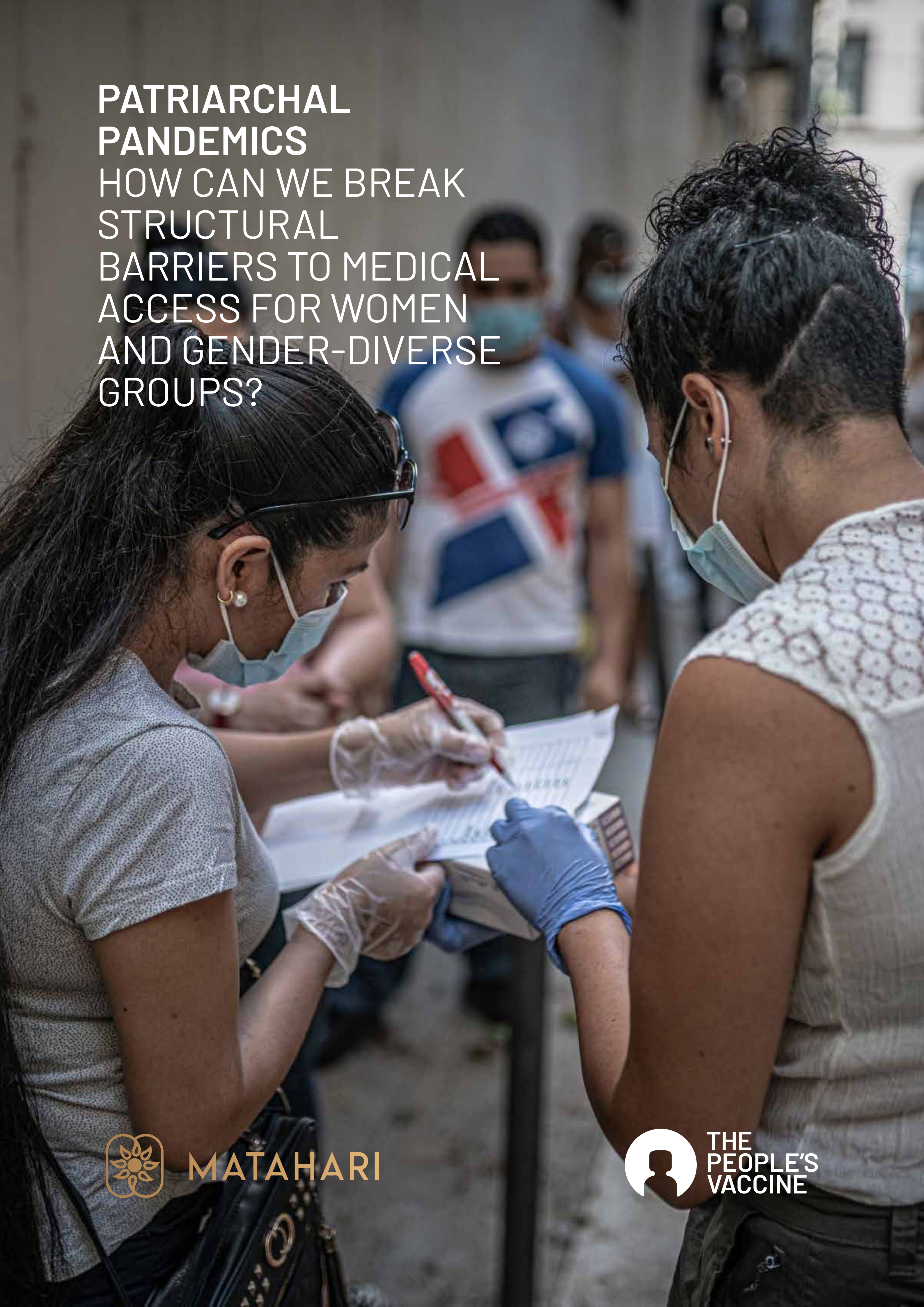
PATRIARCHAL PANDEMICS
HOW CAN WE BREAK STRUCTURAL BARRIERS TO MEDICAL ACCESS FOR WOMEN AND GENDER-DIVERSE GROUPS?



EXECUTIVE SUMMARY

This research was conducted to highlight several structural barriers that women and gender non-conforming people face in accessing COVID-19 vaccines and therapeutics. It is intended as a starting point for further research on this topic and serves to underscore how much more research is warranted on the barriers identified, and methods to circumnavigate them.

