COVID-19 Micro Briefing 2: Consequences of the COVID-19 pandemic: exploring the unequal social and economic burden on women.

May 2021

INTRODUCTION

Evidence is clear that, once infected with COVID-19, the risks of becoming seriously ill or dying are higher for men than for women[1 2]. Women may be at greater risk of developing long-term impacts or complications arising from the disease; further research is needed on this[3]. In broader terms than clinical risk, however – what has become apparent is that women are more likely to bear the brunt of the adverse social and economic consequences of the pandemic[4 5].

The impacts of COVID-19 on women relate to the societal, economic and familial roles that women traditionally occupy and how these intensify existing gender inequalities[6 7]. It is vital that social and economic recovery policy and practice recognise the gendered disparities within the pandemic[8] and respond in ways which challenge existing gender characterisations and address longstanding inequalities; promoting inclusion, participation, choice, opportunity and empowerment among women[9].

This paper presents evidence on some of the key issues and mechanisms through which the pandemic has disproportionately impacted on women.

The evidence is centred around seven themes:

(1) pandemic attitudes and impacts to mental health
(2) essential workers
(3) unpaid, informal care and household duties
(4) economic hardship
(5) violence against women
(6) priority groups, and
(7) power and decision-making.

KEY POINTS

1. Evidence suggests that the mental health impacts of the pandemic are worse for women than men. Women are more likely to be essential workers in the health, care, education and retail sectors - facing higher exposure to COVID-19, increased stress and difficulty reconciling work, family life and care responsibilities.

2. Lockdowns have enabled increased intimate partner violence against women. Women have also taken on a disproportionate share of additional unpaid care and increased household duties during lockdowns in comparison to men.

3. The adverse economic impacts of the pandemic interact with and exacerbate existing gender employment inequalities. Lone mothers and guardians, Black, Asian and minority ethnic women and disabled women are priority groups, among others, experiencing some of the worst social, economic and clinical impacts of the pandemic.

4. Women are under-represented in pandemic task forces and decision-making bodies. Failure to incorporate a gendered perspective within pandemic recovery efforts will deepen existing gender inequalities and worsen outcomes for women.

EVIDENCE REVIEW: MAIN POINTS

1. Pandemic attitudes and impacts to mental health. A representative UK study reports that the mental health impacts of the pandemic are worse for women compared to men[10]. Across metrics relating to anxiety, depression and loneliness, the mental health profile of female study participants was significantly worse than men[10]. Relatedly, female participants were more worried about getting and spreading the virus and perceive the virus as more prevalent and potentially deadly than men do. Within the study, substantially more women – correctly – predicted a new lockdown or virus outbreak by the end of 2020 than men[10]. Women are also more concerned about their income and the current and future state of the UK economy than men and more women choose to donate to food banks[10]. The worsened mental health profile of women during the pandemic reported here is consistent with other studies[11 12] and evidence reviews[13]. The mental health and wellbeing of pregnant and postpartum women is also concerning during the pandemic amid significantly reduced maternity services in some instances[14 15]. Reports suggest pregnant women are concerned about their COVID-19 risk during pregnancy, with some describing significant employer-related stress regarding this issue[16].

2. Essential workers. Lockdown has meant millions of people being confined to their homes, either unable to work or continuing to work digitally[17]. This does not include workers referred to as essential, who continued their jobs on the 'frontline' of the pandemic[18]. This group includes workers in the health and care sector, a range of support services, education, supermarkets, banks and pharmacies. Essential workers have faced significant additional hardship during the pandemic and women are over-represented in the workforces of all these sectors[19]. This is because some of these essential roles are more conducive to part-time working to fit around family and care commitments which tend to fall to women[20]. Due to gender stereotypes women are also more likely to occupy traditional caring roles within society[21]. Essential workers face additional exposure to COVID-19 as they continue to travel to work and interact with patients, clients or customers; social distancing is near impossible in some health and care roles[22]. On average, the COVID-19 death rate for essential workers between March and December 2020 was 40% higher than for the average working age person[23]. Women made up 78% of healthcare workers across Europe in 2019[24]; and thus women have acquired more than double the share (71%) of COVID-19 infection among healthcare workers globally, in comparison to men (29%)[25].

