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TECHNICAL REPORT

COVID-19 and the situation of female health workers in Argentina

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Table of Contents

1. Introduction[1]

The implications of the pandemic once again show the way women are assuming the greatest risk, which is associated with their duties on the front line of health and social care. The main labour sectors in charge of handling this virus are highly feminized. Women are performing roles that often expose them to risk their lives and health, while carrying a greater physical and emotional burden due to extended and strenuous workdays, away from the family (UN Women; IDLO; UNDP; UNODC; Pathfinders for Peaceful, 2020).

In Argentina, women make up 70 per cent of the population employed in the health sector, which represents 9.8 per cent of employed women in the country. Despite being the majority in nearly all occupations of the health sector, the percentage of women is significantly higher in technical occupations (nurses, midwives, etc.), in administrative professions and in cleaning and cooking services. Conversely, the large majority of men in the sector either are engaged in professional occupations (doctors, pharmacists, etc.), or they are the heads of services.

This segmentation explains the significant gender wage gap that still persists in the sector, as well as the greater incidence of informality among women. In Latin America, the income of women who work in the health sector is 25 per cent lower than that of men in the same sector (UN Women, 2020). This leads to a notable difference between women and men in terms of access to labour rights, such as sick leave or employment injury or health insurance. In comparison with their male colleagues, on average female health workers work more additional hours, they are more vulnerable to violence at work, they are more exposed to agents that could be infected and they have less access to personal protective equipment for performing their job (MPyT; SRT, 2019).

On the other hand, the pandemic caused by COVID-19 has shed light on the capacity and the strength of health systems in the majority of the countries, as well as their preparedness to health emergencies. The rapid spread of infections associated with the coronavirus emphasizes the urgent need to count on a stable and solid labour force in the health sector, as a fundamental pillar of an effective and strong health care system.

1 The authors would like to thank the comments and suggestions of Ximena Mazorra and Daniel Contartese (Ministry of Labour, Employment and Social Security); of Paola Ayala (Argentina Health Workers Association, ATSA); and of Emanuela Pozzan, Umberto Cattaneo, Christiane Wiskow and Maren Hopfe (ILO, Geneva). Likewise, the Pan American Health Organization/World Health Organization (PAHO/WHO) provided technical cooperation for drafting this publication. The views and opinions expressed herein are solely those of the authors and do not necessarily represent those of the PAHO/WHO.

In turn, the pandemic has caused the closure of schools and other places providing carework, thus increasing the time families are engaged in non-remunerated housework, which has historically fallen on women. This condition is even more alarming if we consider that a very high proportion of female health workers are heads of households with children and adolescents.

Despite the important job they perform everyday, female health workers are still not valued as they would deserve, neither within the health sector nor in society as a whole. Moreover, there exist no public policies that comprehensively deal with their situation and they are often excluded from decision processes. In spite of being the backbone of the healthcare system, female health workers of Argentina find themselves in a highly vulnerable condition in terms of their health, and their social and economic well-being.

In the context of the health emergency declared by the United Nations, this report provides an analysis of the effects of the COVID-19 crisis on the situation of female health workers in Argentina and it highlights the reasons underneath their increased vulnerability in the current crisis. Subsequently, the document analyses the measures implemented in Argentina and it proposes recommendations and good practices to design a comprehensive policy in support of female health workers in this emergency.

2. Female health workers in Argentina

According to the latest National Survey of Workers on Employment, Work, Health and Safety Conditions (ECETSS),[2] in Argentina there are nearly 760,000 female health workers.3 This labour force represents 70 per cent of employment in the sector and 9.8 per cent of employed women. By comparison, the health sector only employs 3.6 per cent of employed men.

The majority of female health workers are within the range of 35 to 44 years of age. While there is a majority of women in the sector in all age brackets, this percentage increases in the oldest age groups. This occurs because in these age groups there is a predominance of professionals of occupations such as auxiliaries, caregivers, etc., in which womens' over-representation is even greater (Figure 1, Panel A).

The sector is characterised by a labour force with educational levels considerably above average. This characteristic can be observed also within women employed in the sector. In fact, 62 per cent of female health workers hold a degree in higher education (tertiary, university or postgraduate), against a level of less than 30 per cent among female workers in other sectors (Figure 1, Panel B).

A very high proportion of female health workers are heads of household (48 per cent, versus 41 per cent for all other female workers), with 53.8 per cent also taking care of minors under the age of 18 years. In this latter group, 28.7 per cent have children under the age of 5 years (Figure 1, Panels C and D). This situation reflects the dual care load faced by female health workers, who combine their remunerated care work with non-remunerated care, often in single-parent households and with young children. Specifically, every day female health workers perform almost one more hour of non-remunerated domestic work in comparison with their male colleagues (Figure 1, Panel F). While the gap is lower than the levels observed in the rest of the sectors, it is significant if we consider the long workdays that characterize the health sector (Figure 3).

The fact that such a high percentage of female workers are economically in charge of households with the presence of young children adds additional vulnerability that is not always accompanied by high income. While female health workers

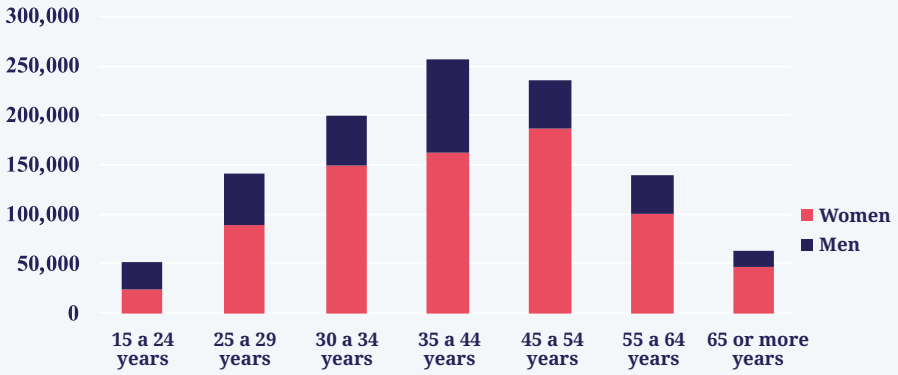
2 The ECETSS was conducted during the second half of 2018 (MPyT; SRT, 2019). Even though the Permanent Household Survey (EPH) offers more recent data about the volume of female health workers, the ECETSS is used because it contains more detailed information about working conditions. For more information about the ECETSS, consult the following web page:
https://www.argentina.gob.ar/srt/observatorio-srt/encuestas-salud-trabajo/ECETSS-2018

3 This category includes activities related to care for human health, social assistance activities related to health care and social services without lodging.

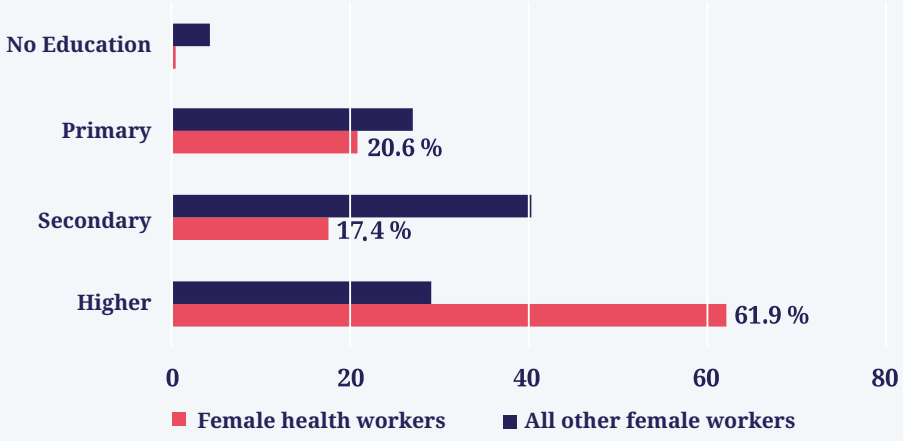
have higher average incomes than all other female wage earners, over half of female health workers (53.9 per cent) live in households in which the monthly income is less than 30,000 Argentine pesos (ARS) (Figure 1, Panel E). Considering this low income and the time burden detailed below (Figure 3), many female health workers must resort to family networks to provide care for their children.

