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The Impact of COVID-19 on Gender Equality and Food Security in the Arab region with a focus on the Sudan and Iraq



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Cover image: ©WFP/Mahmoud Mohamed. The photo is from Egypt where WFP supports over 50 000 mothers in vulnerable communities with livelihood enhancement activities and 10 000 mothers with microloans to help them launch income-generating activities.

Contents

Abbreviations	VI
Authors & Acknowledgements	VII
Executive Summary	VIII
Introduction	1
Rapid gender analysis objectives	1
Methodology	2
Regional Background with a Focus on Iraq & the Sudan	5
Food security in the region	6
Gender roles and relations (paid and unpaid labour)	6
Access to services and resources	8
Coping mechanisms	10
Decision-making, participation and leadership	11
Safety and protection	11
Iraq Country Analysis	13
Demographic profile	13
Findings and analysis	14
Gender roles and responsibilities	15
Impacts on unpaid work	19
Food insecurity	22
Access to services and resources	26
Impacts on resources and coping mechanisms	28
Decision-making, participation and leadership	31
Safety and protection	34
Areas for future analysis	36
The Sudan Country Analysis	39
Demographic profile	39
Findings and analysis	40
Gender roles and responsibilities	42
Food insecurity	46
Access to services and resources	50
Impacts on resources and coping mechanisms	52
Decision-making, participation and leadership	54
Safety and protection	57
Areas for future analysis	57
Conclusion	61
Regional Recommendations	62
Country-level recommendations for the government, FAO, WFP and humanitarian actors	63
Cross-cutting country-level recommendations	65
Notes	67
Annex 1	84
Supporting methodology, field plans and further details on approach	84
Annex 2	87
Demographic breakdown of respondents	87

Figures and Tables

Regional overview

Figure 1: CARE Women Respond data - Unmet needs in the region

Figure 2: CARE Women Respond data - Impacts seen from COVID-19

Iraq – Country analysis

Figures

- Figure 1b: Areas of life most impacted by COVID-19, disaggregated by male and female respondents
- Figure 2b: Priority needs today, disaggregated by male and female respondents
- Figure 3b: How would you best describe your employment status during a typical week? (Overall male)
- Figure 4b: How would you best describe your employment status during a typical week? (Overall female)
- Figure 5b: Percentage of female and male respondents reporting unemployment before COVID-19 compared to today, disaggregated by location and sex
- Figure 6b: Percentage of respondents whose engagement in the following tasks increased since COVID-19, disaggregated by sex
- Figure 7b: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by sex
- Figure 8b: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by age
- Figure 9b: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by relationship to household head
- Figure 10b: Accessing healthcare for yourself, disaggregated by relationship to household head
- Figure 11b: Loss of savings due to COVID-19, disaggregated by residency status
- Figure 12b: Respondents who used credit or borrowed money to purchase food, disaggregated by relationship to household head
- Figure 13b: Respondents who used credit or borrowed money to purchase food, disaggregated by sex and residency status
- Figure 14b: Purchasing food (today), disaggregated by relationship to household head
- Figure 15b: How income is spent (today), disaggregated by relationship to household head
- Figure 16b: Working to earn money for yourself (today), disaggregated by relationship to household head
- Figure 17b: Buying or selling assets, disaggregated by relationship to household head
- Figure 18b: Use of savings, disaggregated by relationship to household head

Tables

- Table 1b: Iraq Population figures, disaggregated by age, for 2021
- Table 2b: Female respondents who reported their engagement on household tasks increased, disaggregated by location type
- Table 3b: Male respondents who reported their engagement on household tasks increased, disaggregated by location type
- Table 4b: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, mostly due to COVID-19, disaggregated by age
- Table 5b: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, mostly due to COVID-19, disaggregated by location type

The Sudan – Country analysis

Figures

- Figure 1a: Areas of life most impacted by COVID-19, disaggregated by male and female respondents
- Figure 2a: Priority needs today, disaggregated by male and female respondents
- Figure 3a: How would you best describe your employment status during a typical week? (Overall male)
- Figure 4a: How would you best describe your employment status during a typical week? (Male youth)
- Figure 5a: How would you best describe your employment status during a typical week? (Overall female)
- Figure 6a: How would you best describe your employment status during a typical week? (Female youth)
- Figure 7a: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by sex
- Figure 8a: Total Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by age
- Figure 9a: Respondents who identified food and nutrition as an area most impacted by COVID-19, disaggregated by residency status and sex
- Figure 10a: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by relationship to the household head
- Figure 11a: Impact of COVID-19 on savings (significantly decreased or totally lost), disaggregated by sex and residency status
- Figure 12a: Actions taken to compensate for impacts on resources, disaggregated by sex
- Figure 13a: Working to earn money for yourself (before COVID-19 and today), disaggregated by relationship to the household head
- Figure 14a: Working to earn money for yourself (today), disaggregated by location and sex

Tables

- Table 1a: The Sudan Population figures, disaggregated by age, for 2021
- Table 2a: Prevalence of severe or moderate and prevalence of severe food insecurity, mostly because of COVID-19
- Table 3a: Total prevalence of severe or moderate and prevalence of severe food insecurity, disaggregated by location
- Table 4a: Total prevalence of severe or moderate and prevalence of severe food insecurity, disaggregated by relationship to household head
- Table 5a: Resources reported as 'significantly decreased' or 'totally lost', by male and female respondents

Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COVID-19	Coronavirus disease 2019
FHH	female-headed household
FIES	Food Insecurity Experience Scale
FSHH	female spouses of household head
GBV	gender-based violence
HH	head of household
HNO	humanitarian needs overview
IDP	internally displaced person
ILO	International Labour Organization
INGO	International Non-Governmental Organization
IPC	Integrated Food Security Phase Classification
IPV	intimate partner violence
KII	key informant interviews
MENA	Middle East and North Africa Region
MHM	menstrual hygiene management
MHPSS	mental health and psychological support
sNFI	non-food items
RGA	rapid gender analysis
SRH	sexual reproductive health
WHO	World Health Organization

Authors & Acknowledgements

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Executive Summary

This rapid gender analysis (RGA) explores the impact of the COVID-19 pandemic on gender equality and food security in the Arab region. It is a joint collaboration between the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and CARE International (CARE). This collaboration recognizes the need to expand the evidence base on gender-differentiated impacts of crises for informed recovery and response planning, while highlighting the imperative of collecting sex- and age-disaggregated data (SADD) more consistently.

This initiative was an innovative pilot project between FAO, WFP and CARE. The aim of the collaboration was to foster multilevel partnerships and strengthen gender analysis for the food security sector in crisis contexts. The initiative brought together technical experts in food security, nutrition and livelihoods across the agencies involved, as well as gender specialists to explore, develop and test tools, methods and approaches. The regional focus of the study identified key themes, challenges and norms across multiple contexts in the Arab region, while highlighting specific findings for Iraq and the Sudan. While sources have varying regional definitions for the Arab region, for the purpose of this review, the denomination includes the countries under the FAOⁱ Near East and North Africa region, the WFPⁱⁱ Middle East and North Africa region, and the CAREⁱⁱⁱ Middle East and North Africa (MENA) region. The findings and successes of this initiative are intended to strengthen the relationship between gender and food security actors regionally, and in particular within Iraq and the Sudan, while increasing the availability and transparency of gender analysis in the sphere of food security.

Gender norms and dynamics impact women's social, economic and political participation, as well as their access to resources and services. Crises tend to reinforce and exacerbate existing barriers and discriminatory practices, which affects the ability of individuals (particularly those most vulnerable) to respond, adapt and recover from them. In some contexts, such as in Iraq and the Sudan, COVID-19 struck at a time when coping strategies were already quite compromised due to pre-existing crises and an already fragile context.¹ This is especially true for individuals and groups with pre-existing vulnerabilities, which have been compounded by the pandemic.

The first confirmed COVID-19 case in the region occurred in the United Arab Emirates in January 2020² with the first case of COVID-19 recorded in Iraq on 24 February³ and in the Sudan on 13 March 2020. This RGA was developed from March 2021 to June 2021, based on a comprehensive review of regional and country-level secondary data and the collection of primary data in selected areas in Iraq and the Sudan.

Primary data collection was conducted through both quantitative and qualitative methods, from a total of 1 292 respondents. Quantitative surveys were conducted for 1 207 respondents randomly selected within FAO and WFP beneficiaries (in the case of Iraq) and within the population living in CARE working areas (in the case of the Sudan). Key informant interviews (KII) were conducted with 45 respondents, and individual stories were collected from 40 respondents with the aim of hearing diverse perspectives based on gender, age and diversity factors (e.g. female-headed households (FHHs), the elderly, internally displaced persons (IDPs), refugees, returnees, etc.). Areas of enquiry included "Impact areas and priority needs"; "gender roles and responsibilities"; "access to services and resources"; "impact on resources and coping mechanisms"; "decision-making and participation"; and, "safety and protection."

While there are clearly some common trends (e.g. the increase in women's work burden), the analysis of both primary and secondary data clearly shows that the impacts felt by individuals and households are quite different in each country context. Effective programming will hinge on the extent to which updated data can appropriately identify evolving needs and priorities for those most vulnerable.

i. FAO countries in the Near East and North Africa include Algeria, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, the Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen.

ii. WFP countries in the Middle East and North Africa include Algeria, Armenia, Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, the Syrian Arab Republic, Tunisia, Turkey and Yemen.

iii. CARE countries in the Middle East and North Africa include Egypt, Iraq, Jordan, Lebanon, Morocco, Palestine, the Syrian Arab Republic, Turkey and Yemen.

Introduction

This rapid gender analysis (RGA) explores the impact of the COVID-19 pandemic on gender equality and food security in the Arab region, focusing on Iraq and the Sudan as case studies. This RGA is a collaboration between the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and CARE International (CARE), which share a commitment to promoting gender equality and social inclusion as an integral part of their programmatic work.

The initiative brought together technical experts in food security, nutrition and livelihoods across the agencies involved. It also brought together gender specialists to explore, develop and test tools, methods and approaches. The findings and successes of this initiative were intended to strengthen the relationship between gender and food security actors regionally, and in particular within Iraq and the Sudan, thus increasing the availability and transparency of gender analysis in the sphere of food security.

Rapid gender analysis objectives

An RGA provides information about the different needs, priorities, capacities and coping strategies of women, men, boys and girls in a crisis. It is built up progressively, using a range of primary and secondary information to understand gender roles and relations, and how they may change during a crisis. It provides practical programming and operational recommendations to deliver adapted and targeted assistance that meets and responds to the differentiated needs of women, men, boys, girls and specific at-risk groups. While an RGA aims to provide practical assistance, it is also important to make sure that humanitarian actors adhere to the principles of “leaving no one behind” and “do no harm.”

An RGA uses the tools and approaches from Gender Analysis Frameworks⁴ and adapts them to the shorter time frames, rapidly changing contexts and insecure environments that often characterize humanitarian interventions. This aims to ensure that data is available in a timely way to inform humanitarian response efforts, and contributes to more equitable recovery and preparedness efforts.

This RGA initiative was an innovative pilot project between FAO, WFP and CARE. The aim of the collaboration was to foster multilevel partnerships and strengthen gender analysis for the food security sector in crisis contexts.

The specific objectives of this RGA were to:

- understand the extent and nature of the direct and indirect impacts of COVID-19 on food security, nutrition, safety and access to different resources, services and information for women and men;
- understand the impact COVID-19 has had on the paid and unpaid workloads of women and men;
- understand the different coping strategies, barriers, capacities and specific needs of women and men in responding to the crisis (considering intersectional inequalities);
- identify key priorities for future programme responses, establish adaptive management strategies needed for medium- and long-term approaches, and develop effective modalities to support the most at-need groups in outbreak situations; and
- highlight the importance and value of collecting and analysing sex- and age-disaggregated data (SADD) for more informed and equitable decision-making in humanitarian programme planning and response.

Methodology

This RGA is based both on a review of regional and country-level secondary sources, and the collection of primary data in selected areas in Iraq and Sudan.

The overview of the “Arab region” is based exclusively on secondary data. While sources have varying regional definitions, the “region” referred to in this review include the countries under the FAO^{iv} Near East and North Africa region, the WFP^v Middle East and North Africa region, and the CARE^{vi} Middle East and North Africa Region.

At country level, data were collected from over 1200 individuals (about 600 for each country). The selected sample is not meant to be representative of the overall population in Iraq and Sudan. It is representative of women and men living in the (target) areas, randomly selected among FAO and WFP beneficiaries (in the case of Iraq), and within CARE working areas (in Sudan).

The country-level analysis is based on the findings emerged from primary data collection and a comprehensive review of available secondary sources. Additional information on the methodology is provided in Annex 1.

Iraq

Five governorates were selected for primary data collection based on operational programme sites and access considerations: Anbar, Duhok, Erbil, Missan and Ninewa. Two gender in emergency consultants (one male, one female) conducted the qualitative primary research, with a team of enumerators conducting the quantitative survey in parallel. Qualitative data collection took place between 14 April and 6 May 2021, and the quantitative data collection took place between 14 April and 22 April 2021.

A total of 601 individual surveys were collected (with 236 women and 365 men). Further demographic breakdown of the respondents can be found in Annex 2. The selected sample was randomly selected from the lists of beneficiaries provided by the FAO and WFP country offices. Male enumerators interviewed male respondents and female enumerators interviewed female respondents. Qualitative data collection was conducted using a snowballing strategy and comprised of key informant interviews (KIs) and individual story telling tools. A total of 19 KIs were conducted with key stakeholders in the community, as well as with community members across a diverse range of livelihoods and occupations. A total of 21 individual stories were collected with the aim of hearing perspectives across respondents based on gender, age

and diversity factors. The quantitative and qualitative data collection was entirely conducted remotely via phone due to logistical and security concerns, as well to respect “do no harm” principles.

It must be acknowledged that telephone surveys may be biased by design because they target only those in the population with access to mobile telephones.

The Sudan

Three states were selected for primary data collection: Khartoum, South Darfur and Kassala. Locations were selected based on the operating areas of CARE International in the Sudan (Care International Switzerland). These are displayed in the table in Annex 1.

Three female gender in emergency consultants conducted the qualitative primary research, with a team of enumerators conducting the quantitative survey in parallel. This research took place over four days in each state, spanning the period between 30 March and 15 April 2021.

A total of 606 individual surveys were collected (with 356 women and 250 men). Further demographic breakdown of the respondents can be found in Annex 2. The quantitative sample was selected based on the working areas of CARE International in the Sudan and random sampling, calculated by community size. Male enumerators interviewed male respondents and female enumerators interviewed female respondents. Qualitative data were collected using a snowball strategy and comprised KIs and individual story telling tools. A total of 25 KIs were conducted with key stakeholders in the community and with community members across a diverse range of livelihoods and occupations. An additional two KIs were conducted with FAO and WFP representatives. A total of 20 individual stories were collected with the aim of hearing perspectives across respondents based on gender, age and diversity factors. Quantitative and qualitative data collection was entirely conducted face to face.

Intersectional approach

- To ensure that data could be disaggregated by demographic factors of interest, all quantitative data was collected at the individual level rather than at the household level. This decision emerged from a recognition of the broader gaps in sex-, age- and diversity-disaggregated data, and the critical need for such data in crises, including the COVID-19 pandemic, to provide a realistic understanding of the context. Disaggregated data also enables recommendations to be as targeted and relevant as possible.

iv. FAO countries in the Near East and North Africa include Algeria, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, the Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen.

v. WFP countries in the Middle East and North Africa include Algeria, Armenia, Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, the Syrian Arab Republic, Tunisia, Turkey and Yemen.

vi. CARE countries in the Middle East and North Africa include Egypt, Iraq, Jordan, Lebanon, Morocco, Palestine, the Syrian Arab Republic, Turkey and Yemen.

- The intersectional nature of the analysis was seen as crucial to an understanding of food security and gender inequality both in the region and for the Sudan and Iraq. Therefore, data was analysed based on the following variables: sex, age, residency status, disability status, pregnancy, relationship to the household head, location (rural/urban/semi-urban), as well as by state and governorate.
- The sections of this report correspond to the areas of enquiry agreed for the study including: “impact areas and priority needs”; “gender roles and responsibilities”; “access to services and resources”; “impact on resources and coping mechanisms”; “decision-making and participation”; and “safety and protection.” Therefore, the regional and country-specific reports are not meant to be exhaustive, but aim to unveil gender-differentiated impacts within these specific areas of enquiry.
- While data was collected during March 2021 and April 2021, the time frame for the analysis was the entire COVID-19 pandemic period to the date of data collection, that is from March 2020 to April 2021. Analysis includes comparisons from before the crisis and throughout the research period. Pre-crisis data was identified using secondary data sources as well as from the perceptions of respondents, comparing their pre-crisis situation to their current situation. There was no baseline assessment conducted as part of this analysis.
- In cases where the number was for a female respondent, often the phone was shared with male members of the family. This added time to the assessment, as the male family member would need to check the caller's identity and potentially arrange another time to call or provide an alternative number.
- When using remote data collection modalities, a greater number of women respondents chose “prefer not to answer” options. It was observed by the data collection team that for topics considered more sensitive, women may not have wished to answer (e.g. on decision-making, food security and safety). This was particularly the case if a husband or male family member was within the vicinity. Sometimes male family members would try to provide answers during the call, or female respondents sometimes dropped off the call if they preferred not to answer the questions.
- The process for primary data collection took place during Ramadan, and therefore this impacted the availability of respondents and could have impacted the depth of responses given due to conflicting priorities.

Research limitations and considerations for Iraq and the Sudan

- There is a general lack of updated sex-, age- and diversity-disaggregated data from which to draw accurate up-to-date analysis for both the pre-pandemic situation and the current situation.
- Due to COVID-19 restrictions, data was collected remotely in Iraq. This came with challenges, including limited observations from the data collection team, as well as respondents having multiple tasks to prioritize during the survey, particularly women, who were also cooking or caring for children.
- Contact information sometimes did not correspond to the intended respondent, for example in some cases residency status was different to that recorded, or the phone number was not valid anymore. This meant that sampling was based on those respondents available, rather than a more specific sampling strategy. This also added time limitations on the data collection.

Regional background with a focus on Iraq and the Sudan

The first positively tested COVID-19 case in the Arab region occurred in the United Arab Emirates in January 2020⁵, with the first case of COVID-19 recorded in Iraq on 24 February 2020⁶ and in the Sudan on 13 March 2020.^{7,8}

As of 5 May 2021, the total confirmed cases of COVID-19 ranged from 6 414 cases in Yemen to 4.96 million in Turkey.⁹ Available sex-disaggregated statistics vary from country to country for both confirmed cases and confirmed deaths.¹⁰ Further, a lack of consistency and coherence in the data reported worldwide – including in the region – makes it difficult to consolidate or compare it across countries. This makes it even more challenging to understand the direct impacts of the pandemic on different populations and groups (based on sex, age and other demographic factors), which would be crucial data for informing the COVID-19 response.

The COVID-19 pandemic struck at a time when the region was already coping with multiple threats.¹¹ Countries in the region are experiencing complex emergencies, such as armed conflicts and protracted crises, extreme weather events and climate change, not to mention the impacts of transboundary plant and animal diseases. As a result, many countries subsequently face the challenge of having to respond to the needs of a high proportion of internally displaced (Libya, Iraq, Syria and Yemen)¹² and refugee populations (Jordan, Lebanon, the Sudan and Turkey).¹³

While Iraq has started to slowly recover from several waves of conflict, intermittent clashes continue to aggravate the poverty rate and threaten the livelihoods¹⁴ of the population, with COVID-19 exposing people to new risks, perpetuating existing vulnerabilities and putting

additional strain on an already fragile public sector.¹⁵ Further, Iraq is experiencing major water shortages which have the potential for greater impacts on land, livestock and access to drinking water.¹⁶

Flooding in the region has impacted the countries' livelihoods and agricultural lands, for example from January 2020 to May 2021 in Iran¹⁷ and from August to September 2020 in the Sudan, affecting nearly all of the 18 Sudanese states.¹⁸ Desert locust outbreaks continue to sweep across East Africa and the Near East regions threatening agricultural production and livelihoods.^{19, 20}

Weather extremes, conflict and insecurity, and economic shocks represent the three main drivers of acute food insecurity, each having compounding impacts on the other.²¹ The economic crisis (e.g. in Lebanon and the Sudan) predated the pandemic.^{22,23} In Lebanon, the currency's loss of value and rising debt is pushing many Lebanese citizens into poverty.²⁴ The economic crisis was persistent for two years prior to COVID-19 in the Sudan, due to the removal of fuel subsidies, severe shortages of essential commodities, limited public expenditure on basic services, high inflation and currency depreciation.^{25, 26} Many countries in the region have fragile, undiversified economies, which are heavily dependent upon specific sectors. For example, Iran, Iraq, Lebanon and Libya are particularly vulnerable because of their dependence on oil exports.²⁴ Egypt, Jordan, Lebanon, Tunisia and Turkey usually depend on tourism. However, 2020 saw revenues from the tourism sector drop by 64.5 percent compared with 2019 due to travel bans and restrictions on movement caused by the COVID-19 pandemic, which also had severe implications on the labour market in these countries.²⁸

Food security in the region

Globally, the prevalence of food insecurity is slightly higher in women than in men,²⁹ with an estimated 60 percent of hungry people and 76 percent of displaced people in the world being women and girls.³⁰ In addition, overall, people with a higher risk of food insecurity are those of lower income, lower education, the unemployed, those with health problems, persons living in rural areas, individuals between the ages of 25 and 49, and those who are separated or divorced.³¹

The Arab region scores 0.856 on the Gender Development Index, below the world average of 0.941³², and is the region with the widest gender gap (of 60.9 percent).³³ Gender inequalities impact women and girls' production of, access to and ability to afford and consume food, which makes women, girls and female-headed households (FHHs) particularly vulnerable to food crises.³⁴ This is compounded by underlying gender biases within government policies that consider men the main household heads, and in contexts where women's participation in the labour market is weak.³⁵

The region currently does not face chronic food shortages,³⁶ but has issues accessing food, a problem exacerbated by the pandemic.³⁷ Countries in the region are among the world's largest food importers, with most depending on imports for over half their needs.³⁸ Price increases, border closures and depreciation of local currencies resulted in an overall average increase in the cost of the food basket of 41 percent at the end of 2020, with the food basket increasing by 236 percent in Syria, 130 percent in Lebanon, 30 percent in Yemen and 261 percent in the Sudan.^{39, 40, 41}

Rising food prices have come under stress due to breakdowns in global supply chains. This, together with reduced income, disruptions in food supply, loss of livelihoods and loss of remittances means that households globally are facing increased difficulties in accessing nutritious foods. This will impact poorer and more vulnerable households in their ability to access and afford healthy diets.^{42, 43} Studies have already shown, pre-pandemic, that migrant populations suffer from the impact of high food prices in obtaining sufficient food to eat.⁴⁴

The economic slowdown, resulting from COVID-19, is estimated to cause an additional 8.3 million people to fall into poverty, meaning that a total of 101.4 million people in the region will be classified as poor,⁴⁵ with 52 million estimated as being undernourished.⁴⁶ Amidst these shifts, women's access to nutritious food is more likely to be affected. In Iraq, for example, by June 2020, already three out of five women had seen their access to nutritious food decrease.⁴⁷ The inability to obtain enough food can lead to undernourishment. Female-headed

households, in particular, have been found to experience lower levels of nutritional well-being compared to male-headed households.⁴⁸ This can, in part, be due to FHHs being more likely to reduce the quality and quantity of their food consumption in the face of crises.⁴⁹ While many countries in the region have a rate of undernourishment of around 5 percent, in recent years several other countries are showing higher rates, with Iraq estimated at 22.8 percent, Yemen at 26 percent, Palestine at 31 percent and the Sudan at 39 percent.⁵⁰ It should be noted that situations of protracted conflict in several countries in the region mean that updated data remains unavailable, and therefore rates may be even higher.⁵¹

Additionally, Arab countries that face prevalent cases of undernutrition and malnutrition, particularly in children, also struggle with underlying health issues and, in extreme cases, dangerous developmental and health conditions.⁵² For example, Yemen reports an increase in acute malnutrition and severe acute malnutrition of 16 percent and 22 percent, respectively, among children under 5 years from 2020.⁵³ Yemen also reports one of the highest rates of severe food insecurity, globally, along with increasing stunting and wasting rates. According to data prior to the pandemic, the Arab region reported the second highest prevalence of obesity and overweight rates for adults, after the Americas, with 62 percent of adults being overweight and 27 percent obese; while women in the region made up the highest percent of overweight and obesity rates compared to any other region.⁵⁴

Gender roles and relations (paid and unpaid labour)

The COVID-19 pandemic is expected to result in the loss of 1.7 million jobs in the Arab region, including approximately 700 000 jobs held by women.⁵⁵ Containment measures, border closures and travel restrictions are limiting transport and economic activity, impacting the ability of people to go to work and businesses to continue.⁵⁶

This raises many concerns as the Arab region already had the world's lowest rate of female economic participation, which is 26 percent compared to the global average of 56 percent. Patriarchal norms create barriers in the types of work deemed "appropriate" for women.

