



Evolving Trends: Women in COVID-19

3 months after CARE's first Rapid Gender Analysis on COVID-19, what has changed, what is the same, and what do we know now?

Executive Summary

In the three months since CARE released its [first Rapid Gender Analysis of COVID-19](#), the situation has evolved quickly and spread globally. CARE has continued to closely monitor this situation, by conducting context-specific analyses in 5 regions covering 64 countries. To date, CARE and partners have [published 27 Rapid Gender Analyses](#), and has 24 more in process. This has included conversations and data collection with more than 4,500 women.

This new analysis confirms the initial findings and predictions of the first analysis. It also reveals new areas of high priority for women and girls—and for men and boys—as the crisis deepens. Our recent research reveals:

- The highest immediate priorities 3 months into the crisis are **food, income, and rights**—including concerns around Gender Based Violence, caregiving burdens, and mobility. Women and girls show these needs most acutely, but they also rise to the top of men and boys' priorities in COVID-19.
- **Women's burdens are increasing.** As frontline workers in the health system, as survivors of Gender Based Violence, as the people primarily responsible for food, cleaning, and childcare—especially with schools closed, women confirm that their burdens are rising, and so is the stress around them.
- Women are **displaying remarkable leadership**, but are still unable to access most decision-making, around COVID-19 and around daily life. They are also **quickly approaching the end of their safety nets.**

In this context, this document provides updated recommendations to focus on lessening the immediate impact on women and providing the chance to build back equal. These recommendations cluster around:

- **Urgently addressing top priorities** of food, income, and rights by expanding safety nets—both in the immediate response and in long-term ways for all people to provide their own food and livelihoods.
- **Reducing women’s burdens** by providing extra support for caregiving, services for GBV prevention and response, and investing in women healthcare workers.
- **Prioritizing women’s leadership** by creating space for women leaders at all levels of the response, and consistently listening to women’s perspectives and data as the crisis evolves.

Introduction

On March 11, WHO declared COVID-19 a global pandemic, and the majority of governments around the world responded by implementing quarantines and social distancing measures to control the spread of the disease as much as possible. Many governments also released stimulus packages and expanded social safety nets to balance the economic impacts of these increased restrictions. On April 1, CARE and IRC released the first [Rapid Gender Analysis](#) to examine the potential gender impacts of the crisis.

As of July 1, 2020, there have been more than [10.6 million confirmed cases of COVID-19 globally](#), and more than 515,000 deaths. This disease has unleashed not only a global public health crisis, but also parallel crises in many areas of life—from food to human rights. There is still woefully little sex-disaggregated data about COVID-19, not only as a disease and its symptoms, but also as the devastating economic and social consequences become clear. For example, the data released by the [World Food Programme](#) and subsequent data about the impending hunger pandemic, do not mention women at all. While death rates are reported for men and women separately, other data about the disease do not yet show us a picture of how the disease behaves differently for men and women.

In early March, CARE International identified the need to analyse the gender and intersectional impacts of COVID-19. To achieve this, CARE first developed a [policy brief](#) to review lessons learned from previous public health emergencies. CARE then adapted its [Rapid Gender Analysis toolkit](#) to develop the **Global Rapid Gender Analysis on COVID-19**, which highlights the gendered impacts of the COVID-19 pandemic. This report is for humanitarians working in fragile contexts that are likely to be affected by the COVID-19 crisis. It is organized around broad themes and areas of focus of particular importance to those whose programming advances gender equality. It seeks to deepen the gender analysis available by bringing learning from the global gender data available for the COVID-19 public health emergency.

In the months since the global pandemic started, the situation has evolved quickly at all levels and in all contexts. CARE has worked with partners around the world to continue analyzing the gendered impacts of the crisis, and to examine the country and regional impacts COVID-19 is having and will continue to have on women and girls; especially those from at-risk or marginalized groups. We have now conducted Rapid Gender Analyses (RGA) in [Latin America](#), [Asia Pacific](#), [Middle East and North Africa](#), [East and Central Africa](#), and [West Africa](#). In addition to regional level analyses, we are also conducting country specific RGAs. Collectively, these analyses cover more than 64 countries around the world. They have involved conversations and data collection from more than 4,500 women. In addition to bearing out the key findings and hypotheses of the [first global RGA](#), this additional analysis reveals a worrying trend in rolling back women and girls’ rights and access, as well as important impacts in women’s economic empowerment, access to income, food and nutrition security, and political participation, as well as safety and security in the home and community.