Figure 1 . Socio-demographic characteristics of female health workers in Argentina

▶ Panel A - **Sex and age**

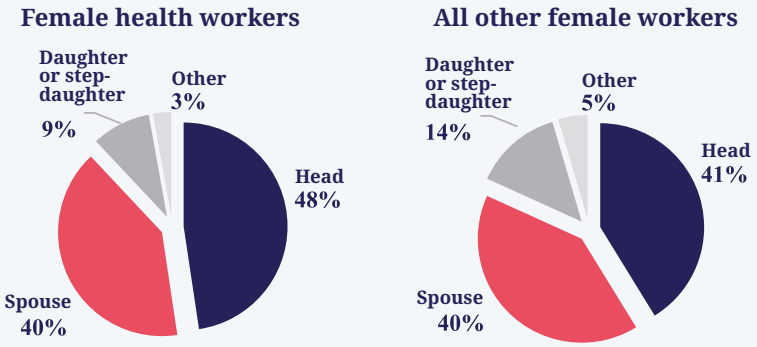


▶ Panel B - **Complete level of education**

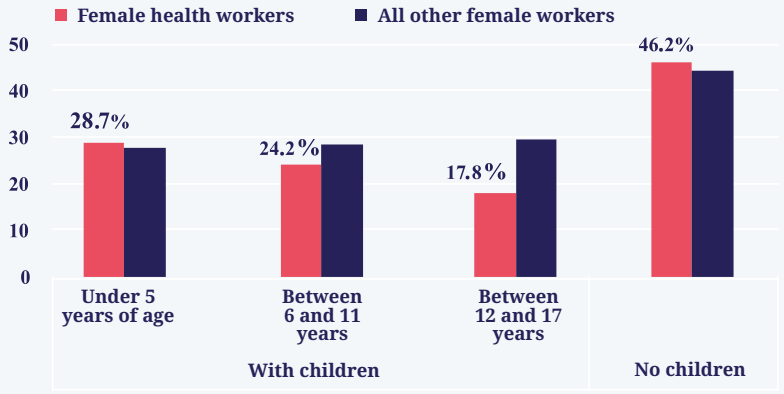


▶ **Source:** Own preparation based on the ECETSS - 2018.

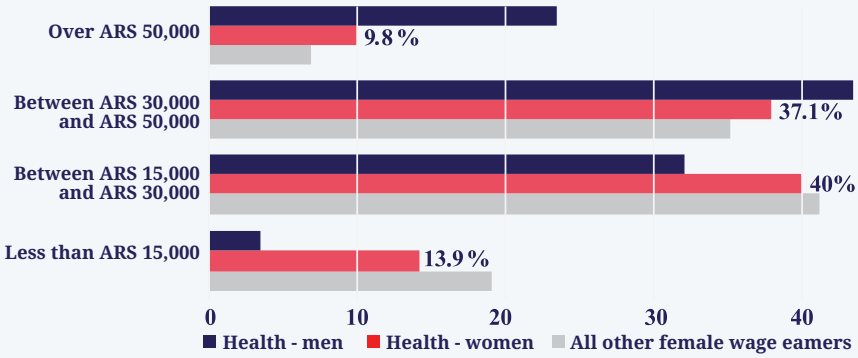
▶ Panel C -
Function in the household



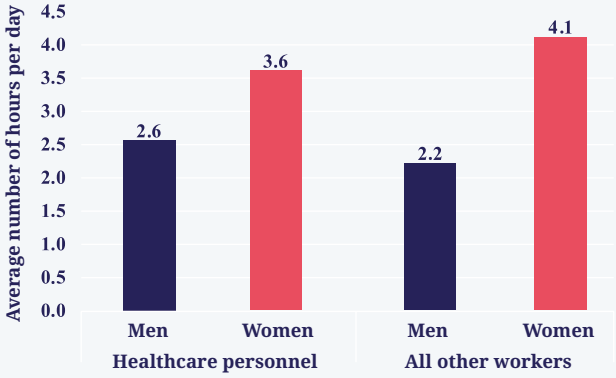
▶ Panel D -
Presence of children in the household



▶ Panel E -
Household income



▶ Panel F -
Non-remunerated domestic work



3. Labour conditions of female health workers in Argentina

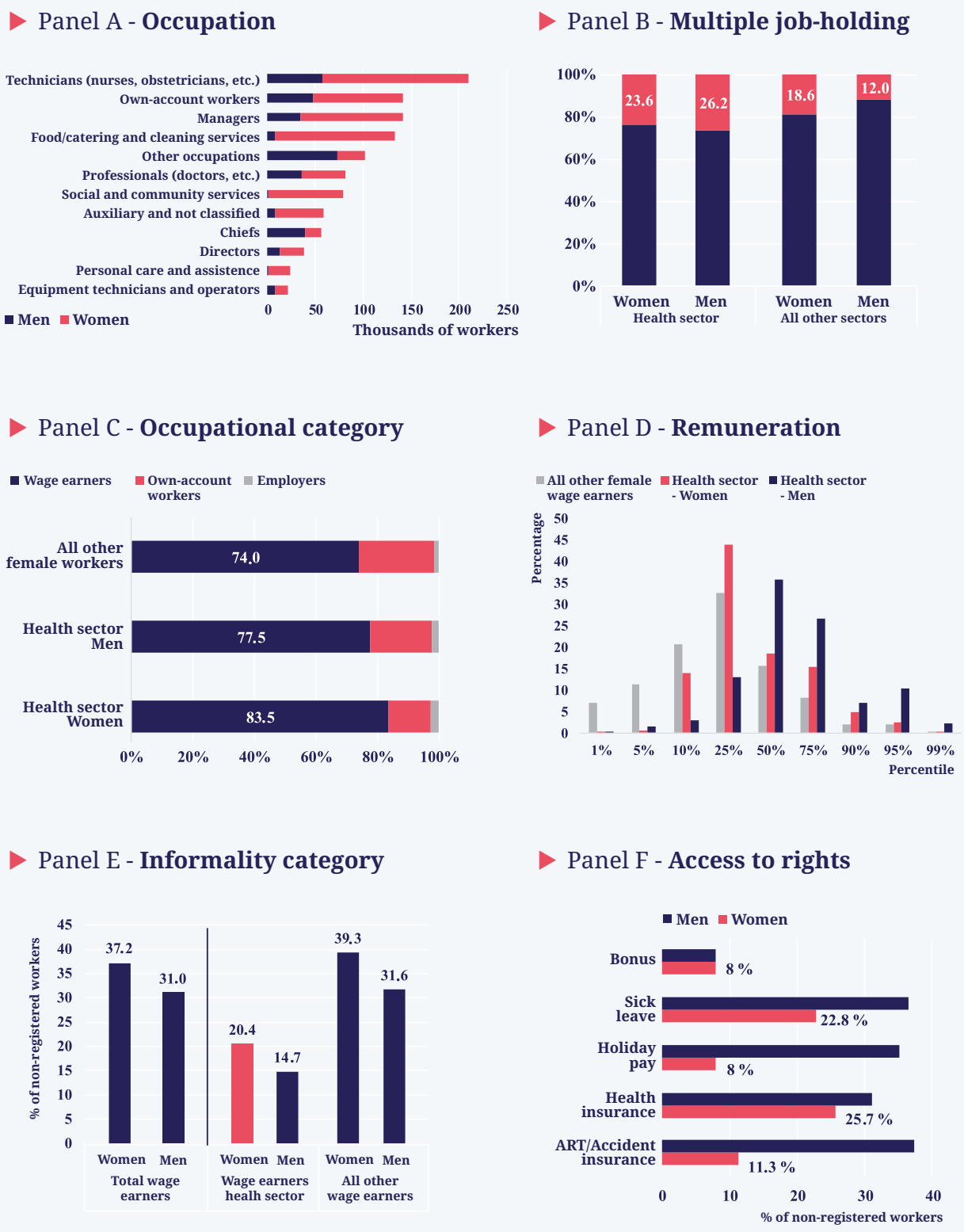
In Argentina, women represent the majority in almost all occupations of the health sector. This segmentation observed among women in the sector is not observed for men, whose occupational structure within the sector is considerably more uniform. The vast majority of men are engaged in professional occupations (doctors, for example), or they are heads of services. On the other hand, the volume and percentage of women is greater in occupations such as nursing, obstetrics and in management professions, as well as in cleaning and cooking services (Figure 2, Panel A).

This composition can also explain the greater percentage of employees among women (83.5 per cent) in comparison with their male colleagues (77.5 per cent) (Figure 2, Panel C). In fact, professions of the health sector that can be exercised as self-employed person are normally those linked to professional occupations (medicine, psychology, etc.).

There are major differences in the working conditions among the various occupations, consequently translating into major gender differences if we consider the varying representation of women and men in each one of the health sector's professions. For example, the wages of female health workers are significantly lower than those received by males in the sector. While the majority of women are at the 25th percentile in the distribution of monthly labour income, males are mainly at 50 per cent of the distribution (Figure 2, Panel D). Moreover, the biggest gaps are located at the highest levels of qualification, thereby showing the greater presence of men in the hierarchical structures associated with higher remuneration.

The segmentation within the sector also translates into the fact that 20.4 per cent of the sector's female workers are informal workers, while only 14.7 per cent of men who are occupied in the sector have informal jobs (Figure 2, Panel E). This greater incidence of informality means less access to essential protection mechanisms within the context of the current pandemic. Specifically, non-registered female health workers have very inadequate coverage of their rights, such as protection against employment injury or illness insurance (11.3 per cent), health insurance (25.7 per cent) and sick leave (22.8 per cent). Access to these rights is considerably less than in the case of non-registered men (Figure 2, Panel F). For instance, in the access to the ART employment injury insurance, the gap between informal women and men workers reaches 26 percentage points.

Figure 2 . Labour characteristics of female health workers in Argentina



Source: Own preparation based on the ECETSS - 2018.

With respect to working conditions, there exist particular aspects that make female health workers more exposed to the risk of infection, stress and other labour risks, that could be exacerbated within the context of the current health crisis.

