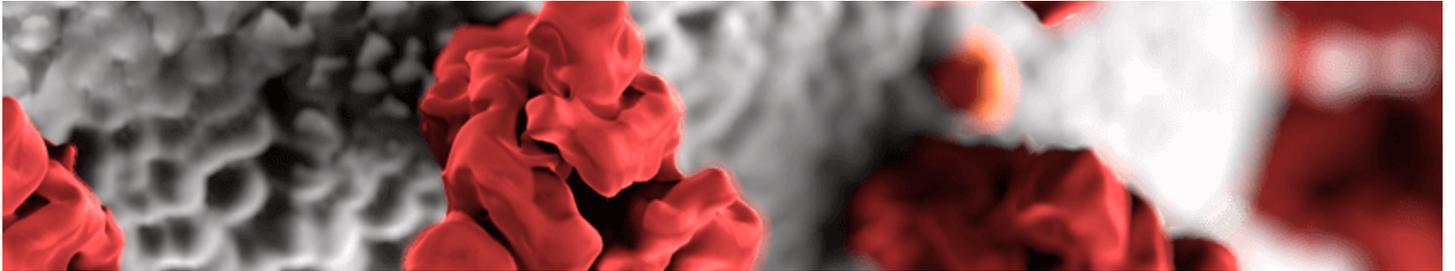


Issue 2020 **76**

GENDER FORUM

An Internet Journal for Gender Studies



Special Issue: Gender In Crisis. COVID-19 and Its Impact

Edited by
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ISSN 1613-1878

Universität
zu Köln



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completed papers (January 1)

Summer Issue:
abstracts (January 1),
completed papers (April 1)

Fall Issue:
abstracts (April 1),
completed papers (July 1)

Early Career Researchers Special Issue:
abstracts (May 1),
completed papers (August 1)

Winter Issue:
abstracts (July 1),
completed papers (October 1)

About

Gender forum is an online, peer reviewed academic journal dedicated to the discussion of gender issues. As an electronic journal, *gender forum* offers a free-of-charge platform for the discussion of gender-related topics in the fields of literary and cultural production, media and the arts as well as politics, the natural sciences, medicine, the law, religion and philosophy. Inaugurated by Prof. Dr. Beate Neumeier in 2002, the quarterly issues of the journal have focused on a multitude of questions from different theoretical perspectives of feminist criticism, queer theory, and masculinity studies. *gender forum* also includes reviews and occasionally interviews, fictional pieces and poetry with a gender studies angle.

Opinions expressed in articles published in *gender forum* are those of individual authors and not necessarily endorsed by the editors of *gender forum*.

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Target articles should conform to current MLA Style (8th edition) and should be between 5,000 and 8,000 words in length. Please make sure to number your paragraphs and include a bio-blurb and an abstract of roughly 300 words. Files should be sent as email attachments in Word format. Please send your manuscripts to gender-forum@uni-koeln.de.

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Article Publishing

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Editorial

by Sarah Youssef

1 According to the most recent gender report by the United Nations Population Fund (UNFPA) “disease outbreaks affect women and men differently, and pandemics make existing inequalities for women and girls and discrimination of other marginalized groups such as persons with disabilities and those in extreme poverty, worse” (*COVID-19: A Gender Lens*). The COVID-19 crisis has affected and continues to affect every aspect of our lives, raising anxieties, limiting spaces, and intensifying tension and conflict in different areas. In response to the current situation, *Gender Forum* dedicates a special issue to the impact of the COVID-19 crisis on gender-related issues.

2 Corinne McSpedon and Mary Dillard’ article titled “‘This Is What You Signed Up for’: Oral Histories of New York State Nurses During the COVID-19 Pandemic” takes issue with the U.S. health care system. One of the first healthcare providers in New York City to die from COVID-19 was a nurse. When the city was already seeing hundreds of cases a day at area hospitals, particularly in neighborhoods already marginalized by health and economic disparities, nurses at one hospital in the Bronx staged a demonstration to protest the lack of essential personal protective equipment. The astounding response by hospital administrators was to threaten nurses that they would be fired if they continued to speak out regarding their concerns. Like many activists, healthcare providers took to social media to warn the public about the realities of both the COVID-19 crisis and the threats to the health and safety of their own families. However, in at least one Facebook thread, the response to nurses was, “This is what you signed up for.” In this remarkable article, based on numerous interviews, McSpedon and Dillard highlight what nurses in the New York metropolitan area, one of the epicenters of the pandemic, experienced during this staggering healthcare crisis.

3 Healthcare issues are also at the center of Gen Eickers’ article “COVID-19 and Trans Healthcare: Yes, Global Pandemics are (also) a Trans Rights Issue”. Trans healthcare has been severely affected by the COVID-19 pandemic In multiple ways: Surgeries and other procedures have been cancelled or postponed, and mental health services have been paused or moved online. Moreover, trans people’s healthcare situations have turned out to be particularly vulnerable in this crisis because they have been precarious to begin with. This article argues that cancelling trans surgeries and procedures in the crisis is made possible through an understanding of trans healthcare as non-essential.

4 The arts are another area that has been severely hit by the pandemic. Lynn Deboeck focuses in her article on intimacy in artistic performances during COVID-19. Intimacy

Directors International was founded in 2016 as an organization that targets the artistic direction of intimate scenes (such as sex scenes or romantic scenes) in theatre, film and television. Partially prompted by the #Metoo movement, the intimacy direction effort is an acknowledgement of the sexual harassment and interpersonal discomfort that many performers (largely women) experience in the entertainment industry. The directing approach advocated by this group, and other newly formed groups with similar purposes, looks at intimate scene-work much like stage combat or stunt work, where the movements are choreographed in order to prevent harm. There are also frequent check-ins so that the actors feel allowed to voice any anxiety or desire to change or stop what is happening. With COVID-19 bringing performance (particularly live theatre performance) to a halt, the Intimacy Directors International organization, according to their website, officially dissolved as of March 15, 2020. While they note that their mission—to *initiate* the intimacy direction industry—has been accomplished, this article explores how the dissolution of such a supportive and large part of the movement might affect performance as it regains its place in society, particularly for those most negatively affected by the negligent and predatory practices that brought about the need for intimacy direction in the first place.

5 One of the most important steps to combat the pandemic was the directive to stay at home. Sanghmitra S Acharya, Mala Mukherjee and Chandrani Dutta’s article “‘Staying Home’ and Safety of Women During Lockdown – The Shadow Pandemic in India” sheds light on the particularly difficult situation of women during lockdown due to the increase of their workload and of their exposure to violence and a denial of vital outside sources of support. The ‘staying home’ rule involves a myriad of issues for women in relation to the respective social environment. Middle-class women tend to be left with the additional burden of taking care of family members and home-schooling children without the support of helpers who have been released during during lockdown. Women working in the informal sector are likely to be hit by a loss of their jobs, and as spouses of often equally jobless informal sector workers are perceived as ‘adding to the burden’ on the financial situation. Addressing the needs of women in times of lockdown is important as gender budgeting is widely known to impact positively on development planning.

6 This special issue of *gender forum* concludes with Robyn Dudic’s review of *Shakespeare and Queer Theory*. The 2019 published monograph by Melissa E. Sanchez is one of the most recent publications in the context of the ongoing critical debate about queer theory both within and beyond Shakespeare and Early Modern studies.

“This Is What You Signed Up for”:

Oral Histories of New York State Nurses During the COVID-19 Pandemic

Corinne McSpedon and Mary Dillard, Sarah Lawrence College, New York

Abstract

One of the first healthcare providers in New York City to die from COVID-19 was a nurse. When the city was already seeing hundreds of cases a day at area hospitals, particularly in neighborhoods already marginalized by health and economic disparities, nurses at one hospital in the Bronx staged a demonstration to protest the lack of essential personal protective equipment. The astounding response by hospital administrators was to threaten nurses that they would be fired if they continued to speak out regarding their concerns. Like many activists, healthcare providers took to social media to warn the public about the realities of both the COVID-19 crisis and the threats to the health and safety of their own families. However, in at least one Facebook thread, the response to nurses was, “This is what you signed up for.” As scholars of women’s history, we have to wonder about the irony of nurses being lauded as heroes in one breath and criticized as hand-wringing turncoats in another. Did such a callous response have anything to do with the fact that nursing is still considered to be a “feminized” profession? As it turns out, nurses—who are always at the forefront of patient care—were right to raise the alarm. By mid-June, more than 140 nurses in the United States were estimated to have died from COVID-19. Countless others continue to put their lives on the line to do the jobs they have committed to do every day. This article does what some hospital administrators and health officials did not. We listen to nurses. Through oral history interviews, we highlight what nurses in the New York metropolitan area, one of the epicenters of the pandemic, experienced during this staggering healthcare crisis.

1 On January 19, 2020 the United States’ Centers for Disease Control and Prevention (CDC) confirmed the first case of COVID-19 in the United States, in a man in Washington state who had visited Wuhan, China. It would be a few more days before cases were identified in Europe. At this point, COVID-19 was a distant concern for many Americans, with top health officials in late January calling their risk of contracting the virus “low” (Miller and Hauck). At an early February campaign rally in New Hampshire, President Donald Trump talked about the virus “miraculously” going away by April (“Clip of President Trump Rally In Manchester, New Hampshire”; Stevens and Tan). As the number of cases in Washington state and elsewhere grew throughout February, the devastation to the healthcare system in northern Italy started to become apparent. On March 1, the first case of coronavirus in New York State was diagnosed in a 30-year-old woman living in New York City. Throughout early March, nurses and other health care providers were increasingly looking for guidance and protocols as they anticipated the arrival of the virus.

2 By the time the virus surged in late March, it became clear that the CDC was changing the protocols on an almost daily basis. Infectious disease protocols requiring that healthcare providers change their PPE (Personal Protective Equipment) after seeing an infected patient changed, leading hospital administrators to tell nurses and doctors to reuse their N95 masks, surgical masks, gowns, face shields, and goggles. As the pandemic progressed, nurses at Jacobi Medical Center and Montefiore Medical Center, both in the Bronx, began to complain about the lack of PPE. One callous response circulated on social media was, “This is what you signed up for.” In addition, some hospitals threatened that nurses would be fired if they continued to speak out about the lack of PPE in their workplace.

3 This article does what the social media trolls and some hospital administrators did not. We listen to nurses. For almost 20 years, nursing—a profession dominated by women—has been regarded as “the most trusted profession” in the United States (Reinhart). Knowing that nurses are always at the forefront of patient care and have a wealth of professional knowledge, we suspected they would be some of the best sources for understanding the early days of the pandemic. In order to learn from these most trusted sources, we conducted oral history interviews with six nurses who worked in hospitals at the epicenter of the pandemic, in New York City and two of its northern suburbs. Of the six nurses, two worked at public hospitals, four at private hospitals.¹ They ranged in age and experience from 24 to 62 years old. Collectively, even in this small sample, they had 74 years of nursing experience. Because of the ongoing nature of the pandemic, the trauma experienced by healthcare providers, and the sensitivity of hospital administrations, three of the nurses we interviewed requested that we change their names in order to maintain their anonymity.²

4 In the early days of the pandemic, New York Governor Andrew Cuomo echoed the state’s Health Commissioner, Howard Zucker, downplaying the risk of death by reassuring the public that most of the people who had died from COVID-19 globally were “debilitated, senior citizens, many of whom have an underlying illness” (“Video, Audio, Photos”). As the health crisis escalated,

1 New York City’s 11 acute care public hospitals are funded by the city, state, and federal government and comprise the largest public health system in the country. Run by the Health + Hospitals Corporation, New York City’s public hospitals are ultimately under the purview of the mayor. Six of the 11 hospitals are trauma centers, and all patients receive care, regardless of their ability to pay or immigration status. The system is the state’s largest provider of care to Medicaid recipients and the uninsured. Medicaid provides coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Private sector hospitals, by contrast, may be for-profit or nonprofit and typically serve fewer uninsured patients.

2 The interviews have been lightly edited to remove audible pauses: “um”, “so”, “like”, which are common in interpersonal conversations, but in a transcript can distract from the power of a speaker’s words.

politicians and health officials increasingly spoke about “flattening the curve”. At the same time, many nurses encountered the sickest patients they had ever seen. They were confronted with a virus about which very little was known and for which there is no vaccine or treatment. Unfortunately, for more than 120,000 Americans (as of May 2020), supportive care to relieve symptoms could not prevent death. Many nurses found they could do very little for the sickest patients. The nurses we interviewed responded with professionalism and competence. However, their interviews also speak to the stress, fear, mixed messages from hospital administrators and health officials, and multiple challenges of responding to a global pandemic, while the infrastructure to inform them became increasingly politicized. At the same time, the interviews demonstrate that COVID-19 is an extremely potent virus that taxed the resources of even the most seasoned professionals.

‘It Hit Us by Surprise’

5 A defining characteristic of nurses’ experiences during the COVID-19 crisis in New York was the extent to which recommendations kept changing—about who could be tested, how to safely care for patients suspected of or known to have COVID-19, and which PPE was available and would protect them. Some of the nurses we interviewed described receiving detailed information about the virus and preparedness plans from their facilities, whereas others noted a lack of guidance and response to their concerns as the crisis unfolded and protocols lagged behind the reality of what nurses were seeing daily.

