IN BRIEF

WOMEN'S NEEDS & GENDER EQUALITY IN EGYPT'S COVID-19 RESPONSE

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What's the issue?

Based on lessons learned from past outbreaks, this 'brief' outlines gender issues related to the COVID-19 pandemic and response in Egypt. Women and girls' immediate and long-term needs must be addressed and integrated into Egypt's response, in order to both ensure women's access to services and human rights, and to enable women to contribute to shaping the response. Recommended guidelines for both immediate and longer-term action are also proposed for COVID-19 stakeholders in Egypt.

A pandemic magnifies all existing inequalities, class, ability, age and gender. Data to date suggest that COVID-19 is less fatal for women than for men.[1] Still, its socioeconomic impact will have far-reaching gendered impacts, from exacerbating already unthinkably high levels of violence against women, to stunting women's engagement in the labour market.

In short, the pandemic threatens to reverse hard-won gains on gender equality by relegating women back to the domestic sphere, while increasing their vulnerability to violence and exploitation.

Global reality, national response

First discovered in Wuhan, China, the Corona Virus Disease 2019 (CoVID-19) outbreak spread quickly across the world and was declared a 'pandemic' by the World Health Organization (WHO) on 11 March 2020. As of 31 March 2020, there were 856,689 confirmed cases of COVID-19 and more than 42,000 deaths across 201 countries.[2]

Since Egypt's first case on 13 February, there have been more than 700 confirmed cases and 46 deaths.[3] The Government of Egypt has responded with a series of measures to limit social interaction among its 100 million inhabitants, including closing schools and universities until at least mid-April, as well as all governmental services and institutions – except those providing health and civil services (such birth and death certificates). In March, air traffic was halted and a curfew (7 pm-6 am) was imposed.

The most relevant document guiding Egypt's action for women's rights is the **National Strategy for Women's Empowerment** (NSWE). The NSWE, developed by the National Council for Women (NCW) through a participatory process, is a strategic framework which addresses the challenges faced by women in Egypt. The NSWE is based upon the principles enacted in the Egyptian Constitution and is aligned with "Egypt's Vision 2030", a national strategy on sustainable development. It is further aligned with the 2030 Agenda for Sustainable Development, which Egypt has committed to.

Key gender issues related to the COVID-19 outbreak in Egypt

Based on lessons learned from other epidemics, namely Ebola and the Zika virus, key gender issues are identified for COVID-19 responders in Egypt.

Increased vulnerability to gender-based violence (GBV):

Quarantine and isolation policies, critical to flatten the growth curve of the pandemic will exacerbate conditions for those already experiencing or vulnerable to domestic violence, as victims and survivors are in isolation with their abusers. Moreover, isolation paired with increased economic downturn are likely to exacerbate individual and household stress. Anecdotal evidence from the COVID-19 pandemic reveals an increase in domestic violence, as Chinese women's rights organizations report receiving two to three times as many GBV inquiries as before the quarantines were in place.[5] In Egypt, an estimated one in four women were already experiencing domestic violence prior to this pandemic[6] and that number could be expected to increase given survey data that suggests that more than 70% of Egyptian men and women believe that wives should tolerate violence to keep the family together.[7]

Outside the home, sexual exploitation is likely to increase, leading to a rise in child and forced marriage, trafficking in women and girls and other forms of gender-based violence, particularly as a result of the economic consequences of the pandemic. Furthermore, women may face increased fear, harassment and violence as they travel through city or rural public spaces where streets and transport are more deserted given the need for social distancing, as seen in several countries.

Moreover, life-saving care and support to GBV survivors (i.e. clinical management of rape and mental health and psychosocial support) may be disrupted when health-service-providers are overburdened and preoccupied with COVID-19. Even where basic essential services are maintained, a collapse in a coordinated response between different sectors (i.e., health, police, justice and social services), due to social distancing measures will mean that sectors will be challenged to provide meaningful and relevant support to women and girls who are experiencing violence. In addition, overstretched health services will invariably divert resources away from essential services that women need, including pre- and post-natal health care and contraceptives, and exacerbate a limited access to sexual and reproductive health services, and GBV prevention and response services.

Unemployment, economic and livelihood impacts:

COVID-19 may have a long-term impact on women's labour force participation in Egypt. Its impact on the global economy will be profound and have a disproportionate impact on women's employment, given the gendered pay gap and women's marginalization from the labour market. In the Arab region, ESCWA is estimating a USD $42 billion decline in GDP as a result of COVID-19, and the loss of 1.7 million jobs in 2020.[8]

As women are encouraged to take leave from paid work to take on greater unpaid care work within the home, their jobs are more likely to be affected by cuts and lay-offs. According to IMAGES survey, 98% of men and 88% of women believe that men should have access to jobs before women when work opportunities are scarce.[1] Such impacts risk further rolling back the already fragile status of women's labour force participation – which stands at around 23.8% in Egypt[9] – while limiting women's ability to support themselves and their families.

