

THE GENDERED IMPACT OF COVID-19

MONDAY 8 MARCH 2021



WGHI | WOMEN IN
GLOBAL HEALTH



GENDER &
COVID-19

SUMMARY: The **Independent Panel for Pandemic Preparedness and Response (IPPPR)**, the **Independent Oversight and Advisory Committee** for the WHO Health Emergencies Programme (**IOAC**) and the Review Committee of **International Health Regulations (IHR)** are important opportunities to consider the **World Health Organization (WHO)** and states' response to the COVID-19 pandemic from a gender perspective. National governments are responsible for developing and implementing laws and policies to respond to crises, and mitigating outbreak impacts on different sectors of society. WHO is responsible for global priority-setting and coordination, information dissemination and knowledge sharing. IHR must mainstream gender in planned actions and obligations. All future pandemic preparedness and response must be gender responsive. This brief builds on existing work done by Women in Global Health and the Gender and COVID-19 Project to provide advice for gender mainstreaming as states and WHO i) prepare for an outbreak, ii) engage in decision making and advice during the crisis and iii) respond to epidemics and potential pandemics.

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HEADLINE MESSAGES

- In most age groups, men have a higher mortality rate from COVID-19 than women but women and girls are bearing the secondary impacts of a pandemic that worsens their already weak social and economic position. These include gender-based violence, unwanted pregnancies and maternal deaths, lost jobs and livelihoods, an increased burden of unpaid work, mental stress and in the case of girls, being withdrawn from school and forced into abuses such as child marriage.
- COVID-19 is not an equalizer, it is exposing inequalities between and within countries including gender inequality. Inequality is compounded by other marginalized identities including race, ethnicity, class, sexual orientation and disability. Non binary and LGBTQI people have faced violence and discrimination during the pandemic in some contexts.
- Although women work at all levels in health security—from the front lines of health services, to research labs and health policy making – women have not been represented equally in global or national decision-making bodies on COVID-19. Health decision-making is losing women’s talent, perspectives and expertise.
- Global health security rests on the fragile foundation of an unequal health workforce with severe health worker shortages. Women are 70% of the global health workforce but clustered into lower status, lower paid jobs and commonly subject to harassment. Large numbers have worked unpaid or underpaid at community level on COVID-19. They are at higher risk of COVID-19 infection, compounded by exhaustion and mental stress. Investment in decent and safe work for women health and care workers will strengthen global health security.
- Ignoring the gendered aspects of outbreaks and pandemics hinders prevention and response management by obscuring critical risk factors and trends. Policy measures responding to COVID-19 should be based on evidence and research that factor in gender differences and the impact of gender inequality.
- The response to outbreaks and pandemics is stronger when global movements, including women’s networks, coordinate global and local action. But women’s organizations – especially those based at community level in low- and middle-income countries most at risk – are underfunded.

RECOMMENDATIONS TO THE INDEPENDENT PANEL:

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“The path to economic and social recovery from COVID should not be built on women’s backs.”

Dr Kealoha Fox, Hawaii

Decision Making

- Gender balanced leadership from global to community levels must be considered a prerequisite for effective pandemic preparedness and response

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- An intersectional approach must be taken to ensure pandemic decision-making bodies reflect the communities they represent, including the diverse voices of women and frontline health workers. Global decision-making bodies must be geographically balanced, including women from the Global South particularly.
- Legal and policy measures should be enacted by governments to support gender parity in leadership in health and social care to build resilience for future health emergencies
- Research should be conducted on the impact of the gender of political leaders on the effectiveness of country responses to the pandemic

Women's Economic Security

- Investment in care (health, social, child and adult) must form a key part of pandemic response plans
- Ensure protection mechanisms are in place for women's employment and re-entry to labour force: This must include affordable/subsidised childcare; retraining for women whose sectors are decimated/may cease to exist; bailing out not only masculinized industries, but equal support for feminised sectors
- Governments and donors need to continue to provide cash assistance to women while expanding access to financial services and ICT; strengthen labor market policies aimed at women; provide tailored support to women-owned firms and women farmers, as well as industries where women predominate as wage workers; strengthen the care economy; and support women's groups and networks.
- Due recognition and financial support must be provided to HCWs during and after COVID-19 as we seek to re-value what's important in our societies.

Violence

- Ensure due support is provided to services supporting women during emergencies
- Data is recorded (where possible) to ensure documentation of the extent of violence
- Mitigations for intimate partner violence form part of wider pandemic response plans.
- Increased support and funding for women's peacebuilders and organisations providing much needed social assistance during crisis.

