



CARE-supported water, sanitation, and hygiene facilities in the Dadaab Refugee Camp in Kenya. (Photo: CARE/Sven Torfinn)

# CARE Rapid Gender Analysis for COVID 19 East, Central and Southern Africa

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The views in this RGA are those of the authors alone and do not necessarily represent those of CARE, its programs, country partners or respective governments.



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## Executive Summary

The novel coronavirus (COVID-19) has had a devastating impact globally. Governments across East, Central and Southern Africa (ECSA) are imposing lockdowns and other restrictions, which although critical in slowing the spread of the disease, can themselves impose significant social and economic costs on millions of people, especially those living in informal settlements or overcrowded refugee and internally displaced person (IDP) camps. Most countries in ECSA have little to no prior experience in responding to such a pandemic.

The impacts – direct and indirect – of public health emergencies fall disproportionately on the most vulnerable and marginalized groups in society. Interconnected social, economic, and political factors pose complex challenges for the ECSA region's ability to respond to COVID-19. The region already faces significant health challenges that would exacerbate the severity of COVID-19, such as high levels of malnutrition, malaria, anemia, HIV/AIDS, and tuberculosis. Access to healthcare in the region is the lowest in the world, thus there is limited capacity to absorb the pandemic<sup>1</sup>.

Gender-based inequality is extensive in the region. Women are at a higher risk for exposure to infection due to the fact that they are often the primary caregivers in the family and constitute 70% of frontline healthcare responders.<sup>2</sup> Most women already face limited access to sexual and reproductive health and rights (SRHR) services, and the region struggles with high levels of maternal mortality. For example, mother mortality rates recorded in South Sudan were 1150 per 100 000 live births<sup>3</sup>. COVID-19 will only increase women's safety risks and care burdens as health services become stretched and resources shift to COVID-19 responses.

Women and girls are at increased risk of violence during the COVID-19 period. Current rates of violence against women and girls combined with the prevalence of harmful traditional practices leads to increased vulnerability. Income loss and limited mobility, compounded with existing gender role expectations, may contribute to increases in intimate partner violence and other forms of gender-based violence.

Further, women are more likely to lose income as many are in the informal sector and engaging in activities that are highly sensitive to economic downturn and market disruption (such as petty trade or primary production).

With COVID-19, existing food crises will be exacerbated in the ECSA region, resulting in worsening food security and nutritional outcomes for the most vulnerable

### Key Findings

- Women's care burden is likely to increase due to the closures of schools and as health systems become less accessible in the shift to COVID-19 responses.
- Women are at the frontline of the response as community health workers and nurses, which places them at increased risk and exposure to infection. Risks may be exacerbated by limited access to personal protective equipment (PPE).
- 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, potentially resulting in an increase in maternal mortality and intimate partner violence.
- Women's economic and productive lives will be affected due to restriction in movement as most are engaged in informal trade, where they earn less and have no social safety nets.
- Data reflects an increase in GBV. Use of the military and service personnel to enforce restrictions is likely to expose women to sexual harassment and exploitation.
- Women have limited decision making in governance and policy making bodies. There has been limited engagement of women in COVID-19 decision making processes.
- Gender gap in the use of technology and literacy may influence prevention, awareness and resource access.

<sup>1</sup>Kaseje, Neema (30 March 2020). Why Sub-Saharan Africa Needs a Unique Response to COVID-19. World Economic Forum. <https://www.weforum.org/agenda/2020/03/why-sub-saharan-africa-needs-a-unique-response-to-covid-19/>

<sup>2</sup><https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?ua=1>

<sup>3</sup> UNICEF Data: Monitoring the situation of children and Women: 2017

households. Given expected trajectories and historical knowledge, already high levels of hunger and malnutrition will further increase. Preparedness for the possibility of increasing food and nutrition insecurity, particularly among women, is imperative, given the likely effects of this pandemic on livelihoods, markets, and the delivery of basic health services such as maternal and child health<sup>4</sup>.

The region has limited access to water and sanitation services and varying levels of knowledge, attitudes and practices with regards to environmental health and hygiene. This creates challenges and burdens for women who have the primary responsibility around water, sanitation and hygiene (WASH) at the household and community level. Furthermore, the region is host to more than five million refugees and IDPs that are living in temporary and cramped shelters. These facilities do not have adequate WASH facilities. These socio-economic and health contexts, combined with high population densities and dependency on fresh food marketing in urban areas, makes policy recommendations such as physical distancing and quarantine difficult to implement.

## Key recommendations

- Collect sex- age and disability disaggregated data on the direct and indirect impacts of COVID-19.
- Ensure that appropriate COVID-19 awareness and risk communications reach all people, including marginalized groups, the disabled, women in refugee camps and IDP settlements, remote areas and those in conflict areas. Ensure that information is delivered through multiple channels and understood by diverse populations.
- Meaningfully engage women and girls and people with disabilities (via existing formal and informal social networks) in all COVID-19 decision-making on preparedness and response at the national, provincial and community levels to support their efforts as first responders and their efforts to prevent social isolation.
- Interventions on water and sanitation services must be informed by the specific role and needs of women and girls, with particular attention to those in densely populated communities, camps and slums.
- Prioritize support to women on the frontlines of the response, formally and informally, including access to personal protective equipment (PPE) and psychosocial trauma-sensitive support resources.
- Governments and local authorities should ensure that policy decisions are gender-responsive, particularly those related to restricted movement and protecting essential lifesaving health services for women and girls, including sexual and reproductive health services.
- Gender-based violence and child protection risk mitigation should be prioritized across sectors and programming in COVID-19 response.
- Ensure access to diverse and nutritious food among the urban and rural poor, especially women, pregnant and lactating women and girls, older people, IDPs and refugees during lockdowns via food aid, cash-or-voucher based support or other saving models.
- Prioritize resiliency-based livelihood approaches, including the use of safety nets and food and nutrition security actions that target the most vulnerable, especially women.
- Engage men and boys, as well as women and girls to raise awareness about sharing care-giving roles to reduce women's care-giving burden, including ensuring psychosocial trauma-sensitive support.

