

# **Expert Report for the UK Covid-19 Public Inquiry**

## **Module 10 - Impact on Society Unequal Gender Impacts of the Pandemic**

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### **Author statement**

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.

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## Preamble

1. 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 epidemics (and broader health) policy, considering how the gender neutrality of global health policies differentially affects women. She has conducted multiple research grants and has several 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 Organisation, UN Women, European Parliament, World Organisation for Animal Health, and the German government on policy related to gender and epidemics/pandemics. This report has received support from Dr Asha Herten-Crabb.
2. The Covid-19 pandemic exposed and intensified existing gender inequalities across the UK, with women disproportionately affected in multiple, intersecting ways. From increased unpaid care responsibilities and heightened risk of job loss in female-dominated sectors, to disruptions in access to healthcare and rising rates of mental distress, the crisis magnified structural disparities across our society. These impacts were particularly severe for women already facing disadvantage - such as single mothers, disabled women, ethnic minority women, migrant women, and those in precarious work - deepening socio-economic inequalities. This report predominantly examines the unequal effects of the pandemic on women in the UK, highlighting how public health measures, economic shocks and service disruptions contributed to widening gender gaps. However, where the evidence shows and within my competencies, the report also identifies any unequal effects on men in the UK.

## Rates of infection, morbidity, mortality

3. There were notable gender differences in infection rates of Covid-19 in the UK, influenced by biological, social, and behavioural factors. Although data from the Office of National Statistics showed similar overall infection rates between men and women, variations appear across age groups and waves of the pandemic.
4. Although women were more likely to test positive for Covid-19 in the early stages of the pandemic (spring/summer 2020) - partly due to higher exposure through frontline roles in health, social care, retail and education, and greater access to testing - overall infection rates between men and women were relatively similar according to the Covid Infection Survey (CIS) (Diamond, 2023). UKHSA reported case rates of males at 94.8 per 100,000 and the same figure for females, with case positivity being closely aligned between the two groups (9.5% compared to 9.1%) (UK Government, 2025). However, when disaggregated by occupation, female-dominated sectors such as protective services, caring roles, secretarial and administrative work, teaching and education and leisure and personal services showed the highest rates of positive tests. In contrast, a prospective cohort study – where researchers follow a group of individuals over time - using UK Biobank data found that men were more likely than women to test positive overall. Moreover, certain factors - living in more deprived areas, lower household income, working night shifts, residing in larger households and being clinically vulnerable - significantly increased the risk of infection, or severe illness from infection (UK Government, 2024) (Azizi et al., 2022).
5. Men were at higher risk of severe illness, hospitalisation and death from Covid-19 (Mohamed et al., 2020), with an almost 18% difference in the total number of deaths from men and women between March 2020 and January 2021 in England and Wales (Office for National Statistics, 2021a). This is also consistent with all-cause mortality (a measurement of the total number of deaths over a specific time period, regardless of cause of death) being higher in men than women. There are a number of suggestions as to why this might be; ranging from biological factors, such as hormone effects, or differences in immune response (Takahashi, 2020); to higher prevalence of underlying health conditions, such as cardiovascular disease; to social effects including delayed health seeking behaviour. In both males and females, the majority of Covid-19 deaths occurred among disabled people, and when the data is standardised for other factors (e.g. age, socio-economic status), in minority ethnic groups (Diamond, 2023).
6. ONS data points to those working in traditionally male dominated industries as having a higher risk of death from Covid-19, including transport and machine drivers, elementary administration and service occupations, textiles printing and other skilled trades and process, plant and machine operatives (Office for National Statistics, 2020). Conversely, it points to those women dominated sectors of the economy, including teaching and education professionals, culture and sports occupations and secretarial and related occupations as having the least occupational risk of mortality from Covid-19 (Office for National Statistics, 2020), but these sectors were the most likely to have been closed during the pandemic. Moreover, occupational risk of

infection was not static during the pandemic, for example, as schools reopened in latter waves, risks for those in the education sector increased (Rhodes et al., 2022).

7. Moreover, healthcare workers and health care professionals, 77% of whom are women (NHS England, 2023), had the highest occupational risk. A study in *The Lancet* demonstrated a three-fold increased risk of infection compared to the general population, even when accounting for testing bias (healthcare workers were initially able to access testing when the routine population was not, and given their work may be more inclined to, and know the process of, seeking testing) (Nguyen et al., 2020). Black and Minority Ethnic (BAME) women were particularly at risk. This risk reduced as healthcare workers were some of the earliest to get vaccines (in December 2020 as part of the first JCVI priority group) and, for those that were able, access to Personal Protective Equipment (PPE). PPE was also widely reported to be ill-fitting for women's bodies (Kuehn, 2022). Male healthcare workers experienced a statistically higher Covid-19 mortality rate compared to the general population and to their female counterparts, while the risk of death for female healthcare workers was comparable to that of the general population (Office for National Statistics, 2021e).
8. During the initial stages of Covid-19, care workers were not given the same priority access to PPE as NHS workers, with unclear testing protocols, leaving many exposed to infection. The mortality rates for social care workers in England and Wales is double that of the rest of the population (The Health Foundation, n.d.).
9. Pregnant women were also at increased risk of adverse outcomes from Covid-19 infection. At greatest risk were those in the third trimester of pregnancy, those with underlying health conditions, clinically vulnerable, overweight, 35 or over, and from a minority ethnic group (NHS England, 2020a). By July 2021, 9% of all Covid-19 admissions to intensive care units in the UK were pregnant or post-partum women (ICNARC, n.d.). 38 pregnant or post-partum women in the UK were reported to have died from Covid-19 between 2020 and 2022 (MBRRACE-UK, 2022a). Data from Oxford University highlights significant ethnic disparities: 55% of pregnant women admitted to hospital with Covid-19 were from Black, Asian, and minority ethnic (BAME) backgrounds, despite these groups accounting for only around 25% of births in England and Wales (NHS England, 2020b). Asian women were four times, and Black women eight times, more likely than White women to be hospitalised with Covid-19 during pregnancy (NHS England, 2020b). This could be on account of greater occupational risk (they are more likely to work in public facing roles); or structural and institutional racism within accessing healthcare; and disparities in underlying health conditions (Care Quality Commission, 2024).
10. ONS data demonstrated that the risk of death involving Covid-19 was 1.6 times greater for more-disabled women (those who self-identify as limited a lot by their condition) and 1.3 times greater for less-disabled women (those who identify as limited a little by their condition), compared with non-disabled women (not limited at all). (By comparison, 1.4 times greater for more-disabled men and 1.3 times greater for less-disabled men, compared with non-disabled men) (Office for National Statistics, 2022a). Thus, the relative increase in risk of death for disabled females compared with non-disabled females was greater than that for disabled males.

11. Women are 20% more likely to report long Covid than men. Rates of long Covid are highest in women, people aged 35-69, living in the north-west of England, and living in more deprived areas (Diamond, 2023). Several factors contribute to this pattern. First, occupational exposure likely played a role, as women were more represented in frontline roles and therefore at greater risk of contracting the virus. Second, women may be more likely to seek healthcare and report symptoms, resulting in higher rates of documented cases. Third, the disproportionate burden of unpaid care work in households and communities may delay women's recovery from acute Covid-19, increasing the likelihood of reporting long Covid symptoms (Kwon J et al., 2024).
12. Some of these differences in exposure, positivity, and morbidity can be explained through gendered differences in perceptions of Covid-19 and health-seeking behaviour. Women were more likely to perceive Covid-19 as a serious health threat and thus comply with public health and social measures than men (Galasso et al., 2020). Women, those older, those wealthier, and those in England were most likely to adhere to public health and social measures than any other sub-group of the population (Kale et al., 2022). Conversely, men were less likely to adhere to public health measures such as social distancing and mask wearing. For example, a randomised control trial using mental imagery interventions demonstrated men were more than twice as likely as women to avoid wearing a facemask (Conroy et al., 2023), a behaviour partly attributed to perceptions that masks infringed on personal independence, a view more commonly held by men (Howard, 2020). Men were also slightly less likely to complete the full Covid-19 vaccination course, with 76.8% of women compared to 74.7% of men receiving three doses (Department of Health and Social Care, 2023). However, vaccine uptake varied significantly across demographic groups, with the highest rates of non-vaccination observed among individuals who were Black Caribbean, Black African, or White Other; those living in deprived areas; people who had never worked or were long-term unemployed; disabled individuals; Muslims; and men (Office for National Statistics, 2023a). Moreover, women are four times as likely to have an autoimmune condition (Kronzer et al. 2020) and 52% more likely to be immunosuppressed (Martinson and Lapham 2024). Those with immunosuppression are less likely to have an adequate response to vaccines and are more likely to experience severe Covid-19 symptoms even after vaccination (Link-Gelles et al. 2023). Being clinically vulnerable in this way also increases the long term sequelae risks of Covid-19 exposure, aside from long Covid, such as worsening of pre-existing autoimmune conditions and new onset of cardiovascular conditions (Gracia-Ramos 2021).
13. The main lessons to take from this are:
  - 13.1. There may be gendered differences in infection with future pathogens. These may be caused by biological reasons, or social differences in society or employment, or in gendered differences in behaviour.
  - 13.2. Recognising these patterns early can then lead to enhanced and targeted public health interventions to protect those at greatest risk.
  - 13.3. Enhanced public health messaging and communication, in accessible formats, are needed to target those who are less likely to believe they are at

risk, or be less able to protect themselves from that risk, for example those from lower socio-economic groups or those more likely to be receiving health or social care.

- 13.4. Ensure that PPE is available for all those in frontline health and social care roles, or those in a range of settings who require PPE, and in appropriate sizing for women's bodies. Other mechanisms for reducing infection such as mechanical ventilation or air filtration should also be available, protecting all without gendered variance.

## Physical health more broadly (including health behaviours, access to health and social care services)

14. The Covid-19 pandemic and the public health and social measures introduced in response have had wide-ranging impacts on physical health in the UK. However, these effects have not been experienced equally. Emerging evidence highlights that gender played a significant role in shaping individuals' health behaviours, access to healthcare and social services and broader physical health outcomes during the pandemic.

