COVID-19: Where are the women?

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Feminist Theory and Health

- *In order to understand the state of health security for all people on the planet we need to understand the embodied realities of people's lives that result in health security for some people and insecurity for others. This means drawing attention to the narrowness of the mainstream discourse of global health security that renders invisible the actual people who are impacted by global health emergencies, and illuminating how current ideologies and structures of governance shape the life chances of individuals the world over"* (O'Manique & Fourie, 2018, p. 1)

Lacuna in Global Health Security Policy

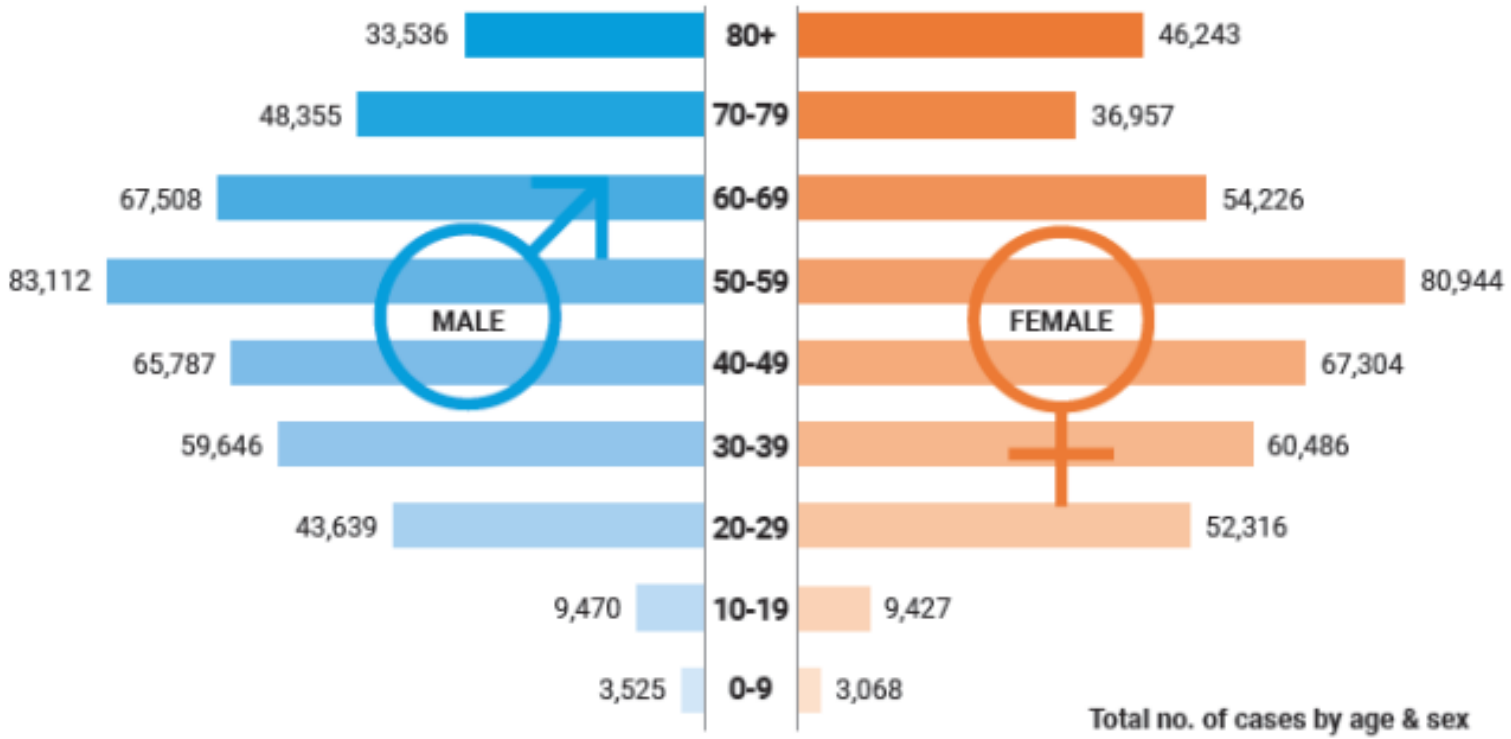
- There is no mention of any woman specific or gender sensitive inclusion in:
  - International Health Regulations (2005)
  - Joint External Evaluation (JEE)
  - Global Health Security Agenda (and country action packages)
  - Biological Weapons Convention
  - WHO Research and Development Blueprint
  - United States Government Global Health Security Strategy
  - United Kingdom Health is Global Strategy
  - United Nations Security Resolution 1308

