they are obliged to report this to the immigration authorities.

Figure 4: Extract from Interview with Chee Yoke Ling, Executive Director of Third World Network

Social prejudice also impacts women, transgender and non-binary people with diverse migration status. Respondents recalled conversations with community organisations that spoke of migrant workers going into hiding due to perceived increases in police raids for illegal workers during the COVID-19 pandemic and specifically during lockdowns. Even when early in the pandemic the Ministry of Health in Malaysia had negotiated with immigration authorities to not arrest people based on their migration status in order to not impact people's willingness to seek COVID-19 testing and – in the early absence of vaccines – seek treatment at hospitals, in reality arrests still happened and stoked fear among this community. Other sectors that have a lot of women migrants include domestic work and the food industry, including small restaurants and food stalls. Similar to above migration situation, many have lived in Malaysia for years and have children that were born in Malaysia, but because neither parent holds Malaysian citizenship, their children do not receive Malaysian citizenship either, rendering them effectively stateless, if their parents are in the country without documentation. According to Chee Yoke Ling:



“

If they grew up in this country (but are undocumented), they won't get to go to school, they won't have access to health. Both girls and boys, obviously. It's a big issue in Southeast Asia.¹³⁶

”

Despite the fact that most people regardless of who they are can access hospitals, would be treated, and would receive the same treatment, Malaysians frequenting public hospitals were initially not able to access COVID-19 treatment because of unavailability of medications. Paxlovid or remdesivir were available for private purchase for wealthy persons in an insufficient quantity. Insufficient supply may have caused some complacency with regards to seeking out treatment among the public, according to Chee Yoke Ling. And while the country has tried to stock up, therapeutic drugs remain a limited good. Chee Yoke Ling elaborated further:

“

Of course, we see a lot more countries that were in far worse shape. They don't even have the COVID-19 medicines. But I think for the communities we are talking about; they didn't come to seek treatment? Why didn't they come out? They didn't come out because they were scared and felt they would be discriminated against. I think that was quite a big factor in many countries.¹³⁷

”

Another compounding factor of people experiencing societal marginalisation included people staying away from hospitals due to the fear that they may experience long wait times given the crowded conditions, which could make them subject to discrimination during their long wait times. While this issue exists during non-pandemic times and is not limited to communities of migrant workers, the early COVID-19 pandemic was perceived to have increased the wait time at hospitals.

Impact on Gender-Specific Health Services

Interviewees noted that the inequalities that people such as sex workers, transgender women, and lesbians face with regards to accessing healthcare in the public sector are not a new phenomenon appearing with the COVID-19 pandemic, pointing for example to the case of South Africa re differential access to HIV prevention and sexual and reproductive health services.¹³⁸

At the same time, some gender-specific healthcare services have been severely impacted during the pandemic, including due to reallocation of resources towards the COVID-19 response. Some interviewees suggested that women, girls, transgender, and gender-nonconforming people were predominantly affected by closure of services. Mainly, respondents pointed to the unavailability of sexual and reproductive health services.

In some cases, gender and sexual health and reproductive rights experts suggested that gains in accessibility of these services have regressed during COVID-19, in part due to budgetary reallocations away from these services largely aimed at women and girls.¹³⁹ Respondents from many countries, including India, Malaysia, Mozambique, South Africa and other Southern African



countries commented on the interruptions in sexual and reproductive health services, including general OB/Gyn check-ups, maternity care, family planning services, and prevention, diagnosis and treatment for sexually transmitted diseases. In the words of Dr Lesley Ann Foster in South Africa:

“

997 pregnancies in one province were among girls 10 to 14 years old. I think that speaks to the fact that there was a lack of safety, a lack of protection, a lack of respect for the dignity and human rights, bodily autonomy and integrity of girls. All of that went out of the window with COVID. For women, intimate partner violence has been one of the main factors that they have struggled with, and the lack of access to health care services for pregnant women.¹⁴⁰

”

According to Dr Foster, people with disabilities women’s groups across the African continent spoke out about their many challenges because their community “was left out of everything”. In addition to being left out of COVID-19 vaccination planning as described above, they also encountered challenges attaining standard sexual and reproductive health services, e.g., routine exams or preventative technology. Dr Foster elaborated that SRH services are even harder to attain when you have a disability during COVID-19, given that even in non-pandemic periods, people with disabilities often get denied SRH services, and that pandemic times and associated health system pressures put these services even further out of reach.¹⁴¹

Another community negatively impacted by COVID-19 related challenges were people undergoing breast cancer treatment and cancer survivors. In the case of Malaysia, breast cancer has the highest incidence among all cancers in the country. Availability of cancer treatment was affected as hospitals temporarily shut down so-called non-essential services, the risks that COVID-19 posed for immunocompromised cancer survivors, both those who have completed treatment or are still undergoing treatment, increased.¹⁴² As one gender expert told us:

“

Access to vaccines affects everything.¹⁴³

”

Positive developments

Interviewers asked respondents to identify any positive developments with regards to gender-sensitivity and access throughout the ongoing COVID-19 pandemic. Those that shared any positive perspectives all pointed out that some issues of gender-based discrimination received media or public attention.

Several interviewees stated that the public has become more aware that frontline workers and the invisible workforce are majority women. In Malaysia, for example, the largely invisible service workforce cleaning services contracted by hospitals and clinics are mainly young women. Because they are engaged by contractors and not directly by the state, they have limited benefits and are treated poorly. While a movement of support groups for this population precedes the COVID-19



pandemic, the intertwined problems this population faces garnered more public attention. Predominantly low income, these women did not have the financial means to hire care for their children who were home during school closures, they were needed at work, and they were also getting sick. Many men lost their jobs during the early waves of the COVID-19 pandemics, resulting in the analysis of some in higher rates of domestic violence.¹⁴⁴

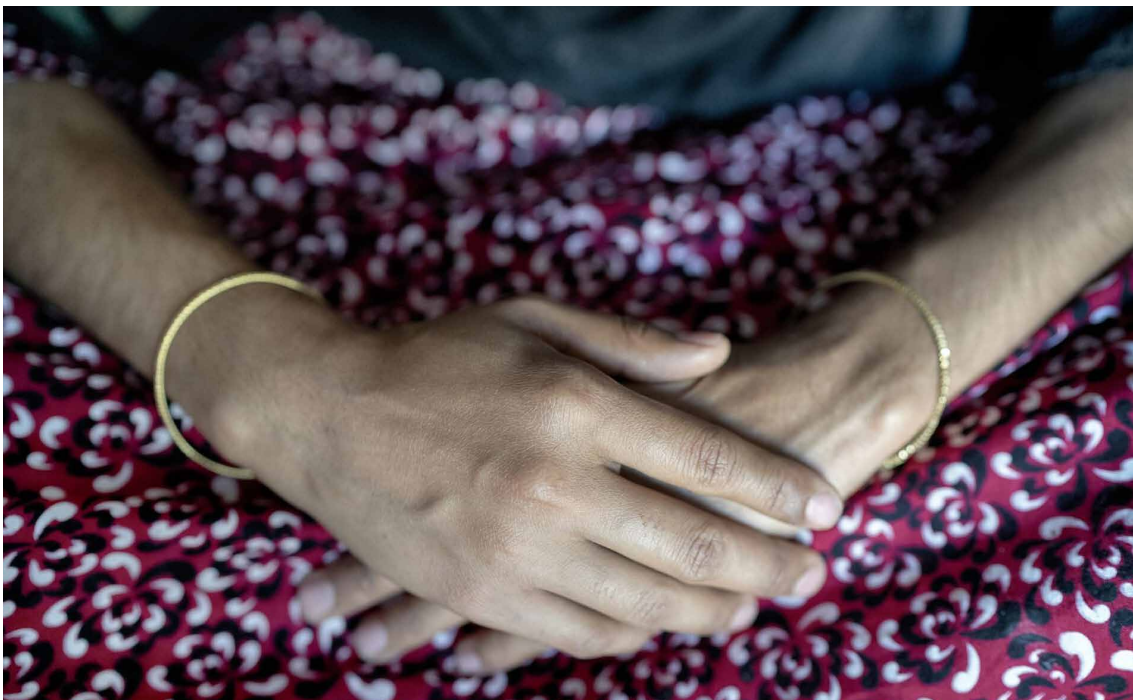
Women in some communities in South Africa recognised the need to produce their own food when lockdown and movement restrictions limited market access, or when transportation to markets was restricted to roughly one hour in the morning and one hour in the afternoon, effectively stranding women in marketplaces during the day.

Masimanyane Women's Rights International reflected on the renewed recognition that a gender sensitive response requires a holistic approach to services. In the words of Dr Foster:

“

These include pathways of referrals, because we discovered that there were gaps that women didn't know where to go for help or support. And that was important for us to develop. For us, a lot of what COVID did was highlight the gaps in service provision, that women really needed wraparound services. We couldn't give them that. We started to look at how to strengthen the services for women. I think understanding the value that women bring to the economy was very clear during COVID, because they cover so many essential services.¹⁴⁵

”





In the face of these intersectional and deeply ingrained challenges, the words of one expert, Chee Yoke Ling, were particularly notable – that integrating a gender analysis into all programming rather than having a standalone gender programme is integral: “It’s the entire ethos of our work. We collaborate a lot with women’s rights groups and feminist groups.”¹⁴⁶

There remains an absence of strong intersectional analyses guiding public health responses, including responses to health emergencies on the international, regional, and national levels. In light of this and the above analysis, we make the **following recommendations:**

1. National public health systems through their governments need to create more space for the voices of those representing intersectional communities. These communities can speak for themselves, have concrete ideas on how to guarantee access, and know how to organise. They should be respected partners in creating gender-sensitive guidelines that govern responses to health emergencies; and guidelines to strengthen national health systems based on intersectional gender analysis.
2. Civil society networks focused on policy work at the national and international levels need to collaborate with gender rights organisations and intersectional communities to gain momentum towards spaces and strategies for gender equality in health.
3. UN should create dialogue spaces focused on developing intersectional, intergenerational policy dialogue, that recognise power asymmetries. Tokenistic mention of communities in guidelines is not equal to participation by communities in policy-making processes. A focus on single-issue representatives i.e., a single young people representative, or a single disability representative without resources to bring intersectional experiences to the discussion does not allow for the full recognition and inclusion of the myriad inequalities highlighted throughout this report.
4. In the short run, a lot of resources should go to making disaster responses gender inclusive and respond to the fact that whoever is excluded in society will get services last.
5. In the long run, investing in health systems because the countries that were able to protect women and children and other marginalised groups were those that had resilient health systems, whose health systems were working, and accounted for GBV.