6 Three of the nurses, working in private hospitals in Manhattan and Westchester County, described their facilities as being adequately prepared and were pleased with this response. One recalled how her hospital began holding town hall-style COVID-19 informational meetings by late February, whereas the others said they were attending regular emergency meetings, in which strategies and protocols were discussed and the establishment of facility command centers were announced by early March. They all said they received regular updates about COVID-19 from administrators thereafter. “I felt very aware that this is being taken seriously and that there are resources in place and that they’ll be updating us,” said Blima,³ a nurse practitioner specializing in

3 We decided to refer to the nurses by their first names for readability and to help maintain the anonymity of the nurses who didn't want to be identified. We recognize that the academic convention is to use last names and that our choice to use first names may be misconstrued as a gendered practice, by writing in an overly familiar way about women professionals. This is not our intention. We hope our work demonstrates our deep respect for each of the women we've interviewed.

oncology. “And we got updates by email really frequently. . . I felt like there was a lot of information being shared.” Jessica,⁴ a labor and delivery nurse in Westchester County, was similarly impressed with her hospital’s preparedness. “I was actually amazed at how on top of it they were and how organized leadership was and transparent,” she said.

7 Other nurses described starkly different preparedness levels, inadequate communication from administrators, and insufficient—or dangerously nonexistent—protocols. “There wasn’t a whole lot of preparation per se, because I feel like it hit us by surprise,” said Lily,⁵ an advanced practice nurse who works at a public hospital in the Bronx. “At first, I think, many people uttered the words, ‘Oh, it’s just like the flu. Wash your hands, wear a mask, do your regular PPE stuff.’” She did not fault her facility, though. She regarded the virus as being so new, with so many unknown factors, that the situation was difficult to prepare for.

8 Protocols restricting who could be tested—and a lack of tests due to faulty manufacturing processes at two of the CDC’s facilities (Kaplan)—led to delays in testing throughout the United States. In the New York City–area, as elsewhere, these delays masked vital information about how long and extensively the virus had been circulating. It was a turning point in New York’s COVID-19 crisis when, on March 2, a man in New Rochelle, a city in Westchester County that borders the Bronx, became the second person in the state to be diagnosed with the virus. Before his diagnosis, he had spent four days in a local hospital with what was suspected to be symptoms of pneumonia (Goldstein and Salcedo). A week later, finding evidence that the virus had been spreading widely in the man’s community in New Rochelle, the governor established a one-mile “containment area” in his neighborhood, closing all schools and religious facilities, banning large gatherings, and bringing in National Guard troops to help disinfect public facilities and provide food to people who were quarantined due to illness or contact with the man (“Governor Cuomo Accepts Recommendation”; “N.Y. Creates ‘Containment Zone’”).

9 Just a few miles away, nurses at public hospitals in the Bronx were still being told by administrators, per local and state health department guidance based on CDC protocols, that evaluation and testing criteria would be based on a person’s travel history to China or Italy and a narrow set of symptoms. Kelley, an emergency department nurse at a public hospital in the Bronx that includes a trauma center, and her coworkers were frustrated by their hospital administrators’

4 ‘Jessica’ is a pseudonym.

5 ‘Lily’ is a pseudonym.

lack of action. “We had already been saying, ‘Hey, guys, New Rochelle, they're on lockdown. You know, they have the military there. . . . It’s 15 minutes from here. What are we going to do?’ And we still weren't really getting . . . any real answers. It was always like, ‘Well, the Department of Health says’”. She described how one day, while using her hospital’s computer system, she watched as the triage questions were updated right in front of her. A question about whether a patient had been in New Rochelle, in addition to China and Italy, was added. For Kelley, it was shocking to see the protocol change so randomly. “It was 3 p.m. and it literally flipped.” Describing her hospital’s preparation for the virus as “pretty bad,” she said, “if anybody is to look back at that point in time and say that we did a good job, they would be lying.”

10 Tara,⁶ an ICU nurse at a private, Rockland County hospital, said her facility seemed to be completely unprepared for the crisis and disregarded nurses’ concerns about PPE, beginning with the first patient she cared for:

. . . it surprised me how much we weren't prepared for it . . . We'd already heard about cases in Westchester and in the city. It was just like, ‘When is this going to happen?’ And then it just suddenly did . . . the very first day I assumed care of that patient, I got a text right before I went into my shift from my manager, forwarded from administration, saying that we were not to wear masks in any room that was not suspected . . . and, at that point, they were not officially suspecting anybody. We were all upset, because we were saying, ‘Well, *we* all suspect it,’ but it wasn't an official suspected case until a doctor ordered the tests . . .

They locked up the masks on us . . . We’re all scared, because we haven't even seen it [the virus] yet. . . . They did not swab the patient until the day he died . . . about five days into the admission. . . . all those staff members that had taken care of him . . . we all knew that we were in there, we had all wanted to wear masks, but we weren't allowed to. We were all begging the doctors to test this poor patient, and . . . it just ended up in massive exposure to the very first patient we had. . . .

I think they were trying to save what [PPE] we had, but, at the same time, they didn't have a protocol in place to establish who could be a case. . . . They should have immediately started screening patients in the E.R., as soon as we heard about this, even in February. ‘If they meet these criteria, just isolate them and wear a mask,’ and that’s it. Maybe we would have run out [of masks] sooner, but we ran out anyway.

Tara’s comment that administrators “were trying to save” the existing supply of PPE hints at a lack of preparedness beyond the control of her department and facility; namely, a federal response to a growing global crisis that failed to anticipate the need for increased testing capabilities and PPE. The World Health Organization (WHO) declared a global health emergency on January 30 (“Committee regarding the outbreak”), and the United States followed the next day with a declaration of

⁶Tara’ is a pseudonym.

a public health emergency (“Statement on the second meeting”). It was another two months, however, before President Trump, amid much pressure, invoked the Defense Production Act, a decades-old law that allows presidents to order manufacturers to produce vital supplies during an emergency. Even then, the act was initially used to increase the production of ventilators only—not PPE, despite its growing unavailability nationwide.

‘Making Sure That We are Doing the Right Thing’

11 That nurses are the most trusted professionals stands in stark contrast to the difficulty they often have in ensuring their voices are heard. This was powerfully exemplified in the experiences of several of the nurses we interviewed, who described their resiliency and willingness to confront hospital administrators and restrictive policies. Such advocacy for the safety of their patients, themselves, and their colleagues took many forms, from demanding greater availability of PPE and testing to promoting changes in policies separating patients and family members. Many described the institutional responses they received as deeply frustrating and counterproductive to their safety and work. Yet, unlike some of their colleagues in other New York hospitals, the nurses we spoke with did not report experiencing professional repercussions for their activism.

12 Kelley, who became her union’s top official at her hospital in February, described how she and the nurses at her facility held a protest in late March to demand improved access to protective equipment (Schwartz), which was locked in administrators’ offices, requiring the emergency department staff to locate a manager and request PPE when it was needed. It had become apparent as the crisis unfolded that what they thought was a problem limited to their hospital was a much more widespread issue. Kelley recalled contacting her network of nurse friends and colleagues and learning that their facilities had also restricted access to PPE:

We're like, 'Oh, my God, they're really going to not give us protection.' Like, everywhere. And that's when we had a protest. . . . We highlighted the issues with the Trump administration. Why was the Defense Production Act not enacted forever ago? . . . Why were we not making this stuff? . . . You're making us wear masks for five days at a time, knowing full well that a week before then, if we had been caught doing any of that, we would have gotten in trouble. . . . These things are one-time use. You're supposed to wear them once. . . . The biggest, frustrating thing was how fast the standards changed.

The protest, and the nurses’ willingness to use local news outlets to amplify their voices, resulted in a groundswell of community support and provisions, including the donation of much-needed masks and face shields, “which was great,” said Kelley, “but it just kind of highlighted the bigger

issues, that we were getting by on the help of everyday people when our government was just kind of letting it all happen.”

13 At her institution, she noted, the protocols nurses received “were not at all for the possibility of getting a multitude of these patients. . . . We had one room set aside. ‘If you have somebody that you think has it [COVID-19], this is the room that you’re going to use.’ One room. And that room in particular didn’t even have a bathroom in it.” Kelley described how the nurses questioned administrators about what they should do if another person with the virus arrived in the emergency department. “We can’t pretend that we’re only going to get one at a time. . . . Obviously, nobody was ever going to prepare us for what we actually saw and experienced.” Ultimately, administrators set aside five rooms with bathrooms. The amount of patients who soon began arriving in the hospital’s emergency department far outweighed this capacity.

14 The confusion and challenges due to shifting recommendations from administrators, city and state health officials, and the CDC were mentioned by several of the nurses. As the crisis ramped up, the CDC released guidelines detailing changes to long-standing infection control policies when caring for patients with confirmed or suspected COVID-19 (“Interim Infection Prevention”). Notably, these revised guidelines recommended the use of surgical rather than N95 masks, unless a provider is involved in an aerosol-generating procedure.⁷ The document acknowledges the breakdown in the supply chain of masks and says that when it is restored, facilities “should return to use of respirators [N95s] for patients with known or suspected COVID-19.”

15 Nurses described how this sudden shift in PPE guidance prompted daily attempts, both at home and while at work, to remain aware of new and revised recommendations as the crisis evolved. Lily said her facility held “daily meetings of what the rules are today. What’s the CDC guidelines today? What did Cuomo say today? So, we had a 12 o’clock meeting every single day.” Christine, a nurse on a critical care step-down unit at a hospital on the northern tip of Manhattan, said, “The policies were constantly changing: What was the proper PPE to wear? What was proper protocol for certain things?” Her hospital sent institution-wide emails to keep staff updated about new recommendations. Kelley’s experience, by contrast, was distinguished by a lack of communication:

It just seemed like we were yelling into the abyss, because nobody seemed to have any answers. And, meanwhile, we were expected to just go in there and work. And there was

⁷ Aerosol-generating procedures include airway suctioning and intubation, such as when putting a patient on a ventilator.

the whole issue with the masks. The CDC changed their criteria for the masks. It was, ‘You wear an N95 at all times,’ and then it turned into ‘No, only for aerosolizing procedures.’ ‘Actually, you can wear the mask for multiple days in a row.’ ‘Actually, you could just wear a bandana.’ It just kept changing and changing.

Some nurses said shifting recommendations were to be expected. “They were giving us information as they knew it, but they didn't know much,” said Blima. “As you learn things, you change your recommendations. And to me, that seems logical. . . . The New York City surge was so disastrous that my impression of the CDC is that they gave us the information as they learned it.”

16 Tara said the constantly changing protocols caused her to doubt the CDC’s authority: “We felt really abandoned by even the CDC guidelines. . . . It’s almost like they just bowed to whatever shortages they were anticipating in the hospitals, and that is really disappointing, too, because that ignores people’s safety.” She recalled an interaction she had one night with her nurse managers, when she was working as the charge nurse in the ICU:

. . . they handed out our brown bags with our names on them, because that’s how they were distributing the masks at this point, per week. . . . They handed it to me [and] said, ‘Can you hand these out?’ I looked in the bag, and there was no N95. There was just a surgical mask. And I [asked], ‘Well, where’s the N95s?’ And they said, ‘Oh, we ran out.’ . . . Just like, you know, ‘not only are we not going to protect you, but you have to be the one to break the news to your coworkers, too’. . . . There was a point where we really did completely run out. But most of the nurses had saved their N95s, because we all had kind of felt like that might happen, that they’d just not give it to us anymore. So, at the worst point of it, we were using the same one for about a week.

As a nurse practitioner, Blima volunteered to be on her facility’s first COVID-19 team and found the PPE to be “not great” during the first week. Her institution updated its policies regularly to reflect the CDC’s recommendations, but she cited an example of how challenging it could be in practice to obtain the recommended PPE:

I had a patient on airborne precautions who had coronavirus and was on a nonrebreather mask. . . . I wanted an N95, and it took about 10 minutes of negotiating with the RNs on the floor. They went to their manager to see if they could give me an N95. . . . And I remember getting that [N95 mask] and wearing it around my wrist all day, so I don't lose it. And I remember videotaping it and saying, ‘More precious than diamonds. Here’s my new bracelet’. . . . I think they were trying to conserve the PPE and not let it all run to waste, but, I mean, I was literally on the first COVID team. . . . It was a little frustrating that I had to go through hoops to get it.

She points out that the other COVID team members she was making rounds with had to wait while she tried to obtain the N95. “We were limiting people going into the room, and I was the nurse practitioner, so I wanted to go in. . . . There’s [also] the emotional implications of thinking that

I'm not important enough for an N95. . . . I stood my ground on that. You know, you've got N95s, and I need one." The implication of such a struggle to obtain appropriate PPE includes delayed care and wasted time, as well as the risk of nurses being excluded from essential discussions and care.

17 Other nurses described how their observations and work at the bedside with patients and families informed their efforts regarding restrictive visitation and contact policies during the crisis. Lily advocated for evidence-based best practices when caring for women who tested positive for COVID-19 and their babies, making sure the new mothers had contact with the infants and the opportunity to breastfeed:

. . . the thought was that they had to separate them. But really, it doesn't make sense. . . . Keeping her from her baby on Tuesday, when she's going home with the baby on Thursday [and will still be COVID positive], doesn't really give you any kind of benefit. Instead, while she's in the hospital, you can teach her how to take care of her baby and still keep the baby safe. So, she wears a mask, she wears gloves. . . . It's really vital and important that she learns how to take care of her baby and breastfeed and recover and have her baby with her. That was probably the strongest role for advocacy, of just making sure that we're doing the right thing.

She added that her hospital always allowed women to have a support person accompany them during labor. Some private hospitals had stopped allowing this as the crisis accelerated in late March, before the governor signed an order reversing such policies (Van Syckle and Caron). "I'm really proud of the hospital," said Lily. "They were really staunch in 'Absolutely, every woman gets a support person.'"

