A2 | GENDERED INEQUITIES DURING COVID-19 TIMES: A VIEW FROM THE GLOBAL SOUTH

The COVID-19 pandemic is one of the biggest challenges that the global community has faced in recent times. Along with having a devastating impact on the social, cultural, economic, and public health systems of countries across the world, the pandemic is bringing to light a deeply problematic narrative of inequality, precipitated on the one hand by the sustained structures of gender, caste, race, religion, work, location, ability, sexual orientation, and ethnicity, and on the other by neoliberal global structures and institutions.

While some COVID-19-related vulnerabilities are shared by most people, it is important to acknowledge how the pandemic has widened pre-existing inequalities and the disproportionate effect it has had on persons with various gender identities. Based on the wheel of privilege (Duckworth 2020), this chapter recognizes that on the gender spectrum, cisgender women, trans persons, intersex persons, and non-binary persons are more likely to be marginalized. In this chapter, all of these identities will be referred to collectively as "various gender identities" for the sake of brevity. Gender, though, is not the only factor in such inequalities as it interacts with many more social and personal identities to create lived realities, as will be discussed in later sections of this chapter. The pandemic, apart from having direct health outcomes, has also had indirect health outcomes for various genders – it has increased gender-based violence (UN Women 2020), it has brought to light gendered inequalities within the health system, and it has disrupted essential sexual and reproductive health services.

These times have made the widening gaps between the haves and have-nots more evident. Prior to COVID-19, it was well established how inequities on these grounds lead to vast gaps in health outcomes – be they in access to the social determinants of health and healthcare facilities or in receiving successful treatment. These inequities worsened significantly during the pandemic (Makau 2021). While countries in the Global South for decades have experienced serious challenges in obtaining ideal health outcomes due to a variety of socio-structural factors (Orach 2009), they are now also struggling with additional pandemic-related difficulties including the repercussions of lockdowns on their economies, weak social protection schemes, poor health infrastructures, and political conflicts, all of which have further worsened their response to COVID-19 (UNICEF 2020).

In light of these concerns, this chapter focuses on the gendered impact of the COVID-19 pandemic with an emphasis on experiences in the Global South, and with reference to current health activism seeking to mitigate gendered health inequities.

Gendered implications and experiences of COVID-19

Prior to the pandemic, researchers, feminist scholars, and activist organizations had written extensively about pervasive gender inequalities, gendered differences in health outcomes (Sen 2007), and the role played by inequitable access to social determinants of health including education and employment opportunities, healthcare, safe workspaces, healthy food, and social protection. COVID-19 has worsened these conditions, furthering the severity of the infection:

> The elderly, immunocompromised, and those with preexisting conditions – such as asthma, cardiovascular disease (CVD), hypertension, chronic kidney disease (CKD), or obesity – experience higher risk of becoming severely ill if infected with the virus. Systemic social inequality and discrepancies in socioeconomic status (SES) contribute to higher incidence of asthma, CVD, hypertension, CKD, and obesity in segments of the general population. Such preexisting conditions bring heightened risk of complications for individuals who contract the coronavirus disease (COVID-19). (Singu et al. 2020)

Women, who constitute the majority of healthcare, social, and domestic workers, along with trans persons, who often have to engage in high-risk livelihoods, are both at greater risk of infection. This is especially so in low-income countries where their relative poverty further renders them more vulnerable due to their existing physical, social, and health conditions (Levine et al. 2021).

Lack of access to COVID-19 testing and treatment also threatens the health and lives of women and adolescent girls. At the time of writing (June 2021), only 52 countries out of 194 are reporting sex-disaggregated data on infections and mortality (Global Health 5050 2021). For countries that have reported data, a majority report more infections in men. In countries such as Afghanistan, Pakistan, and Yemen, less than 30% of COVID-19 cases are female compared to the global average of 50% (Peyton 2020). Some of the causes for the low reporting of cases in women include some testing facilities are not designed to be accessible to all genders, women's health is not given as much priority as men's and women's symptoms are not taken as seriously, loss of livelihood for various genders is not seen as important as its loss for men, and general prioritizing of pandemic-related resources and money on men. Additionally, there is a growing vaccination gap with more men getting vaccinated than women in India (Srishti 2021), and an even harsher vaccination gap for trans persons, as a report from India has shown (Deol 2021). Since vaccinated men can continue to be carriers of COVID-19, such disparities put people from various genders at risk as they continue to perform duties as frontline and domestic workers, or as they continue to engage in high-risk livelihoods.