"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." – Global Health 50/50, Towards gender equality in global health."

These include social barriers, such as traditional gender roles and social norms; practical barriers, such as lack of transport means or funds to obtain them; scientific barriers, such as the early exclusion of pregnant and lactating people from clinical trials; technological barriers, with these groups being less likely to access medical information digitally; legal barriers with prohibitive laws pertaining to legal gender recognition and the criminalisation of trans people blocking patients accessing healthcare safely; all of which are underpinned by the systematic barriers of a patriarchal world order which blocks women and gender-diverse people from joining decision-making tables. Men dominate leadership and governance in global health which manifests in the exclusion of diversity.

Despite these documented barriers, and their far-reaching impacts on women and gender-diverse people, as well as those who rely upon them, most gender-responsive interventions were adopted retroactively. Moreover, the vast majority of policies developed throughout the pandemic were gender-blind, ignoring the impact of gender-social norms.

This manifested in structural barriers – preventable and navigable through awareness and targeted policy – that prevented women and gender-diverse people from accessing the support they needed, medical, psychological and rights-based.

This paper recommends:

- Governments proactively include and advocate for an intersectional gender perspective and gender-sensitive approach to pandemics at the start of pandemic response planning;
- Global Health Agencies adopt a gender-inclusive lens to pandemic programming and ensure this endures as a priority throughout, expanding its definition beyond a binary view of gender (ie cis-men and women) to include gender-diverse people;
- The above approaches are co-created with at-risk communities, feminist organisations and LGBTQIA+ non-governmental (NGO) facilities;
- Scientists and researchers ensure that clinical trials involving new pandemic technologies include pregnant and breastfeeding people, as well as accounting for responsiveness to skin colour, genetic diversity, and hormone treatment.

INTRODUCTION

Throughout the pandemic, most gender-responsive interventions were adopted retroactively. The Sex, Gender and COVID-19 Project reviewed over 450 policies from countries across all World Health Organization (WHO) regions and World Bank income groups. The research found that 91% of policies were gender-blind, ignoring the impacts of gender norms, roles and relations[1].

Kim Robin van Daalen surmises, "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."[2]

Lockdowns heralded an increase in gender-based violence, with countries like Cyprus and Singapore reporting an increase in helpline calls by 30% and 33% respectively[3], and an increase of up to 131% of domestic violence complaints in districts in India.

Whilst more men were infected with and died from COVID-19 than women, women and gender-diverse people faced complex barriers in accessing COVID-19 vaccines and treatment. Women faced cultural constraints, such as needing to be accompanied by a man to the clinic, and practical barriers, such as having little or no access to a vehicle, or being time-poor, juggling childcare and other domestic tasks. This is neither new nor unique to COVID-19, with transportation adding "hidden costs" in many settings[4].

Charlotte Baker, the Director of Small Steps for Africa, describes how the integration of health services can help to access women in places they already were and reduce transport costs,

> "We have observed that one barrier for the parents we support in the community of Ambohidratimo [Madagascar] 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 the 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."[5]

The criminalisation of gender identity and cultural norms in some countries meant trans and gender-diverse people faced significant safety barriers in accessing vaccines and in some cases were discriminated against by healthcare workers.

A representative from Sama Resource Group for Women and Health (India) reflected that trans people tend to use private sector clinics to avoid the discrimination and intrusive questioning they face at public clinics. This of course carries a financial implication, however, and erects further barriers to trans people accessing healthcare.

Despite the far-reaching impacts of gender-blind policy and programming, leadership positions in global health continue to be dominated by men. This default mode of governance perpetuates an outdated model of policy development that manifests adversely for women and gender-diverse groups. Kim Robin van Daalen describes it as a "symptom of a broken system where governance is not inclusive of any type of diversity…excluding those who offer unique perspectives, expertise and lived realities."[6]

Furthermore, this research found that the majority of global health agencies or countries tended to adopt a binary understanding of gender – 'cis men' and 'cis women' – meaning people identifying as trans, non-binary, gender fluid or otherwise diverse in their relationship with gender, were left out entirely. Dr Sagri Singh, Chief of Gender and Health at the International Institute of Global Health describes,

> "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 over academic research that, in some cases, doesn't always capture all the nuance."[7]

Currently, world leaders are negotiating WHO Pandemic Accord, which will guide prevention, preparedness, and response for future pandemics. Gender-sensitive programming must be prioritised in all health planning, including in the Pandemic Accord.

