

STUDY

Requested by the FEMM committee



The gendered impact of the COVID-19 crisis and post-crisis period



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Abstract

Outbreaks affect men, women and other genders differentially. This can be both the direct infections with a pathogen, or the secondary effects of public health response policies. COVID-19 is no exception, and the gendered impacts thus far and in the future are numerous. This study outlines some of the key gendered effects thus far and suggestions for how these may extend into the post-crisis period based on currently available data on COVID and longer-term effects of previous outbreaks. This includes the lack of sex-disaggregated data, the role of healthcare workers and care workers, domestic violence, the impact of quarantine on feminised sectors of the economy, the additional unpaid labour on women as a result of lockdown, access to maternity, sexual and reproductive health services. This study commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee.

This document was requested by the European Parliament's Committee on Women's rights and Gender Equality.

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LIST OF ABBREVIATIONS

ACE2	Angiotensin-converting enzyme 2
COPD	Chronic obstructive pulmonary disease
COVID	Coronavirus Disease
ECDC	European Centre for Disease Prevention and Control
EIGE	European Institute for Gender Equality
IHME	Institute of Health Metrics
ILO	International Labour Organization
IPVNF	Intimate Partner Violence
LGBTIQ	Lesbian, Gay, Bisexual, Trans, Intersex and Queer
OECD	Organization for Economic Cooperation and Development
PPE	Personal Protective Equipment
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
WHO	World Health Organization

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EXECUTIVE SUMMARY

COVID-19, like previous epidemics infect and affect men, women and other genders differently. Whilst indications suggest that more men than women are dying of COVID-19, the impact of the (short and longer term) socio-economic effects of COVID-19 fall disproportionately on women. Beyond this gendered effect, these outcomes intersect with other drivers of vulnerability and are particularly acute for black, Asian and minority ethnic groups, as well as LGBTIQ communities. Importantly, these effects are not because of the pathogen itself, but as a consequence of the public health interventions and policies introduced by governments to minimise the spread of SARS CoV-2 pathogen. These gendered affects are evident in several fora:

Firstly – women comprise 76% of the c. 49 million healthcare workers in the EU. This means it has been predominantly women on the frontlines combatting the COVID-19 pandemic, delivering care to those infected. It is estimated that approximately 10-11% of COVID-19 infections are amongst healthcare workers¹. These healthcare worker infections mirror workforce trends and have been predominantly amongst women. Women not only make up most of the healthcare workforce, but they also comprise much of the broader care sector, including elderly care, social care, disability carers, childcare, domestic assistants, and cleaners. These jobs each have increased exposure to infection with COVID-19 due to prolonged, proximal contact with people daily.

Recommendation: The gendered nature of healthcare workforce must be recognised, and the additional risks on women performing these roles mitigated through access to Personal Protective Equipment (PPE) and financial and personal security for them to perform their work safely.

Recommendation: Invest in care led economy to stimulate employment and ensure continuity of these essential services.

Secondly, women have not only provided care formally as healthcare workers, but women have absorbed most of the informal and unpaid care in the COVID-19 pandemic too. As quarantine and self-isolation orders came into place, and schools and childcare providers were closed, social norms and decisions related to pay have meant that women have increased their time spend on domestic tasks. In dual parent households, whilst being at home has seen an increase in men's domestic labour and childcare, women's domestic labour has increased more than men's (and women were doing significantly more hours of invisible labour in the pre-pandemic period). For some women this has meant having to take unpaid leave from paid employment, or a dramatic reduction of hours. Others have significantly shifted their working patterns to be able to accommodate multiple paid and unpaid demands. These trends are even more acute amongst mono-parental households, the majority of whom are women. This change to working practice has significant impact on family finances, and there are concerns that job security may become an increasing problem in the post-pandemic period if women, needing to care for their children and thus reduce their work load, have demonstrated to their employers that their work is "non-essential". As job cuts and recession is widely expected across EU states, this might put women at greater risk of redundancy and unemployment than their male counterparts who have continued to work during lockdown. Women's informal care role during

¹ Nguyen LH, Drew DA, Joshi AD, Guo C-G, Ma W, Mehta RS, et al. Risk of COVID-19 among frontline healthcare workers and the general community: a prospective cohort study. medRxiv. 2020:2020.04.29.2008411;

COVID-19 is also producing significant effects on women's mental health, with women reporting increased anxiety and worry about their family and well-being, and about their finances.

Recommendation: Employers must recognise the distribution of domestic labour within households and how this impacts paid employment. Redundancy protection on account of childcare responsibilities should be mandatory.

Recommendation: As COVID-19 related home working and quarantine may continue for a number of months, social and financial protection, such as children allowance, or paid parental leave must be provided to families.

Recommendation: Data on redundancies and job losses must be disaggregated by sex.

Thirdly, domestic violence is a significant problem during COVID-19 related lockdown. Most domestic violence occurs within the home, thus, requiring people to stay at home to avoid COVID-19 transmission unsurprisingly led to increased rates of violence. Domestic violence is notoriously hard to measure, and concerns have been raised that lockdown requirements also limits women's ability to report domestic violence. Calls to domestic violence hotlines have provided a pertinent proxy for rates of inter-personal violence. These calls have increased by 20 – 60 % across the EU, demonstrating a significant problem for societies and governments. EU governments have taken strides to try and reduce the risks to women, including increased funding to these hotlines, subsidising hotel rooms for women at risk, and introducing mechanisms for women to report violence clandestinely.

Recommendation: governments must actively seek to reduce risks to women in their own homes through increased mechanisms to report domestic violence, creation of subsidised safe spaces for women who wish to leave their homes and increased vigilance and intervention for those reporting to hotlines.

Fourth, COVID-19, like outbreaks in the past, have led to a distortion of health systems as health resources get diverted to manage the crisis at hand. This has several downstream effects for women, particularly in their access to safe sexual and reproductive health services (SRH). Firstly, there have been significant changes to maternity provision across EU states. This means that women are likely not accessing routine ante- and post- natal care, or this care has moved to online or phone delivery. Data is still being collected to understand the effect that this might have on safe birth outcomes for mother and baby. There are also concerns about increased anxiety amongst mothers if they are unable to have in person checks of baby and/or are not allowed to have a partner with them in clinics. Contraception access has been disrupted because of COVID-19. The supply of contraceptives has been disrupted as production has halted due to self-isolation orders and the closure of manufacturing plants. This has a lag effect across the EU, compounded by disruption to supply chains and travel distribution routes with limits on trade to EU states. Demand for contraceptives may also be affected as women may not wish to visit a clinic to seek contraceptives due to fear of potential COVID-19 infection. Abortion services are also at risk by COVID-19. Abortion is a time sensitive health need, and if women's access is limited, either because the service is deemed "non-essential" or as supply is reduced as resource is shifted to COVID-19 this risks women seeking unsafe abortion elsewhere posing danger to their lives.

Recommendation: quality SRH services must be maintained throughout the pandemic and post-pandemic period. To facilitate access, contraception should be freely available in pharmacies and supermarkets.

Recommendation: Ante- and post- natal services should be maintained in person for those who need them. Provision could be moved from clinical settings to community settings to reduce risks of infection and/or perceptions of risk of infection.

Recommendation: Access to abortion should be facilitated through telemedicine and reduction in mandatory waiting periods for procedures.

Fifth, women's economic empowerment will likely continue to be significantly affected in the coming months and years due to the sector wide affects of COVID-19 interventions. The sectors of the economy which have been most significantly affected by lockdown measures are hospitality, recreation, tourism, and education/childcare. These sectors are highly feminised and thus as organisations become insolvent because of changes to daily lives, this risks significant unemployment for women. Unlike usual recessions which tend to affect traditionally male sectors of construction and manufacturing, this COVID-19 related recession has been dubbed a "she-cession"

Recommendation: Ensure governments focus stimulus and/or bailout packages on those sectors which have been disproportionately affected by COVID-19 shutdown.

Recommendation: Ensure childcare sector is a priority in the post-pandemic period, as an employer of women, and as facilitator of women's participation in the labour force.

Sixth, whilst these trends are emerging during COVID-19, data which demonstrates the differential effect of COVID-19 and related policies are lacking. Fewer than 50% of countries globally are reporting sex-disaggregated data for COVID incidence and mortality. Even fewer countries are reporting disaggregated data to understand the distribution of the downstream socio-economic effects of COVID-19 interventions.

Recommendation: Governments to increase collection and reporting of data related to COVID (and other health issues) in line with WHA resolution 60.25 (2007) and socio-economic effects disaggregated by sex, and where possible by ethnicity and age to understand real-time trends to inform decision-making.

1. GENDER AND COVID-19

KEY FINDINGS

COVID-19 has significant direct and indirect effects on women and other genders. These are not uniform, but the disproportional effects of the pandemic will likely fall on further marginalised groups within Europe. This will include low income groups, black, Asian and ethnic minority groups, Roma, and LGBTIQ communities.

Policy must be cognisant of these intersecting vulnerabilities and ensure purposeful recommendations to address their particular needs.

1.1. Introduction

COVID-19, like Zika and Ebola, differentially infects and affects women and men. As this report highlights, whilst men may be experiencing worse health outcomes of COVID-19 infection, we do not yet know the true sex-disaggregated incidence between males and females due to a paucity of sex-disaggregated data on cases.

However, all crises, whether caused by disease, natural disaster, climate change or conflict exacerbate gender inequalities. Identifying the ways that disease outbreaks affect men and women differently is key to creating effective, equitable policies and public health interventions to reduce disease transmission and mitigating strategies to limit the secondary effects of social and economic policy. These are multi-faceted, as outlined below. Firstly, feminised sectors of the economy have been particularly acutely hit by COVID-19 restrictions. This can be seen primarily amid healthcare workers, 76% of whom in the EU are women. Women are not only exposing themselves to risk of infection (and indeed death), but have seen increased workloads, mental health concerns, and some have distanced from their families causing emotional harm. Beyond healthcare settings, those industries which have been most disrupted by stay at home orders are those of hospitality, tourism, education and recreation; sectors which employ more women than men. This means that women have been at greatest risk of unemployment and/or being placed on furlough or equivalent employment protection schemes.

Women's employment may also suffer given the additional domestic load that women are performing during lockdown. Data from across the EU has shown that women have absorbed more of the unpaid care during months of lockdown, both limiting their ability to continue with paid work, and causing considerable stress and mental health concerns. These are even more acute amongst single parents.

Lockdown has also posed a significant risk to women's physical health. Distortion of health services has meant that women have changed the way they engage with healthcare providers, affecting access to reproductive health services, namely contraceptives, ante- and post- natal care and abortion. This may have long-term effects for women across the EU which are yet to be fully understood. Women have also faced a shocking increase of domestic violence because of mandatory quarantine orders. Whilst notoriously hard to measure, proxy measures such as calls to violence support hotlines have skyrocketed across the EU and globally. This in depth analysis summarises the currently understood socio-economic effects of COVID-19 for women across EU states.

At the global level, COVID-19 threatens progress for women and girls within the Sustainable Development Goals (SDG) including SDG 1 : Eradication of Poverty, SDG 3: quality education, SDG 5: on gender equality and SDG 8 : on decent work and economic growth. As gender is context specific,

the effects of COVID-19 will be distinctly different in different parts of the world. Within the EU, COVID-19 poses risks to recent gains in gender equality such as increased participation of women in the labour market, increasing availability of work-life balance and flexible working provision, paid parental leave, access to affordable childcare, reduction in gender pay gaps, recognition of invisible and under-recognised labour that women perform, increased representation of women in leadership positions etc.²

A definitional note, for the purpose of this paper, sex denotes biological markers and attributes of men and women in terms of reproductive organs and functions based on chromosomes and physiology. Gender reflects socio-cultural norms, identities and relations that are deemed “masculine” and “feminine” behaviours.

1.2. Methodology

As COVID-19 is emerging in real time, with data being continually collected, and subject to analytical and publication delays, the methodology for this paper is multi-method. Firstly, a scan of journal databases; Web of Science, Medline and Google Scholar has identified peer reviewed academic publications which were available (albeit limited, and mostly commentary rather than based on original data). Secondly, grey literature was reviewed through compilations created by gender advocates and feminist organisations which have been collating evidence of the gendered effects of COVID-19. This has included the Gender and COVID-19 working group³ and other resource compilations, including Data 2X⁴, Centre for feminist foreign policy, EuroMed Women, EIGE, and beyond. Thirdly, EU institutional websites were scanned for data related to gendered effects of COVID and incorporated where possible. Conducting analyses mid pandemic is always difficult – however, following guidance of the Inter-Agency Standing Committee⁵, gender analysis should seek to be rapid, and work with the best data available, including non-peer reviewed or official sources where necessary, in order to document the potential concerns. Thus, I recognise any gaps in the literature presented, and offer this as a living document, which can be updated as new data and findings emerge. Once data was compiled, gender analysis involved consolidating findings into key domains including formal and informal care, intersectionality, violence, structural inequality, decision making and access to resources. The results presented are categorised as requested in the terms of reference.

1.3. Impact of COVID-19 on LGBTI Communities

COVID-19 intensifies the difficulties for LGBTI populations. A gender analysis of the outbreak must consider the differential experience of all genders to ensure equality is maintained. The impacts of COVID on LGBTI communities can be wide-reaching.

Social distancing may be particularly difficult for LGBTI individuals who may have been rejected by their families, who have not come out to their families and find themselves in lockdown with them and/or those who are facing mental health issues. The 2019 Eurobarometer indicated that only 55% of Europeans would be comfortable if their child was in a relationship with an LGB person, dropping

² European Commission. 2019. 2019 Report on equality between men and women in the EU. As accessed: https://ec.europa.eu/info/sites/info/files/aid_development_cooperation_fundamental_rights/annual_report_ge_2019_en.pdf

³ Gender and COVID Working Group: Resources. As accessed: <https://www.>

³ ILGA [genderandcovid-19.org/resources-page/](https://www.ilga.org/resources-page/)

⁴ <https://data2x.org/>

⁵ Inter-Agency Standing Committee. 2020. Global Rapid Gender analysis for COVID-19. As accessed: <https://interagencystandingcommittee.org/global-rapid-gender-analysis-covid-19>

to 44% for an intersex person and 43% for a trans person. Quarantine policies can mean that they are unable to access support.

This can result in an increase in domestic violence experienced by LGBTI people. During COVID there have been reports of increased domestic violence from 23 countries across Europe and Central Asia, evidenced by greater volumes of calls to LGBTI hotlines. Whilst some domestic violence refuges have only been open to women, in Italy some actively opened their doors to LGBTI individuals too⁶.

Mental health issues have also been thought to be rising amongst this group because of self-isolation alone or in difficult circumstances⁷. This is compounded by changes to or reductions of mental health services as a result of COVID-19's distortion of the health system. Alterations, cessations, or reduction of mental health provision has been documented in Greece and Netherlands⁸. Specialists are particularly concerned about the mental health of these communities during lockdown, amongst a group who are at higher risk of developing psychological health problems⁹. There have been examples of civil society groups actively trying to mitigate against these concerns across Europe. Online groups for mental health support for LGBTI communities have seen an increase since February 2020 in Belgium and United Kingdom¹⁰. A mental health provider in Bulgaria began to offer psychological support online. In Sweden, socially distanced outdoor activities have been arranged for LGBTI people.

The literature is consistent on the discrimination and stigma posed to LGBTI groups seeking healthcare and other social services. Consequently, LGBTI people have significantly worse health outcomes (prior to the pandemic)¹¹. These are caused by negative attitudes and discrimination, shortage of specialised healthcare professionals, denial of appropriate care and treatment, and demand side delays to accessing healthcare for fear being reported to authorities in countries that criminalise sexual and gender minorities¹². It is likely that these factors would be heightened during COVID-19 whether seeking COVID or non-COVID related care. This is compounded by disruption to sexual and reproductive health (SRH) services (as detailed below). In particular relation to transition related care, this has been significantly impacted by COVID prioritisation in health systems. Transition healthcare was halted in 26 European countries, affected those in transition and their ability to access continued treatment, such as hormone therapy¹³.

⁶ ILGA Europe, 2020, COVID-19 impacts on LGBTI communities in Europe and Central Asia: A rapid assessment Report. As accessed: <https://www.ilga-europe.org/sites/default/files/covid19-lgbti-assessment-2020.pdf>

⁷ van der Miesen, A. I., Raaijmakers, D., & van de Grift, T. C. (2020). "You Have to Wait a Little Longer": Transgender (Mental) Health at Risk as a Consequence of Deferring Gender-Affirming Treatments During COVID-19. *Archives of Sexual Behavior*, 1.

⁸ ILGA Europe, 2020, COVID-19 impacts on LGBTI communities in Europe and Central Asia: A rapid assessment Report. As accessed: <https://www.ilga-europe.org/sites/default/files/covid19-lgbti-assessment-2020.pdf>

⁹ Wang, Y., Pan, B., Liu, Y., Wilson, A., Ou, J., & Chen, R. (2020). Health care and mental health challenges for transgender individuals during the COVID-19 pandemic. *The Lancet Diabetes & Endocrinology*.

¹⁰ ILGA Europe, 2020, COVID-19 impacts on LGBTI communities in Europe and Central Asia: A rapid assessment Report. As accessed: <https://www.ilga-europe.org/sites/default/files/covid19-lgbti-assessment-2020.pdf>; Social Development Direct, 2020: SDDirect COVID-19 Pandemic Blog Series: Three Reasons why we need to make the COVID-19 response LGBTIQ inclusive. As Accessed: <http://www.sddirect.org.uk/media/1898/three-reasons-why-we-need-to-make-the-covid-19-response-lgbtiq-inclusive-final-002.pdf>

¹¹ ILGA Europe, 2020, COVID-19 impacts on LGBTI communities in Europe and Central Asia: A rapid assessment Report. As accessed: <https://www.ilga-europe.org/sites/default/files/covid19-lgbti-assessment-2020.pdf>

¹² Social Development Direct, 2020: SDDirect COVID-19 Pandemic Blog Series: Three Reasons why we need to make the COVID-19 response LGBTIQ inclusive. As Accessed: <http://www.sddirect.org.uk/media/1898/three-reasons-why-we-need-to-make-the-covid-19-response-lgbtiq-inclusive-final-002.pdf>

¹³ ILGA Europe, 2020, COVID-19 impacts on LGBTI communities in Europe and Central Asia: A rapid assessment Report. As accessed: <https://www.ilga-europe.org/sites/default/files/covid19-lgbti-assessment-2020.pdf>

Moreover, the economic downstream effects of COVID-19 will disproportionately fall on marginalised groups and the most vulnerable in society. LGBTI people are unemployed and in precarious jobs, and live on very limited and unstable financial resources, much beyond the average statistics.

Aggregate data show that LGBTQ communities are more likely to work in those industries most affected by the public health interventions to respond to COVID-19. This includes restaurants and food services, hospitality, hospitals, education, colleges and universities and retail sectors¹⁴. As these industries have shut due to quarantine restrictions, that has led to unemployment and/or precarious employment for many people. The likelihood of a sustained recession as a result of COVID and the public health response will increase the risk of job insecurity in these sectors for a long time, disproportionately affecting LGBTI communities.

