ACTION BRIEF

UN WOMEN

WOMEN, PEACE & SECURITY WOMEN IN DECISION-MAKING: COVID-19 AND BEYOND

WOMEN IN DECISION-MAKING

Women are on the COVID-19 frontlines as healthcare workers, caretakers and community responders. In formal decision-making, however, women's representation is far less visible. Only one in five parliamentary seats in Asia are held by women, and men hold the majority of health leadership positions. This gender disparity has been further highlighted during the COVID-19 crisis when, with very few exceptions, women are overwhelmingly missing from pandemic response and recovery decision-making.

While data suggests that the COVID-19 mortality rate for men is higher, the pandemic is having disproportionate effects on women and girls who are facing increased challenges in accessing healthcare services, are at a higher risk of losing their livelihoods, and are increasingly subjected to sexual and gender-based violence. It is now more important than ever to include women's voices in decision-making to ensure gender equal leadership and gender-sensitive responses to the COVID-19 pandemic, in order to build back a better, gender equal future.

WOMEN'S LEADERSHIP DURING COVID-19

Increasing the participation of women in decision-making, and fostering gender-sensitive responses to the COVID-19 pandemic, are distinct yet complementary agendas.

Countries that have more women in leadership positions, are more likely to deliver COVID-19 responses that consider the effects of the crisis on women and girls. On average, the more women in leadership positions, the more likely a country is to develop an informed and inclusive gendered response to the pandemic. That is, the needs of women and girls are more often recognized and met when women are in decision-making positions, and gender equal governments are more likely to consider the diverse needs of all people as they respond to the pandemic.

Beyond the pandemic, research shows that the higher the share of women in decision-making, the higher the likelihood of passing and implementing legislation that advances gender equality, including laws relating to ending intimate partner violence, rape, and sexual harassment.

Women leaders in the Asia Pacific region have been praised for their rapid responses to the pandemic, which have not only included measures to 'flatten the curve'—such as confinement, social distancing and widespread testing—but also transparent and compassionate communication of fact-based public health information, which communities can engage with.[i] The strong leadership by women in **New Zealand** and **Taiwan** suggests that women in decision-making correlates with handling the pandemic with efficiency, transparency and in a gender-sensitive manner.

This is the fifth action brief on WPS + COVID-19 in Asia and the Pacific. The previous briefs on militarization, cyber security, and women human rights defenders can be found on the UN Women Asia Pacific website: https://asiapacific.unwomen.org/en/digitallibrary/publications

In **New Zealand**, for instance, Prime Minister Jacinda Ardern, supported by a national legislature with almost gender parity (41 per cent), adopted a gender informed approach to manage the pandemic, including identifying and addressing the gendered impact of the pandemic through New Zealand's Human Rights Commission[ii], establishing a courtroom sensitive to the needs of survivors of sexual and gender-based crimes with the support of the Ministry of Justice, and assigning specific COVID-19 response and recovery funds for services for women[iii].

An analysis of COVID-19 responses by Open Democracy found that countries with women in leadership positions have suffered six times fewer confirmed COVID-19 deaths than governments with men at the top.[iv]

Bhutan is also moving towards a more gender equal political landscape. Over the past ten years, Bhutan's parliamentary democracy has raised the importance of women in politics, such as by appointing its first woman minister in 2013 and the Minister of Health, Dechen Wangmo in 2018. Minister Wangmo has been praised for proactively responding to the pandemic, which has resulted in zero COVID-19 related deaths in Bhutan thus far.

LESSONS LEARNT FROM PREVIOUS EPIDEMICS

Previous responses to health epidemics have cemented the importance of women's leadership, essentially because health crises impact women and men differently.

During the Ebola and Zika outbreaks, few women were at decision-making tables, resulting in devastating gendered effects, and gender-blind responses that exacerbated the outbreaks[v]. Ebola and Zika are particularly dangerous for pregnant women, however, during both outbreaks, access to sexual and reproductive health services was limited, and pregnant and lactating women were excluded from vaccination programmes. Nearly 100 per cent of the pregnancies of Ebola-infected women ended in miscarriage or neonatal death[vi].