The increased exposure to COVID-19 and the challenging delivery of healthcare during the pandemic presents additional psychological burden for healthcare workers[26]. During acute waves of the pandemic, healthcare workers have endured longer working hours, in unfamiliar settings, and significant numbers have been exposed to 'moral injury' or trauma when providing care for severely unwell patients with constrained or inadequate resources[26]. Many have reported difficulty reconciling work, family life and care responsibilities[27]. Several quality studies, systematic reviews and meta-analyses have reported increased stress, anxiety, and depressive symptoms among healthcare workers, with women consistently demonstrating the worst of these impacts[28-30].

Across Europe 83% of care workers are women; providing vital home-based professional care to older people and people with disabilities[31]. These essential care workers also face increased exposure to COVID-19 and have endured a range of adverse impacts to mental health and wellbeing during the pandemic[19 32] although the mental health impacts of the pandemic on care workers is markedly less researched than that of healthcare workers. Care workers had a COVID-19 death rate over three times higher than the average working age person, yet their hourly earnings are nearly 30% below the median[23]. Importantly the adverse impacts of the pandemic on care workers interact with and are exacerbated by existing inequalities, economic hardship and income insecurity within the sector[33 34]. It is generally recognised that the care sector is comprised of some of the most undervalued, underpaid, and precarious roles in society[35 36]. Many care workers report significant fears of contracting COVID-19 and the consequent income uncertainty and insecurity that infection would bring[37].

3. Unpaid, informal care and household duties. The approximate 6.5 million unpaid, informal carers in the UK provide a pivotal role in society which could not be met by public services; looking after an ill, older or disabled family member, friend or partner[38]. In public health emergencies, informal home care providers are a crucial human resource that improves the community's healthcare capacity and reduces the burden on healthcare systems[39]. Some 58% of all carers in the UK are women, and women undertake more intensive informal care

roles; 72% of people receiving Carer's Allowance for caring 35 hours or more a week are female[38]. Some sections of the carers community are more likely to experience poverty[40] and to experience mental health issues (particularly employed women with high levels of care responsibilities[41]) in comparison to the general population. The interaction of these existing issues with the pressures of the pandemic is likely to create hidden needs among the unpaid, informal carer population, demanding specific research and policy priority[42].

The closure of many workplaces and schools during lockdowns has significantly increased the levels of unpaid work for women in many countries[43 44]. During lockdowns, European women increased their household duties by a third to 18.4 hours per week on average, compared to men who almost doubled their household duties to 12.1 hours per week[45]. Unequal increases in unpaid care, combined with women taking on substantially more home schooling responsibility than men has resulted in higher levels of psychological distress for women[46]. The combination of these issues may lead to reduced productivity among mothers working from home which could reduce their career progression and pay, reinforcing long standing employment inequalities[47].

4. Economic hardship. The pandemic has led to an economic downturn which is acutely felt in lower income households and has differential consequences for women and men in the labour market[48]. COVID-19 has led to a larger drop in working hours than after the 2008 financial crisis, and the fall in hours was greater for women than for men in almost all European countries[31]. Despite rising employment rates in summer 2020 as many sectors resumed business, men gained more than twice as many available jobs as women[49]. Evidence shows that the economic impact of the pandemic is having longer lasting effects for women[50], although more research and analysis is needed. Certain essential roles within society, such as domestic workers, are comprised almost entirely of women (95% of domestic workers across Europe are women) within precarious roles which are highly vulnerable to economic shocks[51]. Many domestic workers are migrants and are undeclared workers in the informal economy, possessing no or little knowledge of their rights and how to seek support during the pandemic[52].

5. Violence against women. COVID-19 lockdowns have directly led to spikes in reports of violence against women globally[53]. A 60% increase in emergency calls from women subjected to violence by their intimate partner has been reported in the World Health Organization (WHO) Europe member states[54]. Comparing April 2020 with the same period in 2019, WHO reported that online inquiries to violence prevention support hotlines had also increased as much as fivefold[54]. Across the literature reviewed, household stress appears to be the crosscutting pathway through which men are becoming more violent towards women[55]. As people stay at home, families spend more time in close contact, including in cramped conditions. Simultaneously, the disruption of livelihoods and income reduces access to basic needs and services, causing additional stress burdens[56]. There is a well-established socioeconomic patterning to physical violence against women, where women in disadvantaged areas are at higher risk; the impacts of the pandemic on this relationship requires further investigation[57]. There has also been reports of increased violence against women who are sex workers, and the perception that such women are 'vectors of COVID-19 transmission' during the pandemic; this requires further study[58].