For example, on average female health workers dedicate more time to commuting to and from work than all other female workers. To a greater extent, they commute by public transport (over 10 percentage points more), and they are more likely to commute under bad conditions (Figure 3, Panel A). These commuting times and conditions are especially important, considering that they are instances when people face the possible risk of coronavirus infection.

One of the main hazards besetting healthcare personnel during this pandemic is the major increase in the workload, in addition to working an excessive number of hours over long workdays. Along this line, it is important to keep in mind that, while female health workers work overtime to a greater extent in comparison with their male colleagues (a gap of over 10 percentage points), the difference in the percentage who receive remuneration for these extra hours is not as big (Figure 3, Panel B). This gap in working hours is also observed if the total number of hours is considered, meaning the sum of the hours absorbed by the main job and by all other occupations. This is important if we consider the major incidence of multiple job-holding in the sector. In the health sector, 23.6 per cent of female workers and 26.2 of male health workers hold more than one job, while this percentage drops to 15 per cent in the case of all other workers (Figure 2, Panel B).

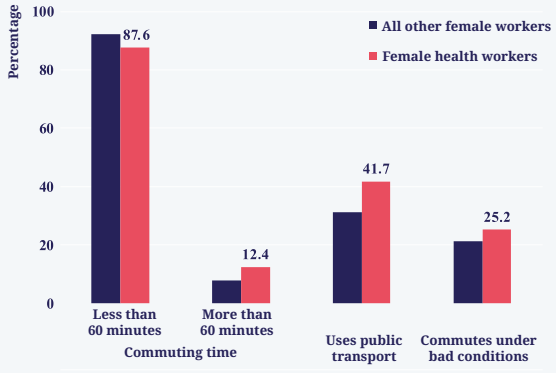
Furthermore, given the possible risk of infection faced by healthcare personnel in the current pandemic, it is important to keep in mind that, even under normal conditions, female health workers are more exposed to agents that could be infected. In 2018, 55 per cent of female workers declared that at least sometimes they handled or were in contact with materials or people that could be infected, while this percentage dropped to 47 per cent in the case of male workers in the sector (Figure 3, Panel C). This difference is explained by the greater presence of women in occupations of the health sector that are on the front line of care, such as nurses, nursing auxiliaries, technicians, gerontology aides, etc.

Despite the greater exposure to the risk of infection, only 40.2 per cent of female health workers are provided with the necessary personal protective equipment to perform their jobs, versus 57.1 per cent of men (Figure 3, Panel D). Given this information from 2018, it begs the question of whether this trend is continuing within the current context of contending with the pandemic, thereby leading to the consequent negative impact on women in the sector.

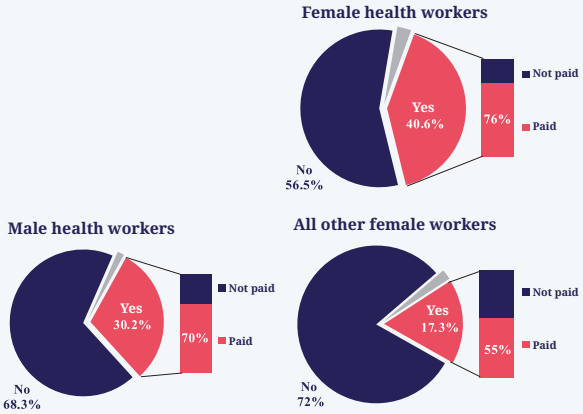
Finally, another aspect related to the working conditions in the sector that must be considered is the greater prevalence of episodes of workplace violence and harassment. Due to the characteristics of the activity performed by healthcare personnel, the majority are all exposed to situations of aggression or harassment – especially by patients, clients, etc. – in comparison with all other workers (Figure 3, Panel E). This phenomenon is observed in Argentina and is common to the majority of countries, where higher levels of violence are recorded for health workers. For example, the health sector occupied the top position in the European Union with respect to exposure to violence and harassment (ILO, 2019). In Argentina, the risk is significantly higher among women than among men (Figure 3, Panel E). Within this context of a pandemic, female health workers are exposed to multiple forms of violence: at their workplace, on the street and even in their homes due to the stigmatization and the non-supportive reactions of neighbours based on the fear of becoming infected (UN Women, 2020).

Figure 3. Labour conditions of female health workers in Argentina

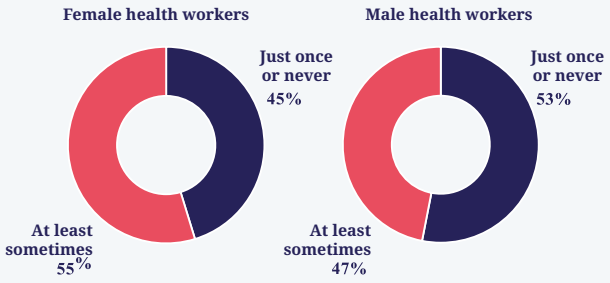
Panel A - **Commuting to and from work**



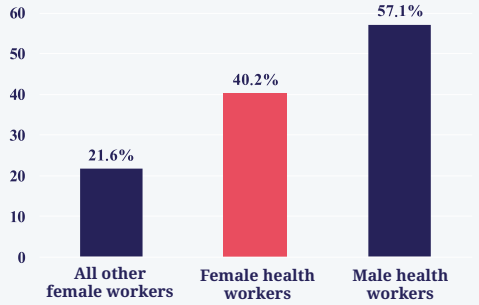
Panel B - **Overtime hours**



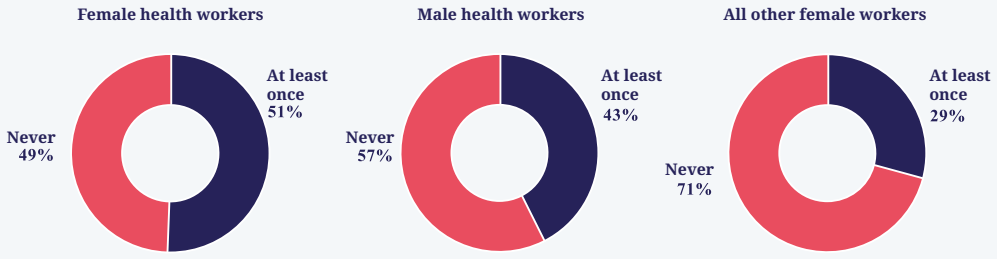
Panel C - **Exposure to materials or people that could be infected**



Panel D - **Availability of protective elements**



Panel C - **Episodes of workplace violence and harassment***



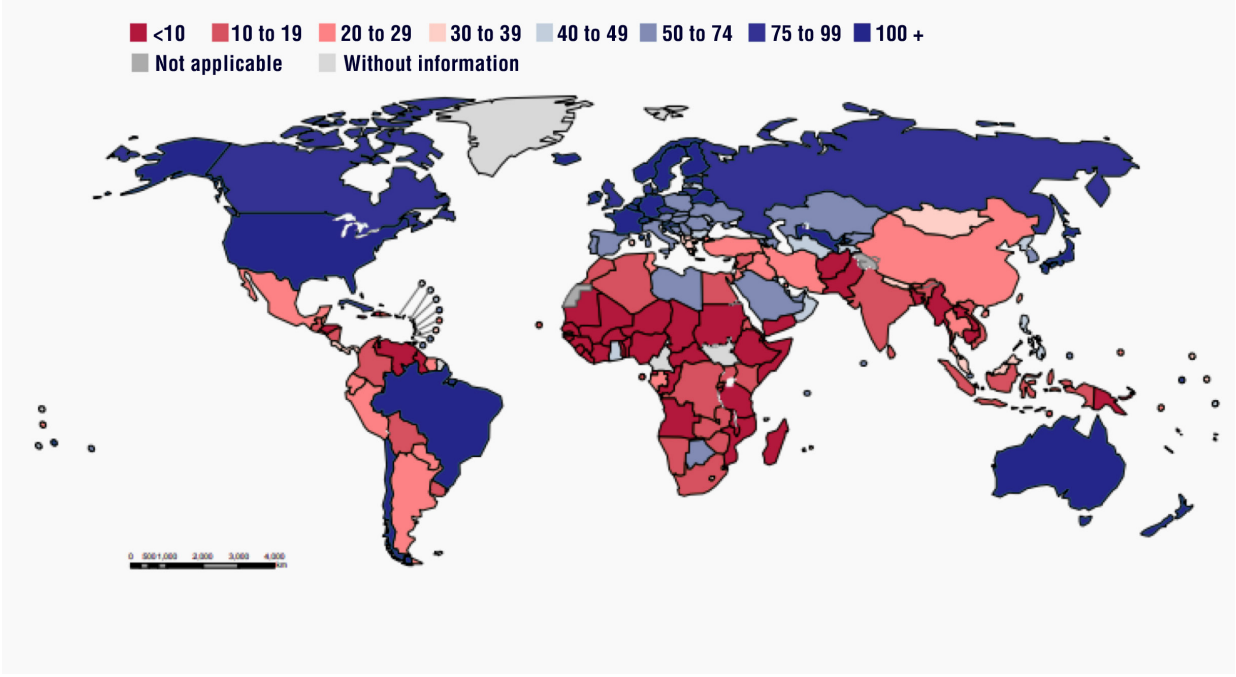
Note: *The figure records the percentage both male and female workers who have answered that, during the last year, they have been the object of situations of aggression at least once by their bosses or employers, by their colleagues or by customers, patients, students, the public, etc.; or they have been the object situations of sexual harassment; of workplace bullying; of psychological harassment and/or mistreatment; and/or of threats of dismissal and/or interruption of their job.

