Health Care Analysis
https://doi.org/10.1007/s10728-023-00463-x

ORIGINAL ARTICLE

Gendering the Pandemic: Women's Health Disparities From a Human Rights Perspective

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Accepted: 9 July 2023

Abstract

As COVID-19 keeps impacting the world, its impact is felt differently by people of different sexes and genders. International guidelines and research on gender inequalities and women's rights during the pandemic have been published. However, data from Taiwan is lacking. This study aims to fill the gap to increase our knowledge regarding this issue and provide policy recommendations. This study is part of a more extensive project in response to the fourth state report concerning the implementation of the Convention on the Elimination of All Forms of Discrimination against Women in Taiwan in 2022. We have drawn on the guidelines and documents published by the United Nations human rights bodies, conducted interviews with advocacy and professional practitioners, and hosted a study group comprising students and teachers from the National Taiwan University College of Public Health to supplement the interview data. The data were analyzed thematically. The results include five themes: (1) particular health risks to carers (primarily women); (2) COVID-related measures' impact on women's health and health behaviors; (3) highly gendered psychological maladjustment; (4) increase in gender-based violence and domestic violence; and (5) mental health inequities and intersectionality. The study has global implications for societies of similar sociopolitical contexts and developmental statuses. To truly live up to the standard of CEDAW and other international human rights principles, we ask that central and local government be more aware of these lived experiences and adjust their policies accordingly, accounting for gender sensitivity.

Keywords COVID-19 · CEDAW · Care work · Health disparity · Gender impact · Taiwan

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Published online: 21 July 2023

Introduction

Background

It has been more than three years since the outbreak of the COVID-19 epidemic. Due to multiple virus variants, the pandemic has fluctuated, and the epidemic prevention measures have been continuously adjusted internationally, including in Taiwan. At the same time, its impact on all aspects of our economic and social life remains tremendous.

Many studies have pointed out the effects and efficacy of COVID-related treatments, medicines, vaccines, and other medical interventions associated with sex differences between female and male bodies [23, 42]. Studies have also identified the impact of various policies on gender relations. Gender relations indicate how people, relying on their attributed gender and related social roles based on societal expectations regarding one's sexed body, relate to and thus interact with one another [2]. The "gendered" policy impact ranges from working from home, unpaid leave, quarantine, lockdown, border control, risk communication, and wage subsidy schemes to vaccination promotion campaigns ([1, 26]. Conversely, existing gender relations would have determined the success or failure of governmental and corporate epidemic prevention measures [17].

As gender and sex are essential factors in COVID-19 experiences, international guidelines have been released to help countries navigate the pandemic.[1] The United Nations (UN) Committee on the Elimination of Discrimination against Women (CEDAW) proposed the *Guidance Note on the CEDAW (Convention on the Elimination of All Forms of Discrimination against Women) and COVID-19*[2] in April 2020, requiring that states pay attention to particular and aggravated health risks to women as primary caregivers, ensure girls' opportunities to receive education, take measures to prevent or protect gender-based violence, mitigate the pandemic's negative impact on vulnerable women, and continue to provide accessible sexual and reproductive health services. In the same month, the UN Office of the High Commissioner for Human Rights developed the *OHCHR Guidelines on COVID-19 and the rights of persons with disabilities*, which provides a quick impact assessment and identifies areas that require particular attention, including the risk of violence faced by women and girls with disabilities.

In June 2020, the UN Independent Expert on Sexual Orientation and Gender Identity (SOGI) also published the *ASPIRE Guidelines on COVID-19 response and recovery free from violence and discrimination based on SOGI*. The six letters ASPIRE represent recommendations concerning "Acknowledging" SOGI as a social

[1] Here, sex refers to variation in the biological attributes that characterize female, male, and intersex, and how they are expressed; gender connotes the social, behavioral, and cultural attributes, expectations, and norms associated with sexed bodies.

[2] The official abbreviations for both the Convention on the Elimination of All Forms of Discrimination against Women and its monitoring organ, the Committee on the Elimination of Discrimination against Women, are the same as "CEDAW".

determinant of COVID's impact, "Supporting" marginalized groups, "Protecting" them from violence and unnecessary negative impacts of the pandemic, avoiding "Indirect" discrimination, ensuring their "Representation" in decision-making and policy processes, and gathering "Evidence" on their health and wellbeing [30].

