



SPOTLIGHT ON GENDER, COVID-19 AND THE SDGS

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



ACKNOWLEDGEMENTS

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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).

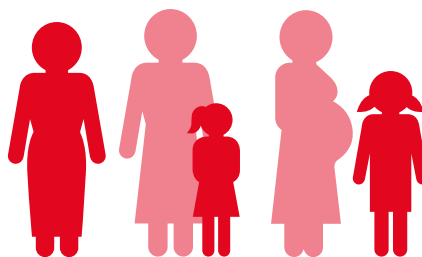
SDGs and COVID-19: Snapshot of key facts and figures

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

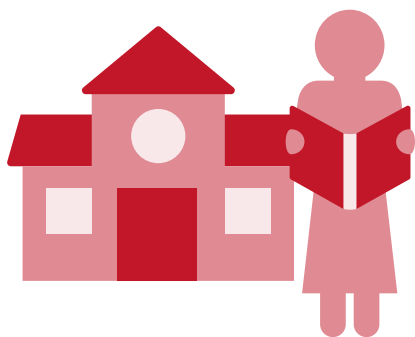
women died from preventable causes related to pregnancy and childbirth every day.

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.

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

500 million

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

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.

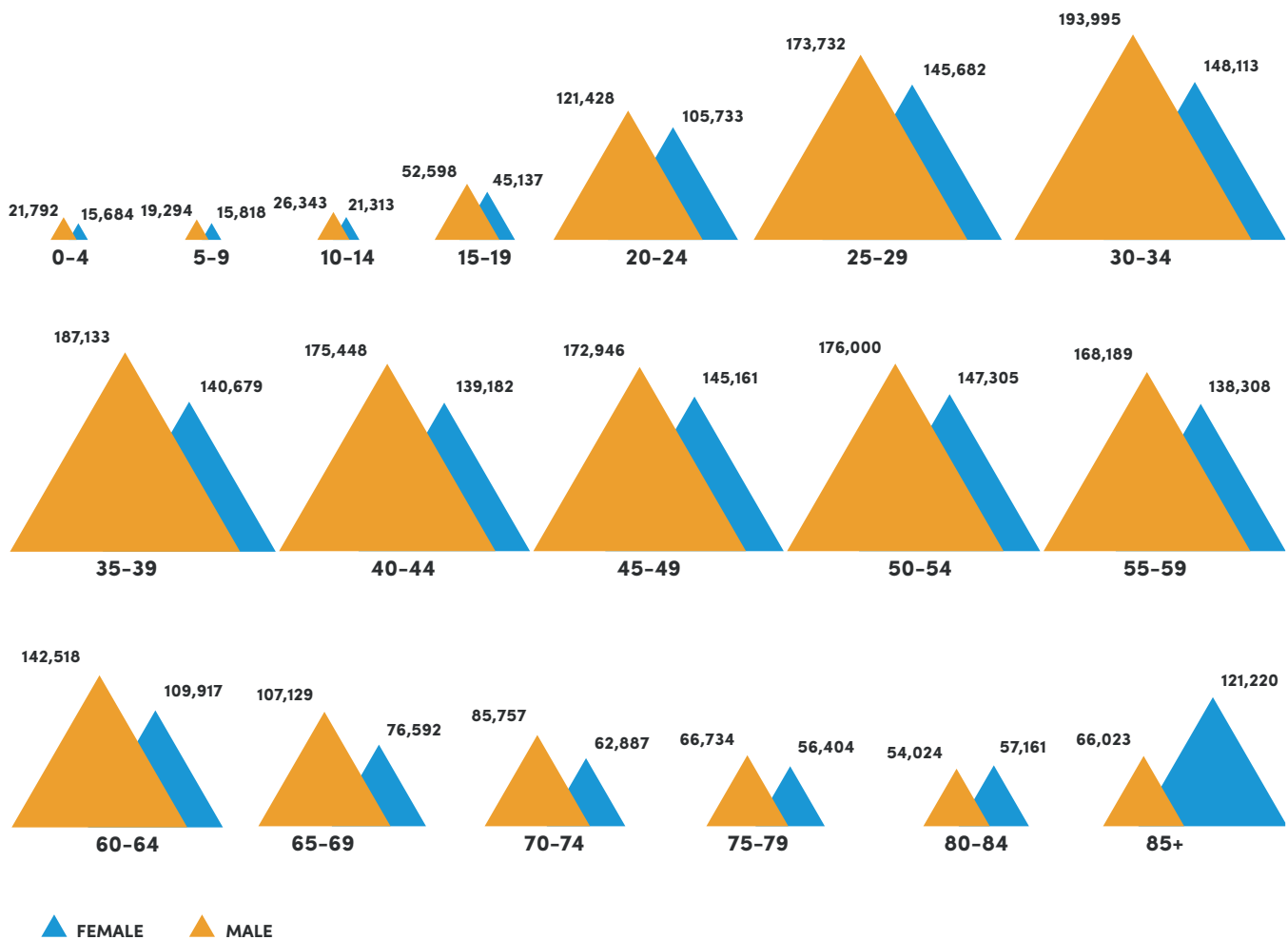
Women and girls must be at the centre of COVID-19 global prevention, response and recovery efforts.

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)



Source: Data submitted to NCOVmart reported through the global surveillance system of WHO, as of 25 June 2020.

Notes: Data cleaning are ongoing. All numbers should be interpreted with caution. As of 24 June 2020, 9,129,146 cases were reported. Data presented here, therefore, represent only 41% of all reported cases. The data by sex and age shown here are based on reporting from 135 countries, areas and territories.

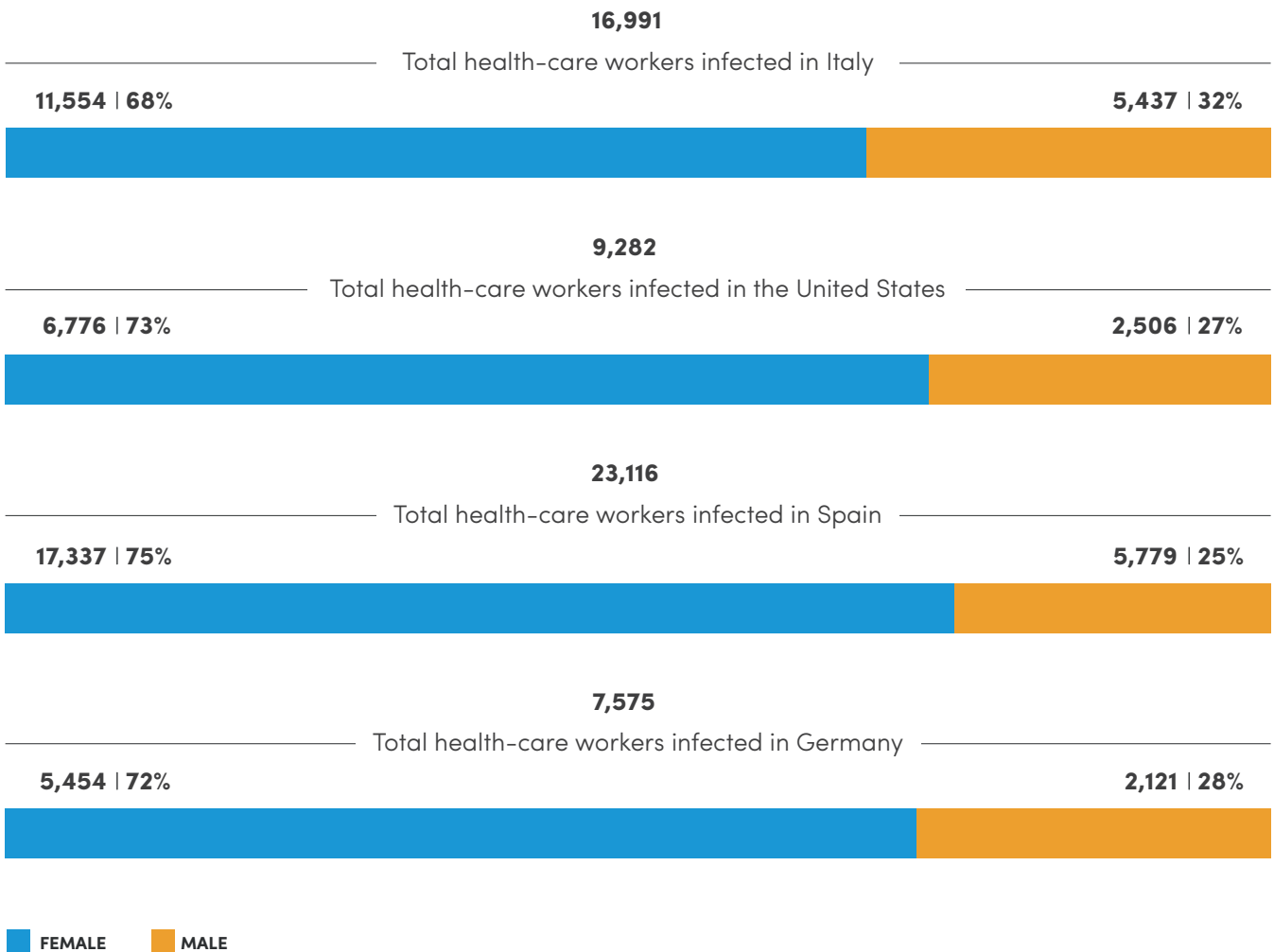
Higher infection risk among front-line workers, hitting women hard

Exposure to the disease differs across subgroups in highly gendered ways. Globally, women make up 70 per cent of the health and social care workforce, and they are more likely to be front-line health workers,

especially nurses, midwives and community health workers. This exposure raises their risk of infection.²⁰ Recent data from Germany, Italy, Spain and the United States show confirmed cases of female health workers are two to three times higher than their male counterparts (figure 2). Greater efforts are needed to ensure the health and safety of this essential workforce.

