

EIGE-2021 Gender Equality Index 2021 Report: Health

The COVID-19 pandemic aggravates and brings forth health inequalities

In the early summer of 2021, most EU countries were simultaneously battling a third wave of COVID-19 and aggressively rolling out large-scale vaccination programmes. Various levels of restrictions were in place and progressively being lifted. At the time of writing, the EU had reported more than 33 million cases and at least 730 000 direct COVID-19-related deaths^[1]. France, Germany, Italy, Spain and Poland have had the highest number of cases – from nearly 3 million in Poland to more than 5.7 million in France^[2]. If, overall, about 7 % of the EU population has been infected, the highest shares of cases by population are in less populated countries – Czechia, Slovakia, Slovenia and Luxembourg – with rates ranging from 11 % in Luxembourg to 16 % in Czechia^[3]. The shock of such a staggering loss of life in little more than a year and the ramifications of many people suffering long-term effects from COVID-19 will be felt for years to come.

The pandemic's impact has been very unequal across the EU and over time. Western and southern European Member States were more affected than central European countries during the first wave in spring 2020. In contrast, the second and third pandemic waves have seen central and eastern European countries such as the Baltic states, Czechia, Poland and Romania more affected (OECD/European Union, 2020).

The pandemic has impacted different groups of people differently, and to different degrees, depending on a variety of factors including the level of exposure to the virus and prior health status. Many authors, such as Bambra et al. (2020b), have pointed out, differences in COVID-19 infection rates and mortality have highlighted pre-existing socioeconomic inequalities and the unequal burden of chronic disease across the population. Some authors have described the current situation as a 'syndemic' – in which the interaction of a pandemic and a NCD, each exacerbating the effect of the other, against the backdrop of significant social and economic disparity, has led to adverse outcomes for large segments of the population (Bambra et al., 2020b; Horton, 2020).

This section presents data gathered during the pandemic on mortality, morbidity, and vaccine uptake and hesitancy. Analysis is also provided on three specific gendered impacts of the pandemic on health: poor mental health, a rise in gender-based violence and the provision of SRH services in a crisis.

COVID-19 deadlier for men, 'long COVID' more likely for women

There are considerable variations in how data is provided across countries. For example, the number of people tested differs greatly between countries. Some countries test individuals more than once and provide data on the number of tests, some countries provide data on the number of individuals tested, and other countries test only people who are severely ill or hospitalised (Rozenberg et al., 2020). In addition, data on testing, prevalence and mortality is not always separated by sex, with evidence showing no progress, or even a decline, in the number of countries reporting sex-disaggregated data over time^[4]. According to the Global Health 50/50 initiative, which tracks sex-disaggregated data on COVID-19 from 119 countries, the most frequently reported data relates to confirmed cases (68 % of countries) and deaths (55 % of countries) (Global Health 50/50, 2020).

Early in the pandemic, women were more likely to get tested than men, as priority was given to healthcare and residential care workers – both groups mostly composed of women. At the time of writing, data on COVID-19 cases disaggregated by sex and age is unavailable for all Member States, hindering a comprehensive gender analysis of the pandemic's toll.

Men are more likely to have severe outcomes

Early in the pandemic, overall infection rates appeared to be similar among women and men across EU countries (Rozenberg et al., 2020). Likewise, at the time of writing, women accounted for just over half of all cases in EU countries for which data is available (52 %) (Figure 42). In only three Member States (Greece, Malta and Finland) were COVID-19 rates higher among men.

When age is taken to account, large gender differences are revealed in the number of cases. A study of 10 European countries, including seven EU Member States^[5], found that, among those of working age (i.e. up until about the age of 60), infections in women far outnumber those among men; at older ages, infection is more common in men. The highest rates of infection among men are among those aged between 70 and 79 years. Higher rates of infection among women have been linked to their presence in caring professions, especially healthcare (Tomáš Sobotka et al., 2020). This is consistent with reports that poor working conditions, including a lack of appropriate occupational health and safety measures and precarious employment, contribute to high infection levels in women-dominated frontline sectors (OECD, 2020b; Pelling, 2021; Shallcross et al., 2021).

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Beyond sex and age, understanding the full impact of the pandemic requires analysis of the other groups who have been most affected.

Gender intersects with occupation, age, and migration status to increase vulnerability to infection

The COVID-19 outbreak has led to an unprecedented shift in remote working to help slow spread of the virus (ILO, 2020). However, teleworking has not been equally accessible to all workers. Key gender differences exist between those who are able to follow 'stay at home' orders and those whose physical presence is still required at work (EIGE, 2021c). Most governments in the EU established lists of occupations deemed 'critical', 'essential' or 'key' (EIGE, 2021c). In most cases, they involved roles considered necessary for national socioeconomic functioning and which could not be carried out remotely. These jobs are mostly in health and care, victim support services, law enforcement, education, agro-industry, supermarkets, pharmacies and banks.