An estimate in USA has suggested that 1 in 10 LGBTQ people are unemployed and 1 in 5 are likely to live in poverty, significantly more than straight and cisgender counterparts.¹⁵ This intersects with other drivers of inequality – indeed poverty rates for transgender adults, and in particular black and Latinx transgender adults are significantly higher at over 40 – 45%. This manifests in similar patterns in Europe. An estimated 25-40% of young people experiencing homelessness is estimated to identify as LGBTI.

Finally, enforcement of lockdown can be discriminatory, making judgements about who lives in a household, disrespecting same-sex partnership and Rainbow Families, which is often worsened by intersecting factors such as race. Furthermore, many trans people are unable to access identity documents presenting their correct name, gender marker, or photo, and increased police identity and paperwork checks can expose them to increased harassment, discrimination, and violence in this context¹⁶.

1.4. Black, Minority Ethnic, Roma and Disability

Previous public health emergencies have demonstrated that migrant, black and ethnic minority groups show disproportionate levels of mortality. For example, during H1N1, hospitalisation and mortality were substantially higher for indigenous groups in Australia and Canada. With regard to COVID-19 in the UK, the Office of National Statistics have reported that the death rate of black and ethnic minority people in hospitals was more than twice that of white ethnic groups¹⁷, mirrored by data from across Europe, such as a disproportionate rate of infection amongst Somali groups in Scandinavia¹⁸. Conversely in France and Germany, there have been concerns that the failure to collect and disaggregate data for historic reasons have meant that the differential exposures and vulnerabilities have not been made evident to policymakers. Explanations as to risk factors tend to focus on exposure: geographical areas where people live, where people work, and how they are treated at work. These structural inequalities are not new – but have been exposed by the pandemic. Many people from black and ethnic minority groups hold essential jobs, such as within the healthcare

¹⁴ Human Rights Campaign Foundation. 2020. The Lives and Livelihoods of many in the LGBTQ community are at risk amidst COVID-19 crisis. As Accessed: <https://assets2.hrc.org/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf>

¹⁵ M.V. Lee Badgett, Soon Kyu Choi, Bianca D. M. Wilson, 2019, LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups. UCLA School of Law Williams Institute <https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf>

¹⁶ Equinet European Network of Equality Bodies. 2020. COVID-19: What's the specific impact on LGBTI people in Europe? As accessed: <https://equineteurope.org/2020/covid-19-what-is-the-specific-impact-on-lgbti-people-in-europe/>

¹⁷ BBC. 2020. Coronavirus: Black Britons face twice the risk of death says ONS. As Accessed: <https://www.bbc.co.uk/news/uk-52574931>

¹⁸ Lena Masri. 2020. COVID-19 takes unequal toll on immigrants in Nordic region. Reuters. As accessed. <https://uk.reuters.com/article/uk-health-coronavirus-norway-immigrants/covid-19-takes-unequal-toll-on-immigrants-in-nordic-region-idUKKCN2260Y2>

sector, public transport, food supply, putting them in greater contact with the population and with those who might be infected. This disproportionately increases their risk of infection. This is heightened by poorly developed or over-crowded housing, the conditions of which can make physical distancing and self-isolation difficult¹⁹.

This can be seen particularly acutely for women. For example, black women are more likely to be the primary breadwinners in their homes than their white counterparts, and thus this means they may have to risk exposure in order to provide food and a home for their families²⁰. Data from USA has shown that black women spend significantly longer on their elderly care and childcare responsibilities within homes than white counterparts also²¹. Black and minority ethnic women are disproportionately represented in the childcare sector which may increase their exposure to infection²², but may also affect their vulnerability to the downstream socio-economic effects of COVID-19 response policy. For example, these differences can also be seen in job security during the pandemic, education of children, access to internet for home-schooling and the mental health burden or readjusting to life under lockdown²³.

Exposure only goes part of the way to explaining the problem. Co-morbidities for COVID-19, such as hypertension and diabetes, play a part in explaining why black and minority ethnic groups are more likely to be at risk and warrants further investigation. Diabetes, stroke, coronary heart disease and COPD are higher in African and South-Asian populations than in white populations. Black women are 60% more likely to have high blood pressure. Black people have lung cancer more than any other population group²⁴. These are risk factors in the outcome of COVID-19. These comorbidities can be further amplified by behavioural factors which reflect social determinants of health and disadvantage including diet, smoking and exposure to psychosocial stressors²⁵. However, grasping biological explanations allows public authorities to abdicate responsibility and ignore the role of systemic racism and socio-economic inequalities which are driving the serious illness and death associated with covid-19 in black and minority ethnic communities. Governments must commit to further disaggregating data across COVID and its second order effects to truly understand the differential burden between marginalised groups.

Roma populations in Europe face risks related to COVID-19. Conditions of extreme poverty and lack of health coverage mean that they are both more likely to be exposed to the virus, and to delay or avoid health service interactions if symptomatic either due to lack of health insurance or limitations on transport to access healthcare, putting their lives at greater risk²⁶. Moreover, 30% of Roma live without

¹⁹ Bhala, N., Curry, G., Martineau, A. R., Agyemang, C., & Bhopal, R. (2020). Sharpening the global focus on ethnicity and race in the time of COVID-19. *The Lancet*, 395(10238), 1673-1676.

²⁰ Christine Michel Carter. 2020. New Research Shows How The Coronavirus Recession is Disproportionately Affecting Black Working Mothers. Forbes. As accessed: <https://www.forbes.com/sites/christinecarter/2020/05/19/new-research-shows-how-the-coronavirus-recession-is-disproportionately-affecting-black-working-mothers/#5bd170561a5f>

²¹ Pew Research Center, 2018. A record 64 million Americans live in multigenerational households. As Accessed <https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/>

²² Catherine Powell, 2020, The colour and gender of COVID: essential workers, not disposable people. Think Global Health. As accessed: <https://www.thinkglobalhealth.org/article/color-and-gender-covid-essential-workers-not-disposable-people>

²³ Civis Data Science. 2020. COVID-19 Impact Research. Highlights from August 2020 Survey. As accessed: <https://www.civisanalytics.com/blog/covid-19-impact-on-the-american-population/>

²⁴ Lackland D. T. (2014). Racial differences in hypertension: implications for high blood pressure management. *The American journal of the medical sciences*, 348(2), 135-138. <https://doi.org/10.1097/MAJ.0000000000000308>

²⁵ Bhala, N., Curry, G., Martineau, A. R., Agyemang, C., & Bhopal, R. (2020). Sharpening the global focus on ethnicity and race in the time of COVID-19. *The Lancet*, 395(10238), 1673-1676.

²⁶ Neda Korunovska and Zeljko Jovanovic, Roma in the COVID-19 crisis: Early Warning from Six EU Member states, Open Society Roma Initiatives Office, Open Society Foundations <https://www.opensocietyfoundations.org/publications/roma-in-the-covid-19-crisis>

running water and 80% live in over-crowded housing meaning COVID-19 interventions such as hand washing, or social distancing may not be possible²⁷.

These health impacts are compounded by discrimination – for example, in Bulgaria soldiers, police and drones have been more present in Roma communities in the last 6 months than nurses, doctors or medical supplies. This increased security presence has exerted additional pressures on to these communities, particularly discriminatory when state provision of social assistance is unable to reach these communities²⁸.

Disability also proves a co-vulnerability to the risks posed by COVID-19. Firstly, disabled individuals may have a greater risk of contracting the virus due to barriers to accessing information about transmission and how to protect yourself if it is not in an accessible format; inaccessibility of water and sanitation; and the unfeasibility of social distancing for those reliant on daily care and support, at home or in residential care. There are 61 million women and 47 million men with disabilities in the EU²⁹.

This is then compounded by greater risks of mortality or worse outcomes, if facing co-morbidities which amplify risk; the inaccessibility of timely care for some, a lack of trained healthcare workers to manage the complex needs of individuals and discrimination against people with disabilities.³⁰

Beyond the direct health effects of COVID-19 on disabled individuals, the downstream effects of COVID-19 on everyday life may pose increased risks to these groups. This could include changes or reduction in access to routine health care provision, medications, food or care services as a consequence of supply chains and/or changes to health sector prioritisation. This could be amplified by changes to social protection schemes, reduction in income – with very real effects on food security and healthy living. Changes to social interaction may also increase risks of stigmatisation; abandonment by informal and formal carers; and ultimately abuse. 34% of women with disabilities have suffered intimate partner violence, compared to 19% of women without disabilities. Disability can further restrict access to support services or being able to leave the at-risk environment. This will likely have been heightened because of COVID-19 mobility restrictions³¹.

²⁷ Neda Korunovska and Zeljko Jovanovic, Roma in the COVID-19 crisis: Early Warning from Six EU Member states, Open Society Roma Initiatives Office, Open Society Foundations <https://www.opensocietyfoundations.org/publications/roma-in-the-covid-19-crisis>

²⁸ Matache, Margareta, and Jacqueline Bhabha. "Anti-Roma Racism is Spiraling during COVID-19 Pandemic." *Health and human rights* vol. 22,1 (2020): 379-382.

²⁹ EIGE. 2020. People in vulnerable situations. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/people-vulnerable-situations>

³⁰ Social Development Direct, 2020: SDDirect COVID-19 Pandemic Blog Series: Why people with disabilities are disproportionately impacted by COVID-19. As accessed: <http://www.sddirect.org.uk/media/1910/covid-19-and-disability-impact-blog.pdf>

³¹ EIGE. 2020. People in vulnerable situations. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/people-vulnerable-situations>

2. SEX DISAGGREGATED DATA

KEY FINDINGS

World Health Assembly resolution 60.25 (2007) requires states to sex and age disaggregate all health data. This remains a considerable gap in implementation globally and at EU level. Less than 45% of global COVID-19 is sex and age disaggregated, either for incidence or for mortality. It is imperative that states openly report disaggregated data (and where possible by ethnicity too) so that we can understand the risk factors and vulnerabilities to infection with COVID-19 and the dynamics of health outcomes.

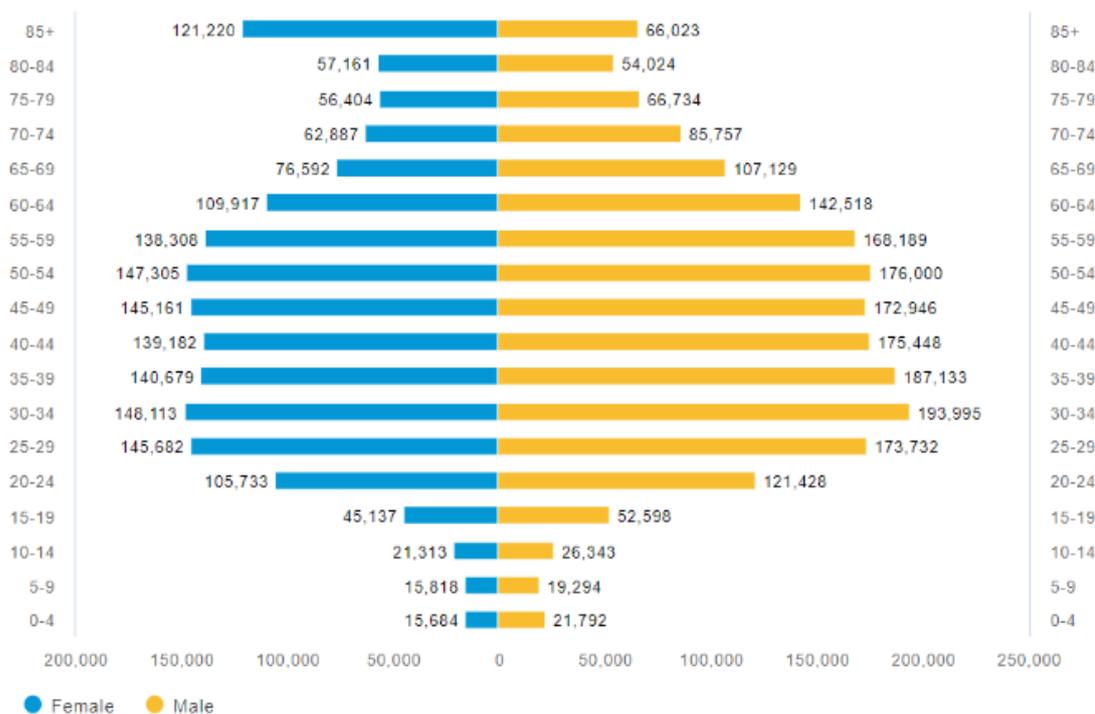
A key data point that is required by epidemiologists and policymakers in an outbreak is to understand who is infected with COVID-19. It is important to understand the distribution within populations, to identify who might be most at risk. Sex-disaggregated data is vital to understand how sex and/or gender can affect health outcomes. In turn this can support decision making for clinical care, prevention mechanisms and public health strategies. This is important as it is only when understanding the burden of disease, who is infected and where transmission is happening that targeted public health interventions can be developed to mitigate against the spread of the virus. During the Ebola outbreak in West-Africa, it was only when sex-disaggregated case data were published that it was possible to understand the burden of disease fell disproportionately on women, assumed due to their informal care role, which allowed for targeted risk communications to mothers³²

To date, COVID-19 incidence between sexes shows no consistent pattern in terms of who is more likely to test positive with COVID-19. The global data retains a sex ratio of approximately 1.03:1 (M:F)³³ (Figure 1), although this trend does change within Europe.

³² United Nations Development Group, 2015, Socio-Economic Impact of Ebola Virus Disease in West African Countries. As accessed <https://www.undp.org/content/dam/rba/docs/Reports/ebola-west-africa.pdf>

³³ Global Health 50/50. 2020 Sex, Gender and COVID-19. Men, sex, gender and COVID, as accessed: <https://globalhealth5050.org/covid19/men-sex-gender-and-covid-19/>

Figure 1: Reported COVID-19 cases by age and sex (global data)



Source: Data submitted to NCOVmart reported through the global surveillance system of WHO, as of 7 am 24th June 2020, 6515796 cases. Data presented here, therefore, represent only 44% of all reported cases. The data by sex and age shown here are based on reporting from 116 countries, areas and territories

These data reveal a number of points for consideration:

Firstly, 80+ women have considerably higher infection rate than men. This reflects the broader distribution of m/f in this age category (i.e. women live longer than men, and so there are more absolute incidence amongst females in this age bracket). Data from Institute of Health Metrics and Evaluation (IHME) consistently shows higher levels of ill health and lower life expectancies for men than women – which means that the older the society, the more female mortality you will have in the higher age categories which can distort data.

In August 2020, the sex-disaggregated data available globally only represented approximately 44% of global cases³⁴, thus there is a need to ensure that sex, age, and ethnicity disaggregated data is routinely being collected and reported by governments. This needs to include testing data (so we know who is being tested) alongside incidence and health outcomes so we can effectively understand the true burden of disease in communities. Early indications suggested that in the adult population the sex-distribution of cases is likely highly correlated with testing strategies. This could include a priority for testing healthcare workers (76% of whom are women³⁵) producing a biased sample, or due to gendered differences in health-seeking behaviour which is well established in the literature (i.e. are women more likely to go and get tested even with mild symptoms than

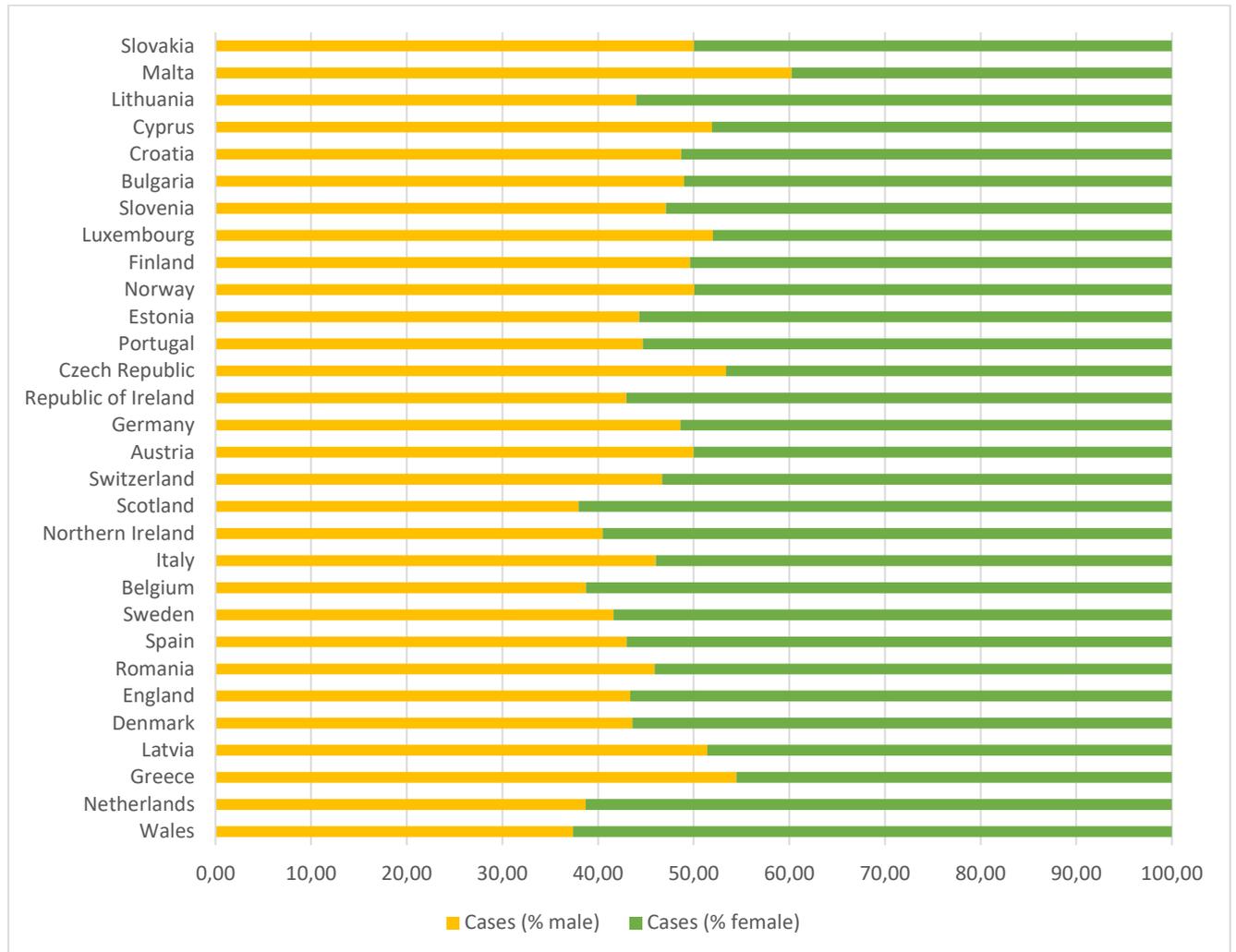
³⁴ UN Women, 2020. Emerging gender data and why it matters. As accessed: <https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters>

³⁵ EIGE, 2020. Frontline workers. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/frontline-workers>

men). Until we have comprehensive testing data, we are unable to interpret these results as to the real burden of disease between male and female.