FIGURE 2

CONFIRMED CASES OF COVID-19 AMONG HEALTH-CARE WORKERS BY SEX, SELECTED COUNTRIES



Source: <https://globalhealth5050.org/covid19/healthcare-workers/>. Accessed 14 June 2020.

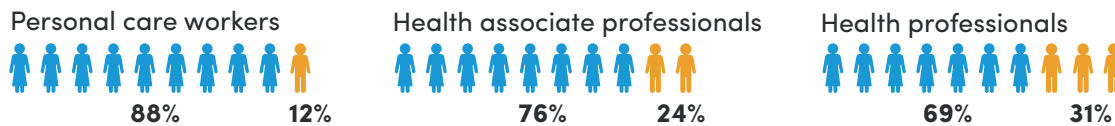
Sufficient and representative data on cases by occupation are not yet available. However, occupational risk to COVID-19 may be greater among occupations that require close contact with others. Cleaners and personal care workers, including long-term-care personnel, are some examples (figure 3). These categories of work often have low pay and hazardous conditions. Poor migrant women and

women from marginalized racial and ethnic groups are often overrepresented in these jobs. Economic necessity forces many to continue working, despite the elevated risk of infection to them and their families. As economies reopen, personal care workers and teaching professionals face the greatest risk as their work requires them to be in close quarters with other individuals for prolonged periods of time.

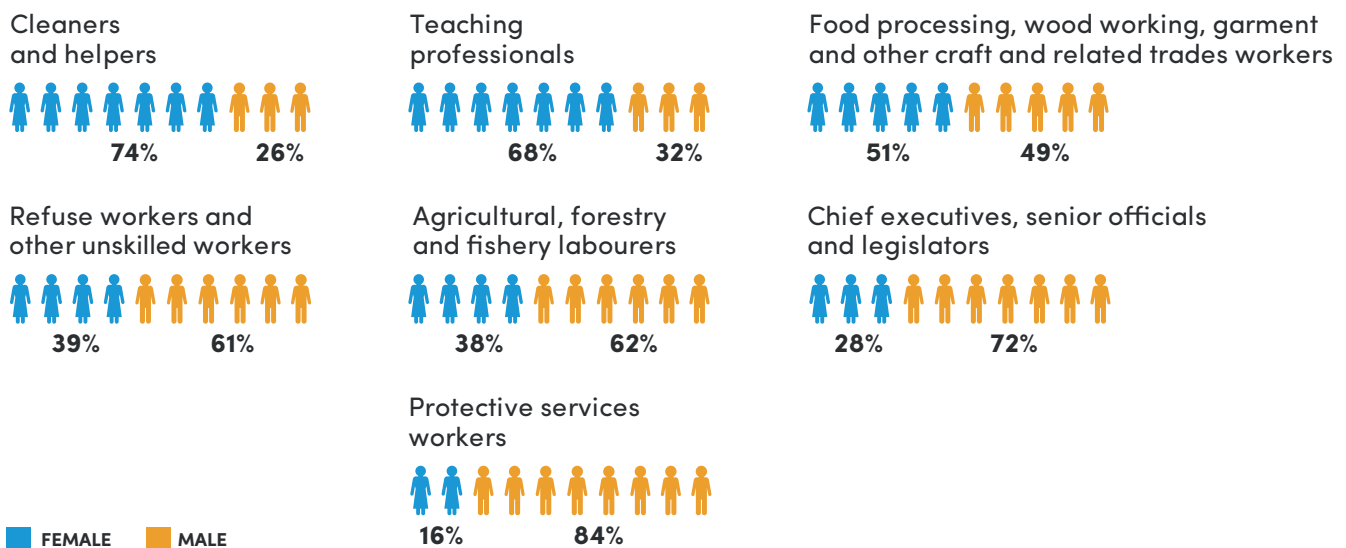
FIGURE 3

DISTRIBUTION OF EMPLOYMENT BY SECTOR, OCCUPATION AND SEX, SELECTED ESSENTIAL OCCUPATIONS

Health sector



Other essential occupations



Source: ILO. ILOSTAT Blog. Accessed 21 April 2020. <https://ilostat.ilo.org/2020/03/06/these-occupations-are-dominated-by-women>.

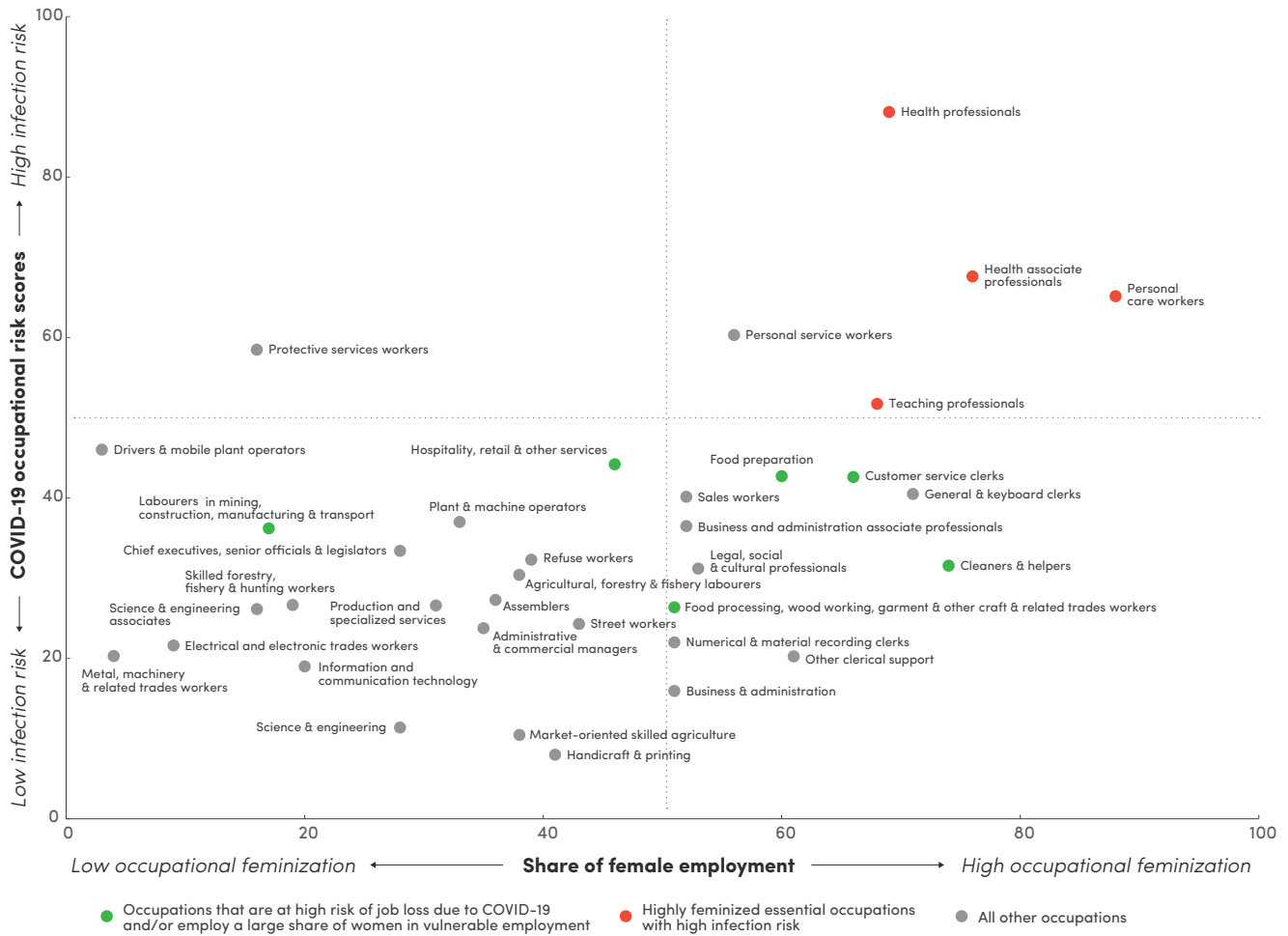
Note: Percent of employment by sex and occupation (ISCO-08 at the 2-digit level), weighted average for 121 countries that represent 63% of global employment using the latest year available. Data for China and India were not available.