Similarly, restrictions to women's individual freedom of movement, excessive burdens of care work, lack of care facilities within workplaces and safety issues pose additional barriers to women's equal participation in the labour market.^{57, 58}

Conflict, in countries such as Syria, Iraq and Yemen and those that host substantial refugee populations such as Lebanon, Jordan, Turkey, Georgia and the Balkans, have seen gender norms shaken up, and an increase in women's presence in the workforce.⁵⁹ However, refugee women, for example in Jordan and Lebanon, can be subject to legal restrictions on their ability to work and earn an income, which are compounded by a general lack of information and support in entering the labour market.⁶⁰ Women in the region are increasingly well qualified and well educated, where countries such as Algeria, Oman and Tunisia have achieved gender parity in tertiary level education in a number of subject areas.⁶¹ Despite these achievements, economic participation has not followed the same trends. Even in countries where incentives to women's economic participation are being integrated within national policies, social and religious norms, as well as conflicting legal frameworks and lack of adequate investments, continue to create barriers for this to be realized for many women. Examples come from Bahrain, Kuwait and Qatar, where personal status laws allow men to stop their wives from working, if it could be interfering with the "well-being of the family."⁶²

Where increases in women's economic participation are seen, these have not resulted in an equivalent rebalancing of men's caregiving responsibilities, meaning women have a double burden in many cases in providing both income and household responsibilities.⁶³ Across the region, COVID-19 is further increasing women's caregiving burdens, with women and girls taking on the role of caring for the elderly, persons with disabilities and the sick.⁶⁴ Women tend to hold responsibilities for food and nutrition and to be on the front line ensuring nutritious food for their families, in their role as caregivers and in terms of producing, storing, cleaning and cooking food for consumption.⁶⁵

Just 10–33 percent of men in the Arab region have ever participated in domestic work⁶⁶ with women spending more time in unpaid work than men, compared to all other regions globally.⁶⁷ An increase in unpaid work can have multiple adverse impacts on women: it reduces the time they have available for engaging in paid work, can lead to emotional and physical fatigue, reduced immunity and therefore an increased risk of contracting COVID-19.⁶⁸ The COVID-19 Global Gender Response tracker found that even when knowing this – the burden of the unprecedented increase in unpaid care resulting from the COVID-19 crisis – measures to support unpaid care are extremely scarce and account for only 4 percent of the total 200 social protection and labour market measures in the region.⁶⁹

The informal sector is projected to be particularly hard hit. This is a sector where women comprise 61.8 percent of the workforce,⁷⁰ contribute to high levels of employment among young people⁷¹ and where incomes

are generally low, inconsistent and without safety nets, social protection or unemployment insurance.^{72,73} The low participation of women in the labour force, and their representation largely in the informal sector means that women are often excluded from contributory social security schemes, which further increases their vulnerability in times of crises.⁷⁴

Children and young people (0 to 24 years old), who currently account for nearly half of the MENA region's population, are also facing vulnerabilities during the pandemic.⁷⁵ While notable improvements have been made in overall enrolment rates pre-COVID-19, the region still faces significant hurdles in providing access to education with approximately 5 million children of school age remaining out of school, 60 percent of whom are girls.⁷⁶ School closures, as a result of the pandemic, mean children spend more time at home. Girls may become increasingly responsible for domestic tasks and spend less time studying remotely,⁷⁷ while boys may face an increased risk of child labour and pressures to economically contribute to the family. School closures also cause girls and boys to miss out on school meal programmes, as well as other important school-based interventions such as awareness-raising campaigns, socialization, deworming education, and health and nutrition interventions.⁷⁸ This gap in their school experience may also have long-term impacts on individual development and even longer-term impacts on the future social and economic development of their community.⁷⁹ With growing social and economic pressures within the household combined with the various roles that boys and girls adopted during the pandemic, there is the risk that boys and girls may not return to school once they reopen or after the pandemic. The COVID-19 pandemic creates additional risks for young people given pre-existing high levels of youth unemployment and the challenges of transitioning into the labour market, coupled with the saturation of the informal sector.⁸⁰

Other at-risk populations when it comes to employment, include the region's 11 million internally displaced persons (IDPs), many of whom are concentrated in Iraq, Libya, Syria and Yemen, as well as refugee populations. For example, Syrian refugees in Jordan, Lebanon and Turkey, who are often completely dependent on informal employment and are hard hit by closures and economic slowdown.⁸¹ Early in the pandemic (April 2020), impact assessments highlighted that shortage of food, was the most important concern for Sahrawi refugees in Algeria, with nearly half of the respondents (45 percent) noting loss of jobs.⁸² In Iraq and the Sudan, those most vulnerable and most affected are those who depend largely on informal economic activities and daily labour wages, including IDPs, refugees,⁸³ migrants, returnees, petty traders/small business owners, smallholder farmers and pastoralists.⁸⁴

Particularly for refugees, IDPs and returnees who often settle in urban centres, reduction in income and loss of purchasing power, coupled with increased food prices, have created increased strain on resources as well as competition for scarce labour opportunities.⁸⁵ Even for smallholder farmers who may cover most of their food from subsistence production, purchased foods can critically contribute to the variety and quality of their diets.⁸⁶ Loss of livelihoods, reduced household income and a reduction in support systems such as remittances,⁸⁷ has meant that households have had to cut down on the quantity and quality of their food consumption.⁸⁸

Access to services and resources

As of February 2021, [CARE's Women Respond dashboard](#), which reports the global impact of COVID-19 in key sectors, shows that 90 percent of respondents (73 percent female and 81 percent male) have unmet needs in the region. These needs are displayed in Figure 1. The greatest impacts seen from COVID-19, which are shown in Figure 2, fall within similar areas.⁸⁹

Lockdowns and other COVID-19 prevention and control measures have restricted access to services, which will impact those most vulnerable, such as elderly populations and those with disabilities, who will remain isolated and harder to reach.⁹⁰ Key areas of enquiry for this report related to access, including access to food (discussed above), water, information and physical and mental health services. The main findings for these areas of enquiry are provided in the following sections.

Access to water: Climate change, conflict, fragility and a growing population make the region the most

water scarce in the world, a problem deeply affecting both its society and economy. Limitations of water additionally create strains in the agricultural system and influence the capacity of the sector and communities to provide food security and livelihoods in the region. The pandemic has created an increase in water demand, in part due to handwashing being a core COVID-19 prevention measure, and in a context where countries are facing interruptions to water supplies, large inequality of access to water, poor water quality and deteriorating water infrastructure.⁹¹ Many countries in the region are dependent on water resources that lie beyond their borders, e.g. Jordan, Palestine and Syria.⁹² In the Sudan, most of the rural poor are vulnerable due to non-existent water and sanitation facilities and long distances to health facilities.⁹³ In water scarce environments, the most vulnerable and poorest communities can suffer due to economic and social impacts.⁹⁴ Internally displaced persons and those living in formal and informal settlements generally lack adequate and reliable access to water and sanitation facilities and services.⁹⁵ Persons with disabilities can face a range of challenges in accessing water, sanitation and hygiene (WASH) facilities, information and services, particularly those who have been separated from family members and/or primary caregivers.⁹⁶ Women can be disproportionately impacted due to discriminatory social and gender norms, for example discrimination related to decision-making power, which is often exacerbated by conflict and water scarcity. Further, due to the role of women and girls in procuring and collecting water, risks of gender-based violence (GBV) can increase in crisis situations.⁹⁷

Access to information: In the Arab region, nearly half of the female population of 84 million are not connected to the Internet, nor have access to a mobile phone.

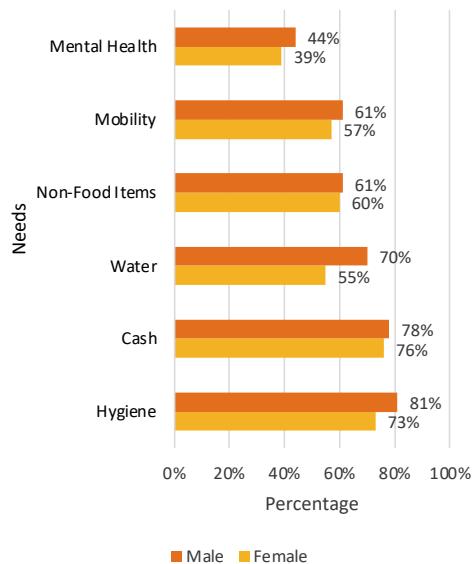


Figure 1: CARE Women Respond data – Unmet needs in the region

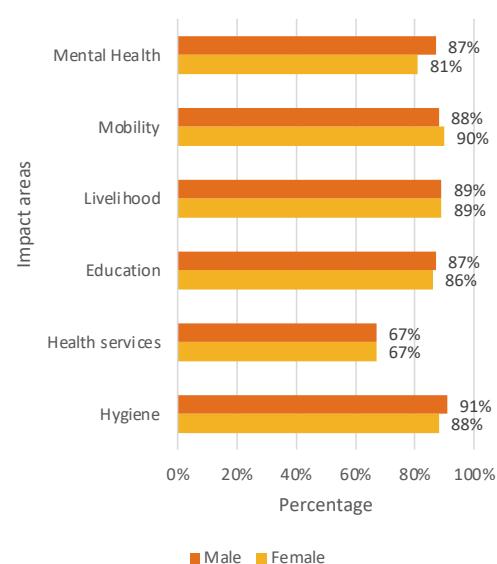


Figure 2: CARE Women Respond data – Impacts seen from COVID-19



@WFP/Sharon Rapose

Women working in the WFP Food for Assets project to contribute to water conservation and flood preparedness on Sinjar Mountain, Iraq

Women's access to and use of computers may be limited within households, due to unpaid work responsibilities, as well as discriminatory norms prioritizing male access to household computers, which could impact their ability to continue education or professional work during lock-downs.⁹⁸ The Arab region has very high rates of literacy among women⁹⁹ which may affect women's ability to access comprehensive information about the crisis in terms of prevention, response and seeking help.¹⁰⁰ The ways in which men and women receive information also differ, with men having greater access to official communications, for example from local authorities and within public spaces, while women and adolescent girls tend to share and receive information by word-of-mouth or through informal social networks, which may be less reliable and effective.¹⁰¹ For persons with disabilities, access to information can become a barrier if information is not adapted or disseminated in accessible formats. In some countries in the region, it has been noted that adapted messaging has been developed, for example in the case of the Jordan Higher Council for the Rights of Persons with Disabilities. However, gaps remain for persons with hearing or intellectual impairments.¹⁰²

Access to physical and mental health services:

The pandemic is challenging weak and overcrowded medical systems in the region, particularly in developing economies, or in fragile and conflict-affected countries

such as Iran, Iraq, Libya, Palestine, Syria and Yemen.¹⁰³ Disruptions to the supply chain and transport issues (e.g. in the Sudan) are impacting the availability of health supplies.¹⁰⁴ Poorer people, including displaced people, often lack sufficient economic resources to access health care and/or live in remote areas far from services.¹⁰⁵ For migrant populations, language barriers, and a lack of documentation and financial resources, particularly if remittances are affected by the pandemic, can impact their access to health services.¹⁰⁶ Social and cultural norms are also creating barriers, with stories of some families, e.g. in Iraq, stopping women in their family from accessing treatment at health facilities or quarantine centres because they do not want them to be in contact with men, to stay in hospitals alone, or fear risks of GBV.^{107, 108}

With health services under strain with the increased demand, resources for sexual and reproductive health (SRH) services often get deprioritized, with health professionals being asked to support the COVID-19 response, instead of providing SRH services such as antenatal care and other maternal health services.¹⁰⁹ Adolescent girls and young women are often the most affected by this shift and the lack of access to SRH services.¹¹⁰

Across the region, the pandemic is taking a significant toll on mental health and psychosocial well-being.¹¹¹ This is in a region that was already seen to be suffering from a mental health burden above the global average,

compounded by stigma towards mental health, and a lack of access to mental health infrastructure.¹¹² Loss of livelihoods, self-isolation, loss of educational and recreational activities for children and young people are some of the many contributing factors seen throughout the pandemic to date. Youth organizations have highlighted mental health as one of the key areas in which it will be most challenging for young people to recover from the crisis.¹¹³ Some of those most vulnerable are refugees, asylum seekers, IDPs and stateless people, as well as those with pre-existing mental health conditions or substance abuse issues.¹¹⁴ Reports have noted that anxiety about COVID-19 may be further compounded by the challenges displaced people face in accessing public health information, either due to lack of connectivity or availability of the information in required languages.¹¹⁵

Coping mechanisms

In times of crisis and in humanitarian settings, women and girls and, more specifically, FHHs, are more likely to reduce the quality and quantity of food consumption and adopt negative coping strategies.¹¹⁶ This is already being seen in the region, with some families reducing their number of meals to only one per day, and prioritizing working men and/or young children over women in the

household when it comes to eating.¹¹⁷ This can impact women's health and therefore ability to fight the disease, while increasing their risk of adopting negative coping strategies.¹¹⁸ These can include borrowing or purchasing of food on credit; going into debt; the sale of productive assets; withdrawal of children from school; and reduction of essential non-food expenditure, such as on health and education.¹¹⁹ The prevalent role of women and adolescent boys in informal labour, particularly in refugee and displacement settings, puts them at unique risk of mistreatment and corruption. This may increase with the pandemic.¹²⁰ Further, in Iraq and Lebanon, early/child marriage has been observed during the pandemic, as families seek to cope by reducing the number of people in the family.¹²¹

Other coping strategies were connected to remittances coming from family abroad,¹²² or using savings and other insurance mechanisms available to individuals, or turning to social networks for support, which in many cases strengthened social bonds and a sense of belonging and solidarity within and across communities. However, many families do not have savings to rely upon, particularly in protracted conflict settings such as in Iraq, Syria and Yemen. This may lead to families resorting to borrowing or debt.¹²³ In addition, due to the overall economic hardship, turning to family members and informal saving groups could become more challenging due to an overall lack of funds.¹²⁴



@WFP/KhansaGhazi

WFP's home gardens initiatives in Iraq help women-headed households to grow and plant to meet their food needs, and sell the surplus

Decision-making, participation and leadership

In the Arab region, the presence of women in leadership roles (15.2 percent) is the lowest participation of women in political life globally and is ranked the lowest in political participation on the Gender Gap Index. Women in leadership roles are even less visible in rural communities, where opportunities for female representation in local authority structures are often non-existent. The under-representation of women extends into public life, for example in political engagement and voting.^{125, 126} Advancements that have been made are at risk, given male-dominated governance structures and current limitations in civil society engagement.¹²⁷

The COVID-19 Global Gender Response Tracker showed that the average proportion of women, for the Northern African and Western Asian region, on COVID-19 task forces is 16 percent, with 8 percent of women as task force leaders.¹²⁸ This has impacts on policy response, with data showing only 42 out of 219 countries and territories (19 percent) having a holistic gender-sensitive policy response, addressing women's economic security, unpaid care work, and violence against women and girls.¹²⁹ Women's participation and leadership, particularly seen in rural institutions, has led to women's rights, contributions and priorities being largely overlooked by mainstream policies and institutions on agriculture, food security and nutrition.¹³⁰ For example, despite the irrefutable role of women in agriculture in the Sudan, particularly in food security at the household level, the recognition of women farmers at the policy level is minimal.¹³¹ On the other hand, some countries have created task forces to address specific needs, e.g. in Lebanon, the Ministry of Public Health created the Technical Task Force of Corona in Pregnancy to monitor the relationship between pregnancy and COVID-19.¹³² In Egypt, the National Council for Women has developed a Women Policy Tracker to track policies and programmes that are responsive to the needs of women during the COVID-19 response.¹³³

Prior to the pandemic, trends (e.g. in Jordan, Syria and Yemen) indicated that women's increased involvement in the workforce correlates to increased participation in decision-making in the household, particularly in areas where conflict settings alter women's productive roles.¹³⁴

Safety and protection

Rates of GBV such as intimate partner violence, "honour killings," early child marriage, female genital mutilation and sexual assault are particularly high in the region and are increasing because of COVID-19.¹³⁵

According to WHO data, in the Eastern Mediterranean Region (Egypt, Iran, Iraq, Jordan, Palestine), 37 percent of women have been subjected to intimate partner violence (IPV) or non-partner sexual violence.¹³⁶ Other forms of violence persist; for example, one in five girls in the Arab region marry under the age of 18,¹³⁷ which as a result of COVID-19 and ongoing instability in the region may see families seeing this as a coping mechanism to deal with economic hardship.¹³⁸ Women with disabilities can be up to four times more likely to experience IPV than their non-disabled peers as well as facing added barriers in seeking assistance due to dependency on their perpetrator for mobility, communication and access to medication and health care.¹³⁹ This is further exacerbated for women and girls with disabilities in conflict settings.¹⁴⁰

Since the emergence of the pandemic, violence against women and girls has increased in severity and scale. According to an assessment by UN Women, half of respondents¹⁴¹ agreed that women faced an increased risk of violence from their husbands because of COVID-19 lockdowns, with slightly more women agreeing to this statement than men.¹⁴² Food insecurity and loss of livelihoods have been noted to contribute to intrahousehold tensions and increased violence; in Jordan, increased rates of child marriage were reported due to loss of informal labour opportunities and increased food insecurity, while women respondents of a rapid assessment (conducted by the Global Health Cluster) indicated that they felt at increased risk of suffering physical or psychological violence as a result of either increased tensions in the household or food insecurity resulting from COVID-19.¹⁴³ Women and girls who are survivors of domestic violence may experience more violence during the COVID-19 pandemic, owing to heightened family tensions caused by increased food insecurity¹⁴⁴ and men's increased feelings of insecurity due to their inability to fulfil their traditional role of breadwinner.¹⁴⁵

It is important to note, that few countries effectively document domestic violence rates, and in the Arab region, GBV including domestic violence rates are alarmingly under-reported,¹⁴⁶ meaning the actual prevalence of such violence and its consequences are likely to be higher and their full extent unknown.¹⁴⁷ Further due to stigma, little data is available on GBV against men, boys, LGBTIQ+ populations and sex workers.¹⁴⁸ At a time where loss of livelihood and income are so prevalent, the increased or sole financial dependency on an abusive partner, in addition to movement restrictions (pre-existing or as a result of COVID-19) and the closure/restrictions on already limited GBV services, can create additional barriers for survivors in seeking support from GBV services, including safe spaces, shelters and medical and psychosocial services.^{149, 150}

Iraq Country Analysis

Demographic profile

The population of Iraq is 41 042 701 (as of 1 June 2021).¹⁵¹ Iraqi women comprise half of the total population and are the head of one in ten of Iraqi households; 80 percent of these female household heads are widows.¹⁵² The majority of the Iraqi population is urban, with 73.1 percent of Iraqis living in urban environments in 2020.¹⁵³ The average life expectancy for women is 73 years, and for men it is 69 years,¹⁵⁴ with 58 percent of the population under 24 years old (11 981 412 males and 11 503 888 females).¹⁵⁵ Population disaggregated by sex and age group, as of 2021 is represented in Table 1a.¹⁵⁶

Almost 75 percent of the Iraqi population is made up of the dominant ethnic group, the Iraqi or Mesopotamian Arabs. Other major ethnic groups include the Kurds (17 percent), Turkmen (3 percent), Assyrians (2 percent), and Persians (2 percent).¹⁵⁷ The official language is Arabic, with 10–15 percent of the population speaking Kurdish.¹⁵⁸ Illiteracy rates are twice as high among Iraqi women compared with men, irrespective of the age group.¹⁵⁹ Of the Iraqi population, 95 percent practice Islam with 5 percent largely Assyrian Christians.¹⁶⁰

The first case of the novel coronavirus (COVID-19) was recorded in Iraq on 24 February 2020.¹⁶¹ Estimates by the World Health Organization (WHO) show there were 1 292 700 cases of COVID-19 with 16 910 deaths up to 20 June 2021.¹⁶² Since, the government has imposed restrictions to curb the spread of the virus, such as lockdowns,

curfews and movement restrictions, which has impacted economic activity and the labour market in Iraq.¹⁶³ There were lockdowns from March until July 2020, with the closure of schools and universities continuing in some form until March 2021. Borders were closed from late February 2020, with changes being made as a result of virus variants around the world.

Iraq ranks at 146 in the Gender Inequality Index¹⁶⁴ (out of 189 countries), with a value of 0.577. Approximately 1.3 million people remain internally displaced within Iraq, and 4.1 million people need some form of humanitarian assistance, including 2.4 million people with acute humanitarian needs.¹⁶⁵ Of these 2.4 million, 28 percent are women, 28 percent men, 22 percent girls and 22 percent boys. Intermittent conflict continues to aggravate the poverty rate and threaten livelihoods. Following the return process that began in 2018, the situation of IDPs and refugees remains precarious, with their needs unmet.¹⁶⁶ In addition, the closure of 14 IDP camps across Iraq since mid-October 2020 has further exacerbated the situation.¹⁶⁷

The number of severely food-insecure people is estimated to be at about 435 000. Among IDPs living out of camps, the governorates with the most severely food-insecure IDPs are Ninewa, Duhok, Erbil and Salah Al Din, while the majority of the returnees are concentrated in the governorates of Ninewa, Salah Al Din, Anbar and Kirkuk.¹⁶⁸

Table 1a: Population figures for Iraq, disaggregated by age, for 2021

Age	Female	Male	Total
0–4	6.5%	6.9%	13.4%
5–9	6.3%	6.7%	13.0%
10–14	5.5%	5.8%	11.3%
15–19	5.0%	5.3%	10.3%
20–24	4.6%	4.8%	9.4%
25–29	4.1%	4.3%	8.4%
30–34	3.6%	3.7%	7.3%
35–39	3.0%	3.1%	6.1%
40–44	2.6%	2.7%	5.3%
45–49	2.2%	2.2%	4.4%
50–54	1.7%	1.8%	3.5%
55–59	1.1%	1.2%	2.3%
60–64	0.8%	0.9%	1.7%
65–69	0.8%	0.7%	1.5%
70+	1.0%	0.8%	1.8%

Findings and analysis

Impact areas and priority needs

For women and men, income and livelihoods, food and nutrition, and mobility were identified as the areas most impacted by COVID-19. The greatest priority needs today, were income and livelihoods, food and nutrition, along with physical health care.

Survey respondents were asked which three areas of their life they saw to be most impacted by COVID-19. Figure 1a shows that “income and livelihoods,” “food and nutrition” and “mental health” were rated the highest for male and female respondents.^{vii} Food and nutrition, income and livelihoods and mental health will be discussed in subsequent sections.

A greater proportion of male respondents in urban areas noted mobility (50 percent), followed by male respondents in rural areas (47 percent) and semi-urban areas (36 percent). A similar trend was seen for female respondents,^{viii} with a greater proportion of female refugees noting mobility (67 percent) compared to other residency groups.^{ix} No large differences were noted between governorates. A greater proportion of male heads of household noted mobility (47 percent) followed by female spouses of heads of household (FSHH) (44 percent) and by female heads of household (38 percent).

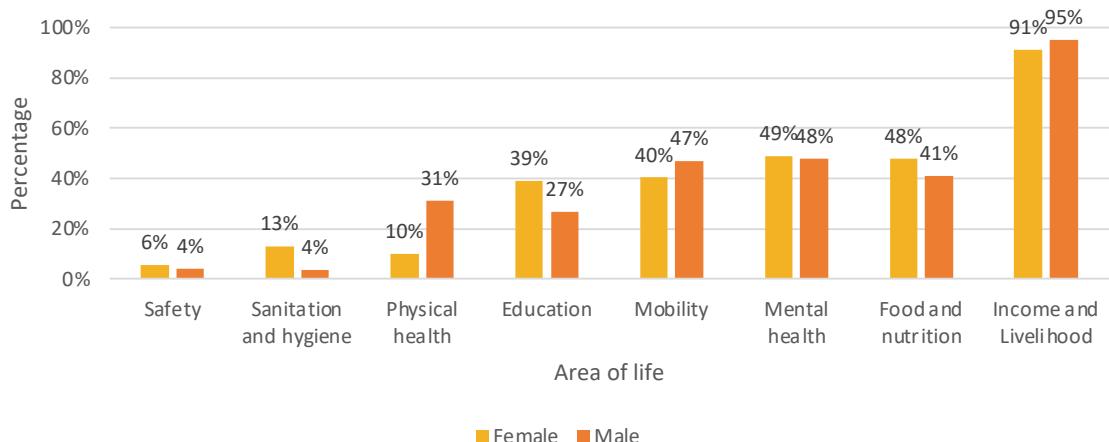


Figure 1a: Areas of life most impacted by COVID-19, disaggregated by male and female respondents

vii. Other areas noted by respondents included access to social networks (1 percent f./2 percent m.) and involvement in community decisions (1 percent f./1 percent m.).

viii. Noted by 46 percent of female respondents in urban, 33 percent in rural and 27 percent in semi-urban locations.

ix. Female returnees (53 percent); IDPs (37 percent); host community (4 percent) and male returnees (56 percent); host community (47 percent); IDPs (46 percent); and refugees (39 percent).

With regards to education, a greater proportion of female respondents in the host community (84 percent) identified this as an impact area compared to other groups. Close to half of female heads of household (48 percent) identified impacts on education compared to 27 percent of male heads of household, and 31 percent of FSHH. Fewer male and female respondents in urban areas identified education. Of all the impacts identified by respondents a greater proportion of respondents identified education in Missan (18 percent), compared to 15 percent in Ninawa, 10 percent in Anbar, 9 percent in Erbil and 5 percent in Duhok.

Noting the many changes that have taken place over the past year with regards to the pandemic, in addition to understanding the impacts, it was important to understand what respondent's priority needs were today. These are displayed in Figure 2a.^x

Physical health care was identified as a priority by a greater proportion of male respondents in urban areas (62 percent) compared to rural and semi-urban areas (56 percent and 34 percent respectively). For female respondents this was more consistent across rural, urban and semi-urban locations (being 33 percent, 32 percent and 24 percent respectively).