Women are over-represented among essential workers. Eurostat data shows that women account for 88 % of personal care workers, 84 % of cleaners and helpers, 73 % of education workers and 72 % of health professionals in EU countries^[9]. Fasani and Mazza (2020) estimated that migrant workers constitute 13 % of all key workers and are also over-represented in some low-skill essential jobs, for example personal care workers, drivers, transport and storage labourers, and food-processing workers. As highlighted by the International Organization for Migration, some EU countries with the highest COVID-19 numbers on 1 March 2021 also have some of the highest numbers of foreign-born workers in healthcare – Czechia, Germany, Spain, France and Italy^[10].

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Women are more likely to have ‘long COVID’

Emerging evidence points to significant numbers of people with COVID-19 continuing to have symptoms weeks or even months after contracting the virus (Dennis et al., 2020). The intensity of symptoms does not always mirror the severity of the initial infection. Symptoms can linger, appear for the first time or become worse (Gousseff et al., 2020). Although the prevalence and risk factors remain unclear, this syndrome, termed ‘long COVID’ or ‘post-COVID-19 syndrome’, can affect multiple organs and lead to long-lasting health issues such as diabetes (Nalbandian et al., 2021).

More than 1 year into the pandemic, estimates of the prevalence of long COVID are emerging, with some studies finding that the phenomenon could affect half of COVID-19 survivors after 14 weeks (Moreno-Pérez et al., 2021), with three quarters of COVID-19 patients showing at least one ongoing symptom after 6 months (Huang et al., 2021). Long COVID has been referred to as a major public health crisis in waiting. Figures from the UK Office for National Statistics show that 1 million people have self-symptoms 4 weeks after first being infected, and nearly 400 000 people still report symptoms after a year (Ayoubkhani, 2021). Women of working age, people with disabilities, those living in deprived areas and people working in care professions are most likely to be affected with long COVID (Ayoubkhani, 2021). Most respondents report that symptoms adversely impact their day-to-day activities.

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Vaccine uptake and hesitancy

In the EU, vaccination roll-outs organised by national governments have prioritised health professionals and age groups most at risk of severe outcomes. Studies from various countries show broad public support for such approaches (Duch et al., 2021; Persad et al., 2021), possibly acknowledging healthcare workers’ essential role in the pandemic response. High vaccination rates are considered essential to end the pandemic. So too is vaccine uptake among high-priority groups (Zintel et al., 2021).

As mentioned previously, women and men have been affected differently by the infection – if only to a degree – depending on age, comorbidities and occupational exposure. While infections among women of working age outnumber those among men, many more men have died from COVID-19.

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A pandemic in hand with a mental health crisis

As the Index domain chapters show, the full effects of the COVID-19 pandemic may still be unfolding, but preliminary findings point to profoundly unequal social and economic consequences across the EU. Social isolation, fear of infection for oneself and loved ones, grief and financial distress are enormous stressors. Evidence of the impact of these consequences on mental well-being is emerging, with multiple accounts of different population groups showing increased signs of distress such as PTSD, suicidality, eating disorders and burnout. These manifestations are likely to exacerbate pre-existing levels of poor mental health and its gender-specific impacts, as discussed in Section 9.1.1. This section mainly focuses on the mental health of the general public and of healthcare professionals.

Mental well-being levels are at their lowest since pandemic outbreak

Pandemic lockdown measures have led to a rise in loneliness, recognised as a major public health concern globally. Groups at most risk before and during the pandemic are near identical – young adults, women, people with lower education or income, the unemployed, people living alone and urban residents (Bu et al., 2020).

Lockdowns and other social distancing measures are known to have had a significant impact on opportunities for physical activity, as discussed in Section 9.1.2. A study on social distancing among UK adults found that those who were physically active had better overall mental health, that is they had fewer depressive and anxiety symptoms and more positive mental well-being (Jacob et al., 2020). In Italy, total physical activity has significantly decreased during the pandemic in all age groups, especially among men. This fall in total physical activity has had a profoundly negative impact on psychological health and well-being (Maugeri et al., 2020).

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Care workers face acute distress

Evidence is mounting on the profound mental health toll of the pandemic on frontline workers, particularly in the care sector. Scholars note that health workers are already at higher risk of poor mental health in normal times. That risk increased with COVID-19 and the stress of poor pandemic preparedness of health systems (Mortier et al., 2021), trauma from having to prioritise care and seeing patients suffer or die (Greenberg et al., 2020), insufficient rest and overwork, and the fear of infection or infecting others.

Psychological symptoms include high rates of stress, depression, anxiety and insomnia. Healthcare workers and those directly engaged with affected patients report PTSD and psychological distress (Kisely et al., 2020). Systematic reviews show that frontline healthcare workers and those with pre-existing mental health issues are at higher risk of poor mental health than others (Bekele and Hajure, 2021).

