Presidium Model UN'21

United Nations Women

Discussing Gendered Impacts of the COVID-19 Pandemic

Background guide

Introduction

Widespread unemployment, job displacement, and income loss have characterized the lives of millions since the onset of the coronavirus disease 2019 (COVID-19) pandemic. Around the world, early findings show that effects of the recent COVID-19 crisis are not equally distributed. People of color and women with caregiving responsibilities are bearing the brunt of the pandemic in the United States and around the globe. Early in the pandemic, the U.S. unemployment rate for women 16–19 years of age hovered at 36.6 percent in contrast to 27.6 percent of men of the same age. The incidence of job loss was higher among women from racial and ethnic minority groups than among whites, with unemployment rates among Black and Hispanic women reaching double digits in September 2020. During the last month of 2020, all of the job losses were sustained by women of color. Millions of women with children were forced to reduce their paid work and leave employment as result of school and child care center closures, social distancing measures, and reduced availability of child care provision.

Are the trends of increased gendered disparities in paid and unpaid work also common in other countries? The answer is not simple. Government policies matter. In Canada, for instance, Fuller and Qian investigated the gender gap in employment among parents of young children. They draw on monthly data from Canada's Labour Force Survey during February through October 2020. They find that gender employment gaps among parents first widened when child care and schools closed but narrowed with reopening of schools and increased availability of child care options. Gender gaps in parents' employment and work hours reverted back to prepandemic levels for university-educated parents and narrowed among less-educated parents. Fuller and Qian conclude that when employment barriers eased, so did the gender employment gap, but that prioritizing affordable child care is critical to ensure recovery.

As Pirtle and Wright show in their article about gendered racism in the United States, so, too, are economic and social disruptions felt differently across a variety of family forms in Australia. Craig and Churchill use data from an online survey of Australians during pandemic lockdown to investigate how subsamples of lesbian, gay, and bisexual mothers and fathers in couples and single mothers subjectively experienced unpaid work and care during the pandemic. They find that these families fared better than heterosexual couples. Single mothers' subjective experiences during the pandemic were more positive than those of partnered mothers. Here, too, government policy matters. These single mothers may have had more time because they did not have to commute, and they also had Australian government support payments during the pandemic. Other families reported time pressures but less inequality between partners than did heterosexuals. Craig and Churchill conclude that many families would welcome greater flexibility in work hours and workplace attendance. Such

flexibility is unlikely to create more inequality in these single-parent and same-sex parent families.

The trends revealed in Israel by Yaish, Mandel, and Kristal mirror those in the United States. Using data from 2,027 Israeli adults who were followed before and during the pandemic, they find that women increased their housework load as the demand for domestic work increased. Women who had flexible working arrangements were particularly penalized as they reduced their employment to bear greater domestic loads and child care.

The research from the United Kingdom shows that the pandemic did not seriously diminish gender inequality between heterosexual partners. Chung and colleagues show that while couples were somewhat more likely to share the household work during the pandemic, women still did the majority. Women did even a higher percentage of the work of teaching their children when that work increased as schools were shut down.

Agarwal's article reminds us that gender inequality during the pandemic increases both within the family and outside of it. In a thorough analysis, Agarwal reveals that in India, too, women bear the brunt of the pandemic. Drawing on data from the Centre for Monitoring the Indian Economy, she illustrates that the incidence of unemployment and joblessness was significantly higher among women than men in India during the pandemic. Joblessness resulted in limited access to food, reduction of daily meals, high debt levels, economic and emotional distress, and erosion of livelihoods. Government relief packages failed to reach and provide women with cash relief, leaving them socially dependent.

These unprecedented social and economic disruptions have provided gender scholars with the opportunity to highlight long-term structural gender disparities and to study the impact of COVID-19 on gender inequality. To what extent are gendered disparities of COVID-19 felt differently across family contexts, across national borders, and by women of different racial and minority groups within national borders? How do the gendered impacts in paid and unpaid work vary cross-nationally? These are questions the Executive Board hopes that this committee will address.

Gendered Violence: A Shadow Pandemic

One in three women worldwide experience physical or sexual violence mostly by an intimate partner. Violence against women and girls is a human rights violation.Since the outbreak of COVID-19, emerging data and reports from those on the front lines, have shown that all types of violence against women and girls, particularly domestic violence, has intensified.