Disaggregating by residency status, it appears that a greater proportion of male respondents from the host community (67 percent) felt this was a priority need, and among female respondents it was female refugees (50 percent) who considered this a priority need more than residency groups.

As can be seen in Figure 2a, mental health care was identified by 27 percent of male respondents compared to 11 percent of female respondents. When we look by governorate, a greater proportion of respondents in Duhok, compared to other governorates noted this.

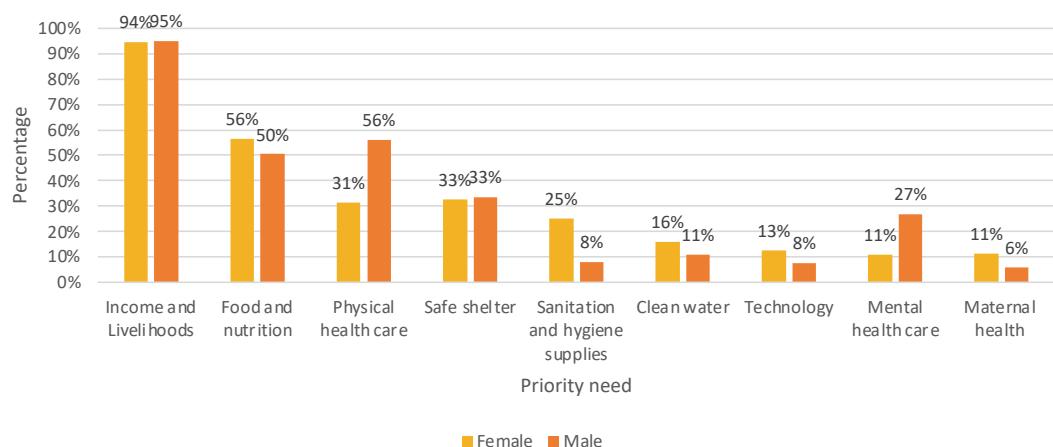


Figure 2a: Priority needs today, disaggregated by male and female respondents

x. Other areas noted by respondents included: family planning (3 percent f./3 percent m.); menstrual hygiene items (3 percent f./0 percent m.); protection (3 percent f./2 percent m.); and NFIs (0 percent f./1 percent m.).

Gender roles and responsibilities

Impacts on paid work

There was a greater overall shift from regular, salaried work to part time or daily work. Overall, full-time salary/wage labour decreased, and unemployment increased.

The impacts of lockdown and restrictions, compounded by national inflation, not only impacted direct access to livelihoods, but also access to inputs and access to markets to sell produce, and led to a reduction in demand for products. Long-term impacts on the ability of individuals to recover are being seen, even once restrictions were lifted.

Participation in the labour market is different for men and women with 72.6 percent of men working or looking for work compared to only 12.4 percent of women, pre-pandemic.¹⁶⁹ Data shows that women account for only 7 percent of employment in non-agricultural sectors.¹⁷⁰ That said, while women may be actively engaged in agriculture, this may not always be recognized in the data, due to women's roles often being invisible, as they are seen as "contributing family members" or "helpers."¹⁷¹

The economic standstill because of the pandemic, significantly reduced employment opportunities and decreased wages. Reports show that small and medium-sized enterprises, for example, reduced paid employment by 40 percent and cut salaries by 36 percent. Specifically, daily workers in the informal labour market, which many refugees and IDPs are part of, were impacted and often lacked safety nets to turn to after a drop in income-generating activities.¹⁷²

Survey results from this RGA showed that 91 percent of female respondents and 95 percent of male respondents identified “income and livelihoods” as one of the top three areas of their life most impacted by COVID-19, and this was consistently the most selected impact across the five governorates. All male refugee respondents identified this as one of the top three impacts.^{xii} In addition to the area most impacted by COVID, 94 percent of women and 95 percent of men then identified “income and livelihoods” as one of their top three priority needs today.^{xiii}

There was a greater overall shift from regular, salaried work to part-time or daily work. Overall, full-time salary/wage labour decreased from 10 percent before the pan-

demic to 7 percent today, and this was true for men and women respondents. Figures 3a and 4a show the results from the survey disaggregated by sex, showing changes in employment type in a typical week before the pandemic until today.

If we disaggregate further, for male respondents in semi-urban areas a decrease was noted from 23 percent before the pandemic to 11 percent, with smaller differences seen for urban areas (8–12 percent) and no difference in rural locations (6 percent).

Daily wage labour saw a decrease of 5 percent among male respondents, with the greatest differences seen in rural locations (a drop from 15 percent of respondents before the pandemic to 4 percent today). This is compared to women for whom the figure shows a slight 1 percent increase which was seen for women in urban areas. Due to this being a small increase and it not being consistent across all female respondents, it will be useful to follow this observation to monitor whether this is a trend that continues as the pandemic continues. For female refugee respondents for example, there was a drop from 8 percent before the pandemic and 0 percent today. Anbar and Ninewa saw the greatest drop in the propor-

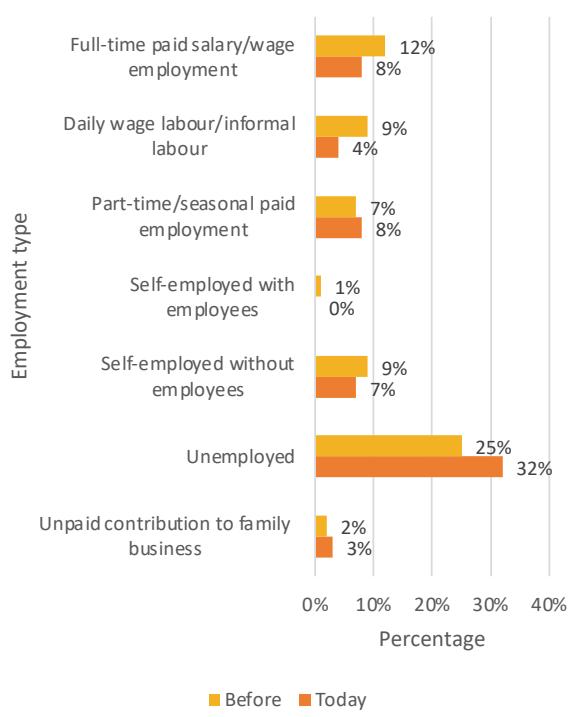


Figure 3a: How would you best describe your employment status during a typical week? (Overall male)

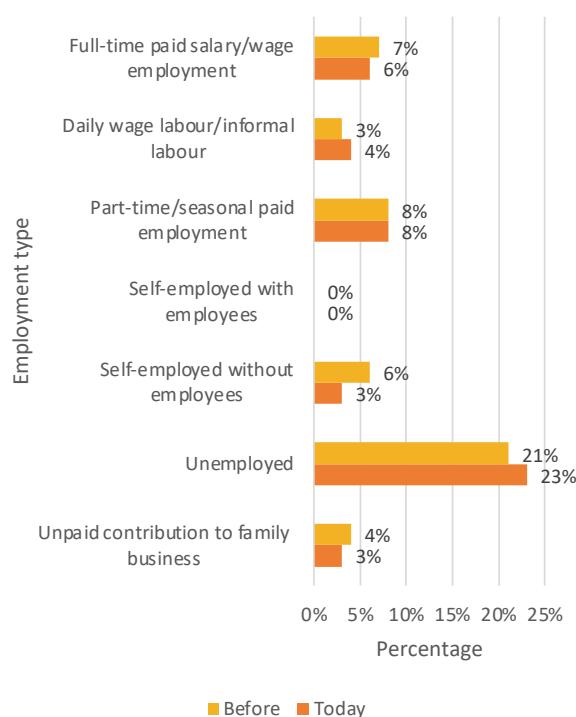


Figure 4a: How would you best describe your employment status during a typical week? (Overall female)

xii. Other groups of male respondents included: IDPs (95 percent); host community (93 percent); and, returnees (93 percent). For female respondents: returnees (94 percent); IDPs (91 percent); host community (88 percent); and, refugees (83 percent).

xiii. No real differences were noted for type of location, education status or age.

tion of respondents reporting “daily wage labourer” as their employment status.

Qualitative data further highlighted the impacts on daily wage earners being hardest hit: *“The majority of the host community in Anbar Governorate are depending on daily resources, daily income or daily labour. The curfew and COVID-19 have strongly affected their life and...their work”* [male, protection focal point, host community].

For those who worked to produce non-essential products or services, they noted a hit due to overall loss of income in the community. For example, one respondent was a house decorator prior to the pandemic said: *“Nowadays I am working as a daily labourer. I work two days per week for 10 000 IQD per day and can barely afford the cost of the food for my family. I plan to start work as a decorator with my friend again, but I need a small budget to start”* [male, small business owner, host community, urban area].

Overall unemployment^{xiii} increased from 24 percent prior to the pandemic to 27 percent today, with the greatest increase seen for male respondents. The largest increase in unemployment from before the pandemic to today, was seen for female refugee respondents (17–42 percent) compared to there being no change reported by male refugee respondents (25 percent prior to the pandemic and today).^{xv} Among male respondents, greater increases in unemployment were noted for male returnees (13–34 percent).^{xv} Figure 5a shows the impacts on unemployment by type of location, where men living in urban areas saw the greatest increase. Interestingly, unemployment appears to have reduced by 6 percent for women in semi-urban areas. If we look within this dataset for women in semi-urban areas, an increase was noted of 9 to 15 percent for female respondents in education, as well as an increase from 0 to 3 percent in part-time/seasonal paid employment. This would be interesting

to explore further in subsequent analysis to understand some of the opportunities that may be opening up to women (and men) as a result of the pandemic.

A big impact on livelihoods were the restrictions imposed as a result of the curfew. One female farmer lost full access to their employment on the landlord’s farm during the curfew and lockdowns. As the curfew continued, the respondent noted that the landlord replaced her, and she therefore needs an alternative livelihood. While she took up sewing, she *“requires capital for this business”* [female, IDP, farmer, Anbar]. Another respondent, a taxi driver, could not work during the lockdown and curfew. As a result of his loss of income, he had to *“sell his taxi, therefore, even once the lockdown was lifted, he is still not able to work”* [male, IDP, Dohuk].

“The biggest change occurred last year, we were economically affected because at the start of COVID, we could barely go to farm. Since, we are seasonal farmers, we are totally financially dependent on the farming of seasonal products. Last year, our products were sold very cheap.”

- Male, IDP, seasonal farmer, Dohuk

Many farmers who lived close to their farms were able to continue working as the government permitted travel to farmland. Although they were able to farm, the loss of income within the community meant farmers had to sell their products for low prices, and there was no movement between districts or governorates. For others,

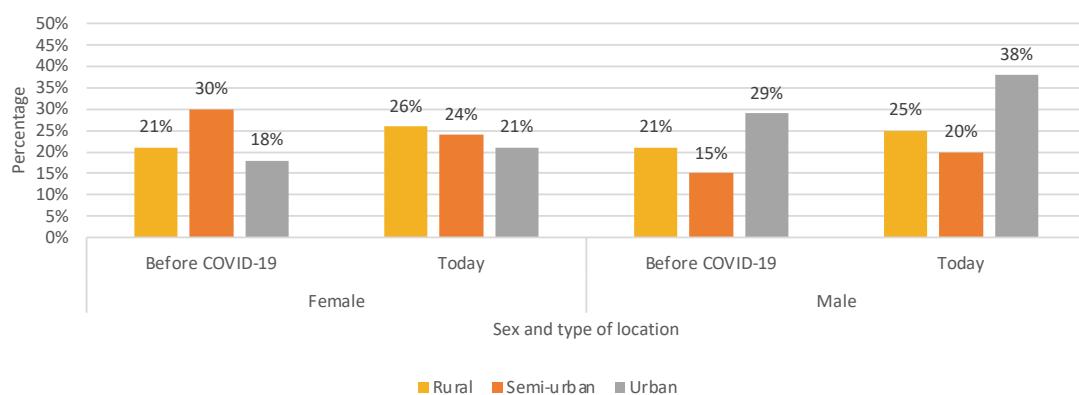


Figure 5a: Percentage of female and male respondents reporting unemployment before COVID-19 compared to today, disaggregated by location and sex

xiii. Both for respondents who are “unemployed and looking for employment,” and “unemployed and not looking for employment.”

xv. With increases seen for male IDPs (27–34 percent) and the male host community (28–31 percent).

xv. With increases seen for male IDPs (27–34 percent) and the male host community (28–31 percent).

COVID-19 made their farming unproductive, given the low costs of selling products and expenses for inputs, labour and equipment, this meant that some were forced to leave their land and work for others, while accumulating debt as a result of not selling their crops. Farmers who did need to travel to farms or to sell produce, spoke of considering changing jobs, as a result of lost earnings during the pandemic. For refugees who were not permitted to move outside camps, these restrictions limited their employment opportunities in nearby towns. These long-term impacts have meant that as a result, many people “are now still in debt and struggling to maintain a steady livelihood, even today, which is a cause for great anxiety” [male, Ninewa].

Women respondents noted that even once the lockdown was lifted, while there remained a lack of work opportunities for both men and women, and if there were work opportunities these were more readily given to men. One respondent spoke of feeling that this was rolling back progress for women in the workplace. Another said: “If any opportunity appeared, the man would be the favourite, and for this reason, the man’s role was the strongest. This psychologically affected many women, as they turned to household work, which included preparing food and cleaning only” [female, women’s group representative, refugee].

“I tried to set my goals...I was not only looking for work but rather I was looking for how to develop my skills such as in language and computers. What happened was a shock to now be at home, just preparing the food and cleaning. The work inside the house increased a lot, all the family’s members inside the house throughout the day, meaning more meals, more movement, more quarrels.”

- Female, rural worker, host community, Anbar

The vital roles that women are playing within the COVID-19 response have been highlighted early on in the pandemic.¹⁷³ The positive role and recognition of women in health service provision were noted by one respondent, who said: “The role of women has increased through medical staff, as the woman has proven her worth like a man, and perhaps more, especially during COVID-19 when prevention and extreme caution is required...in dealing with patients” [female, health worker, Anbar]. This was

seen more so for unmarried medical staff, whereas married staff had to balance additional household and family pressures. Other respondents noted innovation as a result of the pandemic, with women using social media to establish online businesses e.g. in clothes or make up [Female, Community Leader, Dohuk].

A total of 82 percent of respondents noting that their working conditions were worse since the start of COVID-19. This was reported by 84 percent of men and 78 percent of women respondents.^{xvi} A greater proportion of respondents from Ninewa reported worsening conditions (88 percent; 52 percent of which were male and 36 percent were female). 87 percent of female heads of household reported this compared to 84 percent of male heads of household and 66 percent of men and women who were the spouses of heads of household.

“Income was affected, firstly by COVID and secondly, by the changes in the rate of the dollar.”
- Female, market labourer, refugee

Overall this was reported by women from the host community (92 percent),^{xvii} compared to 83 percent of men from the host community.^{xviii} For respondents who classified as having a disability, 90 percent of male respondents noted conditions were worse and 82 percent of female respondents with a disability, which is a higher proportion than the overall average for each gender.

For those who kept their jobs in 2020, there are still concerns over the future, with fewer jobs being available. This was seen to be particularly impactful for the main breadwinner of the family (male or female): “I am the only source of income for the family and live in a rented house. Finding a job to pay rent and cover monthly expenditures is the main problem I am going to face after my contract finishes” [male, Erbil, host community, urban area]. Further, salaries remained the same, but prices increased, for example for food, health and transport, which had an overall impact on the health and food security of the family.

Low oil prices brought about by the pandemic led to the Iraqi Government devaluing the national currency.¹⁷⁴ The impacts of this were identified across respondents as compounding the already stressed economic situation resulting from the pandemic.

As of March 2021, schools were reopening again in Iraq but with limitations.¹⁷⁵ For girls and boys who moved to home schooling, many could not continue online, and therefore they started or increased their participation

xvi. This was followed by 15 percent saying they remained the same (17 percent of women and 14 percent of men).

xvii. Followed by 83 percent of female refugee respondents, 78 percent of female IDP respondents and 74 percent of female returnee respondents.

xviii. For male respondents, 89 percent of returnees, 84 percent of IDPs and 75 percent of refugees noted that working conditions have become worse.

Impacts on unpaid work

Concerns were expressed over girls and boys returning to school, particularly for girls past the age of primary school whose education may no longer be prioritized, as well as for boys who may not return if they have entered into the workforce.

in the family agriculture business. Respondents raised concerns over whether children would return to school, particularly if children were past primary school age where their further education may not be as prioritized, which is especially true for girls whose parents may opt to enter them into marriage instead: “There will be a generation of uneducated people, especially girls whose role will decline again, and their ambition will shift from education to marriage” [female, women’s group representative, Erbil]. Others expressed the greater impact on boys as it was uncertain whether they would return once they entered the workforce: “Schools were closed after COVID and it has affected boys more than girls, because they started working in different jobs and when the school opened, they did not want to study anymore” [male, Moktar, host community, Missan]. Large impacts of school closures have been seen for women in the household, who took on additional care work within the home and had to provide nutritious food for everyone.

“My uncle has four daughters and all were students before the COVID. When the school closed he did not let the daughters continue studying as he said that they are going to get married and no need for them to continue studying, while he keeps sending his sons.”

- Male, small business owner, Ninewa

The burden of unpaid work, which included additional work due to home schooling of children, was seen to increase and to have an overwhelming impact on women, both physically and psychologically, with women feeling the pressure to fulfil their role within the family.

At the same time, male respondents reported that their engagement in household tasks had increased since the pandemic, and this was particularly the case in urban areas and for young men (especially in food preparation and cleaning).

A 2018 study by the International Labour Organization (ILO) showed that the total share of unpaid care work was 86 percent for women and 14 percent for men, with women spending 5.75 hours (345 minutes) per day on unpaid care work compared to almost 1 hour (56 minutes) per day for men,^{xix} and for childcare, this amounted to 3.55 hours (213 minutes) per day for women and 2.13 hours (128 minutes) per day for men.¹⁷⁶

In this analysis, women, pre-pandemic, were mostly responsible for unpaid care work within the home. Since the pandemic, the burden of unpaid work, which included additional work due to home schooling children, was seen to increase and to have an overwhelming impact on women, both physically and psychologically, with women feeling the pressure to fulfil their role within the family: “*The double burden of work was seen to have physical health impacts on women, with fatigue and lack of protein*” [female, Anbar, health care provider].

The respondents were asked, “*Since the spread of COVID-19, how has your engagement in the following tasks changed (if at all)?*” Figure 6a shows the results broken down by sex. There were also further differences noted based on the relationship of respondents to the head of the household and based on age.

xix. Based on the time spent in the three main categories of unpaid care work: community services and help to other households; domestic services for own final use within the household; and, caregiving services to household members.

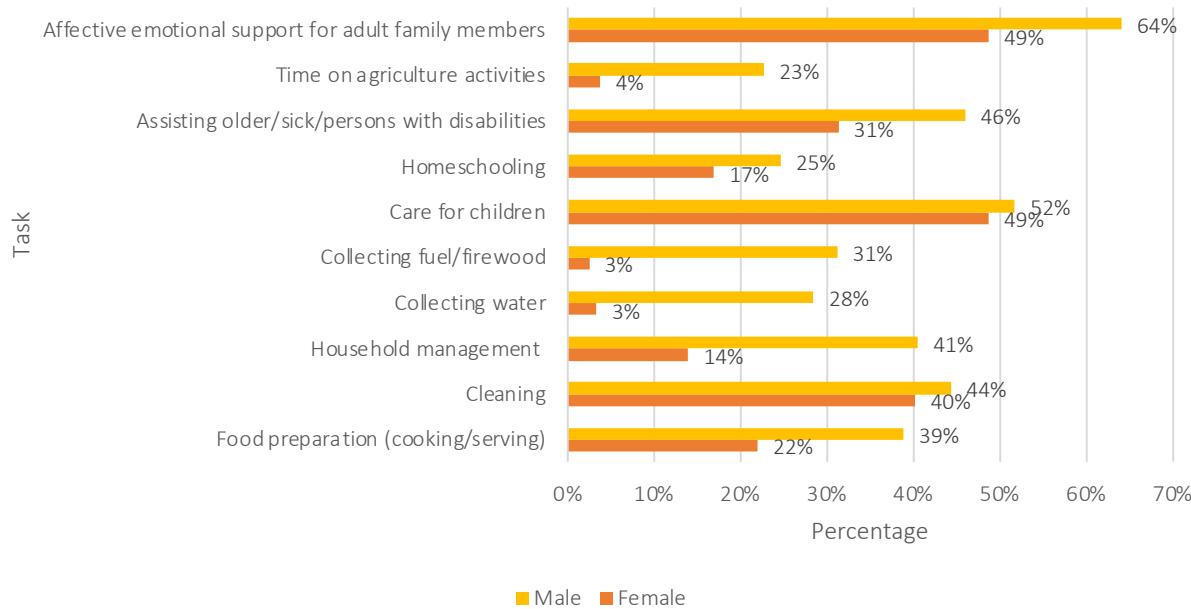


Figure 6a: Percentage of respondents whose engagement in the following tasks has increased since COVID-19, disaggregated by sex

Across all the tasks, men identified that their role increased, with a greater proportion of men reporting affective emotional support for adult family members, as well as caring for children (as seen in Figure 6a). However, when we look at the qualitative data, perceptions are mixed. Many female respondents reported that they have taken on the majority of the additional work and pressure, and male engagement was very much dependent on their temperament: “*In big families, they have divided the responsibility between the mother and the father as each one helps, but in many families, the father does not cooperate with the mother, so the workload of mothers increases*” [female, humanitarian worker, host community].

Based on the survey data, for food preparation, more male heads of household said this increased (46 percent), compared with 29 percent of female spouses and 20 percent of female heads of household. Similar trends were seen with regards to cleaning, where a greater increase was seen for male heads of household, followed by FSHH and FHHs. A greater proportion (close to half) of young men saw an increase in the time they spent on food preparation (47 percent) and cleaning (50 percent), compared to other age categories of male respondents. A greater number of young women, similarly, noted an increase in the time spent on food preparation (31 percent),^{xx} and for cleaning, a greater proportion of 60- to 69-year-old women reported this.

“The woman is the most affected, as she is the one who bears the additional burdens of the house, in addition to bearing the mood changes of family members to avoid disputes and problems.”

- Female, GBV service provider

For household management (e.g. paying bills), this was noted to increase for 45 percent of male heads of household, followed by 21 percent of female heads of household and only 5 percent of FSHH.

Household heads, both male (59 percent) and female (58 percent) saw an increase in their engagement in caring for children, with a 47 percent increase for FSHH. This was further raised in discussions with male respondents who noted some increases in their role looking after children: “*There is a big difference in my life before and after the pandemic and my role in the family as a man. Before the pandemic my responsibilities were much easier, but since the pandemic started, I am very careful about my children, making sure that they do not go out without wearing a mask and do not eat before they wash their hands*” [male, host community, Erbil].

^{xx}. An increase was also noted by 31 percent of female respondents aged 50 to 59.

Table 2a: Female respondents who reported increasing their engagement in household tasks, disaggregated by location type

	Rural	Semi-urban	Urban
Food preparation (cooking/serving)	30%	30%	17%
Cleaning	33%	30%	45%
Household management	9%	9%	17%
Collecting water	2%	3%	4%
Collecting fuel/firewood	0%	0%	4%
Care for children	37%	45%	54%
Home schooling	4%	9%	24%
Assisting older/sick/disabled persons	28%	30%	33%
Time on agricultural activities	9%	3%	2%
Affective emotional support for adult family members	40%	61%	49%
50–54	1.7%	1.8%	3.5%

Table 3a: Male respondents who reported increasing their engagement in household tasks, disaggregated by location type

	Rural	Semi-urban	Urban
Food preparation (cooking/serving)	26%	38%	43%
Cleaning	32%	44%	48%
Household management	25%	41%	45%
Collecting water	13%	13%	38%
Collecting fuel/firewood	19%	11%	40%
Care for children	46%	31%	59%
Home schooling	10%	7%	34%
Assisting older/sick/disabled persons	29%	38%	53%
Time on agricultural activities	11%	8%	30%
Affective emotional support for adult family members	49%	56%	71%
50–54	1.7%	1.8%	3.5%

For emotional support provided to adult family members, a similar trend was seen, with this increasing for 65 percent of male heads of household, 55 percent of female heads of household, and 37 percent of FSHH. For male respondents, this increase was noted more in 50-to-59-year-olds (82 percent), followed by 18-to-24-year-olds (72 percent) and 36-to-49-year-olds (68 percent).^{xxi} For female respondents, this increase was reported by 100 percent of 60-to-69-year-olds, followed by 55 percent of 50-to-59-year-olds and 55 percent of 18-to-24-year-olds.^{xxii}

It should be noted that this data shows the perceived level of change by male and female respondents, rather than the actual level of engagement or a quantifiable time allocation to specific tasks.

Interestingly, even though the data shows a 4 percent increase of the role of female respondents in agriculture, qualitative discussions showed different results. Respondents spoke of the restrictions, meaning farms could not bring in outside labour, which resulted in women in the household taking on additional roles in supporting the farm, e.g. in harvesting and cultivation of the crops. It was noted however that this further increased women's unpaid workload, in addition to working inside the home.

When we look at differences based on types of location, pre-pandemic, time spent in unpaid care work, in one 2018 study, was seen to be slightly higher for women in rural areas (6 hours or 362 minutes per day) than in urban areas (5.5 hours or 330 minutes) with the gap being closer for men (56 minutes in urban and 58 minutes in rural areas).¹⁷⁷

Women who indicated that their engagement in household tasks had increased since the start of the pandemic, with results disaggregated by location type (rural, semi-urban and urban). From the collected data, the majority of the tasks increased the most for female respondents in urban locations (with the exception of time spent on agricultural activities and food preparation), and for male respondents, higher results were noted in urban areas across all the household tasks.

