Expert Report for the UK Covid-19 Public Inquiry

Module 2: Structural Inequalities and Gender

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About the author

Dr Clare Wenham is an academic expert in global health security, global health governance and global health policy, and holds the position of Associate Professor of Global Health Policy at London School of Economics (LSE). Dr Wenham has a PhD in International Relations and her research seeks to understand how state and non-state actors prepare for and respond to epidemics, what political challenges there are in the global health architecture, and what are the downstream, secondary effects of policies introduced to mitigate epidemics. Dr Wenham's research analyses the gendered impact of epidemic (and broader health) policy, considering how the gender neutrality of global health policies differentially affect women. She has conducted multiple research grants for and a number of publications on this topic, considering the involvement of women in policymaking, and the downstream effects of gender-neutral policymaking for health emergencies on women and other marginalised groups; including on economic participation and access to sexual and reproductive health services. During the Covid-19 pandemic Dr Wenham co-founded the Gender and Covid-19 Research Group, bringing together academics from 11 countries to conduct real time gender analysis to identify and analyse the gendered dynamics of the response. She has advised the European Union, World Health Organization, UN Women, European Parliament, World Organization for Animal Health, and the German government on policy related to gender and epidemics/pandemics.

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Statement of Truth

I confirm that this is my own work and that the facts stated in the report are within my own knowledge. I understand my duty to provide independent evidence and have complied with that duty. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Clare Wenham
22 September 2023

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Introduction

1. Gender inequality is a multi-faceted and global problem. The UK regularly ranks relatively highly in global and regional gender equality rankings - 21st in the World Economic Forum's 2020 Global Gender Gap report and 6th in Europe according to the European Institute for Gender Equality's Index. Although gender mainstreaming is considerably advanced in UK policy making relative to other countries (Hankivsky et al., 2019), gender inequality persists.

2. Gender inequality is at its heart a structural issue that plays itself out in the daily lives of UK citizens, exacerbated by intersecting inequalities such as race, age, class, and location, amongst others. The persistence of the patriarchy, a system producing and reproducing gendered and intersectional inequalities, can be found in the UK's laws, norms, policies, and decision-making processes, historically and in the present day.

3. Most of this report focuses on women, but it is pertinent to acknowledge that gender inequality and patriarchy impacts men and non-binary groups too. Moreover, while male violence against women (and against themselves) is indicative of the extreme embodiment of the patriarchy at the individual level, the same social norms drive government policy making which disregards and in many cases harms women, directly or indirectly. Beyond violence, key challenges to gender equality in the UK include women's disproportionate unpaid care burden, women's limited representation in parliament (29% of ministerial positions in 2020), and persistent gender gaps in pay and full-time employment (Barbieri et al., 2020). It is for these reasons that intentional and mandatory attention to gender inequality in the making of government policy is necessary. While no government can be held directly accountable for the choices and behaviours of individuals, they do have the power and responsibility to recognise the structural dimensions of gender inequality, and to work to alter and alleviate the harms of patriarchal norms through purposeful policy making (Wenham and Herten-Crabb, 2021).

4. In 1997, Blair's 'New Labour' government began to do just that. The creation of the Women's Unit recognised for the first time the structural dimensions of gender inequality and the need to redress the situation in UK policy making. The mission of the Women's Unit was to mainstream women's issues throughout Whitehall, such that women's perspectives and experiences were heard across all policy issues (Squires and Wickham-Jones, 2004). In 2007, the Equality and Human Rights Commission (EHRC) was established and the Women's Unit was converted into its own department and renamed the Government Equalities Office (GEO) until 2010 when it was moved into the Home Office. Based at the Cabinet Office since 2019, the GEO leads on issues of equality across UK policy making, including gender, while the EHRC acts as a non-departmental body responsible for enforcing the 2010 Equality Act.

5. The 2010 Equality Act combined three independent commissions and duties on disability, race, and gender and expanded its remit to include sexual orientation, gender reassignment, pregnancy and maternity, age, marriage and civil partnership status, and religion under the Public Sector Equality Duty (PSED). This Duty requires the governments of the UK and devolved administrations to give "due regard" to the potential impacts of their policies on those with the nine protected characteristics identified in the Equality Act (Equality and Human Rights Commission, 2020). It is also important to note that it is sex

rather than gender which is a protected characteristic. While this language is relatively vague, initially both Westminster and the devolved administrations understood 'due regard' to include undertaking equality impact assessments (EIAs) which became a widespread practice across the country (Pyper, 2020). In November 2012 however, then Prime Minister David Cameron announced, in the interest of cutting "reams of bureaucratic nonsense" that EIAs would no longer be required of government departments since "you no longer have to do them if these issues have been properly considered" (Cameron, 2012). This attitude ignores the pervasive and often 'common sense' nature of patriarchal norms that are difficult to overcome without conscious and considered attention to their manifestations.

