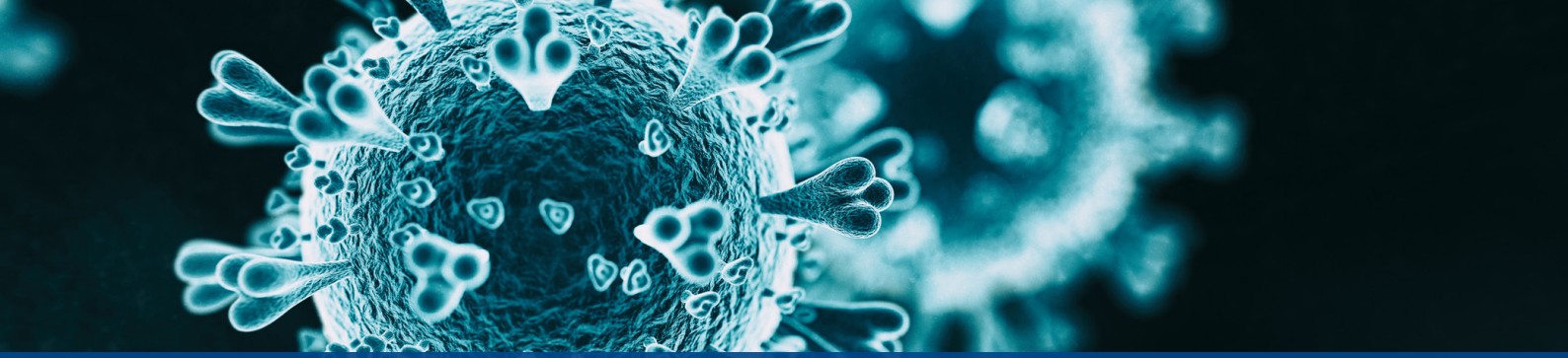


Beyond sex and gender analysis: an intersectional view of the COVID-19 pandemic outbreak and response

Policy Brief | Olena Hankivsky, PhD | Anuj Kapilashrami, PhD

In this COVID-19 pandemic, emerging popular refrains like **'we're all in this together'** and **'we will come through this together'** echo across media. But who is this 'we'? While it's true that the entire globe is being affected, health risks, burdens, experiences and outcomes aren't the same for everyone. The outbreak has prompted calls to better understand its differential impacts. For example, UN General Secretary António Gutteres has appealed for consideration of women's needs in combatting COVID-19. Others have criticized the gender-neutral approach to pandemics in general, including the **lack of gender expertise** in pandemic planning, outbreak response and post-pandemic recovery.[1] Still others note that gender analysis should be a 'reflex' embedded in all global health emergency responses.[2] There are also competing calls to attend to migrants' needs and those of disabled people. Policy makers face dilemmas, then, regarding whose needs should be prioritised in the pandemic response.

Yet, simply prioritising women and building in a sex-and-gender focus won't paint the full picture of COVID-19's impact or provide us with enough information in order to fully address it.

Why a focus on sex or gender differences is not enough?

When only impacts on 'women' or 'men' are considered, there is a risk of homogenizing otherwise diverse experiences and reducing analysis to the simplistic messaging that 'pandemics affect women and men differently.' A narrow gender focus can reinforce binary and competing understandings of the burden posed by COVID-19 on women versus men. An analysis of COVID-19 reduced to sex and gender differences can exclude or not adequately account for critical factors such as **age, geography, disability, race/ethnicity and Indigeneity, migration/refugee status, class**, and other structural conditions, including **precarious housing, employment**, and **political** and **environmental** stressors.

For the 'pandemic era in which we live'[3] a more sophisticated analysis is required. This analysis should indeed **capture experiences of different groups of women, men and gender diverse people**. It must map pathways through which gender roles, patriarchal norms and relations are reinforced or disrupted throughout the outbreak and its responses. But gender must be recognized as an intersecting component of wider structural inequalities. What is needed is a nuanced understanding of sex and gender based on an intersectional analysis and not a silo approach to tackling single-axis vulnerability.