Data from 121 countries highlight the greater risk of COVID-19 infection in highly feminized occupational categories (figure 4). The occupational risk score is based on three job attributes: contact with others, physical proximity to others and exposure to disease and infection. The findings demonstrate that the three occupations with the highest COVID-19

occupational risk are health professionals, health associate professionals and personal care workers. These are highly feminized occupations, in which women account for at least seven in every ten workers. Other highly feminized occupations with high COVID-19 occupational risk scores are teaching and personal service.

FIGURE 4

OCCUPATIONS BY SHARE OF FEMALE EMPLOYMENT AND COVID-19 OCCUPATIONAL RISK SCORE, SELECTED OCCUPATIONS



Source: ILO. ILOSTAT Blog. Accessed 21 April 2020. <https://ilostat ilo.org/2020/03/06/these-occupations-are-dominated-by-women>; and Visual Capitalist. "The Front Line: Visualizing the Occupations with the Highest COVID-19 Risk". Accessed 21 April 2020. <https://www.visualcapitalist.com/the-front-line-visualizing-the-occupations-with-the-highest-covid-19-risk/>

Note: Share of female employment by occupation covers 121 countries representing 63 per cent of global employment. COVID-19 occupational risk scores are based on three physical job attributes: contact with others, physical proximity to others and exposure to disease, infection and hazardous conditions. The Visual Capitalist COVID-19 occupational risk scores were matched to the closest relevant category in ILOSTAT. Where sub-occupations have different risk scores, simple averages were used.

Given the gendered nature of susceptibility to infection, it is crucial to have accurate sex-disaggregated data for COVID-19 incidence, hospitalization and testing. This information must then be used to inform prevention and response efforts, including targeted efforts to address heightened exposure among certain groups and sub-groups of the population. The experience with Ebola in West Africa demonstrates the urgency: It was only when sex-disaggregated case data were obtained that it was possible to understand women's high burden of disease.²¹ This was especially due to women's formal and informal care roles.

It is a social norm that women perform the majority of care within the home during an outbreak of illness. It is likely that women are caring for family members sick with COVID-19, thereby exposing themselves to greater risk.

The 2030 Agenda has a major focus on data. It calls for high-quality, accessible, timely and reliable data disaggregated by sex, age, geographic location, income, race, ethnicity, migration status, disability and other characteristics relevant in national contexts so progress can be measured and governments can ensure that no one is left behind. In the context of COVID-19, disaggregated data are essential to fully understand the outbreak's transmission and its impacts. Given the differences in risk by occupation, case and fatality data by sex and occupation are also vital, as well as sex-disaggregated data on job loss and unemployment.

FOCUS: HEALTH IMPACTS OF COVID-19 (SDG 3)

The pandemic is straining even the most advanced and best-resourced health systems. Countries and regions with already low capacity and preparedness

are facing a monumental challenge. At the top of the resource spectrum, Europe and North America average five hospital beds per 1,000 people, while at the bottom of the spectrum, sub-Saharan Africa has 0.8 hospital beds per 1,000 people. There are also vast regional inequalities in the number of physicians and nurses/midwives.²² Despite the strain on health systems, governments must ensure that health services continue to operate safely and that policies are in place to protect the sexual and reproductive health of women and girls, including pregnant women and girls and their newborns.

The health impacts of COVID-19 on women, like those of Ebola and Zika, are likely to expose broader socioeconomic fault lines across global health, with increased impact based on race, ethnicity, religion, income and disability.²³

Service disruptions and curtailed access to health services

During a health emergency, the 'tyranny of the urgent' often takes over, diverting financial, human and clinical resources to the response.²⁴ This has the downstream effect of disrupting routine services, impeding access to health care for other conditions. National and local authorities and hospital managers must decide how to manage health events, and these decisions can affect men and women differently.

For example, officials may decide to prohibit or limit access to antenatal care, attendance at childbirth, family planning and/or abortion care. They may decide to offer consultations virtually, or only offer services in centralized locations. This can prevent women from accessing quality sexual and reproductive health care services. As demonstrated during an Ebola outbreak in Sierra Leone, disruption in access to antenatal and labour support led to 3,600 additional maternal, neonatal and stillbirth deaths in 2014 and 2015. This number was similar to the total number of deaths due to the virus itself.²⁵

Curtailing access to health services during an outbreak is particularly harmful with regard to sexual and reproductive health services, including contraception, emergency contraception and abortion (where permitted).

Target 3.7 calls for universal access to sexual and reproductive health services and their integration into national health strategies, while Target 5.6 calls for ensuring universal access to sexual and reproductive health rights. Progress towards both of these targets can be limited by health emergencies.

Early evidence suggests that pregnant women might be at increased risk for severe COVID-19 illness. A study of COVID-19 by pregnancy status found pregnant women in the United States were more likely to be hospitalized (32 percent), compared to non-pregnant women (6 percent).²⁶ In light of these findings, governments are emphasizing prevention and calling for pregnant women and their families to take precautions. Barriers to women's access to health services, including access to adequate medical care during pregnancy, must also be addressed.

Based on data from UN Women rapid gender assessments in the Europe and Central Asia region, in 4 of 10 countries, at least 1 in 2 women in need of family planning services reported major difficulties in accessing these services. The survey also found that access to essential sexual and reproductive health services has become more difficult during travel restrictions and lockdown periods. Across the region about 8 percent of women experienced some difficulties in accessing gynaecological and obstetric care.²⁷ Limiting routine maternity services can increase maternal mortality. This could affect achievement of Target 3.1, which calls for reducing the global maternal mortality rate to less than 70 deaths per 100,000 live births by 2030.

Emergencies create a higher barrier for women

Gender influences access to health care services and health outcomes. Globally, men have worse health than women due to risk-taking behaviours, their forms of employment and their lesser inclination to visit a doctor or seek medical advice,²⁸ as found in the case of HIV/AIDS.²⁹ However, during health emergencies, structural inequities may also determine who accesses care, impacting women disproportionately.

Even before the pandemic, household and attitudes surveys showed that in many countries, men have the final say in household decision-making, including in women's own health care, such as regarding visits to the doctor and whether to use contraception.³⁰ A 2016 study looked at the numbers of women and men who visited a local hospital in India and found that, when obstetric care was excluded, there were fewer young women and older women (those outside of reproductive age) compared to young men and old men. Women's lesser attendance at clinics was attributed to distance from the hospital, out-of-pocket and travel expenses, discrimination and danger faced by groups of women travelling alone.³¹ This discrepancy will increase if families or individuals face greater economic insecurity through loss of jobs or income as a consequence of the outbreak. This directly connects to SDG Target 3.8 on reducing financial risks to access quality essential health-care services.

Reproductive health services can't be delayed

Emergencies also affect access to contraception due to problems of supply and demand. Supply chains have been severely interrupted by COVID-19, including for short-term contraceptives. Much of the globe's contraceptive supply is made in Asian countries, which were some of the first to be impacted by travel bans/disruptions and workforce shortages affecting factories and raw material supplies.³² The demand side has also been affected, as some women have

been unable to visit health care providers to access contraceptives, including emergency contraception, because they are in self-isolation or want to avoid exposure to infection in crowded clinics.³³ This is compounded by the affordability of services and the heightened risk of sexual and gender-based violence associated with quarantine that some women face during isolation with abusers.

Barriers to accessing sexual and reproductive health services during health emergencies are more evident in the case of abortion.

As demonstrated during the Zika outbreak, even in jurisdictions where abortion is legal, women seeking access faced significant barriers. These included lack of knowledge of regulations, cost, availability and conscientious objection by health care providers.³⁴ In countries where women require physician approval for an abortion, quarantine severely hinders their access to clinics. This is especially the case if abortion is not designated as an essential service³⁵ or if staff and resources are being channelled to the COVID-19 response.