This question of testing data also becomes apparent in the analysis of the European level data (Figure 2)

Figure 2: European cases % Males/Female



Source: Global Health 50/50 – data is not comprehensive. Not all EU countries report complete sex disaggregated data – and where they do definitions and/or what is reported may vary. Some countries only report M/F as a ratio of deaths, rather than absolute values. Others may only include hospital settings for example.

Incidence amongst European states appear to show differing trends between m/f than at the global level. This might be explained by: older populations (i.e. there are more 80+ population in Europe compared to elsewhere in the world, and indeed most of this 80+ population are women; whether data collected includes infections from care home, in which there are more women, compared to hospital only data which tends to be men; challenges with availability and/or transparency of disaggregated data – so that this European data may have skewed estimates depending on how comprehensively the data is disaggregated and in comparison to elsewhere in the world; prevalence of women in high exposure jobs in Europe compared to elsewhere and thus increased risk of infection; that women’s interaction with the health system is greater in Europe than elsewhere in the

world, and thus cases are identified more readily in Europe than elsewhere. These combined factors still mean that we do not have a “true” sense of the burden of COVID-19 infection between male and female within the population. Thus, we ask that governments continue to collect and share disaggregated data for COVID-19 infection to understand the drivers and vulnerabilities to infection.

Globally, where data is available, mortality is higher amongst men than women, apart from a few outlying countries. There is still some uncertainty as to the cause of this increased mortality amongst males. Immunological and biological arguments suggest that women appear to be producing more antibodies to combat the infection, or there may be hormonal differences which play a role – such as the stimulating effect of testosterone on the ACE-2 receptor for COVID-19 and of the *tmprss-2* (the main enzyme that activates the binding of the virus) meaning more cells may be vulnerable to the virus, and this, in turn, may lead to men’s higher risk of severe COVID outcomes and death³⁶. Differences in co-morbidities and chronic infection may also play a role – heart disease, stroke, COPD are each a risk factor in COVID-19 infection, and each is more prevalent in men than women³⁷. An alternative hypothesis suggests that differences in men and women’s behaviours, highly interconnected with gender norms, might explain this mortality difference, either as factors increasing risk of co-morbidities, or as risk factors for COVID-19 itself, These include increased prevalence of smoking and drinking amongst men, worse hygiene and less adherence to social distancing practices³⁸.

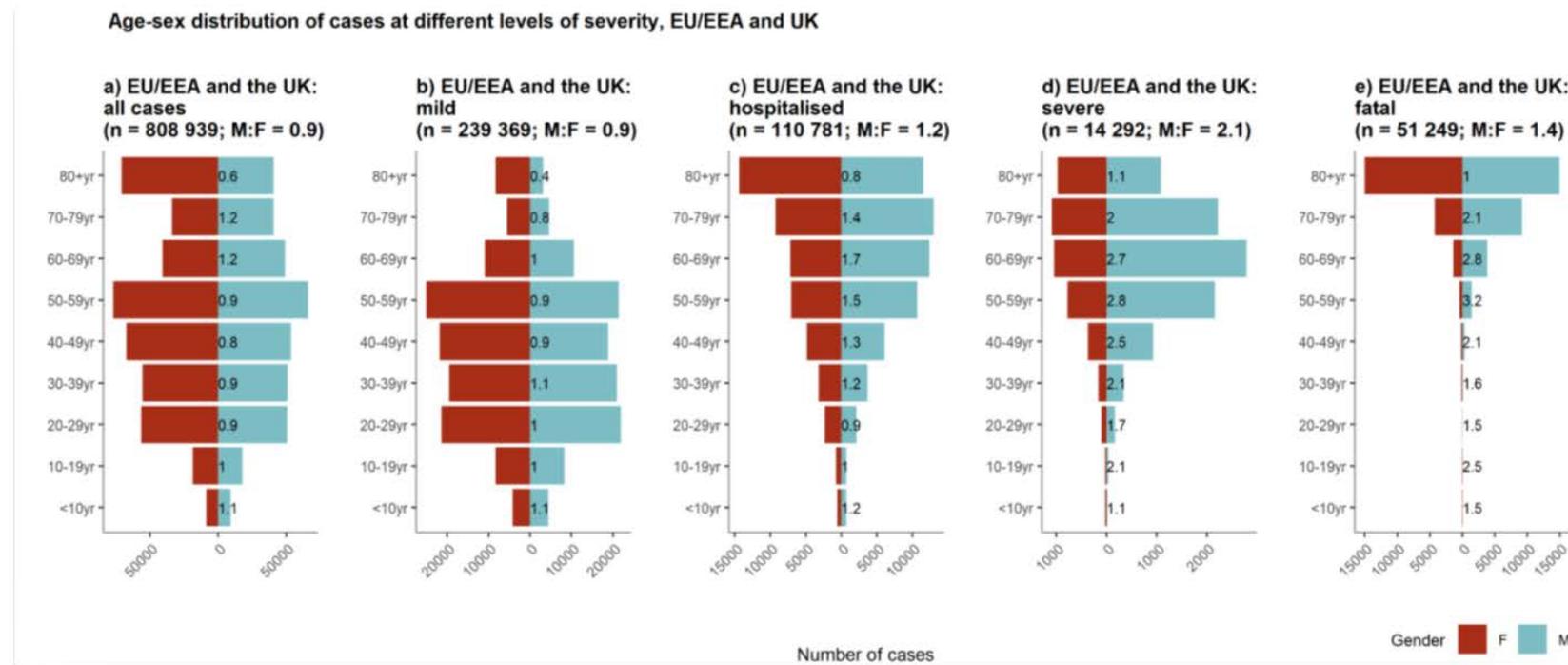
Examination of mortality trends in Europe show important findings for policymakers.

³⁶ Global Health 50/50. 2020 COVID-19 Sex-disaggregated Data Tracker. <https://globalhealth5050.org/covid19/sex-disaggregated-data-tracker/>. ; Gebhard, C., Regitz-Zagrosek, V., Neuhauser, H. K., Morgan, R., & Klein, S. L. (2020). Impact of sex and gender on COVID-19 outcomes in Europe. *Biology of Sex Differences*, 11(1), 1-13.

³⁷ Kyu, H. H., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., ... & Abdollahpour, I. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 392(10159), 1859-1922.

³⁸ Wenham, C., Smith, J., & Morgan, R. (2020). COVID-19: the gendered impacts of the outbreak. *The Lancet*, 395(10227), 846-848.

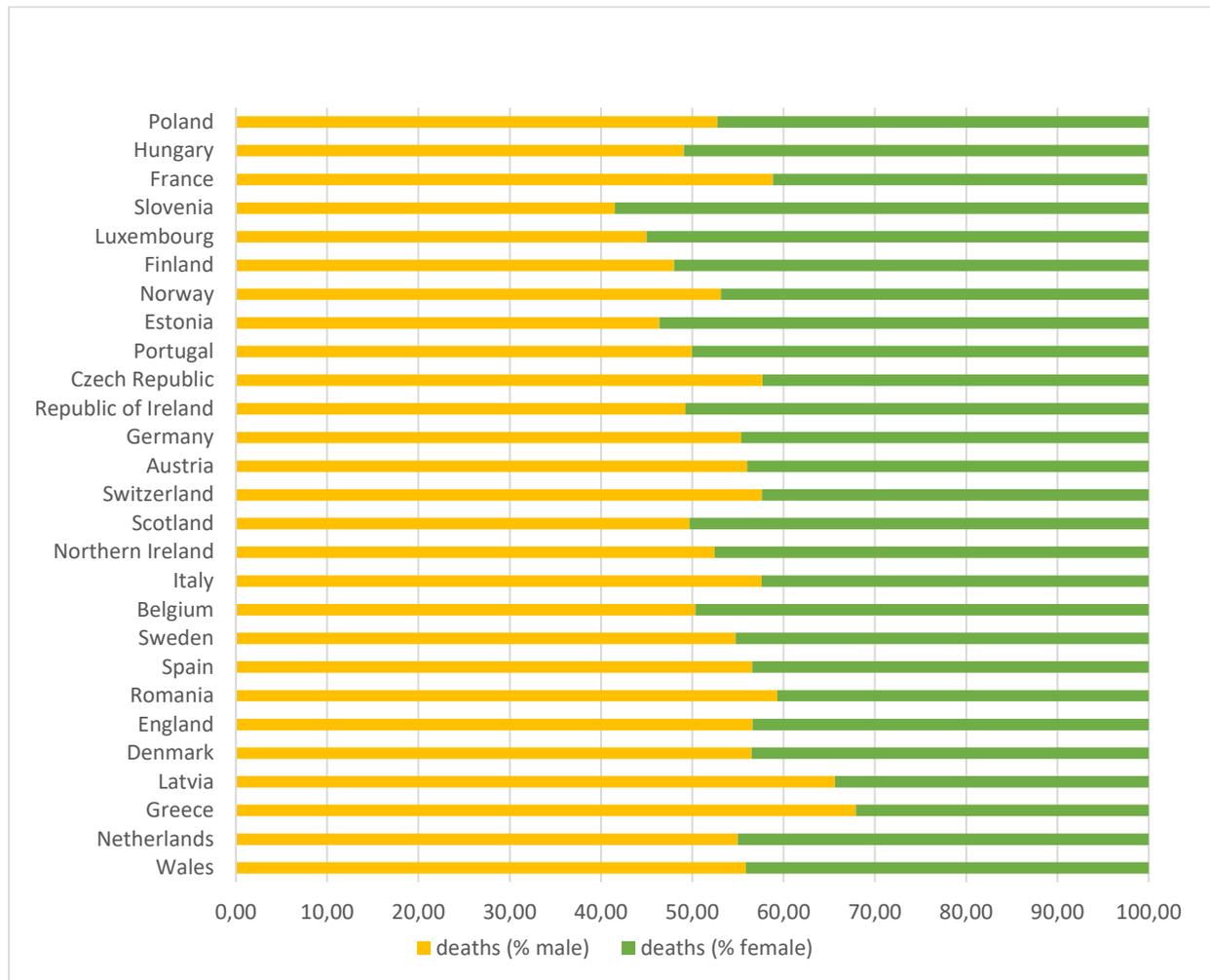
Figure 3: Age and Sex distribution of cases at different levels of severity within EU/EEA and UK



Source: ECDC TESSy COVID-19 case-based data surveillance report week 34, 28th August 2020 ³⁹

³⁹ ECDC, 2020, COVID-19 Surveillance Report, 2020 Week 34, 2020. As accessed: <https://www.ecdc.europa.eu/en/covid-19/surveillance/weekly-surveillance-report> TESSy

Figure 4: European Deaths % Male/Female



Source: Global Health 50/50 – data is not complete (see note above)

As evidenced above, mortality in European region doesn't consistently follow the same patterns as that of the global level, with some states (Hungary, Slovenia, Luxembourg, Finland, Estonia, Portugal, Republic of Ireland, Scotland) each have higher mortality amongst women. This is likely for similar reasons to those listed above for differing incidence data, and particularly related as to whether care home deaths are included in COVID-19 statistics or not. In many European countries, care home deaths, whose residents are predominantly female represent significant proportions of the mortality rates.

Figure 5: Number of affected facilities (long term care and other supported settings) COVID-19 cases and deaths among residents from countries in EU/EEA and the UK, May 2020

Table

Number of affected facilities (long-term care and other specified settings), COVID-19 cases and deaths among residents, examples from countries in the EU/EEA and the UK, May 2020 (n = 58,831 deaths)

Country	Report date (in 2020)	Affected facilities	Confirmed COVID-19 cases in LTCF residents	COVID-19-related deaths in LTCF residents	Total COVID-19 deaths	% of all COVID-19 deaths in the country	COVID-19 deaths in LTCF/1 million population ^a
Belgium [9]	25 May	Unk	5,734	4,735	9,312	51	413.3
France [16]	29 May	7,923	74,402	14,113	28,530	50	210.6
Germany [17] ^a	25 May	Unk	15,757	3,138	8,257	38	37.8
Ireland [20] ^{b,c}	25 May	458	6,392	811	1,354	60	165.4
Norway [21]	25 May	Unk	Unk	139	235	59	25.5
The Netherlands [22]	19 May	Unk	9,474	1,779	5,694 [1]	31	102.9
Spain [13]	25 May	5,457	Unk	19,066	28,752 [1]	66	406.2
Stockholm County, Sweden [14]	15 April	212 (400 ^d , 53%)	1,711	630	1,400	45	409.6
Sweden [15]	18 May	Unk	2,866	1,777	3,661	49	173.7
UK – England and Wales [23]	15 May	Unk	Unk	11,650	45,226	26	196.0
UK – Scotland [24,25]	17May	655 (60%)	5,652	1,623	3,546	46	297.1

COVID-19: coronavirus disease; EU/EEA: European Union/European Economic Area; LTCF: long-term care facility; UK: United Kingdom; Unk: unknown.

^a Eurostat data from 2019 [26].

^b Includes homes for the elderly, migrants and homeless as well as prisons.

^c Personal communication, Lisa Domegan, 27 May 2020.

^d Total number of facilities in Stockholm County provided in the report.

Data for Ireland relate to COVID-19 outbreaks in all residential facilities such as nursing homes for the elderly, centres for those with disabilities, homeless facilities and direct provision centres and for all cases linked to those outbreaks. The data for Ireland include staff and residents.

Source: ECDC Public Health Emergency Team, Danis K, Fonteneau L, et al. High impact of COVID-19 in long-term care facilities, suggestion for monitoring in the EU/EEA, May 2020. *Euro Surveill.* 2020;25(22):2000956. doi:10.2807/1560-7917.ES.2020.25.22.2000956

As demonstrated – the data available has many inconsistencies and lacks comprehensive age and sex disaggregation. This makes it hard to understand the true burden between males and females, and indeed between men and women. Countries must continue and/or start to publicly report disaggregated data of incidence and mortality, as well as testing data to make meaningful policy decisions. WHO has recommended such data collection and reporting since 2007⁴⁰, and this aligns with calls for disaggregated data within SDGs. Without accurate data shared nationally, regionally and internationally, it is hard to make concrete decisions about how to target public health interventions effectively to reduction infection amongst the groups that are at greatest risk.

⁴⁰ World Health Organization. 2014. Addressing sex and gender in epidemic prone infectious diseases. As accessed: <https://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf>

3. HEALTHCARE WORKERS

KEY FINDINGS

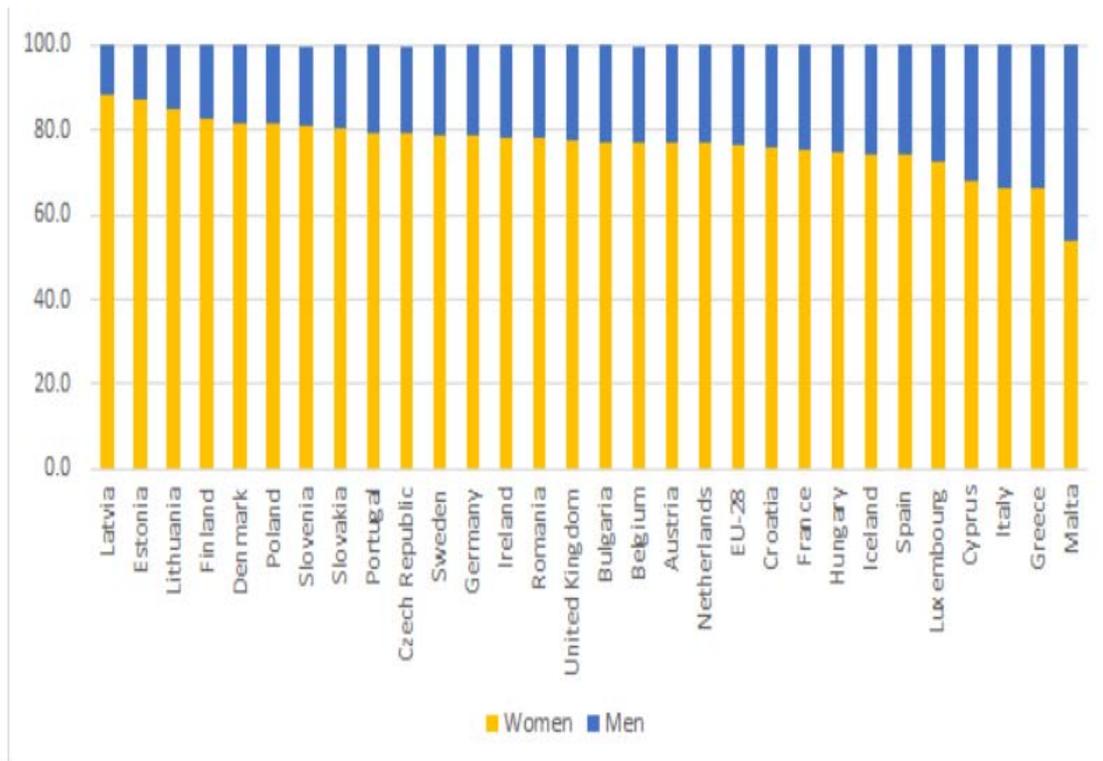
In the EU, women make up 76% of the continent’s healthcare workers. These women have been on the frontline of the COVID-19 pandemic, and the feminised nature of this work must be recognised.

This ratio has manifest in greater number of female healthcare workers being infected with COVID-19. Efforts must be made to ensure that women are provided with suitable protection to be able to perform their function as key workers. This extends not only to the healthcare sector, but women represent the majority of social care workers, elderly care workers, childcare workers and domestic assistants. Analysis has shown that it is these occupations which are most at risk of infection due to proximity to others, many of whom might be high risk.

3.1. Distribution of healthcare workers

In the EU, women represent 76% of the 49 million healthcare workers; This is slightly higher than global trends where this is approximately 70%.

Figure 6: Percentage of women and men employed in health care activities in EU member states



Source: EIGE Gender Statistics Database

Beyond healthcare workers, recent analysis from EIGE suggests that 83% of home-based elderly or disabled carers; 93 % of childcare workers and teaching assistants; and 93% of domestic cleaners and

helpers, including in healthcare settings⁴¹. In stark numbers, 4.5 million out of 5.5 million long term care workers across Europe are women. There are a further 1.8 million disability carers, 83% of whom are women⁴². Thus, when talking about healthcare workers, it must be explicit that this disproportionately refers to women, and women's differential needs must be taken into account in workforce planning and policy.

3.2. COVID-19 infection amongst healthcare workforce

It is estimated that healthcare worker infections represent approximately 10-11% of total cases in Spain and Italy, and up to 32% in Ireland⁴³. 29% of cases in France were nurses or nursing assistants⁴⁴. The European Centre for Disease Control (ECDC) suggest that healthcare workers constitute 23% of all infection across Europe, considerably higher than the ~10% globally⁴⁵. Accordingly, it is thought that frontline health care workers have a 3.4 fold greater risk of infection with COVID-19 than those in the general population⁴⁶.