Moreover, the UN Special Rapporteur on the right to health also presented the report on "Sexual and reproductive health rights: challenges and opportunities during COVID-19" in July 2021. The report outlines the gendered impact of the pandemic and related policy measures regarding women's human rights, particularly in sexual and reproductive health [36]. Despite the concerns regarding the pandemic's gendered impact expressed by these international documents, gender inequalities have still been prevalent during the COVID-19 time worldwide [43]. Data has also shown that sexual and gender minority women have faced higher levels of discrimination and a lack of access to health services during the pandemic due to the intersectionality of gender inequalities and marginalization based on sexual orientation and gender identity [31].

Study Objectives

The more extensive background against which this study embarked was the exacerbated gender inequalities during the COVID-19 pandemic; this study set out to understand the pandemic's impact–including the disease per se and the policy measures in response to it–on women's rights and gender relations in Taiwan. The closer context for this study was the preparation for the *Fourth Civil Society CEDAW Report: Joint Report on COVID-19 Pandemic Issues* initiated and coordinated by the Foundation of Women's Rights Promotion and Development.[3] The Foundation, serving as the information and resource hub for women's rights and gender mainstreaming in Taiwan and a bridge for constructive dialogue between the government and civil society organizations, was established by Executive Yuan's Commission on Women's Rights Promotion in 1997. And the joint report is a response to the 2022 state report concerning the implementation of CEDAW in Taiwan, which has been incorporated into the domestic legal system through an Enforcement Act. International experts and local NGOs have monitored the progress of implementing CEDAW principles and standards.[4]

[3] The contributors to the Joint Report include the Garden of Hope Foundation, Kaohsiung Pride Association, Kaohsiung Women Awakening Association, League for Persons with Disabilities, Modern Women's Foundation, Taiwan Alliance to Promote Civil Partnership Rights, and Young Women's Christian Association of Taiwan–besides the Mental Health Association in Taiwan, for which the two co-authors are responsible.

[4] In fact, among the so-called nine core international human rights, in addition to CEDAW, Taiwan has also internalized, through treaty ratification or an Enforcement Act, the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD); International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Rights of the Child (CRC); and Convention on the Rights of Persons with Disabilities (CRPD). There is an ongoing debate around whether and how to internalise the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

The UN bodies' guidance and the preparation for the joint civil society CEDAW report have informed us of a human rights-based approach to gender equality and women's health and wellbeing. Such a human rights approach requires a perspective that identifies and problematizes the imbalanced power relations between individual citizens and the state, between women and men (both defined broadly beyond biological characteristics as per CEDAW), and between mainstream society and minority/marginalized social groups. The imbalanced relationships are translated into the rights/obligations discourse and assessed against the AAAQ criteria (availability, accessibility, acceptability, and quality) of health and social services, which enable related responsibility and accountability to be identified. The AAAQ criteria have been applied across UN human rights agencies regarding the extent of realizaton of socioeconomic rights, especially the right to health (OHCHR and WHO, 2008). The three main principles of the human rights approach are the principles of equality, non-discrimination, and non-retrogression, which indicates that all efforts should aim to "progressively" achieve the full realization of human and women's rights.

Data and studies from Taiwan have yet to be lacking compared to data collected in the US, the EU, and the UN (of which Taiwan is not a member). Such informational inadequacy implies a lack of commitment to women's rights and a potential violation of CEDAW-related obligations (see [21]). Therefore, this study hopes to shed light on women's lived experiences in Taiwan during COVID-19 and make relevant policy recommendations when possible. Furthermore, the human rights analysis also relocates Taiwan back to a context comparable with other countries, notwithstanding international organizations' neglect of the situation in Taiwan [28]. Such comparability–particularly with the economies of similar income levels or societies with similar cultural backgrounds (e.g. Hong Kong and Singapore)–is also an important indicator for understanding the level of satisfying socioeconomic rights in each location [47].

Theoretical and Normative Foundations

Concerning the human rights perspective on women's health and wellbeing in the pandemic context, in addition to CEDAW, we have also considered other international legal sources, for instance, General Comments No 14 on the right to health [6] and No 22 on the right to sexual and reproductive health [8] adopted by the Committee on Economic, Social and Cultural Rights, the ICESCR's monitoring body. We also find highly relevant the conceptual and analytical frameworks developed by the UN Special Rapporteur on the right to health (e.g. [36]), Special Rapporteur on violence against women and girls, its causes and consequences (e.g. [41]), Independent Expert on SOGI (e.g. [31]). Basing the elimination of gender discrimination and gender-based violence and the pursuit of substantive gender equality on international human rights law articulates a normative critique that denaturalizes and problematizes the gendered impact of the pandemic.

