



Rapid Gender Analysis COVID-19

Afghanistan – July 2020



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This RGA is part of CARE's gender analysis conducted in order to assess how a crisis (in this case COVID-19) has affected women, men, boys, girls, and other vulnerable groups directly or indirectly in terms role, relations and responsibilities, in order to inform development of future programming where needs of the mentioned groups addressed.

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Abbreviations

CDC	Community Development Council
GBV	Gender Based Violence
ICCT	Inter-Cluster Coordinator Team
IDPs	Internally Displaced Persons
KII	Key Informant Interview
HCT	Humanitarian Country Team
MEL	Monitoring, Evaluation and Learning
MoWA	Ministry of Women Affairs
MoPH	Ministry of Public Health
NGOs	Non-Governmental Organizations
PPE	Personal Protective Equipment
PSEA	Prevention of Sexual Exploitation and Abuse
RGA	Rapid Gender Analysis
SEA	Sexual Exploitation and Abuse
SMC	School Management Committee
SRH	Sexual and Reproductive Health

Executive Summary

The COVID-19 pandemic and the response to slow down the spread of the virus is impacting women and men, girls and boys, urban, and rural populations in Afghanistan. As of July 15, 2020, there are 34,740 confirmed cases of COVID-19 in Afghanistan, with 1,045 deaths.¹ The government of Afghanistan continues to impose lockdowns and other restrictions, which has posed significant social and economic costs in the country. The country already faces significant humanitarian crises, including high food insecurity, a large number of IDPs and refugees, ongoing conflict, and natural disasters. The pandemic is currently exacerbating socio-economic issues, and the lockdown is directly impacting the ability of humanitarian actors to provide the necessary assistance.

CARE's Rapid Gender Analysis (RGA) draws from CARE's experience in Afghanistan, and survey questionnaires with 320 people (50.3% women and 49.7% men), and key informant interview (KII) with 59 community leaders (44% women and 56% men) and 18 line representatives (50% women and 50% men) from Ministry of Women Affairs and Ministry of Public Health across seventeen (17) districts in nine (9) provinces in Afghanistan. The RGA points to ongoing severe economic, financial, health, and security impacts that will be especially worse for women and girls. The immediate impacts at the time of this assessment, center around the loss of income, food insecurity, lack of access to basic needs, limited mobility due to government lockdown, increased gender-based violence, and insecurity. The impacts – direct and indirect – fall disproportionately on the most vulnerable and marginalized groups, including women and girls, poor households, IDPs, female-headed households, and people with disabilities.

Gender-based inequality is extensive in the country – decades of conflict, food insecurity, and conservative patriarchal norms limit Afghan women and girl's freedom of movement, decision-making power and access to health, education, and other basic services and resources. The COVID-19 pandemic is exacerbating gender inequalities by restricting the limited rights women enjoy in the country and increasing their dependency. The findings from this assessment show that women are bearing the most significant burden of caring for their families; they have limited freedom of movement; face limited decision-making power at home and in the community and experience an increased level of gender-based violence. All the socio-economic and security implications of COVID-19 will severely and disproportionately impact women and girls. Therefore, it is crucial to ensure that actors responding to the crises adapt their responses, strategies, and policies to ensure that they address the implications that the outbreak has for women and girls.

Key Findings

- The lockdown is limiting humanitarian assistance, and high humanitarian needs are not being met.
- Women's care burden is increasing due to school closure, and the lockdown.
- Loss of income, especially among daily laborers and small traders, is posing an alarming financial challenge and jeopardizing current and future livelihoods for vulnerable households.
- High levels of food insecurity – women are more likely to eat less, affecting their nutrition and food security.
- Gender-based violence is increasing due to existing gender norms and growing tension in the household.
- Limited health services, restrictive mobility on girls and women, and the limited number of female health practitioners affect women and girls from accessing health facilities.

¹ WHO, accessed on 15 July 2020. WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/region/emro/country/af>

- The limited access to gender-based violence (GBV) support and sexual and reproductive health services will be reduced due to restrictions in movement and resources being diverted to fight COVID-19.
- Women are generally missing from decision-making spaces and community participation in COVID-19 decision making processes.

Key Recommendations

- The Humanitarian Country Team (HCT) and the Inter-Cluster Coordinator Team (ICCT) should ensure that the findings and recommendations from the RGA are used by partners to inform the response.
- All Humanitarian Actors, and in particular humanitarian leadership, should recognize GBV prevention, mitigation, and response as lifesaving and integrate GBV into programming by ensuring adequate and appropriate GBV prevention among essential services, including access to resources for GBV prevention and responses, referral mechanisms, provision of safe-space for women and girls at risk of GBV, and provision of psychosocial support.
- All Humanitarian Actors should prioritize livelihood and food security intervention, especially for pregnant women, nursing mothers, children under five years old, and IDPs.
- All Humanitarian Actors should identify and leverage appropriate technologies for information dissemination on COVID-19, GBV, and psychosocial support, especially targeting women and girls, IDPs, persons with disabilities, youth, and other marginalized groups.
- Donors, OCHA, and UN Agencies should make direct funding available for local responders, especially women-led organizations working on women's rights, gender equality, and GBV, as well as make GBV prevention and response, and PSEA compulsory element of all humanitarian interventions.
- Development Actors should ensure the design and implementation of gender-responsive and transformative social safety net responses in coordination with humanitarian actors to complement the emergency and humanitarian effort.
- National and Local Government should ensure women's adequate representation and meaningful participation in all COVID-19 response and coordination mechanisms at national and local levels and adequately address gender and GBV in their responses by ensuring women's and girl's needs in policies and measures.
- All Actors should recognize that this is more than a public health crisis and engage community members in socio-economic, safety, and protection efforts. Engage women, youth (both boys and girls), traditional and religious leaders equally in analysis, problem-solving, and decision making.
- All Actors should ensure policies and programming are based on the findings of a Rapid Gender Analysis that includes data disaggregated by sex, age, and disability, in order to understand and continue to track the differential experience of women and men, girls and boys and to guide gender-informed action in the short, medium and long term.

Context of the COVID-19 Pandemic

The novel coronavirus 2019, or COVID-19, is an infectious disease that has created a catastrophic global public health crisis. In Afghanistan, the first case of COVID-19 was reported in February 2020.² COVID-19 has since spread rapidly throughout Afghanistan, confirmed cases rose by 684% increase in May³. As of July 15, 2020, there are 34,740 confirmed cases of COVID-19 in Afghanistan, with 1,045 deaths⁴ across all 34 provinces in Afghanistan.⁵ Among the provinces covered in the survey for this RGA, Kabul has the highest cases, with 14,007 confirmed cases, followed by Herat, Balkh, Kandahar, and Paktia, with 5,190, 1,764, 1,334 and 1,143 confirmed cases respectively. The remaining provinces, Ghazni, Khost, Parwan, and Kapisa, have lower confirmed cases of 502, 395, 357, and 201 cases respectively.⁶ The country has a meagre testing capacity, with 42,273 people have been tested so far, suggesting a high level of undetected population infection.⁷

The Government of Afghanistan imposed a nationwide lockdown after the first cases were reported in February in the province of Herat, bordering Iran. The government extended the lockdown on 2 May 2020 in a bid to contain the virus's spread. The lockdown measures differ across provinces, and while several provinces have already begun easing their lockdowns formally or informally, other provinces revised previously relaxed measures and reinstated a full lockdown from the end of May as the number of cases began increasing. The lockdown measures have resulted in closures of sections of each city, increased number of checkpoints and/or imposition of movement limitations.⁸ Afghanistan is among a sub-set of fragile countries⁹, with a weak health system, and underlying vulnerabilities, the people of Afghanistan, are facing extreme consequences from COVID-19.¹⁰ Due to its weak health system and limited capacity to deal with major disease outbreaks, Afghanistan is likely to be significantly affected directly from the COVID-19 and indirectly resulting from the negative socio-economic impacts. Furthermore, despite recent agreement to reduce fighting, continued violence is seen and even escalated in Afghanistan, further complicating the response to the pandemic. Natural disasters happening in different seasons also create socio-economic and health impacts. Underlying vulnerabilities combined with current lockdown measures affected the mobility of humanitarian organizations, delaying assistance, and service delivery.¹¹

The disproportionate impacts of COVID-19, lockdown and social distancing measures are recognized globally. CARE's global RGA and CARE's COVID-19 response strategy and policy paper emphasized the gender implications of the pandemic in development and humanitarian settings. Women in Afghanistan face various gender-based discrimination and restrictions with limited decision-making power and restricted mobility, as well as being at-risk of gender-based violence. The COVID-19 pandemic is more likely to increase their dependency and challenge their limited rights and freedoms. In this regard, CARE Afghanistan conducted Rapid Gender Analysis (RGA) in 17 districts in the following nine (9) provinces: Balkh, Ghazni, Hirat, Kabul, Kapisa, Khost, Paktia, Parwan, and Kandahar.

