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GLOBAL RAPID GENDER ANALYSIS FOR COVID-19



Executive Summary

On 11 March 2020, the World Health Organisation classified COVID-19 as a pandemic.¹ Disease outbreaks affect women, girls, men, boys, and persons of all genders differently, to say nothing of the wide variety of at-risk and marginalised groups. The compounding complexities of development and humanitarian contexts can have disproportionate effects on women and girls, as well as those at-risk and vulnerable groups. CARE International identified the need to highlight the gender and intersectional impacts of the COVID-19 crisis.

To achieve this, CARE first developed a [policy brief](#) to review lessons learned from previous public health emergencies.² CARE then adapted its [Rapid Gender Analysis](#) toolkit to develop the **Global Rapid Gender Analysis on COVID-19**, conducted in consultation with the International Rescue Committee (IRC). This report is for humanitarians working in fragile contexts that are likely to be affected by the COVID-19 crisis. It is organised around broad themes and areas of focus of particular importance to those whose programming advances gender equality and reduces gender inequalities. It seeks to deepen the current gender analysis available by encompassing learning from global gender data available for the COVID-19 public health emergency.



Key Findings on the Gender Impacts of the COVID-19 Crisis Include:

Demographic data: While data about the gender and age impacts of COVID-19 is emerging, it is incomplete. COVID-19 shows greater direct risks for people over 60, as well as those with underlying medical conditions. From the limited sex-disaggregated data available, it seems that men are at a slightly higher risk with regards to morbidity than women, and at 51%, men make up a slight majority of the infected.

Care-giving burden: Women perform the vast majority of unpaid care work—more than three times as much as men.³ During public health crises such as COVID-19, this labor will often involve taking care of sick family members, and in the case of school closures, looking after children.

Gender, age, intersectionality, and unequal access to health care: Intersectional gender analysis shows that key groups are at direct and indirect risk from COVID-19. This includes the specific vulnerabilities of older people and people with disabilities, as well as the threat of increased racism against people of specific ethnic groups erroneously associated with the virus.

Women health workers: Female health workers face a double caregiving burden—one at work, and one at home. In the workplace, women are, on average, paid less than their male counterparts and less likely to be in a management position. They also risk stigmatisation due to caring for COVID-19 patients.

¹ World Health Organisation (WHO). Director-General's opening remarks at the media briefing on COVID-19. 11 March 2020.

² CARE. Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings (16 March 2020). https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Full_Paper.pdf.

³ International Labour Organisation (ILO). Care Work and Care Jobs for the Future of Decent Work. 2018. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf.

Access to health care: Maternal health is already a critical issue for women around the world. Unfortunately, redirecting resources to COVID-19 prevention and response efforts can make this issue even more dire. Worldwide, 61% of maternal deaths occur in fragile states, many of them affected by conflict and recurring natural disasters.⁴ Additionally, school closures often lead to increased sexual activity. With COVID-19 likely to increase barriers for accessing contraception, this can result in a spike in adolescent pregnancy, which will lead to school drop-outs that will disproportionately affect adolescent girls.⁵

Gender-based violence: There is a high risk that all forms of gender-based violence (GBV) will increase during the COVID-19 pandemic, creating more demand and greater need for services. Women's rights activists in China have reported that domestic violence cases have risen dramatically as people across much of the country have been quarantined, potentially with abusers, during the coronavirus outbreak.⁶

There is neither gender balance nor a gender lens in global COVID-19 decision-making: Decision-making bodies established specifically for COVID-19 do not reflect a gender balance between women and men. For example, 100% of the original United States' Coronavirus Task Force, appointed by President Trump, were male.⁷ There is also a critical dearth of gender and sexual health specialists who can influence key decision-making.⁸

Household power is not equal: Women's health care is not determined solely by the provision of health-care treatments, but also by whether women have free and safe access to such services.⁹

Women require targeted access to information on COVID-19: Humanitarians should provide information about COVID-19 in ways that take into account differing literacy rates amongst women and men, and their different levels of access to mobile phones.

Recommendations include but are not limited to:

- Collect sex- and age-disaggregated data on the direct and indirect impacts of COVID-19.
- Support the development of local Rapid Gender Analyses on COVID-19 and joint multi-sectoral gender analyses as soon as sectoral gender information is available.
- Provide gender-sensitive support to both formal and informal frontline health workers at the facility and community level.
- Support inclusive, two-way, community-based risk communication on COVID-19 that is localized, evidence-based, dispels myths and misinformation, and meets the unique needs of marginalized sub-groups.

⁴ Center for Reproductive Rights (2017). Briefing Paper: Ensuring Sexual and Reproductive Health and Rights of Women and Girls affected by conflict. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictcrisis_2017_07_25.pdf.

⁵ UNFPA. Dr. Mohammed Elhassein. Recovering from the Ebola Virus Disease. Rapid Assessment of Pregnant Adolescent Girls in Sierra Leone. June 2017. <https://sierraleone.unfpa.org/sites/default/files/pub-pdf/Rapid%20Assessment%20of%20Pregnant%20Adolescent%20Girls.pdf>.

⁶ Axios. Bethany Allen-Ebrahimian. China's Domestic Violence Epidemic. 7 March 2020. <https://www.axios.com/china-domestic-violence-coronavirus-quarantine-7b00c3ba-35bc-4d16-afdd-b76ecfb28882.html>.

⁷ White House. Statement from the Press Secretary Regarding the President's Coronavirus Task Force. 29 January, 2020. <https://www.whitehouse.gov/briefings-statements/statement-press-secretary-regarding-presidents-coronavirus-task-force/>.

⁸ Wenham, Clare with Sara Davies: WHO Gender Failures in Global Health Security (paper in draft).

⁹ Sara E. Davies, Belinda Bennett. A Gendered Human Rights Analysis of Ebola and Zika: Locating Gender in Global Health Emergencies, *International Affairs*, Volume 92, Issue 5, September 2016, Pages 1041–1060, <https://doi.org/10.1111/1468-2346.12704>.

- Plan for an increase in GBV cases, and/or an increase in vulnerability and needs of GBV survivors, and strengthen and fill gaps in the provision of local GBV survivor-centered referral systems and services.
- Ensure decision-making bodies are gender-balanced and inclusive, with attention paid to experts like gender specialists and sexual and reproductive health specialists.
- Engage with existing formal and informal social networks such as women's groups, community groups, civil society organisations, and women's right organisations to support their efforts as first responders and their efforts to prevent social isolation.
- Explore how technology can support those in quarantine who need access to GBV services. Build on existing initiatives that provide online support for legal aid and psychosocial support, noting gender disparities in access to technology.



Nurse Tanmoy Das constantly wears gloves and mask in his OST serving room, where he was photographed on March 22, 2020. The facility also has a hand-washing setup for washing hands frequently. © Tasneem Chowdhury/CARE

Introduction

Coronaviruses (CoV) are a large family of viruses that cause illnesses ranging from the common cold to more severe diseases, such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV). A novel coronavirus is a new strain that has not been previously identified in humans. The current outbreak was first reported from Wuhan, China, on 31 December 2019 and has since spread globally. On 30 January 2020, the World Health Organisation (WHO) announced that the COVID-19 outbreak was a Public Health Emergency of International Concern. On 11 March 2020, WHO categorised COVID-19 as a pandemic.¹⁰

Pre-existing gender and intersectional inequalities often worsen during a crisis, including public health emergencies.¹¹ Tragically, these inequalities are not consistently included as part of global frameworks and policies.¹² Recognising the extent to which disease outbreaks affect women, girls, men and boys, people of different genders, and at-risk and marginalised groups in specific ways is fundamental to understanding the impacts of a health emergency in order to create effective, responsive, and equitable policies, preparedness plans, and responses.¹³

CARE International identified the need to analyse the gender and intersectional impacts of COVID-19. To achieve this, CARE first developed a [policy brief](#) to review lessons learned from previous public health emergencies.¹⁴ CARE then adapted its [Rapid Gender Analysis](#) toolkit to develop the **Global Rapid Gender Analysis on COVID-19**, which highlights the gendered impacts of the COVID-19 pandemic. This report is for humanitarians working in fragile contexts that are likely to be affected by the COVID-19 crisis. It is organized around broad themes and areas of focus of particular importance to those whose programming advances gender equality. It seeks to deepen the gender analysis available by bringing learning from the global gender data available for the COVID-19 public health emergency.