While we do not have specific data on the cause and effect, we can see from Figure 5a that male respondents in urban areas showed the greatest change in unemployment compared to other location types and compared with female respondents. Therefore, it is likely that due to pandemic and related job losses, men have experienced significant livelihood changes and are spending more time in the house, which has led to a shift in their engagement in household tasks. While women overall may, in absolute terms, be taking on the larger share, men are reporting greater increases relative to the situation pre-pandemic.

Outside the labour force, for 76.8 percent of women, there was unpaid care work compared to for only 0.4 percent of men.¹⁷⁸ One women respondent spoke of the impacts that increased demands of unpaid work within the home had had on her pursuits outside of the home. Another women respondent noted that even once the lockdown was lifted, it was more difficult to resume work compared to for men: "*It has been confirmed that society can impose its old backward ideas about the preference for men over women. This has affected women and their self-confidence and of course, this, in turn, leads to a decline in the national economy and income for women*" [GBV service provider, Dohuk].

Food insecurity

Men and women appear to have similar moderate and severe food insecurity prevalence rates, with male respondents showing greater severe food insecurity. Respondents in urban areas reported higher food insecurity.

Pregnant women and people with disabilities were particularly affected by the impacts on access to humanitarian assistance. People classified as having a disability showed higher food insecurity than those not classified as having a disability.

There was a strong reliance on food baskets and a concern over the continuation of these as necessary for food security. However, the quality, quantity and selection criteria of the food baskets were raised as a concern.

Understanding prevalence of food insecurity was addressed in this analysis using the FAO Food Insecurity Experience Scale (FIES). This scale consists of eight questions regarding people's access to adequate food. The questions are focused on the individual level and on self-reported food-related behaviours and experiences associated with increasing difficulties in accessing food due to resource constraints.¹⁷⁹

The results below show FIES data disaggregated by sex, age, type of location, persons classified as having a disability, as well as relationship to the household head.^{xxiii} Results are displayed as both overall FIES prevalence scores as

^{xxi}. Followed by 25-to-35-year-olds (56 percent); 70-year-olds and above (40 percent); and, 60-to-69-year-olds (33 percent).

^{xxii}. Followed by 25-to-35-year-olds (48 percent); 36-to-49-year-olds (44 percent); and 70-year-olds and above (40 percent).

^{xxiii}. Disaggregation by diversity factors was only possible where the sample size for each category (or at least most categories within a variable) was close to or exceeded 100 observations.

^{xxiv}. This was identified by asking respondents after each of the eight variables: "Was it specifically linked to COVID-19?"

well as data showing the prevalence that can mostly be attributable to COVID-19. The difference between the two scores shows the food insecurity level in the absence of COVID-19.^{xxv}

As shown in Figure 1a (above), food and nutrition was the second most reported area by female respondents and third most reported area by male respondents, as having been most impacted by COVID-19 (reported by 48 percent of females and 41 percent of males), as well as the second most reported priority need by female respondents and third most reported area by male respondents (reported by 56 percent of females and 50 percent of males) as shown in Figure 2a. This was reflected through discussions with respondents who spoke of both the quality and quantity of food being impacted as a result of the pandemic, with key impacted groups highlighted to be FHH and daily workers, who often could not afford fresh food or meat.

Based on the FIES data collected through the survey, total food insecurity levels were seen to be at 61.08 for moderate and severe^{xxvi} and at 17.47 for severe.^{xxvi} Of this, food insecurity levels mostly as a consequence of COVID-19 were overall at 48.71 for moderate and severe and at 12.10 for severe. Results disaggregated by sex are shown in Figure 7a, where male and female respondents appear to have similar moderate or severe food insecurity prevalence rates, with male respondents showing greater severe food insecurity.^{xxvii}

In the early stages of the pandemic, the quality of food was a concern, with respondents noting a shift from healthier foods such as vegetables, fruits and meats, to canned or dried foods. However, overtime the quantity reduced, due to continued loss of income and rising food prices [female, person with a disability, Missan].

When the pandemic hit, respondents spoke of aid being stopped or limited, or services becoming unsafe to access due to the virus. This was seen to particularly impact pregnant women and people with disabilities, both in terms of the risks of contracting the virus, but also due to a number of organizations targeting these individuals for projects and aid, prior to the pandemic. This meant, therefore, that they were harder hit when support was withdrawn or reduced. In places where food and health aid were provided, in the initial stages after the pandemic, the competition for resources impacted people with disabilities with regards to access.

Respondents were concerned over the quality of food for young children and the inability to provide fresh food, milk and eggs, with one respondent noting: *“Those more affected are the children. We cancelled many types of food like milk and fruit. There are just available one time in a month or maybe not”* [female, host community, Missan]. A health worker noted: *“Malnutrition is on the rise and there are many daily deaths of children.”* Of the respondents who had children aged 0 to 5 years living in their household, 48 percent noted that the daily food requirements of boys^{xxviii} had deteriorated and 50 percent noted this for girls.^{xxix}

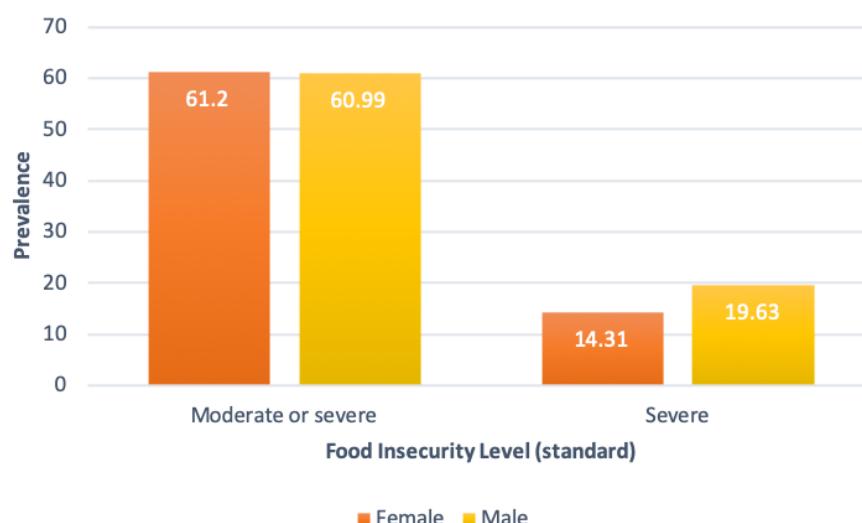


Figure 7a: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by sex

^{xxv}. People experiencing moderate food insecurity have reduced the quality and/or quantity of their food and are uncertain about their ability to obtain food due to lack of money or other resources. See <http://www.fao.org/in-action/voices-of-the-hungry/sdgs/en/>

^{xxvi}. People experiencing severe food insecurity have run out of food and, at the most extreme, have gone a complete day without eating. This group of people are those we call the “hungry.” See <https://www.fao.org/in-action/voices-of-the-hungry/sdgs/en/>

^{xxvii}. With regards to the levels that are mostly a consequence of COVID-19, the proportion for moderate or severe food insecurity is 50.47 for females and 53.03 for males. For severe food insecurity, it is 12.68 for females and 19.47 for males.

^{xxviii}. Analysis based on 271 respondents, who had boys aged 0 to 5 in the household.

^{xxix}. Analysis based on 285 respondents, who had girls aged 0 to 5 in the household.

Table 4a: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, mostly as a consequence of COVID-19, disaggregated by age

Age	Moderate or severe	Severe
18-24	50.72	14.05
25-35	49.61	14.98
36-49	55.9	19.92
50-59	54.78	17.8

Table 5a: Prevalence of moderate or severe, and severe food insecurity, mostly as a consequence of COVID-19, disaggregated by location type

Total	Moderate or severe	Severe
Rural	54.33	17.54
Semi-urban	58.02	11.81
Urban	64.14	18.88
COVID-19	Moderate or severe	Severe
Rural	44.2	15.43
Semi-urban	50.51	9.37
Urban	55.00	18.97

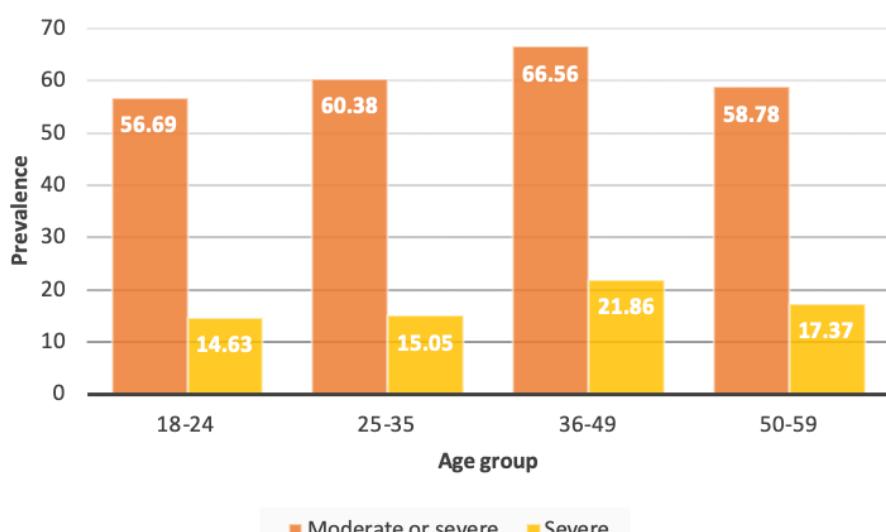


Figure 8a: Prevalence of moderate or severe food insecurity and prevalence of severe food insecurity, disaggregated by age

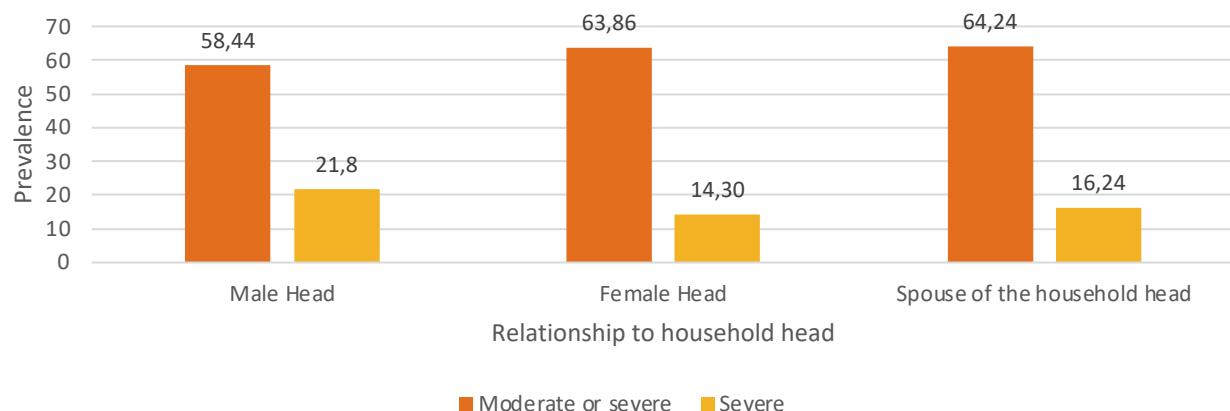


Figure 9a: Prevalence of moderate or severe, and severe food insecurity, disaggregated by relationship to household head

For those who receive food baskets, whether they were from the government, the UN or international non-governmental organizations (INGOs), there is a clear expression of reliance on these. With the rising prices of food, respondents spoke of the fear of food baskets stopping and many are now completely dependent on this: “*Since there is a lack of resources and income, we are not having fresh or safe food, but we depend on the stock and the food baskets that we receive*” [female, farmer, IDP, urban location]. The quantity and quality of food within food baskets were identified by a number of respondents, with recommendations that this should be reviewed by agencies to better address needs: “*The whole family depends on the mother’s monthly income and the monthly food basket, and because it is a large family, this is not enough. We have spent all our savings*” [female, IDP].

Criteria for assistance were also raised by several respondents. One respondent had taken on daily work and as a result, their assistance ceased, however the wage was not full time and they needed additional support. Further, once short-term contracts finish, respondents spoke of assistance not being reinstated, and the need for this [male, daily labourer, refugee]. Similar findings related to the need for increased community engagement on the criteria of food assistance and their assessment of criteria, as has been noted in other assessments.¹⁸⁰

Food insecurity prevalence based on rural, urban or semi-urban locations is shown in Table 5a. This highlights greater moderate or severe food insecurity in urban locations with severe food insecurity similarly being slightly greater in urban locations. While we do not know the exact cause for this, qualitative data highlighted that, for farmers who were able to live off their crops, impacts on food have not been as severe as they had available food for their families. However, even in these cases, respond-

ents did raise concerns over longer-term impacts: “*Yes, if the situation remains as it is, we cannot feed the children, especially because I cannot provide a good meal, we depend on the vegetables that we plant, and sometimes we cannot eat meat more than once in a month*” [female head of household, farmer, host community].

Greater severity of food insecurity was also seen in Duhok (69.11 moderate or severe and 27.01 severe), compared with other governorates,^{xxx} with 66.65 being mostly a consequence of COVID-19 for moderate or severe food insecurity and 28.36 for severe food insecurity.

When we look at prevalence levels for male and female heads of household and FSHH, we also see differences in food insecurity prevalence levels. Figure 9a shows that the total prevalence of food insecurity is slightly higher for spouses of the household head. When we look at the prevalence levels due to COVID-19, we see that the proportion accounted for by COVID-19 is higher for female heads of household, both in respect of moderate or severe, and severe food insecurity.

According to FIES data, total prevalence of severe or moderate food insecurity in respondents who classified as having a disability was 73.6 (compared to 58.6 for persons who were not classified as having a disability) and 23.08 (compared to 16.36 for persons who were not classified as having a disability) for severe food insecurity.^{xxxi} One respondent spoke of their need for medicine and nutritional supplements to improve their health, which would allow them to work. The impacts in terms of reduced quality and quantity of food, and lack of medicine affect the ability to work, which in turn impacts the quality of food they can purchase: “*I have a strong desire to work and the ability to earn income from work such as sewing, bread making and other work, but my stopping taking my medicines and healthy food has increased my weakness*” [female, person with a disability, IDP].

xxx. Total: for Anbar (moderate or severe, 65.6 / severe, 12.65); Erbil (moderate or severe, 59.98 / severe, 10.63); Missan (moderate or severe, 45.28 / severe, 14.67); and, Ninawa (moderate or severe, 55.11 / severe, 16.52)

xxxi. For persons classified as having a disability, the impacts that could mostly be a consequence of COVID-19 were 66.3 for severe or moderate food insecurity, and 23.89 for severe food insecurity. For those who were not classified as having a disability, impacts that could mostly be a consequence of COVID-19 were 49.56 for moderate or severe, and 15.29 for severe.

These findings were echoed through discussions more broadly, with many highlighting FHHs, as well as persons with disabilities as key at-risk groups within the crisis, particularly persons with disabilities who relied on daily wages and aid to ensure availability of food: “*Female-headed households have been the most affected people for food after the crisis, some of them were working as daily labourers, but now and because of the curfew they could not find the right jobs*” [male, protection focal point, Anbar]. The respondent stressed the importance of ensuring food assistance reach these specific at-risk groups.

Access to services and resources

Access to services, resources and humanitarian assistance was impacted during the pandemic, as a result of lockdowns, curfews and movement restrictions. Individuals living in camp settings were impacted by lack of access by humanitarian workers.¹⁸¹ Respondents spoke of aid stopping or being limited when the pandemic hit and this was seen to continue to today: “*After COVID-19 there is no aid from the government or NGOs, to support the people, for food or even clean water*” [female, person with a disability, Missan]. Service providers noted barriers in accessing the communities they worked with and the shift to more remote ways of working. This was highlighted by one key informant who works with persons with disabilities and the additional barriers of trying to reach women with disabilities, due to their phone numbers often being restricted by family members [male, protection NGO representative, Missan]. Even where services were running and accessible, there were concerns over the risk of contracting the virus, which meant people did not access them, particularly pregnant women, the elderly and persons with disabilities who were known to be at greater risk of COVID-19.

Access to health care

There was a struggle between the ability to afford and access health care and providing food for the family, with respondents selling assets or borrowing money to afford medicine. Specific concerns were raised over available health, food and nutritional supplements for pregnant women and babies.

Overall, 10 percent of women and 31 percent of male respondents identified physical health as one of the top three areas impacted by COVID-19 (Figure 1a above) and 31 percent of female and 56 percent of male respondents identified physical health care as a priority need today (Figure 2a above).

The number of respondents who identified impacts on physical health as a result of the pandemic, generally increased with age, and this was also highlighted by a greater number of refugee respondents, both female (17 percent) and male (44 percent) and IDP respondents, both female (11 percent) and male (33 percent).^{xxxii}

A greater proportion of respondents who classified as having a disability identified physical health (56 percent of male respondents with a disability and 32 percent of female respondents with a disability) than those without. This was greater than the overall average for their gender.

Throughout the discussions there was a struggle between the ability to afford and access health care and providing food for the family, with respondents selling assets or borrowing money to afford medicine; these respondents spoke of now being in debt as a result. One respondent noted restricting food intake to afford her son’s medicine: “[I] cannot provide adequate and nutritious food, my children are eating too little, and now it is much less...they try to help me reduce the amount of their food so that I can save the medicine for their brother” [female head of household, farmer, Anbar].

Specific concerns were raised over nutritional supplements for pregnant women and babies. In Anbar one respondent noted that in the past, there were organizations supporting pregnant women but now there is no support in the camp. Women raised specific concerns about becoming pregnant due to fears of the risks associated with the virus, but also concerns of being able to ensure adequate food and nutrition to ensure a healthy pregnancy and there being no support. One male respondent expressed concerns that there was not enough healthy food to support his wife’s pregnancy, and he feels that she lost her child as a result [male, IDP, Dohuk].

One respondent with a disability, noted the greater impacts on her physical health since the pandemic, due to impacts on income, the lack of healthy food and lack of access to medicines and supplements. This has wider impacts on her ability to work: “I have a strong desire to work and the ability to earn income from work such as by sewing or bread making... but stopping taking my medicines and healthy food has increased my weakness” [female, person with a disability, urban location].

Access to health care may be impacted by the ability to decide for oneself. The Humanitarian Needs Overview 2021 noted that women have faced additional challenges in accessing health care, including due to lack of female medical staff or the cultural/normative requirement to

^{xxxii}. Compared to respondents from the host community (4 percent f./23 percent m.) and returnees (9 percent f./30 percent m.).

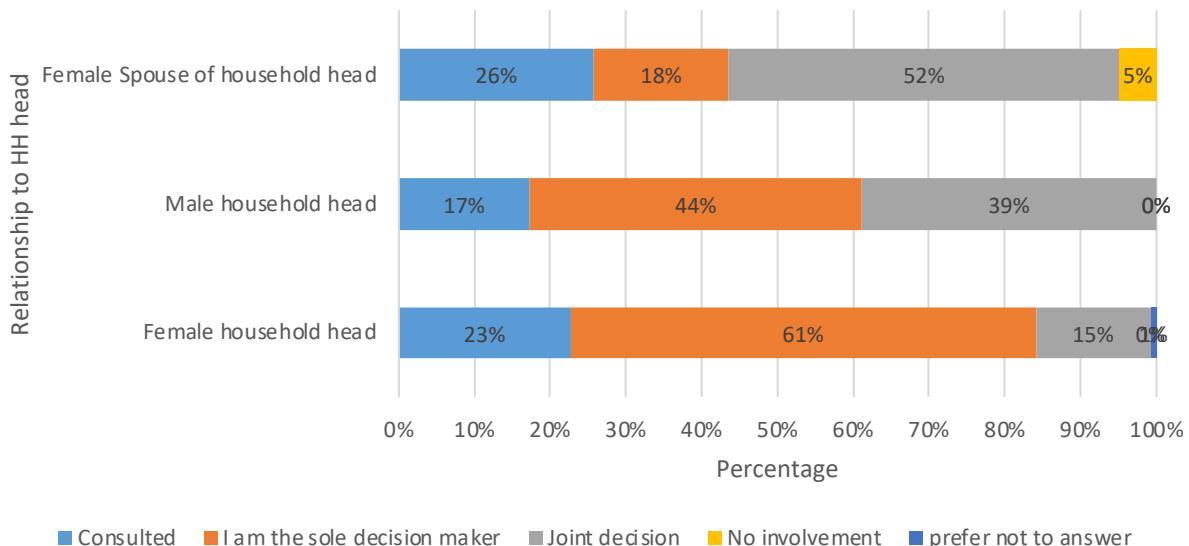


Figure 10a: Accessing healthcare for yourself, disaggregated by relationship to household head

be accompanied by a male guardian.¹⁸³ According to pre-pandemic data, 72.4 percent of women in rural areas require male permission to access health services (64.1 percent in urban areas). In this study, while there were no real differences in comparing types of decision-making prior to the pandemic, with today, with regards to accessing health care for oneself, there appear to be some small differences in decision-making power, based on the role within the household. As shown in Figure 10a, FSHH have less decision-making power over access to health care compared to heads of household (both male and female), with 5 percent noting no involvement.

Mental health was noted by nearly half of men and women respondents as an area most impacted by COVID-19, and was valued as high as food and nutrition.

With regards to mental health, stress, anxiety and psychological impacts of the pandemic were raised by respondents in the survey. And 49 percent of women and 48 percent of men noted mental health as one of the three areas of their life most impacted by COVID-19 (valued as high as impacts on food and nutrition for 48 percent of women and 41 percent of men). Moreover, 11 percent of women and 27 percent of men also identified this as one of the top three priority needs today. Respondents spoke of the long-term impacts of COVID-19 in these terms: “Family tension, and lack of food and income were the

most challenging after the pandemic... we have mentally changed, and we need a long time to recover to get back to normal life and live in dignity” [male, IDP, Youth, Dohuk]. While a number of respondents noted that there were mental health services in their location, the fear of the virus prevented people from seeking support.

Access to information

Women’s access to information is defined by a number of factors. Of the 3.3 million people in Iraq who are illiterate, 2.3 million are women.¹⁸⁴ There is also a digital gender gap in Iraq, where 98 percent of men have access to the Internet compared with just 51 percent of women.¹⁸⁵

Due to social status in society, men were reported to receive information faster and have greater access to evolving situations and opportunities. The types of avenues through which men and women receive information did not change much during the pandemic, however there was a greater use of social media and the Internet. Men had greater access to information being shared within the community and one respondent noted: “*Through the community sharing information, the responded mentioned that he was able to find a job as a daily labourer several times,*” [male, small business owner, host community]. One respondent noted that men will share information with women once they receive it. However, this leaves women reliant on men to pass on information that is relevant and useful to them in a timely way.

The community gets [information] through social media and sometimes television, through which we get market information, COVID-19 messages, health information, in addition to news of friends, healthy foods and when the food will arrive in the market. Theyoung, boys more than the girls have the most access to this information because they are active all the time with these techniques. The elderly, especially women, have barriers, due to their inability to deal with smart devices.”

- Female, refugee, Dohuk

Respondents to this study expressed that younger women, particularly where traditions dictate that women should not use mobile phones, would have increased barriers to accessing information, as would men and women in rural areas and the elderly. One respondent who works with persons with disabilities noted that the change in work modality to remote ways of working during the pandemic, has impacted their ability to provide services to people with disabilities, particularly women. This is due to “*phone ownership often being restricted by family members*” [male, host community].

Particularly for rural areas, “*Lack of information was seen to affect access to jobs and resources*” [male, NGO representative, Missan], and this was seen to be greater for women due to their increased role within the home. This is supported by other studies which show that phone ownership for adolescent girls is mixed, with some sharing phones with other another family member, which may impact access to informal social networks through which they receive and share information.¹⁸⁶

Impacts on resources and coping mechanisms

Survey respondents were asked, “As a result of COVID-19, how have the following resources been affected (if at all)?” Table 6a shows the percentage of men and women who saw their resources either “significantly decrease” or become “totally lost” as a result of the pandemic, with the greatest impacts being reported on savings and pensions, social security payments and other assistance.

Disaggregating further by residency status, loss of pension, social security and assistance was reported by 60 percent of female respondents from the host community^{xxxiii} (compared to 30 percent of male respondents from the host community) and for half (50 percent) of female refugee respondents.^{xxxiv}

For male respondents, the greatest impact was seen for male returnees, with 44 percent reporting a significant decrease or total loss of pension, social security and assistance. A total of 47 percent of women classified as having a disability and 26 percent of men with a disability reported this loss.

Half of refugee women (50 percent), nearly half (48 percent) of host community women and 31 percent of IDP women reported a loss of support from friends/family in the country, and for men this was reported by over one-third of returnees (34 percent), followed by just over a quarter (26 percent) of IDPs. Of the 21 pregnant respondents, 43 percent noted they totally lost this form of support.

With regards to savings, the group that reported the greatest loss (either totally lost or significantly decreased), were female refugees, which can be seen in Figure 11a. When we link this with the analysis in the previous sections, we see that daily workers and those working in the informal labour market (in which refugees are often engaged) have been greatly affected by the pandemic’s impact on livelihoods. From the data in this analysis, there was a decrease of 8 percent in female refugee respondents who reported daily wage labour as their employment status today compared to before the pandemic. Further, for refugees who were not permitted to move outside camps, during times of restrictions, this limited their employment opportunities in nearby towns. Therefore during these times, individuals may have had to rely on existing safety nets including the use of savings.