² Aljazeera, 23 May 2020. Afghanistan coronavirus cases spike ahead of Eid-al-Fitr holiday.

<https://www.aljazeera.com/news/2020/05/afghanistan-coronavirus-cases-spike-eid-al-fitr-holiday-200523135330827.html>

³ International Rescue Committee, 01 June 2020. Afghanistan faces humanitarian disaster as COVID-19 spreads undetected, warns the IRC. <https://www.rescue.org/press-release/afghanistan-faces-humanitarian-disaster-covid-19-spreads-undetected-warns-irc>

⁴ WHO, accessed on 15 July 2020. WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/region/emro/country/af>

⁵ International Rescue Committee, 03 June 2020. Afghanistan: COVID-19 multi-sectoral response operational situation report.

<https://reliefweb.int/report/afghanistan/afghanistan-covid-19-multi-sectoral-response-operational-situation-report-3-june>

⁶ Current Cases of COVID-19, accessed on 22 June 2020. <https://tolonews.com/covid-19-tracker>

⁷ Ibid

⁸ Ibid

⁹ Fragile States Index 2020. <https://fragilestatesindex.org/>

¹⁰ International Rescue Committee, 03 June 2020. Op Cit.

¹¹ Ibid

Objective of the Rapid Gender Analysis

The objective of this analysis is to assess and understand the gendered impacts of the COVID-19 crisis and to formulate practical recommendations for humanitarian and development program adaptation and responses. These include providing answers to the following questions:

- How will the COVID-19 pandemic affect women, men, boys, girls, and other vulnerable groups directly or indirectly?
- How did the COVID-19 pandemic change gender roles, relations, and responsibilities?
- How does gender affect participation in decision-making regarding the response to COVID-19?
- Who needs special protections during the pandemic, and how to provide that protection?
- Who has access to essential goods and services?
- What coping capacities and strategies are being employed to respond to COVID-19?
- What priority needs must be addressed?

Methodology

Rapid Gender Analysis (RGA) provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis. Rapid Gender Analysis is built up progressively using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. Rapid Gender Analysis uses the tools and approaches of Gender Analysis Frameworks and adapts them to short deadlines, rapidly changing contexts, and insecure environments that often characterise humanitarian interventions.

This analysis was conducted from May 17 to June 30, 2020, in seventeen (17) districts in nine (9) provinces in Afghanistan where CARE operates, including Balkh, Ghazni, Hirat, Kabul, Kapisa, Khost, Paktia, Parwan, and Kandahar provinces. This gender analysis is based on qualitative and quantitative data. The methodology used includes the following:

- The review of secondary data was conducted by specialists from the CARE global gender cohort and CARE Afghanistan Program Quality Department's team;
- Primary data was collected through individual survey questionnaires and KII based on the tools developed by the CARE Afghanistan Program Quality (PQ) team. The data was collected through phone and recorded using the Kobo Toolbox application. The collection of the data was led by the country teams under the direction of the Program Quality team particularly the Monitoring, Evaluation and Learning (MEL) team.
- The data collection targeted a diverse set of participants from each province in rural, peri-urban and urban settings, including male and female community leaders, individual men and women in communities, and representatives from the Ministry of Women Affairs (MoWA) and Ministry of Public Health (MoPH).
- A total of 320 people (50.3% women and 49.7% men) participated in the individual survey. Participants were selected randomly from the 17 districts in 9 provinces out of 11,000 lists of beneficiaries from the PQ unit records.
- A total of 59 community leaders (44% women and 56% men) participated in the KII. Additional 18 representatives (50% women and 50% men) from MoWA and MoPH participated in the KII.
- The sex disaggregated sampling data for the survey and KII is presented in [Annex 1](#).

Ethical Considerations

When carrying out this RGA, a **Do No Harm** approach was adopted and prioritized throughout the process in order to mitigate the risks to staff and communities, including the risks linked to virus contamination. Considerations included the following aspects:

- Primary data collection was conducted remotely by phone.
- Data protection, confidentiality, and security of the respondents was ensured by using informed consent practices and removing identifying data from the final report.
- PSEA/GBV: All staff involved in data collection understood and had access to updated mechanisms on accountability and referral system for GBV cases.

Difficulties and Limitations

- National structures responsible for COVID-19 response were slow or unable to provide data disaggregated by sex and age of affected people.
- Trying to access respondents over the phone excludes the poorest and most vulnerable people, and especially make it hard to reach women. Female enumerators were assigned to contact selected families to reach female participants anytime they were home and when they could talk. However, women who do not have phones or/and are not allowed to speak over the phone with non-relatives participated in the survey with men present during the call, which makes it difficult for women to talk freely about their challenges, especially on questions related to GBV. This limits the quality of the discussion and the result generated around GBV.
- Discussing gender issues and GBV is not common in Afghanistan, particularly in rural areas. There is a lack of trust to talk openly to strangers even if they are the same gender. The remote phone interview made it challenging to create a free and trusting environment for women to speak about such taboo subjects. This limits the quality of the discussion on the gendered role and decision-making power in the household and community level.

Demographic Profile

Demographic Analysis

The current population of Afghanistan is 38,858,170,¹² with 48.6% female and 51.4% male.¹³ The median age in Afghanistan is 18.4 years, indicating a young population.¹⁴ Table 1 below presents the distribution by sex and age among the 320 survey participants. The analysis shows a higher proportion of people under the age of 18, 53.37%, followed by 42.74% of people in the age between 18 to 59, and 3.89% of people aged 60 and above.

According to UN data from 2017, the average household size of Afghanistan is eight (8).¹⁵ The average household size of the 320 surveyed participants in the nine (9) provinces is higher than the national average showing 12.47 average household size. Out of 320 survey respondents, only 35 (10.94%) are households headed by women. The average age of women head of households is 44 years, and 45 years for men head of households. The total number of pregnant or lactating mothers in the surveyed population is 206, constituting 5.16% of the surveyed population.

Age Range	Female	Male	Total
	%	%	%
0-4	10.20	9.50	19.70
5-10	8.35	8.00	16.34
11-17	9.20	8.12	17.32
18-59	23.14	19.60	42.74
60+	1.96	1.93	3.89
Total	52.85	47.15	100.00

Table 1. Distribution by Age and Sex

The proportion of disabled people in the surveyed districts shows 0.95% for women (38 women) and 1.05% for men (42 men). Afghanistan has a high disability rate, with almost 80% of adults aged 18 and over have some form of physical, functional, sensory, or other impairment (24.6% mild, 40.4% moderate, and 13.9% severe).¹⁶ Severe disability is more prevalent among females (14.9%) than males (12.6%). Among children aged 2-17 years, 17.3% have a mild, moderate, or severe disability.¹⁷

Results Analysis

Humanitarian Situation

The level of the COVID-19 impact on Afghanistan remains unclear, as there is no reliable COVID-19 modelling for a country with Afghanistan's unique characteristics and vulnerabilities.¹⁸ The Government of Afghanistan has announced a wide range of measures to contain the virus. However, weak health care infrastructure in a country weighed down by poverty and four decades of conflict render Afghanistan especially challenged to manage the

¹² Worldometer, accessed on 06 June 2020. Afghanistan Population. <https://www.worldometers.info/world-population/afghanistan-population/>

¹³ The Asia Foundation, 2020. Model Disability Survey of Afghanistan 2019. <https://asiafoundation.org/wp-content/uploads/2020/05/Model-Disability-Survey-of-Afghanistan-2019.pdf>

¹⁴ Worldometer, accessed on 06 June 2020. Op Cit.