The Role of CSOs in Tackling Gender Barriers to COVID-19 Vaccinations and Treatments

Civil society organisations and networks of community groups were inextricable from effective vaccine and therapeutics uptake. On the latter, Global South countries in particular had access to Paxlovid much later than Global North countries – and when Paxlovid finally arrived, communities still to the publication of the report are poorly sensitised on what Paxlovid is, where they can get it, and at what cost.

On vaccine uptake, CSOs played essential roles in maintaining the continuity of other health services during COVID, but also in addressing vaccine myths, coordinating community engagement through community health workers, and advocating with governments. The following two case studies provide two examples of where VillageReach in DRC and Sama Resource Group on Women and Health in India worked to tackle access to vaccines and therapeutics, with activities ranging from direct community engagement at places where women frequented daily, to high-level interventions at Parliamentary Committees on areas where women and gender non-conforming people were neglected.

CASE STUDY 1: INCREASING VACCINE UPTAKE AMONG WOMEN IN DEMOCRATIC REPUBLIC OF THE CONGO

From April–November 2021, less than 1% of people in the Democratic Republic of the Congo had received vaccinations for COVID-19. The idea for ‘vaccinodromes’ or high-volume vaccination sites, was formulated as a key approach to accelerate vaccine introduction and uptake. In the words of Emily Gibson, Health Systems Associate at VillageReach:

“

The idea of the vaccinodromes came about through discussions between VillageReach and the Bill and Melinda Gates Foundation. VillageReach had supported high volume vaccine sites in King County, Washington state (USA), so we started talking with our Africa-based teams and Ministries of Health in DRC about how that concept could be adapted to their environment. At the time that these vaccinodromes were installed in DRC, COVID-19 vaccination rate was less than 1%.¹⁴⁷

”

The first vaccinodromes were launched in November 2021 and were fixed location vaccination sites as shown in Figure 5 below. After a month of operation, in December 2021, the data showed that women represented only 20% of those vaccinated at the fixed site vaccinodromes. VillageReach colleagues realised that static vaccination sites would not work to reach women. In Emily Gibson’s own words:



“

What we ended up seeing is that a classic high volume vaccination site i.e., a static site designed to serve 1000+ people per day - actually was not the best solution to support increasing coverage in both DRC and Cote d'Ivoire. But we did find that access was a key component of why people were not getting vaccinated and that we required an even higher level of convenience to encourage people to get vaccinated. Through close monitoring of the data at the site, we quickly realised that we were not getting that coverage and the number of visits to the site that we were hoping for, and so pivoted to a strategy that we call the Hub and Spoke strategy, where we had the vaccinodrome as sort of like the 'command centre' for vaccination efforts. And then we had smaller outreach teams going out to, for example, bus stops, or various places in the city that had a lot of people going through them every day. And we would have a vaccination team posted at these outreach sites for short periods of time accompanied by community health workers, who would mobilise people in the surrounding community. And then every so often, we would move the location of these outreach sites. We found that if people didn't have to come to the vaccinodrome, that they were able to receive a vaccine as they were going about their daily life and that a lot of people were relatively open to getting vaccinated. They weren't necessarily against it. It was just that they weren't highly motivated enough to go and seek it out.¹⁴⁸

”

In addition to conducting mobile outreach and mobile vaccination sites, VillageReach had multiple community engagement and communications approaches in order to allow communities to clarify any questions they had about the vaccine and to debunk any disinformation mostly circulating through social media channels. Carla Toko, Senior Manager, Advocacy & Communications, VillageReach, elaborated further:



Figure 5: The 'vaccinodrome' designed to increase vaccine uptake in DRC



“

We had some information sessions at workplaces, markets, women’s associations, local NGOs, and other health facilities caring for vulnerable populations that didn’t directly offer COVID-19 vaccination, and this was a chance to share and to respond to questions (from women in communities), and some concerns that women had around the vaccines. Our engagement showed that for many women, hesitancy was related to fertility and breastfeeding concerns. As you know, a lot of rumours and misinformation circulating around the vaccine didn’t help vaccine rollout and uptake. In addition to (elucidating concerns), we talked to them about where they could access COVID-19 vaccinations if at that very moment they were not ready to receive the vaccine. However, there is one element that we couldn’t change in DRC, and it still is the case today. During the early days (of the COVID-19 vaccine rollout), per WHO guidelines, pregnant women were not allowed to get vaccinated. A few months later, they were allowed to with newer and up to date WHO guidelines. However, in DRC to this day, pregnant women still need a doctor’s note before they can get vaccinated. With documented worldwide hesitancy from health workers themselves, who might not easily recommend vaccination to pregnant women or those wanting to get pregnant, this is an additional barrier that impedes vaccination uptake among women.¹⁴⁹

”

The VillageReach team elaborated that while advocacy has been done through high-level meetings with government to remove the requirement for a doctor’s note, the decision has remained to keep this procedure in place. According to the team, the requirement of a doctor’s note perpetuates hesitancy concerns.

The team’s Hub and Spoke model of splitting vaccination teams between the fixed vaccinodrome site and different outreach locations (informed by traffic and CHW suggestions) was highly effective in reducing the gender deficit, with the proportion of women vaccinated out of total vaccinated persons reaching 40% in June 2022 compared to only 10% in the beginning of the initiative. Operations occurred as follows:

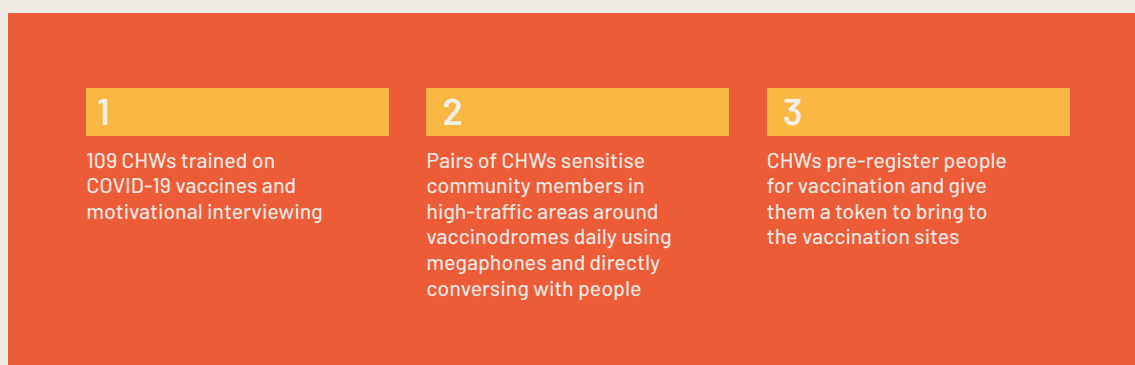


Figure 6: VillageReach (DRC) Hub & Spoke model of Community Health Workers driving vaccination uptake via mobile sites



The team credited person-to-person communication through CHWs as central to the success of the initiative. In the words of Emily Gibson, Health Systems Associate at VillageReach:

“

So much of the way that we promoted the vaccine and supported increased coverage was through person-to-person communication, not through media or ads, although we did have a small amount of that. But by far our most effective strategy was community health workers, who are known in the community and trusted in the community. Carla’s team did extensive training with community health workers to support their confidence in vaccines, which they were able to then translate into conversations with the community.¹⁵⁰

”

Carla Toko, Senior Manager for Advocacy and Communications at the organisation described how CHWs communication of their own experience with vaccinations, as well as fact-checking misinformation on vaccines was essential to increasing vaccine uptake. In Toko’s own words:

“

Community health workers going to areas surrounding the vaccination site and sharing their own personal testimony of being vaccinated themselves also helped. And more specifically, it was really just about sharing information (about the vaccine), because a lot of the hesitancy was simply due to the lack of information that people had on the vaccine itself considering all the misinformation that was spread through social media and WhatsApp.¹⁵¹

”

Like in the [South Sudan case study](#) below, vaccination teams also targeted markets as well as women’s associations with vaccine messaging.

Key Takeaways and Best Practices

1. CHW recommendations and expertise was essential to the success of the program. Funders and organisations should tap into the depth of CHW expertise to engage communities on tools uptake.
2. A gender-inclusive lens includes bringing vaccines (and other health technologies) to where women are congregating or going about their daily lives.



CASE STUDY 2: THE ROLE OF CSOS IN RIGHTS PROTECTION AND ACCESS TO ROUTINE HEALTH CARE IN NEW DELHI, INDIA

Sama Resource Group for Women and Health is a feminist organisation based in New Delhi, India. When the pandemic hit, and with it lockdowns and related restrictions, Sama worked tirelessly on, inter alia, human rights advocacy (including with the Parliament of India), in supporting the community to access accurate health information in local languages, assisting women within communities to access routine health services, and providing in-kind support to marginalised communities.

At the start of the pandemic, there was a dearth of accurate and science-based information for local communities in the languages they understood. In addition, government-imposed lockdowns resulted in panic, decimation of income generation activities, isolation from families and support systems, and numerous human rights violations. Sama played a multifaceted role – issuing media and policy statements on human rights violations and impact on women and gender non-conforming people, as well as playing a critical role in channelling resources to marginalised women.

As the pandemic went on, it became evident that maternal and child mortality were on the rise. Due to areas being designated red zones due to being deemed a COVID-19 'hotspot', pregnant persons from red zones were denied admission to facilities, despite requiring urgent attention or undergoing delivery complications. In Noida, a city in the state of Uttar Pradesh, a 30-year old woman who was eight months pregnant with her second child died on Friday after she was refused admission by eight hospitals over 12 hours across Noida.¹⁵² Another pregnant woman was denied treatment in GMC Baramulla, Kashmir until her COVID-19 test report was returned, which resulted in foetal/intrauterine death.¹⁵³

Dr Sarojini Nadimpally, Executive Director, in interview for this report, told us of one woman from a so-called red zone who had to rely on the kindness of private sector clinicians for admission because she faced denials at public hospitals:

“

There was no transport at the time of lockdown and one pregnant woman, a young domestic worker with a congenital heart problem and a three-year-old child came from an area that had been declared a red zone. She was denied admission into a hospital because they said this one is only for COVID and that she would have to go to another hospital despite there being no transportation and the fact that she was nine months pregnant. We decided that we needed to do something and finally in the middle of the night a kind medical professional from a private clinic got her admitted and we managed to transport her. So then we knocked on the door of the High Court of Delhi – we knew that there would likely be many women in the same situation.¹⁵⁴

”

Sama compiled up to 45 cases of maternal healthcare denial linked to the COVID-19 lockdown, and released statements urging the Ministry of Health and Family Welfare (MoHFW) to take immediate steps to issue a directive to all healthcare facilities to NOT deny healthcare services to pregnant



persons to ensure safe delivery and prevent maternal and perinatal deaths, as well as the prevention of reproductive complications and access to safe abortion.