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<sup>4</sup> FSNWG COVID-19 Food Security Alert; March 30, 2020. Accessed on April 5 at [https://reliefweb.int/sites/reliefweb.int/files/resources/FSNWG\\_COVID\\_19\\_Alert\\_30.03.2020.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/FSNWG_COVID_19_Alert_30.03.2020.pdf)

## Introduction

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### Background: COVID-19 in East, Central and Southern Africa

First categorized as a pandemic by the WHO on 11 March 2020, the novel coronavirus (COVID-19) has had a devastating impact globally. The number of confirmed COVID-19 cases in Africa was relatively low until mid-April 2020<sup>5</sup>, but it should be noted that levels of testing to date have been very limited in Africa<sup>6</sup>, and many experts are concerned that the continent could still experience outbreaks on – or beyond - the scale experienced in other regions. In response, governments across East, Central and Southern Africa (ECSA) are imposing lockdowns and curfews, requiring self-quarantine and restricting gatherings and movement of people<sup>7</sup>. Although critical in slowing the spread of the disease, these measures can themselves impose significant social and economic costs, especially for the many millions of people in ECSA living in urban slums, informal settlements or overcrowded refugee and IDP camps, often with poor access to health care, clean water, and sanitation<sup>8</sup>. The ECSA region also includes remote and rural areas where both access to services and basic information about the disease and means of prevention is limited. Preparedness and response to previous epidemics, such as Ebola, provides a strong foundation for some ECSA countries, such as DRC, to tackle the spread of COVID-19: however, most countries in ECSA have little to no prior experience in responding to such a pandemic.

Everyone is affected by COVID-19, but the impacts – direct and indirect – of public health emergencies fall disproportionately on the most vulnerable and marginalized groups in society. Initial research indicates that the elderly and those with underlying health conditions are at a higher risk of suffering serious complications if they contract COVID-19<sup>9</sup>, whilst early evidence suggests that fatality rates are higher amongst men than women<sup>10</sup>. Beyond health outcomes, the wider impacts of the pandemic, including increased burdens of care giving, disrupted livelihoods, increased malnutrition and an increase in violence, will significantly and disproportionately affect women and girls, as this report will show. Pervasive levels of existing gender inequality across the region, particularly in the critical domains of leadership and decision-making, access to and control of resources and gender-based violence, amplify these effects and make an already challenging public health response to COVID-19 more complex.

### Rapid Gender Analysis Objectives

This preliminary Rapid Gender Analysis (RGA) has the following objectives:

- To analyze and understand the different impacts that COVID-19 potentially has on women, men, girls and boys and other vulnerable groups in East, Central and Southern Africa (ECSA)<sup>11</sup> context.
- To inform humanitarian and development programming in the ECSA region based on the different needs of women, men, boys and girls with a particular focus on gender-based violence (GBV), health, water, sanitation and hygiene (WASH), food and nutrition security and women's economic

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5 Kaseje, Neema (30 March 2020). Why Sub-Saharan Africa Needs a Unique Response to COVID-19. World Economic Forum. <https://www.weforum.org/agenda/2020/03/why-sub-saharan-africa-needs-a-unique-response-to-covid-19/>

6 Testing per capita in the 3 sub-regions is extremely low, with Kenya testing at the highest rate of 41 per 1m citizens. Zambia is testing 34 per 1m and Ethiopia 16 per 1m and the lowest submitted testing rate is Mozambique at 11 per 1m. By way of comparison, Germany is testing 10,000 per 1m and the US 5,000 per 1m citizens (data as at April 7, 2020). This lack of testing in Africa will constrain policy decision-making that may avert higher transmission and mortality rates.

7 WHO Africa (02 April 2020). WHO concerned as COVID-19 cases accelerate in Africa. <https://www.afro.who.int/news/who-concerned-covid-19-cases-accelerate-africa>

8 ICRC (30 March 2020). ICRC response to the coronavirus in Africa. <https://www.icrc.org/en/document/covid-19-icrc-response-coronavirus-africa>

9 World Health Organization (WHO) (11 March 2020). Coronavirus disease 2019 (COVID-19) Situation Report – 51.

[https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57\\_8](https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_8)

10 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30823-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30823-0/fulltext)

11 Somalia, Kenya, Uganda, Ethiopia, Sudan, South Sudan, Democratic Republic of Congo, Rwanda, Tanzania, Burundi, Mozambique, Malawi, Zimbabwe, Zambia and Madagascar

empowerment. **These focus areas have been used to structure the report's main findings.**

## Methodology

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Rapid Gender Analysis (RGA) is built up progressively, to understand gender roles and relations and how they may change during a crisis. This RGA provides information about the potential different impacts, needs, capacities and coping strategies of women, men, girls and boys and other vulnerable groups in the Eastern, Central and Southern Africa (ECSA) region throughout the COVID-19 pandemic. The research methods for this preliminary RGA were secondary data review of existing gender information and the most recent COVID-19 data. This is in line with CARE's Adapted RGA toolkit and its ethical considerations guidance note for conducting RGAs during COVID-19.

This initial analysis will be updated as the crisis evolves, and new issues arise. The analysis provides recommendations for the humanitarian system and humanitarian and development actors to ensure consideration of the gendered dimensions of risk, vulnerability, and capabilities in response to this crisis. This report does not aim to answer questions about the epidemiology and pathology of COVID-19.

The research has several limitations, which include lack of access to gender disaggregated data, as well as access to some secondary data on COVID-19 response and impact.

## Demographic Profile: ECSA Region

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### Sex and age disaggregated data

See Table 1 for sex disaggregated population data for countries in the ECSA region. As in Africa as a whole, the ECSA region has a young population, with children aged 0-14 making up about 41% of the population. However, the region also has a high prevalence of malnutrition, anemia, malaria, HIV/AIDS, and tuberculosis, which could lead to a higher incidence of severe forms of COVID-19 among younger patients than we might otherwise expect<sup>12</sup>. These risk factors also have a gender dimension: in the Southern Africa Development Community (SADC), for example, 59% of people living with HIV are women<sup>13</sup>. Additionally, women are more likely than men to suffer from food insecurity and malnutrition: even though women produce more than half of the world's food, they comprise 70% of the world's hungry<sup>14</sup>.

### People living with disability

In the ECSA region, Ethiopia shows the highest prevalence of people living with disability at 18%, followed by 16% in Uganda, 15% in Somalia, 11% in Zimbabwe and 9% in Kenya. Those with disabilities may be at greater risk of contracting COVID-19 due to difficulties in maintaining physical distancing as they need additional physical and/or personal support. In addition, those living with, or susceptible to mental health issues, may find the restrictions of movement and abnormal social pressures exacerbating their condition.

### Urban demographics

Built-up areas across much of Africa have higher population densities than those in Europe and the United States. Influenza transmission rates have been found to increase above a population density of 282 people per square kilometer. The density of many built-up areas in Africa is over five times this threshold.<sup>15</sup> Kinshasa, for example, has a peak population density greater than New York City (56000 people per square kilometer).<sup>16</sup> Slums and informal settlements are often extremely densely populated, rendering physical distancing and self-isolation all but impossible. Further, many urban and peri-urban dwellers are in rented accommodation,

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<sup>12</sup> Kaseje, Neema (30 March 2020). Why Sub-Saharan Africa Needs a Unique Response to COVID-19. World Economic Forum. <https://www.weforum.org/agenda/2020/03/why-sub-saharan-africa-needs-a-unique-response-to-covid-19/>

<sup>13</sup> SADC Gender Protocol 2016, Barometer

<sup>14</sup> UNFPA. 10 Things You Should Know About Women and the World's Humanitarian Crises. (2016), cited in IASC,

<sup>15</sup> Africa Center for Strategic Studies, April 3, 2020. Mapping Risk Factors for the Spread of COVID-19 in Africa. Access on April 9 at <https://www.printfriendly.com/p/g/PwXvDC>

<sup>16</sup> Ibid

often with precarious contractual security, meaning that loss of income earning due to lockdowns or sudden unemployment will increase the risk of harassment and eviction.

