Rapid Gender Analysis during COVID-19 Pandemic

Mekong Sub-Regional Report

Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam

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Cover page photo: Women working in a garment factory in Cambodia.

Image: Josh Estey, May 2017

Contents

Abbreviations and acronyms

ASEAN	The Association of Southeast Asian Nations
COVID-19	Novel Coronavirus 2019
CSAGA	Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents
CSO	civil society organisation
DPO	disabled person's organisations
FHH	female-headed household
GBV	gender-based violence
IDP	internally displaced person
IPV	intimate partner violence
KII	key informant interview
LGBQTI+	Lesbian, Gay, Bisexual, Queer, Trans and Intersex plus people
LFTU	Lao Federation of Trade Unions
LWU	Lao Women's Union
MHM	menstrual hygiene management
MOH	Ministry of Health
MP	Member of Parliament
NCD	non-communicable disease
NGO	non-governmental organisation
PPE	personal protective equipment
PSHEA	prevention of sexual harassment, exploitation and abuse
SOGIESC	People of diverse Sexual Orientation, Gender Identity and Expression, and Sexual Characteristics
SRHR	sexual and reproductive health and rights
SRMNCH	sexual, reproductive, maternal, newborn and child health
SWIM	Sex Workers In Myanmar
VMU	Village Mediation Unit
VSLA	Village Savings and Loans Associations
WASH	water, sanitation and hygiene
WHO	World Health Organisation
WPS	Women, Peace and Security

Executive summary

The Novel Coronavirus 2019 (COVID-19) was first detected in Hubei province, China, in late December 2019, and has since spread to 213 countries and territories around the world.[1] As of 31 August 2020, there were 25,405,845 confirmed cases globally, and 849,389 deaths.[2] There have been 5,612 cases in the Mekong region – Cambodia (274), Lao PDR (22), Myanmar (882), Thailand (3,390) and Viet Nam (1,044).[3]

This unprecedented crisis unfolds against many existing challenges including persistent gender inequalities, existing inequalities in access to health, weak health infrastructures, and a high risk of secondary disasters in the region. COVID-19 presents a range of contextual challenges, that will have a greater impact on the most vulnerable, such as for migrant workers, indigenous and ethnic minorities, refugees and internally displaced peoples, migrants, urban slum-dwellers, and people working in the informal sector.[4] As with all crises, women and children are disproportionately impacted.

The purpose of this Rapid Gender Analysis during COVID-19 is to analyse and better understand the impacts of the COVID-19 pandemic on women, men, girls, boys and specific at-risk groups in the Mekong region.

Country-level Rapid Gender Analysis was conducted in Cambodia, Lao PDR, Viet Nam, Myanmar and Thailand using primary and secondary data collection that took place between 15 April and 28 May 2020. The report outlines the key findings; commonalities and differences across the countries to provide a regional perspective on the impacts of COVID-19 on women, men, boys, girls and at-risk groups in the Mekong. The report placed a specific focus on: migrant workers, garment factory workers, ethnic minorities, people with disabilities and people working in the informal sector, such as female sex workers.

Key findings

Unpaid care responsibility

- Across the region, traditional gender roles have continued and in many cases been reinforced, with the increasing burden of household and care responsibilities falling on women. In some cases, due to loss of livelihoods, men have taken on household duties – however this is seen (by men and women) more as 'supporting' or 'helping' women with their role, rather than a re-shaping of gender roles and responsibilities.

Financial impact

- Impacts on Village Savings and Loans Associations (VSLA) were noted across the region due to social distancing restricting groups from meeting, and the economic downturn means members (largely women) are struggling to repay loans or purchase shares.

- Lower salaries and job losses have led to a reduction in remittances being sent home from migrant workers. Women migrant workers were noted to be particularly financially vulnerable as they generally send a significant proportion of their wages home. Families of returnee migrants are facing a double strain, with a loss of remittances and increased demand on existing resources.

Decision-making power

- Women's decision-making power is linked to household-related decisions (e.g. food consumption, hygiene practices for COVID-19 prevention, household saving). Larger decisions such as income use, business development, land or asset purchase were noted as being made increasingly jointly (Thailand, Vietnam and Lao PDR) or by men (Myanmar). In Cambodia, decision-making power in the household was strongly linked to household income contribution, highlighting the potential impacts that loss of income may have on women in the family.

- At the level of national governments, as well as leadership in trade unions – women are significantly under-represented in the Mekong and this has been mirrored in COVID-19 taskforces and committees across the region. Sex workers and other marginalised groups face further exclusion from public decision-making spaces.

Protections

- Protection concerns, such as human trafficking, child marriage and gender-based violence (GBV) are increasing. Lack of awareness of existing services and barriers to access due to restricted mobility, limited privacy, and fears of the pandemic are a concern. Groups highlighted to be particularly at risk include Lesbian, Gay, Bisexual, Queer, Trans and Intersex plus individuals (LGBQTI+), women with disabilities and migrant women.

- The COVID-19 pandemic has exacerbated prejudices or tensions. Discrimination against returnee migrant workers (e.g. in Lao PDR and Myanmar), and ethnic and religious minorities (e.g. in Cambodia) were noted.

- Funding to Civil Society Organisations (CSOs) and grassroots organisations are being impacted, leading to critical services being suspended, particularly for at-risk groups.

Health and hygiene

- Access to health and SRH services is being impacted by fear, safety of women and girls traveling to services, discrimination (e.g. of ethnic minorities), language, freedom of movement, and limited services in rural areas. This was seen to be greater for undocumented migrant workers (particularly pregnant women migrant workers).

- Women and girls are heavily concentrated in industries that expose them to COVID-19 (including in the health sector, informal work, the tourism industry, the garment and textiles industry) and have lacked the employee and social protection needed during the pandemic

Food security and WASH

- Loss of income combined with an increased need to purchase hygiene-related products as a prevention measure is leading to food insecurity, with coping mechanisms such as using savings and selling assets being activated. This has additional pressure on women who are responsible for household food security.

- Lack of access to basic water, sanitation and hygiene (WASH) facilities in the region is likely to be compounded by the Mekong drought, which has severely impacted Viet Nam and Thailand. High-costs of water, physical and safety access issues are likely to affect urban slum-dwellers, particularly women, children, persons with disabilities and the elderly.

- Women and girls experience a disproportionate burden from inadequate water and sanitation facilities, due to both physiological differences such as menstruation, and gender norms that require them to clean, cook and collect the household water (placing them at greater risk of GBV[1]). Additionally, many WASH facilities also do not cater to the accessibility and needs of persons with disabilities.

Information and education

- Barriers to accessing COVID-19-related information include: literacy, language, access to technology, digital devices and data. These barriers were seen to be greater for the elderly, the poor, people with disabilities, ethnic minorities, remote communities, and for women, as a result of barriers to their participation in the public sphere.

- While boys and girls across the region remain in remote learning or are gradually returning to school, there are concerns over girl's access to online learning platforms as well as continuing education. In particular, girls from rural, poor and minority ethnic communities are impacted due to social and cultural barriers, gendered roles within the home, cultural practices, and limitations around digital devices, and mobility due to safety concerns.

Psychosocial stress

- High levels of financial stress and expectations (especially on men) to provide for the family, fear of contracting the virus, impacts on family (especially children), school closures, and discrimination are all contributing to increases in mental health concerns across the region.

- Women are suffering from: increased stress; anxiety and pressure to manage the household and feed the family with limited resources; difficulties balancing domestic work; increased levels of caregiving and home learning; reduced personal safety and increasing financial difficulties, especially in female-headed households.

Recommendations

Below is a summary of key recommendations. Detailed action steps can be found in the main report.

For responding agencies:

Recommendation 1: Collect and ensure the availability of sex and age disaggregated data, as well as data and information based on disabilities and at-risk groups. This should include rates of morbidity and mortality, differential economic impacts, differential care burdens, access to health services (including sexual and reproductive health services), education and technology.

Recommendation 2: Ensure information, messaging and community outreach on COVID-19 is inclusive and accessible to all, and does not reinforce harmful gender stereotypes.

Recommendation 3: Provide immediate emergency relief support to those most impacted by COVID-19 and those who are experiencing barriers to accessing social protection mechanisms. This includes a focus on those working in the informal economy (where women are the majority), informal migrant workers and sex workers (also where women are the majority), people with disabilities, rural communities, urban slum-dwellers and female-headed households.

Recommendation 4: Develop mitigation strategies that specifically target the economic impact of the outbreak on women and build women's financial resilience. A particular focus should be on those in sectors hit hardest by the pandemic, which include tourism; sex work; the clothing sector, which includes those working in garment factories, and those working in other informal sectors.

Recommendation 5: Ensure women with diverse backgrounds and from different socio-economic strata are given opportunities to meaningfully engage in structures and processes established for COVID-19.

Recommendation 6: Prioritise and strengthen services for the prevention of, and response to, GBV and sexual and reproductive health services in communities affected by COVID-19, with an emphasis on mitigating barriers identified for specific groups in this report.

Recommendation 7: Prioritise mental health and psychosocial support services in communities.

Recommendation 8: Ensure school closures, where they exist, do not further disadvantage girls or at-risk populations such as children with disabilities, ethnic minorities and those from rural communities.

Recommendation 9: Prioritise services for prevention and response to human trafficking in communities affected by COVID-19, and provide capacity building to ensure services are gender responsive and inclusive (with a focus on women and at-risk groups identified in this analysis).

For regional and national governments:

Recommendation 10: Ensure all response strategies and measures to the COVID-19 pandemic respect human rights (including the rights of women and at-risk groups identified in this analysis).

Recommendation 11: Ensure that border control procedures and quarantine facilities are established and maintained according to gender-responsive best practices.

Recommendation 12: Ensure gender responsive COVID-19 testing, contact tracing and community outreach at Mekong borders and in at-risk communities.

Recommendation 13: Countries in the Mekong should ensure they are well coordinated and work together to ensure gender-responsive services are in place.

Introduction

Background information – COVID-19 and the Mekong

First detected in China's Hubei Province in late December 2019, the Novel Coronavirus 2019 (COVID-19) has since spread to 213 countries and territories around the world.[5] On 11 March 2020, COVID-19 was declared a global pandemic and that numbers are expected to continue rising exponentially every month. As of 31 August 2020, there were 25,405,845 confirmed cases globally, and 849,389 deaths.[6] There have been 5,612 cases in the Mekong region – Cambodia (274), Lao PDR (22), Myanmar (882), Thailand (3,390) and Viet Nam (1,044).[7]

When we adjust confirmed deaths across countries in the region relative to the size of the population – the Mekong countries range between 0-1 deaths per 1 million people. This is compared to countries such as the United Kingdom, the United States of America, Peru and Spain, which are recording close to or over 600 deaths per million people.[8] While the Mekong is showing a relatively low death rate, it is important to note challenges in collecting data, particularly in rural and conflict-affected regions. Further and more importantly, while the death rate is relatively low – this report will highlight the importance of the *indirect* effects of the virus, based on gender and at-risk groups, when we consider the overall impact of the pandemic.

This unprecedented crisis unfolds against many existing challenges: The COVID-19 pandemic in the region is emerging amid persistent gender inequalities owing to structural inequalities and discriminatory gender norms,[9] as well as existing inequalities in access to health and weak health infrastructure. The five countries of the Mekong region – Cambodia, Lao PDR, Myanmar, Thailand, and Viet Nam – are also highly prone to hydrometeorological hazards, including floods, tropical storms, and droughts. In early 2020, as the pandemic unfolded, Thailand suffered its worst drought in forty years, while multiple provinces in Viet Nam declared a state of emergency over drought and saltwater intrusion.

For the Mekong region[10], COVID-19 presents a range of contextual challenges, that will have a greater impact on the most vulnerable, exacerbating existing inequalities, including for migrant workers, high numbers of employees in the garment industry and large numbers of vulnerable groups including indigenous and ethnic minorities, refugees and internally displaced people, migrants, urban slum-dwellers, and people working in the informal sector.[11] As with all crises, women and children are disproportionately affected, particularly in the areas of economic empowerment, decision-making, participation, access to resources and services (such as health and education), and protection of human rights. Further disasters, in particular as the region enters monsoon season, will compound the already devastating impacts of the pandemic on women and girls.

Objectives and methodology

Rapid Gender Analysis (RGA) is a process that 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. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls and to ensure we 'do no harm'. Rapid Gender Analysis uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterise humanitarian interventions.

This Rapid Gender Analysis provides information about the potential impacts of COVID-19 in the Mekong region on women, men, boys and girls, persons of diverse gender identities, and at-risk or vulnerable groups. Rapid Gender Analysis has been conducted in countries across the Mekong region including Cambodia, Lao PDR, Thailand (with a focus on migrant workers), Myanmar (both nationally and a specific Rapid Gender Analysis focused on Rakhine State), and Viet Nam. These country-level Rapid Gender Analyses were conducted using primary and secondary data collection. A secondary data review was conducted for the Mekong Region, prior to the individual country-level Rapid Gender Analysis to support data collection and initial analysis. Primary data collection for the country-level Rapid Gender Analysis, took place between 15 April and 28 May 2020.[12]

Collaboration with local CSOs and partners

Lao PDR Rapid Gender Analysis process (data collection and analysis) was conducted together with civil society organisation (CSO) partners. CARE Myanmar worked with local partners to conduct data collection.

The table below summarises the primary data that was collected.