As with the current pandemic, previous health emergencies also revealed that women are more likely than men to experience negative socio-economic consequences. Following the Ebola epidemic, men's income recovered faster than women's[vii]. Experts continue to warn of similar long-term economic inequalities between women and men resulting from COVID-19, primarily because women are overrepresented in informal sectors where they are the first to lose their livelihood and among the last to recover[viii]. Without gender-sensitive response plans, women are less likely to access and benefit from COVID-19 recovery measures.

WHO has noted that health systems would be stronger if women had an equal say in the design of national health plans, policies, and systems[ix]. Despite this, women remain excluded from policy and decision-making, resulting in the needs of women and girls being largely unmet during and post health crises and other emergencies.

In 2019, the Global Preparedness Monitoring Board called for more women leaders as a vital part of preparedness efforts[x]. These leaders establish guidelines for crises and emergency management, set priorities for funding, and determine research priorities. Without women in these positions, subsequent decisions will not adequately recognize the gendered dimensions of potential solutions and outcomes. Yet, when analyzing recent emergencies, little has been done to ensure that women's voices are reflected at the decision-making table.

Previous health crises have also demonstrated that women-led civil society organisations play a pivotal role in response and recovery, often reaching those furthest behind and accessing communities marginalized from mainstream relief and recovery programmes. Despite this, less than one per cent of the Global Humanitarian Response Plan for COVID-19 has been allocated to women-focused organisations.[xi]

Persistent underfunding of women-led civil society and women-focused organisations limits the ability to address the drivers of gender inequality and creates systemic discrimination in mechanisms designed to respond to the COVID-19 pandemic in an inclusive manner.

70% of the world's healthcare staff are women, but only 25% of global leaders are women

MALE DOMINATED COVID-19 TASK TEAMS LESS LIKELY TO RESPOND TO THE NEEDS OF WOMEN

Across Asia and the Pacific, COVID-19 Task Force Teams are male-dominated. Despite the WHO Executive Board calling for women to be included in decision-making for outbreak preparedness and response[xii], women remain underrepresented in COVID-19 policy spaces. According to a study by CARE International, 74 per cent of the countries

with COVID-19 Task Force Teams had less than one-third women, with only one committee having gender parity[xiii].

In **Indonesia**, the executive board of the COVID-19 Task Force Team as initially established consisted of six men and no women, and the advisory board of three men and one woman[xiv]. In **Myanmar,** the Team is composed of 18 men and five women[xv], in **Pakistan** it is twelve men and one woman[xvi], and in **Sri Lanka,** 37 men and three women[xvii].

The absence of women in decision-making is likely to correspond with limited gender sensitivity in COVID-19 response plans. For example, unpaid care work, where women are overrepresented, has not yet been incorporated into COVID-19 stimulus packages in **South Asia**[xviii]. Additionally, CARE International found that COVID-19 responses failed to consider gender-based violence, sexual and reproductive health, or women's economic implications in countries such as **Myanmar**, **Pakistan**, and **Sri Lanka**[xix]. In these countries, women's representation in national parliaments is relatively low, with 5 per cent in Sri Lanka[xx], 11 per cent in Myanmar[xxi] and 20 per cent in Pakistan.[xxii]

Reported cases of gender-based violence have increased dramatically during the implementation of quarantine measures in Asia, both in prevalence and intensity. In **Singapore**, gender-based violence helplines have recorded an increase in calls of 33 per cent. In **China**, digital citizens have used the hashtag #AntiDomesticViolenceDuringEpidemic to break the silence and expose violence as a risk during lockdowns and quarantines.[xxiii]

Further in **Singapore**, where only two of 17 members of the COVID-19 Economic Recovery Task Force Team are women, economic recovery efforts have been criticized for excluding women's perspectives[xxiv]. In the **Philippines**, where women hold 10 per cent of the seats in the Cabinet[xxv], 51 per cent of women compared to 71 per cent men, have reported receiving government support since the start of the outbreak.

The lack of gender parity in national-level COVID-19 decision-making bodies reflects wider societal inequalities that constrain women's participation and leadership.

WHERE ARE THE WOMEN IN DECISION-MAKING?

