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Emergency Support Query

Securing the Safety and Wellbeing of Women Frontline Healthcare Workers in the COVID-19 Response

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Overview

This report discusses risks for women frontline healthcare workers[1] in the COVID-19 response and proposes actions for mitigating these risks. While it is essential to reduce risks for *all* healthcare workers, data suggests that the majority of frontline healthcare workers in the COVID-19 response are women. For example, in the United States (US), women hold 76 percent of healthcare jobs, and make up more than 85 percent of nurses, who are generally at the frontline of patient interactions, including in the COVID-19 response.[2] Women frontline healthcare workers are also the primary caregivers at home. As discussed below, their risks are amplified by pre-existing gender roles, power dynamics, and levels of workplace violence, as well as the dramatic measures being taken to address the problem. However, as is also described below, many institutions and organizations fail to undertake a gendered analysis critical to the protection of essential

[1] "Frontline healthcare workers" refers to those providing direct healthcare-related services, either within healthcare institutions (e.g. clinics, health centres, hospitals, etc.), or within the community itself (e.g. community health workers). This includes those such as doctors, nurses, midwives, assistants, community health workers, social workers, vaccinators, etc. They may be employees, incentive workers, volunteers, or of any other status.

[2] US Census (https://www.cnbc.com/2020/03/18/how-the-coronavirus-could-impact-women-in-health-care.html); cited in CNBC (https://www.census.gov/library/stories/2019/08/your-health-care-in-womens-hands.html)

staff and to an effective response. Understanding more about the risk factors can enable organizations to take steps to mitigate these risks for women frontline workers, better respond to instances of violence, and create a stronger and safer response.

This document focuses on women healthcare workers. However, many critical roles within this response, such as cleaners and support staff, will also be filled by women and the risks they face also require further attention. It does not address all aspects of a gendered response. Nor is it a definitive set of guidelines. Rather, it is designed to be a *"living"* document, that will continue to draw upon the expertise of the global community.

Potential Risks for Women Frontline Healthcare Workers

There are many risks that women frontline healthcare workers will face in relation to the COVID-19 pandemic. This section highlights some of the most critical risks to be anticipated and addressed from the outset of the response. These may vary from context to context, and there may be others that are not listed here. However, all organizations can and should take immediate steps to ensure the safety and wellbeing of women frontline healthcare workers.

Heightened risk of contracting COVID-19; high levels of exposure and lack of adequate personal protective equipment (PPE). This is a risk for all frontline healthcare workers. However, with women overwhelmingly in the providing direct care, they will be disproportionately affected. In addition, gender power imbalances increase the risk that men will be prioritized over women, or male-dominated roles such as doctors prioritized over female-dominated roles such as nurses in distribution and decision-making around PPE. Given women's additional gender roles as primary caregivers in their households, the ripple effects of increased health risks to them become even more significant.

Increased risk of workplace violence. The World Health Organization (WHO) defines workplace violence as, "Incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health."[2] Both physical and psychological harm including attacks, verbal abuse, bullying, and sexual and racial harassment, are considered to be workplace violence.[3]

The COVID-19 response may increase female healthcare workers' risk to workplace violence in the following ways:

a. *Lack of safety moving to and from areas of work.* Severe restrictions on movement and day-to-day activities or "lock down" associated with COVID-

[3] Framework guidelines for addressing workplace violence in the health sector. Geneva, Switzerland: International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), Public Services International (PSI); 2002. who.int/violence_injury_prevention/violence/activities/workplace/en/.

19, can cause particular safety concerns for women going to and from their places of work. Drastic changes may disrupt the normal protections afforded in typical daily life--such as the presence of other people, well-lit transport routes, variety of options for travel times, etc.— and leave women vulnerable to violence, including sexual violence. In some contexts, where workers regularly commute across national or state borders e.g. Swiss healthcare workers commuting to northern Italy, more stringent restrictions on movement may also increase vulnerability and risk for women such as getting stuck on the opposite side of the border. Women frontline healthcare workers will need to continue to reach their jobs each day, despite the risks, and with fewer options available.