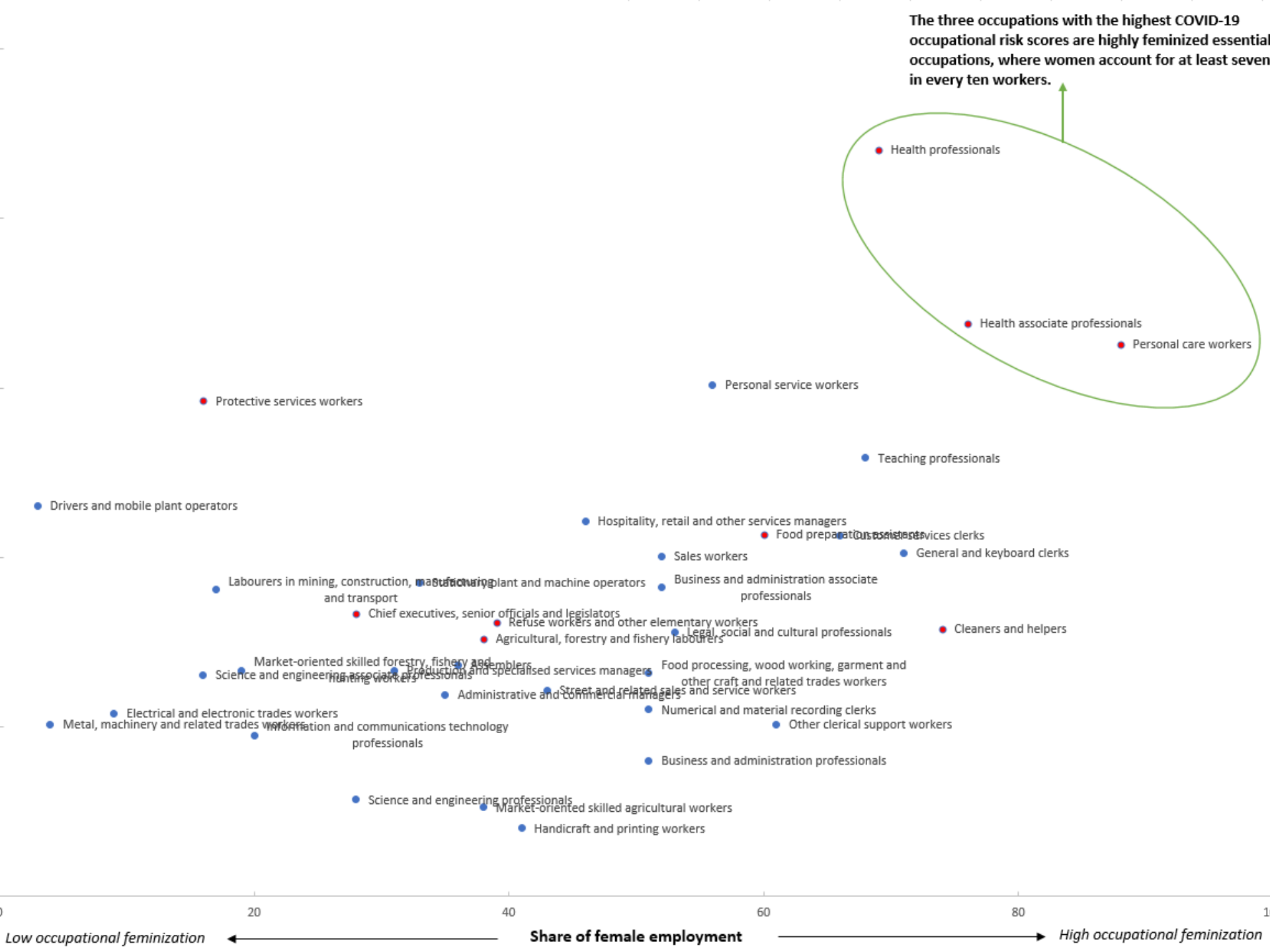
- Or in Academic Reviews of Major outbreaks:
  - Harvard-LSHTM panel on West-Africa Ebola
  - Stocking Report (WHO Review of West-Africa Ebola)

Why a feminist critique?

