**Subject: Call for Contributions - OHCHR analytical study on key challenges in ensuring access to medicines, vaccines and other health products (HRC resolution 50/13)**

This submission responds to questions **(a), (b), (g), (i) and (j)** in the above-referenced Call for Contributions. UN Women’s inputs draw from project experiences and lessons on addressing COVID-19 vaccine hesitancy and uptake among at-risk and hard-to-reach populations of women and girls in sub-Saharan Africa[[1]](#footnote-1),[[2]](#footnote-2). These projects, all funded by the Government of Japan, were implemented in humanitarian and conflict-affected contexts. The overarching goal of each project aimed to reduce the the disproportionate impact of COVID-19 on women and girls, particularly on the most vulnerable groups, by promoting gender-responsive COVID-19 prevention and mitigation measures, including improving access to the COVID-19 vaccine. Population groups in vulnerable situations included: refugees and internally displaced women, ethnic and racial minorities, young women and older women, women with disabilities and women living with HIV.

Inputs also draw from UN Women’s policy work in the area of gender equality and the development of new medicines, vaccines, diagnostics, and other health products, including in clinical trials.

**(a) What are the major obstacles at the national, regional and international levels to ensure equitable access to medicines, vaccines and other health products? (b) Please elaborate on the specific barriers, if any, that women and girls, older persons, children, persons living in poverty, or other persons or groups in situations of vulnerability or marginalization face in accessing medicines, vaccines and other health products.**

Some of the **key, systemic gender-related barriers** to access to medicines, vaccines and other health products experienced by women and girls, particularly in hard-to reach populations, at national level, include:

**Women’s and girls’ limited access to correct and accurate information**. Across all project contexts in sub-Saharan Africa, the national roll-out of the COVID-19 vaccine was met with high levels of mis/disinformation, rumours and myths. Literacy, education, and digital gender gaps mean women are less likely to receive relevant and trustworthy information. In addition, the information that is available might be insufficiently tailored to women’s needs, particularly for specific population groups.

**Mistrust in government and public as well as international institutions** also present as barriers to access to medicines, vaccines and other health products, accounting for hesitancy and lack of uptake/adoption of medicine, vaccines and other products. Mistrust may stem from women’s previous encounters with non-inclusive and discriminatory health systems and services as well as lack of information.

**Stigma and discrimination and gender-based violence** experienced at points of service, often linked to age, gender identity, sexual orientation, occupation, citizenship status, HIV status, or other factors, impede access to health prevention and mitigation services, including medicines, vaccines and other health products.

**Prevailing gender norms** where womenexercise limited household decision-making power, including over health-seeking decisions; bear a disproportionate burden of unpaid care and domestic work; are economically/financially insecure and may experience gender-based violence in the home are factors that adversely influence women’s ability to access medicines, vaccines and other health products. The socio-economic fall-out of the COVID-19 pandemic on women and girls has further aggravated these pre-existing inequalities.

Despite women’s frontline roles in responding to health crises as healthcare workers, nurses, or midwives, **women continue to be under-represented in leadership roles and on decision-making bodies in the overall health sector** at national, regional and international levels. There is even lower representation of and engagement with women with intersecting identities or statuses that are often marginalized in society (including race, ethnicity, migration status, disability, HIV status) sexual orientation and gender identities and expressions. Even though women constitute almost 70% of the health care workforce, there were inadequate levels of women’s representation in COVID-19 pandemic planning and response globally, for example.

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**Physical access and limited mobility to health care sites and services,** especially for hard-to-reach population groups of women and girls, such as IDP and refugee women, rural women, women with disabilities. Humanitarian and conflict-affected contexts only exacerbate these challenges. Women’s constrained mobility may in part be due to prevailing gender and social norms, including care work, as well as financial dependence.

Women with **intersecting vulnerabilities** (i.e., income, age, ethnicity, race, geography)face compounded, gender-related barriers to access to medicines, vaccines and other health products.

These gender-related barriers are not unique to sub-Saharan Africa alone. Women and girls in the Asia and the Pacific region encountered similar challenges.[[3]](#footnote-3)

**(g) What are the main challenges to ensure the quality, safety and efficacy of medicines and vaccines?**

Sex and gender are often neglected considerations in the development of new medicines, vaccines, diagnostics, and other health products, including in clinical trials, thereby reducing the safety and efficiency of some vaccines and limiting their acceptability and accessibility for women and girls.