Gendered violence has ultimately emerged as a Shadow Pandemic growing amidst the COVID-19 crisis and we need a global collective effort to stop it. As COVID-19 cases continue to strain health services, essential services, such as domestic violence shelters and helplines, have

reached capacity. More needs to be done to prioritize addressing violence against women in COVID-19 response and recovery efforts. With a rapid increase in the number of COVID-19 cases across the world in the past few months, several international organisations took cognisance of a global rise in Domestic Violence (DV) cases as a result of physical distancing regulations and its subsequent lockdowns. Many countries reported a 15-30% hike in the number of distress calls received from women who were confined in closed spaces with abusive partners.

Women worldwide consider informal channels as their first point-of-reporting in the case of domestic violence. The first respondent is often the family and the police the last. In India, the National Family Health Survey, conducted in 2015-16, revealed that 33% of married women in the age group of 15-49 experienced physical, sexual, or emotional spousal violence. Of these women, only 14% sought help and 77% never spoke about it. Among those who sought help, 65% reported to the natal family and only 3% reported to the police.

The series of COVID-19 lockdowns in India diminished the opportunities of reporting of domestic violence cases. Here's why:

- **Restricted movement:** The lockdown incapacitated women by preventing them from moving to safer places in cases of violence and abuse. With men and women cohabiting together for longer periods, the privacy of women plummeted and instances of violence rose.
- **Handicapped mediums of communication:** The Whatsapp number launched by the NCW had a limited reach as only 38% of women in India own phones and fewer have an internet connection, making this platform inaccessible to majority of women in the country.
- **Reduced contact with the natal family:** Natal family is usually the first point of contact for the victim. They are not only essential in supporting the victim in filing a complaint but also facilitate filing of complaints to the police. The constant presence of the perpetrator made it difficult for the victims to contact their first respondent which ultimately deterred them from reporting to institutionalised channels.
- **Unavailability of the formal support system:** The machinery under the Protection of Women from Domestic Violence Act had not been identified as an essential service during the lockdown. Hence, the protection officers were not able to visit households of victims, NGOs were not able to have physical interactions with them and the police officers being at the frontline in our effort to tackle COVID-19 were overstretched to help victims effectively.

While the nationwide restrictions have been relaxed, various state and district level lockdowns are invoked every now and then, allowing the pandemic of domestic violence to sprout

alongside. We must not count violence against women as an inevitable outcome of a crisis but improve the otherwise delayed policy implications to address the situation.

Internationally, there is a heightened need to address the issue of increased gendered violence at a structural level, and initiate domestic measures to increase access to reparative and retributive mechanisms. Accessibility to these resources remains a challenge, despite several member nations being members to international human rights instruments like the ICCPR, ICESCR and CEDAW.

Economic impact of the COVID-19 pandemic on women

With the onset of the COVID-19 pandemic and widespread national lockdowns, economists had predicted drastic economic shocks in world markets. Experts also warned world leaders of the gendered economic impact of the pandemic, recognising women as a key vulnerable group. Generally, women earn and save less than men, owing to the largely inequitable distribution of wealth and socio-economic privileges in the world economy. Additionally, they are the majority of single-parent households and disproportionately hold more insecure jobs in the informal economy with less access to social protections. This leaves them less able to absorb compounded economic shocks, such as layoffs, caused by the global economic slowdown.

UN Women survey results from Asia and the Pacific show that women are losing their livelihoods faster than men and have fewer alternatives to generate income. Since the start of the pandemic, in Europe and Central Asia, 25 percent of self-employed women have lost their jobs, compared to 21 percent of me— a trend that is expected to continue as unemployment rises. Projections from the International Labour Organization suggest the equivalent of 140 million full-time jobs may be lost due to COVID-19; and women's employment is 19 per cent more at risk than men. In the U.S, women's unemployment – which was lower than men's before the crisis – went up from 2.7 million to 11.5 million while men's reached 11 million over the same period, according to the U.S. Bureau of Labor Statistics. 92 percent of employed women in Sub-Saharan Africa and 54 percent of employed women in Latin America work in the informal sector. During the first month of the pandemic, estimates suggest that informal workers in these regions lost 81 percent of their income. Therefore, as it is evident that the pandemic has impacted the economic status of women more adversely than men's, this portion of the guide aims to delve deeper into the policy issues concerning these differences, their consequences, and the road ahead.