## Refugees and IDPs

Sub-Saharan Africa hosts more than 26% of the world's refugee population. Recent crises and conflicts have led to increased numbers of refugees and IDPs<sup>17</sup> who live in camps, informal shelters and settlements that are frequently overcrowded and therefore at extended risk of higher transmission rates. In 2019, East Africa and the Horn of Africa hosted an estimated 4.6 million refugees and asylum-seekers, mainly from South Sudan, Somalia and DRC, as well as an additional 9.5 million IDPs in South Sudan, Somalia, Sudan and Ethiopia. Southern Africa also hosted close to 534,000 people of concern, including some 204,000 refugees and more than 281,000 asylum-seekers, in 2018<sup>18</sup>. In Central Africa, at the end of 2018, DRC hosted the most refugees and asylum-seekers (534,830), followed by Tanzania (317,980) and Rwanda (145,780). In addition, 5.36 million people were internally displaced within the sub-region, with the vast majority in the DRC. The large scale of displacement and high refugee numbers leave many refugees and IDPs without any legal protection and access to basic services, which results in an increased risk of higher infection rates that not only affects their health but also their security, livelihood and food security.

## Findings and Analysis

COVID-19 in the ECSA region will disproportionately affect women and girls in various ways, including adverse impacts on their gender roles, relations, health, education, food security and nutrition, livelihoods, and protection. Women face a triple burden during the pandemic: they are the primary caregivers, are responsible for managing disease/sickness at household level and constitute the majority of those in community health work and primary care. Women are also the primary producers of 70% of Africa's food<sup>19</sup>, and often rely on agriculture for food and income. As the section below on **Food Security and Nutrition** shows, any impact on women's ability to produce and market food will exacerbate existing food insecurity within the region, especially in counties already suffering from the overlapping effects of droughts, floods, locust outbreaks and conflict. As the section on **Women's Economic Empowerment** describes, most women in the region work in the informal sector, where incomes are generally low, inconsistent, and without safety nets. Weak health systems, including insufficient skilled personnel and shortages in supplies, underpinned by inequitable gender and social norms, result in significant barriers and limited access to **Sexual and Reproductive Health and Rights** (SRHR) services across ECSA, which are likely to be further impacted by COVID-19.

Country	Sex		Total Population
	Male	Female	
Malawi	9,434 49.32%	9,696 50.68%	19,130
Zimbabwe	7,092 47.72%	7,771 52.28%	14,863
Zambia	9,103 49.52%	9,281 50.48%	18,384
Mozambique	15,188 48.59%	16,067 51.41%	31,255
Tanzania	29,851 49.97%	29,883 50.03%	59,734
Madagascar	13,815 49.89%	13,876 50.11%	27,691
Burundi	5,900 49.62%	5,991 50.38%	11,891
DRC	44,710 49.92%	44,851 50.08%	89,561
Uganda	22,547 49.29%	23,194 50.71%	45,741
Rwanda	6,367 49.16%	6,585 50.84%	12,952
Ethiopia	57,517 50.03%	57,447 49.97%	114,964
Somalia	7,924 49.86%	7,969 50.14%	15,893
Sudan	21,907 49.96%	21,942 50.04%	43,849
South Sudan	5,603 50.05%	5,591 49.95%	11,194
Kenya	26,719 49.69%	27,053 50.31%	53,772

<sup>17</sup>UNHCR (accessed 08 April 2020). Africa. <https://www.unhcr.org/africa.html>

<sup>18</sup>UNHCR (accessed 08 April 2020). Southern Africa. <http://reporting.unhcr.org/node/37?y=2019>

<sup>19</sup>The prevalence of undernutrition (PoU) is already alarming in Africa, where since 2015, increases in almost all subregions has been recorded. In the east Africa sub-region, for example, undernutrition stood at 30.8% in 2018. FAO, State of Food Security and Nutrition, FAO, Rome, 2019.

## Gender Roles and Responsibilities

In Africa, women carry out at least 3.4 times more unpaid care work than men<sup>20</sup>. The prevalence of harmful social and gender norms and pervasive structural gender inequalities mean that the COVID-19 crisis will increase women's unpaid care and domestic work.

The most common profile of unpaid care work in Africa is that of a woman between 15 and 54 years old with few economic resources, several children, a low level of education and, often, health problems or disabilities, who simultaneously works for pay/profit in the informal economy and receives little or no formal care support.<sup>21</sup> The region also shows significant patterns of single female-headed households. From World Bank data, the average female-headed households (FHH) for 10 of the 15 countries in ECSA is 28.5%<sup>22</sup>.

Women are also responsible for caring for the sick, the elderly and the orphaned. High HIV prevalence, especially in East and Southern Africa, has resulted in orphaned children mostly cared for by grandmothers.

In addition, most of the ECSA countries, except for Burundi, announced country-wide temporary closure of schools.<sup>23</sup> Increased childcare is expected to further stretch women's existing household and community burdens. Evidence from the 2014-16 Ebola Virus Disease (EVD) outbreak in West Africa shows how an outbreak places a three-fold caregiver burden on women and girls: they are responsible for household-level disease prevention and response efforts; at greater risk of infection; and subject to emotional, physical, and socio-economic harm.<sup>24</sup>

There is also a rural-urban variation on the level of unpaid work among women. For example, women in rural areas spend more time fetching water and collecting firewood than their urban sisters, namely around six times more in Ethiopia, and three times more in Madagascar.<sup>25</sup>

**Women as health workers:** A large proportion of women are also engaged in the health sector; estimates show 68% of community health workers in sub-Saharan Africa are women. The proportion of women in the health sector varies across ECSA region, with 70% in Uganda, 57% in Zambia and 51% in Tanzania. Most of the women health workers in the region are young, and the vast majority of them are unpaid for their services.<sup>26</sup> Many of these women, in spite of the fact that they are first responders, have limited access to personal protective equipment (PPE). Additionally, reports of violence against healthcare workers due to the serious stress that the pandemic places on patients, their relatives and other healthcare workers requires health services to recognize this as a risk for women health workers.<sup>27</sup>

## Women's Economic Empowerment

The COVID pandemic – and measures taken by governments to suppress it – is likely to have a **significant and sustained negative impact on the economies** of countries in the ECSA region. Even in a best-case

“The majority of health workers are women and that puts them at highest risk. Most of them are also parents and care givers to family members. They continue to carry the burden of care, which is already disproportionately high in normal times. This puts women under considerable stress.”