18 The pain of seeing families separated due to COVID-19 was a theme many of the nurses mentioned. It clearly informed the care they provided and their activism. As Jessica recalled:

A man had died in the ICU, and his wife was in there at the bedside, and she wasn't allowed to go hug him or touch him. . . . The family members were in the lobby, and they wanted to come up and see their father. And they were just absolutely hysterical. . . . And the rules were that nobody was allowed to go see the deceased . . . except for one, and the wife was there. . . . I was helping console them in the lobby, and then it was just like, 'We have to make an arrangement for these people to come and see their father.' Not that they can go close or touch him, but to just go and console the mother. . . . It was really distressing to watch a family lose their father, and they couldn't console each other. . . . And that was just one family out of thousands.

Sometimes, the activism of nurses inspired other nurses as they struggled to manage and voice their own concerns. Christine illustrated this point:

I saw a lot of people online saying, 'Oh, this is what you signed up for, this is what you should expect going into this job.' And I actually read an article [in which a nurse who

cared for a patient with Ebola] wrote a statement to nurses taking care of COVID patients, [saying] ‘This is NOT what you signed up for. You didn't sign up for going into the hospital unaware of what you’re walking into and not being properly protected’. . . . It's nice [to hear] because I know you don't sign up to take care of a disease that you've never seen and not have the proper equipment to deal with it. We sign up to take care of patients, but we are supposed to be equipped with the materials we need.

We heard from those we interviewed that when there was lack of guidance and PPE, nurses and patients suffered. Yet, the nurses we interviewed also indicated their willingness to show up for each shift, even amid so many unknowns and while their safety and that of their families was at risk. Tara, who was critical of her hospital’s response during every phase of the crisis, for instance, said she felt unsafe showing up to work, but she still did so—caring for up to eight intubated patients at a time, when the norm in the ICU is one to two patients per shift.

‘It was just like no concern for our lives or anything’

19 The challenge of providing nursing care during a pandemic was compounded by the fact that healthcare providers and other hospital staff (including police officers, security guards and custodians) also got sick. Each of the nurses discussed their worries about bringing the disease home to their families, or the extent to which their families worried about them. Tara took care of the first COVID-19 patient who arrived at her hospital. Her nursing coworkers had to fight some of the doctors and the hospital administration in order for him to be tested. After the patient died, Tara stayed away from family and friends for almost two months in order to keep them safe. Christine lived with her parents. In mid-March, she took care of the first COVID-19 patient in her hospital. “It definitely was scary.” She said, “I didn't want to bring it home to my parents, because this patient that I did take care of was the same age as my parents.” She later learned that her parents had become infected, likely at a Saint Patrick’s Day party.

I even told my manager that I lived with my parents, and they're showing symptoms. I just took them to get tested. They're positive. . . . I was exposed to them. And this was kind of the beginning of the height, like where we were starting to get more of a rush by the time they got their positive results. And he told me that I still had to come to work. I just had to wear a mask at all times. And if I started to feel any symptoms, to let him know. And then I would get tested and then I'd probably be out for two weeks if I had tested positive.

Despite her best efforts to protect her husband and two children, both Blima and her husband were sickened by the coronavirus.

It's a private house. So it was a safe area. My husband would pass me a garbage bag. I'd put everything in there and he passed me a towel and I'd walk straight to the shower, so I

wouldn't let my kids come near me. My four-year-old would run at me to hug me, and I would just shrink back. And my husband had to take him away from me, you know, like those kinds of practices. But I didn't sleep in his bed. I did sleep in a separate bed. I just didn't think it would be smart. I didn't let him kiss me. I said, "Just not smart." You know? So we took some precautions that felt reasonable to us. And I still caught coronavirus.

In contrast, Lily pointed out that she felt safer at work than going to Walmart, "because, I think, people didn't really take it seriously in other places, but at work we did." Jessica credited her experiences with other epidemics with helping her feel safe going to work.

I did feel safe, because . . . the good thing about working for 40 years is that every 10 years or so, we've had some crisis to deal with. And in the beginning of the COVID pandemic, I don't think anybody knew, really, the extent of how bad it was going to be. . . . years ago, I remember the AIDS crisis, when it started . . . you use the techniques that we've learned to protect ourselves, right from, you know, Nursing 101. How to wash your hands and use gloves and protect yourself in that way. So, every 10 years. We've had Ebola. We've had SARS. We've had Zika virus not too long ago, where people just really freaked out, until they knew a little bit more and the research was done and they learned how to protect themselves.

'Like nothing you could ever imagine'

20 By far, the period when nurses witnessed exactly how deadly COVID-19 could be occurred in late March and stretched into April. Hospitals in New York City and the surrounding counties experienced what the nurses referred to as "the surge." The fact that large numbers of staff were out due to illness meant that some hospitals were short staffed during this time. Nurses were shifted around the hospital in order to care for COVID-19 patients. Students, military, and travel nurses (from other parts of the country) also helped tremendously. The nurses learned not to take anything for granted. Patients who presented with mild symptoms could decline quickly. Even nurses, like Jessica, who had years of experience recounted how overwhelming it was.

We were not prepared for the amount of people that came in at the same time, I think. . . . That's what was pretty incredible and the big difference between what happened with AIDS and what happened with the COVID virus. We just had so many people all at once, rapidly deteriorate. Just the numbers that died so fast, it was pretty incredible to see. And how many codes, which is a rapid response to attending somebody that is deteriorating in the hospital. They announced overhead, you know, a code, and the code team comes and helps out and helps do resuscitation. And it was just rapid fire, one after another. You'd hear it overhead, and you're like, 'Oh, my goodness, another code, another code.' It was just multiple ones in a shift. And we had where the supervisors were becoming ill. Half the staff was out ill. The doctors were out ill. Everybody got sick as the numbers increased in patients coming in.

She recalled one particular evening when “I had 12 codes in the 12-hour shift. And it was just going from one floor to the next, helping out the staff, stabilizing the patient, or they died, and then just moved on to the next one and another hour. And it was just . . . it was surreal. I can't even explain how it was.” Tara also recounted how stunning the death toll was in her hospital,

It was just . . . it was like, you could, you just had to kind of accept that, no matter what you did for these patients, they were probably going to die anyway. At least as an ICU nurse, it's not the same on other floors. But as an ICU nurse, you get the patients that are on ventilators, because those patients end up in the ICU, they don't end up on the other floors. So, those are the most unstable patients, and they were just so unbelievably sick that you . . . even in their 30s and 40s, you could do nothing for them. You would do everything that you could, but . . . you could see it from a mile away, when the patient would be dead within three days.

The rapid decline in patients was surreal and heart-wrenching for many. Knowing that patients were dying alone, without family to comfort them, was difficult to watch. Through these interviews, even as people openly spoke with us, it became clear that many had witnessed and experienced trauma. Almost everyone used metaphors of war (“It was like a war zone”) to describe what they saw and experienced. But as Jessica said, “We take an oath when we become a health professional to treat everybody as best as we can.”

Conclusion—Pandemic and Protest

21 We conducted these interviews in the midst and immediate aftermath of another important national and international moment. On May 26, the murder of George Floyd, a Black man arrested by four police officers was recorded by distraught bystanders in Minneapolis, Minnesota. A crowd witnessing Officer Derek Chauvin kneel on Floyd's neck for eight minutes and forty-six seconds begged for Floyd's life. Within two days, the viral video had been viewed over three million times. The United States erupted in protests against police brutality, and these protests quickly spread internationally. “Black Lives Matter” and “End Police Brutality” placards were held by marchers in New York, São Paulo, London, Cape Town, and Tokyo.

22 Floyd's death and the rage expressed by protesters highlighted other racial inequities, including the large numbers of impoverished Black, Latinx and Indigenous people whose deaths from COVID-19 were exacerbated by health conditions related to racial disparities. Many of the nurses we interviewed were well aware of these disparities, through observing who entered their hospitals and who died. What the protesters were likely less aware of was that a disproportionate

number of nurses of color died of COVID-19 in New York (“In Memoriam: Fallen NYSNA Nurses”).

23 For some of the nurses we interviewed, both the #BlackLivesMatter protests and protests to open the U.S. economy after almost three months of COVID-19 lockdowns raised concerns that another wave of infection could result from large crowds participating in demonstrations. If this happens, or if, as anticipated, virus surges occur in other states, how well prepared will the CDC, federal government, state and local health officials, and hospitals be? As Kelley aptly put it, “If there is a second wave, it would be unforgivable to make the same mistakes.”

24 Meredith Turshen argued almost 40 years ago, “bacteria and viruses may occur spontaneously in nature, but there is nothing natural or spontaneous about epidemics” (Turshen, 15). Turshen’s argument is that the response to epidemics, the political will that is in place to address them, the efficient mobilization of resources, the willingness to address health inequities, and clear communication about the progress of disease, all play a role in determining whether the outbreak of a viral illness will be controlled—or disastrous. What more does this mean in a pandemic, especially for nurses?

25 What do nurses really sign up for as they fulfill their oath to take care of every patient who enters the doors of their hospital? The nurses interviewed here consistently demonstrated their skill, knowledge, commitment to patient care, advocacy, and compassion. But did the CDC, federal and state officials, and hospital administrations consistently do the same? We cannot help wondering if part of the dismissal of nurses’ concerns is related to the fact that nursing is a mostly female profession, employing significant numbers of women of color. The nurses we interviewed did not sign up for: having their safety or that of their families disregarded, having to follow inconsistent and nonsensical rules, the chaos that reigned at times, and guidelines suggesting that a bandana was acceptable PPE for a virus as potent as COVID-19. A global pandemic coupled with inconsistent leadership from government officials is more than any dedicated group of professionals can or should have to address. A historical watershed means that nothing is ever the same after that particular moment. There is no “return to normal.” If the United States has reached a watershed moment as a result of the COVID-19 pandemic, we hope that the voices of the nurses featured here will be heard, respected, understood, and deeply appreciated.

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COVID-19 and Trans Healthcare:

Yes, Global Pandemics are (also) a Trans Rights Issue

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Abstract

Trans healthcare and thus trans people have been severely affected by the COVID-19 pandemic. Trans people's healthcare situations have turned out to be so vulnerable in this crisis because they have been precarious to begin with. There are multiple ways in which trans healthcare has been affected: Surgeries and other procedures have been cancelled or postponed, and mental health services have been paused or moved online. This raises ethical questions around discrimination against trans people in the healthcare system. This article argues that cancelling trans surgeries and procedures in the COVID-19 crisis is made possible through an understanding of trans healthcare as non-essential. The article explores how trans healthcare in particular has been affected by the pandemic.

1 In many nations worldwide, the current COVID-19 pandemic has placed an additional burden on trans healthcare. Trans people constitute one of the demographics that is significantly affected by the pandemic. Many trans healthcare services have been cancelled or halted, and it is unclear if or when they will be accessible again. For example, gender-affirming surgeries have been halted so hospital beds can be saved for COVID-19 patients, hormones might not be available in some places due to shortages in production, consultation with psychiatrists or therapists might be on hold, and consultation with new patients for hormone replacement therapy (HRT) might be postponed. When certain medical procedures are getting re-classified as non-necessary, the effects of the pandemic are already larger than what is immediately obvious. This article will explore trans healthcare as one of the many ethical challenges the COVID-19 pandemic presents.

2 There are many trans rights issues when it comes to the COVID-19 crisis, for example: rights for trans sex workers who have lost their income, rights for homeless trans people, rights for trans people who do not have matching documents and are more likely to be confronted by police for being on the street, rights for trans people who need to stay home in unsafe environments, and legal recognition of trans people (this very basic right is currently under attack in Hungary: this is

a result of how the pandemic is enabling governments to rapidly change policy).¹ These are all important topics that must be properly addressed. The focus in this article, however, is on trans healthcare and the social and moral rights of trans people regarding trans healthcare in the COVID-19 crisis. Exploring the effects of the crisis on trans healthcare in an academic article can help to shed light on the situation for trans people in this crisis. Knowledge around trans people's realities is often marginalized. It is important to acknowledge that gender has an influence on people's lived realities in order to understand the overall impact of situations like the COVID-19 crisis.

3 This article explores the ways in which trans healthcare has been affected by the COVID-19 pandemic and analyzes how the pandemic highlights flaws in trans healthcare that have been present long before the crisis. The article especially takes issue with the re-classification of trans surgeries and procedures as non-necessary and argues that this re-classification is based on the idea that trans surgeries are mere aesthetic surgeries that are not essential.

What's the Issue with Trans Healthcare During the Covid-19 Pandemic?

4 Trans people often already find themselves in precarious healthcare situations (Appenroth and do Mar Castro Varela, 2019). This includes being denied treatment or having to wait a long time for hormones or surgeries. Trans people also have to provide several proofs of identity in order to be able to receive treatment, and they have to undergo several (psychological and physical) examinations before starting hormones or before getting surgeries.

5 Trans people are often met with reluctance when they seek medical or healthcare treatment of any kind. This reluctance can include transphobic attitudes or denial of treatment (Bauer et al. 2009, Bradford et al. 2013, Beemyn & Rankin 2011). The degree to which this is the case depends, for one, on how familiar the doctor and medical staff they are seeking treatment from are with trans people. Trans people are less likely to go to the doctor when they are sick since doctors' offices and institutions of the health care system in general are spaces where trans people face discrimination and lack of knowledge on a regular basis (Bauer et al. 2009; Bauer et al. 2014; Bradford et al. 2013; Sperber et al. 2005).

