COVID-19

GLOBAL HEALTH SECURITY DEPENDS ON WOMEN

Rebalancing the unequal social contract for women

WOMEN IN GLOBAL HEALTH

SEPTEMBER 2020

WGH
WOMEN IN GLOBAL HEALTH

INTRODUCTION

COVID-19: thirty million people infected

As of September 2020 around 30 million people worldwide have been infected with COVID-19 and close to 1 million people are known to have died. The pandemic is far from over. In addition, deaths are resulting indirectly from COVID-19 as health systems are disrupted, gender-based violence increases and economic fallout deepens hunger, despair and extreme deprivation. Behind every statistic is a human story. COVID-19 has changed the world profoundly, causing death and devastation now and aftershocks that will scar future generations. This is a break in history and a chance to fix the structural weaknesses in our health and social systems so we can better withstand future shocks. This is our opportunity to rebuild global health security on a stronger and more equal foundation and ensure that the women who deliver health and social care are leading the systems they know best.

COVID-19 is not an equalizer, it is exposing inequalities

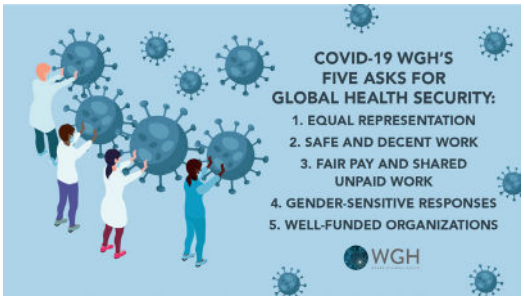
The pandemic is exposing the dark truth of deep social, economic and political inequalities that drive ill health and pandemics within and between countries. Viruses do not respect national borders. The rich are better able to protect themselves and will be the first to access vaccines and new treatments but no-one is immune. None of us will be safe until the virus is eradicated everywhere. That seems an improbable ambition when at least half the world's people lack full coverage for the most essential healthcare services[i], with marginalized groups left even further behind. Universal Health Coverage (UHC) is a distant dream for billions, including large numbers of people in high income countries. Data from the USA shows higher mortality from COVID-19 amongst black and Latina groups[ii] and in the UK, amongst black and South Asian groups[iii]. The primary causes are long standing structural social, economic and health disparities with lower status social groups having more exposure to infection in lower paid, frontline jobs and overcrowded housing, poorer underlying health status and in the USA, less likelihood of health insurance.

Women need a fair social contract

Although in most countries, men have a higher mortality rate from COVID-19[iv], women and girls are bearing the secondary impacts of a pandemic that worsens their already weak social and economic position. At the same time, however, women are much more than victims in this health emergency - our lives and health depend on the women on the frontlines of health and social care cleaning up this man-made disaster. Women are the majority (70%) of health workers and 90% of nurses, community health and social care workers[v]. They also shoulder the burden of domestic work, care for families and children who need to be home schooled in lock downs[vi]. Women's organizations are filling essential gaps left by state provision in services for vulnerable groups, including women subject to gender-based violence.[vii] None of this is new.

Global health was built on gender inequality

Gender inequality has long been hidden by official statistics that do not record women's unpaid work. Gender inequity is hard wired into the health and social workforce, with women clustered into lower status and lower paid sectors. Global health is not a broken system, it was built unequal on the assumptions that women would deliver health care while men made most decisions and that women's unpaid work would form the foundation for global health security. COVID-19 has shown the fragility caused by these structural gender inequalities. Global health will only be secure when women in health have a fair social contract based on decent work and equality in decision making.



WOMEN IN GLOBAL HEALTH: FIVE ASKS FOR GLOBAL HEALTH SECURITY

In March 2020 as the pandemic began to escalate globally Women and Global Health issued a Call to Action with 5 asks to address the impact of pandemics for women and girls and strengthen health security for all. Six months later, our 5 asks remain unchanged.

FIVE ASKS FOR GLOBAL HEALTH SECURITY, NOW AND IN THE FUTURE

1. **Include women in global health security decision-making** structures and public discourse

2. Provide **health workers**, most of whom are women, with **safe and decent working conditions**

3. Recognize and value **women's work in health and social care by bringing women's unpaid work into the formal labor market and redistributing unpaid family care** equally between men and women

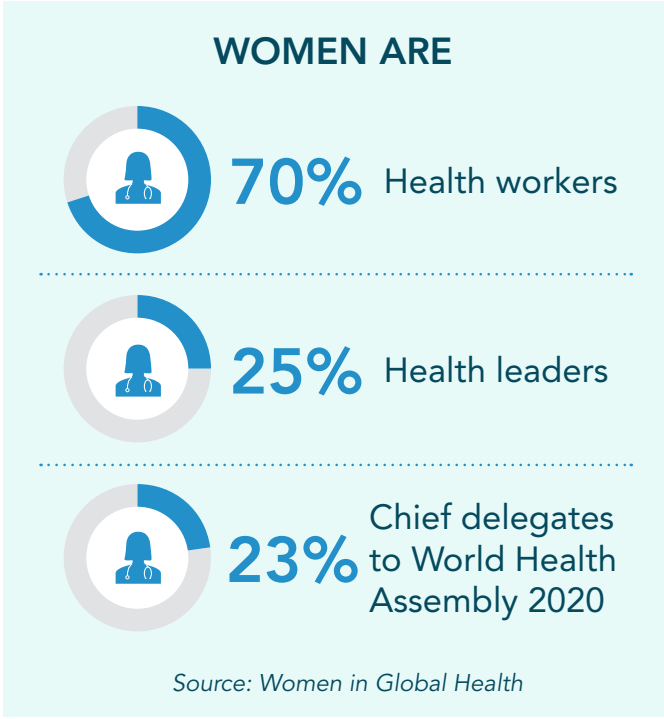
4. **Adopt a gender-sensitive approach** to health security data collection/analysis and response management