“Gender inequities exacerbate outbreaks, and responses that do not incorporate gender analysis exacerbate inequities.”¹⁵

¹⁰ World Health Organisation (WHO). Director-General's Opening Remarks at the Media Briefing on COVID-19. 11 March 2020.

<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020>.

¹¹ Pacific Humanitarian Protection Cluster Support Team, Protection Key Messages for COVID 19 (no link available)

¹² Julia Smith (2019) “Overcoming, the ‘Tyranny of the Urgent’: Integrating Gender Into Disease Outbreak Preparedness and Response,” *Gender & Development*, 27:2, 355-369, <https://doi.org/10.1080/13552074.2019.1615288>.

¹³ The Lancet. COVID-19: The Gendered Impacts of the Outbreak. 6 March 2020 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930526-2>.

¹⁴ CARE. Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings (16 March 2020). https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Full_Paper.pdf.

¹⁵ Think Global Health. Julia Smith. Gender and the Coronavirus Outbreak. 4 February 2020. https://www.thinkglobalhealth.org/article/gender-and-coronavirus-outbreak?utm_source=tw_wfp&utm_medium=social_owned.

Methodology

A Rapid Gender Analysis is built up progressively, to understand gender roles and relations and how they may change during a crisis. Therefore, this initial analysis should be built on as the crisis evolves. This report should be read with CARE International’s recently released Policy Brief, “Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings,”¹⁶ and the Gender in Humanitarian Action Working Group (GiHA) Advocacy Brief, “The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific.”¹⁷

From 12–20 March 2020, a brief secondary data analysis and write-up was undertaken to analyse and explore the current and potential gendered dimensions of the COVID-19 pandemic. The report provides recommendations for the humanitarian system and humanitarian actors to ensure consideration of the gendered dimensions of risk, vulnerability, and capabilities in response and preparedness to this crisis, with a lens toward enabling support for existing humanitarian needs. This report does not aim to answer questions about the epidemiology and pathology of COVID-19.



Officers check a baby's body temperature during his arrival at Indonesia's Yogyakarta Adisutjipto Airport on 5 March, 2020. Checks are carried out to prevent the entry of COVID-19 into the city of Yogyakarta, a tourist destination. © Alamy Stock Photo

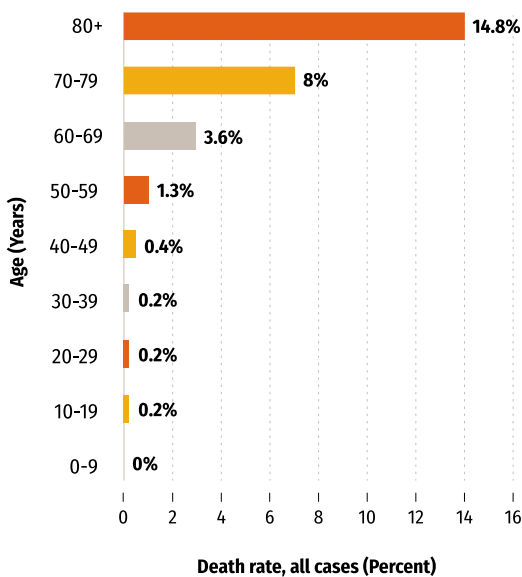
¹⁶ CARE International. Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings. 16 March 2020. https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Full_Paper.pdf.

¹⁷ GiHA Advocacy Brief 'The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific. March 2020. <https://asiapacific.unwomen.org/en/digital-library/publications/2020/03/the-COVID-19-outbreak-and-gender>.

Findings and Analysis

COVID-19 Fatality Rates by Age & Gender

Sex	Death rate, confirmed cases	Death rate, all cases
Male	4.7%	2.8%
Female	2.8%	1.7%



Demographic Data

As of 18 March 2020, health officials had confirmed a worldwide total of 191,127 cases of COVID-19 that had resulted in 7,807 deaths.¹⁸ **At the moment, no global sex- and age-disaggregated data is available for COVID-19.** However, two sources have analysed cases from China. There, the COVID-19 case fatality rate by sex for confirmed cases and all cases is shown in the table to the left,¹⁹ followed by the COVID-19 fatality rate by age for all cases.²⁰ For those over 80 years of age, the case fatality rate for confirmed COVID-19 cases from these studies was as high as 21.9%.²¹ COVID-19 infects people of all ages, although current statistics show greater direct risks for people over 60 years of age, as well as those with underlying medical conditions. The WHO has noted that the risk of severe disease gradually increases with age starting from around 40 years.²²

From the sex-disaggregated data available, it seems that men are slightly more at risk with regards to morbidity than women, and at 51%, men made up a slight majority of the infected.²³ However, women and girls often experience secondary implications during health crises.²⁴

In development and humanitarian contexts, these effects can be magnified, impacting women and girls as well as at-risk and vulnerable groups, including but not limited to:

¹⁸ WHO. Coronavirus Disease 2019 (COVID-19) Situation Report – 58. Updated 18 March 2020. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200318-sitrep-58-COVID-19.pdf?sfvrsn=20876712_2.

¹⁹ Death Rate = (number of deaths / number of cases) = probability of dying if infected by the virus (%). This probability differs depending on sex. The percentages do not have to add up to 100%, as they do not represent share of deaths by age group. Rather, it represents, for a person in a given age group, the risk of dying if infected with COVID-19. When reading these numbers, it must be taken into account that smoking in China is much more prevalent among males. Smoking increases the risks of respiratory complications. See Worldometer. Age, Sex, Existing Conditions of COVID-19 Cases and Deaths. 29 February 2020. <https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/>.

²⁰ *Ibid.*

²¹ *Ibid.* Patients who report no pre-existing ("comorbid") medical conditions had a case fatality rate of 0.9%, compared to those with cardiovascular disease which rose to 10.5%, Diabetes (7.3%), chronic respiratory disease (6.3%), Hypertension (6.0%), Cancer (5.6%) (no sex or age breakdown is available).

²² WHO, Coronavirus Disease 2019 (COVID-19) Situation Report – 51. 11 March 2020.

https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-COVID-19.pdf?sfvrsn=1ba62e57_8.

²³ One theory is that men, particularly in China, are more likely to smoke cigarettes, so have weaker lungs. Cardiovascular disease, which is highly correlated with coronavirus fatalities, is also more prevalent in men. Bloomberg Businessweek. Janet Paskin. Women Are Bearing the Brunt of Coronavirus Disruption. 11 March 2020. <https://www.bloomberg.com/news/articles/2020-03-11/coronavirus-will-make-gender-inequality-worse>.

²⁴ CARE International. Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings. 16 March 2020. https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Full_Paper.pdf.