### Physical Health Status and Health Behaviours

15. In general, women tend to report healthier behaviours than men – for example, healthier dietary choices and lower alcohol consumption – but men tend to report engaging in more physical activity (Kritsotakis et al., 2016). However, compared to men, women were 3.2% less likely to adopt a healthy lifestyle during the pandemic. This is thought to be driven by improvements in men's health behaviours, rather than necessarily a change in women's decision making (Arulsamy et al., 2025). Whilst mental health is covered elsewhere in the Inquiry work, it is important to note here that the protective effect of healthy behaviours on mental health were weakened during the pandemic for women, but not for men, largely driven by declines in the protective effect of fruit and vegetable consumption, loneliness and mental health tensions, as well as reduced physical activity (Arulsamy et al., 2025).
16. Lockdown measures had a notable impact on physical activity and fitness, with gendered differences in both the scale and duration of the decline. Sport England data shows that while overall activity levels fell for both men (-2.4%) and women (-1.4%) over the course of 2020 compared to pre-pandemic baseline, men experienced a sharper initial decline during the first lockdown (March to May 2020), with activity levels dropping by 8.9% compared to a 5.4% drop for women. However, men's activity levels recovered more quickly: by November 2020, male activity levels had returned to pre-pandemic levels, showing no year-on-year change, whereas women's remained 2.8% lower than the same period the previous year (Garnett et al., 2021), albeit both men and women's activity levels are on an upwards trend from 2015-16 (*Active Lives Adult Survey November 2021-22 Report*, n.d.). This suggests that although women's activity levels initially appeared more resilient, the longer-term decline may be harder to reverse - likely highly connected to unpaid care activities (such as childcare) preventing their physical activity (Sport England, 2021).
17. The pandemic also had different gendered effects on diet: during the lockdowns in 2020 women had greater dietary changes, consistently eating less, or consistently eating more (Herle et al., 2021). Such changes have been associated with coping mechanisms, stress and a reduction in sleep experienced by women more so than by men at the start of lockdown (Bann et al., 2021). Moreover, women reported decreased consumption of fruit and vegetables (Braithwaite et al., 2022), and increased consumption of high fat, salt and sugary snacks and meals occurred amongst women, and women in lower socio-economic groups (Dicken et al., 2022).

The impact of dietary changes is thought to have impacts on sleep and mental health (Hepsomali & Groeger, 2021).

18. There were also gendered differences in alcohol consumption during the Covid-19 lockdowns (Arulsamy et al., 2025). Women were more likely to report drinking more than usual and men were more likely to report drinking less than usual during lockdown (Garnett et al., 2021). The Alcohol Toolkit Study found a significant increase in high-risk drinking during the Covid-19 lockdown (+39.5% increase in prevalence of high-risk drinking across the population compared to baseline), contrasted against a small decline (-7.8%) during the same period in 2018/19. This alcohol consumption increase did not differ by age group, but there were greater relative increases among prevalence in women (+55.4%) than among men (+30.7%) (Boniface et al., n.d.).

### **Access to primary and preventative healthcare**

19. Access to primary healthcare services was significantly disrupted across the UK during the pandemic. A reduction of general practitioners (GP) services, and a reallocation of healthcare resources towards Covid-19 care, resulted in the suspension or postponement of non-urgent service provision. It is well accepted in academic literature that women use GP services more than men (Wyke et al., 1998). For example, in the UK, consultation rates are 32% lower in men than women, with men consulting 3,152 times/1000 person-years while women consulted 4,607 times/1000 person-years (Wang et al., 2013), with the magnitude of difference extending across the life course. In 2019-20, women accounted for 57.8% of outpatient attendance across the NHS (NHS England, 2020c); although a significant portion of healthcare service use by women relates to reproductive care, gender differences in service utilisation persist even when such services are excluded. As such, a reduction or change in primary healthcare service provision during Covid-19 was more likely to impact women than men. Across 12 longitudinal studies (where a group is tracked over time to observe changes), women, particularly those under 55 years old, were more likely to report disruption in accessing prescription medication, procedures or surgery and appointments and a combination of the above (Maddock et al., 2022). Women are also more likely to be responsible for taking children, older people, or those with care needs to medical appointments. Thus, the impact of closures of services may be more wide-ranging than simply the direct health needs of women themselves. Evidence during the pandemic also highlighted the increased challenges for migrant women seeking primary health services, exacerbated by digitalisation exclusion and language barriers (Knights et al., 2021).
20. The Covid-19 pandemic significantly disrupted breast cancer screening services across the UK during 2020–21 (routinely offered to females aged between 50-71), leading to delays in diagnosis and treatment. While all four nations experienced service interruptions, the extent and recovery varied. In England, all 78 screening units of the NHS Breast Screening Programme paused services for approximately three months (March–June 2020) (NHS England, 2022). This resulted in a 36.9% decrease in screening invitations, with 1.84 million women invited in 2020–21 compared to 2.92 million the previous year and the number of women screened also dropped by 44.1%, from 2.13 million in 2019–20 to 1.19 million in 2020–21 (NHS

England, n.d.). In Wales, services were similarly suspended, with an overall reduction in diagnosis from screening of 47.8% in 2020, suggesting missed opportunities for early diagnosis (Greene et al., 2022). In Scotland in 2020 and 2021, there was a significant drop (47.3%) in breast cancer diagnoses from screening, with both suspension of services and lower uptake reported (Public Health Scotland, 2022). Northern Ireland reported a 34% reduction in diagnoses (N. Ireland Cancer Registry, n.d.). Differences between these may be accounted for by lengths of suspension of services, capacity to recover health services, and concerns about attending appointments.

21. Cervical screening activities were suspended in many locations. Between April and June 2020, the number of cervical screening samples received at laboratories in England dropped by up to 91% compared to expected figures. Despite efforts to recover, by April 2021, there was still a shortfall of approximately 200,949 samples, indicating a 6.4% shortfall of screening samples was observed (Castanon et al., 2022). Cervical screening coverage (those who were up to date with their screening) in Scotland was 1.9% down in 2020 compared to previous years, following a similar pause in screening at the start of the pandemic. By 2021/22 this was 0.7% lower than the previous year, albeit there had been a considerable increase in tests carried out to compensate for the shortfall in 2020 (Scottish Government, 2022) (Public Health Scotland, 2022). There was an 11% reduction in cervical smears in Northern Ireland compared to baseline (McMullan et al., 2023) and a 3.7% reduction in Wales (Bowden, 2022). There is no clear evidence yet of sustained increase in cervical cancer diagnoses because of these missed screenings.
22. There was a 30.8% reduction (22,419 in 2020 from 32,409 in 2019) in the number of men with newly diagnosed prostate cancer after the first lockdown. Moreover, men diagnosed in 2020 were typically at a more advanced stage (Stage IV: 21.2% vs 17.4% compared to 2019) and slightly older (Nossiter et al., 2022). It is estimated that 20,000 cases of prostate cancer were missed in 2020 (Lemanska, 2024).
23. Peri/menopause services were also disrupted, particularly during 2020. Many routine and non-urgent services were suspended; specialist menopause clinics reported cancelled appointments, redeployment of staff, and disrupted training for clinicians and other health professionals. Services pivoted quickly to remote consultations, which clinicians and patients found acceptable but imperfect (Hamoda & Moger, 2021; Kozica-Olenski et al., 2023; Pedder et al., 2023). This may have impacted the ongoing inequalities of access to HRT across the UK. Moreover, emerging clinical literature emphasises symptom overlap between peri/menopause and long Covid, arguing that disruption of menopause services and lack of clinician training could lead to misdiagnosis, delayed appropriate HRT use, or inappropriate management (Stewart et al., 2021).
24. Gynaecology waiting lists have seen the most significant increase among medical specialties as a consequence of the pandemic. Whilst this was a pre-pandemic trend, it was greatly increased during Covid-19, as most conditions are considered non-emergency or elective and thus deprioritised (Royal College of Gynaecologists, n.d.). In April 2022, over 570,000 women across the UK were waiting for gynaecological care, with more than one in 20 facing waits exceeding a year. The

Royal College of Obstetricians and Gynaecologists (RCOG, 2022) suggested this represents a 60% increase in waiting lists since the start of the pandemic. The focus of clinical provision during the pandemic was on ensuring that maternity care was able to continue safely, protecting access to diagnosis and treatment for gynaecological cancers and acute gynaecological services to manage problems in early pregnancy, such as miscarriage and ectopic pregnancy (RCOG, 2020). This resulted in the total pausing of 'elective care' at the start of the pandemic (RCOG, n.d.). By December 2021, there were 795 patients per 100,000 on the waiting list for gynaecology services in England (56% increase since pre-pandemic); 802 patients per 100,000 on the waiting list in Scotland (94% increase since pre-pandemic); 1,330 patients per 100,000 on the waiting list in Wales (62% increase since pre-pandemic); 1,947 patients per 100,000 on the waiting list in Northern Ireland (42% increase since pre-pandemic). It is important to note that this increase is proportional to the pre-pandemic waiting list in Scotland, which was lower relative to population than other UK nations (RCOG, n.d.). The impact of such delays are thousands of women living in pain, discomfort or limitations on their daily lives.

### **Sexual and Reproductive Healthcare services**

25. The Faculty of Sexual and Reproductive Healthcare (FSRH) analysed service provision during the Covid-19 pandemic demonstrating on average, 22% of SRH staff had been redeployed. This figure rose to 39% among those working primarily in specialist SRH settings, such as standalone clinics or integrated SRH and sexual health services. Additionally, these specialist services reported that 26% of their staff were absent due to Covid-19 infection, other illnesses, or the need to self-isolate (Faculty of Sexual and Reproductive Healthcare, n.d.).
26. The closure of sexual and reproductive health (SRH) clinics disproportionately affects women who are the biggest users of SRH services in the UK (NHS England, n.d.), and particularly affects the most vulnerable populations. These clinics are most frequently accessed by young people and individuals at higher risk of poor sexual and reproductive health outcomes (French, 2017). Evidence shows that the likelihood of young women aged 13–15 using SRH services for emergency contraception increases with the level of deprivation in their area of residence, highlighting the critical role these services play in supporting those from disadvantaged backgrounds.
27. Approximately one-quarter of 2005 condom/contraception-using respondents to a nationwide survey conducted online including open text responses in summer 2020 reported that social distancing measures had made a difference to their access or use (Lewis et al., 2021). Justifications were both in relation to whether they were able to access services during a time of Covid-19, as well as intensified structural barriers to access such as distance to SRH provision and unpaid care responsibilities. 97% of people who contacted SRH services in the UK for contraception-related reasons were female (Kirk-Wade & Rough, 2024). A UCL study demonstrated unplanned pregnancies almost doubled from 1.3% in 2019 to 2.1% in 2021 (UCL, 2021).
28. Maternity services were significantly disrupted by Covid-19, leading to widespread changes in care delivery, reduced interactions with healthcare providers for pregnant women and an increase in risks for women and babies. It is well established that

routine antenatal provision reduces negative outcomes for mother and baby (NICE, 2021), hence why the NHS routinely offers multiple antenatal appointments. A UK wide survey of 170 (out of a total of 202) maternity services during Covid-19 demonstrated that 70% of units reported a reduction in antenatal appointments and 56% a reduction in postnatal appointments, with 89% reporting using remote consultation methods (Brigante et al., 2022a). 59% of trusts temporarily restricted women choosing to have home births and to deliver in midwife led units. Northern Ireland, the Midlands and Scotland reported the highest proportion of midwifery service closures (Brigante et al., 2022a). 86% also noted a reduction in emergency antenatal cases (Jardine et al., 2021). Healthcare providers were concerned about the impact the reduced service provision would have on perinatal health of women, particularly with concerns of postnatal depression and widening inequalities for those most vulnerable women (Moltrecht et al., 2022). For example, changes to provision introduced new barriers for disabled or migrant women amongst others, with physical, digital or language exclusion.

