THE IMPACT OF COVID-19 ON WOMEN

The COVID-19 pandemic has forced the world to embrace a new normal, with self-isolation and physical distancing being the global way of life today. And while such preventive measures are critical, combating the COVID-19 crisis necessitates a robust and inclusive societal and health system response, bearing in mind the specific needs of vulnerable populations.

Policies and public health efforts have not addressed the gendered impacts of disease outbreaks. The COVID-19 pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems, which are in turn amplifying the impacts of the pandemic. Across every sphere, from health to the economy, the impact of COVID-19 are exacerbated for women and girls.

This policy brief explores the differential impact of COVID-19 and makes recommendations to ensure that women and girls remain central to COVID-19 response planning and recovery efforts.

Increased risk to women

Evidence from past epidemics, including Ebola (2014-16) and Zika (2016) suggests that women and children are at greater risk of exploitation and sexual violence.[1] Increasing the risks of violence for women were increased stress, the disruption of social and protective networks, and decreased access to services. Efforts to contain outbreaks have in the past diverted resources from routine health services including pre- and post-natal health care and contraceptives,[2] and exacerbated already limited access to sexual and reproductive health services.[3]

The Report of the High-Level Panel on the Global Response to Health Crises, set up by the United Nations (UN) Secretary-General, submitted in 2016[4] underscored in its recommendations 'Focusing attention on the gender dimensions of global health crises'. It noted the need to incorporate gender analysis into responses, as well as recognize the critical role played by women in responding to health emergencies. It further stated that 'policy-makers and outbreak responders need to pay attention to gender-related roles and social and cultural practices'. Yet evidence across sectors, including economic planning and emergency response, continue to lack a gender lens. Less than one percent of published research papers on both Ebola and Zika outbreaks focused on the gender dimensions of the emergencies.[5] Research on the gendered implications of previous health emergencies is even more scarce.

Economic Impact

Emerging evidence on the impact of COVID-19 suggests that women's economic and productive lives will be affected disproportionately and differently from men.[6] Across the globe, women earn less, save less, hold less secure jobs, and are more likely to be employed in the informal sector. In developing economies 70% of women work in the informal sector with few protections against dismissal or for paid sick leave and limited access to social protection.[7] The Ebola virus showed that quarantines can significantly reduce women's economic and livelihood activities, increasing poverty rates, and exacerbating food insecurity.[8] In India, the nationwide lockdown imposed by the government has left millions of migrant women unemployed and starved for food, placing a huge financial burden on these women, who contribute substantially to their household income.

On an average, women spend two times as many hours as men doing unpaid caregiving work as well as domestic work. With health facilities being overburdened and non- COVID-19 related health and social services being scaled down, women will be primary, unpaid caregivers to ailing family members, including children and old people. Women's greater involvement in the unpaid care economy could also impact their already low workforce participation rate. It is imperative to recognize women's caregiving responsibilities and include this work in economic metrics and decision-making.

Health Impact

Restrictive social norms, gender stereotypes, home quarantining and diversion of resources to respond to the COVID-19 pandemic can limit women's ability to access health services as well as make them more susceptible

PFI's studies to assess the impact of COVID-19

To assess the impact of COVID-19 on young people, girls and women and their access to health services, Population Foundation of India (PFI) commissioned two rapid telephonic surveys; first, with front line workers, grassroots organizations and community members in five states **(Bihar, Jharkhand, Odisha, Rajasthan and Uttar Pradesh)**, and second, with young people (15-24 years) in three states of **Bihar, Rajasthan and Uttar Pradesh**. Key findings from the studies are shared below:

Awareness and perceptions regarding Covid-19

- Both front-line workers (FLWs) and community members in five states were aware of the disease, its symptoms, and preventive measures to be followed.
- There was a predominant perception of fear among FLWs and community members often leading to discriminatory behaviour and stigma.
- Young people's awareness on the symptoms of COVID-19 in Rajasthan, UP and Bihar was high.
- **Sources of information**- For **community members**, media and family members were the major source. **FLWs** received information from capacity building sessions, colleagues and media while **young people** received information from traditional media and face-to-face interactions with FLWs.