These analyses also show glimmers of hope, as women are organizing themselves to take the initiative in COVID-19 response and finding innovative solutions through crisis. Many governments are responding to the crisis with increased social safety nets, including various responses that have been deliberately designed from a gender and intersectional perspective —although there is room for improvement reaching women and including women as leaders in these decisions. We are also seeing instances where men are taking on more unpaid care work while everyone is at home.

Key Findings

Highest Areas of Concern

- **Many women are seeing a rollback in their rights:** As fear and stress are going up, women are often seeing a rollback of their rights. In many countries, families are being “overprotective” and restricting women’s mobility and public participation even further than government restrictions require. In [Bangladesh’s Cox’s Bazar](#), men, women, and community leaders in are blaming women’s “dishonorable” behavior as the cause of COVID-19, causing a backlash against women’s rights. Women are experiencing more behavior policing, mobility restrictions, and Gender Based Violence.
- **Food Security is a primary concern:** All over the world, people of all genders are reporting that food is among their biggest and most immediate challenges as a result of COVID-19. 90% of women in [Bangladesh](#), 64% of families in [El Salvador](#), and 50% of people in [Jordan’s Azraq refugee camp](#) are reporting food shortages. This is even more acute for women, who are most often held responsible for providing and preparing the family’s food, so food shortages put special stress on women. [Haiti](#) and [Bangladesh](#) are struggling to provide lifesaving treatment for malnutrition in the current crisis.
- **Women are the first to feel economic losses:** All people—women and men, girls and boys—consistently identify income as one of their highest concerns in the current crisis, with women experiencing some of the biggest pressures. Around the world, women are most often employed in the informal sector, with few formal protections or paid benefits. They are also most often employed in industries hit hardest by COVID-19 restrictions, such as petty trading and the service industry. In [Palestine](#), 1 in 2 women has lost all income because of COVID-19, compared to 1 in 3 men. In [East Africa](#), 74% of women are in the informal economy, where they are already feeling economic losses. In [Latin America and the Caribbean](#), 126 million women are in informal labor markets, and 40% of women are in the service industry where they are already losing income. In the [Philippines](#), women are 17% more likely to see their hours cut because of COVID-19 than men are, and in [Bangladesh](#), the gap is 69%. In the Mekong region, 75% of women garment factory workers are facing job loss. 24.5 million women in the tourism industry in Asia may be losing their jobs. Men hold roughly 84% of jobs classed as “essential” across the Mekong region. In Cambodia, 94% of women are in the informal sector.

“There is food crisis everywhere and this is even causing violence in families”
- District Commissioner,
Uganda

Women's Additional Burdens in COVID-19

- **Gender Based Violence is rising.** The [original RGA](#) predicted potential rise in GBV, and continued analysis bears this out. Most countries and regions are reporting rises in GBV and increasing difficulty in accessing GBV services. From [Colombia](#), where calls to GBV hotlines have increased 90%, to [Zimbabwe](#), where GBV responders are reporting that cases have more than tripled, to [Asia](#), where reports of GBV through hotlines, women's actual experience of GBV is increasing because of COVID-19. At the same time, quarantines and movement restrictions make it harder to track GBV cases, and harder for women to get support. This may explain why some countries—such as Guatemala and Ecuador—have decreasing GBV reporting, because women in quarantine because their abuser watching.
- **Caregiving burdens are increasing:** [As predicted](#), women are reporting increased caregiving burdens. In addition, caring for the sick, providing more meals for more people each day is further increasing women's burdens. Globally, women do 3 times more unpaid care work than men, adding a total of [\\$10.2 trillion](#) in value to the global economy. Especially in West Africa and [Uganda](#), women are reporting additional stress and caregiving as every member of their family is at home all day. In the Mekong region, the 260,000 migrant workers who have left Thailand for their home countries are adding to women's caregiving burdens at home.
- **School closures are having compound effects for women.** The majority of schools are closed in the countries this analysis covers, with no predicted dates to reopen. Millions of children who relied on school meals—85 million in [Latin America and the Caribbean](#) alone—for some or all of their daily meals are now struggling to access enough food. In [Jordan](#), 61% of refugees and poor households are struggling to access online school platforms. Women are most often responsible for children's education, and this is significantly adding to their caregiving burden and, consequently, decreasing the time they have available for essential, paid work.
- **Women are on the frontlines of the crisis.** In all the countries this analysis covers, women make up between 70 and 80% of the nursing and frontline health care staff, for lower pay than men, and in many cases, for no pay at all. In [East Africa](#), the vast majority of women health workers are unpaid. At the same time, about 75% of people who make decisions about health services are men with limited understanding of what frontline health workers need.