Sama filed a Public Interest Litigation suit [W.P.(C) 2983 of 2020] before the Delhi High Court towards denial of healthcare specifically to the pregnant women in Delhi. Pursuant to the litigation being heard at the Delhi High Court, an order was made on 22 April 2020 that, inter alia, transportation for pregnant women to visit hospitals would also be arranged pre-delivery, for delivery and post-delivery, and that the Central and Delhi Government shall work in tandem to make sure that no barriers are faced by pregnant women and their family members residing in hot spots during the lockdown.¹⁵⁵ This groundbreaking work changed the paradigm and was the key towards ensuring there would be no more maternal and child deaths linked to arbitrary COVID-19 lockdowns and associated restrictions.

But this was just the start. Sama released up to 40 press statements through the pandemic on various issues pertaining to women and marginalised communities – including on COVID-19 stigmatisation, breach of confidentiality of COVID-19 status, maternal and child health, among numerous important and current topics. Sama also provided in kind support such as food, sanitary kits, PPE, and transportation support to migrant worker communities in collaboration with community organisations across Delhi, Uttar Pradesh, Jharkhand and Bihar. Sama also facilitated support to access hospital beds, care, food, transportation, psychosocial and legal support through their wide networks, and provided COVID-19 information kits in local languages.¹⁵⁶

According to Neelanjana Das, Research Coordinator at Sama:

“

One of the things that we did very brilliantly was the listing down all the myths and having a doctor address these with grassroots workers and explain the scientific reasoning behind the vaccines.¹⁵⁷

”

In addition to this work, on 4th April 2022, Sama presented their experiences and views on what gendered impacts COVID-19 had on their communities to the Parliamentary Standing Committee On Health And Family Welfare in the Parliament of India – including gender inequity due to differential access to internet and phones, increases in gender-based violence due to lockdowns, lack of clinical trials on pregnant and breastfeeding persons, disruptions in access to abortion and contraceptive services, and insufficient remuneration for extra efforts of health workers during the pandemic,¹⁵⁸ offering lessons to MPs that hopefully will be integrated as learnings for the next pandemic.



CASE STUDY 3: INTEGRATING GENDER-INCLUSIVE COVID RESPONSES IN AFGHANISTAN

Gender barriers in access to health care in Afghanistan precede COVID-19, as women's access to health services is often determined by male family members (*Mahram*) and is often conditioned on the availability of female staff and segregated infrastructure. Access to healthcare for women is dependent on the willingness and time of their *mahram*.¹⁵⁹ In one 2020 study conducted in Herat province in north-western Afghanistan,¹⁶⁰ women were disproportionately impacted by COVID-related income loss and mental health burdens due to them shouldering significantly more workload of managing household resources and having to restrict food intake to cushion the household impact on their livelihood.

In Herat province, a study revealed females being more impacted by loss of income and increased mental health issues due to COVID-19, with over half of respondents reporting bearing significantly more workload of managing household resources, and resorting to restricted food intake to cushion the household impact on their livelihood.

We interviewed one expert on what were the biggest achievements during their tenure working in the restrictive and patriarchal environment to deliver COVID-19 vaccines to women. In their own words:

“

My biggest achievement was to use the CHW model in ensuring vaccine uptake among women. You see - for a woman to access health services or any other basic services, presence of a female frontline worker within that context is critical. If you don't have a *mahram* who is a chaperone to escort you it's also a stumbling block to access services. In addition, there was the issue of digital access or the lack thereof. The whole issue of digital access - during COVID, there was an RCCE study conducted on the context in Afghanistan, where less than 35% of women said they have access to digital skills, even access to radio, TV, and access to phones. Yet, most of the messaging that Social and Behaviour Change colleagues, (was through) massive awareness campaigns on COVID using digital platforms, radio, TV, and SMS through phones. While the statistics were telling us otherwise in terms of where women are, and what gadgets do they use in terms of accessing messages. As a result, many women within the Afghanistan context were left behind.¹⁶¹

”

This realisation meant that the approach had to be both creative and culturally acceptable. The decision was made to use a CHW model, but using husband and wife, or brother and sister paired up as community health volunteers and vaccination promoters. The expert further described:



“

We decided to follow the CHW model but pairing up a husband and the wife as community health volunteers, or a brother and sister – reducing the chances of security issues and increasing ability for women to be given permission to engage with health care workers. In the Afghanistan context, a male community health worker cannot go into a household with just a woman – so this model was a best practice and we tried to incorporate this model with social workers in other provinces, including those which were then under de facto authority and thus much more difficult to have women-only social worker groups conducting COVID vaccine mobilisation. I piloted this model, and it was also shared with Gavi and other global and regional platforms on what works best to facilitate access to COVID information, vaccines, and other services to women who have been left behind. From this work, we saw an increase in the statistics in terms of how many women were able to access information and the COVID vaccine.

”





Global Health Agencies and Gender-Inclusive Responses: Best Practices and Areas for Improvement

Gavi

Several gender-inclusive initiatives were developed by global health agencies and programmes during the COVID-19 pandemic. One such initiative was the development of a 9-point gender checklist¹⁶² towards equitable COVID-19 vaccine deployment, developed by the Gender Equality Working Group of the SDG3 Global Action Plan for Healthy Lives and Well-Being. This checklist was targeted to both COVAX-supported and self-financing countries, as well as COVID-19 vaccine deployment Coordinating Committees and National Immunisation Programme Managers. The nine checklist items cover, inter alia, regulatory preparedness, human resource management and training, and vaccine delivery strategies, and recommends that countries and agencies:

- Make sex- and age-disaggregated data on pre- and post-market vaccine trials an essential requirement for expedited regulatory approval.
- Value and remunerate the work and time of women healthcare workers and volunteers.
- Use differentiated vaccine delivery strategies to effectively reach women, men, and gender-diverse people.

It is unclear, however, the extent to which this gender checklist was operationalised. Nina Schwalbe, a public health researcher and expert who led the development of the checklist, asserted that COVAX had not operationalised or implemented the gender checklist, and did not understand why it had not been done:

“

The checklist was endorsed by all the major UN agencies that work on gender and health. The question is, could COVAX have said (to countries), it is a requirement that you have to complete this checklist... It is a really simple, really easy-to-use tool.¹⁶³

”

Schwalbe also said that in the USAID role (she was appointed USAID's COVID-19 Vaccine Access and Delivery Director following Biden's commitment of Pfizer doses to the Global South), 'missions were asked to use the gender checklist when designing their programming in support of COVID-19 vaccine rollout.'¹⁶⁴



In response to this statement, Gavi provided a written response, stating that Gavi:

“

(Applies) a robust Gender Policy across its programmes and is proud to have contributed to the development of the checklist. The checklist was communicated to countries by COVAX partners, and elements of the checklist that could be directly implemented by COVAX partners were incorporated into our response, including regulatory preparedness, planning and coordination, and monitoring and evaluation systems. For example, with regard to planning and coordination, gender was explicitly part of the guidance issued on development of the National Deployment and Vaccination Plans (NDVPs)¹⁶⁵... This approach has helped lead to positive outcomes – in aggregate across AMC countries who report there is parity in COVID-19 vaccination coverage for men and women. However, implementation of the checklist was not a precondition to receiving COVAX support, given the pandemic context and the emphasis on a rapid, streamlined process.¹⁶⁶

”

Jean Munro, Gavi's Gender Lead in written feedback to this report¹⁶⁷ stated that the COVAX Delivery Support (CDS) funding applications include the requirement to address gender considerations. While there was no threshold for countries to meet in their requests, it was considered as part of the guidance and eligible activities for CDS funding. In the [CDS 3 guidelines](#),¹⁶⁸ there is reference to considering a gender appropriate response with regards to differentiated service delivery, data monitoring and evaluation, as well as demand generation.

An example of this was Gavi's work on vaccine uptake in Afghanistan, where in the country's most recent (at time of writing) CDS funding request included plans to organise gender-sensitive awareness-raising meetings with community leaders to address barriers to immunisation in the identified communities as well as intensify communication at the community level by broadcasting radio messages in local languages with a gender perspective. By sensitising communities, the country hopes to achieve results that will overcome these challenges.¹⁶⁹

UNICEF

As the organisation leading the COVID-19 Vaccine Delivery Partnership, it was critically important to understand how UNICEF was integrating gender considerations into their vaccine delivery and uptake initiatives. We spoke to UNICEF teams working in South Sudan, across the South Asia region and others, and conducted a document review of UNICEF published reports on Jordan and Sudan to understand their approach to gender-responsive programming.

Unique about the UNICEF country offices' approach to vaccination uptake was the use of social listening approaches to understand what community concerns were vis-à-vis COVID-19 vaccines, what barriers existed to vaccine uptake, and what communities believed would be the best approaches to bring vaccines to them. As a result of these approaches, UNICEF country teams, collaborating with Ministries of Health, were able to deliver solutions that were shaped, and many times led by communities.



In Sudan, insights from social listening and feedback received by the field-based team highlighted that both women and men fear side effects, ranging from fever to infertility. In addition, there had been miscommunication over government criteria for vaccine eligibility – including the fact that pregnant and breastfeeding persons were eligible for vaccines but this fact had not been communicated to all vaccinators.¹⁷⁰

As a result of the social listening work, UNICEF produced four gender-oriented messages (focused on fertility, menstruation, lactation etc) and disseminated them through Facebook, Twitter, and Instagram accounts.¹⁷¹

In South Sudan, as described in more depth in [the case study](#) elsewhere in this report, UNICEF South Sudan conducted social listening exercises and focus group discussions to understand why women were not accessing COVID-19 vaccinations, and in response to these, worked together with the Ministry of Health to institute a multipronged action plan which included interactive radio sessions with communities, creating vaccination sites at markets and churches, engaging existing networks of community health workers, as well as respected female influencers.

An independent evaluation of how well UNICEF South Asia integrated gender considerations into their COVID-19 response detailed how through the pandemic, UNICEF Gender Network meetings (held to provide information on how to integrate gender in planning, implementation, and data gathering) were held at least twice a month through the pandemic and as the pandemic wore on, shifted to once a month.¹⁷² The evaluation also found that country officers did not **uniformly report** data and/or sex disaggregated information on continuity of care services, education, health, and preparedness for increased GBV,¹⁷³ suggesting a need to ensure better reporting from country offices. The report also found, however, that UNICEF was able to work well with partners in Cox's Bazar in Bangladesh (largest refugee settlement due to violence in Myanmar) – demonstrating continued commitment to gender equity in challenging environments and in the midst of a pandemic.