Indirect impacts on health of women, intersex, trans, and non-binary persons due to COVID-19 include loss of livelihood and financial independence, the additional burden and stress of housework due to the pandemic restrictions, as well as care work for COVID-19 patients. In low- and middle-income countries

(LMICs), where larger systemic support systems like social protection, maternity benefits, and pensions fail to reach the most vulnerable, the pandemic has shaken any feeling of security. Many young girls have had to stop their education due to lack of access to digital infrastructure and have been pushed to undergo child, early, and forced marriages, putting them at greater health risks (Girls Not Brides 2020). COVID-19 has rendered persons of diverse genders at further risk of COVID-19's negative impacts, with additional restrictions on mobility, gaps in health-related information that is usually received from their social networks, suppression of voices and rights, and being left behind in the race for adoption of digital technology (Mehrotra 2021). A curb on movement has led to many people losing livelihood opportunities and the safety of spaces outside the home and being pushed back into norms that they had fought hard to counter.

The "shadow pandemic" of gender-based violence

The crisis of gender-based violence (GBV) and its enduring negative health impacts on survivors received renewed global attention after the UN Women termed it a "shadow pandemic." This followed the emerging data and reports from those on the frontlines which show that all types of violence against women and girls, particularly domestic violence, has intensified. The issue of GBV has long been known to be exacerbated in humanitarian settings, disasters, etc. (see Chapter C4), as it remains linked to myriad risk factors originating in the chaos of the crisis such as being separated from the family or community, lack of safe spaces, or having to undertake new responsibilities such as foraging for food (Peterman et al. 2020).

The attention to GBV during COVID-19, albeit limited largely to violence within homes, has sharpened the focus on the issue (Manzoor and Bukhari 2020). Before the advent of the pandemic, more than 40% of women in Southeast Asia faced violence at the hands of their intimate partners. This number is thought to have surged during lockdowns. For instance, a domestic violence hotline in Malaysia reported a 57% increase in calls when the country's movement control order was in force (Gerard et al. 2020). A similar trend was observed in other parts of the world with more women seeking help against domestic violence during the lockdowns: a 30% rise in emergency calls related to domestic violence in Cyprus, 40%–50% in Brazil, 60% in the European Union, and a 100% rise in India (Seth 2021).

Additionally, persons of diverse genders have also had to cope with different forms of systemic violence thrust upon them by the state. These have included violent and harsh lockdowns, being engulfed in an atmosphere of fear and misinformation, being stuck in workplaces that do not adhere to protocols, loss of livelihood, forced migration, and inadequate social protection. In India, the trans community faced, and still faces, additional challenges in getting access to social protection since their official documents often have incongruities (Mittra 2020). It is important that systems working on COVID-19, health, and gender

issues recognize their responsibility in identifying, preventing, and addressing violence especially for persons rendered more vulnerable during these times.

Box A2.1: The struggle for women's health and rights and the setbacks in the discourses and practices of the Brazilian government

The struggle for sexual and reproductive rights is historic in the world, especially for women who face patriarchal social norms in which the body-geopolitical relationship is inseparable. In Brazil, powerful barriers still exist in accessing these rights. Among the major challenges is the feasibility and implementation of equitable and integrative social policies that effectively incorporate gender, race, and health issues facing cis, trans, lesbian, and bisexual women at all stages of life. The country has recently also experienced marked setbacks guided by radicalized conservatism.

In 2018, the Plan of Action for Women's, Children's, and Adolescents' Health 2018–2030 was negotiated and approved by the 56th Directing Council of the Pan American Health Organization (PAHO) (PAHO 2018a). This Plan urges countries "to address the immediate causes of preventable mortality, morbidity, and disability in women, children and adolescents, as well as their underlying determinants in the framework of rights, gender, life course, and cultural diversity, and to promote positive development, health, and well-being" (PAHO 2018b).

Until the end of the meeting, no consensus had been reached on the Plan, especially by US opposition to the use of the terms "human rights," "sexual and reproductive rights," "gender," and "comprehensive sexuality education." Brazil, along with countries such as Panama, Canada, and Ecuador, strongly defended maintenance of these terms and approval of the Plan, which had broad support from other PAHO countries. The USA nonetheless requested that the plan be put to a vote (a rare situation in this forum), which resulted in approval by 24 countries, abstentions of three, and a contrary position from only the US government (PAHO 2018c).

