Written evidence submitted by Eleanor Glanville Centre, University of Lincoln (MRS0204)

1. Response to the Inquiry - Unequal Impact: Coronavirus (COVID-19) and the impact on people with protected characteristics

1.1 The Eleanor Glanville Centre (EGC) at the University of Lincoln welcomes the opportunity to submit its views on the unequal impact of COVID-19 on people with protected characteristics.

1.2 In this submission we respond primarily to question 2 of the Inquiry regarding the impact of COVID-19 and provide our recommendations regarding reviewing the measures.

2. ABOUT THE ELEANOR GLANVILLE CENTRE

2.1 The EGC is the University of Lincoln's department for diversity and inclusion. Led by Professor Belinda Colston, the EGC specialises in the development and evaluation of EDI strategies and interventions, and their impact across the sector. We carry out interdisciplinary research that critiques and challenges social exclusion and inequality in contemporary society, exploring issues of, and connections between, gender, race, ethnicity, sexuality, class and disability. Outcomes of our research inform and influence evidence-based policy and shape best-practice both within the UK and internationally.

3. BACKGROUND

3.1 COVID-19 is throwing a spotlight[1] on the structural inequalities in our society, and in many cases entrenching them. The virus has impacted, and will continue to impact, different groups in society in differing ways. A number of analyses of class, disability, race, and gender are emerging[2].

3.2 Our submission highlights the unequal impact on women and black and minority ethnic (BAME) groups. Our overall recommendation is that the government urgently moves to consider protected characteristics using an **intersectional** approach**,** rather than by individual protected characteristic.

4. SUBMISSION

4.1 In this submission we respond primarily to question 2 of the Inquiry regarding the impact of COVID-19 on people with protected characteristics and provide recommendations regarding reviewing the measures. We focus specifically on the **gendered and raced impacts** of COVID-19 and the response to it. Our submission is not exhaustive and relates primarily to the areas in which we have academic expertise.

4.2 Specific impacts of COVID-19 on people due to them having a protected characteristic

4.2.1 Our research, and that of others, indicates that women and BAME groups are more likely than others to experience negative health, financial and labour impacts as a result of COVID-19.

4.3 Health Impacts

4.3.1 While men have been shown to be more likely to die from the disease than women, BAME groups (including both BAME men and women) have been disproportionately more likely to die than white people[3]. Furthermore, those living in care homes and in the community are not accurately represented in the current death figures. Until England and Wales records ethnicity data in death certificates, a racially accurate analysis of deaths due to COVID-19 is impossible. Past pandemics have highlighted the importance of incorporating gender and ethnicity analysis into the preparation and implementation of institutional response to improve the effectiveness of health interventions and promote health equity goals[4,5].

4.4 Labour Impacts

4.4.1 Women and some ethnic minority groups are over-represented in the human health and social work sector which is at the frontline of fighting the virus. ONS data[6] show that 22.4% of all women workers and 27.3% of workers from a Black or Black British background are employed in the sector, compared to an average 13.3% of the total workforce. Access to personal protective equipment (PPE) that fits correctly is an issue for the many health workers (and others) that require it. PPE that fits correctly is critical if it is to be effective[7]. It has been established for some years that PPE has a gender gap[8], resulting from PPE being designed for the average man.

4.4.2 Our research has examined the combined effects of race and gender in entrenching inequalities. Outside of the health sector, anecdotal data suggests that non-white people, working class people, and women make up the majority of care workers, cleaners, bus drivers and taxi drivers in urban areas. These workers are encountering large numbers of the public and are not prioritised for PPE[9]. Insufficient or non-existent sick pay and precarious contracts push them to work when it is physically unsafe for them to do so. For example, unions have previously reported high proportions of insecure workers working while unwell for fear of losing work[10]. The lack of investment in these precarious workers also exacerbates narratives that people of colour are less worthy than others, and that they are, moreover, disease-spreaders.