6. Since the 2010 election, the Welsh and Scottish devolved administrations have shown greater commitment to issues of equality than Westminster, with Welsh and Scottish regulations and institutional mechanisms in support of the *Equality Act* being stronger than those of England. In 2013, the National Assembly of Wales recommended the Welsh government take primary legislative competence over the PSED, such was the concern that Westminster would repeal the duty (Communities, Equality and Local Government Committee, 2013). Scotland and Wales require impact assessments of government policies and stipulate reporting duties on public sector bodies regarding mainstreaming and pay gaps. Scotland has been a leader in mainstreaming across government departments, whereas Wales has focused on accessible public services for meeting the needs of those with protected characteristics, such as using EIAs to prevent cuts to library services that would disproportionately impact older people and disabled people (Hankivsky et al., 2019; EHRCW, 2014). Northern Ireland has long had its own statutory duty (Section 75, Northern Ireland Act 1998) requiring public authorities to promote equality, including by race, sexual orientation, and religion, however the political commitment to these requirements has been more challenging owing to societal divisions (Hankivsky et al., 2019). Despite these legal duties and commitments in the devolved administrations, challenges remain across all nations. Critically, regional attempts to improve gender and other inequalities have been significantly undermined by the austerity measures implemented by Westminster in 2010. Although commitment to EIAs demonstrates a policy-level commitment to predicting and mitigating harms against people with protected characteristics, implementation of activity to mitigate such harms does not necessarily follow. Further research is needed on the effectiveness of EIAs in UK and devolved administration policy-making (Roberts, et al., 2017).

7. Austerity measures, introduced in 2010 by the Conservative-Liberal Democrat Government, exacerbated gender inequality. By 2015, £1 billion had been cut from healthcare, £6.3 billion from social care, and £13 billion from education; by 2020, £37 billion was cut from welfare payments (Pearson and Elson, 2015). Reducing public services and welfare directly and indirectly exacerbates gender inequality, and are a form of gender discrimination. Women, as carers, mothers, and the majority of older people, are more reliant on public services and welfare than men: affordable, accessible, and quality public services thus function as a means of redistributing unpaid care work from women to the state. Furthermore, women make up two-thirds of the UK's public sector employees, so reductions in public services and pay freezes impact women's employment security and opportunities, and their financial freedom. Without quality public services, women spend more time and energy engaging in care work that benefits the whole of society, but without the support of that society. Wealthy women can afford to shift their care burden onto poorer

and, typically, migrant women and women of colour who are more likely to take on low-paid, insecure, or part-time jobs to facilitate their own care responsibilities. Such feminised and thus devalued labour is a significant contributor to the gender pay gap that all UK governments have committed to reducing.

8. Below, I present a brief summary of the key issues related to gender inequality at the onset of the COVID-19 pandemic, as requested by the Inquiry. Structural discrimination is a key thread, as patriarchal norms – such as women being the primary carer of children – influence which problems are considered policy issues, who is involved in policy development, and how well those policies are financed and implemented.

Gender and pandemics before Covid-19

9. The disproportionate impact of epidemics and pandemics on women was established prior to COVID-19 (Wenham 2021; Smith 2019; Harman 2016; Davies & Bennett 2016). Whilst the below examples are beyond the UK, data on the gendered nature of epidemics and how public health and social interventions brought in to mitigate the spread of emerging infectious diseases was known, and could have been used to consider how this may translate to the UK context. One of the most notable ways in which this has been demonstrated is through the changes to routine health provision during health crises. Research during the Ebola outbreak in West Africa demonstrated that the diversion of health resources resulted in more women dying of obstetric complications and maternal mortality than all people died of the pathogen itself (Sochas et al., 2017). Changes to sexual and reproductive health also had significant impacts during Ebola in Democratic Republic of Congo (DRC), on the demand side with women failing to attend antenatal checks within clinic settings for fear of risk of infection, a fear which was also shared by clinicians not wanting to treat these women (McKay et al., 2019). Gender-based violence was also known to increase during outbreaks (Peterman et al., 2020), and girls' attendance at school disproportionately suffered during both the Zika epidemic in Latin America, and the cholera outbreak in Yemen (Azcona et al., 2020). Domestic violence is also known to increase during lockdowns and school closures, and natural disasters (Roure, 2019; Onyango, 2019; Houghton, 2009; Harville et al., 2011).

10. Women also faced significant economic impacts in previous epidemics. Firstly, women tend to work in sectors requiring face-to-face interaction and these are the locations first to close when an epidemic emerges. Evidence from the Ebola and Zika outbreaks show that women's employment prospects were affected disproportionately (Bandiera et al., 2019, Diniz, 2017). Moreover, prior to COVID-19, it was well understood that women are the primary caregivers in most households, meaning that if there is a sick individual, or any changes to routine care of children (such as school closures) that women will assume the additional load (e.g. Windebank, 2001).

11. This caregiving role was recognised informally within households, but also women's work in primary health delivery – on the frontline of most epidemics and health crises. This not only means that women may be at greater risk of initial infections, but they will likely have longer working hours, and have to carry the mental burden for working amid an epidemic (Manzoor and Thompson, 2019).