- Pregnant women
- Lactating women
- Newborns
- Female-headed households
- Adolescent girls
- Refugees,
- Internally displaced persons (IDPs)
- Migrants
- Homeless & street-entrenched populations
- Indigenous women
- Women living in poverty
- The immunocompromised
- Other social and gender minority groups, such as disabled people and LGBTQI+ individuals



Gendered Impact of the Crisis: Roles and Responsibilities

Inequitable gender norms that affect the roles and responsibilities of women, men, girls, and boys are a global phenomenon. The recently published *Gender Social Norms Index* shows that almost 90% of the world population is biased against women and girls.²⁵ Crises, including public health emergencies, affect women, girls, men, and boys in different ways in large part due to the different roles that society ascribes to people based on their gender. This section looks at some of the most important gender roles, responsibilities, and social norms as they relate to public health. This includes the division of labour inside and outside of households, paid and unpaid work, and access to and control over resources in the household and community. Gender roles and responsibilities impact how people of all genders prepare for, respond to, and recover from crises.

Caregiving Burden: Globally, **women perform 76.2% of the total hours of unpaid care work**, more than **three times as much as men**.²⁶ During public health crises such as COVID-19, this may involve taking care of sick family members. As health systems—particularly weak ones—become overwhelmed, women will likely bear the burden of caring for patients that the health system cannot, increasing women’s risk of exposure to the virus.

In addition, women may have additional childcare responsibilities as schools temporarily close. Increased childcare could further limit work and economic opportunities.²⁷ This would have compounding impacts on single-parent families, as well as low-income families, the self-employed, the precariously employed, or those without employment health rights or benefits. These people may not be able to afford or access childcare or take time off of work. For children—particularly girls in crisis contexts—temporary school closures might mean a permanent end to education and a greater chance of spending their life in poverty, with fewer opportunities for their families and communities.²⁸

The economic instability caused by COVID-19 could further create an increased risk for girls with regards to early and child marriage.²⁹

²⁵ UNDP Gender Social Norms Index. <http://hdr.undp.org/en/GSNI>.

²⁶ International Labour Organisation (ILO). Care Work and Care Jobs for the Future of Decent Work. 2018. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf.

²⁷ The Lancet. COVID-19: The Gendered Impacts of the Outbreak. 6 March 2020 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930526-2>.

²⁸ Their World. Safe Schools, Campaign Briefing (no date) <http://s3.amazonaws.com/theirworld-site-resources/Reports/Theirworld-39-million-girls-at-risk.-Are-humanitarian-response-doing-enough.pdf>.

²⁹ *Ibid.*

Weak workplace protections: Women disproportionately hold jobs in industries with poor protections and few benefits, such as paid family leave and paid sick leave.³⁰ It is likely that female overseas domestic workers and members of the gig economy will be particularly affected. Travel bans and quarantine measures can affect migrant workers' ability to travel to their jobs.³¹ Many migrant women do not have employment contracts and therefore if they cannot work, they may not get paid. Conversely, this also intensifies their dependence on their employers for information, support, care, housing, and essential supplies, increasing their potential vulnerability.³² Movement restrictions may also impact women who work in the gig economy, as they are unable to go out to work.³³



Gender, Age, Intersectionality and Unequal Access to Health Care

Public health emergencies increase the burden on health systems, making barriers to accessing quality health services greater for people of all genders. The Ebola crisis in West Africa reduced access to health care services by 50%, in turn leading to increased mortality rates for persons with malaria, HIV, and tuberculosis.³⁴ These barriers are often acutely felt by those who are most marginalized and those who are already at increased risk, as well as those in caregiving roles who take on the additional care work that health systems cannot support.

Poverty and health.³⁵ In countries or sectors where employees do not have health benefits, paid sick leave, or support for child and/or family care, COVID-19 will affect personal and household income, as well as the ability to travel to and/or pay for healthcare, including Sexual and Reproductive Health and Rights (SRHR).³⁶ As governments encourage social distancing, government social welfare systems and public transport may be suspended, meaning that people may be less able to access health services.³⁷

Older people: COVID-19 poses an increased risk of fatalities and indirect social consequences that are likely to affect older people in specific ways. One study found that approximately 25% of older adults fit the definition of socially isolated before COVID-19.³⁸ The social distancing and quarantine tactics used to limit the transmission of COVID-19 can have harmful effects on the physical and mental health of older persons. The links between old age and chronic illness also highlight the importance of continued health and medical care for this group. The level or frequency of care for older persons may be affected if care workers become sick or are required to self-isolate.³⁹

³⁰ TIME. Xanthe Scharff. Why the Coronavirus Outbreak Could Hit Women Hardest. 12 March 2020. <https://time.com/5801897/women-affected-COVID-19/>.

³¹ South China Morning Post. Raquel Carvalho, Elizabeth Cheung and Phila Siu. Health and Environment. Coronavirus: Hong Kong Families Await Return of Thousands of Stranded Domestic Helpers as the Philippines Lifts Travel Ban. 18 February 2020. <https://www.scmp.com/news/hong-kong/health-environment/article/3051077/coronavirus-domestic-helper-tests-positive-taking>.

³² BBC World Service. Women's Affairs East Asia. Lara Owen. Coronavirus: Five Ways Virus Upheaval is Hitting Women in Asia. 8 March 2020. <https://www.bbc.co.uk/news/world-asia-51705199>.

³³ Ministry of Social Welfare, Gender and Children's Affairs, UN Women Sierra Leone, OXFAM Sierra Leone and Statistics Sierra Leone. Report of the Multisector Impact Assessment of Gender Dimensions of the Ebola Virus Disease in Sierra Leone. December 2014. https://awdf.org/wp-content/uploads/FINAL-REPORT-OF-THE-Multi-Sectoral-GENDER-Impact-Assessment_Launchedon_24th-Feb-2015_Family_kingdom_Resort.pdf.

³⁴ Parpia AS, Ndeffo Mbah ML, Wenzel NS, Galvani AP. Effects of Response to the 2014–2015 Ebola Outbreak on Deaths from Malaria, HIV, and Tuberculosis, West Africa. *Emerg Infect Dis*. 2016 Mar [date cited]. <http://dx.doi.org/10.3201/eid2203.150977>.

³⁵ WHO. Environmental Health in Emergencies. Vulnerable Groups. https://www.who.int/environmental_health_emergencies/vulnerable_groups/en/.

³⁶ Guttmacher Institute. Zara Ahmed and Adam Sonfield. Policy analysis. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. 11 March 2020. <https://www.guttmacher.org/article/2020/03/COVID-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights#>.

³⁷ *Ibid*.

³⁸ Vox Media. Umair Irfan and Julia Belluz. Why COVID-19 is so Dangerous for Older Adults. 13 March 2020. <https://www.vox.com/2020/3/12/21173783/coronavirus-death-age-COVID-19-elderly-seniors>.

³⁹ *Ibid*.

People with disabilities: Persons of all ages who identify as having a disability are likely to face challenges during the pandemic, although women with disabilities face specific concerns, such as increased risk of GBV. Many people who require care and/or support workers to provide day-to-day or round-the-clock care have expressed concerns over whether care workers will be able to continue to provide support.⁴⁰ Simultaneously, there are also concerns as to whether care workers could potentially bring the virus into the home due to their contact with other vulnerable persons.⁴¹ Where parents or caregivers have been quarantined, unaccompanied or separated minors, people with disabilities, or older people may be refused care due to fear of infection.⁴²

Refugees and migrants: Globally, there are more than 20 million refugees, 84% of whom are being hosted by low- or middle-income nations with weaker health and water and sanitation systems.⁴³ Those living in camps and informal settlements often face overcrowded conditions, limited health services, and lack access to sanitation facilities and water supplies, contributing to increased likelihood of COVID-19 transmission.⁴⁴ Measures to contain COVID-19, such as the closure of formal border crossings, will likely result in increased use of informal crossings, in turn intensifying barriers to healthcare for these groups, and reducing the ability of epidemiologists to track the spread of COVID-19.⁴⁵



For example, Colombia announced the closure of the border with Venezuela, unsettling those in Venezuela who rely on medicine, medical supplies, and other goods from Colombia. Migrants who are not registered under the Colombian health system will be particularly vulnerable in this crisis.

