

COVID-19 Vaccines and Vaccination: Some Gender Perspectives



GENDER &
COVID-19



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A pandemic, caused by SARS-CoV-2, a novel coronavirus, has created public health havoc with deep social and economic consequences. Containing infection required closure of economic activities as well as schools while providing essential services. The government lockdown measures have affected employment and earning opportunities, resulting in lower consumption, food insecurity, and asset depletion.ⁱ

Little attention has been devoted to the disparate effects on women. Within households, they often need to take additional responsibilities when schools are closed or if there is a sick member of the household. In advanced economies, where such data are more readily available, labor force participation gaps have widened. There are two forces that have primarily driven this. Firstly, sectors affected adversely by the pandemic also traditionally employ disproportionately more women. Secondly, family caregiving responsibilities have also contributed to women dropping out of the labor force.ⁱⁱ

Hence, the COVID-19 pandemic has gendered implications because of the overall economic impact and traditional gender roles of caregiving women play within the households. This has raised concerns regarding reversal of gender-based parity achieved over the past four decades or so.ⁱⁱⁱ Moreover, there are gender gaps in health seeking behavior. For example, in the US, women reported receiving flu shots 11 percent less compared to men.^{iv} Hence, it is not alarmist to expect disparities in who reaps the benefit from COVID-19 vaccines along gender dimensions.

Bangladesh can be considered somewhat an outlier, as the country is expected to grow by about 3.8% according to projections by IMF.^v This is lower compared to the robust official growth rates the country has registered in recent times, but it is still impressive when the global economy is expected contract.

However, several surveys have suggested that the rate of poverty has increased, and a “new poor” class has evolved resulting from slowdown of the semi- and informal sectors of the economy. The ready-made garment (RMG) sector, the largest private non-agricultural sector of the economy has shown resilience. However, there is emerging evidence that not all firms have coped with the pandemic equally. Smaller factories have struggled, and several have closed since the pandemic hit the country.

Bangladesh has been somewhat exceptional in terms of school closure policies as all educational institutes have remained closed for almost an entire year starting on 18 March 2020, about ten days after the first case of COVID-19 was detected in the country.

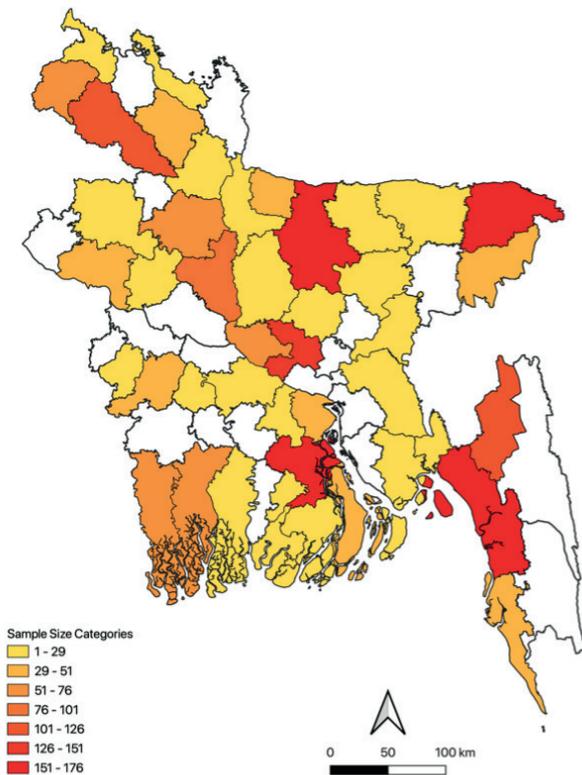


It is impressive the global efforts came together to develop several effective vaccines against COVID-19. Availability and access to such vaccines are expected to provide much needed protection. While availability and access to vaccines is supposed to improve the situation, there are some concerns around the vaccination process. Bangladesh has one of the lowest vaccine hesitations in the world and its success in effective immunization has garnered much praise. However, this experience is anchored in child immunization, whereas the COVID-19 vaccine is aimed at adults. The speed at which the vaccines have been developed may also called for some concerns regarding both their efficacy and possible side-effects.^{iv}

In this study, focused on two aspects. First, in addition to vaccine hesitancy, we wanted to understand people’s knowledge, awareness, perception, and attitude towards the availability of and access to vaccines. Second, in all analyses we stratify the answers by the respondents’ gender to unearth possible gender disparities which may shed light on concerns regarding vaccine distribution. This could foster special attention to making vaccine distribution more equitable and fairer.

