

Written evidence submitted by Professor Sophie Harman, Queen Mary University of London and Dr Clare Wenham, London School of Economics and Political Science (MRS0153)

This submission is based on our joint research experience of over 25 years in global health policy and outbreak response. We recognise the actions of the Government so far in responding to the pandemic and the processes already in place to monitor and address the many effects of the COVID-19 pandemic.

This submission contains eight proposals to help identify the impact, and provide solutions, to some of the detrimental impacts on those with protected characteristics, with a particular focus on women and gender. The first proposal focuses on the importance of collecting data, critical to identifying targeted solutions to address the impacts of COVID-19. The remaining seven look at the potential health, social and economic impacts on women, informed by our research findings from previous epidemics and pandemics and propose solutions to the Government.

Proposal 1: Sex-disaggregated data sets should be compiled and made public:

1.1 Epidemiological data corresponding to the outbreak, including incidence, hospitalisation, mortality/outcomes, and testing must be open access. This should be sex-disaggregated, and include disaggregation by ethnicity, age, and employment (where data protection permits). This is currently compiled by multiple sources (NHS, PHE, ONS, Local Government) and not consistently disaggregated or published on the gov.uk COVID-19 dashboard.

1.2 Not counting or publishing the data is to exclude. Indications suggest that mortality is higher amongst men, but we need to understand distribution of testing, syndromic surveillance and that from sentinel sites. This will allow us to understand what population the case numbers reflect – do case numbers reflect who is going for testing, or reporting symptoms on NHS111.

1.3 During the Ebola outbreak in West-Africa, sex-disaggregated data - only published towards the end of the outbreak - demonstrated greater incidence amongst women. This allowed identification of women's care giving roles formally and in families as a key risk factor for infection, allowing for community interventions.

1.4 Early indications from Spain and Italy's COVID-19 sex disaggregated data demonstrate a spike of infection amongst women aged 18-45 who are healthcare workers. This information can influence prioritisation of PPE and other disease control strategies.

1.5 This is coupled by alarming statistics showing increased rates of infection and mortality amongst BAME communities in the NHS and UK. Whilst PHE are examining any clinical reason for such increased incidence, we remind the Committee of the systemic inequalities within health systems, including in the UK, such as those evidenced by the MBRRACE-UK

study demonstrating the significantly worse birth outcome for women from BAME communities than white counterparts.

1.6 These concerns can be addressed through:

- Including sex and ethnicity in all data published, including on gov.uk platform; and
- Ensuring such questions are included in all clinical, laboratory and public health data collection.

Proposal 2: Inclusion and representation of women

2.1 Representation of expertise on women's issues needs to be present at every level of the Government's response to COVID-19. Where possible, this should be through people with proven experience and expertise on women's health and care needs, and their role in the wider care economy, to avoid token inclusion of women and ensure key issues are raised at every level of the response. Representation of women is currently imbalanced, with women overly represented in delivery and frontline care work but under-represented at levels of decision and strategy making.

2.2 This imbalance can be addressed through:

- Gender parity in key decision-making bodies of senior government on COVID-19: informal senior cabinet 'team' of four, Cabinet, and Cabinet Office Briefing Room (COBR);
- Inclusion of women and gender experts in advisory groups, e.g. Scientific Advisory Group for Emergencies (SAGE);
- Gender parity and inclusion of gender expertise in Local Resilience Forums, Clinical Commissioning Groups, and Local Authority gold structures; and
- Rapid and ongoing consultation with key women's organisations over immediate and long-term strategy in response to the outbreak.

Proposal 3: Gender analysis of key decisions

3.1 Ensuring the direct and indirect gendered impacts of COVID-19 are considered, requires both women's representation and leadership, and the application of gender analysis to key aspects of decision-making. Gender analysis should inform decision-making with immediate effect in the following key areas of the response, to ensure the health and safety of both men and women.

3.2 **Lockdown:** It is unclear whether gender concerns, specifically the increased risk of domestic abuse, were considered in decision-making on curtailment of movement and the 'lockdown' and self-isolation in the UK. Given the concerning growth in demand on domestic abuse services (e.g. use of phone lines), closure of shelters, and early indications of a rise in domestic abuse from the beginning of the lockdown period, concerns as to the long

term safety, well-being, and potential homicides of women on account of these measures must contribute to decision-making over any changes or relaxing of the lockdown period and next stages of the UK response and recovery.

3.3 School Closures: School closures have led to home schooling, increased time and care in the home, and thus demands of the time of working parents. These demands are most likely to fall on working mothers (given previous data on labour responsibilities within the home). This will have an impact of women's paid labour productivity, economic empowerment, and career progression as well as their physical and mental health and well-being as time to care for their own needs becomes limited, and the mental burden of schooling and psycho-social support increases. Gender analysis must be factored in to any future decision on extended school closures and openings.