29. The impact of this was experienced by pregnant women. 53% of women in England with recent experience of maternity care felt that they had experienced changes to their care during Covid-19 and 35% had antenatal appointments cancelled. 32% of women experienced changes to their plans for birth. 50% of women stated they wanted more midwifery contact in the post-natal period (double the pre-pandemic baseline rate). The impact of these changes was significant for post-natal mental health, with an estimated 39% of women reporting anxiety in the post-natal period (a 10% increase from baseline) (Harrison S, Alderdice F, McLeish J, Quigley MA., 2021). This is coupled with reduced support from family, friends and communities, leaving many women feeling unsure of the quality of their care, safety and feeling alone in their pregnancies (Herten-Crabb & Wenham, 2022).
30. A survey conducted in September 2020 showed that only 23% of trusts in the UK allowed birth partners to attend the whole of labour (Topping & Duncan, 2020). Further research demonstrated 81% of birth partners (from a random sample of 16,500 women who gave birth in England over a 2-week period in May 2020, selected from birth registration records) were unable to attend all antenatal appointments and 73% of birth partners faced restrictions around attending births (Brigante et al., 2022b). These restrictions were at the discretion of individual NHS trusts, rather than being nationwide policy, and exact restrictions varied over location and over time. This meant that women across the UK were being forced to give birth alone, or to receive bad news alone. Such restrictions had profound impacts on women, with significant numbers reporting increased feelings of anxiety and isolation during childbirth (Aydin et al., 2022; Irvine et al., 2024).
31. Whilst there is some mixed evidence, a national cohort study (observational research that follows a group over time) of pregnant women admitted to hospital with SARS-CoV-2 infection found that the risk of stillbirth was higher for women with mild or moderate to severe illness during the Delta (Summer 2021) and Omicron (December 2021-February 2022) variant period, compared with those who had mild infections during 2020. The risk of preterm birth was elevated for women with moderate to severe infection across all variant periods (Engjom et al., 2024). Unvaccinated women were more likely to experience both stillbirth and preterm birth.

32. The cumulative effect of the above is that the maternal death rate for the UK for the period 2020-2022 was 13.41/100,000 – a 53% increase compared to 2017-19 (MBRRACE-UK, 2022b). Even when excluding Covid-19 related deaths among pregnant women, this rate was still 11.54/100,000, considerably higher than baseline (8.79/100,000 2017-19). Black women were three times more likely to die during or shortly after pregnancy, and Asian women were twice as likely when compared to white women. Women living in the most deprived areas had twice the maternal death rate of those living in the least deprived areas. Reasons for this include structural and systemic discrimination, racism and bias in health settings, fragmented care and poorer baseline health caused by socio-economic inequalities.
33. To allow early access to abortion, and at the same time reducing the risk of Covid-19 transmission, in March 2020 the Health Secretary approved changes to abortion provision in England and Wales, allowing for teleconsultations to access abortion and the use of both medical abortion pills — mifepristone and misoprostol — at home, a provision which has latterly been made permanent. The National Institute for Health and Care Excellence (NICE) and professional bodies demonstrated evidence for the safety of such changes based on best practice worldwide and care pathways were streamlined creating so-called ‘no-touch’ procedures (Rough, 2025). This was already permitted in Scotland prior to the pandemic. Northern Ireland has not implemented telemedicine for abortion care and mifepristone still must be taken in a clinic (albeit misoprostol can be taken at home).
34. In 2020, England and Wales recorded 210,860 abortions, the highest number since the Abortion Act was introduced in 1967 (Department of Health and Social Care, 2020). In 2021, the upward trend continued with 214,869 abortions (Department of Health and Social Care, n.d.), followed in 2022, by a further 17% rise on 2021 figures. These increases are multifaceted, but research identifies the additional financial and social stresses of Covid-19, the uncertainty surrounding the virus itself, disruption to contraception services, as well as enhanced access to telemedicine provision of abortion as being a contributing factor for women (Bracke, 2021). In Scotland, there were 13,815 abortions carried out in 2020, and a similar rate in 2021, the second highest number since the 1991 regulations were introduced (Public Health Scotland, 2021; Public Health Scotland, 2024). There was a 10% increase by 2022 with the number recorded as 16,607. In Northern Ireland, the number of abortions carried out was 1574 in 2020/1; 1755 in 2021/2 and 2168 in 2022/3 (Department of Health, Northern Ireland, 2024).

#### **Formal and informal social care**

35. The Covid-19 pandemic also profoundly disrupted formal social care services across the UK, exacerbating pre-existing structural weaknesses and revealing stark gendered disparities.
36. Women suffered disproportionately from disrupted access to formal and informal social care. These stemmed from structural gender norms, workforce demographics and policy gaps which left women vulnerable to the knock-on consequences of care system disruptions. This compounded the challenges in the system which had already been strained by years of underfunding, staff shortages and fragmented

provision. During 2020, 4.5 million people in the UK took on additional caring responsibilities, with the total number at the end of 2022 being 13.6 million; 57% of which are women (Office for National Statistics, 2021f). The closures of day, respite, domiciliary and residential centres forced more care into the home, where women took on the bulk of additional responsibilities. In England, women aged between 55 to 59 years provided the most unpaid care (19.9% of all women in this age category are caring for someone informally) (Office for National Statistics, 2021d). The impact of this additional unpaid care on women included having to reduce paid employment and significant increases in mental health concerns amongst unpaid carers. This was not experienced equally across society, with more vulnerable women more likely to experience negative effects of unpaid care.

37. 80% of the adult social care workforce in the UK are women, who are often low-paid and on precarious contracts (Hopkins, n.d.). Ethnic minority women are over-represented in both paid and unpaid care roles (Foster, 2024). Covid-19 worsened existing staffing shortages, the impact being increased workloads, burnout and risk of exposure to Covid-19. Migrant women, and those with no recourse to public funds (NRPF) working in the care sector were particularly at risk, with no alternative than to work and increase their exposure to the virus (Boswell, 2022). Unpaid carers are also more likely to report that they are disabled (Office for National Statistics, 2021). Moreover, the closures of many care settings created further financial challenges for the sector, and in turn for women's secure employment in the sector (Women's Budget Group, 2021b).
38. In addition, women, particularly older women or those with disabilities, are more likely to rely on formal care. The Health Survey for England (2021), demonstrates that among adults aged 65 and over, 28% of women needed help with at least one *activity of daily living*, compared to 24% of men. Similarly, 29% of women required assistance with at least one Instrumental Activity of Daily Living (IADL), versus 21% of men (NHS England, 2023). Women across the UK are also more likely to be admitted to a care home than men (Office for National Statistics, n.d.), even after accounting for variations in health, partly attributed to the fact that men are more likely to have a spouse to provide informal care, because women are more likely to live longer, with more years in poorer health, and lower lifetime earnings meaning less ability to pay for in home support. Given the well documented risks of care home residents and Covid-19 infection, it is important to remember that the majority of those at risk were women, albeit there was higher age standardised mortality for male care home residents in England compared with Wales (this difference was not observed between women in England and Wales (Office for National Statistics, 2022) but the reasons for this are unexplored in the ONS analysis).
39. The lesson to learn from this is that primary health needs, health promotion activity, care work and women's sexual and reproductive health needs do not diminish during a pandemic or any other emergency. Alternative pathways could have been established to ensure routine provision to women. Plans to ensure continuity of care for women must be embedded into pandemic preparedness planning at all levels to ensure that women's broader health and reproductive needs are not an afterthought. The following recommendations are proposed:

- 39.1. Health promotion activities must continue regardless of an emerging health emergency. These are beneficial not just for the immediate health outcomes of women, but for their protective effects on mental health.
- 39.2. Ensure contingency plans are in place for continuity of primary healthcare provision, using telemedicine or community locations if needed to reduce infection risk. Consider users' concerns such as people's fear of accessing services thereby using community centres rather than clinics.
- 39.3. Ensure continuity of screening services to ensure cancers are not missed because of the simultaneous emergency.
- 39.4. Enable all maternity and reproductive health services to continue providing the same level of care to patients in the event of a pandemic
- 39.5. Consider alternative pathways for women (and men) to access SRH services in the community, such as in pharmacies or supermarkets during a pandemic to reduce barriers to access.
- 39.6. Focus on continuity of ante and post-natal care. Develop temporary care provision in the community to reduce hospital visits and women's fear / risk of infection.
- 39.7. Ensure birth partners can support women through labour and the post-partum period to ensure women are safe and not alone.
- 39.8. Guarantee that the social care workforce, or those who need it in other sectors, are able to access PPE and vaccination in the same way as NHS workers, and efforts are taken to reduce occupational risk. Revisit the job security and conditions for the adult social care workforce.