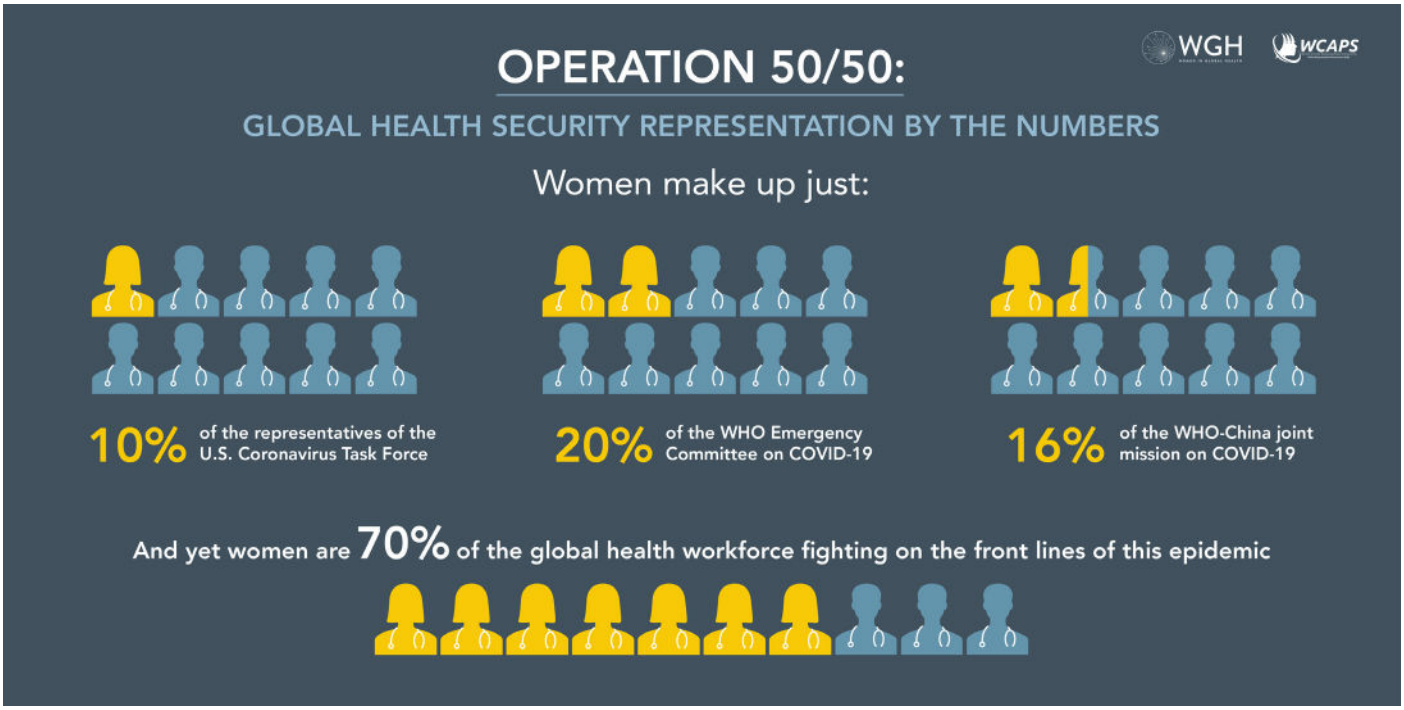
5. **Fund women's movements** – especially women's organizations in low- and middle-income countries – to unleash capacity to address critical gender issues

ASK 1 GLOBAL HEALTH: DELIVERED BY WOMEN, LED BY MEN

The 70%/25% paradox

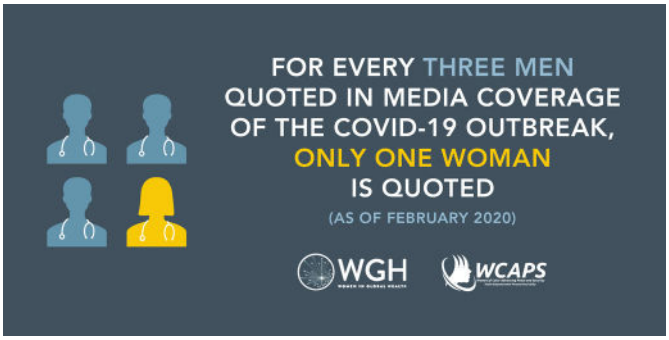
Women hold 70% of health and social care jobs globally[viii]. They are 90% of nurses and midwives and were 90% of the frontline workers in Wuhan caring for COVID-19 patients. But the extraordinary service of women health and social care workers has not earned them an equal say in decision-making. Women hold only 25% of leadership roles in health[ix]. The annual analysis by Women in Global Health also shows that the proportion of chief delegates to the World Health Assembly who are women has remained stubbornly stagnant. After peaking at 31% in 2017, it fell back down to just 23% of delegations being female-led in 2020. Women are the experts in the health systems they know best but their expertise and diverse perspectives are not valued sufficiently to guarantee them equality in leadership.





COVID-19: It's an emergency, men know best?

Although women work at all levels in health security—from the front lines of health services, to research labs and health policy making – they have not been represented equally in global or national decision-making bodies on COVID-19. In January 2020, just 5 women were invited to join the 21-member World Health Organisation (WHO) Emergency Committee[x] on the novel coronavirus. Only 2 of the 27 members of the US Coronavirus Task Force are women[xi]. Typically, national COVID-19 decision making groups have had a small minority of women members. Even in health emergencies women are expected to deliver frontline services while men make decisions. Including equal numbers of women in leadership (and women from diverse social groups and geographies) in this pandemic is about effectiveness and saving lives, not only representation. Diverse leadership groups make better, more informed decisions.



Operation 50/50: Women health experts hiding in plain sight?

In March 2020, alarmed at the under representation of women in COVID-19 task forces Women in Global Health and Women of Color Advancing Peace and Security (WCAPS) launched Operation 50/50—a crowdsourced list of women health security experts. The list is designed to be a resource for organizations looking for health security experts and media commentary on COVID-19. It demonstrates that the justification 'there are no qualified women' is simply false. The current pandemic makes it clear that the gender stereotypes and bias keeping women out of health leadership and decision making put us all at risk. We cannot fight a global pandemic by drawing experts from just half the talent pool.

ASK ONE:

Include women in global health security decision making structures and public discourse

PROBLEM: Women are the majority of the global health workforce but are underrepresented in COVID-19 decision-making bodies/leadership and media commentaries.[xii] Responses to outbreaks are weakened where female talent, expertise and diverse perspectives are excluded.

SOLUTION: We ask that WHO Member States, international agencies, Non-Governmental Organizations (NGOs) and the media include women – particularly women from the Global South – as 50% of global health security decision-making bodies and expert groups.

Are women leaders doing better on COVID-19?