Abortion regulation can be altered during a global health emergency. In England, for example, a recently introduced policy change permits self-managed abortion at home through online or phone consultation with a physician, to reduce the strain on the National Health Service during COVID-19.³⁶ In more restrictive settings, self-isolation will further limit women's access to abortion through pharmacies, women's organizations and the black market.³⁷

Existing gaps threaten the response

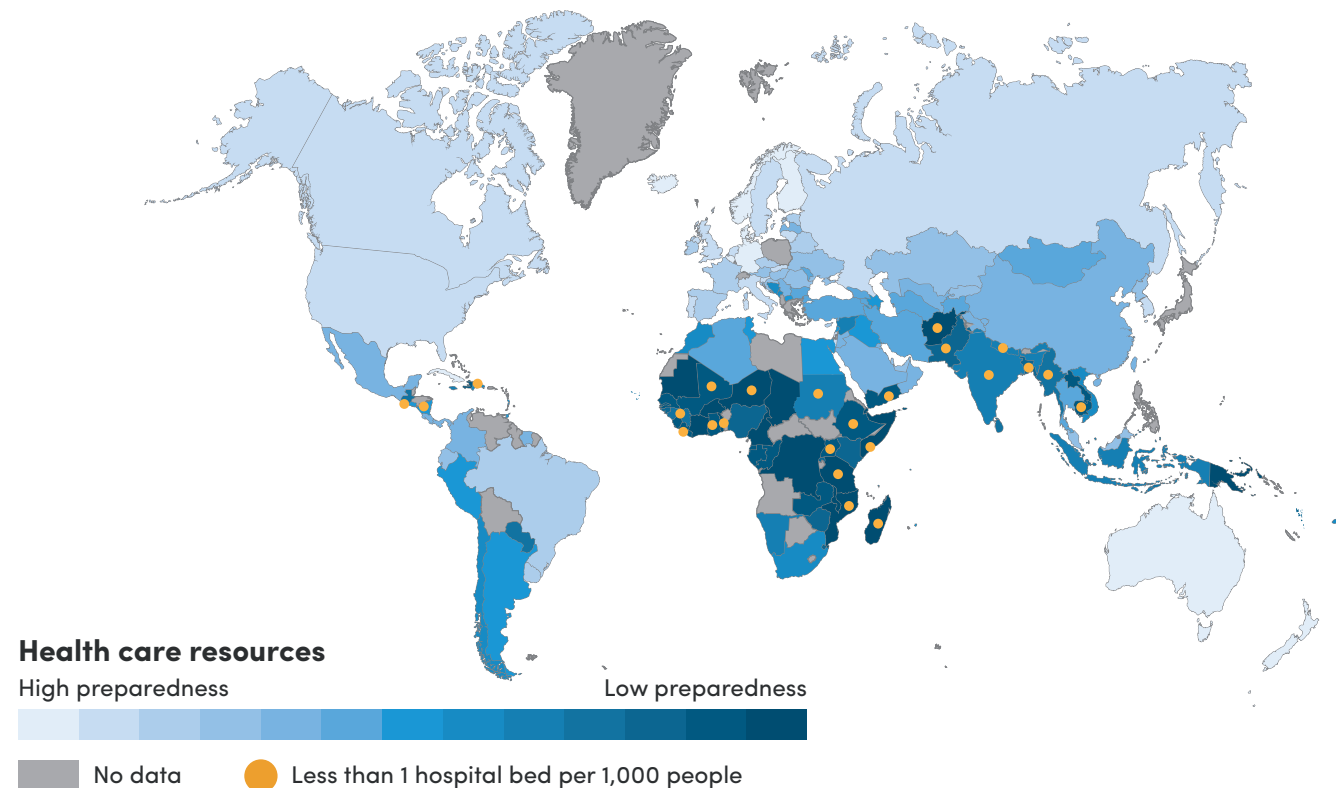
Global data show the disparity in capacity and preparedness across countries and regions. Sub-Saharan Africa, Central and Southern Asia, and parts of East and Southeast Asia and Latin America and the Caribbean self-report low capacity in three core areas of health systems preparedness and response: planning for emergencies, managing health emergency response operations, and mobilizing emergency resources.³⁸ Sub-Saharan Africa has extremely low baseline capacity when it comes to provision of critical care and availability of critical care staff.

The results of gaps in meeting sexual and reproductive health care needs — including high rates of maternal mortality, low rates of births attended by skilled health personnel and low rates of family planning demand satisfied by modern contraceptive methods — mirror the gaps in health system preparedness and response. Since the COVID-19 virus emerged in China in January 2020, the countries hit hardest have been those with relatively greater capacity and preparedness to respond.

As the disease spreads further in other parts of the world (cases have been surging at alarming rates in Latin America and South Asia), the impact could be catastrophic, given the few resources of health systems and multiple capacity gaps (figure 5). Even in countries with relatively greater capacity and preparedness to respond, racial and ethnic inequalities are likely to result in unequal access to health resources.^{39,40}

FIGURE 5

HEALTH CARE RESOURCE CAPACITY AND LEVEL OF EMERGENCY PREPAREDNESS AND RESPONSE, BY COUNTRY



Source: UN Women calculations based on UNSD. 2020. Global SDG Indicators Database. Accessed 20 March 2020 <https://unstats.un.org/sdgs/indicators/database>, World Bank 2020. World Development Indicators. Accessed 20 March 2020. <https://databank.worldbank.org/source/world-development-indicators> and WHO 2020. Electronic State Parties Self-Assessment Annual Reporting Tool (e-SPAR). Accessed 20 March 2020 <https://extranet.who.int/e-spar>.

Notes: Covers 157 countries. Countries are grouped by their aggregate health care resource capacity and level of emergency preparedness and response. Health care resource capacity is proxied through the following indicators: universal health service coverage index (2017), physicians per 1,000 people (2010–2018, latest available) and data on nurses and midwives per 1,000 people (2010–2018, latest available). Emergency preparedness and response levels are captured using the International Health Regulations core capacities: 8.1, planning for emergency preparedness and response mechanism; 8.2, management of health emergency response operations; and 8.3, emergency resource mobilization (2018). The maps have been designed in collaboration with Esra Ozdenorol, University of Memphis, Director of Spatial Analysis and Geographic Education Laboratory.

A further concern is the intersection of gender, COVID-19 and HIV/AIDS. SDG Target 3.3 aims to end HIV/AIDS (and other prominent infectious diseases). If individuals cannot travel to clinics due to lockdown, they may not be able to obtain the antiretroviral medicines required to manage their disease.⁴¹ While there is no evidence that HIV/AIDS is a risk factor for severity of COVID-19, there has been speculation that antiretroviral medicines can prevent infection.⁴² This has led to increasing trade of antiretrovirals on the black market,⁴³ potentially reducing the supply

for people with HIV. This compounds the challenges affecting routine supply chain management.⁴⁴ According to one recent estimate, if efforts are not taken to mitigate COVID-19-related disruptions in health services and supplies, there could be an additional 500,000 deaths from AIDS-related illnesses.⁴⁵

FOCUS: SOCIOECONOMIC IMPACTS OF COVID-19 (SDGS 1, 4, 5 AND 8)

All types of crises tend to exacerbate gender inequalities, particularly against women and girls.⁴⁶ COVID-19 threatens progress for women and girls in four of the SDGs: SDG 1 on eradication of poverty, SDG 4 on quality education, SDG 5 on gender equality and SDG 8 on decent work and economic growth.

In health crises over the past half-decade, including the Ebola and Zika outbreaks and the cholera outbreak in Yemen, the short-term impacts were consistent: a drop in girls' school attendance, increased out-of-pocket health expenditures, declining personal income due to loss of women's employment (from casual labour and/or small market businesses) and additional demands on women to provide unpaid care. In each case, these short-term effects led to longer term harm, with accompanying declines in achievement of the Goals. These included declines in girls' access to schooling, progress on gender equality and women's empowerment, and access to decent work and economic growth.

During the 2014–2015 Ebola outbreak in Guinea, Liberia and Sierra Leone, schools closed for six to eight months. The five million children kept at home faced increased domestic and care responsibilities. In some cases, the primary burden shifted to girls, especially if their parents were caring for family members or had died from the disease. Where girls' economic and social status was already secondary to boys', the crisis exacerbated this trend: Outside of school, girls were at higher risk of sexual and physical abuse and of transactional sex to provide basic needs. Adolescent pregnancy dramatically increased during and after the Ebola crisis, and anecdotal evidence suggests that child marriage also increased as a result of the crisis.

Many girls never returned to school, permanently hampering their exercise of their economic and

social rights.⁴⁷ The risk is high that COVID-19 will result in the same impacts in some locations, as the crisis upends people's lives and disrupts efforts to end child marriage and other harmful practices.