12. Seeds of policy recognition were in place however, prior to COVID-19 such as United Nations Security Council Resolution 2177 examining Ebola in West Africa which expressed concern "about the particular impact of the Ebola outbreak on women" and in the Democratic Republic of Congo with Resolution 2439 for Ebola, emphasising that "men and women are affected differently by Ebola and underlines the gender-sensitive response required to address the differential and specific needs of both men and women". The UN Global Health Crises Taskforce also recognised that "greater attention must be paid to the disproportionate burden on women in health crises both in the health sector (as formal and informal caregivers) and with regard to economic and social impacts on women and girls" (Global Health Crises Task Force, 2017). The Global Preparedness Monitoring Board (2019) recognised "that care givers are women, and their engagement ensures that policies

and interventions are accepted… and it is important to ensure that the basic health needs of women and girls, including those for reproductive health, are met during an outbreak”.

Austerity and the UK economy

13. Few policies in recent decades have negatively impacted women in the UK as austerity. Although austerity cannot be blamed for the norms that perpetuate gender inequality, it has arguably exacerbated gender inequalities (Women's Budget Group, 2022a). As the majority of the public sector workforce, users of public services, and welfare beneficiaries, women pay for austerity through public sector pay freezes, reduced public services, and benefits cuts.

Health

14. Austerity measures have undermined population and individual health in two key ways: the "social risk effect" whereby illness is created and exacerbated through increased unemployment, benefit cuts, poverty, and homelessness; and the "healthcare effect" whereby healthcare is undermined through cuts to healthcare services and workforce which affect access to care (Stuckler et al., 2017). Because health and healthcare are gendered – i.e. our gender impacts our health and our relationship to the healthcare system – austerity measures which limit funding to the NHS also disproportionately negatively impact women.

Gendered interactions with health systems

15. There are a number of structural differences as to how women interact with health systems. Due to reproductive life cycles, women are more likely to interact with healthcare providers than men, notably for antenatal, postnatal or contraceptive services. Secondly, gender influences health knowledge, activity and behaviour (Hawkes and Buse, 2013), and gender can affect how and if women access health services (Sen, 2007; Sen et al., 2007; Xu and Borders, 2003). This can lead to gendered delays in health concern detection, treatment and ultimately produce a gendered impact on health outcomes (Crockett and Cooper, 2016; Thorson and Diwan, 2001). Thirdly, gender can affect the pathways chosen for responding to healthcare needs (Jüni et al., 2010; Russo, 1990); both on the user side through differences in interactions between male and female patients with healthcare providers (Govender and Penn-Kekana, 2008), and on the provider side through evidenced gender biases towards patients (Franks and Bertakis, 2003; FitzGerald and Hurst, 2017).

16. Moreover, the interaction with health systems by women is not homogenous, with vulnerable groups facing additional barriers. For example, Gypsy and traveller communities face additional barriers, with women living on unauthorised sites often missing health appointments due to fear of eviction, with the result that they face some of the most severe health inequalities in the country. Disabled women also report unequal access to health care.

17. I will not detail the full range of biological differences between men and women which lead to differential clinical presentations, prevalence and outcomes as these are beyond my knowledge, not being a clinician. However, different prevalence between genders for certain conditions and/or differing treatment protocols are important to note, given how these may have been differentially impacted by changes to clinical provision during the pandemic.

18. Social differences also appear in women's interaction with clinical practice, which influence outcomes. Well known examples are that women are more likely to be diagnosed later for Alzheimer's disease than men (Sundermann et al., 2016); have fewer GP visits for dementia than men leading to worse outcomes (Hoffmann and Tarzian, 2001); and are more likely to die following a heart-attack given differential understandings of symptoms and treatment protocols (Bakker, 2018; Conrad et al., 2019). Moreover, women, and in particular black women, are less likely to have their pain related symptoms believed, resulting in delayed admissions (Hoffmann and Tarzian, 2001; Hoffman 2016;). One in five women in the UK have a common mental health problem, compared with one in eight men; the Mental Health Foundation links women's role as carers directly to increased levels of stress, anxiety, and isolation (Mental Health Foundation, 2021a; n.d.). Living in poverty and experiencing gender-based violence are also linked to long-term mental health impacts (Mental Health Foundation, 2021a) Young women are particularly affected, where over a quarter experience anxiety or depression, thought to be associated with social interactions and economic factors (Women's Mental Health Taskforce, 2018). Increased rates of mental illness have been reported in girls but not boys (The Children's Society 2016; Lessof et al. 2016). Nevertheless, three quarters of suicides are among men, with men aged 40 to 49 have the highest suicide rate (Mental Health Foundation, n.d.). Older South Asian women are also considered an at-risk group for suicide (Mental Health Foundation, 2021b). People of Indian, Pakistani, African-Caribbean, and Chinese origin have higher levels of mental well-being than White people, although Black men are more likely to have had a psychotic disorder than White men (Mental Health Foundation, 2021b). Black women have less engagement with mental health services (Shundi, 2021). Racism is identified as a causal factor in the ill mental health of people of colour.

