

# GBV AoR HELPDESK

## Gender Based Violence in Emergencies

COVID-19 vaccine rollout –  
What do we know from past public  
health emergencies about gender-  
based violence risks and gender-  
related barriers to vaccine access?



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### Introduction

As initiatives for large-scale global distribution of COVID-19 vaccine get under way, this report looks at what is known from past public health emergencies and vaccination campaigns to understand gender-related barriers that women and girls may face in accessing the vaccine, as well as risks of gender-based violence (GBV) related to vaccine distribution for women and girls at the community level and female health workers.

This is the first time a vaccine distribution initiative has been launched worldwide to address a pandemic. COVAX, the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator, is co-convened by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, and the World Health Organization (WHO). These three organizations work in partnership with UNICEF as a key implementing partner as well as vaccine manufacturers in developed and developing countries, the World Bank and others. It is the only global initiative that is working with governments and manufacturers to ensure that COVID-19 vaccines are available worldwide to both higher-income and lower-income countries. COVAX serves as a humanitarian buffer of last resort in countries where limitations of capacity or resources results lead to the exclusion of certain populations, though countries' national vaccine campaigns are still the primary stakeholders and responsible for vaccine delivery to all populations, including IDPs, migrants and refugees.

Two billion vaccine doses are planned for distribution in 2021 to high-risk and vulnerable populations and frontline healthcare workers.<sup>1</sup> This includes humanitarian contexts, with vaccines being integrated into humanitarian and development packages such as those from WHO and the World Bank. However, the success of this massive rollout may be undermined by gender inequities, GBV, and sexual exploitation and abuse (SEA).

The spread of COVID-19 has been highly gendered with respect to care burden and negative socio-economic and safety impacts (Peterman, 2020; Wenham, Smith and Morgan, 2020). The pandemic has increased GBV risk for many women and girls around the world — not only at the community level, but also among female health workers (Fraser, 2020; Roesch, 2020). Lockdowns implemented to curb the spread of the virus have also increased instances of GBV, particularly domestic and intimate partner violence when women and girls are confined with their abusers, and curbed access to essential sexual and reproductive health services, and

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<sup>1</sup> For more information, see <https://www.gavi.org/vaccineswork/covax-explained>

seriously affected women’s livelihoods and economic opportunities. These gendered risks and consequences parallel the experience of past public health emergencies (Davies and Bennett, 2016; Wenham 2020). The same factors that underlie the increase in GBV during COVID-19 may not only prevent women and girls from accessing vaccines in many settings but may also create additional risks of GBV linked to vaccine distribution (Harman, 2021).

It is of vital importance that all agencies involved in the rollout of vaccines recognize that GBV and the gender inequality that drives it are fundamental issues that will directly undermine the effectiveness of their vaccination campaigns. Addressing gender issues related to access to the vaccine, as well as GBV risk during the vaccine rollout is critical to ensuring success in harnessing COVID-19 around the world. This holds true at all levels of vaccine distribution planning and rollout including national, provincial and district level authorities, international NGOs, private sector, bilateral donors, UN agencies and implementing partners.

This report draws upon examples and research from past public health emergencies and vaccination campaigns to describe challenges in vaccine access as well as exposure to violence for women and girls, and to suggests ways in which the public health response can address these risks. The public health emergencies and specific vaccination campaigns from which learning is captured include (in addition to research on routine childhood vaccines not part of a specific campaign):

- 2018-2020 Ebola outbreak and vaccination in eastern Democratic Republic of Congo (DRC)
- 2014-2016 Ebola outbreaks in West Africa
- 2015-2016 Zika outbreaks in the Caribbean, Central and South America
- 2009–2010 H1N1 pandemic and vaccination
- Polio vaccination (in Afghanistan and Pakistan, as part of the Global Polio Eradication Initiative)

These vaccination campaigns were rolled out in contexts ranging from routine vaccination to humanitarian situations, as during the Ebola outbreak in eastern DRC. They share some characteristics with the COVID-19 health response but also differ in significant ways.<sup>2</sup> The COVID-19 vaccination campaign is unique in its global scale and its prioritization of adult groups such as healthcare workers, people aged over 65 years and people with comorbidities. Nevertheless, there is important information about these pandemic responses related to women and girls’ access as well as their GBV risks. These issues—and strategies for averting them—are explored further below.

