



Gendered implications of the COVID-19 pandemic for policies and programmes in humanitarian settings

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INTRODUCTION

First detected in China's Hubei Province in late 2019, the coronavirus disease 2019 (COVID-19) has spread rapidly, leading the WHO to declare a global pandemic on 11 March 2020.¹ Initial data indicates that older persons and those with underlying medical conditions are most likely to suffer serious complications.²

While COVID-19 could have a devastating impact in any context, the dangers of the pandemic will be magnified for the nearly 168 million people in need of humanitarian assistance and protection worldwide, not least because many reside in fragile settings with weak water and sanitation infrastructure and lack access to quality health services.³ Refugees and internally displaced persons (IDPs) living in densely populated camps and informal settlements are acutely vulnerable as overcrowding could exacerbate transmission. Restrictions on freedom of movement, imposed to contain COVID-19, can also harm populations on the move, hampering their access to safety and protective mechanisms.

Although evidence indicates that emergencies disproportionately affect women and girls,³ there is little research on the implications of public health emergencies on different groups, particularly women and girls. (While this paper focuses on women and girls in humanitarian settings, the analysis will generally apply to other vulnerable groups—including the lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual community and ethnic and racial minorities—and also to fragile contexts.)⁴ To address this gap, we analysed the potential gendered implications of the COVID-19 pandemic in humanitarian settings, drawing on research from past public health emergencies as well as our own experience. We examined policy and programmatic implications

Summary box

- ▶ Although preliminary analysis indicates that COVID-19 poses the highest risk to men, the elderly, and those with comorbidities, available research on the gendered implications of past public health emergencies—such as that from the 2014–2016 West Africa Ebola outbreak—demonstrates that women and girls are disproportionately affected, particularly those who live in ongoing humanitarian crises.
- ▶ Our experience in previous humanitarian and public health emergencies indicated a need for practical, gender-sensitive recommendations for humanitarian practitioners that uphold the rights of affected populations. Consequently, we conducted a rapid analysis of the potential policy and programmatic implications of COVID-19 on women and girls.
- ▶ Our findings indicate that the pandemic will affect every aspect of the lives of women and girls. Their health will suffer, and they will have increased needs for protection, sanitation, shelter, education, food and livelihood support in the short term and long term.
- ▶ These findings informed recommendations that include: support women's and girls' leadership to ensure that COVID-19 prevention and control measures do not exacerbate harmful norms; bolster water, sanitation and hygiene services along with psychosocial support, essential health services, safe shelter and the provision of food, nutrition and hygiene commodities; prepare to respond to possible surges in gender-based violence and sexual exploitation and abuse; and ensure that vulnerable populations are included in national surveillance, preparedness and response plans and activities.

for key humanitarian sectors—including health; water, sanitation and hygiene; protection; shelter; education; food security and nutrition; and economic empowerment and well-being—with the aim of offering practical, gender-sensitive recommendations for humanitarian practitioners while recognising

the unique needs and capabilities of women and girls in humanitarian settings.

HEALTH

Women and girls are exposed to multiple caregiving burdens that lead to greater physical and mental health risks.⁴ In many humanitarian contexts, they are responsible for household-level disease prevention and response efforts, which may place them at a higher risk of infection and of emotional, physical and socioeconomic harm. Women also often perform caregiving roles outside of the home; they comprise 70% of the health and social care workforce in many countries.⁵ This again increases the likelihood that they will be exposed to communicable diseases. In addition, social norms prevalent in many humanitarian settings dictate that women and girls are the last to receive medical attention when they become ill.⁶ These norms could prevent women and girls—particularly those who are already stigmatised, such as IDPs and refugees, members of certain ethnic or racial groups or those of different sexual orientations—from accessing testing and timely treatment for COVID-19. Furthermore, testing may not be available for some displaced populations, as illustrated in Bangladesh, where testing facilities are limited to the capital, Dhaka, which is 400 km away from the world's largest refugee camp in Cox's Bazar.⁷