During the pandemic, family, friends and neighbours become more remote and less likely to spot signs of abuse[59]. In addition, the pandemic has presented several new barriers for victims of intimate partner violence to find help[60]. Violence support services were often closed or operating at reduced capacity[61]. Services also face increased demand and heightened distress and vulnerability of victims; challenges in adapting to remote support whilst maintaining victim confidentiality and safety; difficulties maintaining quality of support - assessing victim's level of risk and developing trust without meeting face to face[62]; and maintaining work-life boundaries and managing increasing levels of stress among support staff within the violence against women sector[63].

6. Priority groups.

Lone mothers or female guardians. Within the UK there are approximately 2.9 million lone parents, around 90% of whom are women[64]. Proportions of people from Black, Asian and minority ethnic (BAME) backgrounds and people with disabilities are higher among lone parent families compared to couple families[64]. Lone parent or guardian families have experienced some of the worst social and economic impacts of the pandemic across

society[65] including high levels of social isolation[66]. A range of studies describe how lone mothers (or lone female guardians) report the, at times overwhelming, strain of coping on their own with reduced or insecure income, ongoing work commitments, home schooling and additional childcare, increased household duties and reduced support from family and friends amid restrictions[12 67 68].

Black, Asian and minority ethnic (BAME) women. Multiple studies have confirmed that BAME populations, including women, experience worsened COVID-19 outcomes compared to white populations[69 70]. Pregnant women admitted to hospital with COVID-19 are more likely to be of BAME background[71]. In clinical terms this has been attributed to elevated levels of pre-existing conditions such as hypertension, cardiovascular disease, diabetes and obesity among BAME groups[72 73]. However, the dominant characteristic in the societal patterning of these risk factors is socioeconomic[74]; thus, many have argued that the origins of COVID's disproportionate clinical impact on BAME populations most likely lies in structurally determined racial inequalities[75]. Relatedly, BAME women are more likely to be employed within roles and sectors which experience higher COVID exposure and reduced safety measures[76]. BAME women, particularly migrants and asylum seekers may experience barriers in accessing pandemic public health messaging, COVID-19 testing and related health services[71].

Disabled women. A variety of mechanisms explain the disproportionate impact of the pandemic among disabled populations, including women[77]. Disabled people experience elevated clinical risk; the worsening of existing poverty and inequalities; barriers in accessing vital services including COVID-19 testing; and the disruption of vital healthcare and other services[78]. The unintended impacts of lockdowns are acutely felt by disabled women who have high rates of existing common mental disorders, are more likely to be socially isolated and to be digitally excluded[78]. Sources report that disabled women have experienced higher levels of abuse and violence during the pandemic, although this topic has received little attention[79].

7. Power and decision making. Little is known about the gendered differences in national leaders adapting to and managing national crises. However, analysis relating to 194 countries reveals that women-led countries performed better in COVID-19 outcomes, particularly in terms of preventing deaths[80]. Key factors here were that female leaders deployed risk averse, proactive policy responses, especially in initiating lockdowns more quickly than in male-led countries[80]. This analysis uses a credible approach but relates only to the initial responses of national leaders and initial outcomes; findings must be treated with caution at this stage. Despite the evidenced increased burden on women in terms of their lived experience of the social and economic impacts, a noticeable lack of women in COVID-19 decision-making bodies has been reported. A 2021 report by the European Union (EU) found that men significantly outnumber women in the bodies created to respond to the pandemic[51]. Of 115 national dedicated COVID-19 task forces surveyed across 87 countries, including 17 EU Member States, 85.2% were mainly comprised of men, 11.4% comprised mainly women, and only 3.5% had gender parity. At the political level, just under 30% of health ministers in the EU are women[51].

