

IMPACT OF THE PANDEMIC ON WOMEN AND MINORITIES

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ABSTRACT

The overall purpose of the study was to find out about the struggles faced by oppressed groups in the society during an already difficult time. The article focuses upon medical and social challenges faced by women, ethnic/racial minorities, and sexual and gender minorities.

Some of the major findings revolve around the extent of the problem such as lack of access to reproductive services and prejudice surrounding the queer community.

Keywords: COVID – 19, Human Rights, Women, Racial/Ethnic Minorities, LGBTQIA+

Introduction

With the spread of the ongoing coronavirus pandemic, many countries implemented tough restrictions in order to minimize infection rates. As a result, many individuals have experienced foreboding traits of declining job security and mental health. This article introduces the unique struggles faced by women and minorities.

1. Women

1.1 Medical Effects

With all non-essential services closed down by the governments of several countries, important services, such as those of contraception and abortion, that are not seen as essential by numerous countries closed down as well. For example, countrywide lockdowns in India and Nepal have forced clinics operated by Marie Stopes International (MSI) — the largest provider of family planning services in India outside of the public sector — to close.

The United Nations Population Fund (UNFPA) predicts there could be up to 7 million unintended pregnancies worldwide because of the crisis, with potentially thousands of deaths from unsafe abortion and complicated births due to inadequate access to emergency care. In

addition, the MSI predicts that the closing of these services could leave 9.5 million women and girls vulnerable without contraception. This could lead to 2.7 million unsafe abortions. MSI's call center in Nepal received countless calls for abortion and contraception services since the beginning of the lockdown.

Meanwhile in India, millions of women living in hard-to-reach areas have been unable to access contraceptive services. When the Indian government classified reproductive health services as essential, proper implementation introduced a problem at the ground level. The Foundation for Reproductive Health Services India, an affiliate of MSI, estimates that the disruption caused from lockdowns could leave 26 million couples in India unable to access contraception, leading to an additional 2.3 million unintended pregnancies and over 800,000 unsafe abortions, which is the third leading cause of maternal deaths in India.

Public health-care facilities have been repurposed for COVID-19. Facilities which offered services for women had to be repurposed and have been allocated to COVID-19 prevention, identification, and treatment instead of offering family planning services. Additionally, many private clinics had to shut down because of transport shortages, provider unavailability, and a lack of personal protective equipment. Research from Ipas has found that the closure of pharmacists, the disruption of the supply chain, and travel restrictions had prevented millions of women from accessing medical abortions during lockdown.

Pregnant women are found to be the most vulnerable group during public health emergencies. With other emergent coronaviruses, such as those responsible for severe acute respiratory syndrome (SARS) and middle east respiratory syndrome (MERS), pregnant women who became infected were found to be more likely to experience severe complications than nonpregnant women.

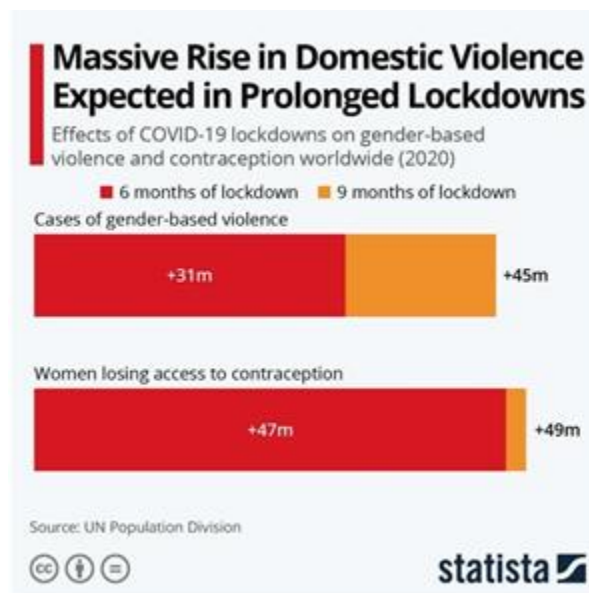
Some countries have made an effort to help with these problems. In Australia, telehealth services have been an effective way of providing abortion services. Other countries that have tried to enable access to medical abortion outside of health facilities include South Africa, where telehealth services are in place for remote consultations including the dispensing of medical abortion pills, and Ethiopia, where the government has approved a scheme for nurses to provide medical abortion in homes in Addis Ababa.

1.2 Social Effects

In addition to medical challenges, women have also faced social struggles. Gender roles such as family care giving, and frontline occupations increase women's exposure to COVID 19 and critical outcomes.