"You carry your suffering alone because women cannot even come to keep you company and console you anymore."

Woman in West Africa

Access to Resources and Information

- **Women are losing access to critical services.** As [predicted](#), women are losing access to critical services as a result of COVID-19, and it's costing lives. In [West Africa](#), women report that they are too afraid to go to health services even where they remain open. In [Bangladesh](#), 25% of health workers report that they are seeing fewer women come to get maternal health services, and 43% report hearing of a

"I have given up going to the Safe Space because the staff don't come to work anymore. That reduces my chances to get the services I need."

Displaced Woman in North East Nigeria

Voices of Women: Gloria* in Ghana

“I am just praying that the medical scientist gets the vaccines because the disease has come to stay with us and some of us may not survive in our homes if this continues. Now ***I’m experiencing the fear of my husband and the fear of the disease at the same time.***”

Before, her husband worked in another city, and only came home at night, if he came home at all. She describes her life when he was working as a “partial peace.” Now, her husband isn’t working because of the pandemic, and is at home all day. ***“Hmmm!!!, my sister there are two major things that my husband can do in this house, to either beat you mercilessly or sex you violently.”***

In addition to the burdens of an abusive husband with nowhere else to go, Gloria and her family are struggling to eat. Before, women could take public transport to the market, but public transport has stopped, and markets have been closed for weeks. Gloria hasn’t been able to buy soap, and her family are eating more starches and less protein because they can’t buy a more balanced diet in the market. Gloria hasn’t been able to earn money either, since she used to sell vegetables in the markets that are now closed.

Gloria has a hard situation, but she’s not giving up. She’s been working with a savings group for nearly 4 years. The group has been hit hard, and no one has extra money to save. Even without money, they are still finding ways to support each other. These women, in the scariest of situations, are finding ways through. More than that, they are supporting their communities.

The women in Gloria’s savings group are organizing themselves to plant and harvest each other’s fields. That way, no one’s crops rot in the field, and no one has a field without crops in it. This means these women and their neighbors might get to eat this year.

“I think there is more to learn about the disease and would wish to obtain knowledge about the coronavirus disease from health workers than just what I have heard. In this way, we can boldly go out there to speak to each household.”

maternal or child death in the last week. In [Palestine](#), only 8% of women—compared to 67% of men—can access a mental health service. Women have often relied informal safe spaces as primary way to get care, and these are closing as “non-essential services” in [Asia Pacific](#), [Latin America and the Caribbean](#), the [Middle East and North Africa](#), and [West Africa](#). In [MENA](#) especially, women cannot access services because most or all of the medical professionals who are still active—100% of workers in [Palestine’s](#) quarantine centers for example—are men. This makes it unsafe and socially unacceptable for women to access lifesaving care.

- **Women are struggling to access information:** As the majority of information sharing moves online to comply with social distancing requirements, women are getting left behind. In [Palestine](#), 30% of women—and zero men—report having trouble accessing information because they cannot get access to technology. 76 million women in [Latin America](#) and the Caribbean cannot access mobile internet services. Africa has the biggest digital divide in the world, with as few as 19% of women able to access the internet. Even more traditional media—like radio and TV—are hard for women to access, as men control what families consume and when. COVID-19 mobility restrictions are compromising the informal and in-person networks women typical rely on to access information and support.