While IDP respondents did not report as highly as other groups in the survey, during the interviews respondents noted specifically that impacts on their assets were compounded by the loss they already faced during displacement, prior to the pandemic.

When the pandemic hit, it was unknown how long this would continue for. This uncertainty led to a depletion of stores and reserves as well as additional costs for items such as masks and sterilization materials: “*After COVID, we lost everything. Any assets we had, we lost to pay our debts during COVID, such as for buying medicines, and food, and the situation worsened*” [young woman, rural worker, host community].

We asked respondents whether they took any actions to compensate for the changes to their resources. The top three coping mechanisms identified by respondents were: reducing essential non-food expenditures such as education and health (25 percent male and 11 percent

^{xxxiii}. Followed by 50 percent of female refugees, 42 percent of female IDPs and 25 percent of female returnees.

^{xxxiv}. With 50 percent being totally lost, as 0 percent noted significantly decreased.

Table 6a: Loss of resources by male and female respondents

Resource	Female	Male
Pensions, social security payments and assistance received from INGOs/NGOs or other non-profit organizations	30%	30%
Savings	30%	38%
Money from people living abroad	22%	27%
Support from friends/family in the country	25%	25%
Assets (land)	27%	27%
Assets (livestock)	25%	26%

female); using credit or borrowing money to purchase non-food items (NFIs) (13 percent male and 5 percent of female) and using credit or borrowing money to purchase food (13 percent male and 22 percent female).

For reducing non-essential expenditures, this strategy was noted by 15 percent of FSHH compared to 9 percent of female heads of household, and for 16 percent of male heads of household. When we disaggregate by residency status, 25 percent of female refugees and 54 percent of male returnees noted this strategy would be applied,

which was higher compared with other groups. Almost one-fifth of pregnant respondents also reported applying this, and while the sample is small, this is above the average for women respondents overall. This strategy was reported by 29 percent of male and 29 percent of female persons with a disability – which is higher than the average for each gender, as well as being higher than the proportion of respondents who were not classed as having a disability (8 percent female and 25 percent male).

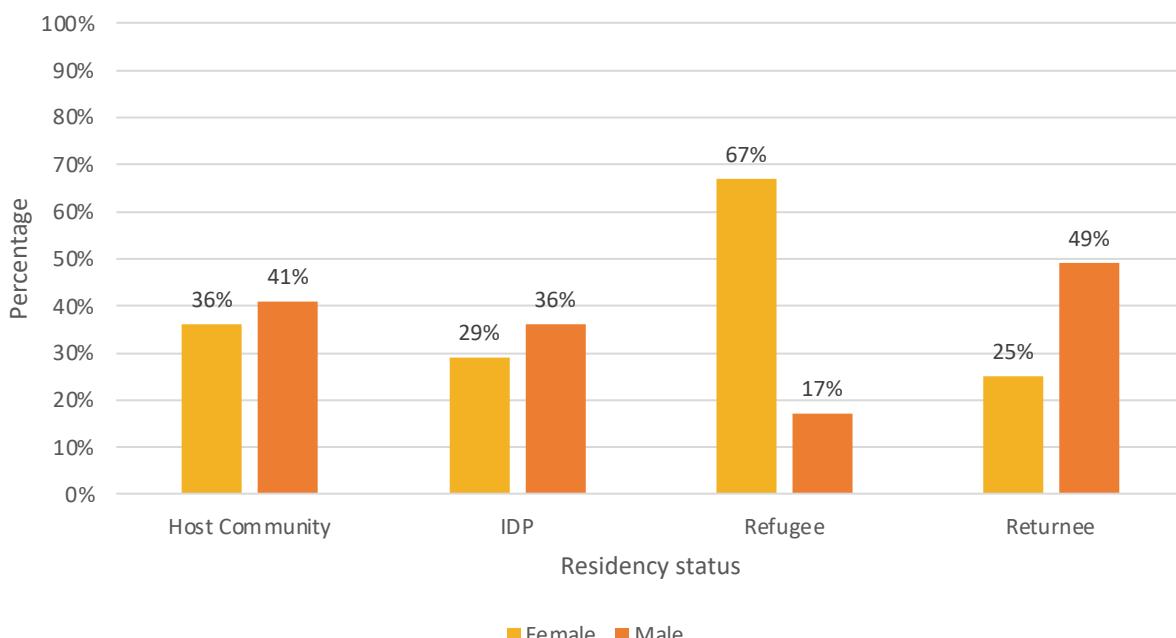


Figure 11a: Loss of savings as a result of COVID-19, disaggregated by residency status

Figures 12a and 13a show the differences in the proportion of groups that used credit or borrowed money to purchase food. Figure 12a shows results, disaggregating by relationship to the household head and Figure 13a by residency status and sex. Here we see the greatest impacts on female heads of household as well as on female respondents in the host community.

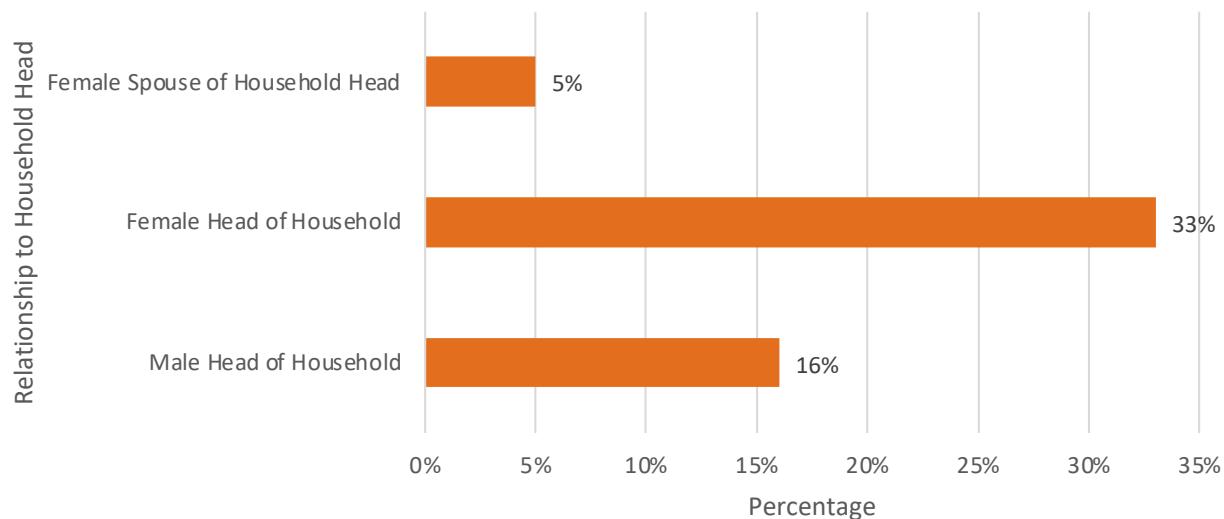


Figure 12a: Respondents who used credit/borrowed money to purchase food, disaggregated by relationship to household head

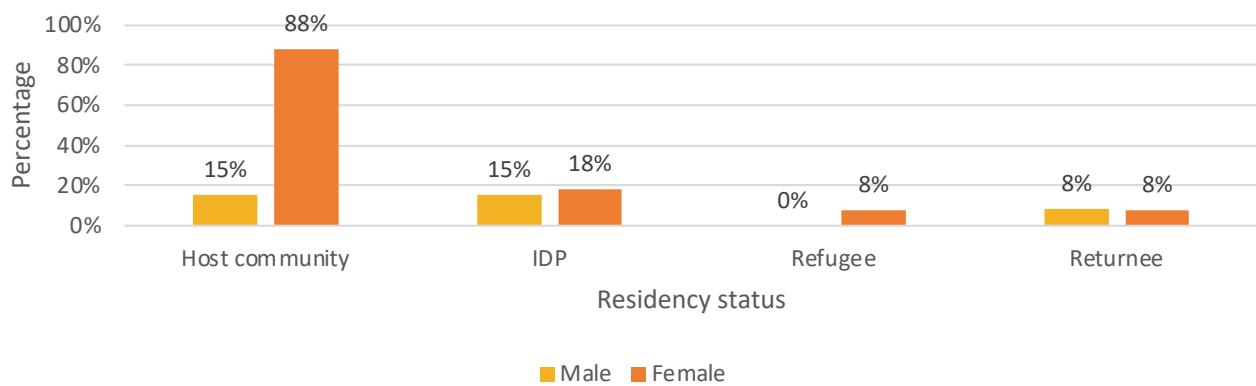


Figure 13a: Respondents who used credit/borrowed money to purchase food, disaggregated by sex and residency status

Decision-making, participation and leadership

Decision-making in the household did not appear to have changed much since the pandemic.

Joint decisions were being made regarding purchasing food, compared to other forms of decision-making, and this was especially the case with refugee respondents.

Household decision-making

Traditionally the male head of the household would be the primary decision maker and in control of household assets: “*I am the decision maker of the family before and after the COVID. As for the rest of the community and due to some traditional aspects, the male is the one who is responsible and in control of the family assets*” [male, NGO representative, Missan]. One respondent noted that “*it is*

a shame that men take the consultation of women, in the business of men,” and while women may be consulted on certain decisions, the final decision would rest with the man of the house.

However, there were differences in the responses from the qualitative data collection. In a number of cases, respondents spoke of women being responsible for decisions around food, with regards to purchasing and preparing food and cooking, decisions on the type and quantity of food required in the house. And for men, decision-making related more to income, health care and matters outside of the home. For FHHs, they are in control of household assets and decisions within the home, with some consulting with other male family members on issues outside of the home. For women in a joint or male-headed household, decisions related to the home are taken jointly. However, it was noted that even if there was consultation, and in the cases where women would be responsible for the quantity and quality of the food available in the household, they were not the overall decision maker [female, host community, Missan].

For some, there were slight shifts during COVID-19, where women took on more of a decision-making role regarding household decisions, or with there being an increase in consultation. This was noted to be either as a result of the husband being out of the house more seeking work, or as a result of women taking on more of a role in paid work, or where the husband is out of work.



@CARE/Ninja Taprogge

An IDP and young entrepreneur in Northern Iraq growing her poultry business to support her family

In Erbil, for example, a respondent noted that since COVID-19, women are more responsible for decisions related to income spending and health as they have been seen to manage the family budget more during the pandemic. If a woman does work, respondents noted that she would be in charge of her salary and income. In Dohuk, however, one female respondent noted that while women have taken on more responsibility for earning an income, there is still no change in terms of decision-making. And one respondent in Erbil said, “In the household, it is the male who makes decision over the work and income while his wife is responsible for the food and other household needs. Every decision remains the same before and after COVID” [male, daily labourer, refugee, Erbil].

Supporting this, across the different types of decision-making, the survey results did not highlight large differences comparing decision-making before COVID-19 and today. This being said, there are interesting findings related to the levels of decision-making for men and women and what this means for food security and livelihood opportunities.

Figures 14a to 18a show decision-making patterns across male respondents who are heads of household, female respondents who are heads of household and FSHH, so as to compare the different power dynamics based on the relationship with the household head.

Based on the survey data, joint decisions were seen to be taken more for purchasing food, compared to other forms of decision-making. Joint decisions over purchasing food were seen more for female refugees (58 percent) compared to female host community (12 percent), female returnees (26 percent) and IDPs (35 percent). This was shown through the qualitative data whereby a community leader (female) noted that control and decisions over assets involved everyone in the household.

While power dynamics with regards to decision-making in the household have not seen much change so far, it would be interesting to continue to monitor changes considering we are only one year into the pandemic.

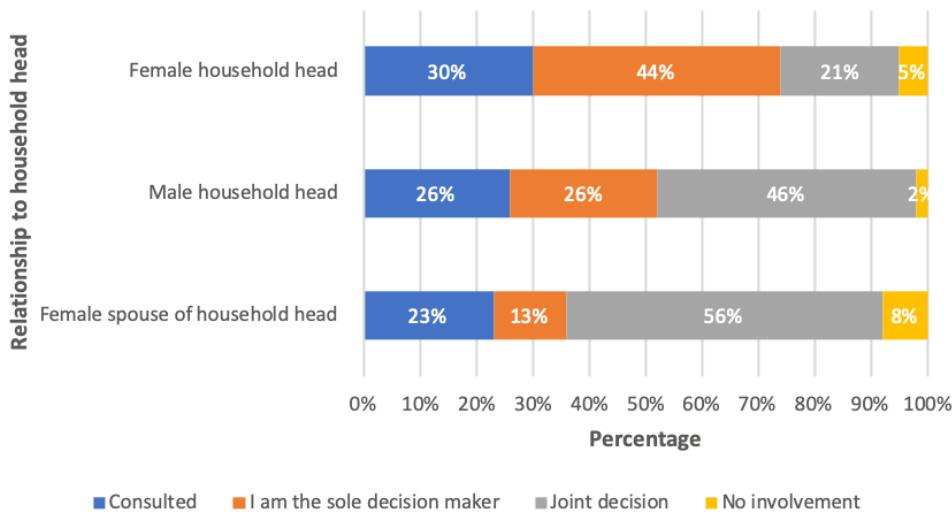


Figure 14a: Purchasing food (today), disaggregated by relationship to household head

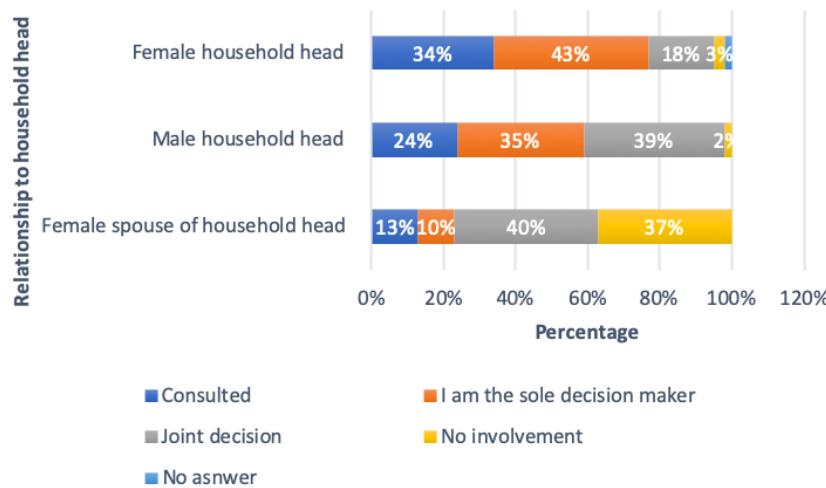


Figure 15a: How income is spent (today), disaggregated by relationship to household head

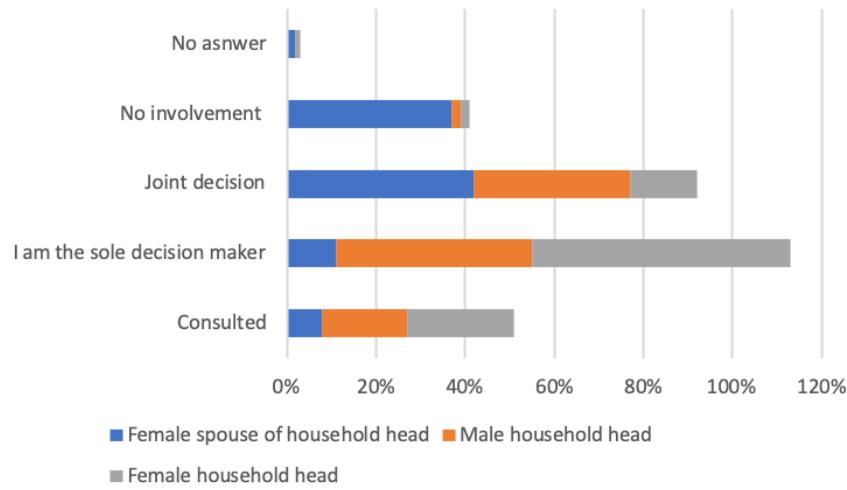


Figure 16a: Working to earn money for yourself (today), disaggregated by relationship to household head

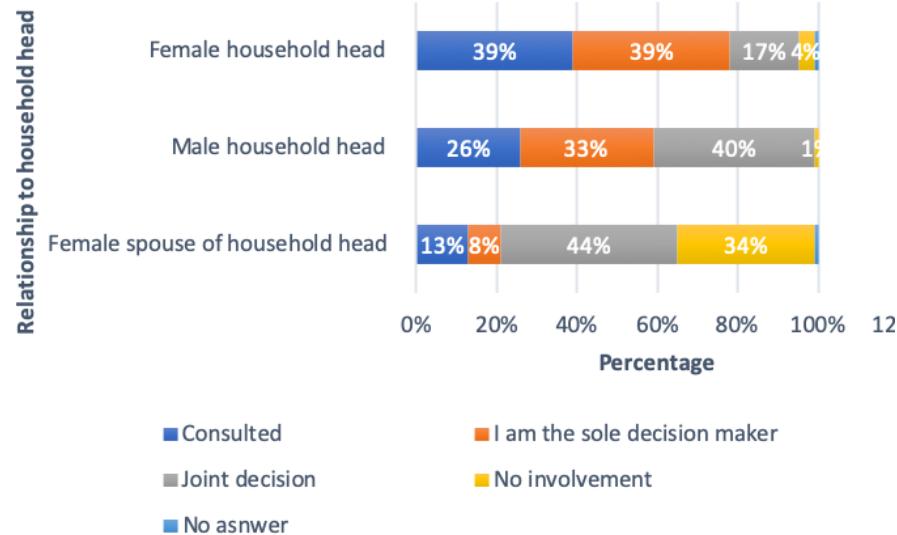


Figure 17a: Buying or selling assets, disaggregated by relationship to household head

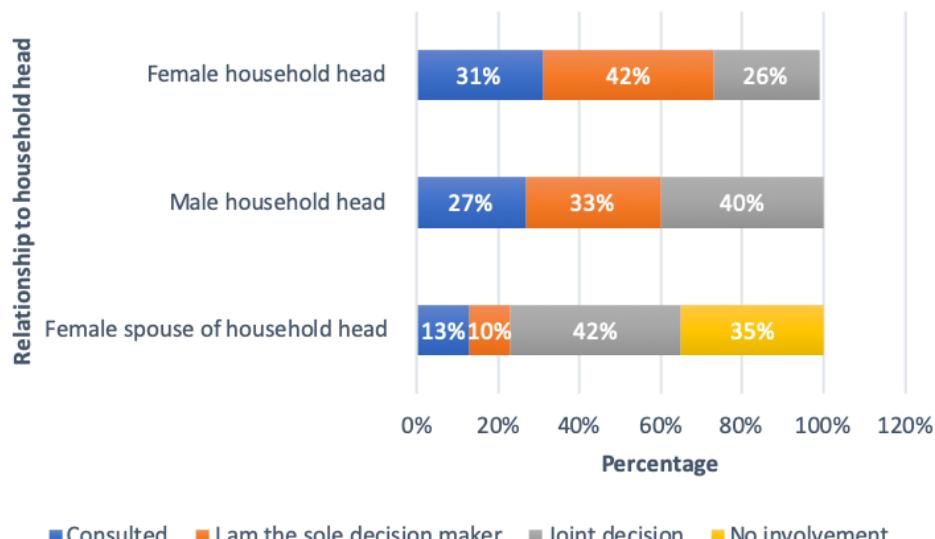


Figure 18a: Use of savings, disaggregated by relationship to household head

Community decision-making

Men traditionally would be part of community groups, processes and structures responsible for decision-making in the community. In some cases, these would also involve female heads of household, and elderly men and women.

Where women were participating, this has reduced during the pandemic due to a decrease in support from organizations, fear of the virus, remote ways of working and and an increased work burden in the home.

While women comprise around 25 percent of parliamentarians in federal Iraq and in the Kurdistan region there is a 30 percent quota for women at the regional parliament, women's representation in government is still limited in Iraq.¹⁸⁷ Before the COVID-19 pandemic, community decisions were made by various groups, including mukhtars, community leaders and religious and/or tribal leaders. Most of these community-level decision makers are male, and the decision-making bodies mainly comprise men. While a limited female representation is not uncommon, the decision-making bodies and/or groups remain patriarchal in nature.¹⁸⁸ Various groups, associations and networks of women have been active in the county since long before the pandemic. These women's groups have been quite active in taking a role in responding to the crisis and advocating for women's rights.¹⁸⁹

Respondents identified that men traditionally would take part in community groups, processes and structures responsible for decision-making in the community. In some cases, these would also involve female heads of household and elderly men and women. This was not seen to change as a result of COVID-19. Due to traditions, women pre-COVID would not have influence over decisions made at the community level: "*Women due to traditions do not have influence over community decisions. [This] remains the same after COVID*" [female, community leader, Dohuk]. It was felt that women's participation may be greater in urban areas than in rural areas. However, again, decision-making remains limited.

Once the pandemic hit, some community food groups moved to discussing issues over the phone. When we review access to and ownership of phones, this would create another barrier for women's participation in the groups.

Respondents noted that in IDP camps (pre-COVID) there were groups of women who would come together through livelihood activities and use this network to

share ideas and discuss issues within the camp. Women also participated in a number of platforms organized by INGOs or the government, related to farming, agriculture, livelihoods and hygiene promotion. However, while participation is for men and women, "*decision-making within these structures is limited for women*" [female, Erbil]. It was noted that the participation of women has decreased in some groups due to a decrease in support from organizations, as well as fear of the virus: "*Yes, many women participate in formal community groups in this area, but the participation of women decreased greatly due to the decrease in the number of organizations running these groups. Society became more masculine, and women returned to the first ages*" [female, women's organization representative, Anbar]. One barrier to participation related to women's work in the home and the inability to participate due to workload.

Safety and protection

Respondents linked the economic and psychological hardship, as well as a lack of food and income, with increases in GBV cases.

Barriers to accessing support services were highlighted for women and specifically girls. Exploitation of labour was highlighted as a concern, especially for female heads of household.

Gender-based violence

Gender-based violence in Iraq is widespread, including domestic violence, sexual violence, exploitation and abuse (including by security actors and humanitarians), forced marriage, including child marriage and denial of resources to FHHs with perceived affiliations to extremist groups.¹⁹⁰ A 2012 survey highlighted that the percentage of women aged from 15 to 54 years who believed that women in general are exposed to "violence against women" in the house, in the street and in public areas were 64.2 percent, 63.1 percent and 55.4 percent respectively.¹⁹¹ Early marriage is an issue in Iraq, with reports indicating that 5 percent of women are married under 15 years of age and 24 percent under 18 years of age.¹⁹²

During 2020, a resurgent Islamic State of Iraq and the Levant increased its activity in Iraq, through isolated incidents in the central and northern part of the country.¹⁹³

The pandemic then exacerbated pre-existing gender and social inequalities that disadvantage women and girls, with an increase in different forms of GBV.^{194, 195, 196}

Results from this survey showed that 24 percent of women respondents and 39 percent of male respondents reported that there had been an increase in safety and security concerns since COVID-19.^{xxxv} And 11 percent of women and 27 percent of male respondents identified this as being related to there not being a safe place in the community and 2 percent of women and 5 percent of male respondents noted violence in the home.^{xxxvi} The limitations and risks associated with rapid, remote, quantitative assessments should be noted with regards to understanding the true extent of GBV, and as a result this study did not ask directly about GBV. However, qualitative discussions did highlight the current risks of GBV and impacts on this, as a result of the pandemic, which provides further support to existing assessments.

“Due to the reduction in the number of security personnel and the deterioration of economic and psychological conditions, there have been many cases, such as murder, many girls were subjected to abuse and cases of violence, as well as some cases of girls who were subjected to electronic abuse.”

- Female, women’s organization representative

The impacts of loss of income, livelihood opportunities, confinement within the household, increased stress and anxiety have been noted through other assessments as risk factors reported for the increase in GBV during the pandemic.^{197, 198} Respondents in this study linked the economic and psychological hardship of people, as well as a lack of food and lack of income as a result of the pandemic, with increases in GBV cases. Pregnant women and the elderly were seen to be the most at risk from domestic violence, with all family members being at home and the lack of space. One respondent noted that during the lockdown, his neighbour was physically attacking his wife because she had cooked something that he did not like; the respondent had to intervene.

The increased burden on women in the home, a lack of resources and the inability for society to adapt to the pandemic situation were seen to increase cases of violence in the home, as well as the number of divorce cases [GBV actor, Dohuk]. While divorce cases were noted

to increase, it is also likely that many survivors stay in relationships, trapped with their perpetrators due to societal expectations surrounding divorce and seeking justice.¹⁹⁹ One respondent noted cases of online abuse and while this was not elaborated on further, the issues around online abuse have been raised in the context of the COVID-19 pandemic and would be important to continuously monitor. With people spending more time online and using phones and the Internet as a means of communication with social networks, for education and business, this can create and fuel an environment for abuse and control, particularly if women and girls have less access to creating content and would be more likely to be the targets and consumers of information.²⁰⁰

According to a GBV subcluster rapid assessment conducted in April–May 2020, 65 percent of assessed service providers reported an increase or worsening in one or more types of GBV during the time of COVID-19, compared with the months before the outbreak, and 61 percent reported an increase in domestic violence cases (accounting for 94 percent of the total respondents who reported an increase). For other types of GBV, 31 percent of respondents reported an increase for harassment\psychological\emotional abuse cases, 14 percent for physical assault cases, and 13 percent for child or forced marriage cases.²⁰¹ While these figures are high, it is also known that not all survivors will report violence against them, and therefore data often underestimates the true reality. One respondent noted that while GBV cases are increasing, many are not reported to NGOs but rather to clan leaders and mukhtars (who are male).