Women's participation in decision-making is fundamental to democratic governance. Across Asia, however, women continue to be underrepresented in all types of decision-making. Women still have far to go towards equal representation in positions of power and leadership, whether that is in COVID-19 Task Force Teams, legislative bodies or political parties. Discriminatory laws, institutions and attitudes restrict women from equal access to decision-making tables. The COVID-19 pandemic has demonstrated how existing gender inequalities are being exacerbated, further reducing women's opportunities to take on leadership roles at local, national and global levels.

Globally, women's political representation has stagnated at around one in four parliamentary seats held by women[xxvi]. In Asia, this figure is even lower. As a result, government responses to the pandemic remain largely uninformed about specific issues facing women, inadvertently discriminating against women. In **Malaysia**, during COVID-19 movement restrictions, only the "head of the family" was permitted to leave the home, a role usually assigned to men due to social norms that position the husband as the head of the household[xxvii]. As of 2019, Malaysia ranks 143 out of 190 countries on women's representation in national parliament and women only hold 14 per cent of the parliamentary seats in the country[xxviii].

Women hold around 21 per cent of the seats in the national parliament in **Bangladesh**,[xxix] however, their representation is far less at the local level. Women's rights organizations in Bangladesh have reported that they are being excluded from local and national consultations on COVID-19 responses[xxx]. While the government cash allowance programme was expanded for 'widow, deserted and destitute women' within the 100 most poverty stricken Upazilas (administrative regions), women from indigenous communities, ethnic minorities, and marginalized groups, such as sex workers and the LGBTIQ+ community, as well as women-led households outside identified Upazilas, have not been targeted for relief support. According to a survey conducted by UN Women in April 2020, 61 per cent of women in Bangladesh reported being unable to seek medical care when they needed it, and only one per cent of women reported being covered by health insurance.[xxxi]

Understanding how COVID-19 affects women and men differently, and recognizing women as leaders and decision-makers, is fundamental to an effective response for all. As communities manage the long-term socio-economic impacts of the pandemic, the leadership of women is critical to ensure effective responses for all genders.

BUILDING BACK BETTER REQUIRES WOMEN IN LEADERSHIP POSITIONS

As 2020 marks the 20th anniversary of the Security Council Resolution 1325 on Women, Peace and Security, the multiple impacts of the COVID-19 pandemic and the inequalities it unveils are a stark reminder of how women can lead to turn the tide, as powerful agents of change, decision-makers, and leaders at all levels.

Women must be at the center of COVID-19 response and recovery efforts, starting with women's equal representation and participation in decision-making, particularly in national legislative bodies where decisions on COVID-19 responses are made. A response that does not consider the impacts of COVID-19 on women and girls will not only fail to meet the needs and requirements of half of the population, it will also be less effective for communities overall.

As the virus continues to spread, governments, organizations and health facilities should commit to ensuring that women's full, equal and meaningful representation and leadership is not the exception, but the norm. More now than ever, it is crucial to support and advance women's leadership to build back a better, gender equal future for all.

The COVID-19 pandemic provides an excellent opportunity to do things differently and to build back better with women at the forefront, not only as healthcare workers, but also at the decision-making table.

RECOMMENDATIONS

For all actors responding to COVID-19 in Asia and the Pacific:

1. Promote women's full, equal and meaningful participation in decision-making and leadership positions, from the local to the national level, including through the provision of quotas and other temporary special measures designed to accelerate gender parity and address persistent obstacles preventing women's participation and driving gender discrimination.

2. Ensure COVID-19-related decision-making bodies and processes provide for the full, equal and meaningful participation of women, gender equality experts, and women's healthcare professionals, to inform gender-sensitive responses and inclusive programmes.

3. Work with diverse women-led and women's rights organizations, movements, and leaders to identify the barriers to women's participation and leadership in decision-making structures, such as COVID-19 Task Force Teams, health policy-making, parliaments and governance institutions, and work collaboratively with them to address and dismantle those barriers.

4. Recognize the unique expertise and contribution of women-led civil society and women-focused organisations in responding to COVID-19, including by increasing funding to support sustainability of organisations beyond COVID-19.

5. Institutionalize women's equal participation in crisis preparedness now in order to ensure gender-inclusive policy and responses to future health, and other, crises.

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