Source: Own preparation based on the ECETSS - 2018.

4. Nursing in Argentina: challenges between precarious work and the lack of rights

Nursing is one of the professions within the wide range of occupations that make up the health sector. Nurses face many of the situations described in the preceding sections, yet they are also subject to specific aspects that put them in a more vulnerable position. The scarcity of nurses, deficient levels of qualification, multiple job-holding, the relative situation of devaluation of nursing activities in health teams are additional problems to the challenges that are common to all female health workers (Aspiazu, 2017; Pereyra F., 2014; Pereya & Micha, 2015).

Figure 4. Density of nursing personnel per 10,000 inhabitants in 2018



Source: National Health Workforce Accounts, World Health Organization, 2020

The World Health Organization's report on the situation of nursing in the world (2020) highlighted the international inequalities in the sector in the context of the diffusion of COVID-19. While Europe and the Americas have an average of around 81 nurses per 10,000 people, in Africa there are only 8.7 nurses per 10,000 people. With a density of between 20 and 29 nurses per 10,000 inhabitants, Argentina is ranked in a mid-low position in Latin America, together with Paraguay, Peru and Ecuador (OMS, 2020).

In this regard, the considerable territorial heterogeneity regarding the density of nursing technicians and registered nurses between provinces must be kept in mind. This density varies between the lows of Santiago del Estero, Catamarca and Corrientes (5.1, 10.8 and 17.5 per 10,000 inhabitants, respectively) and the clearly higher densities of Neuquén, Entre Ríos and CABA (49.9, 50.3 and 61.2, respectively) (OFERHUS, 2020).[4]

Nursing is the most numerous occupational group of the health sector, representing approximately 59 per cent of healthcare professionals (OMS, 2020). According to official data of the Argentine Health Information System, 179,175 people were registered in the field of nursing in 2018, and data from the Federal Network of Registries of Health Professionals show an increasing trend (OFERHUS, 2020). According to a 2018 study by the Union Health Observatory of Argentina (OSINSA), 74 per cent of workers in the nursing sector are women. This sector has the particular feature of having the greatest level of feminization.

Employment in the sector is organized into professional, technical and assistant occupations, and it is characterized by considerable heterogeneity. The least-qualified labour force represents a high percentage in the nursing profession. Specifically, 34.7 per cent of the workers are nursing auxiliaries, 49 per cent have technical training and 16.2 per cent hold degrees in nursing (OFERHUS, 2020). The degree program is offered by 53 universities and 250 technical schools in the country, totalling nearly 30,000 new enrolments per year and a total of approximately 107,000 students in the degree program at both types of institutions (Costa & Marcó del Pont, 2017).

The World Health Organization highlights that 70 per cent of tasks in the health sector come under the scope of nursing, and it recognizes nursing as one of the pillars that form the structure of the health system in Argentina.

4 In Argentina, the Nursing Practice Act (No. 24004, 1991) distinguishes two levels in the nursing practice: auxiliary (educated to a pre-university level) and professional (who could have a technical degree or a bachelor's degree). Professional practice is defined as "consisting in the application of a systematic body of knowledge for the identification and resolution of health-illness situations submitted to the scope of their competency" and the Auxiliary practice as "consisting in the practice of techniques and knowledge that contribute to nursing care, planned and arranged by the professional level and executed under the supervision thereof" (Article 3).

At a union level, nurses are distributed according to their qualifications and competences. In the province of Buenos Aires, for example, those with an auxiliary or technical qualification who work in public health are represented, among others, by the Association of State Workers (ATE), the Union of Civil Personnel of the Nation (UPCN) and the Public Health Union (SSP). Other nurses with professional training are grouped in the Association of Health Professionals of the Province of Buenos Aires (CICOP). Conversely, within the private sector, the vast majority of nurses in the country (whether they hold a university degree or they are technicians or auxiliaries) form a union in the Argentine Health Workers Association (ATSA), which combines various categories of workers (Aspiazu, 2017).

On the other hand, beyond the structural and situational vulnerability of nurses in Argentina, the sector is characterized by the existence of regulatory vacuums and heterogeneity with respect to qualifications, wage categorization, union representation and the appropriate jurisdiction, all of which affect effective compliance with nurses' rights.

The Bachelor's Degree in Nursing has been included in the scheme of higher education since 2013. In the city of Buenos Aires, the profession is regulated by Act 298, which includes it within the category of general personnel. In November 2018, the Legislature of the City of Buenos Aires approved Act 6035, which establishes a regulatory framework for health professionals in the public sector. While the Act covers over thirty professions, it still does not include, among health professionals, persons who hold Bachelor's Degrees in nursing, bioimaging and surgical technology.[5] This exclusion implies that all the nurses of the 33 public hospitals in the city are categorized as administrative personnel, thereby blocking their ability to compete for positions, participate in internal training of the sector and access wages in accordance with their profession (Domínguez Cossio, 2020).

It is important to point out that in February 2019, the head of government of the City of Buenos Aires, together with trade union representatives (Single Union of State Workers of the City of Buenos Aires, SUTECBA), elaborated a Collective Bargaining Memorandum (No. 3/19 – Central Joint Committee) to advance a new degree in nursing and technical-professional specialities in health, which would include nursing auxiliaries, professional nurses, graduates in nursing and technical specialities. However, the Memorandum does not include nursing personnel of the public sector in the Health Professionals Act, on a par with all other professions requiring a university degree. The inclusion was then proposed in a legislative bill in 2020 (Box 1). This is an especially relevant point if we consider the high number of nursing personnel who work in CABA and its metropolitan area.

5 Act No. 6035, Ch. II, On the scope of application, Article 6, Included professionals, 1 November 2018, Official Gazette of the City of Buenos Aires – No. 5508 – 28 November 2018.

Finally, it is important to mention that Argentina still has not ratified the ILO Nursing Personnel Convention (No. 149). This Convention recognizes nursing personnel as essential in benefit to the health and well-being of the population. Moreover, it establishes minimum labour standards that regulate aspects such as working conditions, the adoption of standards on occupational safety and health, and the establishment of labour dispute resolution mechanisms, among other standards.

Box 1

Regulatory framework and public policies related to nursing in Argentina

The practice of nursing within the health area is covered by a law on professional practice (Act No. 24004), which was approved nationally in 1991. The Law also serves as the legal framework for orienting provinces that lack legislation or want to make their existing laws compatible. Article 1 of Amendment No. 2330 thereof, dated 4 December 1992, incorporates Graduates of Nursing in Health Professionals Degrees of the Nation. Nursing specialities are established and recognized in Act 24004/91, on the practice of Nursing, and in Decree 2497/93. In this regard, the following specialities exist: Adult Health Nursing; Elderly Health Nursing; Maternal, Child and Adolescent Nursing; Mental and Psychiatric Health Nursing; Critical Patient Care Nursing (neonatal, paediatric and adult); and Palliative Care Nursing.

In the City of Buenos Aires, Act 6035 of 1 November 2018 defines the list of health professionals in the City. Nurses are excluded from the list. A legislative bill of 7 April 2020 proposed by the legislator Victoria Montenegro (File 712-D-2020), proposes that Act 6035 be amended, thereby including graduates in nursing within the amended text of Health Professionals Degrees of the City of Buenos Aires.

In 2016 and 2017, the Argentine government launched a plan to promote the nursing degree. Thus, through Resolution 209, Argentina has the **Nursing Training Programme (PRONAFE)**, drafted together with the Secretary of University Policies of the Ministry of Education and Sports of the Nation and with the Ministry of Health of the Nation. The objective of the programme consists in promoting and training nurses, who contribute to resolving health problems and cooperate in transforming services, by offering quality care services. The ultimate goals are to improve population's state of health and to contribute to human development.

Source: Aspiazu (2017) and the Ministry of Education and Sports, INET and the Ministry of Health (2017).

5. Women with degrees in obstetrics: from a strategic role in public health to a needed law befitting their education and rights

Women with degrees in obstetrics, professional birth attendants or midwives are health professionals whose practice consists in the following: "trained, expert and compassionate care of women of childbearing age, newborns and families throughout the entire, continuous process of pregnancy, birth, post-partum and the first weeks of life. The main characteristics of this model include optimization of the normal biological, psychological, social and cultural processes of reproduction and early life; prevention and handling of complications; consultation with and referral to other services; respect for the individual circumstances and opinions of women; and the strengthening of the abilities of women to care for themselves and their families" (Renfrew, et al., 2014).

The State of the World's Midwifery 2014 report showed serious gaps at a global level in the access to care services from qualified health personnel, including midwifery personnel (United Nations, 2015). In the countries where 92 per cent of all maternal and neonatal deaths occur, only 42 per cent of all midwifery, medical and nursing personnel were available to care for women and newborns. The majority of these deaths are preventable, and therefore each one is a clear example of the profound inequalities in those regions. It is also an example of the need to strengthen public policies and increase investment in the number and availability of qualified human resources for pre-pregnancy and prenatal care, in addition to care during birth, post-partum care and the immediate care of newborns, in settings of urgent and basic obstetric care as the main objective for the health improvement of women(UNICEF, 2016).

