



SOCIAL PROTECTION FOR SOCIOECONOMICALLY VULNERABLE WOMEN OF PAKISTAN- DURING COVID-19 AND BEYOND

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Abstract

Ensuring United Nations Sustainable Development Goals are met collectively for the protection of women, requires a broadening of discussion and efforts from reproductive health to investigate ethical challenges facing women during COVID-19. The aim of this paper is to discuss issues of ethics, equity, and rights for the health access of socioeconomically vulnerable women of Pakistan. Deriving from two feminist approaches to ethics-power and care, we analyse four different areas which are contributing to women becoming further disadvantaged, including (i) state and health sector response, (ii) income loss and worsening poverty, (iii) patriarchy and decision-making, and (iv) neglect of health issues not pertaining to infectious disease. We conclude with recommendations to form a triadic partnership between the health sector, government and the economy to provide women with a social protection floor to improve health outcomes.

Keywords

COVID-19, women, Pakistan, ethics, socioeconomic vulnerability

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Introduction

The United Nations Sustainable Development Goals collectively recognize the importance of identifying social vulnerability when assessing ethics and equity in healthcare for women (Riberio & Zoboli 2007). Utilizing the paradigm of social vulnerability (Riberio & Zoboli 2007), we aim to discuss the ethical challenges of health access and health services for women of Pakistan facing socioeconomic vulnerabilities, estimated at around 50 million (World Bank 2017). Investigating the response and ethical issues related to the pandemic from a gender lens is critical because the socioeconomics of lockdown and burden of infectious disease affects women differently. There are two kinds of feminist approaches to ethics—the power approach and the care approach (Tong 2018). The former suggests that patriarchy sustains structural inequality for women, and the latter proposes that women face exploitation due to traditionally allocated roles of unpaid care work. Deriving from both these approaches, key ethical challenges during the pandemic will be discussed in this paper. First, we will consider the state and health sector structural response to COVID-19. Second, the increase in poverty, unemployment and income loss will be deliberated. Third, we will address the possible impact of patriarchy, the added burden of being allocated roles for prevention and recovery, and lack of agency due to low decision-making power. Lastly, we will examine the consequences of neglecting other health issues during the pandemic, namely mental health, violence, and chronic disease burden. We believe the discussion in this paper is of value for women facing similar socio-structural inequalities in developing nations.

State and Health Sector Response to COVID-19

Pakistan reported its first case of COVID-19 in February 2020. Since then, a trial and error of various mechanisms to control the spread of the infection prevailed; partial or complete lockdowns were established in March 2020 and October 2020. The public health sector of Pakistan, which has a history of resource shortages and inadequate provision (Shaikh, Haran, & Hatcher, 2008), has been hit hard by the pandemic (Abid 2020), with data also confirming that both basic and emergency health needs of women remain unmet (Markhof 2020). Despite this state of affairs, the National Preparedness & Response Plan for COVID-2019 has not given attention to introducing gender-sensitive plans in the country. Specific women populations, who remain bereft, include urban slum dwellers, informal labourers, low-paid daily workers, and those residing in rural and remote locations. There has been almost an absence of services during the pandemic for non-emergency and elective health conditions (Stone 2020), which begs the ethical question of long-term health consequences due to deferral and its impact on morbidity. Another human rights concern is consideration of neglect in coverage of “hidden” and “invisible” women populations (Hassan 2014).

Rationing of health care systems and triaging of health services has been a major problem to contend with globally since the pandemic started (McGuire et al. 2020). Local health centres and clinical departments related to women's health, like gynaecological and maternity wards, have been closed down due to infection of staff (Saroop Ijaz, May 9th 2020). Greater infection vulnerability for women practitioners, specifically junior women doctors and women nurses, is also a problem due to the short supply of protective gear (J. Ahmed et al. 2020). In Pakistan, there is a great possibility for postponement and neglect of treatment for women, due to cultural preference prioritizing male health (Jafree 2020). Even women from the developed world are suffering from an absence of services for elective surgeries, termination of unintended pregnancies, surgical sterilization, and clinical services for family planning and breastfeeding (Bruno, Shalowitz, & Arora 2020). We need to urgently consider not just the rights of women patients for access to health services, but also women health provider rights for safe working environments and equitable supplies of protective gear.

