

GENDER ALERT FOR COVID-19 OUTBREAK: March 2020

TAKING INTO ACCOUNT THE SPECIFIC NEEDS OF WOMEN, GIRLS, MEN AND BOYS MAKES HUMANITARIAN RESPONSE MORE EFFECTIVE AND ACCOUNTABLE TO ALL AFFECTED POPULATIONS.

On March 11, 2020, the WHO declared that the COVID-19 outbreak is a pandemic.¹ Particular concern, in humanitarian terms, must be for populations in high-risk settings, such as camps, poor high-density population areas and contexts with weak health care service provision, WASH facilities, and social protection settings.

Recognizing the extent to which the COVID-19 outbreaks affects women and men differently is hugely important. Some preliminary data suggested that more men than women are dying, potentially due to sex-based immunological differences, higher rates of cardiovascular disease for men and lifestyle choices, such as smoking. However, the experiences and lessons learned from the Zika and Ebola outbreaks and the HIV pandemic demonstrate that robust gender analysis and informed, gender-integrated response are vital to strengthen the access and acceptability of the humanitarian services needed to meet the distinct needs of women and girls, as well as men and boys.

Gender norms and pre-existing inequalities disproportionately impact women and girls in emergencies, including health emergencies. Gender, together with other factors including age, sexual orientation and identity, ethnicity, disability, education, employment, and geographical location may intersect to further compound individual experiences in emergencies. In the COVID-19 health emergency, a number of gendered impacts have emerged, including:

- Women are more likely to be front-line health workers (globally, 70% of workers in the health sector are women²) or health facility service-staff (e.g. cleaners, laundry) and as such they are more likely to be exposed to the virus and dealing with enormous stress balancing paid and unpaid work roles.
- Women may have limited access to accurate, official information and public service announcements, due to limited access to public spaces, and group gatherings (e.g. through safe spaces) and outreach activities. This can contribute to increased risk of infection, as well as increased stress and protection risks.
- In most locations, norms dictate that women and girls are the main caretakers of the household. This can mean giving up work to care for children out of school and/or sick household members, impacting their levels of income and heightening exposure to the virus.
- Women are also more likely to be engaged in short-term, part-time and other precarious employments/contracts which offer poorer social insurance, pension, and health insurance schemes, and are particularly at risk in an economic downturn. This can lead to women engaging in risky coping strategies, such as transactional sex and/or heighten their exposure to risks of sexual exploitation and abuse.
- Overwhelmed health services, reduced mobility and diverted funding will likely hamper women and girl's access to health services, including sexual and reproductive health, GBV survivor care, HIV/AIDS treatment and attended childbirth and other natal services, exacerbating preventable maternal deaths, 507 of which occur every day from complications of pregnancy and childbirth in emergencies.³

¹ WHO. *Situational report* (March 16, 2020) [Link](#)

² Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K, Campbell J. *Gender Equity in the Health Work Force* (WHO, 2019) [Link](#)

³ OCHA. *World Humanitarian Data and Trends* (2016) [Link](#)

- Given that pregnant women are more likely to have contact with health services (antenatal care and delivery), they experience greater exposure to infections in health facilities which may discourage attendance.
- This also applies to older women and men who will continue to access health facilities for their pre-existing conditions, adding to their virus exposure risk.
- Furthermore, overwhelmed health services may limit access to family planning services and to modern contraceptives, potentially leading to a rise in unwanted pregnancies and the socio-economic impact that they have on individuals, households and communities.
- During the COVID-19 outbreak, strategies such as ‘shelter-in-place’ and other movement restrictions, combined with fear, tension and stress, may place women and girls at heightened risk as they are confined with their abusers.
- School closures, social distancing and containment strategies will impact girls and boys differently, especially adolescent girls who due to gender roles may be expected to take on care duties, limiting their access to remote learning programmes. As such, the provision of remote learning must be designed to meet the needs of all children and youth.
- Livelihood concerns will also present new, gendered risks of exploitation, abuse and violence for women and children.