## **Finances (including access to economic opportunities/socio-economic disadvantage)**

40. Women entered the pandemic with structurally lower access to economic opportunities, shaped by the gender pay gap, concentration of labour in low-paid sectors and disproportionate unpaid care responsibilities (Government Equalities Office, 2019; ONS, 2019). These pre-existing inequalities meant women were more likely than men to lose jobs, be furloughed, or reduce paid hours during lockdowns. Adams-Prassl et al. (2020a) show that during the first lockdown women in the UK were 4.8 percentage points more likely than men to lose their jobs, even after accounting for job characteristics, and that 36% of UK employees reported being furloughed in April 2020. Women were significantly more likely than men to be furloughed when doing the same job and they were also 4 percentage points more likely to initiate furlough themselves, often due to care responsibilities (Adams-Prassl, 2020b). By July 2020, 31% of women who had ever been furloughed had worked zero hours since March, compared to 20% of men (Jones & Cook, 2021).
41. By late 2020, the overall numbers on furlough had declined but women continued to be over-represented. ONS (2021b) figures show that by 31 October 2020, 1.2 million women and 1.1 million men remained on furlough. By February 2021, women still made up a disproportionate share of those on furlough: 52.1% of all recipients, despite comprising only 47.3% of the workforce. Age differences reinforced these gaps: 24% of young women aged 18–25 (around 425,300) were furloughed compared to 20% of young men (345,100) (Women's Budget Group, 2021). Mothers were 1.5 times more likely than fathers to have stopped work (Andrew et al., 2020), with 35% of working mothers reporting job or hours loss due to unmet childcare needs (The Fawcett Society, 2020). Low-paid, part-time, and insecure employment - where women were overrepresented - was disproportionately hit by Covid-19 related closures (Blundell et al., 2020, p. 8).
42. These labour market shocks translated into sharp income losses for many women. Crossley et al. (2021) show that nearly half of all working-age individuals in the UK experienced a drop in household earnings of at least 10% during the first wave of the pandemic, with the steepest losses concentrated in the lowest income quintiles, disproportionately affecting women, single parents, and racially minoritised groups. While higher-income households often relied on savings, low-income women were more likely to rely on borrowing, informal transfers, or food banks, highlighting the limitations of formal state support. Migrant women were especially affected, as they were disproportionately concentrated in low-paid, part-time and insecure sectors such as hospitality, social care, and cleaning, compounding financial insecurity with heightened exposure to the virus (Women's Budget Group, 2020a). Many migrant workers with NRPF reported acute financial insecurity during the pandemic, as they were ineligible for Universal Credit and other benefits; 127 of 170 (74.7%) survey respondents in one study said they had not been offered the option to be furloughed, leaving them with little to no safety net during job losses (Migrants Rights Network et al., 2020).

43. The number of Universal Credit claimants rose by 90% between March and October 2020, with 2.2 million new applications in the first two months alone (Department for Work and Pensions, 2020). While initially more men claimed the benefit, reflecting its origins as a replacement for income-based Jobseekers Allowance, since 2018, women have made up the majority of claimants, especially following the inclusion of legacy benefits such as Child Tax Credit and Income Support. The spike in male claimants during the pandemic marked a shift in claimant composition but did not alter the fact that women remained the majority. These trends reflect both gendered patterns of employment loss and the widening reach of economic insecurity.
44. However, Universal Credit's design features, such as the single household payment and benefit cap, meant that many women, particularly those who were single parents, on low incomes, or in precarious work, struggled to access timely or sufficient support. Evidence shows that women on low incomes were significantly more likely to apply for benefits (25% vs. 7% of higher-income women) and over four times as likely to use food banks (13% vs. 3%) (Women's Budget Group, 2021c). A third of BAME women reported concerns about affording rent or mortgage payments, almost double the proportion of White women, further revealing the racialised dimensions of financial hardship. Moreover, Universal Credit's default single-payment model also increased the risk of financial control and abuse within households (Stop Economic Abuse, 2021).
45. Single parents (around 85% of whom are women) were disproportionately impacted by the benefits cap during the Covid-19 pandemic (Duncan, 2020). Although the government introduced a temporary £20 weekly uplift to Universal Credit to mitigate the crisis's economic fallout, many single mothers were unable to access the full increase due to the cap on total benefits a household can receive. This meant that, despite being among the most financially vulnerable groups, they were effectively excluded from the support measure intended to alleviate hardship. The policy thus compounded pre-existing gendered inequalities in the welfare system, disproportionately penalising women with caring responsibilities who are less able to increase paid work hours to compensate for lost income.
46. Disabled women and BAME women experienced sharper economic shocks and reduced access to support (Fawcett Society et al., 2020a, 2020b). Drawing on a nationally representative survey of 3,280 people, with booster samples for key groups, the data reveal that 51% of disabled women were struggling to make ends meet, compared to 34% of non-disabled women. Nearly one in three (32%) disabled mothers had lost support networks. BAME women were more likely than white women or BAME men to report income loss, difficulty affording essentials, and increased caring responsibilities. Notably, 42% of BAME women expected to be in more debt after the crisis, compared to 37% of white women and 34% of BAME men. These intersecting inequalities of gender, race, and disability, left BAME and disabled women both more economically exposed and less able to access the support they needed to recover (Fawcett Society et al., 2020a, 2020b). Importantly, many disabled men and women were in receipt of "legacy" benefits such as Employment and Support Allowance, which were excluded from the £20 uplift applied to Universal Credit (Mackley et al., 2021). This policy decision created a two-tier system of support during the pandemic, deepening existing inequalities and leaving disabled

women on legacy benefits (55% of disabled claimants) at greater risk of financial hardship (Welsh Government, 2021; Women's Budget Group, 2018).

47. Evidence from the ONS further indicates that people advised to shield were disproportionately unable to sustain employment or meet financial obligations (Office for National Statistics, 2020): in May–June 2020, only 36% of clinically extremely vulnerable (CEV) adults in work could work from home, while 17% had stopped working entirely. Of the 32,000 (5% of those surveyed) who continued to work outside the home, 19,000 reported they would be unable to meet financial commitments if forced to stop on-site work. Later, ONS data show that CEV households continued to report greater difficulty keeping up with bills and higher levels of borrowing through winter 2021-22 compared with the general population (Office for National Statistics, 2022b). Among clinically and financially vulnerable people, women reported higher levels of mental distress than men, suggesting that gender compounded the financial pressures associated with clinical risk (Simha et al., 2020).
48. The pandemic did not only worsen existing inequalities, it generated new, gendered forms of financial disadvantage. Most notably, the collapse of childcare became a unique cause of job loss for mothers. Furlough for caregiving was not formally introduced until late 2020, by which point many mothers had either exited the workforce or reduced hours; even then, it was at the discretion of employers, and 70% of requests by mothers for furlough on childcare grounds were denied (Topping, 2021).
49. Childcare closures disproportionately affected women's paid work and job security. For single parents, approximately 85% of whom are women (ONS, 2023b), there were few options: in a qualitative study, some women interviewed during the first 2020 lockdown even reported declining furlough because they couldn't afford the reduced income (Herten-Crabb & Wenham, 2022). *Pregnant Then Screwed* (2020) found that nearly half of mothers (46%) facing redundancy linked it to lack of childcare. Disabled mothers were at even greater risk: Fawcett Society (2020) reported they were more likely than non-disabled mothers to have lost their job during the pandemic, reflecting the compounded pressures of caring responsibilities, discrimination and lack of accessible childcare (The Fawcett Society, 2021).
50. New forms of digital exclusion also emerged, for example migrant women with no recourse to public funds (NRPF) and others unable to access aid due to lack of digital tools or eligibility (Johnston, 2020; Topping, 2020). These newly emergent inequalities were often shaped by pre-existing structural exclusions but manifested in distinct ways under pandemic conditions. Welfare design flaws (e.g. single-payment Universal Credit), digital exclusion and policy gaps (e.g. NRPF exclusions) all contributed to gendered economic vulnerability, particularly for migrant, minoritised, and disabled women. Further, women in female-dominated sectors with lower qualifications struggled to re-enter training and skills pathways (Blundell et al., 2021).
51. Financial inequalities were shaped not only by gender but also by age, race, disability, income level and geography. For example, 63% of people who lost jobs between February 2020 to February 2021 were under 25 (Office for National

Statistics, 2021c), and one-third of young women surveyed were concerned about paying rent or mortgage, compared with just 10% of women over 45 (Women's Budget Group & Young Women's Trust, 2020). BAME women, disabled women, and those on low incomes experienced the most acute financial hardship. Employment among BAME women fell 17% between Q3 2019 and Q3 2020, compared to just 1% among white women (Women's Budget Group, 2021a). Disabled women were more likely to report that their households had run out of money: 34% did so in April 2020, compared to 24% of non-disabled women (Fawcett Society et al., 2020b). Meanwhile, 42.9% of BAME women expected to end the pandemic in greater debt, compared with 37.1% of white women and 34.2% of white men, and nearly a quarter of BAME mothers (23.7%) reported struggling to feed their children, significantly more than white mothers (19%) (Fawcett Society et al., 2020a).

52. For migrant women with NRPF, the effects of income loss were even more severe. Many worked in insecure sectors such as care and cleaning, yet were excluded from furlough, Universal Credit and housing support (Women's Budget Group, 2020b). As a result, sudden earnings shocks translated directly into destitution, with women forced to rely on overstretched charities or limited Section 17 local authority support. Unlike other low-income groups, they faced financial precarity without any meaningful safety net. For victim-survivors of domestic abuse with NRPF, exclusion from welfare and Housing Benefit often meant staying with an abuser during lockdown (UK Government, 2023).
53. Looking beyond the immediate crisis, the economic fallout of the pandemic - combined with post-Covid-19 inflation, rising living costs and the return to austerity measures - has further entrenched gendered financial inequalities (Women's Budget Group, 2022b). Since the pandemic, women, particularly those already disadvantaged by job loss, reduced hours, or increased care burdens during the pandemic, are facing disproportionately intensified pressures as social support diminishes, wages stagnate and the cost of essentials rises. These structural pressures risk undoing even limited gains in gender equality and disproportionately affect low-income, minoritised, and single-mother households.
54. The pandemic revealed and intensified longstanding gendered and intersectional inequalities in access to financial stability, employment and state support. Women, particularly those who were single parents, on low incomes, in insecure work, or from marginalised groups, were disproportionately affected by job loss, care burdens, and barriers to welfare. These impacts were not only a continuation of pre-existing inequalities but also the result of policy failures that failed to account for gendered realities. To build resilience for future crises and redress structural disadvantage, the following recommendations are proposed:
  - 54.1. Design financial support with intersectionality in mind, ensuring single parents, migrant women and others at structural disadvantage are not excluded due to eligibility or household payment models.
  - 54.2. Reform Universal Credit to allow for independent access and protect against economic abuse.

- 54.3. Embed caregiving considerations into labour protections, including guaranteed furlough and job security for parents during school closures and crises.
- 54.4. Invest in childcare infrastructure and social care, treating them as essential economic enablers (see paragraphs 82-92).
- 54.5. Target support to low-paid and insecure workers, particularly women in female-dominated sectors who are less able to work from home and more vulnerable to job loss.
- 54.6. Monitor and address digital exclusion, especially for migrant women with NRPF and those outside formal employment.
- 54.7. Avoid austerity-driven recovery measures that would deepen existing socio-economic disparities and instead pursue redistributive policies that prioritise gender equity.