Country	Type of data collection
Cambodia	Remote Key Informant Interviews (KIIs) with a total of 28 people (14 women, 13 men and one un-identified sex) including: Community members (four returned migrant workers from Thailand, six factory workers, three workers who had lost their jobs and six people with disabilities) and Non-community members (two factory Human Resource managers, two health care providers, one health manager, one National Committee for Counter Trafficking Deputy General Secretary, two commune chiefs and one deputy district governor).
Lao PDR	Remote 58 Key Informant Interviews with Ministry of Health (MOH) at provincial and district levels, Lao PDR Women's Union (LWU) Laos Federation of Trade Unions (LFTU) and village representatives and 22 Individual stories from four provinces. Data analysis also included initial findings from a rapid data collection (8 April to 10 April) with garment factories workers who are project participants in the Vientiane capital (32 women and 8 men)
Myanmar	Interviews with 82 people (62 women and 20 men), aged between 16 and 53 years old. Respondents were from six states and regions: Mandalay region (10 interviews); Mon state (10 interviews), Kayah state (8 interviews), Kayin state (1 interview) Shan State (4 interviews) and Yangon region (47 interviews). Key informants included factory workers (29); sex workers (14); representatives of humanitarian, legal and women's organizations (13); government officials (8); health workers (6); and other members of the community (12) with diverse disability, LGBTQI, Internally Displaced Persons (IDPs) and migration status.
Thailand	A total of 29 migrants (18 women and 11 men) were interviewed from Fishery and Seafood Processing industries in two districts of Thailand, Samut Sakon and Pattani. The respondents comprised single men and women, married men and women, single mothers (widowed or divorced), housewives (women without paid income) and pregnant women or those with infant children.
Viet Nam	Remote in-depth interviews with two of CARE Viet Nam's programming impact groups. A total of 42 remote in-depth interviews were conducted, including: 14 with ethnic minorities (which included 2 female-headed households (FHH), 2 women with disabilities); 10 local authorities; 13 factory workers and 5 informal workers. This was complemented by a quick scan of resources from 20 Village Saving and Loan Associations (VSLAs).[13]

This Rapid Gender Analysis brings together the initial regional secondary data analysis as well as the primary and secondary data analysed from the following country-level Rapid Gender Analysis:

- CARE, Rapid Gender Analysis for COVID-19, Cambodia, (July 2020)
- CARE, Rapid Gender Analysis, COVID-19, Lao People's Democratic Republic (July 2020)
- CARE, Rapid Gender Analysis for COVID-19, Viet Nam (May 2020)
- Raks Thai, Rapid Gender Analysis for COVID-19. Gendered Impact of the COVID-19 Pandemic on Migrants in Thailand (June 2020)
- CARE, Rapid Gender Analysis of COVID-19 in Myanmar (June 2020)
- CARE, Rapid Gender Analysis, Myanmar – Rakhine State (August 2020)[14]

The purpose of this COVID-19 Rapid Gender Analysis for the Mekong region is:

- To analyse and better understand the impacts of the COVID-19 pandemic on women, men, girls, boys and specific at-risk groups in the Mekong region.
- As an advocacy tool to highlight specific risks to women, girls, men, boys and specific at-risk groups. This tool will be targeted at government, UN agencies, decision-makers and other responding agencies.
- To provide a set of recommendations to responding agencies for implementing COVID-19 response initiatives.

Demographic profile

Disaggregated country level population data by sex

In 2019, the Mekong region had a combined population of 220,133,111 people, with just over half of the population being women:

Population figures by country[15]	Cambodia	Lao PDR	Thailand	Myanmar	Viet Nam
Male	8,047,364 (48.81%)	3,599,028 (50.20%)	33,904,846 (48.70%)	26,044,666 (48.19%)	48,151,352 (49.92%)
Female	8,439,178 (51.19%)	3,570,428 (49.80%)	35,720,735 (51.30%)	28,000,756 (51.81%)	48,310,756 (50.08%)
Total	**16,486,542**	**7,169,456**	**69,625,581**	**54,045,422**	**96,462,108**

Gender inequality: According to the Global Gender Gap Index 2020, no country has achieved full gender parity, with the Mekong countries ranking: Lao PDR (43); Thailand (75); Viet Nam (87); Cambodia (89); and Myanmar (114) out of 153 countries in terms of the gender gap.[16] Cambodia, Lao PDR and Viet Nam have signed and ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and Thailand and Myanmar have ratified and acceded to the Convention.[17]

Age and life expectancy: The populations in the Mekong countries are young. An average of one in five are 0–14 years old, with the highest proportions in Lao PDR (34 per cent) and Cambodia (31 per cent), while just 17 per cent are in this age group in Thailand.[18] The average life expectancy varies greatly by country, with Lao PDR reporting the lowest life expectancy rates at an average of 67 years, and Thailand reporting the highest, at an average of 76 years. In all countries, women have a higher life expectancy than men, with the average life expectancy for men at 68 years compared to women at 74 years.[19]

Non-communicable diseases (NCDs): Including cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases, are high in the Mekong. NCDs are estimated to account for on average 62 per cent of deaths in the region, (64 per cent of all deaths in Cambodia, 60 per cent in Lao PDR, 68 per cent in

Myanmar, 74 per cent in Thailand and 77 per cent in Viet Nam).[20] Men are more likely to die from NCDs than women. These statistics are of significance given that those at higher risk for severe illness or death from COVID-19 are those with underlying health conditions related to NCDs.

Disability rates: The rates for each Mekong country vary, with Lao PDR reporting a low disability rate, at just 1 per cent of the population in comparison with Viet Nam at 7.8 per cent of the population. This is significantly less than the global average, with about 15 per cent of the world's population identified as living with a disability[21] and may be attributed to how disability is defined and identified across different countries.

About the same number of women identify as having a disability as men in the Mekong, however, data indicates that women with disabilities continue to face additional barriers compared to men with disabilities: for example, 38.5 per cent of women with disabilities in Myanmar have not received a formal education, compared to 26.9 per cent of men.[22] Cambodia, Lao PDR, Thailand and Viet Nam are currently full signatories and have ratified the Convention on the Rights of Persons with Disabilities, while Myanmar has acceded to the Convention.[23]

Disability rates, 2015[24]	**Cambodia (2.1%)**	**Lao PDR (1%)**	**Thailand (2.2%)**	**Myanmar (2.3%)**	**Viet Nam (7.8%)**
Male	157,008 (2.2%)	34,676 (1.2%)	689,619 (2.1%)	695,824 (2.6%)	2,716,393 (7%)
Female	144,622 (1.9%)	22,051 (0.8%)	789,042 (2.3%)	580,176 (2.1%)	3,358,150 (8.4%)

Intimate partner violence (IPV) rates in the Mekong are high, with 37 per cent of ever-partnered women experiencing IPV, in comparison with the global average at 30 per cent.[25] At a country level, rates of IPV vary:

- Approximately 30 per cent of Cambodian women have experienced physical, sexual, emotional or economic IPV in their lifetime.[26] For women aged 15-64, 32 per cent experienced psychological violence by an intimate partner in their lifetime.[27]
- In Myanmar, 16 per cent of women aged 15-49 have experienced physical or sexual violence; however, under-reporting is likely and the same survey notes that 7 of 10 women who have ever experienced sexual violence have neither sought help nor told anyone about it.[28] For women aged 15-49, 13.5 per cent experienced psychological violence by an intimate partner in their lifetime.[29]
- In Viet Nam, nearly two-thirds (62.9 per cent) of women experienced at least one or more types of violence (physical, sexual, economic and/or psychological violence) in their lifetime by a husband, and 31.6 per cent experienced such violence in the last 12 months.[30]
- In Thailand, approximately 16 per cent of women encountered domestic violence in its various psychological, physical, or sexual forms.[31]
- In Lao PDR, the overall lifetime prevalence of physical violence by a partner or husband among ever-partnered women in Lao PDR was 11.6 per cent, with little difference between urban and rural areas (12.0 per cent to 12.4 per cent respectively).[32] For women aged 15-64, 26.2 per cent experienced psychological violence by an intimate partner in their lifetime.[33]

Ethnic minority groups

Viet Nam has 54 ethnic groups, of which Kinh people (Vietnamese) make up the majority (85.3 per cent) of the population. Most of Viet Nam's ethnic minorities live in remote, sparsely populated mountain regions in northern, central and western Viet Nam. While the government has made efforts to address the needs of ethnic minorities with numerous programmes that specifically target ethnic minority groups, ethnic minorities remain disadvantaged compared with other groups.[34] In particular, women and girls among ethnic minority groups are considerably disadvantaged in terms of the nature and quality of opportunities

and resources available to them, e.g. many still lack equal rights to land and equal access to agricultural credit and technologies, making them more likely to bear the negative impacts of a financial crisis.[35]

In Cambodia, 97 per cent of the population are Khmer and 2.2 per cent are indigenous ethnic minority (mother tongue). Khmer is the official language and ethnic minorities have their own language (which is not written).[36] The people of Lao PDR include 49 distinct ethnic groups.[37] These comprise the majority Lao ethnic group (53 per cent); Khamu (11 per cent); Hmong (9 per cent); and others (27 per cent).[38] In Myanmar, there are 135 officially recognised ethnic groups, with the Bamar ethnic majority comprising an estimated 68 per cent of the population.[39] The Rohingya ethnic minority group is not recognised under law (specifically the 1982 Burma Citizenship Law[40]) as one of the national races of Myanmar, which effectively renders the Rohingya stateless.[41]

Urban rural divide

Cambodia has by far the largest rural population (79.2 per cent of the total population in 2015) and Thailand the lowest (49.6 per cent), with Vietnam's rural population at 66.4 per cent of the total, Myanmar 65.9 per cent and Lao PDR 61.3 per cent.[42] Rural to urban migration across the Mekong countries is common. In Vietnam, poverty rates are higher among ethnic minorities, and in rural and remote areas, which in turn drives labour migration from rural areas.[43]

In Lao PDR, four in 10 people in Vientiane are internal migrants.[44] In Myanmar, many female sex workers are internal migrants – having been recruited directly from rural areas or among recent migrants to cities.[45] COVID-19 is highlighting disparities between rural and urban communities, including access to services (e.g. health, WASH and education) as well as information.

Demographic analysis of specific at-risk groups, COVID-19

The following highlight key demographic data of at-risk groups likely to be impacted directly or indirectly as a result of COVID-19. While it is noted that there are other groups impacted, the following were identified through the country-level Rapid Gender Analysis.

Migrant workers:

As of December 2019, there were 2,788,316 registered migrant workers in Thailand (the largest migrant receiving country in the Mekong) and an unknown number of undocumented migrant workers. These workers are from a range of countries, largely Lao PDR, Cambodia, and Myanmar, and just over 50 per cent of them are women.[46] Women from the Mekong (especially Cambodian women), are more likely than men to rely on informal social networks and chain migration, following their relatives or friends who are already employed abroad.[47]

The Cabinet of Thailand approved visa extensions for migrant workers from Cambodia, Lao PDR, and Myanmar under a Memorandum of Understanding (MOU), and at time of writing this report, gave them the right to remain in Thailand until 31 May 2020 (International Labour Organization, 2020). Registered migrant workers under Article 64 could extend their visa and work permits until 31 July[48] in order to mitigate potential labour shortages as the country's economy reopens (Foreign Workers Administration Office, 2020).[49]

Garment factory workers:

Millions of garment factory workers are employed in the Mekong region, and the majority of these workers are women. There are over 750,000 garment factory workers in Cambodia, 77 per cent of whom are women.[50] In Viet Nam, 2.5 million people (82 per cent women) are employed by textile and garment companies, with another two million in supporting industries, such as packing.[51] In Myanmar, more than 700,000 people are employed in the garment sector in Myanmar, and an estimated 90 per cent of them are women.[52]

Lao PDR has the smallest garment factory sector out of the five countries, employing about 30,000 workers,[53] 85 per cent of whom are women.[54] In Thailand, there are 1.03 million garment factory workers, with 70 per cent being female.[55]

Working conditions and employee protections in the garment sector were poor pre-COVID, for example, with many garment workers in Myanmar lacking written contracts.[56] In Viet Nam, a study highlighted that over half (53.3 per cent) have experienced sexual harassment in the garment sector.[57]

Informal workers:

1.3 billion people – or 68.2 per cent of the employed population in Asia-Pacific make their living in the informal economy (such as in agriculture, as street traders or as domestic workers). Informal workers are those who do not have access to rights at work (such as a contract) and social protection.[58] Informal employment is predominant in rural areas (85.2 per cent of employment) and makes up almost half of employment (47.4 per cent) in urban areas.

Women in employment are more likely to engage in informal work than men.[59] Informal employment rates (excluding agriculture) are high in Cambodia (87 per cent for men and 94 per cent for women) and Myanmar (81 per cent for men and 87 per cent for women), and lower in Thailand (36 per cent for men and 37 per cent for women).[60]

Female sex workers:

The bulk of sex workers in the Mekong region are women, recruited directly from villages and small towns or among the recent migrants to cities. The majority of the world's trafficked people are in Southeast Asia, and about half of those are forced into sex work.[61] In Cambodia there are approximately 34,000 sex workers, 13,400 in Lao PDR, 66,000 in Myanmar, 147,000 in Thailand and 71,900 in Viet Nam.[62] Female sex workers face stigma, discrimination and higher levels of GBV because of their involvement in sex work. Patriarchal norms across the Mekong region related to sexuality, and women's disadvantaged economic and social position, maintains the sex industry in many countries.[63]

A significant proportion of female sex workers are illiterate and sexual exploitation and abuse (as well as other forms of violence) is rife.[64] Female sex workers (and in some cases, their children) face stigma and discrimination, which affects their access to healthcare, the rental market, and social and economic opportunities.[65] Transgendered female sex workers are a particularly vulnerable group due to intense stigmatisation and social marginalisation, which can create additional barriers to services and information.[66]

Findings and analysis

Gender roles and responsibilities

Gendered division of domestic labour

Despite cultural, historical and political differences between countries in the Mekong region, patriarchal gender roles pervade all five countries. Although traditional values are changing, in Cambodia, traditional moral codes for women (Chbab Srey) and men (Chbab Pror) state that women are of lower status than men and should serve and respect men, particularly their husbands.[67]

In Viet Nam, there is strong familial and community culture towards "son preference". While daughters are often valued for their emotional closeness to their parents, and the practical and economic contributions they add to their households, the 'reliability' of a son is thought to be essential for carrying on family lines and names, performing ancestor worship, and taking financial care of the parents in their old age.[68]

Across all countries in the Mekong region, the allocation of unpaid domestic work largely falls upon women. Women are primarily responsible for caring responsibilities (e.g. children, the elderly, the sick) and domestic labour such as cleaning and food preparation. Research by the International Labour Organization has found that women in the Asia-Pacific undertake on average 76 per cent of the unpaid care work.[69]

In Viet Nam, employed women worked on average 38.8 hours per week in their paid jobs (1.2 hours less than men), *plus* 23.5 hours per week in the household (12.7 hours more than men).[70] In Cambodia, women traditionally spend more than 10 times as much time on unpaid care and domestic work than men.[71] In Thailand, migrant women worked approximately 28 hours (21 hours more than men) in unpaid tasks.[72] In Lao PDR, women spend significantly more time on unpaid domestic labour and caregiving (an average of four hours per day) compared to men (30 minutes per day). This increases for families with children, where women spend, on average six hours per day, compared to men who spend an hour a day.[73] For ethnic minority families in Lao PDR, these gender norms are deep-rooted and children are socialised into their roles from an early age.[74]

The increased demand on unpaid care and domestic work has been notable during the COVID-19 pandemic. In areas where healthcare systems become stretched by COVID-19 outbreaks, caring responsibilities are even more likely to be transferred onto women in the home.