**(i) What concrete recommendations would you make to enhance access to medicines, vaccines and other health products?**

Addressing gender-related barriers to access to medicines, vaccines and other health products is key to designing effective response strategies and to reducing health disparities and outcomes.[[4]](#footnote-4) Effective strategies used to address the underlying causes of COVID-19 vaccine hesitancy and vaccine uptake in UN Women’s projects included:

**Prioritizing the different needs of women and girls in policy and/or programming interventions, with special attention given to the most marginalized,** by ensuring outreach and vaccination efforts and strategies address their specific gender-related barriers.

**Opening strategic spaces for women’s leadership and participation in health policy and decision-making**, especially at provincial and local levels, can bridge the gap between policymakers’ perspectives and the lived realities and diverse experiences of women and girls. Women’s meaningful engagement in such spaces is not only critical for highlighting gender-related barriers to access to health programmes and services, but it can also lead to a more inclusive and accountable health sector response, one that is more attuned to the priorities, needs and constraints of women in all their diversity. Increasing women’s leadership in health organizations, including on medical boards, can help ensure that women’s health and well-being receive due attention in relation to the availability, accessibility, affordability and acceptability of medicines, vaccines and other health products.

**Community-wide education and engagement efforts** to combat misinformation and to disseminate correct and accurate information on medicines, vaccines and other health products and services proved to be one of the most effective strategies against further disease outbreak and transmission, particularly in a context where little was known globally about the COVID-19 virus.

* **Centering the role of women’s leadership and participation**, including their networks and organizations as well as female health care workers, in the dissemination of health information and knowledge; raising community awareness and mobilizing concerted actions was instrumental in increase COVID-19 vaccine confidence and uptake among women and girls in several sub-Saharan country contexts. Women leaders and women-led organizations are at the forefront of maximizing the reach of prevention efforts by cascading and making available accurate information to their communities, especially women and girls.
* **Harnessing the trusted voices of other community influencers, such as traditional, religious and opinion leaders, also significantly contributes to increased awareness of and utilization of COVID-19 prevention and mitigation methods and services, particularly vaccine uptake, among women and girls and the broader community, promotes behaviour change and reduces stigma and discrimination.**

**Developing tailored and targeted information, education and communication (IEC) messages** that take into account the literacy needs of women andaddress the specific concerns of different sub-groups of women and girls, **including adolescent girls, pregnant and lactating women, refugee and internally displaced women, women living with disability.** UN Women produced IEC materials in local languages as well as graphically; these materials formed part of community outreach and sensitization activities on important COVID-19 prevention measures and behaviours.

**Through the use of a combination of several communication channels - mass community awareness raising and education campaigns, listening dialogues, peer-to-peer support groups, house-to-house visits, community radio, as well as s**ocial media and digital platforms – different sub-groups of at-risk and hard-to reach populations can be reached. Community radio in contexts where there is limited literacy as well as access to mainstream and digital media plays a particularly important role in broadcasting and disseminating accurate and correct COVID-19 information related to hygiene and other protective behaviours to curb the spread of the virus and on access to prevention and mitigation services and tools.

**Making COVID-19 prevention and mitigation services more accessible to communities** facilitates the access of women’s and girls, especially in hard-to-reach population groups, to COVID-19-related health services and expands health service coverage. UN Women’s projects relied on alternative health delivery methods such as the (i) deployment of mobile clinics and vaccination teams to communities; (ii) co-location/integration of health services in social service centers; and (iii) building the capacity of district and/or community level female health care workers on COVID-19 prevention and mitigation measures as well as respond to stigma, discrimination and gender-based violence at health care sites.

Promising evidence from UN Women programming on COVID-19 and on sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) demonstrates that **integrating women’s economic empowerment/livelihood component into health sector interventions** can help to shift gender norms, empower women at household and community levels and contribute to improved access to health prevention and mitigation solutions, including medicine, vaccines and other health products.