Availability of and access to healthcare

- While **OPD services** were functional, communities were encouraged to access health care for deliveries or medical emergencies only.
- The fear of being infected kept many away from accessing services at health facilities and led to resistance in interacting with ASHAs and ANMs on family planning during their home visits.
- Consistent with national guidelines and state orders, across states, Village and Health Nutrition Days (VHNDs) were suspended during lockdown period.
- In absence of VHND and service provision by ANMs in villages, nearly 50 percent or more FLWs reported that women were not accessing **Ante-natal care (ANC) services**; and 70 percent or more reported beneficiaries not accessing **immunization services**.
- Young people in UP, Bihar and Rajasthan reported an unmet need for reproductive health services, sanitary pads and IFAs during the lockdown.
- While **contraceptives** were available at the district level, limited access to public transport prevented FLWs to collect supplies from PHCs/CHCs.
- Concerns were raised around complications arising from limited availability of essential and emergency health services,
- Concerns were also raised around increase in unwanted pregnancies and unsafe abortions due to inadequate supply of contraceptives and limited service provision.
- Increase in **domestic violence** at home were only reported by one-fourth of the participants, most of which were women.
- Young people expressed the need for mental health care services, and those who have used these, have found them to be positively influential.

to health risks. Global lockdowns have led to several women being stuck at home with their perpetrators and incidents and reports of violence against women has been on a rise globally. Women's access to sexual and reproductive health services has also been severely impacted due to the COVID-19 emergency response and global lockdowns. Multiple responsibilities has also put severe strain on their mental health.

1. Violence against women and girls

According to the WHO, violence against women remains a major threat to global public health and women's health during emergencies. Although data are scarce, reports from China, the United Kingdom, the United States, and other countries suggest an increase in domestic violence cases since the COVID-19 outbreak began. The National Commission of Women in India has also reported a surge in the reported cases of violence in the country. Stress, the disruption of social and protective networks, and decreased access to services can all exacerbate the risk of violence for women. As distancing measures are put in place and people are encouraged to stay at home, the risk of intimate partner violence is likely to increase.

In India, 1 in 4 girls get married by age of 18 years (27% prevalence).[9] One third (32 per cent) of women who had married before the age of 18 had experienced physical violence at the hands of their husbands. The sex ratio at birth in India is 899 girls for every 1,000 boys born.[10] According to UNFPA's recently released **State of the World Population (SWOP) report**, COVID 19 may exacerbate the already concerning numbers around early marriage, violence and sex birth ratio at birth.[11] UNFPA's recent projections estimate that **31 million additional cases of gender-based violence** can be expected to occur if the lockdown continues for at least six months. For every three months the lockdown continues, an additional 15 million extra cases of gender-based violence are expected. The projections further suggest that due to the **disruption of programmes to prevent female genital mutilation in response to COVID-19**, two million female genital mutilation cases may occur over the next decade that could have been averted. **COVID-19 will disrupt efforts to end child**

marriage, potentially resulting in an additional 13 million child marriages taking place between 2020 and 2030 that could otherwise have been averted.[12]

The health impacts of violence, particularly intimate partner/domestic violence, on women and their children, are significant. This can result in injuries and serious physical, mental, sexual and reproductive health problems, including sexually transmitted infections, HIV, and unplanned pregnancies. Violence not only negatively impacts women but also their families, the community and the nation at large. It has tremendous costs, from greater health care and legal expenses and losses in productivity, impacting national budgets and overall development.[13]

What can be done to address violence against women during the COVID-19 response?

- Inclusion of measures to address violence against women in preparedness and response plans for COVID-19 by Governments and policy makers.
- Development of a public health response to violence against women.
- Ensuring preventive, curative and systematic referral support to the survivors of violence and early detection cases.
- Training of healthcare providers to provide better quality of care and counseling services to victims of violence.
- Facilitating hotlines, telemedicine services, shelters, rape crisis centers, counselling for survivors of violence must be ensured.
- Emphasis on greater reporting on violence in COVID-19 response plans.