## Housing (with a focus on the quality and suitability of housing/access to outdoor space, as opposed to access to housing itself)

55. The Covid-19 pandemic underscored the critical role of housing in shaping health, safety and well-being. Lockdown restrictions meant people spent unprecedented amounts of time at home, intensifying the effects of inadequate, overcrowded, or unsafe living environments. These burdens were not distributed equally. Pre-existing gender inequalities intersected with race, socio-economic status, disability, migration status and care responsibilities shape the housing experiences of women in the UK. Overcrowding, already more common among low-income and racially minoritised communities, became a public health risk. During lockdowns, cramped housing heightened exposure to the virus, worsened mental health and limited the ability to isolate sick family members. In a nationally representative survey of 4,116 people, the National Housing Federation of those *“who said their home was not big enough said this had led them to seek medical help during lockdown or take medication for their mental health”* (National Housing Federation, 2020). Though there is a lack of specific evidence, these impacts are likely to have disproportionately affected women, particularly those responsible for caring for large families in small homes. In 2015/16, women heads of households were more likely to live in overcrowded homes (Women’s Budget Group, 2021c). Census data from 2021 show that 13% of lone-parent households with dependent children in England were overcrowded, compared with just 4.4% and 2.2% of all English and Welsh households, respectively (ONS, 2023a). Since approximately 85% of lone-parent families are headed by women, this points to persistent gendered inequality in housing (ONS, 2023b).
56. In England, only 2% of White British households were officially overcrowded before the pandemic, compared to 24% of Bangladeshi, 18% of Pakistani and 16% of Black African households (Office for National Statistics, 2020b). Research by Nafilyan et al. (2021) found that elderly South Asian women in multigenerational households were at significantly higher risk of dying from Covid-19 than White women, a disparity not seen among South Asian men or other women of colour. This has been attributed to South Asian women spending greater time in the home and in caregiving roles, which made them more vulnerable to household transmission.
57. Pre-existing housing deficiencies, such as damp, mould, inadequate heating and disrepair also became more damaging when residents could no longer escape them. Prior to the pandemic, approximately 4.3 million UK households - around 10 million people - lived in “non-decent” homes. Women, trans, and non-binary people were more likely to be affected due to their overrepresentation in low-income housing, often a consequence of the gender pay gap and caregiving responsibilities (Vásquez-Vera et al., 2022). Continuous exposure to unsafe or unhealthy housing conditions contributed to both physical and mental health deterioration (Women’s Budget Group, 2022a). Interviews conducted during the first lockdown captured how people living in poor housing experienced constant stress from unrelenting issues like the sound of dripping taps or the smell of damp, now unavoidable due to confinement. Drawing on telephone interviews with 50 households in substandard

private-rented and owner-occupied homes, the research highlighted the cumulative mental strain of sensory discomforts that became inescapable during lockdown (Brown et al., 2021).

58. Housing inequalities during the pandemic were shaped by the interaction of gender, income level, race, migration status and geography. For example, residents living in dense urban areas like London faced high rates of overcrowding and limited access to repairs. Scotland's largest social landlord suspended non-urgent maintenance during lockdowns, leaving many households with leaks, damp, or broken utilities (Goodwin, 2020). While rural households often had more outdoor space, women in particular experienced heightened risks of social isolation and digital exclusion. These inequalities were further stratified by income and racialised disadvantage: one in five children in low-income households lived in overcrowded homes during lockdown, and a quarter of children from BAME communities were in substandard housing (Maguire, 2021). These spatial and structural disparities, including housing conditions, income inequality and access to healthcare, had measurable health consequences: Covid-19 death rates were more than twice as high in the most deprived parts of England and Wales and highest for Black and South Asian men in part due to their disproportionate concentration in overcrowded housing (ONS, 2020b). Migrant women were also affected: asylum-seeking women reported living in extreme isolation and unsafe initial accommodation during lockdown (Doctors of the World, 2020, 2022), while others experiencing domestic violence were unable to access refuges or publicly funded services and were forced to remain with perpetrators (JustRight Scotland, 2020). Only 7% of English homes are accessible for those with mobility impairments and disabled women, who are more likely to live alone and earn less than disabled men (ONS, 2021i).
59. The pandemic also highlighted the distinct experiences of homeless women. While men made up the majority of rough sleepers, and were thus more visible in public discourse and policy responses, women, who account for around 60% of statutory homeless households, were more likely to experience 'hidden' homelessness, such as sofa surfing or remaining in unsafe domestic situations. As informal living arrangements collapsed, frontline workers reported rising numbers of women requiring urgent assistance, including survivors of domestic abuse (Boobis & Albanese, 2020). The UK Government's *Everyone In* scheme temporarily housed over 37,500 people, including some migrants who would have otherwise been excluded from statutory support (Dawes et al., 2022). Access to *Everyone In* also varied geographically, with a significant 'postcode lottery' in whether local authorities accepted undocumented migrants or those with NRPF into emergency housing (Boswell, 2022). Policy reversals in May 2020 instructed local authorities to reassess eligibility on a case-by-case basis, limiting access for those with No Recourse to Public Funds (London Assembly Housing Committee, 2021).
60. The termination of *Everyone In* without follow-up funding or planning raised concerns that gendered and racialised homelessness would re-emerge in its previous forms (Boobis & Albanese, 2020). While additional funding was made available through the Next Steps Accommodation Programme (from July 2020) and the Protect Programme (announced in November 2020), as well as targeted Cold Weather and Winter Pressures funding in early 2021, these schemes were more limited in scope

and eligibility (Cromarty, 2021). During the winter lockdowns, the government maintained that support continued, but many local authorities and homelessness charities reported that *Everyone In* had effectively been wound down by summer 2020, with subsequent schemes lacking the same clarity, inclusivity, and urgency, particularly for people with No Recourse to Public Funds or those in informal housing situations. As a result, while the explicit *Everyone In* programme ceased by mid-2020, its ethos lived on through successor measures, but with narrower scope, less secure funding and disputed continuity among frontline providers (Cromarty, 2021).

61. The internal layout and functionality of housing also became more important during lockdowns. For many families, home became a combined site of work, school, care and leisure, but not all households were equally equipped. The new reality of working from home exposed spatial inequalities. Women were less likely than men to have a separate room to work in, compromising their ability to focus or maintain boundaries between work and domestic responsibilities (Felstead, 2022). Survey data and interviews showed that mothers working from home received far fewer uninterrupted hours than fathers and often gave up workspace to accommodate children's remote schooling or their partner's needs (Andrew et al., 2020; Herten-Crabb & Wenham, 2022). These experiences underscore how domestic space, already structured by gendered norms and household bargaining hierarchies, became even more starkly divided during the pandemic, as care demands intensified and spatial inequalities within the home were exposed and exacerbated.
62. Another newly salient inequality was access to outdoor space. While gardens and balconies may have once seemed optional, they became essential for mental health, physical activity and parenting during lockdown. About 12% of UK households had no access to a private or shared garden, a figure that rose to 21% in London (Office for National Statistics, 2020a). Even when public parks reopened, safety concerns limited women's access: quieter streets during lockdown, shorter daylight hours and increased domestic responsibilities all made outdoor time less feasible for women, despite its growing importance for health and well-being (Gray & Kellas, 2020; Hailey et al., 2022).
63. The pandemic made clear that quality, space and location shaped not only people's exposure to illness, but also their safety, privacy and mental health. Several key lessons emerge. First, housing policies during the pandemic did not adequately account for the gendered nature of living conditions. Women were more likely to reside in overcrowded, insecure, or poor-quality housing, yet these realities were not directly addressed in mainstream housing interventions. Second, emergency schemes such as *Everyone In* demonstrated that rapid, inclusive housing interventions are possible. Third, the pandemic highlighted forms of housing inequality that had previously received less policy attention - such as lack of access to private outdoor space or suitable space for remote work and schooling - which disproportionately affected women, particularly those on low incomes or living in high-density urban areas.
64. Recommendations include:

- 64.1. Invest in safe, secure and adequate housing for women in low-income and marginalised communities.
- 64.2. Treat access to private or safe shared outdoor space as essential for health and wellbeing.
- 64.3. Align housing policy with workforce requirements for remote working and care demands to address spatial inequalities within households.
- 64.4. Require gender-disaggregated data and intersectional analysis in all housing policy reviews and reports.

## Social Networks and social inclusion

65. The Covid-19 pandemic created and intensified gendered and structural inequalities in social networks, inclusion, and experiences of loneliness, disproportionately affecting women and other marginalised groups. Even before the pandemic, certain characteristics, such as being female, young, disabled, LGBTQ+, or living alone, were associated with higher levels of loneliness (ONS, 2018). Women were significantly more likely than men to report feeling lonely “often/always,” “some of the time,” or “occasionally,” and were much less likely to say they “never” felt lonely. These differences may partly reflect gendered norms around emotional disclosure, as research suggests that men may be more reluctant to report undesirable feelings such as loneliness (ONS, 2018). The pandemic magnified these disparities: national analyses confirmed that women were more likely than men to experience chronic loneliness during lockdown, continuing and compounding a pre-existing trend (UK Government, 2022). One UK study found that the drop in mental wellbeing during the first weeks of lockdown was twice as large for women as for men, with young women particularly affected (Etheridge & Spantig, 2020). Using data from the UK Household Longitudinal Study (UKHLS) collected between 2017 and April 2020, the authors tracked changes in mental health through the General Health Questionnaire (GHQ-12) across a large, nationally representative sample. The gender gap in wellbeing was not explained by employment changes, childcare responsibilities, or pre-existing mental health conditions, but rather by differences in social relationships and personality traits. Women were more likely to have had larger and more frequent social networks pre-pandemic and experienced a sharper decline in contact with friends and family, leading to increased loneliness. They also reported greater rises in anxiety and boredom. The study concludes that social disconnection was a key driver of the decline in women’s mental wellbeing during the initial lockdown period.
66. During the first lockdown, women of colour reported the lowest life satisfaction and highest anxiety, with over half (51.4%) unsure where to turn for help, compared to just 18.7% of white women (Fawcett Society et al., 2020a). Disabled and/or clinically vulnerable women faced heightened isolation due to shielding requirements and the closure of essential services; 32.3% of surveyed disabled women said they were not sure where to turn to for help during the pandemic (Fawcett Society et al., 2020b). Complementing these findings, a large-scale longitudinal study following the same group of 38,000 adults over the first lockdown (March-May 2020) identified younger adults, particularly those aged 18–29, as experiencing the most severe loneliness, especially if they were women, economically inactive, on low incomes, or living alone (Bu et al., 2020).
67. Resilience to loneliness mirrored pre-pandemic patterns: being male, non-disabled, older and/or living in a couple continued to be associated with lower reported loneliness (UK Government, 2022). Those living in households of three or more people were also less likely to report loneliness during the pandemic (UK Government, 2022). This aligns with findings from the aforementioned longitudinal study of 38,000 adults in March-May 2020, which found that people with greater social support, more close friends, and those living with others were significantly less likely to belong to the most lonely group (Bu et al., 2020). Researchers investigating

how loneliness was experienced interviewed 8 people over 16 years of age in May 2020. Their analysis revealed both men and women, especially those living alone, missed physical contact, especially in the context of bereavements (McKenna-Plumley et al., 2021). Notably, the longitudinal study also found that loneliness was not static but followed distinct trajectories over time, with the most isolated group experiencing increased loneliness in the early weeks of lockdown, a nuance that underscores the emotional toll of prolonged restrictions on those already at risk (Bu et al., 2020). This pattern was echoed in ONS data from the second and third UK lockdowns, which showed that between October 2020 and February 2021, the proportion of adults reporting they felt lonely “often or always” rose to 7.2% - up from 5.0% during the first lockdown - marking the highest level recorded since the start of the pandemic. Young adults, disabled people and those living alone were disproportionately affected; these data were not disaggregated by gender (ONS, 2021h).