¹⁵ UN, 2017. Household Size and Composition Around the World 2017. https://www.un.org/en/development/desa/population/publications/pdf/ageing/household_size_and_composition_around_the_world_2017_data_booklet.pdf

¹⁶ Akseer, Tabasum, 14 May 2020. Model Disability Survey of Afghanistan 2019. Relief Web. <https://reliefweb.int/report/afghanistan/model-disability-survey-afghanistan-2019>

¹⁷ Ibid

¹⁸ Relief Web, 24 March 2020. Afghanistan: COVID-19 Multi-Sector Humanitarian Country Plan. <https://reliefweb.int/report/afghanistan/afghanistan-covid-19-multi-sector-humanitarian-country-plan>

pandemic.¹⁹ The country's complex landscape, natural disasters, displaced population, and ongoing conflicts make it difficult to maintain a robust response to the pandemic.²⁰

Even before the COVID-19 pandemic, 14 million people in Afghanistan have insufficient access to food, many of whom depend on international assistance.²¹ The Government of Afghanistan quickly initiated emergency grain distribution in Kabul and across the country to respond to economic strains due to pandemic responses. However, the strategic reserves are not sufficient to cover the population's urgent needs. The UN and other humanitarian actors have raised the alarm about the potentially massive scope of starvation, but lockdowns have restricted their ability to provide aid. With the lockdown, both city-dwelling Afghans and those in the rural areas risk losing access to food and income.²² The country is also the home to an estimated 3.5 million IDPs, many of whom are living in extreme poverty in so-called 'informal settlements' with extremely low standards of hygiene and limited access to water. Most IDPs live in urban areas in close proximity to economic centres.²³ Out of the 322 survey respondents, 35 people (23 female and 12 male) are displaced with a host family, 31 people (5 female and 26 male) are displaced in a temporary settlement, and six people (6 male) are displaced collective centres. The lockdown is leaving hundreds of thousands of day labourers out of work; loss of income and rising food prices is prompting panic, desperation, and potential risks of criminality and social unrest.²⁴

Afghanistan experienced a sharp deterioration in the welfare of the Afghan population, with an increase in the national poverty line from 34% in 2007 to 55% in 2017.²⁵ This increase is experienced throughout the country; in urban and rural areas.²⁶ With deep and widespread poverty and continuing security and political uncertainties, the World Bank estimated COVID-19 to have a strong negative impact on Afghanistan's economy.²⁷ Considering existing vulnerabilities and conflict in Afghanistan, COVID-19 poses not just a public health crisis, but also a socio-economic catastrophe for the country.

Gender Roles and Responsibilities

Division of Labour

The COVID-19 crises and preventive measures taken in Afghanistan, including nation-wide lockdown, physical distancing, public gathering restrictions, and school closure, have had an impact on all aspects of people's lives. Time allocated to paid and production activities has been drastically reduced while time allotted to unpaid domestic work has increased. For instance, according to the survey, 140 people said women collect water, 64 said male collects water, and 99 people said both genders collect water. The result shows women disproportionate domestic work burden. The result did not show significant differences between urban and rural districts in the targeted provinces. With the lockdown measures, many family members stay at home, increasing the domestic workload (cooking, carrying for children), and more hygiene and care for sick people due to the pandemic. Such work usually falls to women and girls.

¹⁹ Watkins, Andrew, 06 May 2020. COVID-19 in Afghanistan: Compounding Crises. Crisis Group. <https://www.crisisgroup.org/asia/south-asia/afghanistan/covid-19-afghanistan-compounding-crises>Watkins,

²⁰ Monte, Lacort. Ricard, 14 May 2020. How Can Fragile Countries, Like Afghanistan, Respond to COVID-19? Gavi, the Vaccine Alliance. <https://www.gavi.org/vaccineswork/how-can-fragile-countries-afghanistan-respond-covid-19>

²¹ Andrew, 06 May 2020. Op Cit.

²² Ibid

²³ Relief Web, 08 May. 2018. Displacement Survey Shows 3.5 Million Internally Displaced Returnees from Abroad in 15 Afghan Provinces. <https://reliefweb.int/report/afghanistan/displacement-survey-shows-35-million-internally-displaced-returnees-abroad-15>

²⁴ Andrew, 06 May 2020. Op Cit.

²⁵ UNICEF, 21 April 2020. Female-headed households bear the brunt of COVID-19 as livelihood gaps increase. <https://www.unicef.org/rosa/stories/female-headed-households-bear-brunt-covid-19-livelihood-gaps-increase>

²⁶ Ibid

²⁷ The World Bank, 07 May 2020. World Bank Approves \$400 Million to Sustain Afghanistan's Reform Momentum, Mitigate COVID-19 Crisis. <https://www.worldbank.org/en/news/press-release/2020/05/07/world-bank-approves-400-million-to-sustain-afghanistans-reform-momentum-mitigate-covid-19-crisis>

Livelihood and Income

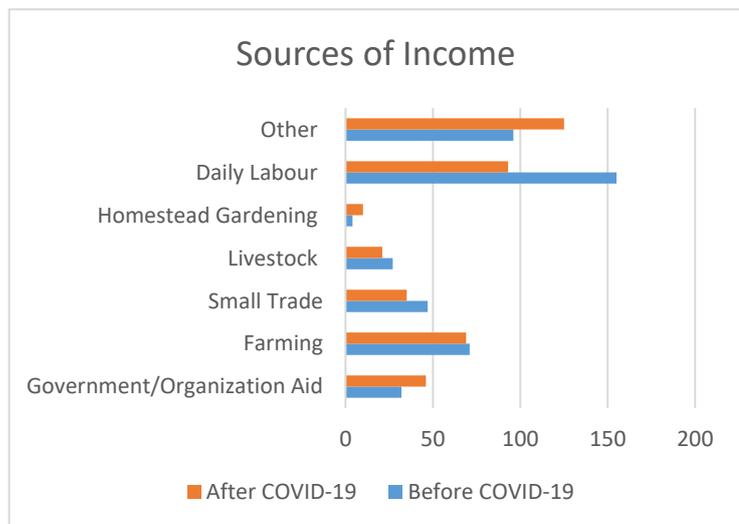
At the macro level, the restrictive measures consisting of systematic border closure affect thousands of Afghan workers and overall commercial movements between neighbouring countries. The return of nearly 300,000 Afghan migrant workers²⁸ since February from Pakistan and Iran is one clear case of the impacts of border closure on jobs. Representatives from MoPH and MoWA highlighted that the returnees from Iran and Pakistan also challenged the government's ability to manage the outbreak, as they were coming from COVID-19 hotspot locations.

Urban lockdowns cripple informal and day labour employment and remittances from abroad and increases in prices of essential goods.²⁹ Such economic impacts affect an entire family, but again disproportionately affect women by aggravating the existing social and economic dependence of women in Afghanistan.³⁰ Poverty and unemployment are on the rise; the lack of food and income is a significant challenge for most vulnerable households. Households with large family sizes are more susceptible and struggling to put food on the table, as the lockdown shakes their livelihood. The market shock and the loss of income are determinantal for daily wage labourers, people who work on the street, and small traders, predominantly men, who completely lost their source of income. Afghanistan has the highest proportion of people living under the poverty line, an estimate of 54% of the population lives under the national poverty line³¹; livelihood challenges due to the lockdown is making difficult situation unbearable.

“Small scaled income generation activities, for example, flower making, embroideries, home-based sweet confectioneries, were available for us before COVID-19 to generate income. With the COVID-19 outbreak, this is no longer available for us, as both markets demand reduced, and men started doing these works when available”.

Women respondent, Herat Province

Survey participants also experienced the loss of income, as their engagement in different income generating activities has declined or reduced due to lockdown measures. As highlighted in graph one, participation in daily labour activities has declined significantly, before the pandemic, 155 survey participants (37.4% women and 62.6% men) used to engage in daily labour to generate income. After the pandemic, only 93 (46.2% women and 53.8% men) of them continued to work. Out of the 62 who lost their daily labour work, 47 are men, and 15 are women. Daily labour was a significant income-generating activity for both men and women in rural and urban areas. The number of people dependent on government or/and organizational aid also increased from 32



Graph 1. Sources of Income Before and After COVID-19

(81.2% women and 18.8% men) to 46 (56.5% women and 43.5% men) due to the pandemic. The increase on aid was witnessed among men respondents only. Respondents also witnessed a loss of total income due to job loss, 43 respondents (60.5% men and 39.5% women) said they are jobless because of the pandemic. The loss of income has

²⁸ Andrew, 06 May 2020. Op Cit.

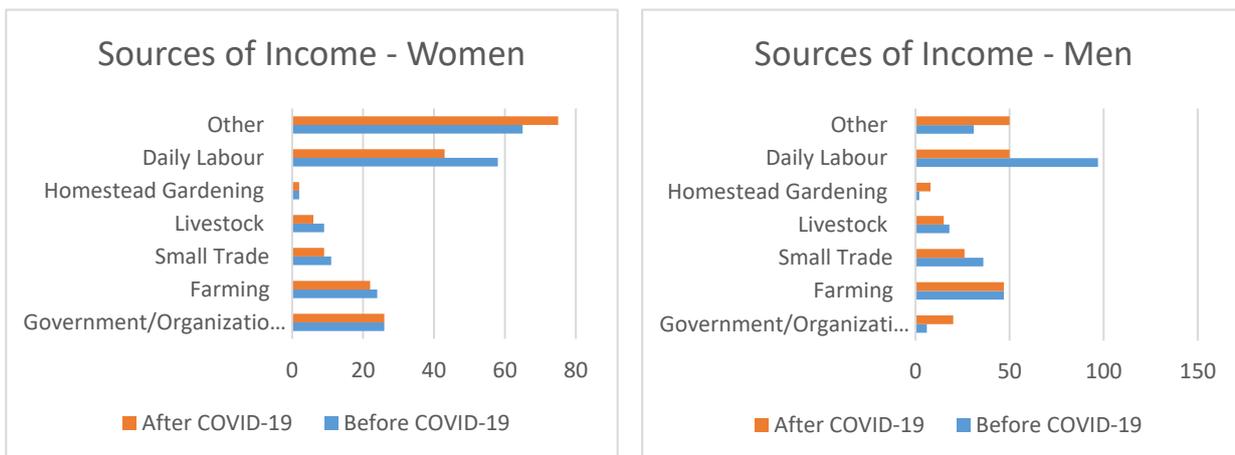
²⁹ Ibid

³⁰ Oxfam, April 2020. A New Scourge to Afghan Women: COVID-19. Oxfam Briefing Note.

https://reliefweb.int/sites/reliefweb.int/files/resources/COVID%2019.%20A%20New%20Scourge%20to%20Afghan%20Women_OXFAM.pdf

³¹ World Bank, access on 10 June 2020. <https://data.worldbank.org/indicator/SI.POV.NAHC?locations=AF>

shifted household dynamics, both men and women, are stressed due to financial losses and borrowing money, spending savings, and selling household assets to make ends meet. As the lockdown continues, many fear the pandemic's economic impact would have a long-lasting effect on the well-being of their families and communities.