Exactly one year later, with the new far-right government in Brazil, the country sided with the USA, Guatemala, Iraq, Poland, and Hungary at the High-Level Meeting of the United Nations General Assembly on Universal Health Coverage. Brazil supported one of the most regressive speeches concerning these rights, opposing the use of agreed terms, as well as arguing against the provision of services and rights already achieved to advance the quality of life and health of people (UN Web TV 2019). And it was not just the speech that Brazil changed, with gender rights setbacks being identified daily in the country:

- The participation of women in the Bolsonaro government is one of the smallest in the world.

- The Women's Secretariat, under the management of church representatives, promoted a disinvestment in actions that provide care for and promote the financial autonomy of women victims of aggression.
- Amendment of Decree No. 8,086/2013, which established the Women's Program: Living Without Violence (Secretaria-Geral Subchefia para Assuntos Jurídicos 2013), excluding all references to "gender," implying that such violence had no underlying gender dynamics or determinants.
- Repeal of the Ministry of Health's rule that authorized nurses to insert IUDs (Valda da Silva 2019).
- Return of the Bill of the Statute of the Unborn, which overlays the right of the fetus to that of the woman and typifies abortion as a heinous crime, even precluding legal abortion already guaranteed. Although unsafe abortion is one of the main causes of maternal death in the country, the issue has not been treated as a public health issue but, instead, has been treated using the punitive logic of a religious approach.
- Federal Government campaign in 2020 on the prevention of adolescent pregnancy, which promotes sexual abstinence and paves the way for blaming adolescents without considering data from the Ministry of Health itself, which indicate that almost 70% of girls under 14 years who had children were rape victims who had suffered violence in their own residence (Ministério da Saúde 2018).
- Publication of an Ordinance of the Ministry of Health that makes it difficult to perform legal abortion and can revictimize women and girls who are victims of sexual violence (Ministério da Saúde 2020).

In addition to these setbacks, other factors are important threats to women's rights, such as environmental and land deregulation and frequent public disasters. During the COVID-19 pandemic, for example, cases of violence against women and girls increased considerably. Contrary to the evidence, the Ministry of Health withdrew guidelines dealing with the continuity of assistance services to cases of sexual violence and the strengthening of sexual and reproductive planning in the context of the pandemic. A repudiation note was published and signed by 98 organizations (Centro Feminista de Assessoria, Grupo Curumim Gestação e Parto, and Observatório de Sexualidade e Política 2020).

To prevent access to abortion, even in cases authorized by law, governments of Brazil, the USA, Egypt, Hungary, Indonesia, and Uganda, led by the US Trump administration, created and signed a 2020 initiative called the "Geneva Consensus Declaration" (Bomfim 2020) (from which the US Biden administration quickly withdrew).

Intentional state violence that reproduces racism, epistemicide (the destruction of local knowledge systems associated with colonization), and Indigenous extermination in service of colonialism, capitalism, imperialism,

and patriarchy particularly affects women. It is necessary to break with the alliance between the Brazilian oligarchy and imperialism, which has been reproduced for over 500 years and is a fundamental reason for the subjective and objective genocide of social groups targeted by white supremacy.

Existing in and actively resisting the current Brazilian and international social and political context has been challenging. But women's movements and the struggle for the right to health are actively resisting such policies and fighting against anti-gender offensives. The Feminist Alert (#AlertapelaVidadasMulheres #AlertapelaDemocracia), for example, calls for everyone to support feminist, anti-racist actions against all forms of oppression, in support of rights, and in support of lives free of violence in the firm defense of reproductive justice (Frente Nacional PLA 2020). Other initiatives, such as the Observatory of Favelas, seek to build experiences that overcome inequalities and violence, and strengthen democracy based on the affirmation of favelas and suburbs as territories of powers and rights (Observatório de Favelas do Rio de Janeiro n.d.).

The COVID-19 pandemic has further exposed the contradictions between care and capital and the greatest burden on women. It is imperative to socialize care, implement technologies of decolonization, and radicalize solidarity at all levels. Projects and initiatives such as the case of female sex workers in Brazil point out that mutual aid can also be "a space for political and personal connection like a measure of survival that is also transformative" (Moraes, Santos, and Assis 2020).