Since the pandemic, one effort by the state and NGOs for preventive communication and health services has been to reach out to populations digitally. However, such interventions cannot help women who suffer from digital exclusion, with local research confirming that a considerable number of women in the country still do not own smartphones or have access to the internet (Rashid 2016). We also need to consider that many younger females, disabled women, or victims of violence are unable to communicate through SMS or other social media channels. Similarly, women who share limited electronics within one household are usually less likely to benefit from digital access. If future plans rely on digital technology and telehealth, we need to consider two important ethical questions concerning (i) who will pay for comprehensive access to smartphones and the internet for women across the country? and (ii) will there be cultural acceptance in a patriarchal society like Pakistan for women to own and utilize technology and the internet?

The Ehsaas Emergency Cash Program was introduced in April 2020 to provide support to socioeconomically vulnerable women during the pandemic. However, access to the cash benefits requires having a computerized national identity card and mobile phones, which excludes many women from the program. Studies have confirmed that nearly eighty percent of impoverished women in the country will be excluded as cash recipients of the Ehsaas Emergency Cash Program due to gender gaps in mobility and ownership (Bourgault & O'Donnell 2020). It is also true that women in the country are unable to apply for identity cards, SIM registration, loans, benefits schemes, or property ownership unless they have the identity cards and signature approval from male family members (Hanmer & Elefante 2019). We conclude this section with critical questions related to ethics of access, and asking how women suffering from legal deprivation, or those without male family

support, will be able to benefit from cash transfers, or other benefits requiring legal registration, for emergency relief during the pandemic.

Poverty, unemployment and income loss

Prior to the pandemic majority of Pakistani women lived in poverty (Mumtaz 2007), due to multiple factors such as: (i) male-headed households, (ii) lack of control over resources, (iii) labour market inequalities, (iv) inadequate access to education and health, and (v) inequality in social protection. Since the pandemic, it is feared that women's poverty rates have worsened (Malik & Naeem 2020). Issues related to poverty and ill-health are also a cause for alarm in considerable Pakistani women suffering from displacement. An estimated 3.6 million women across the country are displaced due to climate change or regional conflict (UNNHCR 2020). A moral question post-COVID-19 is how we can expect impoverished women to successfully combat the virus given handicaps of undernutrition, inadequate housing and utilities, infectious living environments, and lack of access to public health services?

A majority of working women in Pakistan are informal workers occupied in labour-intensive occupations like agricultural work, small business development, domestic services, vending, or retailing in urban slums. As is true for other populations (Anser et al. 2020), lockdown and social distancing have contributed to women becoming jobless or suffering from losses in income (Mamun & Ullah 2020). Many women have also been affected due to a decline in income from family businesses, farming, fishing, or remittances. Another informal sector women's group are poor loan-takers, who face considerable challenges in repaying loans since the pandemic started (Zheng & Zhang 2020). Microfinance loan providers of Pakistan are predominantly commercialized and many have not been providing women borrowers with social development features of savings or health insurance (Jafree & Mustafa, 2020). What is important to consider ethically is that this large group of unemployed or informal women workers are not covered by employment benefits, social insurance, or health protection. The latter includes allowances for health leave, coverage for hospital admission and prescription medicine. With the pandemic and social distancing, we must also ask how poor informal women workers can sustain income-generating work, pay for basic necessities, and repay loans?