Informed by these documents, we analyze the gender impact of COVID-19 at four levels. First, COVID-19, as a disease, affects female/women's bodies differently. Second, COVID-19, as an epidemic, affects the sociopolitical context and

policy landscapes in Taiwan, where decision-making processes, forms of risk communication, and social relations are reconfigured. Third, the government, corporate, and household measures and discourse in response to the pandemic (e.g., preventing transmission, responding to infections of close members, recovery, and the attempts to return to normal, accept the "new normal" and "live with the virus") affect family and gender relations. Lastly, such impacts at different levels are distributed unequally and often associated intersectionally with other factors beyond gender.

As reiterated and reaffirmed by CEDAW's [4] General Recommendation No 25, the principle of substantive equality recognizes that the law must consider elements such as discrimination, marginalization, and unequal distribution of resources to achieve equal results for fundamental freedoms, opportunities, and access to goods and services. Hence, substantive equality is sometimes primarily achieved by implementing special measures to assist or advance the lives of disadvantaged individuals, such as women experiencing marginalization in multiple forms. Such measures should ensure that they not only are given the same opportunities as everyone else but also have the agency (which requires an appropriate temporal-spatial context and material support) and access to the use of such opportunities [13].

Drawing on the human rights approach to gender equality, we have focused on articles 12[5] and 13[6] of the CEDAW, which are concerned with eliminating discrimination in health care and economic and social life for women. However, other international human rights legal sources are also consulted, as mentioned above. CEDAW adopted General Recommendation No 24 in 1999, requesting that the state initiate and implement a comprehensive strategy to address issues surrounding women's health throughout their lifespan. Such comprehensiveness is defined, in addition to biological factors regarding male and female bodies, as including accounts for psychological and sociocultural factors, with close attention to unequal power relationships between men and women in the household and workplace and vulnerability to gender-based and sexual violence, which may result in a higher risk of mental health conditions (CEDAW, 1999, paras 12–25).

Therefore, from a human rights perspective, substantive equality in health and socioeconomic life requires a holistic understanding of women's lives, out of diverse positionalities, in society (Goonesekere, 2019). That is, both direct and indirect

[5] Article 12 of the CEDAW:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

[6] Article 13 of the CEDAW:

States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to family benefits;

(b) The right to bank loans, mortgages and other forms of financial credit;

(c) The right to participate in recreational activities, sports and all aspects of cultural life.

discrimination should be identified and addressed.[7] Substantive equality–as elaborated upon in CEDAW's [4] General Recommendation No 25, CESCR's [7] General Comment No 16, and CRPD's [15] General Comment No 6–is a fundamental aspect of human rights norms concerned with equal opportunities and equitable outcomes for disadvantaged and marginalized people and groups. It becomes a principle for examining the output and effect (including intended and unintended consequences) of state and private actors' policies, procedures, and practices against institutional and systemic discrimination.

Methods

Data Collection

This study consisted of two parallel stages of data collection. For a rapid data collection process in response to the fast-changing context of the pandemic, we interviewed key informants whose organizations offer immediate and long-term support and networks for women clients in Taiwan. This data collection included a focus group interview and three individual interviews, attending to the impact of the disease and preventive/responsive measures on women and gender-diverse groups. The participants included advocacy and professional practitioners such as those from the Taiwan Association of Family Caretakers (TAFC), the Taoyuan Lifeline Association (TLA), and the Taiwan Counseling Psychologist Union (TCPU). The individual interviews included stakeholders from the Taiwan Women's Link (TWL), Taiwan Nurses Union (TNU), and the Mental Health Association in Taiwan (MHAT).[8] Although health-related social studies of this kind do not require institutional ethics approval according to relevant laws and ethical regulations, all the participants involved in this study have expressed informed consent to both the research process and publication of the results.

In addition, we organized a study group, which is still running, comprised of teachers and students based at the National Taiwan University College of Public Health, which aims to summarize and discuss literature related to a gender analysis of COVID-19 and health issues in general. This study group started in the early stage of the pandemic and continues to review literature together and share observations and reflections regarding life events related to the pandemic. The discussion

[7] According to CEDAW's General Recommendation No 28, different treatment explicitly based on the grounds of sex and gender differences constitutes direct discrimination against women; indirect discrimination occurs when a policy "appears to be neutral as it relates to men and women, but has a discriminatory effect in practice on women" due to pre-existing inequalities [5, para 16].