To contain the spread of COVID-19, 193 countries and areas have temporarily closed educational institutions nationwide or locally. These closures have kept over 1.54 billion children and youth out of primary, secondary and tertiary schools, including nearly 743 million girls. Over 111 million of these girls live in the world's least developed countries, where access to education was already limited.⁴⁸

Who benefits from remote learning?

Almost three quarters (73 per cent) of countries have begun implementing various forms of remote learning, including online classes. Yet not all children can benefit equally from these measures (figure 6). More than a third of countries and areas (36 per cent) rely on online and broadcast tools (TV and/or radio), while 31 per cent rely on online tools only. A smaller share (6 per cent) depends on traditional broadcast tools (TV and/or radio) only. But more than one quarter of countries (27 per cent) have not implemented any form of remote learning. These inequalities across countries add to those within countries, such as in rural versus urban areas, as well as among households within a community and even within households.

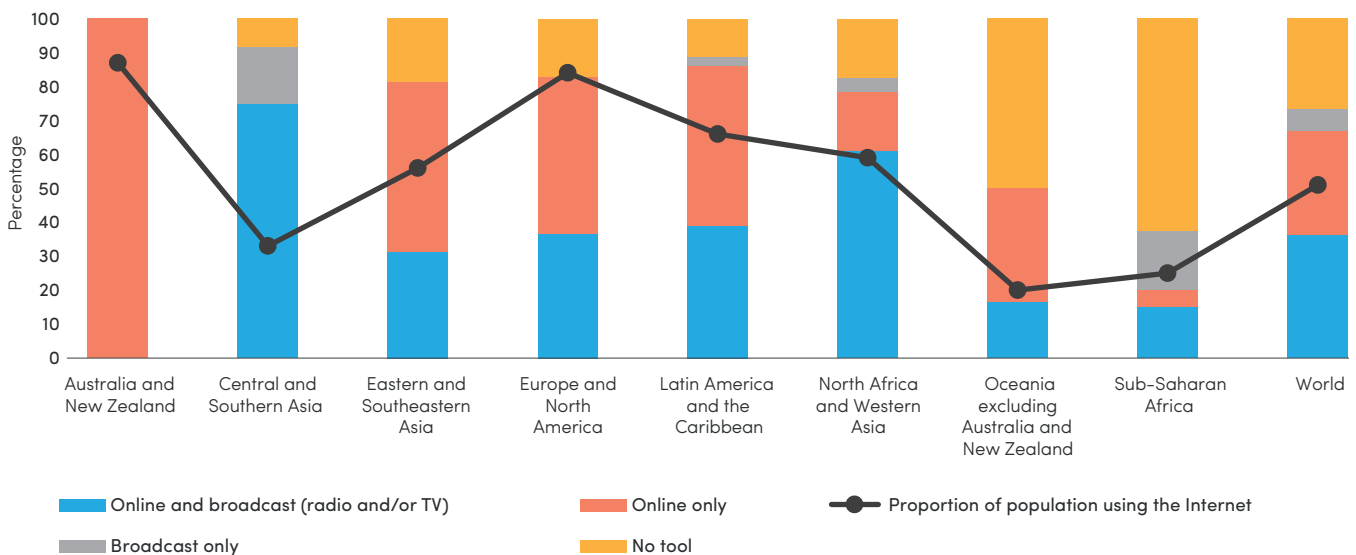
Across low- and middle-income countries, many girls from poor households cannot participate in remote learning, since both their homes and their schools lack the required tools, skills and technologies. In sub-Saharan Africa, the majority of children out of school during COVID-19 lack access to the tools required to continue their education. In Oceania (excluding Australia and New Zealand), where only 20 per cent of the population has access to the Internet, 50 per cent of the countries closing schools are not

using any remote learning tools to continue children’s education during this crisis. In Central and Southern Asia, a large share of countries have implemented online and broadcast learning options, but only 33 per cent of the population has access to the Internet. This suggests there are large inequities in access to remote learning.

Those inequities may extend to the household. Evidence from low- and middle-income countries shows that girls receive access to digital technology at a later age than boys, and their use of digital technology is more likely to be curtailed by their parents.⁴⁹ These disparities contribute to widening the gender gap in digital skills.

FIGURE 6

PERCENTAGE OF COUNTRIES RESPONDING TO SCHOOL CLOSURES WITH REMOTE LEARNING, BY REGION



Source: UN Women calculations using data from Brookings Institution Center for Global Development and World Bank

Note: Based on a sample of 176 countries for which information on modes of remote learning was available. School closures include both national and/or regional within the country.

It is clear that school closures disproportionately harm girls and may result in long-term damage to their educational, economic and health outcomes. During Yemen’s 2017 cholera outbreak, for example, the crisis exposed gender inequalities within communities.⁵⁰ The majority of girls did not return to schools after they reopened, and there is evidence that the crisis increased rates of early marriage and of child and teenage pregnancy.⁵¹

The digital gender divide

Digital technologies have been a boon during the COVID-19 crisis. They have facilitated business continuity in some sectors and connected people through social media, which helps them maintain good mental health. Yet it is estimated that almost half the world’s population – 3.6 billion people – remains offline, the majority of them in the least developed countries.⁵² In Bangladesh and Pakistan,

for example, rapid assessment surveys show a clear gender divide in access to technology and information: women and girls are less likely than men to own a cellphone, and they have less access to the Internet. Women also reported having less access to information about how to prevent COVID-19.⁵³

The pandemic lays bare women's precarious economic security

COVID-19 risks reversing decades of progress in the fight against poverty and exacerbating inequality within and between countries.

The effects are expected to be substantial in economies with a large informal sector, where social protection systems do not exist or are limited, or where the formal sector is highly exposed to market volatility.

Globally, 50 million women aged 25 to 34 live in extreme poverty (living on less than \$1.90 a day) compared to 40 million men. The COVID-19 crisis is likely to worsen women's poverty.

Women typically earn less and hold less secure jobs than men. With economic activity at a halt during the pandemic, women working in the informal sector have seen a dramatic decline in their capacity to earn a living. It is estimated that during the first month of the crisis, informal workers globally lost an average of 60 per cent of their income. The drop was 81 per cent in sub-Saharan Africa and Latin America, 70 per cent in Europe and Central Asia, and 22 per cent in Asia and the Pacific.⁵⁴

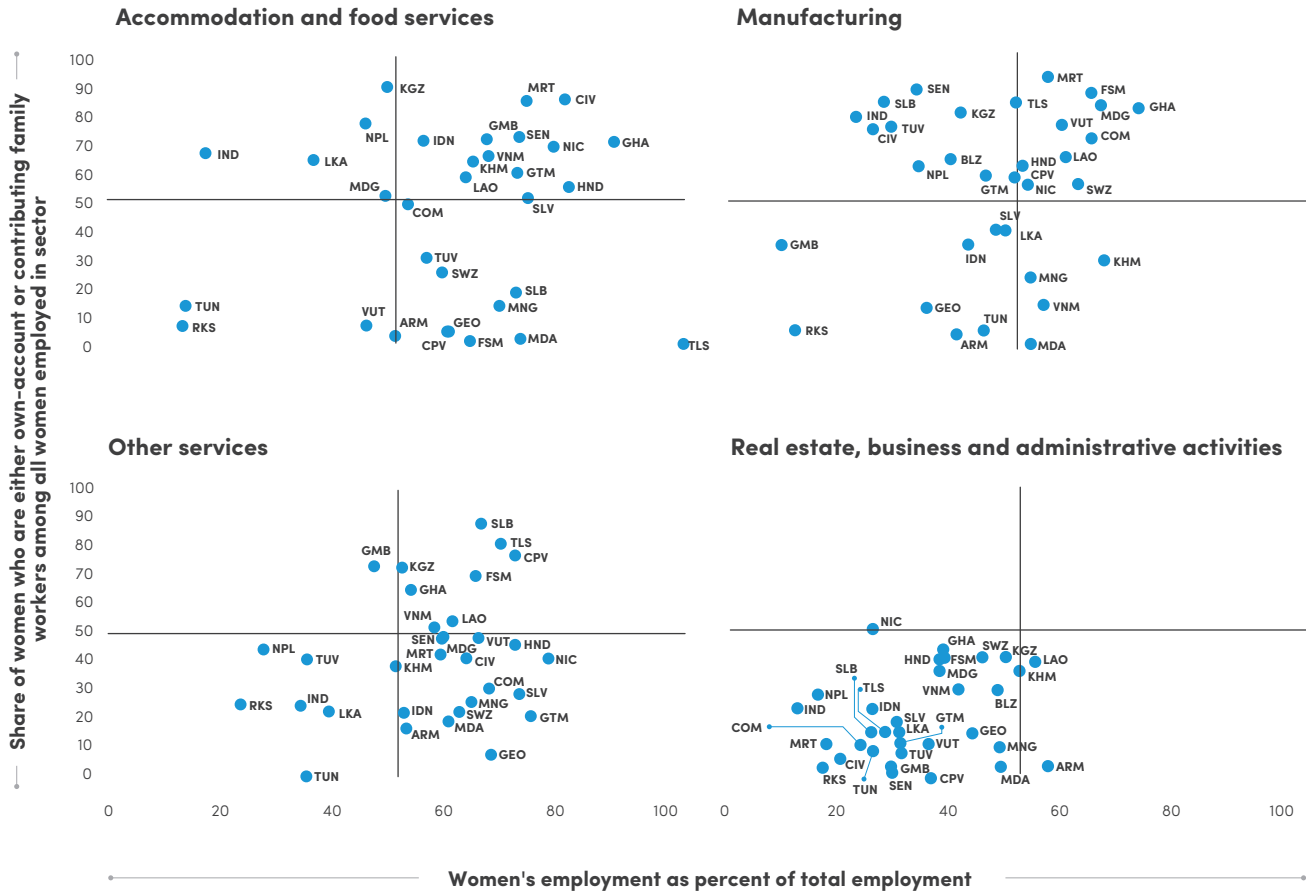
Before the Ebola outbreak, women were already in a precarious economic position, with less financial capital and lower wages than men.⁵⁵ For their income, women depended more on marketplaces, which were hard hit by the shutdown.⁵⁶ During the Zika outbreak, the many women who worked in the accommodation and tourism sector, often in low-income, casual positions, were the first to lose their income as tourism revenue declined. Poorer and ethnic minority women were hardest hit, and they continue to face burdens as they care for their children and other relatives diagnosed with congenital Zika syndrome.⁵⁷