This risk is highly gendered, reflecting the disproportionate number of women in the healthcare workforce. As such, there has been a disproportionate rate of infection of COVID-19 amongst female healthcare workers (Figures 6 and 7). Note, at present we only have this granular employment data for Italy and Spain and thus cannot make more generalised assumptions across the EU healthcare workforce. However, it is thought that this trend may be particularly acute in Southern Europe which has a lack of healthcare workers as a proportion of the general population, leading to greater workload for those employed and greater risk of infection⁴⁷.

Figure 7: Infections of health-care workers in Spain



Source: UN Women and Ministerio de Sanidad, Gobierno de Espana.

⁴¹ EIGE. 2020. COVID-19 and Gender Equality. As accessed: <https://eige.europa.eu/topics/health/covid-19-and-gender-equality>; European Commission. 2020. Coronavirus Pandemic: Impact on Gender Equality. As accessed:

https://ec.europa.eu/info/sites/info/files/research_and_innovation/research_by_area/documents/ec_rtd_covid19-gender-equality_factsheet.pdf

⁴² EIGE. 2020. Frontline workers. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/frontline-workers>

⁴³ Health Protection Surveillance Centre (HPSC). 2020. Epidemiology of COVID-19 in Ireland: Report prepared by HPSC on 07/06/2020 for National Public Health Emergency Team [Internet]. Dublin: HPSE; As Accessed:

[https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/june2020/COVID-19%20Daily%20epidemiology%20report%20\(NPHET\)%2007062020%20v1%20website.pdf](https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/june2020/COVID-19%20Daily%20epidemiology%20report%20(NPHET)%2007062020%20v1%20website.pdf)

⁴⁴ Maltezou HC, Dedoukou X, Tseroni M, Tsonou E, Raftopoulos V, Papadima K, et al. SARS-CoV-2 infection in healthcare personnel with high-risk occupational exposure: evaluation of seven-day exclusion from work policy. *Clinical Infectious Diseases*. 2020.

⁴⁵ ECDC. 2020. Epidemiology of COVID-19. As accessed: <https://www.ecdc.europa.eu/en/covid-19/latest-evidence/epidemiology>; WHO. 2019. Gender equity in the health workforce: Analysis of 104 Countries. Geneva: WHO.

⁴⁶ Nguyen LH, Drew DA, Joshi AD, Guo C-G, Ma W, Mehta RS, et al. Risk of COVID-19 among frontline healthcare workers and the general community: a prospective cohort study. *medRxiv*. 2020:2020.04.29.20084111;

⁴⁷ European Data Journalism Network. 2020. COVID-19 pandemic exposes southern Europe's nursing shortage. As accessed: <https://www.europeandatajournalism.eu/eng/News/Data-news/COVID-19-pandemic-exposes-southern-Europe-s-nursing-shortage>

Figure 8: Infections of health-care workers in Italy



Source: UN Women and Istituto Superiore de Sanita.

Importantly, despite this volume of women employed as healthcare workers, and the occupational risk they have faced in this employment WHO continues to report an 11.5% pay gap for male and female healthcare workers employed in similar occupations and working the same working hours. This needs to be readdressed as part of the recognition and amplification of women's role in the formal care economy⁴⁸.

3.3. Other at-risk occupations

This is not just for those who work as healthcare workers, other essential workers that are predominantly women and at greater risk of disease transmission. For example, women are overrepresented in food production/processing, education, childcare sectors, sales and retail, sectors which have been identified by ECDC as potential hotspots for COVID-19 clusters or outbreaks⁴⁹. Women are also disproportionately employed in higher COVID-19 risk occupations such as cleaners and personal care workers, including as long-term-care personnel. These categories of work often have low pay and hazardous conditions and require direct contact with individuals⁵⁰.

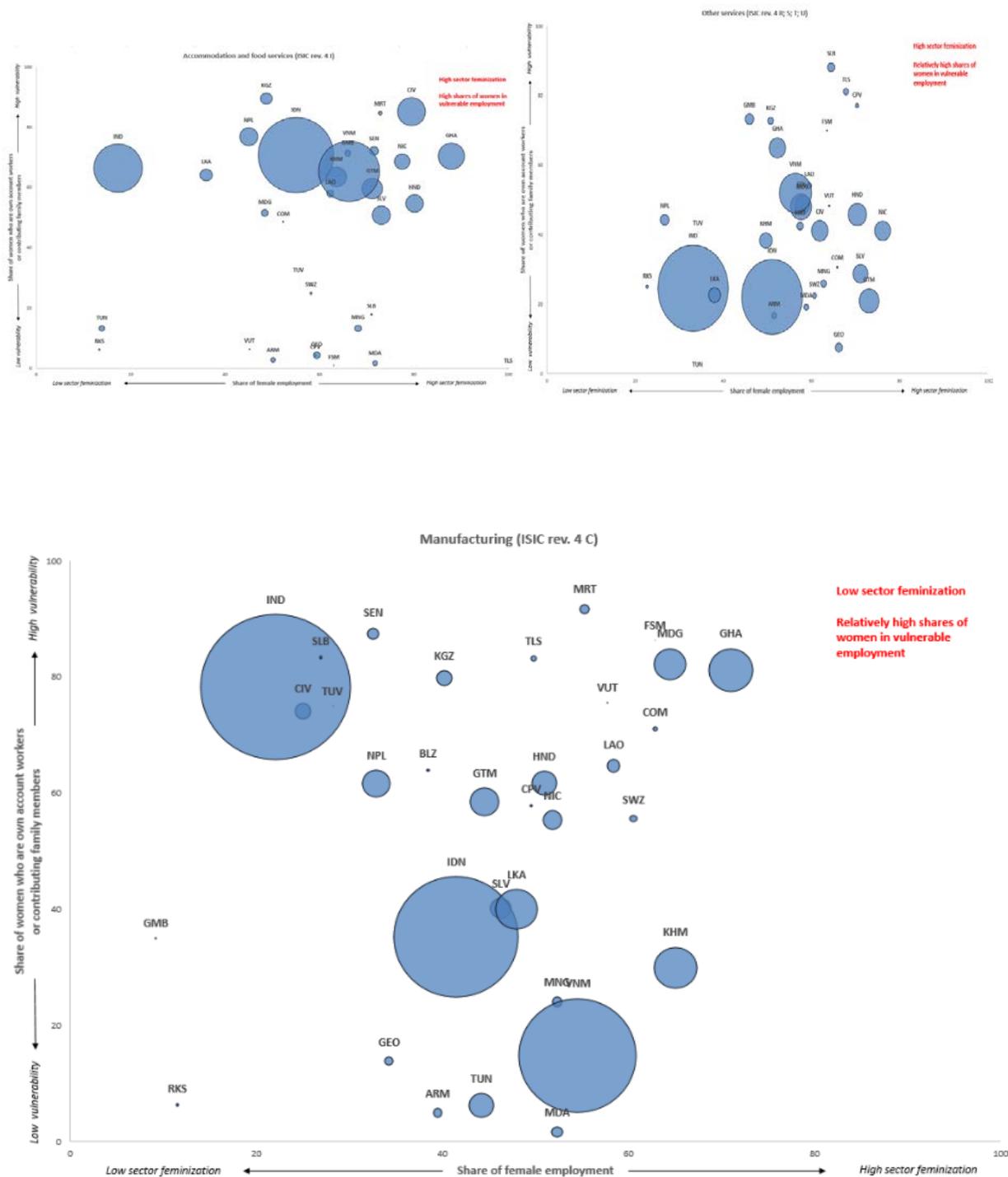
As Figure 8 demonstrates on examining data from 121 countries – there is a strong association between those occupations which expose workers to risk of COVID-19 (through contact with others, physical proximity to others and exposure to those infected), and feminised sectors (those sectors which are disproportionately comprised of women – approximately 7 out of 10). The three occupations with the highest COVID-19 risk are health professionals, health associate professionals and personal care workers, all of which have at least 70% female workforces in Europe. Moreover, it is often migrant women and women from marginalised racial and ethnic backgrounds which are over-represented in these jobs. Better data to understand the impact of this at national and European levels, would allow for in depth analysis of risk factors in return to work policies.

⁴⁸ Boniol, M., Mclsaac, M., Xu, L., Wuliji, T., Diallo, K., & Campbell, J. (2019). *Gender equity in the health workforce: analysis of 104 countries* (No. WHO/HIS/HWF/Gender/WP1/2019.1). World Health Organization.

⁴⁹ ECDC. 2020. COVID-19 clusters and outbreaks in occupational settings in the EU/EEA and the UK. As accessed: <https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-in-occupational-settings.pdf>

⁵⁰ Azcona, G., Bhatt, A., Davies, S. E., Harman, S., Smith, J., & Wenham, C. (2020). Spotlight on gender, COVID-19 and the SDGs: will the pandemic derail hard-won progress on gender equality? UN Women.

Figure 9: Share of female employment and share of women in employment vulnerable to infection with COVID-19.



Source: UN Women, 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. As reproduced by UN Women, Spotlight on COVID-19 and SDGs

3.4. Additional Labour of healthcare workforce

Beyond the additional risk of infection working as a health worker during COVID-19, given additional exposure to the virus and in some cases lacking suitably protective equipment, the predominantly female healthcare and key worker workforce have had to endure additional burdens at work during

the pandemic, with increased activity at work, and limited resources. Owing to COVID-19, health systems have become overly strained, and although they were unable to extend contract hours due to EU regulations and safety standards, there is considerable anecdotal evidence suggesting healthcare workers were working beyond their hours to deal with the volume of patients presenting in healthcare facilities with COVID symptoms and requiring treatment.

Predominantly female healthcare workers were then required to manage their new working patterns and stresses alongside their routine lives. This has raised a number of concerns.

Working conditions of health workers, in particular those working in COVID-19 wards has deteriorated. This has been amplified by excessive working hours in intensive care units⁵¹, and compounded by lack of secure access to suitably sized personal protective equipment (PPE) which have been shown to be oversized and uncomfortable to wear, reducing the safety of female healthcare workers compared to their male counterparts⁵². Whilst EU states have collectively pooled efforts to ensure access to PPE⁵³, there is further anecdotal evidence of women working without PPE due to shortages or comfort, further exposing them to risk.

Importantly, these health care and care jobs are often underpaid or fulfilled through temporary or zero-hour contracts. The additional workload has caused difficulties for those healthcare workers who are also parents of school aged children who require care whilst schools have been closed as a public health intervention. Some European states have taken measures to try and provide relief to healthcare workers working extended hours during the pandemic. France, Germany and Netherlands have ensured that childcare provision is available to healthcare workers, despite the closure of schools. Italy introduced a financial mechanism to pay for childcare of healthcare workers whilst they were at work. Some workers have expressed concern about exposing their family to risk, returning home to work after being in close proximity with those infected. This is a particular concern with those living in multi-generational households, or with individuals at increased risk of infection or poorer health outcomes. Some healthcare workers have chosen to find alternative accommodation during the outbreak so as not to expose their family members to risk. This can have knock-on and emotional effects for families, as well as practical impacts such as distribution of childcare and a strain on financial resources⁵⁴.

Data is also emerging highlighting the increased mental health and stress that healthcare workers are suffering as a consequence of being on the frontline of the fight against COVID-19⁵⁵, and the downstream effects on their social and family lives. Women are reporting greater anxiety and stress than men, with those who report the greatest concerns are those who have

⁵¹ International Labour Organization. 2020. The COVID-19 response: Getting gender equality right for a better future for women at work. As accessed: https://www.ilo.org/global/topics/coronavirus/WCMS_744685/lang--en/index.html

⁵² Maya Oppenheim. 2020. Female NHS Staff at risk due to not being able to access protective gear correctly sized for women. The Independent. As accessed: https://www.independent.co.uk/news/uk/home-news/coronavirus-ppe-women-wrong-size-doctors-nurses-uk-cases-a9476766.html?utm_medium=Social&utm_source=Twitter#Echobox=1587486176

⁵³ European Commission, 2020. Public Health. As accessed; https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/public-health_en#health-crisis-management

⁵⁴ International Labour Organization. Women health workers: Working relentlessly in hospitals and at home. As accessed: https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_741060/lang--en/index.html; http://www.sddirect.org.uk/media/1896/202003-securing-safety-and-wellbeing-of-women-frontline-healthcare-workers-covid-19_final_version.pdf

⁵⁵ Spoorthy, M. S., Pratapa, S. K., & Mahant, S. (2020). Mental health problems faced by healthcare workers due to the COVID-19 pandemic—A review. *Asian journal of psychiatry*, 51, 102119.

worked for over 10 years and have at least 2 children⁵⁶. France, Denmark and United Kingdom established confidential support hotlines and other counselling provision for health care workers to offer assistance to deal with their personal and work difficulties as a result of COVID-19 or associated violence against healthcare workers⁵⁷.

⁵⁶ Li, G., Miao, J., Wang, H., Xu, S., Sun, W., Fan, Y., ... & Wang, W. (2020). Psychological impact on women health workers involved in COVID-19 outbreak in Wuhan: a cross-sectional study. *Journal of Neurology, Neurosurgery & Psychiatry*.

⁵⁷ International Labour Organization. 2020. The COVID-19 response: Getting gender equality right for a better future for women at work. As accessed: https://www.ilo.org/global/topics/coronavirus/WCMS_744685/lang--en/index.html

4. CARE BURDEN

KEY FINDINGS

School closures and stay at home mandates have dramatically increased the domestic labour within households across the EU. Whilst men have taken on some of this additional work, women's time spent on domestic activities and childcare has increased considerably more than men. This has implications for women's ability to undertake paid employment during the pandemic, and therefore many women have had to reduce or leave employment for the duration of lockdown. This care burden is even more acute for mono-parental households, many of whom will be driven (further) into poverty because of this childcare demand prohibiting their earning potential.

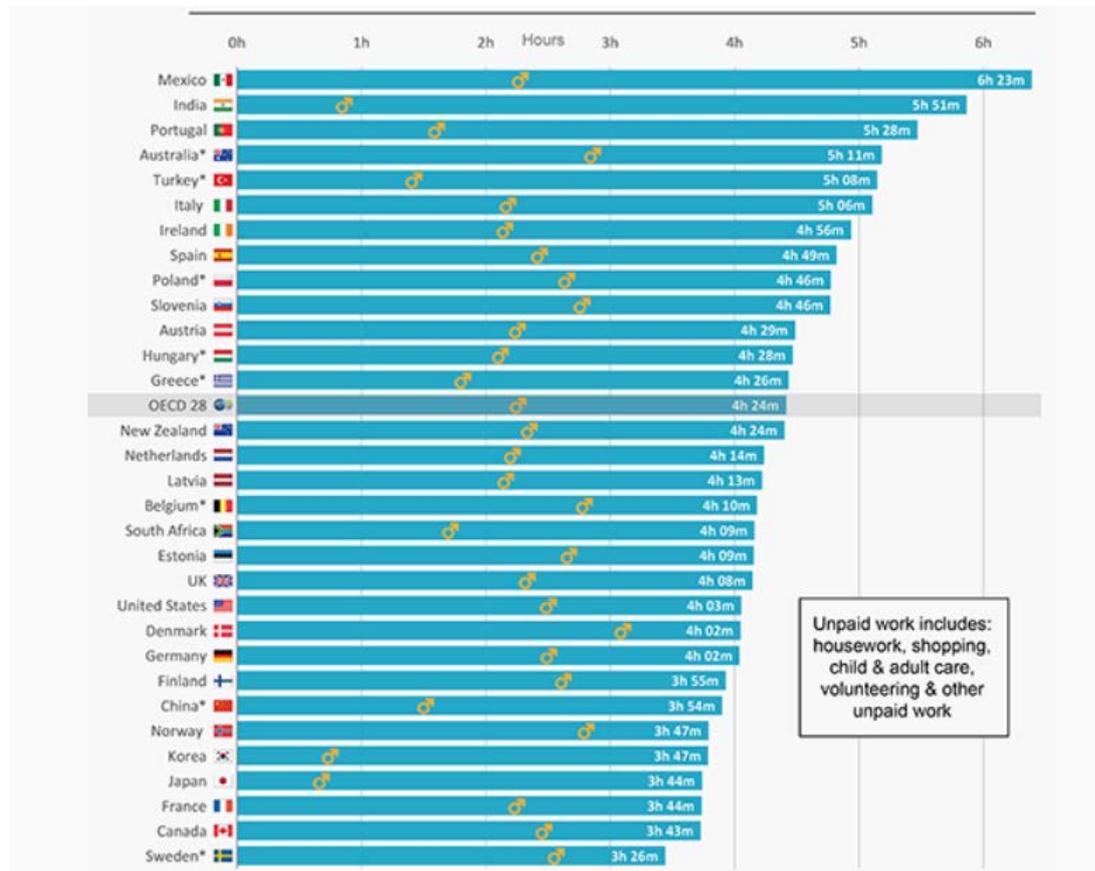
Of course, care isn't just for children, we see increased feminisation of care for elderly, with (predominantly female) relatives providing care for their elderly (predominantly female) loved ones and neighbours. There are real risks for elderly living without support during lockdown and what longer term consequences this might have.

4.1. Dual Parent Households (Pre-Pandemic)

Before COVID-19, women in dual parent households globally did between two and ten times more unpaid care and domestic work as men. Whilst this care work can vary, depending on socio-economic status, it usually includes childcare, cooking, cleaning, caring for elderly relatives, shopping as well as mental tasks such as planning schedules and the additional emotional labour, the "third shift" of ensuring a family's wellbeing⁵⁸. As the OECD have estimated, this is heavily gendered (Figure 9).

⁵⁸ Power, Kate. 2020. The COVID-19 pandemic has increased the care burden of women and families, *Sustainability: Science, Practice and Policy*, 16:1, 67-73, DOI: [10.1080/15487733.2020.1776561](https://doi.org/10.1080/15487733.2020.1776561)

Figure 10: Unpaid work for men and women (Amount of daily unpaid work for women and men (15-64) in hours (2015) (OECD)



Source: OECD (2017) Time Use Database

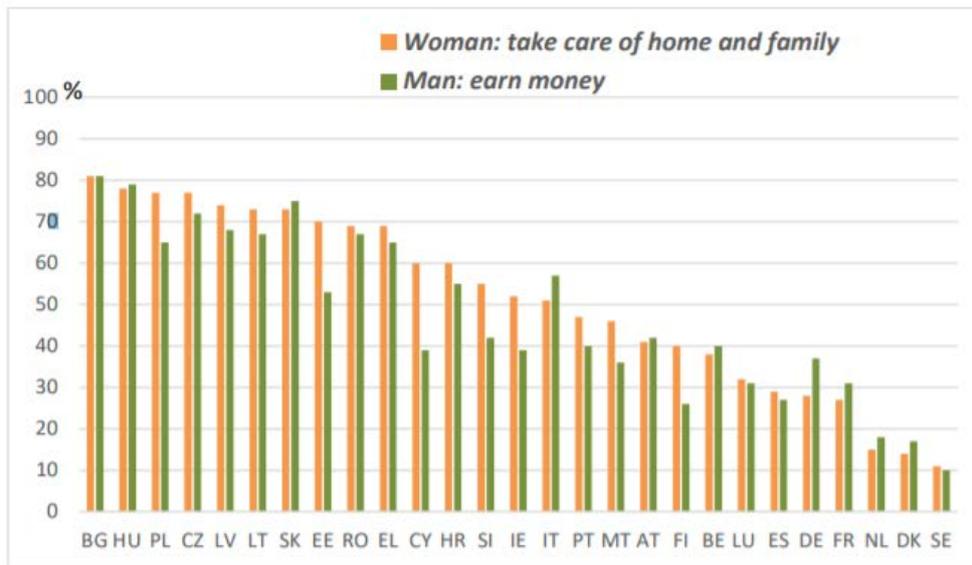
Notably, in every country men have more leisure time each day and women spend more time undertaking unpaid and invisible domestic labour⁵⁹.