We have a social order that is collapsing, and another must be born against a background of human emancipation in dispute.

An impediment to sexual and reproductive health services

Already overwhelmed inadequate healthcare resources were diverted from "lesser priority" areas to managing the pandemic. It is little surprise that these "lesser priority" areas comprised sexual and reproductive health services, such as maternal healthcare, abortion services, and treatment for diseases like hypertension, diabetes, cancer, and cardiovascular emergencies. The World Health Organization (WHO) stated that the most common reasons for discontinuing or reducing such services were cancellations of planned treatments, decrease in public transport available, and lack of a healthcare workforce which had been routed to support COVID-19 services. One in five countries among the ones that were surveyed reported disruptions or suspension of their healthcare services for non-communicable diseases (NCDs) due to shortage of medicines, diagnostics, and other health technologies (Brunier and Harris 2020).

The lockdowns imposed in 2020 had an unprecedented impact on people's abilities to access safe abortion services due to suspension of transport and lack of adequate services for non-COVID-related healthcare issues. The International

Planned Parenthood Federation (IPPF) reported that over 5,000 reproductive health clinics across the world were shut down when lockdowns were initially put into effect (Gomez Sarmiento 2020). The Ipas Development Foundation modeled abortion access and estimated that 1.85 million abortions, or nearly 47% of an expected total, were likely compromised because of the lockdown restrictions (Ipas Development Foundation 2020a; Jain et al. 2021). Similarly, a Nepalese study found that the number of women accessing safe abortion services at a tertiary healthcare center during the lockdown dropped by 25% in the lockdown's first three months because of mobility issues and financial constraints (Aryal et al. 2021). Later, in September 2020, the Nepal government approved home-based medical abortion through an outreach model and telemedicine, which was a critical move in addressing barriers to accessing safe abortion (IPPF 2020).

In Bangladesh, the Rohingya refugees settled in the city of Cox's Bazar were dependent on the reproductive health clinics being operated by non-governmental organizations inside the camps. However, when lockdown was initially imposed, menstrual regulation was not designated as an essential service, which led to the temporary suspension of these health clinics. After weeks of advocacy by civil society representatives, the Refugee Relief and Repatriation Commissioner provided reproductive healthcare workers with "vehicle pass(es)" so that they could resume their work (Ipas Development Foundation 2020b).

Box A2.2: The Argentine "green wave"

On December 30, 2020, the National Congress of Argentina passed by a large majority a bill that legalizes the voluntary termination of pregnancy until the 14th week of gestation. The path that led to this historic achievement has been a long one.

The Argentine feminist movement has its own tradition that began with the return to democracy in 1984 and entails the National Women's Meetings, held uninterruptedly for 34 years, which take place in different provinces each year so that the movement can have a genuinely federal (national) reach. Within this context, in 2003 began the "Workshop of Strategies for the Right to Abortion," which advanced year after year onwards. At the same time, the Campaign for Legal, Safe, and Free Abortions helped to unify all the groups that had been working towards achievement of this right in Argentina.

In 2015, following the atrocious femicide of a pregnant teenager by her partner and family simply because they did not want the pregnancy, the *#Niunamenos* (#Notoneless) movement arose which was later taken up internationally. In 2016 the movement began to call for the right to abortion, joining both claims in the fight against gender-based violence. In

2018 a proposal to legalize abortion was presented for the eighth time. This was the closest such a proposal had come to passing, as it was approved in the Chamber of Deputies before losing in the Senate. However, what was unstoppable was the social debate regarding the issue that led to a mobilization of unprecedented scope. The so-named "green wave" used green-colored handkerchiefs that traversed the entire country and that were named heirs of the white handkerchiefs belonging to the *Madres de Plaza de Mayo* (Mothers of Plaza de Mayo).[1]