[8] These organizations have provided support regarding information and consultation services, policy advocacy initiatives, and networking of people who are in need and agencies who offer professional help. Taiwan Association of Family Caretakers: https://www.familycare.org.tw/book/10729l; Taoyuan Lifeline Association: http://www.1995line.org.tw/; Taiwan Counseling Psychologist Union: https://www.tcpu.org.tw/; Taiwan Women's Link: http://twl.ngo.org.tw/; Taiwan Nurses Union: https://sites.google.com/twnu.org/tnu/%E9%A6%96%E9%A0%81; Mental Health Association: https://www.mhat.org.tw/.

has corroborated the data from the individual and focus-group interviews and informed us of new ideas and narratives that might have been missed out or omitted by key informant interviews. Stories, academic references, and official statistics included in our findings came from the study group, which significantly buttresses the study as it serves as data triangulation within and beyond Taiwan's context [45]. As discussed and clarified in the study group, these citations enabled us to better link the interview narratives to the broader social and policy context. The reflections from students of younger generations and family backgrounds in different geographical areas were then used to triangulate the data collected through the interviews with key informants.

Data Analysis

To pursue the two parallel stages of data collection, the synthesis of evidence and arguments will be more comprehensive as time goes by. We want to create a broader impact on participants involved in the study group sessions. Altogether, we consider that a more inclusive picture of women's and girls' experiences of COVID-19 can be explored and thus offered. Following the individual and group interviews with key informants in March and April 2022 and the notes taken from the focus discussion and reflection of the study group, the two researchers transcribed and analyzed all the data collected. We coded the narrative data and compared our codes with the data published by various governmental sectors on issues directly or indirectly related to gender inequalities during COVID-19 and in non-pandemic times, especially the Ministry of Health and Welfare (MOHW).

The two authors undertook the coding process and preliminary analysis individually and together. When comparing the codes identified, we found the central theme to be the distribution of care work and responsibility (see Fig. 1). We found that "care matters" was particularly demonstrative during the COVID-19 Level-3 alert (starting on 15 May 2021 in Taipei and then all parts of Taiwan and ending on 27 July 2021).[9] That was the period in Taiwan when people's movement and routine schedules were affected the most by tighter regulations, including the closing of care institutions and schools and stricter enforcement of "work from home" policies. The two categories of carers (or caregivers) were professional caregivers and family carers. Despite playing an essential role in sustaining lives, these two types of carers have significant differences in their stressors, available resources and supports, and other concerns such as jobs and salaries.

As shown in Fig. 1, the first category can be further classified based on the sites where care services are provided–in households, institutions, the community, and healthcare settings. The other category, too, is subcategorized into those who had always been primary carers regardless of the pandemic (mainly mothers, daughters, or daughters-in-law) and those who had become a carer because of the disease or epidemic regulations. The preliminary analysis also maps out a "care matrix", which

[9] Later, the CECC cancelled the alert-level system on 24 February 2022.

locates one's position in and beyond the chain of caretaking and caregiving–concerning who gets what care versus who gives what care. It is an organic ecology defined by care policies and organizing, sociocultural and gender norms, and the socioeconomic context (Yeh and Liu 2022; [24], in which multiple actors negotiate the content, extent, and responsibility of care. In certain circumstances, the allocation of care and the care burden remained unchanged, while, in others, it was rearranged and redistributed due to the COVID-related impact.

Findings

Particular Health Risks to Carers (Primarily Women)

During the Level-3 alert, carers experienced extremely high stress. Hospital nurses–a profession with an overrepresentation of women [9]–were at the frontline of COVID-19, facing exacerbated overwork and burnout, tensions with patients and conflicts in clinical settings, and negative labeling of nurses and their children. As many nurses faced stigma as "carriers of viruses" and were shunned by society, their children faced associative stigma and were also ostracized at school (TNU interview data, [14]. Their increased workload included non-care-related jobs (such as the COVID-19 taxi arrangement business or telemedicine technology). Nurses' menstrual health was at higher risk due to the lack of protective clothing and the tight regulations regarding protective clothing. Once a nurse put on the protective clothing, she could not change it for hours,if she was on her menstrual period, she could not change her menstrual products for an extended time. This problem, however, was rarely discussed.

Due to the higher risk of exposure, some nurses chose or were asked not to go home for fear of spreading the virus to their families, and these nurses had to pay for alternative lodging and were deprived of family support. Some faced a double bind through simultaneously being professional caregivers and home carers: which side of care should be prioritized? Some nurses had to deal with the guilt of not being able to care for their young children, and some even reported their children being bullied at school because of their profession as nurses.