b. *Violence from patients and/or patients' families.* Even before the COVID-19 outbreak, global reports indicate high levels of workplace violence against female healthcare workers.[4] Research conducted in a general hospital in northern Italy prior to the pandemic found that 45% of healthcare professionals reported workplace violence.[5] The research found that men were more likely to commit physical violence than women, and that assaulted professionals were more likely to be female.[6] Already, there are reports of violence against healthcare workers within the COVID-19 (or novel coronavirus) outbreak across countries, the majority of whom are women. Acute stress and fear have been noted to contribute to agitation and aggression for patients and their families, which lead to violence.[7] The stress and uncertainty of this current crisis alongside the reduction of available support to staff caused by overstretched staff, isolation and IPC protocols, etc. may escalate this risk for women frontline healthcare workers.

c. *Sexual exploitation and abuse (SEA).* Sexual exploitation and abuse is a serious global problem, that is heightened in times of humanitarian crisis.[8] In the context of COVID-19, the pre-existing power imbalances and risks

[4]Refer to "References" section for full citations, including: Alhassan, R.K., Poku, K.A. (2018); Cheung, T., & Yip, P. S. (2017). Cheung, T. et al (2017); Dr. Fraser, E. (2020); and Ferri et al (2016)

[5] Ferri, P, Silvestri, M, Artoni, C and Di Lorenzo, R (2016) 'Workplace violence in different settings and among various health professionals in an Italian general hospital: a cross-sectional study', *Psychology Research and Behavior Managemen*t, Vol. 9 263–275

[6] Ferri et al (2016) cited in Dr. Fraser, E. (16 March 2020). *Impact of COVID-19 Pandemic on Violence against Women and Girl*s. VAWG Helpdesk Report No. 284. UKAid from the Department for International Development.

[7] Stephens, W. (May 12, 2019). Violence Against Healthcare Workers: A Rising Epidemic. https://www.ajmc.com/focus-of-the-week/violence-against-healthcare-workers-a-rising-epidemic

[8] Inter-Agency Standing Committee (3 December 2018). *IASC Plan for Accelerating Protection from Sexual Exploitation and Abuse (PSEA) In Humanitarian Response at Country-Level*. https://interagencystandingcommittee.org/system/files/iasc_plan_for_accelerating_psea_in_humanitarian_response.pdf

faced by women healthcare workers are exacerbated by the scarcity of critical resources such as personal protective equipment (PPE), soap, and hand sanitizer as well as the dramatic measures being taken as part of government responses. This creates a risk of sexual exploitation in exchange for key resources (e.g. offering hand sanitizer or PPE in exchange for sex) as well as controlling or harmful behaviors towards women healthcare workers, whether physically or psychologically, in the name of public health. For example, media in China have been accused of mistreating women healthcare workers for purposes of propaganda. A video run through a local newspaper that claimed to honor women healthcare workers, showed men forcibly cutting women's hair while they cried and looked away with expressions of shame. It sparked outrage from critics who called it humiliating and degrading to women, and an assertion of men's power over women's bodies; male colleagues did not appear to be subjected to the same treatment.[9]

Increased risk of violence in the home. Experience shows that intimate partner violence tends to increase during times of crisis.[10] In this pandemic, the severe measures that encourage or force women to stay in their houses, is expected to increase the risk of intimate partner violence significantly; women's rights organizations in several countries are already sharing that they are receiving increased reports of IPV since the pandemic.[11] This risk is also true for women frontline workers, including community health workers. Recognizing that women on the frontlines face serious risks not only at work but also at home, can help organizations and institutions better . Several factors may contribute to the increased risk that they face in their homes, including but not limited to:

- Being isolated and/or quarantined with an abusive partner and lacking access to support or other options.
- women frontline healthcare workers continuing to work while their partner stays home, disrupting longstanding gender norms;
- using infection, prevention and control protocols such as "social distancing" to isolate women frontline healthcare workers from their children or loved ones, particularly in light of their increased exposure to COVID-19;
- exacerbating fear in women frontline healthcare workers about causing their families to contract COVID-19 and/or using this as an excuse for violence

[9] Li, J. (18 February 2020). *China's coverage of coronavirus nurses provokes backlash*. https://qz.com/1804040/chinas-coverage-of-coronavirus-nurses-provokes-backlash/

[10] Erickson, A. and Rastogi, S. (January 2015). Private Violence, Public Concern: Intimate Partner Violence in Humanitarian Settings Practice Brief, International Rescue Committee (IRC): New York. https://www.rescue.org/sites/default/files/document/564/ircpvpcfinalen.pdf

[11] Dr. Fraser, E. *Impact of COVID-19 Pandemic on Violence against Women and Girls* (16 March 2020), VAWG Helpdesk Report No. 284, UKAid from the Department for International Development.