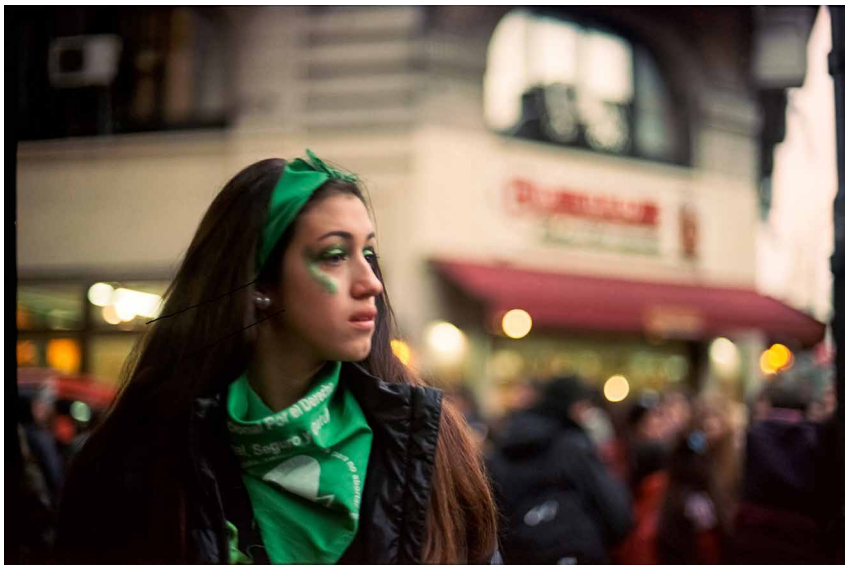

Image A2.1 A young woman wears the trademark green handkerchief of Argentina's "green wave" movement.

Source: Photo by María Laura Collasso.

What happened to the health system during that period? For 100 years, Argentina's Penal Code has allowed abortion in cases of risk to the life of the pregnant woman and of rape by an "idiot or insane person." In 2012, the Supreme Court of Justice interpreted this article, expanding the possibility of abortion to include any case of rape against women and, in addition to the risk of life, the risks for health. From that moment, a window of possibility opened for the application of abortion on three grounds: rape, risk of life, and risks for health, which was referred to collectively as the ILE (the Spanish acronym for Legal Interruption of Pregnancy). The Ministry of Health developed an implementation guide that interpreted health as integral, widening further the unevenly accepted legal spectrum.

Since then, the health system's behavior has been uneven. A very important commitment at the level of primary care, where interdisciplinary

pre- and post-abortion counseling was introduced, in which psychologists and social workers actively participated. This practice progressively expanded to outpatient abortion using medications and, in a few jurisdictions, also manual vacuum aspiration (MVA), all being performed by general practitioners. An interdisciplinary network of primary care professionals was created to support the right to decide, coining the phrase "you can count on me." Meanwhile, at the level of secondary care, most specialists in obstetric gynecology in general hospitals were opposed to this right. A very important autonomous movement emerged from civil society, under the name *Socorristas en Red,* inspired by the Women on Waves Movement.[2] This movement, which arose from a collective in the province of Neuquén, went national. By means of a cell phone passed between volunteers, the movement offered a line that guaranteed a safe abortion and the necessary support (food, lodging, medications, company) free of charge to any woman who needed it. This movement, together with the network of professionals for the right to decide and the political action of the National Campaign for Legal, Safe, and Free Abortion,[3] achieved the social decriminalization of abortion, which permitted the attainment of its legal decriminalization.

What are the current challenges? Two are particularly important: 1) undergraduate and post-graduate training in health professions to ensure healthcare workers are updated on the practices of the current framework of this achieved right; 2) monitoring compliance with current regulations without delays, knowing that the sectors that oppose this achievement will try to fight it through conscientious objection and delay with every woman and procedure that passes through their hands.

In this landscape, the Latin American Social Medicine movement (ALAMES), the People's Health Movement, and the health feminist movement have an unparalleled opportunity to act together for the expansion of rights. We hope to rise to the occasion offered by the history we were able to achieve.

Thus, one realizes that amidst pre-existing social, cultural, and systemic impediments, the pandemic merely highlighted that sexual and reproductive health rights have little priority in government policy or programs and continue to be neglected. The repercussions of this neglect are expected to persist unless there is an urgent push for commitment and accountability from the state as well as community solidarity and support to pressure fulfilment of these health rights.

Community health workers and COVID-19

Women comprise 70% of the global health workforce but earn substantially less than men, 28% lower on an average. This gender gap exists mostly because

women are less likely to be in "highly skilled" jobs than their male counterparts and because of variations in working hours. However, even with "equal work" and "equal pay," a gap of 11% remains. The gender inequity that is ingrained in the health system has resulted in women health workers being relegated to lower stature and lower paid work and being often required to take on unpaid roles even in the health workforce. The harsh realities of gender inequities they face has only worsened with COVID-19 (Boniol et al. 2019).

