COVID-19 AND GENDER EQUALITY: WHAT WE KNOW SO FAR

Key messages for IPPF Member Associations

Gender equality—the concept that all individuals should be treated in a way that ensures equal opportunities and outcomes—is a human right. The highest attainable standard of sexual and reproductive health is not possible without gender equality. This has been recognized at the international policy level. For example, the Sustainable Development Goals recognize that sustainable development cannot be achieved without gender equality.[i]

Yet, there is still a long way for duty-bearers to respect, promote, and realize this human right. This shortcoming has become even more visible today. Policies, strategies, and plans implemented up to date to respond to the COVID-19 pandemic require further analysis from a gender lens to the effect of the pandemic on individuals in all their diversity. This data is critical for designing and implementing successful, effective, and equitable policies.

International Planned Parenthood Federation (IPPF) and the Member Associations are leading actors in promoting **Sexual and Reproductive Health and Rights and Gender Equality**—including during crisis situation —it is fundamental to be fully informed about the consequences that the COVID-19 response has had (and will have) from a gender perspective and be ready to adapt existing strategies to meet emerging needs.

COVID-19: A RAPIDLY EVOLVING EPIDEMIC

COVID-19 is an infectious disease caused by the most recently discovered coronavirus. The outbreak of the virus began in Wuhan city, Hubei Province, in China, in December 2019. After assessing the alarming levels of spread and severity of the virus, on 11 March 2020 the Director-General of the World Health Organization (WHO) declared COVID-19 as a pandemic.[ii] [iii]

People who are infected experience symptoms that are usually mild; others may not develop any symptoms at all. However, around 1 out of 6 people become seriously ill and can develop difficulties in breathing. Older people and people with underlying medical conditions are more likely to become seriously ill and to present a higher mortality rate.[iv] The disease spreads either from person to person through droplets from the nose or mouth from a person with COVID-19, or when these droplets land on surfaces which are touched by other people who later touch their eyes, nose, or mouth.[v] This is why social distancing and regularly washing hands with soap are key measures to deter infection.

RESPONDING TO COVID-19

After the pandemic was declared, governments around the world adopted measures to limit the public health impact of COVID-19. To implement those measures, several countries declared a State of Emergency, which gave national governments provisional extraordinary powers to react to the pandemic.

Common measures implemented under a state of emergency restrict people's freedom of movement through the imposition of quarantines, lockdowns, and curfews. Examples include, closing of educational institutions, and majority of private and public employees working from home. Likewise, health authorities have prioritized their limited resources for emergency departments, infectious disease units, and intensive care units. The implementation of these measures is intended to non-

discriminatory and respect human dignity. However, at this early stage of the response, there is already evidence suggesting that these measures might aggravate gender inequality and disproportionally affect women and girls and marginalised groups.[vi]

COVID-19: ANALYSIS FROM A GENDER PERSPECTIVE

Evidence from China, Italy, and Spain, among other affected countries, suggests that the mortality rate of COVID-19 is higher among men than women. In China, the mortality rate has been 2.8% for men and 1.7% for women. Likewise, in Italy men register 71% of all deaths, while in Spain, the number of deaths in men is double that of women.[vii] Although some hypotheses refer to biological differences and lifestyle factors to explain this trend, scientists and health experts have not yet identified underlying factors for the pattern.

On the other hand, the disproportionate impact of COVID-19 on women is not reduced just to the health consequences of the virus. In reality, women and girls are also significantly impacted by social and economic measures adopted by policymakers.

At risk: Sexual and reproductive health and rights

Sexual and reproductive health services and commodities—including those related to fertility management, maternal health, STIs including HIV, and abortion—are interlinked with human rights, gender equality, and human dignity. Considering mobility restrictions, supply chains, and logistic challenges to respond to the COVID-19 pandemic, the consequences of the virus will disproportionally affect some individuals, particularly left behind populations, including on the basis of of gender identity, status, disability, age, sexual orientation and other factors.