It is worth noting that access to COVID-19 vaccines falls within the broader Universal Health Coverage discourse on a human rights-based approach to health, which highlights the inequitable health outcomes for women and girls caused by discriminatory practices and unjust power relations. While outside the scope of this rapid research report to expand on this framework in detail, health policies and programs, including COVID-19 vaccine rollouts, should be designed explicitly to prioritize marginalized groups toward greater equity.<sup>3</sup>

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<sup>2</sup> For example, the response to the West Africa Ebola outbreak of 2014-16 and to the Zika outbreak of 2015-16 did not include a vaccine. By the time of the DRC Ebola outbreak of 2018-20, an effective vaccine had been developed and was deployed as part of the Ebola response strategy. Also, while routine vaccination campaigns such as polio are directed towards children, the Ebola vaccine in DRC targeted adults, while the H1N1 influenza vaccine was aimed at both adults and children.

<sup>3</sup> For more information, see <https://www.uhc2030.org/our-mission/>

## Gender-related barriers to vaccinations

Ample research and documentation show that gender-related barriers to vaccine access limit the demand, utilization, coverage and impact of immunization services, especially in relation to routine childhood immunization (Figure 1). Barriers to accessing vaccine sites include women and girls' lower literacy levels and education, lack of access to information, gender norms that limit movement for women and girls and the gender of the health worker administering vaccines and making home visits. Boys' health needs are often prioritized over girls', and poverty, lack of transportation and time, and issues related to socio-economic background, age, disability and ethnicity make matters even worse. Especially in the COVID-19 context, additional barriers to vaccine access related to confinement include limited access to health services (especially when movement is restricted outside of the home or there are concerns about exposure to illness when accessing health facilities) and increased care responsibilities and housework that keep women and girls in the home.<sup>4</sup>

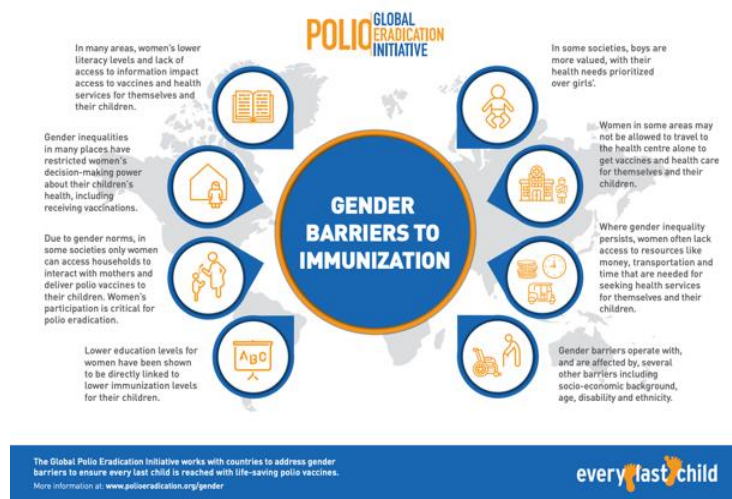


Figure 1 (Click to view in detail) Gender barriers to immunization.

Source: Global Polio Eradication Initiative (GPEI) (2019).

Women's lack of decision-making power is also linked to the control and restrictions on vaccine access imposed by a spouse or family members for the whole family. The presence of intimate partner violence, the normalization and acceptance of GBV within families and hesitation in seeking permission to access healthcare were associated with children not receiving routine vaccines (Hilber, 2010). Notably, however, research on influenza vaccine uptake showed that pregnant women who are single, divorced, or widowed "may exert more control over their health and the health of the unborn child, as they are likely the primary providers for themselves and their unborn child" and thus elect to vaccinate more (Schmid, 2017).