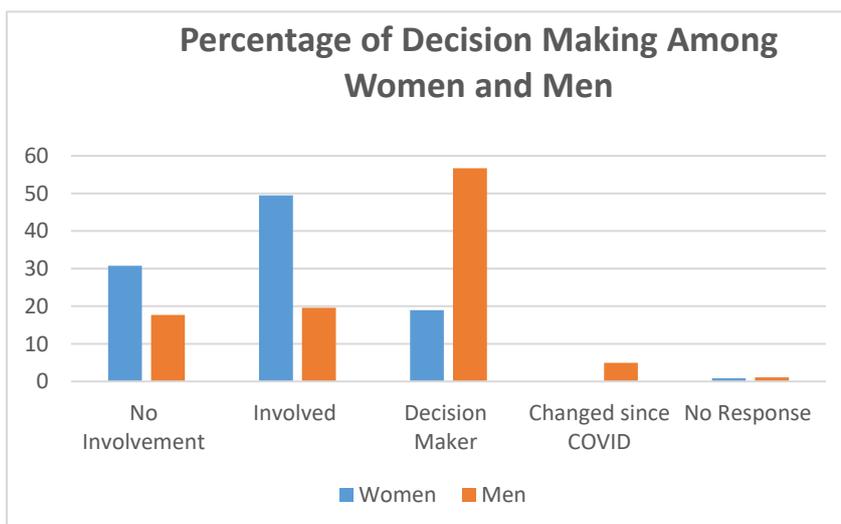


Graph 2. Sources of Income Before and After COVID-19 for Women and Men

Decision-making and Participation

Household Decision Making

In general, before the pandemic, the majority of the decisions in the household around the use and management of resources and access to services, including health care, had been made by men. Similar decision-making trends are reflected in the survey responses. Participants were asked to highlight their level of decision-making in a range of decision-making areas including working to earn money, buying and selling assets, visiting relatives, migration/displacement, accessing health care for self and children, whether to have another child and children's education. As presented in graphs three, only 50% of women respondents stated that they are involved in a range of decision making, while only 19% of them hold decision-making power, the remaining 31% reported no involvement in household decision-making. On the contrary, 56.68% of men respondents indicated they have decision-making power, and only 17.6% claimed no involvement in important household decisions. 5% of men responded that their decision-making power is shifting since COVID-19, and they are jointly making decisions with the women in their family. None of the women respondents highlighted such changes.



Graph 3. Percentage of Decision Making Among Women and Men

Regarding financial decision-making, 127 (45.6% women and 54.3% men) respondents said both wife and husband make the decision together, while 118 (37.3% women and 63.6% men) said husbands, and 22 people (86.4% and 13.6% men) said wives make the decision. Additional 48 people (77% women and 23% men) said others such as father, son, in-laws, and elders in the house make the financial decision.

On average, there are no significant differences in involvement in decision-making among women in urban and rural districts in the nine (9) provinces. Regarding decision making, women respondents from urban districts of Ghazni, Hirat, Kabul, Khost, Gardez, Charikar, and Kandahar provinces reported higher decision-making proportion over decisions related to working to earn money, selling assets, visiting relatives, accessing health care and children's education. Both urban and rural women respondents have lower decision-making power over migration/displacement and whether to have another child. On aggregate, women in urban centers hold relatively higher decision-making power over certain decisions than rural women, showing the rural-urban disparity between women over household decision-making.

The overall lack of decision-making power among women could be worsened during the pandemic. With more men staying at home, women and girls might face further decision-making restrictions. However, the few changes in decision-making witnessed among men respondents also indicate the advent of the COVID-19 pandemic and related changes is causing some men to seek input from their wives before making decisions.

Community Participation and Decision-making Related to COVID-19

The majority of survey respondents said they did not have any participation and consultation regarding their needs by aid agencies. Out of 320 respondents, only 34 women and 33 men were consulted about their needs in response to the pandemic.

Line department representatives said there is a critical need to engage the community and religious leaders to curb misinformation among community members. According to some representatives from MoPH, community members have a lot of misconceptions about the virus, and awareness creation from religious leaders could be an excellent tactic to challenge misinformation. Community leaders indicated they don't have a lot of formal actions to provide specific services. Still, they are trying on ad hoc bases to help households that are struggling in their community. The support includes borrowing money, food, land, and organizing *Zakat*³². Some community leaders have health committees and have provided washing services. They have Community Development Council (CDC) members and influential elders who engage in supporting the public health directorate in the provinces and districts. However, they all said the level of livelihood assistance is non-existent in many areas, and there is minimal outreach in cases where there is support. Some provinces have bi-weekly or monthly meetings between CDC members and community members. Representatives from Balkh said they have bi-weekly meetings; other provinces such as Kapisa, Khost, and Parwan noted there is no proper coordination and meeting in place between community and service providers. Women sometimes engage in community discussion and decision-making through Community Development Council (CDC), School Management Committee (SMC), members of community-level '*Shuras*,' however, their decision-making power, and participation and engagement are not apparent particularly during this COVID context.

Access to Services and Resources

The COVID-19 pandemic has disrupted access to critical services and has diminished livelihood sources for households. Women in Afghanistan face restrictions regarding their movement and social life due to traditional and patriarchal norms, which prevent them (mainly in rural and conservative areas) from accessing education, healthcare, employment, and deprives them from public participation and freedom of movements. Progress has been made in recent years allowing women to travel between within and between communities to access social and

³² Zakat is an Islamic finance term referring to the obligation that an individual has to donate a certain proportion of wealth each year to charitable causes.

economic activities. However, some speculate, whether the lockdown and quarantine measures could reverse the progress, restricting women to their homes once again.³³

Access to Health Services

Even before the pandemic, Afghans face massive challenges to access proper health care. The health system is under-developed and burdened far beyond its capacity due to countless conflict casualties, lack of funding, insufficient medical staff, deterioration of infrastructure, and other resources. The challenges are further aggravated by malnutrition, poor access to water, lack of sanitation and hygiene, air pollution, and geographic and security challenges to access health care facilities.³⁴

Health Services

Regards to COVID-19 cases, data shows that Afghanistan recorded As of July 15, 2020, there are 34,740 confirmed cases of COVID-19 in Afghanistan, with 1,045 deaths.³⁵ Among the surveyed population for this RGA, only three respondents had family members affected by COVID-19. Respondents highlighted six cases in their families (i.e., three men, one woman, one girl, and a boy), with five of the cases recovered. The majority of respondents indicated changes in the health services since the crisis, including the lack of proper medication and limited services due to the lockdown. A few highlighted that people are now concerned about their hygiene and their general health to protect themselves from COVID. Out of 322 survey respondents, 82 (25.62%) said they don't have safe access to health services; among those without safe access to health, 44 (53.6%) are women respondents. The majority of women who don't have safe access to health service said lack of money, lack of functioning health facilities and long distance to the clinic are among the reasons for their lack of access to health care services. Respondents also highlighted the lack of sufficient medication in health facilities, with 82 respondents (52.4% women and 47.6% men) stressing the lack of proper medical access. A large number of respondents, 280 people (51.1% women and 48.9% men), said they don't have health and hygiene kits to take COVID-19 protection measures. Line department representatives fear the high level of risk for health workers contracting the virus could affect the limited workers they have on sight. This is a validated risk, as 13 healthcare workers are among those who have died from COVID-19, and more than 5% of the total confirmed cases are among health care staff.³⁶

In addition to the limited health services, the practice of a 'Mahram' – a male family member accompanying a woman when she goes out of the house puts a strain on women's ability to access health services.³⁷ Out of 161 women respondents, 108 (67%) said they are allowed by their family to visit health facilities only accompanied by someone. Only 52 women (33 %) can go to health facilities on their own, and these respondents are mostly from the urban centres of Herat, Ghazni, Kabul, and Kandahar.