The accommodation, food services and manufacturing sectors are likely to be some of the most affected sectors in terms of job loss and economic output contraction, according to the International Labour Organization's preliminary assessment of financial data for COVID-19 from 33 countries. In a majority of countries, these sectors are highly feminized and/or employ large shares of women in vulnerable employment (figure 7).

While men represent the majority of workers in the manufacturing sector, in 63 per cent of the countries in the sample, a majority of women who work in this sector are in vulnerable employment. These women were more likely to lack decent working conditions before the COVID-19 crisis, and they are now at high risk of losing their jobs or facing substantial decreases in income. At the same time they have limited access to social protection.

FIGURE 7

SHARE OF FEMALE EMPLOYMENT AND SHARE OF WOMEN IN VULNERABLE EMPLOYMENT, SELECTED SECTORS HIGHLY IMPACTED BY COVID-19



Source: ILO and WHO. 2019. Dataset on Employment at Risk by Gender – countries that have applied to the first round of the UN COVID-19 Response and Recovery Multi-Partner Trust Fund.

Note: The three letter ISO country code standard is used for the representation of names of countries. Covers 32 countries for the accommodation and food services (ISIC rev. 4 I) and other services (ISIC rev.4 R; S; T; U) sectors, and 33 countries for the manufacturing (ISIC rev. 4 C) and real estate, business and administrative activities sector (ISIC rev.4 L;M;N). The other services (ISIC rev.4 R; S; T; U) sector includes arts, entertainment and recreation activities, activities of households as employers, undifferentiated goods and services-producing activities of households for own use, activities of extraterritorial organizations and bodies and other service activities. The impact of the COVID-19 crisis on the four sectors' economic output is considered high based on ILO's assessment of real-time and financial data.

Domestic workers, whether employed formally or informally, are particularly vulnerable to the COVID-19 crisis. However, those working informally face greater hardship and are often unprotected against income loss and ill health. In a 2015 study, ILO estimated that 75 per cent of domestic workers worldwide were in informal employment, which puts

them among the groups of workers with the highest informality rates.⁵⁸ While the need for caregiving services has increased with school closures, and the need for cleaning services has grown due to stay-at-home orders and the importance of hygiene, the inability of domestic workers to work remotely results in loss of employment and/or income, particularly

among those who lack a formal contract.⁵⁹ In Brazil, 39 per cent of domestic workers were dismissed from employment without receiving any payment in response to fears of COVID-19 transmission.⁶⁰

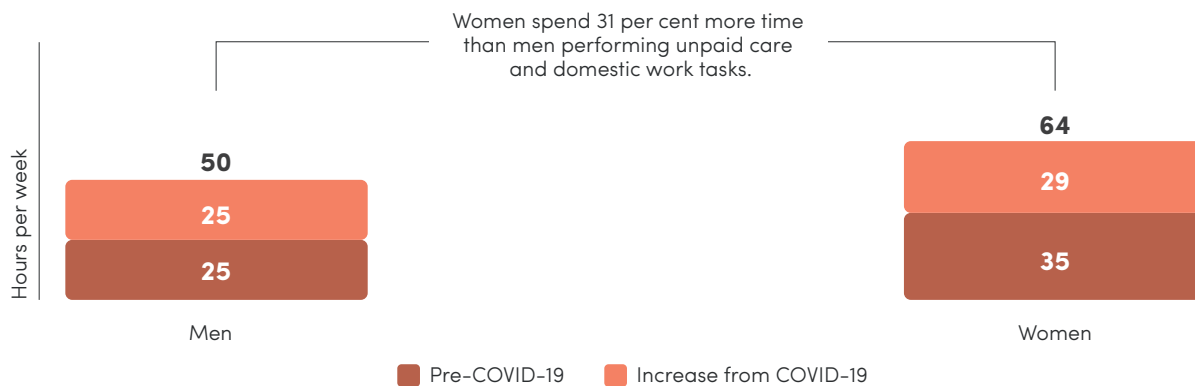
work as men.⁶¹ A recent study involving France, Germany, Italy, the United Kingdom and the United States found that working women on average do 15 hours more a week of unpaid care and domestic work compared to men.⁶² In self-isolation, men are reportedly contributing more to this work, but women continue to do the lion’s share.

The great intensifier: a further squeeze on women’s time

Before the pandemic, women globally did nearly three times as much unpaid care and domestic

FIGURE 8

UNPAID CARE AND DOMESTIC WORK BEFORE AND DURING THE PANDEMIC, BY SEX, SELECTED DEVELOPED COUNTRIES



Source: BCG COVID-19 caregivers survey 2020.

Note: The BCG COVID caregivers survey 2020 included parents who were working more than 10 hours per week at the time of the survey. Care responsibilities were proxied by specific tasks and activities such as cleaning at home, cooking and meal preparation, grocery shopping and planning, preparing schedules and activities for children, overseeing remote learning and/or teaching children, and watching or physically engaging with children. The hours per week increase due to COVID-19 was collected using a seven-point scale: decreased a lot (by 5 or more hours per week); decreased somewhat (by 3-4 hours per week); decreased a little (by 1-2 hours per week); no change; increased a little (by 1-2 hours per week); increased somewhat (by 3-4 hours per week); and increased a lot (by 5 or more hours per week).

While families shelter at home, many women are juggling an increase in unpaid care work while also contending with losses in income and paid work. Single mothers in particular have no one to share the care burden with and are more likely to work for low pay and in vulnerable occupations.

The pressure of balancing work and family life is taking a severe toll on women’s well-being. In a recent IPSOS poll in the United States, 32 per cent of women reported suffering from anxiety as a result of COVID-19, in comparison to 24 per cent of men.⁶³ These findings were mirrored in the United Kingdom in a poll by Fawcett Society, Women’s Budget Group,

Queen Mary University and the London School of Economics.⁶⁴ The US IPSOS poll also found greater insomnia among women as a result of COVID-19, 22 percent compared to 13 percent for men. Similarly, surveys in China and Hong Kong found women were more likely than men to suffer from anxiety related to COVID-19.⁶⁵

Declining access to civic participation

Finally, the additional care and domestic burden due to COVID-19 may affect women's political participation and achievement of SDG 5. Evidence on the relationship between pandemics and democratic participation is thin, and it is too early to draw reliable conclusions from COVID-19. However, feminist scholarship has long pointed out that the burden of domestic work limits women's social engagement and ability to engage in democratic politics,⁶⁶ such as by participating in campaigns, writing to political representatives and voting. This is significant for COVID-19 as it potentially restricts women's ability to engage in the response to the pandemic and speak up about how it is affecting their lives.

The burden of responding to the immediate and long-term impacts of the pandemic also threatens women's involvement in politics in the long term.

For both response to the pandemic and recovery from it, it is vital to pay attention to long-term gender inequalities. This includes women's lesser access to land, banking, civic and public spaces, and protection by security forces, which may further compromise women's access to support and services. Economic support packages must have quotas that

reflect women's lesser financial capital and ability to bounce back and rebuild their small businesses (such as market stalls). Social and economic support must reflect women's labour outside and within the home and their status in society. It needs to address how to adapt accountability structures so that aid interventions can be accessed by hard-to-reach and marginalized women.

