COVID-19 and the gender paradox

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Back in 2008, David Fidler coined the term ‘the gender paradox’, which he described in the following terms: ‘We perceive that problems concerning women’s health . . . are growing at the same time that gender-informed analysis of global health issues has become more pervasive’ (Fidler, 2008: 148). He goes on to describe an inverted triangle within global health where there are numerous standards related to women’s health, but little incorporation of these into organizational practices or national implementation, and even less evidence of improved health outcomes for women. The response to COVID-19 has taken the gender paradox to a new level. We see unprecedented attention to the gendered effects of pandemics, in terms of not only health effects, but also the disproportionate social and economic impacts on women, yet little progress in rectifying these inequities (Harman, 2021). In this brief comment, I share two examples of how the gender paradox plays out in policy spaces – both global (the World Health Organization (WHO)) and national (Canada) – and then reflect on what can be learned in order to overcome barriers to transformative change.

The WHO is mandated by the International Health Regulations to lead and coordinate responses to Public Health Emergencies of International Concern. While not an implementing organization, WHO provides technical guidance and holds normative power in its ability to set standards and champion agendas within global health; as such, its leadership in promoting gender-sensitive health responses is paramount (Wenham and Davies, 2021). The WHO has demonstrated some follow through on its commitments to mainstream gender (adopted in its Gender Strategy in 2008 and continued in the 13th General Programme of Work 2019–2023) in its COVID-19 response. In May 2020, it released a Gender and COVID advocacy brief and issued guidance on monitoring the unintended consequences of public health lockdowns, including gender-based violence and access to sexual and reproductive healthcare (WHO, 2020). Partially in response to pressure from organizations like Women in Global Health, as well as feminist advocates within and outside the organization, WHO Director General Dr. Tedros Adhanom Ghebreyesus met with civil society organizations, in September 2020, and

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discussed forming a Gender and COVID-19 Working Group. In July 2021, he reiterated WHO’s commitment to gender equality at the 2021 Gender Equality Forum in Paris (Relief Web, 2021). Yet, below this high-level activity, an analysis of WHO COVID-19 policy documents found only 20% explicitly mention gender equity and over half do not mention gender or sex differences (Tomsick et al., in press). Furthermore, most documents focus only on the experiences of women and girls, as opposed to people of all genders, and on sexual and reproductive health, as opposed to the broader gendered determinants of health. This raises questions as to whether WHO (2019) is meeting its own standard of gender mainstreaming, defined as ‘assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels’. The WHO is responsible not only for setting global standards within the pandemic response, but also demonstrating commitment to and providing guidance on meeting them; when it fails on the second part of this equation, the legitimacy of the broader gender equity agenda is threatened.

Much of the responsibility for implementing pandemic response lies with the state. I am writing this from the privileged position of Vancouver, Canada, where our federal government has instituted a policy approach termed gender-based analysis plus (GBA+). Reflecting its long-standing commitment to GBA+, Canada ranks, among 30 comparable countries, as leading on domestic commitments to gender-responsive COVID-19 action (CARE, 2020). The United Nations Development Programme (UNDP) and UN Women (2021) COVID-19 Gender Response Tracker identifies 19 gender-sensitive COVID-19 measures at the federal level, putting Canada among the top 10 countries in terms of number of measures. The federal government has described its response as ‘feminist’, and women, including racialized women, fill key positions within COVID-19 leadership (WAGE, 2021). Feminist organizations produced an economic response plan, which directly influenced the September 2020 budget allocations for the COVID-19 response (Piscopo, 2021). The pandemic has created a policy window, following decades of feminist advocacy, through which we finally see the announcement of a national childcare strategy.

However, despite this high-level progress, women (particularly racialized women) have been disproportionately forced out of paid employment due to increased care burdens and COVID-19’s impacts on female dominated sectors (Knight et al., 2021). A gender mental health gap has also emerged, with women reporting higher levels of anxiety and loneliness than men, and parents experiencing higher levels of depression compared to those without children (CAMH, 2020). Meanwhile, at the foreign policy level, despite its Feminist International Assistance Policy, Canada is (at the time of writing in September 2020) one of the worst offenders in terms of stockpiling vaccines and failing to meet COVAX commitments – having only delivered 2 million of the 40 million doses promised (Our World in Data, 2021). This vaccine nationalism denies lower- and middle-income countries one of the most effective tools to overcome the secondary gendered effects of the pandemic and protect healthcare workers, the majority of whom are women. If Canada’s response is among the most gender-sensitive, the bar is pretty-low.

Considering the continued limits of translating increased awareness about COVID-19’s gender effects into comprehensive policy adoption that improves the lives of women, the question becomes how do we overcome the COVID-19 gender paradox? While this question requires greater space and deliberation than is available here, two initial lessons emerge from the examples above.
Lesson 1: Global health hierarchies need to be reorganized. Harman (2021) writes that the COVID-19 response reflects ‘the hierarchies of the global health issues that matter, the people that matter and the women that matter’. Global vaccine inequity is a stark reminder of which people matter. While it is not surprising that countries like Canada have privileged their own populations’ vaccine access, lack of support for global vaccine access is incompatible with feminist claims as it denies women living in those areas without access, such as most of Sub-Saharan Africa, the health security essential for empowerment. Within the COVID-19 response, those gender issues historically associated with western-based women’s rights movements remain prioritized, such as gender-based violence (as has been the case in Canada) and sexual and reproductive health (as has been the case within the WHO). While both require sustained attention, research on gender and COVID-19 also demonstrates dire disparities in economic security, unpaid care burdens and mental health, among other issues, which remain neglected. For example, the UNDP/UN Women Gender Response Tracker has recorded 1299 gender-sensitive measures globally, but only 180 focused on unpaid care, a policy issue that particularly affects women experiencing compounded inequities, such as those living with disabilities and undocumented migrants. A hierarchy based on social justice principles would privilege the needs of those most at risk and affected, and respond first to issues they deem most important.

Lesson 2: The above can be fostered through stronger links between gender equality organizations and global health organizations and governments, and by increased presence of feminists and feminist approaches within global health governance; this requires institutional change. What progress has been achieved both within the WHO and in Canada can be largely attributed to the influence of those committed to gender equality within the institution/government and the external influence of feminist organizations. Piscopo (2021) demonstrates the importance of this combination in multiple contexts, including the need to intensify relationships between feminist advocates and decision-makers. However, the participation of (or consultation with) women does not guarantee action to address gender inequities, and can be limited by formal and informal rules and institutional cultures, as well as women’s disproportionate share of unpaid care work, which reduces time for participation. In addition to representation, there needs to be greater acceptance of feminist expertise and approaches, and redress of the institutional barriers to meaningful participation of traditionally excluded groups in global health forums (Wenham and Davies, 2021).

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1. The tracker defines gender-sensitive measures as those that ‘seek to directly address the risks and challenges that women and girls face during the COVID-19 crisis’. (UN Women, 2021: 1).
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