Globally, women with concerns about a health care provider's gender (i.e., if the provider is not a female) are less likely to access vaccines (Hilber, 2010). In some settings, women have limited access to trustworthy information and are dependent on men, including those in the family, teachers, local healers and religious leaders, for information, health care decisions and money. Under such circumstances, women and girls can be influenced or compelled by men to avoid vaccinations (Hilber, 2020; SDG3, 2021). Women in DRC's Ebola response reported that trustworthy information on the health response was not accessible, either because of language, or because of complicated or irrelevant messaging (Kapur, 2020; Translators Without Borders, 2019). Misinformation and myths related to the vaccine's impact on women's reproductive health—such as infertility and birth defects—also led to fears of stigmatization of the vaccinated, lower vaccine uptake by women, and women being forbidden by male family members from receiving the vaccine (Kapur, 2020; Hilber, 2010).

Another feature limiting women and girls' access to vaccines is the fact that they are overlooked. In the DRC Ebola response, despite the recommendation of WHO's Strategic Advisory Group of Experts on Immunization (SAGE) that pregnant and lactating women should be eligible as a priority group for the Ebola vaccine, nearly 1,000 pregnant and lactating women who were registered contacts of Ebola cases were denied vaccines precisely because they were pregnant until this recommendation was implemented in DRC several months later. Discriminatory policies such as this have the potential to exclude an important proportion of the population; in the case of the DRC Ebola response, women of childbearing age made up 35% of the total caseload (Kapur, 2020).

This review found no previous research linking women's access to vaccine documentation with GBV, SEA or

<sup>4</sup> For further in-depth analysis of gender-related barriers to vaccinations, as well as examples of global good practices, see: Gavi, 2021; GPEI, 2019; SDG3, 2021; Feletto, 2018; Feletto and Sharkey, 2019; UNICEF, 2019.

gendered decision-making power at the household level. Possession of vaccine cards has been shown to be linked with higher uptake of routine childhood vaccines, and in some contexts, they are essential for children's school enrollment (Imran, 2018; Mahadevana and Broaddus-Shea, 2020). The importance of vaccination documentation may increase substantially, however, in the case of COVID-19 if countries adopt vaccine passport-style regulations that require proof of vaccination for movement or for access to social spaces and services, potentially putting vaccination documentation more on the level of national identification cards or other civil documentation in terms of significance. Gender gaps have been documented in civil documentation, with women in low-income countries being particularly affected by a lack of identification cards, and specific challenges in humanitarian contexts (Desai, 2018; UNFPA, 2020). If women have less access to COVID-19 vaccine documentation than men, as is the case for civil documentation in many contexts, this may translate to lack of mobility or access to services.

Finally, in some settings, women and girls fear they will be exposed to various forms GBV when attempting to access a vaccine, leading to distrust of health workers and the overall pandemic health response. Some of these risks are described below.

### GBV and SEA linked to vaccination campaigns

GBV is rooted in patriarchal norms that reflect and reinforce an imbalance of power between males and females. Immunizations are often historically designed to be gender-neutral but that does not necessarily translate to 'gender equal.' When past vaccine campaigns and emergency public health responses have ignored the specific needs and experiences of women and girls, their risk for multiple forms of GBV increases (Harman, 2016). Past public health emergencies and vaccine campaigns show, for example, risks of violence linked to accessing sites in insecure settings; increased incidence of SEA by male health workers against females seeking the vaccine; and violence (e.g., intimate partner violence) as backlash to breaking gender restrictive norms, such as those related to mobility (Wenham, 2020; Wenham, Smith and Morgan, 2020). As well, evidence suggest that female health workers are particularly at risk of violence, both in the community and at work. These issues are briefly discussed below.

This review finds, however, that the risk of GBV, including SEA, related to or worsened by vaccine rollouts and in pandemic settings is much less researched and documented than the gender-related barriers to vaccine access discussed above. Most of the evidence discussed below is based on women's perceptions of risk, formal allegations and investigations under way, and second-hand anecdotal evidence of SEA from organizations working with survivors. There are considerable methodological and ethical challenges in obtaining prevalence data on GBV during epidemics, as is the case in other emergency settings and in particular for SEA related to service provision (IASC, 2015; Feather, 2021). The evidence showing GBV risks during emergencies is consistent across both conflict and natural disasters but specific data linking GBV risks and pandemics is difficult to isolate since many crises, such as health and natural disasters, overlap and risk factors cut across them all. This important gap in data, noted as well by Fraser (2020), limits our understanding of the scope of the problem and the pathways that influence GBV in pandemics.

