SPOTLIGHT ON GENDER, COVID-19 AND THE SDGS

WILL THE PANDEMIC DERAIL HARD-WON PROGRESS ON GENDER EQUALITY?

COVID-19 RESPONSE

UN WOMEN | WOMEN COUNT

ACKNOWLEDGEMENTS

This Spotlight is a joint product of UN Women and the Gender and COVID-19 Working Group. It was written by Ginette Azcona and Antra Bhatt (UN Women), and Sara E. Davies (Griffith University), Sophie Harman (Queen Mary University of London), Julia Smith (Simon Fraser University) and Clare Wenham (London School of Economics and Political Science). The authors would like to acknowledge the valuable comments and inputs from Priya Alvarez (UN Women), Emma-Louise Anderson (University of Leeds), Nazneen Damji (UN Women), Gaëlle Ferrant (OECD), Rosina Gammarano (ILO), Steve Kapsos (ILO), Ann Beth Moller (WHO), Amy Patterson (The University of the South), and Papa Seck (UN Women). They are also grateful for the excellent research analysis support by Guillem Fortuny and research assistance by Julia Brauchle and Gabrielle Leite. The work of Sara Davies, Sophie Harman, Julia Smith and Clare Wenham was supported by the Canadian Institutes of Health Research under grant OV7-170639 and by The Leverhulme Trust.

Editor: Catharine Way

Design: Benussi & The Fish

COVID-19: HEALTH AND BEYOND

COVID-19 has been declared a public health emergency of international concern and a global pandemic by the World Health Organization. This global threat to health security underscores the urgent need to accelerate progress on achieving Sustainable Development Goal (SDG) 3, particularly Target 3.D, which calls for improving early warning systems for global health risks, as well as reduction and management of such risks.[1] The pandemic highlights the need to massively scale up international cooperation to deliver on SDG 3. It also reveals what is less obvious, but no less urgent: how health emergencies such as COVID-19, and the response to them, can exacerbate gender inequality and derail hard-won progress not only on SDG 3 but on all of the SDGs.

To date, more men than women have died from COVID-19. Lack of data on testing and infection rates by sex, however, leaves many questions unanswered, including on risks and exposure among different groups of women and men, particularly those from marginalized communities. As more disaggregated data become available and testing expands, it is important to revisit the gendered effects of COVID-19, including by analysing sex-disaggregated statistics on fatalities. In tandem, the gendered economic and social impacts of the pandemic also need attention as they are already predicted to bring more and broader harm to women and girls, exposing and reinforcing entrenched gender norms and inequalities.[2] This impact will continue for generations, and if unchecked it could reverse gains in gender equality and poverty alleviation in many countries.

The SDGs, gender and health

COVID-19 brings into sharp focus the gendered aspect of pandemics, and the knock-on effects of the outbreak and response on the SDGs. This Spotlight presents the latest evidence on the gendered impact of the pandemic, highlights potential and emerging trends, and reflects on the long-term impact of the crisis on the achievement of the 2030 Agenda for Sustainable Development.

First, it presents key facts and figures relating to the gendered impacts of COVID-19. Second, it reflects on the health impacts of COVID-19 on SDG 3 targets. Third, it explores the socioeconomic and political implications of COVID-19 on women and gender across five of the Goals: SDG 1 (poverty), 4 (quality education), 5 (gender equality), 8 (decent work and economic growth) and 10 (reduced inequalities). Fourth, it addresses the intersection of COVID-19 and other inequalities, showcasing the close links with SDGs 5, 6, 10 and 11. The Spotlight concludes by outlining policy priorities drawn from the evidence presented.

The 2030 Agenda presents a potentially transformative framework for urgent change throughout the world. Adopted by United Nations Member States in 2015,[3] the Agenda and its 17 Goals and 169 targets acknowledge the relationship among peace and security, poverty and inequality, economic growth, and environmental protection and mitigation. SDG 3 encompasses a set of hugely ambitious health targets that build on the progress of the Millennium Development Goals, which concluded in 2015.[4] The Agenda goes further by including broad and diverse global health challenges. It encompasses the main drivers of inequality, mortality and morbidity and calls for countries to build sustainable health systems for the future.

SDG 5, which addresses gender equality and the empowerment of women and girls, is equally comprehensive and ambitious. Embedded in SDG 5 is the need to break down barriers to gender equality, including by transforming the underlying norms, structures and practices that prevent women and girls from enjoying their rights. Recognized as a core tenet of the 2030 Agenda, gender equality is both a stand-alone goal of sustainable development and a cross-cutting priority for achieving all the SDGs.