Other professional care workers faced different difficulties, also consisting primarily of women (OCED, 2017; [38]). Also, during the Level-3 alert time, care institutes were shut down (e.g., day-care centers, community-based dementia care centers, and tribal culture health stations),many faced pay cuts or salary freezes. Though home nursing aid services were not suspended then, many stopped working due to fear of COVID-19 and were also facing income problems. On the other hand, the closure of 124 long-term care sites enormously increased family carers' stress because care work was shifted back home. Many carers, most likely mothers, daughters, daughters-in-law, or grandmothers, had to take on extra care work, often in direct conflict with their original jobs (TAFC interview data,Ministry of Health and Welfare, 2017).

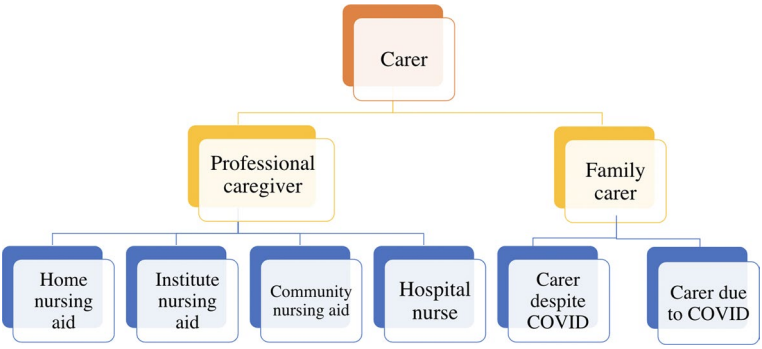

Fig. 1 Coding scheme for care work

According to the *Act of Gender Equality in Employment* in Taiwan, only seven days per year are allowed for family care leave (during which the employers cannot give any salary). Yet, the Level-3 alert lasted three months (the same problem arose whenever schools were suspended due to COVID-19 case spikes in the following year), putting many carers in a predicament. Although the government called for a more flexible leave of absence policy due to family care duties because of COVID-19, employers were not obligated to do so, and there was a lack of enforceable rules. Tellingly, home care leave is stipulated in the Act of Gender Equality in Employment rather than in the Labor Standards Act or other labor laws, suggesting that family care is a gendered matter.

The disruption of job participation caused wage losses and imposed feelings of isolation on many women (TAFC interview data; TCPU interview data; TLA interview data). It is also related to the reduction of external supportive networks and an almost total absence of mental health support. Moreover, family carers were not given vaccine priority, which is determined primarily based on age and "essentialness" of work which does not include care at home; they worried about their health and safety and the people they cared for. However, in such difficult circumstances for most professional care workers, the government offered little intervention in terms of programs for caregivers regarding their capacity building, resilience, mental health literacy, and empowerment strategies.

COVID-Related Measures' Impact on Women's Health and Health Behaviors

During the Level-3 alert period, reproductive health services were significantly disrupted. Regular visits were often delayed, and emergency visits were made more difficult. When pregnant women visited hospitals, the PCR testing requirements burdened pregnant women and their companies, subjecting pregnant women to more isolation and psychological stress as they needed to undergo strict quarantine protocols, while they needed physical and mental support the most. Pregnant women are a special case, given that their health and health behavior are associated with more

responsibility and risk, and they face at least twice as much stress as non-pregnant people.

However, information regarding pregnancy care in the early days of COVID-19 was conspicuously lacking, including whether and what vaccines were safe for pregnant women, and whether the virus could be vertically transmitted (TWL interview data). Similarly, those preparing to get pregnant, those experiencing miscarriage, or those needing an abortion were also subject to higher risks and uncertainty. As most of the attention and resources were focused on COVID-19 treatment and recovery, persons needing sexual and reproductive health and mental health services were discouraged from seeking help and support since these medical needs were not considered urgent. Even those who did seek help found themselves having to cope with the risk of contracting the virus while navigating the health system that had been excessively complicated by COVID-19 distancing and quarantine protocols, which were constantly changing in response to the evolving pandemic.

The situation was even direr for pregnant women who did contract COVID-19. COVID-19-infected pregnant women were seen or made to feel like "unqualified mothers": since they had "failed" to take care of themselves, they were exposing their fetuses to this unknown and deadly virus. Even though later data have shown little chance of vertical transmission, during the Level-3 alert, such information was not yet readily available. Once they had tested positive, they had to be quarantined and have a C-section rather than a vaginal birth, despite their birth plan. After delivery, quarantine continued, and thus their newborn babies were kept away from them. The new mothers were unable to breastfeed or bond with their newborn babies, all while lacking support from their families. Similar to the lack of information concerning prenatal care, it was not clear whether the COVID-19 virus could be passed through breastmilk, adding more uncertainty to new mothers, who often faced physical and psychological stresses along with infections and other family members' lack of understanding and support [12].