During past public health emergencies, resources were reallocated from routine healthcare services towards containing and responding to outbreaks,⁴ constraining access to essential healthcare, including mental health and psychosocial support and sexual, reproductive and maternal health services. Many of these services are already limited in humanitarian settings, particularly for some groups. For example, adolescent girls have unique sexual and reproductive needs that often go unmet,⁸ while non-citizens—including IDPs, migrants and refugees—may be unable to access government health systems. Others already suffering from diseases such as HIV, malaria and tuberculosis may find their treatment interrupted by these resource diversions at the same time that their pre-existing illnesses make them more susceptible to serious forms of COVID-19.⁹ It is likely that COVID-19 will exacerbate existing gaps and result in new ones, increasing women's and girls' vulnerability to COVID-19 as well as to other health conditions.

The COVID-19 pandemic could also increase the need for mental health and psychosocial support services just as resource diversions jeopardise them. This puts women and girls at risk, as frontline health workers—many of whom are female—women and girls with caregiving burdens, and community members fearful of becoming infected or infecting others may all experience stress and trauma relating to the outbreak.¹⁰

Fear of contracting Ebola led fewer women to attend health clinics during the 2014–2016 West Africa outbreak.⁴ Coupled with resource diversions from

primary healthcare services and prevailing social norms, this led to a 75% increase in maternal mortality in three of the affected countries.⁴ A similar combination of factors during the COVID-19 pandemic could exacerbate other health conditions or delay COVID-19 treatment for women and girls in humanitarian settings.

WATER, SANITATION AND HYGIENE

In humanitarian settings, the COVID-19 pandemic may reduce women's and girls' access to hygiene and sanitary materials due to decreased household income, increased household competition for resources and disrupted supply chains. Women and girls who are reliant on humanitarian agencies for their water and sanitary supplies—including menstrual hygiene goods, soap and water treatment tabs—may find those services interrupted. Consequently, their ability to conduct household-level disease prevention efforts or to meet their own hygienic needs could be compromised. They may have to travel further to collect water and procure essential hygiene goods, making them more vulnerable to gender-based violence or sexual exploitation and abuse.¹¹

PROTECTION

As illustrated above, health and humanitarian crises exacerbate gender inequalities and place women and girls at increased risk of gender-based violence and sexual exploitation and abuse.^{12 13} For example, movement restrictions or quarantine measures to mitigate the COVID-19 pandemic in humanitarian settings may increase the incidence of intimate partner violence.¹⁴ Women and girls who are already stigmatised in their communities may be unjustly blamed for the spread of the disease.¹⁵ As the pandemic spreads, their access to medical and psychosocial services for survivors of harassment and violence could decrease as resources are re-prioritised to fight COVID-19.

Children face additional protection risks in humanitarian settings if schools are closed: girls may have less access to health, hygiene and protection messaging and resources, and their caregiving burdens may increase.¹⁶ The negative economic impacts of public health emergencies may prompt families to resort to negative coping mechanisms, such as requiring girls to engage in transactional sex or arranging forced, early marriages.¹⁶ All children are at risk of becoming separated from their caregivers, who may be hospitalised or die.¹⁶

SHELTER

In humanitarian settings, female-headed households are nearly 30% more likely to have inadequate shelter than male-headed households.¹⁷ Inadequate shelter increases the risk of illness by 25% throughout a person's lifetime, while overcrowded shelter conditions can greatly increase the spread of infectious diseases.¹⁷ Past public health emergencies have also prompted populations to

Box 1 Policy and programming recommendations to support women and girls in humanitarian settings during the COVID-19 pandemic

