BRIEFING

European Parliament

Covid-19: The need for a gendered response

SUMMARY

In the midst of the current pandemic, adopting a gender perspective may seem a secondary concern. However, pandemics are known to affect women and men differently, making it essential to recognise these differences in order to understand the impacts on individuals and communities and to respond effectively and equitably.

There is already clear evidence that the ongoing health, social and economic crisis is having gendered impacts. Disaggregated data show that sex and gender are playing a role in exposure to the virus and risks of severe outcomes, and that some groups of women and men are particularly vulnerable. Lockdown measures have led to an increase in violence against women and disrupted access to support services. Access to sexual and reproductive healthcare has also been affected. Successive lockdowns have widened the existing gender divide in unpaid care work that was already keeping more women than men out of the labour market. Greater work-life conflict is one of the factors leading to women's employment being worse hit than men's, with potential long-term impacts on women's employment, pay and career advancement. The pandemic has also brought the issue of women's participation in decision-making to the fore.

Without a gender-sensitive approach, the pandemic could have far-reaching implications, including a real risk of exacerbating gender inequalities and sending progress into reverse. At the same time, gender mainstreaming tools such as gender impact assessments and gender budgeting exist that could, if used effectively, mitigate the negative consequences and contribute to achieving gender equality.

Internationally and within the European Union (EU), there have been calls for gender-sensitive emergency and long-term responses. In January 2021, the European Parliament adopted a resolution setting out recommendations on both aspects.

IN THIS BRIEFING

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Author: Rosamund Shreeves: Graphic: Giulio Sabbati
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Background

Gender experts warn that during emergencies, from wars to economic and public health crises, there is often a temptation to see gender analysis as something to be considered later, once the immediate crisis is over. However, one lesson learned from past situations, including earlier pandemics and the 2008 economic and financial crisis, is that not asking questions about potentially different impacts on women and men, not collecting data on their experiences and not acting on this information can result in outcomes and policies that inadvertently deepen existing inequalities.

In the context of the ongoing coronavirus pandemic, there is therefore an urgent argument for making gender impact assessment an integral part of the measures being taken in the immediate term and the policy choices being made for the longer term. Under the Treaties, the EU and its Member States are committed to a gender mainstreaming approach of this kind.

As the pandemic has unfolded, a growing number of researchers, international organisations, EU bodies, and women's organisations have stressed the importance of including a gender dimension in responses to the outbreak of the coronavirus disease Covid-19. Concerns include: the need to understand how sex and gender are affecting infection risks and clinical outcomes; the impacts of the measures being taken to curb the spread of the virus; the potential social and economic fallout and long-term impacts of the pandemic on gender equality; and the importance of women and men being equally involved in decision-making, to ensure gender-equitable responses to the immediate health emergency and beyond.

Gender dimensions of the health emergency

Impacts of sex and gender on risk and clinical outcomes

There is strong evidence that the risk of severe outcomes from Covid-19 increases with age. However, empirical data on SARS-CoV-2, the virus that causes Covid-19, are incomplete and the scientific community is still building up evidence on which other demographics are most vulnerable and why. In this context, researchers emphasise that sex-disaggregated data and gender analysis are important tools, both in the immediate term – to assess who is most at risk of contracting Covid-19 and suffering severe outcomes in order to develop guidance to care for specific groups – and in the longer term – to develop treatments and make health systems more resilient.

Higher mortality rates among men in most countries

Ongoing tracking of available sex-disaggregated data by the Global Health 50-50 initiative and UN Women demonstrates that sex and gender are significant drivers of risk and responses to infection.