Many respondents (male and female) spoke of the police as a main entry point for community members who had safety and security concerns. However, some respondents noted barriers in women seeking help in that women and girls cannot access services such as the police, even when they are available due to traditions: “*The right of women to speak is neglected in the community*” [male, livelihoods actor, Ninewa], and “*Some women can access with the presence of a man with them, but for girls, it’s impossible, it is considered a stigma if they access.*” In addition, it was also noted that remote service provision was not providing the same support as before COVID-19.

Safety concerns

Exploitation of labour was noted by male and female respondents. One noted: “*I work in cultivation and harvesting as daily labourer. After COVID-19, the owners say they will pay our money only if they sell the crop. If the sale is not done, we will be deprived of our wages, and we bear the loss with the owner. This means we can work*

xxxv. Women were asked about women and girls, and men were asked about men and boys.

xxxvi. It should be noted that this was an open question on the kinds of safety and security concerns affecting women and girls, or men and boys.

for a month, for nothing" [FHH, farmer, host community, Anbar]. This is particularly important to note for at-risk groups who are relying solely on this as an income source. It was further noted that women, particularly female heads of household, were particularly sought after as workers on farms, due to the ability to pay them less than male workers.

Respondents from Missan particularly, noted an increase in begging as a result of COVID-19 and families sending children to beg due to the lack of work. One respondent also noted "*an increase in boys and girls selling masks on the street, which did not happen prior to the pandemic*" [male, Anbar]. While this analysis did not focus on the impacts on boys and girls, and the specific protection risks they face, the impact of loss of income for families, coupled with longer-term impacts of school closures are important to monitor, to ensure children are not exposed to increased protection risks as a result.

Areas for future analysis

It would be interesting for future analysis to explore some of the initial changes seen in the types of employment between men and women, as well as some of the educational and employment opportunities that may have come about because of the pandemic and changing context. This would be interesting to monitor as it would help tailor approaches to livelihoods programming, skills building and longer-term recovery initiatives. It is recognized that the level of qualitative data for persons with disabilities for this analysis is limited, due largely to the challenges in remote data collection. While the results from the current findings do provide a level of analysis, it would be interesting to further explore the impacts of the pandemic for persons with disabilities and to unpack in more detail the findings in this report, specifically, the reasons for higher food insecurity scores and individuals reporting greater impacts on their physical health as well as impacts on certain resources such as pensions, social security and assistance. This would be useful to develop a more comprehensive picture.

Main findings from primary data collection in Iraq

- For women and men, “income and livelihoods,” “food and nutrition” and “mental health” were identified as the areas most impacted by COVID-19. The greatest priority needs today were “income and livelihoods,” “food and nutrition,” and “physical health care.”
- There was an overall shift from regular, salaried work to part-time or daily work (by 3 percent), with unemployment increasing.
- The impacts of lockdown and restrictions, compounded by national inflation, impacted not only direct access to jobs, but also affected access to inputs and contributed to a reduction in the demand for products. Long-term effects are still being assessed even as COVID-19 restrictions are being lifted.
- Concerns were expressed over whether girls and boys would return to school, particularly girls past the age of primary school whose education may no longer be prioritized, and boys who entered the workforce.
- The burden of unpaid work was seen to have the greatest impact on women, both physically and psychologically, as women expressed increased mental stress, pressure and physical fatigue in fulfilling their roles within the family.
- Male respondents reported that their engagement in household tasks had increased since the start of the pandemic, and this was more evident in urban areas and for young males (especially in food preparation (47 percent) and cleaning (50 percent)).
- Men and women showed similar prevalence of moderate to severe food insecurity. More male respondents showed severe food insecurity than female respondents (19.63 percent of men versus 14.21 percent of women). Respondents in urban areas reported higher food insecurity than in rural areas.
- Pregnant women and people with disabilities were the most negatively impacted by inadequate access to humanitarian assistance. Barriers to pregnant women’s access to humanitarian assistance were largely due to the distance of services and the need for a male guardian. Additionally, service providers reported that they could not reach persons with disabilities because their phones were restricted by family members. People classified as having a disability showed higher food insecurity than those not classified as having a disability.
- Individuals were strongly reliant on food baskets and expressed concern over their continuation. However, the quality, quantity and selection criteria of the food baskets were questioned. Suggestions were made to include more fresh foods, to increase the amount allocated per household and to include more households as needs have grown since the distributions started.
- Respondents had the challenge of deciding between accessing and paying for health care or providing food for the family, often selling assets or borrowing money to afford medicine.
- Specific concerns were raised over available health, food and nutritional supplements for pregnant women and babies.
- Mental health was noted by nearly half of men and women respondents as an area most impacted by COVID-19, and was reportedly just as critical as food and nutrition.
- Respondents linked economic and psychological hardship, as well as a lack of food and income, with increases in cases of gender-based violence (GBV) in the community.
- Barriers to accessing support were highlighted for women, specifically girls, and particularly harmful social norms such as hesitancy in reporting incidents to the police, sometimes precluded them from accessing needed services.
- Exploitation of labour was highlighted as a concern, especially for female heads of household.

Sudan Country Analysis

Demographic profile

The population of the Sudan is 44 734 464 (as of 16 May 2021)²⁰² and, based on 2019 data, 50 percent male and 50 percent female. The majority of the Sudanese population is rural, and the urban population is just 33.2 percent.²⁰³ In the Sudan, 62 percent of the population are young people under the age of 25,²⁰⁴ and the fertility rate is relatively high, with 4.43 births per woman.²⁰⁵ The average life expectancy of women is 68 years and 64 years for men²⁰⁶ with an average household size of 5.9.²⁰⁷ Population figures, disaggregated by age, for 2021 are shown in Table 1b.²⁰⁸

Sudanese Arabs account for 70 percent of the population of the Sudan, with the rest of the population being from ethnic groups including Beja, Copts and Nubians. Of the Sudanese population, 97 percent practice Islam with other sections of the population following indigenous beliefs or Christianity (particularly those from refugee or immigrant populations).²⁰⁹ According to the last population census (2008) in the Sudan, the disability rate has increased over the years, from 1.6 percent in 1993 to almost 5 percent^{xxxvii} in 2008.²¹⁰ Female-headed households comprise approximately 14.2 percent of all households.²¹¹ As of 2018, literacy rates for adults aged 15 and above was 60.7 percent (56 percent for adult women and 65.4 percent for adult men). Rates are higher for young people (aged 15 to 24) at 73 percent (73.5 percent for young women and 72.5 percent for young men).²¹² The Sudan ranks at 138 in the Gender Inequality Index^{xxxviii} (out of 189 countries) with a value of 0.545.²¹³

Based on the 2014–2015 poverty survey, 36.1 percent of the Sudanese population was considered below the national poverty line.²¹⁴ According to the 2020 Global Report on Food Crises, the Sudan was one of the ten countries constituting the worst food crises in 2019, with at least 35 percent of the population in a state of food crisis.²¹⁵ According to the latest estimates, about 7.1 million people were severely food insecure (Integrated Food Security Phase (IPC) Phase 3: “Crisis” and Phase 4: “Emergency”) in the period from October to December 2020.²¹⁶

The first case of COVID-19 was recorded in the Sudan on 13 March 2020. Estimates by WHO show there have been 36 304 confirmed cases of COVID-19, with 2 732 deaths up to 16 June 2021²¹⁷ (no sex or age disaggregated data is available).²¹⁸ During the first three months of the pandemic, the Government of the Sudan implemented preventive measures, such as partial lockdown, contact monitoring, risk communication, social distancing, quarantine and isolation to prevent the spread of the virus.²¹⁹ A three week partial lockdown for Khartoum State was announced to start in March and this continued into mid-July with the airport closed. After July, while lockdown restrictions eased in Khartoum, nationwide curfews remained in place and some states had closed borders and limited movements of people.²²⁰ Schools were closed in March 2020 and by March 2021 most basic schools had reopened, except within states experiencing escalating intercommunal violence.²²¹

^{xxxvii} No further updated data on disability is available, nor sex disaggregated data.

^{xxxviii} A composite measure reflecting inequality in achievement between women and men in three dimensions of reproductive health, empowerment and the labour market. See http://hdr.undp.org/sites/default/files/2020_statistical_annex_table_5.pdf

Table 1b: Population figures for the Sudan, disaggregated by age, for 2021

Age	Female	Male	Total
0–4	7.1%	7.3%	14.4%
5–9	6.5%	6.7%	13.2%
10–14	6.0%	6.1%	12.1%
15–19	5.4%	5.5%	10.9%
20–24	4.7%	4.8%	9.5%
25–29	3.9%	4.0%	7.9%
30–34	3.2%	3.2%	6.4%
35–39	2.8%	2.7%	5.5%
40–44	2.4%	2.2%	4.6%
45–49	2.0%	1.9%	3.9%
50–54	1.7%	1.6%	3.3%
55–59	1.3%	1.2%	2.5%
60–64	1.0%	1.0%	2.0%
65–69	0.8%	0.7%	1.5%
70+	1.2%	1.0%	2.2%

The COVID-19 pandemic arrived on top of multiple crises in the Sudan, which have now left 13.4 million Sudanese in need of humanitarian assistance (4.1 million more than in June 2020).²²² Humanitarian needs are particularly high for IDPs, estimated at 2.5 million people and for 1.1 million refugees, including 762 000 people from South Sudan and 74 000 people from Ethiopia.²²³

Widespread flooding in August and September 2020 affected 875 000 people across all 18 states in the Sudan.²²⁴ In February 2021, a new transitional government was sworn in, following the military coup in 2019. Inter-communal violence continues in western and eastern areas of the country, including clashes in January and April 2021 in Darfur and Geneina, respectfully, triggering new displacements.²²⁵ The Sudan is facing an economic crisis whereby inflation rates have made essential commodities

unaffordable for vulnerable populations; nationwide protests have taken place leading to seven states declaring a state of emergency, limiting access to markets, curfews and closure of schools.²²⁶ The combined effects of these multiple crises with the COVID-19 pandemic have compounded existing vulnerabilities of people within the population.²²⁷ The reader should keep this in mind when reviewing the findings of this RGA and should take these multiple impacts into account.

Findings and analysis

“Income and livelihoods” and “food and nutrition” were identified as the areas most impacted by COVID-19, as well as the two most cited priority needs today, by men and women.

Impact areas and priority needs

Survey respondents were asked which three areas of their life they saw to be most impacted by COVID-19. Figure 1b shows that “income and livelihoods” and “food and nutrition” were rated the highest for male and female respondents.^{xxxx} These impacts will both be discussed in more detail in subsequent sections.

Impacts on education were identified more by men and women in urban areas (54 percent) compared to rural (36 percent) and semi-urban areas (16 percent). Proportionately, a higher number of female respondents (58 percent) aged 18 to 24 years identified education as an area of impact, compared to other age groups (both male and female).

Impacts related to access to social networks were reported more by residents in urban areas (40 percent) followed by IDPs (35 percent), residents in rural areas (25 percent) and refugees (5 percent). Proportionately more FSHH (39 percent) noted their social networks being impacted, compared with respondents who were male heads of household (24 percent) or female heads of household (27 percent). Respondents who had a disability spoke of the impact they felt because of a loss of community and family support available to them. One respondent noted that: *“My domestic work increased. As you see I am an old woman and I use a wheelchair. In the past all my neighbours would come and help me to clean the house and wash dishes. Now they come and offer their help less frequently”* [female, Kassala].

^{xxxx} Other areas noted by respondents included: sanitation and hygiene (3 percent f./1 percent m.); mental health (1 percent f./0 percent m.); sources of information (1 percent f./1 percent m.); involvement in community decisions (1 percent f./0 percent m.); and, involvement in household decisions (1 percent f./0 percent m.).

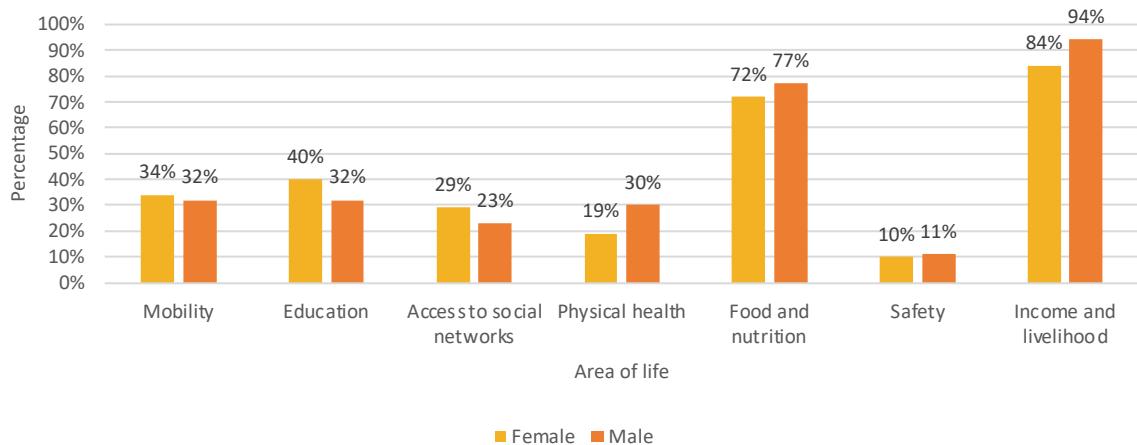


Figure 1b: Areas of life most impacted by COVID-19, disaggregated by male and female respondents

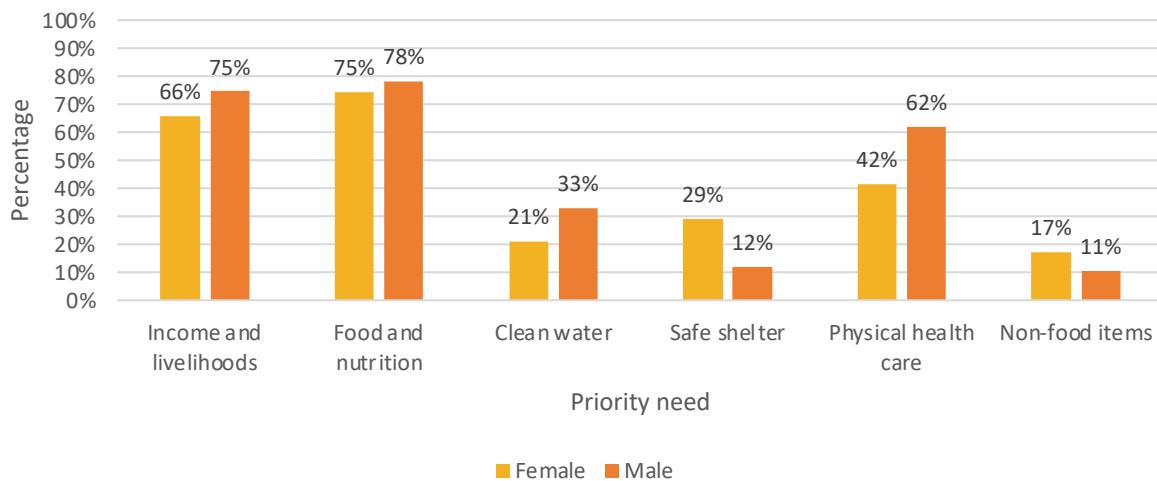


Figure 2b: Priority needs today, disaggregated by male and female respondents

Impacts related to mobility, physical health and safety are discussed in subsequent sections.

Noting the many changes that have taken place over the past year with regards to the pandemic, in addition to understanding the impacts, it was important to understand what the priority needs of respondents were today. These are displayed in Figure 2b.^{xL}

Similarly, the areas most impacted, “food and nutrition” and “income and livelihoods” were identified the most by respondents. Safe shelter was identified by a greater proportion of residents from rural areas than other residency categories. This was higher for women residents in rural areas (60 percent) than for men

(31 percent). Women across all residency categories highlighted this (7 percent of female residents in urban areas, 10 percent of female IDPs and 23 percent of female refugees), compared to male respondents where only IDPs and residents in rural areas noted this. The priority of NFIs was identified by a greater proportion of refugee respondents, both male (23 percent) and female (25 percent) compared to other residency status. This could be linked to the withdrawal of support from outside organizations during the pandemic, noted by refugee respondents. Analysis related to clean water and physical health is provided in subsequent sections.

^{xL}. Other areas noted by respondents included: sanitation and hygiene (6 percent f./6 percent m.); mental health (3 percent f./3 percent m.); family planning (3 percent f./7 percent m.); menstrual hygiene items (13 percent f./9 percent m.); technology (1 percent f./1 percent m.); protection (6 percent f./6 percent m.); and, maternal health care (3 percent f./0 percent m.). Note that priority needs are calculated out of 599 respondents (2 f./5 m. missing responses).

Gender roles and responsibilities

Loss of livelihoods, loss of business capital, savings, income and the ability to earn a living were cited across men and women respondents. Impacts were seen to be greater for single heads of household and persons with disabilities.

Impacts on paid work

Prior to the pandemic, women's participation in the labour force was at 31 percent, compared to 76 percent for men,²²⁸ with the burden of unpaid work already being disproportionately skewed towards women, with 96 percent of women reporting spending over 40 hours per week, and 46 percent spending over 80 hours per week on unpaid activities.²²⁹ The economy of the Sudan is highly dependent on the agricultural sector as nearly 65 percent of its population is engaged in agriculture,²³⁰ with women traditionally being very active in agriculture and food security, although with wide regional variations.²³¹

While women may be actively engaged in agriculture, this may not always be recognized in the data, due to the role of women often being invisible, being seen as "contributing family member" or "helper."²³²

Since the pandemic, both men and women respondents spoke of great impacts on the loss of livelihoods, loss of business capital, savings, income and the ability to earn a living. Drawing from qualitative discussions, there was a greater overall shift from regular, salaried work to part-time or daily work, as well as a shift in focus towards small businesses, to compensate for a lack of income. However, when we disaggregate by sex, we see slight gendered nuances in the data. The figures below show a reduction in the proportion of men (Figure 3b) and young men (Figure 4b) in full-time paid salary/wage employment, comparing before the pandemic to today, with women (Figure 5b) and young women (Figure 6b) showing slight increases.

Part-time/seasonal paid employment increased slightly (by 2 percent) for adult male respondents, while it remained constant for adult female respondents. Greater changes were seen for young people, with an increase of 7 percent for young women and 4 percent for young men.

There was a decrease seen in male respondents who were self-employed with employees before the pandemic, to today, whereas those self-employed without employees increased. This could be explained by overall



IDP women farmers harvest the Okra they planted in Azaza village-Blue, the Sudan

loss of income causing a reduction in the ability to hire employees, as well as by the impacts of lockdowns, restrictions on movement and fears over safety for employees to attend work.

As expected, those unemployed and looking for employment increased from 9 percent to 13 percent for women, and 4 percent to 10 percent for male respondents, with similar trends being seen for young people.

Women and young women took on additional roles within family businesses, including on farms, to offset losses in employees, creating additional work burden.

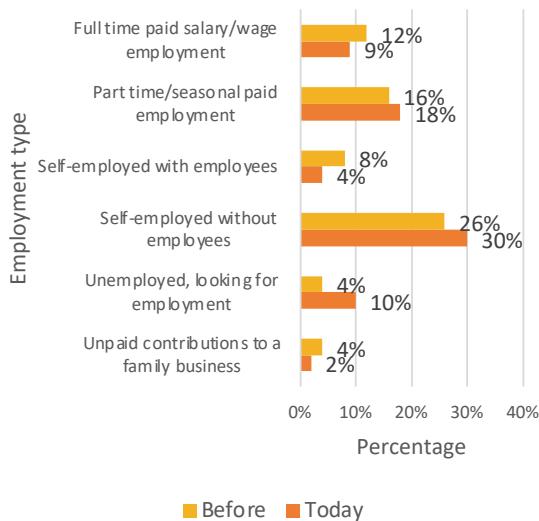


Figure 3b: How would you best describe your employment status during a typical week? (Overall male)

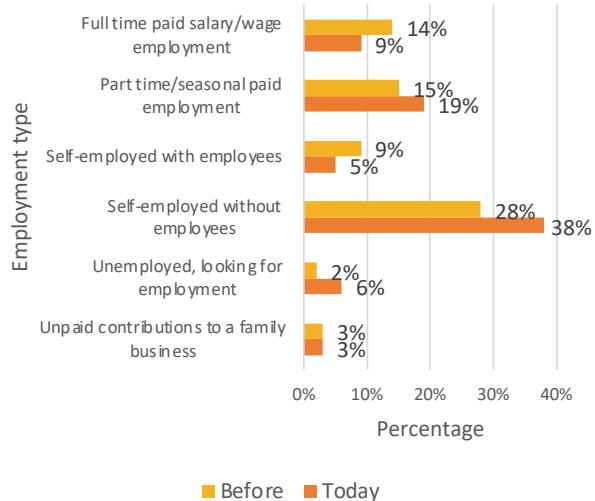


Figure 4b: How would you best describe your employment status during a typical week? (Young male)

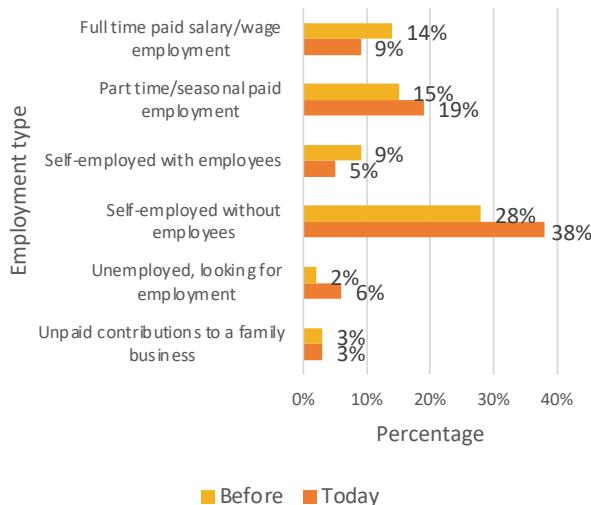


Figure 5b: How would you best describe your employment status during a typical week? (Overall female)

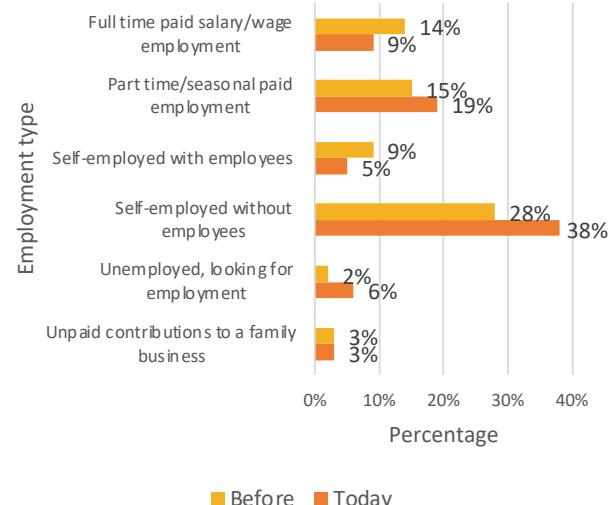


Figure 6b: How would you best describe your employment status during a typical week? (Young female)

With regards to unpaid contributions to a family business, increases were seen for female respondents, with the greatest increases seen for young women (by 3 percent). Similar findings came through the qualitative data. During the pandemic, due to fears of infection and reduced income for engaging labourers expressed by farm owners, women in the family started or increased their roles by participating in harvesting [female, women's union representative; male, health worker] and in growing vegetables within the home [male, small business trader]. Their role was highlighted by male respondents: "*Here [women] have proven their efficiency more than men in the task of harvesting*" [male, government employee]. However, for women, this additional role in harvesting, plus the increases in domestic work, was seen to have adverse impacts on physical health, especially for pregnant women and women with children.

It is important to note that while these changes in livelihoods have occurred since the pandemic, it is not necessarily only attributed to the pandemic due to multiple, overlapping and compounding crises being experienced in the Sudan.

The impact of loss of livelihoods and income for male and female heads of household was particularly expressed across respondents, as they had the overriding responsibility to fulfil their families' needs. This was seen to be compounded for single heads of household. For people with disabilities, one respondent noted that curfews during the pandemic restricted their ability to continue running their business due to the limited time available to travel to the market. This barrier was further compounded by increases in the price of commodities, which meant he could not afford transport. For those with jobs, the high rates of inflation^{xli} impacted purchasing power and ability to afford food for the family: "*The direct effect is increased prices of goods which have negatively impacted the quantity and quality of food. All family members have been affected*".

"We all suffer from the high prices and the deteriorated conditions; we have to feed our children and we already lost our businesses. We sell things that are not considered a priority such as utensils. Now we are approaching Ramadan, we used to have a big season, in these days, but no one even asked me whether I have plans to come back to business."

- Female, Kassala

Respondents noted that non-essential businesses were impacted because of the pandemic. Even once restrictions had relaxed, the general economic situation and loss of income for many, meant that people were not seeking services such as construction or buying certain goods (e.g. utensils). Further, while lockdown restrictions eased, individuals had lost the capital required to start new ventures, or had sold or used the goods that would have been used for their business. This created a barrier to restarting work. One woman noted that: "*Due to pregnancy, I stopped working completely because I was physically unable to work and walk to the city due to lack of transport... There is no money at all to start any business suitable to my condition*" [pregnant woman, Umbeda, refugee settlement].