In addition, there is also a clear preponderance of cases and fatalities amongst the older sections of affected populations, and as with women and girls, the needs, rights and contributions of older people in emergencies are often neglected. Their susceptibility to the virus is exasperated by pre-existing conditions, more prevalent in older people, which compromise patients’ immune systems. Reduction in the mobility of older people can potentially lead to their isolation and neglect due to their lack of visibility.

INTEGRATING GENDER INTO COVID-19 RESPONSE PLANS AND THE INCLUSION OF WOMEN AND GIRLS AS DECISION MAKERS

The participation and leadership of women and girls – and their respective women’s networks and youth rights organizations – in responding to this crisis will be crucial to ensuring the most effective humanitarian response. With only 54% of crisis contexts holding at least one consultation with local women’s organizations in the planning of their humanitarian response strategies in 2018, it is clear the humanitarian system has a long way to go to address this debilitating gap⁴. In addition, the role of women and girls in the post-crisis recovery will be essential to facilitate effective social and economic changes.

The World Health Organization’s [2019-nCoV Strategic Preparedness and Response Plan](#) (SRSP) relies heavily on social mobilization and community engagement in the development of country readiness and response. As with recent experience of Ebola and Zika responses, the resilience, cultural roles and responsibilities of women and girls will be a crucial aspect in the success of such community-based strategies.

Below are some key standards to guide the integration of gender into formulation and implementation of COVID-19 preparedness and response plans:

MINIMUM STANDARDS FOR INTEGRATING GENDER EQUALITY INTO PREPAREDNESS AND RESPONSE PLANNING PROCESS

- Conduct a regularly updated, multi-sectoral gender analysis to identify inequalities, gaps, and capacities to identify the specific impacts of the crisis on the women, girls, men and boys of the affected population and to inform the priorities of the preparedness and response plans.

⁴ IASC Gender Reference Group and UN Women. *IASC Gender Accountability Framework Report* (2019) [Link](#)

- Integrate gender equality and the empowerment of women and girls' considerations into any Multi-cluster Initial Rapid Assessment (MIRA) or Joint Needs Assessments, Response Plans, and appeals, with appropriate budgets.
- All data and information gathering efforts from needs assessments to monitoring and evaluation should include dedicated consultations with women and girls, women's groups and organizations, and women leaders from the community in the modality that is accessible, safe, and culturally appropriate.
- All assessment teams should include men and women and be gender-balanced, if feasible. Data collected throughout the response by all actors should be disaggregated by sex, age, and disability.
- All M&E frameworks should include gender-focused indicators.
- Needs assessments, response plans, and implementation should proactively adopt a do-no-harm approach and prioritize the mitigation, response and prevention of GBV and PSEA.
- Ensure that restriction of movements and surveillance systems to detect cases do not inadvertently expose women and girls to additional harm.
- All social mobilization, community engagement and surveillance-mechanism be developed and implemented in conjunction with representatives including women and youth groups, female community health workers, traditional birth attendants, and traditional female healers.
- Factor in gender-based differences in literacy levels and access to information tools such as mobile phones and internet, ensure that communication is inclusive and transmitted through multiple media options including radio, visual guides, and community mobilization, as well as in a diversity of languages, accessible formats and with use of accessible technologies.
- Adopt interventions that recognize, reduce and redistribute the unpaid care and household responsibilities assigned to women and girls and safeguard their dignity.
- Ensure that each cluster has dedicated gender expertise such as a gender focal point or advisor and where present, collaborate with the Gender in Humanitarian Action Working Group (or alternative), the GBV sub-cluster and the Interagency Working Group on Reproductive Health (or their equivalents) to utilize existing expertise.
- All projects/programmes should use the IASC Gender and Age Marker tool (or equivalent) to guide gender considerations in their design <https://iascgenderwithagemarker.com/en/home/>

For more details on how to integrate gender throughout the humanitarian programme cycle, please refer to the 2018 IASC Gender Handbook for Humanitarian Action which is available in Arabic, English, French and Spanish at: <https://www.qihahandbook.org/>

Also, the [IASC Gender Policy](#), the [IASC GBV Guidelines](#) and the [Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming](#) as additional resources.