According to the UN Commission on the Status of Women, COVID-19 has led to a larger drop in female employment, 8 percent, as compared to 7 percent for their male counterparts, whereas female owned firms (FOFs) are more likely to on look a greater contraction of sales as well as worse financial situations than male owned firms (MOFs). These figures point to the systemic

differences between men and women in the global economy, and indicate that the pandemic has largely worked to exacerbate them. These systematic differences can be traced back to certain economic policy categories that, generally, have proven to be inadequate in addressing the pandemic's impact from a gender-sensitive lens.

- **Labour market issues:**
  Problems facing women in the labor market have never been hidden, but they have been inconvenient to address because they are so entrenched in the basic operations of our economy and society. The low wages associated with "pink collar" occupations have long contributed to the feminization of poverty, and the chronic shortage of affordable, high-quality child care reflects outdated notions of women's societal roles, how the economy functions, and child development. COVID-19's massive disruption to employment, childcare, and school routines has crippled the economy and pushed millions of women and families to the financial brink. This moment provides an important opening to rethink how policy supports women's roles as financial providers and parents. For as long as they have been a part of the global economy, women have faced discrimination in the labor market, even when they make the "right" choices. The earnings disparity between women and men specifically illustrates the devaluation of women's contributions to the labor force. Occupations dominated by women, particularly care and domestic workers like home care aides, offer lower wages globally. As we know, COVID-19 has massively disrupted life. At the beginning of the pandemic, non-essential businesses closed their doors, workers were laid off, and schools and daycares sent children home. Given their concentration in the informal economy, low-wage and face-to-face jobs, these layoffs hit women especially hard. While many higher wage jobs could transition from an in-person to remote work environment, that is not the case for the majority of low-wage and informal sector jobs that rely on interaction between customers and workers, such as retail sales and hospitality, two of the most common occupations among low-wage women. COVID-19 has also increased the pressure on working mothers, low-wage and otherwise. Even in a developed State like the U.S, women who became unemployed during the pandemic reported the job loss was due to a lack of childcare, twice the rate of men surveyed. These long-standing concerns for women in the labour market have become imperative for policy makers to address, specifically through a gender-sensitive lens. Addressing unpaid care through legislative means on a local, national, as well as inter-governmental level must be an urgent priority. Similarly, making the labour market more equitable in the distribution of women and men in low-wage and informal sector jobs is a policy goal that must be painstakingly achieved if women are to be protected from falling into the vicious cycle of extreme poverty.

- **Fiscal and economic issues:**

> Economic policy measures have largely been gender non-responsive, meaning that they do not recognize or address the specific challenges and vulnerabilities that women face, more so in the pandemic context. Out of 2,280 fiscal, labour market and social protection measures identified in the COVID-19 Global Gender Response Tracker, coordinated by UN Women and the United Nations Development Programme (UNDP), only 287 explicitly address women's economic security, mostly through policies to support women entrepreneurs and informal traders, or through provision of cash transfers or grants. So as to neutralise the effects of the pandemic, governments must identify gender needs and allocate resources to programmes, including social protection and employment, that are vital for a gender-responsive recovery. Equitable and sustainable support and recovery measures will require adequate and targeted public investment as well as the reprioritization of public spending to address policy gaps. Ministries of finance have a critical role to play in expanding resource availability, including by modifying budget rules, introducing supplementary budgets or increasing spending within existing lines—or some mix of these fiscal measures. Faced with the immediate demand for additional spending in the health sector and to support employment and incomes, the global economic and fiscal response has been unprecedented. So far, the overwhelming majority of the spending has been disbursed by high-income countries and it is anticipated that countries unable to borrow at low rates of interest will be required to introduce austerity measures to reduce their budget deficits and debt-to-GDP ratios once the pandemic is under control. This may shift their focus away from gender-responsive fiscal policies. However, prioritising women as individuals in the economy, macroeconomic sectors that are dominated by women, and ensuring women's economic security appear as very necessary policy objectives if governments aim to soften the catastrophic blow of the pandemic.