These new mothers were set up to fail as carers, at least for the first months of pregnancy and the first few months of motherhood, because they had to be separated from their newborn and were usually blamed for not taking care of themselves. Other mothers and family carers (mostly women) also experienced more stress due to uncertainty regarding vaccination. The lack of accessible and comprehensive health education resulted in vaccine hesitancy, even indirectly, due to an infodemic. An infodemic is "too much information, including false or misleading information in digital and physical environments during a disease outbreak" (WHO, 2020). The infodemic may have caused these women to experience vaccine hesitancy as carers. Their care work could have been disrupted if they had experienced side effects and adverse events from the COVID-19 vaccines.

Another set of women who experienced an added layer of COVID-19 burden were people on hormone replacement therapy (including transgender men and women and certain types of cancer survivors). There was little information regarding the impact of the virus, the vaccine, and the treatment of their hormone therapy.

Highly Gendered Psychological Maladjustment

Also, during the Level-3 alert time, there were increasing needs for mental health resources and services due to COVID-related anxiety and depression, economic consequences (e.g., unemployment), and family conflicts, while the health system's capacity, including the service provision, was reduced. One sector heavily interrupted is the volunteer services (e.g., lifelines and all sorts of hotlines) since it was not a part of the essential work. Data has shown that women continue to count for more than half of all volunteers across all age groups, with the latest data from 2021 showing 70.7% of all volunteers were women [33–35]. Thus, the disruption of volunteer services affected women's volunteer participation in social services and cultural life.

When most telemedicine and telecare services were deregulated, psychological counseling services were ruled out until the government accepted NGOs' constant advocacy to make mental health services available to people in need.

In this context, the TCPU launched the "mental health homecare" (xīn zháipèi) program, providing online counseling services free of charge. The counselors found that, out of their records, the services were used chiefly by women (87%) more than men (12%), who were more hesitant to seek support and accept counseling services. They also found that, among the service users, people suffered a great deal from psycho-physical stress (67%), emotional disturbance (59%), and life-career concerns (39%). Many were diagnosed as requiring counseling intervention (57%) and even having suicidal ideation (37%). However, intense and constant psychological stress and the shortage of break time may have prevented people from intending to seek professional help.

It is also noteworthy that volunteer psychologists and counselors initiated this mental health homecare program without pay; those providing the services added more working hours to meet the urgent need the government failed to attend to. These volunteer psychologists and counselors were mostly women (TCPU interview data); thus, this service added to their already exacerbated workload.

Increase in Gender-Based Violence and Domestic Violence

According to the interview data, the fact that people had spent more time at home due to the quarantine and isolation measures increased tension between intimate partners and between family members and the risk of domestic violence, with reduced opportunities to report and seek help. The phenomenon has a global resonance that has caught health researchers' and professionals' attention (Moreira and Pinto da Costa 2020). Drawing on the data released by the Taipei City Centre for Prevention of Domestic Violence and Sexual Assault, much social work and mental health support were disrupted, the immediate contact between victims and their social support network was blocked, and the intention and confidence in seeking professional health were also affected.

When forced to stay home, working mothers and fathers face intense role conflict regarding their work-life balance, also assuming a more permanent care role from a

temporary, "after-work" status (interview data from informants from Taiwan Association of Family Caretakers, TLA interview data; TCPU interview data [22]. The traditional gender role expectations in Taiwan clash with the heightened household care work when people work from home [29],this phenomenon may have provoked violence-related stress and depression and induced domestic and intimate partner violence events and child and elder abuse. Indeed, there has been an increase in gender-based and domestic violence cases in the past three years (MOHW, 2021.

Domestic violence shelters, while still running, had to lower their capacity to meet the social distancing requirement and required self-paid PCR testing, negative COVID-19 test results within three days, and 14 days of quarantine after leaving the shelter. These requirements made it extraordinarily difficult for people in need to utilize the resources (TLA interview data; TCPU interview data; [10]).