Afghanistan has a massive shortage of female health care staff, with only 15% of nurses and 2% of medical doctors.

The same social norms that prevent women from joining the health care sector also prevent them from accessing health care. Many families do not wish their daughters, sisters, and wives to be treated by male doctors. This leads to women having less access to health services in general and could also limit women's access to COVID-19 testing

"The number of female visitors for health check-ups reduced significantly. This is because now a day their male members are at home due to the COVID outbreak who are reluctant to allow women to receive health support in health centers and as well as because of communities' fear over infection at hospitals. Similarly, most deliveries are now done at home through traditional midwives; this is also because of the mentioned reasons"

A Female Doctor from Balkh Province

³³ Oxfam, April 2020. Op Cit.

³⁴ Ibid

³⁵ WHO, accessed on 15 July 2020. WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/region/emro/country/af>

³⁶ International Rescue Committee, 03 June 2020. Op Cit.

³⁷ Oxfam, April 2020. Op Cit.

and treatment facilities.³⁸ The lack of sex-disaggregated data on COVID-19 cases makes it difficult to assess who have more confirmed cases, men or women. Existing news and survey respondents believe there are more confirmed cases among men; however, women's lower cases might be because of their lack of access to testing and health facilities. On the other hand, respondents indicated that men are breadwinners; their role requires them to go out, which exposed them to the virus. However, women and girls are responsible to take care of sick family members in Afghan society. This not only places an additional burden on women but also brings a higher risk of contracting the virus. The lack of health facilities and services combined with restricted movement and decision making among women are more likely to affect Afghan women's ability to access health services disproportionately.

Sexual and Reproductive Health Services

Some respondents indicated that they have access to maternal health services; however, many highlighted the movement restriction affects many women (particularly in rural areas) from accessing such services. Among women respondents, 60 women (37.2%) said they don't have access to maternal health services; and majority women, 118 (73%), don't have access to family planning services. The lack of functioning health services and long-distance are significant factors affecting women's access to maternal and family planning services. Some respondents indicated the lack of money and the lack of female health practitioners also affect them from accessing such services. UNFPA brief indicated that, public health emergencies tend to divert human and financial resources from various health programs to respond to the outbreak. Sexual and reproductive health services are more likely to be impacted with diverted funding and human resources.³⁹ The existing inadequate sexual and reproductive health services in Afghanistan could further be stranded as health sector resources and overall responses shifts to the pandemic. This could particularly affect the accessibility of reproductive health services, particularly for pregnant women. This could lead to an increase in maternal and newborn morbidity and mortality, as well as to unwanted pregnancies.

Mental Health and Psychosocial Support

Besides physical health issues, stress, and psychological problems resulting from the pandemic was pointed out by respondents. Other sources also identified issues related to stress from a loss of income, and psychological stress due to movement restrictions and subsequent isolation women are facing.⁴⁰ This is augmented by the fact that many households are confined, population movement is limited, and social networks are broken due to restriction on social gatherings. People are not socializing with their relatives; they are not going to Mosques, which takes away the social interaction and spiritual support they used to rely on. The unpredictability of the situation has left many uncertain about what is to come and how to survive today's impacts.

Formal mental and psychosocial support seems to be lacking in Afghanistan. Almost 45% of women respondents said the government could be a system that helps people with psychosocial support. While 30% said they don't know any informal psychosocial support system, 27% said they think community leaders, and 15% said religious leaders could provide such support. Only 4.9% thinks they could get psychosocial support from aid agencies. There is a high-level of mental health issue in Afghanistan; estimates show that half of the population experience depression, anxiety, or post-traumatic stress.⁴¹ With unclear formal and informal existing psychosocial support, further aggravated by social isolation, the distress by the pandemic and related socio-economic disruptions could have a higher impact on mental

"The loss of jobs and income is causing an increase in the poverty level among people, creating anxiety, stress, and frustration – you can see the desperation in people's faces."

A Male Doctor from Kabul Province

³⁸ Ibid

³⁹ UNFPA (23 March 2020). Coronavirus Disease (COVID-19) Preparedness and Response. UNFPA Interim Technical Brief. Sexual and Reproductive Health and Rights, Maternal and Newborn Health and COVID-19. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Maternal_and_Newborn_Health_-23_March_2020_.pdf

⁴⁰ Oxfam, April 2020. Op Cit.

⁴¹ Ibid

wellbeing in Afghanistan. Women's risks of stress become more significant when we add the high burden of domestic and caregiving work and their high risk of domestic violence. The GBV and safety risks due to COVID-19 is discussed further under the section on protection.

Access to WASH

Secondary sources show the challenges to access clean water and hygiene and sanitation services in Afghanistan. Severe geographical conditions combined with decades of conflict have curbed investment in public infrastructure and made it difficult to enforce proper sanitation and hygiene regulations. The country has no functioning sewage and wastewater treatment systems, and existing septage management systems are informal. Only 63% of Afghans have access to basic drinking water, and only 39% have access to basic sanitation. The situation is even dire in displacement and refugee settlement, who have limited access to WASH.⁴² 57% of displaced households have insufficient or barely enough water. More than 65% of returnees live in settlements that do not have access to any WASH services, while others stay with host communities where services are already over-stretched. Women and people with disabilities have even lower access to WASH facilities.⁴³

Despite the dire water, sanitation, and hygiene access at the national level, the majority of survey respondents indicated that they have safe access to water, latrine, and washing facilities. Collecting water is mainly done by women; 267 respondents stated that it takes less than 30 minutes to access water. Out of 322 respondents, 289 of them (51.5% women and 48.5% men) said they have safe access to water; 291 respondents (49.5% women and 50.5% men) said they have safe access to a latrine; additionally, 302 respondents (50% women and 50% men) said they have access safe bathing facilities. Only 12 (33.4% women and 66.6% men) and 25 (52% women and 48% men) said they don't have access to a safe latrine. The limited respondents who confirmed their lack of access to safe WASH services are from Herat, Enjil, Nawur, Nadirshahkot, Chariker, Gardez, Matun, and Hisa-e-Awal-e-Kohestan districts. Respondents without safe access mentioned the lack of water and latrine, safety, and lack of separate toilets for men and women as major reasons for their lack of safe access to such services. Given the challenging access to safe water and sanitation in the country, the survey respondent's level of access to WASH services is surprising. The survey result does not reflect the national level WASH situation; thus, these results should be seen in consideration of the country's overall WASH context.

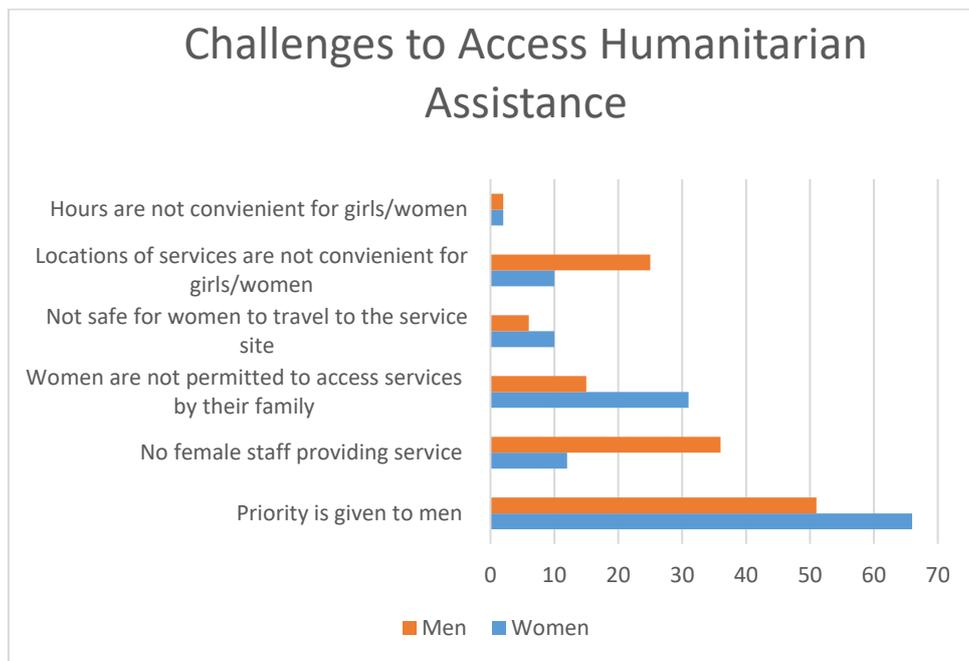
Access to Humanitarian Assistance

The level of humanitarian assistance in the surveyed districts is minimal; only 27 respondents (44.4% women and 55.6% men) indicated receiving humanitarian assistance in the last 30 days at the time of the data collection. Of the 27 who received support, 40.7% said men collected the distribution, 33.3% said both men and women collected the distribution and only 11.1% said women collected the distribution directly. The remaining 14.8% said everyone including boys, girls, men and women collected the distribution. The majority of respondents believe men were given priority to the assistance; 117 respondents (56.4% women and 43.6% men) said the priority is given to men. 67.4% of women respondents listed family restriction as a significant challenge curtailing them from accessing humanitarian assistance. In contrast, men respondents highlighted the lack of female service providers and the services' locations as crucial challenges for women. Some women respondents also highlighted the services' location and listed safety issues to travel to the service site as challenges to access assistance. Some respondents highlighted the lack of women distributors, which can affect women's access to humanitarian assistance. Some respondents indicated if humanitarian assistance is available, both women and men can have access; however, the major problem is the there is not enough assistance so far.