What is Intersectionality?

Intersectionality promotes an understanding of human beings as shaped by the **interaction of different social locations**, e.g., 'race'/ ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion.

These interactions occur within a context of connected systems and structures of power, e.g., law, policies, state governments, religious institutions, media. Through such processes, interdependent systemic bases of privilege and oppression derived from colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.[4]

Produced by Olena Hankivsky[1], PhD | Anuj Kapilashrami[2], PhD
[1]Melbourne School of Population and Global Health, The University of Melbourne
[2] Centre for Global Public Health, Queen Mary University of London

THE UNIVERSITY OF MELBOURNE

Queen Mary University of London
Global Policy Institute

Intersectionality approaches have gained traction in global health as a way to **analyze and address the interplay between different vulnerabilities and advantages** – including those related to gender – by trying to uncover complex social factors and power structures that create and sustain them.[5] Intersectionality can also facilitate links across single-group campaigns to open the power of solidarity and coalition building to tackle social and health inequities. The scale of the COVID-19 outbreak – with 1/3 of the world's population under some form of lockdown – urgently **requires an intersectionality informed approach to public health policy and decision making**. An intersectionality analysis allows for more nuanced understandings of how intersecting factors and processes of power across geopolitical contexts shape risks, needs, experiences and capabilities of differently situated women and men.

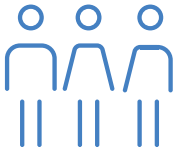
Distribution of COVID-19 risks illustrates the importance of an intersectional approach:

Age/health status

Early data shows elderly people and those with pre-existing health conditions are most vulnerable and least likely to recover.[6] This demands foregrounding age and health status. Health status is determined by a broad set of social determinants, including income, education and access to nutrition.

Disability

People with disabilities often have underlying health conditions and are more likely to be poor, making them more susceptible to serious illness or death if they contract COVID-19.[7]



Sex/Gender

To date, while both sexes appear equally at risk, proportionally more males than females die of COVID-19. Emerging assumptions are that this is due to sex-based immunological differences, as well as smoking and drinking patterns, and general poor health, which are amplified in low- and middle-income countries.[8] Frontline health and social care providers, the majority of whom are women (70% globally), as well as those providing essential services have a disproportionately high risk of infection as well as transmitting the disease.[9]

Socioeconomic status

Poor people, homeless people, and those engaged in precarious work (e.g. service, tourism) and unemployed people, especially in low income countries and communities, bear the brunt of the pandemic. This includes not being able to secure basic needs such as food, shelter and necessary social and health services.[10]

Indigeneity

Living in remote locations with little access to health services, overcrowding in housing, poverty, and underlying health conditions such as cardiovascular disease and diabetes, can make some Indigenous populations particularly at risk should COVID-19 reach their communities.[11]

Migration status

Migrants, refugees and internationally displaced persons remain at heightened risk.[12] Population-dense environments they inhabit, including conflict zones and refugee/detention camps with poor amenities make social distancing and other preventive measures impractical and medical resources scant.

Geographic location

Populations living amidst urban density, near transport hubs, or in areas that see high levels of population movement/tourism may be more exposed.[13] Different levels of strength in health and social protection systems affect treatment, outcomes and abilities for recovery. In lower resourced regions, characterized by weak and under-funded health systems, outcomes may be poorer and impacts more severe.[14]

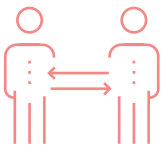
Olena Hankivsky, PhD | Melbourne School of Population and Global Health, The University of Melbourne
Anuj Kapilashrami, PhD | Centre for Global Public Health, Queen Mary University of London