19. The above is partly because of a lack of research on how conditions affect women, in comparison to men, and because women are less likely to be enrolled in clinical trials. This has resulted in either the same clinical guidelines being applied to men and women, or a reduced treatment regime be instigated. The combination of this has resulted in the UK having one of the largest female health gaps worldwide (ie. the difference between outcomes between men and women for the same conditions) (Manual n.d.).

20. In the remaining part of this section, I will focus on reproductive health, noting the important gendered impacts the pandemic might create, but not to dismiss or deny the range of other gendered health impacts which the pandemic generated.

Reproductive Health

21. Under Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, States have an obligation to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, including free services where necessary…'. There are several structural barriers which continue to prevent women from accessing these services.

22. In the UK, reproductive health services focus on contraception. In 2019, there were 1.9 million contacts to Sexual and Reproductive Health (SRH) services (England), 1.26 million of these were for contraception (Office for National Statistics, 2020c). 82% of all contacts were by women, thus these services predominantly serve women. However, since 2015,

there have been significant reductions of SRH budgets, with a knock on effect on delivery (Advisory Group on Contraception, 2018), coupled with a workforce crisis (Faculty of Sexual and Reproductive Healthcare, 2021). Access to services is reportedly limited for disabled, LGBTIQ* and migrant women (Health and Social Care Committee, 2019).

23. The maternal mortality rate in the UK in 2018 was 8.8 per 100,000 pregnancies (Knight, 2019), yet this is disproportionately high amongst women of colour up to 4 times higher amongst black women, a finding mirrored by the fact that stillbirths predominantly occur in the most deprived areas (Care Quality Commission et al., 2020; University of Oxford, 2019).

24. Following the introduction of a charging regime for migrants requiring secondary healthcare (hospital treatment)[1], for many vulnerable pregnant women, midwifery, obstetric, and general healthcare is no longer free. The charging regime had a deterrent effect on pregnant women and has caused women to avoid healthcare professionals (Maternity Action, 2018).

25. Almost half of pregnancies in Britain are unplanned or where women are ambivalent (Wellings et al., 2013) and it is estimated that more than half of unplanned pregnancies in Britain end in abortion (Department of Health and Social Care and Office for National Statistics, 2019). Access to safe abortion is fundamental to women's rights. It is estimated that one in three women seek a termination during their lives, yet the UK has a number of systemic barriers for women to access such services. In England and Wales, termination of pregnancy requires the consent of two doctors, without which both women and health practitioners are subject to prosecution under the 1967 Abortion Act. The Abortion Act also limits the role of nurses and midwives, who cannot provide abortions, despite these practices being recommended by WHO. Abortion policy was devolved to the Scottish Parliament in 2015 so while the Abortion Act still applies in Scotland, abortions taking place outside the conditions stipulated in the Act are subject to Scottish Common Law.. In England and Wales, abortion is legal up to 24 weeks of gestation, although in Scotland there are no providers of abortion post 16-18 weeks gestation, which places barriers to access. While abortion is provided by the NHS in Scotland, abortion in England and Wales are provided by independent sector providers alongside the NHS (Astbury-Ward, 2015), resulting in inconsistent provision of services between different areas of the UK, leading to unequal pressures on services, waiting times and travel requirements to access care.

26. Prior to 2019, the 1967 Abortion Act did not extend to Northern Ireland, where abortion remained illegal until the repeal of its criminalisation in 2019. However, the power sharing executive within Stormont had failed to commission provision of abortion services, and so despite decriminalisation, there remain several physical and structural barriers to accessing abortion in Northern Ireland. It is well established that making abortion illegal does not reduce women's seeking of termination of pregnancy, rather it exposes them to the greater health risks of unsafe abortion and to risks of criminal conviction. Those who are able to access abortion, such as through travelling to Great Britain to seek such services are exposed to financial, social and cultural risks, meaning that those in rural settings, and from lower socio-economic groups will be less likely to be able to access an abortion.

[1] This charging regime refers to England, there are different charging mechanisms and regulations in Wales, Scotland and Northern Ireland.

27. One key development during COVID-19 was the legislative change to allow for all stages of medical abortion to take place in the woman's home, rather than requiring women to attend a clinic. This was facilitated by a 2018 amendment to the Abortion Act 1967 in Scotland, Wales and England (but not Northern Ireland), which allows the second stage of medical abortion to be administered at home, to prevent the risk of women aborting on the way home, rather than in a safe space. At the start of the pandemic, legislation was further amended to allow the first stage of the medical abortion process to occur at home as well, which removed the requirement for any clinic visit and allowed for a telemedicine model of care, up to 10 weeks gestation in England/Wales and up to 12 weeks in Scotland. This had widely been demonstrated to be as safe and effective as in clinic care in other countries (Ngo et al., 2011).

Women in the healthcare sector

28. Women comprise more than 77% of the NHS workforce in England and each of the devolved administrations (NHS Employers, 2019; NHS Scotland, 2022; Northern Ireland Department of Health, 2019).