In Lao PDR, respondents noted that during the pandemic, women's roles have centred around staying at home, keeping the house clean, ensuring sanitary meal preparation and caring for children. On the other hand, men's responsibilities have included going to community meetings to receive information about COVID-19, advising family members on prevention (e.g. handwashing, mask wearing, social distancing) and being responsible for essential trips outside of the home.[75]

Some respondents noted that both men and women were sharing household responsibilities, including domestic chores and childcare, as a result of men spending more time at home.[76] Respondents, for example, noted "*both men and women have the same tasks (e.g. social distancing, handwashing, following the news)", "we discuss with each other", "We work together"* and "*both men and women have the same responsibility for prevention*".[77]

Ethnic minority communities in Lao PDR noted that they are in a transition phase; bringing together traditional practices with the increasing modernisation of society. Respondents noted that this transition is being reflected in the response to COVID-19, with women taking on more domestic tasks whilst shifts are also being seen with men and women helping each other at home with regards to housework and childcare.[78]

In Viet Nam, most respondents noted little change in the gendered division of labour during the pandemic. Women still take on most of the housework and caring role in both rural and urban areas. While men sometimes take these roles on to *support* women, it is not seen as their responsibility. Some changes in the gendered division of labour were reported in families where both the husband and wife are migrant workers, and in cases where the wife is employed outside the home, men are taking on childcare responsibilities while they are at home due to being unemployed. However, housework is still considered the woman's responsibility:

***"He looks after our son when I go to work. But when I come back, I take that responsibility, do the cooking and washing. He never does these when I am at home."* - Female garment worker in Ho Chi Minh City, Viet Nam.**

For migrant workers in Thailand, the level of unpaid domestic work men and women engage in depended on their occupation. Fishermen would spend the majority of the day out at sea and therefore contributed little to domestic tasks. Women married to fishermen therefore bore the burden of domestic responsibilities and had little time for paid work. Male and female seafood processing workers appear to have spent similar amounts of time on paid and unpaid work.[79] For migrant worker families who returned back to Cambodia, traditional gender roles continued, with men seeking work in the village or in Phnom Penh to support the family, while women stayed at home to take care of the house and the children.[80]

In Myanmar, some key informants reported that with both women and men spending more time at home, some men were taking on a greater share of the caring and domestic work, including childcare and cooking.

***"During COVID-19 crisis, there are economic and income related changes due to business being shut down and [people] staying at home. As men stay at home long, they understand more about the burden of house chores on women and get engaged to help. Previously my husband and I discussed only on important issues, now, they are more at home and have more conversation, not only on business matters but also on children's education"* – 53-year-old woman in Mandalay**.[81]

In addition to household and caring duties, full and partial closure of schools across the region have exacerbated the burden of unpaid care work on women. While schools are gradually re-opening, e.g. in Thailand[82] and Lao PDR[83], it is likely that the schools will continue to open and close as the pandemic situation evolves in each country.

In Viet Nam, interviewees reported facing challenges, such as difficulty dividing their time between work and caring for children, especially those with younger children and/or children participating in online learning: *"I have a child at grade one. Now besides other things, I need time to teach her. In the past, [her] grandmother can help but now I must do it since it is online study which my mother cannot control. It is hard for all of us working in factories if the study time of children is during working hours."* - Trade Union representative in a garment factory in Hai Phong.

As formal and informal childcare declines, the demand for unpaid childcare will fall more heavily on women and adolescent girls, possibly resulting in women needing to make sacrifices in other areas, such as paid work.[84] Women's caring responsibilities also puts them at greater risk of contracting and spreading COVID-19 and, as the primary carers in the household, if women fall ill, others may struggle to care for them.

While it was noted across the region that men had taken on some of the household and domestic responsibilities, this was often framed as men 'supporting' or 'helping' women with work that was still perceived (by both men and women) to be the role of women, rather than a significant re-shaping of gender roles. Nevertheless, this is being noted as an opportunity and an important starting point.

Gendered division of paid labour

Many of the sectors in which women are predominantly employed – often part-time, lower paid, informal or insecure employment – have been the hardest hit by COVID-19 containment measures, such as

shutdowns and travel restrictions. Women and girls also face specific risks to infection due to the types of work that they do.

Globally, 70 per cent of the health workforce are women.[85] They are also the majority of health facility service-staff – usually employed as cleaners, laundry staff or in catering – and as such they are more likely to be exposed to the virus.[86] In Southeast Asia, 80 per cent of nurses are women, with increasing numbers of women moving into higher skilled positions such as physicians and pharmacists.[87] In Lao PDR approximately two-thirds of nurses are women[88] as well as women occupying management positions within the healthcare section, on par with men (49.3 per cent women; 50.7 per cent men).[89] As nurses, women's roles involve particularly close and prolonged contact with sick patients[90] which puts them at increased risk of the virus.

Healthcare workers interviewed in Lao PDR raised several issues brought on by the pandemic, including concerns over their physical and mental health. Healthcare workers spoke of experiencing stress and anxiety around contracting the virus, and referred to a lack of protective equipment that was placing them at greater risk of infection. One interviewee explained:

"[We are] worried about our safety because we do not have the protection kits and there are many people coming into the health center."[91]

Women and girls are also heavily concentrated in other industries that expose them to COVID-19. Globally, **women are the majority of sex workers**.[92] Sex workers in Myanmar are increasingly finding it challenging to earn an income due to government-imposed curfews as they and their clients are unable to leave their homes.[93] All 14 female sex workers interviewed during the Rapid Gender Analysis reported that COVID-19 was having a critical impact on their lives and livelihoods. With karaoke bars/clubs, massage parlours and restaurants closed, and curfews imposed, it is extremely difficult to work.[94]

Some have no income at all, while others are continuing to work, but less, and at much greater personal risk; now working on the street and/or going to client's homes:

***"Because the guesthouses are shut down, when I work, I had to follow the customer to his friend's place. His friend also joined us but paid for only one person. If I complain, I might be beaten, therefore I had to accept what they paid. If I report to the police, I will be the one who arrested."* - Female sex worker in Yangon.**

In Thailand, an estimated 300,000 sex workers are without work due to the closure of walking-streets, bars, massage parlours, and other entertainment venues. A community-led rapid assessment in Bangkok, Pattaya, and Dannok found that 75 per cent of respondents no longer made enough money to cover daily expenses, and 66 per cent could no longer cover the cost of housing.[95] Although the Thai government has announced a US$58 billion stimulus package to assist workers, small enterprises and other businesses, sex workers are not able to access this support as they lack documentation to prove their self-employment status.[96]

The tourism industry has also been affected substantially by the pandemic, with 75 million jobs at risk globally, of which 49 million are in the Asia-Pacific.[97] On average, just over half of all tourism workers in the Mekong region are women, with women tending to be employed in lower-skilled jobs that pay lower wages, while men hold more managerial positions in government and private tourism enterprises.[98] Travel restrictions have been widely imposed in the Mekong region, moving the tourism industry into a standstill,[99] which will have significant impacts on women's economic security and survival.

The garment and textiles industry is also predominantly comprised of female workers. Working conditions in garment factories put women at risk of contracting COVID-19 as social distancing may not be possible on the factory floor and employers may not be implementing appropriate health and safety measures.[100] Women may have little decision-making power over their working hours, breaks to wash their hands or other sanitary needs, and accommodation provided by employers is often overcrowded with only basic WASH facilities.[101] If women do fall ill, they may have little or no access to sick pay, health insurance or healthcare services.[102]

The pandemic has impacted the job security of many garment factory workers who may be affected by cancelled export orders.[103] This has led to protests by garment factory workers outside of their factories to protest unpaid wages.[104] Women garment factory workers in Cambodia are excluded from leadership roles, receive a lower salary (81 per cent of men's earnings), receive less education and training than men, are recognised less for their contributions, and are more likely to be exploited and harassed in the workplace.[105] In Viet Nam, an estimated 78 per cent of garment workers have had their jobs suspended or hours cut due to the pandemic.[106] In Myanmar, 50 per cent of the 700,000 garment workers are at risk of either being suspended without pay, or losing their jobs permanently, due to the pandemic.[107] Many of the garment worker respondents in Myanmar described struggling to meet their basic needs, including food and healthcare. They reported reducing expenditure, borrowing money, and selling household items to survive.[108]

In Lao PDR, respondents confirmed that many garment factories had closed with 90 per cent of the interviewees not working at the time. The respondents' financial situations were mixed, with 37.5 per cent still receiving their full income, 7.5 per cent receiving reduced income (generally 50 per cent of their income), and 15 per cent receiving no income. Most respondents (40 per cent) were unsure about their factories' plans to pay them and whether they would receive full, partial or no pay. Similar findings were found in Viet Nam where male and female factory workers experienced a decrease in working hours, with salaries reducing by 20 per cent to 50 per cent.[109]

Fishing and seafood processing: Other industries are facing similar challenges. In Thailand: 50 per cent of fishermen interviewed during the Rapid Gender Analysis said that their salaries were reduced; 20 per cent noted that their salaries did not change; while others remained unemployed due to factory closures, were suspended from work without income, or had changes to their shifts.[110] One fisherman noted that since the pandemic, due to the suspension of fishing, his income reduced from 12,000 – 13,000 Baht (US $390-420) to 6,000 Baht (US $195) per month.

Respondents in Thailand, shared experiences which pointed to the differential treatment of men and women in the seafood processing industry with regards to pay, income security and benefits. A respondent noted that female workers were paid by the amount of work (by the kilo) completed, yet male workers received a steady income with a promise of health benefits if unwell, and were on monthly salaries regardless of the amount of work they completed.[111] Two of the female seafood processing workers said that their working days were cut by 1 to 2 days per week, which resulted in income loss, while another undocumented female worker without a contract was paid on commission.

Impact on remittances: It is estimated that informal remittance flows from Thailand to Cambodia, Lao PDR, Myanmar and Viet Nam are potentially double the size of formal flows and amount to US$6-10 billion. Women migrant workers generally send a larger proportion of their income home (17 per cent, compared to 10 per cent sent by men)[112] and the majority of remittance recipients are women in rural areas.[113] Hence, women migrant workers may be more financially vulnerable than male migrant workers, with a lower percentage of their income remaining after remittances.

In Thailand, the majority of migrants interviewed stated that they suspended sending money back home, despite being one of the primary reasons for migration. In Cambodia, one factory worker stated that lack of overtime, lower salaries and job suspensions limited the workers' ability to send remittances to their families in the provinces. They also reported struggling to get enough food due to increased prices and limited access to markets during lockdown. Some respondents reported using savings and selling items in order to buy food and necessary supplies.[114]

Returnee migrant workers: In Lao PDR, financial difficulties were the most common issue raised by returnee migrant workers. While some had returned to Lao PDR with small savings, many returned with no resources. Some reported the 14-day quarantine period increased stress levels, as it was perceived as "wasted time" in which they were unable to look for other work. Some returnee migrant workers resumed previous forms of work, such as working on familial agricultural plots or producing handicrafts, while searching for alternative forms of work.[115] The families of returnee migrant workers are experiencing a double financial blow: a reduction in remittances and increasing demand on family resources. Some have resorted to borrowing money from family, village funds or banks, creating further stress.

In the Mekong countries, women tend to be highly active in small-scale income generation and agriculture.[116] In rural Viet Nam, 63.4 per cent of working women are in agriculture, compared to 57.5 per cent of working men, and they are more likely to work on smaller farms and cultivate subsistence crops.[117] Existing gender inequalities such as women's limited access to agricultural extension services and technology transfer, combined with the drought and saltwater intrusion early in the year, and the pandemic, mean women are in an increasingly precarious position.

In Viet Nam, farmers from ethnic rural areas noted impacts as a result of travel restrictions, with farmers not being able to bring their agricultural products to central areas to sell: *"Our main distribution channel is the bus stops, but the number of bus trips is reduced…Thus, we could not sell banana chips and dried bananas there. In the meantime, green bananas [unprocessed banana] were sold to traders but now they do not collect, even though I had dropped price to 2.500 VND /kg because the border with China is closed. Currently, we still have around 400-500kg dried banana in store and it is going to be out of date in the next couple of months. The income of cooperative members are reduced*." - Male head of banana production cooperative in Bac Kan.

In Lao PDR, nearly 70 per cent of the population live in rural areas, and many women generate income through agriculture. While respondents in Lao PDR noted the loss of work and income has affected men and women, they noted specific impacts on women, including the closure of markets which has affected women's ability to sell their crops and non-food items such as handicrafts and charcoal. This has placed women and their families in a state of financial distress.[118]

For rural ethnic communities in Lao PDR, this has caused many women to have either no income or reduced income from their agricultural work;

"Women…get offers from an external dealer to [buy from their] cucumber garden, but when it grows, nobody comes to buys as promised. If we will sell it to people in the village, no one comes to buy it."