The goal of gender equality intersects with SDG 3 in myriad ways. Target 3.1 focuses specifically on reducing maternal mortality, while Target 3.7 addresses universal access to sexual and reproductive health services. Though this should be the concern of both men and women, social norms often leave this responsibility to women. Similarly, Target 3.3 is heavily gendered, given that HIV/AIDS prevalence is higher among women. For example, 61 per cent of people living with HIV/AIDS in sub-Saharan Africa are women.[5]

Universal health coverage and a robust health workforce underpin achievement of SDG 3. Gender cuts across both of these issues. Globally, women make up 70 per cent of health care workers, but they are underrepresented in senior and decision-making roles in most national and global health settings (Target 5.5).[6] This is due to gendered norms regarding women's and men's work (Target 5.4) and structural bias and sexism in the health sector both nationally and globally. This in turn limits women's input into decision-making in health. The concentration of women in lower paid jobs also hampers their economic empowerment and job security and increases their work burden, given their dual responsibility for paid care and unpaid care (for their families and communities).

Achieving universal health coverage requires recognition of how women, men and non-binary people access health services

This is linked to gender norms in terms of who is responsible for the health and well-being of the individual and the household (Target 5.4); how people perceive health services and their rights to access such services (Target 5.6); gender, racial, sexuality and transgender discrimination within health services (Target 10.3); and, in the majority of health systems around the world, the ability to pay for health care and the decisions individuals and families make to pay for it (Target 3.8).

Inclusive practices and solidarity movements such as UN Women's 'HeforShe' are fundamental to realizing Targets 3.1 and 3.7. However, at the core of these targeted areas are women, and how access to health services is influenced by gender norms in societies, as well as by women's political power, location (rural/urban), ethnicity, citizenship and economic status. Gender (in)equality affects the resources available to women to invest in their own health, their agency in decision-making and how their needs are provided for.[7] Similarly, social norms around masculinity may prevent men from seeking health care or encourage them to engage in behaviours that are risky to their health and well-being.

Global health emergencies and responses can and often do exacerbate gender inequality and other forms of inequality.

Finally, though a particular microbe or disease may not discriminate, they exist in societies that do. A woman who is from a minority ethnic group, or who is poor and rural, or who is a refugee, for example, faces heightened health insecurity during a crisis. This comes on top of the food, income and physical insecurity she was already facing.

Lessons learned from past health crises

Previous public health emergencies of international concern in the past decade — such as Ebola in West Africa and Zika in Latin America — further exposed the vulnerability of women and girls and the lasting impact of outbreak response on their health and well-being. They revealed that:

1. Women are more vulnerable to infection as front-line health care workers or carers in the family and community.[8]

2. Women's burdens grow as they often (a) are the focal point of community responses, (b) are the targets of interventions to curtail spread, (c) take part in front-line service delivery or behaviour change initiatives, and (d) take on additional care burdens within the family.[9] Women often embrace these roles despite the harm to their own health, including mental health, well-being and economic security.

3. Women face secondary health impacts in terms of increased maternal mortality and reduced access to sexual and reproductive health services.[10]

4. Public health emergencies can lead to a rise in domestic violence and sexual assault.[11] Quarantine measures such as isolation and stay-at-home orders can be extremely dangerous for victims of domestic abuse. They can exacerbate tensions, increasing abuse and leading to new forms and patterns of it. There is also some evidence of sexual assault by those responsible for guarding people in quarantine.[12]

5. Despite the gendered implications of pandemics and health emergencies, gender experts tend to be excluded from public health interventions. The gender components of outbreaks and their response are often ignored until they become a problem.[13]

Findings from emerging data on COVID-19

The COVID-19 pandemic is causing unimaginable human suffering. As of June 2020, 10 million people had been infected globally and 500,000 people had died.[14] Research suggests that the virus affects all people regardless of age, gender, race/ethnicity, sexual orientation, migration status or location. Yet structural factors within societies result in uneven distribution of cases, deaths and secondary effects of response measures.

In the United States, data from New York City show significantly higher COVID-19 death rates among Black and Latino people compared to white and Asian people.[15] In the United Kingdom, data from England and Wales show that Black women are 4.3 times more likely than white women to die due to COVID-19. The death rate for Bangladeshi/Pakistani women is 3.4 times higher than for white women, and for Indian women it is 2.7 times higher.[16]

These differences in risks of infection and fatalities reflect broader economic and social disparities already in place before the pandemic, including inequalities in living, working, health and social conditions. Public health emergencies often exacerbate long-standing systemic health and social inequalities, including disparities in access to resources needed to protect, prepare and respond to outbreaks. The response to the pandemic must include support for vulnerable groups, including for women and girls who were already at risk due to pre-existing inequalities and who are likely to be disproportionately affected as the pandemic further heightens gender and other forms of inequality in society.