DKT International, for example, one of the largest providers of family planning products in the world, reported that the supply of raw material such progesterone was impacted after China closed down some factories during the height of COVID-19 in the country. Likewise, DKT has also alerted that there are stock-outs of contraceptive implants in Myanmar, and shortages of condoms in Mozambique.[viii]

Closer to home, a recent survey of the impact of COVID-19 on IPPF Member Associations showed that 41 out of the 92 who participated had scaled down on service delivery for sexual and gender-based violence (SGBV). Further, 40% were experiencing commodity shortages, including contraceptives, safe abortion, and HIV-related medicines. There are already signs of scale down on HIV services within Member Associations. The subsequent dismissal of skilled staff will have a significant impact across services and will have an effect on survivors of intimate partner violence, reproductive coercion, and other forms of SGBV.

Globally, the pandemic is being used as an opportunity to threaten sexual and reproductive health and rights. For example, this can be seen in the United States: in Ohio, the Attorney General's office ordered clinics that provide abortions to stop 'non-essential' and 'elective' surgical abortions. Abortion clinics, as well as different organizations, are raising their voice defending abortion as essential and lifesaving healthcare. A pandemic cannot be used as an excuse to undermine women's rights, to make decisions regarding their reproductive and health rights, or to regress in the implementation of hard-fought sexual and reproductive health programmes. The consequences of these measures will probably be evident in a peak of unintended pregnancies and in the use of unsafe abortion methods exposing pregnant women and girls to real risk.[ix]

Furthermore, for pregnancies and childbirth during this period of overstretched medical capacities, women and girls have been advised to avoid visiting health facilities as a prevention and protective measure against COVID-19. However, this measure also imperils women and girls, especially because monthly to weekly interactions are needed for prenatal care.

While some countries already have telemedicine and other forms of remote consultation, others are still behind in the use of innovative models of service delivery due to lack of resources, funding, and qualified staff. Even when this type of service is available, clients may not have access to the necessary resources, to benefit from this innovation. The reality is that millions of individuals do not have access to internet,
do not have a computer at home or do not have access to the relevant devices (e.g. Smartphones). According to data from the International Telecommunication Union from the UN, 93% of the global population within reach of mobile broadband (3G network or higher), and yet 3.6 billion people remain offline.[x] In addition, there is, currently, a lack of insurance coverage for telemedicine and other models of not-in-person care which poses a larger barrier in accessing healthcare for women and girls during this pandemic.[xi] Another obstacle is that, in many settings, women and girls work in formal and information sectors and have lost their jobs. As a result, they have lost their insurance and/or income that would help pay for healthcare services during and after their pregnancies. This also makes them more exposed to economic violence in their relationships.

Sexual and Gender-Based Violence (SGBV): more present than ever

Since the global inception of lockdown measures, early evidence has shown that SGBV, including intimate partner violence, has increased. Those who experience SGBV are now isolated with their perpetrators, unable to leave and get support. This is concerning as SGBV survivors will be exposed to repeated violence and abuse without healthcare support for the whole duration of the lockdowns and restriction of movement.

Through past experiences of global crises and pandemics, it is globally recognized that women and girls, as well as the LGBTQI+ population, face a heightened risk and exposure to SGBV. This was evident during the previous Ebola outbreak in West Africa in 2014 to 2016; several reports were published denouncing sexual exploitation of women and girls by state officials. For example, in Liberia, Guinea, and Sierra Leone, armed forces and community members responsible for enforcing the quarantine were accused of sexual assault.[xii] When there are gender inequalities and perpetrators are able to act with impunity, women and girls experience SGBV at alarming rates.

Care: a differentiated division of labour

According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO) over 160 countries have implemented nationwide or localized closures of schools and education centres, impacting around 87% of the world's student population.[xiii] These measures to control the spread of COVID-19 have resulted in nearly 300 million students globally missing class, and many of those are undertaking distance learning education.[xiv] This ad-hoc situation also has a significant impact on children who are already left behind or at risk of domestic violence.