3.4 Recovery planning: The pandemic is already impacting on men, women, and BAME people differently. Recovery planning must apply a gender analysis taking into account these differential impacts and the recovery needs. For example, investment in domestic abuse support centres, return to work packages, and job security in the formal care sector.

Proposal 4: Enhanced support to reduce domestic abuse

4.1 Homes are not safe spaces for all. Measures to respond to health emergencies such as self-isolation and quarantine have track records of increasing domestic abuse and sexual and gender-based violence. In the UK, self-isolation and stay home measures put in place to curtail the spread of COVID19 have had a direct impact on rising numbers of domestic abuse. In addition to the risk to women's lives, this is leading to increased demand on domestic abuse services at a time when their service provision is being threatened by loss of staff due to isolation and health concerns and funding.

4.2 Recognition of this issue has been through Home Office campaigns such as #YouAreNotAlone and #NoExcuseForAbuse, and the Treasury's commitment of £750 million to support the charity sector, and the Home Affairs Committee's inquiry into domestic abuse during COVID-19.

4.3 We recommend specific funding commitments to reduce the harmful outcomes of COVID-19 response measures on victims of domestic abuse:

- Emergency Funding and Protection for domestic abuse victims, survivors, and the charities that support them to ensure no shelter or domestic abuse-related charity closes during the pandemic; and
- Provision of long term support for domestic abuse victims, survivors, and charities in the post-COVID-19 recovery period. Including up to at least 3 years of funding support to ensure sustainability and long-term commitment to the sector.

Proposal 5: Access to Sexual Reproductive Health (SRH)

5.1 The distortion of health services during pandemics means that routine provision of SRH can be compromised. Sex and reproduction does not stop on account of a health emergency. COVID-19 is demonstrating this compromise in routine provision.

5.2 Supply chains for contraception have disrupted distribution of condoms and long acting reversible contraceptives. These supply chain disruptions are amplified by self-isolation, and restricted access to GP and local health services which may affect women's on the ground demand for SRH services.

5.3 Autonomy and self-determination over sexual and reproductive lives is constrained by sexual violence, domestic abuse, and wider social changes, including quarantine. This resulted in a growth in teenage pregnancy in Sierra Leone and Liberia after the Ebola outbreak in 2014 and in the DRC in 2019. Similarly, neither pandemics nor restrictive policies alter women's determination to terminate pregnancies, they just add to the risks of these terminations being unsafe.

5.4 We welcome the move by DHSC to allow abortion via telemedicine during the COVID-19 pandemic, but this needs to extend to the whole UK territory, including Northern Ireland. Otherwise, women face stark choices between travelling to seek abortions, defying lockdown, exposing themselves to risk in clinics, seeking an unsafe abortion or continuing with an unwanted pregnancy.

5.5 Maternity services, whilst already disrupted, must not see a reduction in maternal safety or the psycho-social wellbeing of new mothers. Women's inability or fear of accessing maternity care during the Ebola outbreak in 2014 led to an additional excess mortality of almost 4000 women - a number similar to those that died of Ebola that year. Moreover, women may be particularly vulnerable to post-natal depression if regular contact from midwives is interrupted in early post-partum periods.

5.6 These concerns could be mitigated by:

- A range of contraceptives being made (temporarily) available, free of charge, in supermarkets and pharmacies, without a requirement for a prescription for the duration of the outbreak;
- Similarly other SRH needs including HRT treatment and IVF activities must be provided where possible, noting the potential risks;
- Access to medical abortion and telemedicine consultations must be extended to all devolved administrations within the UK, efforts to facilitate this should focus on Northern Ireland; and
- Additional support pathways and care packages should be provided to pregnant women to reduce negative pregnancy outcomes, and this should extend into the post-partum period.

Proposal 6: PPE for Care Providers

6.1 The Government should accelerate and prioritise provision of personal protective equipment (PPE) first to all front line staff working in the NHS, and second to all workers in the formal care sector. Women make up the majority of health care workers in the world. In the UK, women make up the majority of non-medical staff in the NHS, and 80% of adult social care jobs. Formal care work makes women particularly vulnerable to risk of transmission and transmitting COVID-19.

6.2 While we support the Government's position on the need to prioritise PPE provision for frontline staff working in the NHS, given the number of COVID-19 cases and confirmed deaths occurring in care settings, provision of PPE must be wider to reduce women's vulnerability.

6.3 Provision should include:

- Staff in public and private care homes;
- Staff and volunteers working for registered care charities involved in provision of basic needs and in-community and in-home care, e.g. Age UK; and
- Care providers working for and on behalf of local authorities.

Proposal 7: UK Aid for COVID-19

7.1 UK aid has an established record in responding to health emergencies around the world and investing in post-crisis recovery. A strong element of this work has focused on women's health projects to support the United Nations Sustainable Development Goal (SDGs) 3, with specific reference to key targets 3.1 to reduce global maternal mortality, and 3.2 end death of preventable newborn and children under 5 by 2030. UK funding to support global efforts to respond to COVID-19 in low and middle income country partners should continue to safeguard comprehensive sexual and reproductive health services during the outbreak to reduce risk to increased maternal mortality rates, teen pregnancy, sexual violence, and newborn child fatality. These have all been issues of concern in previous outbreaks such as Ebola in West Africa 2014/16.

