Gender Equality Index 2020: Digitalisation and the future of work

Unprecedented impact of COVID-19 calls for gender-sensitive policies and research

The COVID-19 pandemic has challenged health systems and affected the health and lives of innumerable people, both directly and indirectly. Although gender-disaggregated data are not provided by all countries, data suggest that infected men are more likely to die from COVID-19 than infected women (BMJ Global Health, 2020).

A similar trend was seen in the SARS outbreak in 2003 (Jin et al., 2020). Gender disparities may be rooted in biological differences (e.g. genetic and immunological differences, gender differences in pre-existing health problems), behavioural risk factors (e.g. a history of smoking), working conditions and other social factors (Gebhard et al., 2020). For example, women participate less in the labour market, but they work as front-line providers of healthcare and social care.

A study of eight countries found that women are more likely to see COVID-19 as a very serious health problem, to agree with restrictive public policy measures adopted in response to it and to comply with them (Galasso et al., 2020).

The number of victims extends beyond the count of those who have died from COVID-19, with the unprecedented increase in deaths exceeding the recorded numbers of directly COVID-linked deaths. This may be because health systems have become overwhelmed and people have not received the help they need (Wu et al., 2020) and because people have not sought help because of a fear of leaving home (Roxby, 2020). The situation is most grave for those with pre-existing physical or mental health conditions.

The impact of the COVID-19 pandemic and the policy responses of closing infrastructure (including health facilities) and social distancing may have a more far-reaching impact. The grief of losing people to COVID-19, the fear of infection, unpredictability, work–life balance struggles due to closures of schools and kindergartens, the stress of job and income loss, and the loneliness and isolation caused by social distancing, stigma and discrimination are likely to generate significant stress, anxiety and thus related mental health issues.

For instance, a study found that the number of calls to a German helpline increased significantly during the pandemic owing to increased loneliness, anxiety and suicidal ideation (Armbruster and Klotzbücher, 2020).

The gender differences in mental shealth are well established and it is likely that the pandemic and resulting economic crisis will only exacerbate these differences. For instance, job loss is a major stressor for men. Studies have shown that during periods of high unemployment during the financial crisis suicide rates in men significantly increased – particularly among those of working age and the unemployed – while suicide rates among women were largely unaffected (Parmar et al., 2016).

However, women's struggle with work–life balance may have been aggravated by the unbalanced division of care responsibilities within the family. Living in lockdown may foster unhealthy lifestyles, substance abuse, lack of physical exercise and unhealthy eating habits. The subdomain of health behaviour shows that these behaviours are more common in men than women, although lockdown and the resulting economic crisis may increase unhealthy behaviour among both women and men.

Social isolation over long periods of time can increase the risk of a variety of negative health outcomes, including heart disease, depression, dementia and even death (Miller, 2020). It has been shown to be comparable to well-established risk factors for mortality, such as smoking and alcohol consumption, and worse than physical inactivity and obesity (Holt-Lunstad et al., 2010).

There is added stress for older adults and people with certain health conditions, who are at particular risk and who may also be cut off from care by physical distancing. Women, particularly older women, are more likely to live alone than men (EIGE, 2020e).

Women may be at risk of exposure as a result of occupational gender segregation: globally, women make up 70% of the health workforce and are more likely to be front-line health workers, especially nurses, midwives and community health workers (WHO, 2018).

In its mental health guidance, WHO specifically targets healthcare workers, health facility managers, childcare providers, older adults, care providers, people with underlying health conditions, and those living in isolation to try and contain the spread of the pandemic (WHO, 2020c).

Children's mental health also needs special attention, with children affected by the changing situation, isolation and general anxiety levels in the home, particularly in tense/violent households. Of young people with a history of mental illness in the United Kingdom, 83 % said that the COVID-19 pandemic had made their condition worse and 26% said that they were unable to access mental health support. Peer support groups and face-to-face services have been cancelled, and support by phone or online can be challenging for some young people (YoungMinds, 2020).

The total costs of mental ill health are estimated to amount to more than 4 % of GDP across EU Member States (over EUR 600 billion per year)[1] (OECD-EU, 2018). A considerable number of children experience mental health problems, with many such issues beginning in adolescence or even younger (OECD-EU, 2018).

Mental health issues are among the health conditions with the highest burden of disease for young children and young people, particularly adolescent girls (Baranne and Falissard, 2018). Children who have been isolated or quarantined during pandemic outbreaks have been found to be more likely to develop acute stress disorders, adjustment disorders and grief disorders (Sprang and Silman, 2013).

Only 1% of all academic research on previous outbreaks of Zika and Ebola explored the gendered impact of those outbreaks (Criado Perez, 2019)[2]. The COVID-19 outbreak has seen quite numerous publications on gender implications, but WHO points out that there is limited availability of sex- and age-disaggregated data, which hampers analysis of the gendered implications of COVID-19 and the development of appropriate responses (WHO, 2020b).

The biological differences between women and men need to be considered in clinical testing of vaccines and drug treatments for COVID-19, including the special situation of pregnancy. Sufficient and timely research on mechanisms of spreading the virus is needed to advise pregnant and breastfeeding women.

Health pandemics can make it more difficult for women and girls to access sexual and reproductive health services, as a result of the reallocation of resources and priorities (UN Women, 2020; WHO, 2020b). Those with specific conditions (e.g. autism) may be particularly at risk, as they may not be able to tolerate disruption to their daily routines (Lee, 2020).

A more in-depth analysis of gender inequalities in health will be reported on in 2021, when health will be the thematic focus of the Gender Equality Index. That Index will also focus on important topics such as mental health, reproductive and sexual health, and the gendered impacts of pandemics.

Footnotes

[1] A large part of these costs arises from lower employment rates and productivity of people with mental health issues but also from spending on social security programmes and direct spending on healthcare.

[2] In her book Invisible Women: Exposing data bias in a world designed for men, Criado Perez (2019) notes that 29 million papers were published in more than 15 000 peer-reviewed titles around the time of the Zika and Ebola epidemics, but less than 1 % explored the gendered impact of the outbreaks.