Social-, sexual-, and gender-minority groups: Minority groups experience additional barriers to accessing health care and social support systems. LGBTQI+ individuals, particularly older persons, are less likely than their heterosexual and cisgender peers to be able to access programs and healthcare due to discrimination, unwelcoming attitudes, and a lack of understanding from providers.⁴⁶ The same is true of people working in marginalized professions, such as sex workers, who also face many of the same barriers of attitude, knowledge, and service.

⁴⁰ ABC. Nastasia Campanella. How Will People With Disabilities Deal With the COVID-19 Lockdown? 14 March 2020. <https://www.abc.net.au/radio/programs/am/how-will-people-with-disabilities-deal-with-COVID-19-lockdown/12056176>.

⁴¹ *Ibid.*

⁴² IASC. Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak-Version 1.1. 2 March 2020. <https://interagencystandingcommittee.org/system/files/2020-03/MHPSS%20COVID19%20Briefing%20Note%202%20March%202020-English.pdf>.

⁴³ UNHCR. UN Refugee Agency Steps Up COVID-19 Preparedness, Prevention and Response Measures. 10 March 2020. <https://www.unhcr.org/en-us/news/press/2020/3/5e677f634/un-refugee-agency-steps-COVID-19-preparedness-prevention-response-measures.html>.

⁴⁴ The New Humanitarian. Eric Reidy. How the Coronavirus Outbreak Could Hit Refugees and Migrants. 27 February 2020. <https://www.thenewhumanitarian.org/news/2020/02/27/Coronavirus-Iran-refugees-IDPs-Italy-Europe-disease>. See also Medecins Sans Frontieres. As Coronavirus Spreads, Evacuating Greece's Squalid Refugee Camps is More Urgent Than Ever. 12 March 2020. <https://www.doctorswithoutborders.org/what-we-do/news-stories/news/coronavirus-spreads-evacuating-greeces-squalid-refugee-camps-more>. and Social Science in Humanitarian Action. Annie Wilkinson. The Impact of COVID-19 in Informal Settlements – Are We Paying Enough Attention? 10 March 2020. <https://www.socialscienceinaction.org/blog/impact-COVID-19-informal-settlements-paying-enough-attention/>.

⁴⁵ Al Jazeera. Steven Grattan. Fear as Colombia Closes Border With Venezuela Over Coronavirus. 14 March 2020. <https://www.aljazeera.com/news/2020/03/fear-colombia-closes-border-venezuela-coronavirus-200314190110784.html>.

⁴⁶ National LGBT Cancer Network. Coronavirus 2019 Information. <https://cancer-network.org/coronavirus-2019-lgbtq-info/>.

Racism: Increasingly, reports of mistreatment of and prejudice against people who are or are perceived as being Asian, due to myths that they could be a source COVID-19.^{47,48} As the COVID-19 crisis continues, this discrimination and prejudice could expand to other groups perceived to be from areas where the virus is developing. As of March 18, there were reports of this occurring in countries across Europe, North America, and West Africa, among others. Furthermore, the fear of stigmatisation and discrimination due to association with the disease is a common response, and this fear compromises the well-being of individuals.⁴⁹ The fear of discrimination or experience of actual discrimination can affect health-seeking behaviour as well as health service provider attitudes. These concerns will be further compounded for refugees, migrants, IDPs, and homeless and street-entrenched populations who are, even at the best of times, often subject to xenophobic policies and attitudes.



Women as Health Workers

The WHO have identified the people most at risk of COVID-19 infection as those in contact with COVID-19 patients and/or those who care for COVID-19 patients, meaning health workers are at a high risk of infection.⁵⁰ Research has shown that 70% of workers in the health and social sector are women.⁵¹ This sub-section explores the specific issues facing women as all types of health workers.

Double burden of care: The additional demands placed on health services may require health workers to work longer hours, which can place physical and psychological strain on women who may have to juggle this additional workload with their household caregiving role. The double-burden may also limit their access to other social support, due to the increased workload.^{52,53}

Women's lack of decision-making power in health systems: Despite women constituting the majority of health and social care workers, a recent report showed that more than 70% of CEOs in global organisations active in health are male, and **just 5% are women from low- and middle-income countries**.⁵⁴ These statistics demonstrate an extreme lack of women in leadership and decision-making positions, a disparity that negatively affects health outcomes for women and children worldwide.⁵⁵

⁴⁷ IFRC, WHO, UNICEF, Social Stigma Associated with COVID-19. [https://www.unicef.org/media/65931/file/Social%20stigma%20associated%20with%20the%20coronavirus%20disease%202019%20\(COVID-19\).pdf](https://www.unicef.org/media/65931/file/Social%20stigma%20associated%20with%20the%20coronavirus%20disease%202019%20(COVID-19).pdf).

⁴⁸ The New Humanitarian. Eric Reidy. How the Coronavirus Outbreak Could Hit Refugees and Migrants. 27 February 2020. <https://www.thenewhumanitarian.org/news/2020/02/27/Coronavirus-Iran-refugees-IDPs-Italy-Europe-disease>.

⁴⁹ IASC. Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak-Version 1.1. 2 March 2020. <https://interagencystandingcommittee.org/system/files/2020-03/MHPSS%20COVID19%20Briefing%20Note%202%20March%202020-English.pdf>.

⁵⁰ WHO. Health Workers Exposure Risk Assessment and Management in the Context of COVID-19 Virus. Interim Guidance. 4 March 2020. https://apps.who.int/iris/bitstream/handle/10665/331340/WHO-2019-nCov-HCW_risk_assessment-2020.1-eng.pdf.

⁵¹ WHO. Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender Equity in the Health Workforce: Analysis of 104 Countries. Working paper 1. 2019. <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?ua=1>.

⁵² IASC. Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak-Version 1.1. 2 March 2020. <https://interagencystandingcommittee.org/system/files/2020-03/MHPSS%20COVID19%20Briefing%20Note%202%20March%202020-English.pdf>.

⁵³ Think Global Health. Julia Smith. Gender and the Coronavirus Outbreak. 4 February 2020. https://www.thinkglobalhealth.org/article/gender-and-coronavirus-outbreak?utm_source=tw_wfp&utm_medium=social_owned.

⁵⁴ Global Health 50/50, 'The Global Health 50/50 Report 2020: Power, Privilege and Priorities', London, UK, 2020. <https://globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf>.

⁵⁵ The Lancet. Female Global Health Leadership: Data-driven Approaches to Close the Gender Gap. 9 February 2019. <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2930203-X>.

Lack of gender balance and gender lens in global COVID-19 decision-making. Despite the WHO recognizing that women must be included in decision-making, decision-making bodies established specifically for COVID-19 do not reflect a gender balance between women and men.⁵⁶ For example, 100% of the original United States' Coronavirus Task Force, appointed by President Trump, were male.⁵⁷ Despite a clear need for a gender lens in the COVID-19 crisis, there is a critical gap of gender specialists who can influence key decision-making. The WHO's framework of governance of outbreaks of infectious disease do not require a gender specialist to be involved in decision-making task forces.⁵⁸

Stigmatisation of health workers: There could also be increased stigmatisation against frontline workers who may have been in contact with patients of COVID-19.⁵⁹ An increased risk of violence and harassment towards health workers as a result of the crisis has been noted, a trend reported particularly against female health workers in previous public health emergencies.⁶⁰

The health profession's gender pay gap: Women health care workers face gender-related pay gaps. On average they earn 28% less than their male colleagues.⁶¹ The impacts of this pay gap may be exacerbated in crisis, as lower pay means a person has less ability to save money and less financial security to fall back on if necessary.⁶²

Care in the community: Even with social distancing, there has been evidence of social solidarity within communities. However, this likely means an increased general care burden for women, which also increases their health risks and exposure to the virus. These risks need to be taken into account when designing community care and community health strategies. Finally, it is important to note that people of different genders and marginalized groups may be overlooked in community care networks unless they receive specific outreach and safe, inclusive, support.