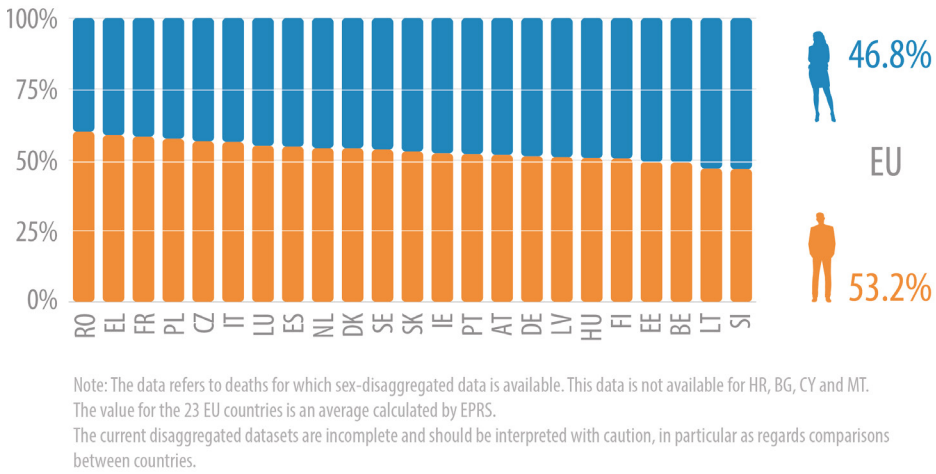
A broad pattern, first identified in China and now clear in most but not all countries, is that, while similar numbers of men and women have been diagnosed with Covid-19, men are at higher risk of becoming severely ill and dying from the disease.[1] At the beginning of February 2021, the Global Health 50-50 Sex-Disaggregated Data Tracker included data on deaths from Covid-19 for 23 EU Member States.[2] The mortality rate was higher for men in all but four countries (Belgium, Estonia, Lithuania and Slovenia). The tracking shows that the size and direction of the gender gap in deaths may change over time. For example, in Portugal, mortality was slightly higher for men in February 2021, but in July 2020, the country was reporting equal mortality for men and women, while at the beginning of April 2020, Portugal reported the widest gender gap in mortality, which was more than twice as high for men as for women (64% compared to 34%). Similarly, Estonia and Slovenia reported higher mortality among women both in February 2021 and July 2020, whereas Ireland, Finland and Hungary reported higher mortality among women in July 2020, but not in February 2021.

Since men were found to be at higher risk of suffering severe outcomes from previous coronaviruses (SARS and MERS), the predominant pattern is not wholly unexpected, but the reasons behind it are

not yet clear. An initial review of the data in the British Medical Journal (BMJ) and subsequent analysis cite several potential explanations relating to biology and socio-cultural factors:

- **Biological (sex) differences** in men's and women's immune responses to infections could be one contributing factor. In general, women have been found to have stronger immune responses to viral infections and correspondingly better outcomes. In Covid-19 too, stronger immune response appears to be more effective in controlling the virus. Research indicates that there are multiple points where biological sex differences may be impacting immune responses and the progression of the disease.
- **Gender differences in health risks and behaviours** could be another contributing factor. The data show that patients who become severely ill with Covid-19 often suffer from pre-existing medical conditions, including cardiovascular and chronic lung conditions. These tend to affect more men than women and are partly driven by drinking and smoking, which are more frequent among men. Men also tend to make lower use than women of preventive health services, which means that their illness may develop before they seek care.

Figure 1 – Sex-disaggregated data on confirmed cases and mortality in the EU



Note: The data refers to deaths for which sex-disaggregated data is available. This data is not available for HR, BG, CY and MT.
The value for the 23 EU countries is an average calculated by EPRS.
The current disaggregated datasets are incomplete and should be interpreted with caution, in particular as regards comparisons between countries.

Data source: Global Health 50/50.

It is not certain why mortality is higher for women than men in some countries. Interaction between sex and age could be one contributing factor. A study for the European Parliament notes that Europe has a larger population of people aged over 80 than many other parts of the world and that women make up the majority of this population. In addition, deaths in care homes, whose residents are predominantly female, represent a significant proportion of mortality rates.[3]

Sex-disaggregated data for safe, effective treatments and vaccines

The existing sex-disaggregated data has already identified men with underlying health conditions as a group likely to need early, intensive care and shown that sex-differentiated research into immune responses has potential for developing effective treatments for Covid-19. Experts are urging governments to collect and publish more sex-disaggregated data and stressing the importance of applying it in practice to ensure better identification of vulnerable groups, treatments and care. They identify several areas needing further exploration:

- **Hormonal changes and increased risk**: Women in general may have stronger immune responses than men and be better at fighting off viral infections, but responses change throughout life, meaning that some women may face higher risk and require targeted interventions. Hormonal changes during pregnancy make women more susceptible to viral infections, which can sometimes pass from mother to child. Researchers are calling for further

investigation and for specific care, such as screening for the virus during pregnancy and long-term follow up of new-born babies and their mothers. Post-menopausal women with lower levels of oestrogen may be at higher risk of developing severe Covid-19. Hormone replacement treatment (HRT) and the contraceptive pill may reduce this risk, but further investigation is needed. More research is also needed to see how responses to treatments could vary for trans people undergoing hormone treatments as part of their transition process.