- acute stress for abusers and breakdown of social protections

Shame, stigma or violence in the community. As fear of the pandemic spreads in a community, so does panic and panic behavior. Women frontline healthcare workers are at increased risk of shame and stigma from their community and family for their perceived role in managing the pandemic, and amidst fears of spreading it within the community. Examples of this were reported in the Philippines and the Democratic Republic of Congo (DRC), where health workers were expelled from their homes because landlords feared that they would carry COVID-19.[12] There may also be unintended consequences to sudden upswings in community health workers or volunteers, who may also face shame and stigma based on their involvement with the response and/or bending of traditional gender roles.

Intense stress related to conflicting work demands and personal caretaking responsibilities. Overwhelmingly worldwide, women are the primary caretakers in their families. Estimates across different countries indicate that 57% to 81% of all caregivers of the elderly are women. Women are often the wives or adult daughters of the person they are caring for.[13] Women frontline healthcare workers are very likely to also be the primary caregivers in the home. Therefore, they can be disproportionately affected by the COVID-19 response in several critical ways:

a. *Lack of childcare.* While the need for healthcare workers increases, schools across the globe are being shut down and the vast majority of people are being told to stay home. This creates a serious challenge for women frontline healthcare workers who also are responsible for caretaking in the home. Lack of childcare and/or elderly care adds stress and financial burden to women frontline workers.

b. *Fear of causing negative health outcomes for family members.* Healthcare workers on the frontline face daily exposure to COVID-19 patients. This can create fear of putting their families at risk. This is a concern for all healthcare workers, however, as primary caregivers for their families, this emotional stress is most common and may be most acute for women frontline healthcare workers.

c. *Fear of causing negative health outcomes for patients and other medical providers.* Conversely, women frontline healthcare workers— who are most

[12] Global GBV AoR.

[13] 17. Bush EC. Gender differences in specific caregiver burdens. Master's thesis. The University of Utah. 1997. Available from: http://content.lib.utah.edu/utils/getfile/collection/etd1/id/960/.../700.pdf. [Ref list]

likely to be caring for others at home, including those who are sick—may fear their families putting them at risk, and the impact that this could have on their work and on those they interact with each day. Fear of putting others at risk may combine with fear of having to self-quarantine and potentially miss work at the time when they are most needed. This fear confounds with institutional gaps such as lack of paid sick leave (see below) or support for childcare.

d. *Emergency preparation and care for family.* Women frontline workers are also responsible for ensuring that their families have adequate supplies and are taken care of emotionally and physically during the crisis, including if relatives fall sick. This creates additional layers of logistical *and* emotional work, that compounds with their responsibilities as direct service providers to heighten acute stress.

Specific risks for those who are migrants, refugees, internally displaced persons (IDPs) or from other vulnerable groups

Women healthcare workers who are migrants, refugees and IDPs working on the frontlines will face additional challenges such as limited mobility and access to resources, less power both as displaced people and as women. Following social distancing and IPC protocols may not be an option. They may face language barriers or barriers to implementing IPC protocols within their cultural context, e.g. women not being allowed to access services without a male partner, or risking violence in isolation. They may require special permissions to travel outside of their immediate confines, which in times of lock down could become more stringent and risky. In addition, women who work as volunteers or for small incentives, may be forced to choose between public health protocols, protecting themselves and others, and maintaining their earnings or status as a community health worker.

Mental health impacts in the short-term and long-term

The acute stress women frontline healthcare workers experience can negatively impact their psychological and emotional wellbeing both during the response, and after the peak has passed. A recent study published in the New England Journal of Medicine looked at the mental health impacts of the COVID19 response on healthcare workers in China. They found that symptoms were higher in amongst women frontline healthcare workers, nurses, and people caring for COVID-19 patients, as well as those working in the epicentre of the outbreak. There were high rates of depression (50%), anxiety (45%), insomnia (34%), and distress (72%). While many healthcare workers may not experience such symptoms, women frontline healthcare workers face increased risk of negative mental health consequences.

