Gender inequalities in the job market negatively affect women’s access to social protection acquired through employment such as pensions, unemployment benefits or maternity protection. Cultural factors like gender stereotypes, which require women to perform a vast majority of household works also play an important role. Lower income and fewer opportunities make women more dependent on social and welfare benefits and leave them at a greater risk of experiencing poverty.
According to UN data, women are more likely to assume responsibility for taking care of children, older persons and persons with disabilities. Mothers of children with disabilities, especially those living in poverty, are often the sole caregiver of the child. Usually, in order to reconcile their professional career and family life, women work part-time and on average spend around 3 times more hours on unpaid work than men. Most informal carers for older persons and/or persons with disabilities in the EU are women (62%). In the EU, 15% of women and 10% of men are involved in informal care for older persons and/or persons with disabilities, several days a week or every day. Among informal carers, only 42% of women are working, compared to 56% of men. The amount of time devoted to unpaid care and household work negatively correlates with their social and pension benefits. As a long-term consequence, women are more likely to experience pension poverty, receiving pension benefits on average 38% lower than men.
Poverty also has a direct impact on women’s health and well-being. Women in poverty often lack the necessary financial means to pay for doctor’s and dentist’s visits, for treatments, or medication. In addition, transport costs to obtain health care services can also be too high for their precarious budget. Women with young children do not always have access to childcare to be able to attend a doctor’s appointment. Women in poverty often prefer to prioritize other essential expenses for their family and to postpone their own health care. In the long term, this results in more complex medical issues and higher medical expenses, pushing these women further into poverty.

The reduced access to health care also has a negative impact on women’s sexual and reproductive health. The right to sexual and reproductive health is considered a basic human right, however, women in poverty often lack the financial means and the necessary information to have access, for example, to contraception, safe abortions or other high-quality health services.

In addition, the situation of poverty – of not knowing when and if they will have the means to provide for the next meal, to care for their families and themselves –, can lead to increased levels of stress and anxiety, to depression and burn-outs. Poverty has an impact on women’s psychological well-being too.

The challenges of poverty increase for women from extra vulnerable groups, such as women with a disability, older women, migrant women, Roma women, asylum seekers, homeless women, etc. Language barriers or low educational levels, for example, can limit their access to information and complicate communication with health practitioners.
Women with a disability, for example, can face elevated health care costs. They can also experience additional barriers when physically accessing adapted health care services. In many countries, there is a lack of affordable specialised care services than can meet their needs.

On average, older women with low income spend more years in poor health than older men. Yet, they struggle to access the health and long-term care they need, such as preventive and mental health care, hearing aids, dental care, glasses, and residential care. Older women face a much higher risk of needing to move to a nursing home. Yet nursing homes are very costly and women’s pensions are in general far from enough to cover their long-term care needs.
Lockdown measures undertaken by the governments have negatively affected, in particular, persons with disabilities, older persons, and their caregivers, who are most often women. While the movement restrictions caused additional stress for persons with disabilities and older persons with support needs, in many cases, public support services i.e. day care centers and other facilities, were closed due to the COVID-19 crisis. Therefore, many persons requiring assistance were left without any help and/or forced to look for fully paid alternatives. Other services, such as food banks, meals-on-wheels, social centres serving hot meals, homeless shelters, etc., also closed temporarily due to confinement restrictions. This affected women in greater numbers than men, and older women in particular.
In some countries, food banks and other charity organisations received less donations. These services were often closed during confinement periods, and when they reopened, they saw a significant increase in the number of people seeking their help.

In the Czech Republic, many persons with disabilities experienced problems with applying for social benefits as the state bodies switched to on-line application systems. The same issue emerged in Ireland as the online application system made it impossible for many Roma women to apply due to literacy and language barriers, as well as issues with access to technology and internet connection. In other countries, similar issues were faced by migrant women and older women with low digital literacy. Moreover, the switch from weekly social welfare payments to fortnightly payments during the pandemic posed significant challenges for Travelers and Roma women, many of whom already lived with limited income and/or in poverty.
Digitalisation of healthcare

Shifting to online/telehealth created additional barriers in accessing health care for persons in poverty, including older women, who often do not have mobile phones or do not have access to computers or internet connection. Using online/telehealth was even more challenging for the most vulnerable groups e.g. Roma women in some countries who have a language barrier, and the fact that many Roma families share a mobile phone, which can discourage patients from seeking medical help. Language barriers and limited access to technology have also been an obstacle for migrant women in accessing online health services. Many older women also face digital exclusion and lack access to mobile phones or computers.

Unavailable health services

In many countries the public health sector has mobilized all its capabilities in the fight against COVID-19. As a result, some medical treatments and services, which could not be consulted on-line, were paused or delayed. Postponing non-urgent care resulted in poorer outcomes, for example, for breast cancer patients. Moreover, as women make up the majority of carers, they were often denied access to health care services when they were accompanying people with disabilities, leaving them unable to care for specifically their own disabled children. During the peak of the first wave, some nursing home residents diagnosed with COVID-19 were denied access to emergency care or the hospital, and were kept in their nursing home, where significant numbers died alone, without even basic palliative care.
due to a severe lack of human and care resources. This isolation in hospitals and nursing homes may have been further exacerbated for women in poverty who had no access to information and communication technologies such as laptops, tablets or (smart)phones.

The pandemic had a particularly negative impact on the sexual and reproductive rights of women. Women in general had less access to reproductive health services, contraception and safe abortions. The pause in the screening of women as well as the pause in gynae appointments and procedures has raised concerns for women belonging to vulnerable groups i.e. for many Travelers and Roma women who have been on waiting lists. The COVID-19 crisis also negatively affected pregnant women. In Poland, for example, some medical facilities introduced restrictive visitor policies and/or internal hospital regulations barring partners from the labor and delivery rooms. Lack of spousal emotional support during labour left many expecting mothers fearful and anxious about their upcoming delivery. Even though family births were eventually made available again in some countries, persons who wished to support pregnant woman were often obliged by medical staff to fulfill additional requirements e.g. presenting negative results of a blood test for SARS-CoV-2 performed no later than 5 days before the delivery. Given that the cost of a blood test was not covered by Polish health insurance, such an option was affordable for very few patients.
Movement restriction measures, together with the economic uncertainty, triggered a **dramatic rise of domestic violence in many EU countries**. While some of them reacted swiftly to the new challenges, others ignored the risk of surges or even adopted a hands-off approach to enforcing domestic violence orders during this pandemic. Lack of adequate reactions endangered the lives and health of women, who are disproportionately affected by domestic violence. The situation of women living in poverty was particularly difficult as many free of charge shelters were closed due to the pandemic.

**Surge of domestic violence cases**

**Increased health risks for women in essential jobs**

During the pandemic, it became clear that frontline workers were more exposed to health risks related to the COVID-19 virus. The majority of frontline workers are women, often in precarious jobs, such as nursing staff, care workers, nursing homes’ staff, shop assistants, cleaning staff, domestic workers, etc. Many of these workers did not receive the necessary protective equipment, but were expected to keep working.