In Argentina, the majority of maternal and newborn deaths occur in poor and rural areas and areas with minority populations, where the regional and national averages of the personnel who provide sexual and reproductive health services are masked by the enormous differences in health results within the country and between provinces. While the national maternal mortality rate (MMR)[6] is 3.7 deaths per 10,000 live births, this ratio increases to 14.4 in the province of Formosa, 12.2 in Santiago del Estero and 7.3 in Chaco. These figures contrast with those observed in provinces such as Rio Negro, La Pampa and Jujuy, whose MMR

6 The annual number of women who die due to causes related to pregnancy and birth for every 10,000 live births. The denominator of number of live births is used as an approximation of the number of women exposed to dying due to causes related to pregnancy, childbirth and the post-partum period.

is below 1 (MSAL, 2020). It should be pointed out that, in the provinces with the highest MMRs, in addition to having the country's lowest GDP figures, there are large indigenous populations (Tobas-Wichís, Mocovíes and Guaraníes) living in remote areas that are far from urban centres or where access to health services is difficult.[7] While evidence shows that investments in developing the capacities of health teams translates into positive health results, women still face economic, geographic, social, legal and attitude-related barriers that impede their access to quality services.

Regarding the labour force, the Directorate of Health Statistics and Information (DEIS) of the Ministry of Health of the Nation (MSAL), in a demographic study referring to 2014, reports the figure of 1.2 graduates in obstetrics per 10,000 inhabitants[8] in Argentina.[9] Yet, in order to provide essential maternal and child health services, the WHO has established the cut-off point of 23 doctors, nurses and midwives for every 10,000 inhabitants (MECCyT; MSDS; Presidencia de la Nación, 2019). In Argentina, there are 13 public and private universities that offer a degree in obstetrics, involving four to five years of superior education, plus residency and hospital internships.

It should be pointed out that it is difficult to obtain an accurate estimate of the quantity of graduates in obstetrics who are practising in the country, given that not all provinces have professional associations that bring together and register these professionals. Moreover, the same person could be signed up in several jurisdictions, or they might not be active but could continue to be registered. The report that probably comes the closest to providing an accurate number was drafted by the National Directorate of Maternity and Childhood of the previous Ministry of Health and Social Development, which is currently the National Directorate of Perinatal Health and Childhood, based on a survey of provincial references of maternity and childhood conducted in 2017[10]. It reported a total of 6,667 agents who fulfil the function of "Obstetrician". Given that this function was covered in only 4 jurisdictions by professionals who were not graduates in obstetrics (meaning, obstetric technicians, nurses and birth attendants), representing 15 per cent of the sample total, it can be inferred that there are currently around 5,500 graduates in obstetrics practising in the country, 2,200 of which are registered in the province of Buenos Aires (MECCyT; MSDS; Presidencia de la Nación, 2019).

7 For example, the impenetrable Misiones rainforest or the old-growth forests of Chaco and Formosa.

8 The provinces of Buenos Aires, Córdoba, Tucumán and Santa Fe did not report data. The latest data available for Entre Ríos, Formosa and La Pampa are from 2013, and for Mendoza they are from 2012.

9 In 2019, the National Plan for the Prevention of Unintentional Pregnancy in Adolescence published a technical document on the strategic role played by graduates in obstetrics in access to sexual and reproductive health. It describes the status of personnel and analyses sources regarding the quantity of available personnel (MECCyT; MSDS; Presidencia de la Nación, 2019).

10 The survey was conducted in 22 of the 24 jurisdictions, with the sole exceptions of CABA and Santa Cruz.

Despite the difficulties and the lack of official mechanisms to acknowledge the real number of professionals in this discipline in the country, the biggest problem is related to regulation of the profession. Currently, the professional practice of obstetrics is framed within a national law that is 52 years old (National Act No. 17132, on the Practice of medicine, dentistry and "collaborating activities"). This law poses that obstetricians are collaborators in medicine, and it only makes reference to care for pregnancy, birth and the post-partum period, without considering sexual health, access to birth control methods and the detection of diseases, among other essential duties, which in many cases are already being performed.

The International Confederation of Midwives (ICM) deems that all countries should have adequate legislation on midwifery, which should be recognised as an autonomous profession. In April 2019, the legislative bill, "Professional Practice of Graduates in Obstetrics", was presented and approved in the Chamber of Deputies, with the objective of regulating the practice of this profession in accordance with the education these graduates receive at university and their professional skills.[11] This bill is pending in the Senate, and it should be pointed out that this is the seventh attempt in 13 years to clarify and regulate the functions that graduates in obstetrics have on health teams (ICM, 2011).

Likewise, on 20 November 2019, the Ministry of Education, Culture, Science and Technology approved the inclusion of the university degree in obstetrics in Article 43 of the Higher Education Act. Thus, all university degrees in obstetrics must, beginning in 2020, accredit their quality before the National Commission for University Evaluation and Accreditation (CONEAU). This will have an impact on unifying criteria related to curriculum design, education and competencies, among other benefits. Said approval by the ministry finalized a cycle of including university degrees of the health area in Article 43, which is highly relevant as these degrees are linked to the life and health of all inhabitants.[12]

11 This bill, passed by the Congress of Deputies, establishes that graduates in obstetrics will be able to advise and provide instruction about, insert and remove birth control measures; prescribe medicinal products for obstetrics use; request laboratory and image studies; indicate the recommended vaccinations according to age and during pregnancy; investigate sexually transmitted infections and cervical cancer for the appropriate referral to specialists; handle low-risk pregnancies during the entire pregnancy and promote breastfeeding, among other duties. Legislative bill passed by the Chamber of Deputies: 2070 and 4364-D-18 OD 1051. File 17/19.

12 https://www.argentina.gob.ar/noticias/nuevas-carreras-de-interes-publico-y-nuevos-estandares-de-acreditacion

6. The impact of COVID-19 on female health workers in Argentina

Work overload, a lack of equipment, occupational risks, low wages and a lack of access to labour rights are conditions that form a part of female health workers daily routine. This level of precariousness has been notably increased by the COVID-19 health crisis. In Argentina, female doctors, nurses, obstetricians, caregivers and other healthcare personnel, just like in any other country affected by the pandemic, are all facing an unprecedented workload in healthcare systems that are being taken to their breaking point, and in a situation in which the predictions about the end of the crisis are still uncertain. Moreover, due to a socio-demographic profile characterized by the high presence of female heads of household with low income and children and adolescents under their care, the social impact on female health workers and their families is also notable.

Some of the effects produced by the COVID-19 crisis on female health workers are detailed below.

- **Deficits in occupational health and safety, including exposure to infection.** In Argentina, 3,652 health professionals had tested positive for COVID-19 as of 24 June 2020, which represents 7.3 per cent of the total of 249,851 infected people recorded in the country to date. These figures clearly show the high risk faced by all healthcare personnel. However, due to the greater presence of women in occupations that are in closer contact with patients, such as nursing, women are more exposed. The risk of infection can be exacerbated due to the insufficiency of appropriate protective equipment at health facilities or due to the difficulty of accessing diagnostic tests. This combination of a greater number of patients and a reduced number of personnel available to provide care is contributing notably to jeopardize the capacity of the healthcare system.

- **Longer workdays and greater workload.** In emergency contexts, health personnel have to work under abnormal and atypical conditions. Within the response to the pandemic, female health workers are facing huge additional workload, extended working hours and a lack of rest. Media have recently called attention to the situation in various hospitals, characterized by “long workdays for organizing hospitalization and therapy units, re-arranging traffic areas, setting up new beds, distributing supplies, providing training to colleagues and unifying criteria for using elements of biosafety protective equipment” (Gioberchio, 2020). This situation is even more acute if we consider that, under normal conditions, 24 per cent of the more than 40.6 per cent of female workers

who work overtime do not receive any kind of remuneration for the additional hours (Figure 3, Panel B). In addition, it should be recalled that, due to the closure of schools and other places that provide care, female health workers also have to organize their personal lives and care provision for the people depending on them. This precariousness and the lack of rest not only jeopardizes female workers themselves, but also affects the quality of the care services they offer to patients.

■ **Increased stress and greater psycho-social risks.** The pandemic puts healthcare personnel in exceptionally demanding situations. Female health workers are on the front line of the health response, therefore assuming greater physical and emotional costs. They are subject to an enormous workload, and they occasionally find themselves in traumatic situations and facing difficult decisions. This affects the reorganization of their private life and care work as already mentioned above. On the other hand, the long workdays and the time away from their families can generate stress and cause even greater emotional vulnerability.[13] In addition, they have to sustain the emotional burden of facing a higher risk of infection for themselves and their families, together with the potential discrimination they undergo in their communities, building and/or in public transportation.