Participating in Decisions

- **Women have less access to decision making.** Women in all countries report that they have little access to decision making. There is little change during the COVID-19 crisis, although cases like [Cox's Bazar](#) in Bangladesh show that women are losing ground on access to decision making. Similarly, few women are involved in national and global decision making about COVID-19 response. In Vietnam, out of 22 members of the COVID-19 task force, only 4 members are women. In [Colombia](#), migrant women report they no longer have access to formal local decision-making structures at all, because their only avenue was formal municipal meetings, which have been suspended because COVID.
- **Water and Hygiene needs hit women the hardest, and men are overlooking them.** Women around the world are most responsible for collecting and managing water for their families, and women repeatedly raise this as their primary concern. In [Bangladesh](#), women report that they feel least safe when collecting water, and that they are spending more time collecting water to meet increased handwashing measures. In [Palestine](#), 100% of women and zero men report that water is one of their primary concerns. In [West Africa](#), women report having to choose between buying food and soap. Because men do not often see these needs, we risk overlooking them in our response to this crisis.

“Impossible doesn't exist in our language. We should stand up and find ways to fight this pandemic and save our lives.”

-President of a Savings Group Federation, Niger

Women as Leaders

“She died not because of negligence, only that there was no transport to take her to the hospital since by that time all the public transport means had been blocked due to the danger of COVID”

Woman in Uganda

- **Women are finding ways to lead in crisis.** In [West Africa](#), women in savings groups are organizing to share information with each other, especially those who do not have access to mobile phones or internet. They are also organizing to make and sell masks and soap, arrange for handwashing stations in towns and markets, and to keep markets open. In [Palestine](#), women were more likely to adapt their businesses to COVID-19 realities than men were. In [Cox's Bazar](#), refugee camps with women leaders were more likely to have democratic processes to include women's voices and vulnerable people in organizing COVID-19 response. Women are still dramatically underrepresented in decision making spaces around COVID-19, especially at formal and national levels, but they are mobilizing their own responses.
- **Women are coming to the end of their own safety nets.** While women in [West Africa](#), [the Pacific](#), and [ECSA](#) are finding ways to adapt their activities, the savings groups that they depend on as safety nets are less able to function in COVID-19. Mobility restrictions are already compromising activities, and many groups have shared out all of their existing savings to help women meet immediate needs. In [Palestine](#), all of [MENA](#), and [West Africa](#), women are diverting money from businesses and income generating activities to meet basic family needs. In [Palestine](#), 39% of women say they have no additional resources that they can use to respond to the crisis.

Voices of Women: Aichatou Sittou, Mali

Aichatou Sittou is the president of her savings group and mother of 7. “My children’s education is one of my biggest worries. I just want them to go back to school. Eid is approaching and we will still be in lockdown at home.

We were planning to do some agro-business, sale cosmetics and do some tailoring as a means to earn an income. The pandemic has put a stop to that.

We were able to adapt by sewing face masks to save lives instead of new cloths for the Ramadan Eid. We are a group of 20 young women. Since the start of the pandemic, I personally make 300 masks on average per day. I have produce 6000 masks since then and was able to make a turnover of 3,000,000 FCFA (5000 USD) over a period of one month at a price of 500 FCFA (0.9 USD) per mask. I made a net profit of 700,000 FCFA (1165 USD). The other members of the group also make masks, some faster than others. The slowest makes 20 masks per day, the average ones make 100 to 150 mask per day.”

Refugees are at special risk

- **Refugees are facing additional burdens.** Especially in [ECSA](#), [MENA](#), and [LAC](#)—regions with very high populations of displaced people—densely crowded settlements, lower access to information, little access to water and hygiene services, little access to markets and supplies, and weak or nonexistent health systems are greatly increasing the risk of COVID-19 and its secondary effects like lack of food and income. In [Cox’s Bazar in Bangladesh](#), 45% of people are already malnourished, and the number is even higher for women. In [Northwest Syria](#), 91% of people have no access to soap.

Recommendations

Address Women’s Biggest Concerns Immediately

“Without adequate support, the long-term costs of stretching women’s work to patch up the holes in social protection and public services provision can be enormous.”

