COVID-19 and Sex, Gender and Intersectionality

This guidance document, prepared by the Gender and Health Unit at Health Canada, highlights key intersecting sex, gender and diversity issues and considerations in preparing responses to COVID-19. Information sources and other reference documents are included. Further details on specific COVID-19 health issues can be found on the Health Portfolio SGBA+ GCpedia page.

The Government of Canada is committed to ensuring that policies, programs and services consider how diverse groups of women, men and non-binary people may be impacted.

In the **Health Portfolio,** we know that health risks, burdens, experiences and outcomes are different for everyone. In responses to COVID-19, we need to consider **intersecting factors** such as age, geography, disability, race/ethnicity and Indigeneity, migration/refugee status, class, and other structural conditions, including precarious housing, employment, and political and environmental stressors.

Highlights of Key Factors

SEX/GENDER: Frontline health and social care providers, the majority of whom are women (70% globally), as well as those providing essential services have a higher risk of infection as well as of transmitting the disease. Women still predominantly hold caretaking & household responsibilities – putting them at increased risk while caring for ill family members.

AGE: Early data shows elderly people and those with pre-existing health conditions are most vulnerable and least likely to recover.

DISABILITY: People with disabilities often have underlying health conditions and are more likely to be poor, making them more susceptible to serious illness or death if they contract COVID-19.

GEOGRAPHIC LOCATION: People living in dense urban areas & near transportation hubs may be more exposed. In lower resourced regions with weak and under-funded health systems, impacts can be more severe. Physical distancing is more challenging for those who live in population dense locations such as multi-dwelling units or in communal facilities such as retirement homes or prisons.

HEALTH STATUS: Health status is influenced by a broad set of social determinants, including income, education and access to nutrition. Disruptions to critical services occur during pandemics while resources focus on fighting spread.

INDIGENEITY: Living in remote locations with little access to health services, overcrowding in housing, poverty, and underlying health conditions such as cardiovascular disease and diabetes, can make some Indigenous populations particularly at risk.

RACE/ETHNCITY: There is often higher percentage of cardiovascular, diabetes and other chronic diseases among racial and ethnic minorities. A number of risk factors – from biological to social & environmental – underpin these differences.

SOCIOECONOMIC STATUS: People in precarious employment positions are less likely to have paid sick leave or the ability to miss work due to illness. They are more likely to rely on public transport, with increased risk of exposure. Women are overrepresented in part-time and precarious work. The result is decreased access to social protections such as employment insurance, security, and benefits.

When preparing responses, consider:

In Canada, the pandemic is predicted to "hit people facing intersecting forms of discrimination the hardest: Indigenous women, racialized women, newcomers, women with disabilities, lone parents."

Functional Considerations — A Sample

DATA COLLECTION AND CONSULTATION

- ◊ When attempting to capture differing rates of infection and outcomes, data collection should not be limited to sex disaggregated data. Integrate biological explanations with other social factors including, but not limited to, gender norms and roles and behaviours (e.g., smoking tobacco and drinking alcohol).
- ◊ Factor gender relations into research on the impact of the pandemic, as physical distancing puts women and girls at higher risk of domestic violence due to heightened tensions in the household.
- ◊ Support and listen to those who are predominantly on the front lines of the response (70% women).

SOCIAL, BEHAVIOURAL OBSERVATIONAL AND SERO-PREVALENCE STUDIES

- ◊ Sex, gender, age and other identity characteristics should be considered in survey questions and sampling strategies.
- ◊ Investigate gendered behaviours in studies of disease susceptibility. For example, men are more likely to smoke than women and are less likely to seek healthcare, whereas older women are more likely to live alone and experience social isolation.

COMMUNICATIONS

- ◊ Women and men consume and respond to information differently, as do distinct age cohorts; strategic packaging of communication materials is necessary in terms of both messaging and optimum channels for maximized impact.
- ◊ Consider multi language access: Often, fast-paced, ever-evolving information is presented primarily in English and French. Make key documents and messaging available in other languages (including Indigenous languages); those with limited official language ability are potentially at a disadvantage regarding details of changing public health directives, bylaws, etc. It is also important to consider braille and audible messaging and communications targeting different comprehension levels and styles.

Government of Canada:

Government of Canada Coronavirus disease (COVID-19) Outbreak updates: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

Public Health Agency of Canada. Vulnerable populations infographic: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html

Canadian Institutes of Health Research. COVID-19: https://cihr-irsc.gc.ca/e/51917.html

Canadian Institutes of Health Research. Why Sex and Gender Need to be Considered in COVID-19 A Guide for Applicants and Reviewers (posted on the Health Portfolio SGBA GCpedia page)

Department of Women and Gender Equality. Supporting women's shelters and sexual assault centres during COVID-19: https://cfc-swc.gc.ca/fun-fin/shelters-refuges-en.html

International Organisations:

Global Health 5050. Towards gender equality in global health. COVID-19 sex-disaggregated data tracker: http://globalhealth5050.org/covid19/

UN Women. COVID-19: Emerging gender data and why it matters: https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters

UN Women. The shadow pandemic: Violence against women and girls and COVID-19: https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters#vaw

UN Women: https://www.unwomen.org/en/news/stories/2019/8/news-publication-of-the-report-of-the-g7-gender-equality-advisory-council

World Health Organization. Coronavirus disease (COVID-19) pandemic: https://www.who.int/emergencies/diseases/novel-coronavirus-2019

United Nations Human Rights. COVID-19 and the human rights of LGBTI people: https://www.ohchr.org/Documents/Issues/LGBT/LGBTIpeople.pdf

Data2X: https://data2x.org/resource-center/gender-and-data-resources-related-to-covid-19/

Canadian Non-Governmental Organisations:

Wellness Together Canada: Mental health and substance use support. Online portal: https://ca.portal.gs/

Canadian Women's Foundation. Signal for help: https://canadianwomen.org/signal-for-help/

National Collaborating Centre for Determinants of Health. Equity-informed responses to COVID-19: http://nccdh.ca/our-work/covid-19/

Intersectionality and COVID-19 Guidance:

Beyond sex and gender analysis: n intersectional view of the COVID-19 pandemic outbreak and response. Policy Brief | Olena Hankivsky, PhD | Anuj Kapilashrami, PhD https://www.qmul.ac.uk/media/news/2020/pr/queen-mary-research-calls-for-an-intersectional-view-of-the-coronavirus-pandemic.html