#### Physical and sexual violence *en route* to vaccine sites

Accessing vaccine sites that are far away and in insecure zones puts women at risk of GBV, whether they are patients or healthcare workers. Women in such situations are less likely to access vaccines for themselves or their children (Hilber, 2010; Feletto, 2018). For example, during the Zika outbreak in the Dominican Republic, the majority of women who suspected they had Zika did not seek healthcare services. In interviews, women reported that a key factor was fear of being assaulted on the way to the healthcare facility (Oxfam, 2017).

## Sexual exploitation and abuse by healthcare providers and others in power

Incidents of SEA in exchange for health care and access to the Ebola vaccine were recounted by women and girls in DRC (IRC, 2019). Reports also indicated that it was common for men in positions of power within the response effort to sexually exploit and abuse female health care workers by demanding sex as a pre-requisite for employment or receiving a salary (Kapur, 2020). There are a variety of conditions from past public health emergency responses that stand out as precursors of increased SEA risk. Several of the most common are highlighted below.

“The influx of Ebola responders and associated cash flow may also inadvertently have created conditions which favorise economic or sexual exploitation and abuse...”

-Nidhi Kapur (2020)

- **Male-dominated vaccine response teams and supervisory positions.** In the DRC Ebola response, the majority of workers in government commissions and NGOs were male, with women constituted fewer than 30% of the response teams in many organizations, including the United Nations (CASS, 2020; Kapur, 2020). Moreover, female healthcare workers may respond to the threat of SEA by either quitting their jobs or avoiding such work altogether. This makes healthcare teams less gender-equal, as happened in the DRC Ebola response (Kapur, 2020).
- **The influx of cash in resource-poor settings.** In the DRC Ebola response, demanding sex in exchange for employment was linked with scale-up of vaccine staffing required by the rollout of the response, including the vaccination campaign (Kapur, 2020). In addition to male-dominated employment in response teams in the DRC Ebola response, men were also the primary owners of hotels, restaurants and car rental businesses, limiting women’s opportunity to benefit from pandemic-related areas of economic growth, and in turn widening power differences between men and women (CASS, 2020).
- **Low availability and high demand for services,** especially when service allocation structures are poor and people in charge of deciding who should receive services are poorly supervised (Feather, 2021). During the West Africa Ebola outbreak, there were reports of SEA by taxi drivers transporting needed goods and Ebola burial teams in exchange for their services (Fraser, 2020). In the context of COVID-19, vaccine shortages, cost to patients<sup>5</sup> and rationing may increase the power of those in charge of administering vaccines. Abuse of this power can increase SEA, including sex for vaccines, mistreatment and corruption in the health sector (SDG3, 2021).
- **Lack of effective reporting and accountability mechanisms or lack of trust in existing mechanisms.** In DRC, only a few cases of SEA related to the Ebola response were formally investigated because most women did not know how to report the abuse or exploitation or were too ashamed or afraid of reprisals to report the incidents (Flummerfelt and Peyton, 2020). This lack of response allows SEA to continue with impunity.

SEA harms women and girls not only in terms of physical and mental health impacts of the incident itself, but also in terms of discouraging women and girls from accessing vaccines. Distrust in vaccine services undermines the quality and success of public health emergency responses and vaccination campaigns. During the rollout of influenza vaccines during the H1N1 pandemic, vaccine hesitancy among pregnant women was most frequently linked with under confidence, including distrust of authorities (Schmid, 2017). In the DRC Ebola response, even rumors of SEA were sufficient to prevent women and girls from accessing Ebola-related health services (IRC, 2019; Kapur, 2020). Similarly, women and girls in the Dominican Republic said they were afraid of experiencing abuse and psychological violence in public hospitals and medical centers and so did not seek healthcare services during the Zika outbreak (Oxfam, 2017).