It was noted, however, that for COVID-19 vaccine uptake, a gender lens was only deployed reactively rather than proactively – in other words, a gender lens was only integrated when data emerged that women weren't taking up vaccines. An approach of ensuring a gender lens at the beginning of pandemic tools rollout would therefore be more efficient and would reach women quicker.



WHO

As mentioned [elsewhere in this report](#), WHO guidelines for uptake of novel antivirals did not initially include pregnant and breastfeeding persons because of the lack of safety and efficacy data. In addition, DART animal data (data from trials among animal specimens) was slow to emerge in 2021.¹⁷⁴ The scenario was similar for vaccines, and this translated into confusion in countries about whether pregnant and breastfeeding people could get vaccinated or whether they could be treated with the novel antivirals.

In a background paper prepared by Dr Shirin Heidari and Tracey Goodman from the Department of Immunization, Vaccines & Biologicals at the WHO to be presented to the WHO SAGE (Strategic Advisory Group of Experts) COVID-19 Working Group, the authors stated that 'historically, pregnant women have been excluded from clinical trials due to ethical concerns of potential harm to the foetus' however that there was growing concern of the exclusion of pregnant and lactating women as it denies them opportunities to receive vaccines that could protect them and their offspring from diseases.¹⁷⁵ The background paper recommends, inter alia, that vaccine developers and funders prioritise assessments of vaccine safety and immunogenicity among pregnant women in clinical development and of safety and effectiveness in post-marketing surveillance plans,¹⁷⁶ and that reproductive toxicology animal studies must be initiated at an early stage.¹⁷⁷

Part of understanding differential trends between men and women is having sex-disaggregated data – not the norm despite it being recommended in the Convention on the Elimination of All Forms of Discrimination Against Women, among others. According to Tracey Goodman, Team Lead, Life Course and Integration in the Immunization Programme at WHO, of 194 WHO member states, only 84 at time of interview reported sex-disaggregated COVID-19 vaccinations data, and while recommended, member states are at liberty not to submit this data if their domestic systems aren't set up to do so.¹⁷⁸

According to a Global Health 50/50 report, in November 2022, WHO's COVID-19 Vaccine Tracker¹⁷⁹ began integrating sex-disaggregated data available on the WHO COVID-19 surveillance and WHO coronavirus vaccination dashboards for countries where public reporting could not previously be found, or where more comprehensive data was available from the WHO dashboard. This led to an increase in the number of countries reporting sex-disaggregated data.¹⁸⁰

Outside of vaccine safety for pregnant and lactating women and the need for sex-disaggregated data, the background paper for the SAGE also spoke about the 'disproportionate burden of paid and unpaid care on women and their frequent contact with children and elderly people either as caregivers or in predominantly female workplaces, such as nurseries, schools, and nursing homes' and their greater risk in coming into contact with persons who may have a symptomatic or asymptomatic COVID infection.¹⁸¹ The paper also spoke about the gender gap in education in many settings which 'may further limit access to accurate vaccine information and result in less vaccine confidence for women.'¹⁸²

According to Dr Shirin Heidari and Tracey Goodman, WHO co-authors of the background paper:



“

We did quite a bit of work of trying to raise awareness around these issues where opportunities arose - through presentations to the SAGE, and working with different departments, and doing presentations to WHO regional offices and country offices that are engaged in immunisations to try to reach people who are specifically active in the immunisation rollout.¹⁸³

”

World Bank

Our literature review demonstrates that the World Bank responded quickly with comprehensive analyses of what impacts the pandemic might have on women. For example, an April 2020 Policy Note detailed, inter alia, that especially in LICs women are largely engaged in informal work and other vulnerable forms of employment and that ‘cash transfer programs to the most vulnerable groups including women-only households (e.g., single mothers with children, widows, or female farmers) will be necessary both as part of the emergency response and in the longer term’.¹⁸⁴ The Policy Note also states that in the absence of any alternative support mechanisms, and considering social norms around women as primary caregivers, many families across higher income countries may be confronted with the need to choose ‘to prioritise the highest-paid job in the household - most often corresponding to men’, meaning that it is more likely for women to stay out of the labour market as the crisis hits.¹⁸⁵ It should be noted that studies to date have shown that more men than women have diagnosed with COVID-19 infections¹⁸⁶, and have experienced more severe symptoms and higher mortality.¹⁸⁷





The World Bank's approach to gender equity is contained in their 2016–2023 Gender Strategy¹⁸⁸ focused on Gender Equality, Poverty Reduction, and Inclusive Growth, to be updated in 2023 as the World Bank Group Gender Strategy Update (2024–30): Accelerating Equality and Empowerment for All.¹⁸⁹ The 2016–2023 strategy is underpinned by four objectives – improving women's health, education, and social protection, removing constraints for better jobs for women (participation in the labour force and income-earning potential), removing barriers to women's ownership of assets (land, housing and technology), and enhancing their voice and agency (ability to define goals and act upon them).¹⁹⁰ It should be noted here that the gender strategy does not mention transgender women or gender non-conforming people throughout – thus their gender approach is focused upon cisgendered women.

As part of grant and project application processes across disciplines, including World Bank projects on agribusiness,¹⁹¹ global health, etcetera, the Bank 'gender tags' projects through (i) identifying gender gaps in outcomes between men and women in a given project or sector; (ii) devising interventions to address gaps between women and men, and (iii) indicators in the results framework that measure closure of a gender gap, stating that simply sex-disaggregating indicators is not sufficient to get the Gender Tag.¹⁹² Dr Sameera Al Tuwaijri, the Global Lead for Population and Development at the World Bank, described how these Gender Tags work in practice:

“

We have something called the Gender Tag and it really is a tag placed on projects so they will be gender-responsive or have gender-smart solutions. The pathway to gender tagging is really very simple. Within each project, regardless of what it is you're doing, there must be a gender gap analysis. And there has to be actions within the deliverables to address the gap that was identified, and finally, there has to be at least one indicator in the results framework that answers with actions you've decided to take to bridge the gap that was identified during the gender analysis. And we have a cascade structure, meaning that we have people in country offices and regional focal points helping the project teams to look at the gender gap.¹⁹³

”

When COVID-19 hit, however, an imperative arose to get projects funded more quickly than usual, leading to the decision to suspend the gender tagging process and replace them with 'cheat sheets.' As Dr Al Tuwaijri elaborated:

“

We were putting together projects in record time – days rather than months – which was our usual pre-pandemic practice. We created what we call, for lack of a better term, cheat sheets. And those cheat sheets give you entries and guidance into how gender can still be incorporated into the project.¹⁹⁴

”



One such document was contained in the **World Bank Gender: Guidance for Health COVID-19 (Coronavirus) Response Projects** document,¹⁹⁵ last updated June 2020, and was intended to provide guidance for World Bank teams on how client countries can respond to the different needs of men and women. The guidance contained numerous important recommendations for ensuring gender-responsiveness in World Bank COVID projects, however it remains unclear how extensively it was operationalised, and the extent to which gender impacts were exacerbated as a result of the suspension of gender tagging and associated gender gap indicators. Some of the recommendations provided are illustrated in the figure below:

- Train health care staff to identify GBV cases, appropriately handle disclosures and refer patients for additional services.
- Consider paying people for the provision of unpaid care (largely provided by women) as part of an economic reactivation strategy.
- Include equitable representation of women and men in emergency management groups.
- Consider female healthcare workers' specific needs (beyond personal protective equipment) such as menstrual hygiene and transportation needs.
- In cases of detection, confirmation, and contact tracing, consider 'are there cultural/ normative/ infrastructure aspects that prevent women from accessing health care or getting tested?' (eg. women might not be able to go out without male companions)
- Does PPE need to be tailored to male and female sizes?
- Childcare for women essential staff.

Figure 7: World Bank COVID-19 Response Projects Guidance: Recommendations to address differentials between men and women during implementation.

Given that these considerations manifested as real-life barriers, and are illustrated in case studies elsewhere in this report (such as the [South Sudan case study](#) where permission from male companions prevented vaccines access), these are important considerations, and according to Dr Tuwaijri: "These cheat sheets were really useful to give task team members a platform to think about how gender can still be incorporated, and how the health system in general can react favourably in consideration of these factors."¹⁹⁶

In a separate document, the World Bank states that 'Gender inequality begets gender inequality, and this process is only exacerbated in times of crisis or in the face of major shocks such as the outbreak of COVID-19'.¹⁹⁷ And while practicality and crisis response dictate the need to disburse funding quickly, the exacerbation of gender inequalities during crises raises questions about the suspension of Gender Tags – which is a unique best practice among global health agencies we examined. No other global health agency we examined has a similar process. While the full gender analyses and indicator monitoring were not practicable in a fast-moving environment, the World Bank implemented an adjusted gender approach. With the experience of the adjusted gender approach, this would be an opportune moment to conduct a review on if and how the intended results were achieved and for the World Bank to consult civil society and communities on the finetuning of gender-inclusive models for future pandemic preparedness.



Countries and Gender-Inclusive Responses: Best Practices and Areas for Improvement

Countries generally did not deploy gender-inclusive responses at the outset of the pandemic. While some course-corrected with stakeholder engagement, many more exited the acute phase of the pandemic without fully considering women and gender non-conforming individuals, much less these populations living with disabilities, in refugee camps, those who are part of minority ethnic people, racialised or other persecuted groups.

According to Dr Lesley Ann Foster from Masimanyane Women's Rights International, in Ghana, South Africa, and Uganda, many women who worked at markets were left without income when markets were shut down, with public transport options halted, and the governments did not provide social protection for their incomes. In Dr Foster's own words:

“

They were stuck at markets and couldn't travel home, and there were problems with (gender-based) violence, and there was a lack of protection and support, with children left unprotected in the homes. The way the ad-hoc decisions were made and how they were carried out was very problematic. The last thing (women) were thinking about was access to vaccines.¹⁹⁸

”

This statement points to how social support and security for communities is a significant factor influencing access and uptake of vaccines. This was also illustrated in an August 2022 report with security factors in Haiti, including gang violence, flooding, kidnapping, and fuel shortages meaning that people simply didn't have COVID-19 vaccinations as the top priority.¹⁹⁹ In other words, not only should countries be integrating a gender lens, but also a conflict lens, within vaccines, therapeutics, and diagnostics deployment strategies.