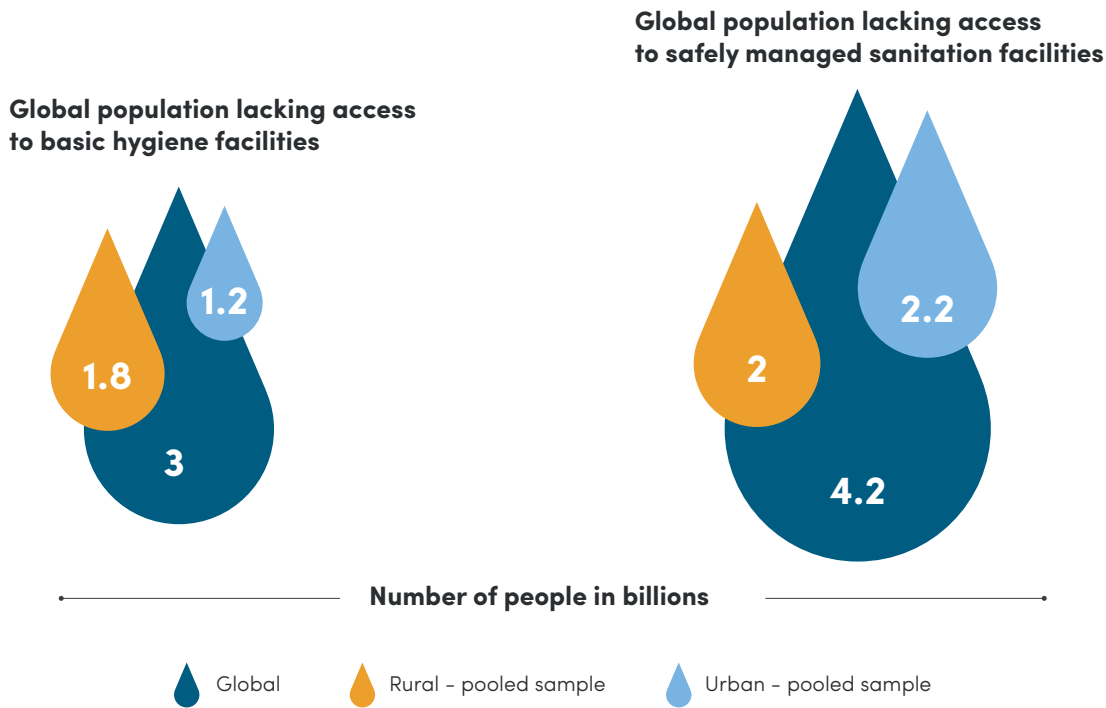
FOCUS: INTERSECTING INEQUALITIES (SDGS 6, 10 AND 11)

COVID-19 dramatically underscores the need to accelerate progress towards achievement of SDG 6 (clean water and sanitation), 10 (reduction of inequalities) and 11 (sustainable cities and communities). Women are the majority of people lacking access to essential services such as water, sanitation and housing, particularly those in low- and middle-income countries and marginalized women around the world. This lack of access limits the ability of women to protect themselves from COVID-19 infection and exacerbates the secondary impacts of the outbreak and response.

For example, the importance of handwashing as a means of protection against the virus is widely known.⁶⁷ But globally, an estimated 3 billion people, or 40 per cent of the world population, lack basic hygiene facilities in their homes (figure 9). This includes 1.8 billion people in rural areas (55 per cent of the rural population). Even more people, 4.2 billion, lack access to safely managed sanitation facilities. Also, physical distancing is key to preventing contagion, but people living in crowded settlements, slums or collective households cannot truly exercise physical distancing practices.

FIGURE 9

GLOBAL POPULATION WITHOUT ACCESS TO BASIC HYGIENE AND SAFELY MANAGED SANITATION FACILITIES, BY LOCATION



Source: UN Women calculations based on the WHO/UNICEF Joint Monitoring Programme dataset. Accessed 20 April 2020: <https://washdata.org/data/downloads#WLD>. Note: Estimates are based on a sample of 94 countries. Rural - pooled sample and urban - pooled sample is based on the aggregation of data across respective location for 94 countries. Urban and rural location categorizations may not be standardized across countries. These depend on the definition of residence (urban/rural) by national data sources.

The complexities of COVID-19, hygiene and housing

Around the world, women are more likely to live without adequate access to water, sanitation and hygiene. Data from 59 developing countries in Latin America and the Caribbean, Central and Southern Asia, and sub-Saharan Africa show that more women than men live in urban settings characterized by extreme poverty and lack of basic services such as clean water.⁶⁸ According to a cross-national study covering 18 low- and middle-income countries, the percentage of women who lack handwashing facilities with soap and water on premises ranged from 21 per cent in Honduras to 99 per cent in

Ethiopia.⁶⁹ In households without access, it is typically women who are responsible for collecting water. For example, a study in Malawi found that women without safe drinking water in the household spend an average of 54 minutes a day collecting water, while men spend 6 minutes.⁷⁰

In such contexts, COVID-19 hygiene requirements may increase the time women and girls spend collecting water, which in turn can limit their ability to work for income and participate in social and educational activities. Lack of access to water and hygiene supplies increases women’s risk of COVID-19 infection, while attempting to mitigate this risk through greater water collection exacerbates ongoing inequalities.

Women are also less likely to have secure and safe housing compared to men, limiting their ability to self-isolate and maintain physical distancing measures. Research in Benin, Kenya, Peru, Rwanda, Thailand and Uganda shows that over 6 per cent more women than men in urban settings are likely to lack security of tenure.⁷¹ Around the world, gender wage gaps and patriarchal laws or customs mean fewer women than men own property. Housing insecurity results in forced evictions and overcrowding, both of which become more likely during economic crises, such as that caused by COVID-19. This in turn increases the risk of infection.

Such risks can be further exacerbated by additional inequalities. For example, in Canada, over 20 per cent of Indigenous Peoples live in overcrowded houses, almost double the national average.⁷² This raises their risk of contracting infectious diseases. During the H1N1 pandemic, Indigenous Peoples accounted for 28 per cent of all hospital admissions and 18 per cent of all deaths, while making up just 4 per cent of the population.⁷³

COVID-19 also increases the risks faced by women who sell sex, whose ability to protect themselves from infection is limited by the nature of their work. With the closing of spaces where sex is often sold, such as bars and nightclubs, women who sell sex may be forced into less safe spaces, increasing the risk of violence and incarceration. Such risk taking may be exacerbated by declines in demand for sex work, due to fear of infection and the broader economic crisis, increasing the economic insecurity of women who sell sex.

Research in Zimbabwe found that among young women who sell sex, the immediate risk of loss of income often trumps the less immediate and unclear risk of infection with HIV.⁷⁴ Similar calculations are likely to go into decision making regarding sex work during COVID-19. This is particularly the case given that women who sell sex are unlikely to have access to economic stimulus payments from governments due to the informal and often criminalized nature of their work.

The shadow pandemic: Violence against women and girls

For many women and girls, home is not a safe space, and emerging data suggest it has become less safe since the outbreak of COVID-19. Globally, it is estimated that 243 million women and girls aged 15–49 have been subjected to sexual and/or physical violence perpetrated by an intimate partner in the 12 months prior to the survey.⁷⁵ This number is likely to increase as security, health and financial stress heighten tensions, which are exacerbated by lockdown measures.⁷⁶ The need to isolate may also prevent women from leaving violent homes, as they fear for their health or that of their children. In Lebanon and Malaysia calls to domestic violence helplines doubled in March 2020 compared to March 2019, and in France they rose 32 per cent.⁷⁷ Notably, these figures reflect reporting, not incidence, and it has long been known that domestic violence is grossly underreported. The restrictions on movements and limited privacy due to isolation measures during the pandemic likely mean that many women are unable to phone for help or receive support from their social networks.

While restrictions on movement, social isolation and increased social and economic pressures are leading to an increase in violence in the home globally, the challenge of responding differs by context and must reflect intersections with existing inequalities. In high-income countries like Canada, service providers are facing shortages in supplies for those fleeing violence.⁷⁸ In low- and middle-income countries, where such services were already struggling to meet demand, providers must compete for scarce resources with needs resulting from COVID-19.⁷⁹ It is also important to consider the groups at high risk of violence: women with disabilities, who are two to three times more likely to experience violence from partners and family members.⁸⁰ Mandatory or recommended shelter-in-place orders may particularly limit these individuals' ability to flee violence, given their limited connections to support people outside the home. Institutionalized women with disabilities may be at further risk of violence when visitors and monitors are not allowed due to infection concerns.