## Violence by intimate partners, family and community related to accessing vaccines

Though restrictive gender norms and lack of decision-making power are often cited as barriers to accessing vaccines, this review found very few studies that investigated the potential consequences for women if they access vaccines without or against the permission of their husband or family in contexts where gender norms

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<sup>5</sup> While immunization services are usually free of charge, Hilber (2010) notes both indirect costs (transportation, travel, waiting time, and missed opportunities for income generation) and “under the table” payments as barriers to vaccine access.

deem this as obligatory. Scott (2017) documented that women who violated health-related gender norms faced 'negative consequences' such as 'scolding' or movement restrictions by their spouse or family members. Though often not explicitly stated, it is important to understand that these gender norms pose a barrier to vaccine access wherever they occur because the underlying threat of defying them is violence, notably intimate partner violence or backlash by family or community members. Also, it must be noted that such instances where a woman acts in opposition to her family or community's prevailing gender norms are not likely to be reported by either the woman or the family, making such cases difficult to count. These norms also pose a threat to women working in healthcare, as discussed below.

### Violence Targeting Female Healthcare Workers

In many settings, the majority of formal and informal health providers and especially frontline workers are women, yet women healthcare workers are typically employed in lower-status and lower-paid health occupations (such as informal community led care) and therefore may be excluded from decision-making related to pandemic response design. As such they are at greater risk of violence (WHO, 2019; Feletto and Sharkey, 2019). George and colleagues (2020) provide an analysis of the gendered dimensions behind violence against health workers (figure 2). These dimensions revolve around the lack of space, opportunity, resources, visibility and recognition afforded to women healthcare workers, and have grave implications on their safety and wellbeing and as well as the ability to deliver quality care.

Women working in health care report being hampered by gender norms around their roles and work. For instance, women polio vaccine workers in Afghanistan reported requiring the permission of a husband or other male family member to work in healthcare settings. Even with permission, women remained vulnerable to threats and stigma from the wider community, especially as the only female on an all-male team (GPEI, 2020 and 2021). Female health workers tend to work in more unsafe settings which expose them to violence. Especially in pandemic contexts and vaccine campaigns, health workers who visit households or are based in remote locations may be particularly exposed to violence (George, 2020). In Sierra Leone, nurses working in the Ebola response, particularly women, reported stigmatization, isolation and abuse (IRC, 2015). Even at the time of writing this report, three women polio vaccine health workers were shot and killed in Afghanistan (Nossiter, 2021).

Reports of violence against health workers within the context of the COVID-19 pandemic, or from past public health emergencies or vaccine campaigns do not always indicate the sex of the health workers or include an analysis of the gendered risks.<sup>6</sup> This insufficient data and lack of visibility is itself an

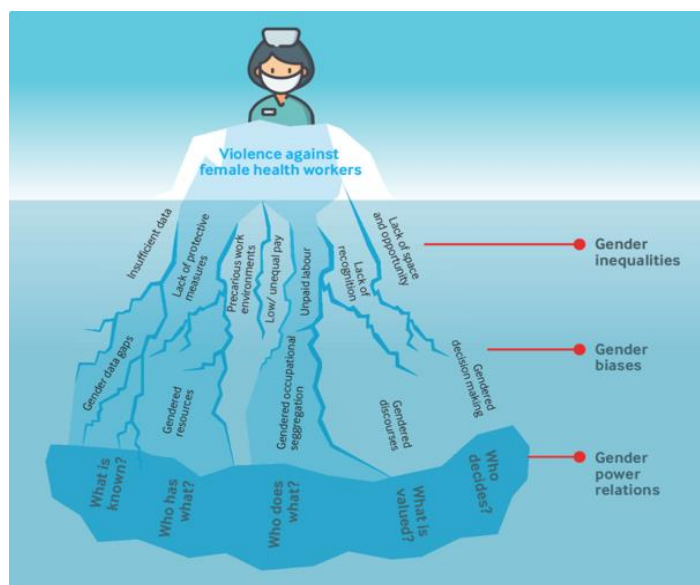


Figure 2 (Click to view in detail) Gendered dimensions of the health workforce underpinning violence against female health workers. Source: George (2020).

“Attacks on health-care workers and immunization teams are a real concern in global health settings... Given that most health-care workers are women, such attacks could be seen as a form of violence against women. As has been seen during COVID-19 thus far, violence against healthcare workers exists and might be amplified over access to the finite resource of COVID-19 vaccines.”

