

Gender and the COVID-19 pandemic: Multinational research indicate that we must support and compensate LMIC women's leadership in crises

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These three years under the COVID-19 pandemic have yielded rapid scientific advancements for management of outbreaks and reduction of hospitalizations and deaths.¹ However, despite early recognition of gender inequalities and gendered social and mental health impacts of the pandemic,² efforts to address these gendered impacts have received less focus, both in terms of research and policy. This series sought to fill this gap with new research focused on low middle income countries (LMIC) contexts. Findings from this work offers important implications for policy efforts toward pandemic protectiveness and gender equality and empowerment.

The first paper, from McDougal et al.,² positions the series as a whole by offering a bibliometric analysis of gender and COVID-19 research, with a focus on health effects beyond infection as well as social and economic outcomes. Their review of papers published on gender and COVID-19 in LMICs from February 2020 to May 2021 shows rapidly generating research during this time, but predominantly written by authors affiliated to high-income countries (HICs). Importantly, this research, conducted in the first year of the pandemic, relied on convenience samples due to data collection difficulties, showed poorer mental health effects of the pandemic on females, impediments to uptake of reproductive and maternal health services, and concerns of increased vulnerability to household violence and control. Demonstrated unequal domestic labor burdens and financial stressors were contributors to these health and safety outcomes for women and girls. Research included in this series aligns with and extends upon these findings with further contextualized insights, and with authorship inclusive of – and in many cases led or senior authored by – LMIC scholars based in the nations of study.

With regard to healthcare needs and services, we continue to see unmet needs for women and girls, but with more clarity on how these unmet needs are due to

both infrastructure issues as well as deprioritizing of women and girls in households. Woods' study with adolescent girls and young women in urban Kenya shows that poorer access to menstrual supplies during the COVID-19 pandemic was due to both supply availability and also due to families choosing against purchasing of menstrual supplies while financially strained.³ Similarly, Dey et al.'s⁴ research with young married women in rural India found that concerns regarding health system capacity and greater increases in household burdens during the pandemic were associated with lower likelihood of women seeking care for themselves or their children. Global research also shows growing violence against health workers, a predominantly female population globally, and here again, the infrastructure burdens and patient stresses combined with devaluing of women and particularly women caregivers give rise to these abuses.⁵

Economic and domestic labor stresses are also contributors to gendered social and health impacts from the pandemic. As with prior research, studies in this issue from Williams et al.⁶ and Oakley et al.,⁷ respectively, document gender unequal labor burdens among adolescents in Kenya, Ethiopia, Jordan, and Palestine. These studies with adolescents both show that females more than males took on unpaid domestic labor and caregiving, while males more than females took on more paid labor or agricultural work.^{6,7} Notably, girls faced more constraints related to their social connectivity and entertainment in the household as a consequence of the pandemic and greater presence of male household members.⁷ These findings may explain the differential mental health effects seen for girls relative to boys under the pandemic.² These findings with adolescents correspond with those seen in Allard et al.'s study with migrant adults returning from urban centers to their rural communities due to the pandemic in India. Migrant women compared with migrant men in India were more likely to remain in their home villages and to remain unemployed over the pandemic, and they faced greater longer-term economic hardships and food insecurity.⁸ These disproportionate socio-economic vulnerabilities for females relative to males may have long-term health impacts beyond just mental health.

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While there are some relatively worse consequences of the pandemic for females compared with males, findings also show the important role women have in pandemic management and rebuilding. Research from Northern Nigeria documents that even in this context of lagging progress for women and poor infrastructure generally, women health care workers are working alongside with the more numerically dominant male workforce in this region to ensure care.⁹ In this context, we also see female more than male health workers contending with increased domestic labor responsibilities during the pandemic, but male health workers are undertaking seven rather than five-day work weeks to provide care.⁹ While this constitutes more earning for males, it also highlights that gender unequal burdens and risks harm both women and men. Household burden explains some of the observed gender difference in workdays seen for Nigerian healthcare workers in India. We see similar findings from Priyadarshini et al.'s¹⁰ study with locally elected women in rural India, where again, these women are highly instrumental in COVID-19 management and social and welfare supports during the pandemic, and those who receive greater instrumental support from their families for both their work and domestic labor are more productive. These findings offer an important entrée to consider how policies might provide domestic labor supports for frontline crisis workers, a largely female population, and normative change might help build better gender balance on paid and unpaid labor burdens.

In sum, the COVID-19 pandemic has taken a serious toll on our health and socioeconomic well-being globally, and in disparate ways based on gender and other social determinants of health. We see that traditional gender roles and the unequal value and treatment of women and girls relative to men and boys were exacerbated during the pandemic, and these led to resultant harms. Yet, we can also see emergence of women's leadership in managing the pandemic, which can offer important opportunity for us to restructure crisis responses to be more gender equitable and more positive. If we can increase financial compensation, structural supports including those for unpaid domestic labor responsibilities, and social value for women's work, we will not only have a stronger system of workers for crisis

management, we will also be able to support more gender equitable societies and responses to crises.

Contributors

A.R. conceptualized and wrote this commentary.

Declaration of interests

Author has no conflicts of interest to report.

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