2. Mental health

While there have been reports suggesting that men, the elderly, and persons with compromised immune systems may be at be greatest risk of fatality from COVID-19, the greater caregiving role that women and girls are expected to perform may compromise their mental health and well-being. Results from a recent PFI study to assess the knowledge and impact of COVID-19 on young people in three Indian states of Uttar Pradesh (UP), Bihar and Rajasthan show that 51% female adolescents experienced an increase in workload during the nationwide lockdown, as compared to 23% male adolescents. In UP 96% females experienced an increase in workload, with 67% being below 18 years of age.[14]

Specific population groups are showing high degrees of COVID-19-related psychological distress. Frontline healthcare workers are facing backlash from communities leading to stress. In the wake of the lockdown, people across all strata and age groups are finding it increasingly difficult to deal with social isolation and stress at home, with some facing increased abuse, disrupted education and uncertainty about their futures.

In addition to the caregiving burden, social norms in some contexts dictate that women and girls are the last to receive medical attention when they become ill, which could hinder their ability to receive timely care for COVID-19. Furthermore, **myths, misconceptions** and **stigma** surrounding COVID-19 can further drive people, particularly vulnerable sections like women and childrenparticularly vulnerable sections like women and children to hide their illness to avoid discrimination. This would prevent people from seeking health care immediately as well as discourage them from adopting healthy behaviours.

The caregiving responsibilities of women extend beyond their homes, with women making up 70 percent of the health workforce globally.[15] In India, there are 1 million ASHAs (Accredited Social Health Activists)[16], 0.9 million ANMs (Auxiliary Nurse Midwives)[17] and 1.4 million nutrition workers called Anganwadi workers.[18] During the ongoing crisis, these frontline health workers are leading the health system's response to COVID-19. In Italy 66% of the total health workers infected with COVID-19 are women while in Spain 72% of the total infected health workers are female.[19]

Outbreaks could also result in disruptions to mental health and psychosocial support services. Given the increase in such cases during the COVID-19 outbreak, frontline health workers, women and girls with caregiving burdens, and community members fearful of becoming infected or infecting others may all experience stress and trauma relating to the outbreak.

What can be done to address mental health issues stemming from the COVID-19 pandemic?

- Inclusion of psychological support services for women into primary health care.
- Development of a comprehensive crisis prevention and intervention system including epidemiological monitoring, screening, referral and targeted intervention to reduce psychological distress.
- Awareness campaigns to ensure vulnerable groups including women, are well informed about the availability and accessibility of mental health related services.
- Increased investments in mental health research.
- Building a cadre of trained professionals to strengthen mental health services.

3. Access to Sexual and Reproductive Health Services

Evidence suggests that during past public health emergencies, resources have been diverted from routine health care services toward containing and responding to the outbreak. These re-allocations constrain already

limited access to sexual and reproductive health (SRH) services, such as clean and safe deliveries, contraceptives, and pre- and post-natal health care.[20]

What do projections tell us?

Guttmacher Institute recently released an estimate of the potential impact of COVID-19 pandemic on provision of sexual and reproductive health services (SRH services) in low and middle income countries (LMICs).[21] The study takes into account data from 1.6 billion women of reproductive age across 132 LMICs and makes the following projections:

- A 10% decline in use of reversible contraceptive methods in LMICs due to reduced access would result in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over the course of a year.
- A decline of 10% in coverage of pregnancy-related care and newborn health care would result in an additional 1.7 million women giving birth and 2.6 million newborns experiencing major complications due to lack of care they need.
- Countrywide lockdowns which are forcing clinics to close or if abortion is considered a nonessential service, an additional 3.3 million unsafe abortions would occur in LMICs over the course of a year.