Among reported cases of COVID-19 for which data on age and sex are available, 54 percent are among males. However, once disaggregated by sex and age, older women (85+), account for a greater share of total cases (figure 1).

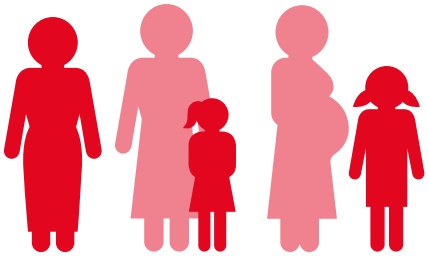
SDGs and COVID-19: Snapshot of key facts and figures

SDG 1: NO POVERTY

Globally, there are at least

193 million

women and girls aged 15+ living on less than $1.90 a day.



The current crisis threatens to trap and push millions more into extreme poverty.

SDG 3: GOOD HEALTH AND WELL-BEING

As of June 2020, more than

10 million

COVID-19 cases have been recorded

and more than

500,000

have died.

Infections among female health care workers are

up to

3x

higher than among their male counterparts.

Women's access to sexual and reproductive health services may be disrupted as resources are diverted to respond to the health emergency.

Already, before the pandemic

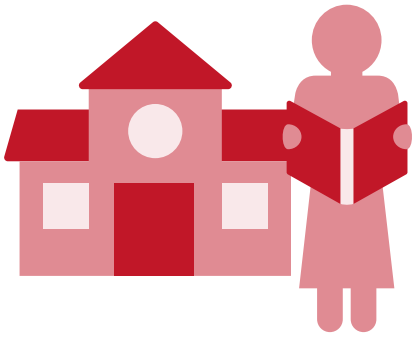
810

women died from preventable causes related to pregnancy and childbirth every day.

SDG 4: QUALITY EDUCATION

Nearly **743 million**

girls are out of school due to closures resulting from the pandemic.



Over 111 million live in least-developed countries.

SDG 5: GENDER EQUALITY

243 million

women and girls were victims of sexual and/or physical violence by their partners in the last 12 months prior to the survey.

The figure is likely much higher since stay-at-home measures were put in place.

The impact of the crisis on the number of girls becoming child brides is not yet known, but the crisis may hasten child marriages.

Currently

12 million girls marry before age 18 every year.

SDG 6: CLEAN WATER AND SANITATION

The provision of safe water, sanitation and hygienic conditions is essential to protecting human health. Yet, today

3 billion

people lack basic hygiene facilities in their homes.

500 million

women and girls globally are estimated to lack adequate facilities for menstrual hygiene management.

This puts women and their families at greater risk of infection.

SDG 8: DECENT WORK AND ECONOMIC GROWTH

The pandemic lays bare women's precarious economic security.

740 million

women work in the informal economy.

Their income fell by 60 percent during the first month of the pandemic.

Around

7 in 10

workers in essential occupations are women.

2 in 3

teaching professionals are women.

They will likely be highly exposed to the virus with the reopening of educational institutions.

SDG 10: REDUCED INEQUALITIES

Health capacity is greater in developed regions compared to less developed regions. For every 1,000 people, there are:

Hospital beds

less developed regions

VS

developed regions

Nurses and midwives

less developed regions

VS

developed regions

SDG 11: SUSTAINABLE CITIES AND COMMUNITIES

Living in slums where population density is high raises women and girl's exposure to infection.

In **80%** of countries with available data,

women are overrepresented in slums and slum-like settings.

SDG 17: PARTNERSHIPS FOR THE GOALS

Gender data

Disaggregated data on COVID-19 cases and deaths as well as on hospitalization and testing is vital to understand the gender impacts of the pandemic.

Women and girls must be at the centre of COVID-19 global prevention, response and recovery efforts.

Women's greater longevity and their propensity to marry or cohabit with older men means that many women live alone in old age. In Europe, for example, 56 percent of women aged 80+ live alone.[17] Those who do not live alone or with family members typically live in congregate care facilities. The quality of these facilities varies widely, increasing the risk for this already vulnerable population.[18] Almost half of COVID-19 deaths in Europe have occurred in long-term-care settings.[19] Prolonged periods of isolation also pose health risks, including mental health risks, for seniors, who may have less access to support and services, including psychosocial services.

FIGURE 1

REPORTED COVID-19 CASES, BY AGE AND SEX (PROVISIONAL ANALYSIS)