1 Novak, Benjamin. "Hungary Outlaws Changing Gender on Documents After Birth." New York Times, May 28, 2020, www.nytimes.com/2020/05/28/world/europe/hungary-transgender-law.html, Accessed: June 09, 2020.

6 The degree to which this describes the lived reality of many trans people differs depending on the country or region or city one lives in. In Germany, for example, trans people who transition medically need to provide proof of their trans identity at various stages into medical transition. In order to undergo HRT, for example, the trans person in question is typically required to have a letter from their therapist or psychiatrist confirming their being trans. This does not describe a legal requirement, however. It reflects the practice doctors make use of when being confronted with the wish of a trans person for medical transition (DGfS 2019).

7 A consequence worth mentioning that follows from what has been described so far is that trans people are more likely to be discriminated against by medical staff and in hospitals in general, and thus also in the case that they are infected with COVID-19. This discriminatory treatment disproportionately affects BIPOC trans people.² The disproportionality is not restricted to trans people, of course. However, Black trans people are more likely to have already existing and often untreated health conditions (Smedley et al. 2003, Xavier et al. 2005). This is the case since Black trans people might have been avoiding medical care due to experiences of discrimination (Smedley et al. 2003, Xavier et al., 2005, Cicero et al. 2019, Salerno et al. 2019). A study by Kattari et al. (2015) found that Black trans people and trans People of Color experience higher rates of discrimination in healthcare. They found “high rates of discrimination against transgender/GNC individuals when they are trying to access doctors and hospitals, emergency rooms, and ambulances/EMTs, with significantly higher rates of discrimination experienced by those individuals who are also people of color” (74). Black people might also have been financially unable to seek medical care due to being in precarious economic situations and due to other factors like unclear insurance coverage, regional variation in care, and even quality of care within the same institution.³

Background of Trans Discrimination in Healthcare

8 Historically, trans healthcare is built on a pathologizing understanding of trans identities (Sauer & Nieder, 2019). The ICD-11 (International Statistical Classification of Diseases and

2 Cineas, Fabiola. “Covid-19 is disproportionately taking Black lives.” *Vox*, April 8, 2020, www.vox.com/identities/2020/4/7/21211849/coronavirus-black-americans, Accessed: May 13, 2020.

3 Badgett, Lee M.V. et al. “LGBT Poverty in the United States. A study of differences between sexual orientation and gender identity groups.” October 2019, williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf. Accessed May 10, 2020.

Related Health Problems, 11th revision) is the first to hold a fairly de-pathologized account of what it means to be transgender. The ICD-11 speaks of gender incongruence but does not classify being transgender to be a disorder any longer (World Health Organization 2018). Furthermore, it does not understand being transgender as a rigorous transition from female to male or male to female but includes more flexibility and includes non-binary identities explicitly. The ICD-11 was passed in 2018 but will probably not be in legally binding effect before 2022. Before the ICD-11 will be considered legally binding, the ICD-10 remains in place. Before the ICD-11, trans individuals have been and continue to be pathologized under the label “transsexualism” (ICD-10) and further labels that all belong to the ICD-10 category of “gender identity disorders” (World Health Organization 2004). That is, to be transgender has been considered to be a (mental) disorder. Thus, to be transgender has been highly pathologized.

9 On the basis of the conceptualization of trans people as people suffering from a disorder, medical practices have emerged that have led to gatekeeping and to further pathologizing trans people. These practices can look as simple as interrogations or comments from a medical professional that a trans person goes to in order to receive hormones, but they might also be as complex as interfering with a relationship between a therapist and their patient that has been helpful to the patient and non-discriminatory up until the patient came out as trans.

10 Trans persons are often asked by cis persons to explain why using the new pronouns and new name is so important and to explain other things related to being trans. Asking these questions is based on cis privileges; the practice of asking such questions is cis-normative. As Serano notes,

There is a straight line that connects inadvertent pronoun slips, [...]and trans people who are beaten, even murdered, while their assailants claim that they are somehow victims of the trans person’s “deception.” These acts may differ greatly in their severity, but they all communicate the exact same message: that trans people’s gender identities, expressions, and sex embodiments are not deserving of the same rights or respect that are regularly extended to our cisgender counterparts. (2009, 4)

That is, in contrast to the cis-normative conviction, the questions mentioned are anything but value-free. They are permeated by values and normative signals that are projected onto the trans person being asked. Questions and statements of this type are instruments of discrimination. Structurally institutionalized cis-normativity is also commonly referred to as cisgenderism or cissexism, both of which terms inhabit the idea that cis-normativity can be discriminatory:

cissexism – forms of sexism that construe trans people’s gender identities and expressions as less legitimate than those of cis people (those who are not trans). Cissexism—or as some

describe it, transphobia – can be seen in how individuals, organizations, and governments often refuse to respect trans people’s lived experiences in our identified genders/sexes; in the discrimination we may face in employment or medical settings; and in how trans people are often targeted for harassment and violence. (Serano 2013, 45)

11 The obstacles in trans healthcare are part of a system that repeatedly fails trans people, since these obstacles contribute to denying trans persons their personhood by way of rejecting their knowledge about their own personhood. Bettcher calls this basic denial of authenticity, which she further classifies as a kind of transphobia (Bettcher 2006). She defines basic denial of authenticity as “the kind of transphobia whereby trans people are viewed contrary to our own self-identifications” (Bettcher 2006, 204).

Physical Health: Cancellation of Surgeries and Other Procedures

12 On March 12th 2020, the German government declared that surgeries that are not necessary or urgent should be postponed indefinitely.⁴ This was not a decision specific to Germany. Rather, surgeries were declared unnecessary and to be postponed in many nations worldwide.⁵ By (re-) categorizing some surgeries as unnecessary, governments hoped that hospitals could prepare for the expected increasing demand for intensive care and ventilation capacities for the treatment of patients with severe cases of COVID-19. That is, surgeries that are not considered ‘necessary’ or ‘urgent’ are halted for the time being and postponed to an unknown date.

13 These rulings affect trans people since this includes smaller and bigger gender-affirming surgeries (e.g., hair removal, mastectomy, genital reassignment surgeries). These are processes and surgeries with long lead times. The application process alone for top surgeries in Germany, for example, can range from two to six months. In addition, in order to be eligible for trans

4 “Sozialkontakte vermeiden, Ausbreitung verlangsamen” [“Avoid Social Contacts, Slow the Spread.”], Die Bundesregierung, March 12, 2020, www.bundesregierung.de/breg-de/themen/coronavirus/mpk-1730186, Accessed: June 11, 2020. “Hunderttausende Operationen wegen Corona verschoben” [“Hundreds of Thousands of Surgeries postponed due to Corona.”], MDR aktuell, May 16, 2020, www.mdr.de/nachrichten/politik/regional/corona-hunderttausende-verschobene-operationen-100.html, Accessed: June 11, 2020. LSVD, “Corona und Lesben, Schwule, Bisexuelle, Trans- und Intergeschlechtliche Menschen. Wie sich Covid19 auf das Leben von LSBTI auswirkt.” [“Corona and Lesbians, Gays, Transgender, and Intersex People. How Covid19 affects the lives of LGBTI.”], www.lsvd.de/de/ct/2067-Corona-und-Lesben-Schwule-Bisexuelle-trans-und-intergeschlechtliche-Menschen, Accessed: June 11, 2020.

5 “Tens of millions of surgeries are being postponed as a result of the pandemic.”, The Economist, May 18, 2020. www.economist.com/graphic-detail/2020/05/18/tens-of-millions-of-surgeries-are-being-postponed-as-a-result-of-the-pandemic. Accessed: June 11, 2020.

surgeries, one typically needs proof of at least 1.5 years of therapy and six months of hormone replacement therapy (HRT). That is, needing to wait two years for a gender-affirming surgery is not an exception (Deutsche Gesellschaft fuer Sexualforschung (DGfS) 2019). Surgeons who perform those surgeries are rare and usually have long waiting lists as well. All of these requirements and factors make a fast proceeding in trans healthcare impossible. Trans people typically have to wait a long time to get the treatment they need. Now, in times of COVID-19, things look even more difficult.

14 For a trans person taking hormones or undergoing surgery, these procedures are experienced as necessary in the most literal sense. The decision to take hormones or undergo surgeries is based on a need. For many trans people, these are life-saving procedures (Bailey et al. 2014). For most, hormones and surgeries are life-altering and can greatly reduce gender dysphoria (WPATH, Murad et al. 2010).⁶ Green (2004) makes clear that when trans people undergo surgeries, “the purpose, usually, is to facilitate our being perceived socially by others as the men or women we know ourselves to be, even though we may acquire or retain physical differences from other men or women in the process” (90). Being perceived as the gender one is can be an essential step in reducing gender dysphoria and can help in navigating social contacts.

15 Trans surgeries are not comparable to aesthetic or cosmetic surgeries that are pursued in order to move closer to an aesthetic ideal. Trans surgeries are not based on a wish for solely aesthetic change. In any case, the analogy would not undermine the claim that trans surgeries are necessary. Those who conceive of trans surgeries as aesthetic should bear in mind that some aesthetic surgeries are necessary for well-being. Trans surgeries, like reconstructive surgeries, are necessary for some trans people for coping with social environments that can be otherwise hostile and threatening. Trans surgeries and other medical processes are needed for those who pursue them as these surgeries can be of help for a trans person moving around in a cis-normative world. That is, oftentimes trans people feel a strong need to ‘pass’ – i.e., to be perceived as the gender they are or as the gender they want to be perceived as.⁷

⁶ “Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).” (WPATH, 5)

⁷ The suggestion here is not that being trans means wanting to be perceived as a certain gender. However, this can be part of someone’s trans experience. For example, some non-binary folks want to be perceived as male or female rather than „queer/ non-binary / other“ when they move around in the world – this might be due to a need for safety or due to the need to move around without being stared at or noticed.

16 Passing can be of high importance to trans people since it protects them from being the recipient of violence. As an AFAB trans person, one might pass as a woman before or without hormones (and surgeries), and with hormones (and surgeries) one might pass as a man.⁸ The risk of direct violence is mitigated for some people when they pass. This is often especially important for trans women since they are the most vulnerable to and affected by transphobic violence. When someone is suspected to be a trans woman, rather than a cis woman, they are at a greater risk of being attacked (Bettcher 2007, Stoljar 2018, Turner et al. 2009).⁹

17 The felt need for trans surgeries is not simply a matter of navigating the social world. As noted, trans surgeries can also help alleviate gender dysphoria or body dysmorphia and thus might ultimately lead to an improvement of associated mental health issues (such as depression and anxiety). Depression is a life-threatening condition, and rates of self-harm are alarmingly high in the trans community (Marshall 2016). Trans surgeries are not about achieving to have an aesthetically pleasing body in the cis-normative sense. This understanding of trans surgeries needs to be changed: trans bodies – even after surgery – will typically not manage to comply to cis-normative ideas of beauty. Rather, trans surgeries are mostly about trying to have a (comfortable) body at all. Green (2004) notes, “Most of us are not seeking perfection when measured against external stereotypes; rather, most of us are seeking an internal sense of comfort when measured against our own sense of ourselves” (90). When deemed unnecessary and not urgent, trans surgeries are equated with all aesthetic or cosmetic procedures. That equation itself can be harmful because it perpetuates transphobic attitudes and failures of understanding.

18 One might ask, why is it ethically questionable that trans surgeries are being postponed? The world is facing a pandemic and hospital beds need to be kept free. It is unlikely you will hear a trans person say they are angry at COVID-19 patients for taking up space. It is likely however, that you will hear trans people complaining, being angry, being depressed and devastated about their surgeries being postponed, and rightly so. These postponements can be indefinite, with no guarantees about alternate dates. That itself can be a source of psychological hardship and it can be perceived as a societal failure to take trans-identities seriously. This article does not suggest

8 AFAB: assigned female at birth

9 See for example: Human Rights Campaign. “Addressing Anti-Transgender Violence. Exploring Realities, Challenges and Solutions for Policymakers and Community Advocates.” 2015, www.assets2.hrc.org/files/assets/resources/HRC-AntiTransgenderViolence-0519.pdf, Accessed: May 13, 2020.

that trans surgeries are more important than saving the lives of COVID-19 patients. Instead, it looks at how these medical ethical choices of prioritization have specific impacts on trans people. The assumption that gender-affirming surgeries are much like aesthetic surgeries and thus are not necessary is a misconception. Trans people undergo surgeries because they wish to do so, yes. But their wish is based on a need that is life-altering, and often life-saving (Bränström and Pachankis 2019, Baily et al. 2014, Bauer et al. 2015). Those who classify trans surgeries as aesthetic need to conceive of them as more analogous to reconstructive aesthetic surgeries than to cosmetic procedures that are considered to be based on a wish to move closer to an aesthetic ideal. The intention here is not to weigh different kinds of aesthetic surgeries against each another *per se* but only in the face of a pandemic that forces prioritization upon hospitals. Like reconstructive surgeries, trans surgeries can be regarded as essential.

19 Skeptics should also know that there are no good alternatives to surgery for many trans people: AFAB folks often wear binders (a chest-flattening garment) so that their chests appear flat. Binders make it difficult to breathe and to move, sweating is greatly enhanced in summer, it is even difficult to put them on and take them off, and back problems from long-term wear might follow. Binders also have more detrimental long-term effects: if worn incorrectly, the chest tissue can deform to such an extent that top surgery with good results becomes impossible. However big the discomfort and risks that come with wearing a binder, many AFAB trans people nevertheless do it because they feel a strong need to present that way.