Women and Girls' Access to Sexual and Reproductive Health Rights

The scale of the COVID-19 pandemic means that resources are already being diverted from existing health services to support responses to the crisis. In some contexts this may lead to a shortage of health professionals, financial resources, and medication to support critical SRHR services.⁶³ Tragically, maternal health is already a critical issue for women around the world: 61% of maternal deaths worldwide occur in fragile states, many of them affected by conflict and recurring natural disasters.⁶⁴

⁵⁶ WHO. [Strengthening Preparedness for Health Emergencies: Implementation of International Health Regulations \(IHR, 2005\)](#).

⁵⁷ White House. Statement from the Press Secretary Regarding the President's Coronavirus Task Force. 29 January, 2020. <https://www.whitehouse.gov/briefings-statements/statement-press-secretary-regarding-presidents-coronavirus-task-force/>.

⁵⁸ Email correspondence with Wenham, Clare and Sara Davies: WHO Gender Failures in Global Health Security (paper in draft).

⁵⁹ IASC. Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak-Version 1.1. 2 March 2020. <https://interagencystandingcommittee.org/system/files/2020-03/MHPSS%20COVID19%20Briefing%20Note%202%20March%202020-English.pdf>.

⁶⁰ DFID. Dr Erika Fraser. Impact of COVID-19 Pandemic on Violence against Women and Girls. 16 March 2020. <http://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-COVID-19-and-vawg.pdf>.

⁶¹ WHO. Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender equity in the health workforce: analysis of 104 countries. Working paper 1. Geneva: World Health Organization; 2019. https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019_1-eng.pdf?ua=1.

⁶² Bloomberg. Jeff Green and Katia Dmitrieva. Women, on the Front Lines of COVID-19, Are at High Economic Risk. 18 March 2020. <https://www.bloomberg.com/news/articles/2020-03-18/women-on-the-front-lines-of-COVID-19-are-at-high-economic-risk>.

⁶³ Guttmacher Institute. Zara Ahmed and Adam Sonfield. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. 11 March 2020. <https://www.guttmacher.org/article/2020/03/COVID-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights#>.

⁶⁴ Center for Reproductive Rights. Briefing Paper: Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict. 2017. https://www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/ga_bp_conflictnrcris_2017_07_25.pdf.

Reductions in SRHR services will have a greater effect on patients who rely on free or subsidized care; particularly women, girls, and/or other marginalized groups living in poverty and/or those already facing other barriers to SRHR health care.⁶⁵

Contexts with weak health systems, poor access to SRHR services, restrictive laws, and unequal gender norms often have poor reproductive and maternal health care, which is exacerbated when scarce resources are diverted to outbreak responses.⁶⁶ The West African Ebola outbreak resulted in NGOs and non-Ebola health service providers closing across the region. This reduced access to family planning services, increasing the risk of unplanned pregnancies.⁶⁷ The closure of maternal health clinics consequently led to the maternal mortality rate in the region, which was already one of the highest in the world, to increase by 70 percent.⁶⁸

School closures often lead to increased sexual activity amongst teenagers.⁶⁹ With enhanced barriers for accessing contraception, this can result in an increase in adolescent pregnancy and, eventually, school drop-out rates that will disproportionately affect adolescent girls.⁷⁰

It is important that there are no disruptions to the provision of and access to lifesaving SRHR services while health systems continue to adapt to the additional demands to their services and supplies, in line with the Minimum Initial Service Package (MISP) for SRH in crisis-settings.⁷¹ Existing government policies can make the scale-up of SRHR services for women and girls in crisis situations challenging. For example, the Mexico City Policy, also known as the Global Gag Rule, will hamper the ability of non-U.S. organizations to fill gaps in sexual and reproductive health services created by the COVID-19 response.⁷²

Pregnancy: No reliable evidence is yet available to support the possibility of vertical transmission of a COVID-19 infection from mother to child.^{73,74} However, pregnant women and newborns experience physical and developmental changes that often make them vulnerable to viral respiratory infections such as COVID-19.

⁶⁵ Guttmacher Institute. Zara Ahmed and Adam Sonfield. Policy analysis. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. 11 March 2020. <https://www.guttmacher.org/article/2020/03/COVID-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights#>.

⁶⁶ Julia Smith. 2019. "Overcoming the 'Tyranny of the Urgent': Integrating Gender into Disease Outbreak Preparedness and Response," *Gender & Development*, 27:2, 355-369, <https://doi.org/10.1080/13552074.2019.1615288>.

⁶⁷ *Ibid*.

⁶⁸ Think Global Health. Julia Smith. Gender and the Coronavirus Outbreak. 4 February 2020. https://www.thinkglobalhealth.org/article/gender-and-coronavirus-outbreak?utm_source=tw_wfp&utm_medium=social_owned.

⁶⁹ Kostelny, K., Lamin, D., Manyeh, M., Ondoro, K., Stark, L., Lilley, S., & Wessells, M. (2016). 'Worse Than the War': An Ethnographic Study of the Impact of the Ebola Crisis on Life, Sex, Teenage Pregnancy, and a Community-driven Intervention in Rural Sierra Leone." Save the Children. <https://resourcecentre.savethechildren.net/node/14092/pdf/worse-than-the-war-post-ebola-ethnographic-report-on-sierra-leone.pdf>.

⁷⁰ UNFPA. Dr. Mohammed Elhassen. Recovering from the Ebola Virus Disease. Rapid Assessment of Pregnant Adolescent Girls in Sierra Leone. June 2017. <https://sierraleone.unfpa.org/sites/default/files/pub-pdf/Rapid%20Assessment%20of%20Pregnant%20Adolescent%20Girls.pdf>.

⁷¹ Interagency Working Group on Reproductive Health in Crisis. MISP. <http://iawg.net/areas-of-focus/misp/>.

⁷² Guttmacher Institute. Zara Ahmed and Adam Sonfield. Policy analysis. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. 11 March 2020. <https://www.guttmacher.org/article/2020/03/COVID-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights#>.

⁷³ The Lancet. What Are the Risks of COVID-19 Infection in Pregnant Women? 12 February 2020 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930365-2>.

⁷⁴ Centers for Disease Control and Prevention. Information on COVID-19 and Pregnant Women and Children. Pregnancy & Breastfeeding. Information about Coronavirus Disease 2019. https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/pregnant-women-and-children.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fpregnant-women.html

Further, the indirect effects of COVID-19, including disrupted health services, are likely to have consequences for pregnant women. This warrants an enhanced focus on primary prevention and data collection on pregnant women.⁷⁵ To date, there has been one case of a newborn testing positive for COVID-19, but it is not known whether the virus was contracted in the womb or during delivery.⁷⁶ No evidence of the virus has been found in the breast milk of women with COVID-19 to date and, thus far, no information is available regarding whether COVID-19 could be present in the breast milk of an infected woman.⁷⁷ Thus, advice from WHO and UNFPA states that breastfeeding women should not be separated from their newborns, but ill and symptomatic mothers should heed precautions including self-isolation.