Recently released projections by the UNFPA suggest that 47 million women in 114 low- and middle-income countries may not be able to access modern contraceptives and 7 million unintended pregnancies are expected to occur if the lockdown carries on for six months and there are major disruptions to health services. For every three months the lockdown continues, up to an additional two million women may be unable to use modern contraceptives.

UNICEF has estimated that in the nine months span dating from when COVID-19 was declared a pandemic, the countries with the highest numbers of forecast births are expected to be India (20.1 million), China (13.5 million), Nigeria (6.4 million), Pakistan (5 million) and Indonesia (4 million).[22]

An analysis of the projected demand for contraceptive methods, based on previous year's contraceptive methods distribution and use of services, basis Government of India's Health Management Information System (HMIS)[23] indicates that approximately one million women undergo sterilization or accept IUCD or an injectable method in the month of March alone. **The data from HMIS further suggest that approximately 2.8 million condoms and 4.3 million pills are distributed monthly during the months of April and May . With the country under extended lockdown and a large number of migrants returning to their villages, the demand for contraception will likely be higher. This phenomenon, in normal course, is witnessed during major festivals, and is directly proportional to an increase in the number of pregnancies in states like Bihar, which have a huge migrant population.**

What can be done to mitigate the risk to family planning programs?

- Social marketing organizations and FP service delivery organizations could support the government in ensuring **uninterrupted supply of reversible methods of contraception** and take some burden off the public health system.
- The availability of **self-care methods** like condoms, oral contraceptive pills, emergency contraceptive pills, pregnancy test kits and sanitary pads at the pharmacies should be ensured. Furthermore, continuity of contraceptive supply chain is imperative to rule out stock outs in districts upto PHCs.
- **ASHAs** and other community level health workers should be supported to ensure continued access to family planning services.
- **Counseling on family planning** through helplines, telemedicine services, community radios, chatbots and mobile services should be ensured.
- **The government should leverage partnerships with NGOs** to support information and service delivery in this time of crisis. The government has recognized the critical role of NGOs in delivering services to vulnerable groups at this time of crisis. Ensuring easy mobility and smooth operations of NGOs providing health and family planning services will be critical to many women and children accessing essential non-COVID-19 healthcare services.

Way forward

Going forward, it is important for us to not view COVID-19 as a standalone disaster impacting the world. It is afterall, the third coronavirus outbreak the world has witnessed in the past two decades. The impact of COVID-19 has been, by far, the most fatal and widespread, partly because of the severity of the condition and partly because today the world is way more connected making transmission quicker. It is the need of the hour to develop a health systems approach to disaster management, both natural or manmade, where lessons identified from disasters are effectively collated and used to enhance disaster preparedness of the country.

First, we need effective solutions to ensure that women's health does not remain on the fringes in

the post-COVID-19 era. Given the evidence, we must apply an intentional gender lens while designing programmes and prepare ourselves with adequate knowledge, gender disaggregated data and evidence to address the socio-economic impact of COVID-19.

Second, investing in our **3.3 million strong female frontline workforce** is the only solution for combating the aftermath of COVID-19. Even in the cases of HIV and polio eradication, it was the support of the community, which proved to be effective. Our community health workers need to be valued prioritized and resourced.

Third, there is a need to step up investments in family planning. Studies from across the globe have revealed that investing in family planning is one of the most cost-effective public health measures and a development "best buy". A study conducted by Population Foundation of India for the period of 2015-2031 estimated that effective family planning interventions can prevent 2.9 million infant deaths and save 1.2 million maternal lives. Additionally, availability of quality family planning services can prevent 206 million unsafe abortions in India during the same period. In contrast, inaction in family planning can have a disturbing influence on several fronts – it can disrupt the growth equilibrium and result in loss to individuals, households and the economy.