Interviewees also raised issues of decreased agricultural outputs, increased barriers to accessing agricultural plots, reduced prices of the produce they are selling and decreased income from other sources as well as a lack of savings. This has all lead to "women [needing to] work harder than before."[119] Due to men's greater freedom of mobility compared to women in Lao PDR, they tend to travel further to seek alternative forms of work and income – which is also seen as putting them more at risk of contracting the virus.[120]

Access and control of resources

Despite women's significant contribution through their productive and reproductive labour (the former of which they are paid for and the latter pertaining to the unpaid duties they carry out in the household such as cleaning and caregiving) across the Mekong region, persistent gender inequalities remain at large when it comes to women's access to productive resources, such as land, services and inputs, finance, training, information, markets and institutions.[121] Ownership of land, and access to and control over resources within the home are greatly shaped by gender and control across the region, and can further be used to assess the potential coping mechanisms of each household during the health pandemic, depending on whether the households are male- or female-headed. The need for safe shelter is particularly relevant during the pandemic as both a prevention and response measure.

In Cambodia, both men and women can inherit property[122] however, intersectional factors such as age and wealth play a role in determining a woman's status and access to resources. Women who are older, divorced, separated, or widowed and those who live in urban areas, are better educated, or are paid in cash, will have greater financial control over the assets they own.[123] The extent to which women control the household's financial resources is crucial as it may affect their ability to seek medical care for themselves or their children if they fall ill with COVID-19, or it may affect how they handle other needs that arise due to the pandemic, particularly if household financial resources are scarce.

CARE has been supporting women's access to, and their control over resources, through establishing savings groups such as Village Savings and Loans Associations (VSLAs) implemented in Viet Nam, Cambodia, Lao PDR and Myanmar. Since 1991, CARE has worked with women to set up VSLAs, which have had proven positive effects on women's economic, social and political empowerment.[124] However, the pandemic has the potential to seriously affect CARE's global network of 8.4 million VSLA members, more than 80 per cent of whom are female.

Interviews with VSLA leaders in Viet Nam highlighted the link between savings and unpredictable employment due to the crisis.[125] There has been a significant increase of members borrowing money in the period between January to April 2020, compared to the same period in 2019. Interviews with VSLA leaders critically emphasised the high demand of borrowing money from VSLA and the safety and effectiveness of the fund in supporting women's lives during the crisis in both rural and urban settings: "*Many members want to borrow but do not have enough money, we have to divide the loan into smaller amounts so everyone in need can get a loan. This fund is very useful although the amount is not large, it helps sharing difficulties in short-term*" - VSLA leader in Dien Bien.

Anecdotal evidence from CARE International in Cambodia[126] and CARE International in Lao PDR[127], has found that VSLA groups are being impacted by social distancing restrictions and are unable to continue to meet. VSLA groups are also struggling to pay back loans due to the economic downturn.[128] CARE International in Myanmar has noticed similar challenges with its VSLA groups,[129] while CARE International in Viet Nam has noted a significant reduction in monthly purchased shares per member, per VSLA.[130]

Decision-making, participation and leadership

Household decision-making

In Lao PDR, women, generally made decisions over food consumption and housework and men largely made decisions around earning money, financial planning, raising livestock, construction or repairs and problem solving. There was a general pattern of women being responsible for smaller decisions and men for larger decisions or the "final" decision.

"We share decision making on everything, both women and men. However the husband would be the final decision maker".[131]

There were, however, differences seen between provinces. In Luang Namtha province of Lao PDR, most interviewees stated that women 'keep' the money and manage daily household expenses, whereas men manage family assets such as transportation (e.g. motorbikes). In Phongsaly and Sekong provinces, most interviewees reported that husbands and wives manage financial resources and expenses together.

Across all provinces, a small minority of households reported that the woman is the decision-maker. While there were no changes noted in rural areas as a result of COVID-19, within the capital of Vientiane, changes had been seen as a result of financial pressures, with increased discussions taking place between husbands and wives on how to manage their financial situation, with husbands consulting their wives more now, than before the pandemic, when making purchases.[132]

In Viet Nam, while women's engagement in decision-making at the household level is increasing, men have more power over important decisions in both rural families and migrant families living in the cities. Vietnamese husbands and wives are increasingly more likely to discuss and make joint decisions on major decisions including income usage, savings, and business development.[133] In the context of COVID-19, women usually make decisions related to prevention, such as monitoring the personal hygiene practices of family members and purchasing prevention supplies, which is closely associated with their traditional caring roles in the family.

For other decisions on coping strategies, including alternative income generation activities, replacement sources for loan and interest payment or housework arrangements, interviewees indicated that the participation of both men and women in decision-making was relatively equal.[134] With regards to debt

repayments, in many cases the husband is considered the person responsible for repayments, however women believe that women must take on the burden and worry of making payments. This worry is likely to be greater in female-headed households where the women will need to take on the full burden of debt: "*We got loans for purchasing 2 cows, two years ago [35 million VND] and building house last year [25 million VND] from the Social Policy Bank [the government program for poor households]. I have to pay around 4.4 million VND every month. This month, I could not earn any money for payment*" - Migrant woman, 27 year old, Khmer ethnicity, in Tra Vinh.[135]

In Thailand, the majority of male and female respondents indicated that the wife or the mother of the family made decisions regarding household matters, including the management of spending and saving. However, joint decisions were generally made on important matters, such as purchasing land or expensive goods, debt repayment and sending money home, with only a few female respondents indicating they were sole decision-makers in these issues. The decision-making power of female migrants varied based on their marital status and financial dependency. Financially dependent women had less decision-making power and financial confidence, compared to those who were financially independent, single or living alone.[136]

Similarly, in Cambodia, decision-making power in the household was strongly linked to household income contribution, highlighting the potential impacts that loss of income may have on women in the family.[137]

In Myanmar, women's lack of control over household finances is even more acute, with women only being responsible for small daily purchases, such as groceries, and all other financial decisions being made by men, without consultation.[138] For respondents in Myanmar, key informants (men and women) overwhelmingly reported that COVID-19 had not resulted in any changes to decision-making patterns at household level, access to or control over resources at household level, or decision-making at community level.

Participation in public decision-making

In the Mekong, community decision-making tends to be dominated by male leaders.[139] During community decision-making meetings and consultations on disaster risk management and climate change adaptation, only a small number of women are present, making it less likely they will receive critical information for preparedness or influence decisions. When women are excluded from decision-making, their needs and priorities become invisible. This results in preparedness, relief and recovery approaches that neither engage women, nor serve them, which can increase the impact of crises, such as COVID-19. This is particularly so for marginalised women, such as female sex workers in Myanmar who are perceived as improper and undignified, and generally not invited to participate in decision-making processes.[140]

At the level of national governments, women are significantly under-represented in the Mekong region.[141] Globally, women comprise 25 per cent of national parliamentarians (as of May 2020), but the percentage of women in the Asia-Pacific parliaments is currently around 20 per cent.[142] Although Viet Nam has a higher proportion of seats held by women in national parliaments at 26.7 per cent,[143] women are still under-represented in government and have little opportunity for meaningful participation in local, regional, and national governance and decision-making. In Lao PDR, female representation in national parliaments is 27.5 per cent,[144] which includes 76 women Members of Parliament (MPs), 4 LGBTIQ MPs, and 418 male MPs.

However at the provincial level, there are no women governors, only three women vice-governors[145] and at the village level 1.7 per cent of village chiefs and 7.2 per cent of deputy village chief are women.[146] Myanmar is a leader in women's participation in the public sector, with women representing 63 per cent of all civil servants.[147] However, this has not translated into more women in senior leadership roles. Women are under-represented in parliament, filling just 10.5 per cent of seats in the national parliament, less than half the global average and representation is even lower at the local level.

In Thailand, women make up 15.8 per cent of MPs and 10.4 per cent of senators.[148] This means government decisions about COVID-19 preparedness and response plans and resource allocations may be made without women at the table or without sufficient representation to address women's short and long-term needs. Not only are women best placed to identify their needs, they also have the right to influence the decisions that impact their lives.

Women's machineries play a critical role in the response to COVID-19, especially in relation to GBV, and are an important vehicle for women's leadership at a broader level. Women's rights NGOs operate across the Mekong region, are well organised, and work on specific issues, such as in Cambodia where there is a significant focus on violence against women and trafficking.[149] In Myanmar, a large focus of women's organisations is on peace and security, law reform, and violence against women.[150] These women-led NGOs are critical and have been an invaluable resource during the pandemic, to provide expertise and guidance in developing gender-sensitive COVID-19 response strategies and supporting women's leadership in the response.

Already, the pandemic is threatening the organisational continuity of many grassroots organisations in the region: for example, as early as April, 71 per cent of women-focused CSOs surveyed by UN Women reported that COVID-19 was affecting them somewhat or very negatively, with 12 per cent suspending activities altogether.[151] The Asia-Pacific Transgender Network reported that all of their project partners expressed concern about how to sustain the operational costs of their organizations[152] which provide critical services for transgender people in the region. Similarly, the ASEAN SOGIE Caucus reported that several funders of LGBTQI+ groups had reneged on agreed funding, threatening organisational continuity.[153] The current crisis is a time when CSOs, NGOs and advocacy organisations, including those for disabled persons, LGBTQI+ people, sex workers and migrant workers, are needed more than ever and their continued support is vital.[154]

Structures and processes established for COVID-19

Despite women constituting a majority of frontline healthcare workers, placing them in prime positions to identify COVID-19 trends at the local level, they are a minority in national and global health leadership.[155] Gender expertise is lacking in current pandemic planning, outbreak response, and post-pandemic recovery.[156] In Cambodia, the government's COVID-19 National Committee has 27 members and only two of them are women.[157] In Lao PDR, the National Taskforce Committee for COVID-19 Prevention and Control is comprised of 11 people, of which two are women.[158] In Myanmar, the governance mechanisms established for the COVID-19 response are largely drawn from existing governance systems, and therefore continue to underrepresent women. Women with disabilities, sex workers, and other marginalised groups are even less likely to be represented.[159]

In Viet Nam, the government COVID-19 Taskforce has 22 members, only four of whom are women,[160] with the most important positions (such as the head and deputies) filled by men.[161] This under-representation means that women have fewer opportunities to ensure that women's needs are taken into consideration during COVID-19 decision-making processes and response planning. As an example, the Vietnamese government introduced a range of new policies and procedures such as the Decree 41/2020/ND-CP (Decree 41); Decision 15, which focuses on economic impact and includes tax breaks, delayed tax payments and land-use fees for businesses, and reduced interest rates. Whilst important, other measures such as access to safe reproductive health services and prevention of and response to GBV have not been adequately prioritised in policy responses.[162]

Responses were mixed from respondents in Lao PDR when it came to women's participation in community decision-making platforms for COVID-19 prevention and response. In Luang Namtha province, respondents stated that women were involved in the design, planning, implementation and evaluation of the COVID-19 response, whereas others (e.g. Phongsaly and Vientiane) said only a limited number of women were involved in decision-making. Across all provinces however, there were respondents who felt that women who were engaged had a primary role in disseminating information and following guidance, rather than developing and leading the response.[163]

Trade unions also play a role in representing the needs of their members. The Cambodia garment industry has more than 100 trade unions, with over 90 per cent female membership, however, only two women fill national leadership positions.[164] This highlights that groups who can lobby and advocate during the pandemic also do not have women represented in top positions. A lack of consultation with members has also been reported, with respondents in Viet Nam noting they were informed rather than consulted with, regarding changes to their employment status or conditions such as contract terminations, changes in working hours and changes in monthly bonuses. One woman explained,

"I was informed by the factory to take leave without pay by April 30th afterward until the factory get new order. We do not know when we can come back."[165] - Female garment worker in Viet Nam

Access to services and resources

Access to WASH services

Proper handwashing (alongside social distancing) has been identified as an important COVID-19 prevention strategy by the World Health Organization (WHO) and supported by governments, UN agencies, NGOs, civil society organisations and healthcare workers.[166] Despite the centrality of handwashing to prevent COVID-19, access to basic WASH facilities across the Mekong region is varied (66 per cent in Cambodia; 50 per cent of the population in Lao PDR; 79 per cent in in Myanmar; 84 per cent in Thailand; 86 per cent in Viet Nam),[167] and lack of access is likely to be compounded by the Mekong drought which has, in particular, severely impacted Viet Nam and Thailand.

Specific segments of the population have particular difficulties accessing proper WASH facilities. For example, access to WASH facilities is much lower in rural communities (e.g. In Myanmar, urban WASH access is 92 per cent, whilst rural access is 74 per cent; Cambodia urban 88 per cent, rural 60 per cent; Viet Nam urban 93 per cent, rural 82 per cent).[168] In Myanmar, the WASH Cluster coordinator and six key informants (four women, two men) reported challenges with water scarcity, making frequent hand washing more difficult for men and women living in these areas, potentially increasing their risk of contracting COVID-19. One 25-year-old female sex worker in Mandalay reported having to purchase water and needing to limit usage, highlighting the disproportionate impact on marginalised groups, who are likely to have fewer social and economic resources to cope with water shortages.[169]

Those interviewed in Lao PDR observed a number of changes since COVID-19. Both women and men have an increased knowledge of hygiene and sanitation practices as it related to the pandemic, with an emphasis on maintaining a clean living environment and improving personal hygiene practices. Boys tended to be guided by their parents and showed some improved level of personal hygiene. Girls often had a dual role in being cared for by parents but also caregiving through household cleaning tasks.[170] Hygiene and handwashing promotion may inadvertently increase the workload of women and girls who are responsible for collecting water and maintaining household sanitation and hygiene. This is particularly so in rural areas lacking water supply infrastructure, where long walks may be required to collect water.[171] Water fetching can also expose women and girls to the risk of GBV.[172],[173]

Women and girls experience a disproportionate burden from inadequate sanitation facilities, due to both physiological differences such menstruation and gender norms which place them at risk of GBV.[174] Many WASH facilities also do not cater to the accessibility and needs of persons with disabilities. These issues are not limited to rural settings but also found in informal urban settlements which are common across the Mekong countries (Cambodia 50 per cent; Lao PDR 31 per cent; Myanmar 41 per cent; Thailand 25 per cent; Viet Nam 27 per cent).[175] Urban slum-dwellers, particularly women, children, persons with disabilities and the elderly, may have difficulties accessing adequate WASH facilities due to physical access or safety issues, a lack of running water, or the high price of water. This combined with cramped living conditions and communal spaces, mean urban slums across the Mekong region present a significant risk for the spread of COVID-19.[176]

The dignified management of menstruation is particularly challenging for adolescent girls and women in the subregion during the pandemic. Restrictions on mobility due to self-isolation and quarantine, combined with potential reductions in income, have been reported to negatively impact women and girls' ability to access menstrual health products. This is compounded by the social taboos surrounding menstruation, common in most cultures of the Mekong. In Myanmar, for example, it is believed that touching or preparing food whilst menstruating may bring bad luck to men and boys.[177] During quarantine or self-isolation, this may exacerbate violence towards menstruating women or increase the workload of other women in the household. Such myths and misconceptions may also adversely affect caregiving for children, people with a disability, the elderly and those who are sick.