This gender divide between the care burden and invisible labour within homes reflect societal and cultural norms of a woman and man's role in a household and within communities. As Figure 10 demonstrates, 2017 data on perceptions of men and women's respective roles in the family, two thirds of the adult population in Bulgaria, Hungary, Czechia, Latvia, Lithuania, Slovakia, Estonia, Romania and Greece believed that the most important role for a woman is to take care of her home and family⁶⁰.

⁵⁹ OECD, 2018. Balancing paid work, unpaid work and leisure. As Accessed: <https://www.oecd.org/gender/balancing-paid-work-unpaid-work-and-leisure.htm>

⁶⁰ Zsuzua Blasko, Eleni Papadimitriou, Anna Rita Manca, How will the COVID-19 crisis affect existing gender divides in Europe. JRC Science for Policy Report. https://publications.jrc.ec.europa.eu/repository/bitstream/JRC120525/covid_gender_effects_f.pdf

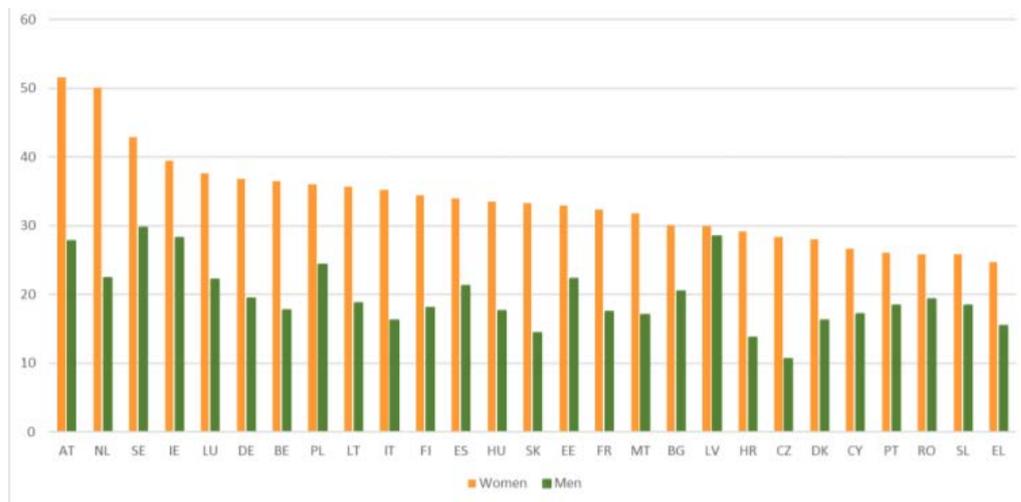
Figure 11: Perceptions of societal roles in EU Member States



Source: European Commission and Eurobarometer: Special Eurobarometer Report 465 (Gender Equality 2017)

A further study by Eurofund identified that women consistently recorded more hours per week spent on caring for their children (Figure 11. EIGE calculated that prior to the COVID-19 outbreak, women in the EU spent 13 hours more than men every week on unpaid care and housework⁶¹. In the UK analysis of parent’s days showed that women spend 2 to 3 times more of their time on care and routine housework compared to men, even when both parents work fulltime⁶².

Figure 12: Weekly number of hours caring for children in EU Member states



Source: Eurofund Quality of Life Survey 2016.

⁶¹ EIGE. 2020. Beijing + 25 : the fifth review of the implementation of the Beijing Platform for Action in the EU Member States. As Accessed: <https://eige.europa.eu/publications/beijing-25-fifth-review-implementation-beijing-platform-action-eu-member-states>

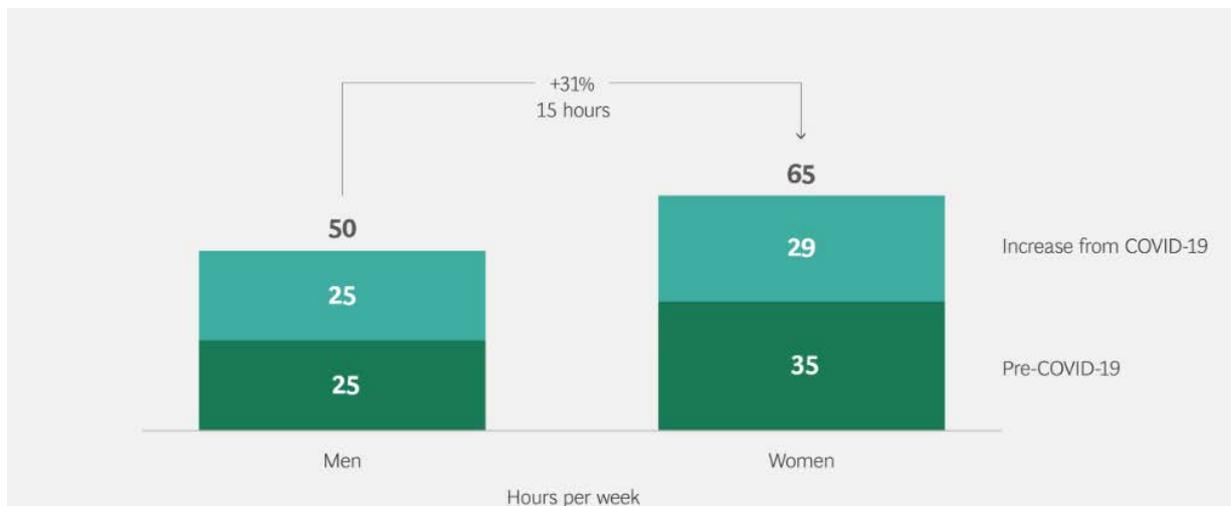
⁶² NatCen. 2019. Changing patterns in parental time use in the UK. As Accessed: https://natcen.ac.uk/media/1722408/Parental_time_use_report.pdf

Importantly, these data points are self-reported use of time each day. This methodology is known to rely on memory and estimation of time spent. Women tend to underreport their hours spent in these time-use surveys, whilst men tend to overestimate⁶³.

4.2. Dual Parent Households (During -Pandemic)

With school closures, quarantine and stay at home orders, there is an overall increased care burden for all households with children. Previous research has shown that even when both parents work at home, working at home leads to a gendered division of labour⁶⁴ In Germany and Poland, when women work at home they tend to do 3 hours more childcare per day than when working out of the home. Men, however, tend to do more overtime.⁶⁵ Early data collected during the pandemic suggests that men are contributing more than normal to this domestic load, but women continue to do the majority of childcare during lockdown (Figure 13). This might be partly due to the persistence of gender norms, as described above, and partly due to the structure of women's economic employment and labour activity which makes them more likely to be in flexible or part time roles, as well as compounded by the gender pay gap, whereby it makes the most financial sense for the woman to reduce working hours to cover the childcare whilst the more financially secure continues to work to support the family.

Figure 13: Unpaid care work before and during pandemic, by gender (US, UK, France, Germany and Italy)



Source: BCG COVID Caregivers Survey 2020

As seen, there are increases of unpaid care for both men and women, but these are greater for women than for men. These findings from BCG have been mirrored elsewhere, data from UK, USA and Germany has demonstrated that working from home mothers are doing approximately 1h 30m extra

⁶³ EIGE. 2020. Coronavirus puts women in the frontlines. As Accessed: <https://eige.europa.eu/news/coronavirus-puts-women-frontline>

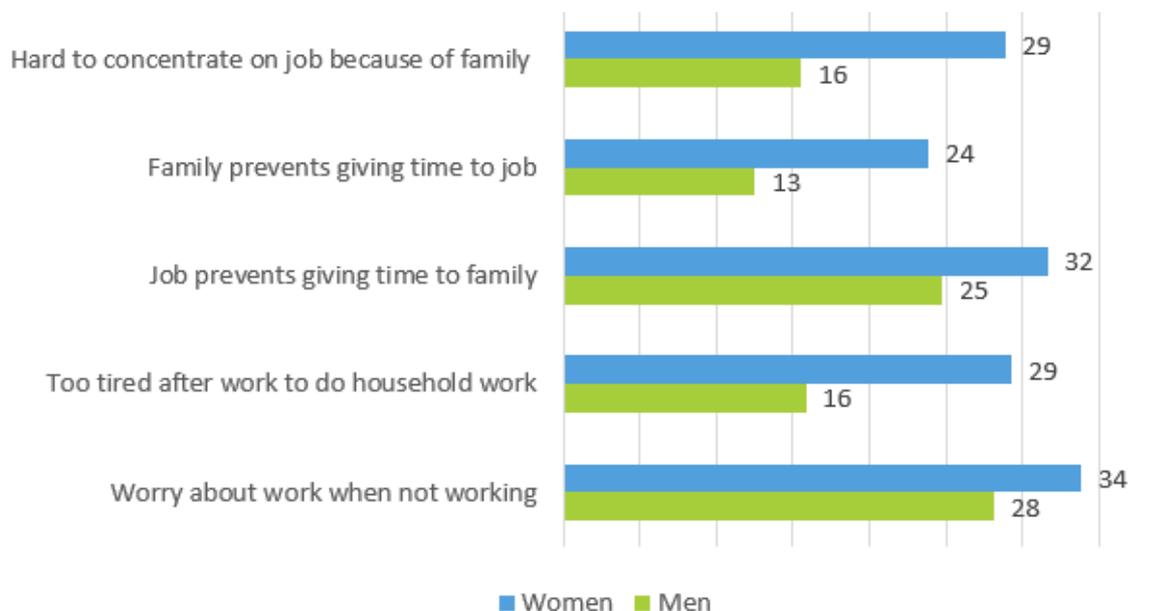
⁶⁴ Sullivan, C. and Lewis, S. (2001), Home-based Telework, Gender, and the Synchronization of Work and Family: Perspectives of Teleworkers and their Co-residents. *Gender, Work & Organization*, 8: 123-145. doi:[10.1111/1468-0432.00125](https://doi.org/10.1111/1468-0432.00125)

⁶⁵ DW. 2019. Germany: Flexible working conditions lead to overtime, study shows. As accessed: <https://www.dw.com/en/germany-flexible-working-conditions-lead-to-overtime-study-shows/a-47771436>; <https://link.springer.com/article/10.1007/s11205-018-2034-9>

on childcare a day compared to working from home fathers⁶⁶. Similar findings have been documented in Spain, Germany, and Italy⁶⁷

Thus, women's childcare and other domestic responsibilities have increased during lockdown, and many women have been doing so whilst trying to undertake paid employment. Research from Eurofund has found that women with small children struggle the most. This has impacted outputs at work and may have longer term repercussions if/when redundancies start because of economic crisis and recession linked to COVID-19. This unpaid care work must be recognised by policymakers to account for this disproportionate burden on women, and to recognise the gendered effects of this activity furthermore. This could lead to redistributive policies within society elsewhere, such as provision of child support; government subsidies to replace pay for workers who are unable to work during the pandemic; removing the requirement to be actively seeking work as a parent/carer who is unemployed; paid parental leave or non-discriminatory protocols for redundancies in the wake of COVID-19⁶⁸.

Figure 14: Percentage of women and men with young children experiencing work-life conflicts



Source: Eurofound (2020), Living, working and COVID-19: First findings – April 2020

As a consequence of the economic sectors in which women work (see below) and the additional care responsibilities that women form, the COVID inequality project and the Institute of Fiscal Studies have both found that women, and in particular mothers have been more likely to have lost jobs or to be

⁶⁶ Adams-Prassl, A., T. Boneva, M. Golin and C. Rauh (2020). "Inequality in the impact of the coronavirus shock: Evidence from real-time surveys." CEPR Discussion Paper 14665.

⁶⁷ Farre, Lidia and Fawaz, Yarine and Gonzalez, Libertad and Graves, Jennifer, How the Covid-19 Lockdown Affected Gender Inequality in Paid and Unpaid Work in Spain. IZA Discussion Paper No. 13434, Available at SSRN: <https://ssrn.com/abstract=3643198>; Möhring, K., Naumann, E., Reifenscheid, M., Blom, A.

G., Wenz, A., Rettig, T., Lehrer, R., Krieger, U., Juhl, S., Friedel, S., Fikel, M. and Cornesse, C. (2020) *Die Mannheimer Corona-Studie: Schwerpunktbericht zu Erwerbstätigkeit und Kinderbetreuung*, Mannheim: University of Mannheim.; Manzo, L. K. C., & Minello, A. (2020). Mothers, childcare duties, and remote working under COVID-19 lockdown in Italy: Cultivating communities of care. *Dialogues in Human Geography*, 10(2), 120–123.

⁶⁸ Power, Kate. 2020. The COVID-19 pandemic has increased the care burden of women and families, *Sustainability: Science, Practice and Policy*, 16:1, 67-73, DOI: [10.1080/15487733.2020.1776561](https://doi.org/10.1080/15487733.2020.1776561)

furloughed than men⁶⁹. This has meaningful ramifications for the makeup of the labour force, and the ability for sustained gender equality in the long term. As the childcare sector is one of the industries significantly affected, any long-term reduction in childcare provision may dramatically reduce women's future participation in labour force and the ability to return to work.

Importantly, ongoing analysis considers the different type of domestic labour that men and women are performing. Recent analysis of Office of National Statistics data in the UK has shown that whilst men's involvement in childcare has increased during lockdown, this has specifically been in areas of development care (i.e. playing, drawing, home school) and women's activity increase in childcare has focused on non-developmental childcare (i.e. cooking, bathing, putting children to bed). This gendered divide is important, as it also may contribute to how men and women report their time use for these surveys of time⁷⁰.

Further considerations must be given to the households which depend on informal care in normal times, and these options have been cut off as a consequence of the pandemic, and those households which have children with special educational needs and disabilities which are used to receiving additional care and support beyond the school system.

Finally, many mothers have reported feeling additional anxiety and concern about the mental impact on their children from quarantine and prolonged periods of isolation⁷¹, as well as the stress of trying to juggle paid and unpaid employment during lockdown. Research from the US and Germany has suggested that 57% of mothers reported their mental health is worse because of COVID-19 compared to only 32% of fathers⁷².

4.3. Mono-parental families

School closures more likely to disproportionately affect single parents than dual parents. While dual parent households have re-adjusted distribution of labour between them, single parents have not had the ability to share the care burden with anyone during lockdown. 85% of all single parents in the EU are women⁷³. Moreover, 15% of households with children are single parent households, totalling almost 8 million across Europe, with greater concentration in Denmark, Estonia and Ireland⁷⁴.

48% of single mothers are at risk of poverty, compared to 32% of single fathers and 17% of those in dual parent settings⁷⁵. This risk is likely to be heightened by COVID-19 if they are required to work at

⁶⁹ COVID Inequality Project. 2020. As accessed: <https://sites.google.com/view/covidinequality/>; Institute for Fiscal Studies. 2020. Parents, especially mothers, paying heavy price [https://www.ifs.org.uk/publications/14861#:~:text=Mothers%20are%2023%25%20more%20likely,likely%20to%20have%20been%20furloughed](https://www.ifs.org.uk/publications/14861#:~:text=Mothers%20are%2023%25%20more%20likely,likely%20to%20have%20been%20furloughed, for lockdown. As accessed: <a href=).

⁷⁰ Office of National Statistics. 2020. Parenting in lockdown: Coronavirus and the effects of work-life balance. As accessed: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/parentinginlockdowncoronavirusandtheeffectsonworklifebalance/2020-07-22>

⁷¹ Fawcett Society. 2020. Parents are struggling to cope financially, and women key workers are more anxious. As accessed: <https://www.fawcettsociety.org.uk/news/parents-struggling-and-women-keyworkers-are-anxious>

⁷² Hamel, L., and A. Salganicoff. 2020. *Is There a Widening Gender Gap in Coronavirus Stress?* Washington, DC: Kaiser Family Foundation. <https://www.kff.org/global-health-policy/poll-finding/kff-coronavirus-poll-march-2020>; Christian S. Czymara, Alexander Langenkamp & Tomás Cano (2020) Cause for concerns: gender inequality in experiencing the COVID-19 lockdown in Germany, European Societies, DOI: [10.1080/14616696.2020.1808692](https://doi.org/10.1080/14616696.2020.1808692)

⁷³ EIGE. 2016. Poverty, gender and lone parents in the EU. As accessed: <https://eige.europa.eu/publications/poverty-gender-and-lone-parents-eu>

⁷⁴ Zsuzua Blasko, Eleni Papadimitriou, Anna Rita Manca, How will the COVID-19 crisis affect existing gender divides in Europe. JRC Science for Policy Report. https://publications.jrc.ec.europa.eu/repository/bitstream/JRC120525/covid_gender_effects_f.pdf

⁷⁵ EIGE. 2019. Single-parent households at risk of poverty or social exclusion. Gender Statistics database. As Accessed: https://eige.europa.eu/gender-statistics/dgs/indicator/eustrat_sege1619_gpaygap_ilc_peps03

home and care for their child / offer home-schooling to the child single handily. Data from Germany has shown that 30% of single mothers have taken leave for lack of childcare (compared to 19% of the general population), others have had to leave work all together, with only 15% of single parents continuing in employment during lockdown⁷⁶. Others have reported forming informal “bubbles” with another person to access the additional support to be able to manage paid work.⁷⁷

Poverty in some single parent households will be compounded by COVID-19. In Bulgaria, Ireland, Greece, Croatia, Lithuania and Malta, where poverty amongst single parent households was over 50% prior to the outbreak, this is particularly concerning. Single mothers are also more likely to work for low pay and in vulnerable occupations which have traditionally offered flexibility. This poses an increased risk of economic insecurity during times of job cuts and recession. Thus the COVID-19 crisis will further increase existing vulnerabilities of already vulnerable households⁷⁸

4.4. Elderly care

Women live longer than men. In Europe, women are 55% of 60+ age range, 64% of 80 + age range and 82 % of 100+ age range⁷⁹. Consequentially, many women live alone in old age. In Europe 56 percent of 80+ year old women live alone⁸⁰. Those who do not live alone, either live with family members or live in formal care facilities.