Several pieces of research and many media articles have examined whether women political leaders have been more effective in managing the response to COVID-19 than their male counterparts? There are two caveats. First, that the pandemic is far from over so we can only assess early stage responses and second, that the sample of female heads of government is regrettably small. In January 2020 only 12 out of 193 countries (6.2%) had a female head of government.[xiii] Nevertheless, one study in July found female-led countries had fewer COVID-19 deaths per capita, a shorter number of days with confirmed deaths, a lower peak in daily deaths per capita, and a lower excess mortality. The study concluded that female leaders had acted quickly, implementing measures of lockdown early on as recommended by national health experts.[xiv] A second study concluded that deaths from COVID-19 were six times lower in female-led countries due to early, decisive action.[xv] Other commentaries have noted that more inclusive communication skills of female leaders have helped build collective action, public trust and compliance with public health pandemic response measures.

DEATHS FROM COVID-19

6X ***Lower in countries with women leaders***

Source: Chamorro-Premuzic, T and Wittenberg-Cox, A.2020

Moving beyond gender parity to gender transformative leadership

Equal representation of women in leadership needs no justification in a workforce with 70% women. Women in Global Health, however, argues that beyond gender parity, leaders of all genders must promote gender transformative policies to realize better global health. Gender transformative policies 'seek to transform gender relations to promote equality'.[xvi]

Gender transformative leadership will be grounded in principles including:

- a framework for gender equality, women's rights and human rights
- challenging privilege and power imbalances based on gender that undermine health
- intersectionality, addressing social and personal characteristics that intersect with gender — race, ethnicity, geography etc — to create multiple disadvantages
- being applicable to leaders of any gender, not exclusively women leaders.

Gender transformative leaders in global health will aim to leave no-one behind in access to health and equally, aim to leave no-one behind in leadership and decision-making.

Women leaders are not born with an empathetic gene

We do not assert that all female leaders are better than all male leaders or that women are born with an empathetic gene that men do not have. But, on average, countries led by women are doing better to contain COVID-19 and we would argue it is because female leaders have a leadership style that is more likely to succeed - not asserting with war analogies that 'we can beat this enemy' but placing human life first, listening to the evidence, being prepared to take unpopular decisions and communicating those decisions openly to the public, emphasising a collective approach. We want gender parity in health leadership but we also want health leaders of all genders to be gender transformative leaders.

ASK 2: WOMEN ARE DRIVERS OF HEALTH SYSTEMS IN COVID-19 AND BEYOND

Health systems before COVID-19 were already weakened by gender inequality

Women deliver health and social care to around 5 billion people globally. COVID-19 hit health systems already weakened by the unequal treatment of women, who are the majority of the workforce. In 2019 WHO launched a landmark report **'Global health: Delivered by Women, Led by Men'**[xvii] calling for urgent action to address gender equity in the health workforce as essential to achievement of global targets, including Universal Health Coverage. The report highlighted:

- **The gains to be made by empowering women – who hold 70% of health worker jobs – are largely untapped.** Women mainly occupy low-status, lower paid jobs. Many are further disadvantaged on the basis of their race, class or other social factors.
- **Gender norms and stereotypes about jobs affect the roles occupied by women and men** (occupational segregation). Men dominate higher wage health roles (CEOs, surgeons) while women hold the majority of lower paid nursing and midwifery jobs.
- **Stereotyping and occupational segregation** contribute to men, on average, earning 28% more in health than women (gender pay gap). Women's considerable unpaid work in health and social care is not included in employment statistics or gender pay gap analysis.
- **Women health workers often face bias, discrimination, and sexual harassment.** Sexual harassment, often not addressed, damages both women affected and health systems.
- **The gender balance will not equalize on its own.** Countries need gender transformative policies to address underlying causes of gender inequity, change work culture, create decent work for women and close gender gaps in leadership and pay.

ON AVERAGE, MEN EARN

28%

MORE THAN WOMEN IN HEALTH (GENDER PAY GAP)

NB: THIS GAP WOULD BE MUCH WIDER IF STATISTICS INCLUDED WOMEN'S UNPAID WORK

Source: Boniol et al[xviii]

ASK TWO:

Provide health workers, most of whom are women, with safe and decent working conditions

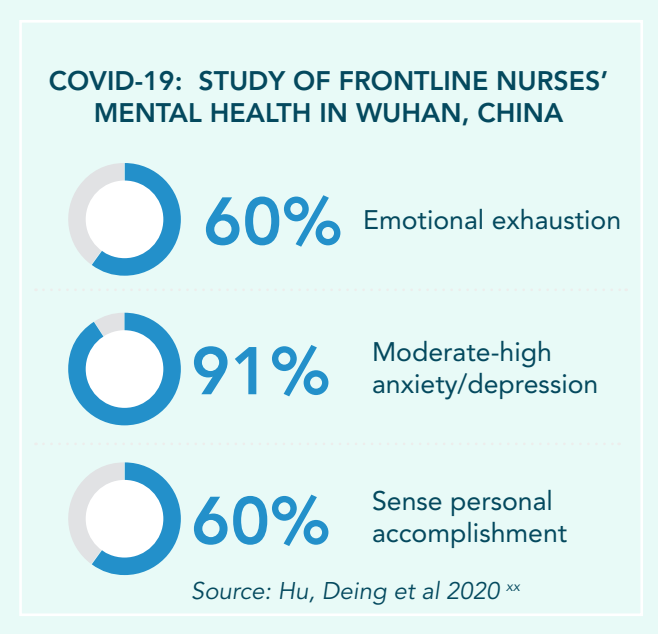
PROBLEM: Women are 70% of the global health workforce but underrepresented in leadership, clustered into lower status, lower paid jobs and commonly subject to harassment.[xix] Women are at higher risk of COVID-19 infection, which is compounded by exhaustion and mental stress. Women health workers need safe and decent working conditions to enable them to care effectively for patients, their families and themselves.