4.4.3 In many sectors, including our own (higher education), women and BAME groups are more likely than men to be on insecure, temporary, and low-paid contracts[11]. This means that even among professionals, there may be disproportional impacts among those with protected characteristics. Some of these effects may be long-term, with consequences for career progression. For example, anecdotal evidence suggests that journal editors are receiving fewer submissions than women[12].

4.5 Housing Impacts

4.5.1 The quality of housing has exacerbated differences between women who live in safe, spacious accommodation and those from lower incomes. Bangladeshi and Black families are more likely to be housed in low-quality, high occupancy social housing[13], thereby exacerbating stress levels and childcare responsibilities for women in these groups during the pandemic.

4.5.2 The message to ‘stay home, save lives’, assumes that the home is a place of safety, but for many women that is simply not the case. A rise in domestic abuse has been documented during previous crises or natural disasters[14], and early indications are that COVID-19 is no different[15]. Self-isolation and social distancing will allow perpetrators of domestic violence increased opportunity for coercive control and has shut down routes to safety and support[16]. Stress, alcohol consumption, and financial difficulties are all considered triggers for violence in the home. The job and income losses experienced as a result of the pandemic are also likely to aggravate financial instability, which has the additional burden of making it harder for those experiencing domestic violence to leave.

4.6 The Second Shift

4.6.1 COVID-19 highlights the full breadth of what women are responsible for on a day-to-day basis. Women still take on the physical and cognitive burden of running the home and the pandemic has increased their unpaid domestic responsibilities which take place after the working day has ended. This ‘second shift’ includes the planning and execution of tasks such as food shopping, laundry, newly essential home supplies (hand sanitizer and wipes), cooking and cleaning (which are more burdensome as everyone is at home all the time), social organising (Zoom parties and FaceTime playdates), homework and communicating with schools and watching over or supervising (babies, children, elderly relatives). Our research demonstrates that the overall mental and emotional responsibility aspect of childcare is resistant to change even among couples where the father is the primary caregiver[17]. As a consequence, the overlapping working hours and cognitive burden of childcare can also affect women who previously had an equal division of childcare and housework or where their partners were the primary caregivers.

4.6.2 For those women who are able to work safely from home, they may be juggling home schooling alongside working from home. Our research, for example, has shown that in heterosexual, couple households men and women have very different patterns of working from home. On average, women tend to do fewer hours work at home, with work interspersed around other activities like domestic work and childcare. Men, on the other hand, are much more likely to work full-time hours, shut away in a home office, maintaining productivity levels[18]. Nevertheless, the increase in fathers staying and spending more time at home through the lockdown, may present an opportunity for them to be more involved in housework and childcare and future research will be required to examine the extent to which COVID-19 has reinforced or disrupted gender divisions of labour.

4.6.3 For those women in key worker roles, in health, social care and food services, there are different challenges. While some will benefit from the decision to keep schools open for children of key workers, this only solves part of the problem. Four in 5 women[19] working in these sectors don’t work standard hours, and with no grandparent care available, the childcare strain for these families increases. This is particularly true for the 65% of Bangladeshi and Pakistani women who are unemployed, compared to 27% of white British women and 21% of white British men[20]. Many women will be unable to work from home and juggle childcare. For many this means taking unpaid leave; but as women are over-represented in low paid, precarious work[21], many do not have access to adequate paid sick leave. This is problematic for the

many working families, especially working single parents, who were experiencing poverty at increasing rates[13] even before the pandemic struck. As women represent the majority of single parents, they are at higher risk of poverty or social exclusion[22,23] and the pandemic is likely to increase that risk.

4.7 Digital exclusion

4.7.1 The need to physically distance from others highlights our increasing reliance on technology. In 2019, 5.3 million adults (10% of the adult population), more than half of whom were women, had little to no access to the internet[24]. The 2019 Lloyds Digital index[25] showed that women were less likely to have essential digital skills than men, and that one of the groups most at risk of digital disengagement were ethnic minority groups aged over 40. Lack of access to the internet and a lack of digital literacy impacts on a person's ability to work from home, to home-school children, to do online food shopping (especially important for those at high risk from the virus), and to stay socially engaged with friends and family.