-Sophie Harman (2021)

<sup>6</sup> For example, the International Committee of the Red Cross has highlighted reports of violent incidents against healthcare providers in the COVID-19 response, including physical assault, verbal assault or threats, and fear-based discrimination (ICRC, 2020). Reports of violence against polio vaccine health workers in Afghanistan, Pakistan, and Nigeria show heightened risks of violence in conflict zones and where distrust in health services is high (Abimbola, 2013). See Fraser (2020) for additional examples of violence against healthcare workers linked to COVID-19 and considerations of gender.

example of how gendered power relations undermine female health workers and heighten their vulnerability to violence in the workplace. Other examples of GBV faced by women healthcare workers globally include sexual harassment in the workplace; verbal abuse and threats of violence; sexual assault related to movement for home visits (particularly with midwives); threats of or actual violence from husbands of female patients (related to HIV testing); attacks on health workers in conflict; and attacks linked to stigma and misinformation on disease spread (related COVID-19).

## Lessons Learned & Way Forward

Gender inequality and GBV affect the decisions of individuals, households and communities on how, when and where they access healthcare, including vaccines. Planners of vaccine rollouts worldwide must prioritize addressing GBV risks and gender barriers as essential for a safe, equitable vaccine distribution. Ensuring that the distribution of COVID-19 vaccines is safe and accessible for women and girls will enhance its success overall.

Existing guidance and learning from past public health emergencies and vaccination campaigns are summarized below in recommendations and advocacy points to keep women and girls safe and ensure access for COVID-19 vaccine distribution. We should assume that these issues will play out in the COVID-19 pandemic in a similar way, affecting women beneficiaries and healthcare workers– and will be more complicated in humanitarian settings.

All data collected, including data on who has received the COVID-19 vaccine, must be disaggregated by sex and age.

Improving the consistency and visibility of data disaggregation will allow health authorities to better understand how men and women are affected differently by COVID-19, in addition to ensuring that vaccination programs effectively reach all groups within the population equally (CASS, 2020; Kapur, 2020; Global Health 5050, 2020). According to the COVID-19 Sex-Disaggregated Data Tracker<sup>7</sup>, across 194 countries, 138 countries are reporting sex-disaggregated data on confirmed cases compared to 29 that are reporting sex-disaggregated data on vaccinations.

## Guidelines & Recommendations

### Gender, GBV and COVID-19 vaccination

- COVID-19 vaccination and implications for GBV prevention and response in humanitarian settings. Gender-Based Violence Area of Responsibility (GBV AoR). 2021. [Link](#)
- Proposed Actions vis-à-vis Emerging GBV Risks in relation to the deployment and vaccination plan for COVID-19 vaccines. GBV AoR. 2021. [Link](#)
- COVID-19 Vaccines and Implications for GBV Prevention and Response in Humanitarian Settings. GBV AoR. Webinar, Feb 25, 2021. [Link](#)
- Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable COVID-19 Vaccine Deployment. SDG3 Global Action Plan for Healthy Lives and Well-Being: Gender Equality Working Group. 2021. [Link](#)
- Identifying & Mitigating GBV Risks within the COVID-19 Response. Inter-Agency Standing Committee (IASC). 2020. [Link](#)
- Gavi Guidance to Address Gender-Related Barriers to Maintain, Restore and Strengthen Immunisation in the Context of COVID-19. Gavi, The Vaccine Alliance. 2021. [Link](#)

### Gender and vaccination campaigns

- Global Polio Eradication Initiative (GPEI) Gender Equality Strategy 2019-2023. WHO. 2019. [Link](#)
- Immunization and Gender – A practical guide to integrate a gender lens into Immunization Programmes, UNICEF Regional Office for South Asia. 2019. [Link](#)

### COVID-19 Vaccination general information

- Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines. WHO. 2020. [Link](#)
- SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in The Context of Limited Supply. WHO. 2020. [Link](#)
- COVID-19 Vaccine Introduction Toolkit. WHO. 2019. [Link](#)

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<sup>7</sup> Part of the Sex, Gender and COVID-19 Project, produced by Global Health 50/50, the African Population and Health Research Center and the International Center for Research on Women. Available at <https://globalhealth5050.org/the-sex-gender-and-COVID-19-project/>. Accessed on 8 April 2021.