20 On a broader scale, there is evidence that health outcomes during the pandemic have gotten significantly worse; a United Kingdom study has shown a dramatic spike in mortality, only a quarter of which is linked to COVID-19 (Denaxas et al. 2020). This is likely be due to the pandemic having a negative effect on healthcare and its accessibility in general. Thus it is important to face the fact that measures taken to contain the virus are having a wider impact, especially when important medical procedures get reclassified as non-necessary.

21 Stating that trans surgeries are not necessary falls in line with the historical placement of being trans as a pathology but also with the assumption that being trans is a choice. The assumption that being trans is a choice and therefore one can choose to seek medical transition is often held and made by people who are seemingly liberal towards trans folks. Bettcher warns about the assumption that trans people choose to be trans:

A natural question one might ask is why trans people transition. One of the things to observe, however, is that this question is probably already problematic. One might worry that such a question reflects a bias analogous to the question “What causes homosexuality?”—a question that seems to presuppose that heterosexuality is not in need of explanation. [...] If we understand it merely as a conscious self-identification of oneself or as the belief that one is a man or a woman, then it turns out that it cannot be used as a complete explanation of trans gender discontent. (Bettcher 2017, 128)

22 The wrongdoing does not begin with writing off trans surgeries when hospital beds are needed for a pandemic crisis, the wrongdoing begins at a much more basic level, which concerns the foundations of the healthcare system. In Germany, for example, when surgeries that are not considered ‘necessary’ have been written off, it was immediately obvious that gender-affirming surgeries would fall into this category. They have not been recognized as necessary from the start.

23 If the healthcare systems worldwide were prepared for a pandemic, there would be no need to write off surgeries that might not seem necessary on the surface but that are necessary in order for the respective human being to continue living their life.

Mental Health Care

24 As noted, the COVID-19 pandemic does not only affect physical or medicinal trans healthcare, it also affects mental healthcare for trans people. Trans mental healthcare includes not only approved therapists and psychiatrists but also community centers, organizations, and meeting points providing an infrastructure for trans people. Because mental healthcare is harder for trans people to access than for cis people, mutual aid and community spaces serve as a form of mental healthcare that is more essential to trans people than people who have easier access to other forms of mental healthcare.

25 Having a functioning infrastructure is not only important for society as a whole, but especially for marginalized groups who cannot rely on society at large providing them with a safe space to exist. As trans community centers are forced to shut down during the COVID-19 crisis, the infrastructure and the community many trans people rely on are lost. Trans organizations and community services that offer trans consultations can only offer digital consultations for the time being. Thus, there is no place left to go other than public spaces: i.e., spaces where trans people experience discrimination and harassment on a daily basis. Public places that are trans-friendly are extremely important for maintaining psychological well-being for trans people since they can

provide a space to feel seen without being stared at, a space free from judgment, a space to explore oneself.

26 A further issue is the added social isolation many marginalized people, including trans people, face in times of this pandemic crisis. Groups that are already affected by marginalization are subject to the restrictions and possible dangers to a greater extent. Social isolation is likely to result from the closing of community centers, bars, cafés, any hang-out spots. Trans people are at a higher risk of having mental health issues like depression or anxiety, and thus ultimately at a higher risk of suicide (Bailey et al. 2014, Bauer et al. 2015). None of this means that trans people are inherently more likely to have depression or anxiety, however. Rather, it is important to acknowledge that the structural and everyday discrimination and violence trans people have to face contribute to and perhaps even constitute the development of depression, anxiety, and suicidal ideation. Isolation during COVID-19 can have a deleterious effect on mental health issues, and, for trans people, that means both a loss of community support and reduced access to trans healthcare, which may compound the impact of lockdowns and exacerbate already existing mental health challenges.

27 There are also fears about the community falling apart. Group meetings and events are an important part of many trans people's everyday lives. Often, these community gatherings provide a space of safety and stability that many trans people do not otherwise have access to (due to having been abandoned by blood family for being trans, due to constant exposure to transphobia, or due to complications in the transitioning process).

28 In addition to organizations and community centers having to close their doors, i.e. important infrastructure for trans people disappearing, a lot of therapists and counsellors have switched to online sessions instead of in-person settings or even have paused therapy altogether. Some counsellors, therapists, and people working for community centers are affected by having to take care of their children at home, which further restricts the time they can dedicate to counselling work. Appointments with psychiatrists and psychologists are not only necessary for mental healthcare for trans people but also necessary to qualify for surgeries or gender marker and name changes in official documents. Transitioning socially and medically goes hand in hand with a lot of discrimination, and thus creates further therapy needs. Already before the COVID-19 crisis it has been difficult to find a competent therapist as a trans person. Many therapists are not familiar with LGBTIQ* issues; getting into the wrong hands as a trans person might well mean that they

will not be able to receive HRT, undergo surgeries, or change documents. Being taken seriously as a trans person and not being questioned constantly can result in better mental health. Bailey et al. (2014) have looked at suicide risk in the UK trans population, for example, and found that access to transitioning and surgeries and a supportive environment decrease the risk of suicidal ideation and suicide attempts in trans people. A supportive environment for social transition and timely access to gender reassignment, for those who needed it, emerged as key protective factors (Bailey et al. 2014).

29 Some mental healthcare is still available via online services. However, this crisis also shows how access to the digital community is different at different intersections of identities. Younger trans folks who are digitally skilled and economically stable enough to afford a smartphone or another device with internet access might experience less of a sense of community loss than older trans folks who are not digitally skilled and poor trans people who cannot afford a device to access the internet. There are also trans people who do not have safe private living spaces; for example, trans people who live with their family of origin which is not supportive. For them, having to do virtual therapy sessions in a shared home environment is just not safe or realistic. Access to free wi-fi has also been dramatically reduced with the closure of cafés, libraries, and other public places. There are many trans people who do not have access to digital services due to economic instability, homelessness, or other reasons. These disparities become all the more obvious in the COVID-19 pandemic, where the possibility to rely on digital services provides us with a replacement for the physical infrastructures that have been lost.

Conclusion

30 The COVID-19 pandemic highlights inequalities at different levels and intersections. The pandemic has placed an additional burden on trans healthcare and thus helped shed light on how trans people are affected by the pandemic. This is vital to understanding social inequalities and to understanding that social inequalities tend to get even more emphasized in times of crisis.

31 A lot of trans healthcare services have discontinued during this crisis. As discussed, this raises ethical questions around prioritization of and discrimination against trans people in the healthcare system. This paper has explored how the re-classification of trans surgeries and procedures as non-necessary during the pandemic is based on an understanding of trans healthcare as not essential.

32 Removing barriers in healthcare for trans people before the pandemic would have led to trans people being less affected by the COVID-19 pandemic on a physical and mental level. In addition, removing barriers in healthcare for trans people would possibly have allowed the healthcare system to respond to the effects of the pandemic on trans healthcare in a more reasonable and flexible way.

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**Close Encounters of an Intimate Kind:
Gender and Performance during COVID-19**

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Abstract

Intimacy Directors International was founded in 2016 as an organization that targets the artistic direction of intimate scenes (such as sex scenes or romantic scenes) in theatre, film and television. Partially prompted by the #Metoo movement, the intimacy direction effort is an acknowledgement of the sexual harassment and interpersonal discomfort that many performers (largely women) experience in the entertainment industry. The directing approach that is advocated by this group, and other newly formed groups with similar purposes, is one that looks at intimate scene-work much like stage combat or stunt work, where the movements are choreographed in order to prevent harm. There are also frequent check-ins so that the actors feel allowed to voice any anxiety or desire to change or stop what is happening. With COVID-19 bringing performance (particularly live theatre performance) to a halt indefinitely, the effects on performers' careers are substantial. I focus on the consequences to the intimacy direction movement which already targets gender differently, given the inequity faced by most women in these industries. The Intimacy Directors International organization, according to their website, officially dissolved as of March 15, 2020. While they note that their mission—to *initiate* the intimacy direction industry—has been accomplished, I will explore how the dissolution of such a supportive and large part of the movement might affect performance as it regains its place in society, particularly for those most negatively affected by the negligent and predatory practices that brought about the need for intimacy direction in the first place.

1 The #MeToo movement has made it abundantly clear, if it were not already, that women have a disproportionate level of experience of being victimized. In particular, recent years have seen and heard women in the theatre, media and film industries step up to voice their realities of sexual exploitation (Whyte, “The Media’s #MeToo Problems”). Several groups and individuals have made it a mission to support victims of sexual harassment and abuse, and the movement has fueled more awareness as well as funding to be directed toward their coffers (Noveck, “Groups Fighting”). One movement that specifically takes on the hardships faced by performance artists is intimacy direction. Intimacy direction cuts to the heart of the issue many performers (of all genders, but most heavily women) face—that of the pressure to expose their bodies and engage in intimate acts without complaint or resistance. Directors in these industries pressure female performers into exploitative situations explicitly and implicitly. Explicitly, there are sexual advances made toward female performers by fellow actors as well as directors themselves, with the caveat that *if* they do this *then* they will be able to keep their job, or indeed get more job offers

in the future. Implicitly, directors can and sometimes do take advantage of the entertainment industries being saturated with female performers, which creates the unspoken reminder that if they do not comply with the directions given, they are easily replaceable. Intimacy director Claire Warden explains how this treatment “strips actors of their basic human rights and the agency over their body” (“Intimacy Direction” 00:5:41-5:50). Directors have sustained this unfortunate environment both consciously and unconsciously.

2 Intimacy direction is a movement intended to target intimate, sometimes sexual, scenes in real time and to construct rules to follow to make sure consent and comfort are primary goals. Even in the best of times, this effort is a difficult one, swimming against the forceful tide of how it has always been done. When asked what the reasons are behind poorly performed or directed intimacy scenes, Warden explains that “it’s not been allowed the structure and the consideration that every other part of a play [or film] is” (“Intimacy Direction” 00:3:21-27). So much energy is put into exact details of blocking, comic timing, theatrical entrances and pacing, but when it comes to a stage kiss or simulating sex, often directors have resorted to a limited direction to the actors of “go for it” (“Intimacy Direction” 00:4:01-07). Another hindrance is the practice of viewing intimacy coordinators skeptically, assuming they will take over or behave as censors to the work (“Intimacy Direction” 00:7:31-8:02). However, as many have learned and as I will show, the intimacy direction effort is an acknowledgement of the sexual harassment and interpersonal discomfort that many performers (largely women) experience in the entertainment industry, and it has been serving performers quite well. In a 2018 article in *The Washington Post*, intimacy consultant Emily Sucher explains the need behind coordinating and choreographing all intimacy on stage—even something as seemingly simple as a kiss, stating that clear boundaries must be set with actors (Catlin, “Meet the Theatre Specialists...”). Now more than ever, when we face the drastic effects of a global pandemic, it is important to highlight and build up such a well-meaning movement, lest it suffers from inadequate support when society reopens.

3 COVID-19 continues to dissect our lives in specific and debilitating ways. Hardships range, but as is often the case in times of crisis, gender is a prominent dividing factor. Financial and emotional hardships have been shown to be exponentially higher in women than in men in the transition to being homebound¹ (González Laya & Linde, “Gender Equality”). This is not

¹ These hardships tend to be felt even more for transgender and non-binary genders than for cis-women, but this is beyond the scope of this article.

surprising, given that women typically hold fewer of the higher-ranking positions that come with extra protections against job loss (Medland “Today’s Gender Reality”). In addition, while current literature on marriage, parenthood and children is now including more references to the gender discrepancy regarding women doing more of the housework and child rearing in families, this has not changed the fact that women are picking up more at home now than ever, when there is more at home than ever to be picked up.² These differences are not limited to workload. In particular, there has been a significant spike in women reporting abuse, largely due to the fact that victims are living with their abusers and unable to leave because of stay-at-home orders³ (Godin, “Victims of Domestic Violence”). Prior to the coronavirus outbreak, leaps were being made in response to the #MeToo movement that were helping these women.⁴ In the entertainment industry, including theatrical performance, a movement to help prevent a similar abuse of power charged onto the scene.

4 Intimacy Directors International was founded in 2016 as an organization that targets the artistic direction of intimate scenes (such as sex scenes or romantic scenes) in theatre, film and television. In the moment of an intimate scene, women performers can and have felt pressured to perform, regardless of their feelings, in order to retain their employment and not get a reputation for being hard to work with. They are taught that “‘no’ is a dangerous word” (“Intimacy Directing” 00:5:22-24). The directing approach that is advocated by IDI, and other newly formed groups with similar purposes, is one that looks at intimate scene-work much like stage combat, where the movements are strictly choreographed in order to prevent harm. There are frequent check-ins so that the actors feel allowed to voice any anxiety or desire to change or stop what is happening. Notably, SAG-AFTRA, the union for screen talent in the U.S. “announced its aim to standardize the practice of intimacy direction for all union projects” (Ates 6). With COVID-19 bringing performance (particularly live theatre performance) to a halt indefinitely, the effects on performers’ careers are substantial. I focus on the consequences to the intimacy direction

2 On top of the gendered disparity noted regarding housework and child rearing (Germano, “Women are Working”), COVID-19 and the ensuing lockdown measures have now extended mothers’ work to include homeschooling, home-nursing and extra sanitation measures on top of working from home.

3 It should be noted that there are men who are also abused by their male, female and non-binary partners, and that these men rarely come forward. This article does not include these men (or those who identify outside of the gender binary). The examples used here involve women victims to illustrate the binary discrepancy in sexual violence.