Part of a robust pandemic tools deployment strategy is intersectional gender-sensitive communications. According to Vanita Nayak Mukherjee from DAWN and Feminists for a People's Vaccine:

“

(Information about treatments and vaccines) was completely lacking in the beginning. It was much later that radio and television and other forms of communications through the phone was put into place. Slowly over time (it improved), but it was very sketchy, very confusing. And over time it improved.²⁰⁰

”

In addition to a lack of clarity in communications in the beginning of the pandemic, the vaccine rollout was not initially disability inclusive in India. However, as time passed, the Indian government began an approach of identifying persons with disabilities and attempting to reach them where they were. Mukherjee elaborated further:



“

They started identifying people with disabilities and actually trying to reach them where they are. Different strategies did come into place and that's why there has been huge coverage of vaccines in India (among persons with) disabilities, which changes to their protocol (to) having paramedics and nurses going to where do the vaccinations at home for persons with disabilities or for very elderly people.²⁰¹

”

Access to vaccines for transgender communities in Malaysia

Malaysia does not have legal gender recognition, complicating access to health services generally for fear of bullying and the lack of gender-appropriate healthcare. In addition to that, states criminalise gender identity under sharia laws.²⁰² Malaysia also has a government that has vowed that LGBTQIA+ people 'will never be recognised'.²⁰³

We spoke to Mitch Yusof and Jane Kasim, respectively Executive Director and Program Officer at SEED, a civil society organisation working on health and welfare of transgender, marginalised communities, and the urban-poor in Kuala Lumpur, Malaysia. According to Mitch:

“

We do not have our gender markers stated in our IC (identity cards) – there is no legal gender recognition. That itself is a huge barrier, especially for trans people to access health, education, housing, and things like that, because the IC does not depict the gender that we are. That is our primary challenge.²⁰⁴

”

As a result of this, trans people fear being bullied, harassed, refused health care on the ground of inconsistency of appearance with legal documentation, or arrested. In the words of Jane Kasim:

“

When you get your vaccine registration, you have to go (and stand) in a long queue. The police are always there (at the vaccination centre), and you get worried that the police will start looking at you up and down and check if you have the correct QR code. And you know in the QR code your birth name and appearance are so different. Trans people are so afraid of that interaction.²⁰⁵

”

Given this legal and social environment, it seemed improbable that any work would be done to increase uptake of vaccinations among trans people. However, SEED was approached by a government-linked NGO with the objective of increasing vaccination uptake among socially excluded populations. Mitch Yusof told us:



“

During COVID, a local government-linked NGO contacted us to collaborate or work together on vaccinating those who are marginalised or socially excluded. They wanted us (as a collaborator) because we were able to approach those who are under the radar – i.e., those who are not willing to be known to the government. So, we agreed that we could collaborate, and what we had to do was to identify people, then we would register them for vaccinations, and we were there with them during the vaccination days, so we could welcome our community and make them feel safe. All in all, at that point of time, we were able to recruit more than 3000 trans people for vaccinations.²⁰⁶

”

The best practice inherent in this example is the community engagement by a government linked body to provide access to vaccines in a repressive legal and social environment. However, there is much to improve. Legal gender recognition is a prerequisite of and first step towards harassment-free healthcare for transgender people and must be seen as essential within a public health framework. The Malaysian authorities may also draw upon the Zimbabwean example below, where vaccination services were integrated at the LGBTQIA+ support centre, thus preventing the safety and harassments risks from trans people attending a generic vaccination centre.





Gender Inclusive Test-and-Treat Programmes in Mozambique

The IMPAACT4C19 project is a project led by The Aurum Institute in partnership with KNCV Tuberculosis Foundation and Treatment Action Group to improve access to COVID-19 diagnostics and therapeutics in 5 countries (including Mozambique) through technical support to Ministries of Health, supply chain and procurement assistance, and demand generation in communities.²⁰⁷

In Mozambique, Muleide – a women-led organisation focused on gender equality in Mozambique – was engaged to work on COVID-19 tests and treatment demand generation in communities. According to Sharon Truzão, Program Officer at Muleide, the decision was made to focus on increasing demand in communities of women living with HIV, because ‘they are the most marginalised community.’²⁰⁸

Muleide worked to increase demand for testing, and treatment with novel antivirals, through community awareness sessions, policy briefs, discussions with district health services, government officials, and community leaders. According to Truzão, women are expected to stay at home and take care of children, making it difficult for them to go to ‘health posts’ (primary health centres) to access COVID-19 tests, treatments, and vaccines. Additionally, in 2016, one study noted that 90.2% of Mozambique was considered an underserved area in terms of walking distance to a primary healthcare centre.²⁰⁹ While more recent data was not available at time of writing, geographic distance to health centres combined with patriarchal norms about women’s roles and where they should be in the daytime decrease the ability of a woman to be able to access COVID-19 tests, treatments, and vaccines.

COVID-19 lockdowns also meant that women living with HIV couldn’t access their antiretroviral treatments and many stopped taking their medications. In addition, these women lost the ability to conduct any income-generating activities. Today, but for the IMPAACT4TB project, they would have no knowledge of available novel antivirals to treat COVID-19. According to Truzão:

“

The government weren’t exactly gender sensitive, nor were they completely gender blind – implementation continues to be a problem when it comes to (access to) COVID-19 treatment. In addition, the ‘stay-at-home campaign’ (lockdowns) made women think: ‘how are we going to survive?’ And the government didn’t apply the gender lens on to that fully.²¹⁰

”

This testimony illustrates how integral a gender analysis is to ensure that women aren’t left behind in a pandemic response – particularly where women are expected to stay at home and where that is compounded by health infrastructure that isn’t within walking distance – it becomes an imperative to bring services to them.

COVID-19 Vaccinations at LGBTQIA+ Organisations in Zimbabwe

Same-sex sexual conduct is criminalised in Zimbabwe,²¹¹ and LGBTQIA+ persons suffer intense stigma due to decades of anti-gay bigotry by political regimes.²¹² GALZ, An Association of LGBTI People in Zimbabwe, is an NGO that was established in 1990 to create a community of LGBTQIA+ people and to advocate for their rights and welfare.²¹³



The Zimbabwean government began phased vaccinations in February 2021, targeting healthcare workers and frontline workers (such as those working at borders).²¹⁴ This later expanded to be aimed (in order of priority) at those with chronic conditions, other essential workers (such as those in the education sector), and the rest of the adult population above 18 years of age, provided free of charge and on a voluntary basis.²¹⁵ As time went on, GALZ realised that vaccine uptake among the constituency they served was lacking, and that the lack of legal gender recognition, combined with long queues and poor Sexual Orientation and Gender Identity and Expression sensitisation among health staff, were cited as key reasons why LGBTQIA+ people were reluctant to access COVID-19 vaccines in local clinics. In the words of Michelle Ruhonde, Gender and Community Officer at GALZ:

“

Documentation was the first barrier, and there were very long queues. Everyone was targeting the closest health facility (to them), and a lot of people were in queues, so it became very difficult for members of our constituency to really express themselves and feel comfortable being there for so long. It wasn't the appropriate service, so it became a barrier for community members. And we also looked at how not all healthcare providers are sensitised when it comes to issues of SOGIE. This became a challenge - with the kind of questions and also issues of identification with trans people, because what's on the ID and what's being presented in person would not be matching. It became very difficult for people to then try and get vaccines from their local clinics, which also speaks to lack of safe spaces. We saw that as a structural barrier.²¹⁶

”

Ruhonde and colleagues worked extensively to centre messages of safe vaccination spaces for LGBTQIA+ people. The advocacy and engagement worked - with government agreeing to using GALZ facilities for vaccinations for LGBTQIA+ communities.

“

We realised the rollout's lack of focus on women, disability, and the LGBTI community we serve. The various consultations that the government had with stakeholders and CSOs made a difference. These consultations helped in getting GALZ to a point where we were able to administer the vaccine at our own facility.²¹⁷

”



CASE STUDY 4: **INCREASING VACCINE UPTAKE AMONG WOMEN IN SOUTH SUDAN**

In South Sudan, innovative and multipronged solutions were deployed by Ministry of Health, with support from UNICEF South Sudan and other partners, mobilising the expertise and networks of community health workers, religious leaders, and female influencers to tackle gender disparities in vaccination rates, conducting interactive media engagement, radio listener groups and focus group discussions. To address structural barriers to vaccinations, such as distance to vaccinating sites, mobile teams were brought closer to where women congregated, such as churches and markets. The following paragraphs detail the proactive work done to integrate a gender lens and gender-sensitive interventions within the COVID-19 response in South Sudan.

In April 2021, the vaccination programme was launched in South Sudan, with vaccinations being made available to key priority groups, including health care workers, and located predominantly within big health facilities such as at hospitals in Juba and in other states. As weeks passed, it became apparent to the National Risk Communication and Community Engagement Technical Working Group (RCCE TWG) that few women were taking up COVID-19 vaccines. In the words of Aping Kuluel Machuol, Social and Behaviour Change Officer at UNICEF South Sudan:

“

When the COVID vaccination programme was launched in the country, it was designated for key target groups within specific health facilities. We have 10 states and three administrative areas (in South Sudan), so the focus was (to roll out vaccines) to health workers both in Juba and other states. However when it became available for everyone aged 18 years and above, it was actually very clear from the data that the people coming for vaccinations were mainly males – very few females were coming for vaccinations.²¹⁸

”

At this stage, data showed that only 22% of those vaccinated for COVID were female versus 78% males. Upon this realisation, discussions between the National COVID-19 Technical working group through the RCCE TWG precipitated a shift in approach. In June 2021, behavioural and social drivers assessments and focus group discussions were carried out with women in communities and health workers to better understand behavioural and social drivers of demand and uptake of COVID-19 vaccines. Aping Kuluel Machuol described to us how these exercises to consult communities enabled gender-specific interventions:



“

After doing focus group discussions and Behavioural and Social drivers studies, we came up with recommendations and presented them to the COVID-19 Technical working group. Some of the key things that were suggested by women in communities for them to get vaccinated were: if you want to reach us (with COVID vaccinations), some of us are busy in the market, some of us are busy at household level, some of us are busy - you have put the vaccination sites at the health facilities and for us, that doesn't work. How do you expect us to balance this with our domestic work that we always do or the market work that we do for a living?²¹⁹

”

The UNICEF South Sudan team presented key recommendations to the Ministry of Health, and these were operationalised as follows:



This multipronged strategy enabled the realtime debunking of myths and concerns about the vaccine, sustainability and ownership of interventions through solutions that were identified by women in communities (community-led solutions), the beginning of a shift in men's ideologies around women's autonomy in health, and approaches that brought vaccines closer to where women were in their daily routines. Males were also sensitised to allow women and support them financially if need be, to reach the vaccination sites.



