

Professor Wei Shen Lim
Chair, COVID-19 sub-committee, JCVI

February 12, 2020

Dear Professor Lim

We are writing to express our disappointment with the JCVI's latest guidance on COVID-19 vaccination released on 30th December 2020, which seriously underplays men's greater risk of serious morbidity and mortality and, through its inadequate analysis of the role of sex and gender, risks significant issues once the vaccination programme extends to the working age population.

We particularly regret the decision to remove all references to sex and gender from the overall paper and, as a result, leave it outlining an incomplete and insufficient overview of the risks faced by different groups in the UK today. Given men's lower compliance with COVID-related guidance, it's essential that all parts of the health system are clear about the greater risk that men face.

In addition, while sex and gender are associated with relatively small differences in health behaviours - including vaccination uptake - amongst the older age groups vaccinated to date, this is not the case amongst the working age population, where, historically, vaccine uptake patterns have been lower amongst men. Research on COVID vaccine uptake amongst health care workers is also showing sex-based differences. The small differences in uptake amongst older cohorts so far cannot be used to justify complacency for the future.

While we do not believe that a shift to prioritising uptake by sex or gender is currently appropriate, we would like to see:

- Future JCVI guidance that properly highlights the greater risk faced by men
- A sex- and gender-aware approach to identifying the jobs at highest risk of COVID, and updated guidance that gives these roles priority as the vaccination programme reaches the working age population, particularly in respect of health & care workers and professional drivers, but amongst elementary occupations and leisure and other service occupations more generally
- JCVI recommendations for improved and more timely publication of equality-disaggregated data - particularly amongst working age cohorts - and targeted interventions to address any shortfalls in male or female uptake.

The facts are stark:

- Men are more likely to die from COVID than women.
- These effects are intersectional and combine with other inequalities to leave some groups of men at particularly high risk.
- The causes relate to both biology and behaviour. Men's attitudes, beliefs and behaviours are different for COVID and different for vaccination.
- The responses also need to be different with sex reflected in intervention design - including communication and, as part of an intersectional approach, targeting.
- Gendered differences in health behaviours are strongly affected by work status. While GP attendance rates, for example, are very different between men and women overall, they are virtually identical as soon as men and women retire. The workplace risks faced by men - including from COVID - are also very different.

For England, data for the mortality rate for COVID positive patients have shown over the past 12 weeks that men in England are consistently making up 60% of these deaths (source: [NHS England](#)). Men are also more likely to require treatment in critical care units, with men making up 66% of all patients admitted into critical care units since 1st September 2020 (source: [ICNARC](#)). Amongst the working age population, the effects are more stark, with men having an 86% higher mortality (source: [ONS](#))

These effects are intersectional. We strongly support the extra attention given to the risks faced from COVID by BAME communities - but this effect compounds with sex - with black men, for example, experiencing 2.1 times the age-standardised mortality rate of black women, 2.9 times the ASMR of white men and 4.9 times the ASMR of white women (source: [ONS](#)).

We would also like to see acknowledgement of the different risks faced by different jobs. Just-published data from the ONS show, when looking at broad groups of occupations, that men who worked in elementary occupations (699 deaths) or caring, leisure and other service occupations (258 deaths) had the highest rates of death involving COVID-19 (source: [ONS](#)).

The analysis shows a particular risk amongst drivers - a historically hard-to-engage group - with male taxi and cab drivers and chauffeurs (209 deaths) being the male employment group at highest risk, but also a very high number of deaths amongst large goods vehicle drivers (118 deaths), van drivers (97 deaths) and bus and coach drivers (83 deaths). Other groups include male security guards and related occupations (140 deaths). One group with strikingly high ASMR (albeit on a small sample) is police officers who we also believe merit early priority.

The outcome differences between male population sub-groups, as well as the differences between men and women, require an intersectional approach that identifies the specific groups at greatest risk and how that risk might be mitigated through vaccination policy.

We are disappointed with the approach of the guidance document towards recognising and monitoring disadvantaged groups, which includes the total absence of any strategy to address the role that sex and gender plays in COVID health outcomes. In Annex A accompanying the guidance, it is asserted that 'focusing on men's higher death rates compared to women may be misleading since the absolute differences will be higher, despite similar relative risk, given men's higher baseline mortality'.