While health systems globally grappled with the challenge of the pandemic, in many countries Community Health Workers (CHWs) played a pivotal role in mitigating the crisis, often putting their own lives at risk. In India, CHWs have assisted various state governments in contact tracing, spreading awareness about precautionary measures, and conducting regular follow-up visits. CHWs are known as Accredited Social Health Activists (ASHAs) in most states across India, or by colloquial names like "Mitanin" in the state of Chhattisgarh or

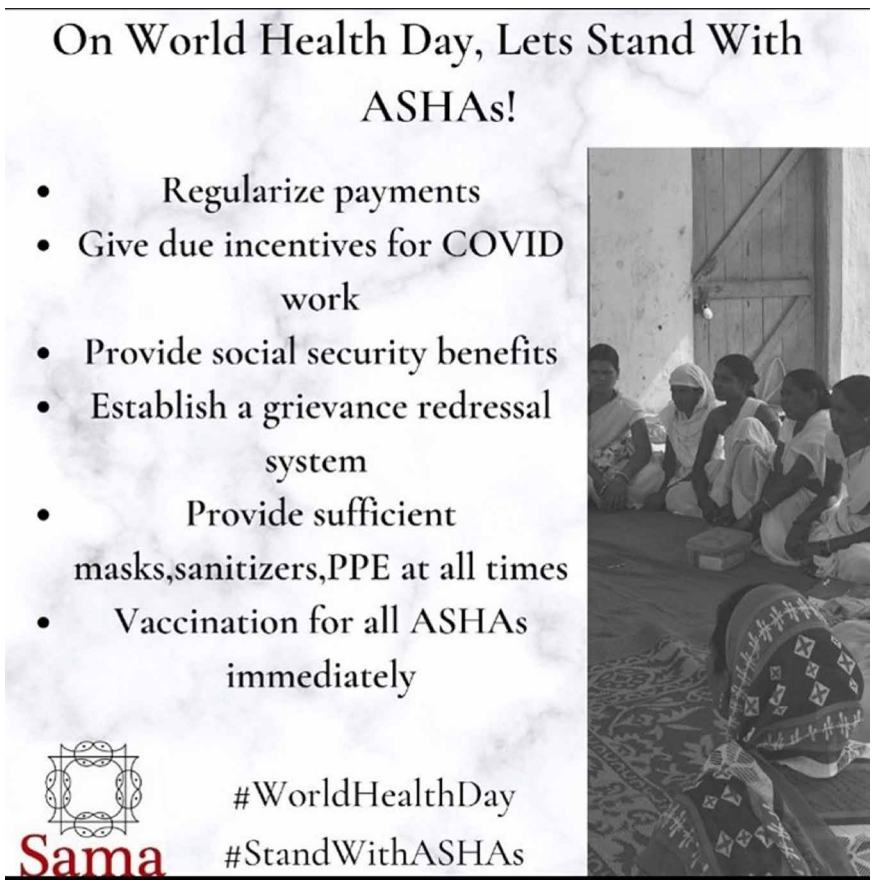

Image A2.2 Demands for accredited social health activists (ASHAs) in the form of a poster.
Source: Photo by the Sama Resource Group for Women. http://www.samawomenshealth.in/

"Sahiya" in Jharkhand.[4] As one example, in the State of Uttar Pradesh, CHWs helped in contact tracing of three million migrants who were returning from urban areas to their villages following lockdown orders early in the pandemic ("ASHA workers played" 2020).

In Bangladesh, over 1,400 Rohingya refugees were trained as Community Health Volunteers (CHVs) to provide essential health services in cramped refugee camps and surrounding areas of Cox's Bazar. The CHVs not only acted as a bridge by building trust between refugee communities and health facilities, they also countered misinformation and rumors that restrained a vulnerable community from accessing health facilities (Bezbaruah et al. 2021). In Thailand, Village Health Volunteers (VHVs), a cadre of CHWs originally established in 1977, played a pivotal role in the management of COVID-19 crisis in rural areas (Tejativaddhana 2020). During the Songkran New Year period in mid-April of 2020, lockdown measures led to several Thai residents living in urban areas returning to their rural homes. Without the VHVs, it would have been a Herculean task to trace the returnees who had contracted COVID-19 in their respective villages (Narkvichien 2020; Bezbaruah et al. 2021).