For donors and policymakers

- ▶ Bear in mind that the global COVID-19 response is only as strong as the weakest health system and provide immediate, flexible surge funding to ensure that operations in crisis settings can rapidly adapt and scale up.
- ▶ Require that all funding proposals contain adequate gender analyses and protection mainstreaming provisions.
- ▶ Ensure that aid and healthcare workers have access to all populations in need, including across borders, to accommodate surges in health personnel and allow the transport of humanitarian and medical supplies as needed for preparedness and response activities.
- ▶ Ensure that any COVID-19-related movement restrictions account for the different needs of vulnerable groups.
- ▶ Maintain compliance with international legal obligations, including the right to seek asylum.
- ▶ In the long term, ensure that emergency preparedness and response plans are grounded in sound gender analyses that consider gendered roles, risks, responsibilities and social norms and that account for the unique capabilities and needs of all vulnerable populations.
- ▶ In the long term, devote more resources towards researching the gendered implications of public health emergencies, especially disease outbreaks, so that public health preparedness and response plans can mitigate harm to women, girls and other vulnerable groups.

Across all humanitarian sectors

- ▶ Commit to proactive, early information sharing and coordination to ensure a robust response that uses intersectional analyses to account for the needs of all individuals, irrespective of age, disability, ethnicity, gender, migration status, nationality or sexual orientation. Ensure the full participation of at-risk populations, particularly women and girls.
- ▶ Partner equitably with trusted, locally relevant information channels to engage local communities and provide evidence-based information on COVID-19 for all populations while avoiding convening large groups.
- ▶ Bolster water, sanitation and hygiene services along with psychosocial support, essential primary and sexual and reproductive health services—including adequate protective equipment, as defined in the Minimum Initial Service Package for Sexual and Reproductive Health in Humanitarian Settings—safe shelter, and the provision of food, nutrition and hygiene commodities, using cash and/or voucher assistance where feasible and using an inclusive and gender-sensitive lens while taking care to prevent and mitigate the spread of COVID-19.
- ▶ In the long term, work with local communities—particularly women's groups—before, during and after public health emergencies to provide the best possible services and ensure continued access and trust.

Health and water, sanitation and hygiene

- ▶ Involve female healthcare workers and local women leaders in decision making to rebuild their trust in health systems and cocreate COVID-19 responses that adequately address the needs of women, girls and other vulnerable groups in each community.
- ▶ Engage frontline health workers in community-based risk communication and disease surveillance to rapidly detect COVID-19. Disaggregate related data by sex, age and disability so that health experts can understand differences in exposure and treatment and tailor preventive measures.
- ▶ Implement responsive and inclusive approaches for COVID-19 outreach, information sharing and service delivery towards populations who may be less visible due to age, disability, gender or sexual orientation, immigration status, stigmatisation or other factors.
- ▶ Train and equip gender-balanced healthcare workers in COVID-19 infection prevention and control and clinical management. Ensure they are competent to identify gender-based violence risks and cases; handle disclosures in a compassionate, non-judgmental way; and know to whom they can refer patients for additional care.
- ▶ Ensure that menstrual hygiene, obstetric, reproductive and other primary healthcare commodities are well-stocked and available.
- ▶ Consider the effects of quarantine or social distancing measures on the physical and mental health needs of different populations.
- ▶ Where social distancing is not possible, work with local communities and authorities to explore localised solutions and emplace protective mechanisms, such as additional hygiene and sanitation support.

Protection

- ▶ Prepare for possible surges in gender-based violence and sexual exploitation and abuse affecting women, girls, people with different sexual orientations and other vulnerable populations. Support mobile hotlines to mitigate and respond to these risks where it can be done safely, understanding that not all women and girls will have access to phones.
- ▶ Plan for and mitigate the risk that pandemic response measures might result in unaccompanied or separated minors, including girls.

Shelter

- ▶ Ensure that gender analyses and the meaningful participation of asylum seekers, internally displaced persons and refugees, particularly women and girls, are fundamental considerations in national surveillance, preparedness and response plans and activities, including safer living and housing conditions to allow for social distancing.

Education

- ▶ Prepare and emplace plans to ensure the continuity of education, including via remote learning or radio broadcast.