Race/ethnicity

Studies report a higher burden of cardiovascular, diabetes and other chronic diseases among racial and ethnic minorities. A number of risk factors – from biological to social and environmental – underpin these differences and place them at greater risk of more severe illness from COVID-19.[15] Further, the assumption that COVID-19 belongs to or was caused by a race of people (e.g., references to the 'Chinese' or 'Wuhan virus') has led to increased stigma, discrimination and violence.[16]

Risk factors do not operate in isolation. Different factors intersect in different ways to shape experiences of COVID-19. Intersecting factors are, in turn, embedded in sociopolitical processes and power structures that create disparate risks and exposures for different people. These processes and structures include globalization, capitalism urbanization, climate change, patriarchy, racism and xenophobia.

Disparate Impacts:



Quarantine, self-isolation and physical distancing

Overcrowding, precarious housing and living in shelters make self-isolation especially difficult for poor, minority populations and for people in low- and middle-income countries. Migrants in camps and detention facilities, people living in poverty and homeless people may be unable to access resources needed for preventive measures (e.g., hand sanitizers and water for hand washing) or practice quarantine or social distancing.[17] In addition, quarantine measures pose significant risks for women and children experiencing domestic abuse. Reports from several countries, including Australia, China, Brazil, Germany and the UK, show increased rates of sexual violence and abuse against children, adolescents and women in these conditions.[18] Others note the potential for increased abuse against people with disabilities and elderly people as care workers become stressed and overworked.[19]

Unemployment

The International Labour Organization estimates that up to 25 million jobs will be lost globally, with certain groups bearing the brunt of unemployment, including youth, older workers, women, migrants, low-paid workers and service-sector workers.[20]

Increased care work

Care responsibilities predominantly fall on the shoulders of women. However, women differ in access to resources that assist with this burden (e.g. lower savings, more responsibilities, and less support in carrying out the care work they are suddenly burdened with). In Canada, the pandemic has been predicted to "hit people facing intersecting forms of discrimination the hardest: Indigenous women, racialized women, newcomers, women with disabilities, lone parents."[21]

Resource deployment can jeopardize critical health and other services for vulnerable groups

As governments prioritise COVID-19, critical services and needs are at risk of being sidelined. For instance, sexual and reproductive health (SRH) services, as well as services for migrants and refugees, as evidenced in countries like Poland and the US. For example, Texas and Ohio have classified abortion services as non-essential.[22] Interruptions are not limited to SRH, however. Other lifesaving services in hospitals and emergency rooms are also compromised due to pressures stemming from COVID-19.[23]

Olena Hankivsky, PhD | Melbourne School of Population and Global Health, The University of Melbourne
Anuj Kapilashrami, PhD | Centre for Global Public Health, Queen Mary University of London

Recommended actions:

Move beyond sex disaggregated data using a gender perspective

When attempting to capture differing rates of infection and outcomes, data collection should not be limited to sex disaggregated data. Biological explanations need to be integrated with other social factors, including but not limited to gender norms and roles and behaviours (e.g., smoking tobacco and drinking alcohol). Burden of disease is not only gendered, but rather, overlaid with other factors, such as age, health status, disability, occupation, socioeconomic status, migratory status and geographic location.

Collect diverse data

Data must be generated from diverse sources (governments, practitioners, civil society) in order to yield a true, global picture of the pandemic beyond what occurs in the global north and countries with more advanced surveillance systems. Governments and research councils across all countries must prioritise partnerships with researchers in academic and third-sector institutions in order to generate national and regional case studies using qualitative and mixed methods. This work should document different lived experiences, health needs and interactions and include the voices of those affected.

Contextualize data

In reporting the effects of pandemics, individual and group experiences must be placed in broader contexts. Social forces, which include socioeconomic and political context, governance, policy, and cultural and societal values and norms, influence a person's social location within their household, community and the wider health system. Special consideration should be given to how COVID-19 is exacerbated by globalization, capitalism, urbanization, war, conflict, climate change, racism and xenophobia.