⁴² Global Waters and USAID accessed on 07 June 2020. Afghanistan. <https://www.globalwaters.org/wherewework/asia/afghanistan>

⁴³ COVID-19 Multi-Sector Humanitarian Country Plan. Afghanistan. 24 March 2020.

https://reliefweb.int/sites/reliefweb.int/files/resources/covid-19_multi-sector_country_plan_afghanistan_final.pdf



Graph 4. Challenges to Access to Humanitarian Assistance by Women

To support the response mechanism, government authorities are putting in place a coordination mechanism. Various sectors meet bi-weekly or monthly; they also coordinate with NGOs. The critical priority among government sectors is the provision of health services, information, and some livelihood assistance. As the director of MoWA from Heart province highlighted, the department is focusing on three priorities: first is awareness-raising regarding COVID-19 for women and girls; second is coordination and facilitation of distribution of raw food materials to vulnerable people, especially women by working with aid agencies; and third is hygiene kit distribution for women. Despite the key priorities in place, funding is challenging for all line departments to address the socio-economic needs of the community.

The main actors in response to the crises are government departments, and provincial governor, municipality, and hospitals/ clinics. There are some international organizations and NGOs providing support, but support has decreased as movement restrictions affected humanitarian workers.

Access to Information Related to COVID-19

Respondents indicated limited access to information about COVID-19. Out of 161 women respondents, 73 think their community has limited information about the pandemic; 63 feels that people have all the right information, and 24 said people have no information. A large number of women know about the COVID-19 referral system, with 111 saying COVID-19 cases have to be referred to hospitals identified by the government to treat the case. Only 50 women (20 from rural and pre-urban and 30 from urban areas) said they do not know the referral system. The respondents also indicated an understanding of who is at higher risk due to COVID-19. Information on both the COVID-19 pandemic and prevention measures are disseminated through traditional media (television and radio), which are presumed to be the most accessible for most urban and rural populations.

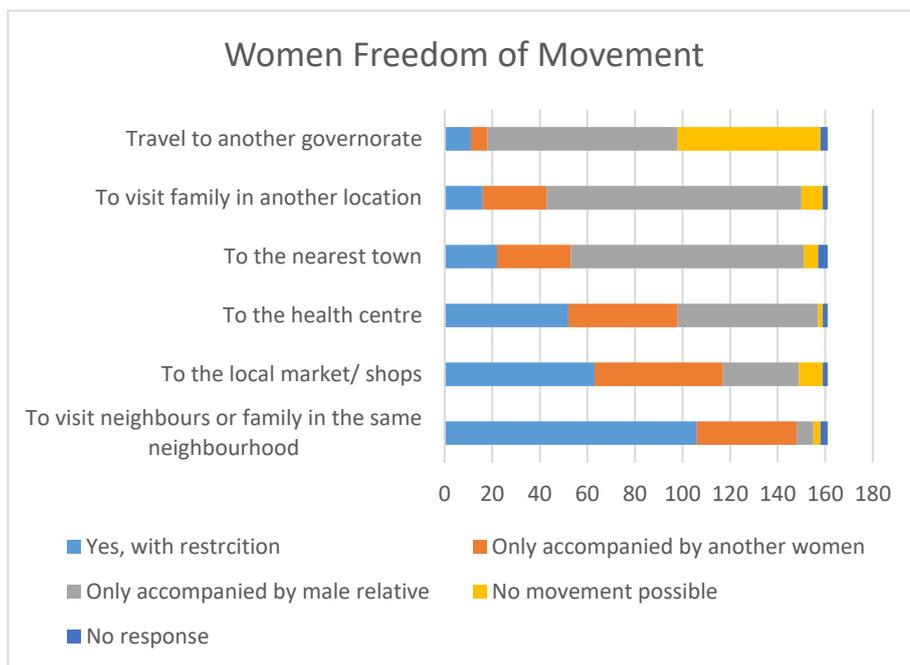
MoWA and MoPH are engaged in door to door awareness raising, the Ministry of Information and Culture is also disseminating information using TV and other media. The Ministry of Hajj and Religious Affairs is also playing a role, advising people to avoid large health gathering in Mosques and to conduct prayer at home to encourage social distancing. However, representatives indicated that a high level of illiteracy could affect people's perception of the virus and the preventive measures. The male literacy rate is higher than women; the male literacy rate (age 15+) is 62%, the female literacy rate is 18%. Data shows that only one in five women in Afghanistan is literate, and the

literacy rate for women in rural areas is three times lower than in urban areas.⁴⁴ This shows the need to consider women’s low levels of literacy in the information dissemination efforts.

Mobile phones are also used to expand outreach but in areas where there is mobile network coverage. Study shows that 80% of Afghan women now have some access to mobile technology, either through their own phone or through a phone belonging a family member.⁴⁵ Although the level of access and control Afghan women have over a mobile phone is not clear, mobile phones can be leveraged by government and non-government actors to reach out to women, disseminate information, and provide technology-based psychosocial and financial support.

Mobility Analysis

Women in Afghanistan often face restrictions regarding their movement and social life due to traditional and patriarchal norms, which prevent them, particularly in rural and conservative areas – from accessing education, healthcare, employment and deprives them from public participation and freedom of movement.⁴⁶



Graph 5. Women Freedom of Movement

Except for movements to visit nearby family, neighbours, and local shops, which often require respondents to be accompanied by another women, other movements such as visiting the health care centre, nearest town, and other region requires women to be accompanied by male relatives. As shown in graph 5, women's freedom of movement is highly restricted; the majority of women survey respondents across rural and urban districts indicated limited freedom of movement. Respondents said issues of cultural acceptance, and security concerns are significant factors contributing to the limited freedom of movement. Some respondents said, cost of transportation also a factor challenging their mobility. Restricted movement affects women's access to basic services, participation in public spheres, and economic activity. The lockdown and quarantine measure could further challenge women's limited freedom of movement in Afghanistan as families might use the lockdown measure to restrict the mobility of women and girls further.

⁴⁴ Islamic Republic of Afghanistan, Ministry of Education. National Education Strategy Plan (2017-2021).

https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/nesp_final_20-01-2017_0.pdf

⁴⁵ USAID, 22 May 2013. Survey of Afghan Women’s Access to Mobile Technology. <https://www.usaid.gov/where-we-work/afghanistan-and-pakistan/afghanistan/survey-mobile-technology>

⁴⁶ Oxfam, April 2020. Op Cit.

Protection

Gender Based Violence

The risk of domestic and gender-based violence has increased globally, as lockdown measures trapped those at risk of domestic violence at home with their abusers, unable to leave. Financial stress also said to aggravate domestic violence. Afghanistan already sees high levels of domestic violence, with 87% of women reportedly experience at least one form of physical, sexual, or psychological violence.⁴⁷ According to respondents, the majority have not witnessed an increase in conflict within their families, and only 29 respondents experienced conflict in their households after the COVID-19 crises. While respondents didn't experience conflict in their households, they indicated that more men are on the street and in the neighbourhood because of job loss. The loss of income and home confinement could aggravate conflict and domestic violence. Other risks of sexual abuse and exploitation are heightened in many countries, as protection measures are weak/broken due to the lockdown. The restriction of movement and the social isolation could put girls at greater risk of experiencing GBV and the threat of harmful practices including FGM and child, early and forced marriage.⁴⁸ Line representatives said early and forced marriage affect adolescent girls and women in the targeted districts. Such practices could increase during the pandemic.

Some representatives from MoWA and community leaders said they are witnessing increasing violence and GBV cases. They also highlighted the lack of referral mechanism. Some clinics have GBV focal persons, however, the service is limited, and there is no legal advice for GBV survivors. In GBV cases that require medical assistance, survivors seek medical support at clinics/hospitals. However, the clinics are not equipped to provide adequate services; they are not trained on how to address GBV cases and survivors. There is little to zero counselling and psychosocial support. The majority of GBV survivors prefer to be silent about GBV cases; if they seek remedy, they prefer to use informal remedies and handle the situation with community elders (*Malak*), religious leaders (*Mula Imams*) and member of the community (*'Shuras'*) through a male family member. They rarely go to the police and women affairs directorate to report GBV cases. According to a representative from MoWA, among the limited reported cases, the majority of them are domestic violence of a physical nature, alimony, and inheritance issues, and forced and underage marriage. Line department representatives and community leaders highlighted that school closure puts girls at a higher risk, and most mothers are not literate enough to home school their children. Afghan women's and girls' vulnerability to domestic violence put them at an increased risk of insecurity during the lockdown.