Common Institutional Gaps in Supporting Women Frontline Healthcare Workers

Many organizations and employers lack strong policies and procedures that reference and address the distinct needs of female staff and volunteers. in some cases, policies actively discriminate against women healthcare workers (e.g. offering inequitable pay between women and men). In other cases, the specific needs of women are overlooked by gender-neutral policies, or by a response that is designed and managed primarily by men. Even when strong policies and procedures are in place, they often lack enforcement and/or the organizational culture doesn't reflect the policies on paper. Some of the critical gaps that emerge to affect women frontline healthcare workers are:

a. *Lack of paid sick leave.* Workers who don't have paid sick leave, have to make impossible choices between their own health, the health of others, and the need to continue to provide for their families. As seen above, this will fall disproportionately on women.

b. *Weak systems for protection from sexual exploitation and abuse (PSEA).* Though zero-tolerance policies may be in place for organizations and institutions, most have a long way to go in addressing PSEA and making it safe for women to actually come forward.

c. *Inadequate support for maintaining menstrual hygiene.* Menstrual hygiene is often put aside in professional settings, particularly during crises, and regarded as "non-essential." Reports from China indicate that women frontline workers often went entire days without being able to address their menstrual needs. When they brought it up to supervisors, they were chastised. Some women frontline workers began to take birth control as a means to skip their periods all together.[14] This has both a physical and psychological impact on those on the frontlines, who are already under great stress.

d. *Lack of mental and psychosocial support.* In times of crisis, care and wellbeing for ourselves, staff, volunteers or others tends to get overlooked for the more 'urgent' work of saving lives. However, this leads to fast burn out, decreases the quality of healthcare, exacerbates stress, creates challenges to maintaining the response in the long run, and can have long-term harmful consequences for frontline workers. Women frontline workers,

[14] https://www.newsweek.com/periods-dont-stop-pandemics-opinion-1492753

as all frontline workers, need access to strategies, resources, and moments to care for themselves as individuals and collectively that are tailored to the specific challenges and stressors they face as mentioned above.

Mitigating Risks: Key Actions for Employers and Organizations

The following are recommendations for immediate actions to help mitigate risks for women frontline healthcare workers in the COVID-19 response. As above, these will vary from context to context, and are not prescriptive but are important to consider from the outset.

1. *Ensure that women are well-represented in decision-making across the response and hold key decision-making positions.* One of the best ways to ensure that our actions, policies, and ideas reflect the need of women frontline workers is to have women at the table for decision-making—not just to contribute but to *lead.* This includes women on senior management teams, involved in the allocation of PPE, in designing/setting up new clinics/hospital wings/health spaces, organizing rosters for surge capacity, etc.
2. *Consult with female staff and volunteers about their needs, concerns, and ideas.* Creating space for women staff, volunteers and others is critical to being able to meet their needs. Ideally this would be led by other women staff. It could take the form of individual check-ins, or collective groups such as "women at work." This may be by phone, email, what's app or online fora. Make sure they feel heard, *are* heard, and are responded to.
    a. *Ask about the specific risks they are facing and what support would be best for them.* Use guidance below to consider how to address anticipated risks and discuss with women frontline healthcare workers any specific risks such as violence, shame, or stigma they face. Listen to their ideas for how to mitigate risks.
    b. *Communicate decisions clearly, addressing women's concerns and ideas.* Acknowledge the specific concerns of women frontline healthcare workers and address them, as well as their ideas and suggestions. Update them on progress.
    c. *Create a culture of care, using a gendered lens.* Check in regularly about the well-being of women frontline workers. Make sure to check-in as a form of emotional support, separate from supervision and to communicate clearly and address concerns. Pay attention and look for the ways in which female and male staff may be experiencing things differently, including your

organization's actions. Consider the specific risks to women outlined above. Consult with gender experts on your team to help maintain your duty of care sufficiently for women staff.