- “Taking gender seriously not only adds to analysis – but produces different analysis too” (Enloe, 2003)
- “by recognising the importance of gender as an analytical category, feminism opens a pathway for disaggregating the effects of policy” (Paxton & Youde, 2018).
- We seek to challenge the current path dependency in global health security focused on “prevent, detect, respond” for its gender neutrality and its failure to recognise the unequal burden of infectious disease on women
- Instead – we see a heavily gendered outbreak, celebrating them as heroes, and in doing so reinforcing gender inequalities
- Putting women at the centre of policymaking processes would lead to a different response.

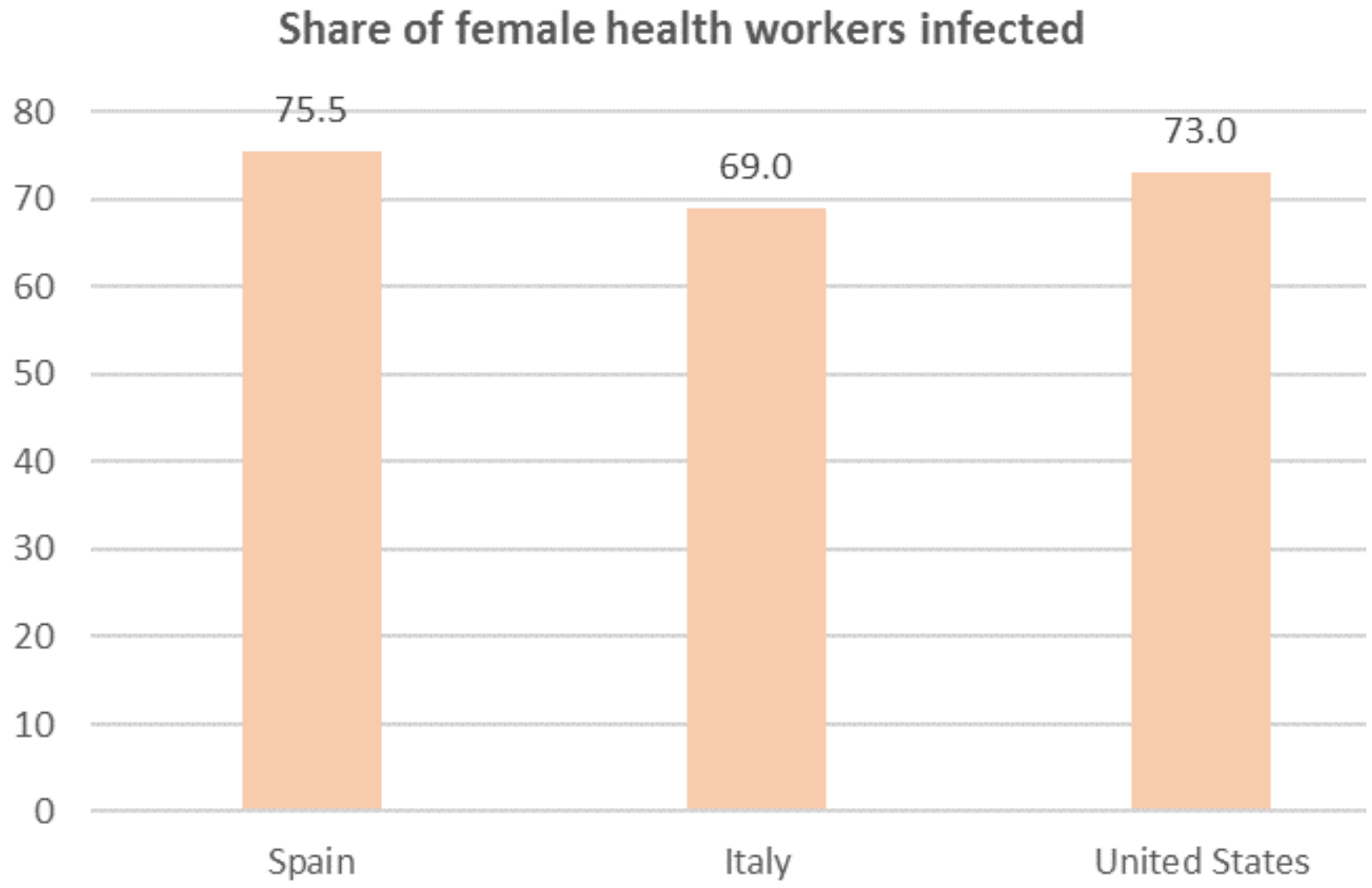
Reported COVID-19 cases, by age and sex




The three occupations with the highest COVID-19 occupational risk scores are highly feminized essential occupations, where women account for at least seven in every ten workers.
Health professionals
Health associate professionals
Personal care workers
Personal service workers
Protective services workers
Teaching professionals
Drivers and mobile plant operators
Hospitality, retail and other services managers
Food preparation assistants
Customer services clerks
Sales workers
General and keyboard clerks
Labourers in mining, construction, manufacturing and transport
Stationary plant and machine operators
Business and administration associate professionals
Chief executives, senior officials and legislators
Refuse workers and other elementary workers
Agricultural, forestry and fishery labourers
Legal, social and cultural professionals
Cleaners and helpers
Market-oriented skilled forestry, fishery and hunting workers
Assemblers
Science and engineering associate professionals
Production and specialised services managers
Food processing, wood working, garment and other craft and related trades workers
Street and related sales and service workers
Administrative and commercial managers
Numerical and material recording clerks
Electrical and electronic trades workers
Metal, machinery and related trades workers
