

EDITORIAL

Vaccinating women across the life course: Gendered social norms, obligations and vaccine uptake

Immunization Agenda 2030 (IA2030) explicitly aims to ensure that all people benefit from immunization across the life course.¹ Integrating immunization with other health services helps to reach age groups beyond childhood,² and embedding immunization into obstetric and gynecological care will ensure women have access to vaccination at all life stages.

Two papers in this issue support healthcare providers in vaccinating women across their life courses. In the first paper, Divakar et al.³ present a synthesis of the global evidence-based recommendations for vaccination of women of four key age groups: adolescence, reproductive age and pre-conception, during pregnancy and the postpartum period, and post-menopause. In the second paper, Hodge et al.⁴ review the global vaccination recommendations in the context of pregnancy. Both papers touch on some of the drivers of vaccine uptake, describing programmatic, information, and trust issues in relation to hesitancy, and advocating for the empowerment of frontline healthcare providers as vaccine advocates through information, training and support. The papers divide a woman's life course into age groupings based on vaccine preventable disease risk; however, it is important to recognize that these age groups also signify significant transitions in a woman's role in society, how she is viewed, and the societal norms and expectations she must adhere to.

When thinking about vaccine hesitancy, it is important to delineate between hesitancy as a motivational state and vaccine uptake as a behavior.⁵ The two are often conflated, which is problematic because women who are hesitant can and do still vaccinate, while women who are not hesitant can remain unvaccinated for a variety of reasons. It is helpful to locate hesitancy as one part of a complex constellation of intra-personal, inter-personal, community, institutional, and societal drivers and barriers to vaccination. To address low vaccination rates, we must move beyond simply identifying the issues in each of these domains to ask why these issues are driving vaccination behavior for different groups of women. This requires understanding the social context women inhabit at different life stages, and the place vaccination occupies in each.

HPV vaccination particularly reflects the complex interplay of beliefs, attitudes and access. HPV vaccination is recommended for adolescent girls and young women, and it has been introduced into

routine immunization programs around the world. Implementation and accessibility barriers are commonly reported for HPV vaccination, including human and infrastructure resource constraints, and lack of accessible information for communities.⁶ Adolescence represents a transition in the social role occupied by women, how they are viewed and how they are expected to act. Understanding the role of social norms and expectations, and social constructions of diseases can shed light on the reasons for observed behaviors and how to address them. In the case of HPV, societal expectations of purity and honor—and social stigma associated with HPV infection—often play a pivotal role in HPV vaccine acceptance.⁷ Parents from various global cultural settings express concern that vaccinating their daughters against a sexually transmitted infection might sanction sexual behavior, and worry about the vaccine impacting their daughter's fertility.^{6,8} Social taboos around sexual activity before a certain age or before marriage, coupled with vaccination delivery before sexual debut, can restrict discussion and information sharing between parents and daughters, and influence whether and how healthcare providers speak with patients and their parents.⁸ In some settings, parents prefer to delay vaccination until their daughters are of an age more aligned with culturally acceptable sexual activity. Older adolescents are also more likely to be able to consent to vaccination without parental involvement.⁸ Conversely, parents in other settings see vaccination at an earlier age as an advantage, especially where social taboos are less restrictive, or where an early age of sexual contact, either consensual or non-consensual, is more likely.^{8,9}

Pregnancy, also a time of social and cultural transition,¹⁰ is another life stage at which vaccination is recommended. Although vaccine uptake in pregnancy varies between countries and settings, there are common practical and social drivers of pregnancy vaccination behavior. Practical barriers stem from programmatic challenges and social disadvantage and include, for example, vaccine shortages and poor access to antenatal care.^{11–14} Knowledge and understanding drive vaccine acceptance in pregnancy across all settings. Pregnancy is often a time of increased safety concerns; disease awareness, risk perception and health worker recommendation are important factors in uptake.^{11,14}