- **Including women in clinical trials**: Sex and gender impact on how individuals respond to medication and vaccines, so medicines are safer and more effective for everyone when clinical research includes diverse population groups of all ages. Since women are more likely to experience adverse reactions to medications and are more likely to have a stronger reaction to vaccines, sex-disaggregated data are particularly important in clinical trials for Covid-19 treatments and vaccines so as to identify any differences in side-effects and establish appropriate dosing. The European Institute for Gender Equality (EIGE) highlights that medical research has tended to be gender blind, leading to concerns that many drugs are mainly tested on men, possibly ignoring adverse side effects that are more common among or exclusive to women. The EIGE has called on scientists working on Covid-19 vaccines to include gender-balanced representation in their clinical trials. The forthcoming EU Clinical Trials Regulation will requires the consideration of gender in trials.[4]

- **Long-term effects of Covid-19**: As the pandemic unfolds, some people are experiencing enduring long-term effects from the virus (long Covid), with early data indicating that this is about twice as common in women as in men. Further research is needed, together with guidance for care and support for those affected. Some medical professionals are reported to be dismissive of patients presenting with these symptoms. Investigations into past neglect of women's health concerns illustrate that it will be especially important to ensure that women presenting with 'long Covid' symptoms are not ignored.

Proposals for action in the EU

The European Commission's Horizon 2020 Expert Group on Gendered Innovations recommends:

- disaggregating all data relating to Covid-19 morbidity and mortality by sex;

- integrating sex as a biological variable in all further research on Covid-19 and in the development of tests, treatments and vaccines.

Source: The impact of sex and gender in the current Covid-19 pandemic, European Commission, June 2020.

Gender and risk of exposure to Covid-19

Gender is also an important factor in assessing and preventing the risk of contracting and transmitting Covid-19. A significant proportion of cases derive from exposure to the virus in the workplace. The European Centre for Disease Prevention and Control (ECDPC) has evaluated evidence from the EU, the European Economic Area and the United Kingdom (UK) from occupational settings where workers are at increased risk of Covid-19. It concluded that jobs involving close interpersonal interaction, such as assisting or caring for others or working directly with the public, are associated with a high risk of becoming infected, especially where this involves working in indoor settings or sharing transport or accommodation.

Patterns of sectoral and occupational gender segregation mean that women and men are distributed differently across these high-risk settings. It is clear that exposure to the virus is particularly high for workers in the health and care sectors, especially those who carry out procedures that generate virus-carrying aerosols or those who have frequent, close contact with people who are infected. The latter include nurses and carers in hospitals, care homes and domiciliary settings. According to statistics from the EIGE, women make up the majority (76 %) of the 49 million healthcare workers in the EU and the bulk of the formal domiciliary care workforce (82 %). In most EU countries, women also make up the overwhelming majority of informal carers. Other occupational sectors where workers face greater risks of coming into contact with the virus include pharmacies, cleaning services, teaching, childcare and customer-facing roles in the food

sector, where women predominate, and sectors such as waste disposal, law enforcement and transport, where the majority of the workforce are men.

More data are needed to build up a full picture of the gender aspects of transmission in occupational settings, but some findings are available. Analysis of 'key professions' and 'key workers' by the EU's Joint Research Centre (JRC) finds that more women than men under the age of 55 are being diagnosed with Covid-19 and concludes that this could be partly due to their disproportionate representation in the health and care sectors.[5] The ECPDC reports that women make up the majority of confirmed cases of Covid-19 in all types of healthcare facility in the EU countries providing information by sex.[6] Homes are also a key site of transmission meaning that women's role as primary carers for sick family members puts them at increased risk of contracting the virus themselves. The JRC concludes that in the under-55 age group, women's care-giving responsibilities in the family may be contributing to the higher proportion of diagnosed cases in women.

In settings where the risk of infection is high, measures to prevent exposure to the virus and onward transmission are particularly important. Equitable provision of personal protective equipment (PPE) is a key issue. However, there have been serious concerns over access, particularly for key workers in lower paid, more precarious or informal work, where women are over-represented. For women, the longstanding issue of access to properly fitting equipment is also taking on particular importance. Associations representing health professionals have warned that unisex, one-size-fits-all equipment such as gowns, gloves, visors and facemasks are actually designed for the male body. As well as causing discomfort and making it more difficult to care for patients, this poses direct risks to heath and care staff, particularly with respect to facemasks, where a proper fit is vital. They are calling for PPE to be made specifically for women and for the fitness testing of equipment to include monitoring of gender-disaggregated data.[7]

Proposals for action in the EU

The European Commission's Horizon 2020 Expert Group recommends:

- factoring risks at work and home into public health strategies;

- applying gender-sensitive budgeting when allocating emergency resources;

- equitable testing for SARS-CoV2 and provision of PPE for all those at comparable risk, including workers at all levels in the health and care sectors and informal carers. PPE must be properly adapted to women's morphology.

Source: The impact of sex and gender in the current Covid-19 pandemic, European Commission, June 2020.