■ **Increase in the care load.** Due to the pandemic, female health workers must face not only longer workdays but also a greater load of non-remunerated care work at home. The costs of providing care fall disproportionately on women and girls, who assume the immense majority of non-remunerated care work (UN Women, 2016). Under normal circumstances, female health workers perform nearly one more hour of non-remunerated domestic work per day in comparison with their male colleagues (Figure 1, Panel F). The pandemic, which has caused the closure of schools and daycare centres, as well as other places that provide care, has substantially increased the time that female health workers are engaged in this type of non-remunerated work on a daily basis. The situation is even more acute for those who are heads of household and who are the only ones responsible for family care. The lack of care alternatives for their children or for the elderly increases the risk of infection and exacerbates the high levels of stress and emotional wear they face.

13 In a recent survey taken by the UNFPA and conducted of 971 professional midwives in 9 countries in the region (including Argentina), 58 per cent declared that they did not feel safe when providing care, mainly due to a lack of PPE. Moreover, 58.6 per cent stated that they did not have the materials, equipment or basic infrastructure for providing safe care. The same survey reported that 63.4 per cent of professional midwives are afraid of being infected, and 82.9 per cent indicated that they feared infecting users, colleagues and relatives due to not having access to such protective materials. The aforementioned reflects serious inequalities, given that the majority of professional midwives are women who, in an emergency such as COVID-19, continue to take care of women, both pregnant and not pregnant, whose rights could be viewed as being violated, whether due to a lack of birth control or a lack of continuity in care, and even due to sexual or gender violence within the context of a lockdown (UNFPA, 2020).

■ **Loss of jobs and income**. Even though Decree 297/20 (19 March 2020), which regulated preventive and mandatory social isolation, declared that the entire health sector was an essential activity, the Argentinian healthcare system focused its priority on the response to the pandemic, as in other countries. Consequently, health professionals who perform activities that are less linked to the immediate response to the pandemic (such as ophthalmology, dentistry, etc.) have watched their number of office visits drop, and therefore their income as well. Due to the high feminization of these professions, this could have a significant impact on the income of a notable percentage of female workers.

■ **Discrimination**. The extent of the COVID-19 pandemic could worsen discriminatory practices towards female health workers, as well as among their male colleagues. The experience from previous health crises, such as the 2014 Ebola epidemic in West Africa, shows that healthcare personnel can be the victims of discriminatory practices and stigma due to the public's fear of contracting an illness. In fact, the media in Argentina have recently shown episodes of attacks on female health workers (Piscetta, 2020).

■ **Lack of labour protection.** In order to tackle the pandemic, it may be necessary to resort to contracting healthcare personnel under temporary employment contracts, in addition to using volunteers, students in internships or retired health workers. It is likely that women may also be over-represented in this atypical contracting. While such measures could be key to ensuring the necessary assistance, it is likely that these female workers do not have the same labour and social protection as the rest, thereby putting them in a special situation of vulnerability because of the aforementioned impacts.

7. Support measures for female health workers in Argentina

Argentina is one of the countries that reacted the quickest in responding to the economic and employment effects caused by the health crisis of the COVID-19 pandemic. Measures that have a direct impact on healthcare personnel, and therefore on female health workers, are described below:

- **Reinforcement of the healthcare system.** Strengthening the healthcare system is essential for alleviating the burden on health personnel, which falls mainly on women. In this regard, the Ministry of Productive Development offered financing opportunities for those who, mainly in the medical-health sector, develop productive and technological solutions that contribute to handling, containing, treating and mitigating COVID-19.[14]

- **Financial compensation.** The Argentine government has granted an extraordinary cash payment for healthcare personnel. The payment amounts to ARS 5,000 during the months of April, May, June and July for health workers of the public and private sectors and of social security who have effectively provided services during those months.[15]

- **The inclusion of COVID-19 as an occupational illness.** In mid-April, the Occupational Risk Supervisory Authority established that the COVID-19 illness would ostensibly be considered an occupational illness for employed persons who perform essential activities.[16] This is a measure that would benefit all healthcare personnel, and therefore the high percentage of women in the sector.

- **Health Personnel Protection Programme** (Silvio Law). This law, enacted by the Senate on 21 May and bearing the name of the first Argentine worker who died from COVID-19, includes a series of measures targeted at protecting healthcare personnel performing essential activities and services during the current health emergency. The main actions set forth in this rule of law include: i) guaranteeing biosafety measures in areas that are engaged in caring for and taking samples of cases of COVID-19; ii) establishing protection protocols and training for the prevention of infection by health personnel exposed to infection from COVID-19; iii) establishing a permanent team of digital advising on the protection of health personnel; and iv) creating a Single Register of Health Personnel infected by COVID-19[17]. This law will be in effect until 30 September 2020, although it could be extended as long as the health emergency lasts.

14 Resolution 132/2020 of 31 March 2020.
15 Decree 315/2020 of 27 March 2020.
16 Decree 367/2020 of 13 April 2020.
17 https://www.parlamentario.com/2020/05/21/el-senado-sanciono-virtualmente-la-ley-silvio-de-proteccion-al-personal-de-salud-durante-la-pandemia/

- **National plan for the care of health workers.** The Ministry of Health developed a plan whose objective is to prevent infections from COVID-19 and the consequences thereof on the health of workers. The plan includes coordination between the Ministry of Health and the various jurisdictions, in addition to training and supervision measures on work processes and the implementation of a strategy for identifying risk scenarios and supporting health personnel and their families.[18]

- **Agreements based on social dialogue.** In Argentina, an agreement was reached between the federation of associations of health workers and the government to guarantee that all health workers would continue to earn their full salaries for as long as preventive and mandatory social isolation might last. Moreover, it was also agreed that health workers would be eligible for free, government-subsidized transport during the pandemic.

- **Awareness-raising campaigns.** Ever since the first effects of the COVID-19 crisis began to be felt in Argentina, the importance of raising awareness over the work performed by women in the health sector was perceived. In this regard, the United Nations System supported the UN Women campaign, #CuidarEsTrabajo (#CareIsWork), driven by the Campaign for the Socialization of Care. The main objective of this initiative is to recover the voice of female health workers, caregivers and community representatives within the context of the pandemic, as well as to reinforce the message that the tasks they perform are a socially useful job, which must be valued and remunerated.

18 Resolution 987/2020 of 4 June 2020.

8. Good practices and public policy recommendations

The policy response for improving the situation of female health workers during and after the COVID-19 crisis must follow an integrated and multidimensional approach that allows the aforementioned impacts to be handled. In addition to ensuring protection, safety and health of healthcare workers within the current context, suitable coordinated actions must be adopted to improve their medium- and long-term conditions.[19]

- **Guarantee the health, safety and immediate needs of health workers.** Every health worker who may be infected by COVID-19, in addition to being a victim and a person who will need medical care, also represents one less resource in the fight against the pandemic. Therefore, it is vitally important to guarantee not only their health and safety but also the health and safety of all support people (for example, people who handle the laundry, cleaning personnel and those in charge of eliminating sanitary waste), the majority of whom are also women. The protection and safety of healthcare personnel, particularly workers on the front line (who are predominantly women), must be guaranteed. Therefore, information about both transmission of the disease as well as measures for preventing infection must be distributed extensively and rapidly. It is likewise essential to not only have personal protective equipment available but to also have instructions and training on how to put it on, take it off and dispose of correctly.[20] In this regard, the ILO has several tools available, which establish detailed guidelines on the protection of female health workers.[21]

- **Establish maximum limits of working hours and promote flexible working arrangements.** Currently a large part of female health workers are facing a huge additional workload, extended working hours and a lack of rest periods. Appropriate provisions must be adopted with respect to the working day so that female health workers can balance the demands of the healthcare service they provide, with their family life and their own well-being. The ILO guidelines on decent work in public emergency services (ILO, 2018) set forth the principles for defining working time arrangements during an emergency. The ILO Nursing Personnel Convention (No. 149)

19 This section adapts the recommendations included in the document "COVID-19 and the health sector" to the context in Argentina (ILO, 2020).

20 In addition to protective equipment, the WHO indicates the importance of other strategies for preventing or limiting the spread of COVID-19. Highlights of these strategies include applying standard measures of precaution for all patients; ensuring triage, early recognition and control of the source; implementing additional precautionary measures for cases of COVID-19; implementing administrative controls; and using environmental and engineering controls. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-infection-prevention-and-control-for-health-care-workers-caring-for-patients-with-suspected-or-confirmed-2019-ncov

21 The ILO document, "COVID-19 and the health sector" (ILO, 2020), presents a list of these tools.

and its Recommendation (No. 157) establish standards for setting decent working hours in the nursing sector.

- **Reward the work performed in response to the crisis.** Female health workers, just like all other healthcare personnel, assume the greatest physical and emotional burden of the response to the pandemic. This, in addition to the precarious conditions faced especially by female workers of the sector, puts them in a situation of particular vulnerability. In this regard, some countries have implemented measures designed to reward the work performed by those who are on the front line of action. For example, on 15 April 2020 France announced that doctors, nurses and healthcare personnel in general in the zones most affected by COVID-19 would receive an exceptional payment of 1,500 euros, while those who work in zones where the incidence of COVID-19 is less would receive a bonus of 500 euros. Belgium also announced a wage premium of 1,450 euros for health personnel, which will be allocated to approximately 10,000 people and will imply an investment of about 14.5 million euros.