Paying attention to the social context and lived experience of pregnancy can illuminate underlying values that drive observed

vaccination behaviors in this life stage. In any culture, there are socially expected behaviors that signify the expectant mother is “performing” pregnancy in the “correct” way, against which she is judged as either a “good” or “bad” mother.^{15,16} The expectant mother must do everything in her power to ensure the optimal health and development of her unborn infant, which, in neoliberal western societies such as Australia, Canada, New Zealand, the United Kingdom, and the United States of America, entails an expectation that she prioritizes the health of her unborn infant over her own comfort and sometimes her own health.¹⁷ Pregnant women are judged poorly if they are seen to digress from the prescribed “best practice” and often find their bodies policed by health professionals, family members and communities.^{16,18} In an example of how the social construction of pregnancy impacts vaccination, pertussis vaccine uptake is consistently higher than influenza or COVID vaccines.^{12–14} Good “reproductive citizenship”¹⁸ can explain the difference between pertussis and influenza vaccine uptake: pertussis is seen as a risk to the fetus, whereas influenza is perceived as comparatively less severe and affecting the mother, and therefore less important.^{19,20} This separation of risks to the mother and the fetus is often reinforced in the framing of vaccine information and advice.¹⁷ How women navigate and operationalize being a good “reproductive citizen”, including vaccination decisions, depends on a combination of culture, awareness, risk perception, perceived necessity, experience, personal values, level of responsabilisation, institutional trust, and the manner in which they engage with their antenatal healthcare provider.²⁰

So how can women's lived experiences of cultural expectations and societal norms inform how to increase vaccine uptake across their life courses? Holistic, multicomponent approaches that simultaneously address information needs, health systems access, and individual and community awareness and attitudes are preferable as they approach the lived experience as a whole, rather than attempting to address different facets of vaccine uptake individually. Community-led methods that embed social and cultural norms in these approaches will make them more likely to succeed long term. One such method is a culturally aligned “designathon”, a participatory research method that involves end users co-designing interventions.²¹ This has been used to co-create HPV screening and vaccination approaches for mothers and daughters in Nigeria, for example, and is an instructive approach.²²

Healthcare provider recommendations, in particular, drive vaccine uptake, especially when coupled with an offer of vaccination,^{8,11,14} however, an effective recommendation goes beyond simply providing a pamphlet.^{19,23} It requires a carefully framed discussion aligned with the social and cultural values that women are enacting when deciding on vaccinations, and a trusted patient-provider relationship. Giving healthcare providers the time, training and socially informed tools to confidently discuss, recommend and provide vaccines are therefore crucial. Furthermore, it is not just the message, but who delivers it that makes it trustworthy. Social context can be used to identify the right health providers for training and support. For example, in many cultures, midwives hold a trusted and elevated

social role¹⁰ and could be key champions for vaccination of women in their communities. However, globally, midwives have a spectrum of beliefs and vaccine recommendation practices²⁴ and, along with other healthcare providers, are often not confident in recommending vaccines, often through concerns about vaccine safety or discomfort at discussing socially taboo topics.^{8,14} Therefore, understanding the social and cultural values that healthcare providers are enacting is just as important as understanding those that women are enacting, and tools and training should account for these in addition to providing technical information.²⁵

To encourage and maintain high vaccine uptake among women across the life course we must understand the social and cultural roles and expectations that they are held to at various times in their lives, the social construction of diseases and how these social constructions underpin vaccine decision-making. The social and cultural roles and world views of health workers who recommend and deliver vaccines to women must also be understood and embedded in program and intervention design. This can be done in several ways, including community-driven participatory approaches, supportive training for health workers and better integration of vaccination into other health programs to increase equitable access.

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adolescence, immunization, pregnancy

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Kerrie Wiley: Conceptualization, writing—original draft; **Hema Divakar:** Conceptualization, writing—review & editing; **Dharmindra Pasupathy:** Conceptualization, writing—review & editing. All authors, including FIGO Committee on Infection During Pregnancy members, reviewed the final manuscript draft.

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The authors have no conflicts of interest.

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Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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