68. Care responsibilities during the pandemic created new and intensified barriers to social participation. Women took on the bulk of increased childcare and homeschooling, leading to even less time for maintaining friendships or seeking support. Data shows that young people who took on new caring responsibilities during the Covid-19 pandemic had significantly higher odds of experiencing chronic loneliness (UK Government, 2022); 31% of young female carers (16-18 years) were providing “high-intensity” care (more than 10 hours per week) relative to 20% of young male carers (Letelier et al., 2024). Among parents of school-age children, feelings of loneliness during the first UK lockdown were significantly more likely among women, those who were unemployed or less educated, had limited access to technology, lacked a dedicated study space for their child, experienced disruptions to their child’s sleep, engaged in less physical activity, or were caring for a child with special needs (El-Osta et al., 2021). Moreover, government policies such as the rule of six introduced in England impacted mothers, who undertake the majority of childcare, as their potential to meet friends and interact socially was limited by the number of children they had in their care. By contrast, policies in Scotland and Wales excluded children under the age of 12 from the household limit, potentially mitigating some of the isolation experienced by mothers in those regions. However, there is little available evidence assessing whether these policy differences had a measurable impact on maternal loneliness across the UK’s devolved administrations, as most studies do not disaggregate findings by both region and caregiving status.
69. Digital exclusion further magnified these inequalities for particular groups of women. The shift to virtual interaction disadvantaged older women, low-income mothers and women from minority backgrounds who were less likely to have access to digital tools or skills (UK Government, 2022).
70. While UK data suggests women were particularly vulnerable to loneliness during the pandemic, global findings point to a more complex picture. Prior to the pandemic, a meta-analysis revealed no significant gender difference in experiences of loneliness across 575 studies (Maes et al., 2019). The BBC Loneliness Experiment which surveyed loneliness in 46,054 participants across 237 countries found that younger men living in individualistic cultures were most likely to report loneliness (Barreto et al., 2021). Individualistic cultures, such as those typically found in Western Europe,

North America and Australia, prioritise personal independence, self-reliance and individual achievement over collective social ties or community belonging. This emphasis on autonomy may weaken everyday social support structures, increasing vulnerability to loneliness. These findings suggest that cultural context, pre-existing social norms and how loneliness is measured all influence the apparent gendered dimensions of social isolation.

71. In summary, the Covid-19 pandemic exposed and exacerbated pre-existing gendered and intersectional inequalities in social connection, inclusion and access to support. Women, particularly those who were younger, disabled, from minority backgrounds, carers, or living alone, faced significantly higher risks of chronic loneliness, compounded by digital exclusion, disrupted routines and the withdrawal of community infrastructure. The disproportionate decline in mental wellbeing among young women outlined above highlights the importance of recognising social ties as critical to health and resilience, not secondary concerns. Crucially, care responsibilities and structural inequalities limited women's ability to maintain networks, while digital inequalities further excluded marginalised groups from virtual forms of participation.
72. Recommendations include:
  - 72.1. Prioritise social infrastructure in future emergency responses, including the safe continuation or rapid reinstatement of community spaces, support groups and informal social contact points that are lifelines for women and marginalised groups.
  - 72.2. Ensure inclusive digital access, targeting investment in digital tools, skills and connectivity for older women, low-income households and racially minoritised communities to reduce exclusion during remote service delivery.
  - 72.3. Embed intersectional gender analysis into loneliness and social wellbeing strategies, ensuring that data collection and policy responses account for overlapping vulnerabilities across gender, age, ethnicity, disability, migration status and caring responsibilities.
  - 72.4. Support carers and parents, particularly young women, with tailored mental health services, respite care and community-based peer networks to alleviate isolation and strengthen social support systems.
  - 72.5. Design mental health and loneliness interventions that are culturally sensitive, gender-responsive and recognise the specific challenges of prolonged restrictions on different population groups, including solo-living older women and high-intensity young carers.
  - 72.6. Fund longitudinal research to monitor the long-term trajectories of loneliness post-pandemic, with particular focus on groups shown to be most at risk and evaluate which interventions have been most effective across diverse communities.

## Skills, training, apprenticeships and education for adults (not including universities)

73. The Covid-19 pandemic disrupted adult education and training across the UK, affecting both apprenticeships and other further education pathways for learners aged 19 and over. While the crisis exacerbated long-standing inequalities - particularly for women, disabled learners and those from ethnic minority or low-income backgrounds - it also revealed patterns of resilience and adaptability. Some learners, especially women over 25 and those in full-time employment, expressed a strong interest in continuing to learn online (Tu et al., 2022). Broader survey data echoed this, showing that intention to continue online learning was most common among adults over 25, individuals in higher socio-economic groups and men slightly more than women overall (Aldridge et al., 2020). This suggests that although women learners, especially those with caregiving responsibilities, were more likely to report difficulties such as reduced motivation, many nonetheless remained committed to continuing education where possible. These seemingly contrasting trends highlight both the structural barriers faced by women and their persistence in navigating them. At the same time, the shift to remote learning, heightened care responsibilities and reduced employer capacity constrained engagement for many others. The impacts of the pandemic were not uniform, but rather shaped by the intersections of gender, age, socio-economic status, geography and ethnicity, underscoring the need for targeted, inclusive policy responses.

### Apprenticeships

74. Apprenticeships have long served as a key route into employment and vocational training particularly for young people and those not pursuing higher education. Before the pandemic, most apprenticeship starts were concentrated in a handful of sectors. In 2018-19, English data showed over 80% of new apprenticeships were in just six areas: Business, Administration and Law (30%); Health, Public Services and Care (25%); Engineering and Manufacturing Technologies (16%); Retail and Commercial Enterprise (10%); Construction, Planning and the Built Environment (7%); and Information and Communication Technology (6%) (Cavaglia et al., 2022). Women were especially represented in business and health-related apprenticeships, while men predominated in construction, engineering, and ICT. Apprenticeship participation declined sharply at the onset of the pandemic. Starts fell sharply during the first lockdown: between March and July 2020, new apprenticeship starts declined by 45.5%, with a further 27.6% drop recorded between August and October compared to the same periods in 2019 (Blundell et al., 2021) and only 40% continued as normal (Doherty & Cullinane, 2020). Women were disproportionately affected due to their concentration in hard-hit sectors such as hospitality and retail (Blundell et al., 2021). Around 40% of apprentices reported that care or work responsibilities interfered with learning at home, with women (47%) significantly more affected than men (29%) (Tu et al., 2022). These barriers were particularly pronounced among older apprentices (aged 25+), those from Black or Asian backgrounds and those living in areas of high deprivation. While the survey authors note that such disparities may have predated the pandemic, the crisis likely amplified their effects. Prior to the pandemic, the Young Women's Trust (2017) highlighted how the lack of flexible or part-time

apprenticeships acted as a structural barrier for many young women with caregiving responsibilities. While formal data on post-pandemic earnings outcomes is still emerging, a number of analysts and advocacy groups have warned that pandemic-related career interruptions are likely to have long-term consequences for women's earnings progression, particularly among single parents, most of whom are women, who faced compounded barriers to labour market re-entry (Blundell et al., 2021).

75. There is some data to show that the pandemic intensified intersectional inequalities. In Scotland, the proportion of disabled apprentices had increased from 3.9% in 2015/16 to 15.4% in 2019/20 before falling to 13% in 2020/21 (Skills Development Scotland, 2021, p. 20). Many remote platforms lacked accessibility features, disadvantaging deaf and neurodiverse learners. Across the UK, ethnic minority apprentices remained underrepresented and faced compounded challenges. While their share of apprenticeship starts rose from 8% in 2009/10 to 13.4% in the first quarter of 2020/21, this remains significantly below their 25% share of the secondary school population, pointing to persistent structural barriers to access. Moreover, the overall number of available apprenticeships declined following the pandemic, suggesting that even this modest progress may have come amid shrinking opportunities overall, with those from minoritised backgrounds disproportionately affected (Clark & Nolan, 2021). Individuals in more deprived areas - where access to adult training was already limited - experienced compounded disadvantage during the pandemic. Many of these local economies were heavily reliant on sectors like retail and hospitality (which themselves are heavily gendered), which were among the most severely affected by lockdowns (McCurdy, 2020).
76. In response to declining apprenticeship uptake, the UK government introduced incentive schemes to encourage employers to take on new apprentices. In August 2020, employers were offered £1,500 for hiring apprentices over 25 and £2,000 for those under 25, rising to £3,000 in June 2021. Apprentices were also granted improved rights, such as extended breaks between training and contracts (Smith, 2024). However, the schemes lacked gender monitoring or safeguards and no evaluation was conducted to assess their differential impact on women.

### **Adult education and training**

77. The pandemic also exacerbated pre-existing inequalities in adult education and training in the UK, particularly for women. Before Covid-19, the number of adult learners had already declined by 50% since 2004 due to changes in funding cuts with expenditure decreasing by more than a third (approx. £1.3 billion per year) over 15 years (Child Poverty Action Group, 2022, p. 8). Women make up around 65% of adult learners over 19 years (Tu et al., 2022), meaning they were disproportionately affected by the decline in provision.
78. 47% of young people reported a decline in job skills learning during the pandemic, while 17% felt their learning had improved (Green et al. (2022)). These impacts varied depending on whether young adults were employed or solely in education during the pandemic. Among those in employment, young women aged 16-25 were more likely than their male peers to report negative effects on their job skills development.

However, no significant gender gap was found among those still in education, diverging from global patterns observed by the International Labour Organization (2020), which identified more pronounced gender inequalities in educational outcomes internationally.