Specific impacts were noted with regards to agricultural livelihoods. These included lack of and price increases in transport, lack of access to farmland, labour shortages, lack of access to and price increases of agricultural inputs, and closure of or restricted access to markets for selling produce, particularly during the lockdown periods. Further, limitations on movements for market vendors led to a shortage of agricultural inputs in many areas [male, Health Action in Crises (HAC) representative, Kass]. Lack of access to agricultural inputs has been highlighted by other reports during the crisis period.²³³

The pandemic led to unprecedented levels of disruption to education, impacting over 8.1 million students across the Sudan,²³⁴ with most schools being closed from March 2020 to March 2021. This was compounded by impacts of unusually heavy rains and extensive flooding between July and September 2020, which caused damage or complete destruction to schools across the country,²³⁵ on top of the impacts from 2018–2019 when schooling was interrupted during government protests.²³⁶ In the Kass locality, respondents noted that due to schools closing and reopening at different times than usual, and thus not aligning with the seasons for cultivating and harvesting, girls and boys who would usually help out were not available during the pandemic [male, nutrition officer, Kass]. In addition to this, elderly members of the family, who would have worked in agriculture were asked by their families to stay at home as they were more at risk of infection [male, government employee, Khartoum North]. Both these circumstances contributed to the labour shortage highlighted by many respondents.

Overall working conditions have worsened for 48 percent of female and 76 percent of male respondents, and this was highlighted more by male heads of household (79 percent), followed by female heads of household (57 percent) and FSHH (26 percent). Male respondents in urban areas were impacted the greatest, and 90 percent of respondents highlighted that their working conditions had worsened, compared to 47 percent of women in urban areas.

^{xli}. Inflation escalated to an estimated 124.9 percent in 2020, compared with 82.4 percent in 2019, as indicated in <https://www.afdb.org/en/countries/east-africa/sudan/sudan-economic-outlook>

Unpaid work and psychological impacts

While women have absorbed most of the unpaid work burden, men also reported increased engagement in household tasks since the pandemic.

When asked about the most significant changes during the pandemic, one respondent said, “*changes in women’s work and their responsibilities*” [female, women’s union representative, Khartoum North]. With regards to unpaid work, women have undoubtedly taken a disproportionate burden during the pandemic, be it because of cleaning, cooking, washing clothes, taking care of children, the elderly and the sick. Women’s roles within the house were noted not to have changed in nature, but to have increased in intensity [female, small business owner, Umbeda], and that this was compounded by more limited resources and school closures, leading to women bearing the burden of managing issues of food, childcare and health in the home [female, sultana, Umbeda; male, farmer, Alysam IDP camp; male, famer, Kass locality].

Despite male and female respondents highlighting the disproportionate impact of household work on women compared to men, and the perception by women respondents that “*men were not affected by the increase in domestic work as they did not participate*” [female, small business owner, Umbeda], male respondents did perceive their role within the home to have increased during the crisis period: “*After the pandemic, the traditional pattern changed for us as men, which led men to participate in domestic work, for example, we learned to cook, ironed and washed clothes to reduce stress, tension and emptiness*” [male, government employee, Khartoum North]. This perception was reflected in the survey responses. With regards to engagement in specific household tasks, an increase in time was noted in food preparation for 25 percent of women and 16 percent of men, and cleaning for 28 percent of women and 22 percent of men. The greatest increase was noted for female heads of household (34 percent in food preparation and 37 percent in cleaning) and for women in rural areas (32 percent increase in the time spent cleaning). For male respondents in urban areas, 30 percent noted their engagement in caring for children increased in time (compared to male respondents in rural locations, who reported a 15 percent increase, and semi-urban areas, who reported a 13 percent increase). For women, there was more consistency in their caregiving roles across locations, with 31 percent noting this in semi-urban areas, 26 percent in urban areas and 25 percent in rural areas.

School closures have increased the unpaid work burden for girls, causing concern over whether they will later return to school.

Due to the increase in the unpaid work burden on women and school closures, girls have also taken on household tasks to support their mothers “*with some even taking on the majority of this work*” [male, health worker, Khartoum North]. A young woman respondent noted that particularly being jobless and unmarried impacted her role with regards to domestic work, which had increased since the pandemic. Prior to the pandemic, 49 percent of primary school-age girls were out of school.²³⁷ There is the risk that the longer girls are out of school or experience disruptions in schooling, the less likely they are to return to school, as their roles and responsibilities in the household become increased. This has short-term impacts with girls missing out on school feeding programmes,²³⁸ as well as contributing to longer-term impacts increasing the likelihood of early or forced marriage and pregnancy.²³⁹ A 2017 report indicated that, in the Sudan, 10.7 percent of women aged 15 to 49 were married before the age of 15, and 38 percent were married before the age of 18,²⁴⁰ and this is seen to be more prevalent in more conservative locations, such as in Kassala, the state with the highest percentage (45 percent) of women married before the age of 15.²⁴¹ Once girls are married it is more difficult for them to pursue education,²⁴² and they are less likely to earn an income,²⁴³ highlighting the wider economic, social and livelihood impacts of girls being out of school as a result of the pandemic.

Of male respondents, young men reported increased engagement in household tasks compared to before the pandemic.

Across young respondents (18-to-35-year-olds), increases in engagement in household tasks since the start of the pandemic were seen for young women in the following areas: cleaning (for 30 percent of young women); collecting water (29 percent); caring for children (28 percent); food preparation (27 percent); and, affective and emotional support (22 percent). For young men, increases were noted in the areas of: collecting water (33 percent of young men); collecting fuel and firewood (30 percent); household management (25 percent); caring for children (24 percent); and, assisting older, sick people (24 percent). Respondents highlighted that

indeed, small shifts were seen with young men starting to take on responsibilities, for example: “*By staying home in a permanent way, we found ourselves raising children and correcting their behaviour, and it was left to women before*” [young man, Umbeda]. Respondents noted that before the pandemic, young men would not have contributed in this way to the family. However, due to young men staying at home for long periods of time and seeing the emotional strain placed on their sisters, they are now sharing the responsibility: “*There is a change in the traditional patterns of work at home, especially [young man] helping family members in some work, such as washing and ironing. That gives us positive energy (emotionally)*” [male, daily worker, Khartoum North].

Women and men are suffering psychologically trying to fulfill their roles within the family.

The psychological impacts on women, due to the increased unpaid work burden, as well as concerns over the safety of loved ones during the pandemic, were clearly expressed by respondents. Psychological impacts were also noted for men, with respondents saying that men felt that they could not fulfil their role as breadwinners and provide for their families: “*This leads to depression because we see ourselves as responsible for the family condition and we feel completely helpless*” [young man, Umbeda].

It should be noted that respondents in Khartoum North highlighted that the impacts of COVID-19 occurred on an already stressed situation, where the flooding had already resulted in loss of income for many households [male, small business trader, Khartoum North].

“Women were psychologically affected by the situation. In addition to physical impacts, we were affected because of workload in the home, cleaning, cooking, washing clothes and taking care of all family members, whilst in this bad situation of having no money, no food, and income.”

- Pregnant woman, Umbeda

Food insecurity

Women are experiencing greater food insecurity compared to men. The top three categories of respondents who faced the highest levels of food insecurity were female heads of household, females married to male household heads and male heads of household.

Women and men respondents from urban and semi-urban locations are reporting higher food insecurity, as are female refugees. Older age groups (60+) and people who were classified as having a disability reported higher food insecurity.

Understanding prevalence of food insecurity was addressed in this analysis using the FAO FIES. This scale consists of eight questions regarding people’s access to adequate food. The questions are focused at the individual level and focus on self-reported food-related behaviours and experiences associated with increasing difficulties in accessing food due to resource constraints.²⁴⁴

“The most affected by the pandemic is the mother as the woman responsible for the family members because they do not have a breadwinner, so the effect on my livelihood was direct, and it also affected my body, which caused me to lose weight due to the lack of food. I prefer to feed my children instead of myself... I have no money to support my family.”

- Female headed household, Umbeda

The results below show FIES data disaggregated by sex, age, type of location, persons with a disability as well as by relationship to the household head.^{XLII} Results are displayed as both overall FIES prevalence scores and data showing food insecurity that can be seen to be mostly a consequence of COVID-19. The difference between the two scores shows the food insecurity level in the absence of COVID-19.^{XLIII}

XLII. Disaggregation by diversity factors was only possible where the sample size for each category (or at least most categories within a variable) was close to or exceeded 100 observations.

XLIII. This was identified by asking respondents after each of the eight variables the question: “Was it specifically linked to COVID-19?”

As mentioned above, food and nutrition was the second area most reported by respondents as having been most impacted by COVID-19 (reported by 72 percent of females and 77 percent of males) (see Figure 1b) and was the second most reported priority need today (reported by 75 percent of females and 78 percent of males), as shown in Figure 2b. This was reflected through discussions with respondents who spoke of both the quality and quantity of food being impacted because of the pandemic, in combination with the other shocks the Sudan has been facing.

Lack of quality and quantity of food was seen to have direct impacts on the nutrition of children (boys and girls), the elderly (male and female), the sick and pregnant women: *“As a pregnant woman, I need to eat meat and vegetables like tomatoes, onions and legumes. I cannot afford this now”* [pregnant woman, Aroma]. Of the respondents to the survey who had children aged 0 to 5 years living in their household, 67 percent of them noted that the daily food requirements met for boys^{XLIV} had deteriorated, and 61 percent of respondents noted this for girls.^{XLV}

“We use less food and with poorer quality. In the past I used to cook vegetables and meat stew every day. Now we eat vegetables with ground nuts, butter or tomatoes with Kisra (traditional Sudanese bread). We eat two meals a day instead of three.”

- Female head of household, Kassala, urban area

Based on the FIES data collected through the survey, total food insecurity levels were seen to be at 69.44 for moderate or severe,^{XLVI} and at 40.26 for severe food insecurity.^{XLVII} Out of this, food insecurity levels mostly due to COVID-19 are 58.13 for moderate or severe and at 34.44 for severe.

Results disaggregated by sex are shown in Figure 7b, where female respondents appear to have higher overall food insecurity prevalence rates compared to male respondents. The proportion of this that can mostly be seen because of COVID-19 is 65.14 for females and 49.07 for males for moderate or severe, and 37.40 for females and 28.43 for males for severe food insecurity.

Total food insecurity prevalence disaggregated by age can be seen in Figure 8b, and the prevalence mostly because of COVID-19 in Table 2b (below). From this we can observe that the 60-to-69-year-old group and the 70-year-old-and-above group appear more food insecure overall.

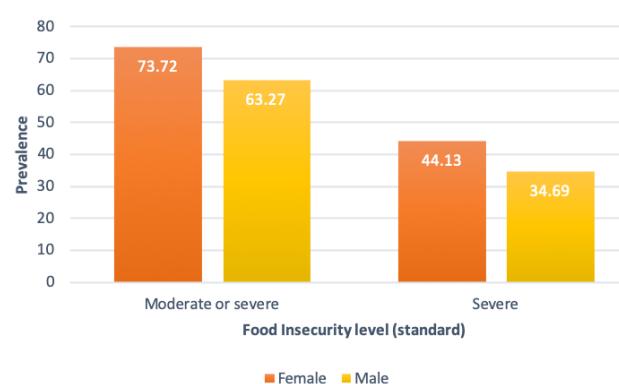


Figure 7b: Prevalence of moderate or severe, and severe food insecurity, disaggregated by sex

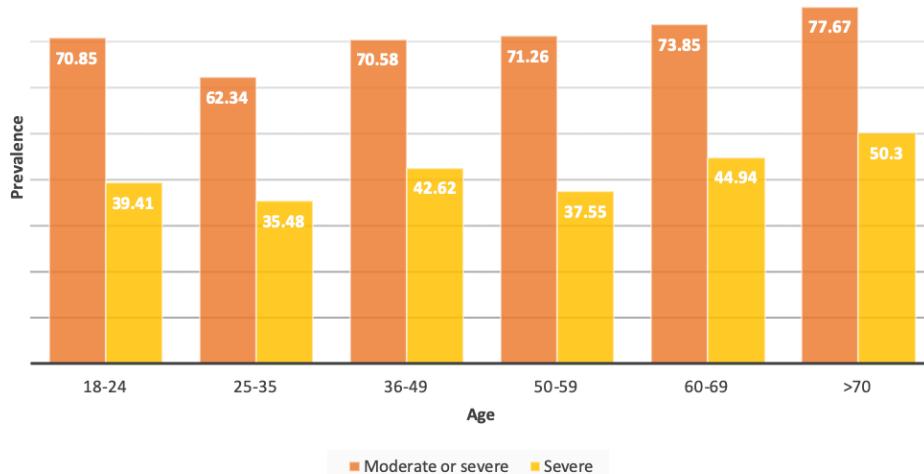


Figure 8b: Total prevalence of moderate or severe, and severe food insecurity, disaggregated by age

XLIV. Analysis based on 213 respondents, who had boys aged 0 to 5 in the household.

XLV. Analysis based on 196 respondents, who had girls aged 0 to 5 in the household.

XLVI. People experiencing moderate food insecurity have reduced the quality and/or quantity of their food and are uncertain about their ability to obtain food due to a lack of money or other resources. See <http://www.fao.org/in-action/voices-of-the-hungry/sdgs/en/>

XLVII. People experiencing severe food insecurity have run out of food and, at the most extreme, have gone days without eating. This group of people are those we call the “hungry.” See <http://www.fao.org/in-action/voices-of-the-hungry/sdgs/en/>

Table 2b: Prevalence of moderate or severe, and severe food insecurity, mostly because of COVID-19

Age	Moderate or severe	Severe
18–24	62.26	34.35
25–35	52.27	29.07
36–49	60.9	36.24
50–59	60.65	32.91
60–69	54	32.99
70+	69.27	44.24

Based on survey results, 82 percent of respondents in semi-urban areas (75 percent of them male and 86 percent female), 76 percent in urban areas (83 percent of them male and 70 percent female) and 70 percent in rural locations (75 percent of them male and 67 percent female), highlighted that food and nutrition was one of the three areas most impacted by COVID-19, with similar trends for respondents who reported this as a priority need today, with 88 percent of them in semi-urban, 85 percent in urban and 67 percent in rural areas. Other research, similarly, has shown that challenges in access to food were more pronounced in urban areas,²⁴⁵ and this can also be reflected in the FIES data, when disaggregated by rural, urban or semi-urban locations in Table 3b.

“I am a farmer. My work has been negatively affected. The limited movement jeopardized the agricultural season. My land is far away and because of the lockdown and the limited transportation means I used to go to a farm less frequently. Cleaning the land was less and therefore productivity reduced. I could not go frequently to build terraces. This is the most important change as the terraces are critical to ensure good yield in terms of seeds and fodder.”

- Male, farmer, host community, Kassala

Table 2b: Prevalence of moderate or severe, and severe food insecurity, mostly because of COVID-19^{XLVIII}

Location	Moderate or severe	Severe
Rural	59.14	29.00
Semi-urban	98.29	73.46
Urban	68.75	38.28
Prevalence due to COVID-19		
Rural	49.86	25.06
Semi-urban	84.95	60.33
Urban	56.00	30.89

This is supported through the qualitative discussions, where farmers who depended on local produce and continued to have access to their land during the pandemic, and even during lockdowns, reported that the impact on availability and access to food was less: “*In Kassala... men grow vegetables and trees... women can harvest. We collect our daily needs from vegetables available in the farms*” [female, housewife, Kassala].

Figure 9b shows disaggregation based on residency status and sex in respondents who reported food and nutrition as one of their three areas of life most impacted by COVID-19, with female refugees identifying this the most compared with respondents from other residency groups.

From the qualitative data, IDPs in South Darfur and refugees in Umbeda noted that the combination of food assistance being stopped by outside organizations, being prevented from moving outside the camp and markets closing, has had direct impacts on the quality and quantity of food: “*At times we ate one meal*” [male, farmer, Kass]. Now, even as restrictions lift, the impact of rising prices and lack of income or external financial support during the lockdown periods, mean people cannot afford food: “*There was no organization that offered us any financial support or food during the closure period*” [female, sultana, Umbeda].

People with disabilities spoke of the specific impacts which limited access to their livelihoods has caused on their food security. According to FIES data, total prevalence of moderate or severe food insecurity in respond-

XLVIII. Based on the results of this RGA with 606 individual surveys (369 women and 252 men). https://fscluster.org/sites/default/files/documents/fsms_report_q1_2020.pdf

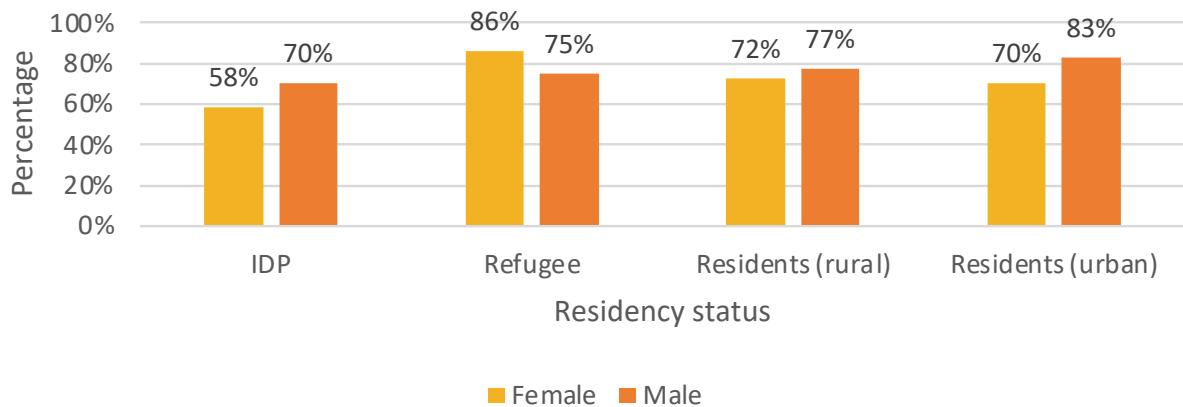


Figure 9b: Respondents who identified food and nutrition as an area most impacted by COVID-19, disaggregated by residency status and sex

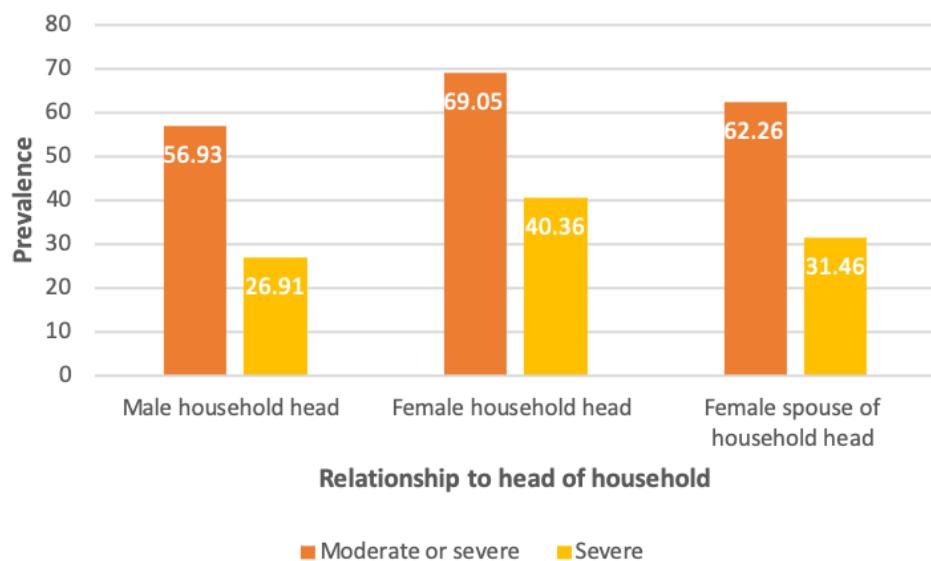


Figure 10b: Prevalence of moderate or severe, and severe food insecurity, disaggregated by relationship to household head

ents who classified as having a disability was 81.69 (compared to 66.11 for persons who were not classified as having a disability) and 50.98 for severe food insecurity (compared to 37.14 for persons who were not classified as having a disability).

Finally, when we look at prevalence levels for male and female heads of household and FSHH, we also see differences in food insecurity prevalence (Figure 10b). We can see that female respondents who were heads of household reported higher food insecurity levels, followed by female respondents who were the spouses of heads of household; this trend is followed for both moderate or severe and severe food insecurity. The prevalence mostly due to COVID-19 can be seen in Table 4b.

Table 4b: Total prevalence of moderate or severe, and severe food insecurity, disaggregated by relationship to household head^{XLIX}

Relationship to household head	Moderate or severe	Severe
Male head of household	42.8	23.33
Female head of household	63.65	35.22
Female spouse of head of household	50.9	24.49

^{XLIX}. Based on the results of this RGA with 606 individual surveys (369 women and 252 men).

Access to services and resource

Throughout the pandemic there is a clear and continued tension around household priorities and decision-making around health care needs versus providing food for the family, given limited financial resources. The overall welfare of the family was typically a burden women expressed having responsibility for, whether they controlled the financial resources or not.

The psychological and mental health impacts as a result of lack of livelihoods, loss of income, food insecurity and inability to provide for the family are particularly concerning, especially considering the lack of mental health and psychosocial support services (MHPSS) across the states.

School closures as a result of lockdown were seen to increase anxiety and tension in students “*due to the emptiness we feel*” [young man, refugee settlement, Umbeda]. While psychological impacts of the pandemic cut across the majority of respondents, only 3 percent each of the male and female respondents noted mental health as one of the top three priority areas today. This highlights concerns that due to many competing priorities at this time, as well as a lack of access to services, this crucial issue may not be addressed.

Access to information

Persons with disabilities, the elderly, lower income individuals and non-Arabic speakers experienced more barriers to accessing timely information.

In addition, access to informal networks has become even more challenging for FHHs and for those who already experienced barriers to accessing community information.

Access to health care

Impacts on physical health care were noted by 19 percent of female and 30 percent of male respondents (Figure 1b), with 42 percent of female and 62 percent of male respondents highlighting this as a priority need today (Figure 2b). Social norms (e.g. in Kassala) prior to the pandemic meant that women already had less access to health care than their male counterparts, and this was seen to be further compounded by movement restrictions caused by prevention measures implemented during the pandemic.

It was noted that for pregnant women even before the pandemic, there was no specific food assistance in the Umbeda camp in Khartoum. However while there were distributions of medicine free of charge, during the pandemic, pregnant women lost access to this medication and to subsidies. This was compounded by the increase in transport prices meaning pregnant women could not access services outside the camps: “*As a pregnant woman, I experienced a lot from non-continuing health care, when I find the money to go to the clinic for the follow-up, I prefer to feed my children than to go to the clinic*” [pregnant woman, Umbeda].

The psychological and mental health impacts as a result of lack of livelihoods, loss of income, food insecurity and inability to provide for the family are particularly concerning, especially considering the lack of MHPSS across the states. It was noted, for example, that there are no services in the Umbeda refugee camp, with the nearest one being two hours away.

Access to information is crucial to enhance access to other services and resources, enhance social networks and increase income and livelihood opportunities.

Other studies found that the marketplace provides an opportunity for men to exchange news and information, negotiate deals, make alliances and share experiences.²⁴⁶ In this RGA, respondents also noted that men are more likely to receive information through the markets, and from within the community, as well as from radio, TV and the Mosque, while women only had access to the radio and TV for accessing health information.

“The delay in getting the information has a negative effect, for instance, the bread comes on a specific vehicle, sometimes you lose time waiting for it, and sometimes you might come late and find it finished.”

- Female, teacher, Khartoum North, key informant

It was noted that persons with disabilities, the elderly, lower-income individuals and non-Arabic speakers experienced more barriers to information [male, NGO worker, Kassala]. Approximately 45 percent of the households in the Sudan have access to electricity, and availability of electricity widely varies among the states from 94.4 to 8.7 percent. The 76 percent of households with access to electricity are in urban areas.²⁴⁷ It was noted that, when there are electricity shortages, for example during the floods, there were greater negative impacts on access to information transmitted via typical outlets.

Access to information was seen to be greater for young people as they are more exposed to social media [male, NGO worker, Kassala; male, health worker, Khartoum North]. As information is increasingly digitalized, this can create barriers for those not connected to phones or the Internet. Ways of receiving information were not seen to have changed much during the pandemic, and only 1 percent of male and 1 percent of female respondents noted this as one of the top three impacts of COVID-19. However, the lack of social interaction for men and women was raised. This was seen to impact informal methods of receiving information, particularly for those who experience barriers to community life as a result of social norms, such as restrictions on mobility for women and girls, and restrictions due to impacts of COVID-19. This RGA highlighted specific impacts in this regard for the elderly, who are spending more time alone at home and for single female heads of household, who, due to an increased work burden, have less time to participate in the community.

Mobility and access to markets

As displayed in Figure 1b, mobility was highlighted by 34 percent of female and 32 percent of male respondents as having been impacted by the pandemic. For women and girls in locations where traditional social norms related to mobility prevail, access did not change as a result of the pandemic, particularly for young or unmarried girls [female, housewife, Kassala], but it remained a barrier for women and girls engaging in livelihood activities outside the home. While this was not an impact of COVID-19 with overall household income being impacted, limitations on women's participation outside the home reduce opportunities to generate income and increase food insecurity for themselves and their families.

The greatest barriers to markets were seen towards the start of the pandemic. High transport fees, a surge in commodity prices, and a lack of cash due to impacts on

income, all reduced purchasing power, impacts which have also been seen in other assessments.²⁴⁸ Market vendors spoke of movement restrictions impacting their ability to import goods from outside their state and having to rely only on existing resources [male, market vendor, Nyala]. High transport costs of food commodities, due to fuel shortages and increased reliance on costly fuel on the informal market, coupled with limited movement, have further impacted food stability in almost all markets, and although not caused by the pandemic, they were seen to be exacerbated by it. For those who would encounter more physical barriers, for example, the elderly, pregnant women and persons with disabilities, the inability to queue for hours and compete for limited transport options, had compounding impacts on their access to markets and therefore their ability to earn an income during these periods.