Free services for testing, healthcare consultancy, and medication for symptom management are not being provided during the pandemic to the poor in Pakistan (Khalid & Ali 2020). Women specifically are at risk of negligence as families may give preference to male family members for testing, patient care, and health recovery due to cultural factors of patriarchy and son preference (Sathar, et al. 2015). Ethical questions of justice and equity must consider that unemployed, informally employed, and debt-ridden women in the

country would choose to spend their limited income on children, household necessities and loan instalments. Poor women suffering from income loss during the pandemic would be unable to afford coronavirus testing and purchases for infection prevention, such as household sanitation supplies and equipment, protective gear (like masks and gloves), and nutritious food or vitamins for immunity-building and health recovery. Furthermore, it is imperative to pre-emptively address questions of pricing, access and distribution of a vaccine. There may be a devastating impact on public health in the long-run if impoverished populations remaining unvaccinated.

Patriarchy, added burdens of care, and decision-making control

With the advent of COVID-19, domestic and household tasks for women have surged across the globe (Power 2020). This is of greater consequence in a country like Pakistan where historically women have been exclusively responsible for household duties. Some additions to the home-shift burden borne by women include increased care for infection control and health recovery of family members; monitoring children for longer hours and supervising home-schooling; procurement, storage and rationing of food and water; and sanitation and disinfection of house, eating utensils, bedding, and clothing. The fatigue and role burden associated with managing household tasks, without symmetrical assistance, in socioeconomically vulnerable women may be greater because they have less agency and experience in how to manage their tasks more efficiently. In a real-life ethical scenario, we can assess how patriarchy may add to household chores for women from poorer families during the pandemic. For example, a husband may choose to save money and not buy disposable masks from the market, thus tasking his wife to stitch homemade cloth masks for the family members and also be responsible for washing the masks daily and replacing them when needed.

It is the women who have been allocated primary responsibility to fulfil care duties as ‘protection agents’ against infection and ‘recovery agents’ for the sick during the pandemic (Bali 2020). Ironically, socioeconomically vulnerable women are unable to provide optimal protection and recovery due to numerous regressive traditions such as poverty and immobility. Lack of access to social media also prevents them from gaining updated information and coordinating for online purchasing and other transactions during the lockdown. The complexity increases when we consider that a majority of Pakistani women are not educated or highly educated (Sabzwari 2017). Decisions related to household matters are exclusively or heavily influenced by male members of the household. The decline in women’s income may also have an impact on the ability to influence decisions for household purchases and nutrition. We must morally consider whether it is just to allocate roles for protection and recovery to socioeconomically vulnerable women when they face crippling barriers such as inadequate knowledge about infection

management and inability to modify family expenditure for hygiene, sanitation, and nutrition.

Women of Pakistan lack the agency to control decision-making. This has been further highlighted during the pandemic with respect to religious interpretations being controlled by male members of society and male religious clerics (Stone 2020). Many men have advocated that engaging in ablution is the best protection against the coronavirus and this belief has sustained mass gatherings for male congregational prayer, and also assemblies for marriage and funeral ceremonies. The spread of infection from congregational assemblies- religious or social- has a direct effect on women at home, both due to the risk of infection and added burdens of care for infected family members. The ethical issue is that even if a woman has a personal preference to maintain isolation and avoid mass gatherings, she is vulnerable to the decision-making of male family members. Ultimately, women in the country are also dependent on the decisions of male community notables and politicians with regard to public laws for congregational assemblies and all other policy matters related to equity and development.

Specific health vulnerabilities: mental health, violence, and chronic disease burden

Before the COVID-19 pandemic, feminists predominantly investigated the rights of women with regard to reproduction and fertility (Donchin & Scully 2004). Infection rates and morbidity data have shown us that men are at greater risk of contracting and dying from the virus. However, data also suggests that it is the women whose life quality and emotional health has been harmed, compared to men, which can have compounding consequences on the holistic health of women and their contribution to family and society (United Nations 2020). Factors that may make poorer women in the country more susceptible to mental health deterioration during the pandemic include fears of greater vulnerabilities for infection and other health complications, losing family members to the virus, loss of livelihood and worsening living conditions. Again, limited support for mental health through telemedicine or mass media means that most socioeconomically vulnerable women have no access to mental health services. With health demographics documenting men as facing greater mortality due to the pandemic, there are additional ethical concerns with regard to neglect of investment for the varied mental health needs of women.