Mobility

The requirement to self-isolate or quarantine across the Mekong region has resulted in restricted access to public spaces and services that will affect women and children in terms of childcare, education, livelihoods, access to health and other services, or seeking social support from friends and family.[178]

Men and women may have different access to transportation, impacting their mobility, especially during a crisis when transportation may be essential to accessing services or maintaining livelihoods. A Rapid Gender Analysis by CARE of the 2015-16 Cambodia El Nino Phenomena identified that many women in rural Cambodia, especially older women, had limited or no access to transportation and many stated they feared for their safety and health when leaving their villages to collect water.

As men usually have access to a motorbike, it was reported that they had increased coping capacities compared to women.[179] Similarly, in Myanmar, transport options for poor and middle-class women are limited, since men control the use of the family vehicle.[180] In Lao PDR, rural women are dependent on men to accompany them on motorbikes. Furthermore, rigid gender norms can undermine women's confidence and driving skills.[181] COVID-19 response strategies must therefore consider the access of different groups, especially women, to reliable transportation, as well as considering the protection issues associated with using transportation.

Government imposed mobility restrictions will also have a significant impact on migration flows in the Mekong region, with an estimated three million migrants across the region,[182] many of whom are women. For example, closures and restrictions along the Thailand-Myanmar border have had adverse effects on migrants returning to Myanmar. The Thailand-Myanmar migration corridor is the largest in Asia and a large percentage of the population of Myanmar (10 per cent) migrate for work.[183]

The Myanmar Ministry of Health and Sport has constructed quarantine facilities along the border and there have been reports of substandard living conditions and overcrowding; inadequate WASH facilities, which lack of dignity for women and girls; and child protection issues.[184] Closures and restrictions on the Thailand-Myanmar border have also affected refugees, through extensive delays, family separation and disrupting their ability to seek appropriate support and protection.[185] Government restrictions have affected the provision of services, limiting access to health and humanitarian workers, and exacerbating the multiple gender-based barriers faced by refugee women such as exclusion, discrimination and GBV.[186]

Health

Barriers to accessing healthcare can be compounded by multiple or intersecting inequalities, such as gender, ethnicity, socio-economic status, disability, age, race, geographic location and sexual orientation.[187] In April, more women (24 per cent) than men (17 per cent) reported being unable to access medical care when they needed in Cambodia, with similar gender gaps reported also in Thailand.[188]

In Lao PDR, around half of the interviewees reported reduced accessibility and less people using health care services. The primary reason for this was the fear of contracting the virus and a loss of trust in the healthcare system (reported by both men and women);

"people do not go to the hospital because they are afraid of infection, as there are many people in the hospital and they do not know who is carrying the virus or being infected."

Other reasons included that it was not seen as safe for women and girls to travel to the healthcare facilities, as well as the impacts of quarantine and social isolation measures.

In Lao PDR, there is significant discrimination against ethnic minorities living in the Northern Uplands which prevents many from receiving or even seeking healthcare. Many do not speak or understand the Lao language, particularly women, girls and the elderly, which is a barrier to accessing COVID-19 health information, and understanding prevention and treatment measures.[189] Respondents told CARE that, there are difficulties as people "*do not know and cannot answer some information in Lao (and so they) have no [health] information*."[190]

Language barriers also exist in accessing health care in Rakhine, Shan and Kachin states in Myanmar. Populations in areas affected by conflict rarely accept to be referred to governmental health facilities because of an existing lack of trust and confidentiality.[191] Additionally, the lack of freedom of movement, and access to healthcare for some communities in Rakhine State has the potential to further hamper any response to the COVID-19 pandemic.

In Viet Nam, respondents noted that people in both urban and rural areas can access health care services with few barriers, but again, the main issue being people's concerns over fear of contracting the virus. *"One woman in the village had [a] catastrophe but did not dare to go to the hospital; another has joint pain that need to take medicine periodically, but in this situation, she could not go to the hospital to get medicine so she need to live with the pain*." - Commune Women Union representative in Bac Kan."

Key informants in Myanmar reported local clinics closing, and some mobile health services suspending their operations as a result of the pandemic. Closures are disproportionately affecting women and girls, who are more likely to have additional restrictions on their movements imposed by their families. Service closures have greater impacts in rural areas, where there are fewer facilities available. Even when alternatives are accessible, there may be cultural, language, psychological, discriminatory and practical barriers to accessing a new service, particularly if it is in a different area, or the individual is from a vulnerable group.

Migrant workers may not seek medical support due to a lack of access to health services, cost, and fear of repercussions, such as deportation if they are undocumented. Research conducted by the Raks Thai foundation found that migrant women, especially those without documentation, rely heavily on NGO staff for procuring medication and referrals to health services, especially for chronic diseases such as Tuberculosis and HIV/AIDS.[192] Respondents highlighted concerns, particularly for pregnant undocumented migrant women, in their access to healthcare, including reproductive health during the pandemic due to a lack of legal documentation. In addition, women who experience GBV may not be able to access essential health and support services.[193] Migrant workers with pre-existing health conditions also face further challenges in accessing health services, and in some instances are more vulnerable to COVID-19. Many migrant workers also live in dormitories with poor conditions, which enhance the transmission of the disease, putting them at an additional risk.[194]

Smoking has been identified as a possible risk factor for COVID-19.[195] Adult men in Asia-Pacific are eight times more likely than women to be smokers.[196] The highest rates for smoking amongst men are in Lao PDR, with 57 per cent of men smoking, and lowest in Myanmar with 32 per cent of men smoking.[197] Men may exhibit less health seeking behaviour as a result of rigid gender norms, wanting to be viewed as tough rather than weak, potentially resulting in a delay in detection and access to treatment for the virus. Additionally, stereotypical masculine norms that encourage risk-taking may also negatively impact the uptake of recommended prevention measures, such as social distancing and mask wearing. These social factors may place men at a higher risk of contracting COVID-19 and also of facing complications.

Mental health, stress and anxiety

Even before the COVID-19 pandemic, anxiety affected 60 million people in Southeast Asia alone, with close to 86 million living with depression. The impact of COVID-19 on populations' mental health living in the Mekong countries is still emerging, however early evidence from Thailand points to increasing mental health issues as a result of economic distress.[198] Rapid impact surveys have also indicated that in Thailand, more women (84 per cent) than men (79 per cent) reported that their mental health is affected by the pandemic.[199] Gender differences occur particularly in the rates of common mental disorders – depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately one in three people in the community and constitute a serious public health problem.[200]

All respondents interviewed in Cambodia reported an increased level of stress and anxiety due to loss of income, social distancing and movement restrictions. Reasons were varied but included: concerns over the closure of schools, children's vulnerability to infection, loss of jobs and income; including the expectations placed on men to earn money for the family.[201]

"It really affects the mental health because usually we go back home with the warm welcome from our family and relatives, but now it is different because of the social distancing. People avoid me and my husband. The stress level is also increasing because of the increase in price of food and water. We also have a lot of fear of going out and are always wearing masks" **- Migrant worker, Cambodia**

In Lao PDR, the main concerns for men included fears of becoming infected, followed by financial stress as a result of reduced or loss of employment or income. For women, key concerns included the mental health impacts of the pandemic (e.g. stress and fear) as well as the risk of infection to their families (e.g. husband and children) and of themselves. Women also had concerns regarding the impact of COVID-19 on pregnancy (e.g. risk of infection, health of the baby, access to healthcare); family finances (reduced or loss of employment or income); increased unpaid labour (housework, childcare) and the impact the pandemic would have on children (e.g. schooling). Overall a smaller number of men compared to women stated that they had no worries or concerns related to the pandemic.[202] The overall availability of mental health services appeared to vary between the provinces in Lao PDR.

For migrant workers in Thailand, fear of being infected with COVID-19 is the most common concern and source of stress. Concerns about family wellbeing were found to be the main source of stress among housewives and married women. Those who are pregnant or have small children were especially stressed about their children's vulnerability to COVID-19. Meanwhile, male respondents were more concerned about work-related issues and rarely mentioned household challenges.[203]

Sex workers routinely face discrimination by healthcare providers, which can be a barrier to accessing healthcare. One sex worker in Mandalay explained that she used to receive her antiretroviral treatment at an NGO-run drop-in centre (specialised in providing HIV related care to female sex workers), but now had to go to the General Hospital to receive the treatment. Although the treatment was still available to her, she emphasised that it was much more difficult to go somewhere she did not have a pre-existing relationship with the healthcare provider.

A survey by the Asia-Pacific Transgender Network has noted that 43.2 per cent of respondents reported no or limited access to gender-affirming health services, compounding the existing social violence and stigma faced by transgender persons.[204]

Sexual and reproductive health and rights (SRHR)

Provision of sexual and reproductive health services, including family planning and menstrual health, are central to women and girls' health, empowerment and dignity, and may be impacted as health services and supply chains are strained from the COVID-19 response.[205] Evidence from past epidemics, such as Ebola and Zika, demonstrate that efforts to contain outbreaks often divert resources from routine health services and exacerbate the often already limited availability of sexual and reproductive health services.[206] There are also increased risks for pregnant women in quarantine or self-isolation who may not be able to access healthcare. This is of particular concern as maternal mortality is still one of the leading causes of death for women aged 15 to 49 in some Mekong countries, such as Cambodia.[207]

The COVID-19 pandemic has led to disruptions in supply chains across sectors regionally, nationally and globally, including essential medical supplies and contraceptives. With many contraceptives manufactured in the region and factory closures and migrant workers being sent back to their homes, these emerging issues will have large implications on the availability of these important resources.[208] This, along with disruption to family planning services and a reluctance to attend health centres for fear of contracting COVID-19, is likely to limit women's control over their own fertility. Several key informants expressed concerns that the crisis would lead to an increase in unwanted pregnancies.[209]

Before the pandemic there were significant unmet needs with 23 per cent of women in Lao PDR reporting difficulties accessing sexual, reproductive, maternal, newborn and child health (SRMNCH) services, particularly for young women aged 15-19.[210] During the pandemic, mixed responses were noted in regards to increased difficulties to access SRMNCH services and less women and girls able to use such services. Lockdown measures and fear of infection were the largest barriers: "*less people go to hospital*

[for SRMNCH services] because we are afraid of getting infected so we don't go to hospital if not necessary."[211] Even in areas where services continued, there remains a fear of contracting the virus from a health facility, which saw a reduction in people attending the facilities. However, despite the reluctance of patients, an increase in information and provisions at health facilities around COVID-19 has also enabled some services to continue operating through the crisis.[212]

Decision-making power and access to transport also impact women's access to SRMNCH services. In only two out of the 62 households interviewed in Lao PDR, did decisions on family planning lie with women. Decisions around healthcare in Lao PDR followed a similar pattern although women were more active in decision-making. Men also tend to control family transportation and therefore the wife is reliant on her husband to take her to healthcare facilities.[213]

Food security and nutrition

Since COVID-19, difficulties in accessing food during the COVID-19 pandemic were repeatedly raised during interviews conducted by CARE – particularly for families with lower socio-economic resources; "*we are facing money problems and we do not have enough food" "we need more dry food during times when we cannot go out or are under home quarantine".* A primary reason for insufficient food supplies was reduced income or the diversion of income to purchase hygiene-related products. Some families reported selling assets and resources to buy food for their family. Monitoring and reducing food intake was noted as a coping mechanism by respondents in Lao PDR, "*planning and reducing the amount of food we are consuming, reducing expenses, reducing resources we are using and reducing the amount of electricity we are using"*. Furthermore, women also face cultural barriers to equal food access relative to men in the community e.g. in the Mekong ethnic community, women are not permitted to eat with their in-laws and must eat on a separate table, and in the Katang community, pregnant daughters-in-law are not allowed to join the family meal (although these practices are changing).[214]

In Cambodia, some respondents reported that they have already used savings and had to sell items to buy food and necessary supplies. Further, since they can no longer afford food from the markets they need to search for wild foods, such as mushrooms, in the forest.[215] Loss of income and food insecurity was also raised by respondents in Thailand and Myanmar.[216],[217]

In Viet Nam, access to food and essential items was seen as a big concern among the poor, and also among those facing job losses and reduced income, such as informal sector workers and factory workers. Due to traditional gender roles and responsibilities, women are more likely to bear the brunt of the increased pressures around household food security. Urban poor women and migrant workers are more likely to suffer from the burden of finding alternative sources of food to reduce family expenses.[218]

People with disabilities

People with disabilities in the Asia-Pacific have two to three times less access to sexual and reproductive health services. People with disabilities also face greater barriers to employment, with those in Asia-Pacific being two to six times less likely to be employed and, if employed, often considered more expendable. Women and girls with disabilities, in particular, in the Mekong, experience multiple and intersecting forms of discrimination, increasing particular vulnerabilities and risks in relation to the COVID-19 pandemic.

In Cambodia, services for people with disabilities are very limited, and even more so in areas outside of large cities. People with disabilities rely on community-based social services or specialised services to meet basic daily needs such as meals and hygiene services. Due to fear around transmission and lack of personal protective equipment (PPE), disability rights groups are concerned that these services may be interrupted.[219] Further concerns relate to the need for physical support and mobility, which contravene the requirement for social distancing. These barriers contribute to an avoidance of or reduction in access to health services by people with disabilities.[220] This may increase the support required from family members or carers at home, usually women.