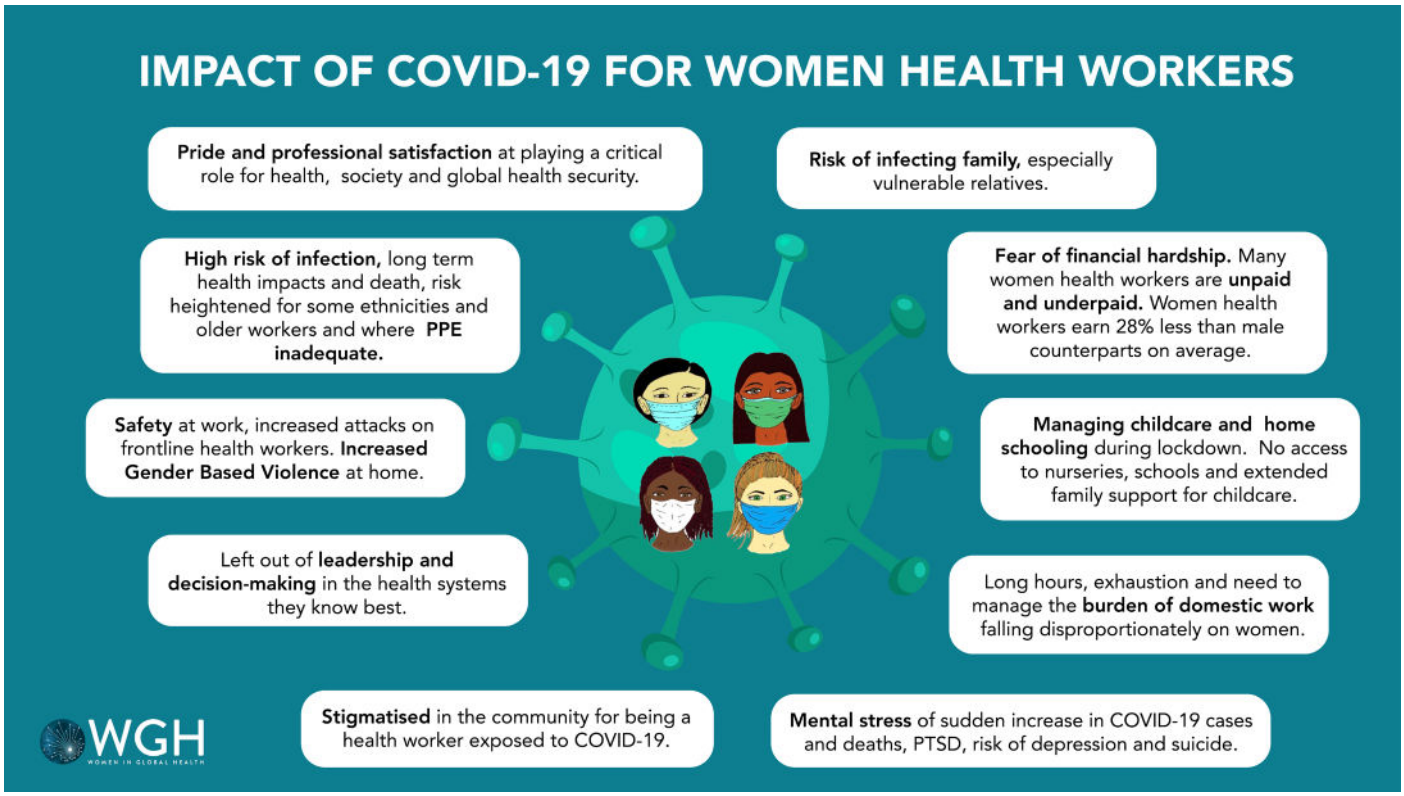
SOLUTION: We ask that WHO Member States, international agencies and NGOs, and health sector employers provide health workers, most of whom are women, with safe and decent working conditions. This includes providing adequate personal protective equipment, and procedures, and protecting workers from harassment and bullying.

COVID-19 is taking a harsh toll on female health workers

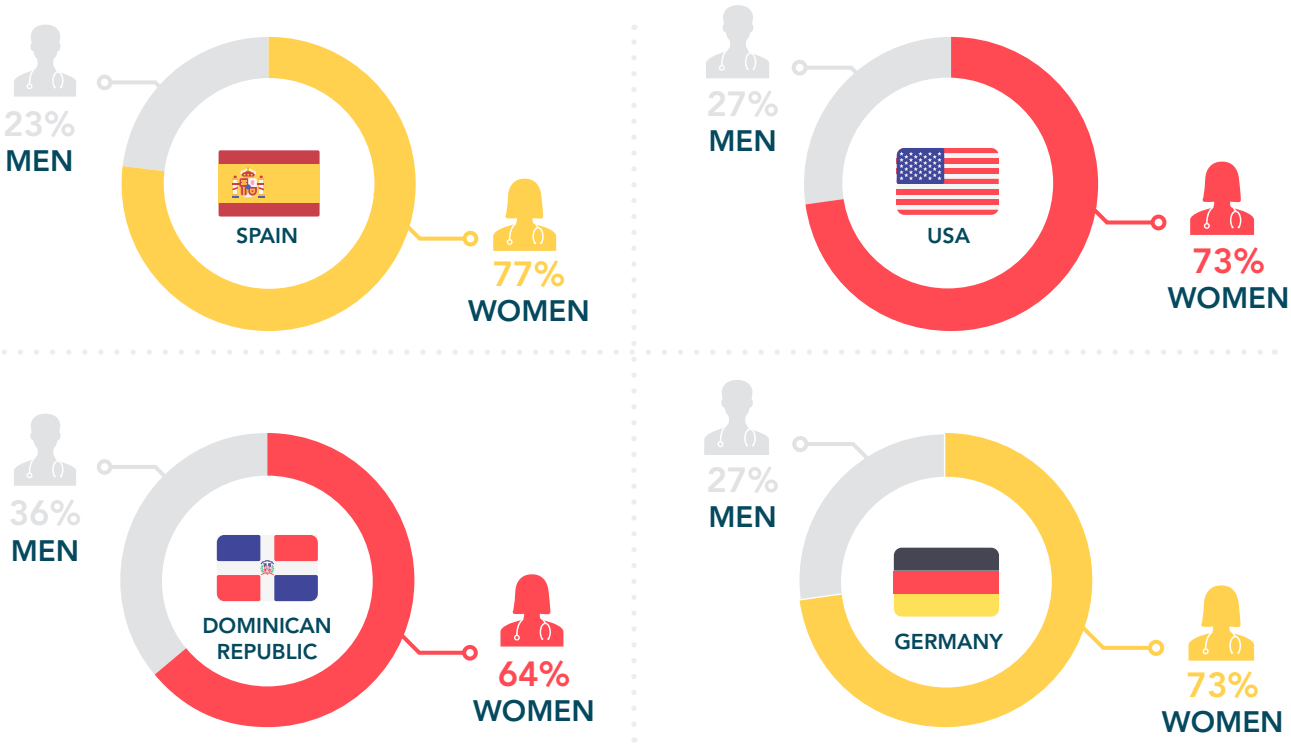
The graphic below summarizes the diverse and serious impacts of the COVID-19 pandemic for women health workers. Women health workers have stepped up to the challenge of COVID-19, coping with a surge in seriously ill patients, juggling scarce resources and risking their own health and lives, particularly since in many contexts personal protective equipment (PPE) has been in short supply, non-existent or designed to fit male not female bodies.[xxi] Women health workers are generally the majority of health workers infected since they tend to deal directly with patients. Some female health workers have chosen to live separately from their families to avoid taking the infection home. Others have juggled long hospital shifts with domestic work and childcare. Women health workers have put their health at risk from infection but also risked violence and harassment. In September, Amnesty International[xxii] reported that over 7,000 health and social care workers had died from COVID-19, many because they lacked personal protective equipment (PPE). In July, WHO[xxiii] reported COVID-19 related attacks on health workers in many countries, often related to misinformation, fear and stigma. Reports have also come from several countries of mental health issues, including suicides, amongst health workers who have been on the COVID-19 frontlines.

