This article highlights some of the gendered effects emerging from the COVID-19 pandemic in the global healthcare sector, which is dominated by women. Women comprise 70% of the global healthcare workforce, and yet they only hold 25% of the senior roles in the healthcare profession. They also hold lower-status roles, many of which are underpaid or unpaid. For example, in India accredited social health activist (ASHA) community health workers are women, but the government considers them to be honorary volunteers rather than employees. As a result, although they receive a small stipend, ASHA workers do not receive employment benefits, such as leave (e.g., paid, sick or maternity) or health insurance.

Today, more than ever, the world needs healthcare workers responding to the pandemic, but they are struggling to stay healthy in an environment where there is a shortage of personal protective equipment and of access to rapid testing for the virus. Healthcare workers face a greater risk of exposure to COVID-19 and of transmitting the virus to others because of their close and prolonged contact with sick patients.

While the global COVID-19 infection rate of healthcare workers is unknown, in European Union countries that have available data, between nine and 26% of healthcare workers tested positive for the virus. A higher proportion of healthcare workers diagnosed with COVID-19 were women, reflecting workforce demographics. In Spain 72% of infected healthcare workers were women (5,265) and in Italy 66% of infected healthcare workers were women (10,657). Similarly, in the United States, the Centers for Disease Control and Prevention found that 73% of infected healthcare workers were women (6,603).

Healthcare workers are suffering from elevated stress levels not only from exhaustion and loss of life, but from also having to make painful, ethical decisions on patient care in an environment of constant shortages. In a study of healthcare workers in China, more women experienced more severe symptoms of 

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depression, anxiety, and distrust than did men.9 To add to an already stressful environment, medical staff are facing layoffs, furloughs, or reduced hours as non-essential medical procedures are canceled or postponed.10 Initial unemployment data in the United States showed more women losing jobs than men in the healthcare sector.11

Caretaking responsibilities are also added stressors for healthcare workers. In dual-parent households, school and daycare closures and sick family members force couples to choose who stays home as the unpaid caregiver. The burden for unpaid care, however, tends to fall on women, which is especially problematic in single-parent households headed by women.12 For example, researchers estimated that 1.7 million Canadian healthcare workers are single mothers to young children. They noted, “Because healthcare is predominantly female, the rate of single mothers to young children, 7.7%, is double that of the workforce in the rest of the economy.”13 Furthermore, the typical support systems for care giving, such as grandparents or friends, were unavailable due to social distancing. And, in some hard-hit areas such as New York, babysitters and nannies were unwilling to care for the children of healthcare workers because of the risk of contracting COVID-19.14

Health and social systems are also struggling to cope with the COVID-19 pandemic, making it difficult for women to receive health services in remote rural areas.15 For example, in India, the government has suspended all non-critical services in rural communities so that the ASHA community health workers, who are all women, can redirect their efforts toward the pandemic. While this effort may be commendable as a public health response, it is troubling for the ASHA community health workers. The services deemed as “non-critical” because of the pandemic also happen to be “critical services” for women, especially at a time when they need to stay healthy. Consequently, women are not receiving immunizations, prenatal vitamins, and birth control.16 The decision to temporarily suspend “critical services” can contribute to potential health effects, such as adverse pregnancy outcomes, infant mortality, diseases, and/or unplanned pregnancies. As a result, the United Nations is stepping up its effort to maintain continuity of sexual and reproductive health services, and to protect healthcare workers.17

There is a need for more research to understand the gendered dimensions of the COVID-19 pandemic to improve pandemic response for all populations, including healthcare workers. Policymakers can make a difference by using a gendered lens, rather than a gender-neutral approach for response and recovery efforts.18 In April 2020, the State of Hawaii took the first step by publishing a gendered economic recovery plan for COVID-19, the first of its kind in the United States.19 By focusing on the development of gender-responsive and gender-transformative policies, institutions and communities, it is possible to build a more resilient society centered on individual health and wellbeing.

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