It is also essential that already limited funding for existing gender integrated programming – including protection, SRH, and livelihoods initiatives, in existing crisis and fragile settings are not withdrawn and redirected to cover the COVID-19 response.

CLUSTER PROGRAMME PRIORITIES FOR A GENDER-INTEGRATED RESPONSE

CAMP MANAGEMENT AND COORDINATION

With the limited space and tight living conditions of displacement camps, together with limited access to WASH facilities and health care services, these are likely to be challenging environments with regards to the control and management of a COVID-19 outbreak. Planning may require evacuation of populations at high risk, in particular older persons, those with pre-existing health conditions, pregnant women, unaccompanied children and survivors of GBV.

It may also require the redesign of camp structures and layouts to ease over-crowding and the management of service provision and continuity. To that end it is essential that all camp occupants – women and girls included – are consulted, and their specific needs ascertained and considered based on a comprehensive gender analysis.

Action Points for Camp Management and Coordination:

- All coordination and planning efforts to prepare and respond to COVID-19 must include representation from women residents of the camp. Strengthen the leadership and meaningful participation of women and girls in all decision-making processes in addressing the COVID-19 outbreak.
- Resource mapping, needs assessment and safety audits should consult and be inclusive of women and girls, as well as men and boys.
- Any re-planning of sites and accommodation of individuals must consider protection and rights of women and girls – including segregated and safe WASH facilities, lighting, accommodation for single women and men, female-headed households, child-headed households and separated children.
- Prioritization of continued service provision must consider the most urgent needs of women, girls, men and boys - especially care for older persons, pre-existing conditions, SRH, mental health and natal care.
- Camp community engagement must include representation of women and girls in risk assessments, identification of high-risk populations and the establishment of monitoring mechanisms.
- Establishment and management of community mobilization and communication strategies must have women at their core. All messaging and information on COVID-19 must be appropriate, understandable and relayed through proven effective mechanisms, such as women’s groups, adolescent youth, women with disabilities, and older people’s associations.
- Households and individuals required to self-isolate must be monitored and supported by community health workers with regards to mental health and the prevention and/or management of GBV risks, and abuse of older people.

 **SHELTER**

COVID-19 brings additional risks to slums, informal settlements and for those living in crowded living arrangements and/or in substandard housing. Dense populations and poor sanitation make COVID-19 transmission preventative measures such as handwashing and social distancing particularly difficult. To that end, the role of women and girls in community mobilization, risk communications and surveillance mechanism will be crucial.

With cities suspending activities and restricting movements, access to daily wage-work, which many women are reliant for their own survival and that of their dependents in urban settings, will be severely curtailed. Many female-headed households, in particular, will be at risk of eviction and/or sexual exploitation due to lack of rent payments.

Action Points for Shelter:

- All coordination and planning efforts by the government and local authorities to prepare and respond to COVID-19 must include representation from women residents.
- Community mobilization, risk communication and surveillance mechanisms should be localized with women taking a leadership role in their design and implementation.
- Any communication, information sharing initiatives must take into consideration appropriate means of communication to reach all community members, reflecting literacy levels and language requirements. Initiatives utilizing technology, including mobile phones, must consider those who do not have access to such resources, including women and older people.
- Specific focus on the protection of female-headed households, older people and those with pre-existing conditions from sexual exploitation and abuse must be included in all housing rights and tenure security initiatives. Where appropriate, a moratorium on eviction and rental support interventions should be considered.

- Installation of additional WASH resources in densely populated areas must consider safety and protection concerns for women and girls. Locks, lighting, accessibility, and sex-segregation must be integral to their design.