Though confirmed statistics locally are not available, research suggests that women and girls are facing an increase in domestic and intimate partner violence since the pandemic (Roesh, et al. 2020). Social deprivations such as poverty, food insecurity, water shortage, and overcrowded households can further aggravate violence and abuse in a LMIC like Pakistan. Lockdown has also prevented victimized women from being able to seek

social support or health referrals. Of concern is that some temporary urban shelters have been converted into coronavirus quarantine facilities by the government (United Nations Office on Drugs and Crime 2020). Furthermore, helplines and departments, owned by the state, that are responsible for responding to cases of violence, have shut down or reduced their hours of service. Again, multiple questions related to rights and morals are at hand, such as: (i) even if helplines and departments are functional in limited urban areas it is not clear how women without social media access will benefit or how women from remote locations will gain; (ii) when will the safety of women be considered essential services and not be deprioritized? and (iii) during times of crises and shortages why are resources and infrastructure for women's protection deprioritized and even usurped?

Pre-COVID-19 research has confirmed that disadvantaged women from the region are at greater risk of chronic diseases and multimorbidity (Jafree 2020) Women in the country are specifically known to be vulnerable to chronic ailments such as: breast and uterine cancer, arthritis and osteoporosis, diabetes and blood pressure. Due to the pandemic, health resources and budgets have shifted toward the prevention and control of infection, thus reducing investment or side-lining plans for investment in community health. Primary health services for socioeconomically vulnerable women in the country were a means to encourage referrals for chronic diseases, mainly provided by the Lady Health Worker Programme. However, the pandemic and social distancing have considerably reduced services of community outreach (Ahmed, et al. 2020). There are serious ethics to consider in continuing community health services through women health workers, including (i) should community health services continue face-to-face? Or (ii) if there is transfer to digital health provision, who will pay for free provision of smartphones and internet to underprivileged women across the country?

Concluding lessons for a social protection floor

In this paper, we conclude that ensuring the health of socioeconomically vulnerable women is the triadic responsibility of the health sector, government, and economy. To start with, we need immediate research clusters to be established in order to better plan policy for health and social relief. Evidence needs to be collected about the impact of the pandemic on women's mental health, trans-placental infection and after-effects of disease, family planning and reproductive health, maternal and child morbidity, domestic and intimate partner violence, and neglect in chronic disease treatment. The response from the health sector must consider comprehensive outreach for known and hidden women populations, provision for non-emergency and elective procedures, and triaging guidelines which do not exclude women patients.

There has been a void in recognizing that developing interventions for a social protection floor during the pandemic is the key to supporting women's health vulnerabilities. There is a need for state, employers and loan providers to ensure the provision of universal health and social benefits to women across the country, including the unemployed, informal workers and formal sector workers. These benefits must include savings insurance, health insurance, health leaves, vaccination coverage, provision for hospital admission and prescribed medicine, and cash subsidies. There is also a need for low-installment loans for poverty alleviation, food security and housing development. Free provision of protective gear and sterilization material must be secured for disadvantaged women groups and also women healthcare providers, especially lower-ranked providers, like junior doctors, nurses, and community health workers.

If the primary means of communicating and delivering health awareness, health services, relief packages, and cash subsidies are through digital means and formal registrations, there is a need for mobilization of digital access and registration of women across the country. Reform of laws is needed in order for women to be able to assume control for health and capability expansion, with a specific focus on rights for ownership, inheritance and ability to apply for benefits and loans autonomously. Specific benefits must be launched for single-women households, the sick and disabled, and women victims of violence. Given the uncertainty of continued lockdown and the burden of additional care duties on women of the country, we recommend support for home-based work opportunities to be mobilized through cash transfers and microcredit. Finally, in order to secure long-term goals for equity and development of women we also need critical interventions to improve the cultural status of women, decision-making power, educational enrolment for girls, literacy and skill development for adult women, and improved quotas for representation of women across government structures.

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