29. Real term cuts and underinvestment in public services in the decade prior to COVID-19 has meant that the healthcare workforce was understaffed at the start of the pandemic. The Health Foundation estimated in 2018 that the NHS in England had a deficit of 100,000 healthcare professionals, and this would increase to 250,000 by 2030 without intervention (The Health Foundation et al., 2018). The majority of the gaps in the workforce is amid the nursing profession, which in 2019 represented a 12% shortfall of needed staff, with 40% of all vacancies in the NHS being for nurses (Buchan et al., 2019). The Royal College of Nursing also reported understaffing of nurses in Scotland (4000 posts) and Wales (1651 posts) in 2019 (RCN 2019a; 2019b). Nursing, alongside nursing associated roles and healthcare assistants, are disproportionately feminised sectors.

30. The result of these workforce shortages are twofold; that human resource was as much of a threat to the NHS as financial limitations, and the reduction of staff resulted in a significant toll on the health and well-being of those that remained in the workforce through burnout, anxiety and depression. This would then be amplified by the impending burden of the pandemic.

Participation in the labour market

Occupational segregation

31. Women generally enter the labour market with higher qualifications, but earn on average less per hour because they are more likely to work in lower paid industries, and in low paid positions (Government Equalities Office, 2019).

32. Occupational segregation is both informed by and serves to further entrench patriarchal norms and gender inequality.

33. Collectively, health and social care, education and early years employ 37% of working women in the UK (20%, 12%, and 5%, respectively). Women comprise 77% of NHS (78% of health and social care workforce in Northern Ireland) and 58% of social care workforce, 75% of the education workforce, and 96% in early years care (Carers UK, 2019; NHS Confederation, 2021).

34. Occupational segregation happens in a number of ways: by industry, and by role type. Due to structural discrimination and norms, industries that involve an element of care typically attract lower wages. Conversely, occupations coded 'male' like construction, engineering, and finance, disproportionately employ men and are accompanied by higher wages. Men continue to be disproportionately represented in positions of seniority, as directors, managers, and senior officials across sectors (Equality and Human Rights Commission, 2021).

35. In June 2019, the employment rate for women was at its highest on record at 72.1% (80.1% of men), while the economic inactivity rate for women aged 16 to 64 was at its lowest at 25.1% (16.3% of men) (Office for National Statistics, 2019a). Social reproductive forms of activity are excluded from definitions of 'economic activity' – a measurement of people who are unemployed but not actively seeking work. The cost and availability of childcare is a key factor in women's economic 'inactivity' and their labour as carers is considered uneconomically valuable by government statisticians. The rising costs of an unregulated childcare sector have had significant impacts on women's ability to engage in economic activity. Moreover, women are more likely to work part time than men – in 2017 38% of women in the workforce were on part time contracts (Office for National Statistics, 2017).

36. Occupational segregation also impacts underemployment (involuntary part-time work) which has risen in the UK as a result of increasing numbers of employers offering part-time contracts following the 2008 financial crisis. Male-dominated industries and occupations in the UK experience less underemployment than female-dominated industries. Part-time work limits opportunities for promotion, training, and pay (Kamerāde and Richardson, 2018).

37. Bangladeshi women (57.8%), Pakistani women (54.5%), and Chinese women (38.5%) have the highest rates of 'economic inactivity', while White British women (24.4%) have one of the lowest rates (Office for National Statistics, 2019b). Moreover, women from ethnic minority backgrounds are unemployed at higher rates than white women with the same qualifications (McGregor-Smith, 2017). Disabled women work fewer hours and are

disproportionately represented in low-wage jobs relative to non-disabled women (Lisney et al., 2019).

Pay

38. In 2017, the Government introduced a statutory requirement for companies to report gender pay gap information. The 'gender pay gap' typically shows the difference in average hourly wages between men and women, not necessarily for the same roles or level of seniority.

39. Across the UK, the gender pay gap in hourly earnings between full-time workers in 2018 was 8.6%, rising to 17.9% when part-time workers were taken into account (Office for National Statistics, 2018). Every English region had a larger gender pay gap than Northern Ireland, Scotland and Wales (Office for National Statistics, 2018). Between 2012 and 2019 the gender pay gap declined 0.6 percentage points, from 17.9 to 17.3% (Office for National Statistics, 2019d).

40. Gender pay gaps pervade all three of the main feminised sectors: among the early years workforce the gender pay gap is 29%, and in England the gap is 18.9% for hospital doctors, 15.3% for GPs, and 11.9% for clinical academics (British Medical Association, 2020; Shannon et al., 2019). The smallest pay gap is in secondary schools where men earn 1.7% more than women (Department for Education, 2021).

41. Although differences between the pay of full-time, seniority-equivalent men and women are real, the significant difference between the wages of working-aged women and men are due to a number of other factors: women typically work in feminised industries that have been devalued under the current economic model and thus are low wage; and women, due to their many and varied caring responsibilities, are more likely to be part-time, or leaving the workforce for childcare responsibilities. Moreover, feminised, low-skilled sectors are more likely to include flexible, zero-hours contracts which offer little job security (MacLeavy, 2011).