A study of nurses in Wuhan, China[xxiv] who had coped with the first surge of pandemic cases found near universal anxiety and depression (91%) but also that 60% felt pride and professional satisfaction in the role they had played. With COVID-19 women health workers have been expected to manage impossible professional and personal workloads, all the time earning 28% less[xxv] than their male counterparts and largely excluded from decision making.





COVID-19: % FEMALE AND MALE HEALTH WORKERS INFECTED



Source: Global Health 5050 24 July 2020 [xxvi]

COVID-19: Applause is welcome but women health and social care workers need decent work

COVID-19 has put unprecedented stress upon health systems built on weak and unequal foundations. Women health and social care workers in many countries have been lauded and applauded for their sacrifice and commitment but above all, they need decent work and equality in pay and leadership. Many health systems have been further challenged by COVID-19 because they are desperately short of trained health workers. With a predicted shortfall of almost 18 million health workers needed to achieve Universal Health Coverage by 2030[xxviii] investing in decent jobs for women in the health and social workforce is investing in global health security. Creating decent jobs for women in health would significantly contribute to achievement of the Sustainable Development Goals by 2030 and reduce the 18 million global health worker gap. Investing in women to enter formal sector jobs in health would have the wider benefits of increasing gender equality and women's economic empowerment. New jobs created in health could accommodate young populations in low income countries, fuel economic growth and strengthen health systems. But these new jobs cannot be created on the current model of inequality between women and men in the workforce. COVID-19 has exposed the cracks in an unequal system that we must put right to build strong and resilient health systems ready to face the next emergency.

> ***"With women making up nearly 8 in 10 of the NHS workforce, it's a disgrace we don't have protective uniforms in women's sizes. Our workers deserve better"***
>
> *Frances O'Grady, General Secretary General of the Trades Union Congress UK, July 2020* [xxvii]

ASK 3: GLOBAL HEALTH SECURITY RESTS ON WOMEN'S UNPAID WORK

The poorest women subsidize global health working unpaid in health systems

Women in health contribute an estimated $3 trillion to the world economy, of which almost half is unrecognized and unpaid.[xxx] Women, more than men, are recruited for core health system roles such as vaccinators and community health educators on the frontlines of health and not paid, paid a stipend for performance or given a non-financial incentive. India's ASHAs (see insert) are an example of women working in core health system roles but not part of the formal labour market and therefore uncounted in official statistics. Many low-and middle-income countries, particularly, engage women in health systems in unpaid or underpaid roles with no career advancement, pension, social security or other protections since they are outside the formal labour market. This doubly disadvantages women by denying them formal labour market wages and protections and also uses their time which is a scarce resource. Basing health systems delivery on women's unpaid work makes a fragile foundation for global health. In an emergency, unpaid workers are likely to be the first to leave their posts, diverted by other domestic duties or as in COVID-19, afraid of contracting the virus since these low status workers may also be low priority for provision of protective gear.

"This is part of unpaid labour of women and is seen as an extension of the work women do at home."

Ranjana Nirula,Convenor All India Coordination Committee of ASHA Workers[xxix]

India's ASHAs (Accredited Social Health Activists) are government accredited female frontline health workers and typically, the first point of contact for communities in rural India where there is little or no access to health care facilities. This one million strong cadre of women make an average of around $50 a month in incentives and bonuses for meeting targets in areas such as child vaccinations. ASHAs are classified as volunteers, not part of the formal labour market and not covered by social security or minimum wage legislation. Enlisted to go door to door to trace COVID-19 patients in addition to their normal duties, some ASHAs went on strike in August to demand job recognition, better pay and protective gear.

ASK THREE:

Recognize the value of women's unpaid care work by including it in the formal labor market and redistributing unpaid family care equally

PROBLEM: Women's unpaid work provides a fragile foundation for global health, including responses to outbreaks and pandemics. Female health workers contribute an estimated $3 trillion to our Gross World Product, of which almost half is unrecognized and unpaid.[xxxi] Women, more than men, are recruited for unpaid roles in health and expected to provide indispensable care and domestic work for their families.

SOLUTION: We ask that WHO Member States, international agencies and NGOs bring women's unpaid work in health and social care work into the formal labor market and help redistribute unpaid family care equally between men and women. This includes paying women fairly for their health and social care work, and implementing family-friendly policies (e.g. equal paid family leave for men and women) that help redistribute unpaid family care.