On this latter point, establishing vaccination sites at markets and churches where women regularly were, combined with extensive advocacy with males in these highly patriarchal communities, contributed to more females coming for the vaccines. According to Atem Kuek, Social and Behaviour Change (COVAX) Consultant at UNICEF South Sudan:

“

The women signed their own consent (forms). We brought vaccines to the vaccination sites such as markets, regularly attended by more women than men, which improved accessibility for women. This has also addressed the issue around conflicting daily priorities among women.²²⁰

”

Aping Kuluel detailed advocacy done to engage men to support women in accessing COVID-19 vaccines:

“

There was a lot of advocacy done when we realised that permission from husbands and/or male family members to women was a key issue making women hesitate on (COVID) vaccinations. There was a lot of advocacy done at the national level, at the state level, and even at grassroots levels with key women influencers, taking lead and engaging with messages to both men and women, (communicating) that the wife should get moral and financial support from the husband. Advocacy was also done with religious leaders, with local chiefs, and with local authorities.²²¹

”



Figure 8: Female COVID-19 vaccination mobiliser working in Gudele market, Juba, South Sudan (photo credit: UNICEF South Sudan)



Messaging via radio combined with interactive sessions where listeners could ask clarification questions from female influencers was highly effective in addressing concerns that women had. Community Radio as a medium was key to reaching areas that heavily rely on radio for health messages as the main ways of engaging with government and current affairs and obtaining information in general. There is only one TV channel, and TV is generally only available in urban areas. Aping Kuluel Machuol emphasised: "Radio is the most effective channel to reach out at the grassroots level because it is the most widely used source of information and they use local languages."

As a result of these multipronged efforts, by November 2022, the proportion of women vaccinated in South Sudan reached 51.5% versus men at 48.5%. Leveraging existing community health worker and social mobiliser networks was key to the success of this initiative. In the words of Scolastica Njagi, Social and Behaviour Change (COVAX) Consultant, UNICEF South Sudan:

“

The social mobilisers (for the gender-based strategy for COVID-19 vaccinations) were pulled from existing community health networks. Here in South Sudan, we have several (existing health networks); we have the Boma Health Initiative, Integrated Community Mobilizer Initiative, among others. Basically, pulling from this pool of social mobilisers to be engaged initially in the COVID response enabled them to be the foot soldiers. With this we have seen a redefinition of power – social mobilisers don't necessarily mean health workers, but also community leaders, religious leaders, and numerous other leaders sensitised and engaged at the local level as champions.²²²

”

The strategy was not without challenges. According to Aping Kuluel Machuol from UNICEF South Sudan, the main challenge cited was literacy levels of social mobilisers (a longstanding issue that preceded the COVID-19 pandemic). In Aping's own words:

“

A major issue that we always face here is in South Sudan is literacy levels. For someone to be recruited as a mobiliser, you need some basic understanding or some basic level of education to be able to effectively engage communities. When you compare the level of education among women versus men in the country, the (rates) are way lower when it comes to literacy and education among females. That has been a key challenge we faced when recruiting female community mobilisers, and this was even worse in rural villages where the level of education is even lower compared to cities. But through some networks of women and engagement with community leaders, we were able to help the community leaders understand the whole process, and they even recruited women who were not formally educated but were able to be trained on skills like talking to and engaging the communities on COVID-19 vaccinations.²²³

”



This example speaks to several points: that while literacy can be a challenge in training community health workers and mobilisers, it is possible to work within these challenges i.e., that literacy need not be a barrier to engaging women, and that individuals can be educated in different ways to do certain kinds of work. The example also demonstrates that peer-to-peer engagement and community-led solutions are arguably still the best model to increase uptake of medical technologies such as vaccines.

Key Takeaways and Best Practices

1. Vaccines deployment must be paired with community-led solutions/community engagement and context-specific communication campaigns.
2. A gender lens at the outset is necessary to mitigate gender disparities in pandemic tools uptake.
3. Peer-to-peer mythbusting and mobilising creates optimal uptake conditions, especially in countries with low digital and social media coverage.
4. Poor literacy need not be a barrier for engaging women and can be overcome with alternative training approaches.
5. Engaging influencers who are respected in a specific context is essential to combat misinformation. In some contexts, religious leaders and village chiefs may convey more credibility than medically trained health workers and thus engagement is necessary.
6. Men must be included as targets of advocacy and engagement in tackling gender-related barriers in accessing vaccinations.
7. Effective communications and outreach campaigns should utilise:
 - a) The communication medium that is most prominent in society.
 - b) Interactive/two-way sessions that allow women to ask clarification questions directly from key influencers and female leaders.

The method of bringing vaccines to where women worked and conducted their daily activities, combined with using trusted influencers, was also employed in the Democratic Republic of the Congo, [see case study above](#).



Gender Considerations in Investment and Resource Allocation during COVID-19

Part of ensuring a gender-inclusive approach is ensuring that gender is considered at the resource allocation stage and being considered at inception of COVID-19 response by donors, financiers, and banks, and that this approach prioritises equity as a key tenet and baseline for discussions. Elsewhere in the report, we have discussed how communities without security of finances struggle to prioritise vaccine uptake and indeed any form of healthcare – and thus it remains critically important that investments and resource allocation is gender-inclusive.

In one webinar organised by the Bank of Ghana on gender-inclusive finance during COVID-19, held in September 2020, it was stated that 2 billion people worldwide work in the informal sector, with 40% being women. During the webinar, various partners presented key initiatives to support women during the pandemic, such as the distribution of 30,000 mobile phones and 20,000 solar panels to the underserved populations in Zambia (an initiative of the Bank of Zambia), financial support packages to female garment workers in Bangladesh, and grants to support women through mobile money in Eswatini.²²⁴

The webinar also discussed, however, that many women operate informal businesses and thus do not have bank accounts associated to their businesses – thus making it more difficult to support them financially under a pandemic. The report of the webinar made several recommendations, including that surveys be conducted to understand what is preventing the financial sector from addressing women's inclusion, and that governments should leverage digital platforms to provide social safety nets to women.²²⁵ Given digital divide considerations discussed in the Barriers section above however, it would be important that other routes for social safety be explored to ensure that persons without digital access be supported.

According to a Gender Advisor from UNICEF interviewed for this report, their Gender Action Plan²²⁶ requires that at least 15% of all country office budgets be allocated for gender programming – however allocation also depends on the country office priorities.²²⁷ The interviewee noted additionally, however, that the Asian Development Bank's COVID programme had a robust threshold of at least 40% investment allocation for women reached, although this could not be independently validated.

In South Africa, Dr Lesley Ann Foster stated that healthcare workers – the majority of which were women – had been insufficiently financially supported during the pandemic. According to Dr Foster:

“

One doctor being assigned 3,000 patients in a community is ridiculous and they are overworked. Overstretched and overworked health workers have an impact on service delivery. We need to be able to support the training of nurses and doctors to a great extent so that we have a greater distribution of them in the country and ensure less of a burden on them.²²⁸

”



Several interviewees pointed to the discrepancy between what some called “tokenism” to describe gender equality without clear programmatic and monetary commitment. In the words of one advocate with the Feminists for a People’s Vaccine Campaign when it comes to strategy and other documents of international organisations:

“

It has become a second habit to add women and girls to everything. And one really doesn’t know, in what ways they translate into making it meaningful for women’s lives... What exactly are they doing? What are they prescribing? What are some of the things that they are setting in motion in terms of advocacy?²²⁹

”

This quote is illustrative of two things – that gender inclusivity language must be linked to accountability, and that civil society and community groups are necessary to keep governments, philanthropies, donors, the World Bank and global health agencies accountable. Elsewhere in this report we found that at least two global health agencies suspended established procedures related to gender inclusivity and responsiveness during the pandemic, attributing this to the urgency of the COVID-19 pandemic and the need to get funding out quickly. This raises questions about what is seen as central when a crisis hits – and whether organisations could have done more to ensure gender-related resource accountability and to ensure that gender policies are in line with emphasis in communications materials.



ANALYSIS

Gender-related structural barriers were expressed by interviewees as ingrained, multi-layered, and as having preceded the pandemic. Using the Jphiego gender analyses framework we attempt to offer some thematic analyses – but because of a systemic neglect of gender in all policies and instead the utilisation of a gender lens only as a reactive (rather than proactive) process, the barriers sit deep within entire systems – whether related to health, welfare, economic, community, or governance systems. As Dr Sarojini Nadimpally, Executive Director of Sama Resource Group for Women and Health elaborates:



The gender gap in COVID vaccinations is attributed to several underlying factors. These include barriers affecting women, young people, transgender people, and the wider LGBTQIA+ community. There is limited mobility and the ability to reach vaccination and testing sites, restricted decision-making power determining their health-seeking behaviours, and limited control over resources required for making any informed health decisions. We have seen this over many years – it's not something new in the context of COVID-19 or access to vaccinations only. For any health-related decisions there exists very strong patriarchal attitudes within families that makes it difficult for women to access any healthcare services. And the second thing is the knowledge power dynamic. It always plays a critical role in the process of marginalisation. There is limited accessibility to strategic and critical information on health, and the production and dissemination of information. It is dominated by overtly technical terms which excludes the marginalised from health seeking opportunities. The result is a visible gender divide in accessibility of treatments and vaccines partly culminating from unequal dissemination of information related to the disease or any treatment.²³⁰



The following paragraphs try to summarise our findings vis-à-vis this gender divide, contextualised within a gender analysis framework focused on i) assets; ii) beliefs and perceptions; iii) practices and participation; and iv) impact on institutions, laws, and policies.

Access to Assets: The Intersection of Access to Land, Capital, Tools, Knowledge, Education, and Information and Gender

Based on our findings, women's access to vaccines and therapeutics was disproportionately influenced by their access to assets. This predominantly related to their ability to access transportation as well as electronic devices required to access accurate information about COVID-19 tools and to register for the vaccines, but also about access to accurate and timely information about whether vaccines and therapeutics could be used by pregnant and breastfeeding persons.

In Madagascar, the cost of the bus fare was cited as a key barrier for accessing vaccines, as well as the time tax needed to travel – with some individuals requiring a whole working day to access vaccines. This is especially a deterrent for those working in the informal sector, who lose a day's



income in order to get vaccinated.²³¹ Financial loss due to time spent away from work was also cited as a barrier to vaccine uptake in a 2021 study in Nigeria,²³² which suggested that door-to-door campaigns would help to increase vaccine uptake.

