

# Maintains



Research supporting social  
services to adapt to shocks

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## Rapid Literature Review: Gender

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COVID-19 Series

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## About Maintains

Maintains aims to save lives and reduce suffering for people in developing countries affected by shocks such as pandemics, floods, droughts and population displacement. This 5-year programme, spanning 2018-2023, will build a strong evidence base on how health, education, nutrition and social protection can respond more quickly, reliably and effectively to changing needs during and after shocks, whilst also maintaining existing services. Maintains will gather evidence from six focal countries — Bangladesh, Ethiopia, Kenya, Pakistan, Sierra Leone, and Uganda — to inform policy and practice globally. It will also provide technical assistance to support practical implementation.

Maintains is funded by UK Aid from the UK government and implemented through a consortium led by Oxford Policy Management ([www.opml.co.uk](http://www.opml.co.uk)). For more information about the programme, visit [Maintains Webpage](#) and for any questions or comments, please get in touch with [maintains@opml.co.uk](mailto:maintains@opml.co.uk).

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# 1 Introduction

The COVID-19 pandemic, as with many other epidemics in the past, has begun to expose social, political, and economic gaps in the response to curtail it. Most public health efforts are concentrated on improving systems' capacity to respond to the situation. In doing so, they tend to overlook issues relating to gender at the health system, community, and policy levels. However, in overlooking gender-specific experiences and challenges, the approaches employed to curtail a health crisis miss a crucial opportunity to design and implement policies and systems more effectively; indeed, existing policies may even deepen structural inequalities. Focusing on multifaceted gendered experiences enables us to better understand the primary and secondary effects of a health emergency on different communities (Wenham *et al.*, 2020). These differential challenges stress the need for adaptive policies and programmes that are both increasingly responsive and effective.

This rapid study reviews the literature on how a health crisis such as an epidemic has adverse implications for gender, especially for women. Some of these implications include disadvantages in the formal and informal employment sector, increased caregiving responsibilities, and an increase in the incidence of domestic violence against women. By reviewing the literature on previous epidemics, we extract concerns that are relevant for the current COVID-19 pandemic. Furthermore, wherever possible, we have updated our review with literature specific to the current crisis.

The review concludes with a set of recommendations, drawn from the literature and directed at any organisation or government body responsible for designing and executing interventions both in response to the COVID-19 crisis and in creating resilient systems going forward.

## 2 Direct and indirect impacts of a pandemic on women

This section addresses the direct and indirect impact of the COVID-19 pandemic on women, firstly within the health system and secondly at the individual level, while acknowledging that often the boundaries between the two are blurred with individual experiences warranting systemic responses.

Issues discussed at the level of the health system include women's role as health workers and the reduced ability of the health system to provide routine Sexual, Reproductive, Maternal, Newborn, and Child Health and Abortion (SRMNCH-A) services. Increases in the incidence of domestic violence, intimate partner violence (IPV), and the economic consequences of COVID-19 are discussed at the individual level.

### 2.1 Impact on women at the health system level

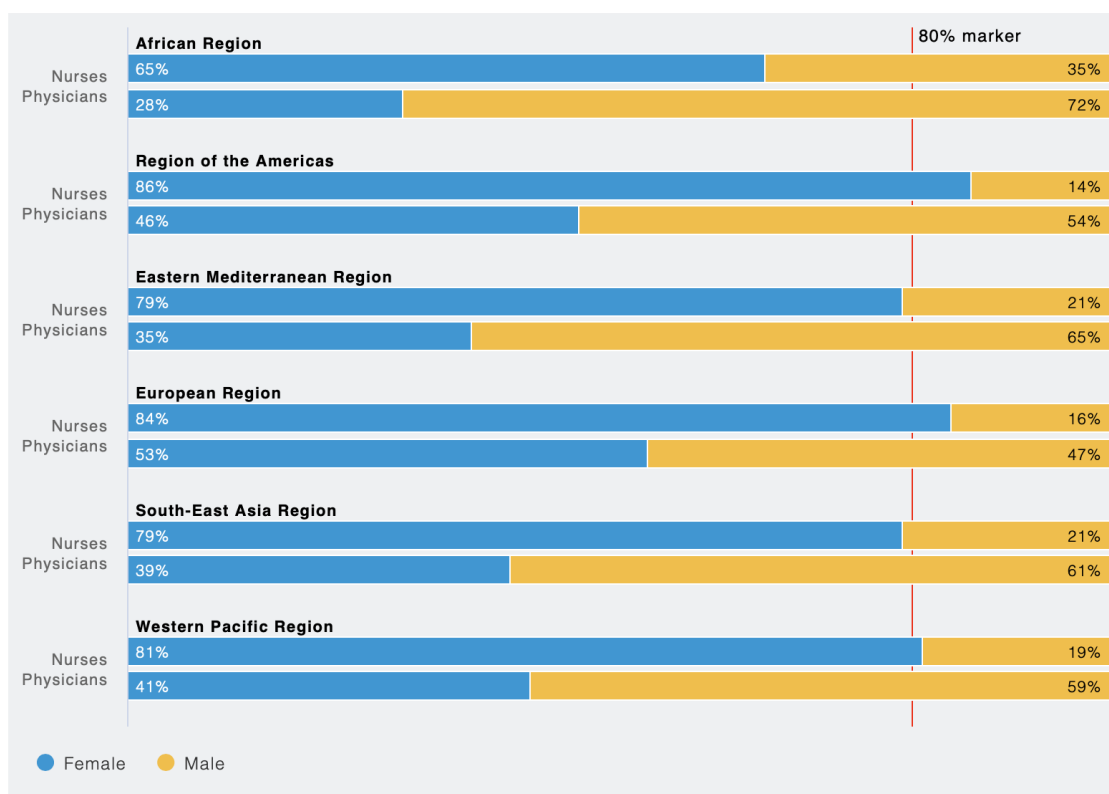
Gender intersects with the health sector at two levels: the first relates to women's employment as formal and informal workers within the sector, while the second relates to the health system's provision of SRMNCH-A services during crises.

#### **Discrimination against women working in the health sector**

The COVID-19 pandemic underlines once again the need for decent and safe work for women across the health sector, at the systems, policy, and planning levels. It provides an opportunity to invest in the careers of women health workers.

A review of the literature on human resources for health finds that health systems rely on a foundation of female workers who are most often informally employed, underpaid, and poorly supported (George, 2008). Results from surveys conducted in 104 countries show that the proportion of women in professions such as nursing and midwifery is much higher when compared to professions such as physicians and teaching associates (Boniol *et al.*, 2019). A recent World Health Organization (WHO) study illustrates how women make up at least 70% of health workers and 80% of nurses globally (Figure 1). As a result, there are higher proportions of women in occupations that require low educational criteria and have less job security. In fact, in some contexts women are paid less even within the same professional band (Himmelstein and Venkataramani, 2019). These discrepancies have led to the health sector being described as 'delivered by women, led by men' (Dhatt *et al.*, 2020).

**Figure 1: Distributions of physicians and nurses by sex**



Source: Turquet and Koissy-Kpein, 2020

Not only is there a wage and occupational differential, women are more likely to receive less managerial support and even be subject to workplace violence and abuse. In India, female health staff are required to travel to remote villages especially during late hours, putting themselves at risk of harassment in order to carry out their job (Sarin *et al.*, 2016). Similarly, in Rwanda 39% of health workers are reported to experience some form of workplace violence, whether verbal abuse, bullying, or sexual or physical harassment (Newman *et al.*, 2011). In contexts where managerial support for women health workers is low, many women ‘adjust’ to their circumstances to carry out their work, often doing more than is required of them in their job role (George, 2008). Also, women health workers have to manage not only their job roles as service providers but also often take on the additional responsibility of home-care, an additional burden during times of crisis and when a family member falls sick.

Several reasons explain this gender imbalance in the workforce, including the historical development of professions such as nursing and home-care (Carpenter, 1993), structural barriers to entry, stereotypes of women as ‘carers’ who can perform menial tasks but not medical interventions (DeVries, 1993), and discrimination based on pregnancy, maternity, and family responsibilities (George, 2007). Given this imbalance, with women occupying low-paying positions, with little decision-making power, at the time of a pandemic they are likely to have lower access to resources than men and less bargaining power in terms of the roles and responsibilities assigned to them. The absence of safe working conditions, including fear and stigma around health workers, negative mental health consequences, and risks to physical safety in a pandemic all serve to make women who are already vulnerable in the health system even more so.

One example of how the health system actively discriminates against women during epidemics relates to the **poor safety standards for community health workers (CHWs)**, who are mostly women. There is an acute Personal Protective Equipment (PPE) shortage across the globe. The WHO estimates that 89 million medical masks, 76 million gloves, and 1.6 million goggles are required for the COVID-19 response every month, and that industries must ramp up production by 40% to meet the global demand (WHO, 2020a). In this context, CHWs are likely to have the least access to PPE kits. For instance, in India CHWs are responsible for identifying possible COVID-19 cases at the community level, reporting on travel history within the community, and ensuring uptake of medical services for possible COVID-19 cases (Ministry of Health and Family Welfare 2020). In spite of the fact that CHWs have been instructed to wear masks, media reports (Madhukalya, 2020) indicate that these resources have not yet been provided. Oxford Policy Management's (OPM) rapid evaluation on the role of CHWs in the prevention and management of COVID-19 found that workers had not been provided with masks or sanitisers; however, their senior male colleagues had received PPE kits, highlighting how structural discrimination within the system puts female CHWs at increased risk (OPM, 2020). In addition to poor safety standards within the health system, female health workers are put at risk by the communities who they work with, as they face backlash for recommending individuals go into quarantine (Altstedter *et al.*, 2020). By overlooking or inadequately engaging with problems faced by CHWs, the health system loses a vital opportunity to effectively influence community behaviours for combating COVID-19.

### **Reduced ability of health systems to provide regular services important for women's health**

Learnings from other epidemics point to the potential impacts of COVID-19 on sexual and reproductive health. Epidemics in low- and middle-income countries (LMICs) strain the existing health system, as most of its resources are diverted to the epidemic response. As a result, there is limited availability or suspension of routine SRMNCH-A services, which have the following implications for women:

1. **Limited access to safe and institutional delivery**<sup>1</sup>: In Liberia during the Ebola outbreak, facility-based deliveries, deliveries by skilled attendants, and Caesarean sections declined by 35%, 32%, and 60% respectively, when compared to pre-Ebola baseline levels (Shannon *et al.*, 2017). Similarly, in Guinea fewer institutional deliveries occurred during the outbreak (Delamou *et al.*, 2017). Reasons for the decline in institutional deliveries include: (i) a general fear of contracting Ebola among women; (ii) a strict no contact policy at health facilities; and (iii) a scarce supply of PPE (Shannon *et al.*, 2017). Indeed, the diversion of resources to the Ebola response in 2014/15 resulted in an estimated 3,600 additional maternal, neonatal, and stillbirth deaths in Sierra Leone (Sochas *et al.*, 2017).
2. **Antenatal care**: In Liberia, there were severe decreases in the numbers of pregnant women who accessed antenatal care during the Ebola outbreak due to poor health-seeking behaviour and the closure of health facilities (Shannon *et al.*, 2017). Similarly, in Guinea fewer women achieved at least one antenatal care visit or at least three

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<sup>1</sup> One important limitation to many studies in this section is the lack of data and low levels of reporting from hospitals and health facilities during an epidemic.

antenatal visits per month during the outbreak when compared with a pre-Ebola baseline (Delamou *et al.*, 2017). Scenario modelling for COVID-19 indicates that a 10% decline in the service coverage of essential pregnancy-related and newborn care is likely to result in 1,745,000 additional women experiencing major obstetric complications without care, 28,000 maternal deaths, and 168,000 additional newborn deaths (Talor *et al.*, 2020).

3. **Routine and other check-ups:** Studies in rural Liberia (Lori *et al.*, 2015; Iyengar *et al.*, 2015) and Guinea (Barden-O'Fallon *et al.*, 2015) highlight reductions in the utilisation of maternal health services during the Ebola outbreak. In addition to a lack of reporting, these reductions are due to disruptions in the provision of services and declines in care-seeking due to fear.
4. **Immunisation:** Immunisation coverage declined by half in Liberia after the Ebola outbreak, which perhaps contributed to a measles epidemic in the country after the Ebola outbreak (Wesseh *et al.*, 2017). Similarly, in Guinea there were significant reductions in all vaccinations during and after the outbreak (Delamou *et al.*, 2017). Some reasons explaining the decline in immunisation include reduced demand for maternal healthcare services, lower health seeking, closed facilities, and low access to facilities due to security restrictions (ibid, 2017).
5. **Access to contraception/family planning:** The Zika outbreak in 2015/16 highlighted the importance of removing barriers to access contraceptives, especially since the virus caused birth defects, and the areas with the highest unmet need for contraception in Mexico showed a high prevalence of confirmed cases of Zika (Darney, 2017). Ebola outbreaks also resulted in sharp declines in contraceptive use in Guinea, Liberia, and Sierra Leone (Bietsch *et al.*, 2020; Camara *et al.*, 2017). The reduction in use was partly due to health system failures and partly due to fear and suspicion of healthcare services (Barden-O'Fallon *et al.*, 2015). In order to contain COVID-19, governments in LMICs have restricted movement, thus restricting access to contraception and abortions. Moreover, factories that manufacture condoms have shut down due to lockdowns, suggesting that there may be global shortages of contraception as a result of COVID-19 (Reuters, 2020). Scenario modelling indicates that a 10% decline in the use of contraceptive methods in LMICs will result in an additional 49 million women with an unmet need for contraceptives and an additional 15 million unintended pregnancies over the course of a year (Talor *et al.*, 2020).

Data from other public health emergencies thus highlights the negative impacts that COVID-19 is likely to have on sexual and reproductive health during the pandemic response and in recovery periods. One of the action points moving forward will be to build the preparedness of health systems to continue to ensure the availability of RMNCH services under safe conditions during epidemics.

## 2.2 Impact on women at the individual level

At the individual level, the reduced ability and willingness of women to access health services, in addition to the various forms of violence they are subject to both inside and outside the home, are discussed.



## Reduced ability of women to access COVID-19 health services

Women suffer various gender biases while accessing healthcare, even in non-crisis situations, suggesting that their access to health services during the COVID-19 pandemic is likely to be highly reduced. Some barriers women face to include geographical and financial accessibility.

- **Geographical accessibility:** In LMICs, health facilities are often highly dispersed in rural areas, making it difficult for women to access them. A survey of women in rural areas in Egypt found that 30% of respondents consider distance and transportation the main barriers to healthcare (Chiang *et al.*, 2013). In Ghana, the probability of a woman delivering at a facility is 68% among those living within one kilometre of the facility, with the probability of facility delivery decreasing with distance (Nesbitt *et al.*, 2016). In its study of women patients travelling from four states to a government hospital in New Delhi, the All India Institute of Medical Sciences found similar results: the one-time cost incurred had a direct correlation with whether the woman would seek care (Kapoor *et al.*, 2019). Those living in rural areas in Liberia cited transportation as a challenge during the Ebola outbreak, with geographical proximity becoming even more important when medical facilities shut down (Korkoyah and Wreh 2015).
- **Financial accessibility:** Financial barriers are a key limitation in terms of accessing healthcare. The results of a systematic review show that in Nigeria, Ghana, and Kenya between 35 and 40% of women cited 'money' as a key barrier to accessing healthcare (Asante *et al.*, 2016). Furthermore, the costs of healthcare are likely to increase during a pandemic. For example, in Liberia 83.8% of 1,562 respondents surveyed found that the costs of healthcare during the outbreak were far higher than usual.

These barriers to access are likely to become more pronounced during the COVID-19 crisis, with situations of lockdown affecting geographic accessibility and the economic impact of the crisis affecting financial accessibility.

## Gender and health-seeking behaviour

Women, especially those from lower-income groups, tend to delay access to healthcare, which includes prevention, treatment, and coping with illnesses in the case of non-communicable diseases (Vlassoff, 2007). A qualitative study on gender bias in India finds that women have internalised values such as acceptance of illness and bearing pain uncomplainingly, which results in them avoiding medical treatment (Kapoor *et al.*, 2019). This is especially worrying since women are more vulnerable to contracting a communicable disease due to caregiving responsibilities in the domestic space.

The health sector needs to invest in behaviour change communication and messaging to improve health seeking behaviour amongst women. At the policy level, there needs to be a discussion on the possibilities of subsidised costs of treatment and consulting for women to encourage greater access to healthcare.

## Household power relations impacting on decision-making

Within households, women have less decision-making power than men, making it less likely that their needs will be met. For instance, they are less likely to take decisions about reproductive health, property, and finances. As a result, it is unlikely that they will take decisions about healthcare and health-seeking behaviour during a pandemic (Upadhyay and Karasek, 2012).

For example, during the Ebola crisis women were unable to refuse sex with infected husbands, often resulted in them becoming infected. A study found very low prevalence of safe sex among a cohort of male Ebola survivors in Guinea. Their female partners were unaware of the risks associated with having unsafe sex (Kondé *et al.*, 2017).

## Increase in domestic violence and IPV

There is a body of existing literature that suggests that violence against women and girls (VAWG), especially domestic violence and IPV, is heightened at times of epidemics. While necessary, measures such as home quarantining have been criticised for their gender-insensitive implementation, as to flatten one curve we are ignoring a steep rise in another – that of gender violence within the home (Deshpande, 2020).

While there is anecdotal evidence about the increase in domestic violence and IPV during outbreaks such as Ebola and HIV, the number of cases reported and the prevalence of VAWG are difficult to quantify. Emerging data indicates that, already, incidences of domestic violence and IPV have increased since the start of the COVID-19 pandemic. In France, reports of domestic violence have increased by 30% and Cyprus, Singapore, and Argentina have reported an increase in helpline calls of 30%, 33%, and 25% respectively (UN Women 2020a).

The increase in domestic violence and IPV can be attributed to the following factors: epidemic-led additional poverty-related stress, economic insecurity, confinement in close quarters and domestic spaces, and poor mental health (Harman, 2016; UN Women, 2020a). The following list of practical challenges needs to be considered in relation to the response, recovery, and reform phases of the COVID-19 crisis in terms of its impact on VAWG:

1. **Reduced availability of health service delivery staff:** Frontline and medical health staff are often the first point of contact for seeking medical assistance in instances of abuse. During an epidemic, however, these staff are unavailable because they are focused on providing healthcare to patients of the epidemic.
2. **Governments and administrations redirect their focus:** Governments tend to redirect their capacities to making the health system more responsive to the epidemic and this often takes away from providing and maintaining shelters for victims of domestic violence. Moreover, a collapse in the level of coordination between the health, police, and justice departments makes it difficult for women to file and follow up on complaints (UN Women, 2020a).
3. **Reduced reporting and treatment due to fear of contagion at the medical centre:** Since emergency medical services are focused on managing the epidemic and there is often merging of physical spaces for care after abuse, there is a possibility of reduced

access to healthcare among women due to fear of contracting infections (O'Donnell, *et al.*, 2020).

- 4. Pandemic response measures can reduce women's ability to escape abusive partners:** Specific pandemic measures such as reduced mobility, social distancing, and reduced social and legal services complicates women's ability to escape abusive partners.

### **Increase in sexual violence against women**

Outside the confines of the home, there is evidence that health crises cause an increase in the incidence of sexual violence against women and children.

Instances of rape, sexual assault, and violence against children increased during the Ebola outbreak. In Guinea, gender-based violence (GBV) increased by 4.5% during the Ebola epidemic (Caspani, 2015). Sexual violence against children was also common. In parts of Sierra Leone, the teenage pregnancy rate increased by 65% (UNDP, n.d.). In Liberia, in 2014 the most commonly reported form of GBV was child rape, with most cases related to victims under 17 years old (Korkoyah and Wreh, 2015). Sexual violence against women also leads to unplanned pregnancies, which introduce additional health risks to women who are not able to access safe abortions either due to affordability or lack of quality healthcare options (Kelly, 2020).

Transactional sex, although not always classified as sexual violence,<sup>2</sup> was also common during the Ebola outbreak. Women entered into equations of transactional sex where they exchanged sex for money to meet basic needs for themselves and their families (Kelly, 2020) or to receive other benefits: for instance, women in DRC entered into transactional relationships with health workers in the hope that they would get a job as a nurse or home-carer (Kapur, 2020). Coercive sex is common in epidemic contexts due to an unequal power dynamic – that is, those responsible for providing services such as aid workers, taxi drivers, and burial teams enter into sexual relationships with vulnerable women in exchange for vaccines, cash, food, and transport (O'Donnell, *et al.*, 2020).

Many of the factors responsible for the increase in sexual violence – such as restrictions on movement, economic factors, out-of-school children, and social isolation – are applicable to the current COVID-19 pandemic. As noted above, there is emerging evidence that reports of violence against women have increased in many countries. In fact, online abuse and cyber violence is also increasing (UN Women, 2020a).

### **Increase in caregiving responsibilities in the domestic sphere**

Literature from both previous health crises and the current COVID-19 crisis suggests that a health crisis is gender disadvantageous in that it reinforces and heightens existing socio-cultural norms expecting women to be primary care givers. Care giving in LMICs involves regular domestic chores, looking after family members (especially children and elderly

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<sup>2</sup> There is debate about whether transactional sex can be classified as violence. On the one hand, humanitarian crises such as epidemics restrict women's choices and they may be forced to engage in sex for very basic services such as food, money, or to support a family. On the other hand, classifying it as violence may obscure the strategic choices women make to engage in it. See Formston and Hoillhost (2016) for a literature review and discussion on transactional sex.

members), and ensuring that basic resources like water and firewood for cooking are adequate. To amplify these, during a health crisis schools and other caregiving options like creches are closed and there is an additional expectation to be tending to the sick in the family.

These caregiving responsibilities affect women's employment disproportionately to men as they are forced to dedicate reduced hours to their income-generating employment or are unable to deliver as efficiently. In addition, previous epidemics like Ebola have shown that, given women's roles of caregivers within the family and as frontline health workers, they are more susceptible to being infected (Wenham, *et al.*, 2020).

### **The economic and employment sector**

The COVID-19 pandemic and the related lockdown measures from various governments have led to a global economic downturn, with the closure of businesses and industries. This is likely to impact women more because they tend to work more in insecure, lower-paid, and part-time employment when compared to men (UN Women, 2020a). In addition to this, women are also specially impacted as they are expected to take on domestic work and caregiving responsibilities at home, leaving them with less time for their formal/informal employment.

Recent economic analysis suggests that the effects of COVID-19 are likely to have a disproportionate and negative effect for women when compared to men. This is because women's employment is concentrated in sectors such as hospitality, education, and services, all of which have suffered shut-downs due to COVID-19. Moreover, workers who lose jobs in crises are less likely to secure employment in the future (Alon *et al.*, 2020), underlining the importance of addressing gender-specific issues in the designing of safety nets. In the informal sector, women who work as domestic labour are severely affected by the current lockdown, as some have been laid off by the families they work for and many are not receiving their monthly pay (Un Women, 2020b).

## 3 Intersectoral perspectives

Given the multiple vulnerabilities that women and girls face, there is a need for intersectoral convergence and governance to provide an integrated package to address life cycle vulnerability.

This section provides a very brief overview of gender issues within key sectors, while the specific rapid literature reviews in other sectors provide a more detailed overview. Section 3.1 discusses gender concerns for governance and state capacity; Section 3.2 discusses gender concerns for social protection programmes and; section 3.3 discusses gender concerns for education.

### 3.1 Governance and state capacity

Gender intersects with governance and state capacity in three key ways:

- **Poor gender analysis at the level of policymaking.** This is driven by a combination of factors such as limited representation of women at decision-making levels, inadequate understanding of the importance of engaging with gender concerns on policy effectiveness, and lack of the sex-disaggregated data necessary to influence policy design.

Health systems that are predominantly steered by male policymakers tend to misconceive or deprioritise women's health issues and challenges faced by largely feminised cadres of the health workforce. Gendered power relations also influence the scope for accountability within health systems (Waldman, *et al.*, 2018). Through its inadequate representation of women in leadership and decision-making roles, the sector misses the opportunity to factor in the experience of almost 70% of its workforce and takes decisions based on the experience and expertise of only 30% of its workforce. Under representation of women in decision-making increases the probability of taking poor and less effective decisions that does not benefit from gender diversity within the health sector. (Dhatt, *et al.*, 2020).

- **The need for fiscal commitment to gender-specific measures** such as continuing maternal health programmes, cash transfers targeting women, and setting up helplines and constructing and maintaining shelters for victims of IPV and sexual abuse.
- **This public health crisis offers a unique opportunity for increase in accountability of both new policies and measures** being put in place to combat the crisis, and in the use of existing policies and laws. It is important to engage with the possible effects of any such policies on gender rights. For instance, medico-surveillance could be used as a way to gain information on pregnancy history and curtail abortion rights.

### 3.2 Social protection

The demand on government social protection programmes is likely to increase manifold due to COVID-19. In designing social protection programmes for women, especially a programme that is a substitute for loss of livelihood, it is important to not make women more vulnerable than they already may be within the household. In cases where multiple social protection programmes are disproportionately targeted toward women, they are likely over-

burdened in the short term. In addition, their responsibilities increase as they are expected to financially provide for the family by meeting the conditions to access the social protection programme and continue to undertake domestic responsibilities. Social protection programmes also need to account for intersectional vulnerabilities, which is done by looking at women as a disaggregated and not a homogenous group.

### 3.3 Education

Epidemics have a severe impact on education, with a particularly strong impact on girls in two areas:

- **Reversing the advancement made for women's rights and efforts to reduce the gender gap:** During the Ebola crisis in 2018 in DRC, schools were either closed or parents were hesitant to send their children to school due to fear of contagion (Rohwerder, 2020). Studies have shown that in cases where schools remained closed for a significant period of time (such as a full academic year), as happened in Sierra Leone, girls and young women found it harder to re-enrol even after schools re-opened, with enrolment rates falling close to 16% in the most disrupted villages. This situation of either a school drop-out or delayed reenrolments was mainly due to their involvement in income-generation activities (ibid, 2020). Early drop-outs for girls have several negative effects, including forced early marriage (Mawere, 2012; Prakash *et al.*, 2017), pregnancy (Sandoy *et al.*, 2016), and fewer job opportunities and lower salaries (Chabaan, 2017).
- **Gender disadvantages in using digital platforms:** Digital platforms for learning as an alternative to school widen the gap between urban and rural populations, with rural populations finding it harder to access necessary gadgets, electricity, and internet connectivity. These differences in access are further exacerbated by the digital gender divide, with multiple factors leading to gender-based digital exclusion. These include access-based challenges, affordability, lack of or lower levels of education, skills, and technological literacy, and inherent gender biases and socio-cultural norms (OECD, 2018).

## 4 Successful strategies to respond to gender concerns

Gender-specific concerns need to be factored in across programmes and interventions. There is a need for concerted effort between a variety of stakeholders, including civil society organisations, foundations and funding organisations, and UN agencies such as UN Women and the WHO, which must all work strategically with national and sub-national governments.

The following points detail successful interventions that could enable an adaptive response to gendered concerns surrounding COVID-19.

### 4.1 Response

1. **Identify and enlist civil society groups working especially with women:** Learning from the gender-specific response to the Ebola crisis, UN Women argues that an effective approach could be to enlist women's organisations and communicate key messages through them.<sup>3</sup> These messages could cover a range of gender-specific challenges that are a direct or indirect outcome of COVID-19 such as information and messaging on domestic violence, accessing healthcare services, and awareness on social protection programmes targeted toward women.
2. **Place gender concerns at the heart of the health response:** This involves creating explicit safety measures for female healthcare workers at all levels of the health system, ensuring that CHWs have the required safety gear, are being paid for their extra work, and that there is acknowledgement and accommodation of their dual responsibilities. Health systems should also provide alternative mechanisms to enable women and girls to access services associated with routine RMNCH. At the community level, messaging on the importance of social distancing and quarantining needs to be accompanied with messages on redressal against IPV and domestic violence (O'Donnell, *et al.*, 2020).
3. **Communication of practical messaging over information on the disease:** Studies show that communities in Liberia during the Ebola outbreak preferred to hear messaging on practical gender concerns like how to manage a family of children, including infants and toddlers, in quarantine (Kelly, 2020). Practical messages could also provide information to both men and women on domestic violence and IPV.
4. **Involving women early in social mobilisation campaigns:** One of the lessons learnt from the Ebola crisis in Sierra Leone is the missed opportunity of effective social mobilisation by women. Delayed involvement of women led to reduced information amongst them (as primary care givers) about potential approaches to tend to the sick within the household (acaps, 2016). In the current COVID-19 crisis, New Delhi in India has set up 'sehat apas' (translated as *elder sisters for health* or *health sisters*), who are groups of local women from within the locality of low-and middle-income households. They are responsible for conducting a health survey of their locality. Along with the survey they also handed out masks and sanitisers (with support from the Delhi government and foundations) in each house and informed residents of helplines they could use if they developed COVID-19 symptoms (Mishra & Roychowdhury, 2020).

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<sup>3</sup> See [UN Women envisions a more gender-equal post-pandemic society](#), 6 April 2020, Devex.

5. **Social protection for women-headed households:** Government social protection schemes should be pivoted so that women-headed households whose livelihoods have been affected by the pandemic have immediate economic support. Governments across the world are making direct transfers of cash to address household-level economic crises and ensure that women have access to resources. In India, payments of INR 500 are being made to women who have a specific type of bank account (PTI, 2020).
6. **Food assistance programmes to target pregnant and lactating women.** One of the indirect impacts of an epidemic is the shift in focus of the existing healthcare system to manage the epidemic. In LMICs, this shift in focus of the health system away from the regular efforts of vaccination, messaging on health, and food provision has negative impacts on maternal and child indicators. To counter this, in addition to continuation of routine immunisation and vaccination, it is important that food assistance programmes are targeted toward pregnant and lactating women. The WHO has recently published guidelines on the management of pregnant and breastfeeding women in the context of the Ebola virus (WHO, 2020 b).
7. **Measures to address domestic violence and IPV.** Funds should be marked for shelters and temporary housing in the pandemic relief packages announced by national or sub-national governments. Canada, for instance, marked 50 million dollars out of 82 billion dollars for domestic violence and sexual assault centres.<sup>4</sup> Understandably, LMICs might struggle with financial allocation for shelters when the resources required to combat the health crisis itself are limited. Here, the role of behaviour change communication, functional helplines that focus on counselling over legal measures that are difficult to access, and funding support from international bodies like UN Women and philanthropic donors becomes increasingly relevant.

## 4.2 Recovery and reform

The COVID-19 crisis, despite its unveiling of glaring gender-based disadvantages across sectors, does present an opportunity to meaningfully engage with and reduce this disadvantage. It presents an opportunity to both reflect on the existing systems, which negatively impact the effectiveness of the response, and to undertake measures that could correct this gap. The following points list measures undertaken to bridge this gap that have been successful in the past and also discusses a few measures related to system resilience.

1. **Focus on creating livelihood options for women through cash transfers and skills development.** In West Africa, many development programmes with a focus on cash transfers sought to support those affected by Ebola disruptions by creating livelihoods (Kelly, 2020). These livelihoods need not necessarily follow the existing gendered livelihood options that are disadvantageous to women in terms of the income. Livelihood creation should focus on systems where women are encouraged to undertake relatively higher-income livelihoods.
2. **Design and implementation of national digital strategies that actively aim to close the gender digital gap as a resilience measure to counter the long-term effects of COVID-19.** A focus on access to and affordability of digital infrastructure will enable

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<sup>4</sup> See [www.canada.ca/en/department-finance/news/2020/03/canadas-covid-19-economic-response-plan-support-for-canadians-and-businesses.html](http://www.canada.ca/en/department-finance/news/2020/03/canadas-covid-19-economic-response-plan-support-for-canadians-and-businesses.html).



women to engage with a wider platform for livelihoods, upskilling, and education (OECD, 2018). The gendered nature of digital transformations needs to be discussed and reflected in national and international forums, with concrete commitments made through fiscal allocations and dedicated monitoring and evaluation.

3. **Initiatives to work with men and boys to reduce gender violence:** Promundo, an organisation in Brazil, engages young boys and men to increase beliefs in gender equality and improve sexual health outcomes. Similar initiatives could be scaled up across LMICs so that policies on GBV are focused on prevention and not only redressal.
4. **Representation of women at all levels of decision-making:** The argument for equitable representation of women at all levels of decision-making including at the level of policymaking is not based on tokenistic diversity alone. Given that women form the majority of the health workforce, and are affected differently by the response to COVID-19 in terms of travel restrictions, quarantining, and so on, it is important for decisions to include voices from women for improved effectiveness and better preparedness (Wenham, *et al.*, 2020). Over time, the health system must be strengthened and restructured so that women are able to participate in leadership and decision-making roles, addressing what has until now been a fundamental imbalance in the health system workforce.

## 5 Gaps in the literature

While there have been some efforts to look into the gender-specific responses to and impact of epidemics, these have been few and isolated. In general, there are limited universal commitments or gender-specific studies that engage with gendered experiences in decision-making processes both at the policy level of system resilience and at a more immediate level of response and recovery. Here we discuss three major gaps in the existing literature: (i) the lack of sex-disaggregated data; (ii) poor engagement with the gender impact of policies and state capacity; and (iii) a gap in understanding which gender-specific measures have worked in the past and why. This latter gap in particular is a potential focus area for Maintains.

One of the biggest gaps is the **lack of sex-disaggregated data on how COVID-19 affects men and women differently and if so to what extent**. Consider this quote from Wenham *et al.*: 'Although sex-disaggregated data for COVID-19 show equal numbers of cases between men and women so far, there seem to be sex differences in mortality and vulnerability to the disease. Emerging evidence suggests that more men than women are dying, potentially due to sex-based immunological or gendered differences, such as patterns and prevalence of smoking' (Wenham, *et al.*, 2020). This lack of sex-disaggregated data severely hinders our capacity to influence both the response to an epidemic and systems and policies at a later stage of systems resilience (Devlin, 2020).

At an economic level, there is also a need for more rapid data gathering and assessment on **the extent to which women are more vulnerable to losing their jobs or suffering reduced wages as a result of formal austerity measures**. Data on the impact of an epidemic on female employment could help influence our design of social protection programmes and cash transfers, influence behaviour change campaigns on distribution of caregiving responsibilities, and create policies and systems where companies have to justify certain actions against female employees under epidemic conditions.

Additionally, we need more studies on gender and the impact of various policies during crises. Smith (2019) argues that gender analysis has been conspicuously missing from policy debates, documents, and processes. These debates have instead given way to the 'tyranny of the urgent' where gender considerations are seen to be less urgent and are overtaken by a focus on immediate biomedical needs (Smith, 2019). At the implementation level, ensuring a coordinated response between the police, justice, and health departments has been given limited attention, even as cases of domestic violence and IPV rise in number.

**There is also a gap in our understanding of which gender-specific measures may have worked in the past.** There is some discussion on the role of international bodies like UN Women in ensuring that national governments commit to certain goals but studies are limited in regard to the pathways to influence states. Useful questions here would be as follows: to what extent is advocacy by civil society groups effective? What are the other sources for advocacy? Whom within the government must those undertaking advocacy target? Answers to some of these concerns would help us learn from global experience and strategise our efforts toward gender equity, especially during a health crisis.

## 6 Recommendations for further technical assistance within Maintains

Across donors and foundations, and especially for DFID, there is an increasing acknowledgement of the need to factor gender into projects to ensure that social inclusion programmes and other responses to crises do not further exacerbate existing social differences and are able to effectively respond to gender issues and the needs of women.

Based on the literature review, this chapter lists a number of technical assistance opportunities that need a specific gendered reading and response.

### 6.1 Maintains could create an evidence base on the gender-specific impacts of the COVID-19 pandemic

- **Creating an evidence base via rapid data collection on the economic impacts of crises and differential gender outcomes for specific sectors.** Data on women's employment and wage losses in the formal sector will help assess how severely women will be affected by the economic downturn and can inform gender-sensitive social protection programmes. Gender-disaggregated data on formal employment was collected using phone-based surveys of firms in Liberia after the Ebola crises.
- **A rapid review on strategies for the prevention of domestic violence in crises.** A review to understand what strategies are likely to be the most successful in addressing domestic violence in conflict or crisis scenarios would help inform government health policy during lockdowns. The WHO and UN Women are currently gathering data on the prevalence of this problem by monitoring the number of phone calls to helplines and complaints made to health workers.

### 6.2 Maintains could provide technical assistance on gender-specific government policy

- **Technical assistance on gender analysis at the level of policymaking during crises,** including on issues such as limited representation of women at decision-making levels, inadequate understanding of the importance of engaging with gender concerns on policy effectiveness, and lack of sex-disaggregated data necessary to influence policy design.
- **Understanding the fiscal commitments involved in gender-specific measures** such as continuing maternal health programmes, cash transfers targeting women, and setting up helplines and constructing and maintaining shelters for victims of IPV and sexual abuse. It would be important to do a gendered analysis and accounting of how much of the financial packages governments are announcing for addressing the economic distress of companies and enterprises will actually go to women-led business.
- **Understanding the roles of women workers in the formal and informal healthcare system.** Concerns around full-time employment, the nature of women's roles, and gender pay gaps need to be addressed through better gender-transformative health policies where, along with removing barriers that affect employment, there is also access

to professional development and leadership positions. Themes that could be explored include managerial support to women and supportive supervision of their work.

- **Implications of a health crisis on both formal and informal female employment.** Women either drop out of the workforce due to increased domestic and caregiving responsibilities or, in the formal sector, make up the majority of the initial workforce categories to be laid off when companies adopt austerity measures. A better understanding of how governments allocate and distribute economic and employment packages will help design better social safety nets for women.

### **6.3 Maintains could assist stakeholders adopt a more gender-sensitive focus to programme implementation**

- **Create a gender toolbox for every section/thematic focus of the project.** Gender needs to be mainstreamed across all projects, by identifying gender-specific concerns in projects and integrating these into delivery and monitoring and evaluation. A sector-specific gender toolbox will help teams think about their approach on gender. For instance, some of the gender questions a study on state capacity in response to a health crisis must ask include: is the proposed state response sensitive to disadvantages faced by women? Are the policies employed by the state gender sensitive? Similarly, those working on health systems must ask: What is the best approach to ensure equitable access to healthcare services by women? What is the best approach to ensure that women workers who comprise the bulk of frontline healthcare workers and nurses receive adequate support?
- **Refine the role of international organisations.** Given the current pandemic, it is likely that government progress toward the Sustainable Development Goals related to gender equality (4, 5, and 6) will be negatively impacted. Technical assistance could focus on how governments can build in resilience into their implementation strategies for these goals.

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