Phumzile Mlambo-Ngcuka

Executive Director, UN Women

20 ILO (2018). CARE work and care jobs for the future of decent work. ILO. [https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms\\_633135.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf)

21 Ibid

22 World Bank Data, <https://dhsprogram.com/>

23 UNESCO (accessed on 7 April 2020). COVID-19 Impact on Education. <https://en.unesco.org/covid19/educationresponse>

24 Interagency Standing Committee (IASC) GBV Sub-Sector Nigeria. (7 September 2017). “Briefing Note: Integrating Gender in Cholera Prevention and Control Interventions In North East Nigeria”. [https://reliefweb.int/sites/reliefweb.int/files/resources/briefing\\_note-gender\\_in\\_cholera\\_response.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/briefing_note-gender_in_cholera_response.pdf)

25 Ibid

26 Ibid

27 Fraser, Erka (16 March 2020). Impact of Covid-19 Pandemic. On VAWG. UKaid. <http://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf>

scenario, GDP growth is expected reduce by half, pushing close to 27 million people into extreme poverty<sup>28</sup>. This impact will fall disproportionately on women and girls.

In Sub-Saharan Africa, 74% of women in non-agricultural jobs work in the **informal sector**, without any social protections such as pensions, health insurance and sick leave<sup>29</sup>. Informal jobs typically pay less and are more vulnerable to disruption, such as during the 2014–16 West Africa Ebola outbreak, when restrictions on the movement of goods and people severely hampered women’s trading activities’ leaving them unable to pay back loans from village savings and loan associations and affecting their longer-term economic prospects<sup>30</sup>.

Across the ECSA region, women are less likely to have access to and control over productive assets and resources such as land<sup>31</sup>. In CARE’s rapid gender analysis following Cyclone Idai in Mozambique in 2019, all women respondents stated that they did not own the land they worked on. If their husbands died, women told CARE, the land would pass to his family – and may face eviction<sup>32</sup>. Women face widespread discrimination in the distribution of other services and opportunities, such as credit, training, employment opportunities, mobility, climate and market information services, inputs and technologies<sup>33</sup>.

The roles and rules in producing, processing (including cooking) and marketing food are often divided along gender lines<sup>34</sup> and continued imbalance in gender relations perpetuate cycles of poverty for women.

## Food Security and Nutrition

The pandemic is likely to have significant direct and indirect impacts on already fragile levels of food and nutrition security across the ECSA region. Even before COVID-19, a record 45 million people in **Southern Africa** were deemed food insecure as the region entered the peak of the lean season (January-March 2020)<sup>35</sup>. In East Africa and the Horn, swarms of desert locusts are currently threatening harvests and animal feed<sup>36</sup>. FEWS NET anticipates that restrictions introduced by governments as part of the COVID-19 response could affect life-saving humanitarian food imports and delivery.

In 2018, Africa (together with Asia) bore the greatest share of all forms of malnutrition, accounting for more than nine out of ten of all stunted children, nine out of ten of all wasted children, and nearly three-quarters of all overweight children worldwide.<sup>37</sup> The highest levels of child malnutrition in the ECSA region are recorded in Burundi at 58% and Malawi at 48%<sup>38</sup>. Globally, women are more likely than men to suffer from food insecurity and malnutrition: even though women produce more than half of the world’s food, they comprise 70% of the world’s hungry<sup>39</sup>.

Poverty, inequality and marginalization are amongst the underlying causes of food insecurity and malnutrition. Restrictions imposed because of COVID-19 will likely exacerbate these drivers by interrupting supply chains, disrupting casual labor markets and reducing remittances. Food shortages and price spikes can be expected<sup>40</sup>, risking the food security and nutrition of vulnerable households in both urban and rural areas

<sup>28</sup> ECA (13 March 2020). ECA estimates billions worth of losses in Africa due to COVID-19 impact. <https://www.uneca.org/stories/eca-estimates-billions-worth-losses-africa-due-covid-19-impact>

<sup>29</sup> UN Women (accessed on 07 April 2020). Women in informal economy. <https://www.unwomen.org/en/news/in-focus/csw61/women-in-informal-economy>

<sup>30</sup> UN Development Group (UNDG) Western and Central Africa, “Socio-Economic Impact of Ebola Virus Disease In West African Countries,” UNDG, February 2015, <https://www.undp.org/content/dam/rba/docs/Reports/ebola-west-africa.pdf>

<sup>31</sup> Beuchelt, T., & Badstue, L. 2013. Gender, nutrition-and climate-smart food production: Opportunities and trade-offs. Food Security 5, no. 5

<sup>32</sup> CARE, Rapid Gender Analysis for Cyclone Idai Response, Sofala Province, Mozambique, 2019. Accessed at [Mozambique RGA Idai](#)

<sup>33</sup> Simelton, E., and Ostwald, M. 2019. Multifunctional land uses in Africa. Sustainable Food Security Solutions.

<sup>34</sup> FAO and CARE. 2019. Good Practices for Integrating Gender Equality and Women’s Empowerment in Climate-Smart Agriculture Programmes.

<sup>35</sup> FEWSNET: Tackling Southern Africa’s Climate-Driven Food Crisis Update #3, 14 January 2020. Accessed April 6 at: <https://reliefweb.int/report/zimbabwe/tackling-southern-africa-s-climate-driven-food-crisis-update-3-14-january-2020>

<sup>36</sup> FEWSNET; Desert Locust Crisis: Appeal for Rapid Response and Anticipatory Action in the Greater Horn of Africa (January–December 2020), accessed on April 6 at: <https://reliefweb.int/report/ethiopia/desert-locust-crisis-appeal-rapid-response-and-anticipatory-action-greater-horn-0>

<sup>37</sup> FAO, State of Food Security and Nutrition, FAO, Rome, 2019.

<sup>38</sup> Blessing J. Akombi et al., May 2017 Child malnutrition in Sub Saharan Africa: A meta-analysis of demographic and health surveys 2006-2016

<sup>39</sup> UNFPA. 10 Things You Should Know About Women and the World’s Humanitarian Crises. (2016), cited in IASC,

<sup>40</sup> Chase Sova, acting Head of Public Policy for WFP-USA; March 30, 2020 – accessed on April 5 at <https://insight.wfp.org/covid-19-and-the-5-major-threats-it-poses-to-global-food-security-1c4da2ff6657>

across the region, especially in countries that are reliant on food/cereal imports. More than ever, the most vulnerable will be disproportionately affected, especially female headed households<sup>41</sup>.

In populations where women are responsible for food security within the household, food shortages and increased food insecurity places them under heightened pressure and could expose them to intimate partner violence or reliance on negative coping mechanisms, such as resorting to transactional sex, sexual exploitation and abuse (SEA) or even entering girls into child marriage<sup>42</sup> (see section on GBV below).