Fourth, as the pandemic and its ramifications on the economy, social dynamics and health outcomes continue to spread, health education and **social and behavior change communication (SBCC)** campaigns can help spread awareness on all aspects of sudden disasters across all stratas of society and dispel surrounding myths and misconceptions doing the rounds. Changing mindsets is only possible by adopting innovative SBCC strategies pertaining to health, which enable people to observe and imbibe healthy behaviours. **For instance, Population Foundation of India, is providing content support to government of India to improve people's access to verified, reliable and updated information on COVID 19.** Vetted by leading public health experts and epidemiologists, the information is being translated into different languages to reach a wider audience. In addition, as we prepare to embrace a 'new normal', SBCC strategies will play a crucial role in promoting self-care, fighting stigma and transforming regressive social norms which have impacted the status of women for centuries.

Fifth, given that routine health services are the first to be impacted at the time of health disasters, such as COVID-19, extra efforts are needed to revamp and strengthen public health, especially primary health care and increase health budget. It is crucial to optimize service delivery settings and platforms by mapping health facilities, maintaining supply chains and establishing outreach mechanisms. There is an urgent need for redistribution of health workforce, capacity building of frontline workers and strengthening paramedics and greater investment in medical research. This will not only enable accurate prognosis and subsequent referrals to specialists but also ensure uninterrupted service provision with the limited health workforce.

As researchers continue to study the coronavirus and develop therapeutic strategies to prevent and stop the spread of disease, the public health system needs to simultaneously evolve and prepare itself to combat severe health challenges, which is not at the expense of other healthcare priorities.

How can we combat the aftermath of COVID-19?

- Ensuring women's equal representation in all COVID-19 response planning and decision-making.
- Targeting women and girls in all efforts to address the socioeconomic impact of COVID-19.
- Integrating prevention efforts and services to respond to violence against women into COVID-19 response plans.
- Partnerships between government and civil society organizations to ensure uninterrupted supply of sexual and reproductive health services.
- Extend basic social protection to informal workers
- Health systems strengthening and adequate/ increased health budget allocation.
- Capacity building of community level health workers to ensure continued access to family planning services, improved quality of care and counseling services to women.
- Strengthening counseling services though helplines, telemedicine services, community radios, chatbots and mobile services.
- Greater health awareness through behaviour change communication campaigns- stepping up advocacy and awareness campaigns, including targeting men at home.
- Ensuring psychosocial support for women and girls combatting mental health issues and stigma.
- Developing a public health response to end violence by providing preventive, curative and systematic support to the survivors of violence and early detection.

PFI's efforts to combat the COVID-19 crisis

- **Small grants to organizations in Bihar, Uttar Pradesh, West Bengal, Delhi and Jharkhand** relief and rehabilitation work by way of providing daily essentials, sanitizers, masks and livelihood support to approximately 18,000 beneficiaries since March 2020.
- **Content partner** for Government of India's citizen-centric platform for **creating the content strategy, messaging and creatives around COVID-19**
- Conceptualized and created a short film on female healthcare workers at the forefront of COVID-19. The video garnered **4.6 million views within 24 hours** of being posted. [Hindi Version, English Version]
- In collaboration with the renowned theatre and film director, Mr Feroz Abbas Khan, PFI has been working on a social and behaviour change campaign to disseminate key messages, tackle misinformation and reinforce a sense of solidarity around the fight against COVID-19. Hasya Kavi Potliwala is a short animation film featuring a poet who recites a short "kavita" addressing stigma against COVID-19 patients. We have also conceived a **five-episode animation series, titled Corona Ki Adalat (Court of Corona)** - the first film of the series addresses the issue of stigma and discrimination against healthcare workers.
- **Partnerships with State Governments and NGOs.** PFI is working directly with state governments, Ministry of Health and Family Welfare and civil society organizations to develop and disseminate materials on COVID-19 in Hindi, English and regional languages for their use.
- **Generating evidence on the impact of COVID-19**
  - PFI commissioned a study on impact of COVID-19 on availability of services and commodities in public health facilities and outreach by front line workers in five Indian states (Bihar, Odisha, Jharkhand, UP, Rajasthan) – *May, 2020,*
  - PFI conducted a telephonic rapid assessment with adolescents and youths in three states (Rajasthan, UP and Bihar) to understand the level of knowledge and impact of COVID-19 – *May, 2020.*

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