Data and Policies

- Ensure all data collected at global and national levels is disaggregated by sex, gender, age, ethnicity etc, in line with SDGs
- Ensure diverse sources of gender are used by decision makers, and not just positivist epidemiological methods, including the vital role of women's voices through story-telling, testimonies, oral histories etc.

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- Gender mainstreaming IHR as a key mechanism to hold governments to account for gendered and intersectional concerns during preparedness, crisis and response periods.
- Different groups have been disproportionately impacted by COVID-19 due to their social identities and their intersections. If our response is going to be equitable, we must take into account these disproportionate impacts

Overview

COVID-19, similar to previous health emergencies impact men, women, and non-binary groups in different ways. This can include both the direct effects of infection with the pathogen, with men suffering more severe health outcomes; and the indirect effects of the non-pharmaceutical interventions introduced by governments to mitigate the spread of the disease, which have disproportionately affected women. Yet, gender neutral policy making by international organisations and governments, focused solely on case numbers, rather than who those numbers are masks these differences.

The exchange on the Gendered Impact of COVID-19, hosted by IPPPR and coordinated by Women in Global Health (WGH) on 8 March 2021 brought evidence and testimonies to the differential effects of COVID-19 as experienced by different sectors of society. We recognise that whilst there are considerable gendered differences, the impacts of COVID-19 and associated policy do not fall evenly across men, women and non-binary groups, but are compounded by additional drivers of vulnerability, including age, race, ethnicity, location, sexuality, employment, socio-economic group and marital status. These need to be considered simultaneously, rather than separately.

MAIN THEMES

Theme 1: Women's Role in Decision Making

“Gender imbalances in leadership and power have impacted responses to the pandemic. We need to challenge the prejudices that disenfranchise women all over the world”.

Hon Minister Dr Magda Robalo, Guinea-Bissau

Key message: Women have not been equally represented with men in decision making on COVID-19 from global to national levels and as a result, suboptimal and gender blind policy decisions have been made that harm women and girls and hinder the pandemic response.

Detail: Women comprise around 70% of health and social care workers globally and 90% of the nursing and midwifery workforce and yet they hold only 25% of leadership roles in health. Women are typically clustered into lower-status, lower paid jobs in health and social care. Nurses - 59% health workers – are significantly underrepresented in global and national health leadership. Women’s limited opportunities to enter leadership are often compounded by the intersection with other identities such as race or caste, making it even harder for women from marginalized groups to attain leadership roles. Women from the Global South are particularly underrepresented in global health decision making.

The same pattern of women’s underrepresentation in leadership has been repeated in the pandemic. Women have made an extraordinary contribution to the pandemic response in all sectors from science and vaccine development to health policy making and delivery. Women have been 90% of frontline health and care workers but typically, national COVID-19 decision-

making groups have had a majority of male members, sidelining female talent, perspectives and knowledge. Health systems function better when the women who manage them have an equal say in their design and delivery.

At political level women have also been marginalized in pandemic decision-making since only 6% countries had female heads of government (2020). It has been observed that women political leaders have been more effective in responding to COVID-19 than men by acting quickly, listening to scientific advice and communicating inclusively with citizens.

Beyond gender parity in leadership at all levels, leaders of all genders must promote gender transformative policies to realise better global health and future global health security. Addressing gender inequality in the health and social care sector is not solely the responsibility of women leaders.

“We cannot return to business as usual. The pandemic has brought greater understanding of global solidarity, the centrality of health for economic prosperity and the urgent need to tackle the inequalities – including gender inequalities – that undermine global health security.”

Dr Roopa Dhatt, USA

Theme 2: Women’s Economic Security

“You can’t understand gender inequality in the labour market without acknowledging inequality in caregiving within the home. This has been blazingly obvious in the pandemic.”

Professor Abi Adams-Prassl, UK

Key messages: The impact of COVID and societal disruption has been absorbed by women, through unpaid and paid labour changes.

Detail: Whilst gender is context specific, women’s economic security has been a global theme during COVID-19. Women have disproportionately lost paid employment, or have had to endure harder work conditions in order to earn an income. In higher income settings, women have greater rates of job loss (50,000 women lost jobs in December 2020 alone in USA) and at same time men’s participation in the labour force increased. In low- and middle-income countries, sectors where women predominate as entrepreneurs and wage workers have been harder hit. Facing a lack of income-generating opportunities, women are depleting their savings and relying on borrowing to make ends meet. Yet, only 10% of government social protection, labour market and fiscal/economic policy response measures target women’s economic security.