According to data from the Labor Force Survey (LFS), within the formal workforce, Egyptian women represent 70% of the paid care sector (mainly as teachers, health and social workers). In fact, the paid care sector in Egypt represents around 28–31% of overall female employment, compared to only 7–8% of total male employment. Health care and social workers are disproportionately vulnerable to COVID-19 transmission.

However, Egyptian women are most likely to work informally. Informality is often coupled with lack of social protection, which means that women informal workers are unprotected in case of sickness, old age, maternity, etc. and more vulnerable to poverty. Informally employed women earn on average half as much as informally employed men, while working longer hours and more days per week.[10]. Furthermore, a large percentage of women workers are contributing (unpaid) family workers (26.2% of women versus 4.1% of men)[11]. Moreover, most migrant domestic workers in Egypt are women, who respond to care deficits with little to no access to social protection or health-care services themselves.

Limited access to health insurance:

Egypt's social protection system is backed by a strong legal, societal and historical foundation and its social security system is considered one of the most comprehensive in Africa and in the Arab region.[12] On 30 March, the Egyptian Government announced its biggest budget yet, with health spending set to rise by a third to EGP £95,7 billion.[13] However, Egyptian women have limited access to health insurance, which becomes even more essential in the context of COVID-19.

A sizable portion (72%) of the population was not covered by any type of health insurance in 2018.[14] There are also gender gaps in health insurance coverage rates. In 2018, 80% of women versus 63% of men did not have access to health insurance. Due to the low levels of women's labour force participation, they are much more likely to fall out of health insurance coverage.[15] Research has shown that health-care spending is biased in favour of men and urban areas, due to the association between health insurance and the formal sector (especially governmental employment).[16] A series of focus groups conducted in 2015 identified cost as being a major barrier to women accessing health care.[17]

Women and girls' unequal burden of unpaid care:

With health systems overloaded and children at home due to school closures, women across the country are shouldering the added burden, from home-schooling to looking after the elderly and sick, to performing household chores and ensuring increased cleanliness, pulling them from the labour market and exposing them to higher workloads and vulnerability to intimate partner violence.

Entrenched patriarchal norms mean that unpaid care work is largely seen as the responsibility of women. Research shows that 98% of Egyptian men surveyed believe that taking care of children should be a mother's responsibility and, among ever-married men, fewer than a quarter report having cooked or cleaned in the past month.[18] Girls home from school are also more likely than boys to be asked to contribute to domestic work and care, thereby missing out on home-based learning. This added care burden adds stress and affects their mental well-being.

Low access to life-saving health information:

The most marginalized women and girls are at great risk of being excluded from critical, life-saving measures. Of particular concern in the COVID-19 pandemic are at-risk populations such as refugees, people with disabilities and those living in peri-urban and urban settlements, prisons and locations already underserved by social services – where information and strategies such as testing, handwashing, self-isolation and quarantine will be particularly difficult, due to lack of space, resources and services. Targeted approaches are needed to reach all social groups with COVID-19 prevention information.

Given the low levels of literacy among women and girls, it is important that messaging is relayed through appropriate materials that are accessible and understandable by all. According to Egypt's 2017 Census, illiteracy is much higher among women – 31% of women over age 10, versus 21% of men; the percentage of illiterate women is higher in rural areas (39%) and among elderly women.

The COVID-19 pandemic also highlights the importance of women's ability to access and use the Internet effectively. According to the 2017/18 HIECS, 28.1% of households have Internet access.[19] Statistics also show that 87.5% of people own a mobile phone (albeit 90.7% male versus 84.2% female)[20] and most people rely on capped Internet cards.

Women's equal access to decision-making

Women currently comprise 15% of Egypt's Parliament and 25% of the Cabinet, and in 2017 the first-ever woman governor was appointed. Following the 2011 Revolution, women contributed to the establishment of new syndicates and trade unions (including the Nursing and Female Rural Leaders Syndicates, exclusively composed of women, or the Independent Teachers Syndicate).[21] However, the voices of Egyptian women, particularly the poor and marginalized, are often absent from decision-making, especially in times of crisis. We need grass-roots women, community mobilizers and front-line health workers to be heard and to help shape the policies and measures that will directly impact them.

Affected communities must be holistically engaged in the COVID-19 response as it continues. The Gender and COVID-19 Academic Working Group has stated that better inclusion of women front-line workers in all decision-making and policy spaces can improve health security surveillance, detection and prevention. This is likewise acknowledged by the Inter-Agency Standing Committee Gender Policy, which states that "the knowledge, capacities and agency of women and girls, alongside those of men and boys, must be recognized and strengthened in all humanitarian action, with equitable participation in planning and programming."[22] This includes engaging women's groups and networks at the outset of a crisis to ensure they can adequately inform and engage within decisions that impact their lives.