Economic empowerment and well-being

- ▶ Develop targeted economic empowerment strategies and/or explore cash transfer programming to mitigate the impact of the COVID-19 pandemic, including support for populations who are employed during the pandemic and lose their income once it is contained and for communities to recover from and build resilience against future shocks.

migrate from rural to urban areas that were perceived to have more or better services,¹⁸ in turn leading to overcrowding, making social distancing impossible and increasing the risk of communicable disease transmission.

Given these considerations, IDPs and refugees, especially women and girls, who live in crowded camps or urban settings are at particular risk should COVID-19 reach humanitarian settings.

EDUCATION

As discussed under Protection, schools in many humanitarian contexts will likely close for an indefinite period to mitigate the spread of COVID-19. School closures can also have negative effects on displaced or refugee children for whom school can provide a reliable source of food and psychosocial support. For example, during the 2014–2016 West Africa Ebola outbreak, girls whose mothers were infected had to take on additional caregiving responsibilities.¹⁹ Even if their school was open, girls found it difficult to balance caregiving burdens with education. This led to increased absenteeism or to the girls leaving school completely, which had long-term effects on the girls' educational, economic and health outcomes.¹⁹

FOOD SECURITY AND NUTRITION

Public health emergencies can have tremendous impacts on food systems, including supply chains, which communities in humanitarian settings often rely on. In addition, movement restrictions and quarantine measures may result in less access to food, increasing prices at the same time that populations are less able to conduct economic activities and food production. Some households may resort to negative coping mechanisms, such as reducing food consumption, engaging in transactional sex, borrowing money or going into debt to pay for food. Surviving the declared end of an outbreak may not automatically ease food insecurity or malnutrition in affected communities, as it will likely take months to restart agricultural activities and trade.

The risk of heightened food insecurity and malnourishment during public health emergencies is particularly grave for women and girls because social norms in some humanitarian contexts dictate that they eat last and least.²⁰ When food becomes scarce, women and girls—who are already more likely to be malnourished and suffer from anaemia than men and boys²¹—could face additional health complications quickly, including increased susceptibility to COVID-19 or other infections, miscarriages and postpartum haemorrhage.²²

ECONOMIC EMPOWERMENT AND WELL-BEING

Women living in humanitarian settings may be employed in informal, low-wage activities that are likely to be disrupted during the COVID-19 pandemic. During the 2014–2016 West Africa Ebola outbreak, restrictions on

the movement of goods and people hampered women's trading activities and their ability to engage in agricultural activities, decreasing their earning potential.²³ Concerns over spreading the infection, travel restrictions and xenophobia may limit the work opportunities of internally displaced or refugee women.²⁴

Moreover, women's and girls' unpaid caregiving burdens will increase rapidly as governments close schools and care services to prevent the spread of COVID-19 and household members contract the disease. With already limited time—and likely employed at a lower wage, due to the global pay gap—women and girls will have even less self-directed time, including to spend on their own paid work.²⁵ These factors, along with the potential loss of income due to the death of other household income earners, mean that the economic impact of COVID-19 on women and girls could be long-term and widespread.

CONCLUSION

To anticipate and address the potential challenges that the COVID-19 pandemic poses in humanitarian settings, [box 1](#) lists priority considerations and recommendations for donors, policymakers and practitioners. Critical to mounting an effective COVID-19 response are understanding the implications of the pandemic on women and girls as well as working with them to design appropriate mitigation and response interventions. This can be actualised, for instance, by supporting women's and girls' leadership in health programming to ensure that COVID-19 prevention and control measures do not further exacerbate harmful gender inequalities and social norms; ensuring that all COVID-19-related funding proposals and data analyses consider age, sex and gender effects; and bolstering water, sanitation and hygiene services along with psychosocial support, essential sexual and reproductive health services²⁶—including interventions to prevent and respond to gender-based violence, as defined in the Minimum Initial Service Package for Sexual and Reproductive Health in Humanitarian Settings—and providing safe shelter and food, nutrition and hygiene commodities.

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