Behavioural research highlights that gender could also be an important aspect of effective messaging and take-up of health measures. Before the pandemic, there was evidence of a gender gap in attitudes to seeking and acting on health information, for example, take-up of hygiene measures such as handwashing. Evidence is emerging that more women are being tested than men, which may be connected with gender differences in health behaviours. Research has also found that men, younger age groups, parents of dependent children, key workers and people with lower socioeconomic status or experiencing greater hardship during the pandemic are less likely to adhere to Covid-19 self-isolation measures following a positive test. It concludes that there may be a need to develop specific messaging and policies for men, younger age groups and key workers to improve adherence to test, trace and isolate systems, alongside practical and financial support enabling people to comply.

'Intersectional' data and approaches

To understand who is at most risk from Covid-19 and identify where existing prevention and protection measures may be inadequate or could be improved, it is important to adopt an intersectional approach. This entails considering the interplay between sex/gender and other factors, such as age, ethnicity, disability, sexual identity and orientation, geography, socio-economic background and migration status. However, challenges remain with regard to the availability of this kind of disaggregated data, understanding of the underlying drivers and translation of the findings into concrete policy and action to keep people safe.

Available intersectional data on infection risk and mortality identifies some populations as particularly vulnerable. Data from Sweden, the UK and the United States shows that men and women from Black, Asian and minority ethnic groups are at significantly higher risk of serious illness and death from Covid-19 than those from a White ethnic background.[8] In the UK, mortality has also been disproportionately high among people with disabilities. Women with severe disabilities and disabled women of working age are at higher risk than non-disabled women and disabled men.

The current thinking is that these outcomes are the result of cumulative disadvantage, stemming from multiple factors such as underlying health conditions, where people live, their socio-economic circumstances, the work they do and the impact of discrimination. These risk factors also apply to other populations. Many Roma and Travellers live in housing that is overcrowded, with no access to running water, making it difficult to comply with hygiene, social distancing and isolation requirements. This population also suffers disproportionally from underlying health problems and barriers in accessing healthcare. Migrant groups, including refugees, asylum-seekers and migrant workers also face specific obstacles in accessing health care owing to lack of entitlement or fear of arrest or deportation. In many EU countries, they are more likely to have low incomes, be living in deprived areas and work in insecure or frontline jobs. In some EU Member States, seasonal migrant workers, often undocumented, living in poor conditions and without health insurance, are at heightened risk of exposure to the virus. LGBTI+ people present a number of risk factors for Covid-19, including higher rates of underlying health conditions, particularly in older age groups, lower access to comprehensive health insurance and barriers to accessing health care, including stigma, discrimination and biases held by healthcare providers. Scientists are stressing the need for better understanding of whether LGBTI+ people are more likely to become infected with SARS-CoV-2, and whether they are more likely to develop complications or to die as a result of infection. A European Parliament study on the gendered impacts of the pandemic highlights the need for governments to take account of the structural socio-economic inequalities that are driving risk of exposure and serious illness and death associated with Covid-19.

Recommendations on intersectionality

The UN finds that limited data is leaving many questions unanswered. It urges all countries to start collecting and publishing data on cases, fatalities and economic and social impacts by sex, age and other key characteristics – such as ethnicity and race, migratory status, disability and wealth – as a vital way of understanding the pandemic's differential impacts.

The Director of the EU's Agency for Fundamental Rights (FRA) is urging EU Member States to do a better job of auditing public health measures to assess their impacts on minorities, to collect the requisite disaggregated data and to include more human rights expertise in decision-making.

Sources: UN, From insight to action: gender equality in the wake of Covid-19 and FRA statement at the event 'Racism and the Covid-19 crisis: Experiences and responses'.

Gender impacts of measures taken to curb the spread of the virus

EU Member States have adopted a range of measures to curb the spread of the virus and prevent national health care services from being overwhelmed. These have ranged from restrictions on public gatherings to closures of nurseries, schools, public venues such as restaurants, bars, cinemas and theatres, and full 'lockdowns' on movement, with populations largely confined to their homes. Against the background of resurgences in Covid cases in many countries, the prospect of future localised or broader lockdowns and the need to find ways of balancing health, economic and social concerns, it is vital to learn from earlier waves of the pandemic. There is emerging evidence that, while men have been disproportionately affected by the disease itself, women are being more severely hit by the policies introduced to combat it and the social and economic fallout. This has been evidenced in an increase in gender-based violence, lack of access to vital services, an unequal division of childcare and domestic labour, particularly for mothers, and increased likelihood of losing paid work and falling through gaps in government employment and income support schemes.