Key informants also reflected on the underreporting of abuses during the Level-3 alert because schools were shut down, and emergency rooms were mainly reserved for COVID-19 cases. When children from abusive families go to school, teachers, who are mandatory reporters, might be able to pick up cues from or be informed by the students about abuses at home. Likewise, emergency rooms are another place where domestic violence can be discovered and reported. When those places were closed, while gender-based violence and domestic violence were increasing, victims of such abuse were left at risk of even more dangerous situations.

Intersectional Marginalization and Inequalities

In general, there has been a lack of representation in policy considerations and design regarding the needs and concerns of indigenous women, women with disabilities, women with mental illnesses, lesbian, bisexual, and transgender women, and middle-aged and older women [13]. Joblessness and loss of income have been unequally distributed and experienced more gravely by, for instance, workers in sex-related industries, cleaners, and other atypical workers (primarily women), who suffer job insecurity and precariousness without financial and psychosocial support [10, 44]. Some female taxi drivers, for instance, were forced to stop working on their menstrual periods due to the lack of access to public restrooms under the Level-3 alert (MHAT interview data).

Other than joblessness and loss of income, stigmatization and shaming of women were prominent for certain professions, such as sex workers and flight attendants. As some infamous early cases were linked to men visiting "tea houses" (places that provide sexual services and serve social functions for elderly men) [12]; others were linked to sexual encounters between female flight attendants and male pilots, and public opinion was overwhelmingly against the women in these cases. Some cases were linked to gay men's sex encounters, and thus misogynistic and homophobic discourses were rampant not just in online forums and news reports but even among influential politicians (TWL interview data; TCPU interview data; also drawing on collective reflections of the study group).

It was painfully clear that public education on non-discrimination was far from satisfactory, even though the then Health Minister Chen Shih-Chung had made

explicit efforts to ease the stigmatization. For example, the CDC used the euphemism of "human-to-human connection" instead of "sex" in the context of contract tracing of relevant cases, and reminded people not to use derogatory terms against specific persons and occupations (Central Epidemic Command Center, 2021). However, news and social media users made fun of and created memes, rather than feeling cautioned about the efforts, as mentioned by our interviewees (also drawing on collective reflections of the study group).

All of these factors contribute to worsened mental health, and yet, as an integral part of health from a holistic perspective, mental health has been greatly overlooked by decision-makers in the policy processes of the public and private sectors. The general omission of mental health needs is related to the unavailability of mental health information, education, and services in rural and mountainous areas; even when this does exist (mainly that implemented in indigenous communities), it has been designed without considering cultural appropriateness and safety [27]. These disparities have also exacerbated health inequities against women of different professions and those undertaking various caregiving roles.

Discussion

Our findings have identified an adverse impact on women's health and socioeconomic conditions in Taiwan; more importantly, these events are intertwined, surrounding the onus of care work and their shift in the pandemic context. We collected data from key informants and analyzed the data textually using focused group interviews, individual interviews, and study groups. The five themes identified include particular health risks to carers (mostly women), the impact of COVID-related measures on women, highly gendered psychological stressors, an increase in gender-based violence, and intersectional mental health inequalities.

Firstly, professional and home carers faced various "newly added" burdens, such as excessive care work, pay cuts, and the dilemma between caring for patients and their families. However, some carers were not given vaccine priority, and this access inequality subjected them to another layer of anxiety and burnout risks [9].

Secondly, pregnant women and new mothers experienced insufficient prenatal, gestation, and postnatal care [36]. The quarantine mandates stripped them of crucial support, subjected them to forced C-sections, and kept their babies away from them for a month. They risked feeling like unqualified mothers, and the infodemic surrounding vaccines propelled some into heavy vaccine hesitancy.

Thirdly, mental health needs surged due to COVID-related anxiety and depression, economic consequences (e.g., unemployment), and family conflicts, especially for home carers. Despite some relief programs, the needs were barely met. Some such programs were run voluntarily without pay, adding another layer of burden to professional care providers, who are primarily women.

Fourthly, gender-based and domestic violence increased due to loss of income, quarantine, isolation, and traditional gender role expectations clashing with increased household care work [41]. However, social work services were disrupted, schools were shut down, and emergency rooms were reserved for COVID-related

cases, blocking some necessary means for reporting violent incidents. Shelters needed to follow COVID-19 preventative measures that prohibited women in need from using them.

Finally, intersectional identities and multiple inequalities were overlooked while dealing with COVID-19. The needs and concerns of indigenous women, women with disabilities, women with mental illnesses, and lesbian, bisexual, and transgender women were marginalized, and shame and stigmatization against women of certain professions, such as sex workers and flight attendants, were rampant. The accompanying and worsened mental health problems were met with an under-resourced and understaffed system, as alerted by the UN human rights experts since the early outbreaks of COVID-19 [31, 36].