42. As the 'gender pay gap' typically looks at hourly earnings, and women on average do fewer hours of paid work a week than men, actual differences in earnings are larger than the gender pay gap suggests. The Institute for Fiscal Studies reported that in 2019 working-aged women in the UK earned 40% less than working-aged men (Andrew et al, 2021). These differences in earnings during the working life lead to a knock on effect on women's pension pots (Office for National Statistics, 2015).

Pregnancy, motherhood and employment

43. The UK has also introduced family friendly policies, such as flexible working hours, and maternity and paternity leave. For women, this is up to 52 weeks' maternity leave, with the potential for shared parental leave, and the right to return to the same job. These policies have the potential to make combining work and family easier to increase women's involvement in the labour market (Olsen, 2021). However, disparities in the periods of maternity and paternity entrench societal gender roles (Smithson and Stokoe, 2005), the result of which is that maternity and childcare interventions can lead to long periods of leave that can hinder women's abilities to return into elite positions (Mandel and Semyonov, 2006).

44. The result of these differences is that the motherhood penalty has real, financial impacts for women around the UK: around one in nine mothers reported losing their jobs due to pregnancy and motherhood between 2010 and 2015,, and three quarters of mothers had faced some form of discrimination in the workplace (Equality and Human Rights Commission, 2018). This is in spite of the fact that legislation prevents dismissal or discrimination because of pregnancy, childbirth or maternity leave

45. Moreover, the gender pay gap between mothers and women without children is wider than the pay gap between men and women without children (Grimshaw and Rubery, 2015). Thus, by the time a mother's first child is twelve, her hourly rate of pay will be 33% behind a man's on average (Costa Dias et al., 2016).

46. In 2019, the OECD singled-out the UK for having the most expensive childcare system in the world, with 35.7% of income being spent on it (as much as most pay for housing). As such, 17% of parents have to leave their jobs (Pregnant then Screwed, 2020). Moreover, there are issues with availability, with only 45 local authorities having enough childcare for parents who work full time (Women's Budget Group, 2017a), and thousands of private nurseries having to close in recent years, following financial pressures. In turn, this sector has had to increasingly rely on insecure working conditions for their staff, further continuing a circle of precarity. The result is that many women have to withdraw from the workforce to deliver unpaid care within the home, or indeed their communities, which further broadens the gender gap in employment.

Exposure to violence/harm and safeguarding

47. Most of the data below focuses on women's exposure to violence perpetrated by men. Male violence against women, men, and non-binary people contributes to, on average, 78% of total violent crimes (Office for National Statistics, 2020a); male self-harm is also disproportionate with three-quarters of suicides by men (Office for National Statistics, 2020b). And yet funding for prevention and intervention programs directed at men is even lower than funding that supports women victims of male violence; practitioners are also aware that funding for prevention programs often comes to the detriment of women's support services when both types of initiatives are forced to compete for the same, minimal, funding opportunities (Burrell, 2018).

Austerity and gendered violence

48. Poverty puts downwards pressure on the poorest people, exacerbating unequal power relations between highly stressed men and women. Violent crime has increased since the 2008 financial crisis and this, combined with austerity measures, has manifested in an increase in domestic violence (Walby et al., 2016). At the same time that domestic violence has increased, funding for women's shelters and other programmes to support victims have been cut which, along with differences in commissioning practices in local councils, has created a geographic lottery for women survivors of domestic abuse (Mawby, 2016).

Domestic abuse

49. Domestic violence in the UK is pervasive, prompting the UK government and devolved administrations to pass legislation to prevent and prosecute this abuse. One in five adults in England and Wales experience domestic abuse in their lifetime; for every three victims, two are female and one is male (Office for National Statistics, 2019c). Disabled women are especially impacted – nearly one in every two disabled women experience domestic violence in their lifetime (Lisney et al., 2019). The Domestic Abuse Bill (DAB) was introduced to parliament in 2019 and became law in 2021 to better facilitate the prosecution of abusers and protect victims. The Serious Crime Act 2015 also introduced coercive control as a criminal offence, and the DAB built on this by proposing extending the offence to include coercive controlling behaviour after a separation (Home Office, 2022). Scotland's Domestic Abuse Act passed in 2018 also criminalises coercive control, however in Northern Ireland there was no such law until 2021, nor did Northern Ireland have a gender-specific Violence Against Women and Girls strategy.

50. While the legislation contains measures to protect victims, the DAB places the duty on local authorities to provide shelter and support to victims; amid a context where local authorities already face severe budgetary pressure, as discussed above. While the Serious Crime Act 2015 criminalised coercive control, in the years after it was passed it was used to prosecute and there was little training and funding of police officers to implement it (Travis, 2017).