It is time to establish safeguards to ensure gender-sensitive approaches to pandemics to articulate concrete measures for the adoption of a 'gender lens' in future pandemics.

INADEQUATE DATA LEAVES AN UNCLEAR PICTURE OF VACCINE UPTAKE BY GENDER

The rollout of life-saving vaccines, tests and treatments throughout the pandemic has been marred by grossly unequal access between and within countries in a situation that many global health activists characterised as a "vaccine apartheid".

A focus on inter-country disparity in access to these lifesaving health tools is crucial, but we must also examine the intra-country inequities that manifest in unequal access for people with protected characteristics.

Though more men were infected with and died from COVID-19, women faced extra risks to their safety and health when they could not access vaccines and treatment. Understanding the disparity in vaccine uptake between gender groups is challenging due to the lack of countries collecting

sex-disaggregated data. For example, of the 157 countries that reported on COVID-19 vaccine coverage, only 13% provided sex-disaggregated data[8]. Further, sex-disaggregated COVID-19 data does not report or account for gender identity, leaving trans and non-binary people out altogether[9]. Other factors can be used to deduce the extent of the gender disparity in uptake, such as literary, educational and digital gaps.

This inequity was amplified by healthcare providers and governments using technologies for registration, without considering how to mitigate the potentially exclusionary impacts of this decision. For example, 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. Feminist scholar Tiffany Nassiri-Ansari reflected,

> "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."

One study inferences 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 sexual and reproductive health and rights (SRHR) disparities even pre-pandemic – outlining how overlapping comorbidities could be affected by COVID-19[10].

Robust, comprehensive and nuanced data must be collected before a clear picture can be painted of the different barriers faced by different demographics to enable informed mitigation strategies to be planned. This must be the cornerstone of any inclusive pandemic preparedness and response strategy.