4 Some of these organizations include RAINN (Rape, Abuse and Incest National Network), National Domestic Abuse Hotline, GLBTQ Domestic Violence Project, Womenslaw.org, Take Back the Night Foundation, among others.

movement which already targets gender differently, given the inequity faced by most women in these industries.

5 The originating U.S. branch of the Intimacy Directors International (henceforth IDI) organization, according to their website, officially dissolved as of March 15, 2020. (“Thank You For Visiting”) In their dissolution message, they include that the IDI Apprenticeship Program (which trained intimacy directors and coordinators) is also ending. While they note that their mission—to *initiate* the intimacy direction industry—has been accomplished, it is useful to inquire how the dissolution of such a supportive and large part of the movement might affect performance (“Thank You For Visiting”). As the entertainment industry regains its place in society, those most negatively affected by the negligent and predatory practices that brought about the need for intimacy direction in the first place will likely still need such support.

6 Tonia Sina was the first to coin the term and position of Intimacy Coordinator in her 2006 graduate thesis entitled “Intimate Encounters: Staging Intimacy and Sensuality”. The timeline between this moment and 2016 when IDI was founded, moves to incorporate stage combat principles into the choreography of stage scenes that depict intimate moments. However, intimacy pioneers (and IDI co-founders) Tonia Sina, Alicia Rodis and Siobhan Richardson were working independently. Championing their cause individually was difficult. They longed to broaden the understanding of stage intimacy and the need for training in the practice of directing intimacy. Their goal in founding IDI was to make the intimacy director a known, recognizable role and to promote it as something legitimate and necessary. What evolved with the #MeToo movement was a mad rush to hire intimacy directors, and IDI struggled to keep up with demand (Percy). At that time, in 2016, there was no specific structure to getting certified other than applying to their apprenticeship program. In 2017, Theatrical Intimacy Education was founded by Chelsea Pace and Laura Rikard as a “consulting group specializing in researching, developing, and teaching best practices for staging theatrical intimacy” (“Mission”). Pace and Rikard also authored the formative book, *Staging Sex*, in an effort to “offer practical solutions and exercises, provide a system of establishing and discussing boundaries, and suggest efficient and effective language for staging intimacy and sexual violence” (Pace, back cover).

7 IDI founder Tonia Sina notes that the frequency of harassment and abuse is connected to a lack of structure, saying it was “because there were no rules that people were following,” going on to conclude that her goal was “to create a standard protocol” (Catlin, “Meet the Theatre

Specialists...”). This protocol is exemplified by the five pillars that IDI established in their training, which include context, communication, consent, choreography and closure (Morey, “The 5 Cs”). The first and quite critical element, context, concerns the storytelling, which Claire Warden stresses is one of the main functions of an intimacy coordinator—to ask “what is the story we are trying to tell with this moment of physical interaction?” because, as she goes on to say, “[t]here are a thousand stories in a handshake. And that’s just a handshake” (“Intimacy Direction” 00:2:00-11). It takes a great deal of training to understand and uncover the meaning behind intimate scenes and translate that into conscientious scene direction. Warden lists a few of the skills intimacy directors acquire in training: “We’re mental health first aid trained. We’re trained in anti-sexual harassment. We’re trained in diversity. We’re trained in sensitivity training. We’re trained in working with actors with trauma” (“Intimacy Direction” 00:2:46-58). IDI’s founders knew that much would be required of someone coordinating intimacy in performance. Early trainees have continued to build upon IDI’s mission.

8 Marie Percy, certified intimacy coordinator and choreographer from the University of Connecticut, attended the first choreographer’s intensive training that IDI offered in Urbana, IL in the summer of 2018. She describes the experience as a rigorous nine days, including 60+ hours of contact with her instructors, Tonia Sina and Claire Warden, among others (Percy). Percy’s university wanted to model an intimacy direction best practices document that Yale had created and she was consulted as someone with expertise since she has an extensive movement background and had already been doing similar work with actors in the department. The choreographer’s intensive was seen as the best way for her to get the training necessary to help her department and the students. In addition to the training sessions, she had an extensive application process which involved doing a mental health first aid course, multiple online trainings and in-depth research on the laws regarding sexual harassment (Percy). After this process, in early 2019, she was certified according to IDI’s specifications. The draw to be certified and practice intimacy direction was already strong for Percy from a practical, art-making standpoint, but through the training she “really found that the advocacy side of the work can’t be done in a vacuum” (Percy). She was empowered by the other, like-minded theatre artists in the room who all shared ideas about how best to approach the direction of intimate scenes.

9 One of the first to join the apprentice program, Percy has now taken further steps to continue the effort Sina, Rodis and Richardson started. After Percy was approached in early 2019

to run a workshop, her pedagogical skills were tapped when she, Alicia Rodis, and Jessica Steinrock founded Intimacy Directors and Coordinators (IDC) with the goal to create a comprehensive, extensive training and certification program. The program they developed has four levels. The first consists of introductory, three-day workshops focused on covering the basics.⁵ The second level is another series of three-day workshops on specific topics. The participant will be given a selection of special topics to choose from and they must choose at least three.⁶ The third level, which is only open to those who have completed the first two, is similar to the IDI choreographer's intensive where participants choreograph and receive feedback on specific intimate scenes, including hyper-exposure such as simulating sex. The final level consists of fieldwork. Candidates would submit a proposal for a final project to be performed in the real world. They would then be paired with a certified intimacy coordinator who would mentor them through the process. A final evaluation would then be administered by a group of certified intimacy coordinators, not including the mentor on the project (Percy). IDC launched its first, first-level workshop in February of 2020 and completely sold out. The participants met for this workshop from February 21-23, but then the subsequent workshops which were planned for this first group of participants were cancelled due to COVID-19 (Percy).

10 Starting March 12, 2020, Broadway theatres in New York City closed their doors due to the pandemic. Touts of theatres being the symbolism of New York's resilience, notwithstanding, the closure of so many theatres had a real and devastating effect on the many individuals working on Broadway. Hollywood has also taken a hit, having to reschedule filming and furlough behind-the-scenes workers indefinitely. Though everyone wishes to return to normal as soon as possible, the reality is that the new normal we come back to may look very different from before COVID-19. Perhaps masks will be handed out to theatre goers as they take their seats. Perhaps blocking will have to incorporate distancing actors six feet from one another, or film actors will be recorded on separate days. In a similar way, the practice of intimacy direction may look quite different than prior to quarantine. This is not to say that there will never be touching or intimacy on stage, but what will it mean to a performer and what will it look like? Though theatres and production companies are showing an increase in the use of intimacy directors and coordinators, there are

5 The basics, in this case, refer to the definition of intimacy direction, understanding consent, and what the central tenants and pillars are of this focus in training (building on IDI's framework). (Percy)

6 Some topics include performing intimacy, movement vocabulary, choreography basics in storytelling, etc. (Percy)

other significant statistics that show how much money these industries are losing while having to remain closed⁷ (Brzeski et al “Global Film Industry”). Once they reopen, it is not far-fetched to surmise that some artistic directors and producers might feel they cannot afford some services. And while the #MeToo movement still carries much weight, if given the choice between hiring someone to design the set or run the lights versus hiring an intimacy specialist, the financial strain may make such decisions moot. In many ways, the reopening of theatres will mimic the same type of job-surplus that has always plagued women in performance. In other words, the drive to get back to performing could easily affect the industry in the same way that the surfeit of women performers in a market with too few female roles affected them before the pandemic. With the possibility of fewer intimacy coordinators (since they have been unable to be trained during lockdown) and fewer acting jobs all around (due to the slow re-opening process) who will be there to protect the actress who is pressured to be intimate?

11 I write this article not to be definitive about our future but to remind audiences and my fellow performance artists that while a lot may change as we re-open theatres, our values should not. The same motivations behind protecting our performers need to remain strong or our industry will falter and people will get hurt. Intimacy direction is “about destroying the power dynamic that’s been set up which makes actors’ bodies the property of a director to do whatever they want [. . .] and to bring an equity to the room [. . .]” (“Intimacy Direction” 00:06:51-7:06). The director’s exclusive and ultimate power interrupts actors’ ability to speak up for themselves in the room (Pace 7). As Percy rightfully asserts, “[i]n no other job do we ask this type of intimacy from employees” without it being a crime (Percy). Having an advocate is essential to having the performers’ boundaries respected. The power dynamics have been abused in the past (both knowingly and unknowingly). After learning about an actor’s boundaries, the next question to be asked is “how do we adapt to make sure that the story is still told while both people are in full consent and agency over their bodies?” since “it’s about really tying it to the story and the impact of intimacy so that we build the world of intimate touch that is relevant” (“Intimacy Direction” 00:12:15-24; 00:17:18-30). It is important to note that what is considered relevant with respect to intimacy has been limited due to the avoidance of facing the issues at play and other constraining elements (such as

⁷ Not only statistics, but there have also been pleas to the public, asking for help to ease the financial hardships. (Wiegand “Buy Plays”)

the male gaze). Intimacy direction holds the key to unlocking new representation in intimacy performance and depicting broader stories that encompass more than just “cis, heterosexual, male-dominant power dynamic sex,” but instead telling stories about “all kinds of bodies and all genders and all orientations and all races and all kinds of people [who] have many, many different ways of being intimate and showing intimacy” (“Intimacy Direction 00:25:20-44).

12 The reality today is that for Hollywood or Broadway producers, hiring an intimacy coordinator is much cheaper than facing a sexual harassment lawsuit. This means that despite the setbacks stemming from the COVID-19 crisis, larger industry professionals will be willing and able to support the ongoing industry of intimacy specialization. In addition, other intimacy groups have been formed, such as Intimacy Directors and Coordinators, whose goal to help train and certify more directors to meet demand are lofty and attainable, once we are able to come together physically once again. Sadly, however, much in the same way that the pandemic has revealed the disparities in society regarding job loss and access to healthcare and insurance, it will likely also expose the socioeconomic factors that will hinder intimacy coordination continuing for less affluent theatre and film companies. In university theatre departments across the country, as well as in amateur and community theatres, women performers frequently outnumber men. This is also prevalent in film (Lang “Study Finds”). With the pressure right now to maintain employment and the continuing gender gap in pay compounded by income insecurity brought on by COVID-19, women will continue to feel the brunt of this much more (Elkins “Michelle Williams”).

13 The good news is that the groups which have been put on hold, such as IDC, are making every effort to meet the needs going forward. Percy’s team understands that “there’s a difference between best practice and available practice” and they want to create “resources for people who can’t afford best practice but would like to do the best they can” (Percy). Other groups such as Theatrical Intimacy Ed are currently offering online workshops and the demand is high.⁸ So while the situation is dire, perhaps the pandemic culture of offering services online will support the movement further and give people the skills they need to protect the most vulnerable. We all need to stay informed and ready to help all performers, especially women, who are all too familiar—

⁸ Currently, all Theatrical Intimacy Ed. online workshops are sold out.

intimately familiar—with the discomfort, shame and danger associated with how they’ve been directed in the past.⁹

⁹ A good resource for anyone exploring intimacy directing is Intimacy Directors & Coordinators’ website, where their motto is “Raise the bar. Eliminate harm.” (“Homepage”) This site has information on training, consultations as well as hiring intimacy directors.

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**The Shadow Pandemic in India:
'Staying Home' and The Safety of Women During Lockdown**
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Abstract

The unprecedented health crisis caused by COVID-19 has taken the world by storm. The only way deemed plausible to tackle the crisis in most countries was a policy of restricting mobility and of staying home. However, there are varied views on the merit of such a lockdown. In India the enforcement of 'staying home' also needs to be considered in light of the fact that about one-third of the households in the country have to accommodate 3-4 persons per room defying the requirement of social distancing. The situation of women during lockdown is particularly difficult, as their workload has increased, as has their exposure to violence and a denial of vital outside sources of support. The 'staying home' rule involves a myriad of issues differing according to the respective social environment. Middle-class women tend to be left with the additional burden of taking care of family members and home-schooling children without the support of helpers who have been released during lockdown. Women working in the informal sector are likely to be hit by a loss of their jobs, and as spouses of often equally jobless informal sector workers 'add to the burden' on the financial situation. Addressing the needs of women in times of lockdown is important as gender budgeting is widely known to impact positively on development planning.

1 The most vehemently propagated measure to contain the spread of COVID-19, is that of 'staying home'. However, being locked inside the house not only increases the chances of violence, but also cuts women off from any kind of support by people and resources assisting them. Violence against women is a major threat to global public health during emergencies (WHO). Globally, 18% of ever-partnered women and girls aged 15–49 have experienced physical and/or sexual violence at the hands of a current or former partner in the previous 12 months (UN Women). Intimate partner violence is the most common form. Globally, one in three women has faced physical and/or sexual violence, mostly by an intimate partner during her lifetime. In India, 31.1% ever-married women have been subjected to violence by intimate partner (IIPS and ORC).

2 In addition, the lockdown has triggered indescribable suffering for migrant women workers. During lockdown, these women have delivered babies, have tended to sick and disabled people, and have often fallen ill themselves. They are herded in spaces which rarely

allow personal hygiene to be practiced as per the WHO advisory for the pandemic. Given the scarcity of food and water supplies, following the WHO guidelines of using water and soap for frequent handwashing is impossible. Menstrual hygiene is affected particularly badly.