78,79

Gender-based Violence

Globally, more than 35% of women will experience GBV in their lifetime. In humanitarian crises, compounding factors, such as increased anxiety and stress levels and economic hardships, can further increase GBV rates.⁸⁰

Women's rights activists in China have reported that domestic violence cases have risen dramatically as people across much of the country have been quarantined during the coronavirus outbreak.⁸¹ Wan Fei, a retired police officer and founder of an anti-domestic violence nonprofit in Jingzhou, reports that “the epidemic has had a huge impact on domestic violence...According to our statistics, 90% of the causes of violence are related to the COVID-19 epidemic.”⁸²

Lockdown and violence: As important as mandatory lockdowns, quarantine, and self-isolation are, these measures can have harmful effects on those in already violent situations. Individuals, particularly women, are essentially trapped with their abuser with no physical respite from the abusive relationship.⁸³ The abuser can also use the virus to further isolate their victim from family, friends, and social networks, as well as from the services that could support them.⁸⁴

⁷⁵ Guttmacher Institute. Zara Ahmed and Adam Sonfield. Policy analysis. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. 11 March 2020. <https://www.guttmacher.org/article/2020/03/COVID-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights#>.

⁷⁶ The Guardian. Simon Murphy. Newborn Baby Tests Positive for Coronavirus in London. 14 March 2020. <https://www.theguardian.com/world/2020/mar/14/newborn-baby-tests-positive-for-coronavirus-in-london>.

⁷⁷ Centers for Disease Control and Prevention. Pregnancy & Breastfeeding. Information about Coronavirus Disease 2019. https://www.cdc.gov/coronavirus/2019-ncov/prepare/pregnancy-breastfeeding.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fpregnancy-faq.html.

⁷⁸ WHO. Clinical Management of Severe Acute Respiratory Infection. (SARI) When COVID-19 Disease is Suspected. Interim guidance. 13 March 2020. <https://apps.who.int/iris/handle/10665/331446?show=full>.

⁷⁹ UNFPA. UNFPA Statement on Novel Coronavirus (COVID-19) and Pregnancy. 5 March 2020. <https://www.unfpa.org/press/unfpa-statement-novel-coronavirus-COVID-19-and-pregnancy>.

⁸⁰ WHO. Health Cluster. Gender-based Violence in Health Emergencies. <https://www.who.int/health-cluster/about/work/other-collaborations/gender-based-violence/en/>.

⁸¹ Axios. Bethany Allen-Ebrahimian. China's Domestic Violence Epidemic. 7 March 2020. <https://www.axios.com/china-domestic-violence-coronavirus-quarantine-7b00c3ba-35bc-4d16-afdd-b76ecfb28882.html>.

⁸² An example in the report comes from a police station in Jianli County, which is administered by Jingzhou, had received 162 reports of domestic violence in February—three times more than the 47 reported during the same month the previous year. The number of cases reported in January had also doubled compared with the same period last year. See Sixth Tone. Zhang Wanqing. Domestic Violence Cases Surge During COVID-19 Epidemic. 2 March 2020. <https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-COVID-19-epidemic>.

⁸³ Huffington Post. Melissa Jeltsen. Home Is Not A Safe Place for Everyone. 13 March 2020. https://www.huffingtonpost.co.uk/entry/domestic-violence-coronavirus_n_5e6a6ac1c5b6bd8156f3641b?ri18n=true&guccounter=1.

⁸⁴ Time. Melissa Godin. As Cities Around the World Go on Lockdown, Victims of Domestic Violence Look for a Way Out. 18 March 2020. <https://time.com/5803887/coronavirus-domestic-violence-victims/>.

GBV services: There is a high risk of GBV increasing during the COVID-19 pandemic as movement restrictions trap women and children.⁸⁵ Potential loss of income due to self-isolation, potential lack of information regarding which GBV services remain available, and fears of contracting the virus at service points could create multiple barriers whereby survivors of GBV may find themselves in a near impossible situation: unable to seek support, unable to access services, and unable to leave their abusers.⁸⁶

Simultaneously, GBV response and prevention services may be weakened as already limited resources are diverted to fund infection control and treatment. Movement restrictions and court closures could prevent or delay legal protection for survivors.⁸⁷ Access to services could be further restricted for survivors with unclear immigration status, sex workers, and/or homeless and street-entrenched populations.⁸⁸

Sexual exploitation and abuse: An overall economic downturn can result in a spike in sexual exploitation and abuse. At-risk groups—such as those listed on page 8, among others—who are struggling financially may be forced or coerced to provide sex in exchange for food.⁸⁹ This was seen during the West Africa Ebola outbreak, with single female-headed households at additional risk.⁹⁰ Emerging evidence, as well as research undertaken following the West Africa Ebola outbreak, suggests that the COVID-19 pandemic has the potential to increase the risks of sexual exploitation and violence by state officials and armed guards.⁹¹

Decision-making and Leadership

In almost every country around the world, women are less likely than men to be decision-makers and leaders at all levels. This exclusion is compounded for marginalized women. According to the UN Gender Social Norms Index, more than 50% of men and women around the world believe that men are better political leaders than women.⁹² This belief is reflected in the gender-balance of parliaments worldwide, with women comprising only 24.5% of parliamentarians.⁹³

Household Power: Women's health care is not determined solely by the provision of health-care treatments, but also by whether women have free and safe access to such services.⁹⁴ In contexts where men hold the majority or all decision-making power in the household, this can limit women's access to health and SRHR services, particularly if they have restricted freedom of movement or if they have no control over household finances.

⁸⁵ The Alliance for Child Protection in Humanitarian Action, Technical Note: Protection of Children during the Coronavirus Pandemic, Version 1, March 2019.

⁸⁶ Huffington Post. Melissa Jeltsen. Home Is Not A Safe Place For Everyone. 13 March 2020. https://www.huffingtonpost.co.uk/entry/domestic-violence-coronavirus_n_5e6a6ac1c5b6bd8156f3641b?ri18n=true&guccounter=1.

⁸⁷ Sanctuary for Families. Hon. Judy H. Kluger. An Update From Sanctuary for Families Regarding COVID-19. 13 March, 2020. <https://sanctuaryforfamilies.org/update-COVID19/>.

⁸⁸ *Ibid.*

⁸⁹ IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action. Reducing Risk, Promoting Resilience and Aiding Recovery. 2015. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

⁹⁰ CARE. Nidhi Kapur. Gender Analysis: Prevention and Response to Ebola Virus Disease in the Democratic Republic of Congo. 31 January 2020. <https://reliefweb.int/report/democratic-republic-congo/gender-analysis-prevention-and-response-ebola-virus-disease>.

⁹¹ It was noted that there is no data yet on gendered state violence due to the pandemic. DFID. Dr Erika Fraser. Impact of COVID-19 Pandemic on Violence against Women and Girls. 16 March 2020. <http://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-COVID-19-and-vawg.pdf>.

⁹² United Nations Development Programme. 2020 Human Development Perspectives. Tackling Social Norms: A Game Changer for Gender Inequalities. 2020. <http://hdr.undp.org/en/GSNI>.

⁹³ Inter-Parliamentary Union. "Women in National Parliaments." 2019. <http://archive.ipu.org/wmn-e/world.htm>.

⁹⁴ Sara E. Davies, Belinda Bennett. A Gendered Human Rights Analysis of Ebola and Zika: Locating Gender in Global Health Emergencies, *International Affairs*, Volume 92, Issue 5, September 2016, Pages 1041–1060, <https://doi.org/10.1111/1468-2346.12704>.