The study aimed to understand the impacts of the COVID-19 pandemic along gender lines using quantitative survey-based data and qualitative interviews of men and women. The survey will follow a cohort of nationally representative adults over three rounds of data collection over a period of one year. The first round of survey was carried out in December 2020.

Figure 1: The distribution of the final sample by respondents' current locations

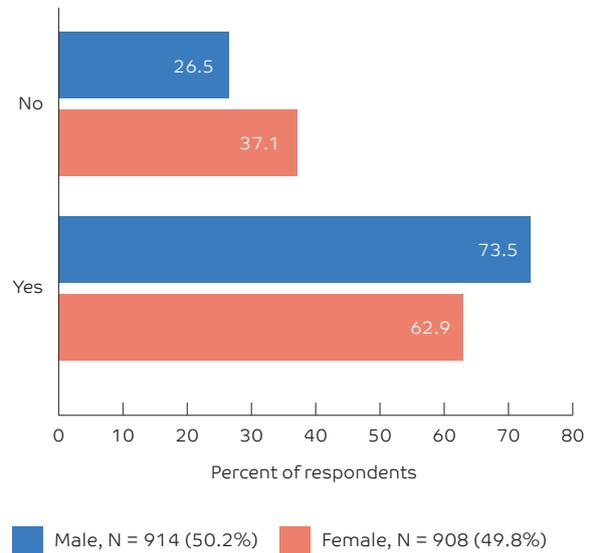


The survey encompassed a comprehensive set of modules covering many different economic and health related outcomes. We collected information from 1822 people (914 men and 908 women). The average age of the respondents was 43 years (SD = 14) and 84 percent were married at the time of the survey. Figure 1 presents how the final samples were geographically located by district.

In Round 1, we asked a series of questions on vaccines. First, we asked whether the respondent heard about vaccine development over the past month. The survey overlapped with a period when media was rife with positive Phase Three trial outcomes for a number of major vaccines (e.g., AstraZeneca/Oxford) and subsequent approval and deployment by different national governments.

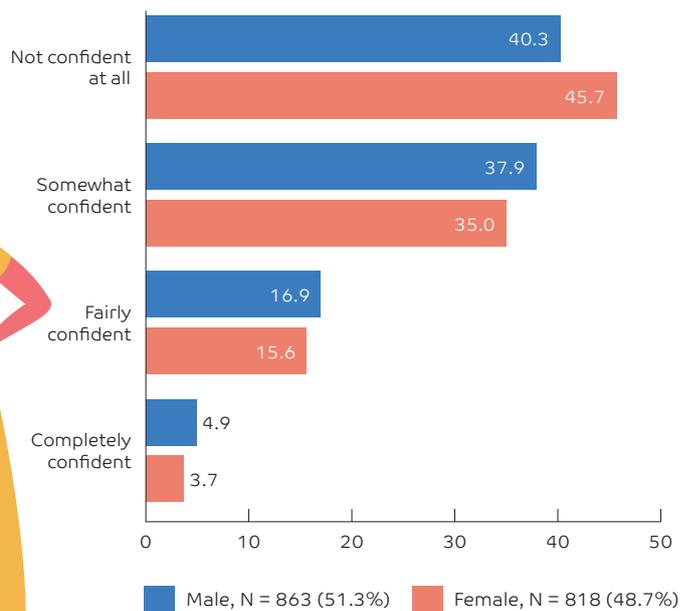


Figure 2: Have you heard about vaccine development over the past month?



As we can see in Figure 2, 73.5 percent of male respondents reported being aware of such developments while 62.9 percent of the female respondents reported knowing about the development of any vaccine – a gap of 10.6 percentage points ($p < 0.01$).

Figure 3: How confident were the respondents that a vaccine would be available in Bangladesh?



Next, we asked how confident the respondent was that a vaccine will be available in Bangladesh. This and the subsequent questions are categorized into four groups and the results are shown in Figure 3. We can see that women are less confident about vaccines against COVID-19 being available in Bangladesh – about 40.3 percent of the male respondents reported being not confident at all while 45.7 percent of the female respondents reported as such.