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Key questions for COVID-19 decision-makers in Egypt

The following questions are based on UN Women's COVID-19 checklist, issued on 20 March 2020:[23]

1. How do we ensure women have access to essential GBV response services – such as health centres, hotlines and shelters in the current context – where social distancing and isolation limit access? Much of this work will need to move online in the short-term. Are 'protection against sexual exploitation and abuse' services being maintained and expanded?

2. How are we targeting our economic responses? Men's incomes are higher than women's in general and there are significant inequalities in terms of access to health insurance, unemployment benefits and other social protection. Do all national social protection packages also specifically target working poor and unemployed women?

3. Men are overrepresented in political decision-making. Have we considered how women's voices and interests are reflected in the decision-making processes and outcomes we are leading? Have employers and trade unions representing female-dominated labour market sectors had a say? Are women's organizations, women's shelters or NGOs consulted?

4. Women are poorer than men and have less economic power. When we are thinking about cash transfers, will these target individuals rather than households in order to mitigate women's economic dependence on men? Are 'cash for care' programmes possible – where women providing unpaid care are compensated for their time?

5. Are we preparing targeted interventions for single parents, the majority of whom are women, when economies slow down or even come to a halt?

6. We know that elderly women and men are at a higher health risk right now. Women are the majority of the elderly around the world, especially over the age of 80. Yet, they tend to have lower pensions, if any, and less possibility to buy care or other services. Do we know whether they are left alone or have support?

7. When elderly-care exists, it is often women who provide it. This may be through paid work or simply through their support to their family members. What are we doing to ensure that they have protection against transmission? Are we able to provide 'cash for care' to ensure they are being paid for their work?

8. Schools are closed. Those with the resources may be moving to online or remote teaching. Are we doing enough to ensure that girls are not caring for younger siblings or grandparents while boys continue to study?

9. Are we ensuring that maternal care continues under safe circumstances for staff and mothers? The burden on health systems are straining them to the breaking point. How are we protecting women's health, including the health of mothers?

NOTES

[1] Evidence suggests that more men than women are dying, potentially due to sex-based immunological or gendered differences, such as patterns and prevalence of smoking. Clare Wenham, Julia Smith and Rosemary Morgan, Gender and COVID-19 Working Group. 6 March 2020. "COVID-19: the gendered impacts of the outbreak," *The Lancet*.
[2] Worldometers. "Coronavirus" [consulted on 31 March 2020].
[3] Ibid.
[4] NSWE https://bit.ly/2UA3TPR
[5] Feng Yuan, director of Beijing-based women's rights non-profit Weiping, said they had received three times as many inquiries from victims than before quarantines were in place. (Lara Owen. 8 March 2020. "Coronavirus: Five ways virus upheaval is hitting women in Asia". *BBC*.)
[6] CAPMAS. 2014. Egypt Demographic and Health Survey.
[7] UN Women & Promundo. 2017. *Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES) Middle East and North Africa*
[8] UN ESCWA. 2020. "COVID-19: Economic cost to the Arab region". E/ESCWA/CL3.SEP/2020/Policy Brief.1.
[9] World Bank. 2019. "Labor force, female (% of total labor force)" https://data.worldbank.org/indicator/SL.TLF.TOTL.FE.ZS
[10] African Development Bank. 2016. "Addressing informality in Egypt," Working Paper – North Africa Policy Series.
[11] Calculated using the LFS 2017 data set.
[12] https://bit.ly/2WZ22Wg
[13] Egyptian Cabinet. 30 March 2020. Facebook post.
[14] https://erf.org.eg/wp-content/uploads/2019/10/1363.pdf
[15] *According to ELMPS 2018, only 15% of women age 18–64 report having health insurance, and only 46% of employed women and 66% of wage worker women have it (calculated by Caroline Kraft).*
[16] Maia Sieverding & Irene Selwaness. 2012. "Social protection in Egypt: a policy overview", *Gender and work in the MENA Region*, Working Paper Series, N.23.
[17] Salama Sandy. 2015. "The emotional and financial barriers preventing low-income Egyptians from accessing health care", *Women's World Banking*.
[18] UN Women & Promundo. 2017. *Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES) – Middle East and North Africa*
[19] Household Income, Expenditure and Consumption 2017/18 report
[20] CAPMAS. 2018. National Statistical Report to Monitor the SDGs.
[21] OECD. 2018. *Women's Political Participation in Egypt*.
[22] IASC Reference Group on Gender in Humanitarian Action. 2017. *Policy: Gender Equality and the Empowerment of Women and Girls in Humanitarian Action*.
[23] UN Women. 2020. "Checklist for COVID-19 response."