51. Asylum-seeking women are particularly vulnerable to violence and abuse due to their precarity and risk of destitution. Perpetrators use women's precarious immigration status or poor access to alternative housing to threaten them, and refugee women often fear reporting abuse to police or seeking treatment for fear of being reported to the authorities (End Violence Against Women, 2018). The 2016 Strategy to End Violence Against Women

and Girls did not include any commitments to safeguard women asylum seekers' safety and the Home Office did not consult stakeholders on women asylum seekers (Baillot and Connelly, 2018). Migrant or refugee women with 'no recourse to public funds' status have particular difficulty accessing women's refuges. Research Women's Aid found that women with no recourse to public funds only had access to one refuge space per region in England (Smith and Miles, 2017). Many of these women had already been subjected to violence prior to coming to the UK and there are also cases of sexual abuse and rape at UK detention centres (BBC News, 2016).

Sexual violence

52. Programmes to assist victims of sexual violence in the UK are severely underfunded. The Istanbul Convention requires that there is one rape crisis centre per 200,000 women; in 2019 the UK was 100 short (Engender Scotland et al., 2019). In 2019, Rape Crisis England and Wales had a waiting list of over 6,000 people. Funding cuts have forced rape crisis services to close and the government's decision to pursue a commissioning model – a competitive market for commissioning services – means the number of service providers has declined (Hirst and Rinne, 2012). There is no sustainable funding model for Rape Crisis centres in England, Wales, and Northern Ireland. The Scottish Government's Rape Crisis Specific Fund has been frozen for ten years since 2008 despite continual increases in reporting of sexual crimes and a 160% increase in demand (Engender Scotland et al., 2019). In January 2020, Northern Ireland had no specialist rape crisis service, and reports in 2019 indicated that its only sexual violence counselling charity had over 800 people on its waiting list (Engender Scotland et al., 2019).

53. The UK legal system has also proven inadequate at bringing perpetrators to justice. Conviction rates for sexual violence are very low; in England and Wales in 2019, 55,259 rapes were reported, yet only 1,659 resulted in a charge and only 702 convictions were secured – just over 1% (The Centre for Women's Justice et al., 2020). In Scotland, only 39% of cases resulted in conviction in 2016-17, the lowest rate in eight years (Justice Directorate, 2018). In Northern Ireland, under section 5 of the Criminal Law Act, failure to report a rape carries a sentence of up to five years, whilst this may place pressure on victims to report, the conviction rate for sexual offences in 2019-20 in northern Ireland was 64% (PPSNI 2020).

Unpaid work

54. For many women in the UK, given persistent gender norms, compounded by the gender pay gap, their ability to engage in paid work is dependent on their unpaid care responsibilities (Perrons, 2005). This is seen as an amplification of the motherhood penalty (Correll et al., 2007).

55. Mothers provided 74% of UK childcare in 2015. The estimated financial value of all unpaid childcare was approximately £132 billion (Office for National Statistics, 2016b). In 2016, on average men do 16 hours of unpaid work a week, which includes cooking, childcare, cleaning and other household or community jobs while women do 26 hours, (i.e. 60% more than men). These statistics of time use have not changed much over the last 20 years across the UK.

56. These are averages, but the effects are likely stratified by socio-economic group, whereby the poorest women are more likely to provide more unpaid childcare than those more affluent and/or more educated. Given changes to childcare provision during the last 10 years, more women have taken on more unpaid labour within homes, and this is particularly true of those who are the most marginalised (Pearson and Elson, 2015). It is also stratified by age: women aged 26-35 undertake the most unpaid work, suggesting such inequalities are interlinked with the birth of a first child (Women's Budget Group, 2020).

57. There is a significant burden of stress associated with unpaid care within households and communities, particularly if juggled alongside paid work (Ervin et al., 2022). This falls disproportionately on women, and in particular single mothers.

58. Unpaid care can also refer to care for family, friends or neighbours such as for those who have long term physical or mental ill health or disability, or relating to old age. In 2011, it was estimated 10% of the UK population were providing some form of unpaid care (Parliamentary Office of Science and Technology, 2018), 58% of which were women.

59. Social care budgets fell by £7 billion between 2010-2017, with the result that more of the care burden is unpaid, and falls to women (Women's Budget Group, 2017b). This is compounded by women undertaking the majority of unpaid care work, for children and elderly relatives, meaning their professional role is likely to be accompanied by unpaid work (Elson, 2017).

Public services and benefits

60. In 2019, government spending on public services as a proportion of GDP was 40%, down from 47% in 2010 (Women's Budget Group, 2022b). Between 2010 and 2018, funding for English councils was cut by over 49% (Wakefield, 2022). Unpaid carers, disabled people, women of colour, and other marginalised groups are disproportionately impacted due to their increased reliance on public services and welfare. As has been detailed above in the sections on health, gender-based violence, and unpaid care work, the introduction of austerity measures in 2010 have been detrimental to women across the country.