HEALTH CARE

Women make up 70% of the global health workforce and as such, are the frontline responders in the COVID-19 pandemic. However, this is often not reflected in the decision-making spaces within healthcare systems, with men taking up most of the senior level roles.

Lessons from previous epidemics suggest that women health staff face increased risks of abuse, intimidation and harassment.⁵ In humanitarian settings where resources are already constrained, these risks are further heightened.

The frontline of treatment of the disease not only involves dedicated health-care professionals, but it also includes support staff – such as cleaners, laundry, catering – who are in the majority women. All such frontline workers experience significant higher virus exposure. It is essential that they are adequately considered in the protective measures and training developed for health care workers.

At the domestic level, globally women and girls disproportionately bear the care responsibilities in their households. This will exponentially increase with increased strains on health care systems as more people get ill and with the potential closure of education centers for children.

Lack of adequate health services already leads to a high maternal mortality rate and other severe gaps in humanitarian settings.⁶ The strain placed on these health facilities due to COVID-19 can draw resources away from other life-saving needs including SRH, MHPSS, and clinical care for survivors of GBV. Further, fear of infection can also prevent people from accessing life-saving health care including GBV survivors and older people. It is essential that wherever feasible, standard health services – in particular health care services for older men and women, GBV survivors, as well as antenatal, postnatal care and delivery services including emergency obstetric and newborn care – are continued with priority, albeit with the necessary infection control measures in place.

Action Points for Health Care:

- The health response should ensure that all data gathered is sex, age, and disability disaggregated, as well as pregnancy status.
- Preparedness actions should be taken before disruption of services — including distribution of dignity kits, condoms, and increased supplies of contraception for clients/patients.
- In COVID-19 affected communities and quarantined areas, women from marginalized groups including female-headed households, older persons, widows, older women, women with disabilities, and pregnant and nursing women should be prioritized in the provision of medical supplies, food, care, social protection measures and psychosocial services.
- When access to health care is negotiated (specifically in negotiations with countries hosting refugees), ensure that referral pathways and access also meet the specific needs and priorities of women and girls.
- Health care response must facilitate the development and dissemination of targeted messaging on preventive, protective and care-seeking behaviors and on available health resources responsive to the different contexts and concerns of women, men, boys and girls. It is important that any targeted programming does not exacerbate potential stigmatization or discrimination due to gender, age, citizenship status, disability, sexual orientation and identity, and other factors. In particular, LGBTIQ individuals often face higher rates of physical

⁵ Fraser E. *Impact of COVID-19 Pandemic on Violence against Women and Girls* (UK Aid, March 2020). [Link](#)

⁶ OCHA. *Global Humanitarian Overview 2020* (2019). [Link](#)

and mental health concerns, thus programming must take into consideration their needs to order to increase access to health services.

- With low levels of literacy - especially amongst women and girls - it is important that messaging is relayed through appropriate materials and means that are accessible and understandable by all. If mobile phones and other devices are used for awareness-raising, ensure that women and girls who have less access to mobile phones and the internet are not excluded. Mixed methods that utilize multiple media options such as radio and visual graphics should be used.
- The health care response must ensure that protective training, provision of Personal Protective Equipment (PPE) (which should be women friendly) and medical care facilities for health-care workers must also be extended to the treatment facility support staff who are primarily women.
- All healthcare workers should be trained to safely handle disclosures of GBV and the abuse of older people, and be familiar with existing support mechanisms to be able to refer those in need to the right pathway for psychosocial support, health and legal assistance, and case management.
- Given the heightened vulnerability of female frontline workers, clear measures should be in place to prevent and mitigate harassment, abuse or other forms of GBV towards them.
- The health care response must develop strategies to help mitigate the effects of stress for all its health care workers (male and female), as well as develop strategies to counter potential stigmatization and discrimination.
- The health care response must provide messaging that pregnant women and girls should continue with their natal care and seek out assisted deliveries. Such messaging should also advise them on precautionary measures they must take relating to their pregnancy. These messages should be conveyed by health care workers and social mobilizers.
- All health workers performing and/or assisting deliveries should be trained in safe-delivery protective measures.
- The health care system must ensure the continuity of care for reproductive health services as well as clinical management care for GBV survivors in both COVID-19 affected areas and non-affected areas, where most health care workers have been pulled into the COVID-19 response and many health services/facilities have been abandoned.
- Provision of the MISP service package⁷ should be adhered to as the minimum standard for SRH provision.
- The health care response must develop adequate guidance for precautionary measures for healthcare workers in non-COVID-19 treatment health facilities.
- The health response should ensure the delivery of adolescent-friendly and elder-friendly health information and services.