UN Women

- **Urgently prioritize women’s access to social safety nets.** All of the countries included in this analysis highlight that women are facing the biggest impacts in food security, income loss, and caregiving burdens. They are also quickly reaching the end of their own resources. We applaud governments’ efforts to expand social safety nets and offset economic impacts for COVID-19, and call on all governments to continue to expand this support, with a specific focus on women as recipients who can control resources.
- **Expand benefits and safety nets to those who are currently excluded.** Refugees, migrant workers, and those in the informal sector are often left out of the current support systems. For example, sex workers in [Myanmar](#) are unable to access any safety nets. Refugees in [Latin America and the Caribbean](#) are not entitled to benefits

of the regular protection systems. We need to include all women in employment benefits and protections that currently exist, but women are dramatically less likely to access.

- **Include messaging around women’s rights and gender equality in all COVID-19 related communications campaigns.** As women are facing a rollback of rights, governments and humanitarian actors are in a position to combat that problem by designing COVID-19 messaging that promotes women’s rights and gender equality, reconfiguring mobility restrictions to specifically create space for women to leave the house and access markets and services, and preserving women’s safe spaces in socially distanced ways.

Act to Reduce Women’s Burdens

- **Prioritize GBV prevention and response as life-saving interventions:** Include them as part of the initial COVID-19 responses. This includes, but is not limited to, the clinical management of rape, psychological first aid, and referral to other services, including case management. Apply a zero-tolerance approach to sexual exploitation and abuse. All staff and volunteers must be briefed on and have signed and understood an industry-standard code of conduct and PSEA obligations. PSEA reporting mechanisms for the local context must be understood and followed by all staff.
- **Find ways to help women with childcare.** Women are struggling under a dramatic burden of childcare, especially with school closures. This is further pulling women out of the workplace and creating economic and income impacts for women and their families. Encouraging men to support more with childcare, finding appropriate and safe ways to keep childcare and schools open, and other ways to reduce that burden are urgently needed to reduce women’s burden and make other activities—like providing incomes and food—possible. This is especially true for women healthcare workers who are making difficult choices about how to care for their families and keep their jobs.
- **Engage men in water, hygiene, and increased care work.** Women are continuously calling for more support around water and hygiene in ways that men are not. We need to ensure that all humanitarian responses are including water and supplies for hygiene, and reducing women’s burden to access and allocate water to the household. Current analysis and decision-making risks overlooking this critical need because men do not seem to recognize it as acutely as women.
- **Invest in women healthcare workers.** Women are doing most of the frontline health care and provide the dramatic majority of behavior change work around the world promoting hygiene, vaccines, and other basic health behaviors. They will be key in not just the immediate response to COVID-19, but also the long-term changes we will need to prevent future pandemics. Governments should prioritize paying these workers, providing them with the protections they need, and getting more women health workers active on the frontline—safely and with attention to their needs and rights.

Support access for women

- **Design information systems that reach women.** The information gap between men and women is widening because of COVID-19. In the short term, this means all actors should find ways for women to access information about COVID-19 and related services and support. In the long term, it requires all actors to invest in women’s access to technology, internet bandwidth, and other remote ways of accessing information.

- **Continue to monitor women's experience in COVID-19.** This second round of data collection and analysis displays that women's experience of COVID19 is critical, rapidly evolving, and varied from country to country. These experiences provide vital information for informing responses at all levels. We need to continue prioritizing collecting sex and age disaggregated data, and continually updating our understanding of impacts on women as the crisis evolves. We also need to continue the Rapid Gender Analyses over time to continue to understand national-level context and the trends as the situation evolves.

Prioritize Women's Leadership

- **Build responses with women as leaders.** In the current crisis, women are reaching the least reachable people, providing the frontline health response to the most remote people, keeping markets functional, and finding ways to provide care and education for millions of children out of school. To reinforce women's leadership, we recommend:
 - All COVID19 taskforces at all levels should include these women to ensure that solutions work for them.
 - In immediate humanitarian responses, all COVID-19 quarantine and response centers must include women health workers, and women trained in GBV response and reproductive healthcare to start covering critical gaps in women's health needs.
 - All actors should continue investing in work that promotes women's leadership at all levels.
- **Support two-way, community-based risk communication and accountability approaches.** Leverage the capacities of community groups, particularly women's groups, to support two-way risk communication approaches in order to dispel myths and misinformation about COVID-19. Where feasible, engage them to support local surveillance systems.
- **Address gaps in women's participation in decision-making in the workplace.** Work with employers, including health care providers, to address the specific risk of COVID-19 exposure to women and to take into account women's heightened unpaid care work responsibilities.