With abusers exploiting the inability of women to seek help and leave threatening situations, there has been a rise in domestic violence. In Colombia, gender-violence is rampant with domestic violence against women increasing by 175%.

According to the International Labour Organization, women perform 4 hours and 25 minutes of unpaid care work as opposed to 1 hour and 23 minutes for men. Married women in South and South-East Asia traditionally bear excessive family responsibilities, and the novel corona virus has resulted in diminishing mental health among them. With more than 1.5 billion children out of schools, the need for childcare has considerably increased. To avoid infecting themselves, families cannot hire babysitters nor can their grandparents take care of them due to high mortality rates. Therefore, due to the existing division of childcare duties, mothers are more affected than their fathers.



1. Expected rise in domestic violence in prolonged lockdowns

The pandemic has caused augmented anxiety and confusion in pregnant women due to increased worries regarding the status of the pandemic, impacts on maternal and child health, and treatment and prognosis of the mother and fetus. Containment strategies, such as those that require women to deliver without a companion present have already been put into place in some cities in the United States, and those that separate newborns from their mothers immediately after birth if the mother is infected with COVID-19 may be medically important to reduce transmission but they may also have profound short- and long-term mental health implications for women.

Therefore, COVID – 19 anxieties can be an influential factor in mental health.

2. Effect of the pandemic of ethnic and racial minorities.

Public health recommendations to contain COVID-19 can worsen disparities due to a lack of resources and underlying institutional racism. From earlier reports in the United Kingdom, racial and ethnic minorities are the hardest hit with COVID-19 both in terms of critically ill as well as higher mortality. Furthermore, according to a report by Pan et al., there is emerging evidence of disproportionate clinical outcomes among the ethnic minorities in several countries against COVID-19.

There could be several explanations for the disproportionate burden of COVID-19 in ethnic minorities such as social and economic inequalities as well as genetic predisposition, biological or pathophysiological differences in response to infection. The ethnic minorities have higher counts of comorbidities such as diabetes, cardiovascular disease and obesity. The studies indicated that ethnic minorities had increased prevalence of vitamin D deficiency and increased inflammatory burdens which could increase the severity of COVID-19 in those populations.

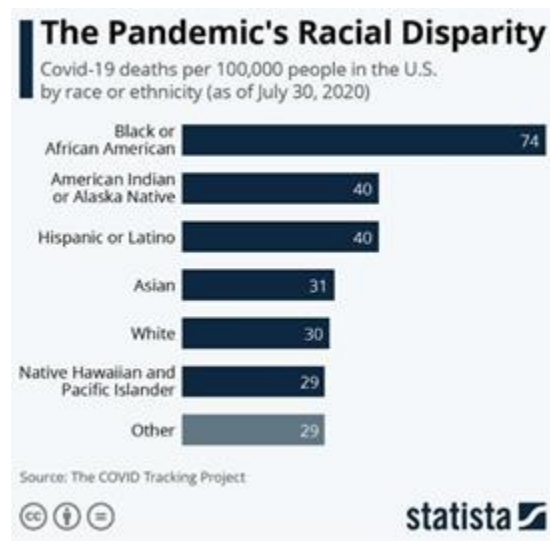
However, it is not only genetics that influence the effects on such communities but also health inequalities. Health inequalities is defined as “unfair and avoidable differences in health across the population, and between different groups within society that are results of wealth, power and prestige”, by NHS England. A proportion of minor racial/ethnic groups face troubles due to their working conditions because they do not allow them to practice social distancing, work from home, isolate the sick, they do not provide paid leave nor do they provide the workers with proper protective measures.

Looking into the United States, a developed country, it has been noted that racial/ethnic minorities and those from the working class have worse health outcomes due to COVID-19. In Chicago, Blacks comprise 30% of the city’s population but 70% of COVID-19 deaths.

One of the major issues with diagnosing patients with COVID – 19 was limited availability of testing kits. At first, testing was centralized which resulted in a smaller number of testing centers. To control the number of patients presenting for tests, residents in New York were obligated to obtain a doctor’s prescription. Previous studies have shown that racial/ethnic minorities are less likely to have access to a primary care provider.

The next issue came up when the concept of “drive-thru” testing was implemented by the state. This proved to be an obstacle for those that do not have a vehicle. Controlling access to tests in this way also impacted those who rely on public transportation.

Lastly, significant disparities have risen from the lack of health insurance due to one of the highest unemployment rates in history. Given the current increase in unemployment, it is unclear what will happen in situations when these uninsured patients need medical care. Those without health insurance will no longer receive routine check-ups, cancer screening, and disease management visits. This likely will result in a widening of the disparity gap in the long term, especially among vulnerable populations.