Gender-based violence

Even in 'normal times', violence against women is a considerable but under-reported problem in the EU. Past crises and epidemics, including the outbreaks of SARS and swine flu, were associated with increased levels of violence against both women and children. Warnings[9] about the risks of a similar situation unfolding during the pandemic have, unfortunately, been confirmed, with evidence of a surge in domestic abuse and increased vulnerability to other forms of gender-based violence. Globally, lockdown measures have led to increased internet usage, putting more women and girls at risk of various forms of cyber-violence. There is also an increased risk of harmful practices such as early marriage and female genital mutilation (FGM). Before the pandemic, 1 in 10 women in the EU reported experiencing cyber-harassment since the age of 15. Women and girls in Europe were also affected by forced marriage and FGM. Although travel restrictions are making it more difficult to take girls abroad for forced marriage and FGM to be performed, school closures, isolation and pressures on prevention and support services are making them more vulnerable. Victims of trafficking, and women in prostitution are also reported to be facing increased risks of violence.

Within the EU, the biggest spotlight has fallen on the rise in domestic violence, which has been an unintended consequence of mandatory lockdowns. There are many reasons why quarantines can increase the risks of domestic violence and abuse. Victims are confined with abusers and isolated from support networks and have fewer avenues for escape. Perpetrators may capitalise on lockdown measures to exercise power and control, for instance by monitoring use of telephones and computers more closely, giving victims fewer opportunities to contact helplines and other support services. Shelters and other support services are likely to be under pressure and unable to operate normally due to the distancing measures and redeployment of resources to deal with the health emergency. Legal proceedings needed to issue barring and protection orders, and evict perpetrators from the home may be interrupted. Support for men who have already been violent or controlling towards their partners before a quarantine, or who may become so as a result of the situation, may also be reduced.

Figures released by victim support organisations, police forces and governments show that in the first lockdowns, many countries, including France and Spain, experienced sharp increases in the numbers of women reporting incidents, particularly online. In other countries, such as Italy, reports to helplines decreased, but this reflected added difficulties in reporting and seeking help. In Germany, 2 % of women who responded to a survey said that, during the strict lockdown period in April and May 2020, they had been unable to leave their home without their partner's permission and 4.6 % reported that their partners had controlled their contacts with others, including their digital communication. The survey also found that around 3 % of the women were subjected to beatings or other forms of physical violence by a partner and 3.6 % were raped. The risk of all forms of domestic violence and abuse was significantly higher when women were self-isolating or when they or their partner had lost work or were in financial difficulty. At the most extreme, the UK Parliament heard evidence that the number of suspected domestic abuse killings doubled in the first three weeks of the first lockdown compared with the same period over the past 10 years. LGBTI+ people forced into isolation with hostile family members have also faced a rise in domestic violence. Simultaneously, the pandemic has created challenges for organisations supporting survivors of domestic violence. Reports to the Council of Europe show that domestic violence shelters in some areas stopped all admissions because they were unsure how to manage the risk of infection, while others privileged online or telephone support, leaving women at risk from their abusers. European and national women's organisations have flagged gaps in essential services before the pandemic and limitations caused by the pandemic, including drastic cuts in funding for specialist support services in some countries. This is particularly worrying in view of the likelihood of increased demand for emergency intervention, counselling and therapy in the months after the crisis passes.

The EIGE and the European Parliament's Women's Rights and Gender Equality (FEMM) Committee have issued analyses of data on violence against women during the pandemic and responses from support services and governments. The two studies for Parliament, on the gendered impact of the

Covid-19 crisis and the added value of the Istanbul Convention, found that all EU Member States had adopted some promising measures. Nearly all had conducted awareness-raising campaigns on where to get help. Some had developed temporary help points in supermarkets and pharmacies or innovative apps or online means of alerting the police. Some classified hotlines and shelters as essential services, enabling them to continue to provide assistance. Some provided additional funding for these services or expanded capacity by converting empty tourist accommodation into shelters. A few countries introduced comprehensive action plans. However, initial findings from the EIGE's ongoing research into what the EU and the Member States can do to protect women more effectively from gender-based violence during crises show that support systems for victims of gender-based violence are shaky in the majority of EU countries. No EU country had a disaster plan in place to deal with domestic violence. The research for Parliament demonstrates that ratification of the Istanbul Convention – one of the EU's priorities for preventing and combating violence against women – remains an important way forward. The Convention has contributed directly to the creation of services for victims in a number of countries, while countries that have ratified the Convention have implemented more measures during the pandemic than those that have not, suggesting greater political awareness and readiness to respond to violence against women.