In Mozambique, Sharon Truzão told us how vaccination campaigns were held in other districts and because of women's childrearing roles and patriarchal norms requiring women to stay at home, it was difficult for women to access vaccines. In households with one owned vehicle the male(s) of the household are more likely to be the primary user of the vehicle, leaving women more dependent on public transport compared to men,²³³ and during COVID-19 lockdowns and related public transport shutdowns women had drastically reduced mobility. Transport was also cited as a key barrier to vaccination uptake in a UK government publication examining lower vaccine uptake among ethnic minority groups and cited cultural factors such as 'men versus women having more say' as influencing health-seeking behaviours.²³⁴

Notable was the lack of access to accurate and timely information about whether COVID-19 vaccines and novel antivirals could be taken up by pregnant and breastfeeding persons. As a result of clinical trials excluding these populations, and slow progress on animal studies, there was widespread confusion about whether and when pregnant and breastfeeding persons could access these tools. And while the WHO released infographics and information in scientific journals, these were not necessarily translated and adapted, and widely disseminated in local languages to communities. Therein lies the value of culturally appropriate and accurate pandemic communications – that governments invest in timely communications through channels that women and gender non-conforming people access the most, in languages and terminology they can understand.

Many gender non-conforming people are in precarious labour situations, including sex work. This is due to stigmatising environments and in many countries a lack of legal gender recognition that prevents individuals from being employed in the formal sector, and therefore, stable and steady sources of income. COVID-19 lockdowns meant that sex work also halted, leaving many trans sex workers without income and therefore without means of transportation.²³⁵ In addition, our interviews showed that trans people in Malaysia and Zimbabwe were reluctant to go to vaccination centres for fear of harassment and stigma, and that vaccination uptake was higher if services were placed in a safe space such as an LGBTQIA+ support centre.²³⁶

Transportation was also more restricted to trans people because of the requirement for vaccination certificates to board transportation, whether public transportation or for international travel. Because of a lack of legal gender recognition, trans peoples' vaccination certificates did not often match their gender identity, resulting in barriers for accessing transportation. In the words of Manisha Dhakal, Executive Director of Blue Diamond Society, an LGBTQIA+-led NGO in Nepal:

“

For people who want to go outside of the country, vaccination cards are necessary, and the (gender displayed in the) passport must correspond with that same gender in the vaccination card.

”



Women, and especially elderly women, women from rural areas, and those with less formal education, were acutely affected by the use of digital platforms as the main routes for dissemination of COVID-related information and for vaccine registration. 165 million fewer women in LMICs own a mobile phone compared to men.²³⁷ In El Salvador, one study found that 47.59% of vaccinated rural women did not use technology to make their appointments online – instead they looked for alternatives to register for the vaccines, such as making their appointments directly at the Health Unit or through promoters and community health workers who make home visits.²³⁸ In Afghanistan, one interviewee told us of how international agencies were still using radio, TV, and digital platforms for COVID-19 messaging despite RCCE assessments showing that less than 35% of Afghan women reported having access to these platforms. This was exacerbated by a patriarchal environment that controlled (and still controls) women's movements and freedom – and caused many women to be excluded.

Based on these, in the next pandemic, governments and global health agencies will have to ask themselves the following questions:

1. What proportion of women versus men versus gender non-confirming people and LGBTQIA+ communities have connectivity via digital tools? Based on this, how should I design outreach and pandemic tools rollout?
2. What proportion of women (a) work in the informal sector and (b) are homemakers and will have difficulty accessing transportation? Based on this, what proportion of my budget should I allocate to reimbursement of transport costs for these populations OR how much should I budget for door-to-door sensitisation and vaccination campaigns by community health workers?
3. Would it be safe for trans people and other gender non-confirming people to access vaccines in our government-designated vaccination centers? Can I utilise the facilities of LGBTQIA+ support centers and LGBTQIA+ NGOs for vaccinations and provision of pandemic-related information?
4. How does legal gender recognition affect access to pandemic tools? Which LGBTQIA+ NGOs and community groups can I meet with and engage with to ensure our policies help gender non-confirming people access pandemic information and tools?

Beliefs and Perceptions, and Interplay of COVID Communications

This section of the analytical framework draws from cultural belief systems or norms about what it means to be a man, woman, or gender minority in a specific society, and influences access, mobility, decision-making, and expectations about expected behaviour.²³⁹ Several gendered beliefs and perceptions affected access to COVID-19 vaccines and therapeutics. These included patriarchal norms around the need for women to obtain permission from men to access healthcare (South Sudan), the belief that males should access vaccines first as they are the breadwinners (Mozambique), beliefs about the roles of women in society as childminders and homemakers restricting their ability to travel to vaccination centres and make decisions about their health (multiple countries), anti-trans bigotry affecting access to vaccines (Malaysia, Nepal, Zimbabwe),



and institutional beliefs and binary definitions about gender, leaving gender non-conforming people out of pandemic planning and interventions (World Bank, Gavi).

In Mozambique, women's rights organisation Muleide worked to address these ingrained beliefs and perceptions about males requiring access to vaccines first. In the words of Sharon Truzão:

“

It is a common belief that the strength of provision comes from the man. So, if there's a health issue, the one that needs to be healthy first is the man. Our awareness sessions were mainly on this issue (because) when we went on campaigns, families said the father went to this vaccination campaign (because he should get vaccinated first). Our response was no – you are all susceptible to catching the disease (and it) doesn't mean that he's more important, all of you are important. And even if you if you say that he's the one who's going to be providing, she's the one that needs to take care of the child and (needs to be vaccinated as well).²⁴⁰

”

And as described in the South Sudan case study [above](#), given that permission from the male partners and guardians were still required to access healthcare, including COVID-19 vaccines and therapeutics, the government and UNICEF South Sudan engaged in multilevel advocacy with men on the need to support women's autonomy in healthcare decision-making and in supporting women for vaccine access. In addition, vaccination sites were placed at markets and churches, where women already frequented daily and therefore did not need to ask for men's permission.

Many environments continue to be hostile towards trans people. People's beliefs about heteronormativity translated into gender non-conforming individuals not wanting to frequent vaccination centres because of potential stigma and harms that could be inflicted upon them. Hence, as discussed elsewhere in this report, gender-sensitive pandemic response must account for safe spaces where LGBTQIA+ communities can access pandemic tools and information without harassment.

In addition, many global health agencies and governments continue to define gender in binary men- and women- terms. Excluding gender non-conforming people means that pandemic planning neglects uptake of pandemic tools in these populations. Regardless of criminalisation status or beliefs on heteronormativity, gender-planning during pandemics must account for gender non-conforming people.

Robust and context-relevant pandemic communications plans can help to address beliefs and perceptions that negatively impact pandemic tools uptake. For example, in South Sudan, women were reached through radio programmes – the widest used communications platform. In contexts where trans people are criminalised, communications plans would likely entail person-to-person information by trusted peers i.e., trained trans community workers/vaccinators.



Based on these, in the next pandemic, governments and global health agencies will have to ask themselves the following questions:

1. What are the patriarchal beliefs and norms in society about women's roles in society? Do women need permission from men to access transport or to make decisions about their health? How does this affect their access to pandemic tools? How can I engage men to support women's access to tools? How do I strategically place tools to reach women where they are?
2. What do women in my community believe to be the best approach to getting pandemic tools to them?
3. What are societal attitudes and beliefs towards trans people? How best should I account for the safety of trans people in pandemic response?
4. What do gender non-conforming people believe to be the best approach to getting pandemic tools to them?

Structuring Pandemic Interventions around Gendered Practices and Participation

This section of the analytical framework requires examination of how the norms that influence men and women's behaviour also structure the type of activities they engage in and their roles and responsibilities, and how information is captured vis-à-vis men and women's different roles, *the timing and place where their activities occur*, their capacity to participate in different types of economic, political, and social activities, and their decision-making.²⁴¹

This was especially relevant in considering where vaccines and access to novel antivirals were rolled out and where information about these tools was disseminated, and whether these lined up with where women and gender non-conforming people were during the day. For example, at the initial stages of the pandemic, many vaccination centres were placed at placed beyond the reach of many women who did not have access to transportation, who were bound by patriarchal norms around permission and around who makes decisions about health in the family unit, and who did not have the finances to be able to take transportation to vaccination centres. In addition, many women were occupied in their daily activities at churches, markets, women's associations, engaged in work in informal settings, such as at hawker stalls, or were engaged with childrearing.

In many environments, modifications were only instituted when data emerged of disparity in uptake among women – such as work in DRC to have community health workers engage women at markets and bus stops, in South Sudan at markets and churches. As a result of these regimes women are only allowed to access healthcare from women – and at the same time women's education is restricted, meaning that opportunities for women to obtain vaccinations and/or information about COVID-19 tools were few. Some agencies took the approach of using husband-and-wife or brother-and-sister community health worker teams to reach out to women in their communities and to negotiate healthcare for women with their male guardians and partners – who would be unlikely to authorise vaccinations if negotiating with all female CHW teams.²⁴²



In DRC, as illustrated [elsewhere in this report](#) VillageReach conducted outreach sessions specifically designed to reach women:

“

We had some information sessions at workplaces, markets, women’s associations, local NGOs, and other health facilities caring for vulnerable populations that didn’t directly offer COVID-19 vaccination, and this was a chance to share and to respond to questions (from women in communities), and some concerns that women had around the vaccines.²⁴³

”

In [South Sudan](#), establishing vaccination sites at markets and churches where women regularly were, combined with extensive advocacy with males in these highly patriarchal communities, contributed to more females coming for the vaccines. And in Madagascar, we found that women were more likely to get vaccinated when they were offered the COVID-19 vaccination when already attending the health clinic for their children’s routine immunisations.²⁴⁴

“

We heard anecdotally that some of those who had got their vaccine, received it when they attended the health clinic for another reason e.g., immunisation for their children.²⁴⁵

”

All of these data points to the need to provide COVID-19 vaccinations and indeed future pandemic tools where women will already be or are likely to frequent and to account for this at the outset of pandemic plans – not just as a reactive measure upon the emergence of disparity. In addition, countries could consider cash programs, voucher programs, and social protection programs to facilitate vaccination uptake. Taking an intersectional lens, it would also be important to ensure that pandemic tools and information are provided to refugee and migrant women where they are.