People with disabilities in the Mekong region have higher rates of poverty and more precarious forms of employment, often without social protection. In Cambodia, the closure of massage services and bars has

highlighted impacts on income opportunities for people with disabilities, with one respondent reporting that they can no longer find places to sing on street corners for money (busking).[221] Hence, as well as increased restricted mobility from lockdown measures, the economic insecurity experienced by many people with disabilities may be worsened during the pandemic, which also impacts their ability to access basic services.

People with disabilities related to mobility limitations face a range of other barriers in relation to the pandemic, including an inability to abide by prevention guidelines related to regular handwashing, and people with disabilities relating to visual impairments face challenges in their inability to touch things safely in order to perceive them.[222] If caregivers or family members are quarantined as a result of COVID-19, people with disabilities may no longer receive the support or care needed.[223] There is a lack of recognition of people with disabilities in emergency response and development plans, with emergency shelters often not accessible to those with physical disabilities.[224] Quarantine facilities may not be inclusive of, or able to cater to, the needs of people with mental and/or physical disabilities[225] and people with disabilities are less likely to be prioritised in prevention and treatment measures.[226]

In addition, women with disabilities face gender-related barriers, such as increased rates of gender-based and sexual violence. In Lao PDR, respondents spoke of the difficulties faced by women with disabilities during the COVID-19 pandemic, including increased stress on their mental health, fear of contracting the coronavirus and the possibility of more severe symptoms due to underlying health conditions, barriers to accessing services and difficulties travelling. Respondents noted that women with disabilities can face additional stressors if their families are not able to support them. They may also face hostility from family members or discrimination from the broader community.[227]

Access to information and technology

Public health messaging has been a key COVID-19 prevention strategy across the Mekong region.[228] In Cambodia, it was noted that healthcare staff cooperate with local authorities and volunteer groups in the community to visit households and provide health information; particularly those who are at greater risk of not receiving enough information such as: the elderly, the poor, and people with disabilities.[229]

The dissemination of public health information has relied heavily on the internet and the media. Whilst internet access has expanded rapidly across the Mekong region, there are still inequities in access, particularly for women, people with disabilities and people living in remote communities. There have been reports that the 'digital gender divide' in Asia-Pacific is growing, in part due to the increase in e-commerce.[230] In Myanmar, women are 28 per cent less likely than men to own a mobile phone.[231] In Lao PDR, women are less likely to read the newspaper on a weekly basis (women 7.2 per cent; men 8.6 per cent), listen to the radio (women 17.4 per cent; men 23.4 per cent), watch TV (women 76.5 per cent; men 83.3 per cent), own a mobile phone (women 73.1 per cent; men 84.3 per cent) or to have used a computer in the last three months (women 8.5 per cent; men 12.5 per cent).[232]

Respondents in Lao PDR noted two main challenges to women's access to information was illiteracy and, for ethnic minority women, a limited understanding of the Lao language. Other challenges included: information being presented in a manner that was not understood, not having direct access to information or knowing how to obtain information (due to lower levels of participation in the public sphere). While all respondents (men and women) stated that they personally were able to access information, they note that broadly:

"women do not have time to follow the news, but men are able to get information because they have time to watch television, use their mobiles and interact with others online", and "Men receive information faster than women, as men can access social media and meet with friends more often."[233]

Similarly, in Viet Nam, while COVID-19 information has been communicated in local languages in some ethnic minority areas,[234] this is not always the case, which has resulted in limited access to timely information for ethnic minority communities, especially the women and the elderly. The most popular information source among ethnic minority people, workers and migrants was the internet. Other channels

included posters, loudspeakers in villages and factories, mobile loudspeakers, television and local police. "*I mainly see information online, posters at the gate, parking lot, canteen and in production areas, also loudspeaker play the Ghen Covy song during the short- breaks and lunch time*" - Female garment worker in Thai Nguyen.

There were positive examples highlighted by respondents in Lao PDR who noted that, in some provinces, COVID-19 information had been translated to local languages, presented in short and easy to understand formats, and presented pictorially. Training has also been conducted for the community with information being presented in a variety of mediums e.g. through village volunteers, radio, social media and news boards.

In Northern Shan State in Myanmar, the government has conducted awareness raising sessions with communities, but only in Burmese and English and has yet to make these available in Palaung language or other minority languages.[235]

Internally displaced persons (IDPs) are at heightened risk due to a lack of access to information and technology. For example, a government lockdown of internet and mobile phone services in Rakhine State, Myanmar, has limited access for displaced and non-displaced populations to vital preventive health, hygiene and protection information, while high levels of malnutrition may make these populations more susceptible to the disease.[236]

Access to livelihood-related information differed based on occupation. For garment workers, cuts in employment and reduction in working hours tended to arrive without notice; lack of access to timely information regarding changes in the pandemic and its impacts on workers has exacerbated anxiety and insecurity for both men and women.

"*We absolutely understand the situation, but if the company shares with us openly, it will be better. We know that it is a common challenge for all but it is really annoying and unacceptable when the information of every single change comes to us very suddenly*." - Male garment worker in Ho Chi Minh City, Vietnam.

Those working in forestry and agriculture rely heavily on agriculture product information. Even with travel restrictions, information regarding prices and product types was available on social media and television and some people joined cooperatives, which allowed them to access information.[237]

In Thailand, fishermen and their wives tended to have less access to information as many relied on their friends' mobile phone to communicate with their family and receive COVID-19 news. Whereas, a majority of male and female migrants in seafood processing seemed to own a mobile phone. The perception that all migrants have access to digital devices, internet and social media may be misleading. An undocumented female migrant from Samut Sakon who had three children revealed that she knew about COVID-19 from Facebook but she did not own a mobile phone. Instead, she received information from her neighbour's mobile phone. Female migrants, who are undocumented, in particular may have limited access to COVID-19 information, as Thai law requires all mobile phone owners to provide valid identification.

Education

Countries across the Mekong region implemented school closures as a prevention measure against COVID-19. The Ministry of Education, Youth and Sport in Cambodia, appealed to parents of students to provide home education in a proper environment and support access to learning materials during the pandemic. On March 13, 2020, the Ministry launched an e-learning programme where students can study free of charge, on social media, Facebook, YouTube and the Ministry's website.[238] However this situation risks increasing the gender gap in education. Girls may be expected, due to gender norms and roles, to devote more time than boys to unpaid work such as caring for younger siblings, older family members, and those who are ill within the household, rather than focusing on education.[239]

A digital gender divide is anticipated when families have limited devices or money for internet access and priority will be given to boys, with girls assigned to take on more domestic tasks.[240] It has been reported in Cambodia that only 20 per cent of all students have online access.[241] There is a particularly high risk that poor families without digital devices will be unable to provide their children access to e-learning modules and they will be excluded from education. Lack of access to education can have long-term impacts with regards to livelihood opportunities, decision-making power, income and age of marriage; with education being a protective measure against early marriage and early pregnancy.[242]

Similar concerns are noted in Lao PDR; students from poorer or rural communities who lack computers, smart phones, internet and electricity have not been able to keep up with their education as it has moved online.[243] This has exacerbated the urban/rural divide in education which was already significant pre-pandemic (28.5 per cent of children from rural communities and 64 per cent of children from an urban background attending secondary school).[244] Girls from rural, poor and minority ethnic communities are the most vulnerable to not being able to attend and complete school due to a variety of social, cultural barriers, gendered roles within the home, cultural practices (such as child marriage) and limitations on mobility due to safety concerns.

Respondents to the Rapid Gender Analysis raised concerns that families who are struggling financially, may not be able to afford to send girl children back to school or may prioritise the education of boy children if family resources are limited.[245] Active measures to address the gender gaps that prevent girls from accessing online learning is crucial e.g. UNICEF Viet Nam has supported the Ministry of Education and Training (MoET) on an inclusive distance learning strategy focused on ethnic minority groups, with a focus on equitable access for girls, providing tablets and WIFI access to support their education.[246]

Social protection

Social protection can be critical during the COVID pandemic, as illness, job reduction or losses, and economic downturn can drive many into poverty or further poverty. Social protection systems vary across the Mekong region. While some countries offer limited social protection, such as Cambodia and Lao PDR, others have emerging or established protection systems, such as Thailand and Viet Nam.[247] Viet Nam, in particular, has invested more in its social protection system compared to other countries in the region.[248]

In Myanmar, the government has provided support through in-kind food transfers to at-risk households, top-ups of social pensions for three months, and cash transfers to vulnerable populations, including IDPs, through mobile banking services.[249] Through European Union funding in Myanmar, garment factory workers who have lost their jobs will also be given emergency cash funds for three months, at K75,000 per month.[250] In Cambodia, the government has provided a social fund of US$70 per month[251] for garment factory workers who have lost employment, with US$40 from the government and US$30 paid by the factory.[252] However, workers are yet to receive payments as garment factories struggle with decreased profitability given decrease demands.[253]

Despite these measures, established social protection systems and emergency financial support may not reach the most vulnerable and those in need[254] such as rural communities, urban slum-dwellers, those in the informal economy, people with disabilities, women, children and other vulnerable groups. Informal migrant workers, for example, are among the most vulnerable in the region since many are not covered by government benefits or reached by emergency support packages.[255] In Viet Nam, the government passed Resolution No. 42/NQ-CP (“Resolution 42”), on 9 April 2020, to support people facing difficulties due to the COVID-19 pandemic. However, there is no specific criteria targeting vulnerable women and concerns that some of those most at risk in society will not be able to access support e.g. female heads of household from rural or ethnic minority areas and urban migrant women in informal employment. For this, as well as other social protection programmes, being an unregistered migrant poses a barrier to eligibility for support, an issue raised by informal female workers in the Rapid Gender Analysis.[256]

Women migrant workers may also face increased difficulties accessing social protection due to travel and movement restrictions during the pandemic, as well as stigma around the perceived risk of virus transmission.[257] This adds to the existing barriers faced by women migrant workers in accessing routine healthcare services, including those for sexual and reproductive health. With regards to COVID-19, they

may face high costs of testing and treatment, as well as difficulty reaching diagnostic and service locations.[258] Without sickness benefits, many informal migrant workers cannot afford to stop working even when ill, which will likely exacerbate their medical condition and increase transmission to others. Without social protection, many families and individuals, and in particular women, will face significant challenges in weathering this pandemic.[259]

In some cases, such as in Viet Nam, government loans are available for the poor, however while all women interviewed as part of this assessment said that the conditions and procedures for a government loan were not a barrier to access, many were too concerned about meeting interest repayments to borrow money.[260]

Safety and protection

Gender based violence

Globally, violence against women and girls is increasing with the COVID-19 pandemic, linked to economic and social stresses, and measures to restrict social contact and movement. Crowded homes, substance abuse, limited access to services and reduced peer support are exacerbating these conditions.[261] Historically, past financial downturns in the Mekong region have resulted in increased domestic violence. For example, after the 1997/98 Asian Financial Crisis, there was an increased rate of domestic violence in Thailand related to the heightened economic stressors experienced within families and across communities.[262] In addition, experience has demonstrated that where women are primarily responsible for procuring and cooking food for the family, increased food insecurity, as a result of the crises, place them at greater risk of intimate partner and family violence.[263]

With women often holding more precarious employment, such as part-time or casual work, women who lose their income will also become more financially dependent on their partners, making it even more difficult to leave unsafe environments.[264] [265] Alcohol consumption was linked to violence in the home in Viet Nam[266] and Cambodia, by almost all key informant respondents. In interviews, factory workers stated that the additional stress from losing their job, financial insecurity, travel restrictions and closing of schools can lead to discussions which end in violence in the family. One woman said that she feels annoyed that her husband does not practice social distancing and the recommended hygiene practices in the house; but when she complains, her husband becomes upset.[267]

In Lao PDR, anecdotal reports have indicated that tensions within households related to an increase in household work, financial pressure, stress and fear from infection may have an impact on contributing to increased cases of GBV. While the Lao Women's Union (LWU) with support from United Nations Population Fund (UNFPA) in May 2020, launched a hotline to provide Psychosocial Support Services (PSS) to the community, with the target being women who are experiencing violence, few interviewees were aware of support systems for GBV survivors; with most stating that cases can be solved within the family, with assistance from the village chief, or with the Village Mediation Unit (VMU).