PROTECTION

The disruptive impact of COVID-19 on existing legal, social and policing structures means that security, justice and social services are likely to be severely curtailed, leaving limited avenues to services, safety and justice for survivors of gender-based violence. In addition, with many health services abandoned or severely disrupted, survivor's ability to access essential treatment will be further restricted. This is further compounded by the fact that GBV increases in all emergencies.

Globally 1 in 3 women have experienced some form of GBV. In humanitarian settings, sexual violence, trafficking, early marriage, intimate partner violence and sexual harassment, exploitation and abuse are also prevalent. Survivors can be stigmatised and isolated from the support of their communities and left with no means of shelter and livelihood. In addition, orphaned children are at particular risk by being shunned from their community and leaving them vulnerable to exploitation and abuse without a lack of income or adult support. The strains imposed by the pandemic – isolation, reduced access to basic services, financial challenges – as in the case of other crises will likely lead to an even further increase in GBV.

⁷ UNFPA. *Minimum Initial Service Package - MISP*. (2015) [Link](#)

Emerging evidence from the COVID-19 response already points to spikes in domestic violence, as well as abuse and violence towards female health care workers.⁸ Furthermore, experience from previous epidemics suggest that restrictions on movement and other contingency measure can create opportunities for sexual exploitation and abuse (SEA), that existing support for GBV survivors may break down during a public health emergency, and increased tension in the household due to isolation, food and financial insecurity, and suspension of educational activities, may all lead to increased Intimate Partner Violence (IPV) at a time when women and girls are further isolated and unable to access support. Suspension of education activities can also increase the risks for adolescent girls of different forms of sexual exploitation and abuse, and early marriage.

Furthermore, with older people being the most adversely affected by the virus, their additional care requirements and need to shelter at home, could potentially increase their risk of isolation and/or abuse.

Action Points for Protection:

- A do-no-harm approach and GBV risk analysis must be adopted in all aspects of the response and protection priorities should be mainstreamed into all preparedness and response activities. This requires every sector to prioritize risk mitigation.
- It is of utmost importance that any and all surveillance systems established to detect COVID-19 cases should not inadvertently expose women and girls to additional harm in line with human rights.
- All frontline workers should be sensitized to existing and expected protection risks including GBV and elder abuse and be trained to respond to disclosures of GBV, including IPV and elder abuse, as well as to guide individuals through the existing referral mechanisms.
- Assume increases in GBV and plan and resource the overall response accordingly. Include strategies on IPV information sharing, neighborhood/community support for families at risk.
- The Protection response must prepare for an increase in need for GBV response and support, identify gaps in GBV survivor-service provision, prepare to provide essential stop-gap measures where feasible. This especially applies to quarantined and/or locked down areas.
- The Protection response must endeavour to prevent household separation, including the provision of alternative care arrangements to preserve as much as possible household unity (e.g. keeping siblings together, keeping elderly relatives with the family unit). However, there should also be planning and implementation measures taken for gender-segregated areas for instance when individual women or girls may need to be placed in isolation.
- The Protection response must develop community mobilisation to counter stigmatisation and xenophobia, and to assist in the reintegration/acceptance of persons of concern into their communities/host communities, households and schools. Any such community mobilisation efforts should include women and women's groups.
- Assess safe distribution of dignity/hygiene kits so that homebound/quarantined women can access essential items for their health and dignity as well as updated COVID-19 risk mitigation information and GBV referral information, especially hotline/remote support options (including for remote psychosocial support)
- The protection and safety of healthcare workers, specifically frontline workers who are predominantly women, should be included in the Protection cluster's response, and preventive and mitigation measures should be implemented against abuse or violence.
- Ensure survivor response services are maintained as life-saving interventions (including telephone support where feasible).
- All PSEA protocols must be in place, including training and code of conduct for responders and complaint mechanisms and services for survivors.
- Working closely with the Education cluster, take preventive measures to ensure that if educational activities/schools are suspended, that this does not expose girls to GBV risks including early marriage, sexual