In a broader context, economic insecurity is not just jobs, and income loss today. It has a snowball effect on the lives of women and girls for years to come. Impacts on education and employment have long lasting consequences that, if unaddressed, will reverse hard-won gains in gender equality. Estimates show that an additional 11 million girls may leave school by the end of the COVID crisis; evidence from previous crises suggests that many will not return.

A widening education gender gap has serious implications for women, including a significant reduction in what they earn and how, as well as an increase in teen pregnancy and child marriage. Lack of education and economic insecurity also increase the risk of gender-based violence. Without sufficient economic resources, women are unable to escape abusive partners and face a greater threat of sexual exploitation and trafficking. Women are likely to experience long-term setbacks in work force participation and income. Impacts on pensions and savings will have implications for women's economic security far down the road. The fallout will be most severe for the most vulnerable women: migrant workers, refugees, marginalized racial and ethnic

groups, single-parent households, youth and the world's poorest. Those who have recently escaped extreme poverty will likely fall back into it.

Beyond the public health crisis, COVID-19 has rapidly morphed into a full-fledged economic and social crisis. The effects will likely reverberate for years to come. As governments try to contain the damage, rampant inequalities have once again been revealed. Within countries, the spread of the virus and its impact have been exacerbated by inequalities along class, race/ethnicity, age and gender lines. Globally, rich and poor countries alike are struggling to keep their citizens safe and secure. The Beijing Platform for Action and the targets of the SDGs continue to be relevant road maps for action, and it is more crucial than ever to achieve them. Without coordinated action to mitigate the gendered impacts of COVID-19, there is a risk that the fragile gender equality gains achieved over the past 25 years will be lost. There is a dire need for policies to address the social and economic consequences of the crisis, wherein women's leadership and perspective are paramount and will help to ensure a more equitable recovery.

Healthcare for women during the COVID-19 pandemic

Historically, women and girls have been often denied healthcare outright or face dangerous delays getting the services they need. The impacts of misguided policies and barriers to care are especially severe in places with weak or overburdened health systems, which constitute a vast majority of the world during the pandemic. According to the Beijing Declaration, "Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well-being elude the majority of women and a major barrier for women to the achievement of the highest attainable standard of health is inequality."

This inequality stands true in the face of the pandemic, as women represent 70% of workers in the health and social sectors, while they also perform the bulk of unpaid care and domestic work in homes, including caring for sick family members, which leads to more exposure to the virus. Although the majority of cases have been among men, women account for more than 63% of cases in the 85+ age cohort. Furthermore, according to Kaiser's KFF survey, when asked about their experiences accessing health care services during the pandemic, a larger share of women than men say they have skipped preventive health services, such as a yearly check-up or routine test (38% vs. 26%) or skipped a recommended medical test or treatment (23% vs. 15%). Nearly half of women who report being in fair or poor health report skipping preventive care (46%) and nearly one-third have skipped recommended tests or treatment (32%). Those in poor health may view themselves as more at risk for COVID exposure and opt to skip routine preventive care. This gap in care among those with the greatest health problems could portend an increase of the

share of patients experiencing more severe health conditions resulting from care that was foregone or delayed during the pandemic.

Nevertheless, women also have unique health needs, but they are less likely to have access to quality health services, essential medicines and vaccines, maternal and reproductive health care, or coverage for routine or catastrophic health costs, especially in rural and marginalized communities. It is well established that healthcare largely concerning women and girls has proved to be inadequate during the COVID-19 pandemic, thus, this portion of the guide aims to delve deeper into the policy issues concerning these difficulties, their consequences, and the road ahead.

Based on interviews conducted with Médecins Sans Frontières (MSF) staff in Colombia, Honduras, Greece, Uganda, Mozambique, South Africa, Iraq, and Afghanistan, the biggest challenges facing women and girls right now include: closures and cuts to sexual and reproductive health services; movement restrictions, including travel bans, lockdowns, and curfews; global supply chain disruptions; lack of clear public health information and guidance. Additionally, refugees, migrant workers, and people working in informal jobs face more difficulties than usual in getting access to basic healthcare, as these challenges are compounded by COVID-19.