Our next two questions focused on the efficacy and possible adverse side effects of the vaccines. We first asked how concerned the respondents were about the efficacy of the vaccine. We found that half of the respondents were not at all concerned about the efficacy of the vaccines and there is not much gender difference.

Figure 4A: How concerned were the respondents that the vaccines would not be effective against COVID-19?

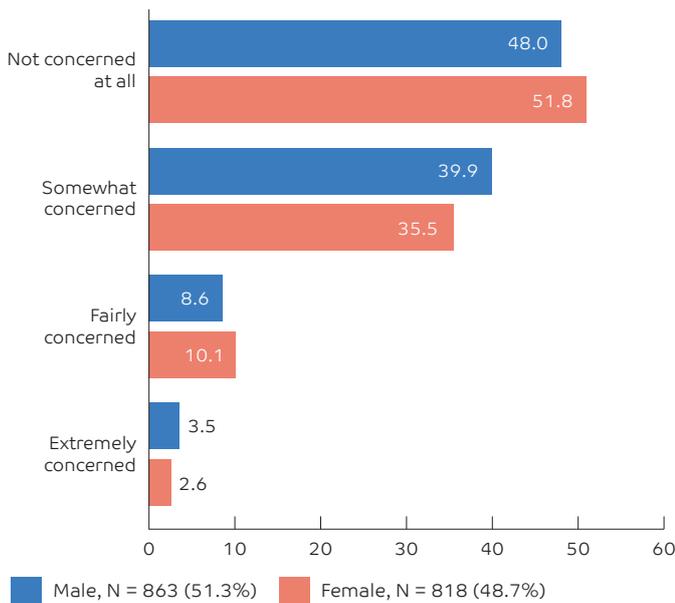
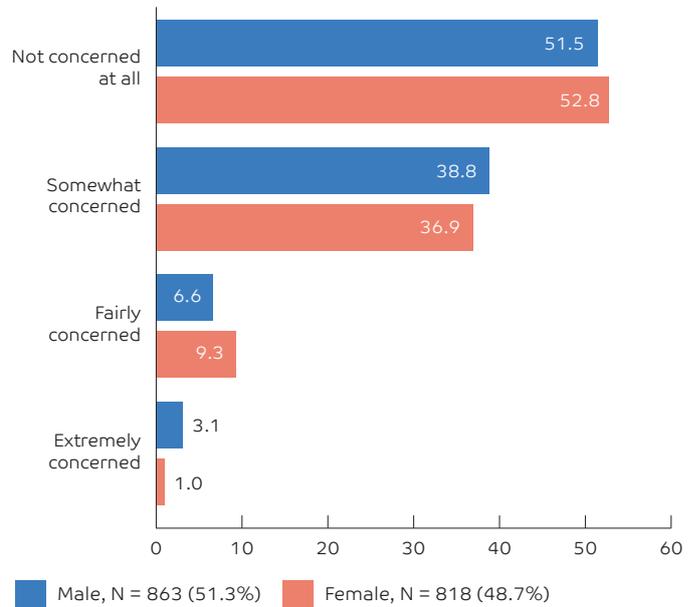


Figure 4B: How concerned were the respondents about the adverse side-effects of the vaccines?



The pattern is similar for being concerned regarding the adverse side effects of the vaccines. We find majority of the respondents were not concerned at all about the vaccines. For both cases, the respondents did not exhibit major concerns about the efficacy and adverse side-effects of the vaccines.

Next, we explored a series of questions to understand how confident the respondents were about getting access to the vaccine, if such vaccines would become available within the next six months.