Ensuring thatnew medicines, vaccines, diagnostics, and other health products are safe, efficacious, acceptable and accessible by both women and men requires that sex and gender considerations are fully integrated into the research and development process: from *study design, data collection and interpretation, peer review and critical evaluation to testing and roll-out.* Examples of specific measures include:

* Explicitly addressing sex and gender in the study protocol to prevent and address harm to study participants, ensure fully informed and voluntary participation, and ensure that men and women accrue equitable risks and benefits from participation.
* Collecting and analyzing sex-disaggregated data to ensure the results are representative of the population and to determine sex-specific dosage, compliance, adverse effects, and outcomes.
* Use gender-sensitive artificial intelligence and machine learning drug discovery, because the data-driven drug modeling and repurposing allows precise prediction of efficiency, efficacy and adverse effect.
* Require that all vaccines be tested for efficacy and safety for **all**users prior to acceptance for national use.
* Identify and address the gender issues that may impede recruitment, retention, and adherence of women.

1. **(j) Please add any other information or data you would like to share that have not been covered above?**

**Systematically collecting, analyzing and using sex-, age-, race- and disability disaggregated data** is crucial not only for understanding the differentiated impacts of health interventions on women, men, girls and boys but also for developing gender-responsive, evidence-informed solutions that address barriers to access to medicines, vaccines and other health products for different population groups.

**Key references:**

[Guidance Note and Checklist For Tackling Gender-Related Barriers to Equitable Covid-19 Vaccine Deployment](https://www.who.int/publications/m/item/gender-related-barriers-to-equitable-covid-19-vaccine-deployment), SDG3 Global Action Plan For Healthy Lives and Well-Being: Gender Equality Working Group (WHO, GAVI, the Global Financing Facility, UN Women, UNFPA, UNDP, ILO, UNAIDS, UNICEF) and the United Nations University International Institute for Global Health (UNU-IIGH). March 2021

[Gender and COVID-19 Vaccines: Listening to women-focused organizations in Asia and the Pacific](https://asiapacific.unwomen.org/sites/default/files/Field%20Office%20ESEAsia/Docs/Publications/2021/07/ap-GiHA-GENDER-AND-COVID-19-VACCINES-June-29-21.pdf), The Asia-Pacific Gender in Humanitarian Action Working Group, Gender-Based Violence Area of Responsibility, and Voice, May 2021.

[COVID-19 Global Gender Response Tracker, UNDP and UN Women. September 2020](https://data.undp.org/insights/covid-19-global-gender-response-tracker).

1. Mozambique, Niger, Nigeria, Somalia, Uganda and Zimbabwe. [↑](#footnote-ref-1)
2. *Preventing the spread of COVID-19 among women and girls: integrating gender perspectives in the COVID-19 response* (March 31, 2022 – June 30, 2023); 2) *Prevention of COVID-19 infection among vulnerable women and girls in drought-affected districts (Guruve and Mbire) of Mashonaland Central Province in Zimbabwe* [*03/02/2022 - 03/31/2023]* and *Prevention of COVID-19 infections among women and girls displaced into IDP and refugee camps in East and Southern Africa Region* [April 2022 to March 2023]. [↑](#footnote-ref-2)
3. See [Gender and COVID-19 Vaccines: Listening to women-focused organizations in Asia and the Pacific](https://asiapacific.unwomen.org/sites/default/files/Field%20Office%20ESEAsia/Docs/Publications/2021/07/ap-GiHA-GENDER-AND-COVID-19-VACCINES-June-29-21.pdf), The Asia-Pacific Gender in Humanitarian Action Working Group, Gender-Based Violence Area of Responsibility, and Voice May 2021. [↑](#footnote-ref-3)
4. See [Guidance Note and Checklist For Tackling Gender-Related Barriers to Equitable Covid-19 Vaccine Deployment](https://www.who.int/publications/m/item/gender-related-barriers-to-equitable-covid-19-vaccine-deployment), SDG3 Global Action Plan For Healthy Lives and Well-Being : Gender Equality Working Group (WHO, GAVI, the Global Financing Facility, UN Women, UNFPA, UNDP, ILO, UNAIDS, UNICEF) and the United Nations University International Institute for Global Health (UNU-IIGH). March 2021.

   [↑](#footnote-ref-4)