Despite their pivotal role in the management of COVID-19, CHWs have had to deal with the risk of infection, heightened by state negligence and lack of preparedness due to inadequate personal protective equipment (PPE). In countries like India, Bangladesh, and Nepal, CHWs' lives were endangered due to an acute shortage of supplies in the early days of the pandemic (Antara and Narayanganj 2020; Basnet 2020; Chauhan 2020; Rahman 2020). CHWs did not receive adequate training on infection prevention and control, including on how to use PPE in their work; they received negligible reimbursement for their work and no social security, unlike their medical counterparts (Bezbaruah et al. 2021). The prevalent bias against CHWs, considered to be the lowest rank of healthcare provider in the medical hierarchy – no matter what name they go by in different countries – was reflected in the minimal concern for their safety by most countries' health system responses (Bezbaruah et al. 2021). The experiences of CHWs during the pandemic garnered from various South

Box A2.3: Nurses' health is unfairly affected during the COVID-19 pandemic: a look into the reasons why

The current COVID-19 pandemic has directed visibility to the vulnerability nurses across the world face in their everyday work (WHO 2020a). Professional nurses and nurse aides, the majority of whom are women, are disproportionately affected by COVID-19 (Hughes et al. 2020). The International Council of Nurses (ICN) has reported that as of December 31, 2020, the cumulative number of reported COVID-19 deaths of nurses

in 59 countries out of the world's 195 countries is 2,262 (International Council of Nurses 2021).

Nurses' health is influenced by several factors and the political context significantly affects nursing employment and working conditions, ultimately creating health inequalities (Gunn et al. 2019). Prior to the pandemic, the 2008 economic crises led to neoliberal austerity measures imposed in many countries that significantly curtailed government spending. One of the measures implemented set caps on employment in the public sector which had a substantial impact in the precarization of nurses. For example, in Croatia, austerity resulted in overburdening already employed nurses while the inability of newly professional nurses to access employment led to an increase in migration and a deepening of the serious shortage of nursing personnel (Friganovic et al. 2020). Similar consequences of austerity were noticed in other countries, e.g., Spain, Italy, and Mexico, where prioritization in hiring nurse aides instead of professional nurses first started as a response to the economic development plans of the 1970s (Squires and Juarez 2012). Several countries in South Asia also followed a similar trajectory (Baru 2003). At the same time, to date only 41 countries have ratified the International Labour Organization (ILO) Nursing Personnel Convention of 1977 (No. 149) and the accompanying Recommendation (No. 157) that set standards for fair employment conditions for nursing personnel.

Currently, countries' general policies on COVID-19 do not address nursing work and needs. The declaration of COVID-19 as an occupational disease has been uneven, and several countries have not yet developed this policy. Furthermore, while students and retired nurses are employed as actual workers during the COVID-19 crisis, they are not always covered by existing labor laws, and collective bargaining coverage in this sector of workers is unknown. Global economic dynamics also play a critical role in countries' purchasing capacities, availability of personal protective equipment (PPE), vaccine production capacities, vaccine distribution, and the international competition over scarce health workers.

Nursing vulnerabilities are heightened by gender inequalities. A predominantly female nursing staff requires a range of work time arrangements, such as extended work shifts, night work, and on-call scheduling. The inappropriate use of these arrangements has been shown to negatively impact nurses' health (ILO 2018). During this pandemic, female nurses worked on the "second shift," undertaking higher workloads while maintaining their unpaid job as key caregivers within their families, which in turn added additional stress and fear of infecting cohabiters (Fernandez et al. 2020). During the first wave of COVID-19 pandemic, there was a lack of consensus and clear information regarding risks for pregnant women workers and breastfeeding mothers exposed to COVID-19, which resulted in hospitalizations and deaths (Topping 2020).

Violence against the nursing workforce is reported worldwide and within all types of healthcare settings. During the COVID-19 pandemic, health workers in India have been excluded from their communities, evicted from their homes, and forced to sleep in hospital bathrooms and on floors for fear that they may carry the coronavirus (Ellis-Petersen and Rahman 2020). In the city of Rimini in Italy, 70 cars of health workers were damaged overnight outside the hospital (Rimini 2020). In Mexico, cases of physical and verbal assaults on health workers, including nurses, have been documented both inside and outside hospital facilities, as well as while making home visits to assess patients and as health workers make their way home (Caldera-Villalobos et al. 2020).