4.8 Raced responses to COVID-19

4.8.1 Early responses indicate that the pandemic is exacerbating existing prejudices, including Islamophobia, with fake news circulating about mosques remaining open[26]. Raced reporting on minority groups is in evidence: for example, the Police and Crime Commissioner for West Midlands stating that the spike in infection rates in the West Midlands was due to households who do not speak English[27] and would be unaware of the social isolation restrictions. The implication is that certain minority groups are ignorant and more likely than others to spread the virus. No mention was made at the time of the lack of contact tracing which would allow accurate statements about who has the illness in the West Midlands, and how it spreads. Regional variances in police force responses to stopping members of the public on the street have the potential to exacerbate the widespread mistrust of the police by non-white and working-class communities. The whiteness of the UK government's response, compounded by a lack of consultation, has led to the naming of the new hospitals after Florence Nightingale (a white heroine of the British Empire), rather, than Mary Seacole, a Black British nurse who the Government recently tried to remove from the school curriculum. Whitewashing the medical response to the pandemic is an inevitable result of excluding marginalised voices from national decision making.

5. Reviewing the measures

5.1 What needs to change or improve, which could be acted on in three weeks' time:

5.1.1 Ensure that race and ethnicity data is captured on death certificates in England and Wales. The categories used should be consistent with the 18 categories recommended by the UK government[28].

5.1.2 The Government must increase funding to shelters for women to be able to respond to the increased numbers of domestic abuse cases.

5.1.3 Risk management measures should be implemented and involve the police, justice and health sector in order to guarantee a coordinated response to the increased risk of domestic violence.

5.1.4 Adequate PPE must be provided to vulnerable workers, including those on zero-hour contracts.

5.1.5 Eligibility for, and rate of, Statutory Sick Pay must increase, in line recommendations from the Women's Budget Group[29].

5.1.6 The Government should guarantee affordable and accessible childcare (not just school-based) for parents who are essential workers.

5.1.7 Financial support for families, especially single parents, to assist with childcare and other household expenses alleviating some of the financial hardship, especially in light of potential job losses in relation to COVID-19.

5.1.8 Minority groups who are at higher risk of discrimination and social exclusion need to be identified and targeted measures must be designed to mitigate those risks.

5.1.9 Clarify the ethnic and gender makeup of the Scientific Advisory Group for Emergencies secret (SAGE) committee and ensure that further appointments include BAME representation to advise on improved public health information, culturally appropriate and accessible support, and development of trust with BAME communities.

5.2 What needs to change or improve, which could be acted on in 6 months' time:

5.2.1 Guarantee that the long-term and indirect impacts of COVID-19 for those with protected characteristics continue to be monitored far beyond the end of the immediate crisis.

5.2.2 Ensure that gender, ethnicity and other data relating to protected characteristics is routinely captured in data that enables us to accurately measure the impact of COVID-19 on different groups, including intersectionally. For example, the ONS' 'Employment by Industry: Labour Force Survey' which is published quarterly only includes one dataset disaggregated by ethnicity in response to a specific user request[30] . There is no data disaggregated by gender and race.

5.2.3 The economic measures adopted to respond to the 2008 financial crisis had a disproportionately negative impact on women. COVID-19 economic recovery measures should take into account the different impact the pandemic has on women, men and minority groups and be designed accordingly. A gender and raced analysis of proposed interventions would support this.

5.2.4 Greater diversity of journalists, including citizen journalists, on broadsheet journalism and more meaningful engagement of BAME media outlets by the government.

5.2.5 A commitment to equality, diversity and inclusion, that ensures EDI does not fall off the agenda of government and business, if the UK experiences a sustained economic downturn as a result of COVID-19, as has been the case in previous recessions[31].

6. CLOSING

6.1 We are happy to provide further information or clarification on any of the recommendations made. We would also be happy to present this evidence online or in person at any hearings. We are very interested in the content of this enquiry and the questions it is asking. We would like to be kept informed of any findings, publications or future work in relation to the subject.

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