61. The devolved administrations have tried to mitigate the impacts of austerity. Scotland, Northern Ireland, and Wales (but not England) each have welfare funds for emergency hardships, and the Scottish Government (2019) reported spending an additional £125 million in 2018-19 protecting those most impacted by austerity. The Scottish Government has called on Westminster to end the freeze on benefits and the two-child limit. In 2019, the Northern Ireland Audit Office warned that the devolved administration was likely to experience additional hardship as welfare reforms continue and when the current mitigation measures put in place by the NI Executive end in 2020 (Northern Ireland Audit Office, 2019).

62. The government introduced a benefit cap in 2013, limiting the amount in benefits working households could receive. Single parents, of whom 90% are women, comprised two-thirds of Universal Credit recipients who had their benefits capped (Alston, 2018).

63. The benefit caps included the two-child 'family cap' whereby only two children per family are covered by the cap, unless subsequent children are conceived due to coercive control or rape. On average, the cap, which equates to a restriction on the reproductive rights of low-income women, equated to a yearly loss of £2800 per 'extra' child and was expected to push more than 200,000 children, and therefore their parents, into poverty by 2020 (Child Poverty Action Group, 2017). The policy disproportionately impacted women in Northern Ireland and BAME women who are more likely to have three or more children, and to rely on benefits for support.

64. Changes to Universal Credit delivery via single household payments entrench gendered power dynamics, limit women's financial autonomy, and risk increasing the control of financially or physically abusive partners (Alston, 2018). Although universal credit can be split where financial or physical abuse is known and the partners decide to remain living together, this requires disclosure of abuse which women have felt could worsen the abuse (Howard and Skipp, 2023).

65. The Welfare Reform Act of 2012 instituted the 'Bedroom Tax' or 'spare room tax'. This tax decreased housing benefits for private renters on social housing benefits. Women make up 60% of those on housing benefits such that women were disproportionately impacted by the 'Bedroom Tax' (Women's Budget Group, 2019).

66. In 2012, the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) drastically reduced legal aid, on which women are more reliant than men, in England and Wales (Women's Budget Group, 2016). In Scotland, the prospects of accessing an affordable,

knowledgeable or specialist Legal Aid lawyer who takes on domestic abuse cases is unlikely (Scottish Women's Rights Centre, 2017). The Government acknowledged in its own Equality Impact Assessment that women, BAME, and those with disabilities would be more negatively impacted by cuts to legal aid.

Gender inequality in the UK in January 2020

67. As the evidence highlighted above shows, gender inequality and discrimination was pervasive across UK society prior to the onset of the COVID-19 pandemic. Government policy always has a role to play in ameliorating patriarchal social norms that serve to subjugate women: without conscious effort and resources the unequal position of women, harming their health and well-being will be exacerbated.

Missed Opportunities

68. It is well established that routine antenatal provision reduces negative outcomes for mother and baby, hence why the NHS routinely offers multiple antenatal appointments. The decision to reduce these, and/or offer phone provision goes against global best practice for maternity care. In particular, Ebola outbreaks in 2014-6 and 2019 demonstrate the negative externalities for maternal and infant mortality if women are not able, or not willing for fear of exposure to pathogens, to access antenatal care. Alternative pathways could have been established to ensure routine support to pregnant women, such as moving antenatal care out of hospital settings.

69. Women comprise most of the health and social care workers across the United Kingdom. As such, it would have been easy to anticipate the need for gender-sensitive support for women as the majority of those on the frontline of an impending pandemic. Noting also that women disproportionately suffer from mental health challenges, this could have been factored into occupational health provision and support for those on the frontline. Moreover, noting that the frontline workforce was overwhelmingly women could have led to decision-making around appropriate procurement of PPE to fit women's bodies.

70. Women undertake most of the unpaid care within households and communities within the UK. This, combined with the gender pay gap and associated household decision-making, it could have been anticipated that with schools or childcare closing, women would absorb the additional unpaid care demands within homes. Interventions could have been made to ensure that this would not affect paid employment, such as protected provisions for those who had dependents and/or caring responsibilities.

71. Feminised labour forces within the UK are predominantly health and social care, education, retail, hospitality and tourism, i.e. those which would suffer most from the pandemic related policies. Whilst social distancing requirements may not have changed the decisions to close these settings, the reopening first of masculine labour forces such as construction and manufacturing, created greater gender labour market inequalities. Moreover, by not starting the re-opening of the childcare and education sectors as a first step post lockdown will have limited many women's return to paid employment.

72. For some women, home is not a safe space. By asking the population to stay at home, this put vulnerable women at risk of increased violence, without access to appropriate support. Domestic violence support mechanisms could have been excluded from social distancing and lockdown provision from the start.

73. Women are not a homogenous group, and thus the inequalities experienced would be stratified by intersecting drivers of vulnerability such as race, ethnicity, age, location, socio-economic group, disability, etc. This could have been considered to a greater extent, such as through equality impact assessments prior to policy interventions to understand the downstream effects of policy decisions across society.

74. Since we knew all the above factors, gender advisory or expertise could have been incorporated and valued into decision making at all levels of government. This was seemingly absent across government considerations.

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