WOMEN CONTRIBUTE

$1.5 trillion

TO GLOBAL HEALTH ANNUALLY IN UNPAID WORK[xxxii]

WOMEN CONTRIBUTE

$11 trillion

TO THE GLOBAL ECONOMY ANNUALLY IN UNPAID WORK (HEALTH AND OTHER SECTORS)[xxxiii]

THE VALUE OF WOMEN'S UNPAID WORK IS ESTIMATED AT[xxxiv]

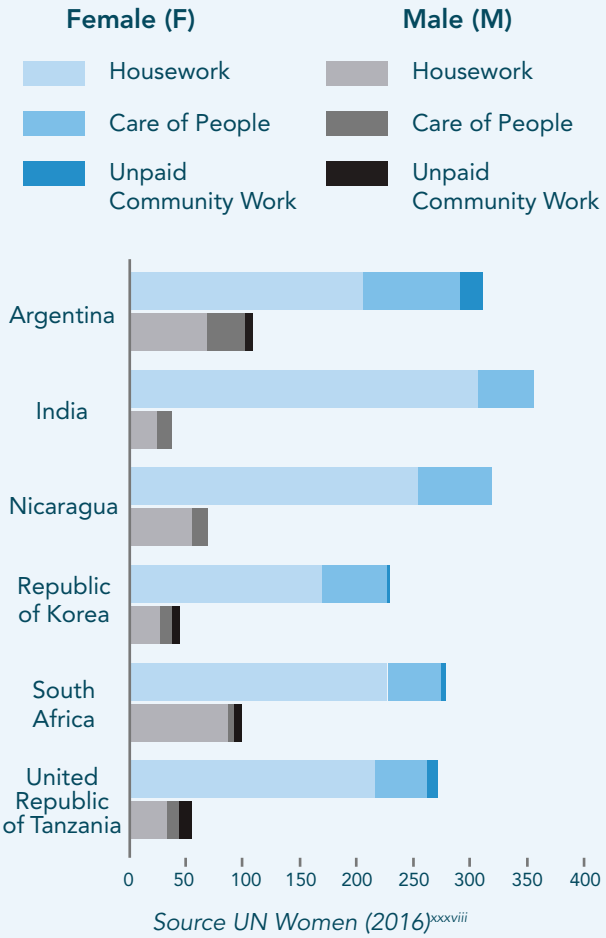
15.2%
GDP Ecuador

25.3%
GDP Costa Rica

Women do more unpaid domestic and care work than men – this has increased with COVID-19

As noted above, for some women their unpaid work includes roles in health systems. For most women it includes unpaid care and domestic work at home (housework and care of people) and may include unpaid community work. Differences between countries can be seen in the attached graphic but in all cases women are spending more hours each day than men on unpaid domestic work and care of people. On average, women spend 3-4 times the hours on unpaid domestic and care work than men.[xxxvi] By mid May schools in 162 countries were closed due to the pandemic,[xxxvii] increasing demand for care work at home, which is generally invisible and accorded no value in official statistics. Given the existing unequal gender division of labor, a disproportionate burden of this extra work has fallen on women and girls. Many governments have taken unprecedented measures to support workers who have lost incomes from formal labor market jobs but few have offered support to enable parents in the pandemic, and primarily women, to reconcile paid and unpaid care work.

TIME SPENT PER DAY ON UNPAID CARE AND DOMESTIC WORK, BY SEX



Source UN Women (2016)[xxxviii]

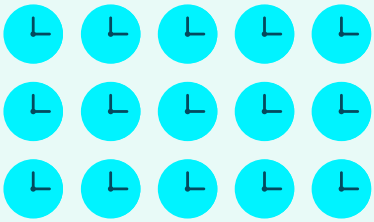
Source: UN Women 2020[xxxv]

Women are the shock absorbers of society: urgent action is needed on women's unpaid work

In any crisis, including a pandemic, women are the social shock absorbers of society, expected to respond with unpaid work to whatever needs to be done. But women's time is not infinitely elastic. Before COVID-19 women, on average, already had less 'free time' than men due to the longer hours they were devoting to unpaid work in the home and outside. The additional pressure on women's time from COVID-19 has almost certainly led to mental stress and physical exhaustion and may have impacted negatively on girls' education and life chances as they have been drawn into supporting the care burden of their mothers. Unpaid care work needs to be recorded, recognized and policies put in place to support redistribution of women's domestic work equally with men. All governments have committed in Sustainable Development Goal 5, Target 5.4 to achieve this by 2030. In addition, all governments should bring the unpaid work women are doing in health systems into the formal labor market as decent work so it can be measured and made part of government accountability and performance systems and women properly compensated. All these measures are essential underpinnings for strong health systems and global health security.

In a study of USA and 4 European countries both mothers and fathers were spending more time during the COVID-19 pandemic on household and family unpaid work.

But women spent 15 hours a week more than men on domestic labor.



Source: BCG Caregivers survey[xxxix]

Sustainable Development Goal 5: Achieve gender equality and empower all women and girls

Target 5.4 recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies, and the promotion of shared responsibility within the household and the family as nationally appropriate. (Target end date 2030)

ASK 4: GENDER RESPONSIVE HEALTH SYSTEMS SERVE EVERYBODY'S NEEDS

Without gendered research and data health systems are working blind

Despite international agreements and countless papers on good practice, fewer than 60 countries are currently reporting sex disaggregated data to WHO on COVID-19 infections and mortality.[xl] This has serious implications for policy making because lack of data hides health vulnerabilities that differ by sex. Men generally have higher COVID-19 mortality than women and we need to know why. Comprehensive data is critical to targeting measures to protect men in the most vulnerable groups (by age, race, ethnicity, health status etc). In June 130 countries reported sex disaggregated data on COVID-19 infections[xli] and the vast majority reported roughly equal numbers of infections in men and women. But 13 out of 130 countries reported that 70% or more of COVID-19 infections were in men. Nepal and Qatar, reported 91% infections were in men and only 9% were in women. Without further research, it is impossible to know whether this pattern of infection reflects exceptional circumstances where men in general were exposed to the infection in a way that women were not, or whether it reflects women's lack of access to COVID-19 testing. Those two possibilities have very different implications for women's health.

SERIOUS GAPS IN COVID-19 DATA

Fewer than 60 out of 193 countries report data on COVID-19 infections and mortality by men/women.

In June 2020 13 out of 130 countries reported that 70% or more COVID-19 infections were in men.

Source: Global Health 5050

ASK FOUR:

Adopt a gender-responsive approach to health security data collection/analysis and response management

PROBLEM: Ignoring the gender aspects of outbreaks and pandemics hinders prevention and response management by obscuring critical risk factors and trends.