Small-scale food producers in some areas of the ECSA region may be protected from the most severe impacts of COVID-19 to some extent by the fact they grow most of their own food – or sell at local markets. This however assumes that some form of marketing is possible, and that purchasing power is not significantly affected in the longer term. In some cities and peri-urban areas of ECSA, urban agriculture remains a vital source of food, dietary diversity and income. In many rural areas, foraging and wild food collection is an important source of dietary diversity and this, coupled with a revival of certain orphan crops, could represent possible coping mechanisms for food insecure households. During the COVID-19 crisis, small-scale gardening and horticulture in towns could be an important source of food, especially if incomes fall as a result of declining employment<sup>43</sup>.

## Health, including Sexual and Reproductive Health and Rights

**Impacts of multiple health crises:** Health systems in Africa are already burdened with high level of life-threatening communicable diseases coupled with increasing rates of non-communicable diseases such as hypertension and coronary heart diseases. Africa has 11% of the world's population but 60% of the people with HIV/AIDS. More than 90% of the estimated 300-500 million malaria cases that occur worldwide every year are in Africa, mainly in children under five years of age<sup>44</sup>. COVID-19 will likely burden health systems that are already stretched to capacity.<sup>45</sup>

**Weak health systems:** In most African countries', health systems remain weak with a narrow 5-6% of the GDP spent on the health sector (well below the Abuja Declaration threshold of 15%). Access to health services differ among the genders. Women in Africa are more likely to die from communicable diseases (e.g. HIV, tuberculosis and malaria), maternal and perinatal conditions, and nutritional deficiencies, than women in other regions.

Weak health systems including insufficient skilled personnel and shortages in supplies, underpinned by inequitable gender and social norms, result in significant barriers and limited access to **Sexual and Reproductive Health and Rights** (SRHR) services across ECSA. Although this is a vast and diverse region, it is also home to several fragile states where these barriers to SRHR result in some of the highest Maternal Mortality Ratios (MMR) in the world (South Sudan and Somalia for example). The limited SRHR and GBV services could further be strained as resources and personnel may be diverted to respond to the outbreak. Restriction in movement introduced by most governments will also curtail women's access to SRHR, perinatal and postpartum support and GBV services. Women and girls are also at risk of increased violence in the region with high rates of existing violence against women and girls, and prevalence of harmful traditional practices. High population densities in some urban centers, refugee and IDP centers in the ECSA region, combined with lack of resources, limited infrastructure and remoteness pose unique challenges in the response to COVID-19 pandemic. These limitations combined with various interconnected factors will leave millions of women, men, girls and boys in the region vulnerable.

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<sup>41</sup>Ferrant, Gaelle; Luca Maria Pesando & Keiko Nowacka (December 2014). Unpaid CARE Work: The missing link in the analysis of gender gap in labour outcomes. OECD Development Center. [https://www.oecd.org/dev/development-gender/Unpaid\\_care\\_work.pdf](https://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf)

<sup>42</sup> Gender Alert for COVID-19 Outbreak - Interim Guidance, March 2020, IASC Reference Group for Gender in Humanitarian Action

<sup>43</sup> Gillespie, S. and Whiteside, N.; IFPRI, comment – accessed 5 April at <https://www.ifpri.org/blog/lessons-aids-epidemic-how-covid-19-may-impact-food-and-nutrition-security>

<sup>44</sup>Who Africa (2014). The health of the people: What works. The African Regional Health Report 2014.

<http://extranet.who.int/iris/restricted/bitstream/handle/10665/137377/9789290232612.pdf;jsessionid=EC3CA61B13F4D2BF8C83FF1640A5983C?sequence=4>

<sup>45</sup>Kaseje, Neema (30 March 2020). Why Sub-Saharan Africa Needs a Unique Response to COVID-19. World Economic Forum. <https://www.weforum.org/agenda/2020/03/why-sub-saharan-africa-needs-a-unique-response-to-covid-19/>

**Sexual and reproductive health and rights:** Even before COVID, rates of maternal mortality in ECSA are high ranging from 213 maternal deaths per 100,000 live births in Zambia to 829 in Somalia and 1,150 in South Sudan<sup>46</sup>. Access to family planning remains limited across the region, with one quarter of women reporting an unmet need in family planning in 2012<sup>47</sup>. Amidst a global pandemic, it is typical to expect a diversion of human and financial resources from other health programs to manage an emergency response. Thus, there is a clear risk that sexual and reproductive health services will be impacted<sup>48</sup>. During the Ebola outbreak in Western Africa, non-Ebola cases of morbidity and mortality increased and reproductive, maternal, and child health services were especially affected. Sustaining access to quality routine health services for women and girls will be critical, particularly for life-saving SRH services such as emergency obstetric newborn care, family planning and clinical management of rape, in line with the Minimum Initial Service Package for SRH in Crisis Settings. The indirect impact on health services is thus likely to be substantial with COVID-19 and highlights the importance of support to maintain routine health service delivery including vaccination, child health, treatment of wasting and antenatal and safe delivery programmes<sup>49</sup>.

## Education

The impact of Covid-19 on education is likely to be most severe in countries that already have poor learning outcomes, high dropout rates and low resilience to shock, further widening the gender gap<sup>50</sup>. Dropout rates are higher among girls than boys due to pregnancy<sup>51</sup> and child marriage, a situation likely to worsen due to school closures. Closure of schools in some areas have not only affected children's access to education, but also to food. In many parts of ECSA, children and their parents rely on school feeding programmes for their nutritional intake. According to the World Food Program, 4.7 million children have already missed meals in Djibouti, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, and Uganda alone.

## Access to WASH services

Regular hand washing is an important guard against infection, and across the ECSA region the responsibility for household **water, sanitation and hygiene (WASH)** management is largely born by women. Yet in many areas access to water is limited, and women and girls may have to walk long distances to collect water. Ensuring adequate hygiene is a particular challenge in crowded urban settlements or in refugee and IDP camps<sup>52</sup>.

Women and girls in Africa face multiple challenges in managing **menstruation** effectively and with dignity. The lack of water and sanitation services highlighted in the above section plays a significant role. The need for menstrual hygiene management (MHM) products, access to water and soap, a private place to change sanitary pads and disposal facilities are important yet often overlooked, especially during crisis<sup>53</sup>. Physical distancing and limited mobility could further challenge the limited MHM and hygiene access women and girls have in the ECSA region. House confinement could affect women and girls' privacy during menstruation, and

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46 UNICEF (accessed 07 April 2020). UNICEF DATA.