According to recent data from Peace House Shelter[268], in Viet Nam, the number of women who came to the service doubled compared to the same period last year.[269] According to Center for Studies and Applied Sciences in Gender Women and Adolescent (CSAGA), in the first four months of 2020, there were 624 cases reported to the CSAGA service, which was an increase of 208 cases compared to the last four months of 2019. Psychological violence, in particular, has increased dramatically since the pandemic. Some perpetrators use social distancing as a way to exercise their power to prevent survivors from seeking help. Cases from CSAGA confirmed that social distancing increases tensions, with some couples facing difficulties isolating at home.[270]

Some women face multiple intersecting disadvantages, such as women with a disability or migrant women, and are at a particularly heightened risk of GBV during the COVID-19 pandemic. For example, a gender analysis on GBV in Thailand found that migrant women tend to tolerate violence due to their economic dependence, reduced ability to negotiate safe sex, and lack of access to support services. The pandemic is likely to increase migrant women's risk of abuse, especially sexual violence, and infectious

diseases such as HIV.[271] Across the Mekong region, LGBTQI+ activists and organisations have also highlighted increased concerns about domestic violence, compounded especially in countries where there are no legal protections for LGBTQI+ people. In Myanmar, NGO Equality Myanmar has highlighted increases in domestic violence and the harassment of LGBTQI+ people.[272]

In the Mekong region, life-saving care and support to GBV survivors may also be disrupted when frontline service providers and systems, such as health, policing and social welfare, are overburdened and preoccupied with handling COVID-19 cases. In addition, having law enforcement and security forces on the streets in some countries to enforce lockdown measures and monitor the movement of people can lead to higher levels of sexual harassment and other forms of violence in public spaces.[273]

In Viet Nam, two GBV services currently supporting survivors (CSAGA and Hagar) were consulted during the Rapid Gender Analysis process. Both had made changes to adapt to social-distancing measures, movement restrictions and the specific needs of survivors in this new context, through mobile hotlines and online support which is being used instead of face to face modalities. While these are very positive steps, further adaptations will be needed to ensure services reach ethnic minorities, informal sector workers and other vulnerable groups.[274] It is not clear from the data available whether physical distancing and quarantine measures have impacted shelters, however it has been noted that there is a risk, shelters could be closed as a virus prevention measure, or diverted to quarantine centres leaving women without safe accommodation and essential services.[275]

One barrier to accessing GBV services highlighted in Myanmar, (even pre-COVID-19), is the low public awareness of the existence of hotlines.[276] This issue is likely to be compounded in the context of COVID-19, with many outreach and awareness-raising activities being suspended due to movement and social distancing restrictions.[277] One woman with a disability who works for an advocacy organisation for people with disabilities emphasised the difficulties posed by the information barrier for people with disabilities: "*Differently abled people could not access the WASH, SRHR and GBV services as they could not get any information related to those services. Most of the differently abled people are poor and do not have a mobile phone and TV so it is very difficult to get the information regarding services*. Reporting incidents can also create barriers for people with disabilities; respondents noted that when reporting incidents to local authorities or police, they were asked to give identifying details of the perpetrators. These requests are not sensitive to the situation of survivors with visual impairments, who have difficulty supplying such information.[278]

In Myanmar, key informants indicated that GBV case management services and safe houses are generally open, with adapted services and some limitations. Some organisations are operating phone hotlines, which allow survivors to seek support even if they cannot travel due to movement restrictions. However, respondents noted there are still barriers to access, especially for the most vulnerable. The combination of movement restrictions and widespread job suspensions/losses has meant many men and women are home together 24 hours, leaving few opportunities for women to make phone calls undetected. One staff member of a legal organisation in Yangon explained:

"Because of stay at home [orders], some women faced domestic violence. When they called and asked for help, we cannot discuss openly because their husbands were at home. Sometimes, when we called them, they said 'wrong number' because their husbands are around. Then, they called us back when their husbands are not around."

Women have developed a range of coping mechanisms to address GBV. For example, a report on 'Violence Against Women and their Resilience in Myanmar' outlines the range of coping strategies normally employed by women and girls, such as women talking to their friends and family about abuse and reporting the abuse to authorities or legal counsellors.[279] Under COVID-19 social distancing and lockdowns, it is more challenging for these coping strategies to be used by women who are experiencing violence.

Stigma and discrimination

The COVID-19 pandemic has exacerbated prejudices or tensions against ethnic or marginalised communities. Existing discrimination against minority ethnic or religious groups may be intensified as they are perceived to be spreading the virus.[280] Cambodia's ethnic and religious minorities have become targets of online abuse after being singled out in the government's reporting on COVID-19. Much of the backlash has focused on the Cham ethnic minority, who make up the majority of Cambodia's 300,000 Muslims.[281] As an example, local authorities reported that there had been a Muslim man from Malaysia who stayed in a community close to a market, for a few days in early April 2020. Afraid that the man might be COVID-19 positive, locals stopped purchasing from Muslim meat vendors in the market. However, in the end, the Muslim man tested negative for the virus.

Key informants in Cambodia observed discrimination of urban people and migrant workers when they returned to their hometowns since they were suspected to be carrying the virus to the villages:

"People do not want to talk much with us because we travelled from Phnom Penh and they think we are bringing risk to them."[282]

In Lao PDR, returnee migrant workers reported that since returning to their hometowns, they have been met with fear and hostility "*Some people said that we have COVID-19. When we went out to buy food, they didn't want to sell it to us. The villagers ignore us. We are so nervous and keep thinking about COVID-19 because we came from a risky location.*"[283]

Key informants in Myanmar reported that returning migrant workers were most likely to face COVID-19 stigma, and this extended to the families and communities of returning workers. There were some reports of returning migrant workers being prohibited from re-entering their home community, even after having completed quarantine procedures, due to fear and mistrust. One key informant mentioned this also applied to internal migrants in some areas, with some rural villages not allowing workers to return from Yangon.[284] Furthermore, health workers in Myanmar also spoke of experiencing stigma and discrimination, however they noted that this was decreasing as the pandemic continues and initial panic subsides.

Sexual exploitation and abuse

An economic downturn can result in a spike in sexual exploitation and abuse, where at-risk groups that are struggling financially may be forced or coerced into providing sex in exchange for food.[285] Among those at increased risk are women (including single women living in poverty and widows), children, adolescent girls, sex workers, LGBTQI+ populations, and disabled men and women. Emerging evidence suggests that the COVID-19 pandemic has the potential to further increase risks of sexual exploitation and violence.[286]

Children face additional protection risks. Several global anti-trafficking organisations have already noted a worldwide rise in child marriage, trafficking and forced labour, as families try to struggle to survive. In some settings, families may see these marriages as a way to relieve financial stress, provide a better life for their daughters, or to keep them safe in an unstable environment.[287] Unfortunately, early and forced marriage increases the risk of domestic and sexual violence, and disrupts girls' education, and economic prospects.[288] Whilst no data for the Mekong region has been collected on the impact of COVID-19 on child marriage, this is a significant concern for a region with comparatively high child marriage rates. The percentage of women aged 20 to 24 who were married or in a union before 18 ranges from 35.4 per cent in Lao PDR to 11 per cent in Viet Nam.[289]

People traffickers are also known to target communities affected by crisis, conflict or natural disasters, especially women and children.[290] Economic stress and lockdown measures may also lead to increased abuse and violence against trafficking victims, particularly those trafficked into prostitution or domestic servitude. Restricted in their ability to earn money during the COVID-19 pandemic, victims of sex trafficking are particularly vulnerable. These risks are exacerbated by limited social support services, shelter closures, and restricted access to medical facilities and care. Most victims of human trafficking detected across the world are women; mainly adult women, but increasingly (as seen in the Mekong

region) child victims, especially girls. [291] The vast majority of detected victims of trafficking for sexual exploitation are female.[292]

Risks of online sexual harassment and exploitation have also increased as physical public spaces are closed and people go online for support and social connection. This has already been identified, by Cambodian civil society groups working in GBV prevention and responses, as a possible risk for women and girls that needs to be mitigated.[293]

Human rights and Women, Peace and Security (WPS)

In the Mekong region, the response strategies to the COVID-19 pandemic by governments could give rise to, or further intensify, human rights abuses, including abuses of women's rights. Despite differences in political ideology and government structures, all countries reviewed in this Rapid Gender Analysis have current, or have had in the recent past, allegations of human rights violations and aspects of authoritarian rule. Although an increase in government authority may be needed to impose measures sufficient to control the spread of the virus, such as restrictions in mobility and greater surveillance, these must be proportionate to the impingement on human rights (including women's rights).

For example, in Cambodia, a state of emergency law passed by parliament has granted the government broad powers of unlimited surveillance of telecommunications, control of the press and social media, restricting freedom of movement and assembly, seizing private property, and authority to enact "other measures that are deemed appropriate".[294]

Human Rights Watch has reported a renewed crackdown on opposition supporters and government critics, including arbitrary arrests and detention of opposition party members and journalists.[295] Similarly accusations of violations of freedom of speech and information have also been made in Thailand where the government's 'fake news centre' has led to censorships and arrests, and in Viet Nam which has questioned, fined and arrested citizens, including celebrities, over social media posts on COVID-19[296] and has pressured Facebook to restrict certain content.[297]

Other aspects of state of emergency powers enacted across the Mekong region, such as border closures, military checkpoints, lockdowns and restrictions on movement, also have human rights implications, including on women's human rights. The gendered nature of these measures, enacted by male-dominated governments, military and security forces, heightens the exclusion of women from decision-making structures and processes for the COVID-19 pandemic.[298] For example, women's representation in the police forces varies across the Mekong region, from 8 per cent in Thailand[299] to 20 per cent in Myanmar.[300]

With such significant curtailing of freedoms being developed and enforced primarily by men, the implementation of these measures are, at best, not sensitive to women's needs or rights and, at worst, harmful to women. For example, restrictions in movement, such as quarantine centres set up at borders, do not cater to women's needs (e.g. WASH, safety), and may even perpetrate further harm (e.g. GBV, sexual exploitation and abuse). Women from marginalised groups are especially exposed, with female sex workers in Myanmar reporting that abuse and violence from the police was common.[301]

There has also been a tendency to 'militarise' the language used to address the pandemic as a "war against an invisible enemy", further masculinising the rhetoric and response to COVID-19.[302] Within the militarised context of the COVID-19 response, the four pillars of the Women, Peace and Security (WPS) Agenda (participation, protection, prevention, and relief and recovery) can offer guidance. Drawing on the WPS pillars, UN Women has called on all actors responding to the COVID-19 pandemic in Asia-Pacific to: Ensure women's full and equal participation in leadership and decision-making roles related to COVID-19; for responses to the pandemic that are driven by the security sector to be proportionate and gender-sensitive; to support women's civil society to monitor and document security sector actions, access to justice, governance, transparency and accountability; for women to lead social cohesion measures including countering discrimination and hate speech; and to include women's socio-economic needs and priorities in recovery measures.[303]

Capacities and coping mechanisms

In Lao PDR, garment factory workers have been planning for alternative forms of work or income. This has included moving into other sectors (e.g. construction, food delivery), returning home and taking up previous forms of work (e.g. weaving, animal husbandry), and selling items online. For women, whose childcare responsibilities have increased, many have been unable to spend the time to find alternative forms of work. Some interviewees have had to take out loans to survive financially or have resorted to spending their savings.[304] Similar results were seen in Viet Nam, where garment workers have explored work in private sewing companies, and informal sector workers have tried selling bread and cakes. However, both female and male respondents noted these ventures resulted in little success.[305]

In Viet Nam, many people are changing the way they work. Ethnic minority sellers, retailers and street venders have been using available online resources such as Facebook and Zalo to advertise and sell their products. Informal and migrant workers have also made home-cooked food to sell online and offered alternative services such as delivery/ shipping services, or at-home hair cutting services:

***"Now we have to switch to online selling, selling by phone, before the epidemic, we used to try this method [fan page] but not effective because buyers did not care, now given social distancing, more people ordered via fan page."* - Head of a banana production cooperative in Bac Kan.;**

***"We have done many things, some people have made home-cooked cake and sell online. Some have sold fruit online, buying products from wholesale markets and reselling online."* - Migrant female informal worker, in Da Lat.**

However, these alternative ways of working rely on the seller having access to online marketplaces and or smartphones, which is less likely to be the case for women in the Mekong region, given the gender digital divide.

COVID-19 exacerbates the effects of natural disasters and infectious livestock diseases that in turn affect household savings and loans. Prior to the pandemic, ethnic minority farmers in Viet Nam had already faced crop failures and income reductions, due to frost, hail and a pig disease epidemic, which significantly decreased their savings and increased their loans. Thus, the COVID-19 crisis hit an already struggling sector, preventing recovery and pulling it more deeply into recession.[306]

Respondents in Viet Nam highlighted the importance of support from the extended family and strong community ties to ensure that when people fall during hard times they are picked up and looked after by others. During the time of social distancing measures and an economic downturn, this traditional social capital provides support, including through the sharing of food and information, and encouraging safe behaviour. Women who are likely to be responsible for feeding the family and looking out for the health and nutrition of family members benefit from these traditional support systems.

Respondents also noted, however, the need for external support, in addition to their own coping mechanisms from local and national authorities:

***"We need support from the government for the local community to be able to survive during the lockdown, as we have no jobs".*[307]**

Conclusions and recommendations

COVID-19 is unfolding in the Mekong region amid persistent gender inequalities that exist due to longstanding structural and discriminatory gender norms. This has led to differential experiences of COVID-19 (and its corresponding response) for women, men, girls and boys. The outbreak is impacting mental and physical health, food security, livelihoods and incomes, safety and protection.

The COVID-19 pandemic has seen a reinforcement of traditional gender roles, which has increased the burden of unpaid care and domestic labour on women and girls as family members fall ill, schools are

closed, or families isolate at home. This domestic work burden means less time available for paid work. Many women have also suffered job losses, particularly those in vulnerable employment, who struggle to find alternative sources of income.

Women and girls are heavily concentrated in industries that have been disproportionately affected by the economic downturn arising from the COVID-19 pandemic or sectors that increase their exposure to the virus, such as healthcare, the garment industry, entertainment and tourism, domestic work and sex work. This loss of income can have wider reaching impacts on women when decision-making power is linked to their financial contributions to the household. Women in the Mekong region are traditionally left out of public decision-making processes, national governments and in the leadership of trade unions. This is being mirrored within COVID-19 structures and mechanisms, meaning that the voices and needs of women and girls, particularly in at-risk populations, may not fully be addressed in humanitarian and government responses to the pandemic.

Additional barriers to accessing health services, including sexual and reproductive healthcare, are being reported by communities. This includes fear of contracting the virus, safety risks in travelling to services (particularly for women and girls), stigma and discrimination of populations such as female sex workers and LGBTQI+ individuals, as well as undocumented migrant workers. Concerns of children's access to online learning while schools have closed is exacerbated for lower income families and those without access to digital devices. Where families may not have sufficient resources for all children, concerns that priority is given to boys were expressed. Where girls may take on more household roles and responsibilities, this may have longer term impacts, such as girls involuntarily solidifying their imposed gender stereotypes and not returning to school as they reopen.

As in other parts of the world, factors such as stress, fear, alcohol and substance abuse, combined with isolation and quarantine measures are contributing to a rise in GBV. There is a need for prevention and response strategies to address GBV in the region. Access to support services is reduced as women are trapped at home with their perpetrators and for women who do not have access to technology, internet, and digital devices. These barriers are compounded for those who are illiterate and where service information is not disseminated in minority languages or for people with disabilities. Similar barriers are being seen with regards to access to wider COVID-19 messaging.

A variety of coping mechanisms are being implemented at an individual and family level, such as selling assets and using savings, particularly to mitigate the increasing food insecurity of households, of which the burden is heavily felt by women, whose perceived role is to ensure food security for the family. With policies, programmes and schemes being implemented by local and national authorities, however, it is clear that not everyone is able to access these equitably and therefore more needs to be done to ensure immediate economic and social support is provided to those most in need in order to bridge these gaps.