Figure 5A: Confidence on the household member(s) having access to the vaccine

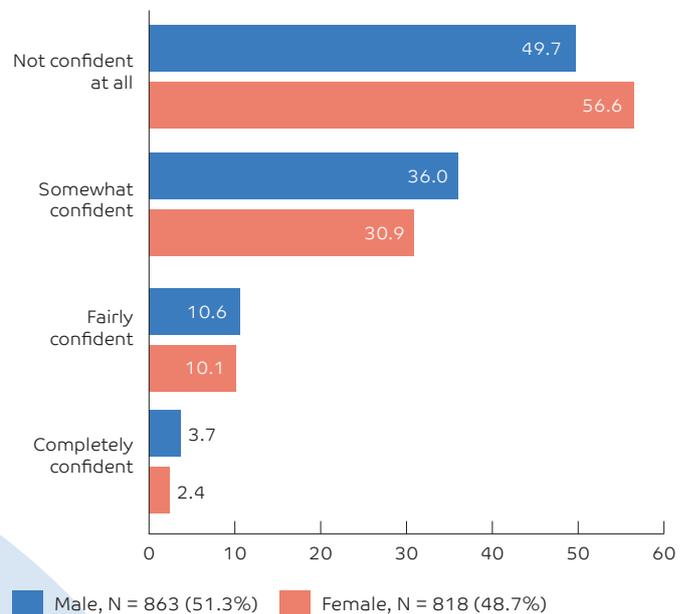
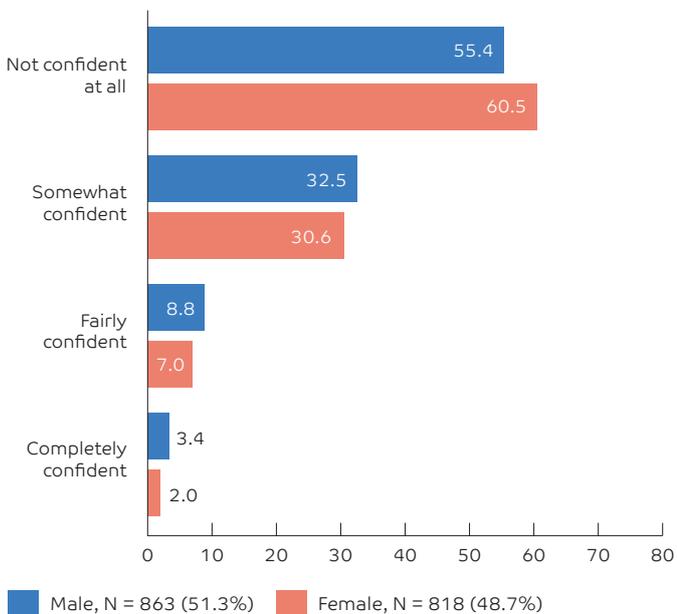
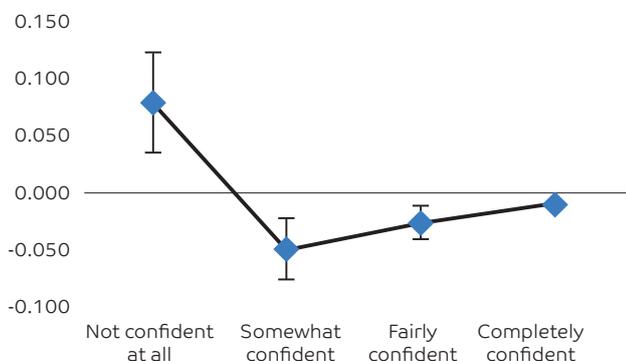


Figure 5B: Confidence that the respondent personally would have access to the vaccine



We found that the respondents were generally not very confident that either their household member(s) or themselves would have access to the vaccine if available in Bangladesh. There is also a gender gap in this outcome – the female respondents were generally less confident that they would have access to the vaccine compared to their male counterparts. These gaps persist even if we control for a number of household characteristics (see Figure 6) – there is an eight-percentage-point difference between male and female respondents on how confident they are regarding having access to the vaccines.

Figure 6: Gender difference in confidence in being able to access COVID-19 vaccine



Note: Here we estimate the differences in probabilities for the individual outcomes as predicted from an ordinal logit model for question: “If a vaccine is available over the next six months, how confident are you that you personally will have access to it?” We have further controlled for a number of household characteristics such as land assets and monthly income.

We further enquired why the respondents may not have access to the vaccines. Interestingly, the supply-chain or overall availability was not a major concern. However, “elite capture” meaning the rich and powerful people having preferential access to the vaccines came as a major reason for not having access. The respondents also worried that the vaccine would not be free, and a high price may deter access.