These facilities are increasingly linked to transmission of COVID-19 infection, either as elderly patients get discharged from hospital into these settings, or through key workers. This poses a risk to a vulnerable population⁸¹. Almost half of COVID-19 deaths in Europe have occurred in long-term-care settings⁸². This is important because of the top 30 countries with the largest percentage of older people, 29 of them are in Europe. In many instances these care homes pose problems for infection control as elderly are not able to be independent. They may rely on formal or informal carers to help get them dressed, provide them with food etc.

This is also where such data is included in official statistics. It is important to remember that whilst Ireland, France and Germany include care setting deaths in COVID-19 reporting, Italy and Spain do not⁸³. Thus, there is inconsistency of knowing how many elderly people / women have died because of COVID.

Whilst residing in care homes brings risk of infection, isolation through living alone also poses significant mental health risks, who may have less access to support and services,

⁷⁶ StraitsTimes. 2020. Single mothers feel invisible in Germany's Coronavirus crisis. As Accessed: <https://www.straitstimes.com/world/europe/single-mothers-feel-invisible-in-germanys-coronavirus-crisis>

⁷⁷ Gender and COVID Research Project. 2020. What is the impact of COVID-19 and the policies implemented to respond to the outbreak on women in the UK. As Accessed: <https://www.sfu.ca/content/dam/sfu/fhs/gendercovid/COVID-GENDER%20PROJECT%20BRIEFING%20-%20CONSTITUENT%20INTERVIEWS.pdf>

⁷⁸ Zsuzua Blasko, Eleni Papadimitriou, Anna Rita Manca, How will the COVID-19 crisis affect existing gender divides in Europe. JRC Science for Policy Report. https://publications.jrc.ec.europa.eu/repository/bitstream/JRC120525/covid_gender_effects_f.pdf

⁷⁹ WHO. 2020. Female Life Expectancy. https://www.who.int/gho/women_and_health/mortality/situation_trends_life_expectancy/en/

⁸⁰ Azcona, G., S. Hertog and A. Bhatt. Forthcoming. “Households and Living Arrangements of Families: A Global Snapshot.”

⁸¹ UN Women. 2019. Progress of the World's Women: Families in a Changing World. New York: UN Women.

⁸² United Nations. 2020. The Impact of COVID-19 on older persons. As Accessed:

https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_covid-19_and_older_persons_1_may_2020.pdf

⁸³ Morris, Chris, Antony Reuben and Tamara Kovacevic. 2020. Coronavirus: Can you compare the UK with Italy? BBC News. As Accessed: <https://www.bbc.co.uk/news/52530918>; Carreno, Belen & Nathan Allen. 2020. Poor data obscures COVID-19 death toll at Spain's nursing homes. Reuters. As accessed : <https://www.reuters.com/article/us-health-coronavirus-spain-nursing-home/poor-data-obscures-covid-19-death-toll-at-spains-nursing-homes-idUSKBN2482MN>

including psychosocial services. Elderly women living alone may be reliant on care from their children or neighbours with groceries, checking or paying bills etc. During COVID-19 these visits may have continued informally, exposing the individual to risk of infection, or they may have halted which might result in real problems with payments of bills for essential services which may have repercussions for individuals' security and everyday living⁸⁴. Moreover, elderly individuals may feel self-isolation more acutely than the general population if they live alone and are not able to interact with others online if they do not have access. This can be compounded for lower-income individuals who have pay-per-minute phone plans and must use this credit to call a doctor rather than with a friend.

⁸⁴ Sarah LaFave. 2020. The impact of COVID-19 on older adults. Hub. JHU. As accessed: https://hub.jhu.edu/2020/05/05/impact-of-covid-19-on-the-elderly/?mc_cid=db54704f9a&mc_eid=3513ac9f9b

5. DOMESTIC VIOLENCE

KEY FINDINGS

COVID-19 has seen surging rates of domestic violence across the globe and EU. Additional socio-economic pressures are put on households, such as economic insecurity, additional childcare work, and inability to interact socially with friends, each of which are risk factors for an increase in violence.

Reporting domestic violence is also challenged by lockdown, as the requirement to stay at home (with a potential abuser) means women may not be able to access services. Calls to domestic violence hotlines have become a useful proxy to signal the extent of the problem. These have increased by 20-40% across the EU since February 2020.

Governments are taking action to mitigate against potential harms to women. This has included subsidising hotel rooms, increasing provision of psychological support to women, and facilitating clandestine reporting.

Home is not a safe space for many women and girls. As lockdowns have required all people to stay at home, data suggests for many women home has become less safe since the outbreak of COVID-19.

It is estimated that 30% of women will experience physical or sexual violence by an intimate partner during their lifetime. This number is higher if included emotional violence or control. Domestic violence is context specific, but it is thought that between 80-90% of domestic violence globally is against women, perpetrated by men⁸⁵. It is also important to consider violence against children within homes.

IPV is defined as physical, sexual, psychological, or economic violence that occurs between former or current intimate partners. While men can also be affected, IPV is a gendered phenomenon largely perpetrated against women by male partners.

In the context of COVID-19, this violence may also control or restrict access to finance or PPE/ health items such as hand sanitiser, soap, medications, or limit interaction or access to health services. In the context of lockdown, a perpetrator may also limit access to digital tools to access friends and family, social services, or informal support networks. These may also have been reduced on the supply side if organisations are working at home, and/or employees have their own care responsibilities. This might include shelters, crisis centres, protection and legal services or counselling⁸⁶. As such, COVID-19 might exacerbate domestic violence, and the outcomes of domestic violence if women are not able to seek the support they need.

Domestic violence can put some women at greater risk than others: women with disabilities, are two to three times more likely to experience violence from partners and family members⁸⁷. 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

⁸⁵ Women's Aid. 2018. Domestic abuse is a gendered crime. As accessed: <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/>

⁸⁶ Roesch Elisabeth, Amin Avni, Gupta Jhumka, García-Moreno Claudia. Violence against women during covid-19 pandemic restrictions *BMJ* 2020; 369 :m1712

⁸⁷ Women Enabled International. 2020. Statement on Rights at the Intersection of Gender and Disability during COVID-19. <https://docs.google.com/forms/d/e/1FAIpQLSdgrf14DRGtDam8hkL6spXTxBkAXI5IijAcF58mMWcbAulmzg/viewform>

disabilities may be at further risk of violence when visitors and monitors are not allowed due to infection concerns. Moreover, domestic violence is more likely to be experienced by LGBTI people, if they are confined with family who do not accept them, or in a location where they are subject to other forms of stigma.

Increased domestic violence has been witnessed in previous crises and health crises: much evidence demonstrates that stressful events can lead to increased aggression in the home, including the recessions, the 2008 economic crisis, natural disasters, and during big football tournaments. During Ebola in Guinea in 2014 there was a 4.5% increase in sexual and gender-based violence compared to prior the epidemic, according to the Minister of Social Action, Women and Children, although this statistic is thought to be wildly underestimated⁸⁸. In 2019, researchers launched a self-reported perceptions study with women and girls in Ebola affected regions of the DRC which reporting widespread increases in sexual and domestic violence since the start of the outbreak⁸⁹.

Economic stressors because of COVID are likely to exacerbate domestic violence, both at the macro level with economically deprived areas and impacts on employment, social mobility and opportunity. At the micro level, economic insecurity can lead to taking on debt, substance abuse both of which can lead to violence against women and children⁹⁰. Data from Finland has shown that alcohol consumption has increased during the COVID-19 pandemic⁹¹. Evaluations of programmes in USA have shown that moving benefit payments from the first of the month to the last of the month increases domestic violence by 6.9%⁹². The economic insecurity posed by COVID-19 as sectors of the economy and shut down and the increased job losses (or worry about future job loss) poses a significant risk to women and children. Mental health challenges, such as those exacerbated by extended lockdown, can also prove a factor in increased domestic violence⁹³.

5.1. Measuring and Reporting Domestic Violence

However, domestic violence is notoriously hard to measure accurately, often women do not report this violence, or do not report it until such time as they perceive it to put their life at risk. Importantly, there are not consistent methods to measure, or indeed report and track, domestic violence across Europe. As EIGE have shown (Figure 14), data variation makes understanding the extent of the problem within jurisdictions and across the EU difficult.

⁸⁸ Maria Caspani. 2015. Violence against women in Ebola hit nations: ministers. As accessed: <https://www.reuters.com/article/us-health-ebola-women/violence-against-women-rises-in-ebola-hit-nations-ministers-idUSKBNOME30520150318>

⁸⁹ International Rescue Committee. 2019. Women and girls in DRC facing an increased risk of violence and higher exposure to Ebola since start of outbreak. As accessed: <https://www.rescue.org/press-release/women-and-girls-drc-facing-increased-risk-violence-and-higher-exposure-ebola-start>

⁹⁰ Doyle Jr, J. J., & Aizer, A. (2018). Economics of child protection: Maltreatment, foster care, and intimate partner violence. *Annual review of economics*, 10, 87-108.

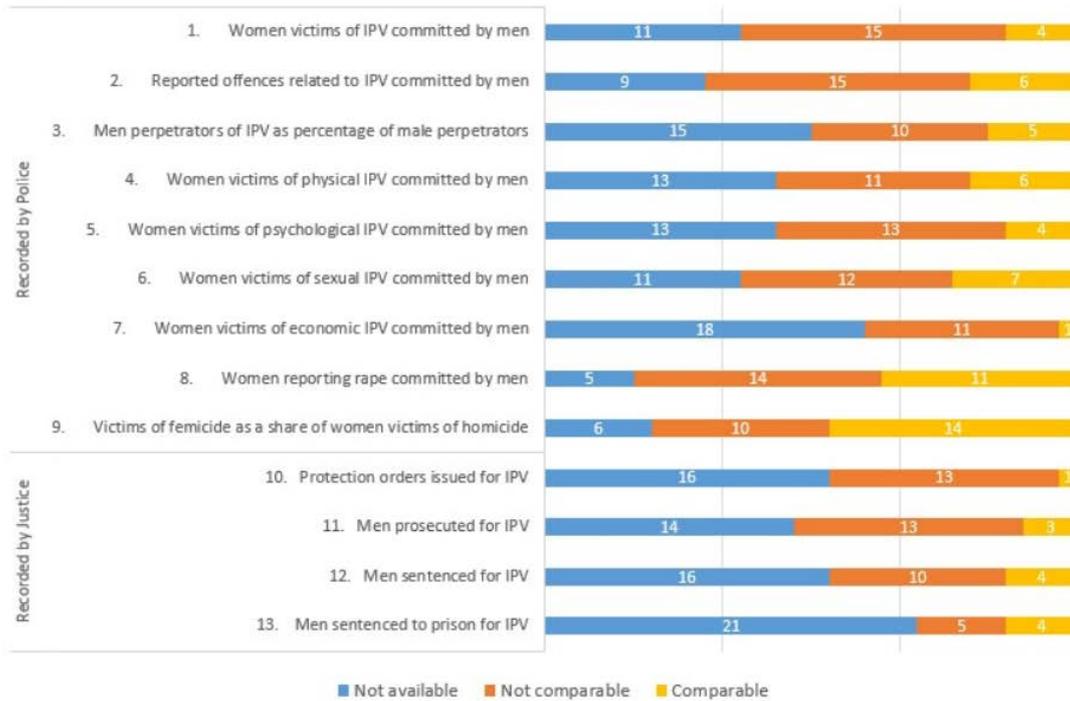
⁹¹ Council of Europe. 2020. Promoting and protecting women's rights at national level. As accessed:

[https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

⁹² Carr, J. B., & Packham, A. (2019). SNAP benefits and crime: Evidence from changing disbursement schedules. *Review of Economics and Statistics*, 101(2), 310-325.

⁹³ Peterman, Potts, O'Donnell, Thompson, Shah, Oertelt-Prigione, and van Gelder, 2020. "Pandemics and Violence Against Women and Children." CGD Working Paper 528. Center for Global Development. <https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children>

Figure 15: Number of Jurisdictions with comparable, not comparable, and not available data on intimate partner violence (IPV), collected from policy and justice national administrative sources from 2014 until 2018



Source: EIGE, 20th June 2020 Gender Statistics Database “The EU is inching towards comparable data on intimate partner violence.”

It can also be assumed that official reporting of domestic violence will be further reduced during periods of quarantine and lockdown where limited mobility and limited privacy will mean that women are unable to phone for help, report abuse to authorities or receive support through their social or formal networks as they are at home with the abuser. This is what was seen in Spain where police have reported that domestic violence has reduced by 40% on previous years⁹⁴. It is thought this is an issue with reporting whilst in isolation with a violent partner, rather than reflecting a true reduction in violence⁹⁵. In Italy it was suggested that a similar reduction in reporting of domestic violence may reflect a lack of confidence amongst women in the state to do anything about these reports⁹⁶. Furthermore, COVID-19 has created a barrier to routine law enforcement, where some security sectors have been asked to limit the number of people who are arrested and detained, in an effort to reduce risk of infection in prisons. This can have a knock-on effect on violence against women if perpetrators are not charged. Thus, data from calls to domestic violence hotlines can be used as a good proxy indicator of domestic violence. In March 2020 calls to these helplines rose 20% in Lithuania, 30% in

⁹⁴ Yuliya Talmazan, Lidia Sirna, Hernan Minoz Ratto and Nancy Ing. 2020. European countries develop new ways to tackle domestic violence during coronavirus lockdowns. NBC News. <https://www.nbcnews.com/news/world/european-countries-develop-new-ways-tackle-domestic-violence-during-coronavirus-n1174301>

⁹⁵ Bergen Stephen. 2020. Women killed in Spain as Coronavirus lockdown sees rise in domestic violence. The Guardian. As accessed: <https://www.theguardian.com/global-development/2020/apr/28/three-women-killed-in-spain-as-coronavirus-lockdown-sees-rise-in-domestic-violence>

⁹⁶ Rachele Marconi. 2020. The gender trap? Being an Italian woman in times of COVID-19. As accessed: <https://blogs.lse.ac.uk/wps/2020/04/28/the-gender-trap-being-an-italian-woman-in-times-of-covid-19/>

Cyprus, 32% in France, 47% in Spain. WHO Europe suggests this rate might be up 60%⁹⁷. This number is likely to increase as security, health and financial stress heighten tensions, with the risk of widespread recession and job losses, which are exacerbated by any reimplementations of lockdown measures⁹⁸. Rosa, a Czech NGO has reported that the length of individual phone calls to these hotlines has tripled⁹⁹.

5.2. Addressing GBV during COVID-19

Ending domestic violence is a key component of the EU Gender Equality Strategy 2020-5. As part of this, the Council of Europe Convention on Preventing and Combating Violence against Women, including Domestic Violence, (Istanbul Convention), requires governments to take efforts to reduce domestic violence, and offer support and protection to women and girls at risk of violence, through law enforcement, social services, and specialist support services¹⁰⁰

As such, governments in Europe have taken steps to protect women and other marginalised groups at risk of domestic violence. These have taken a variety of forms:

Belgium, Croatia, Estonia, France, Greece, Netherlands, Portugal, Romania, Spain, Slovenia and Austria have set up or extended online, Whatsapp and phone support systems to both report violence and offer legal and policy advice alongside emotional/psychological support for domestic violence victims during COVID-19, noting that in person counselling would be restricted¹⁰¹. Spain, Sweden, Slovenia have also included provision of psychosocial counselling to victims of domestic violence, set up online or via WhatsApp so that support can continue whilst in the house with a potential aggressor. In Czech Republic, this service also functions as a record of abuse to pass to authorities for prosecution¹⁰².

Another approach has been to ensure women are able to leave their homes and seek safety. France has subsidised 20,000 hotel rooms as safe spaces for women affected. Italy and Spain have provided a similar service, and Estonia and Germany have explored extending provision, such as through holiday accommodation as provision for this increased demand¹⁰³. In Denmark, municipal councils have a legal obligation to provide temporary accommodation to women at risk of violence, and space

⁹⁷ Mahase, E. (2020). Covid-19: EU states report 60% rise in emergency calls about domestic violence. *BMJ: British Medical Journal (Online)*, 369; UN News. 2020. UN backs global action to end violence against women and girls amid COVID-19 crisis. 6 April. <https://news.un.org/en/story/2020/04/1061132> European Commission. 2020. Coronavirus Pandemic: Impact on Gender Equality. As accessed: https://ec.europa.eu/info/sites/info/files/research_and_innovation/research_by_area/documents/ec_rtd_covid19-gender-equality_factsheet.pdf; Zsuzsanna Blasko, Eleni Papadimitriou, Anna Rita Manca, How will the COVID-19 crisis affect existing gender divides in Europe. JRC Science for Policy Report. https://publications.jrc.ec.europa.eu/repository/bitstream/JRC120525/covid_gender_effects_f.pdf

⁹⁸ UN Women. 2020. COVID-19 and Ending Violence Against Women and Girls. As Accessed <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006>; EIGE. 2020. Gender-based violence. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/gender-based-violence>

⁹⁹ Council of Europe. 2020. Promoting and protecting women's rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹⁰⁰ Council of Europe. 2020. Istanbul Convention: Action against violence against women and domestic violence. <https://www.coe.int/en/web/istanbul-convention/home?>

¹⁰¹ European Commission. 2020. The EU Mutual Learning Programme in Gender Equality: Good Practices for tackling domestic violence in the context of COVID-19. As accessed: <https://rm.coe.int/09000016809ea45a>

¹⁰² European Commission. 2020. The EU Mutual Learning Programme in Gender Equality: Good Practices for tackling domestic violence in the context of COVID-19. As accessed: <https://rm.coe.int/09000016809ea45a>; Council of Europe. 2020. COVID-19: Slovenia, AS accessed: <https://rm.coe.int/09000016809e2e37>

¹⁰³ Yuliya Talmazan, Lidia Sirna, Hernan Minoz Ratto and Nancy Ing. 2020. European countries develop new ways to tackle domestic violence during coronavirus lockdowns. NBC News. <https://www.nbcnews.com/news/world/european-countries-develop-new-ways-tackle-domestic-violence-during-coronavirus-n1174301>

in shelters has been extended due to COVID-19 (and for male victims)¹⁰⁴. This was supplemented with space in disused shopping centres to provide space for women to seek help clandestinely. Importantly, accessing these services were exempt from the strict lockdown enforcements¹⁰⁵. The shelters across Europe have further sought to provide women PPE and introduce measures to reduce the risk of disease transmission in these locations¹⁰⁶.

Poland, Portugal and Romania also worked hard to develop safety plans for those women who were already victims of domestic violence to ensure their continued safety¹⁰⁷. This has been vital to ensure that they remain safe, and that their needs are not forgotten.

As it became clear that people may not be able to report these types of violence, even if they are able to get to a pharmacy or supermarket, France, Greece and other states set-up a Pan-European clandestine notification protocol at grocery stores and pharmacies where women asked for “mask 19” to alert practitioners to the risks they are facing, who in turn can alert the police¹⁰⁸. In a similar effort, Italy and Spain developed apps to allow discrete notifications to authorities.¹⁰⁹¹¹⁰. Czech Republic has trained those who interact with people in their own homes, such as the postal service workers, to identify domestic violence¹¹¹.