Women as frontline workers

3 Women’s attitudes and beliefs about health and illness affect their role as primary caretakers – both on an institutional and a domestic level. Their participation in disease management, control and prevention as professionals and as care-givers at home affects women’s access to health care services and information, and the ways in which they respond to disease and illness. Women face a considerable risk of exposure to COVID-19 due to their disproportionately high representation among health-care and social service personnel. “As front-line responders, health professionals, community volunteers, transport and logistics managers, scientists and more, women are making critical contributions to address the outbreak every day” (www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response). During the pandemic women are at increased risk of infection and loss of livelihood, have less access to sexual and reproductive health, and are exposed to a dramatic rise in domestic violence. Globally, around 70 per cent of health and social service workers are women. In India 38 per cent of all health workers are female. The male–female ratio of all health workers is 1.6, of doctors 5.1, and of nurses and midwives 0.2¹.

4 A gender-based approach to public health² helps to identify the ways in which health risks, experiences, treatments and outcomes are different for women and men, boys and girls, and to design and implement necessary interventions accordingly. The current pandemic foregrounds the necessity of a gender-based approach broadening an understanding of health problems of women of all ages and addresses fundamental social concerns.

5 It has been noted that violence against women tends to increase during times of emergency, including epidemics. Older women and women with disabilities are likely to have additional risks and needs. Due to socio-genic bias associated with violence against women, underreporting is common, and data are scarce. Reports from China, the United Kingdom, the

1 Anand, Sudhir and Victoria Fan (2016) “The health workforce in India - Human Resources for Health Observer Series No”. 16. World Health Organization. ISBN 978 92 4 151052 3 (www.who.int). WHO Press, World Health Organization, Geneva, Switzerland. www.who.int/hrh/resources/16058health_workforce_India.pdf

2 Bird CE, Rieker P. Gender and health: the effects of constrained choices and social policies. Cambridge: Cambridge University Press; 2008

United States, and other countries suggest a dramatic increase in domestic violence cases since the COVID-19 outbreak (Godin; Women's Aid UK). The number of cases of domestic violence reported to a police station in Jingzhou in Hubei Province in China, tripled in February 2020, compared to the previous year during the same period (Bethany Allen-Ebrahimian). Ironically, for victims of domestic violence, staying home for safety turns out to be most unsafe, as they are forced to live with their abusers. Staying home ensures exclusive access to the victim, as the latter is cut-off from all possible support (Natrajan). For many women, 'Stay Home, Stay Safe' does not apply, as 'safe' and 'home' are oppositional rather than synonymous terms (Shivakumar).

6 In India, the first signs of a 'shadow pandemic' became visible in the data provided by the National Commission of Women (NCW) in mid-April, which suggested an almost 100 percent increase in domestic violence during lockdown. In the course of 25 days between 23 March and 16 April the NCW received 587 complaints mainly through email and a WhatsApp number, of which 239 were related to domestic violence. This is almost double the number of complaints (123) received during the previous 25 days, from 27 February to 22 March (DoWCD). There has been a steep increase in crime against women across the country since the imposition of the pandemic-related restrictions (Fig 1) (Source- ncw.nic.in/ncw-cells/complaint-investigation-cell).

Regional Scenario in India

7 Taking note of the warning issued by the United Nations on the 'shadow pandemic' (Mlambo-Ngcuka) of physical and sexual violence against women and children, Tamil Nadu, a southern India state, sounded its police to randomly visit vulnerable localities and susceptible households during lockdown. About 25 calls related to domestic violence have been received every day by the TN police, besides calls made to the women's helpline. Most calls are related to alcohol abuse and fights about a lack of financial means, largely due to a lockdown-induced loss of job.

8 Since the enforcement of the lockdown, Tamil Nadu has witnessed a spike in the number of domestic violence and harassment cases. Until April 9, as many as 24 cases related to domestic violence were reported across the State and about six people have been arrested. It is noteworthy that the closing of liquor shops has caused withdrawal symptoms among those addicted, and as a consequence has led to a major increase in violence inflicted upon their

partners. Withdrawal symptoms have also led to the substitute consumption of varnish sanitizer or other chemicals, from which about 13 persons have died (Vijay Kumar).

9 However, in the initial period of lockdown, a downward trend in violence against women was visible due to systemic reasons. In Karnataka in India, for instance, the number of cases of domestic violence registered in 2019 was 2088. In about 50 days during 01 March to 22 April, 2020, the number of cases registered was 218 (DoWCD, GoK). Thus, in 2019 on average 5.9 cases were registered everyday as compared to about 4.1 during 01 March to 22 April, 2020. In Delhi too, the number of calls made to seek help for violence against women dropped from 8080 during 12-25 March to 337 during 7-20 April 2020 (DoWCD, GoNCToD). This decline in the number of registered cases in Karnataka and in the number of calls in Delhi reflects on two systemic issues. One, gearing of services and personnel towards COVID-19, for instance, deployment of the police to ensure 'curfew' and lockdown; and two, restrictions imposed on women under the lockdown. Thus, violence seems to be perpetrated due to spousal dominance, constant proximity induced conflict and suspicion.³ It was reported in early April that a 42-year-old man killed his wife, suspecting her of infidelity. This happened days after the family was quarantined in a temple in Dodderi in Karnataka, India, following the first nationwide lockdown by the government to contain the COVID-19 pandemic (*The Economic Times*). In Hyderabad, India, a woman experienced spousal violence because her husband could not get alcohol during lockdown. She had to reach out to the police, for help. She was provided with an official helpline number. But the intensity of the abuse increased when the husband came to know about her complaint (Joy). Similar experiences of women in India during lockdown abound and reveal the dark side of homes or private places which are supposedly most safe. Another reported incident involves a young woman who fled to her mother's place to escape spousal violence. As the lockdown announced on 25 March prolonged, her plight increased. The lockdown-induced loss of job of her brother, the only bread winner in her mother's household, rendered her unwelcome in the family as the economic stress increased, until she was beaten up by her brother because of her refusal to return to the husband (Shivakumar).

³ The state machinery was geared towards containing COVID-19. Helplines for gender based violence were diverted for COVID-19. Furthermore, police force, hospitals and health personnel were designated as COVID-19 care centres and personnel. Therefore, there was no or very few helplines for registering violence against women initially (roughly up until the first half of April). However, gradually the helplines were restored as the reported incidence of gender-based violence gained more media attention.

10 The system recognized this gap in services and started to respond. The Department of Women and Child Development ensured functional helplines. Karnataka, for instance, has established 193 *Santhawana*⁴ Centres to address domestic violence. Delhi, too has recorded more calls subsequently (DoW&CD, NCToD). Across states the police officials have been instructed to visit the camps where migrant workers have been housed to ensure that women are safe from exploitation and/or abuse. Police have also been collecting the details of female students residing in private hostels; and children staying at child-care centres. The possibilities of abuse are found to have increased in hostels and child care centres. In addition, children forced to stay at home with their perpetrators during lockdown are more vulnerable to abuse. (Vijaykumar).

11 The health impact of violence, particularly intimate partner and domestic violence, on women and children, is significant. Violence against women can result in serious physical injuries and mental health problems, as well as sexually transmitted infections like HIV, and unplanned pregnancies (Gupta). Access to sexual and reproductive health services for women subjected to violence, was limited as Mother and Child Health Care Centres remained closed until the second week of June 2020. All available pre- and postnatal care was suspended as all health care personnel was diverted to COVID-19. Consequently, victims of sexual abuse as well as those in need of reproductive health service were neglected and unable to find assistance. Staying alone in the house where there is discord and asymmetry in inter-personal relationship, probability of violence increased, as the connect with other was restricted due to ‘social distancing’. Therefore, reporting the violence became restricted as well as limited access to care post violence. “Health systems have an important role in ensuring that services for women who have experienced violence remain accessible during the COVID-19 outbreak” (COVID-19 and Violence Against Women).

Aggravated Risks of Violence Against Women

12 To contain the spread of the infection, lockdown has been embraced globally. But the flipside of this strategy for control is that this is utterly adverse with regard to women’s exposure to violence (Natu and Ganeshan Ram). Disruption of social and defensive networks, and decreased access to public services can intensify the risk of violence against women. As distancing measures are adopted and people are encouraged to stay at home, the risk of intimate

⁴ Means ‘consolation’. A kind of counseling and support Centre.

partner violence is expected to increase as family members spend more time in close contact. Moreover, family members have to cope with additional stress induced by this enforced proximity over a longer period of time. At the same time women tend to have less access to other family members and friends who may provide support and protection.

13 The COVID-19 lockdown is likely to be used by the perpetrators of abuse as a pretext to exert power and control over their partners and other women/girls in the family, to further reduce access to services, help, and psychosocial support from both formal and informal networks. Access to daily essentials such as soap, hand sanitizer, water even toilets, may be restricted. Additionally, control may be exerted by spreading misinformation about the disease and creating fear.

14 As ‘home makers’, women who do not engage in paid employment, bear the burden of domestic chores and increased care in case of an infected person in the family. School closures further worsen this burden and place more stress on women. Home schooling is a decisive addition to the manifold responsibilities of women. On top of everything else the lack of income due to the economic crisis in the wake of the pandemic is a prime stress-causing factor, forcing male family members to engage in indoor activities and leaving women and girls with little alternative but to ‘enjoy in the kitchen’ and complete all household chores in the absence of domestic help under lockdown conditions. All these factors increase the potential for conflict, which is already apparent under ‘normal’ conditions, as nearly a third of ever-married women experience spousal violence. In 2015-16, records show that 31.1 per cent of women experienced spousal violence, which signaled a small decrease in comparison to 37.2 per cent in 2005-06 (IIPS and ORC). The current crisis evolves as a backlash against this development. Accordingly, “the risks of violence that women and their children face during the current COVID-19 crisis cannot be ignored” (COVID-19 and Violence Against Women).

Women in the Informal Economy - Workers and Dependents

15 The unpreparedness for planning the response to COVID-19 through the total lockdown is clearly evident in the plight of the informal sector workers. With economic activity coming to a standstill, the informal sector workers were largely left jobless, homeless and hungry. Closing down the units where they worked deprived many of their livelihood opportunities and regular earnings. This has in turn led to their landlords ousting them from their homes anticipating their

inability to pay the rent. The closing of inter-state borders due to lockdown left many migrant workers in a dilemma, as they could neither stay in their adopted city nor leave it. Women, largely as accompanying spouse, but some as workers too, are bearing the brunt of the twofold predicament of a loss of work and the ‘guilt’ of being an additional mouth to feed. ‘COVID-19 poses a threat to women’s livelihoods as well as increases their burden at home’ (Guterres 7).

16 There are huge inequalities between women and men in terms of access to decent work and associated benefits such as health insurance, unemployment benefits and other forms of social protection. Out of the two billion workers in informal employment worldwide, just over 740 million are women (UN Women Gender equality matters in COVID-19). In non-agriculture sector, in India, the proportion of informal employment is much higher than in formal sector. Among all women employed in non-agriculture sector, 69.2 percent are in informal sector. Likewise, among all men employed in agriculture sector, 73.4 percent are in informal sector (NSS Report No. 557- 68/10/2). About 82 percent of the male and 83.6 percent of the female workers have no written job contract. About 23 percent of the males and 20.6 percent of the females (22.7 percent total) are eligible for paid leave, but only 19.8 percent males and 17.4 percent females have social security amounting to a total of 19.2 percent (MoL&E, GoI 16). Health insurance for the overall population is as low as 28.7 percent as evident from NFHS-4 data (IIPS and ORC 87). For the informal sector workers, therefore, it is bound to be lower. It is also important to note that the proportion of men and women working in informal sector enterprises has been declining for the past two decades, but the decline among women is much higher (more than 10 percentage points) than among men (less than three percentage points) as evident from NSSO report (Table 3).

| Population | 61 st Round (2004-2005) | 66 th Round (2009-10) | 68 th Round (2011-12) |
|------------|------------------------------------|----------------------------------|----------------------------------|
| Male | 76.7 | 71.5 | 73.4 |
| Female | 79.7 | 69.8 | 69.2 |
| Total | 77.5 | 71.1 | 72.4 |

Table 3: Informal Sector enterprises among workers engaged in AGEGC and non-agricultural sectors. NOTE: AGEGC and non-agriculture sectors: Industry groups/ divisions 014, 016, 017, 02-99 of NIC-2008 (NSS Report No. 557(Table 1.1, Page 7; 68/10/2)).

While women workers in the informal sector make up close to 70% (2011-12), the decline from 2004-05 suggests that more women than men are let go. This is corroborated by the declining labour force participation rate of women from 38.6 percent in 2004-05 to 32 percent in 2007-08 (Bhalla and Kaur 7). Thus, unemployment has been increasing among women. In the shrinking employment opportunities, men are prioritized for employment as compare to women.

Women in Regular Employment

17 As wage earners experience the disruption of livelihoods and a significantly decreased access to basic needs and services, stress on family members increases, adding to the potential of conflicts and domestic violence. With the third and the fourth spells of lockdown, depleting resources have put women at greater risk of abuse. Inadequate and unequal distribution of the supplies promised by the government, particularly with regard to migrant workers, has made women more vulnerable to violence. For those with caring responsibilities, the work burden has increased in manifold ways, especially if the men in the family abide by patriarchal standards. The often advertised so-called lockdown ‘leisure time’ (Lewis) is thus an unlikely promise in the case of women under these conditions. Rather, the current health crisis has augmented existing gender inequalities. Even if working from home may be easier within the white-collar job sector, it still adds to the workload of women who are expected to do the households chores in addition to working from home. Across the globe, “women’s independence has become a silent victim of the pandemic” (Lewis).