Even if one were to accept this bizarre baseline argument (which could also be applied to other groups with poorer health outcomes - such as BAME populations or people in areas of deprivation - and would be an equally flawed argument in either case), we find it hard to see how this implies that men's greater risk of COVID mortality is unworthy of intervention.

The Annex A document also comments that 'the explanation for sex differences may reflect social and cultural factors related to gender rather than the biology of sex'. The two are not mutually exclusive, and the emerging consensus is that a combination of both biological and behavioural factors are involved in explaining the higher mortality from COVID among men.

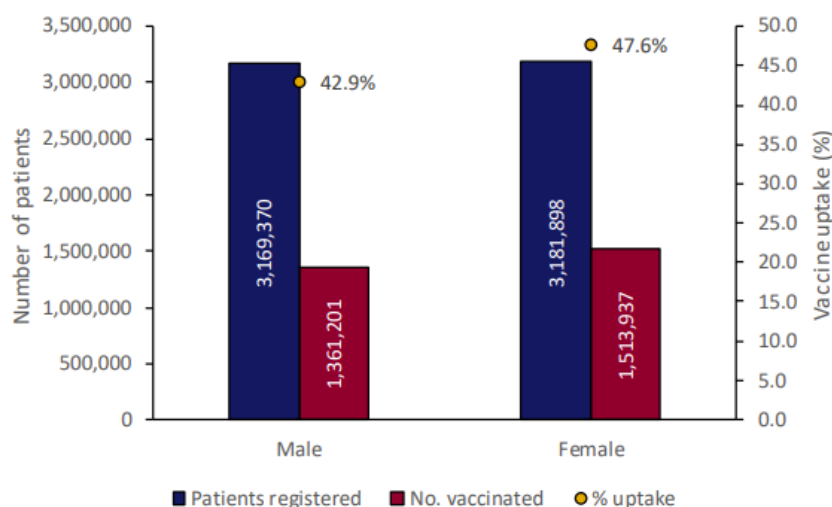
One area that is underexplored is the UK's own experience with flu vaccine uptake. The most recent PHE report (Seasonal influenza vaccine uptake in GP patients: winter season 2018 to 2019 [PHE](#)) suggests that we should not be surprised by the lack of difference in COVID vaccination uptake between men and women over 65, stating:

For those aged 65 and over, there was little or no difference in uptake between genders for the last three seasons

But - in line with previous years' publications - the report also suggests that we should be alert to differences amongst the working age population:

“Vaccine uptake in at-risk patients aged 16 years to under 65 years was 4.6% higher in females than males in England”

Figure 8. Influenza vaccine uptake in at risk patients aged 16 to under 65 years old by gender for England in 2019 to 2020 season.



The recently pre-print of vaccine uptake in Leicester hospitals ([MedRxiv](#)) also shows sex-based differences - albeit in the other direction.

We recognise that survey evidence suggests that men state they are more willing to receive the COVID-19 vaccine than women at all ages, but the link between surveyed intent and behaviour isn't absolute and there is also evidence that men, especially younger men, are less compliant with guidance on social distancing, handwashing and mask-wearing. Whatever the final situation turns out to be, the current failure of overall JCVI guidance to mention sex-based differences cannot be justified.

We therefore strongly recommend that the JCVI reviews its statement on sex and gender inequality with a view to recognising the excess burden on men and the need to address it in both policy and practice. We are not recommending that men should be in a higher priority group than women but we do urge the JCVI to consider how it can ensure the optimal level of uptake in men (and women too, of course) through the use of a gender-sensitive marketing approach. This is particularly likely to be relevant as the vaccination programme reaches the pre-retirement age groups.

While the mortality differences between men and women remain shocking, and the differences in health behaviour and compliance are also a challenge, the differences in vaccine uptake between men and women have so far been small.

Available evidence is that it is not safe to assume that this will remain the case as the vaccination programme moves towards working age men and women. The combination of different health outcomes, different health behaviours and the risk of different vaccination uptake is real. Your current analysis and recommendations do not give this adequate weight and we would ask you to reflect this in your future work.

Yours sincerely

Martin Tod
Chief Executive, Men's Health Forum

cc: JCVI COVID-19 Sub-Committee Members