- **Establish a consistent regulatory policy.** A consistent harmonization of labour regulations that affect female health workers is needed. As an example, in the City of Buenos Aires a process of excluding nurses from the public health system has been observed in Act 6035/2018, which defines the list of health professionals (see section 4). Even though a Collective Bargaining Memorandum (No. 3/19) was signed between unions and the government of the City of Buenos Aires, it is essential that graduates of nursing be included in the list of health professionals.

- **Ensure legislation in accordance with the competencies of female workers.** Graduates in obstetrics have been waiting for 13 years for the approval of a Law that gives them legal protection in accordance with their education, and that defends and recognizes their fundamental role in improving the sexual and reproductive health indicators of the population. It is therefore essential to increase investments in graduates of obstetrics and in the quality of midwife care. These workers are also capable to offer 87 per cent of the essential sexual, productive, maternity and neonatal health services that women and newborns need in any environment. Moreover, they prevent 83 per cent of all maternal deaths, stillborns and neonatal deaths. They likewise offer advice and services on preventing the transmission of HIV between mother and child and on gestational malaria, fistula, sexually transmitted infections and congenital syphilis, among other diseases. They improve access by adolescents to health services, and they contribute to the quality of care and the scope of effective birth control coverage.

- **Advance in making working conditions uniform.** Considerable heterogeneity between agreements for the private and public sectors continues to be observed, in addition to a disconnection between agreements that cover workers encompassed in the various municipal, provincial and national jurisdictions and those who are included among the general wage scale or those who are included as professionals (Aspiazu, 2017). For example, the FATSA 122/75 Agreement for Clinics and Psychiatric Hospitals with Internment[22] establishes the regulation of work hours within a time frame of 6 to

22 See: Federation of Associations of Health Workers of Argentina (FATSA), Collective Bargaining Agreement in force, C.C.T. 122/75, online, sanidad.org.ar/acciongremial/cct/c122.aspx

8 hours and 12 hours for weekends and non-business days. This regulation of labour by time frames that do not exceed 12 hours would seem to be more in accordance with the needs of female workers, it would benefit both men and women and it would facilitate family organization (UNDP, 2018).

- **Increase investments in the health sector.** According to the ILO's estimates, increasing investments in health[23] in Argentina to achieve the SDGs would generate 1.6 million jobs by 2030 (1.45 million jobs in the health sector and 155,000 indirect jobs in other sectors not directly related to care). This is equivalent to over 886,000 jobs in Argentina in comparison with 2015 (an increase of 122 per cent). In turn, this investment would mean a total public and private expenditure in health of 46.2 billion dollars by 2030, which is an increase of 56.8 per cent with respect to 2015 levels. At a minimum, 17.3 per cent of any additional public expenditure would be recovered in the short term through tax income.[24]

- **Hire and train more health personnel.** The pandemic caused by COVID-19 once again clearly shows the dire need for a strong healthcare labour force as an essential element of every resilient health system, an aspect that is now recognized as the indispensable foundation that is needed for the recovery of our societies and economies and to prepare for future health emergencies. It is necessary to invest in all health systems so that they can hire, deploy and maintain a sufficient number of well-trained workers who have the necessary equipment and resources. The introduction and expansion of digital technologies for informing, training and guiding health personnel, especially in remote locations, can improve transparency, the quality of the services provided and management during the pandemic. In the Netherlands, medical students are being used at a telephone assistance centre where assistance and guidance is offered to patients who are experiencing severe symptoms.[25]

- **Protect those who have atypical contracts.** Sustainable health systems depend on the forward planning of their labour force. Ad hoc hiring must take into account not only logistic and financial issues, but also factors such as occupational health and safety, social protection, remuneration, rest periods and provisions related to the working time of hired personnel. Governments must consult with social agents regarding the supervision and regulation of this special contracting and must strengthen the complaint system and take effective measures against labour discrimination (UN Women, 2017), especially in sectors that are more vulnerable and exposed to informality (for example, caring for the elderly and for persons with disabilities at their homes). They must also ensure that all hired personnel are adequately trained and have the necessary skills for responding to the pandemic.

23 Includes investments in the health sector and in social work.

24 For more information about the methodology used for these investments, see (ILO, 2019) and (Ilkkaracan & Kim, 2019).

25 This is an example of how the human resources available in a healthcare system can be redistributed. Thus, health personnel who are retired or subject to risk factors could perform administrative tasks, provide telemedicine assistance, etc.

- **Access to care services.** Women perform the vast majority of non-remunerated care work in households. The increased care load due to the closure of schools and other places that provide care as a measure in response to COVID-19 makes it even more necessary to promote measures that support female healthcare workers in combining the fight against the pandemic and caring for their families. To counteract the care overload placed on women in the household, it is important to strengthen the network of other public, private and labour market players and institutions that could offer care services for children and the elderly. Likewise, it is advisable to implement remunerated maternity leaves, parental leaves and monetary benefits for adults who are responsible for caring for small children, elderly persons or disabled persons in the home. For example, Italy has established a "childcare allowance" of up to 1,000 euros so that healthcare workers can pay for the cost of childcare services in the home. In Germany, Austria, France and the Netherlands, places where the majority of daycare centres and schools have been closed, some facilities remain open with the minimal personnel for taking care of children of workers who provide essential services.

- **Mainstream the gender perspective and involve women in all phases of the response and in decision-making.** This pandemic has shown the importance of integrating a gender perspective in the preparation for and response to public health emergencies, given that women play a predominant role as front-line health workers and caregivers. Applying a gender approach to the problems concerning health personnel allows raising awareness on the various discriminations that affect female labour development and raising awareness about the economic and social undervaluation of certain, more feminized professions, such as nursing. Mainstreaming the gender perspective and including groups of women who are more affected by the crisis (like migrant or indigenous women, among others) in the decision-making processes over labour policies and social protection will allow building sustainable solutions in the long term (UN Women, 2020). An example in this sense is the recent presentation of a legislative bill, supported by UN Women, for including the gender perspective on Crisis Committees. The project provides for the joint composition of committees and the need for consulting women and girls in order to design response strategies to emergencies with the aim of promoting the leadership of women in such response.[26]

- **Acknowledge the value of female health workers.** Often in the health professions, a certain naturalization of the caregiving function of women can be observed, in addition to persistence of the female health professional stereotype, with a vocation and self-sacrifice for the tasks of caring for others (Pereyra & Micha, 2015). For a long time, female healthcare workers were considered to be "auxiliaries" of medicine and therefore subordinate to the medical profession (Ramacciotti, 2019). To deconstruct these stereotypes and gender roles, the value of female health workers must be acknowledged: this will contribute to defining health occupations based more on professionalization and less on vocation. The launch of awareness-raising campaigns on the conditions of the sector would contribute to acknowledging the value of the work of female health professionals within the healthcare sector itself and in Argentine society as a whole.

26 https://www4.hcdn.gob.ar/dependencias/dsecretaria/Periodo2020/PDF2020/TP2020/1449-D-2020.pdf

- **Protect mental health and offer psychological support.** The pandemic places female health workers in exceptionally demanding situations. They are subject to an enormous workload and occasionally find themselves in traumatic situations and facing difficult decisions, in addition to coexisting with the fear of contracting the disease or spreading it to their family members. Therefore, providing social assistance and psychological counselling must form a part of a comprehensive response to the pandemic. The response must consequently establish the provision of social assistance for female workers and their families, in addition to information and guidance about how to manage stress, including post-traumatic stress. For example, nurses in the United Kingdom can contact the *Royal College of Nursing Counselling Service* at no charge to obtain psychological assistance on handling job-related difficulties.[27]

- **Adopt measures directed at eradicating workplace violence and harassment.** Female health workers and their families can be victims of episodes of violence and harassment, discrimination and stigma. It is therefore important to adopt measures designed to eradicate workplace violence and harassment. In this regard, ratifying the ILO's Violence and Harassment Convention (No. 190) and applying Recommendation No. 206, which supplements the convention, is an essential step. These instruments require that states take measures to identify the sectors where there is more exposure to violence and harassment and that they commit to protect the people in those situations, in collaboration with the private sector (Article 8(b) and (c)). The Recommendation clarifies that such sectors can include the health sector (Paragraph 9). Moreover, the COVID-19 pandemic required a review of occupational health and safety policies, thereby providing the opportunity to include risk evaluation and prevention measures related to violence and harassment.

- **Strengthen female worker organizations and promote social dialogue.** Strengthening the voice and participation of female health workers is essential to allow them to play an active role in the response to COVID-19. For example, the freedom to express concerns about occupational health and safety matters or reject activities that put them in harm's way, as well as their right to organize and freely participate in dialogue, are important principles that must be maintained, even in emergency situations such as the current one. Social dialogue is important not only to guarantee prior preparation for future emergencies but also to improve the response and coordination in the current situation. For example, in Italy the government and social agents reached a new collective bargaining agreement on occupational health and safety for health personnel.