⁸ Fraser E. *Impact of COVID-19 Pandemic on Violence against Women and Girls* (UK Aid, March 2020). [Link](#)

abuse and exploitation. Prepare for possible alternate modes of learning where feasible (e.g., radio) and strengthen community mobilization and advocacy as part of preventive efforts.

- Undertake protection risk analysis for marginalised groups, in particular LGBTIQ individuals, who may not present for testing or health services due to stigma and protection concerns.



FOOD SECURITY AND NUTRITION

Globally, women are more likely than men to suffer from food insecurity; even though women produce more than half of the world's food, they comprise 70% of the world's hungry.⁹ In crisis-settings, female-headed households are generally more at risk of food insecurity, due to the fact that there are few work opportunities for women. Globally, women, adolescent girls, and young children are at heightened risk of malnutrition¹⁰ which may in turn increase their susceptibility to infectious diseases such as COVID-19. In populations where women are responsible for food security within the household, increased food insecurity places them under heightened pressure and could expose them to intimate partner violence or reliance on negative coping mechanisms, such as transactional sex.

Action Points for Food Security and Nutrition:

- The food security response must ensure that women and child-headed households – especially in quarantined, locked-down locations or self-isolation- are identified and targeted for food assistance, including in-kind distribution and cash-based transfers.
- Women and girls, including older women, pregnant and nursing women and girls, in all household types should be targeted by malnutrition prevention and response initiatives.
- Food assistance should be designed, delivered and monitored with the engagement of the diverse women, men, girls and boys in the affected populations.
- Food security and nutrition-related responses should understand and address the unpaid care and domestic work of women and girls.
- Food distributions should not put women and girls at additional risks, including long journeys to and from distribution points.
- Regulate and timetable food distributions to avoid large groups congregating to avoid viral spread.
- All employment made available through food distributions should, where feasible, be made available on a gender parity basis.
- Establish alternatives to communal cooking areas in camp/settlement settings, such as increased distribution of cooking stoves, cooking fuel and utensils.

NFI NON-FOOD ITEMS (NFI)

Stockpiling of protective materials by individuals, including hand-sanitizer, gloves and facemasks should be advocated against. All healthcare providers, regardless of gender, seniority or role, should have access to the protective materials they require to reduce their risks at work.

Dignity kits and sanitary materials must be made freely available to populations under quarantine or self-isolation strategies. They should also be made available to women and girls currently under-going treatment and/or in recovery.

⁹ UNFPA. *10 Things You Should Know About Women and the World's Humanitarian Crises*. (2016). [Link](#)

¹⁰ Development Initiatives. *Global Nutrition Report: Shining a light to spur action on nutrition*. (2018) [Link](#)

Action Points for Non-Food Items and Shelter:

- The provision of NFI must include adequate supplies and dispersal of dignity kits, sanitary materials and other materials related to reproductive health (including contraceptives) to locked down, self-isolating and/or quarantined households affected by COVID-19 and treatment centres. The selected items for the dignity kits should be based on a participatory consultation with women and girls to ensure their specific and distinct needs and requirements are addressed.
- Distribution should be accompanied with sensitization on the safe disposal of sanitary supplies/materials to counter potential increased stigma and sanitation issues around menstruation.
- Dignity for patients attending treatment centers and isolation units must be maintained - particularly for women and girls with separate ablutions, toilets and privacy screens as well as safe disposal bins for used sanitary items.
- Regulate and timetable NFI distributions to avoid large groups congregating to prevent viral spread.
- Any changes in times or locations of distribution of NFIs should be implemented only after consultation with women, men, girls and boys in the community. In some areas, women may predominantly be responsible for collection and it is critical that alternate locations and times are accessible for women and do not further increase their burden.

WATER AND SANITATION

Washing hands and maintaining good hygiene is central to preventing and controlling the spread of COVID-19, but not everywhere has readily available soap and water. Often households in high density population areas, such as slums and overcrowded camps, are reliant on water trucking which comes at a cost. Or in rural/semi-rural areas where water collection requires women and girls to walk long distances to collect water, putting a time burden upon them and potentially exposing them to GBV risks on the journey.

Women and girls are also often an untapped source of knowledge regarding cultural WASH practices, which must be understood in order to effectively promote public health through hygiene¹¹, which will be crucial in combating this crisis. Encouraging the participation of women as leaders in WASH service provision can improve both the health of households and the quality of programming by assigning public health outreach roles to the most suitable persons.

WASH interventions should also prioritize menstrual health and hygiene management, including supplies and age-appropriate information for adolescent girls.

Action Points for WASH:

- Creation of any new facilities to promote hygiene in the community should be developed in consultation with women, girls, men and boys in the community. Locations should be accessible to all especially to older women, women and girls with disabilities, to reduce risk of GBV in accessing these facilities.
- Ensure women and girls understand what COVID-19 is, how it is transmitted, the likely symptoms and how to protect themselves and their dependents. Also, equip them with the knowledge and resources to wash hands and engage in good hygiene practices.
- Distribute soap and sanitizer products through community mobilization initiatives. Ensure women are included as recipients and in the distribution process.
- Understanding the respective needs of women, girls, men and boys helps promote access to, and the appropriate use of, facilities. For example, WASH facilities that are adequately designed with privacy and safety measures (including segregation, locks, adequate lighting) increase the acceptability of the facilities for women and girls to use them. Facilities specifically designed for younger girls and boys, i.e., with a smaller toilet bowl and lower washbasin, also encourage use.¹²

¹¹ IASC. *Gender Handbook for Humanitarian Action – WASH Chapter* (2017) [Link](#)

- Use inputs and feedback from women, girls, men and boys in a participatory manner to increase hygiene and encourage measures such as hand-washing in ways that resonate with the community. Utilize women and girls' potential in community mobilization and hygiene promotion.
- Consider the distance and the route that women and girls have to cover to collect water if distributing water. This has implications in terms of a time burden and potential protection risks if it becomes known that they regularly take that route unaccompanied.
- Regulate and timetable water distributions to avoid large groups congregating to prevent viral spread.
- Provide menstrual hygiene supplies/materials and age-appropriate information for adolescent girls.

EDUCATION

With schools and other educational activities being suspended as a preventative measure, children's education will be severely disrupted. Closed schools will likely add to the responsibilities on women as the main caregivers of children remaining at home. Experience in crisis settings show that adolescent girls are less likely than boys to return after a prolonged absence. Closure of schools can also heighten their protection risks with no supervision during the day which can lead to sexual abuse and exploitation, GBV, including early marriage, and risk of engaging in high risk sexual activity potentially leading to STIs and pregnancy.

Action Points for Education:

- It is vital that appropriate preventative measures are in place to minimize the risk of students dropping out of school permanently, especially amongst girls who are often at higher risk due to the increase in their care responsibilities in the household and other factors.
- Promote equal participation of girls and boys during school closures when alternative, remote learning initiatives are implemented. Careful focus should be placed on monitoring the participation of girls in these initiatives.
- Advocate for equal sharing of domestic chores and care duties amongst male and female siblings/household members, so each has time to participate in alternative education initiatives.
- In collaboration with the Protection cluster, take preventive measures to ensure that if educational activities/schools are suspended, that this does not expose girls to protection risks due to being out of the supervision of the school system. Communicate zero tolerance for SEA, strengthen community mobilization and advocacy as part of preventive efforts.
- Alternative/temporary educational facilities must have separate WASH facilities for girls and boys. Remote learning strategies (radio, television, digital delivery) should reinforce good hygiene practices.
- Where schools are not suspended, include sanitation, hygiene and protection information tailored to both girls and boys as needed.
- If utilizing technology alternatives to classroom teaching, consider the potential tech-access differential between girls and boys or for female-headed households.
- If the location, times of schools, or alternate educational activities are changed in light of social distancing efforts, it must be ensured that boys and girls are not placed at additional risk while commuting to school (due to check-points or other accessibility challenges) and that these changes do not inadvertently cause a drop in attendance for girls (due to distance or care responsibilities which may be expected at a certain time of day)
- Sensitize teachers, staff and relevant community members on increased risk of GBV and SEA.

LIVELIHOODS

The COVID-19 crisis is likely to have a significant impact on the ability of affected populations to continue to earn the minimum income needed for subsistence and as a consequence, levels of food insecurity will rise. This is especially true amongst the most economically vulnerable communities and in particular female and child-headed households.

Many livelihood opportunities that women rely on will be at risk due to movement restrictions and government response strategies, these include daily wage earners, small business owners, those working in cleaning, caring,

cashiering and catering sectors and in the informal economy. such as closing restaurants, bars and markets. Small-holder farmers (predominantly women) are likely to face challenges in accessing markets due to travel restrictions and food prices will rise accordingly (in Liberia during Ebola, a market assessment by WFP showed a 30% rise in basic commodities prices). Cross border traders, often women, will be unable to continue their trade activities as borders are closed. Informal sector and daily wage workers will also be at risk of disrupted livelihood activities that will negatively impact their subsistence.

In cases where responses include cash and voucher assistance (CVA), mainstreaming GBV considerations throughout the program cycle and utilizing CVA within GBV case management services, can be optimized as a tool to enhance the protection of crisis- and conflict-affected populations to help promote recovery and build resilience.

Action Points for Livelihoods:

- Targeted women’s economic empowerment strategies should be developed, and/or cash transfer programming explored to mitigate the impact of the outbreak and its containment measures including supporting them to recover and build resilience for future shocks.
- Use of cash-based-programming should consider women’s ability to safely access markets so that they can spend the money on items they need.
- Women – especially those in female-headed households – must be specifically identified and included in all cash and any other livelihood interventions, in ways that are safe for them to access
- Cash and Voucher Assistance (CVA) must take into account gender and protection considerations.
- Care facilities for dependents will need to be made available to allow women and men to work and/or household friendly policies that allow for flexible work arrangements should be considered.
- Livelihood interventions must ensure that women and female headed households are specifically targeted in all post-crisis economic recovery efforts – rural and urban.
- Recruitment of staff by implementing humanitarian agencies for COVID-19 related response should ensure gender parity and recruitment of women in all sectors.
- Given the economic impacts of COVID-19 on both formal and informal markets, livelihood interventions should be informed by gender-based livelihoods and risk analyses.¹²



FOR MORE INFORMATION AND TECHNICAL SUPPORT, please contact the secretariat of the Gender Reference Group at grg.secretariat@unwomen.org, or the co-chairs, Julie Lafreniere, Oxfam (julie.lafreniere@oxfam.org), and April Pham, UN OCHA (april.pham@un.org)

¹² Women’s Refugee Commission. *Cohort Livelihoods Risk Analysis (CLARA)*. New York: New York. ([link](#))