18 It is still generally the mother who has to help the youngsters to take the online class and do their homework online. What was propagated as time for ‘self’ when the lockdown was imposed, metamorphosed into a schedule to accommodate women’s own work, household chores and ‘homeschooling’ the children. Women employed in stores selling essential items in the malls are exposed to the unsafe environment of empty passages in otherwise deserted shopping areas and subjected to potential harassment by male coworkers.

Ancillaries of COVID-19 for Women

19 As a physical illness, COVID-19 appears to affect women slightly less severely (Sepkowitz). But the impact of the pandemic crisis spans out from public health to economy, snowballing to all other aspects of human life. After suspension of normal life for over a month,

job losses are inevitable, and migrant workers are now being sent back to their native places after having suffered humiliation, hunger, and homelessness during lockdown (Acharya). School closures and release of household help have moved child-care from paid economy (nurseries, play-schools, schools), to unpaid women at home. The pandemic cancelled the deal of a double career among middle-class working couples which had been enabled by hiring someone else to take care of their homes and children. Instead, couples now have to decide whether and how to share in child-care and household chores. Given our patriarchal mindset and family structures, the burden does rest largely on women. Therefore, it is imperative to acknowledge these factors and to take measures in response immediately, because ‘coronavirus lockdowns will one day end, but violence against women will not’ (Myersfeld).

20 Poverty amplifies the impact of the COVID-19 induced lockdown. Abiding by the assigned safety-guidelines is much more difficult for the poor who are dependent on daily wages to earn a square meal. While the prime ministerial address announcing the extension of the lockdown on 14 April, 2020, described hunger and misery as sacrifice by the ‘people who love their country’, there is no assurance that the same ‘sacrifice’ will be extracted from employers by enforcing regulations not to cut wages and/or dismiss employees from work. It is notable that the lockdown version 3.0 as well as 4.0 were not announced directly by the honourable Prime Minister like the earlier ones, particularly when relaxations were being announced, too.

21 The ‘protection’ of workers was illustrated by the Ministry of Labour of India which issued a government order on 20 March ensuring protection to workers engaging in small and medium enterprises (SMEs). Its implementation, however, remains to be seen. The poor are unable to stock-up daily essentials and cannot afford to stay home. Globally, more women live in poverty than men: 50 million women aged 25–34 compared to 40 million men of the same age. Globally 8.3 percent women and 7.8 percent men live in poverty. In India, 21.6 percent women and 18.9 percent men employed live below international poverty line (UN Women, 2020). Less than a quarter of women (24.6 percent) work for cash, 23.2 percent in urban and 25.4 percent in rural areas in 2015-16 (IIPS and ORCb), which declined from 57 percent in 1998-99 when 10 percent women reported to work for cash and kind, and 6.3 percent for kind only. Importantly, 27 percent were not paid for their work (IIPS and ORCa).

Gender sensitive response to COVID-19

21 The lockdown induced by COVID-19 has resulted in a large number of negative consequences for women. Violence against women, especially domestic violence, has increased as women are cut off from possible help which they could have accessed during ‘normal’ times. Staying at home has also increased women’s workload. They have to attend to household chores and to the needs of all the other family members who have to stay home too. The responsibilities span from providing food to health care, from care for the elderly and differently abled to the supervision of online classes of school children. All this comes in addition to professional work if women are still employed during lockdown. Those working in the informal sector are experiencing an even more dramatic disruption of their livelihood because of the loss of jobs, with the spouses of informal sector workers finding themselves as additional burden on the household economy. Since the activities of most health facilities and services have been diverted to address the pandemic, lockdown has further restricted access to sexual and reproductive health care. Similarly access to crisis centres, shelter homes, legal and protection services has been affected.

22 It is vital to acknowledge the gendered impact of the pandemic and to develop and support efforts to address this issue. Vulnerabilities of economically stressed women are accentuated by inadequate water, sanitation and hygiene facilities. The situation is additionally aggravated when the women or their spouses have been rendered jobless, and they and their family members need social, economic and emotional support.

I Data and empirical evidence

23 It is important that governments and policymakers include gender and its intersection with aspects of social identity in their considerations when collecting data about the pandemic, assessing the situation and preparing response. Collection and evaluation of specific data about gender and social identity are important and useful in planning support and access to resources.

II For Women in shelters

24 Shelter homes for women working in the informal sector need to be equipped with toilets and bathing spaces with stable water supply. There has to be a continuous reliable distribution of sanitary napkins for women and girls; adult diapers for elderly women; food for vulnerable

persons such as migrant laborers, and persons with disabilities; other daily supplies for children like biscuits, milk, baby food, fruits; and personal protective equipment such as masks, disinfectants and gloves. The provision of all of these items should be a mandatory responsibility of the government, especially in light of the funds collected under ‘PM cares’ and the already existing PM Relief Fund.

III For Women experiencing violence

25 The situation of women with violent partners under the same roof during lockdown has been completely ignored. The availability of functional helplines and access to support from relatives and friends is important. In the wake of distancing measures to be maintained during lockdown, the shelters are not able to accommodate ‘new’ entrants. Therefore, more space needs to be used for expanding shelter homes. Services, such as hotlines, crisis and counseling centers, legal aid and protection services also need to be scaled up, to enable the access to help which women in abusive relationships need. Therefore, governments need to include these measures in their COVID-19 response plans. Police should also continue to prioritize reports of domestic violence.

IV For Women who work

26 To alleviate women’s economic dependence on men, governments need to target individuals rather than households when implementing direct cash transfer and food supply. As working-age women, especially those married and with children, are less likely to have a job than men, their economic and social dependence has increased during the pandemic. Different state governments have announced monetary support of INR 500 to 10005, and are distributing food packets. Food Corporation of India (FCI) has promised to help 81 crore poor people to get food.⁶ But hunger still prevails among the informal workers and their dependents, especially

4 Financial Express (2020) Govt has committed all support to migrant workers during lockdown: Amit Shah. PTI. Updated: March 28, 2020 6:56:22 PM www.financialexpress.com/india-news/govt-has-committed-all-support-to-migrant-workers-during-lockdown-amit-shah/1912258/. Accessed on 11 May 2020. News18 (2020) Jharkhand Transfers Cash to Over 1 Lakh State's Migrant Workers Stranded Due to Virus Lockdown. PTI. Last Updated: April 25, 2020, 8:17 AM IST www.news18.com/news/india/jharkhand-transfers-cash-to-over-1-lakh-states-migrant-workers-stranded-due-to-virus-lockdown-2591891.html. Accessed on 11 May 2020

5 Gupta, Surojit (2020) Ensure migrants, poor don’t go hungry, Centre tells states, UTs. The Times of India. TNN | Apr 17, 2020, 03:36 AM IST timesofindia.indiatimes.com/india/ensure-migrants-poor-dont-go-hungry-centre-tells-states-uts/articleshowprint/75190770.cms. Accessed on 11 May 2020; Dreze, Jean (2020) Excess Stocks of Food Corporation of India. Indian Express Must be Released to the Poor| Updated: April 9, 2020 9:31:44am.

women and children. In the current COVID-19 situation hunger needs to be addressed first, keeping aside market and profit concerns.

Concluding remarks

27 Many of the attempts to address the current COVID-19 crisis emerge from a medical care perspective. However, the current pandemic is a multifaceted crisis. The myriad of issues and areas which are being affected, need to be addressed. Aspects of gender have to be taken into consideration, particularly with regard to what has happened or is happening to women as providers, as patients, as migrant workers, as students and the like. In this context the intersections of gender and social and economic status, religion, ethnicity etc. have to be considered.

28 It has been often stated that the lockdown period is an opportunity to spend time with family, read and write, and engage with passions and dreams. This engagement, however, is different for women and men, even in an average middle-class household. Men mostly manage to engage in the suggested ‘pastimes.’ Women, conversely, have additional work to do through the physical presence of other family members who would normally not be around all the time, and due to the absence of house-helpers who are released because of the lockdown. This adds to women’s burden of work, leaving very little or no time for other activities. The migrant women’s concerns are entirely different and largely focus on the procurement of food and personal safety. In the light of such a situation, it is imperative on the part of the government to provide income support, health care, food and safety for women. Irrespective of their work status – whether working in the informal sector with zero hour, or in regular employment, or as homemakers, women need a regular income, security and safety, and a conducive environment to access resources including helplines and legal support without prejudice and bias.

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Shakespeare and Queer Theory (2019) by Melissa E. Sanchez

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1 Melissa E. Sanchez' monograph, *Shakespeare and Queer Theory* (2019), published in the Arden Shakespeare Series, is situated at the intersection of Shakespeare and Early Modern Studies with Queer Theory, foregrounding how these fields "are not only valuable in themselves, but mutually useful and illuminating" (2) and "have a lot to contribute to that collective project" (55). The idea of the book is to present "queerness as a mode of critique" (Halberstam 2011: 110 in Sanchez 2019: 150), and to explore how "[q]ueer theory reveals the queer within the normal and the ordinary [. . .] [as well as] the normal and the ordinary within the queer" (7). In this sense, Sanchez follows the path of other contributors to the debate, such as Menon (2008; 2011), and Stanivukovic (2017). The book is directed at students and scholars alike and provides a comprehensive introduction to the central concepts, as well as the historical background and origins of the debate. Sanchez furthermore presents the mutual benefit of the intersection of Shakespeare and Queer Theory by supplying her own analyses of several of Shakespeare's works. Sanchez emphasises that "this book [is not offered] as the 'truth' . . . , but as one contribution to an ongoing, productively un-wieldy conversation" (2) and "will [hopefully] not be the last word on either topic, but in its very limitations will catalyse newer, stranger theoretical work and political worlds" (178).

2 Situating herself within the field of academic work on the intersection of Shakespeare and Queer Theory, Sanchez differentiates not only between queer and homosexual, like Menon (2011), but also between queerness and normativity, and extends these distinctions to issues beyond the sexual, as found in, for example, Anthony Guy (2016). Apart from taking up the discussion of aspects of sodomy and usury, as in Stanivukovic (2017), Sanchez additionally looks into aspects of religion, friendship, race, rhetoric, and empiricism. Sanchez shares Menon's (2008; 2011) approach of a re-evaluation of Queer Studies through an analysis of Elizabethan England. However, while Menon (2008; 2011) stresses the comparability of present and past in terms of Queer Studies, Sanchez highlights the differences in the reception of queer issues between Early Modern England and now. Moreover, in her analysis of current Shakespeare reception, Sanchez includes a new set of film adaptations. In sum, Sanchez presents a new approach to analysing the intersection between *Shakespeare and Queer Theory* by offering a self-reflexive 'queer' reading.

3 At the outset of the book Sanchez introduces her terminological uses, f.e. with regard to the difference between "heterosexual desire", "heterosexuality", and "heteronormativity" (7).

Sanchez equips the reader with basic tools to enter the debate around Queer Theory by prompting to read critically in the section “Caveat lector” (18-20), where she emphasises the importance of seeing the fields of Queer Theory and Shakespeare Studies “as recursive and multifaceted”, and her chapter organization as “a rough roadmap” rather than “an exhaustive” and “linear” story (19). In Chapter 1 Sanchez explains the “intellectual forces” and “key investments” (16) of Queer Theory, the difference between Queer Theory and Gay and Lesbian Studies, as well as the historical origins of Queer Theory. Chapter 2 presents the history of Queer Studies and Shakespeare with regard to concepts of homoerotic relations and their influence on “shaping” Early Modern society (16). Chapter 3 displays “forms of queerness that go beyond the gender of object choice” (16) and probes the difference between ‘queer’ and ‘normative’ and how to deconstruct, challenge, and rethink this distinction. In Chapter 4, Sanchez presents “queer readings” (17) of six of Shakespeare’s texts, looking at “[t]he limits of polymorphous perversity” in *A Midsummer Night’s Dream* and *Venus and Adonis* (112-20), “[t]he erotic life of racism” in *The Merchant of Venice* and *Othello* (121-30), as well as “history, memory and futurity” in *Henry V* and *Hamlet* (130-42). Chapter 5 examines queer film adaptations, looking at punk and camp in Derek Jarman’s *The Tempest* (1979), at the representation of the relation between past and present in Jarman’s *Edward II* (1991) and Gus Van Sant’s *My Own Private Idaho* (1991), as well as at conservative readings of Shakespeare with regard to Baz Luhrmann’s *William Shakespeare’s Romeo + Juliet* (1996) and Julie Taymor’s *Titus* (1999). The analyses Sanchez provides are very powerful in their comprehensive structuring, as well as their connection to Queer Theory.

4 Throughout the book, the benefit of intersecting Shakespeare and Queer Theory becomes increasingly evident, as “Shakespeare’s oeuvre” not only “depicts a distinctly queer assortment of desires and acts that do not correspond to modern taxonomies” (10), but Queer Theory also presents a new lens for reading Shakespeare by challenging “the normative” (40).

5 *Shakespeare and Queer Theory* is a comprehensive guide, or “rough roadmap” (19) as Sanchez terms it, for acquiring the basics of Queer Theory, and proves the fruitfulness of exploring intersections between Shakespeare and Queer Theory. It equips the reader with the necessary tools to enter the discourse around Shakespeare and Queer Theory, and teaches the importance of a critical reading. In contrast to other works on the intersection between Shakespeare and Queer Studies, Sanchez goes beyond reflection on the sources she analyses, as she productively foregrounds and fundamentally applies “queerness as a mode of critique” (Halberstam 2011: 110 in Sanchez 2019: 150) to her own text.

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