Other clerical support workers
Information and communications technology professionals
Business and administration professionals
Science and engineering professionals
Market-oriented skilled agricultural workers
Handicraft and printing workers
0
20
40
60
80
Low occupational feminization
Share of female employment
High occupational feminization

Healthcare workers

- 70% Global Health Workforce are women. Not acknowledging the role women perform in this care sector makes women invisible
- But where is the data – and why does this data matter?


Share of female health workers infected
80
70
60
50
40
30
20
10
0
75.5
69.0
73.0
Spain
Italy
United States

Intersectionality

Intersectionality recognises that women are not identical, and gender intersects with additional drivers of inequalities and social determinants of health (S. E. Davies & Youde, 2013). This includes, but not limited to:

- race (Crenshaw, 2018),
- religion (Bilge, 2010),
- ethnicity (Bowleg, 2012) (Yuval-Davis, 2006),
- location (Correa, Reichmann, & Reichmann, 1994),
- disability (Erevelles & Minear, 2010)
- class (Anthias, 2013).

	Nurses and midwives	Healthcare support workers	Doctors and dentists	Other staff
Number	35	27	19	25
Age; yrs median (IQR [range])	51 (46-57 [23-70])	54 (42-64 [21-84])	62 (54-76 [36-79])	51 (34-58 [29-65])
Male; %	39	22	94	55
BAME; %	71	56	94	29
BAME workforce; %*	20	17	44	-

Care is not just formal – informal care vital to understand

- Feminist international political economy focuses on social reproduction; those household activities central to production and reproduction of life and capital / economic contribution (Bakker & Gill, 2003; Luxton & Bezanson, 2006).
- These include, but are not limited to gendered roles in: childrearing, caring responsibilities, small-scale agricultural labour, household work and maintenance

Informal Care within COVID-19

- What happens when schools shut?
- Additional domestic responsibilities – cleaning, cooking, mental load for managing this
- Gendered norms presuppose that women will pick up most of this load.