[https://data.unicef.org/resources/data\\_explorer/unicef\\_f/?ag=UNICEF&df=GLOBAL\\_DATAFLOW&ver=1.0&dq=MNCH\\_MMR+MNCH\\_LTR\\_MATERNAL\\_DEATH+MNCH\\_MATERNAL\\_DEATHS..&startPeriod=2016&endPeriod=2020](https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=MNCH_MMR+MNCH_LTR_MATERNAL_DEATH+MNCH_MATERNAL_DEATHS..&startPeriod=2016&endPeriod=2020)

47 Who Africa (2014). The health of the people: What works. The African Regional Health Report 2014.

<http://extranet.who.int/iris/restricted/bitstream/handle/10665/137377/9789290232612.pdf;jsessionid=EC3CA61B13F4D2BF8C83FF1640A5983C?sequence=4>

48 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](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)

49 FSNWG COVID-19 Food Security Alert; March 30, 2020. Accessed on April 5 at

[https://reliefweb.int/sites/reliefweb.int/files/resources/FSNWG\\_COVID\\_19\\_Alert\\_30.03.2020.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/FSNWG_COVID_19_Alert_30.03.2020.pdf)

50 Kaloie Azhuck and Tigran SHMIS Managing the impact of Covid 19 on education system around the world how countries are preparing, coping and planning for recovery

51 SADC Gender Barometer

52 WHO and UNICEF (September 2017). A snapshot of Drinking Water, Sanitation and Hygiene in Africa. 2017 Update and SDG Baseline. <https://washdata.org/file/553/download>

53 Water Aid (13 June 2018). Water, sanitation and menstruation: lesson from the East and Southern Africa Menstrual Hygiene Management Symposium. <https://washmatters.wateraid.org/blog/lessons-east-and-southern-africa-menstrual-hygiene-management-symposium>

they could experience discrimination as social taboos towards menstruating women and girls are prevalent in the region.

## Access to information

African women are often information-poor, especially in remote communities. Gendered norms and systematic gender inequality strongly affect women's access to information in sub-Saharan Africa. As 'household heads' and community leaders, men have better access to and control over information. African women have less access than men to radio, newspapers, mobile phones, and the internet<sup>54</sup>. Globally, Sub-Saharan Africa has the widest gender gap in mobile ownership (15%) and mobile internet use (41%). This gap is further widened in rural areas, which in ECSA tend to have lower mobile penetration than urban areas<sup>55</sup>. As restrictions on movement push public authorities to rely more on technology to disseminate messages about Covid-19, women and girls will be at a further disadvantage in their inability to access information. This could limit their ability to stay updated on COVID-19 advice, participate in prevention and response strategies, and access services during the pandemic.

Additionally, literacy is a significant constraint on the ability of many women and girls to access, understand and apply information. The literacy rate in the ECSA region varies across countries – available data shows a relatively high literacy rate of between 70-90% among women and girls aged 15-49 in Zimbabwe, Kenya, Uganda, and Madagascar. In the same age group, women and girls in Zambia, Uganda, Malawi, Burundi, Mozambique, and DRC have a relatively average literacy rate of 55-69%, whilst the rate in Ethiopia is the lowest at 42%<sup>56</sup>. COVID-19 related dissemination efforts will need to pay particular attention to gendered levels of literacy to ensure the greatest reach around prevention and response messaging.

## Conflict

ECSA's fragile and conflict-affected states are especially vulnerable to the primary and secondary impact of the pandemic. Violent and latent conflict disrupts public health systems and limits access to medical supplies. Conflict-affected populations are also often starting from higher levels of vulnerability with fewer resource buffers than other populations, making the impact of exposure to an infectious disease all the more severe.<sup>57</sup>In the region, current conflict in Somalia, DRC, Mozambique, South Sudan, Burundi and Ethiopia will compromise health responses to varying degrees – especially affecting women and children whose restricted movement and heightened vulnerability will be more pronounced.

## Shelter

Compounding the myriad humanitarian challenges, Mozambique, Malawi and Zimbabwe are still in recovery phase from Cyclone Idai and many displaced persons are still in temporary shelters. These living conditions place population in close quarters and thus increases the risk of transmission of disease.

## COVID and Gender-Based Violence (GBV)

The prevalence rates for **GBV in the ECSA region** are amongst the highest in the world. Intimate partner violence (IPV) is widespread, with the rates highest in the Great Lakes sub-region, and particularly in the DRC, where 56% of women have experienced some form of violence, and 24% have experienced sexual violence, from their partners<sup>58</sup>. Lockdown confinement, economic stress and anxiety about infection make it very likely that these rates will rise. For survivors of violence, lockdowns have trapped them in their homes with their abusers and isolated them from people and resources of support. South Africa reported 87,000

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54 African Development Bank Group (2015). Empowering African Women: An Agenda for Action. Africa Gender Equality Index 2015. [https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/African\\_Gender\\_Equality\\_Index\\_2015-EN.pdf](https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/African_Gender_Equality_Index_2015-EN.pdf)

55 GSM (2019). 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>

56 USAID, STAT Compiler – The DHS Program (Accessed 09 April 2020). <https://www.statcompiler.com/en/>

57 Africa Center for Strategic Studies, op cit

58 Ibid

cases of gender-based violence in seven days of lockdown<sup>59</sup>, while Kenya has seen a significant spike in sexual offences.<sup>60</sup> A women's rights organization in Zimbabwe, Musasa, that before COVID-19 used to receive an average of 40 cases per day are now receiving a daily average of 150 cases<sup>61</sup>.

Access to justice and support services for victims/survivors of violence vary from country to country across the ECSA region. Some countries offer various affordable and specialized services, including legal aid and shelters, to survivors of GBV. There has also been a notable increase across the region in one-stop centers, fast-tracked justice systems and specialized police units that aim to address domestic violence cases in sensitive ways. For example, Malawi established Victim Support Units in police stations and support units in traditional authority institutions in 2013, whilst Zambia has two user-friendly *fast track courts* to specifically expedite GBV cases. However, at the time when many women and girls need GBV services more than ever, evidence suggests that those services are likely to come under pressure as resources are diverted to the COVID-19 health crisis<sup>62</sup>. Refugee and internally displaced women and girls are particularly vulnerable to sexual violence and exploitation<sup>63</sup>.

**Female Genital Mutilation (FGM) and Child Marriage:** UNFPA has also warned of a potential rise in FGM, as well as child or forced marriages at this time of restricted movement, poor visibility and weakened protection systems<sup>64</sup>. Child marriage is already widespread in the region: in Central Africa, 42% of women are married as children, and, in East and Southern Africa, 37% of women are married before the age of 18. Across ECSA, Mozambique has the highest number of child marriages at 53%, followed by Madagascar (41%), Ethiopia (40%), DRC (37%) and Sudan (34%)<sup>65</sup>. Many factors contribute to child marriage in the region. Poverty is a driver: it is commonly believed that marrying off a daughter reduces family expenses, temporarily increases family income. Also important are the socialized restrictions assigned to girls and young women by culture and tradition which identify them as wives and mothers<sup>66</sup>. Economic pressures and higher food insecurity during the pandemic suggest that a spike in child marriages in the region can be anticipated.