With educational systems closed, children are now at home for the entire day. Given women's traditional role of care providers within their families, women are expected to support their children with their distance learning education, run recreational activities and provide food and comfort. This has added additional responsibilities for women and girls who are already overstretched with the full-

time responsibilities of their regular jobs and/or with the unpaid work at home. These extra responsibilities, together with the uneven distribution of household chores, have heightened women's domestic burden. Likewise, due to gender roles, girls might be expected to help their mother either with household chores, with the care of their siblings and the elderly, limiting their access to join remote learning programmes (where the family has the required technology to participate in remote learning).

Different reports over the years have pointed to the fact that women and girls already do most of the world's unpaid care work. According to the International Labour Organization (ILO), women perform 76.2% of total hours of unpaid care work. This is more than three times as much as men, and in some continents this number rises up to 80%. In Chile, the Sol Foundation recently published a study called 'It is not love, it is unpaid work' analysing women's roles in Chile and how this pandemic has revealed the precarious conditions faced by women in the labour market, as well as inside their homes.

Gender differences in the health sector

Today, it is important to highlight the gendered nature of the health workforce. Globally, women represent 70% of the health and social workforce[xv] and comprise the main part of the primary healthcare workforce. Women are, thus, on the frontline of the response to the COVID-19 crisis. Data from the State Council Information Office in China showed that more than half of the doctors and 90% of the nurses in Hubei Province are women.[xvi] In the United States, women represent 78% of the workforce in the healthcare sector[xvii] and 84.5% of the nurses in Spain.[xviii] According to the WHO Regional Office for Europe, the salaries of nurses and midwives are still below the national salary average in many European countries. Also, nurses receive lower payment than employees in comparable public services that are more male-dominated.[xix] In Africa, gender disparities mean that only 30%[xx] of science professionals in sub-Saharan Africa are women (i.e. the chances of getting into university are five times lower for women than for men in countries such as Nigeria[xxi]). Despite this, it is important to highlight that women participate actively as community health workers and in other health related positions.

Although women represent the majority of the workforce in the healthcare sector in general, and in the COVID-19 response in particular, they have been underrepresented in spaces of decision-making. The design and planning of interventions have been mostly dominated by men. UN Women pointed out that this issue results from the fact that women do not enjoy the same degree of participation in major decision-making bodies as men, including those related to public health. For instance, women represent only 25% of parliamentarians worldwide, less than 10% of Heads of State or Government, and only 20.7% of government ministers.[xxii]

RECOMMENDATIONS: GENDER TRANSFORMATIVE WORK IN THE TIMES OF COVID-19

IPPF Member Associations have a major role to play in the integration of a gender lens in the COVID-19 response. This can be done by ensuring continued provision of rights based and gender responsive services, creating awareness among health authorities and the general public about the connection between COVID-19 and gender equality, as well as amplifying the above gender concerns into advocacy strategies.

All efforts implemented by Member Associations should consider the principles of no harm and consideration of intersectionality. While it is true that any person can be infected with COVID-19, women and individuals who do not conform to traditional gender roles, from low income countries or in a situation of vulnerability in middle/high income countries, may experience additional short and long-

term impacts on their health and economic capacity. In addition, Member Associations should identify alternative mechanisms to guarantee the active participation of individuals in all their diversity in the development and implementation of solutions to face COVID-19.[1] Following are suggested actions:

Delivery of gender responsive health services

⇒ Design a gendered response to COVID-19 in which individual's differential vulnerability to infection, exposure to pathogens, and treatment are taken into account.

⇒ Implement a mapping of populations most affected by COVID-19, aiming to understand their specific sexual and reproductive health needs and how they are affected by gender inequalities; taking into account the fact that while the consequences of COVID-19 may be greater for those who are already left behind, new populations may be pushed to situations of risk and vulnerability.