### Include women in pandemic response, equally and in decision-making roles.

Ensuring the safety of women and girls in vaccine rollouts requires full engagement of women, as well as gender and GBV experts, in all levels of response teams, from planning to implementation. According to the COVID-19 Global Gender Response Tracker<sup>8</sup>, women's participation in COVID-19 task force membership worldwide is far from equal; less than a quarter of task force members are women, and fewer than 1 in 5 task forces are led by women. This change in male-dominated pandemic response infrastructure must be redressed through gender-sensitive hiring practices and protective measures to ensure that women involved in the response, especially women vaccine health workers, are safe at work.

This engagement includes humanitarian contexts, where humanitarian actors are bound by IASC GBV Guidelines to act proactively to mitigate GBV risks (IASC, 2015). Coordination must be reinforced between humanitarian actors and public health response, such as WHO and government-led coordination structures, including country-level COVID-19 national coordinating committees and/or national immunization technical advisory groups (GBV AoR, 2021a). Through this coordination, humanitarian leadership must prioritize action on GBV and ensure that the GBV sector is fully involved in pandemic response efforts. The West Africa Ebola response, for example, saw the exclusion of humanitarian actors from the initial global health strategy, with the GBV sector subsequently falling through the cracks (the GBV sub-cluster was not activated at all during the outbreak in Sierra Leone), thus weakening the overall response and the outcomes for women and girls (Harman and Wenham, 2018; IRC, 2015).

### Conduct dynamic gender analyses and develop action plans to integrate the specific needs of women and girls throughout COVID-19 vaccination rollout and response.

Gender analysis and mainstreaming will help ensure that existing disparities and GBV risks are not deepened and will help address context-specific gender-related barriers to vaccine access. Some previous pandemics, such as the West Africa Ebola response, have largely ignored gender as an analytical lens in policy and response efforts, while at the same time remaining dependent on women's roles as caregivers and health workers within the health system (Harman, 2016; Wenham, Smith and Morgan, 2020). This led to weaker health systems, poor response and dire outcomes for women's health and well-being. On the other hand, vaccination campaigns such as the Global Polio Eradication Initiative have made efforts to include gender analysis in overcoming barriers to vaccine access (GPEI, 2019).

A gender analysis provides a structure to look at women's risks and needs on multiple and interacting levels. The ecological framework analyzes dimensions at individual, household, community, health system, and policy levels. Across each level, analysis can be further broken down by power-related themes: gender roles and responsibilities, access to resources, beliefs and perceptions, needs and priorities, institutions, and laws and policies (Feletto and Sharkey, 2019; UNICEF, 2019). Other tools that are commonly used in humanitarian contexts are the "[Availability, Accessibility, Acceptability, Quality](#)" (AAAQ) framework and [safety audits](#), which are meant to help identify barriers and risks that women and girls face accessing services and can be applied to vaccine campaigns (IASC, 2020a).

Ultimately, these frameworks will help response teams better understand key questions related to increased GBV risk: who facilitates vaccine uptake? What are the formal and informal care structures that surround vaccine distributions? How does accessing the vaccine increase burdens on women and girls, including cost and roles as caregivers? What timing/location of vaccine distribution is accessible for women (for example, health centers, schools, workplace)? Are women able to access online appointments and vaccine passports?

Gender analyses can also address the need to acknowledge the diversity of women and girls' experiences and realities to achieve better equity in response planning. Women and girls are not a homogeneous population: whether in terms of age, disability, education, or access to and control of resources, gender intersects with other characteristics and experiences of exclusion in multiple ways, requiring an intersectional approach to planning vaccine rollout.

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<sup>8</sup> Available at <https://data.undp.org/gendertacker/>. Accessed on 8 April 2021.



Promote protection from sexual exploitation and abuse (PSEA) while reinforcing reporting and referral mechanisms for survivors.