Our new polling data (out today)

- The impact of the coronavirus pandemic on the nation's wellbeing is significant. Women's and men's satisfaction with life has fallen dramatically, by more than half (from 32% to 12%) for women and down from 29% to 15% for men.
- One third (36%) of women are reporting high levels of anxiety compared with a quarter (27%) of men.
- Mothers of young children are among the most anxious. Nearly half (46%) of mothers of under-11s report anxiety above a 7 on a scale of 0 - 10, compared with 36% of fathers. This compares with 32% of women and 24% of men who are not parents of young children.

Access to health

- Access to resources, access to healthcare, protection of health/human rights and political power to influence decision making, are affected by epidemics highlighting the inequitable socio-political and economic structures (Farmer et al., 2004; Leach, 2015).

Distortion of health systems

- Maternal Mortality
- Teen Pregnancy
- Reproductive health services
- Essential medicines
- Menstruation

Sexual Reproductive Health & COVID-19

- Supply chains have been severely affected by COVID-19, and this includes for a range of short-term contraceptives.
- Demand side affected with some women unable to visit healthcare providers and access contraceptives because they are in self-isolation or they do not wish to be exposed to potential disease transmission in crowed clinics
- Abortion regulation can be altered by a global health emergency:
  - in England permitting self-managed abortion at home
  - In Texas, Ohio, Iowa, Alabama, Oklahoma – the opposite!