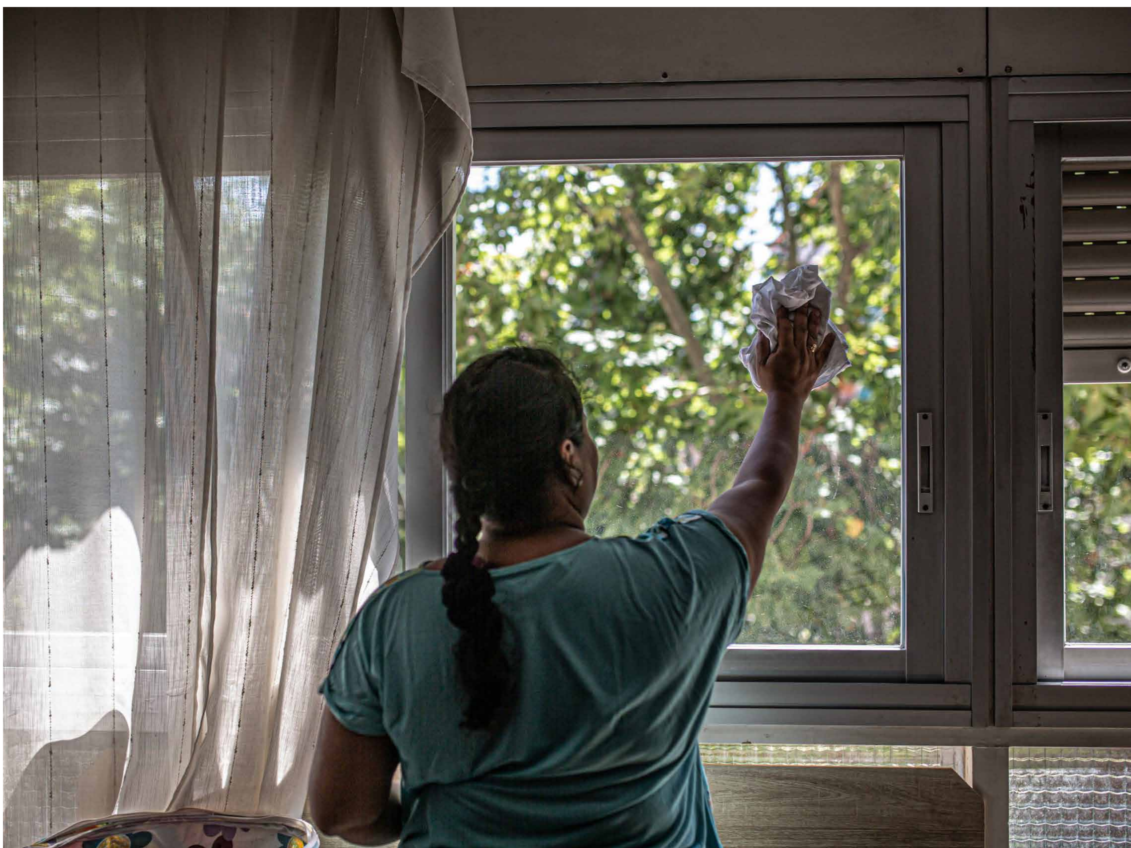
DOMESTIC BURDEN, UNPAID LABOUR AND SOCIAL STATUS IMPACT ACCESS TO MEDICINES

This section highlights the domestic and socioeconomic barriers presented by a patriarchal society which makes access to healthcare more challenging for women. It also explores a case study that demonstrates ways in which these barriers can be addressed, which are contingent on co-creation with local civil society organisations and women.

While the lack of definitive and disaggregated data sets makes it challenging to understand the precise disparities in women's access, it is well established that women's domestic burdens make accessing healthcare services more challenging.

Before the pandemic, women already spent about three times as many hours on domestic work and care work as men[11]. Research from UN Women found that the impacts of the pandemic on women – taking on a greater intensity of care-related tasks and being forced to leave the workforce at higher rates than men – would push many into extreme poverty[12].

Women were also more likely to experience food insecurity because of their gendered roles of childrearing and giving up food to ensure children were fed, raising questions as to the risk of nutritional deficiency comorbidities alongside COVID-19 risk.



Dr Lesley Ann Foster from Masimanyane Women's Rights International in South Africa describes,

> "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."[13]

Being the primary caregivers puts women under an unprecedented workload, working from home or working on the frontline, whilst simultaneously providing care labour for children who were home from school.

Many women found it difficult to find time and financing to travel to vaccination centres. In Mozambique, vaccination campaigns were reportedly held in other districts. Because of women's childrearing roles and patriarchal norms requiring women to stay at home, it was difficult for women to access vaccines[14]. Many women in rural areas listed the distance of vaccination centres to their homes as a key constraint, lacking public transport in their neighbourhoods and villages or the funds to take any.

In consultations with communities to enable gender-specific interventions, Aping Kuluel Machuol, a Social and Behaviour Change Officer at UNICEF South Sudan, described how women would reply,

> "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?"[15]

To mitigate these time pressures, the team presented a set of recommendations to the South Sudanese Ministry of Health. These included establishing vaccination sites at markets and churches where women regularly were, as well as extensive advocacy with men in highly patriarchal communities. The project utilised community radio, where listeners could ask clarification questions from female influencers, and also worked with religious leaders, local chiefs and authorities, as well as community health networks. The result was that by November 2022, the proportion of women vaccinated in South Sudan reached 51.5% versus men at 48.5%.

UNICEF's strategy in South Sudan to tackle the sociocultural or religious norms that restrict women's mobility and access to healthcare services is mirrored in other contexts too. In Afghanistan, women needed to be accompanied by a mahram (male guardian) 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.”[16]

The situation in Afghanistan worsened in the acute phase of the pandemic[17] with the country coming under Taliban control in early 2021. While health services provided by female health workers have resumed[18], at the time this report was written women remain highly repressed and persecuted.

INFORMAL WORK AND INADEQUATE PROTECTION IN THE WORKPLACE

Women workers – particularly women of colour – were and continue to be disproportionately represented on the front lines of the COVID-19 pandemic. Nearly 80% of healthcare workers and 83% of workers providing social assistance, including childcare and emergency services, across the pandemic were women[19].

Community health workers – most of whom are women – continued working through the COVID-19 pandemic to collect sputum samples, provide nutrition to tuberculosis (TB) patients for TB medication adherence, and disseminate COVID-19 information. Many worked without salaries in risky environments, at risk of arrest and police harassment due to lockdown regulations.