It is imperative to focus on sexual and reproductive health needs as they are often neglected in the midst of an emergency – and COVID-19 has been no different. Although access to safe delivery care has long been acknowledged as an essential health service, many pregnant women suddenly found themselves with fewer options for care. For instance, in Likoni, Kenya, health centres where women normally deliver were shut down, and health workers were reassigned to the COVID-19 crisis while in Mosul, Iraq, a main government hospital was temporarily repurposed as a COVID-19 treatment centre. More consequentially, in Brazil, the maternal death rate due to COVID-19 has become 2x higher among Black women than white women and in Azerbaijan and Turkey, 60% of women have had trouble accessing gynaecological and obstetric care as a result of COVID-19.

Some sexual and reproductive health services, such as contraception and safe abortion care, are often seen as non-essential or even illegitimate. These services have been highly politicised, making them all the more likely to be deprioritised during a crisis as we are seeing now. Since the COVID-19 pandemic began, thousands of centres providing sexual and reproductive health services have shut down, and more closures are predicted. A study by the Guttmacher Institute predicts closures could eliminate as much as 80 per cent of these services, including contraception and safe abortion care. The study estimates that even a 10 per cent cut would mean some 15 million additional unintended pregnancies, more than 3 million additional unsafe abortions, and 28,000 additional maternal deaths. The deprioritisation of sexual and reproductive health related matters, such as abortion care, comes at the cost of losing countless lives due to

policy issues and laws surrounding them, as well as the effects that the pandemic has had on transportation and accessibility of healthcare.

The provision of sexual and reproductive health services, including maternal health care and gender-based violence related services, are central to the health, rights and well-being of women and girls. The diversion of attention and critical resources away from these provisions has resulted in exacerbated maternal mortality and morbidity, increased rates of adolescent pregnancies, HIV and sexually transmitted diseases. In Latin America and the Caribbean it is estimated that an additional 18 million women will lose regular access to modern contraceptives, given the current context of COVID-19 pandemics.

Another important key group to consider is women as healthcare workers. COVID-19 continues to exacerbate existing inequalities and place a disproportionate burden on women, including in health-care settings. Women health workers are faced with increased workloads, a gender pay gap, shortages of personal protective equipment that fits them, and harassment and violence as they respond to the pandemic on the frontlines. Although women make up 70% of the health workforce, they hold only 25% of senior roles. Pandemic lockdowns and restrictions have also disproportionately impacted female workforces, especially those who also have domestic responsibilities and caregiving duties, affecting most of the services that helped them find a work-life balance, overloading them more than ever.

The daily emotional and mental pressures have been documented, showing a higher prevalence rate of anxiety, depression and suicide in female frontline workers. Ensuring the mental health and well-being of the healthcare workforce globally, especially women healthcare workers , is an ongoing challenge that, much like other gender inequalities, has been accentuated by the novel coronavirus (COVID-19) pandemic. Already at high risk of experiencing symptoms of stress, burnout, and depression, women are now also facing the psychosocial impacts of the COVID-19 pandemic. Physicians' use of mental health services is low, especially among females, as evidenced by the fact that nearly 50% of women physicians surveyed who believed they met criteria for a mental illness reported not seeking mental health treatment. Previous research has suggested that women healthcare workers frequently cite a lack of time, concerns related to confidentiality and stigma, and fear of professional consequences, including effects on licensure status, as barriers to engaging with mental health services.

Although access to healthcare has been cited as a right granted to women by the power vested in several declarations and conventions, there has been an inadequate focus on it by policy makers, as evidenced by global policy deprioritization of women’s health during the pandemic. To neutralise the impact of the pandemic and improve women’s social status in a post-COVID world, it is necessary for decision makers to invest in gender sensitive reporting of data correlating to healthcare. Furthermore, it is the need of the hour for the UN and national governments to tackle policy challenges surrounding rural, refugee and migrant women’s access

to healthcare; accessibility of sexual and reproductive healthcare; women's inability to access preventive care; women healthcare workers' professional and mental well-being so as to ensure progressive steps towards reversing the damage of the pandemic and improving the status of women in the society.

Resources

Gendered violence sources:

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