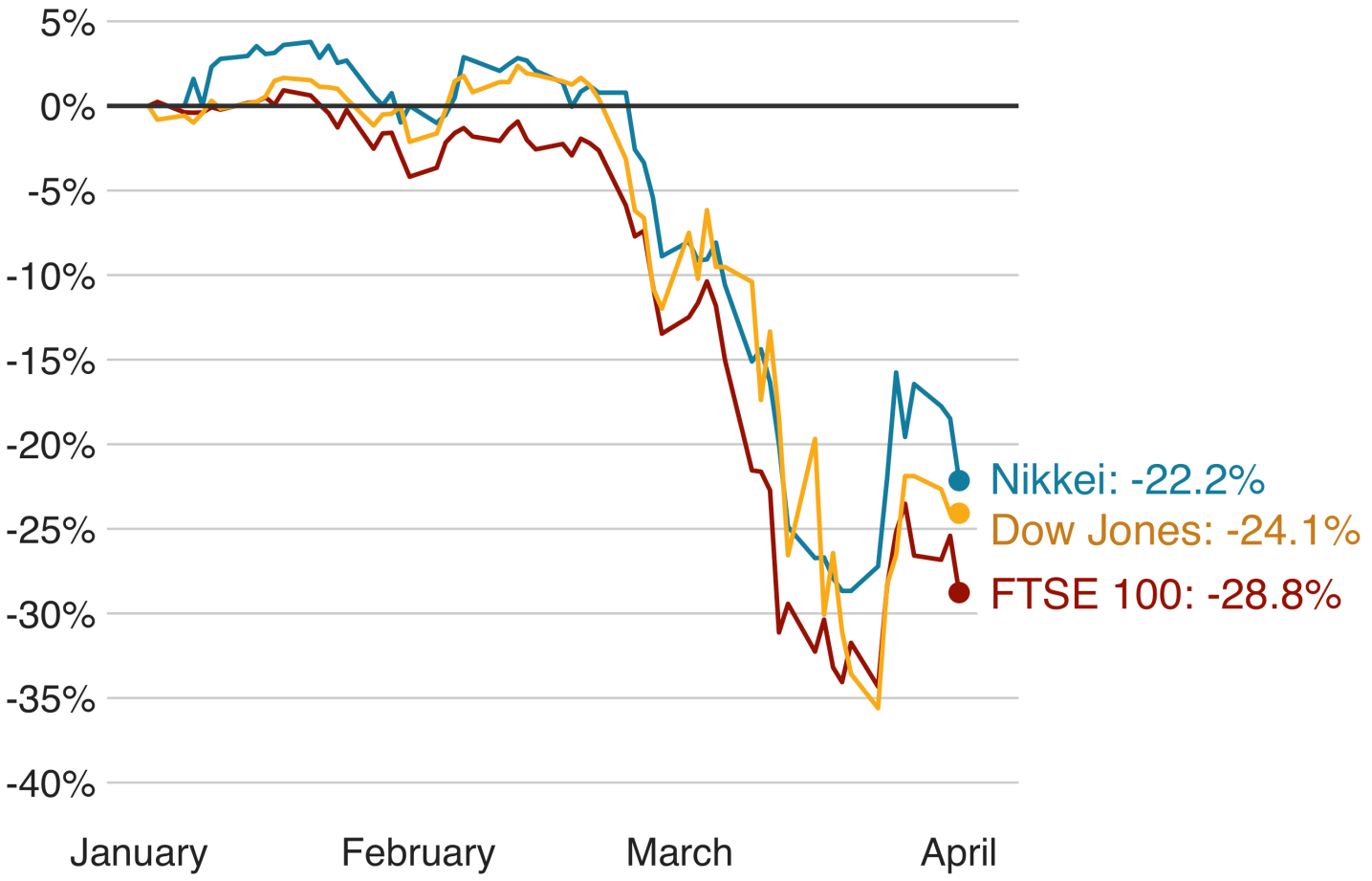
IPV and Domsetic Abuse

- IPV has increased around the world since lockdown measures for COVID-19 have taken effect
- 89% of GBV is against women
- We saw this in Zika and Ebola – nothing new here, unfortunately!
- In El Salvador, currently, as many cases of femicide than COVID-19 deaths

Gov Action

- Malaysia advised women to ‘dress up, don’t nag’
- Italy has increased the number of domestic abuse helplines and has set-up mechanisms to report at grocery stores and pharmacies
- Australia has changed law to increase funding for anti-violence organizations, including those that offer safe accommodations

The impact of coronavirus on stock markets since the start of the outbreak



Source: Bloomberg, 01 April 2020, 09:00 GMT

BBC

Long-term economic impacts

- Economic consequences will likely be gendered
- informal, low income workers at a particular risk, because they lack the social protections of workers in the formal economy – and are mainly women
- During Ebola quarantine measures closed markets destroying the livelihoods of traders, the majority of whom are women
- Men also lost their jobs, but 13 months after the first case was detected, 63% of men had returned to work, compared to only 17% of women (Bandiera et al, 2018)
- Longer-term planning and stimulus for women's protection

Women's leadership and representation

- Are women doing better?
- Representation matters in decision-making: GPMB called for more diversity within health security decisions.