THE ROAD AHEAD: POLICY PRIORITIES

1/

SDG1: End poverty in all its forms everywhere. Enhanced social protections for immediate and medium- to long-term recovery are needed to support families and communities reeling from the health and economic effects of COVID-19. Families across the wealth distribution are suffering from loss of earnings and livelihoods, but poor women and women from marginalized and minority ethnic groups are the hardest hit. Women working in the informal sector especially need income support, as many have been unable to earn a living since the lock-down measures were put in place. A gender-responsive recovery plan is needed that supports all working women, especially those who lack access to decent work and associated benefits, such as health insurance and unemployment benefits.

2/

SDG3: Ensure healthy lives and promote well-being for all at all ages. The COVID-19 pandemic will likely affect global progress on SDG 3, including progress towards universal access to health services. More men are dying from the virus, but the disease-related health vulnerabilities are also acutely felt among health care workers, the majority of whom are women, and by men and women from poor, marginalized and excluded communities. The response to COVID-19 must take into account the risks borne by essential health workers. Provision of good quality and well-fitted personal protective equipment is critical, as are increased testing and prioritization of higher risk populations, including workers in other essential sectors.

National health care system capacity, preparedness and ability to respond to health crises varies significantly within and across regions. As the adverse effects of COVID-19 continue, the extent to which the pandemic spreads in low- and middle-income countries will determine whether access to quality health services becomes even more unequal, with greater impact on women and girls. Experience from past health crises has shown they have serious and long-lasting implications for women's health and access to health services.

Governments must ensure women's access to sexual and reproductive health services is not disrupted. Target 3.D must ensure recognition of the need for gender considerations in the surveillance of infectious diseases and the tools to manage outbreaks. This includes requiring sex-disaggregated data for all outbreaks, recognition of the different gender impacts of disease in the International Health Regulations, and the requirement to include gender advisers in crisis response. Sex and gender must be factored into scientific studies, research and response to COVID-19 and its broader effects on health.

3/

SDG4, Target 4.1: Ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes. Alternative remote-learning practices must be adopted in contexts where digital options are less accessible in order to reach the most marginalized children. Resources must be targeted to children most likely to fall through the cracks, including through measures aimed at recovering learning losses. Moreover, school attendance is likely to continue to fall after the risk of infection has declined. Experience from previous health emergencies shows that girls are most likely not to return to school after they are withdrawn. It is imperative that all children, regardless of sex, are enabled equally to return to or enrol in school once the crisis is over.

4/

SDG5, Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. Essential services to prevent and address violence against women and girls, including increased resources to support shelters, hotlines and online counselling, should be expanded and adapted to the crisis context to ensure survivors' access to support. Psychosocial support for women and girls affected by the outbreak, gender-based violence survivors, front-line health workers and other front-line social support staff must be prioritized.

5/

SDG5, Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action, and the outcome documents of their review conferences. National-level committee decisions on COVID-19 must be made in consultation with groups working on women's rights and sexual and

reproductive health and rights to ensure consideration of best health practice recommendations. Universal health care programmes should include sexual and reproductive health services, and key donors and funding bodies (such as international organizations) should pledge to ensuring that programmes include these commitments.

6/

SDG 5, Target 5.C: Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws. Any recalibration of SDG funds to COVID-19 response (including any new funding mechanisms created) should include a minimum target requiring allocation of at least 30 per cent of the total budget to gender equality or women's empowerment projects.

7/

SDG 6, Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. Frequent handwashing is one of the most important measures to prevent the spread of COVID-19. Yet billions of people are not able to undertake this basic practice because they lack access to functioning handwashing facilities with water and soap. Ensuring everyone has access to hand hygiene services is critical to halt the spread of COVID-19 and other diseases, as is ensuring human waste is safely contained, emptied, transported and disposed or treated. Response and recovery efforts need to prioritize the needs of extremely poor people living in rural areas and urban slums without access to safely managed water and sanitation facilities and safe hand hygiene.

8/

SDG 8, Target 8.3: Promote development-oriented policies that support productive activities, creation of decent jobs, entrepreneurship, creativity and innovation, and encourage the formalization and growth of micro, small and medium-sized enterprises, including through access to financial services. The current crisis threatens to undo the limited gains made on gender equality in the labour market, exacerbating the loss of time dedicated to unpaid care and domestic work and restricting women's equal participation in the labour force. An estimated 4.8 per cent of working hours were lost during the first quarter of 2020 (equivalent to 135 million full-time jobs) as a result of the

COVID-19 crisis.⁸¹ Women are overrepresented in high-risk sectors and they are among the hardest hit by these job losses. A gender-aware response to the economic shock resulting from COVID-19 requires greater support to women in the labour market, especially in those sectors where women make up the majority of workers, and most especially for those working in the informal sector.

9/

SDG 11, Target 11.1: Ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums. More than 1 billion people live in slums and slum-like settings in low- and middle-income countries, where population density is high. They are some of the most at risk and the least prepared to respond to COVID-19. Displaced people and refugees living in crowded camps also face heightened risk. As the majority of residents living in urban slums, women are at higher risk of COVID-19 infection due to overcrowding. Before the crisis, women in slums already lacked adequate access to health facilities and secure housing. They also faced greater difficulty in completing their education. COVID-19 and its aftermath are only expected to worsen such outcomes and increase extreme poverty.

10/

SDG 17, Target 17.18: Increase significantly the availability of high-quality, timely and reliable data disaggregated by income, sex, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts. In responding to the COVID-19 crisis it is essential to keep in mind that data 'blank spots' may result from economic and social norms that keep women confined in their home or village. To establish an accurate picture of the outbreak and its effects, cases will need to be disaggregated by sex, age and location, alongside the data on social and economic gender inequalities and discrimination in these societies.

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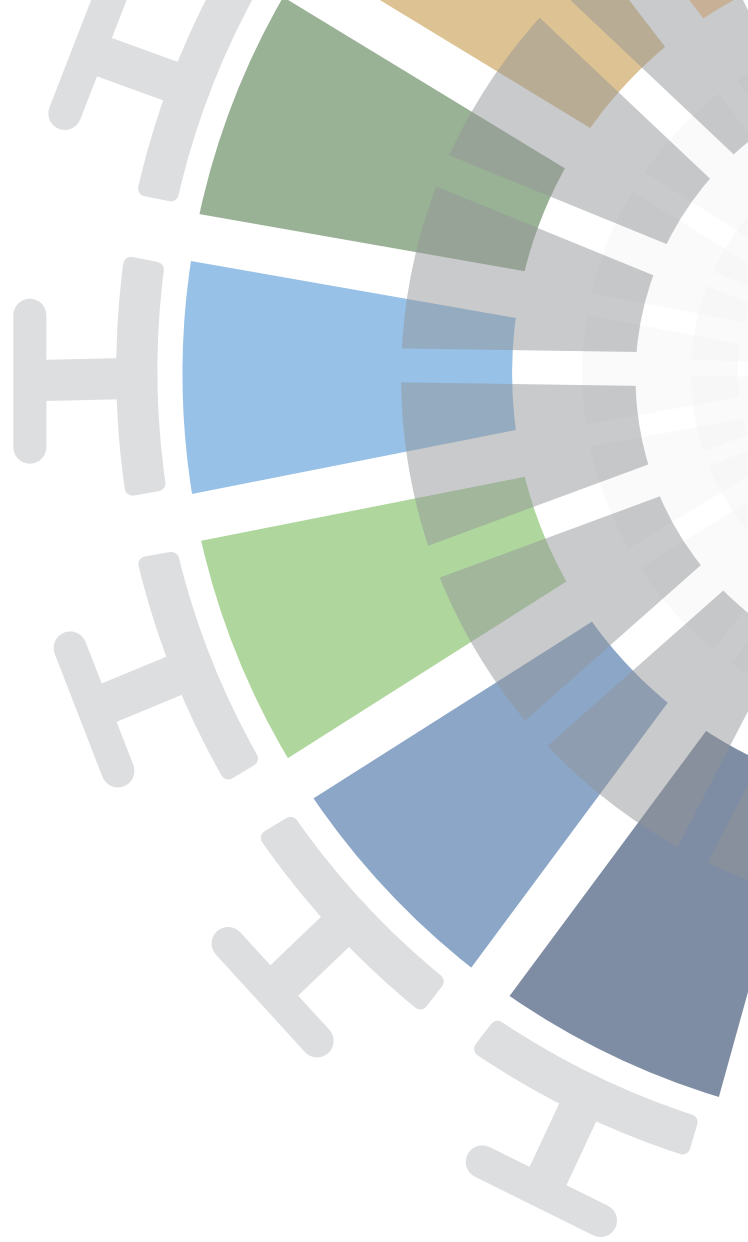
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