Access to sexual and reproductive health services and maternity care

Early in the pandemic, the UNFPA and the Guttmacher Institute highlighted the importance of focusing on sexual and reproductive health and rights during emergencies and warned of possible disruptions to supply chains for contraceptives, strains on health systems and suspension of services. Surveys conducted in Europe find that women and girls have been left without access to essential medical services including contraception and abortion care, testing for sexually transmitted infections and reproductive cancer screening. Some EU Member States, including Belgium and Sweden, have classified sexual and reproductive health services as essential. Several EU countries have introduced new ways of working, such as telemedicine for contraception prescriptions, to ensure that services can continue. Many EU Member States have maintained access to abortion and some have extended the deadlines for access to at-home-abortion-pills or introduced tele-consultations to facilitate access to early intervention. However, certain EU Member States have curtailed women's sexual and reproductive rights during the pandemic. The surveys also highlight impacts on the quality of maternal healthcare. Owing to concerns around transmission of the virus, hospitals in some EU Member States have stopped allowing partners to attend antenatal scans and births or begun to separate new-born babies from mothers suspected of being infected. For new mothers, face-to-face support from health services has also decreased. There is ongoing research into the impacts of these changes on new mothers and their babies in Bulgaria, France, Greece, Malta, Portugal and Spain. UK research shows that disruptions and isolation have contributed an increase in anxiety and depression among new mothers, with potential long-term impacts on their mental health. Specific health services important for the LGBTI+ community have also been withdrawn during the pandemic, exacerbating the likelihood of poor health outcomes.

Work-life balance and well-being

The pandemic has brought dramatic changes to our working and home lives. While some people have been on the frontline in key jobs, some have lost jobs or been furloughed and others have found themselves working from home as part of an unprecedented shift to teleworking. With these changes, a new spotlight has fallen on unpaid care work carried out in the home, which has vastly increased as a result of the extra time family members are spending there. The increase has been particularly significant for families with young children, especially when nurseries and schools have closed. This shift in the balance between the public and private spheres has a significant gender dimension. The EIGE's gender equality index and research illustrate that, before the pandemic, women in the EU were doing a disproportionate share of unpaid childcare and domestic work – on average 13 hours more than men every week – a gender gap that has remained stubbornly persistent over time. The EIGE predicted that the pandemic was likely to increase the amount of

unpaid care work and that the gender gap might widen, or perhaps narrow, if men began to engage more in home life. Research shows that men have been doing more, particularly as regards childcare, which could contribute to more equal sharing in the long-term. However, women have taken on the lion's share of the additional caring and domestic work, including home schooling, even when they are also engaged in paid work. Survey data from Eurofound shows that this is having significant impacts on women's work-life balance and wellbeing. Women respondents are more likely to report that they are finding it hard to concentrate on their job because of family (29 % of women compared to 16 % of men) and harder to concentrate on their family because of their job (24 % of women compared to 13 % of men). Women respondents are also more likely to be worrying about work when not working. Women with children under 12 are finding it especially hard to balance their work and personal life. The precarious work-life balance and income of single-parent families (85 % of which are headed by women) have been disproportionately affected. The pandemic has also placed health and care systems and workers under considerable stress, with impacts on their own health and wellbeing.

Most EU Member States have introduced measures to support parents during lockdowns, by extending entitlements to parental leave or maintaining access to childcare for key workers and other parents, but some measures are more gender-sensitive than others.[10] For example, schemes giving parents a right to coronavirus-related parental leave and a right to a job on their return are more likely to protect women's employment, pay and career progression than measures where taking leave requires consent from an employer or where no job protection is provided. To help tackle the increased gender divide in unpaid care work, the ILO recommends that governments should aim to keep schools open wherever feasible, make adaptations to teleworking and extend entitlements to parental leave. UNICEF stresses that the pandemic could have long-term impacts on the childcare-sector, and is urging governments to invest in public provision of accessible, affordable, high-quality childcare and improve the working conditions of the childcare workforce.

Paid employment

The distribution of care work between households and society and between women and men within households influences the extent to which women are able to enter and stay in paid employment, the type of paid work they do and the pay they receive. The gender divide in unpaid care work is already one of the reasons for women's lower employment rate in the EU and the greater likelihood that they will take up non-standard jobs, despite lower pay and social protection, as these jobs are easier to combine with care responsibilities. Early in the pandemic, the ILO forecast that increased care responsibilities could result in women being one of the groups worst hit by unemployment. While it is too early to measure the long-term impacts, there is evidence that decreased access to childcare has had immediate negative impacts on women's paid employment. For example, in Germany, Hungary and Italy, it is reported to be a key reason for mothers withdrawing from paid work during the crisis, either voluntarily or as a result of being made redundant by their employers, including instances of discrimination.