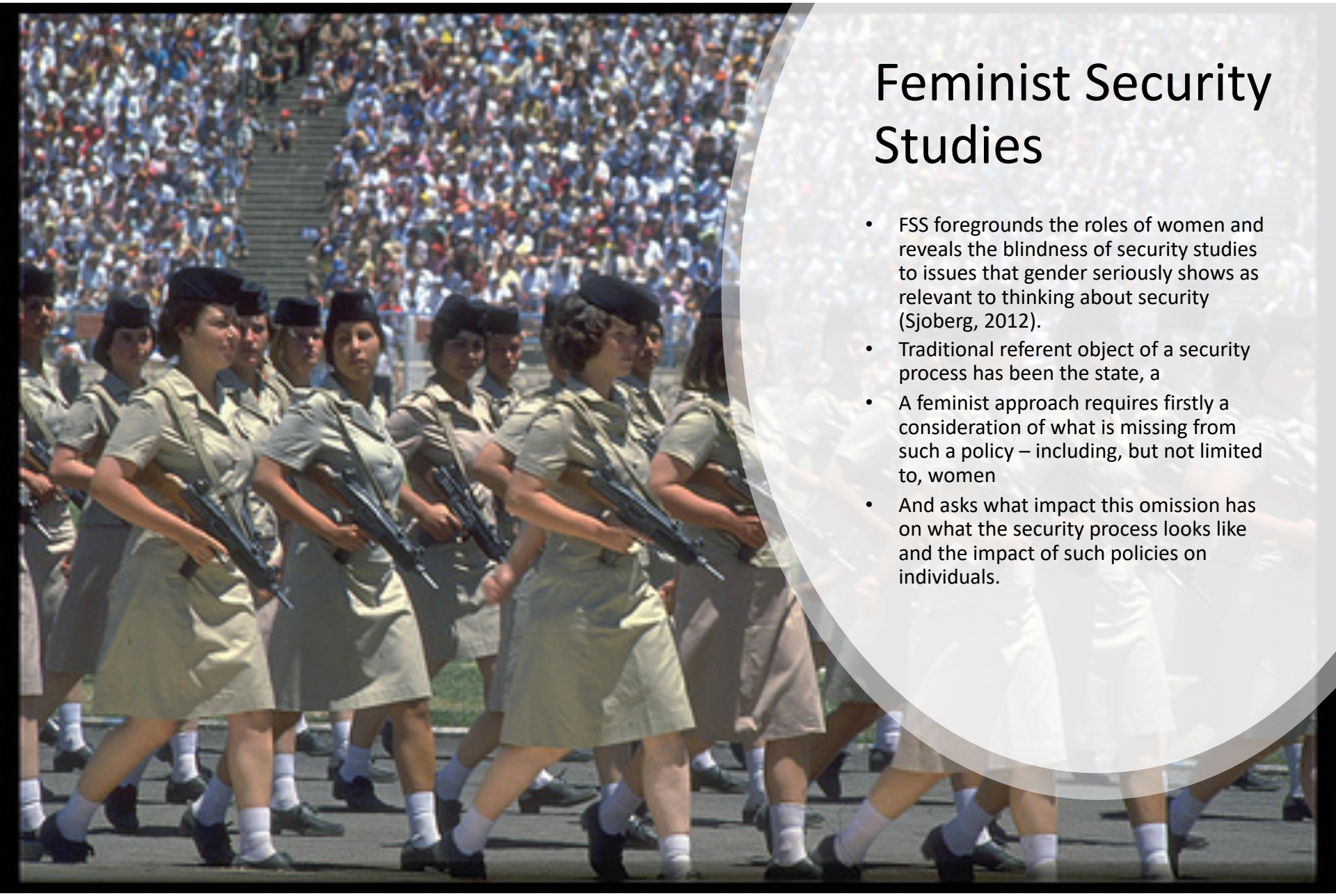
Tyranny of the Urgent

- In crisis moments, the structural underlying issues in a health system can get overlooked – such as an absence of women and gender considerations!
- But this does not happen by accident – the crisis was socially constructed to be a global health security threat – and to focus on economic protections!

Global Health Governance as Masculine

- Globalisation, the pre-cursor to global health as a conceptual node, explicitly recognises a reorganization of politics and power across borders through capital, goods, labour and ideas, has been presented as gender neutral, but this gender neutrality masks “the implicit masculinization of these macro-structural models”(Acker, 2004; Freeman, 2001).
- Global Health “granted as an epistemological authority in health policymaking that does not take into account the subjectivity of the predominantly male Western institutions and individuals who have shaped this form of knowledge and practice (Pruchniewska et al., 2018)
- Epidemiology as “the” approach to policymaking

“If security is a speech act, then it is simultaneously deeply implicated in the production of silence” (Hansen, 2001)



Feminist Security Studies

- FSS foregrounds the roles of women and reveals the blindness of security studies to issues that gender seriously shows as relevant to thinking about security (Sjoberg, 2012).
- Traditional referent object of a security process has been the state, a
- A feminist approach requires firstly a consideration of what is missing from such a policy – including, but not limited to, women
- And asks what impact this omission has on what the security process looks like and the impact of such policies on individuals.

What might this look like for COVID-19?

- Focus who are frontline healthcare workers (women), and ensure care work incorporated into economic decision-making (i.e pay them more!
- Sex-disaggregated data public
- Recognition of gendered effects of response policies launched, and resources follow
- Ensure access to SRH services at home or at pharmacies without prescription
- IPV support financed
- Which sectors open first post-lockdown?
- Ensure gender advisors on decision making bodies