2. The Pandemic's Racial Disparity

3. Effect of the pandemic on sexual and gender minorities.

The people of the LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex, Asexual and more) community who live in a socially compromised condition are said to be more vulnerable during the pandemic.

With hospitals and clinics focusing on diagnosing and treating COVID -19, the focus on the treatment and care of the LGBTQIA+ individuals gets interrupted or deprioritized, which might affect the individuals on hormonal and gender-affirming treatments, thereby creating a disadvantage. Stigma against them also makes access to healthcare facilities difficult. This can decrease testing, promote concealment of symptoms, noncompliance to the precautionary measures, and increase the rates of asymptomatic carrier status in the LGBTQIA+ community. The high comorbidity of STDs and mental disorders in them can relapse due to the lack of follow-up with health care, nonavailability of medications, and travel restrictions. Substance abuse further

compounds the situation. The knowledge, attitude, and practice (KAP) gap is also high in them which contributes to infection spread and susceptibility.

Personal finances, access to food, health care, difficulties in transportation, and trust toward public health agencies like the World Health Organization (WHO) and the Centre for Disease Control and Prevention have also decreased in the LGBTQIA+ community. Studies show that LGBTQIA+ youth are much more at risk to experience homelessness and lack of family support, with the lack of administrative accountability. Social distancing tends to be impossible in temporary shelters and detention facilities, further increasing the risk of infection. Lack of data and societal apathy add to their poverty and impoverishment. Many reports in media mention hunger, overcrowding, and lack of sanitary facilities as broader concerns than the threat of the virus itself. In low- and middle-income countries of Asia and Africa, where racism and xenophobia add to the stigma against sexual minorities, living conditions can be worse for those who do not have a salaried job or are homeless. South Korea was in the news for the increased threats and outcaste toward the LGBTQIA+ community through unfair accusations of them spreading COVID-19, thereby creating conditions of discrimination, harassment, and hostility. Section 377, though legalized in India, has not gained public acceptance. In the current scenario, where one spends more time with their family due to the lockdown, the number of questions raised and the level of discrimination with the hate speeches might be high, thereby making the person more vulnerable to violence, abuse, and associated mental health conditions.

The Human Rights Campaign for the LGBTQIA+ community released a research brief on April 2020 to mention that they are at heightened risk for the socio-economic aspects of COVID-19. People of this community are more likely to work in profoundly affected industries, which has more exposure to the infection as well as financial sensitivity to the pandemic crisis. Data from the PSB (PEOPLE × SCIENCE × BUSINESS) Research Group in the United States show that 30% of the LGBTQIA+ community had their work hours reduced and salary decreased, compared with 22% of the general population.

In this year, due to the COVID-19 crisis, more than 220 Pride celebrations were postponed or cancelled globally, which is an emotional setback for this group, who look forward to these events of the year.

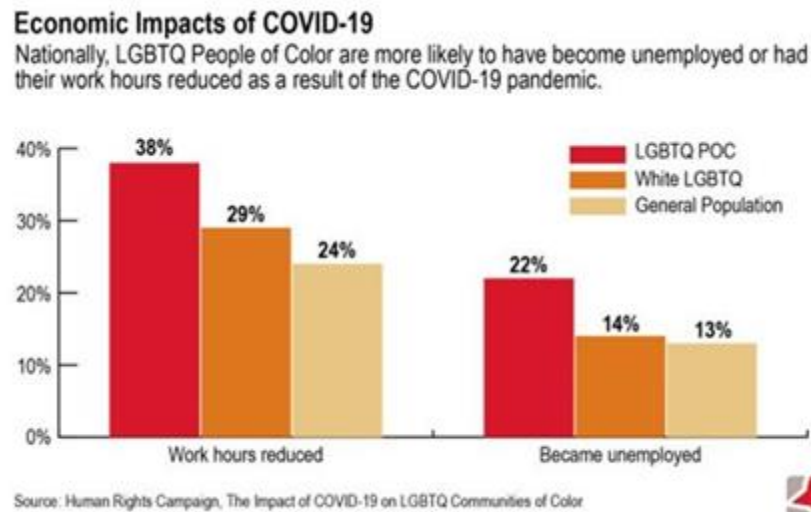


Fig. 3 Economic impacts of COVID – 19

Conclusion

These groups are at the sharp end of health inequalities resulting from a lack of the things many of us take for granted: stable, well-paid work, secure housing or a support network of friends and family to rely on. This makes it difficult for them to cope during these perplexing times. The main problems stem from apathy. Therefore, in order to curb these effects, it is important that the private and public sector have a dialogue and work together to close the gap, improve the referral system and raise awareness.

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