The ILO flagged that the share of women working in the sectors most disrupted by lockdowns, such as retail and hospitality, could also make them particularly vulnerable to reductions in working hours and unemployment. The EIGE predicted that women's over-representation in temporary, part-time and precarious work could make them more vulnerable to job losses. The risk was considered particularly high for young women, women with low qualifications, migrant women and domestic workers.[11] Analysis by Eurofound confirms that this crisis is different to the previous one, when manufacturing and construction were badly hit and job losses were higher among men. This time there have been significant job losses among women working in low-paid service sectors. Young women aged between 18 and 34 have been more likely to lose work (11 % compared with 9 % of young men). Women are also more likely than men to have temporarily stopped working altogether. Intersectional data from the UK shows that workers in shut-down sectors are more likely than average to be Black Asian and minority ethnic, women and part-time workers.

So long as temporary job protection and income support schemes and support for businesses are in place, the pandemic's full impacts on employment will not be clear. However, research shows that women are particularly likely to fall through the gaps in protection. Member States have taken steps to make job and income support schemes inclusive. Nevertheless, there are three common problems: women are less likely to meet eligibility conditions; more likely to work in sectors not covered by support schemes; and more likely to be paid lower benefits.

Scope of national measures

The United Nations (UN) has issued guidance on how countries can meet their obligations under the UN Convention on the Elimination of Discrimination against Women during the Covid-19 crisis. Its Covid-19 global gender response tracker monitors measures taken by governments worldwide and identifies those that directly address the gendered risks and challenges. Gender-sensitive measures are divided into three categories: those that tackle violence against women; those that address unpaid care; and those that support women's economic security. As of February 2021, all 27 EU Member States have adopted at least one gender-sensitive measure in response to the Covid-19 crisis. All but two EU Member States (Hungary and Slovakia) have adopted at least one measure directly addressing violence against women. Twenty Member States (Austria, Cyprus, Czechia, Denmark, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Romania, Slovenia and Spain) have adopted measures that address unpaid care. However, only eight Member States (Belgium, Italy, Latvia, Malta, Netherlands, Romania, Slovenia and Spain) have adopted measures that support women's economic security. Seven Member States (Italy, Latvia, Malta, Netherlands, Romania, Slovenia and Spain) have a more holistic response, with measures spanning all three dimensions. The UN's review of measures adopted in Europe concludes that the relatively low number of labour market, fiscal and economic measures aimed at helping women to keep their jobs or re-enter the labour market is a major gap in the response so far.

Women in Covid-19 decision-making

Some researchers have made a direct link between the paucity of gender-sensitive measures and the lack of gender parity in decision-making around the pandemic. Analysis of the Covid-19 decision-making in 87 countries found that only 3.5 % of Covid-19 decision-making and expert task forces had gender parity in their membership. The picture across the 15 EU Member States included in the survey (Austria, Belgium, Cyprus, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Lithuania, Luxembourg, Netherlands, Portugal, Spain, and Sweden) varied widely. In decision-making task forces, the proportion of women varied from 0 % in Lithuania, 6.7 % in Hungary and 8.3 % in Cyprus to 30.8 % in Greece, 40.6 % in Ireland and 60 % in Austria. The proportion of women in expert groups tended to be higher. Research for the European Commission also points to the importance of including women's organisations with knowledge of the situation on the ground in decision-making to ensure that policy is responds to needs.

Considerations for a gender-sensitive recovery

Potential long-term impacts on gender equality

The UN is warning that the pandemic could reverse global gains in gender equality, just when the international community was set to provide new impetus in this area. The EU itself is facing similar risks. It entered the pandemic facing a combination of longstanding gender inequalities and new challenges, such as climate change, digitalisation and demographic change, which have significant gender dimensions. The EU now also needs to ensure a gender-sensitive approach to the Covid-19 recovery that does not entrench or exacerbate the inequalities and gender gaps that have emerged during the pandemic. The experience of the 2008 economic crisis shows that the risk of gender-blind responses is real. Analysis by the EIGE found that only four EU Member States (Denmark, Finland, Italy and Slovenia) carried out gender assessments before implementing recovery policies. The evidence shows that policies based on austerity, notably budget cuts to welfare and public

services, had a disproportionate impact on women. In the years since the crisis, budget cuts have contributed to the erosion of capacity for supporting gender equality in many EU Member States. Conversely, there is an argument that, with the adoption of a gender lens, the pandemic could be a catalyst for action to ensure that the economy, society and politics work equally for women and men. A sustainable and resilient recovery could include a paradigm shift towards a care economy. Including gender equality in measures of gross domestic product, alongside other social and environment indicators, could bring a sea change in valuing the real contribution of unpaid care work and those who perform it. Economists have demonstrated that switching recovery investment from the traditional focus on construction and manufacturing to the care sector would create more jobs for both women and men and provide a better economic stimulus.