These findings echo the CEDAW's argument that discrimination against women and gender inequalities are generally related to the broad range of risks to physical and psychological harm (CEDAW, 1999) that negatively affect women's health outcomes and access to medical care and social support (also see [6, 8]). We contend that the pandemic–including COVID-19 as a disease and the measures taken by the government and society in response–has revealed and exacerbated the existing inequalities against women in Taiwan. It has also foregrounded a new context in which such imbalanced gender relations are legitimized and, perhaps worryingly, maintained, even when Taiwan gradually moves into a later pandemic stage.

Informed by the human rights framework, these events are linked to the state's willingness to comply with its obligations to respect, protect, and fulfill women's rights to health and freedom from discrimination in economic and social life [19, 20]. According to General Recommendation No 28 of the CEDAW, the state must fulfill its legal obligations through policies and institutions that address women's specific needs to fully develop substantive equality with men [5, para 9]. The state is also obligated not to sponsor or tolerate discrimination through acts or omissions,it is further obliged to react actively to inequitable situations where women are situated [5] and, due to COVID-19, resituated.

However, in their Parallel Reports on CEDAW, multiple NGOs have reiterated their concerns regarding the lack of gender impact assessment associated with COVID-19 policy and responsive measures.[10] Namely, there has been no official attempt to understand and respond to how the pandemic has affected different groups of women in Taiwan of different ages in various areas of their lives, for example, regarding education, employment, healthcare, social security, marriage, family life, race, ethnicity, and class, among others. Relatedly, the government has not taken timely and sufficient measures to address and mitigate the negative impacts on women.[11]

[10] The English versions of all the shadow/parallel reports submitted by civil society organizations can be found at: http://www.cedaw.org.tw/en/en-global/download/index/4.

[11] See also Conclusions and Recommendations of the International Review Committee announced on 1 December 2022, following the Review of Taiwan's Fourth Report on the Implementation of CEDAW (which did not happen yet when the article was written). Available at: https://gec.ey.gov.tw/Page/8311232E3E16856.

Yet, we acknowledge the limitations of a human rights approach, which focuses, intriguingly, on the willingness and ability of a state for socioeconomic rights protection when potentially states are themselves the sponsors, through action or omission, of relevant violations [19, 20]. Also, as Walby [46] identifies, as what happens in Taiwan, most agencies have gender mainstreaming initiatives in place, whereas implementation remains inconsistent due to various social forces operating on interpersonal and cultural levels where the law's interference is and should be restricted, out of human rights considerations too. Legal and policy instruments for addressing intersectional marginalization are still not in place despite official recognition of the need to develop them,the public health crisis has again pushed forward the problem.

With that said, as mentioned earlier, the findings of this study about Taiwan could be extrapolated to understand countries with similar sociopolitical backgrounds and development statuses, for example, Israel [49] and South Korea [25]. A comparative understanding of the phenomenon globally is also necessary regardless of whether a state is a member of the UN, which tends to omit or misrepresent non-member states such as Taiwan [28]. Future research should pursue a comparative study on the gender impact of public health crisis moments (e.g., COVID-19, unusual mpox outbreaks and avian influenza epidemics, and climate change) and the effectiveness of gender-sensitive measures consistent with human and women's rights principles and standards.

Conclusion

This study is among the first attempts to document how COVID-19 has affected women in Taiwan. It found that caregiving was a central theme in women's experiences and other gender and sex-related inequalities. This pandemic has exposed the lack of resilience in our social safety networks, healthcare capacities, and social inclusion while providing vital lessons for everyone. The phenomenon has also been taken to diagnose existing crises across different unpaid and paid domains of care and social reproduction [16]. In this context, we ask that the central and local governments be more aware of these lived experiences and adjust their policies accordingly if we truly hope to live up to the standard of CEDAW and other international human rights treaties.

Acknowledgements We are grateful for the Journal editors' guidance and reviewers' feedback. We sincerely thank all the interview participants, the "COVID and CEDAW" study group members, and friends and colleagues from other civil society and women's rights organizations. We much appreciate the logistical and bursary support from the Foundation of Women's Rights Promotion and Development and the Mental Health Association in Taiwan. Previous drafts were presented at the annual meeting of the Taiwan Society for Medical Anthropology and that of the Taiwanese Feminist Scholars Association in 2022; we thank the participants for their constructive feedback and critical comments.

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