Gender dynamics between heterosexual couples were noted during the Ebola crisis, with women often having less individual agency and decision-making power than their male partners.⁹⁵

Women’s participation in community decision-making: Women’s frontline interaction with communities and socially prescribed care roles place them in a prime position to identify outbreak trends at the local level, which is why it is concerning that women have not been fully incorporated into global health security surveillance, detection, and prevention mechanisms.⁹⁶ In humanitarian crises, women and girls are often excluded from community-level decision-making processes and governance structures that shape the response strategies.⁹⁷ As late as 2018, only 56% of the monitored crisis contexts directly consulted with local women’s organizations in the humanitarian planning process.⁹⁸

Women’s voices: Women should not be further burdened, particularly since much of their labour during health crises goes underpaid or unpaid.⁹⁹ That said, incorporating women’s voices and knowledge is critical at all stages of outbreak preparedness and response. Social norms and gender roles often restrict women’s ability to participate in decision-making processes, and this impacts the degree to which their specific needs are taken into consideration, both during the response itself and later, during the design and implementation of economic relief packages, new services, or other support systems.¹⁰⁰

Equity issues are only meaningfully integrated into emergency responses when women and marginalized groups are able to participate in decision-making.¹⁰¹ Rather than perpetuating existing gender inequalities and disparities, the COVID-19 crisis is an opportunity to challenge entrenched social dynamics in a way that benefits both women and men.¹⁰²



Access to Information

As the COVID-19 crisis develops, updated information is crucially important. At global and local levels, it is important that information reaches and is understood by everyone, particularly at-risk groups. Around the world, literacy is highly gendered: young women accounted for 59% of the total illiterate youth population.¹⁰³ UNICEF’s statistics show that in one-third of countries, particularly in West and Central Africa and South Asia, illiterate women far outnumber their male counterparts.¹⁰⁴ Data on gendered access to information about COVID-19 is scarce. This will be an important area to explore for future analysis as the crisis unfolds, particularly in local-level responses.

⁹⁵ CARE. Nidhi Kapur. Gender Analysis: Prevention and Response to Ebola Virus Disease in the Democratic Republic of Congo. 31 January 2020. <https://reliefweb.int/report/democratic-republic-congo/gender-analysis-prevention-and-response-ebola-virus-disease>.

⁹⁶ The Lancet. COVID-19: The Gendered Impacts of the Outbreak. 6 March 2020 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930526-2>.

⁹⁷ UNWOMEN. Europe and Central Asia. Women in Humanitarian Action. <https://eca.unwomen.org/en/news/in-focus/humanitarian-action>.

⁹⁸ The IASC Gender Accountability Framework Report (2018). <https://interagencystandingcommittee.org/system/files/2020-02/IASC%20AF%20Gender%20Report%202018%20with%20Recommendations%20Table.pdf>.

⁹⁹ The Lancet. COVID-19: The Gendered Impacts of the Outbreak. 6 March 2020 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930526-2>.

¹⁰⁰ CARE. Women and Girls in Emergencies. 2018. https://insights.careinternational.org.uk/media/k2/attachments/CARE_Women-and-girls-in-emergencies_2018.pdf.

¹⁰¹ Think Global Health. Julia Smith. Gender and the Coronavirus Outbreak. 4 February 2020. <https://www.thinkglobalhealth.org/article/gender-and-coronavirus-outbreak>.

¹⁰² Bloomberg Businessweek. Janet Paskin. Women Are Bearing the Brunt of Coronavirus Disruption. 11 March 2020. <https://www.bloomberg.com/news/articles/2020-03-11/coronavirus-will-make-gender-inequality-worse>.

¹⁰³ UNICEF. Literacy. Literacy Among Youth Is Rising, But Young Women Lag Behind. October 2019. <https://data.unicef.org/topic/education/literacy/>.

¹⁰⁴ *Ibid.*

Unequal access to mobile phones: Mobile phones are a critical way of connecting with information and with others around the world. As countries enplace movement restrictions and prevent women and girls from physically accessing safe spaces and services, it is important to understand how gender affects access to mobile phones. While women’s access to mobile phones has increased globally, women in low- and middle-income countries are 10% less likely than men to own one.

The Global System for Mobile Communications (GSMA) estimates that there are 443 million “unconnected” women in the world.¹⁰⁵ Women also have a lower awareness of mobile internet and services than men across almost all low- and middle-income countries. For example, women in South Asia are 28% less likely to own a mobile phone than a man.¹⁰⁶ In refugee populations, data is even more stark. In Tanzania’s Nyarugusu refugee camp, research showed a 42% gender gap in mobile phone ownership.¹⁰⁷

Recognizing the gender-gap: Research conducted by Translators Without Borders highlighted the gender gap in comprehension of Ebola-related community messages.¹⁰⁸ This proves the necessity for hyper-localised key messages, particularly in contexts with low literacy levels and linguistic diversity. Further, not only were women sometimes disadvantaged in terms of access to and comprehension of key messages, they are also frequently hampered in their ability to carry out recommendations precisely because of their gender. For example, while prevention protocols dictated that contact with suspected Ebola cases should be avoided, women were typically expected to care for the sick at home and/or accompany them to hospital, whereas men were not.¹⁰⁹ This highlights the need for those creating messaging to consider and adapt those messages to the roles and responsibilities of men and women to ensure effective prevention and response measures.

Access to inclusive information: There have already been reports that messaging around COVID-19 presents challenges for persons who identify as having a disability and that adapted and inclusive messaging is not being systematically applied throughout responses to COVID-19.¹¹⁰ One example referred to Canadian Prime Minister Trudeau’s recent address to the nation, which did not include sign language interpretation.¹¹¹



Recommendations

A Rapid Gender Analysis is designed to be updated as the situation evolves and new information becomes available. This is particularly important given the lack of gender and intersectional data currently available on the different impacts of COVID-19.

¹⁰⁵ The GSMA defines this as “a person who has sole or main use of a SIM card, or a mobile phone that does not require a SIM, and uses it at least once a month.”

¹⁰⁶ GSMA. “Connected Women: The Mobile Gender Gap Report.” 2019. <https://www.gsma.com/mobilefordevelopment/wp-content/uploads/2019/02/GSMA-The-Mobile-Gender-Gap-Report-2019.pdf>.

¹⁰⁷ GSMA. “Bridging the Mobile Gender Gap for Refugees.” March 2019. https://www.gsma.com/mobilefordevelopment/wp-content/uploads/2019/04/M4H_GenderGapRefugeeContexts.pdf.

¹⁰⁸ Translators Without Borders. Mahrukh Maya Hasan. Missing the Mark? People in Eastern DRC Need Information on Ebola in a Language They Understand. 15 March 2019. https://translatorswithoutborders.org/wp-content/uploads/2019/03/DRC_Ebola_Assessment_English.pdf

¹⁰⁹ CARE. Nidhi Kapur. Gender Analysis: Prevention and Response to Ebola Virus Disease in the Democratic Republic of Congo. 31 January 2020. <https://reliefweb.int/report/democratic-republic-congo/gender-analysis-prevention-and-response-ebola-virus-disease>.

¹¹⁰ CTV News. Michelle McQuigge. Disabled Canadians feel excluded from COVID-19 messaging. March 18, 2020. <https://www.ctvnews.ca/health/coronavirus/disabled-canadians-feel-excluded-from-COVID-19-messaging-1.4857691>.