Overarching recommendations

Country-specific analyses have been conducted across each country represented in this regional Rapid Gender Analysis and provide a current understanding of country-specific dimensions for gender, disability, age and at-risk populations. It is crucial these analyses are regularly updated as the crisis and response measures evolve, taking into account compounding secondary disasters, conflicts and/or disease outbreaks. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure both humanitarian assistance and the preparedness, prevention and response to COVID-19 is tailored to the specific and different needs of women, men, boys, girls and at-risk groups. It is recommended that organisations continue to invest in gender analysis, including inter-agency, multi-sectoral gender analyses, that new reports are shared widely and that programming will be adapted to the changing needs.

Recommendations for responding agencies:

Recommendation 1: Collect and ensure availability of sex and age disaggregated data, as well as data and information on people with disabilities and other at-risk groups. This should include

rates of morbidity and mortality, differential economic impacts and care burden, access to health services (including SRH), education and technology,[308]

Given the differing impacts COVID-19 has on gender, there is a need to ensure gender, disability and inclusion data and information is available, analysed and actionable, across the region and at a country-level. It is important to collect data that is disaggregated by sex, age and disability (using Washington Group Questions) and, if possible, capture data on at-risk groups noted through this current analysis. This includes FHHs, pregnant and lactating women and people of diverse SOGIESC, migrant workers and other vulnerable populations such as undocumented migrants and daily wage workers. This should be conducted in close consultation and collaboration with the representative organisations of these groups.

Responses should be adapted accordingly, recognising how the country-specific social, culture and gender norms, roles, and relations influence vulnerability to infection, exposure, and treatment[309] for women, men, boys, girls, people with disabilities and other marginalised groups. Responses should not perpetuate harmful gender norms, discriminatory practices and inequalities.

Recommendation 2: Ensure information, messaging and community outreach on COVID-19 is inclusive and accessible and does not reinforce harmful gender stereotypes.

Messaging should be designed and delivered in consultation with men, women, boys and girls and vulnerable groups among the target population. It should be available in local language/s, pictorial communication, and accessible for people with disabilities (taking into consideration, sight, hearing, and mobility barriers). Language and images of the messages should not reinforce gender division of labour, but promote the sharing of work and mutual support in a time of crisis.

The modalities used to disseminate information should consider the ways in which women and men, and specific groups access and receive communications, taking into consideration gender, age, literacy, language, location (urban/rural), migrant status, disability and socio-economic background. Messaging should address misinformation that could lead to the stigmatisation and discrimination of specific groups in the community, as we are seeing for migrant workers, minority groups, as well as to mitigate fears among the community regarding access to healthcare facilities and work to create trust in the health sector.

Recommendation 3: Provide immediate emergency relief support to those most affected by COVID-19 and who are experiencing barriers to accessing social protection mechanisms. This includes a focus on those working in the informal economy (the majority of whom are women), informal migrant workers and sex workers (also the majority being women), people with disabilities, rural communities, urban slum-dwellers and FHHs.

Short and long-term interventions to address access to health (including SRH), protection, WASH, economic and livelihood support, must ensure the needs of those most at-risk are addressed. This includes the provision of food and hygiene items as well as exploring conditional or unconditional cash or voucher assistance. Further specific risk assessments should be conducted based on the context, to ensure a ‘do no harm’ approach and to mitigate risks of GBV.

Such immediate assistance will help with bridging the gaps and barriers to access for current government schemes and social protection initiatives, as well as addressing the needs of those who are experiencing barriers to accessing such initiatives e.g. undocumented migrant workers.

Recommendation 4: Develop mitigation strategies that specifically target the economic impact of the outbreak on women and build women’s economic resilience. A particular focus should be on those in sectors hit hardest by the pandemic including tourism, sex work, garment factories and those working in informal sectors.

Responding agencies need to: (i) consider the gender impacts of all economic support and recovery activities; (ii) develop targeted interventions for women and girls which address gender-based barriers and take into account the increased burden women and girls are facing with regards to unpaid domestic and caregiving roles, together with income generation (such as flexible working arrangements, work from home and support for childcare.)

Economic support and recovery activities should also be inclusive of, or specifically target, at-risk and vulnerable women and girls, such as women migrant workers, sex workers, ethnic minorities, or women with disabilities, who may not be included in mainstream economic recovery activities. All economic support and recovery strategies, plans and activities need to apply a gender lens in their design, implementation, monitoring and evaluation, including collecting sex (and age and disability) disaggregated data and monitoring unintended negative impacts on women and girls (e.g. 'family' benefits not reaching female family members; cash transfer programmes for women putting them at risk of GBV).

Programmes need to consider both women's immediate needs, as well as build women's longer-term economic empowerment and resilience. Funding for women's economic empowerment programmes that were being implemented before COVID-19 must continue and should be adjusted to meet the changing context of the pandemic.[310] It is important to work with communities who are already adapting to alternative modalities to support their livelihoods such as social media and online marketing and delivery services and to work with groups who have less or no access to these avenues.

Recommendation 5: Ensure women with diverse backgrounds and from different socio-economic strata are given opportunities to meaningfully engage in the structures, measures and processes established for COVID-19.

Responding agencies should engage local women not just as recipients of support but as leaders in the response, facilitating their collective agency. A focus should be on marginalised women such as sex workers, migrant workers and garment factory workers. Women should be engaged in all aspects of the response (e.g. border control, safety, security), and not just in the traditional 'female' sectors (e.g. nursing, maternal health). Responding agencies should aim for equal representation of women working on all aspects of the response (including in decision-making, implementation and monitoring) as well as reaching out to women's organisations and female community leaders for consultation and response coordination.

Responding agencies should use existing gender analyses (such as this Rapid Gender Analysis) and seek the input of gender specialists at regional, national and local levels to inform decision-making and planning. The inclusion of women frontline workers in the health sector and other sectors (e.g. GBV) in all decision-making and policy spaces can improve COVID-19 prevention, detection and treatment, as well as address COVID-19 related impacts on GBV and other gender issues.[311] Responding agencies should engage with existing informal and formal women's rights organisations or networks to support their efforts as first responders. Funding (through flexible funding mechanisms) should be allocated to support women's organisations, women's networks and women's movements.

Recommendation 6: Prioritise and strengthen services for prevention of and response to GBV and sexual and reproductive health services in communities affected by COVID-19, with an emphasis on mitigating barriers identified for specific groups in this report.

GBV referral services and response mechanisms will need to be resourced and strengthened to enable them to respond to the increased risk of GBV during COVID-19. The safe and continued provision of SRH and maternal health services should also be prioritised.

Funding should be ensured to continue existing services and not reallocated to other activities related to COVID-19. Service providers should be supported to adapt their responses from in-person to remote, with the provision of online help platforms, text message services and telephone help lines, and offered training in how to use this technology. The services available in COVID-19 affected areas should be regularly mapped, and updated information on how to access services in a constrained environment should be disseminated to local communities.

Co-ordination among service providers is crucial to ensure information is shared. Service providers should work with local partners to identify and fill gaps in service provision, such as for shelters, safe spaces, and in supporting marginalised groups such as the LGBTQI+ community, sex workers or trafficking victims who may be at heightened risk of GBV. All service providers (policy, social service and healthcare workers) should be adequately trained to respond in an effective, survivor-centred manner).

Responding agencies should also engage GBV service providers and women's or GBV-focused CSOs in developing COVID-19 response strategies, plans and activities (including building capacity around GBV

with military and police personnel and those working along the borders), as well as developing GBV risk mitigation strategies (including non-GBV focused activities, such as economic empowerment programmes, food assistance and community health messaging).

Recommendation 7: Prioritise mental health and psychosocial support services in communities.

It is clear that loss of income, fear of infection, restrictions on movement, and concerns for personal safety and well-being, as well as that of families and communities, is having a negative impact on the mental health of women, men, boys, girls and at-risk groups. This is being compounded by inadequate services, lack of knowledge of existing services, as well as fears of seeking support. Based on the results of this Rapid Gender Analysis, and the contributing country-focused analyses, there is an opportunity to map and identify gaps in current mental health services. Information on mental health support should be incorporated in community outreach and information initiatives, using a variety of modalities to ensure inclusive information dissemination. Prioritise the continuation of existing mental health and PSS services and ensure that essential resources are not diverted from these as a result of the pandemic.

Recommendation 8: Ensure school closures, where they exist, do not further disadvantage girls or at-risk populations such as children with disabilities, ethnic minorities, and those from remote communities.

Interventions should ensure that online and remote learning opportunities are accessible to all girls and boys and are not determined based on socio-economic status, whether children are from urban or rural communities, or gender. Active measures to address the gender gaps that prevent girls from accessing online learning, such as access to digital devices or data, is crucial. Awareness raising on the importance of continuing education – particularly for girls – should be ensured as part of COVID-19 messaging to mitigate the potential for girls to take on household and caring responsibilities, to the detriment of their education.

Recommendation 9: Prioritise services for prevention and response to human trafficking in communities affected by COVID-19 and provide capacity building to ensure services are gender responsive and inclusive, with a focus on vulnerable women and girls and at-risk groups.

It is essential that responses to COVID-19 address causal factors that might increase human trafficking, including economic stress, food insecurity, gender inequality, and gender norms that make women and children vulnerable to being subjected to sexual exploitation for the survival of them or their families. Responding agencies should aim to prevent further human trafficking (as dedicated interventions or as part of other interventions (e.g. economic recovery programmes). All programmes should have a GBV risk mitigation strategy which includes recognising the risk of human trafficking. Capacity building programmes should be in place for all responding agencies, service providers and protection services (e.g. police) so that all involved are made aware of, and are responsive to potential human trafficking activities and provide survivor-centred support to all trafficking victims, in their work on COVID-19.

Recommendations for regional and national Government bodies:

Recommendation 10: Ensure all response strategies and measures to the COVID-19 pandemic respect human rights (with a focus on women and at-risk groups identified in this analysis).

The broadening of government powers and authorities, such as through ‘state of emergency’ declarations, need to be proportionate and need to respect and protect human rights. The implementation of all COVID-19 prevention strategies and measures, such as surveillance, lockdowns, quarantines, restriction of movement, and border closures, need to respect the human rights of all people, including women and other vulnerable groups (e.g. migrants, refugees, persons with disabilities) and must not enable human rights violations or abuses of power (such as sexual harassment, exploitation and abuse).

Responding agencies should support women’s human rights defenders and human rights NGOs in their monitoring of national and local responses to the COVID-19 pandemic and help to support their rights to freedom of speech and information. Women’s human rights experts should be consulted and involved in all stages of the COVID-19 response, including decision-making, implementation, monitoring and short- and long-term recovery. All COVID-19 response strategies need to adhere to international human rights

standards set out in treaties such as CEDAW, and should draw on the four pillars of the Women, Peace and Security agenda in the development and implementation of their responses.

Recommendation 11: Ensure that border control procedures and quarantine facilities are established and maintained according to gender-responsive best practices.

With the increase in populations moving across borders in the Mekong region, mobility restrictions have had significant impacts on migrant workers, many of whom are women.[312] Quarantine facilities have been reported to be substandard, lacking dignified treatment of women and girls and raising child protection issues.[313] Border quarantine facilities should be cognisant of the different needs of women and children and should set up infrastructure and procedures accordingly. For example, there should be separate toilets for women and men, with lockable doors and lights to increase safety at night. Women should be given access to health and hygiene resources, such as sanitary products and gender-sensitive WASH facilities. Safe accommodation facilities should be established for women and children.

Coordination and decision-making bodies on migration and border facilities should be gender-balanced and should seek the input of gender experts in the design, implementation, maintenance and improvement of quarantine facilities and border control procedures. All facilities should employ a balance of male and female staff. All staff and volunteers at border quarantine facilities must be trained on the prevention of sexual harassment, exploitation and abuse obligations (PSHEA). PSHEA reporting mechanisms must be operational and appropriate for the local context.

Recommendation 12: Ensure more comprehensive COVID-19 testing for more vulnerable and marginalised communities, especially in border areas, and inclusive approaches to contact tracing.

The Mekong region has limited access to testing equipment. If not monitored and controlled appropriately, infection is likely to re-emerge especially in vulnerable communities, such as in urban slums, migrant communities and rural communities. Gender-responsive measures, particularly in border areas and in at-risk communities, is essential. This should include targeted outreach to communities that have less access to certain technologies, such as the internet, as well as account for literacy levels and diversity in languages.

Men and women need to be equally educated on appropriate hygiene responses to ensure this responsibility does not fall to women. However, it is important to recognise women as a key resource in preventing the transmission of COVID-19 and opportunities should be provided for women to become community health leaders; to implement prevention measures and be engaged in efforts to identify cases of COVID-19.

Recommendation 13: Countries in the Mekong region should ensure they are well coordinated and work together to ensure gender-responsive services are in place.

Given the similarities across the region, transience of populations and shared borders, country governments through existing mechanisms[314] across the Mekong region should coordinate, to ensure gender sensitive practices and response. Sharing of information and gender analysis that highlights the impacts of different populations in the region particularly for migrant, returnee workers, those who move between countries, should be ensured to support a coordinated response for at-risk populations. Ensure response services are available, including for those undocumented in the country.

Endnotes

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[13] A quick scan of 20 Village Savings and Loan Associations (VSLAs) was conducted to understand savings and loans among VSLA members during COVID-19. The 20 VSLAs were selected based on a convenience sample approach, and are comprised of a total of 360 members (mainly women) from Dien Bien, Son La, Kon Tum and Tra Vinh. The 'quick scan' method included reviews of VSLA meeting notes and documents, as well as short chats with all 20 female VSLA leaders. The information collected related to group members, purchased shares, available funds, member's loans and payment capacity as well as group challenges and needs during the outbreak
[14] Research was initially undertaken from 27 January to 28 February 2020 and subsequently updated in June 2020 as a result of the COVID-19 crisis. Research methods included a secondary data review, and KIIs with service providers: four women and two men (conducted prior to the COVID-19 pandemic)
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