Capacities for action

The EU and the Member States already have a range of structures and instruments in place for promoting gender equality. In March 2020, the European Commission released a new EU gender equality strategy for 2020 to 2025. The strategy sets out measures in areas spotlighted by the pandemic, including: closing the gender employment gap, achieving equal participation across different sectors of the economy, equal pay, gender-equal parenting and care, gender balance in decision-making, protection against gender-based violence and addressing the specific situations of multiply disadvantaged women. The EU has also adopted an ambitious 2021-2027 EU budget, and an extra €750 billion of Next Generation EU funding for socio-economic recovery from the pandemic. The Member States holding the presidency of the Council during the pandemic, the European Economic and Social Committee, the European Committee of the Regions, and the European Women's Lobby have all called for swift implementation of the new EU gender equality strategy and for gender equality to be a core part of social and economic recovery plans and EU funding. Gender experts are warning that this is not yet the case.

Position of the European Parliament

In January 2021, Parliament adopted a resolution on the gender perspective in the Covid-19 crisis and post-crisis period, addressing the harmful gendered and intersectional impacts of the pandemic and setting out recommendations for overcoming them. The resolution addresses infection risks, increased domestic and gender-based violence, barriers to sexual and reproductive health services, the increased burden of unpaid care work, women's participation in the labour market and the gender impacts of the pandemic outside the EU. Parliament is clear that overcoming current and future challenges will require, 'a gender-sensitive approach, with gender mainstreaming and gender budgeting principles reflected in all aspects of the response to Covid-19'.

FURTHER REFERENCES

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ENDNOTES

[1] Global Health 50-50 notes that data on confirmed cases is not straightforward, since there may be underlying gender differences in the numbers of men and women being tested and treated for Covid-19. The JRC flags age differences: more cases are notified among men aged from 55 to 80 years old compared with women; higher numbers of positive cases are reported among women aged from 15 to 55 and above 80. See Goujon A. et al., Age, gender, and territory of Covid-19 infections and fatalities, JRC Technical Report, 2020.

[2] The data tracker is updated every two weeks. As of 8 February 2021, 21 EU Member States (Belgium, Czechia, Denmark, Germany, Ireland, Greece, Spain, Estonia, France, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Austria, Portugal, Romania, Slovakia, Slovenia, Finland and Sweden) were reporting sex-disaggregated data on mortality and confirmed cases, allowing the percentage of deaths occurring among cases in men and women to be presented as a ratio. Hungary and Poland were reporting sex-disaggregated data for deaths only. A further four Member States (Bulgaria, Croatia, Cyprus and Malta) were reporting sex-disaggregated data on confirmed cases only.

[3] The ECDPC is collecting data from Member States on infection and mortality rates in long-term care facilities, but sex-disaggregated data is sparse.

[4] Under the EU Clinical Trial Regulation No 536/2014, clinical trials should represent gender, age and other population groups likely to use the medicinal product; failure to do so must be justified. There is provision for including and protecting pregnant and breastfeeding women in clinical trials to make sure that medicines are safe for them. Sex and age differences must be included in trial results. The EU clinical trials register has data on Covid-19 related clinical trials

[5] The authors stress that the data must be interpreted with caution, since there may be more testing in healthcare than in other sectors.

[6] Fifteen EU Member States (BG, CY, CZ, DK, IE, ES, FR, HR, LV, LT, MT, NL, RO, FI, SE) responded to the survey. It is not specified which countries reported sex-disaggregated data.

[7] Under the EU Regulation on Personal Protective Equipment, to meet health and safety requirements, PPE must be 'individually adapted'. There must be PPE available that meets the specific needs and characteristics of each end-user: man, woman or young worker, as well as persons with disabilities. The guidance states that 'PPE must (...) provide the highest possible comfort as well as effectiveness for each wearer, thus for different morphology types and for all genders'. It also recommends methods of testing respiratory protective devices to ensure tightness. (pp. 92-93)

[8] The data for Sweden is partial. There is a general reluctance to collect data on race and ethnicity in many EU countries. See: Yamam Al-Zubaidi, Some reflections on racial and ethnic statistics for anti-discrimination purposes in Europe, European Equality Law Review, 2020/2, European Commission, pp. 62-72.

[9] Actors in the EU that sounded the alert include the European Women's Lobby, the Council of Europe's Secretary General and Group of experts on action against violence against women and domestic violence, the EU's Commissioner for Equality, the EIGE and the European Parliament's Committee on Women's Rights and Gender Equality.

[10] Rubery J. and Tavora I., 'The Covid 19 crisis and gender equality', in *Social policy in the European Union: state of play 2020*, European Trade Union Institute, 2021. See in particular Section 3.2 Care support and special parental leave schemes under Covid-19 on pp. 87-91; summaries of national measures on pp. 88-89 and p. 91.

[11] The EIGE will publish a full analysis of the pandemic's gendered social and economic impacts in the spring of 2021.

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