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An epidemic of gender-based violence

Governments in 142 countries around the world imposed lockdown measures in early 2020 (Hale and Webster, 2020), which contributed to the global surge in intimate partner violence (Graham-Harrison et al., 2020; WHO, 2020b), causing a 'shadow pandemic' (UN Women, 2020). Forced cohabitation and economic and labour instability are stressors known to be associated with an increase in intimate partner violence (Buller et al., 2018; Buttell and Ferreira, 2020; Jarnecke and Flanagan, 2020); these factors have been exacerbated by the pandemic and this, combined with the increased psychological distress resulting from lockdown (S. K. Brooks et al., 2020; Gillespie et al., 2021), has led to an increased risk of intimate partner violence (Clemens et al., 2019; Curtis et al., 2019; Straus and Douglas, 2019).

For example, in Spain the incidence of intimate partner violence increased by 24 % during the 3 months of lockdown. This increase can be explained by the lockdown itself as well as by economic stress, health concerns, working under pressure, closure of schools and increased caring demands (Arenas-Arroyo et al., 2020). The stressors arising from the quarantine and having to live with an aggressor without options to escape can aggravate violent dynamics between members of a couple (Hsu and Henke, 2020; Hussein, 2020). As discussed in the domain of violence chapter, lockdown restrictions make it more difficult to find help arise , thereby increasing tensions and leading to a rise in violence (Hsu and Henke, 2020), including femicide (Townsend, 2020; Vagianos, 2020). It is broadly recognised that the end of the lockdown will not lead to a decline in intimate partner violence; the consequent economic instability is highly likely to aggravate already high levels of violence (Arenas-Arroyo et al., 2020).

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The COVID-19 pandemic challenges the quality of sexual and reproductive health services

There is increasing evidence of the pandemic's severe toll on the SRHR of women, girls and other marginalised groups.

With abortion banned in Malta and pandemic-related travel restrictions preventing women from travelling abroad for an abortion, imports of abortion pills in Malta surged (Caruana-Finkel, 2020). During the pandemic, Poland passed additional restrictive legislation, while Hungary was the only Member State to suspend surgical abortions because of pandemic pressure on public hospitals. Belgium, Germany, Latvia, Luxembourg and Slovenia introduced longer waiting periods for abortions for those who tested positive for COVID-19 or were symptomatic (Moreau et al., 2020).

Lockdown led to isolation of pregnant women, during childbirth, as fathers and birth partners were not allowed to attend. This could have long-term consequences for parent–child bonding and increase post-partum depression. Elsewhere, it has been estimated that disruptions to counselling programmes will lead to an increase in FGM of 2 million cases over the next decade (UNFPA, 2020), while school closures have generally curtailed access to SRHR information for young people.

More positively for SRH, the COVID-19 pandemic has made telemedicine more common (Porter et al., 2020). The option to receive sexual and reproductive healthcare online or through messenger apps has made healthcare more accessible and available for people with limited mobility or who are unable to leave home because of care responsibilities.

Footnotes

[1] ECDC COVID-19 surveillance update, <https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea>, accessed 7 July 2021.

[2] ECDC COVID-19 surveillance update, <https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea>, accessed 7 July 2021.

[3] Authors' elaboration based on ECDC daily data, <https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea>, accessed as of 19 May 2021, based on 2020 data for population.

[4] The COVID-19 Sex-disaggregated Data Tracker: April update report, Global Health 50/50, <https://globalhealth5050.org/wp-content/uploads/April-2021-Data-tracker-....>

[5] Belgium, Czechia, Denmark, Germany, Italy, Norway, Portugal, Spain.

[6] This is in line with research on other infectious diseases, which has found that mortality from infectious sepsis is 70 % higher in men than in women. Men are also more likely than women to die from severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (21.9 % vs 13.2 %) (Rozenberg et al., 2020).

[7] The COVID-19 Sex-disaggregated Data Tracker: April update report, Global Health 50/50, https://global-health-summit.europa.eu/rome-declaration_en.

[8] The true death toll of COVID-19: Estimating global excess mortality, <https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimat...>

[9] EIGE, COVID-19 web page, <https://eige.europa.eu/covid-19-and-gender-equality/essential-workers>. Data from EU-LFS, 2018.

[10] International Organization for Migration, Migration Data Portal 'Migration data relevant for the COVID-19 pandemic', <https://migrationdataportal.org/themes/migration-data-relevant-covid-19-...>, accessed 19 May 2021.

[11] The COVID-19 Sex-disaggregated Data Tracker: April update report, <https://globalhealth5050.org/wp-content/uploads/April-2021-Data-tracker-...>, Global Health 50/50.

[12] Each participant reported an average of nine persistent symptoms such as muscle pain, fatigue, impaired sleep quality and short-term memory loss.