COVID-19 also disproportionately affected women and gender minorities in exploitative labour, including frontline workers with informal, insecure contracts like contract nurses and hospital cleaners. These workers continued to work throughout lockdowns, with higher exposure and often inadequate personal protective equipment (PPE). Chee Yoke Lung from the Third World Network and Feminists for a People's Vaccine Campaign underscored these problems 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."[20]

Transgender and non-binary people faced myriad complications in accessing work, due in part to lack of legal recognition and identity cards meaning they are often unable to find work in the formal sector. Many transgender people are in precarious labour situations, including sex work. COVID-19 lockdowns meant that sex work was often halted, leaving many trans sex workers without income and therefore without means of transportation to vaccination centres[21]. Stigmatisation and, in some countries, criminalisation of transgender people left them with fewer formal livelihood options, and less likely to have a regular and secure income. Executive Director at SEED, a Malaysian Trans-Led community-based charity, Mitch Yusof 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."[22]

Even when in formal employment, women are more economically vulnerable than men. Whilst women had lost 54 million jobs and men lost 60 million jobs by October 2021, in percentage terms, job losses were larger for women, at 4.2% compared to 3.0% for men[23]. Women in health tend to occupy lower-status, low-paid, and often unpaid roles. Even as the number of women in high-paid jobs in the health sector is steadily growing, they still earn 24% less than their male counterparts[24].

Lack of savings and having dependents also make women less resilient to economic shocks such as pandemics. This economic vulnerability is rooted in so much of women's labour being undervalued or unpaid, despite contributing trillions to the economy annually[25].

COVID-19 revealed existing inequities within health systems, not new limitations. This research underscores how health systems reflect longstanding patriarchal structures, both in the way diseases and financial allocations are prioritised and in how perceptions of women change based on the needs and convenience of – predominantly male – health governance structures.

As one gender and SRHR expert surmises,

> "Women are being considered more resilient when it serves the system, and weak when it serves otherwise."[26]

CLINICAL TRIAL OMISSIONS AND LACK OF GENDER-SENSITIVE HEALTH SERVICES

Failure to collect timely pregnancy-specific data - with pregnant and lactating people initially excluded from clinical trials and subsequently delayed access to COVID-19 vaccinations - denied pregnant people vaccines to protect themselves and their infants.

WHO guidelines on antivirals and vaccines did not initially include pregnant and breastfeeding persons, due to a lack of data on the potential impact of vaccines on these groups. Drs Shirin Heidari and Tracey Goodman from the WHO reflect that historically, pregnant women have been excluded from clinical trials due to "ethical concerns of potential harm to the foetus"[27]. This leaves them unaccounted for and unprotected.

Dr Janet Diaz, Team Lead at the World Health Organization describes,

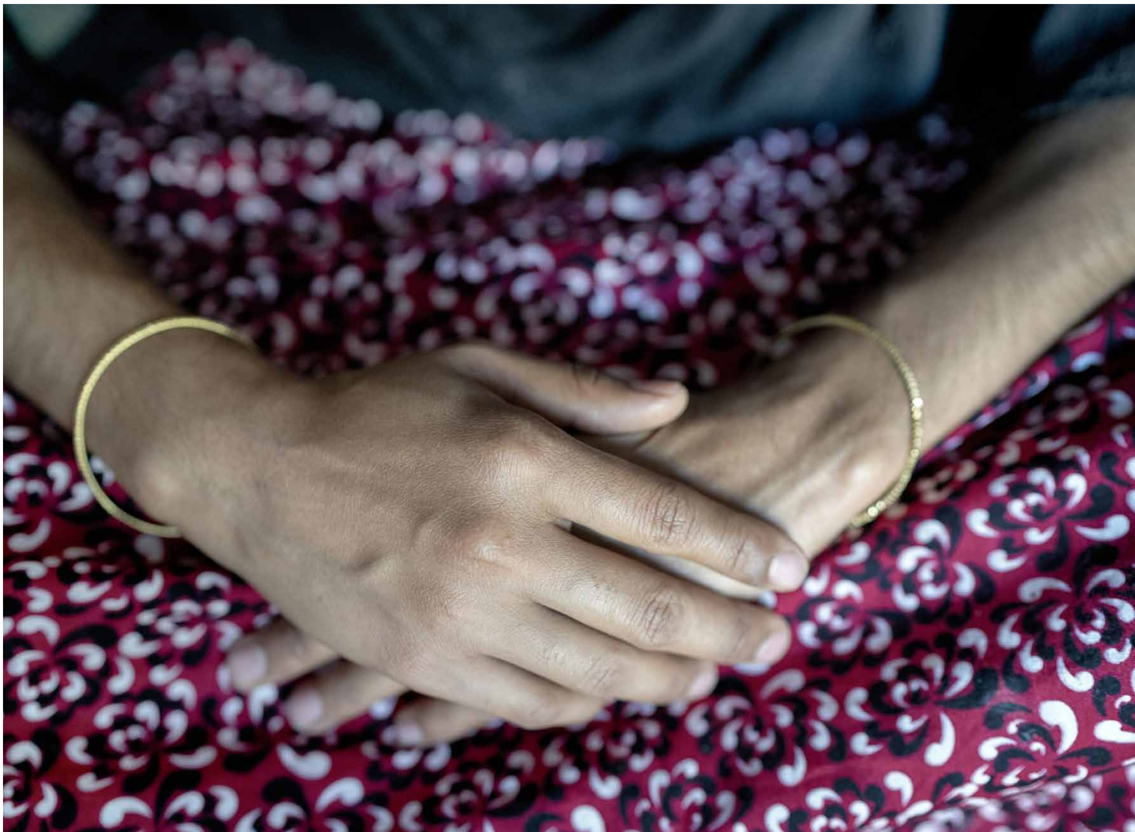
> "In this pandemic…we've had to just stick with the evidence and make recommendations for use of drug X for COVID and say that it is not recommended for pregnant women or breastfeeding, because we don't know (what the effects would be). And in some drugs, there is (a) proper concern for potentially some negative effects. But for others, maybe it's more just that they weren't tested."