Undertake an intersectionality analysis of national and global responses[24]

Pandemic responses at the national and international levels (e.g., WHO) and related budget support plans must go beyond the inclusion of a gender dimension and gender experts, to include expertise in human rights and an analysis across factors such as disability, age, race/ethnicity, migration status, socioeconomic status, and geography.

Broaden bailout and stimulus packages to prioritise those most at risk

We join calls (e.g., by the European Public Health Association, People's Health Movement, EQUINET) for the extension of amnesty provisions to include migrants. Special protection measures are also required to respond to increased caregiving, violence and decreased access to SRH services considering how differently positioned women experience discrimination, domestic violence and access to health services and social supports.

Make policy responses cross-sectoral

Special attention must be paid to ensuring that policies across sectors are coordinated to advance global public health and attain the highest possible level of health as a human right. Relevant sectors shaping health beyond health systems include education, social protection, housing, labour and legal services. Health and communication messages must be tailored for specific contexts and language needs using culturally accepted on- and offline modes of information transfer and exchange.

Move beyond a deficit model

Decision makers should emphasize resourcefulness, resilience, agency and strength. They should also prioritize engagement mechanisms among affected populations, particularly those who despite greater risks may possess strong political and social awareness and collective organizations and coalition building experience and insights.

Commit to leadership diversity

To date, policy making has been dominated by white, Christian, cis-gendered, heterosexual, able-bodied wealthy men. Women from low- and middle-income countries comprise just 5% of leadership positions in global health organizations.[25] In reversing that trend, and by making national and international policy spaces truly representative, substantive participation of women and people from minority caste, religious, ethnic/ race backgrounds could positively impact the health of millions in the future.

Olena Hankivsky, PhD | Melbourne School of Population and Global Health, The University of Melbourne
Anuj Kapilashrami, PhD | Centre for Global Public Health, Queen Mary University of London