SOLUTION: We ask WHO Member States, international agencies and NGOs, and the global health research community to adopt gender-responsive approaches to health security data collection/analysis and response management. This includes:

- Collecting and publishing sex-disaggregated data and including women and men equally in clinical trials and other research
- Conducting specific research to address biological and behavioural risk factors that are different among men and women (e.g. risks to pregnant and breastfeeding women and risks from use of tobacco, indoor cook stoves, etc.)
- Conducting specific research to address the role of women in global health security solutions (e.g. family and community health promotion, impact on health policy of female decision-makers including parliamentarians, etc.)
- Conducting specific research on the impact of outbreaks and pandemics on women's sexual and reproductive health, gender-based violence, invisible/ unpaid labor, poverty, girls' education and other gender-responsive topics.

Going beyond the gender binary

Although gender is on a spectrum beyond the masculine/feminine binary there is a near total absence of COVID-19 related data on the impact of the pandemic on people of non-binary genders. This gap in our knowledge can have serious consequences. Panama, for example, introduced a COVID-19 lockdown with alternate days allocated for men and women to leave their houses[xlii]. The highly contentious measure was discriminatory for people of non-binary genders who faced threats and exclusion.

GLOBALLY 243 million WOMEN AND GIRLS 15-49 HAVE BEEN SUBJECT TO SEXUAL AND/OR PHYSICAL VIOLENCE BY AN INTIMATE PARTNER IN THE LAST YEAR.

VIOLENCE AGAINST WOMEN AND GIRLS HAS INCREASED WITH COVID-19 RESPONSE MEASURES

FRANCE: reports of domestic violence up 30% since lockdown March 2020

ARGENTINA: emergency calls for domestic violence up 25% since lockdown March 2020

SINGAPORE: calls to helplines up 33% since COVID-19

Source: UN Women 2020[xliv]

"Abusers always work from home."

Title UK National Centre for Domestic Violence campaign against domestic violence during COVID-19, August 2020

PROJECTIONS:[xliii]
10% decline in maternity/newborn services in low-and middle-income countries due to COVID-19 could cause:

1,745,000
additional women with major obstetric complications

28,000
additional maternal deaths

2,591,000
additional newborns with major complications

168,000
additional new born deaths

Source: Guttmacher Institute 2020

Gendered data and research guides better response measures

Without gender-responsive data and research, lessons will not be documented that will help combat future health challenges. Policy measures responding to COVID-19 should be based on evidence and research that factor in gender differences and the impact of gender inequality. In Sierra Leone 2014-15 an additional 3,600 maternal and infant deaths resulted from disruptions to safe delivery services due to Ebola.[xlv] That tragic number of deaths was similar to the number who died from the infection itself. Love and pregnancy do not stop for pandemics but despite this and the experience of Ebola, reports have come from several countries[xlvi] of mothers dying in the COVID-19 pandemic, unable to access safe delivery services during lockdowns. Policy measures must be based on an understanding of the different needs and vulnerabilities of different genders. A gendered analysis of lockdown measures would have predicted the increase in gender-based violence seen just about everywhere with COVID-19 since it was known that for many women home is not a place of safety. Ignoring the gender aspects of outbreaks and pandemics hinders prevention and response management by obscuring critical risk factors and trends.

ASK 5: FOLLOW THE MONEY

Women provide solutions whilst bearing the brunt of COVID-19

Women spend more time, on average, supporting their local communities than men, often in unpaid roles.[xlviii] In COVID-19, women's groups in all regions are providing essential services and filling gaps in government service provision at community level. COVID-19 has increased demand for services of women's movements and organizations, particularly following increases in gender-based violence and vulnerability due to lock downs and job losses but without increased funding to match need. With COVID-19, women's organizations are facing stress and burnout and many may close due to funding constraints and donors redirecting funds[xlix].

Women's organizations and movements are underfunded, especially in low- and middle-income countries

Women's movements and women's organizations are historically underfunded in all regions Overseas development aid from bilateral donors for gender equality and women's empowerment has increased in the last decade to a record US$ 48.7 billion in 2017-18. Less positive, however, the vast majority of that funding was devoted to other priorities, gender equality was only the primary objective for 4% of that spending.[li]
Closer examination shows that very little of this expenditure -only US$459 million (1%) - was committed to women's institutions and organizations generally and only US$ 198 million (0.5%) was committed specifically to NGOs working for women's empowerment.[lii] Resources for gender equality may have increased but only a tiny fraction of bilateral aid is reaching frontline women's organizations in low-and middle-income countries delivering essential services in health and social care. Although women's organizations have the experience and expertise to provide community support during COVID-19, lack of a secure funding base has limited their capacity to respond. Flexible and predictable funding for women's organizations at community level would increase global health security for everyone.

Support Provided by Women's Organizations in Eastern Europe and Central Asia During COVID-19 (UN survey)

- Issuing current and reliable information to communities
- Prevention and response to gender-based violence, including free legal aid
- Identifying vulnerable people to target assistance
- Delivery of food and medicines to the vulnerable
- Online campaigns to mobilize volunteers
- Rapid needs and impact assessments of communities and marginalized groups

Source: UN Women[xlvii]

ASK FIVE:

Fund women's movements to unleash capacity to address critical gender issues

PROBLEM: The response to outbreaks and pandemics is stronger when global movements, including women's networks, coordinate global and local action. But women's organizations – especially those based in low- and middle-income countries most at risk – are underfunded; only 1% of gender-focused donor aid to civil society went directly to women's NGOs in low income countries in 2017-18.

SOLUTION: We ask that WHO Member States, international donor agencies and NGOs, and philanthropic organizations fund women's movements and particularly, women's organizations in low- and middle-income countries, to unleash capacity to address critical issues in global health security.