7.2 We recommend:

- Continued support for existing sexual and reproductive health projects and renewal of funding for flagship projects such as DFID's Saving Lives in Sierra Leone programme.
- Specific budget lines in COVID-19 UK aid to support maternal health clinics, midwives, information, and community health workers in the field.
- Maintain partnerships and provide key emergency funding support to key international and domestic non-governmental organisations working in safeguarding from abuse, sexual and gender based violence response, and free to access sexual and reproductive health services

- Partner domestic security and safe-guarding services to ensure protection of women, children, and vulnerable groups in different types of quarantine.

Proposal 8: Economic impact on women

8.1 COVID-19 is likely to have wide-reaching economic effects nationally, and at the household/individual level. These local effects will likely be gendered, as women are over-represented in lower-paid, zero hours contracts and/or gig economy roles, notably it is these roles which have the greatest exposure to infection to COVID-19. In this instance, women may face a stark choice between continuing to go to work and risk infection, or self-isolating but jeopardising household economic security if they do not earn money.

8.2 Notably, the majority of this work is often done by BAME women, and young women are more likely to work in sectors most affected by the lockdown.

8.3 These roles may lack social protections offered within formal employment contracts, such as enhanced sick pay or childcare aware policies to reduce expectations of output during the lockdown period. This can have long-lasting effects: following the Ebola outbreak, the economic disruption to women was much longer lasting than for men. A real concern is whether this precarious employment means that women may be at greater risk of losing their job or to be furloughed.

8.4 If furloughed, it is not yet clear whether this time will count towards eligibility of the full entitlement of statutory maternity pay, and whether employers may use COVID-19 to reduce enhanced maternity packages. Moreover, parents who have taken time off from self-employment for parental leave should not have this period of maternity pay considered in calculations of average earnings.

8.5 Increased care responsibilities, including unseen domestic labour, childcare and community efforts may reduce women's ability to work at the same capacity whilst under self-isolation (women carried out 60% more unpaid labour than men prior to the outbreak). This can have financial implications if women are also paying for increased costs for having children at home all day, and no free-school meals.

8.6 To mitigate some of the longer-term effects to women's economic security, the Government could:

- Ensure the economic impacts of COVID-19 are sex- disaggregated;
- Offer stimulus packages to families and women directly;
- Ensure financial and employment protections cover those on zero-contract hours and flexible contracts;
- Ensure that furlough does not affect maternity pay or entitlements (and vice-versa);
- Gender analysis of all economic recovery plans and bailout plans, to ensure that it is not only predominantly male-dominated industries which are offered government support and/or bailout, as witnessed in the Financial Crisis 08/09;
- Ensure one of the first industries to re-open as part of the exit strategy is childcare providers to facilitate women being able to return to work;
- Increase Child Benefit to reflect the additional costs on households, and remove the 2 child limit.

About the authors

Professor Sophie Harman (QMUL) has over 15 years of research and teaching expertise in global health politics. She has led research projects and published extensively on global health governance, African health systems, health emergencies, global health financing, and women, gender, and global health. She founded the British International Studies Association (BISA) working group on global health, was a Board Member of the International Studies Association (ISA) global health section and was Chair of the Section's Book Prize (2016-2019), is a Visiting Professor at HEARD, University of KwaZulu-Natal, and has received several awards for her pioneering work (e.g. PSA Joni Lovenduski Award for Outstanding Professional Achievement for a mid-career Scholar). She has worked as a consultant to UNDP and WHO. Her current work on COVID19 is as advisor to a CIHR grant on gender and COVID19; a collaborative project with the Fawcett Society, Women's Budget Group and LSE on the gendered impacts of the outbreak on women; and the Mile End Institute Global Health Security series.

Dr Clare Wenham (LSE) has 10 years+ experience of research and teaching in global health security and outbreak response. Her research has focused on the politics and policies of health emergencies including on pandemic flu, Ebola and Zika. Most recently she has led a Wellcome Trust funded project examining the impact of Zika on reproductive rights, and the failure to mainstream women's needs into global health emergency policy. She is an associate academic at Georgetown University Center for Global Health Science and Security, the Vice-Chair of ISA global health section. At LSE she is the Programme Director of MSc Global Health Policy, and sits on the board of LSE's Global Health Initiative. She has consulted for Wellcome Trust, Asian Development Bank and formally worked in policy at an NHS Trust and the Faculty of Public Health. For COVID-19 she is co-PI on a CIHR funded project to understand the gendered effects of the outbreak in China, Hong-Kong, Canada and UK and as a collaborator on a project with Fawcett Society, Women's Budget Group and QMUL.

April 2020