**Trafficking in Persons:** Human trafficking is another key challenge facing women and girls in ECSA and leads to a particularly high vulnerability. An estimated 9.24 million individuals are enslaved in all of Africa, making up 23% of the total global enslaved population. The most common forms of slavery in sub-Saharan Africa are forced labor and forced marriage. The countries with the highest rates of modern slavery in the ECSA Region are Burundi (40% of population); and South Sudan (21% of population).<sup>67</sup> In terms of demographics, East Africa contains the highest proportion of adults who are trafficked, while Southern Africa includes more women trafficked<sup>68</sup>. Bello and Olutola (2018) observes that South Africa is the main destination point for sub-regional and extra-regional flows. In the East African axis, Ugandan and Kenyan women are trafficked for prostitution. Victims of trafficking in Uganda are from the Democratic of Congo (Congo DRC), Burundi, Kenya, Tanzania, Rwanda and South Sudan.<sup>69</sup> A majority of the women and girls have undocumented immigration status, which is used by traffickers as a weapon to keep people under their

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59 Power Digital (03 April 2020). COVID-19 Lockdown: Police Receive 87,000 Gender-Based Violence Calls.

<https://www.power987.co.za/news/covid-19-lockdown-police-receive-87-000-gender-based-violence-calls/>

60 Odhiambo, Agnes (08 April 2020). Tackling Kenya's Domestic Violence Amid COVID-19 Crisis. Human Rights Watch.

<https://www.hrw.org/news/2020/04/08/tackling-kenyas-domestic-violence-amid-covid-19-crisis>

61 UN Women, COVID-19 and ending violence against women

62 CARE International, Gender Implications of Covid-19 Outbreaks In Development And Humanitarian Settings, March 2020

63 UN (26 May 2015). Refugees and internally displaced persons.

<https://unstats.un.org/unsd/genderstatmanual/Print.aspx?Page=Refugees-and-internally-displaced-persons>

64 UNFPA (23 March 2020). Coronavirus Disease (COVID-19) Preparedness and Response. UNFPA Interim Technical Brief. Gender Equality and Addressing Gender-based Violence (GBV) and Coronavirus Disease (COVID-19) Prevention, Protection and Response.

[https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19\\_Preparedness\\_and\\_Response\\_-\\_UNFPA\\_Interim\\_Technical\\_Briefs\\_Gender\\_Equality\\_and\\_GBV\\_23\\_March\\_2020\\_.pdf](https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Gender_Equality_and_GBV_23_March_2020_.pdf)

65 UNICEF, Child Marriage: Latest Trends and Future Prospects:

[https://data.unicef.org/resources/data\\_explorer/unicef\\_f/?ag=UNICEF&df=GLOBAL\\_DATAFLOW&ver=1.0&dq=.PT\\_F\\_20-24\\_MRD\\_U15+PT\\_M\\_20-24\\_MRD\\_U18+PT\\_F\\_20-24\\_MRD\\_U18.&startPeriod=2016&endPeriod=2020](https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=.PT_F_20-24_MRD_U15+PT_M_20-24_MRD_U18+PT_F_20-24_MRD_U18.&startPeriod=2016&endPeriod=2020)

66 Girls Not Brides (no date). Ending child marriage in Africa. A brief. <https://www.girlsnotbrides.org/wp-content/uploads/2015/02/Child-marriage-in-Africa-A-brief-by-Girls-Not-Brides.pdf>

67 ASEC (31 May 2019). Human Trafficking Trends in sub-Saharan Africa. <http://asec-sldi.org/news/current/human-trafficking-sub-saharan-africa/>

68 Rickard, Carmel (18 July 2019). Human Trafficking Reports Show sub-Saharan Africa a global player.

<https://africanlii.org/article/20190718/human-trafficking-reports-show-sub-saharan-africa-global-player>

69 Bello, O. Paul & Olutola, A. Adewale (09 November 2018). The conundrum of human trafficking in Africa.

<https://www.intechopen.com/online-first/the-conundrum-of-human-trafficking-in-africa#B34>

control. With COVID-19 creating a climate of fear, women and girls who have been trafficked are less likely than before to come forward and seek medical services or any other help<sup>70</sup>.

## Conclusions

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COVID-19 in the ECSA region is a public health crisis, but one compounded with complex social-economic and political challenges and inequalities, particularly around gender. Lack of resources, limited health services, large vulnerable populations and low economic capacity means the impact will be profound. The outbreak will disproportionately affect women and girls in the ECSA region in significant ways, including adverse impacts to their health, education, food security and nutrition, livelihoods and safety and protection. Women are the primary care givers in the family and are also the key frontline responders in the health care system, placing them at increased risk and exposure to infection. The outbreak will also burden women by adding to their existing gendered household and community roles. It is also expected to lead to a spike in GBV and harmful traditional practices against women and girls. Providing essential maternal and sexual and reproductive health services during the emergency, and strengthening protection is crucial. Interventions must seek to identify the needs of the most vulnerable, i.e. women, girls, disabled persons, LGBTQ individuals, refugees and IDPs and ensure their representation and participation in the response process. Engaging men and boys during the COVID-19 response is crucial to mitigate unhealthy masculine behaviors and support positive male roles in the crisis.

## Recommendations

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**The Regional Rapid Gender Analysis should be updated and revised as the crisis unfolds and when more data on impact and response becomes available.**

Up-to-date rapid gender analysis of the shifting gender dynamics within affected communities allows for more effective, appropriate and responsive programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, boys and girls. This should include country-specific RGA's for COVID-19 to consider country specific dimensions for gender (including sexual minorities), disability, age and other marginalized populations.<sup>71</sup>

**Recommendation 1: Ensure the collection and analysis of Sex, Age and Disability-disaggregated data on indicators, such as rates of infection; economic impacts; care burden; and trends of gender-based violence.**

Sex and age disaggregated data on confirmed cases in the ECSA region is very limited. Given the gender dynamics already noted in the COVID-19 pandemic, it is important to collect data disaggregated by sex, age and disability<sup>72</sup> and where possible that also captures inter-sectional data such as on female-headed households, pregnant and lactating women and people of diverse genders.

**Recommendation 2: Response agencies should ensure COVID-19 awareness and risk communication reaches all groups, including those most at-risk / hard to reach, such as persons with disabilities, women in refugee and IDP centers.**

Women and girls in the ECSA region have limited access to information and low literacy rates. Ensuring rapid dissemination of timely, inclusive two-way communication to the community is key. Pictures contextualized to the community context and spread through women-friendly technologies is a crucial step to ensure women's access to COVID-19 and other related information. Women should be consulted in the design of awareness materials, methods of communication, and imagery should be gender sensitive.