Several states, including Austria, Germany, Bulgaria and Spain, have launched national awareness and domestic violence prevention campaigns, which are multi-lingual to alert the public to look out for domestic violence amongst their community and friends. In Portugal, these campaigns were prominent in the public through partnership with distribution companies, petrol stations, pharmacies, public transport signs etc. In Romania, these campaigns included public figures to raise visibility of the issue¹¹². Such prevention campaigns were supported by clear guidance and information for women who didn’t know how to get help, should they need, alongside legal advice. In Slovenia, phone numbers for domestic violence support were provided in all news briefings about the outbreak in order to disseminate the details as widely as possible¹¹³. In Austria, there were press conferences particularly related to domestic violence during COVID to increase public awareness¹¹⁴.

In Italy, Austria and Germany, efforts were taken to ensure that in situations of domestic violence, the abuser had to leave the home and not the victim, so as not to expose the victim to potential COVID

¹⁰⁴ Council of Europe. 2020. Promoting and protecting women’s rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹⁰⁵ European Charter for Equality of Women and Men in Local life. 2020. Gender Equal Cities under COVID-19. As Accessed: <https://charter-equality.eu/news/francais-gender-equal-cities-under-covid-19.html>

¹⁰⁶ Council of Europe. 2020. Promoting and protecting women’s rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹⁰⁷ Council of Europe. 2020. COVID-19: Romania. As accessed: <https://rm.coe.int/09000016809e2e38>

¹⁰⁸ Council of Europe. 2020. Promoting and protecting women’s rights at national level. As accessed:

[https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹⁰⁹ Government of Spain. 2020. Alertcops. As accessed: <https://alertcops.ses.mir.es/mialertcops/en/index.html>; Government of Spain. 2020. Contingency Plan to Combat Gender Violence during the COVID-19 crisis. As accessed: <https://rm.coe.int/09000016809e2e41>

¹¹⁰ Yuliya Talmazan, Lidia Sirna, Hernan Minoz Ratto and Nancy Ing. 2020. European countries develop new ways to tackle domestic violence during coronavirus lockdowns. NBC News. <https://www.nbcnews.com/news/world/european-countries-develop-new-ways-tackle-domestic-violence-during-coronavirus-n1174301>

¹¹¹ European Commission. 2020. The EU Mutual Learning Programme in Gender Equality: Good Practices for tackling domestic violence in the context of COVID-19. As accessed: <https://rm.coe.int/09000016809ea45a>

¹¹² Council of Europe. 2020. COVID-19: Romania. As accessed: <https://rm.coe.int/09000016809e2e38>

¹¹³ Council of Europe. 2020. COVID-19: Slovenia. AS accessed: <https://rm.coe.int/09000016809e2e37>

¹¹⁴ Council of Europe. 2020. Promoting and protecting women’s rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

risks in hostel settings¹¹⁵. On the other hand, in Bulgaria, anyone suffering domestic violence is immediately taken to a crisis centre¹¹⁶.

There have been concerns that in some locations police and or judicial services has been reduced to limit disease transmission. This has had a knock-on effect of delayed prosecution for some crimes. However, in Slovenia the police made it clear that there was zero-tolerance policy to domestic violence through Facebook dissemination¹¹⁷. Austria facilitated legal processes to allow electronically activated restraining orders¹¹⁸. In the Netherlands, the prosecution service is prioritising cases of sexual violence, as are the police in Finland¹¹⁹

Elsewhere in the world countries are taking proactive measures to reduce incidence of domestic violence through prohibition on alcohol sales (known to be a risk factor for domestic violence) and curtailing sales of dangerous weapons¹²⁰. Austria has further considered the broader drivers of violence, such as ensuring that there is access to advance maintenance payments by the state, so that financial concerns are mitigated. In Germany, Luxembourg, Slovenia, activities focused on perpetrators were also included (or indeed continued) during lockdown, focused on reduction of violence and identifying coping strategies. These services continued online during periods of quarantine¹²¹.

However, not all governments have been proactive: during lockdown Hungary has adopted a declaration not to ratify the Istanbul convention against violence against women in May 2020, leaving women without protection to domestic abusers, a further 6 EU states have just signed the convention and have not ratified it, which means practically that it does not enter force¹²².

To identify where interventions can prevent most harm there is an urgent need to collect data using a variety of methods during and after the outbreak on what causes violence and where, noting that domestic violence is widely under-reported and thus innovative methods are required. Particularly during a crisis like COVID-19, data gathering poses many challenges.

Governments and researchers must work with survivors' organizations to understand trends and impacts, changing contexts and socio-political dynamics. For example, how are levels of violence changing in response to lockdown or unemployment? To find out, researchers will need to use qualitative methodologies, such as interviews with women who have been affected by violence, community leaders and health care providers, to capture the stories of those affected whose experiences may not be apparent in official statistics

¹¹⁵ Alessandra Guedes, Amber Peterman and Dina Deligiorgis. 2020. Five ways governments are responding to violence against women and children during COVID-19. As accessed: <https://blogs.unicef.org/evidence-for-action/five-ways-governments-are-responding-to-violence-against-women-and-children-during-covid-19/>

¹¹⁶ Council of Europe. 2020. Promoting and protecting women's rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹¹⁷ Council of Europe. 2020. COVID-19: Slovenia, AS accessed: <https://rm.coe.int/09000016809e2e37>

¹¹⁸ Council of Europe. 2020. Promoting and protecting women's rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹¹⁹ Council of Europe. 2020. Promoting and protecting women's rights at national level. As accessed: [https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:\[3\]](https://www.coe.int/en/web/genderequality/promoting-and-protecting-women-s-rights#%2263001324%22:[3])

¹²⁰ Peterman, Potts, O'Donnell, Thompson, Shah, Oertelt-Prigione, and van Gelder, 2020. "Pandemics and Violence Against Women and Children." CGD Working Paper 528. Center for Global Development. <https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children>

¹²¹ European Commission. 2020. The EU Mutual Learning Programme in Gender Equality: Good Practices for tackling domestic violence in the context of COVID-19. As accessed: <https://rm.coe.int/09000016809ea45a>

¹²² <https://www.amnesty.org/en/latest/news/2020/05/hungary-blocking-of-domestic-violence-treaty-further-exposes-women>

5.3. Violence against health workers

Alarming, violence against (female) healthcare workers is an increasing risk that these women face. This can be at the hands of colleagues, patients, or the community. A study in Germany revealed that 76% of female physicians reported sexual harassment during their career¹²³. In Italy 45% of healthcare workers reported workplace violence, but this number rose to 67% amongst nurses¹²⁴. This tended to occur in psychiatry department, emergency wards and geriatric wards, and included both physical and verbal abuse

During COVID-19 these risks may be different, whilst the same risks may be a factor in the hospital, outside the hospital if healthcare workers are travelling during quarantine measures when the rest of the community is not, this makes travelling to and from work a potentially risk laden activity, particularly at night. Anecdotal evidence suggests that female healthcare workers are actively concerned about this in several locations.

¹²³ Jenner, S., & Oertelt-Prigione, S. (2019). Patients as Perpetrators of Physician Sexual Harassment—Reply. *JAMA Internal Medicine*, 179(2), 279-280.

¹²⁴ Ferri, P, Silvestri, M, Artoni, C and Di Lorenzo, R (2016) 'Workplace violence in different settings and among various health professionals in an Italian general hospital: a cross-sectional study', *Psychology Research and Behavior Management*, Vol. 9 263–275

6. DISTORTION OF HEALTH SERVICES

KEY FINDINGS

Health systems can be distorted by the need to respond to the threat of the pathogen. This can disproportionately affect women, as women interact with health providers more than men.

Maternity care has changed, with much ante- and post- natal care being offered online or via phone. This is to reduce risk of infection to pregnant women; however, it poses concerns for birth outcomes and the physical / mental health of the mother.

Contraception supply has been disrupted by pandemic changes to travel and trade patterns. Access has also been altered by the closure of local clinics in some locations. Demand has also changed, with some women not wishing to leave their homes to access such services.

COVID-19 has been an opportunity for some governments to further restrict abortion provision, deeming it "non-essential". A lack of abortion provision does not alter women's determination to terminate a pregnancy, it risks making it unsafe. Some governments have taken effective strides to ensure continued and additional access to medical abortion at home during COVID-19.

Amid epidemics and pandemics, the 'tyranny of the urgent' can take over, with the result that financial, human, and clinical resources can get diverted to the direct response to the circulating pathogen. The secondary and downstream effect of this prioritisation is the disruption of routine health services, impeding access to health care for other conditions. This has included reduced admissions to emergency departments across Europe as individuals delay care seeking behaviour fearing risk of disease transmission; non-essential treatments are postponed, out-patient surgeries are postponed, and cancer referrals showing worrying trends of delay putting individuals at greater risk of effective treatment. These raise several questions of equity within health and prioritisation of resources. However, national, and local authorities and hospital managers must decide how to manage COVID-19, and these decisions can affect men and women differently.

One of the key concerns for women and women's health has been the questioning of "essential services" and what constitutes this in each administration. Activists have been concerned that changes to sexual and reproductive health (SRH) provision will perpetuate political divides and restrictions to reproductive freedom¹²⁵. These freedoms may then be further compromised by shelter in place recommendations prohibiting movement to protest or launch collective action to protect these rights. Further concerns raised are around the economic stressors of COVID-19 on the health system and the knock-on effects this might have on sustainability of readily available SRH services.

Whilst initial quips suggested that lockdown was going to result in a "COVID-19 baby-boom", this effect is yet to be seen (and nor is their evidence that it will be, with trends suggesting broader declines in fertility)¹²⁶. Indeed, 34% of women recently polled stated they were more careful about using contraception because of COVID-19¹²⁷. Furthermore, LGBTI people have significantly greater difficulties accessing quality SRH services due to stigma and discrimination, biases held by healthcare

¹²⁵ Marta Schaaf, Victoria Boydell, Sara Van Belle, Derick W. Brinkerhoff & Asha George (2020) Accountability for SRHR in the context of the COVID-19 pandemic, *Sexual and Reproductive Health Matters*, 28:1, DOI: [10.1080/26410397.2020.1779634](https://doi.org/10.1080/26410397.2020.1779634)

¹²⁶ Luppi F, Arpino B and Rosina A, The impact of COVID-19 on fertility plans in Italy, Germany, France, Spain and UK, SocArXiv, 2020, doi:10.31235/osf.io/wr9jb.

¹²⁷ Laura Lindberg, Alicia VendeVusse, Jennifer Mueller and Marielle Kirstein. 2020 Early Impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. <https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health#>

providers, and lower socioeconomic status, often linked with lower access to comprehensive health insurance, and are therefore more vulnerable. Greater research is required to understand the future needs and priorities of those seeking SRH services.

6.1. Maternity Care

One of the most obvious ways is through provision or access to antenatal care, attendance at childbirth, family planning and/or abortion care. Some choose offer consultations virtually, or only offer services in certain locations. This can prevent women from accessing quality sexual and reproductive health care services. In Sierra Leone during the Ebola outbreak, supply and demand side changes to antenatal and labour support led to 3,600 additional maternal, neonatal and stillbirth deaths in 2015. This number was equal to total number of deaths due to the virus itself¹²⁸. Reducing access to sexual and reproductive health services because of an outbreak risks derailing progress on SDG 3.7 “universal access to sexual and reproductive health services and their integration into national health strategies” and SDG 5.6 “ensuring universal access to sexual and reproductive health rights”.

Early evidence suggests that COVID-19 does not pose a risk to safe pregnancy¹²⁹. Yet pregnancy is a risk factor for other respiratory infections, so many governments are exercising caution in recommendations for pregnant women. A study by IPPF European Network and European Parliamentary Forum for Sexual and Reproductive Rights has demonstrated that 94% of service providing organisations has decreased number and frequency of services during COVID-19 and 78% of clinics or community care points have been closed¹³⁰. Importantly, these changes occurred almost overnight, and impacting women who were already pregnant and had no warning. In the Netherlands, after the 12-week scan, all appointments were moved to online¹³¹. Face to face meetings have been heavily reduced in France, Italy, Spain, and UK also.

The aim of these changes is to reduce the risk of COVID-19 transmission to those who are pregnant, however, the move to online and phone consultations may disadvantage those who lack IT resources or speak the language. Concerns have also been raised about the risk to patient safety and neonatal outcomes if in person checks are not routinely completed, and the impact this reduction, and the inability to bring a partner to scans may have on women’s mental health¹³². A June 2020 study in Spain suggested that infection with COVID-19 might increase risk of pre-eclampsia¹³³. Limiting routine maternity services can also increase maternal mortality, but we will not have clear statistics for this until coming months. There are also broader effects, such as the limitation on birth partners during labour in France, Ireland, Czech Republic, and separation of babies from mothers on birth in France, Slovakia and Romania. This may have effects on maternal bonding and post-partum depression. In

¹²⁸ Laura Sochas, Andrew Amos Channon, Sara Nam, Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone, *Health Policy and Planning*, Volume 32, Issue suppl_3, 1 November 2017, Pages iii32–iii39, <https://doi.org/10.1093/heapol/czx108>

¹²⁹ <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/>

¹³⁰ https://www.epfweb.org/sites/default/files/2020-05/epf_-_ipff_en_joint_report_sexual_and_reproductive_health_during_the_covid-19_pandemic_23.04.2020.pdf

¹³¹ Coxon, K., Turienzo, C. F., Kweekel, L., Goodarzi, B., Brigante, L., Simon, A., & Lanau, M. M. (2020). The impact of the coronavirus (COVID-19) pandemic on maternity care in Europe. *Midwifery*, 88, 102779. <https://doi.org/10.1016/j.midw.2020.102779>

¹³² Coxon, K., Turienzo, C. F., Kweekel, L., Goodarzi, B., Brigante, L., Simon, A., & Lanau, M. M. (2020). The impact of the coronavirus (COVID-19) pandemic on maternity care in Europe. *Midwifery*, 88, 102779. <https://doi.org/10.1016/j.midw.2020.102779>

¹³³ <https://www.aa.com.tr/en/europe/spain-study-warns-of-covid-19-pregnancy-complications/1879291>

Slovakia, the Public Defender of Rights has raised concerns about the harmful practices imposed on mothers and their failure to adhere to the standards laid out by the World Health Organization¹³⁴.

It is likely that disruption and restrictions to reproductive health services will affect some communities more than others, including women living in poverty, women with disabilities, Roma women, undocumented migrant women, adolescents, trans and gender non-binary people, and women at risk of or who are survivors of domestic and sexual violence¹³⁵. For example, Bulgaria, Romania and Serbia, projects supporting the sexual and reproductive health of Roma girls and women have been suspended.

6.2. Contraception

COVID-19 is also affecting access to contraception due to problems of supply and demand:

Supply chains to create short-term contraceptives have been severely interrupted by COVID-19. Most of the globe's contraceptive supply is made in Asian countries, many of which suffered from COVID-19 earlier than Europe, which meant that early in 2020, factories suffered from access to raw materials, compounded by workforce shortages affecting factories and stay at home orders meaning factories had to temporarily close. This has been further challenged by product distribution interruption impacted by travel bans and changes to flight patterns¹³⁶. Albania, Austria, Belgium, Bosnia and Herzegovina, Denmark, Germany, Ireland, North Macedonia, Portugal and Spain have reported that they have been forced to scale back contraceptive care.

Contraception's demand side has also been affected. Due to lockdown requirements some women have been unable to visit health care providers to access contraceptives, including emergency contraception, or, importantly, because they wish to avoid exposure to infection in crowded clinics, whether this is a real concern or a perceived concern¹³⁷. Furthermore, the costs of these services may be prohibitive for those who are facing economy insecurity as a result of changes to work because of lockdown. This will likely be regressive, affecting those already impoverished. This is compounded by the risk of sexual and gender-based violence associated with quarantine, and the barriers to self-determination that some women face during isolation with abusers. This can have significant real-world effects: After Ebola outbreaks in Sierra Leone and Liberia in 2014, estimates suggest that teenage pregnancies were 23% higher than the previous year.

Governments are trying a range of strategies to try and limit the impact of contraception disruption. France has allowed women to use expired prescriptions at pharmacies to access oral contraceptives. Belgium has made the emergency contraception free at the point of access for 18-25-year olds. This not only facilitates access to contraception, but it also changes perceptions about how to access such

¹³⁴ Dunja Mijatovic. 2020. COVID-19 and Europe's Sexual and Reproductive Health Rights. Open democracy. As Accessed: <https://www.opendemocracy.net/en/can-europe-make-it/covid-19-and-europes-sexual-and-reproductive-health-rights/>

¹³⁵ Amnesty International. 2020. Europe: failures to guarantee safe access to abortion endangers health o women, girls amid COVID-19. As Accessed: <https://www.amnesty.org/en/latest/news/2020/04/europe-failures-to-guarantee-safe-access-to-abortion-endangers-health-of-women-and-girls-amid-covid-19>

¹³⁶ Chris Purdy. 2020. How will COVID-19 affect global access to contraceptives and what can we do about it? As Accessed: <https://www.devex.com/news/opinion-how-will-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745>

¹³⁷ Ellen Friedrichs. 2020. The COVID pandemic exposes the need for over the counter birth control. As accessed: <https://rewire.news/article/2020/04/02/the-covid-19-pandemic-exposes-the-need-for-otc-birth-control/>

services, which are particularly important for some groups who have faced historic barriers to accessing health care and SRH services¹³⁸.

6.3. Abortion

COVID-19 can also affect access to 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 providers¹³⁹.

In countries where women require physician approval for an abortion, quarantine severely hinders their access to clinics. Abortion is time sensitive, and delay can lead to worse outcomes, or women seeking unsafe methods. If women are unable to leave their house to get there, or if this facility is closed if such services are deemed to be “non-essential” by providers who instead channel the human and clinical resource to COVID-19 response, as occurred in Italy and Slovakia. These impacts may be particularly severe for those of low income, with disabilities or marginalised in other ways who may not be able to pay or access services via alternative means.

Government policies on abortion during the current pandemic differ widely and will lead to very different outcomes for women. In England and Ireland, for example, a recently introduced policy change permits self-managed abortion, the use of mifepristone and misoprostol pills to terminate pregnancy at home through online or phone consultation with a physician, to reduce the strain on the health services during COVID-19. France has extended home abortion regulation to 9 weeks gestation (previously it was 7 weeks). Germany which requires mandatory counselling before abortion has allowed this to happen by phone or video. These efforts to reduce requirements requiring clinic visits, mandatory waiting periods or abortion counselling have importantly not shown to increase risk to women who seek to terminate their pregnancies¹⁴⁰.