Women’s economic security is also challenged between the binary distinction we make within the market economy between paid and unpaid work - move towards an understanding of the social or care economy. This means we should move away from considering care in

relation to the market economy, but the changing relations of care within society. We must meaningfully recognise care-work:

- Paid care work of the health and social care workforce who are disproportionately women (70% HCW globally, 90% of social care) and the majority of whom are black (in Brazil). These women have increased work loads and working in intense conditions, and in doing so have put their lives on the line to care for COVID-19 patients in the last year, often doing so without adequate PPE or training. The effects of these work conditions have led to increased anxiety and burnout amongst HCW, as well as physical violence on them within communities. For some HCW, such as ASHAs in India this work is unpaid or underpaid (10-12 USD/month), despite the considerable during COVID the work being beyond their capacity, and the added physical and mental burden.
- Many paid care workers are migrant women, such as in health and social care, as well as as domestic workers. This is all true of other forms of undervalued labour performed by women, including waste pickers. These workers rights need to be protected during a crisis, recognised as essential workers so as to protect safe working conditions, and fair employment standards.
- Unpaid care work which occurs within homes and societies, which women have absorbed as a result of government introduced COVID-19 response policies (i.e. lockdown, school closures). It is thought this might be as much as 49% increase in domestic load for women. This has resulted in many women being forced out of the workforce. Childcare is a vital part of public infrastructure which must be a focus of recovery efforts.

“During the pandemic female community ASHA workers have played a major role, working 6-7 hours a day, putting themselves at risk for \$10-12 a month. We cannot call it paid work, it is unpaid work.”

Ms Surekha, India

Theme 3: Violence

“In the pandemic we have seen an increase in girls and women with disabilities as victims of violence by family members and neighbors.”

Dr Livia Istania Iskandar, Indonesia

Key message: COVID-19 exacerbates violence within households, communities and societies, particularly against women, yet women also bear increased burden of violence mitigation efforts.

Detail: Loss of livelihoods, restricted movement, limited access to health, disrupted social networks have all contributed to the high rates of Intimate partner violence amongst young women, high rates of violence against children and huge burden of domestic work among adolescent girls who have been at home due to school closures. For example, in Kenya, this increased by over 40%.

It is vital to be cognisant of the role community structures such as community gatekeepers, community health volunteers, mentors absorb in responding to GBV, IPV, and VAC. Yet many support services were limited by mobility restrictions imposed by pandemic.

Women's participation in peace movements against traditional forms of violence have also been pivotal to COVID-19 response, notably in the negotiation of ceasefires to facilitate distribution of PPE, food packages and beyond. But this labour is unrecognised and unsupported, compounded by reduction resources available to peacebuilding organisations during the pandemic. Similarly, in refugee camps and humanitarian settings women's access to health and resources has been further compounded by the pandemic, and women's labour in these settings is undervalued.

Theme 4: Better data, better policies

Key message: We do not have good quality data on the gendered effects of the pandemic - either epidemiological or socio-economic. This inhibits meaningful decision making.

Detail: Being able to identify the gendered effects of the pandemic relies on good quality data, and for all data to be sex/gender disaggregated. We know that currently only 19% of epidemiological case data is sex-disaggregated when reported to WHO. Moreover, most socio-economic data produced by governments and international organisations are not disaggregated. Thus, we often rely on survey or aggregate data sets to understand the crisis, but the most vulnerable populations are often excluded from such data sources, compounded during covid where participation may be reliant on phone or internet access. There are other data for which we have not been able to reliably collect, such as gender-based violence data, for which proxy indicators are used. Moreover, we need to not only consider gender variables, but ensure that race, ethnicity, location, age and socio-economic indicators are considered simultaneously.

Better data will help inform decision-making, as will having a more diverse decision-making group. Greater participation of civil society can ensure that policymakers understand the realities on the ground, and the effects of policy interventions. Not only do we need greater participation of women and marginalized groups in policymaking, but we must also ensure policies are gender mainstreamed as standard. The lack of meaningful gender consideration within the International Health Regulations, is of particular concern, and this should be

central to any future pandemic treaty. These could be a key step to hold governments to account for recognising and mitigating gender inequalities in pandemic preparedness and response.

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