- **Ensure follow-up on and monitoring of any adopted measures.** Finally, measures related to follow-up and monitoring are indispensable requisites for ensuring that any proposed solutions are effective. Therefore, the following proposal is made: point persons should be appointed in the national, provincial and municipal governments for the specific purpose of improving the labour and wage conditions of female health

27 Royal College of Nursing: COVID-19 (Coronavirus) and your mental wellbeing, https://www.rcn.org.uk/get-help/ member-support-services/counselling-service/covid-19-and-your-mental-wellbeing [consulted 1 June 2020].

workers in Argentina and, in turn, for the purpose of mainstreaming the gender perspective in all spheres of the health sector.

Box 2

Improving the condition of female health workers in Argentina is essential to **comply with the United Nations Sustainable Development Goals** (SDGs), especially the following:

SDG 3:
Ensure **healthy lives** and promote well-being for all at all ages

SDG 5:
Achieve **gender equality** and empower all women and girls

SDG 8:
Promote sustained, **inclusive** and sustainable economic growth, full and productive employment and **decent work for all**

SDG 10:
Reduce inequality within and among countries

9. Final considerations

The coronavirus crisis especially affects several dimensions of the work of female health workers in Argentina, beyond merely the healthcare aspects. Just like in most of the countries in the region, women are the majority in the health sector in Argentina, and a very high percentage is economically in charge of households in which children are present. This generates vulnerability, which is enhanced by the relatively low wages women receive and by the labour precariousness they face. In fact, the wages of female health workers are significantly lower than those received by males in the sector, and the incidence of labour informality is considerably higher among women, consequently limiting their access to essential protection mechanisms within the current context, such as coverage for professional illness, sick leave or health insurance.

Female health workers generally work more hours in comparison with their male colleagues. Likewise, these women face a combination of greater exposure and less protection, which multiplies their risks before the current pandemic. They also suffer situations of violence and harassment to a greater extent than males – especially by patients, clients, the public, etc.

Even though the value of female health workers in the current time of crisis is acknowledged, both within the sector and in society as a whole, this has yet to translate into equitable labour and wage conditions. It is essential that the positive assessment received by female health workers in this crisis be accompanied by a regulatory framework and public policies that recognize and guarantee effective access to their labour rights, while paying special attention to those workers who are employed under atypical contracts or in the informal economy. Therefore, the safety and health of female workers must be guaranteed, maximum limits must be established for their working hours, and the work they perform in response to the crisis must be rewarded.

Acknowledging female health workers not only as caregivers but also as professionals is a necessary and important step to reducing inequalities. Moreover, incorporating the gender perspective in the health sector constitutes an essential step towards better social recognition for female workers of the sector in Argentina. In this regard, strengthening female worker organizations and promoting social dialogue are key aspects, given that they will make it possible to not only raise awareness about female health workers but also acknowledge their value and take into account their needs and interests.

Under these conditions, a consistent framework of active public policies, both during and after the crisis, is crucial to reaching this objective, in conjunction

with the 2030 Agenda for Sustainable Development. In this regard, institutional support for communication actions and the launch of mass campaigns could contribute to complying with the SDGs and to deconstructing gender stereotypes and norms with respect to female professionals of the sector.

Public recognition and the policies implemented in response to the current context have paid greater attention to female health workers than in past crises. Ideally, this should be the basis for future decisions and policies targeted at improving the challenges still faced by female health workers and targeted at recognizing their contribution throughout the entire national territory, including rural and indigenous communities.

As long as this pandemic lasts, female health workers in Argentina will continue to be responsible for caring for society's health, not only with respect to prevention and care regarding COVID-19 but also in relation to all other pathologies and primary healthcare. Their health, safety and economic stability have to be protected and guaranteed as a part of the essential efforts for ensuring the well-being of the entire population during the COVID-19 pandemic.

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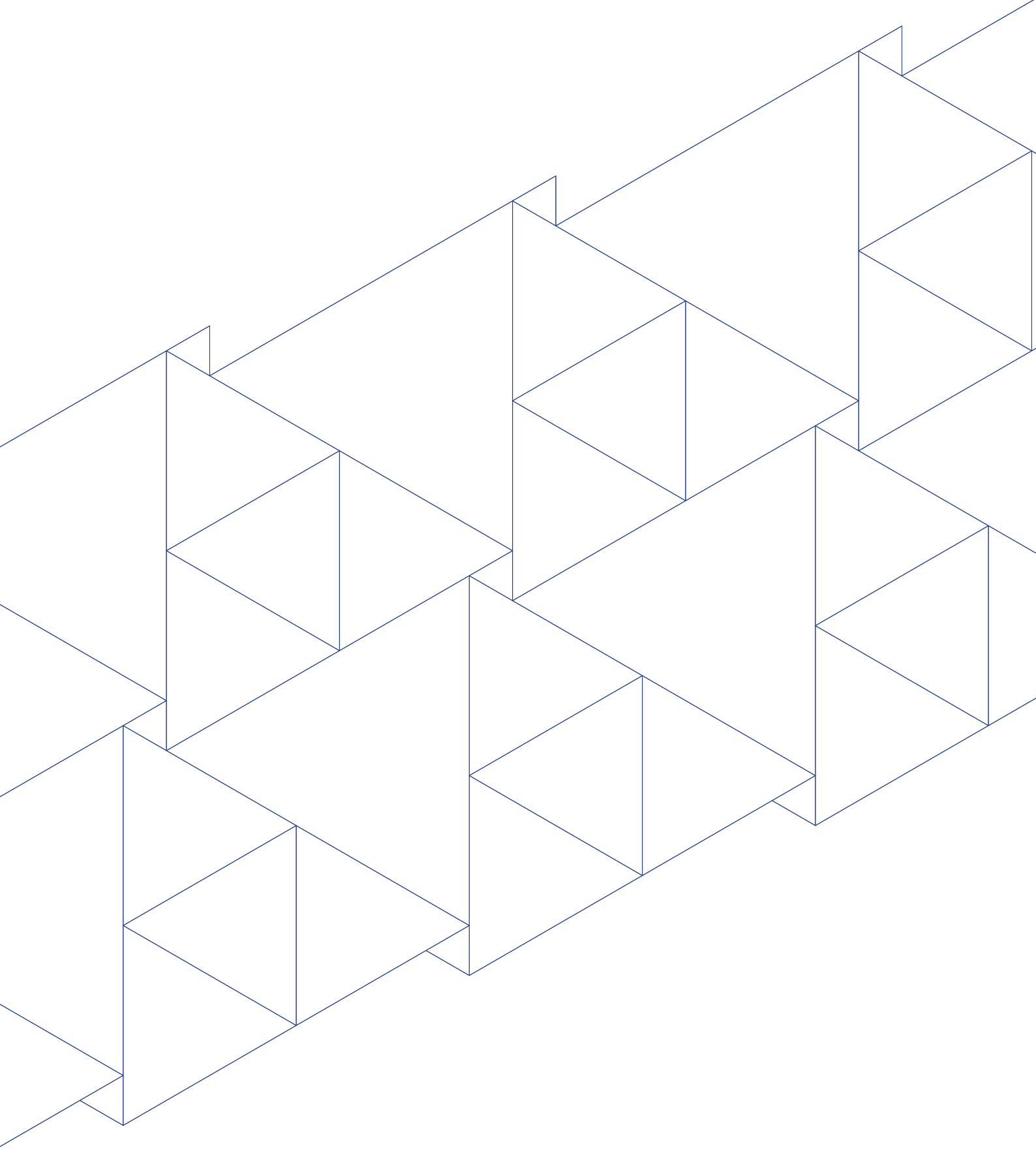
ILO: The only tripartite agency of the UN, the International Labour Organization (ILO) brings together governments, employers and workers from 187 member states to set labour standards, formulate policies and develop programs promoting decent work for all, women and men. The main objectives of the ILO are to promote labour rights, promote decent work opportunities, improve social protection and strengthen dialogue when addressing work-related issues. The tripartite structure of the ILO, in which workers and employers have the same voting rights as governments during the deliberations of the main bodies of the ILO, ensures that the views of the social partners are faithfully reflected in standards, policies and ILO programs.

UN Women: The United Nations Entity for Gender Equality and the Empowerment of Women, UN Women, based on the vision of equality enshrined in the Charter of the United Nations, works for the elimination of discrimination against women and girls; the empowerment of women; and the achievement of gender equality. It has a triple mandate: to coordinate and mainstream gender perspective within the United Nations system; a programmatic one, through the implementation of projects and programs in priority areas; and regulatory support. Regarding its third term, UN Women supports the adoption and strengthening of normative frameworks that respect international standards in relation to gender equality and the empowerment of women. It also works with governments and civil society to formulate laws, policies, programs, and services to ensure that these standards are effectively implemented and truly beneficial to women and girls around the world.

UNFPA: The United Nations Population Fund is the United Nations agency in charge of promoting universal access to health and sexual and reproductive rights for the population. It is guided by the Program of Action of the International Conference on Population and Development (Cairo, 1994) and collaborates with governments, civil society and other organizations, with the purpose of improving the lives of women, adolescents and young people. It focuses on these population groups because their ability to exercise their right to sexual and reproductive health is often compromised. It works towards the fulfilment of the 2030 Agenda

for Sustainable Development and, in line with this Agenda, aims to organize its work around three transformative, people-centered outcomes by 2030, namely: a) end avoidable maternal deaths; b) ending unmet family planning needs; and c) put an end to gender-based violence.



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