⇒ Continue with the provision of the Integrated Package of Essential Services (or the Minimum Initial Service Package, depending on the contexts) and other psychosocial/mental health services, and adapt service delivery models to the current circumstances (quarantine, lockdown, and curfew).
  - Telemedicine, videoconferences, or phone calls may enable some pregnant women to stay at home while accessing their right to health. Ensure that these approaches are not to keep women away from health facilities but done in aco-ordinated and gender sensitive manner.

⇒ Guarantee availability of sexual and reproductive health service commodities, including those related to the prevention of unintended pregnancies.
  - Ensure the implementation of adequate measures, including those related to safety and protection, during the delivery of these commodities.

⇒ Complete a service mapping and referral pathway so that community members know where to go for sexual and reproductive health support; Ensure the referral pathway is kept up to date and community members can access it through IEC materials.

Enabling public health services

⇒ Document the consequences of measures undertaken by national governments, with particular attention to;
  - the differentiated economic and care impacts and barriers that women face in accessing essential healthcare, and incidence of intimate and sexual violence (ensuring data is collected in a safe and ethical way). Call attention to discriminatory policies limit women's access to care and remove administrative and legal barriers preventing women and girls' from reaching the health and services they need.

⇒ Coordinate with national, regional, and local public health authorities and other relevant stakeholders to ensure the continued for the provision of sexual and reproductive health services, including SGBV related services. Mapping actors, programmes, resources, and locations will facilitate the identification of gaps and alternatives to fill those gaps.

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[1] Some examples include (though not limited to) female-headed households, adolescent girls, refugees, internally displaced persons, (IDPs), migrants ; homeless & those sleeping rough, Indigenous women, women living in poverty, The immunocompromised • Other social and gender minority groups, such as disabled people and LGBTQI+ individuals. A contextual approach is critical in ensuring that who face multiple vulnerabilities are prioritised.

Advocacy

⇒ Advocate for improvements in collecting age and gender-disaggregated data for gender analysis and thereby implement evidence informed intervention.

⇒ Advocate to ensure mitigation measures are in place to decrease the burden on primary healthcare structures due to COVID-19 and do not translate into restrictions in accessing sexual and reproductive health services.

⇒ Develop an advocacy strategy to ensure that policies and interventions responding to COVID-19 (during the pandemic and in the recovery phase) meet everyone's needs, especially women and girls and underserved populations by avoiding one-size-fits-all solutions. While lockdowns may create challenges to developing the strategy in a participatory way, Member Associations are encouraged to identify alternatives to bring input and buy-in from community members and other stakeholders (for example, by implementing phone consultations).

⇒ Advocate for support alternatives for women working from home and who have children and other relatives to care for. Call on international stakeholders to guarantee that the COVID-19 response cannot be utilized to perpetuate harmful gender norms, discriminatory practices, and policies or measures that reinforce or perpetuate gender inequalities and discrimination of any form.

⇒ Raise awareness and mobilize decisionmakers and other stakeholders to support and guarantee the inclusion of women in all decision-making spaces and phases of the outbreak preparedness and response. Women are front-line first responders, therefore, they have closer proximity with the infected population, which means they incur greater risks to their own health. They also have equal rights as men to participate in public health decisions.

⇒ Utilize every opportunity and media – including tv, radio, print and especially social media to promote SRH to the people.

⇒ Be vigilant, step up advocacy to end cyberviolence against women and girls linked to online resources during this lockdown.

For further guidance and support, please reach out to your IPPF gender working group:

ARO – Nathalie Nkoume - NNkoume@ippfaro.org
AWRO – Ghita Antra - spa@ippf.org.tn
CO/Humanitarian - Elizabeth Bartolomucci-Hughes**-** EBHughes@ippf.org
CO – Seri Wendoh – swendoh@ippf.org
EN – Koen - KBlock@ippfen.org
ESEAOR – Sangeetha Permalsamy - spermalsamy@ippfeseaor.org
SARO - Aprajita Mukherjee **-** AMukherjee@ippf.org
WHR - Susana Medina Salas **-** smedina@ippfwhr.org

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