The risk of demanding sex in exchange for employment will likely be present to some extent within the COVID-19 response given the scale-up of vaccine staffing required by the global campaign and given the widespread impunity for GBV and SEA worldwide. Recognizing the importance of preventing and responding to SEA, the IASC (2020b) has issued guidelines for the COVID-19 response that should be applied as well to vaccine rollout at the initial stages of planning and preparation. This requires prioritizing and resourcing SEA prevention efforts and committing to zero tolerance for perpetrators of SEA, whether in the context of national vaccine rollout campaigns or humanitarian actions supporting national campaigns. Measures to prevent and mitigate risks include SEA training and codes of conduct for vaccinators, community-based complaints mechanisms, investigative capacity for holding perpetrators to account, and access to safe, confidential, and quality GBV services for survivors of SEA.

Include specific groups of women and girls in vaccine prioritization.

Rollouts of COVID-19 vaccines should acknowledge the important roles women play in family immunization, in health care, in GBV services, and in humanitarian response. The current guidance is explicit that 'health workers' includes community health worker, healers and practitioners of traditional medicine, most of whom are women, and should all be prioritized for receiving vaccines (WHO, 2020).

Vaccine prioritization should include, in addition to health workers, those involved in essential service delivery, and especially those who make home visits and have the most contact with patients and communities, such as frontline humanitarian workers, GBV service providers, sexual and reproductive health workers, and social workers. For example, the COVAX humanitarian buffer, which ensures that vaccines reach humanitarian contexts, must also have clear provision for the GBV sector. In prioritizing access, vaccine rollouts should also consider the disproportionate secondary impact of COVID on specific groups of women and girls, such as female caregivers, GBV survivors, pregnant and lactating women, women with lost livelihoods, single mothers and female-headed households.

GBV services must remain open with sufficient staffing and funding to provide essential and life-saving services throughout the vaccination process.

Essential sexual and reproductive health services for women, including Clinical Management of Rape and Intimate Partner Violence for GBV survivors, should be kept open and active, as should mental health services. Information about their availability as life-saving services and connection with GBV case management should be communicated clearly and adequately to women and girls. The COVID-19 pandemic response (parallel to that of Ebola and Zika) may divert resources from other essential services, including GBV services. The vaccine rollout must work alongside other health efforts rather than causing them to halt (GBV AoR, 2021b; IRC, 2019). Prioritizing GBV service providers for access to vaccines is one way to do this (see above). GBV actors can be sure to update referral pathways and outreach information to ensure vaccine health workers and communities know how to safely link people to GBV prevention and response services (GBV AoR, 2021a). Similar to the PSEA systems that need to be in place, information on how to refer survivors to GBV services should be well integrated into vaccine rollout for non-GBV specialists involved in COVID-19 response. One key tool that is widely used in humanitarian settings is the [GBV Pocket Guide](#), with concrete information on providing basic support and information to survivors of GBV without doing further harm.

Create communication material that women find relevant and can understand.

All messaging and information on vaccine availability, cost, priority groups, and safety must be planned, developed, tested and delivered based on consultations with women and girls. Translators Without Borders (2019) provides a concrete example of testing communication material on the Ebola outbreak in DRC, and the misinformation and lack of understanding that can result from poor messaging. Communication material can and should proactively address potential misinformation and disease-related stigma and should be relayed through appropriate and proven effective mechanisms, such as by mobilizing and empowering women's and disabled persons groups, including through formal and informal communication channels (guidelines from UNICEF, UN Women, UNFPA, and CARE, as cited in CASS, 2020).

When health messaging is customized for women and girls, it can not only carry information about vaccine-related health services but also about available GBV services such as hotline numbers, if they exist. Healthcare visits may be one of the rare opportunities, especially with lockdown measures and travel restrictions, that women and girls living in abusive situations have to interact with people without their abusers present. This interaction then becomes a critical occasion for health personnel to offer compassionate and empathic support and referrals to lifesaving services where available (GBV AoR, 2021c; IASC, 2020a).

Communication and messaging must also address the major challenges related to vaccine hesitancy and misinformation, both among health practitioners and the community. Risk Communication and Community Engagement (RCCE) acquires critical importance, especially when directly targeting women and girls, to advocate for equitable access to the COVID-19 vaccine for disease prevention.

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## The GBV AoR Help Desk

The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect’s Helpdesk roster.

## **The GBV AoR Helpdesk**

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*The Helpdesk is available 09.00 to  
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*Our services are free and confidential.*