79. A key barrier to home learning during the pandemic was lack of motivation, particularly among learners studying at Level 3 and above. This challenge was reported by 70% of both 16-18 and 19+ Education & Training (E&T) learners at Level 3, and by 52% of apprentices at Level 4 and above. Gender differences were also evident among E&T learners: 68% of female learners in both age groups cited lack of motivation as a difficulty, compared to 55% of their male peers. However, this gender gap did not appear among apprentices. (Tu et al., 2022). Caring responsibilities also presented a major challenge. Among adult learners, 40% said these responsibilities made home learning difficult, with women again more affected (45% of women vs. 30% of men) (Tu et al., 2022). The rate was especially high for learners aged 25+ (44%) compared to those aged 19-24 (28%) (Tu et al., 2022).
80. Mental health issues were also a common obstacle: 27% of adult learners cited anxiety or other health difficulties as a barrier to learning. Women learners were more likely to report this than their male counterparts (46% vs. 23%) though the data did not include further analysis of why this gap exists. Although fewer than one in five adult learners left their course early due to Covid-19-specific issues, 21% of those who did leave reported doing so because they found home learning difficult and lacked motivation, with higher rates among White learners (37%) (Tu et al., 2022). These findings reflect the complexity of women's experiences during the pandemic: while many struggled with motivation due to heightened caregiving demands and reduced support (per paragraph 79), this did not necessarily signal a lack of commitment to education. Rather, it suggests that women's continued engagement in learning occurred *despite* the structural obstacles they faced. This aligns with broader trends in educational attainment, where women and girls now consistently outperform their male peers. As such, some analysts suggest that young men may have been disproportionately affected by pandemic-related educational disruptions (Blundell et al., 2021, pp. 10–11), however, these men have received comparatively little policy attention.
81. The Institute for Fiscal Studies calls for integrated policy responses that recognise the interdependence of education, employment and social support systems. It stresses that joined-up thinking across policy areas is crucial to mitigate inequalities exacerbated by crises such as Covid-19 (Blundell et al., 2021). In relation to gender, this implies the need for:
  - 81.1. Expanding flexible and inclusive learning options (e.g. part-time, evening, hybrid, and asynchronous formats) to maintain adult learning continuity during health emergencies, particularly for women managing increased care responsibilities and precarious work.
  - 81.2. Investing in digital infrastructure and foundational digital skills, especially for older women and those on low incomes, to prevent digital exclusion from

becoming a compounding barrier to training and re-skilling during and after lockdowns.

- 81.3. Mandating the collection of gender-disaggregated data on participation, completion and outcomes in adult education and apprenticeships, to allow for real-time monitoring of pandemic-related dropouts and targeted support for re-entry.
- 81.4. Redesigning apprenticeship models to include more accessible formats (e.g. remote placements, modular training) and account for unpaid care responsibilities, which disproportionately fell to women during the pandemic.
- 81.5. Embedding gender equality criteria and monitoring mechanisms into all publicly funded employment and skills recovery programmes, ensuring women are not sidelined in re-employment initiatives post-crisis.
- 81.6. Designing adult education policy with dual-gender responsiveness, recognising both the long-standing structural exclusion of women and the emerging vulnerabilities of young men revealed by the pandemic's differential impacts.

## Informal care (including childcare responsibilities)

82. The Covid-19 pandemic sharply intensified existing gender inequalities in unpaid care work within households across the UK. Women disproportionately absorbed the additional care responsibilities brought on by school closures, the suspension of social care services and increased health needs within families. This surge in unpaid labour not only deepened the time poverty - where an individual does not have enough discretionary or free time due to the demands of unpaid and paid work - experienced by many women but also had significant consequences for their participation in paid work, career progression and mental health.
83. Women in the UK undertake most of the unpaid care within households and communities. In 2016, the ONS reported that women performed 60% more unpaid work than men, including childcare, housework and informal care (Office for National Statistics, 2016). Contributing factors for this include entrenched gender norms of the mother as the care giver, that become stronger at a time of crisis; the fact women are less likely to be in work and/or more likely to have been furloughed and the gender pay gap and associated household decision-making. Thus, it could have been anticipated that with schools or childcare closing, women would absorb the additional unpaid care demands within homes. During the pandemic this trend continued and indeed was exacerbated. Women continued to carry out the majority of unpaid work and childcare during lockdowns. While both men and women spent more time working from home throughout the pandemic, women did more unpaid household work than men. Couples with young children (aged 12 or under) self-reported undertaking an average of 49.7 hours of additional childcare per week, the equivalent burden of a working week in additional childcare. This is double what families reported prior to Covid-19. On average, women have been doing 30.3 additional hours' childcare per week, compared to 19.4 done by men (Sevilla & Smith, 2020). The gender childcare gap is thus large in absolute number of hours.
84. The ONS reports that when men and women moved to homeworking, men initially were helping more with unpaid work and unpaid childcare; however, the difference between hours undertaken on unpaid care increased in September to early October 2020 compared with the start of the pandemic (i.e. women did more, and men did less) (Office for National Statistics, 2021b). The amount of time men spent on unpaid household work increased from an average of 1 hour and 45 minutes per day as baseline prior to the pandemic, to 1 hour and 58 minutes per day during the end of March and April 2020, before reducing to 1 hour and 40 minutes per day during September and early October. As a consequence, during September and early October 2020, women spent 64% more time on unpaid household work than men. Adams-Prassl et al. (2020a) found that women did approximately an hour and a half more childcare per workday than men. In households with a child aged under 5 years, women did on average 78% more childcare than men (Office for National Statistics, 2020c).
85. Additionally, a significantly greater proportion of women (67%) than men (52%) homeschooled a school-age child in late January and early February (13 January and 7 February 2021) (Office for National Statistics, 2021).

86. There are also notable differences in the types of childcare that men and women were engaged in during lockdowns. Men were more likely to devote their time on childcare to developmental work (e.g. reading to children, playing with children or helping children with their school work), compared to women who absorbed the majority of the non-developmental childcare (e.g. feeding, washing or dressing children). Parents report finding developmental care more enjoyable than non-developmental childcare, which also contributed to women's sense of life satisfaction (lower than men's during lockdown) and to mental health concerns (Office for National Statistics, 2020c).
87. Andrew et al. (2020) analysed time-use data – data collected from asking people how they spend time each day – for childcare, and how childcare relates to employment, finding that men's childcare is more sensitive to their employment – i.e. men did less childcare on account of their paid employment. This was not true for women who maintained work hours at the same time as unpaid employment, meaning that many women were left juggling work with (a lot of) childcare.
88. Survey data has demonstrated that, as a consequence of the additional childcare responsibilities, working mothers were 1.5 times more likely than fathers to have lost or quit their job due to increased care responsibilities (Institute for Fiscal Studies, 2020). They were also more likely to have been furloughed. Overall, mothers who were in paid work in February 2020 were 9 percentage points less likely to still be in paid work compared to fathers by May 2020. Moreover, mothers were also more likely than fathers to be doing paid work at home, and simultaneously trying to care for their children during lockdown (University College London, 2020). In heterosexual families, given the fact that women are less likely to be in full time work, that women are more likely to be in industries that used furlough and the gender pay gap, it made more financial sense for the woman, as opposed to the man, to reduce her working hours to undertake the additional unpaid care (Wenham, 2021).
89. This has had longer term effects. Prior to Covid-19 the gender pay gap was declining across the UK (women were paid 83p for every £1 men were paid). However, by 2023, mothers earned on average £4.44 less an hour than fathers (Topping, 2024). Moreover, women's participation in the UK labour market has shown signs of recovery but has not fully returned to pre-pandemic levels. The female employment rate stood at 71.8% in the final quarter of 2024, slightly below the record high of 72.7% observed just before the pandemic in early 2020 (Francis-Devine et al., 2025).
90. Whilst this report will not consider mental health in its entirety, it is important to note the overwhelming evidence which has demonstrated the extent to which women have reported their unpaid childcare responsibilities and homeschooling affecting their wellbeing more so than men, and the increased rates of anxiety and depression reported amongst women compared to men in relation to unpaid care within the home (Diamond, 2023). Working parents who adapted their work patterns reported more psychological distress than those who did not. This association was much stronger if he or she was the only member in the household who adapted their work patterns, or if she was a lone mother (Xue & McMunn, 2021).

91. Single parents (approximately 85% of whom are women) particularly suffered from increases in unpaid care work during the pandemic. These women have consistently reported increased concerns of financial insecurity, risks of falling into poverty and increased mental health concerns (Clery et al., 2021).
92. The impacts of the increased unpaid care burden for women had substantial impacts across the UK. Lessons for future could include:
  - 92.1. Ensure that unpaid care duties at a time of crisis do not affect paid employment, such as introducing protected provisions for those who have dependents and/or caring responsibilities.
  - 92.2. Paid leave for all carers should be provided as part of pandemic preparedness plans if schools are closed.
  - 92.3. Ensure the re-opening of the childcare and education sectors as a first step post lockdowns or other relevant public health measures to facilitate women's return to paid employment.
  - 92.4. Consider incentives through employers to encourage equal engagement in unpaid care at a time of crisis between men and women.

## Exposure to violence

93. Covid-19 exacerbated existing risks of and exposure to violence against women and girls. Lockdown measures, economic instability, social isolation and distancing created conditions which intensified the likelihood of violence occurring in the first place, and in turn limited women's access to support services. This must be considered as part of the longer-term trends demonstrating a steady rise in the reporting of violence against women across England and Wales, albeit there is an indication of declines in Scotland and Northern Ireland. As such, whilst there were increased risks of violence as a result of the policy interventions implemented to mitigate the spread of Covid-19, these cannot be separated from the pre-existing domestic abuse crisis across the UK (Hohl & Johnson, 2021). It must also be noted that new forms of abuse have been documented, such as exploitation of pandemic related fears including using exposure to the virus (refusing to take public health measures, or coughing on victims), technology facilitated abuse, or denying access to medical treatment or food as a mechanism for coercive or controlling behaviour (Davidge, 2020; Dawsey-Hewitt, 2021).
94. Prior to Covid-19 there were already existing inequalities in terms of risks to domestic or gender-based violence. Women consistently report higher rates of domestic abuse than men (Office for National Statistics, 2023c). Age is also a predictive factor, with most domestic violence occurring in younger age groups (Office for National Statistics, 2024). Those from minority ethnic, black or mixed backgrounds are most likely to seek domestic abuse services (Thiara & Roy, 2020). People with disabilities are at increased risk (Public Health England, 2015). There is also an increased risk of domestic violence for those individuals with a long term or temporary illness, older women, or those who are pregnant (NICE, 2023). Urban areas also often report higher rates of domestic violence than those in rural settings (Office for National Statistics, 2019). Migrant women with insecure immigration status, those with no recourse to public funds, or not on spousal visas are especially vulnerable, often lacking access to public funds, excluded from the Destitution Domestic Violence Concession, or fearing enforcement if they seek help (Käkelä & Sime, n.d.). There has been no significant change in victim or perpetrator demographics in the domestic abuse coming to police attention during the Covid-19 pandemic.
95. It is important to note that measuring rates of domestic violence is notoriously hard to achieve, given the clandestine nature of occurrences, under-reporting, the repeat nature, inconsistent definitions and the reluctance many victims feel in coming forward and formally reporting, thus obscuring the true prevalence of abuse. As such, below are a range of proxy indicators that can be used to demonstrate the impact of Covid-19 and lockdown on violence against women. These likely understate the likely incidence (Walby & Towers, 2017).
96. By April 2020, Refuge, the UK's largest domestic abuse charity, had reported a 700% increase in calls to its helpline in a single day (Townsend, 2020). By May 2020, the charity had reported a 957% increase in web traffic (Waitzman, 2020). By June 2020, Marie Stopes International reported a 33% rise in domestic violence reports related to seeking reproductive services (Mostafa, 2020). The National Domestic Abuse

Helpline received 40,000 calls in the first three months of the first lockdown, an 80% increase on pre-pandemic figures. Rape crisis centres reported a 41% increase in sessions of specialist support between 2019-20 and 2020-21 (End Violence Against Women, n.d.).