Based on these, in the next pandemic, governments and global health agencies will have to ask themselves the following questions:

1. Where are women and gender non-conforming people during the day and where are they most accessible?
2. How best do I incorporate an intersectional lens in pandemic tools deployment? Where are migrant/refugee women, elderly women, gender non-conforming people? What would ethnic minority women need?
3. What are societal attitudes and beliefs towards trans people? How best should I account for the safety of trans people in pandemic response?
4. What do gender non-conforming people believe to be the best approach to getting pandemic tools to them?



Impact of Institutions, Laws, and Policies

This section of the analytical framework looks at different formal and informal rights affected by gender, and how they are dissimilarly affected by policies and rules governing institutions, including the health system.

For gender non-conforming and trans people, laws pertaining to legal gender recognition and laws that criminalise trans people are the biggest deterrents to vaccine uptake. In Malaysia for example, there are a variety of sharia criminal laws that criminalise Muslim trans people for their gender expression,²⁴⁶ attracting penalties such as jail and fines. Because there was police presence at vaccination centres for crowd control, according to local NGO SEED,²⁴⁷ trans people were often worried about the risk of getting arrested. In the words of Mitch Yusof from SEED:

“

There are many reasons why I think people choose not to go (for COVID vaccinations), but for trans people I don't think it's about community literacy. I think it's more about the security and the safety of us being there in an ambience where it's filled with police, and get annoying questions from a (vaccinator) who knows where you stay, and who you are (compared to) the ID that was submitted.²⁴⁸

”

In addition, the lack of legal gender recognition meant that the gender on official documentation did not match individuals' gender expression, risking harassment and abuse at vaccination centres meant for the general population. This concern was specifically raised by interviewees from Malaysia, Nepal, and Zimbabwe – and it is suggested for future pandemics that services need to be provided in LGBTQIA+-friendly environments.

In addition to these, a lack of legal gender recognition also meant that the gender listed on vaccination cards did not match gender expression, therefore resulting in complications for trans people when travelling internationally. In the words of Manisha Dhakal, Executive Director of Blue Diamond Society in Nepal:

“

The vaccination card is necessary for people who want to go outside of the country, and the (gender specified in) the passport has to correspond with the same gender in the vaccination card. So, we are forced to have the wrong gender marker on the vaccination card.²⁴⁹

”

Trans people were also reluctant to get tested for COVID-19 for fear of which wards they would be placed in treatment facilities. In Malaysia, where all individuals who tested positive for coronavirus were placed in treatment centres – trans people were placed in wards according to the gender in their government documentation, placing them at risk of harassment and stigma. According to Mitch Yusof, Executive Director at SEED Malaysia:



“

[in the hospital or treatment centers] they were placed according to their IC (Identity Card). So you get transgender women with the men or transgender men with the women and they were able to access treatment, but (faced) stigma or discrimination.

”

These pandemic policies in effect amplify and further entrench existing discrimination – as such, governments and decision-makers alike must work towards ensuring that pandemic tools are provided in environments that are safe for gender non-conforming individuals, and that pandemic policies don't further entrench injustices that exist as a result of a lack of legal gender recognition.

Xenophobic policies and structural racism demonstrated during the pandemic also had an impact on access to COVID-19 tools and on the human rights of undocumented migrants and for minority ethnic people. According to Dr Sarojini Nadimpally, Executive Director of Sama Resource Group for Women and Health:

“

While direct health and economic concerns took centre stage in the discourse on the pandemic, one of the lesser talked about issues is that of the worrying increase in structural racism incidents. For example, people from the Northeastern part of India were blamed to be either 'originators' or 'spreaders' of the coronavirus and were threatened with eviction from their homes and other spaces. Taking cognisance of these issues, the Minister of State of the Ministry of Youth Affairs and Sports registered a complaint with the Ministry of Home Affairs and an advisory was sent to all states and union territories to take action on individuals or groups engaging in racial harassment with regard to COVID-19.²⁵⁰

”

Undocumented migrants elsewhere were also seen as easy targets for COVID-19-related xenophobia and racism, with the Malaysian government in May 2020 rounding up and detaining hundreds of undocumented migrants and Rohingya refugees specifically 'to contain coronavirus,' and with commentators stating that these would deter migrants and refugees from seeking treatment for COVID-19.²⁵¹ In one qualitative study conducted in the UK, undocumented migrants reported fearing immigration checks when taking up vaccines.²⁵²

There are also positive policies that impact upon and influence the efficacy and gender-inclusivity of COVID-19 tools deployment. At least four UNICEF country and regional offices interviewed for this report and reviewed in literature spoke about deploying social listening tactics to understand how best to deliver vaccines to women – ensuring that solutions were informed by the communities requiring services.



RECOMMENDATIONS



To Governments

- To report publicly sex and gender disaggregated data on pandemic tools uptake, and include further disaggregation such as age, race/ethnicity, migration status, and disability, among other variables. Governments should also set targets and publish milestones towards achieving these targets.
- Co-creating this target-setting process with representatives of at-risk communities. To invest in social listening and focus groups with communities – community expertise and community-led solutions leads to more gender-responsive programming.
- To proactively include an intersectional gender perspective at the beginning of pandemic planning. This can be done by recognising and remedying the specific barriers women and gender diverse people face in access and distribution of vaccines and other diagnostics and treatments. This includes the following:
 - a) Recognising and decriminalising the existence of gender diverse people
 - b) Providing access to pandemic tools where women and gender diverse people are during the daytime – this includes safe spaces, markets, churches, LGBTQIA+ NGO facilities, associations for persons with disabilities, and other spaces depending on local context.
 - c) To account for undocumented migrant, refugee, and ethnic minority women – including in terms of information about the pandemic pathogen and availability in local languages.
 - d) To provide travel reimbursements and direct cash support for communities of women and gender non-conforming people who need to take time off childrearing and informal work to be able to access vaccines.
- To invest in robust communications and community engagement strategies through the predominant mode of media that women get information from, as well as through all available channels, using communicators that are trusted by communities (these may not be doctors or the lead medical officer of government entities – this may be influencers, religious leaders, community health workers).
- To invest in community health workers/mobile services/door-to-door services from the outset, including to ensure uptake among elderly communities, individuals who have childrearing duties, persons with disabilities, and migrant populations.



To Global Health Agencies/Donors

- To ensure that commitments to gender-sensitive programming remain during crisis/pandemic periods. Women and gender non-conforming people are disproportionately impacted by poor pandemic responses and this means that abandoning gender procedures and indicators during a pandemic result in poor uptake and access among these populations.
- To adapt the COVID-19 gender checklist for future pandemics and to require applicants to complete it, and validate it with community groups, as a prerequisite of grant approval.
- In patriarchal societies, to ensure that community engagement and advocacy targets male partners and guardians.
- To expand definitions beyond a binary view of gender, i.e., programming only for cis-men and women. A gender inclusive lens must include gender non-conforming people and an intersectional gender lens must include these populations in all their diversity, including migrants, refugees, elderly people, people with disabilities, and minority ethnic persons.



To Scientists/Biomedical Researchers

- In line with international guidance and informed by animal studies, to ensure that clinical trials involving new pandemic technologies include pregnant and breastfeeding people.
- Clinical trials also need to account for responsiveness for global applicability including skin colour²⁵³ and ethnic and genetic diversity, intersectionality and gender, and hormone treatment for transgender people.



CONCLUSION

Drawing upon the expertise of gender experts in global health and feminist organisations, this report finds that:

- gender is often **defined in a binary manner** in global health funding, policy, and programming.
- **female health workers** (including community health workers) were central to a gender-inclusive response.
- gender-inclusive COVID-19 responses were often only included reactively (e.g., in response to poor vaccine uptake among women and LGBTQIA+ communities) **rather than factored in at inception** of pandemic planning activities.
- **community-led and -informed responses**, such as ones informed by social listening and focus groups with affected communities and those led by community health workers, were most effective in addressing gender-related barriers.
- an easy-to-use **gender checklist for COVID-19 vaccinations was not used** as optimally and effectively as it should have been.
- **literacy does not have to be a barrier** to engaging rural communities and in communities with lower levels of formal education.
- there are best practices in **gender-inclusive pandemic communications and community engagement**, including using **trusted influencers** (that may not be health professionals, but rather religious leaders, female influencers, etc), ensuring **communications materials are in local languages**, and occur through all available media channels, but especially through media channels that women and gender non-conforming people engage with the most.
- The need for streamlined and rapid processes were cited as key **reasons for dropping integrated gender approaches and tools**, despite the COVID-19 pandemic amplifying gender inequalities.

Notably, the binary approach to gender (i.e., defined only as cis-men and women) occurs in a complex and increasingly conservative space. As Chee Yoke Ling, Executive Director of Third World Network explains:

“

(Women and girls) fundamentally remain the core of our gender work. In recent years, looking at the range of LGBTQI rights and coming from a part of the world and a country where there are a lot of cultural and religious overtones to dealing even with women's rights and equality, to move into the diversity of gender rights and equality that we are confronting today - the challenges are multiple. The structural discrimination and prejudices (are felt) much, much more. The level of tolerance is still a huge barrier... this is the discussion even among the women's rights activists, because there's a certain degree of conflation. We know we have yet to win the fight for disaggregated data. I don't have any answers to that. But I think unpacking it is so important.²⁵⁴

”



In crisis modes during the pandemic, we found that the impetus to get COVID-19 funding out quickly meant that embedded processes for gender-inclusivity with full gender analyses and gender-related indicators became second priority. While the World Bank implemented an adjusted gender approach through advisory notes to applicants and countries, further work needs to be done as to the efficacy of these approaches in integrating gender considerations versus embedding requirements such as analyses and key performance indicators. While it was critical that funds were disbursed quickly, it can be argued that rapid assessments (perhaps in the format of focus group discussions with groups of women and gender minorities) and the requirement for grantees to include gender-related indicators should have still been included.

This report finds several notable gaps in practice and in policy. Many countries still do not disaggregate data based on gender, much less additional details such as age, migration status, and disabilities. There remains a lack of data on gender and access to therapeutics like oxygen and Paxlovid, the former because there has not been a gender lens applied to oxygen access, and the latter simply because access to Paxlovid remains limited or non-existent in communities in many countries – and even feminist organisations within countries have not been able to assess factors influencing access.



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“For communities of women, including trans women, governments need to acknowledge the value of their experience and engage them in dialogue, bringing them to the decision-making tables...communities know best, and women know best what the barriers are that they face, and they will have solutions.”

Dr Sagri Singh, Chief, Gender and Health,
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MATAHARI



**THE
PEOPLE'S
VACCINE**