The number of child marriage in this Corona situation has been increased; small aged girls are married to older men as a third or second wife for money. I have 14 old daughters, whom I fear that my husband would marry her to head of our IDP camp; I have heard that some negotiations already ongoing between my husband, his family, and the IPD camp head. I am not going to allow this even if it costs my life; this will be a tough issue for me.

Women respondent, IDP camp, Kabul.

Safety

Women respondents mentioned the lack of safe place in the community, violence in the home, risk of attack within and outside of their community, and inability to access basic services and resources among the specific safety concerns they have for women and girls in their community. Additionally, for girls, trafficking and early marriage are significant security concerns. A few respondents also highlighted the lack of privacy at home is among the security concerns. The conservative and patriarchal norms further stranded the limited freedom and security women and girls have in their communities. Majority of the respondents indicated an informal way of seeking help when they

⁴⁷ Ibid

⁴⁸ UNFPA (23 March 2020). Coronavirus Disease (COVID-19) Preparedness and Response. Op Cit.

face some form of violence: 123 respondents would seek help from a family member, followed by, NGO (77 respondents), community leader (38 respondents); friends (36 respondents) and police (15 respondents).

People are also living under the broader security challenges; respondents said there is an explosion, lack of security at night, and they need to establish and strengthen community development councils and increase security force coordination and checkpoints to ensure overall safety in their community. It is critical to create a safe space for women and girls and apply regular monitoring. Most respondents stressed the importance of working with religious leaders. The community would listen to them, and they can be a powerful force to create gender awareness by addressing harmful social norms.

“Sometimes I feel unsafe; criminal, and GBV incidents are increasing”.

Women Community Leader, Herat Province

Capacity and Coping Mechanisms

To respond to the loss of income and livelihood, respondents are utilizing their individual and social network capacities to cope with the situation and changes. Their primary mechanisms include:

- **Livelihoods:** To mitigate the financial loss, respondents indicated that they sold their household assets and have consumed livestock for household subsistence. Thirty-nine respondents (15.4% women and 84.6% men) sold household assets, and forty-two respondents (23.8% women and 76.4% men) have consumed livestock to mitigate food shortage challenges. While these assets are serving as a coping mechanism, respondents will lose assets, contributing to household long term livelihood impacts. Respondents are also using other coping mechanisms by reducing the number of meals and portions of meals per day. Women and men respondents said they consume less preferred food, on average, 4 and 5 days a week, respectively. Additionally, women and men respondents are forced to limit the consumption of their meal at least 2-3 days per week. Women respondents reduce the food portion one day more than men respondents. Few participants also mention they reduce their food intake to feed small children and reduce the number of meals they eat per day. This is challenging for women, especially pregnant and lactating mothers who lack adequate food and nutrition. Line representative fears that as families use less food to cope with the situation, pregnant women and children under five will be at risk of malnutrition. Community leaders and line representatives also said people are using begging as a coping mechanism; they indicated the growing number of women and girls are begging on the streets after the crises.
- **Savings:** A large number of participants are spending their available savings, which again will impact long term household finances. According to respondents, 132 (37% women and 63% men) are spending their savings to meet ends meet in their household.
- **Borrowing:** The majority of the respondents are using their social networks and are borrowing money from friends and relatives. One hundred and seventy-one respondents (36.8% women and 63.2% men) said they are borrowing money. Men and women have to borrow money from friends and relatives at least two days per week. Borrowing creates further financial vulnerabilities, as the future is uncertain, and they are incurring debt that needs to be paid at some point, which again a challenge for household current and future financial sustainability.
- **Aid:** Despite limited available humanitarian support, the number of people depending on aid has increased after COVID-19. Forty-six respondents (56.5% women and 43.5% men) said they are dependent on aid to cope with the livelihood and financial challenges. The number of people dependent on aid before COVID-19 was 32 (81.2% women and 18.8% men); the increase in aid dependency after COVID-19 is witnessed among men respondent only.

Overall, the lack of appropriate support mechanisms pushed people to seek coping mechanisms that have a cost to their health, nutrition, and future household financial and livelihood sustainability.

Vulnerabilities and Needs

Vulnerabilities

Many respondents highlighted that women and girls, poor households, elderly, disable, and IDPs are the most vulnerable in their communities. Respondents also said, daily labourers, mostly men, are vulnerable to loss of job and income. They stated that communities, especially poor households, are worried as lockdown measures, and loss of jobs aggravate poverty. Women's financial dependency and lack of education further put them in vulnerable groups. As a result, women-headed households are very vulnerable. In rural areas, respondents mention, the situation is dire for landless households. Furthermore, IDPs are at a higher risk of accessing food, shelter, and essential services. IDPs living conditions in crowded spaces also challenge them to adhere to COVID-19 prevention guidelines, i.e., physical distancing. The majority of respondents, 148 characterized their areas have IDP settlements, the pandemic restriction can affect social cohesion between IDPs, and host communities, which impacts IDPs safety, and their access to essential resources and services.

Similarly, community and line department representatives shared respondent's vulnerability concerns – they said daily labourers who lost their job, widows, women-headed households, girls, IDPs, and children under five are among the most vulnerable groups in their provinces. Additionally, women's vulnerability to gender-based violence adds to their vulnerabilities, facing socio-economic, health, and safety challenges.

Afghanistan is prone to a number of natural disasters such as earthquakes, flooding, and landslides.⁴⁹ The COVID-19 outbreak comes against the backdrop of the Spring flood season⁵⁰ increasing the vulnerabilities to communities who are already facing natural disasters; as a woman respondent from Khulm districts expressed it, *"the community are affected by a flood, I lost my house, but most people are now jobless and need assistance due to the lockdown."* Her statement, along with others, reflects the multiple levels of vulnerabilities households are facing due to the pandemic.

Needs

When asked to prioritize their three top needs for their households, majority of respondents identified food as number one priority, with 198 (47% women and 53% men) identifying food as their top priority; followed by cash and health care, prioritized by 204 respondents (43.6% women and 56.4% men), and 193 respondents (47.7% women and 52.3% men) respectively. Education, sanitation hygiene, and water needs were selected by an average number of participants. Shelter and protection were the least prioritized by respondents. Out of the 26 respondents who prioritized shelter, 61.5% are women, and 38.5% are men. Only 16 respondents prioritized protection; 87.5% of respondents who prioritized protection are male respondents. Furthermore, respondents noted their preference for humanitarian assistance, with the majority choosing cash transfers, followed by in-kind support and service delivery. Assistance through vouchers received the lowest preference among respondents. The respondents' immediate needs are relatively similar among women and men, and rural and urban respondents. They all mostly prioritized food, cash, and health services. Respondent's response clearly shows the need for food assistance during the lockdown, and cash support as families are striving to maintain some level of livelihood and increasing demand for health care services.

⁴⁹ Global Network of Civil Society Organizations for Disaster Reduction, 2020. Types of Recent Disasters in Afghanistan. <https://www.gndr.org/programmes/advocacy/365-disasters/more-than-365-disasters-blogs/item/1449-types-of-recent-disasters-in-afghanistan.html#:~:text=Afghanistan%20is%20considered%20as%20a,northeast%2C%20and%20often%20trigger%20landslides.>

⁵⁰ COVID-19 Multi-Sector Humanitarian Country Plan. Afghanistan. 24 March 2020. Op Cit.

Representatives from line departments and community leaders echoed the same need as survey respondents. Significant needs remain cash, food, health service (including SRH), jobs and hygiene kits, and PPE. Some respondents highlighted the need for GBV referral systems, legal support, and centres to support GBV survivors. MoWA representative and some community leaders mentioned the need to create safe spaces for women and girls.

Respondents shared their hopes and prayers to see the day without the COVID-19 pandemic, joining the hopes of millions around the globe. They also indicated they want to follow the preventive measures and stay at home, but they need to provide and feed their families more urgently. Accordingly, they hope to gain support from the government and NGOs. The majority of them said cash, food, and support to access health and hygiene kits as their recommendation for NGOs and the government. Some recommended working to raise awareness and provide information about COVID-19 to the community. A few respondents suggested radio-based education for their kids so that they don't miss school.

"We are not allowed to talk through the phone even if the caller is female; we need to have permission from the family before attending a call. We don't have such a problem if female staff visit our home, we can talk to them openly - we call upon CARE to resume their field mission and allow female staff to visit who we can talk and discuss our challenges".