Concerns are raised about the impact of COVID related border closures on access to abortion in restrictive settings. As Poland has the most restrictive abortion regulation in Europe, many women have travelled to Slovakia or Germany for the procedure, but since borders have been closed, this has not been possible. Similar trends have been observed in Malta. An online provider of medical abortion pills in restrictive settings has noted an increase in demand requests in Poland during 2020. Similarly, there are valid concerns that Poland and Romania have used the outbreak of COVID to limit provision of abortion within public and private medical facilities¹⁴¹.

However, restriction to abortion does not reduce women’s desire for termination, it simply means that women will procure unsafe abortion, through pharmacies, women’s organisations, and the black market, placing their lives at risk. The World Health Organization COVID-19 Strategic Preparedness and

¹³⁸ Laura Lindberg, Alician VendeVusse, Jennifer Mueller and Marielle Kirstein. 2020 Early Impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. <https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health#>

¹³⁹ Wenham, C., Arevalo, A., Coast, E. *et al.* Zika, abortion and health emergencies: a review of contemporary debates. *Global Health* **15**, 49 (2019). <https://doi.org/10.1186/s12992-019-0489-3>

¹⁴⁰ Laura Lindberg, Alician VendeVusse, Jennifer Mueller and Marielle Kirstein. 2020 Early Impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. <https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health#>

¹⁴¹ Dunja Mijatovic. 2020. COVID-19 and Europe’s Sexual and Reproductive Health Rights. Open democracy. As Accessed: <https://www.opendemocracy.net/en/can-europe-make-it/covid-19-and-europes-sexual-and-reproductive-health-rights/>

Response Plan, provides no recommendation on how resources should be channelled to provide safe abortion and ensure the supply of contraceptives¹⁴²

6.4. Mental Health

Depression and anxiety have significantly increased as a consequence of COVID-19 and the associated changes to “routine” life¹⁴³. Decades of research have shown the intersection between financial hardship and mental health. It is well established that those in the lowest socio-economic groups have worse mental health than those in the highest. This is also heavily gendered, particularly in crisis environments.

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 because of COVID-19, in comparison to 24 per cent of men¹⁴⁴. 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 Economics¹⁴⁵, and echoed by work at EU Level with the JRC study demonstrating that women report anxiety more often than men. In individual member states, similar trends have been reported in Belgium, France, and Italy¹⁴⁶.

Mental health services will need to be (re)established to cope with the burden of mental health, and changes to mental health provision for those who are already under the care of mental health teams. Disruptions to services have been reported globally, and or provision moved online, There is little evidence to understand the effects of these changes, but they are likely to be wide-ranging¹⁴⁷.

¹⁴² World Health Organization. 2020. Strategic preparedness and Response Plan. As Accessed: <https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus>

¹⁴³ Pieh, C., Budimir, S., & Probst, T. (2020). The effect of age, gender, income, work, and physical activity on mental health during coronavirus disease (COVID-19) lockdown in Austria. *Journal of psychosomatic research*, 110186.

¹⁴⁴ Ipsos. 2020. More suffering from under exercising, anxiety than other health concerns during COVID-19: Poll. As accessed. <https://www.ipsos.com/en-us/news-polls/more-suffering-under-exercising-anxiety-other-health-concerns-due-covid-19-poll>

¹⁴⁵ Topping, Alexandra. 2020. Half of UK Parents with young children face money woes – survey. The Guardian. As accessed: <https://www.theguardian.com/world/2020/may/07/coronavirus-half-of-uk-parents-with-young-children-face-money-woes-survey>

¹⁴⁶ EU Science Hub. 2020. Life dissatisfaction and Anxiety in COVID-19 pandemic As accessed: <https://ec.europa.eu/jrc/en/publication/life-dissatisfaction-and-anxiety-covid-19-pandemic>; Rossi, R., Socci, V., Talevi, D., Mensi, S., Ntoli, C., Pacitti, F., ... & Di Lorenzo, G. (2020). COVID-19 pandemic and lockdown measures impact on mental health among the general population in Italy. *Frontiers in Psychiatry*, 11.

¹⁴⁷ Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., ... & Chen, E. Y. (2020). How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*.

7. ECONOMIC IMPACT

KEY FINDINGS

The economic impact of COVID-19 and ensuing response will be wide-reaching, and will disproportionately affect women, and other marginalised communities. This will occur both at the macro and micro level.

At the micro level, care responsibilities will mean that women are forced to reduce working hours (or may have lost their jobs) with the ensuing loss of income and risk of economic insecurity and poverty for some families. Wider spread recession may affect both parents, heightening this problem. Furthermore, due to flexible or part time working, women are at greater risk of job cuts in the future.

At the macro level, the industries which have been most significantly impacted by COVID-19 are heavily feminised. This includes hospitality, tourism, childcare, education, and healthcare. Female migrants represent a significant portion of women employed in these sectors and need to be given full consideration in policies developed to respond to this and future crises.

COVID-19 is destroying livelihoods across Europe and the world. The OECD predicts frightening consequences for national, regional, and global economies¹⁴⁸. EU economies' GDP contracted by 3.8% in first quarter 2020, and yet the EU has committed to a €750 billion recovery effort¹⁴⁹. These outcomes will affect both the macro and micro levels of analysis, and will, at both levels, disproportionately affect women.

7.1. Financial Impact on Families

Families have been significantly impacted by COVID-19 and the associated interventions to minimise the spread of the virus. The most notable of these has been the changes to employment. As quarantine lockdowns were put in place, much of European industry and services halted and workers were requested to stay at home. Governments of UK, Denmark and Ireland have pledged to cover 75% of workers' income, to ensure parental turnover. Spain has pushed for a universal basic income. In other locations, and for those who work in the informal sector, people have had to risk infection to continue to work or have lost their jobs. This can have a significant effect on family economy security.

Where people have been able to work at home, further challenges have arisen with juggling the additional care burden of children in the home and home schooling. This has meant that some parents (predominantly women) have been forced to reduce their hours or leave their jobs to be able to manage the competing demands of paid and unpaid labour. Those who were able to take reduced or voluntary leave / furlough now face greater concerns as their work may be viewed as non-essential, placing women disproportionately at risk of unemployment and job cuts in future.

As has been shown by initial research in UK, USA and Germany, these cuts and unemployment are falling disproportionately on women¹⁵⁰. This might be due to the additional care role that women perform which means that they are unable to undertake paid work, or that they are already on less secure

¹⁴⁸ OECD. 2020. Coronavirus: The World Economy at risk. As accessed: <https://www.oecd.org/berlin/publikationen/Interim-Economic-Assessment-2-March-2020.pdf>

¹⁴⁹ European Council: Council of the European Union. 2020. COVID-19: the EU's response to the economic fallout. As accessed: <https://www.consilium.europa.eu/en/policies/coronavirus/covid-19-economy/>

¹⁵⁰ COVID Inequality Project. 2020. As accessed: <https://sites.google.com/view/covidinequality/>

contracts which can mean the easiest to make redundant, or are in precarious work¹⁵¹. EIGE data show that 26.5 % of women across the EU are in a precarious job, compared to only 15.1 % of men¹⁵². For example, women comprise over 60% of part time workers, and those working flexibly. These are the first to leave employment at point of recession. Moreover, the closure of many childcare settings because of structural challenges posed by COVID-19 will have a negative impact on women's participation in the labour market.

The COVID-19 crisis is therefore likely to worsen women's poverty at micro and macro levels. 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 are seeing 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 women tend to work in positions that leave them more open to exploitation and abuse, such as in domestic work, home-based work or by contributing to family businesses. High-income countries are not immune to these trends either: data from the EIGE suggests more than a quarter (26.5%) of women employees in the EU work in precarious employment, compared to only 15.1% of men¹⁵³. Domestic workers, whether employed formally or informally, are particularly vulnerable to the COVID-19 crisis. 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.

Some governments created interventions to mitigate against some of the downstream effects on women. In Italy parents were able to take 15 day paid leave or receive a voucher for childcare. Romanian policy introduced extra days leave. Germany has expanded childcare benefits to support low income parents¹⁵⁴. Financial impacts flow across families. lockdown policies have led to the closure of schools across Europe, these children no longer have access to free school meals, with the risk of significant implications on access to nutrition. Similarly, the shift to online learning requires children to have access to online services and digital devices. Lower socio-economic groups may not have these available, or not for multiple children, increasing the risk for existing digital divides and greater sources of educational opportunity. This can be compounded if parents have been made redundant and/or furloughed and/or placed on reduced hours.

By May 8, 2020, 171 countries had adopted fiscal measures to mitigate the economic effect on households including Belgium, Denmark, France, Germany, Ireland, Italy, Spain, Albania. Most governments increased either the coverage or pay-out amounts from existing social protection schemes or made changes to taxation of firms or delays to reporting procedures for income tax or offering loans. Spain has committed to a Universal Basic Income that will protect all workers.

7.2. Structural / Sector / Feminisation of Poverty

Feminised sectors refer to the sectors of the economy which predominantly employ women. Across Europe this includes personal services, health care workers, education, tourism, recreation, and

¹⁵¹ EIGE. 2017. Gender, skills and precarious work in the EU: Research note. As accessed: <https://eige.europa.eu/publications/gender-skills-and-precarious-work-eu-research-note>

¹⁵² EIGE. 2020. Beijing + 25 : the fifth review of the implementation of the Beijing Platform for Action in the EU Member States. As Accessed: <https://eige.europa.eu/publications/beijing-25-fifth-review-implementation-beijing-platform-action-eu-member-states>

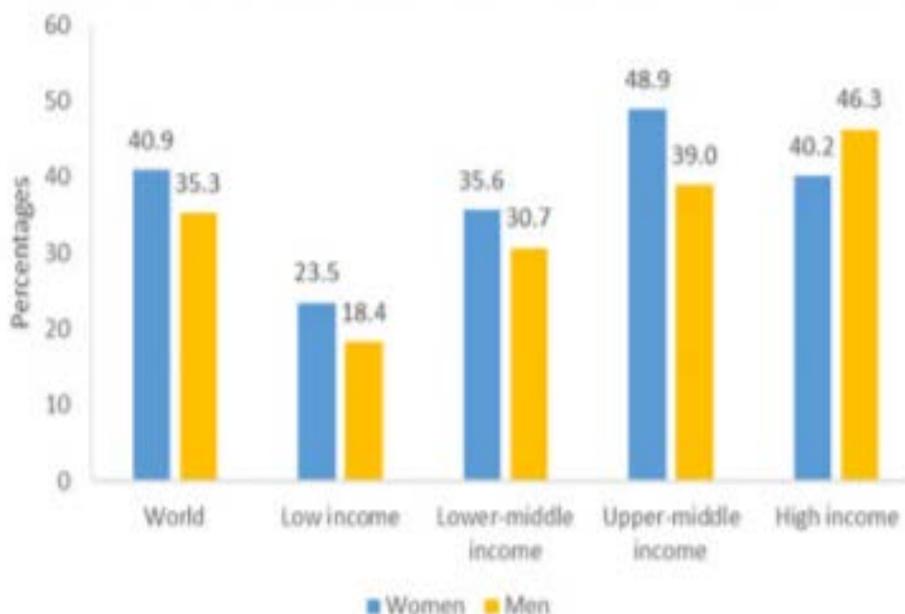
¹⁵³ EIGE. 2020. Economic hardship and gender. As accessed: <https://eige.europa.eu/covid-19-and-gender-equality/economic-hardship-and-gender>

¹⁵⁴ International Labour Organization. 2020. The COVID-19 response: Getting gender equality right for a better future for women at work. As accessed: https://www.ilo.org/global/topics/coronavirus/WCMS_744685/lang--en/index.htm

hospitality, caring and community-based services. The International Labour Organization's preliminary assessment of financial data for COVID-19 from 33 countries show that it is these sectors, and in particular the accommodation, food services and tourism and manufacturing sectors are likely to be the most affected by job loss and economic output contraction as a result of COVID-19. While men represent most workers in the manufacturing sector, the women who work in this sector already were vulnerable. Across the four sectors, 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.

Before the Ebola outbreak, women were already in a precarious economic position, with less financial capital and lower wages than men. During the West African Ebola outbreak of 2014-16, quarantines closed food and other markets. This destroyed the livelihoods of traders in Sierra Leone and Liberia, 85% of whom were women. Men too lost jobs, but 13 months after the first case was detected, 63% had returned to work. For women, the number was 17%¹⁵⁵. 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, and were unable to return to work given the complex care needs of their children born with Congenital Zika Syndrome. Given this evidence which demonstrates women's income recovers slower than men's action needs to be taken to ensure we do not face massive retractions of gender equality. In previous economic crises, it has been masculine industries which have been severely affected, such as manufacturing, construction etc. In that respect, COVID-19 is different to previous economic crises as those which are overexposed because of COVID-19 are those which have a considerable women's employment. This includes childcare, hospitality, tourism and recreation.

Figure 16: Share of employment currently at high risk of reduction of working hours, cuts to wages and layoffs, by sex 2020.



Source: International Labour Organization ILOSATS

¹⁵⁵Bandiera, Oriana and Buehren, Niklas and Goldstein, Markus P. and Rasul, Imran and Smurra, Andrea, The Economic Lives of Young Women in the Time of Ebola: Lessons from an Empowerment Program (February 28, 2019). World Bank Policy Research Working Paper No. 8760, Available at SSRN: <https://ssrn.com/abstract=3344844>

We wait to see how governments will manage the tensions of these industries and the potential for bailout efforts in future. The very real risk is that these industries may not recover, making swathes of women redundant and even if they are able to find a job, without significant support to the childcare sector, women may find themselves unable to return to work due to their care responsibilities. Moreover, women will be further affected by any governmental austerity policies which may reduce public sector spending or employment which also disproportionately employ women.

Investing in a care-based economy can offer real returns for both society and the economy. Not only would such public investment ensure that a tranche of women's jobs are protected in these sectors, but economic analysis have shown that greater economic stimulus can be made by recoveries which are care driven, rather than in construction or manufacturing. This would lead to greater jobs overall, and lead to reduction in the gender pay gap¹⁵⁶.

7.3. MIGRATION

The intersection between migration, gender and economic security is vital within the COVID-19 analysis. Female migrants in Europe (as in North America and Asia) play a disproportionate role in keyworker professions such as healthcare workers, childcare workers, elderly carers, social carers, in food production and are thus vital to the COVID-19 response and future rebuilding of the economy¹⁵⁷. These migrant positions have traditionally not been able to be filled by nationals, and are underpaid, with fewer labour regulations than in other parts of the economy. During COVID-19 these "invisible" labour force have become increasingly visible, not only through a recognition of the value of the care sectors and the Europe-wide "clap for carers" but the invisible communities of migrants have become increasingly visible as considered a medium for disease transmission. Yet, while these populations are being tracked for disease surveillance, they may be prohibited from accessing health or social care due to migration status.

¹⁵⁶ De Henau, J., & Himmelweit, S. (2020). *Stimulating OECD economies post-Covid by investing in care*. IKD Working Paper 85. Milton Keynes: The Open University, Innovation, Knowledge and Development Research Centre

¹⁵⁷ United Nations Population Division: International Migrant Stock 2019. As accessed <https://www.un.org/en/development/desa/population/migration/data/estimates2/estimates19.asp>; Barken, R., Armstrong, P. Skills of Workers in Long-Term Residential Care: Exploring Complexities, Challenges, and Opportunities. *Ageing Int* **43**, 110–122 (2018). <https://doi.org/10.1007/s12126-017-9285-7>

8. CONCLUSION

COVID-19 has infected and affected men, women and non-binary groups differentially. This study has summarised the key areas in which women have been disproportionately affected by the outbreak, and government response to the outbreak. This is an important distinction to highlight: it is not the virus itself that causes socio-economic impacts on women, but rather the mechanisms introduced by administrations to mitigate against disease transmission which cause the downstream effects which have disproportionately affected women.

These ripple effects are wide-reaching. Most acutely, women have faced risks to their physical safety with domestic violence soaring across EU and globally. It was well established prior to COVID-19 that most domestic violence occurs at home, so it was perhaps unsurprising that when people are mandated to stay at home, with the additional stressors of job insecurity, concern of infection, and potentially additional domestic workloads that this increased. Governments across the EU have taken strides to mitigate some of this risk to women, and should be commended, but we are yet to have conclusive data as to the scale of the problem, and how effective different intervention measures have been. Women's health has also been affected by disruption and changes to health systems. Most acutely have been the changes to maternity and sexual and reproductive health services. Many of these services were either cancelled, reduced or moved to online / phone provision. This has meant that women have not had full access to reproductive health services, the effects of which can be long-lasting. There have also been concerns in the delivery of ante- and post- natal healthcare services, and how this might impact birth outcomes and the longer-term care of new mothers, with concerning trends of increased post-natal depression¹⁵⁸.

Women's economic security and future economic participation has also been affected by COVID-19, both at macro and micro levels. At the macro level, sectors of the economy which predominantly employ women have been the most disrupted by nation-wide lockdowns. This has included education, hospitality, childcare, recreation, and tourism. Many women have either lost their jobs or have taken government funded income support packages. In a likely recession, with these employers being the most likely to fold, this risks broader participation of women in the labour-force. Within labour force, women are also disproportionately represented as healthcare workers, working tirelessly on the frontlines of the COVID-19 crisis, exposing themselves to risk of infection for them or their families, additional workloads to manage the case numbers, and increased violence and mental health tensions. This must be recognised and accounted for as we move into the second waves of this pandemic.

Women have also had changes to their paid work due to the additional demands placed on them through school closures, and the unpaid care which has significantly increased within households. Women have absorbed more of this care than men, with the result that they have either not been able to continue with paid employment, or have had to juggle this paid and unpaid labour with the impact of greater psychological and mental health concerns. This was particularly acute for single parents, the majority of whom are women. As we face month 6 of these restrictions, the concern is economic security for many women and we must mitigate against the very real risks of increased rates of poverty across the EU, particularly amongst single parents.

¹⁵⁸ Young, S (2020). Postnatal depression has almost tripled during coronavirus pandemic, study finds. The Independent. As accessed: <https://www.independent.co.uk/life-style/health-and-families/postnatal-depression-pregnancy-mothers-lockdown-study-anxiety-stress-maternal-a9577186.html>

Finally, we must consider how each of these impacts are amplified when considering additional drivers of vulnerability. Women are not a homogenous group, and nor will they all experience these impacts in the same way. Race, location, religion, sexual orientation, ethnicity, socio-economic group (and beyond) will further affect women's experience of COVID-19. When considering policy development and scrutiny, the downstream effects of policy must recognise the real-world of those experiencing the outbreak and seek to mitigate against further harms amongst the most vulnerable.

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Outbreaks affect men, women and other genders differentially. This can be both the direct infections with a pathogen, or the secondary effects of public health response policies. COVID-19 is no exception, and the gendered impacts thus far and in the future are numerous. This study outlines some of the key gendered effects thus far and suggestions for how these may extend into the post-crisis period based on currently available data on COVID and longer-term effects of previous outbreaks. This includes the lack of sex-disaggregated data, the role of healthcare workers and care workers, domestic violence, the impact of quarantine on feminised sectors of the economy, the additional unpaid labour on women as a result of lockdown, access to maternity, sexual and reproductive health services.

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