Prioritisation of assessments of vaccine safety and immunogenicity among pregnant women in clinical development with reproductive toxicology animal studies initiated at an early stage is one suggested way to mitigate this.[28]

In another publication, Dr Heidari and colleagues conclude that the failure to collect timely pregnancy-specific data denies pregnant women crucial medicines and vaccines that could protect them and their infants from severe disease and death.

COVID-19 had a significant knock-on impact on a range of other health issues, with some gender-specific healthcare services being severely impacted, including due to the reallocation of resources towards the COVID-19 response. Women, girls, transgender, and gender-nonconforming people were particularly adversely affected by the closure of services and the unavailability of sexual and reproductive health services.

Data from 63,000 health facilities shows 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[29]. Reports from across India, Malaysia, Mozambique, South Africa and other Southern African countries underscore 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.



Transgender people were also negatively impacted by the discontinuation of specific health services especially in the early part of the pandemic, particularly those undergoing of hormone replacement therapy and antiretroviral therapy for HIV/AIDS. In Nepal, LGBTQIA+ Rights Organisation the 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[30].

The physical, mental, and sexual health of women and gender-nonconforming people cannot be put on the back burner again in the event of future pandemics. Data on the impacts of lifesaving health tools on pregnant and lactating persons must be included at the start of the clinical trial phase, and gender-specific health interventions maintained.

TRANS AND NON-BINARY PEOPLE FACED SIGNIFICANT SAFETY CONCERNS ACCESSING VACCINES

Some of the complex barriers facing gender non-confirming people accessing vaccines and medicines have been described in the previous sections, as they intersect with the barriers faced by women and girls. Some restrictions, however, pertain specifically to trans and non-binary people, particularly in contexts where their existence has been criminalised, or they face particular discrimination.

Lack of legal recognition in some countries puts gender non-conforming people at risk when trying to access vaccines. Jane Kasim, Program Manager at SEED describes safety concerns in Malaysia, where transgender people are currently unable to gain legal recognition on identity cards,

> "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."[31]

Similarly, in Bangladesh vaccination queues separated by binary genders meant that trans people were subjected to harassment and bullying while queuing for vaccinations.[32] In South Africa, women in sex work, transgender women, and lesbians also report suffering discrimination while accessing healthcare. Sibongile Tshabalala, National Chairperson of the Treatment Action Campaign describes,

> "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."[33]

Many transgender people opt to go to private clinics to avoid the discrimination and intrusive questions they face at public facilities[34], but this carries a cost implication and is not an option for everyone. For some, this is the difference between getting vaccinated and not.

Other impacts of COVID-19 affected the transgender community particularly uniquely and adversely. Examples include job redundancies that meant many trans people were confined to non-affirming environments[35], meaning that they were at higher risk of overlapping comorbidities of mental health and COVID-19.