Women respondent, Kabul Province

Conclusions

COVID-19 in Afghanistan is more than a public health crisis. It is a crisis compounded with existing complex social-economic, political, and security issues, that will escalate due to COVID-19 and measures against COVID-19. The challenge will disproportionately affect the most vulnerable, particularly women and girls who are already facing the burden of gender discrimination and limited rights in the country. The lack of resources, inadequate health services, large vulnerable populations, low economic capacity, and the country's fragility mean the impact will be profound. The crisis will disproportionately affect women and girls in Afghanistan in significant ways, including adverse impacts on their access to food, nutrition, livelihood, health, education, safety, and protection. Women are the primary caregivers in the family and are burdened with household chores; the outbreak will load women by adding to their existing gendered household and community roles. The risk to GBV are increasing, and initial data shows that increase in domestic violence, and harmful traditional practices are a critical risk to women and girls. The loss of job and income is among the significant impacts of COVID-19 and the lockdown measures that impact vulnerable households. The ability of families to cope with the market and price shocks combined with job loss due to the lockdown is minimal. Providing essential livelihood, food, and IGA support and strengthening access to health services, including SRH services, and enhancing protection, and GBV mitigation mechanism is crucial. Interventions must seek to identify the needs of the most vulnerable i.e., women, girls, persons with disabilities refugees, and IDPs, and ensure their representation and participation through a community-led process. Engaging men and boys during the COVID-19 response are crucial to mitigate unhealthy masculine behaviors and support positive male roles in the crisis.

Recommendations

Recommendations below addressed to different actors responding to the COVID-19 crisis and looking at its long-term impact.

Inter-Cluster Coordinator Team (ICCT) and Humanitarian Country Team (HCT) should:

- Request the clusters and encourage partners to integrate the Rapid Gender Analysis findings in their planning and response and develop a matrix to track the key actions to be taken by the clusters.

- Mainstream Prevention of Sexual Exploitation and Abuse (PSEA) in all clusters and provide technical guidance and capacity building across agencies.
- Engage the overall humanitarian community, regional level humanitarian team, and government actors to actively support and advocate gender-sensitive response in the emergency preparedness and coordination.
- Coordinate with national and local government bodies to ensure women are part of COVID-19 coordination and response, taskforce, and committees.

All Humanitarian Actors should:

- Recognize GBV prevention, mitigation and response as lifesaving and integrate GBV into programming by ensuring adequate and appropriate GBV prevention and response measures are in place among essential services, including access to resources for GBV prevention and response, referral mechanisms, provision of safe-space for women and girls at risk of GBV, and provision of psychosocial support.
- Encourage engagements of community and religious leaders to provide community-based protection and support for women and girls at risk of gender-based and domestic violence.
- Provide Personal Protective Equipment (PPE) and other essential materials to GBV responders to ensure they can safely and effectively carry out their work.
- Ensure basic health services for issues other than COVID-19 are available. Emphasis should be on ensuring resources for women's SRH services are not diverted as a result of the crisis – services could include remote clinics and increased home visits by trained community women health workers.
- Prioritize livelihood and food security interventions by ensuring adequate food access, especially for pregnant women, nursing mothers, children under five years old, and IDPs. Provide food assistance and, where possible, to this with cash transfers.
- Enhance linkages with development actors to support long term income-generating opportunities and asset-creation for vulnerable households. Support the financial and economic interests of women and girls and support IGAs that consider women's additional time and unpaid work burden as a result of COVID-19.
- Identify and leverage appropriate technologies for information dissemination on COVID-19, GBV, and psychosocial support, especially targeting women and girls, IDPs, persons with disabilities, youth, and other marginalized groups.
- Mobilize community support and build the capacity to establish community monitoring and accountability mechanisms; ensure integration of Prevention of Sexual, Exploitation, and Abuse (PSEA) in all interventions.

Donors, OCHA and UN Agencies should:

- Support community-based responses by making direct funding available for local responders, especially women-led organizations working to address GBV and advance gender equality to help localize the humanitarian assistance and increase women and girls' leadership and participation.
- Make GBV prevention and response, and PSEA a compulsory element of all humanitarian interventions and reporting and allocate sufficient funding for GBV interventions.
- Collaborate with government economic and financial sectors to facilitate safety nets and social protection, especially for women and men daily labourer who lost their income and jobs due to COVID-19.

Development Actors should:

- Ensure the design and implementation of gender-responsive and transformative social safety net responses in coordination with humanitarian actors.
- Identify how they can complement and support the emergency and humanitarian effort to contribute to the country's recovery and resilience through gender-responsive and transformative livelihood, economic, and education programmes, especially targeting women and girls and youth.

- Facilitate collaboration with community-based organizations, private sectors, and local authorities to support IGA initiatives and provide market-stimulating responses to meet basic needs, such as cash transfers/vouchers. When possible, link small traders with whole sellers to mitigate the price shocks.
- Work with diverse women-led and women's rights organizations, women leaders, and movement to foster women's participation and leadership in decision-making structures.
- Prioritize GBV prevention approaches that seek to combat harmful social and gender norms and address the root causes of violence and gender discrimination.

National and Local Government Should:

- Promote women's meaningful participation in decision making, from the local to the national level by creating gender-balanced COVID-19 response mechanisms at all levels and support women's participation by accounting for gender-specific barriers to decision-making spaces.
- Prioritize and officially recognize GBV services as an essential and lifesaving component and put in place policies and guidelines to ensure all government agencies and line ministries address GBV in their responses.
- Strengthen referral and reporting systems for responding to cases of GBV and identify clear pathways for the referral process through women's affairs, health centers, and policies.
- Issue exceptions on movement restriction policies for GBV survivors or those at risk of experiencing violence to seek safety and access support.
- Strengthen security measures and promote safety measures for women and girls and address violence and conflict issues in the community.
- Ensure the lockdown measures effect on humanitarian assistance is minimized by opening roads and putting place exception for humanitarian assistance deliveries.
- Ensure resources are not diverted from SRH services, and MoPH and relevant line ministries should ensure SRH services are an essential response to the COVID-19 crisis.

All Actors:

- Recognize that this is more than a public health crisis, and engage community members in socio-economic, safety, and protection efforts. Engage women, youth (both boys and girls), traditional and religious leaders equally in analysis, problem-solving, and decision making. Women in Afghanistan are generally missing from the community decision-making process; thus, it is critical to creating women-friendly spaces and meaningful engagement. When possible, provide village to village consultation, as most women are not allowed to travel to districts and provinces by themselves.
- Ensure GBV and protection activities are integrated into all current and future responses.
- Ensure policies and programming are based on the findings of a Rapid Gender Analysis that includes data disaggregated by sex, age, and disability, in order to understand and continue to track the differential experience of women and men, girls and boys and to guide gender-informed action in the short, medium and long term.
- Ensure meaningful opportunities for women and girls to participate in all levels of decision-making structures.
- Support the provision and implementation of safe spaces for women and girls at risk of gender-based and domestic violence. Ensure safe space initiatives for women and girls are specifically adapted to the COVID-19 context, including leveraging different technologies such as mobile phones.
- Institute strong policies and approaches to prevent, mitigate and respond to sexual exploitation and abuse (SEA) within the context of COVID-19 interventions.

Annexes

Annex 1: Sex Disaggregated Sample Size by Province and District

Individual Survey						KII		
Province	District	Categories	Female	Male	Total Sample size	Male	Female	Line Department
Balkh	Khulm	Pre-urban	10	10	20	2	2	2
	Dehdadi	Pre-urban	5	5	10	2	2	
	Charkent	Rural	5	5	10	2	2	-
	Mazar e Sharif		-	-	-	-	-	2
Ghazni	Khwajaumari	Rural	5	5	10	2		1
	Nawur	Rural	5	5	10	2	2	1
	Ghazni	urban	15	15	30	2	2	1
Herat	Enjil	Pre-urban	5	6	11	2		
	Herat	urban	11	9	20	2	2	1
Kabul	Kabul	urban	23	25	48	2	1	2
Kapisa	Mahmud-e-Raqi	Pre-urban	8	7	15	1	2	1
	Hisa-e-Awal-e-Kohestan	Rural	8	7	15	3	2	-
Khost	Nadirshahkot	Rural	8	4	12	2	2	-
	Khost (Matun)	urban	13	16	29	2	2	2
	Darkote		-	-	-	-	1	-
Paktya	Gardez	urban	15	15	30	2		
Parwan	Salang	Rural	5	5	10	1	2	
	Charikar	urban	10	10	20	2		2
	Bagram		-	-	-	1		
Kandahar	Kandahar	Urban	10	10	20	1	1	3
	Miyana Shin		-	-	-	-	1	-
Total			161	159	320	33	26	18

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