Reference list

1. Wenham, C., Smith, J., & Morgan, R. (2020). COVID-19: the gendered impacts of the outbreak. The Lancet, 395(10227), 846-848; Lowry Institute (2020). Why gender matters in the impact and recovery from Covid-19. The Interpreter, March 20, 2020. Retrieved from: https://www.lowyinstitute.org/the-interpreter/why-gender-matters-impact-and-recovery-covid-19; CARE. (2020). Gender Implications of COVID^19 Outbreaks in Development and Humanitarian Settings. Retrieved from: https://reliefweb.int/sites/reliefweb.int/files/resources/Gender%20implications%20of%20COVID-19%20outbreaks%20in%20development%20and%20humanitarian%20settings.pdf
2. Soumya Swaminathan, Chief Scientist at WHO, cited in: Willmer, G. (2020). 'Gender blind' coronavirus policies could hinder disease fight. SciDevNet, March 16, 2020. Retrieved from: https://www.scidev.net/global/gender/news/gender-blind-coronavirus-policies-could-hinder-disease-fight.html
3. Morens, D. M. et al. (2009). The persistent legacy of the 1918 influenza virus. New England Journal of Medicine, 361(3), 225-229.
4. Hankivsky, O. et al. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International journal for equity in health, 13(1), 119.
5. Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. The Lancet, 391(10140), 2589-2591.
6. Wang, W., Tang, J., & Wei, F. (2020). Updated understanding of the outbreak of 2019 novel coronavirus (2019-nCoV) in Wuhan, China. Journal of medical virology, 92(4), 441-447; Ruan, Q., et al. (2020). Clinical predictors of mortality due to COVID-19 based on an analysis of data of 150 patients from Wuhan, China. Intensive Care Medicine; Porcheddu, R., et al. (2020). Similarity in Case Fatality Rates (CFR) of COVID-19/SARS-COV-2 in Italy & China. The Journal of Infection in Developing Countries, 14(02), 125-128.
7. Dickinson, H, & Kavanagh, A. (2020). People with a disability are more likely to die from coronavirus – but we can reduce this risk. The Conversation, March 25, 2020. Retrieved from: https://theconversation.com/people-with-a-disability-are-more-likely-to-die-from-coronavirus-but-we-can-reduce-this-risk-134383
8. The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team. (2020). The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) — China, 2020. CCDC Weekly, 2(8), 113-122; Wenham, C., et al. (2020). COVID-19: the gendered impacts of the outbreak. The Lancet, 395(10227), 846-848; Chen, N., et al. (2020). Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. The Lancet, 395(10223), 507-513; Rabin, R.C. (2020). In Italy, Coronavirus Takes a Higher Toll on Men. New York Times, March 20, 2020. Retrieved from: https://www.nytimes.com/2020/03/20/health/coronavirus-italy-men-risk.html; Purdie, A., et al. (2020). Sex, gender and COVID-19: Disaggregated data and health disparities. BMJ Global Health Blog, March 24, 2020. Retrieved from: https://blogs.bmj.com/bmjgh/2020/03/24/sex-gender-and-covid-19-disaggregated-data-and-health-disparities/.
9. Hutt, R. (2020). The coronavirus fallout may be worse for women than men. Here's why. World Economic Forum, March 12, 2020. Retrieved from: https://www.weforum.org/agenda/2020/03/the-coronavirus-fallout-may-be-worse-for-women-than-men-heres-why/
10. UN Department of Global Communications. UN working to ensure vulnerable groups not left behind in COVID-19 response. https://www.un.org/en/un-coronavirus-communications-team/un-working-ensure-vulnerable-groups-not-left-behind-covid-19
11. Ward, J. & Agostino, J. (2020). Coronavirus will devastate Aboriginal communities if we don't act now. The Conversation, March 19, 2020. Retrieved from: https://theconversation.com/coronavirus-will-devastate-aboriginal-communities-if-we-dont-act-now-133766; Government of Canada. (2020). Addressing urgent needs in Indigenous communities related to COVID-19. Indigenous Services Canada. Retrieved from: https://www.canada.ca/en/indigenous-services-canada/news/2020/03/addressing-urgent-needs-in-indigenous-communities-related-to-covid-19.html
12. Liem, A., et al. (2020). The neglected health of international migrant workers in the COVID-19 epidemic. The Lancet Psychiatry, 7(4), e20; Hopman, J., et al. (2020). Managing COVID-19 in Low-and Middle-Income Countries. JAMA.; Iacobucci, G. (2020). Covid-19: Doctors warn of humanitarian catastrophe at Europe's largest refugee camp. BMJ, 2020(368).
13. Velavan, T. P., & Meyer, C. G. (2020). The COVID-19 epidemic. Trop Med Int Health, 25(3), 278-280; Chen, S., et. al.(2020). COVID-19 control in China during mass population movements at New Year. The Lancet.; Wilder-Smith, A. et.al. (2020). Can we contain the COVID-19 outbreak with the same measures as for SARS?. The Lancet Infec Diseases.