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<sup>70</sup><https://polarisproject.org/blog/2020/03/the-effect-of-covid-19-on-human-trafficking/>

<sup>71</sup> UN Women (19 March 2020). Paying attention to women's needs and leadership will strengthen COVID-19 response.

<https://www.unwomen.org/en/news/stories/2020/3/news-womens-needs-and-leadership-in-covid-19-response>

<sup>72</sup> Ibid

**Recommendation 3: Humanitarian, public health actors and governments should ensure systematic, meaningful engagement of women and adolescent girls and persons with disabilities in all COVID-19 decision-making on preparedness and response at the national, provincial and community levels, including within their own structures, to ensure efforts and responses are not further discriminating and excluding those most at risk.**

Responders should ensure an equal voice for women in decision-making in the response and long-term impact planning by reaching out to women's organizations, women movements, networks and women leaders in the community. Women's frontline role in the community as well as health workers is an opportunity for women to influence the design and implementation of prevention, mitigation and response activities and community engagement mechanisms. As part of this commitment, systems should be implemented to ensure that preparedness and response teams, at all levels, include women and are representative of the population to ensure the voices and priorities of women, persons with disabilities, children and other marginalized groups (such as sexual minorities and IDPs) are factored into the response.

**Recommendation 4: Prioritize support to women on the frontlines of the response, including access to women-friendly personal protective equipment (PPE) and psychosocial trauma-sensitive support resources.<sup>73</sup>**

Women are usually at the front line of the response as caregivers, community health workers and nurses. Sometimes these roles are often overlooked and not/poorly remunerated and with poor social and employment protections. In addition, we need to ensure measures are in place to recognize and mitigate the physical and psychological impacts of increased burdens of paid and unpaid work on women as a result of the crisis.

**Recommendation 5: Governments and local authorities should ensure that policy decisions related to COVID-19, in particular those on restricted movement, are gender-responsive and do not disproportionately compromise women's access to health, WASH and SRHR services or compromise their food security and nutrition.**

Restricted movements, quarantine and social isolation can further restrict women from accessing essential health services, WASH facilities and compromise their food and nutrition security through disruptions in the supply chain and limited access to markets (especially in remote areas). Response agencies should actively work with regional, national and local government to ensure policy decisions on restricted movement consider the different needs, roles and priorities of women and girls and other vulnerable groups. The specific needs of women and girls should be considered in travel bans and state of emergency situations.

**Recommendation 6: All actors should prioritize GBV risk mitigation across sectors and programming and prioritize the continuation and scale-up of lifesaving services for the prevention and response to GBV in communities affected by COVID-19.**

GBV risk mitigation should be a priority across all programming for humanitarian, public health and government actors. Response mechanisms and referral services<sup>74</sup> need to be adapted and strengthened to account for the likely increase in GBV incidents due to the pandemic, as well as adapted to account for the necessity for remote working modalities during quarantine.

**Recommendation 7: Prioritize livelihood and recovery initiatives, including the use of safety nets and food and nutrition security services that target the most vulnerable, especially women.**

COVID-19 will inevitably impact the ability of women to earn an income. This will affect a household's ability to purchase essential items, including food and hygiene products, and will also place additional stresses on the household that may lead to an increase in family violence. Therefore, responding agencies need to consider immediate food security needs of vulnerable households, while at the same time building in economic recovery activities that are gender responsive.

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<sup>73</sup> UN Women (19 March 2020). Paying attention to women's needs and leadership will strengthen COVID-19 response. <https://www.unwomen.org/en/news/stories/2020/3/news-womens-needs-and-leadership-in-covid-19-response>.

<sup>74</sup> Ibid

**Recommendation 8: Protect essential lifesaving health services for women and girls, including sexual and reproductive health services.**

Sexual and reproductive health and rights is a significant public health issue that requires high attention during pandemics. Safe pregnancies and childbirth depend on functioning health systems and strict adherence to infection prevention. Provision of family planning and other SRH commodities, including menstrual health items, are central to women's health and empowerment. Lifesaving SRHR services in line with the Minimum Initial Service Package for SRH in Crisis-Settings must be ensured, even in case of severe facility service interruption or other disruption in access for women and adolescent girls<sup>75</sup>. New ways of adapting and supporting the SRHR needs of adolescents such as pregnant adolescents, LGBTQIA adolescents and other sub-groups of adolescents at increased risk must be considered.

**Recommendation 9: Provision of water and sanitation services must be informed by gender analysis and the role and needs of women and girls, with special attention given to those living in densely populated communities, camps and slums.**

In most IDP camps/settlements, urban areas and slums, access to water and sanitary facilities is limited, which puts the communities, especially women and girls, at risk of increased burden of work and infection. Water and sanitation provision that considers that role and needs of women and girls are a high priority to support disease prevention, as well as health and good hygiene. This is also crucial to mitigate risk of gender-based violence (GBV) and sexual exploitation and assault (SEA) for women and girls.

**Recommendation 10: Ensure access to diverse and nutritious food among the urban and rural poor especially women, IDPs and refugees during lockdowns via food aid, cash- or voucher-based support or other savings models, reflecting what is most appropriate in given circumstances using findings from RGAs.**

The provision of social safety nets will be vital in the COVID-19 crisis response and recovery. These programs – whether cash transfer, voucher, or in-kind – must be scaled up to protect those worst affected and most vulnerable, including and particularly small-scale farmers, agricultural workers, and food insecure populations.

**Recommendation 11: Response agents should engage men and boys, as well as women and girls, to raise awareness about sharing care-giving roles, so as to reduce women's care giving burden and exposure to virus. Communications should be delivered through appropriate channels to reach the most vulnerable.**

Support during response and recovery must also address the unequal labor burdens that women face, particularly as their unpaid labor burden will likely increase as they care for children and the sick.

**Recommendation 12: Donor governments must not disproportionately reduce their support to developing countries in addressing the COVID-19 crisis but rather invest in medium and long-term development priorities.**

In order to mitigate long-term impacts of COVID-19 on the most at-risk populations, government and development institutions should minimize disruptions and develop adaptive strategies to existing programming to ensure continuity of lifesaving services, informed by gender analysis.

**Recommendation 13: All actors in the response must ensure essential internal protection policies and child safeguarding mechanisms are in place to prevent, mitigate and respond to sexual exploitation and abuse.**

Response agencies should have child safeguarding, Prevention of Sexual Harassment Exploitation and Abuse (PSHEA) policies in place. Training and awareness raising should be provided for staff, front-line responders and communities. Inclusive community feedback mechanisms should be established, adapted or

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<sup>75</sup> UNFPA (19 March 2020). COVID-19: A gender lens: Protecting sexual and reproductive health and rights and promoting gender equality (March 2020). <https://reliefweb.int/report/world/covid-19-gender-lens-protecting-sexual-and-reproductive-health-and-rights-and-promoting>

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