IMPLICATIONS OF THE EVIDENCE REVIEWED

INEQUALITIES

COVID-19 has delivered a shockwave to existing gender systems that, if adequately supported, could recalibrate gender roles, with positive impacts to population health. Failure to incorporate a gendered perspective within pandemic recovery efforts will deepen existing gender inequalities and worsen outcomes for women.

POLICY

The policy landscape, economic and market forces and embedded cultural norms that determine the distribution of paid and unpaid work across society are powerful structural determinants of health. The ways in which paid (including underpaid and precarious roles) and unpaid labour is unfairly divided between men and women is central to the continuation of societal gender inequalities, and the gender-differentiated effects of COVID-19 on health and wellbeing. Addressing these issues should be a central policy objective.

Policy responses to the pandemic must keep pace with the social and economic experiences of women during lockdowns. The increased levels of intimate partner violence against women requires immediate national policy action alongside increased support for frontline women's support services in the public and third sector. Health

care workers and professional and informal carers (the majority of whom are women) provide an essential role in society which has been underscored by the pandemic. Yet, other than the markedly higher COVID-19 death rate, it is our experience that the impacts of the pandemic on carers are not well understood and thus may become a policy omission unless specific action is taken. In broader terms, regulation to increase pay within the care sector would both reduce economic hardship in a vital sector and contribute towards addressing gender income inequalities. Financial support for lone parents to assist with childcare, rent payments and other household expenses could help to mitigate some of the mental health impacts and financial difficulties, especially in light of potential job losses in relation to the pandemic.

These issues, among others, highlight the limitations of current economic policy and the resulting adverse human impacts and strains particularly for women, which were intensified during the pandemic. A caring economy is an alternative economic model which aims to simultaneously ensure achievement of gender equality, sustainability and wellbeing; and has clear implications for inclusive and fair social and economic recovery from the pandemic[81].

PRACTICE

The lived experiences, wisdom and insights of women of all ages and backgrounds must inform local pandemic service responses and social and economic recovery efforts. The gender impacts of the pandemic must become an enduring consideration in all recovery related services and community-based support.

Women's support services can play a vital role in responding to the gendered impacts of the pandemic but also in terms of representing the views of their service users within pandemic response planning. Challenging gender stereotypes and increasing the representation of women in pandemic decision-making bodies, senior roles and within political and democratic structures could help to ensure that women have an opportunity to shape important strategic pandemic decision making and service delivery.

FUTURE RESEARCH

We have identified a number of groups of women, where significantly more research is required to understand the nature of the impacts of the pandemic on their lives, and thus develop more effective policy and practice to support them within recovery efforts. These groups include: pregnant and postpartum women; women experiencing intimate partner violence; female sex workers; lone mothers and female guardians; BAME women; and disabled women.

Specifically, further research is needed to understand the long-term, gendered impacts of psychological stress and trauma on healthcare workers and carers (paid and informal) during COVID-19 and how best to support these essential roles during and after the pandemic.

Through this evidence review we have observed exclusively binary conceptualisations of gender which must be challenged as this does not reflect a modern and inclusive society. The impacts of the pandemic on, for example, trans women and LGBTQ+ women has not been well studied. Relatedly, it is crucial that researchers adopt an intersectional lens to address systemic inequalities in the wake of COVID-19. This will enable the development of policies and legislation that adequately address the complex interactions of, for example, gender, ethnicity, disability and precarious employment within pandemic inequalities.

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MICRO BRIEFINGS: PURPOSE AND APPROACH

The Glasgow Centre for Population Health and Policy Scotland have developed a series of COVID-19 'micro briefings' written in collaboration with expert partner agencies. They are intended to support a range of partners and decision makers by providing concise, accessible overviews of current evidence concerning complex and evolving issues relating to the COVID-19 pandemic.

This micro briefing has been written with the Glasgow Women's Voluntary Sector Network and Wise Women. The Network aims to bring together women from across Glasgow to provide a forum for the sharing of information and mutual support to raise awareness of and advocate for the alleviation of social exclusion and discrimination faced by women in Glasgow. Wise Women is a charity that aims to address women's fears and experiences of crime and violence through the provision of Personal Safety and Confidence Building courses and workshops in local Glasgow communities.

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