14. Lloyd-Sherlock, P., et. al. (2020). Bearing the brunt of covid-19: older people in low and middle income countries.; Hopman, J.,et.al.. (2020). Managing COVID-19 in Low-and Middle-Income Countries. JAMA.
15. Di Cesare, M., et al. (2013). Inequalities in non-communicable diseases and effective responses. The Lancet, 381(9866), 585-597; Kurian, A. K., & Cardarelli, K. M. (2007). Racial and ethnic differences in cardiovascular disease risk factors: a systematic review. Ethnicity and Disease, 17(1), 143; Yeates, K., et. al. (2015). A global perspective on cardiovascular disease in vulnerable populations. Canadian Journal of Cardiology, 31(9), 1081-1093.
16. Mullis, S. & Glenn, H. (2020). New Site Collects Reports Of Racism Against Asian Americans Amid Coronavirus Pandemic. NPR, March 27, 2020. Retrieved from: https://www.npr.org/sections/coronavirus-live-updates/2020/03/27/822187627/new-site-collects-reports-of-anti-asian-american-sentiment-amid-coronavirus-pand?t=1585401658602; Aratani, L. (2020). 'Coughing while Asian': living in fear as racism feeds off coronavirus panic. The Guardian, March 24, 2020. Retrieved from: https://www.theguardian.com/world/2020/mar/24/coronavirus-us-asian-americans-racism
17. Tsai, J., & Wilson, M. (2020). COVID-19: a potential public health problem for homeless populations. The Lancet Public Health.; Iacobucci, G. (2020). Covid-19: Doctors warn of humanitarian catastrophe at Europe's largest refugee camp. BMJ, 2020(368).
18. Wanqing, Z. (2020). Domestic Violence Cases Surge During COVID-19 Epidemic. 6th Tone, March 2020. Retrieved from: http://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic; Owen, L. (2020). Coronavirus: Five ways virus upheaval is hitting women in Asia. BBC News, March 8, 2020. Retrieved from: https://www.bbc.com/news/world-asia-51705199; Santiago, V. (2020). Countries and homes are on lockdown to prevent the spread of COVID-19. What happens when home isn't a safe space? Plan International Brazil Blog, March 25, 2020. Retrieved from: https://plan-international.org/blog/2020/03/covid-19-quarantine-when-home-isnt-safe.
19. Pradelli, C. & Mettendorf, C. (2020). Action News Investigation: Local nursing homes cited for infection control before COVID-19 outbreak. ABC Action News, March 25, 2020. Retrieved from: https://6abc.com/6046835/; Human Rights Watch. (2020). Protect Rights of People with Disabilities During COVID-19. March 26, 2020. Retrieved from: https://www.hrw.org/news/2020/03/26/protect-rights-people-disabilities-during-covid-19.
20. ILO. (2020). Almost 25 million jobs could be lost worldwide as a result of COVID-19, says ILO. ILO Press Release, March 18, 2020. Retrieved from: https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_738742/lang--en/index.htm
21. Scott, K. (2020). COVID-19 crisis response must address gender faultlines. Behind the Numbers Blog. March 20, 2020. Retrieved from: http://behindthenumbers.ca/2020/03/20/covid-19-crisis-response-must-address-gender-faultlines/
22. Hussein, J. (2020). COVID-19: What implications for sexual and reproductive health and rights globally? Sexual and Reproductive health Matters.; D'Ignoti, S. (2020). How coronavirus hits migrants and asylum seekers in Italy. The New Humanitarian, March 16, 2020. Retrieved from: https://www.thenewhumanitarian.org/news/2020/03/16/italy-coronavirus-migrants-asylum-seekers; Wallis, E. (2020). UK charities demand urgent steps for migrants during Covid-19 pandemic. Infomigrants, March 26, 2020. Retrieved from: https://www.infomigrants.net/en/post/23653/uk-charities-demand-urgent-steps-for-migrants-during-covid-19-pandemic; Gambino, L. (2020). Clinics in Ohio and Texas ordered to stop 'nonessential' surgical abortions. The Guardian, March 24, 2020. Retrieved from: https://www.theguardian.com/world/2020/mar/23/ohio-texas-abortion-us-coronavirus-outbreak.
23. Emanuel, E. J., et.al. (2020). Fair allocation of scarce medical resources in the time of Covid-19. New England Journal of Medicine. DOI: 10.1056/NEJMsb2005114.
24. See for example, Hankivsky et al. (2012) An Intersectionality-Based Policy Analysis Framework. Vancouver. Institute for Intersectionality Research and Policy.
25. Global Health 50/50. (2020). The Global Health 50/50 Report 2020: Power, Privilege and Priorities. London, UK. Retrieved from: https://globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf.