

GLOBAL GENDER ANALYSIS

COVID-19 secondary impacts on health- and protection-related issues

Thematic series on gender – 22 October 2020

Overview

Since the start of the pandemic, concerns have been raised about the possible consequences of government containment measures and how overwhelmed healthcare facilities may have resulted in, and continue to pose, different kinds of challenges to women, men, girls, and boys, along with gender conforming and non-conforming LGBTQI+ (lesbian, gay, bisexual, transgender, queer, and intersex) individuals with or without disabilities.

Women, men, girls, boys, and LGBTQI+ individuals are adapting creatively and resiliently to the pandemic's trying conditions, supporting their families and their communities. Nonetheless, many likely require more support from humanitarian actors, particularly in contexts with challenging pre-existing conditions. Humanitarian programming needs to adapt to the specific needs of disabled and abled-bodied women, men, girls, boys, and LGBTQI+ individuals in their respective contexts. Since the start of the pandemic; however, some trends have emerged that point towards similarities across countries and regions in the impact that the pandemic has had on people's access to healthcare and their exposure to health issues and violence. Some of these include potential increases in intensity and exposure to domestic violence and GBV, alongside abuse and neglect of children, elderly, and disabled people; increased barriers to accessing health services; food insecurity and resulting malnutrition risks; and potential increases in mental health strain. Current challenges faced by healthcare workers are also gendered, and their needs should be incorporated into response planning.

The pandemic and its secondary impacts may also have unpredictable effects and programming should remain adaptable and informed by local contexts; acknowledging lessons learned from the past few months and from previous epidemics, alongside the pre-COVID context, could help in forecasting what these impacts may look like for different demographics. Constant gender- and disability-sensitive monitoring is required to adapt programming to different needs; this, coupled with a crisis-level analytical approach, could assess vulnerability factors to better understand the pandemic's gendered impact and inform adapted and relevant responses that do not neglect vulnerable populations and that address the indirect consequences of the pandemic on people's wellbeing.

About this report

This thematic report is part of the ACAPS Gender & COVID-19 series providing global analysis on the gendered impact of the pandemic in key areas of humanitarian programming such as livelihood, income and employment or health and protection.

This report provides an overview of publicly available information on the identified and projected impacts of the pandemic on gender-based violence (GBV), healthcare provision and access, and other health-related risks. The report focuses on countries experiencing humanitarian crises which have undertaken gender analyses at the national and subnational levels.

Although limited (see "Methodology and Limitations" section), ACAPS hopes this analysis will inform inclusive and nuanced humanitarian responses by highlighting the similar and different ways specific groups have been exposed to the direct and indirect consequences of COVID-19 and by encouraging ongoing intersectional analysis.

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Key findings

- Indicative data worldwide shows that women and girls who are increasingly confined and cut off from outside activities may be **progressively exposed to domestic violence and other forms of gender-based violence (GBV)** and potentially have less access to formal and informal support networks.
- **The temporary or longer-term closure or disruption of many sexual and reproductive health (SRH)** services around the world may result in lifelong health implications, unwanted pregnancies, maternal deaths, and restrictions on women and girls' SRH decision-making.
- **People may be exposed to mental health strain due to the pandemic**, and this is also likely to be gendered.
- **LGBTQI+ individuals may face notable barriers** to accessing health services.
- **As more water may be needed to ensure adequate sanitary conditions** to ward off COVID-19, women and girls may lack access to safe and adapted facilities and may bear the burden of fetching water, stealing time from employment or study.
- **Food insecurity is gendered.** Women are more likely to face food insecurity than men and are more susceptible to malnutrition. This has direct consequences for women themselves and for families living in female-headed households.
- **Children who are exposed to the secondary impacts of the pandemic**, such as reduced household income or closed schools, and who live in areas with reduced oversight mechanisms may face increased likelihood of child marriage, forced labour, or female genital mutilation (FGM).
- **Older women and men, and people with disabilities, are exposed to increased risks** of neglect and/or abuse with reduced community support systems and strained oversight.
- **Women healthcare workers are exposed to more pressures** than their male colleagues, including physical and mental health strain.

Methodology

This report contributes to ACAPS' efforts to provide insight into the global secondary impacts of the COVID-19 pandemic. Further country-specific analysis on COVID-19-related issues and analyses of challenges for humanitarian operations are available.

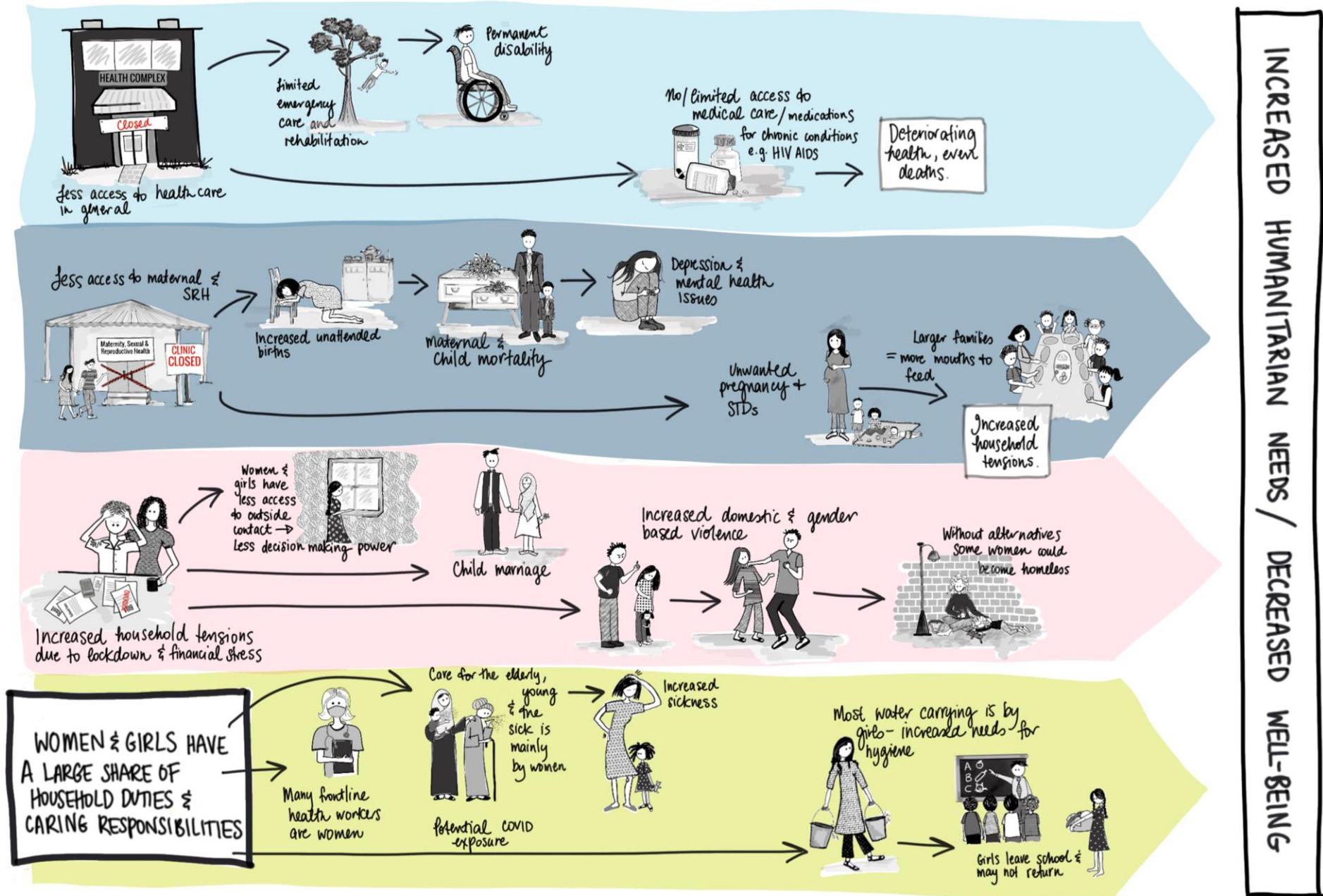
Most of this review is based on 12 reports from a series of country-level and regional-level Rapid Gender Assessments undertaken between April and May 2020 by CARE and/or UN Women. Assessed countries include the occupied Palestinian Territories (the oPT), Bangladesh (primarily dealing with non-camp settings), South Sudan, Ukraine, Timor-Leste, Indonesia, Lebanon, and Jordan (camp and non-camp settings), and regions covered included East, Central, and South Africa, Asia and the Pacific, and Latin America and the Caribbean, collated from individual country assessments.

Most of the assessments were forward-looking at their time of writing, providing an analysis of risks related to GBV, gender-based discrimination, and increased healthcare access constraints. Data used within the reports may also be limited, likely reflective of a small and statistically non-representative pool of respondents who may be programme beneficiaries subject to social desirability biases. Data collection methods adhering to social distancing measures, including phone and online surveys, may result in misunderstanding. Remote data collection also puts women at a disadvantage as they may lack access to phones or lack the privacy to respond honestly. Sensitive questions, such as protection-related questions, cannot be asked safely if the respondents lack privacy, and there a notable dearth of recent GBV data (Devex 06/05/2020). Although sources may be limited, assessments' findings are still important for consideration.

Language limitations

The categories of women, men, girls, and boys is an over-simplification that ignores the complexities within and between groups. Intersectionality with regards to ethnicity, race, nationality, disability, social class, employment status, sexual orientation, and age, to name a few, must be considered. The sum of these intersections influences humanitarian needs, livelihood opportunities, coping strategies, and individual responses. Survey data is also limited to the gender binaries of "man" and "woman", failing to account for individuals outside this binary (CENFRI 25/05/2020). People of different genders may identify with some of the findings and risk analyses in this report. Any use of the gender binaries in the report are not intended to exclude or deny these lived experiences.

GENDERED IMPACT of COVID-19 on HEALTH & PROTECTION ISSUES



Illustrations by Sandie Walton-Ellery

Secondary Health and Protection Impacts

COVID-19 and the associated government containment measures have had varied consequences, notably disrupting both the provision of and access to protection, health, and WASH services (ACAPS 22/06/2020). Good quality gendered data on the consequences of this disruption is scarce, but research suggests that women, men, girls, and boys and LGBTQI+ people, with and without disabilities, have been affected by the pandemic differently.

Protection impacts

Prior to the pandemic, women and girls worldwide faced regular violence throughout their lives. On average, approximately 35% of women have faced physical or sexual violence in their lifetime (World Bank 25/09/2019), resulting in mental and/or physical trauma and, in some cases, death. Children who are exposed to violence are also likely to suffer from trauma. Studies have shown that these children are more likely to be exposed to violence throughout their life or become perpetrators of violence themselves (World Bank 25/09/2019).

Increased Domestic Violence

UN Women reported that 243 million women and girls between the ages of 15 and 49 suffered from sexual or physical violence by an intimate partner in the 12 months prior to April 2020 (UN Women 15/5/2020; UN Women 06/04/2020). They projected this to increase as a result of COVID-19 containment measures due to the reduction in outside activities and increased time with, and proximity to, their abusers. Preliminary studies, protection monitoring, and anecdotal reports support the assumption of an increase in domestic violence in many places (IRC 27/4/2020; CARE 30/4/2020; CCSA 31/08/2020; UN Women 2020; UN Women 06/04/2020; GoB, UN Women 17/5/2020).

There has been global concern about the potential increase in domestic violence and other forms of GBV as the pandemic forced survivors into confinement with their abusers. In many cases, this was accompanied by reduced access to services, as survivors may not have been able to physically access services and may not have been able to call domestic violence hotlines if abusers were also confined. This is in line with research that indicates that domestic violence may spike in post-disaster settings (Vu et al., 2014; Gearhart et al., 2018), in particular in areas with high pre-existing rates of GBV (CARE 30/4/2020; CARE 27/4/2020). Although governments and NGOs face limited capacity to undertake safe data-gathering on GBV as it is nearly-impossible to ensure that respondents are in safe conditions to speak freely on their abuse experiences (Devex 06/5/2020), anecdotal evidence from early in the pandemic reinforced these fears. Surveys by CARE in Jordanian camp and non-camp settings found that respondents felt at risk of physical or psychological violence (UN Women 01/4/2020). In Bangladesh, nearly

50% of female survey respondents in non-camp settings indicated that they were concerned that measures forcing people to stay indoor could enable domestic violence (GoB, UN Women 17/05/2020). Other publications from the oPT, Latin America and the Caribbean, and West Africa found that vulnerable women, such as migrants, asylum seekers and IDPs (Care and OCHA 09/2020; UN Women and Care 01/5/2020), and women who have extra care duties forcing them to venture further from home (UN Women and Care 01/4/2020), would likely be increasingly exposed to violence (CARE 30/4/2020). Women are likely to be facing more pressure and be exposed to partner violence, or they may be forced to undertake drastic coping mechanisms such as skipping meals or adopting sex work (UN Women 01/4/2020; CARE 30/4/2020; CARE 27/4/2020) if there is increased financial stress in the household. Children exposed to family violence are also likely to be subject to trauma, stress, and physical harm (CARE 27/4/2020).

Increased phone calls to domestic violence centres and police reporting of abuse have been reported since the start of confinement in many countries, whilst in other areas calls and reporting have decreased, both indicative of different protection issues. In some countries, intimate partner homicide rates and the number of GBV incidents reported to the police have decreased (CCSA 31/08/2020). In others, such as the UK between 12 March and 23 April 2020, there was a threefold increase in women's deaths due to domestic violence (UN Women 2020). In Tunisia, Argentina, France, Cyprus, and Singapore, an increase in domestic violence was identified through an increase in calls to domestic violence helplines in the early months of the pandemic (UN Women 06/04/2020). A decrease in phone calls to domestic violence centres was documented in other areas, indicating that vulnerable people no longer felt safe enough to reach out to support services (IRC 27/4/2020; CARE 30/4/2020). It must be noted, nonetheless, that these sources may only be indicative, and do not represent the complex situation worldwide.

Women with disabilities are twice as likely to experience violence from partners and family members than able-bodied women, and are ten times more likely to suffer from violence in general (UN Women 2020). They may also find it harder to report violence and access help (UN Women 2020), and risk being under-represented in response planning. It is important to note that men and boys may also be subject to targeted violence such as harassment from law enforcement or military forces, human trafficking, forced recruitment, and domestic violence (CARE 03/05/2020).

Public Service Provision

Public services' access may have become more restricted. Closed clinics and reduced phone service hours reduce women and girls' access to sexual health and GBV services, possibly resulting in persistent illness, injury, or at worst, death (CARE 27/4/2020; CARE 30/4/2020). This is especially concerning in areas where women may not be fully informed of their rights or may not trust enforcement mechanisms. Survey respondents in South

Sudan indicated that they were unaware of laws addressing GBV and other women's rights violations, and many expressed distrust of law enforcement and judicial mechanisms (UN Women 16/5/2020). Respondents in the oPT indicated that women survivors of SGBV may lack the time and privacy to seek support as they have likely seen an increase in care duties (Care and OCHA 09/2020). Globally, women have been severed from community support networks, further reducing their access to safe spaces. This is especially concerning for women who do not have access to cell phones or internet, an estimated 46% of all women in low- and middle-income countries (GSMA 05/2020; CARE, UN Women 19/5/2020). In some countries, domestic violence shelters were repurposed as health centres, reducing options for women exposed to violence (UN Women 06/04/2020). Civil society workers expressed fears that women in Thailand, Myanmar, and Laos may be forced into prostitution or trafficked as lockdown conditions strain access to livelihoods exposing them to harm and trauma (South China Morning Post 05/4/2020).

Health and protection risks to children

By the middle of August, close to 70% of the world's student population had been affected in one way or another by partial or total school closures (UNESCO last accessed 19/08/2020). School closures can expose girls and boys to several types of risks, including abuse at home or on the street, and may limit their future livelihoods, affect the health and education of girls' future children, and increase their exposure to sexually transmitted infections (Center for Global Development 08/04/2020). Lockdown measures resulting in poor visibility and protection systems can also increase children's exposure to violence and exploitation. Children may also be pushed to undertake work to support their families' disrupted livelihoods, which will likely hamper their education prospects after restrictions are lifted. Both girls and boys may be subject to exploitation; in particular, older girls may be vulnerable to sexual exploitation, early marriage, and human trafficking (South China Morning Post 05/4/2020; CARE 27/4/2020). It is also possible that children become neglected as their parents are faced with increased stress and economic strain (CARE 27/4/2020).

Child Marriage

On average, 21% of girls worldwide under the age of 18 are forced into marriage (UNICEF 11/03/2020). Boys may also be forced into marriage. In both cases, children often drop out of school and take on adult responsibilities for which they are unprepared. For girls, early marriage often results in early pregnancy, and younger girls who become pregnant are more likely to face birth complications and to die from such complications. They are also more likely than boys to drop out of school (WHO 31/01/2020) and more likely to be exposed to domestic violence than their older counterparts. More girls may be pushed into marriage as a result of increased economic strain on families resulting from the pandemic or because they are out of school (CARE 30/4/2020; GoB, UN Women 17/5/2020). Save the Children projected that, on top of the on average 12 million girls that are married every

year, an additional 2.5 million girls may be forced to marry by 2025 because of COVID-19-related challenges (BBC 01/10/2020); up to one million girls may also be exposed to early pregnancy due to the pandemic's consequences (BBC 01/10/2020). Girls living in fragile states and those experiencing humanitarian crises are particularly at risk of early marriage, sexual abuse, and early pregnancy, alongside domestic violence (Save the Children 2020).

Female Genital Mutilation (FGM)

As of February 2020, more than 200 million women and girls had been subject to some form of FGM in their lifetime, resulting in trauma, persistent lifelong pain, and reproductive health issues (WHO 03/02/2020). The UN has projected that an additional two million girls may be exposed to FGM over the next decade, as a secondary consequence of the pandemic (Save the Children 2020). Military or police enforcement of lockdown measures may also expose women to harassment (CARE 30/4/2020). Women and girls may also be exposed to other types of violence. In Bangladesh there have been anecdotal reports that humanitarian aid, particularly food and health assistance, is being withheld or used to extort sexual services from women and girls (GoB, UN Women 17/5/2020). The lack of access to WASH facilities in many non-camp setting in Bangladesh, particularly in the slums, results in women having to walk long distances to access latrines, which may result in them being exposed to violence (GoB, UN Women 17/5/2020).

In Zimbabwe, 60% increase in calls to one women's rights organisation

In South Africa, 67,000 calls reporting GBV during seven-day lockdown

In Mexico, 36% increase in calls to domestic violence hotlines from the start of the crisis to April

In Iraq, 65% of GBV sub-cluster service provision points reported increase in one or more types of GBV across 11 governorates between April and May 2020

In Colombia, 95% increase in calls to one domestic violence hotline in the first two weeks of lock-down

In Palestine, 40% to 58% increase in calls from women to domestic violence helpline after it extended its hours (indicating that women had not found the time or privacy to call) just after the start of the crisis



Healthcare impacts

Even prior to the pandemic, healthcare provision worldwide faced limitations. 40% of WHO member countries reported fewer than ten doctors available per 10,000 people, and more than 26% of countries reported less than three doctors per 10,000 people (WHO last accessed 28/09/2020 with latest data for countries, all pre-2020). Over 55% of WHO member countries reported fewer than 40 nursing and midwife staff per 10,000 people, and 23% indicated that this figure is less than ten. In many countries nursing and midwife staff constitute more than half of the country's total medical staff (WHO last accessed 28/09/2020).

73% of countries worldwide ensured some form of sexual and reproductive health (SRH) services through laws and regulations that guaranteed access to sexual and reproductive healthcare, information, and education (UNFPA last accessed 20/08/2020). According to a 2020 study 9% women worldwide between the ages of 15-49 indicated that they had unmet needs with regards to accessing modern contraception (UNFPA last accessed 20/08/2020). This may increase because of COVID-19 strain on health services, movement restrictions, and other limitations that women specifically may face, including exposure to domestic violence. In 2020, only 55% of women worldwide reported that they had decision-making over their SRH (UNFPA last accessed 20/08/2020); this percentage could decrease as women may be confined with potential abusers or controlling family members or may lose their independent livelihoods.

Over one billion people worldwide have some form of disability, and between 110 and 190 million adults have significant difficulty in carrying out daily tasks without regular support (WHO 16/01/2018). This number is increasing annually as populations age and rates of chronic illness increase. People with disabilities may have underlying conditions that make them more susceptible to catching COVID-19 and developing more severe symptoms (World Bank 04/06/2020). Even before the pandemic, many people with disabilities had difficulty accessing healthcare services and had unmet healthcare needs (WHO 16/01/2018); they may now face even more barriers to accessing services.

Reduced access to health services

Disrupted health services are expected to pose several risks to differently gendered populations. For example, disrupted provision of SRH services could result in women experiencing gynaecological issues or not having recourse to detection of sexually transmitted illnesses. A disruption in family planning services has, in past situations, led to increased unprotected sexual activity, unplanned pregnancies, and riskier pregnancies and births among women and older girls, notably in areas with already high rates of early pregnancies (CARE 27/4/2020; World Bank 15/5/2020). A study by the Guttmacher Institute projected that a 10% decline in the use of short- and long-acting contraceptives, a 10% decline in pregnancy and infant care, and a 10% shift in abortions from safe to unsafe are

likely to result in thousands of deaths and complications in 132 low- and middle-income countries (Guttmacher Institute 16/4/2020). Women worldwide are likely facing difficulties in accessing SRH services, because of movement restrictions, financial barriers, and/or service closures as a result of healthcare or community care resources being diverted to address COVID-19 or closed to prevent the virus' spread (CARE 03/05/2020; CARE 30/4/2020; South China Morning Post 05/4/2020; UN Women and CARE 01/4/2020). This is especially concerning in regions where SRH and maternal health services were already severely limited before the pandemic, including in Southern, Central, and Eastern African countries (CARE 30/4/2020). Other health services, for instance mental health services, are in general less accessible to women than men, and family planning services are less accessible to men than women (CARE 03/05/2020). Women in countries where healthcare is costly, and who face more severe socio-economic obstacles and have less livelihood assets, are likely to also risk falling ill if they have limited financial options (UN Women 15/5/2020; UN Women 01/4/2020). For communities in rural areas, healthcare service provision and quality are expected to be particularly strained, as already limited resources may be diverted to treat COVID-19 (CARE 27/4/2020).

In early April, 64% of Planned Parenthood International's member delivery points in the Asia-Pacific region reduced their service provision, with opening hours for community-based distribution and mobile clinics the most affected (International Planned Parenthood Federation 01/04/2020); 36% of member associations also reported shortages in SRH supplies including contraceptives, and the provision of safe abortions and HIV treatment has also been limited (International Planned Parenthood Federation 01/04/2020). Marie Stopes International reported that in three of the 37 countries where it operates SRH programming, there have been increased barriers to accessing SRH services, and an increase in perceptions of reduced availability of abortion services despite needs remaining high. They estimate that 1.9 million fewer women were served by their programmes between January and June 2020, resulting in an estimated 1.5 million additional unsafe abortions, 900,000 additional unintended pregnancies, and 3,100 additional maternal deaths (Marie Stopes International 2020), although this estimation is lower than earlier projections; preliminary global analyses indicate that 56,700 women may have died from maternal health issues as a result of direct or indirect COVID-19 impacts (UN Women 2020). In Timor-Leste, according to a Ministry of Health Report published prior to the pandemic, 60% of women had reported problems in accessing healthcare; in Azerbaijan and Turkey, 60% of women have had difficulty accessing obstetric and gynaecological care as a result of COVID-19 (UN Women 2020). In Jordan, respondents to a post-pandemic gender rapid analysis survey expressed worry over reduced access to sanitary pads and contraceptives (UN Women, 01/4/2020; CARE 27/4/2020). Similarly, a survey undertaken in April 2020 indicated that a high percentage of women and men were unable

to access medical supplies and services in Bangladesh, possibly because of COVID-19-related shortages (GoB, UN Women 17/5/2020).

In the Latin America and Caribbean (LAC) region, an area where the average ratio for patient to hospital beds ranges from less than one in 1,000 to two in 1,000 – compared to the global average of 2.7 – an average of 30% of residents cannot access these already scarce health services for financial reasons, and 22% cannot access them because of geographic reasons. Access is expected to be particularly difficult for migrants, refugees, displaced people, people of Afro or Indigenous descent, and women, who may be more marginalised in these societies (UN Women and CARE, 01/5/2020). The situation may be more severe in Asia and the Pacific, where an assessment undertaken by UN Women found that 60% of surveyed women were unable to access a doctor because of the pandemic (UN Women 2020). A recent study of Nepal’s hospitals found that institutional childbirth has been reduced by an average of 52.4% in nine hospitals over the course of the national lockdown, correlated to increases in stillbirth rates and neonatal mortality. This could be a result of a variety of factors, but it is likely a result of reduced use of healthcare services potentially prior to and during birth as a result of COVID-19 lockdown containment measures (The Lancet 10/08/2020).

Strained household conditions may hamper women’s access to health and sanitary products or services. Households with limited financial means are likely to cut back on spending on sanitary towels or other goods that women require. Women and children may also face difficulties if their husbands or parents prevent them from leaving their homes to access services, especially if they are not the sole or primary decision-maker on issues related to their health (UN Women and CARE 01/4/2020); according to a survey undertaken in 57 countries only 23% of women indicated that they were the sole decision-makers on issues related to their health (UN Women, USAID 13/4/2020). With limited availability of healthcare services, women and girls are also more likely to take on the burden of caring for ill household or community members and may have less time to care for themselves or to devote to education or livelihood activities (CARE 30/4/2020). Disrupted services will place pressure on individuals to seek out private healthcare, which they may not be able to afford, and/or lead to people adopting risky behaviours, including foregoing medical care; these trying conditions may result in higher mortality and morbidity rates for vulnerable communities.

Disrupted routine vaccination services since March 2020 have also been reported in at least 68 countries, including moderate to severe disruptions or total suspensions of services, potentially affecting 80 million children under one year (WHO 22/5/2020). Alongside suspensions of mass vaccination campaigns, is expected to result in higher rates of future infection of diseases like diphtheria, whooping cough, cholera, measles, meningitis,

polio, tetanus, typhoid, and yellow fever, as well as longer-term impacts on child development and death from more severe transmitted infections.

93% of 130 surveyed countries worldwide have also reported disrupted mental health services which could seriously impact populations dependent on these – including trauma-survivors, like vulnerable women and girls, or LGBTQI+ individuals; pre-pandemic, such services were already chronically underfunded (WHO 05/10/2020).

Access to healthcare information is also a major issue for illiterate people – the worldwide majority of whom are women (UNICEF last accessed 13/8/2020). Illiterate adult women are likely to have less opportunities to move in public spaces and access official information, and reliance on informal communication channels can result in exposure to incorrect information that could hurt individuals and their families, especially in cases where women are the primary caregivers (CARE 30/4/2020; GoB, UN Women 17/5/2020).

Healthcare service access is often compromised in war zones, especially for women and children (Refugees International 07/5/2020); healthcare facilities in countries impacted by years of protracted war, like Yemen or Syria, may also have severe healthcare provision limitations, leaving some people reliant on humanitarian aid that could be inconsistent in its service provision and may be strained when dealing with COVID-19 caseloads. For instance, projections indicate that close to 55% of Yemen’s population will be infected, potentially causing over 42,000 deaths (AP News 15/05/2020; UN Women last accessed 29/08/2020). Law enforcement or military forces are more likely to harass men in some areas, which may limit their access to essential services like healthcare (UN Women and CARE 01/4/2020).

Reduced use of healthcare services

Reduced use of healthcare and sanitation services in the context of COVID-19 was likely driven by several factors, including reduced service provision, restrictions on movement, decreased finances, or behavioural reasons related to fear of contracting the virus. Both women and men in many contexts reported a lack of adequate WASH services to prevent the spread of the virus (CARE 03/5/2020).

Many reports highlighted how communities fear catching COVID-19 at health facilities, and in some countries or regions the use of healthcare services has slowed (UN Women and CARE 01/4/2020). There were also reports of widespread distrust and fear of health workers in West Africa, as well as Bangladesh (camp and non-camp settings) and other geographical areas (ACAPS 2020; UN Women and CARE 01/4/2020). This mirrors experiences during the West African Ebola epidemic in 2016, when healthcare workers became feared individuals. In anecdotal reports from Bangladesh, healthcare workers noted that women have not been using healthcare facilities at all. They also expressed concern about reduced antenatal care and life-saving comprehensive obstetric and newborn care,

which could result in increased maternal deaths, although there have been no recent representative data suggesting increased maternal deaths (GoB, UN Women 17/5/2020). Women and LGBTQI+ individuals may also share concerns over the provision of safe and private quarantine spaces (CARE and UN Women 19/05/2020).

LGBTQI+ healthcare access and usage

LGBTQI+ individuals worldwide face discrimination and penalisation due to their gender identity and/or sexual orientation. LGBTQI+ individuals are more likely to experience poverty, lack healthcare, attempt suicide, and be subjected to physical or sexual violence than their heterosexual and/or gender-conforming counterparts. This is often the case even in societies considered more accepting of LGBTQI+ identities (IRIS France 05/2018). Homosexuality is still punishable by law in 68 countries and subject to the death penalty in more than 12 (Business Insider 17/05/2020). In many countries where it is legal, discriminatory legislation still targets LGBTQI+ individuals and legislation such as not allowing name changes may have direct consequences for access to services and general wellbeing. Access to services for LGBTQI+ people has likely worsened during the pandemic as public resources and general livelihood opportunities have become more scarce.

Some specialised healthcare services are particularly crucial for the LGBTQI+ community, such as HIV/AIDS care, hormonal treatment, and counselling. However, it is probable that the provision of these services has been reduced or their resources allocated to COVID-19 treatment in many contexts (CARE and UN Women 19/05/2020); for example, 73 countries reported that they were at risk of running out of anti-retroviral medication stocks in July, putting vulnerable populations, notably LGBTQI+ populations, at risk (WHO 06/07/2020). LGBTQI+ communities may also reduce their use of already limited healthcare services as they may fear discrimination, unwelcoming attitudes, and a lack of understanding from healthcare providers, especially in contexts where reduced frequency of healthcare services could mean that LGBTQI+ people are more conspicuous when accessing services. In some countries, LGBTQI+ individuals have been blamed for the pandemic itself (The New Humanitarian 24/06/2020; National LGBT Cancer Network 2020). They may have less financial capacity to access private health facilities, in areas where public services are overwhelmed (CARE and UN Women 19/05/2020). They may also not be included within community support networks and planning (The New Humanitarian 24/06/2020; National LGBT Cancer Network 2020).

Impacts on men's health

Pre-existing negative perceptions of health-seeking behaviour in men, which studies indicate may be a widespread issue in the US and the UK, could prevent men from seeking health services (Springer and Mouzon 2011; Galdas et al., 04/2005). Health problems arising from this could be aggravated by a context where health services have been reduced, restricted, or redirected to COVID-19, which could result in rises in severe illnesses and injuries, as well as undetected chronic illnesses (UNFPA 03/2020). Men may be more susceptible to certain illnesses and syndromes, are more likely than women to get ill at a younger age, and more likely to suffer chronic illnesses than women (Harvard Medical School 26/08/2019). Men are also over-represented globally in COVID-19 confirmed and suspected caseload figures, in hospitalisation rates, ICU admissions, and in mortality rates (Global Health 5050 last accessed 30/09/2020). Analysis from SARS and MERS, both of which had gendered caseloads, points towards a complex of different pre-existing behaviours and social and economic conditions to account for these differences (NYT 24/06/2020). Some studies have indicated that men in many countries, like China, are more likely to be in a poorer state of health than women (in the case of China, COVID-19 male patients were more likely than female patients to have any comorbidity or to have two or more of them) (NYT 24/06/2020).

Reduced access to WASH services

In 2017, 2.1 billion people worldwide did not have access to safe drinking water at home and 2.3 billion did not have basic sanitation infrastructure (Kayser et al., 2019). This indicates an enormous number of people who do not have adequate access to clean water and/or sanitary spaces needed to limit the spread of diseases. Although both women and men are affected by these challenges, the consequence is often greater for women and girls. In areas where households do not have access to water at home, it is often the job of women and girls to fetch water, which poses a safety risk, with potential exposure to harassment and rape, and a physical toll on the body with regular long-distance travel. This may also result in lost time for education and work (UNICEF 29/08/2016). Women who are pregnant, lactating, or caring for family members may need to use more water than men (Kayser et al., 2019). In many countries, WASH facilities may not be adapted to ensuring the needs, safety, and privacy of women and girls. In such cases, using the bathroom can be a stressful or traumatic experience (Kayser et al., 2019). Women and girls may also face challenges accessing menstrual sanitation products. Public WASH facilities may also not be adapted to requirements for people with disabilities, which will likely make handwashing and other prevention measures difficult (World Bank 15/05/2020).

Other impacts

Food access limitations and increased malnutrition rates

Vulnerable populations are expected to face food insecurity and resulting malnutrition and micronutrient deficiencies in regions where the secondary impacts of COVID-19 containment have led to price rises and/or lost livelihoods (Care and OCHA 09/2020; UN Women 16/5/2020). Disruptions in global economic, food, and health systems, and a lack of effective social safety nets worldwide, may push 140 million people into extreme poverty and food insecurity (projected scenario from April 2020) (IFPRI 16/04/2020). Food insecurity in many places may also be a gendered phenomenon: for instance, in the oPT, on average 31% of female-headed households are food insecure as opposed to 26% of male-headed ones (Care and OCHA 09/2020). Studies have also indicated that, within households, men are more likely to consume more calories than women (Pitt et al., 1990; D'Souza and Tandon, 2015) and to benefit from more food resources than women (Broussard 2012).

Worldwide, women are more likely to suffer from malnutrition than men, which makes them more susceptible to infection and more severe forms of COVID-19, and eventually to mortality (Handu et al., 2020). Pregnant and breast-feeding women are at particular risk of malnutrition or of exposing their children to malnutrition in these conditions.

Risks faced by people with disabilities and older people

People with disabilities worldwide face many barriers in their daily life. Studies have found that people with disabilities were less likely to receive healthcare when they sought it (WHO 2018; WHO 2011), despite often having more healthcare needs than their able-bodied counterparts. People with disabilities were also identified as less likely to receive promotional health information, for their needs to be addressed through advocacy (WHO 2018; WHO 2011) or to receive preventative health care (WHO 2018).

Disability is multifaceted, and people with disabilities do not all experience the same challenges. Disability is not gender-neutral; disabled women and girls worldwide are two to three times more likely to be subject to sexual or physical abuse, forced sterilisations, abortion, and institutionalisation than their able-bodied counterparts, and are less likely to complete primary school (CBM 11/2019). Many governments have expressed commitments addressing some such barriers, but people with disabilities continue to need to negotiate inaccessible public infrastructure, lack of adapted care, and other issues that prevent them from adapting to major events such as the outbreak of COVID-19 (WHO 2011).

Older women and men may be particularly susceptible to contracting COVID-19 if containment strategies are not designed with their specific needs in mind; they may also be exposed to neglect or abuse, which is a particular concern among those living in residential institutions (HRW 11/06/2020) where independent oversight to monitor potential

abuse and neglect may be disrupted as a result of visiting restrictions (HRW 11/06/2020; CARE 27/4/2020). Emerging evidence indicates that abuse and neglect of the elderly have both increased as a direct result of the pandemic (HelpAge 15/06/2020). In Cameroon, disabled people have protested that poorly adapted social distancing rules have discouraged caregiving for disabled people and that containment information was not made available in alternative formats, like braille (VOA 15/06/2020).

Mental Health Impacts

Recent research indicates that COVID-19 could result in neurological and mental complications, including delirium, stroke, and agitation which require adapted aid (WHO 05/10/2020). Pre-existing mental, neurological, and substance use disorders may also increase an individual's probability of catching the virus and of being susceptible to more severe strains of COVID-19 (WHO 05/10/2020). Active and accessible mental health services are therefore necessary, although pre-pandemic an average of only 2% of national budgets were allocated to mental health services, and only 17% of countries surveyed that reported including mental health and psychosocial support as part of COVID-19 response plans have additional funding for these services (WHO 05/10/2020). 93% of 130 surveyed countries also reported that mental health service provision has been disrupted (WHO 05/10/2020); this could especially impact individuals dependent on resources, such as survivors of trauma and LGBTQI+ individuals, alongside individuals recovering from addiction or who may be having a difficult time coping with the emotional or physical toll of the pandemic (WHO 05/10/2020).

The pandemic is likely to have led to increased stress, anxiety, and depression across countries: fear of catching the virus alongside restrictive government measures could be driving these, as well as weakened community support networks as populations undertake physical distancing or isolation (WHO last accessed 07/10/2020). People are also adapting to new ways of life in terms of employment and education, which could increase these stresses. These consequences are also gendered: A survey of Bangladeshi women indicated that 61% had been affected by mental or emotional distress because of the pandemic (GoB, UN Women 17/5/2020). In surveys undertaken across West Africa, Asia and the Pacific, and Europe, a higher proportion of female than male participants indicated that they had experienced fear and anxiety as a result of the pandemic (CCSA 31/08/2020; CARE 19/09/2020). Because of domestic violence and/or their potentially increased domestic care burden, women are particularly likely to face physical, emotional, and mental strain and stress, which could lead to more severe symptoms (Smith 28/06/2019; CARE and UN Women 19/5/2020).

Women as health and care workers

70% of social sector and healthcare workers worldwide are women (WHO 03/2019); women also make up 80% of nurses in most regions, exposing them to prolonged contact with potentially sick patients. Emerging evidence indicates that women health workers are three times more likely than their male counterparts to be infected by the virus (UN Women 2020); women healthcare workers are more likely to be on the “front-line” as responders, including as nurses, midwives, and community care workers, and so are likely to be more exposed to the virus. For instance, in Palestine, a disproportionate ratio of public-facing work – including in the healthcare sector or in education – is held by women, potentially exposing them further to the virus (CARE 03/05/2020). In many Eastern, Central, and Southern African countries, young women make up a large proportion of the healthcare force and most of them are not paid for their services (CARE 30/4/2020). Women worldwide are also more likely to work as cleaners, launderers, and caterers within health facilities (UN Women last accessed 29/09/2020) and potentially work longer hours as a result of the pandemic, resulting in increased stress and strain. PPE equipment is also unlikely to be designed for women’s bodies, which could expose them even further to the virus (UN Women 15/5/2020; CARE 30/4/2020; CARE and UN Women 19/5/2020; GoB, UN Women 17/5/2020; UN Women and CARE 01/5/2020). Women healthcare workers can also face a gender pay gap, which results in fewer financial options for households dependent upon women workers, especially during the pandemic (WHO 03/2019). Some women healthcare workers have also reported being harassed or subjected to discrimination because of their work. For instance, in the Philippines in the months of April and May, reports emerged that some women healthcare workers had been denied transportation and access to basic goods (CARE and UN Women 19/5/2020; Fraser 16/03/2020; CARE 30/4/2020).

As well as the increased hours and workplace intensity resulting from COVID-19, the potential exposure to the virus, and added mental and physical strain and trauma, women healthcare workers often have an extra care burden in their private lives and may be more subject to strain and burnout because of longer working hours and more trying conditions (CARE and UN Women 19/5/2020). This may reduce their wellbeing and the efficiency of their work as COVID-19 responders (UN Women 11/6/2020; CARE and UN Women 19/5/2020; WHO 03/2019). In general, women will likely have to take on additional informal work or add a further load to their care burden because of the pandemic, and they are more likely to do so than their male counterparts (Power 2020). In Bangladesh for instance, as a result of increased handwashing and a need for more water, women and girls must fetch water more frequently, diverting time from other productive activities, and potentially exposing them to violence (GoB, UN Women 17/5/2020).

Lessons learned

Several lessons can be learned from the past about the direct and indirect impacts of epidemics and containment measures on different genders, including lessons from the West African Ebola epidemics and the Zika virus epidemic.

A general lesson derived from previous crises points to the pattern that people who already face multiple forms of discrimination *prior* to a crisis are more likely to face higher risks and more obstacles in accessing essential services *during* a crisis (UN Women and CARE 01/5/2020). Entrenched social and economic inequalities, likely mirrored through gender inequalities, are also strong determinants of health in both crisis and non-crisis contexts (Davies and Bennett 31/08/2016); addressing such inequalities are not usually part of healthcare responses, which often reserve such structural issues for “later”. Addressing inequalities should be part of healthcare responses, within the confines of humanitarian principles.

Conceptions of women and girls as caregivers and mothers also limits healthcare responses, focusing on reproductive health without due attention to other health needs (Davies and Bennett 31/08/2016). Women’s traditional roles as domestic and professional caregivers in many places may also expose them to infection. International health advice disseminated during the Ebola and Zika epidemics was also unlikely to have adequately addressed women’s pre-existing health service access issues and limited rights when providing information directed towards women. For example, women in the LAC region were told to avoid pregnancy because of the Zika virus’ association with birth defects, but many of the most vulnerable women from rural and/or Indigenous communities (who may have been more likely to be exposed to the virus) did not have easy access to contraceptives, sex education, and safe unrestricted abortions and could not necessarily prevent pregnancy safely. Adapted information that is also accessible to disabled populations should be provided and should take into consideration existing contextual barriers (Davies and Bennett 31/08/2016).

Behavioural tendencies identified during other epidemics risk being replicated over the course of the current pandemic. Parents in several countries struck by epidemics like SARS, swine flu, or bird flu were more likely to delay routine check-ups and vaccinations for their children, which could result in preventable diseases occurring at a later stage and potentially affecting childhood development; it was also found that mothers tended to take time off to care for children affected by such diseases (Power 2020). By ensuring that regular health services are still available and encouraging regular health awareness, collateral impacts on children and their caretakers, which are often gendered, could be minimised.

Another key lesson is to plan for the inadvertent consequences of diverting routine healthcare services to respond to a new epidemic. During the West African Ebola epidemic, public healthcare services diverted their resources to containing and treating the epidemic. This resulted in a 6% reduction in public family planning services which in turn resulted in a high number of unplanned pregnancies, especially among poorer women and teenagers who depended on public services. A 22% reduction in antenatal care increased maternal mortality by an average of 70% in a region that already had some of the highest rates, alongside a 13% reduction in postnatal care, again among poorer women and families who depended on public services (Robertson et al., 2020; Smith 28/06/2019). The epidemic also resulted in high healthcare personnel mortality rates and long-term reductions in healthcare personnel, with consequences on the general populations' health; it was estimated that an additional 4,022 women died annually from childbirth in Guinea, Liberia, and Sierra Leone as a result of Ebola healthcare worker deaths (Davies and Bennett 31/08/2016).