Working conditions of nurses during the pandemic have also been complicated because of pre-existing discrimination based on nurses' races, ethnicities, and castes. During COVID-19, data from the Centers for Disease Control and Prevention (CDC) from six US states showed that American Indian, Asian, and black health workers are at higher risk of case fatality (Hughes et al. 2020).

Many nurses who migrated in search of better job opportunities in the UK were held up and unable to register due to COVID-19 and the lockdown. The Nursing and Midwifery Council (NMC) brought temporary registration to those migrant nurses who completed competitive skill examinations, while others were forced to wait for more than two to three months for the registration. In India, the United Nurses Association had to arrange safe repatriation of nurses stranded in Saudi Arabia. Discrimination and racism surrounding a lack of job opportunities, poor career progression, or poor learning environment are causes of poorer health among migrant and minority nurses compared to native-born nurses (Schilgen 2017). Yet, globally, one in eight nurses practice in a country other than the one where they were born or trained (International Council of Nurses 2020).

Professional nursing associations, educational institutions, nursing regulatory bodies and unions, nursing student and youth groups, grassroots groups, and global campaigns such as "Nursing Now" are valuable contributors to strengthening the role of nursing in healthcare teams and to helping them achieve better employment and working conditions (WHO 2020). In many instances, unionization has helped to improve the working and income conditions for nurses. It also has an impact in terms of patient morbidity and mortality from COVID-19 (Dean, Venkataramani, and Kimmel 2020). However, collective organizing and legal rights are still insufficient in many countries. On a positive note, the pandemic has sparked new solidarity actions by nurses to bring more attention to their needs as a collective, with calls for post-pandemic international and nationally enforceable standards.

Asian countries, their positive contributions, and their relative neglect by health systems, underscore the importance of sustained investments in CHW programs.

A step up on the healthcare worker hierarchy finds that conditions for nurses were not much better (Box A2.3).

Conclusion

COVID-19 has left no country unscathed. Gender analysis has become pertinent in the response to COVID-19 because it has become increasingly visible how socially constructed roles and gendered identities affect not only risk of exposure and biological susceptibility to infection, but also individuals' experiences of the kind of treatment received (WHO 2020b).

It is important to go beyond the gender binary lens and ascribed gender roles in order to address inequalities embedded in the larger health system. Adopting a gender analytical approach should not translate into simplistic messaging that "pandemics affect women and men" differently. Rather, it should aspire to surpass a narrow-gendered focus where one tends to homogenize diverse experiences. Instead, a gender analysis must also take into account other intersecting factors such as disability, indigeneity, race or ethnicity, and migration or refugee status. It should also locate gendered and intersectional differences in health in the context of structural health determinants, such as precarious housing, employment status, patriarchy, and political and environmental stressors (Hankivsky and Kapilashrami 2020).

The reiterated concerns in the current context, some of which have been discussed above (gender-based violence, structural marginalization of sexual and reproductive health and rights, precarious environments within health systems for women and other frontline workers), point towards gendered fault lines in our societies and systems globally. Taking cognizance of these is critical towards developing an intersectional perspective and learning from these diverse situations.

Gender justice and equality must remain at the center of health movements globally to make those movements inclusive and fair. As we look back at the Argentine experience (Box A2.2), we see the power of a sustained grassroots struggle where people refused to give up. It is an example of how people's movements have the power to hold their governments accountable for recognizing and upholding systems that respect intersectionalities and vulnerabilities on the basis of gender, caste, class, ability, sexual orientation, religion, or more, whether before, during, or after COVID-19 as we leave the pandemic's shadow.

Notes

1 A movement of mothers who gathered in 1978 to call for the reappearance of their arrested children, disappeared during the civil-military dictatorship (1976–1983). This movement is still active and is famous worldwide for its defense of human rights. These mothers wear a white headscarf as a reminder of their children's diapers.

2 A European movement that had a ship sailing in international waters providing

abortions in countries whose laws did not permit it.

3 A social actor fundamental to this process that since 2005 unites all the groups in the country that defend the right to abortion. See www.abortolegal.com.ar.

4 Mitanin or Sahiya refers to a "female friend" in local dialect of Chhattisgarh and Jharkhand respectively.

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