3. *Implement urgent measures to address the multiple roles women frontline healthcare workers play at work and at home:*
    a. *Create and support systems for childcare for frontline workers.* This may include setting up day care services in facilities that are no longer being utilized (e.g. schools), helping staff to organize together into groups for childcare (while upholding public health guidance), and understanding that women working full time responding to COVID-19 does not take away from social norms that mean they still continue to undertake most household chores, etc.
    b. *Explore options to provide safe housing near health facilities.* Some countries have converted hotels and other spaces into optional housing for healthcare personnel, so that they can avoid putting their families or themselves at further risk. In the Philippines, the Office of the Vice President, in partnership with Rotary Clubs, offered dormitories near hospitals for free to frontline workers. This involves both benefits and risks that need to be explored in each context. The benefits to women must outweigh the risks and steps taken to ensure their safety (such as separate housing for women and men). Women should be involved in planning for this option.
    c. *Supply equipment needed for women to maintain their multiple roles as frontline healthcare workers and family caregivers.* Women may need things such as mobile phone credit, transport money or other resources to effectively be able to do their jobs, stay connected with family, and travel safely to/from work.
    d. *Provide additional training.* This response will require additional skills training to keep up with the changing demands of the jobs, reduce the risks in the workplace and at home, and cope with stress. Training not only helps women to provide better quality care, but to manage stress by feeling more confident and prepared to protect the safety of themselves, their patients, and their families.
4. *Recognize and address the supply needs specific to women frontline healthcare workers,* in addition to all healthcare workers.
    a. *Prioritize PPE before the crisis peaks and ensure access for women frontline healthcare workers.* Prioritize stocking PPE before the crisis peaks. Where PPE is in limited supply, ensure that your organization advocates for

the most efficient ways to get PPE (increased production or redistribution), ensure that women have access to it, and are involved in decision-making around its use and distribution.

b. *Include menstrual hygiene supplies in emergency supplies for healthcare workers.* The experience from China highlights that female workers may require specific undergarments that are designed for periods (e.g. Thinx underwear) which can be used for longer periods of time than traditional maxi pads. Consult with your female staff about what would work best for them and invest in this as a priority.

c. *Stock post-rape kits for staff.* Given the risks to safety for women frontline healthcare workers noted above, it is important to stock post-rape kits for staff.

d. *Provide supplies where needed to follow IPC protocols.* This includes things like soap, water, hand sanitizer, and means to properly dispose of PPE and disinfect clothes and surfaces.

5. *Put in place gender equitable policies and protocols.* Review existing policies and strengthen as needed. These include, at minimum*:*

   a. Paid sick leave for all paid frontline healthcare workers, including women.

   b. Equal pay for men and women in the same position; equal incentives for men and women community workers (if they are receiving incentives).

   c. Protocols for addressing SEA

6. *Activate systems for preventing and responding to SEA.* Make sure your organization has clear reporting and response procedures for SEA. Rapidly train staff on policies and procedures. Develop or adapt a code of conduct for SEA and roll it out to all staff and volunteers to sign

7. *Connect with GBV service providers (within your own team or external) and encourage frontline workers to download the GBV Pocket Guide.* This will enable you to*:*

   a. Understand what GBV services are still available

   b. Connect women frontline healthcare workers—staff and volunteers— to those services.

   c. Ensure that safety planning through trained service providers is available for women frontline healthcare workers

   d. Equip frontline healthcare workers with the GBV Pocket Guide, to help them respond to survivors when no GBV services are available.

8. *Provide resources for self-care and collective care for staff.* This includes specialized and informal support, including:
    a. Make a specialized counsellor available to all staff, confidentially, by phone or email. Share the information for how to reach this person in staff meetings, over email, and by printing and hanging it in common spaces. If one is not already on staff with your organization, hire someone.
    b. Connect with other groups who specialize in self-care and collective healing. Circulate self-care exercises by email, what's app, or other means. Tailor them to your audience.
    c. Acknowledge that self-care rituals will not get rid of the very real stress or trauma being experienced but can help to manage it.
    d. Understand that communicating about the issues that are stressing women healthcare workers on the frontlines is a form of care: including concerns about pay, safety, family, etc.
    e. Ensure that support continues beyond the crisis. After the acute emergency, a period of readjustment will be necessary for women frontline healthcare workers. It is important to offer space and support for them to prioritize their persona reintegration into daily life.[15]
9. *Consider the specific risks faced by women frontline healthcare workers who are refugees, IDPs, migrants, and take pro-active steps to address them.* Speak with them about the challenges they face and what kinds of solutions and support can be offered. This may include actions such as: providing supplies that they cannot access, hiring translators, advocating for policy changes that will improve women healthcare workers' ability to work, brainstorming on how to implement IPC in contexts where social distancing is not feasible, etc.

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