¹¹¹ *Ibid.*

Humanitarian analysis and assessment

- **Collect sex- and age-disaggregated data for COVID-19:** Systematically collect sex- and age-disaggregated data on the direct and indirect effects of COVID-19. Additional disaggregation by identified at-risk groups, such as pregnant women, should be prioritised.
- **Support the development of local and regional Rapid Gender Analyses on COVID-19:** CARE will support such analyses, using context specific primary and secondary data to support local efforts to prevent and respond to both the outbreak and its economic and social fallout.
- **Include gender indicators in sectoral assessments for COVID-19:** To assess the impacts and trends of the virus on different groups, and to ensure effective programming and advocacy, humanitarians should consider gender implications while conducting sectoral assessments. Initial sector-specific recommendations are outlined in the [CARE COVID-19 Policy Paper](#) and in the IASC Gender Alert for COVID-19.
- **Provide inter-agency, multi-sectoral gender analyses:** Such analyses should be prepared as soon as data is available. The findings must be made widely available across the humanitarian, public health, and government sectors to inform multi-level, gender-inclusive responses.

Decision-making and leadership

- **Build on local community capacities of women, men, and adolescent boys and girls:** Engage with existing informal and formal social networks such as women's groups, community groups, civil society organizations, and women's right organisations to support their efforts as first responders and their solidarity efforts to prevent social isolation.
- **Establish and/or strengthen inclusive community outreach strategies:** Humanitarian actors should collaborate with community-based organizations to ensure messaging is localized, evidence-based, clear, and grounded in positive, social norm change stories that address the unique needs of sub-groups of affected populations.
- **Support two-way, community-based risk communication and accountability approaches:** Leverage the capacities of community groups, particularly women's groups, to support two-way risk communication approaches in order to dispel myths and misinformation about COVID-19. Where feasible, engage them to support local surveillance systems.¹¹²
- **Address gaps in women's participation in decision-making in the workplace:** Work with employers, including health care providers, to address the specific risk of COVID-19 exposure to women and to take into account women's heightened unpaid care work responsibilities.
- **Ensure coordination and decision-making bodies are gender-balanced and inclusive:** Meaningfully engage women, adolescent girls, and marginalized groups in leadership and decision-making roles throughout the COVID-19 preparedness and response by using quotas, targets, and other mechanisms at global, national, and local levels.
- **Use existing gender analysis and include gender specialists:** Decision-makers and those coordinating response efforts should use existing gender analyses and include gender specialists at all levels to inform COVID-19 preparedness and response measures.

¹¹² McKay G, Black B, Mbambu Kahamba S, Wheeler E, Mearns S, Janvrin A. Not All That Bleeds Is Ebola: How Has the DRC Ebola Outbreak Impacted Sexual and Reproductive Health in North-Kivu? New York, USA: The International Rescue Committee 2019.

Health, including Sexual and Reproductive Health and Rights

- **Provide gender-sensitive support to frontline health workers at facility and community-levels:** Provide adequate personal protective equipment (PPE) and strive to meet the psychosocial, menstrual hygiene, and family care needs of health workers.¹¹³
- **Offer additional financial, human, or logistical support to female health workers** to offset the additional burden of household management and.
- **Ensure continuity for the provision of life-saving health services including SRHR in line with the MISP,** particularly where primary health resources are diverted to the COVID-19 response.¹¹⁴ Moreover, finances earmarked for SRHR should be not reduced, suspended, or cancelled. Where appropriate, continue cash and voucher assistance to connect communities to the quality products and services they need.



Women's choices and rights to sexual and reproductive health care should be respected regardless of COVID-19 status in line with the MISP. Pregnant women with suspected, probable, or confirmed COVID-19, including women who may need to spend time in isolation, should have access to timely woman-centred, respectful, and skilled care. This should include obstetric, fetal medicine, and neonatal care, as well as mental health and psychosocial support with readiness to care for maternal and neonatal complications.

- **Ensure inclusion of SRHR experts in coordination and planning.** Addressing SRHR gaps in coordination and planning for COVID-related program and clinical guidelines is essential, as learned from the Ebola response.
- **Address stigma, xenophobia, and other power dynamics** that serve as barriers to accessing services. This should include shelter and safe spaces for self-isolation and care. Humanitarian actors must work at the health facility and community levels to address gender and social norms that hinder access to life-saving health/SRHR for marginalized groups.

Prevention, mitigation and response to GBV

- **GBV prevention and response are life-saving interventions:** Include them as part of the initial COVID-19 responses. This includes, but is not limited to, the clinical management of rape, psychological first aid, and referral to other services, including case management.
- **Plan for an expected increase in domestic violence and other forms of GBV cases:** Support supply chain management and service provision plans accordingly to ensure services stay open during the COVID-19 outbreak. Ensure that GBV survivors have access to the cash resources they need to support themselves safely, outside of violent spaces.

¹¹³ Given the limited availability of personal protective equipment, follow WHO guidance on rational use of PPE. <https://apps.who.int/iris/handle/10665/331215>.

¹¹⁴ UNFPA. What is the Minimum Initial Service Package? 2015. <https://www.unfpa.org/resources/what-minimum-initial-service-package>.

- **Liaise with GBV service providers and actors:** Work with providers in COVID-19 affected areas to regularly map available GBV response services and timely identify gaps in service provision. Work with local partners to strengthen and fill gaps in the provision of local survivor-centered referral systems and services caused by the COVID-19 pandemic.
- **Partner with women’s organizations and local GBV service providers:** To provide them with core operational support whenever possible. Extend these arrangements to include shelters, safe spaces, and organizations supporting LGBTQI+ populations and/or others who might be disproportionately impacted and affected by increased violence or safe space closures due to direct or impacts of the COVID-19 pandemic.
- **Explore how technology can provide support to those in quarantine to access GBV services:** Build on existing initiatives that provide online support for legal aid or psychosocial support, noting the gender disparities in access to technology. Ensure updated referral pathways are regularly disseminated to reliably bring information to at-risk groups.
- **Closely monitor GBV trends and protection risks:** Ensure integration of GBV risk mitigation actions, as outlined in the IASC GBV Guidelines, across sectoral interventions related to COVID-19.¹¹⁵
- **Use a GBV risk mitigation approach:** Especially when working toward women’s economic empowerment strategies¹¹⁶ and when providing cash and voucher assistance, due to the unique risks connected to these modalities in times of economic scarcity.¹¹⁷
- **Apply a zero-tolerance approach to sexual exploitation and abuse:** All staff and volunteers must be briefed on and have signed and understood an industry-standard code of conduct and PSEA obligations. PSEA reporting mechanisms for the local context must be understood and followed by all staff.¹¹⁸

The authors of this report are:

Christina Haneef, Emergency Response Specialist – Gender in Emergencies

Anushka Kalyanpur, Team Lead – Sexual and Reproductive Health Rights in Emergencies.

The authors received support from Isadora Quay, Global Gender in Emergencies Coordinator, and Sarah Fuhrman, Humanitarian Policy Specialist.

¹¹⁵ Adapted from: GBV sub-sector Myanmar. Guidance Note on GBV Service Provision during the time of COVID-19 Myanmar GBV Sub-Sector, 18 March 2020.

¹¹⁶ Adapted from the GiHA Advocacy Brief ‘The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific. March 2020. <https://asiapacific.unwomen.org/en/digital-library/publications/2020/03/the-COVID-19-outbreak-and-gender>.

¹¹⁷ See the “Cash & Voucher Assistance and Gender- Based Violence Compendium” for more guidance.

<https://www.calpnetwork.org/publication/cash-voucher-assistance-and-gender-based-violence-compendium/>

¹¹⁸ For example, see the UN Secretary General’s Bulletin on Special Measures for Protection from Sexual Exploitation and Abuse, <https://undocs.org/ST/SGB/2003/13>; the IASC Minimum Operating Standards, <https://interagencystandingcommittee.org/system/files/2020-03/Minimum%20operating%20standards-psea%20by%20own%20personnel%202012.pdf>; and the Core Humanitarian Standard on Quality and Accountability, <https://corehumanitarianstandard.org/the-standard/language-versions>.