% BILATERAL AID FOR GENDER EQUALITY IN 2017-18 GOING TO WOMEN'S ORGANIZATIONS

1% **went to women's organisations globally**

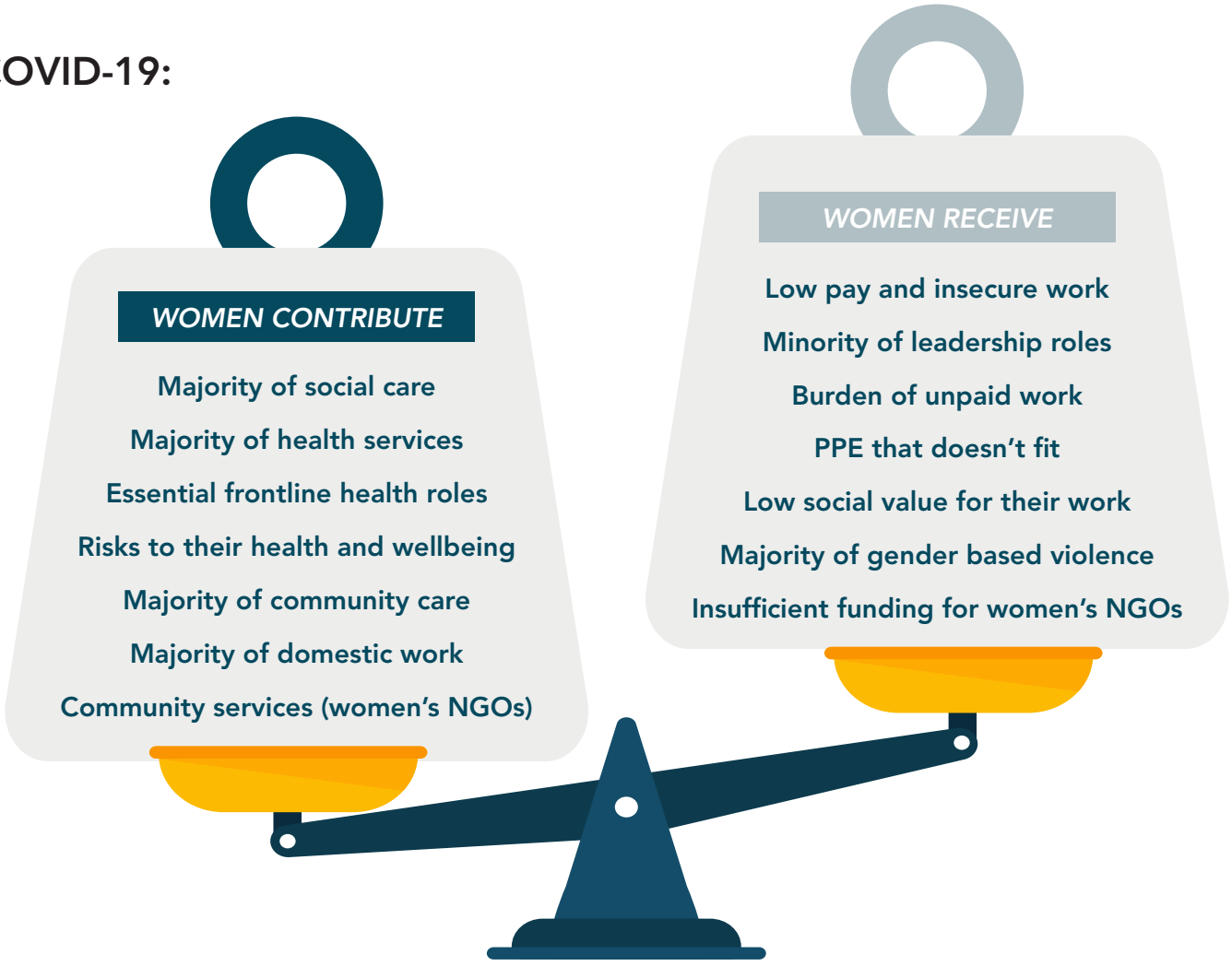
0.5% **went to women's NGOs in Low-and Middle-Income Countries**

Source: OECD DAC Gendernet (2020)[liii]

Final word: Build back global health with a new social contract for women

> *"Men still run the world. I'm not sure it's going so well."*
>
> *Sheryl Sandberg, 2017*

COVID-19:



We must bring all our talent to the table

We cannot win the fight against COVID-19 and other health challenges by using only half of our global talent pool. Diverse perspectives in leadership strengthen health systems and save lives. The voices of women, especially women from diverse backgrounds and women from the Global South, must be elevated into the decision-making arena.

We do not need to ask permission

All Women in Global Health's Five Asks - commitments on gender equality, data, the health workforce and women's unpaid work – have already been agreed by the world's governments in the Sustainable Development Goals (SDGs) — and reinforced in 2019 in the Political Declaration from the UN High Level Meeting on Universal Health Coverage . We are asking governments and multilateral agencies to be accountable for commitments made and the delivery date of 2030.

Global health security depends on women

COVID-19 has been a major health, social, economic and political shock and is therefore a time for radical thinking. To date, global health security has depended on women being in a subordinate position but what if women in health say no to the present social contract that leaves them vulnerable, undervalued, at risk and with too little say in major decisions determining their lives? Then the fragile health security exposed by COVID-19 will fail completely. We cannot return to business as usual after this pandemic. Global health has to change.

FUTURE CHAOS OR FUTURE HEALTH SECURITY?

What if women said no?

Work unpaid?	**NO**
Do majority of domestic work?	**NO**
Paid less than men (Gender Pay Gap)?	**NO**
Majority of leaders are men?	**NO**
Low social value for women's work ?	**NO**
Men get credit for women's work?	**NO**
Women deliver, men lead?	**NO**
PPE designed for men?	**NO**
Sexual harassment at work?	**NO**
Gender based violence at home?	**NO**

This is everybody's business

COVID-19 has focused the world on health and brought greater understanding of solidarity and the centrality of health for economic prosperity. We have had time to consider what we value. This is not a gender war. Women in the health and social sector want the means - decent work, safety, dignity, fair pay and equal leadership - to do their jobs better and deliver stronger health outcomes for everyone. Gender responsive health systems that reward women health workers fairly, engage women equally as leaders from global to community levels and fund women's movements will be a solid foundation for building back better global health and global health security.

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Women in Global Health (WGH)

WGH, founded in 2015 and registered as a not for profit, is a global movement with more than 25,000 supporters across more than 90 countries and national chapters in around 25 countries. We bring together all genders and backgrounds to achieve gender equality in global health leadership. WGH's core leadership team is supported by a large network of volunteer fellows, advisors, coordinators and assistants, all virtually based in different parts of the world. The WGH movement challenges power and privilege in health by mobilizing a diverse group of emerging women leaders in health, engaging with existing global health leaders to transform their own institutions, and holding those leaders to account.

WGH co-chairs the WHO Gender Equity Hub for the Global Health Workforce Network, working with partners to catalyze gender equity and gender transformative change in the health workforce. WGH is one of the founders and co-convenors of the Alliance for Gender Equality and UHC, an alliance of over 100 national and global NGOs working for gender responsive UHC.

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