These many, interlinked barriers and deterrents have the effect of making gender non-conforming people less likely to elect to and be able to access healthcare, be it COVID-19 vaccines and treatments, or other medicines. Without targeted interventions that recognise and circumnavigate the contextual constraints faced by these communities, they will continue to fall through the cracks.

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.

In the meantime, governments, NGOs and decision-makers working collaboratively with local LGBTQIA+ organisations is critical to reaching these demographics. As Executive Director of SEED in Malaysia Mitch Yusof describes,

> "During COVID, a local government-linked NGO contacted us to collaborate or work together on vaccinating those who are marginalized 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."[36]

RECONFIGURING THE DECISION-MAKING TABLE

So, how can we ensure that the crucial omissions that occurred across the COVID-19 pandemic, meaning gender-sensitive programming was an afterthought as opposed to a pillar of pandemic preparedness and response planning, do not happen again?

With 91% of policies created across the pandemic being gender-blind,[37] it is evident that there is a systemic and seismic failure to afford appropriate importance to gender considerations in pandemic policy and programming. Moreover, without a strong gender analysis, existing funding allocations do not sufficiently support policy implementation and programmes. In the words of one feminist campaigner, Dr Lesley Ann Foster from 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."[38]

Despite the well-documented barriers faced by women and gender non-conforming people, most gender-responsive interventions were adopted retroactively – in other words, a gender lens was only integrated when data emerged that women weren't taking up vaccines.

There are cases from which positive learnings can be taken, such as the UNICEF South Sudan intervention described previously. Unfortunately, however, these examples are in the minority compared to instances of gender-sensitive programming being paused or deprioritises during the pandemic.

Large international organisations, such as the World Bank, adjusted their grant-making process to drastically shorten the project approval timeline. Unfortunately, this usually meant that the standard prescriptions for gender-inclusive programs were suspended and replaced by less-strong gender sensitivity requirements. This happened despite early analysis by the World Bank suggesting that gender issues would likely increase and in defiance of its own guidance stating, "When women are underrepresented in decision-making for outbreak prevention and response, their needs are less likely to be met". [39]

The inclusion of women and non-gender-conforming people at the planning and policy stages of pandemic preparedness and response is not a nice-to-have. It is critical for the development and implementation of strategies which ensure the inclusion of everyone, everywhere, regardless of their gender or gender expression.

Feminist and LGBTQIA+ organisations are crucial allies in the development of such plans, with inimitable links to often hidden or ignored communities. Breaking the mould of all-male decision-making tables is critical to ensuring that future pandemics do not continue to make the same mistakes.

In the words of Dr Sagri Singh, Dr Sagri Singh, Chief, Gender and Health at the International Institute for Global Health,

> "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."

CONCLUSION

Now is the time to establish safeguards to ensure gender-sensitive approaches to pandemics if we are to move away from fleeting lip service to the adoption of a 'gender lens', towards securing more concrete solutions.

Currently, world leaders are engaged in negotiations for signing into law a 'Pandemic Accord' that will guide prevention, preparedness, and response for future pandemics. Gender-sensitive programming and policy must be a cornerstone of this – and all other health planning.

RECOMMENDATIONS

- **Governments should proactively include and advocate for an intersectional gender perspective and gender-sensitive approach to pandemics at the start of pandemic response planning**, adopting measures that include publicly reporting gender-disaggregated data on pandemic tools uptake, providing access to pandemic tools at locations that are convenient to and available for women and gender diverse people to access in daylight hours and provide travel reimbursements for those needing to take time off childbearing and informal work to be able to access vaccines and other medicines.
- **Global Health Agencies should adopt a gender-inclusive lens to their pandemic programming and ensure this endures as a priority throughout**, expanding its definition beyond a binary view of gender (ie cis-men and women) to ensure gender diverse people are included in its programming.
- Both above approaches to pandemic preparedness and response planning and programming must be **co-created with at-risk communities, feminist organisations and LGBTQIA+ NGO facilities**.
- Scientists and researchers should – in line with international guidance and informed by animal studies – ensure that clinical trials involving new pandemic technologies **include pregnant and breastfeeding people, and account for responsiveness to skin colour, genetic diversity, and hormone treatment**.

For the full, comprehensive report and its recommendations, please visit www.peoplesvaccine.org or contact info@peoplesvaccine.org

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