Table 1: Reported reasons why respondents may not have access to vaccines

	Respondents		
	Male (N=849)	Female (N=802)	Total (N=1651)
Our local health facilities will not be able to stock the vaccines	71 (8.4%)	47 (5.9%)	118 (7.1%)
The price will be too high for me to bear	280 (33.0%)	341 (42.5%)	621 (37.6%)
It will take time before Bangladesh having access to the vaccine	128 (15.1%)	92 (11.5%)	22 (13.3%)
The rich and powerful people will keep the vaccines	288 (33.9%)	207 (25.8%)	495 (30.0%)
Rural areas will be left out	4 (0.5%)	5 (0.6%)	9 (0.5%)
Others	46 (5.4%)	42 (5.2%)	88 (5.3%)
Don't know	32 (3.8%)	68 (8.5%)	100 (6.1%)

Lastly, we asked who should get priority in terms of getting access to the vaccines. Those working outside of home received the highest priority along with people who are poor. Putting these two categories together, the results suggested economic consideration played a major role in setting the vaccine priorities among the respondents. The elderly population also received high priority while the health workers (doctors, nurses as well as community health workers) came the next.

We should also note women placed a higher priority on the elderly population and children compared to men. This may be driven by women bearing greater caregiving responsibilities for dependents and may also benefit from the support of the elderly in terms of child rearing.



Table 2: Who should get priority?

	Respondents		
	Male (N=849)	Female (N=802)	Total (N=1651)
Frontline health workers	165 (19.0%)	103 (12.5%)	268 (15.8%)
Community health workers	8 (0.9%)	11 (1.3%)	19 (1.1%)
Elderly population	162 (18.6%)	177 (21.5%)	339 (20.0%)
Children	100 (11.5%)	140 (17.0%)	240 (14.2%)
Those work outside the home	225 (25.9%)	199 (24.2%)	424 (25.1%)
Teachers	3 (0.3%)	2 (0.2%)	5 (0.3%)
Women	2 (0.2%)	10 (1.2%)	12 (0.7%)
Poor	108 (12.4%)	95 (11.6%)	203 (12.0%)
Sick & COVID-19 Infected People	49 (5.6%)	44 (5.4%)	93 (5.5%)
All Citizens	19 (2.2%)	13 (1.6%)	32 (1.9%)
Others	18 (2.1%)	11 (1.3%)	29 (1.7%)
Don't Know	10 (1.2%)	17 (2.1%)	27 (1.6%)

Key messages

Our findings suggest overall vaccine hesitancy may not be the main concern among respondents. However, whether the respondents will have access to the vaccines seems more salient to the respondents who participated in the survey.

Female participants seemed to be more worried about having access to vaccines, even after controlling for a number of socio-economic features. The concerns about the lack of access to vaccines are possibly driven by certain, more politically connected people having access to limited supply of vaccines.^{vi} Economic factors such as employment and poverty were important for the respondents in prioritizing who should get vaccines. Prioritization of vaccines may have further gendered implications, as women will continue to be unable to work as long as the elderly population and children population are vulnerable to the pandemic.

References

- ⁱ A recent Science paper has looked at nine countries, including Bangladesh, has documented severe crisis in living conditions and “widespread food insecurity”. See Egger et al. (2021).
- ⁱⁱ A summary of gender gap in labor force participation can be found at Djankov, Trumbic, and Zhang (2020) [link: <https://voxeu.org/article/covid-19-and-gender-gap-advanced-economies>].
- ⁱⁱⁱ The Secretary General of UN has raised this issue uttering that “the global pandemic has already reversed decades of limited and fragile progress on gender equality and women’s rights.” [link: <https://news.un.org/en/story/2020/08/1071372>].
- ^{iv} See, for example, Cameron, K. A., Song, J., Manheim, L. M., & Dunlop, D. D. (2010). Gender disparities in health and healthcare use among older adults. *Journal of women’s health*, 19(9), 1643-1650.
- ^v See “Why is Bangladesh’s GDP growing despite Covid-19, while other economies are contracting?” [link: <https://scroll.in/article/976457/why-is-bangladeshs-gdp-growing-despite-covid-19-while-other-economies-are-contracting>].
- ^{vi} For example, a recent survey carried out Institute of Health Economics, University of Dhaka has found that most respondents reported a “wait-and-see” attitude towards vaccination as they wanted to glean more information from the early adoptees.
- ^{vii} Bangladesh has a population of 170 million, with about 70 percent above 18 years of age. The government has a preliminary agreement with Serum Institute of India to procure about 30 million doses. [link: <https://www.thedailystar.net/online/news/indias-serum-sell-covid-19-vaccine-bangladesh-4dose-report-2027013>]

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