97. 80% of domestic violence support services reported a reduced service because of less face-to-face contact, staff sickness and limitations of working at home (Bhalotra, 2020). Moreover, face-to-face sexual and reproductive health services and providers and GP services play a vital role in identifying the signs of domestic violence, and counselling vulnerable girls and women who may be victims. Given the widespread closures of Sexual and Reproductive Health services and the move to telephone-based provision of GP care during the pandemic, this may have exposed women to greater risks, and the most vulnerable may not have known where to seek help. As such, there may have been missed opportunities for women to report abuse and/or seek support.
98. Police recorded crime data, which are likely underestimates of actual levels of domestic violence, given the barriers for reporting, for the year ending March 2021 recorded 1,459,663 domestic abuse related incidents and crimes in England and Wales. 845,734 were domestic abuse related crimes, representing a 6% increase from the previous years, and the total reflecting 18% of all offences recorded by the police that year (Office for National Statistics, 2021g). Routine data collection relating to domestic violence through the crime survey for England and Wales are not available for 2020-1 as the pandemic moved the survey data collection to a telephone-based approach, which meant it would not be safe to ask questions related to domestic violence and thus was excluded from the survey. Thus, both forms of data probably do not reflect the full extent of domestic violence endured during pandemic years. In 2021 in Scotland, 65,251 domestic abuse incidents were reported, a 4% increase from the previous year, albeit the fifth consecutive annual rise (Victim Support Scotland, 2022). Recorded Crime National Statistics show that there were 1,760 crimes recorded under the Domestic Abuse (Scotland) Act 2018 in 2021-22, the third year this legislation has been in place. This was a 7% increase compared to 2020-21 (from 1,641 to 1,760) and a 5% increase compared to 2019-20 (from 1,681 to 1,760). Of those crimes, 92% (or 1,627) involved a female victim and 8% (or 133) had a male victim. These proportions are like those in the previous year, at 94% and 6%, respectively (Scottish Government, 2023). In Northern Ireland, there were 31,196 domestic abuse incidents in 2021/2 and 19,036 domestic abuse crimes – the third highest level recorded since the data series began. 69% of these were against females (Women's Aid Federation in Northern Ireland, n.d.).
99. In the UK, in the first month after the initial lockdown, the rate of homicide in women was more than twice the average of two women a week, and the highest rate in the last 11 years (Bhalotra, 2020). Such a trend did not continue over the course of the pandemic, with domestic homicides (the majority of the victims of which are women, and the crime committed by men) not appearing to have increased substantially (Bates et al., 2022). Since 2021, Northern Ireland has the joint highest rate of femicide in Europe, and the highest rates of domestic violence in the UK (McCambridge, 2024).

100. Furthermore, some domestic abusers used the coronavirus context to further their abuse - to intensify and conceal their violence: isolating victims from friends and family, preventing their leaving the house, extending their abuse through childcare arrangements, limited communication through digital exclusion and control, and blaming abusive behaviours on pandemic associated stresses (Hohl & Johnson, 2021).
101. During the pandemic, women also delayed separating from abusive partners, with many torn between Covid-19 restrictions on mobility and violence within the home. Research has demonstrated that escalation of domestic abuse-related harm and risk can occur at the point of separation - 43% of domestic homicides occurred after victims had separated or attempted to separate from their abusive partner, after Covid-19 restrictions were lifted (Karim et al., 2020). This ties into a broader trend of delayed contact with support services, longer recovery times and continuing economic and mental health impacts of domestic abuse during the pandemic (Woman's Trust, n.d.).
102. Given the difficulties of reliable and accurate statistics, it is also important to consider qualitative research about domestic violence during the pandemic. For example, McKinlay et al. (2023) and Desai et al. (2024) found that lockdowns meant confinement to a space where abuse was occurring, barriers to accessing support/networks; and increased sense of fear, psychological distress and isolation. Lyons and Brewer (2022) also note the use of Covid-19 by the abuser. On the supply side, Horney et al (2023) demonstrated the very real struggles that domestic violence institutions faced in seeking to continue provision of services to those at risk of violence.
103. By 2024, the National Police Chiefs' Council determined there had been a 37% increase in stalking, harassment, sexual assault and domestic violence in England and Wales, with 1 in every 12 women a victim, representing 20% of police time (National Police Chiefs' Council (NPCC), n.d.). Whilst this cannot all be causally linked to the pandemic, the year-on-year increases in violence demonstrates that Covid-19 restrictions might have been a catalyst for broader patterns of violence, and changes in behaviours becoming more common amongst perpetrators. In Scotland, between 2008-2020 there had been a decrease in reported partner abuse, but police data show an increase in domestic abuse incidents in 2020/1 and 2023/4 (Scottish Government, 2024). In Northern Ireland, domestic abuse incidents and crimes peaked in 2022/3 and since then have been showing a decline (Northern Ireland Statistics and Research Agency, 2025; Police Service of Northern Ireland, 2022, 2024).
104. Domestic violence should have been considered as a likely consequence of lockdown measures from the start. Recommendations for the future could include:
  - 104.1. Early recognition of the impact of pandemics and lockdowns on domestic abuse, and the particular risks faced by those women from black, minoritised, disabled and migrant communities and those with no access to public funds.

- 104.2. Domestic violence support mechanisms excluded from social distancing and lockdown provision from the start (i.e. so there is safe refuge for victim-survivors).
- 104.3. Early planning, consultation and engagement with the VAWG sector, including increased funding to domestic violence charities in the early stages of a health emergency to facilitate additional provision of care and support for victims and potential victims.
- 104.4. Clear, accessible and translated messaging that those experiencing domestic abuse are permitted to leave their homes, and about safeguarding duties and statutory rights of those feeling abuse.
- 104.5. Training community members to identify risk behaviours (such as postal workers, community workers and others that may visit door to door routinely).
- 104.6. Greater investment in domestic violence mitigation strategies in routine times to mitigate potential challenges at a time of crisis. This can involve working with potential abusers to identify the root cause of their violence.

## Conclusion

105. The Covid-19 pandemic exposed and intensified longstanding gendered inequalities across UK society. This report has demonstrated that women, particularly those already marginalised by poverty, ethnicity, disability, migration status, or single parenthood, were disproportionately affected across nearly every domain of life: health, care, housing, employment, safety, education and social connectedness. These unequal impacts were not simply the result of the virus, but of policy responses that too often treated gender-neutrality as fairness, overlooking the structural realities that shape how crises are experienced and absorbed.
106. From the rise in unpaid care and the collapse of childcare infrastructure, to increased exposure to gender-based violence and disruptions to sexual and reproductive healthcare, the pandemic's toll on women has been profound. Women were more likely to lose income, shoulder additional domestic labour and see their health needs deprioritised. At the same time, many continued to sustain families, communities, and essential services, often invisibly and with little institutional support.
107. Critically, these inequalities did not arise in isolation. They intersected, compounding one another and deepening disadvantage, and were shaped by pre-existing structural conditions, including the gender pay gap, racialised housing inequalities and unequal access to welfare. The pandemic revealed not only the fragility of existing systems, but their lack of preparedness to account for gender and intersecting forms of inequality in moments of crisis.
108. As this report has shown, women - especially those with intersecting vulnerabilities such as low income, single parents, disabled or ethnic minority status - bore the brunt of increased unpaid care, employment insecurity and disrupted access to essential health and social services. These inequalities were significantly deepened by the UK government's pandemic response, which lacked gender-sensitive planning (Wenham & Herten-Crabb, 2021). Without targeted recovery efforts, these inequalities risk becoming further entrenched. Moreover, now is the opportunity to rethink social and economic policies to build greater gender equity and resilience into future health crisis responses.
109. While this report has focused on the gendered impacts of Covid-19 on women in the UK, particularly in relation to care, health, housing, economic security and safety, other important areas warrant further exploration. These include the experiences of trans women, sex workers, women in detention, disabled women and those working in informal or precarious sectors — many of whom faced heightened exclusion and risk. Issues such as menstrual and menopause health, adolescent girls' wellbeing, and the lack of women's representation in pandemic decision-making also merit closer attention. Future research and policymaking must take an intersectional and inclusive approach to ensure that these groups are no longer overlooked in times of crisis.
110. Yet this crisis also offers a turning point. The fact that emergency measures such as *Everyone In*, telemedicine abortion access, and digital training provision were rapidly introduced shows that responsive, inclusive policy is possible. What remains is the

political will to ensure that such measures are not temporary exceptions, but foundational principles in health emergency preparedness, economic recovery and social policy.

111. I remind the Inquiry that 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 should be 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, and recognising that policy interventions will in turn support some women more than others.
112. The central lesson of this report is not only that women were unequally impacted, but that they were largely unseen in the policymaking that shaped those impacts. Future pandemic planning and crisis response must embed gender-responsive analysis at every stage, recognising the differentiated risks and needs that exist across society. Crucially, this must include the routine application of intersectional equality impact assessments, the collection and use of disaggregated data, and the active involvement of diverse women's voices in shaping public policy. Without such changes, the gains made towards gender equality risk not only being undone, but forgotten in the next crisis.

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## Annex 2: Inquiry Documents

Document	INQ
Diamond, I. Additional witness statement of Professor Sir Ian Diamond	INQ00271436