Water, sanitation and hygiene

As noted in Figure 2b, clean water was highlighted as a priority need by 21 percent of female respondents and 33 percent of male respondents. This was greater for female residents in rural locations (31 percent), and male residents in urban locations (51 percent).¹ Some respondents who relied on water vendors noted that during the lockdown, the vendors increased the cost of water [female, midwife, Kassala]. While in Umbeda, water was not impacted by COVID-19, it was a pre-existing issue whereby the water stations in the camp were built with water tanks distributed, but these were not appropriate for pregnant women, people with disabilities and the elderly. Therefore, for these groups access to water is still a challenge [female, sultana, Umbeda]. Impacts of the lack of water, sanitation and hygiene (WASH) facilities is impacting children's education. According to the 2019 national WASH in School (WinS) Assessment, nearly 55 percent of schools do not have access to improved water and 49 percent of schools do not have access to improved sanitation facilities. When functionality is considered, the rate is even lower, with only 30.3 percent of schools with functional water sources and 32.1 percent of girls' latrines with functional doors lockable from the inside. This adds challenges to the safe reopening of schools in the Sudan.²⁴⁹

¹. For male respondents: residents in rural areas (34 percent); IDPs (33 percent); and refugees (2 percent). For female respondents: IDPs (19 percent); refugee (17 percent); and residents in urban areas (11 percent).

Impacts on resources and coping mechanisms

Reducing the quantity, diversity and quality of food were the coping mechanisms employed to offset the decline in income.

At the start of the pandemic, women and men used savings, a strategy that a higher percentage of female household heads employed. Loss of savings was reported more often by refugees and IDPs, who had also lost access to humanitarian assistance.

As the pandemic continued, respondents turned to selling household and business assets and supplies, creating longer-term impacts on their livelihoods and ability to earn an income.

Impacts on income were seen across respondents both in this study and other studies conducted during the pandemic, with one showing that 38 percent of households had seen a general decrease in income by June/July 2020, with greater impacts in urban areas.²⁵⁰ This, along with the impacts seen on food security meant respondents had to identify ways to cope to mitigate the effects.

Respondent spoke of strategies employed to cope with food shortages such as reducing the quantity of food to 1 to 2 meals per day, and reducing the diversity and quality of food, e.g. not eating meat and drinking milk. Identifying strategies was largely seen to be the responsibility of women and girls: ‘*Women and girls managed with what they had already at home and reduced it in quantity and quality. Men and young men are doing nothing in this matter*’ [male, sultan, Umbeda].

“We relied more on the goats we had and the sorghum my husband cultivated the year before. We also lived on some of the goods of my husband’s trade. This has affected his work now.”

- Pregnant woman, Kassala

At the start of the pandemic, women and men used savings and reserves, but one year on, there are little to no means left. Respondents spoke of turning to use food and goods meant for their business to feed their families, as well as selling household or business assets to afford food, “*sugar, coffee and medicine*” [female, housewife, Aroma]. This has now impacted their livelihood and ability to continue their trade. A sultan in Umbeda noted that “*anyone who had savings before COVID-19 has now sold or used this during the period.*”

A route many respondents took as the pandemic continued, was to diversify their income. This aimed to mitigate the impacts of lockdown, movement restrictions and/or loss of primary livelihoods due to needing to sell assets, consumption of foodstuffs required for the business, or as a result of inability to farm. As a result of transport restrictions one respondent started offering hair cutting services under a tree in his backyard [young man, Kassala]; women and girls sold vegetables and watermelons in front of their house; and, a farmer took up a second job as a night guard as well as selling tea and coffee during his shift to increase income [male, seasonal farmer, Kassala]. Women worked as cleaners in family homes [female head of household, Umbeda], and youth started construction work [female, teacher, Khartoum North] with some young people in Umbeda making bricks from local materials to sell or build houses [young man, Umbeda].

Table 5b: Resources reported as “significantly reduced” or “totally lost,” by male and female respondents

Resource	Female	Male
Pensions, social security payments, and assistance received from INGOs/NGOs or other non-profit organizations	53%	51%
Savings	40%	53%
Remittances from abroad	30%	23%
Support from friends/family in the country	28%	12%
Non-productive assets	16%	24%
Productive assets	15%	14%

Table 5b shows the percentage of men and women who saw their resources either “significantly decrease” or become “totally lost” as a result of the pandemic.^u Pensions, social security and assistance, and savings were noted to have decreased the most for men and women overall. One study similarly found that about half of households for whom a non-farming family business, assistance from the government, or assistance from NGOs/charitable organizations was their source of income, experienced a reduction or loss in income.²⁵¹ More follow-up analysis would be required to understand the reason for a decrease in pensions, social security payments and assistance, however the aforementioned study also noted that social assistance programmes were almost non-existent to support poor and vulnerable households during the pandemic.²⁵² If any support was received this was free food, followed by in-kind transfers with no direct cash transfers being reported in June/July 2020.²⁵³

The impact on savings was more noticeable for female heads of household (with 60 percent noting the severity of this impact) compared to male heads of household (49 percent) and female respondents who are the spouses of heads of household (18 percent). Loss of savings was greater for male refugee respondents (71 percent), followed by female IDP respondents (62 percent) (as shown in Figure 11b). Speaking with refugee and IDP respondents who relied on external assistance or who were restricted from leaving their camp due to COVID-19, their ability to generate income was more limited and therefore this may have resulted in these respondents using their reserves more, or more quickly during the pandemic. When we disaggregate by disability, just over half (51 percent) of respondents who were classified as having a disability noted a significant decrease or total loss of savings compared with 44 percent of respondents who were not classified as having a disability.

Refugee respondents noted a greater impact on pensions, social security and assistance (71 percent).^u Women IDP respondents saw greater impacts on the support from friends and family (58 percent)^u as did male residents in urban areas (40 percent).^{uv} With reference to remittances received from people living abroad, a greater number of women IDPs noted a significant decrease or total loss of this support (62 percent) compared to other groups.^u No real differences were noted with regards to age or disability.

Figure 12b^{vi} shows the overall actions taken by respondents, to compensate for impacts on resources, disaggregated by sex. The number of those who used

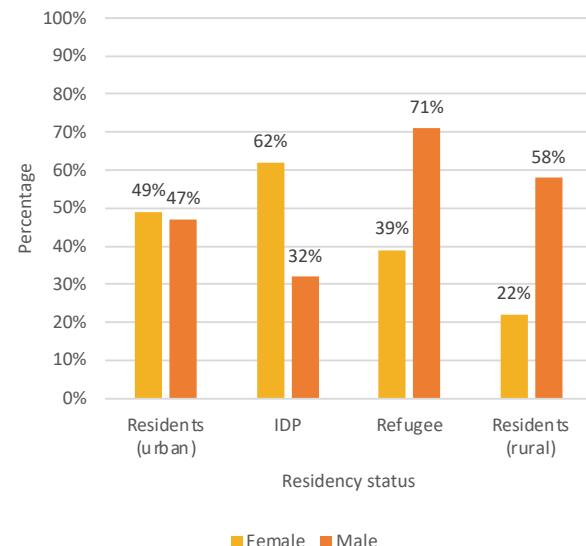


Figure 11b: Impact of COVID-19 on savings (significantly reduced or totally lost), disaggregated by sex and residency status

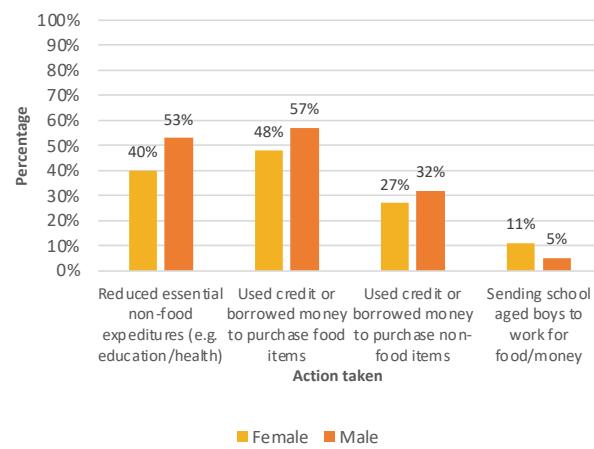


Figure 12b: Actions taken to compensate for impacts on resources, disaggregated by sex

credit or borrowed money for non-food expenditures was greater among male and female respondents in urban areas (43 percent) compared with in rural (28 percent) and semi-urban (14 percent) locations, as well as among IDPs (41 percent) and residents in urban areas (43 percent) compared with residents in rural areas (21 percent) and refugee respondents (14 percent).

u. As a result of COVID-19, how have the following resources been affected (if at all)?

u. Followed by residents in rural areas (58 percent), IDPs (50 percent) and residents in urban areas (33 percent).

u. Followed by women in urban areas (31 percent), women refugees (23 percent) and women in rural areas (13 percent).

uv. Followed by male refugees (23 percent), male IDPs (18 percent) and male residents in rural areas (14 percent).

vi. Female residents in urban areas (29 percent), female refugees (23 percent) and residents in rural areas (17 percent). Only 23 percent of male IDPs reported a significant decrease or total loss of money from abroad.

vi. Other actions taken included: marrying a girl (under 18) in the family for dowry or material support (1 percent f./0 percent m.); marrying a boy (under 18) in the family for dowry or material support (1 percent f./0 percent m.); marrying an adult female in the family for dowry or material support (3 percent f./0 percent m.); marrying an adult male in the family for dowry or material support (0 percent f./0 percent m.); sending girls of school age to work for food or money (3 percent f./1 percent m.); sending girls of school age to beg for food or money (1 percent f./0 percent m.); and, sending boys of school age to beg for food or money (1 percent f./0 percent m.).

For respondents who used credit or borrowed money to purchase food, a larger proportion of respondents was seen for women aged 70 or above (67 percent) compared to respondents in other age ranges,^{LVII} with a greater proportion of refugee respondents reporting this (60 percent) compared to IDPs (53 percent) and residents from urban (53 percent) and rural areas (46 percent). This could be explained by varying levels of access to food between rural and urban areas as well as among populations who relied on assistance which was removed, particularly in the early stages of the pandemic. Refugees also noted a greater loss of savings and therefore perhaps needed to rely more on credit or borrowing money once reserves were low or ran out.

For respondents who had a pregnant woman in the household, 53 percent reported reducing essential non-food expenditures (such as education/health), compared to 42 percent of households who did not have a pregnant woman in the household. Qualitative discussions, including with pregnant women, reinforced the need for continued health care during the pandemic with particular attention to needs, services and specialized expertise throughout the pregnancy continuum, including but not limited to nutritional guidance, supplements and access to pre- and post-birth support services [pregnant woman, Khartoum, Umbeda]. This was particularly stressed for cases where the nearest health centre is far from the location.

It is important to note that as the pandemic continues, if people are unable to recover due to loss of resources, savings and reserves, this is likely to have increased adverse impacts in the future. It has been noted by other research that populations already at risk, including IDPs and refugees, who have fewer resources (as shown also in this study), are more vulnerable to poverty and the secondary impacts of negative coping behaviours.²⁵⁴

Household decision-making

The majority of household decisions were and continue to be taken by the household head (male or female). However, women with husbands have a role in decision-making when it comes to food preparation, budgeting for food, what to eat and when, and with regards to water collection [pregnant woman, Kassala; pregnant woman, Umbeda]. Women were also seen to be more responsible for strategies for solving issues of food shortage, compared to men and boys. This is reflected in the overall survey data for decision-making.

When asked the level of decision-making in “working to earn money for yourself,” we can see slight changes with regards to the level of involvement between before COVID-19 and today for female heads of household, male heads of household and female spouses of household heads (FSHH) (see Figure 13b). While this is not a large change, it is rooted in strong social norms as well as in law that women require permission from a male guardian to work for a wage. However, once a woman does have permission she can spend the money as she wishes.²⁵⁵ This is supported by respondents who noted that while their husbands would make decisions, they would “decide on my business affairs” [female, market vendor, Kassala] and “my wife decides what she owns, as she works as a teacher, so she decides what to do with her salary” [young man, Kassala].

Figure 14b highlights the differences in the type of decision-making in rural, urban and semi-urban settings by male and female respondents today.

Based on the qualitative findings, in some cases, where women had started taking more of a role in income generation for the family, particularly where the husband had lost his job, this was seen to slightly increase their role in decision-making processes within the household. With regards to accessing health care for oneself, small differences were seen in FSHH, with 61 percent noting they held joint decisions over this today, compared to 55 percent before the pandemic, and 10 percent noting they were the sole decision maker today compared to 8 percent before the crisis. However, overall, there did not seem to be fundamental shifts in household decision-making from before the pandemic to today. Nevertheless, it would be interesting to continue seeing how these small changes manifest, particularly as roles and responsibilities around income and livelihoods adapt into the next phase of the pandemic. It would also be important to track the impacts of such changes including, acceptance by family members and the community, of women’s increased role in such areas.

Decision-making, participation and leadership

While there did not seem to be fundamental shifts in household decision-making from before the pandemic to today, small changes were noted in decisions concerning work to earn money and for female spouses of household head, in accessing health care.

LVII. Proportions were 44 percent for 18-to-24-year-olds, 45 percent for 25-to-35-year-olds, 48 percent for 36-to-49-year-olds, 51 percent for 50-to-59-year-olds and 46 percent for 60-to-69-year-olds.

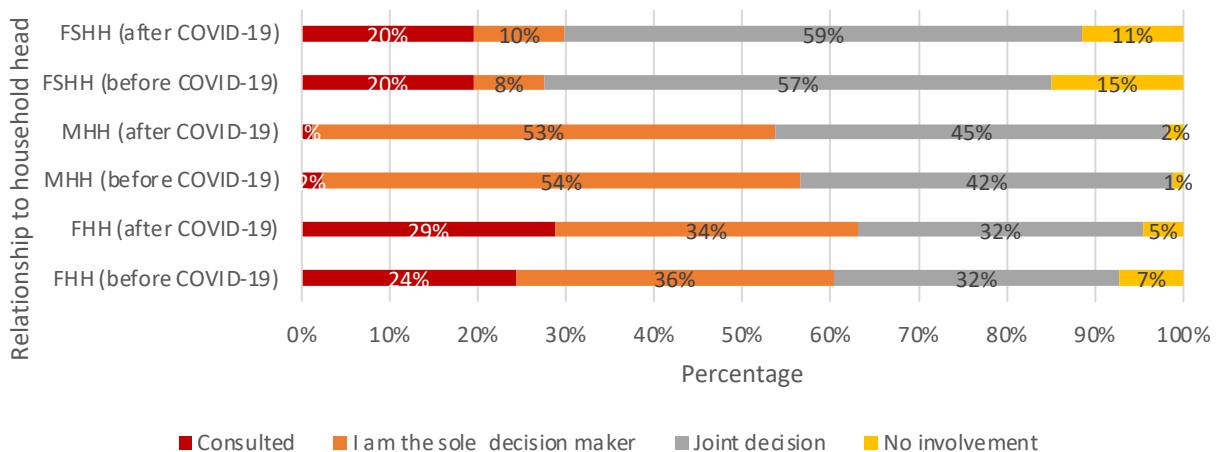


Figure 13b: Working to earn money for yourself (before COVID-19 and today), disaggregated by relationship to household head

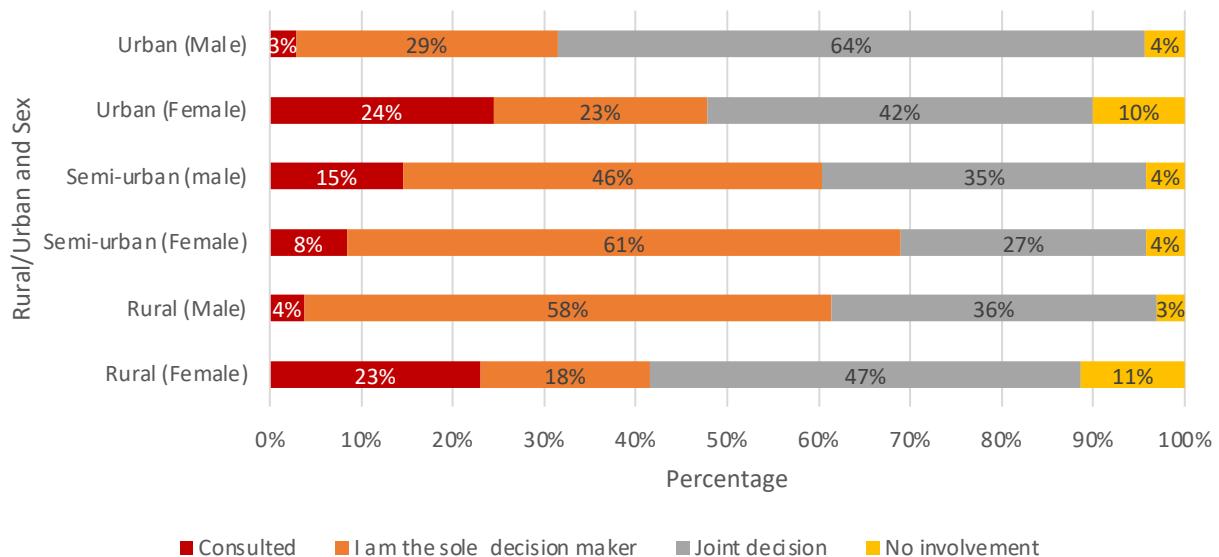


Figure 14b: Working to earn money for yourself (today), disaggregated by location and sex

Community participation

Activities of community of groups and associations slowed or stopped during the pandemic. Barriers to re-start remain; both for individual participation and groups themselves.

Female-headed households noted specific challenges in participation due to other communities and the inability to take up opportunities in the community.

In terms of community participation, before the pandemic, women were involved in savings groups and rotating savings and credit associations (ROSCAs) and water committees, and men identified being involved in farmers' unions, activities which were halted at the start of the pandemic to avoid group gatherings [male, sultan, Umbeda]. This affected women and men coming together, and stopped activities that were being decided on, by these groups. While some groups have restarted, many are limited in their operations and there remain barriers for all to participate.

Longer-term impacts have been seen for women, whose engagement in community and women's associations during the pandemic decreased. One reason expressed for this, was due to the increased work burden and increased dependency of the family. Female-headed households noted specific challenges in participation due to work commitments and the inability to take up opportunities: "*Working as a volunteer in committees and associations needs someone who does not have a workload and has free time. My children desperately need me, I play the father and the mother role both at once and being without money would cause me financial troubles. That is why I cannot participate in such activities, I'm a day-to-day worker.*" Further, for savings groups, men and women found that they could not rejoin due to a lack of money for participation.

"Association activities were stopped due to the pandemic, for example, women in the water committee decided to own agricultural machinery, to plant in the area around the water station and take advantage of the water flowing around the station. Unfortunately, the pandemic stopped the project, and they did not find any supporter or donor to continue."

- Female, Sultana, Umbeda

Impacts were seen with regards to livelihoods projects where women were engaged in making handicrafts and soap, and men in constructing baths. However, these were said to have stopped during the pandemic [female, midwife, Umbeda]. It was not expressed whether these projects restarted, and it would be important to explore this further as these groups would provide both social and economic means for those participating.

Young men and women, particularly those who are educated, were noted as being very active in the community, especially in urban areas. Many are involved in resistance committees in their communities. Resistance committees are local, grass roots entities, composed mainly of young people who are engaged in organizing and mobilizing their communities during political demonstrations, some dating back to 2013.²⁵⁶ Members of resistance committees took up opportunities during the pandemic to work on awareness-raising initiatives and distribute goods within the community.²⁵⁷ There was a feeling, particularly among young respondents, that co-operation within the community was a key coping strategy during the pandemic [young female, Khartoum North], and many expressed a strong interest, particularly young women, in being more active in community associations and in COVID-19 response and recovery. However, young men and women were often not permitted to do so due to their age: "*Previously, I wanted to participate in a women's association, but they refused saying, 'your participation under your mother' Thus, they disappointed us.*" [young female, Khartoum North].

Research had shown the value placed on unions, civil society and neighbourhood committees, by women, concerning the role of women in decision-making processes.²⁵⁸ A disproportionate representation of women in positions of leadership does remain, however. Despite women's active voice in processes during the transitional period in the Sudan,²⁵⁹ in 2019, just two of 11 positions in the country's Sovereign Council were appointed to women.²⁶⁰ Further, although in April 2021, the Sudan ratified the United Nations 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),²⁶¹ there remained reservations (decided on by a council with a male majority) with regards to equality at political and social levels.²⁶² With such resistance, it is important, not only to find avenues to increase the participation and leadership of women and young people, one way being through the COVID-19 recovery process, but also to ensure that the barriers and impacts being created by COVID-19 do not create setbacks for women in this space.

Young men and women, particularly those who are educated, were very active in the community, especially in urban areas and many expressed a strong interest, particularly young women, in being more active in community associations and in COVID-19 response and recovery.

Safety and protection

Women, the elderly, persons with disabilities and young people were more affected by social isolation.

Respondents pointed to increased stress and tensions in the home due to the impacts of the pandemic, which also may link to the increases in domestic violence.

Potential economic exploitation of at-risk and vulnerable groups, whose livelihood options may be limited, was noted.

As noted above, the psychological impacts of COVID-19 came out strongly during the discussions across all groups. Social isolation was particularly noted for women, the elderly, persons with disabilities and young people: “*Lack of visitors is the most important change for me because no one can live without others. I live alone as my son works in the market the whole day*” [65-year-old woman with a disability]. The disbanding of some community associations was seen to impact social connection and removed a space for women, in particular, to discuss problems and issues: “*Women have been affected negatively, now we do not go to visit each other and spend our spare time drinking coffee together*” [pregnant woman, Kassala].

Respondents noted increased stress and tension for men, as they lost their income during the pandemic and increased their time in the home. A human rights activist noted that “*the tension led to cases of GBV, and domestic violence resulted in divorce cases. I am a lawyer and I received cases related to domestic violence which occurred during the restrictions. Men became aggressive towards women.*” Violence in the home was noted in response to an open question, by 9 percent of women and 3 percent of men survey respondents.¹⁸⁸ However, due to sensitivities around this topic, the rapid nature of the survey and the fact that domestic violence is often accepted as a cultural norm,²⁶³ it is highly likely that this is not a full representation of the issue. Existing research shows that domestic violence is highly prevalent, with one study in eastern Sudan showing that 33.5 percent of women reported having current experience of physical violence and, out of these, 53 percent and 47 percent reported moderate and severe forms of physical violence, respectively.²⁶⁴ Further reports highlighting the increase in GBV during the pandemic have been noted.²⁶⁵

A total of 44 percent of women and 56 percent of men survey respondents said that there has been an increase in safety or security concerns facing men and boys in the community since COVID-19. Issues related to safety in the community, including the risk of attack when moving within the community (9 percent female and 13 percent male), the risk of attack when moving outside the community (21 percent female and 34 percent male), and trafficking (6 percent female and 17 percent male) were among those reported in the survey. Discussions with respondents noted that there were concerns over women and girls collecting firewood, with cases of violence increasing in the community. For men, women, girls and boys there were concerns over travel for harvesting due to groups of armed young people in the community. Preliminary research has shown that restrictions introduced in response to COVID-19, particularly border closures and restrictions on mobility, have had significant impacts on trafficking in and through the Sudan. It is noted that as poverty increases, displaced populations, in particular, are at heightened risk of trafficking as well as of recruitment by armed militias, exploitation, forced labour and sexual exploitation.²⁶⁶

With regards to vulnerability to exploitation, preliminary research also highlighted that the populations who have been particularly negatively affected include refugees, IDPs and migrants, children and in particular girls who have left school due to the pandemic, and workers in the informal sector and the seasonal agricultural and domestic sector.²⁶⁷ In this RGA, women who were working on other people’s farms noted that they ended up in a situation where they would only get paid if the farmers were able to sell their crops, and therefore they were finding themselves working more days, for less, with no or an unreliable wage. This raises concerns over the potential economic exploitation of at-risk groups, whose livelihood options may be limited as a result of the pandemic and the impacts on individuals’ economic situation.

Areas for future analysis

It is clear from the analysis that COVID-19 and the compounding complex crisis in the Sudan are having detrimental impacts on the lives and livelihoods of men, women, girls and boys. RGAs are progressive and iterative in nature and thus require the need for continued analysis, particularly where gaps are seen. Future analysis to track decision-making patterns within the household would be of interest, particularly as they relate to livelihoods and the agency and ability of women to earn an income. Building on the findings that male respondents noted

¹⁸⁸ This was asked as an open question rather than directly about violence in the home.

an increase in their engagement in unpaid work since the pandemic, poses an interesting space for discussion on the division of labour in the home. This study was not able to look at the impacts of this more broadly. Future analysis could focus on the extent to which this is sustained or changes over time and whether this has wider impacts on food security, livelihoods and gender equality.

Main findings from primary data collection in Sudan

- There is a clear and continued tension around household priorities and decision-making concerning health care needs versus providing food for the family, given limited financial resources. Women typically expressed responsibility for managing the burden of the overall welfare of the family whether they controlled the financial resources or not.
- There has been a rise in psychological and mental health impacts due to the compounding factors of lack of livelihoods, loss of income, food insecurity and inability to provide for the family. This is concerning given the lack of mental health and psychosocial support services (MHPSS) reported across the states, combined with service providers reporting an increase of domestic violence.
- Activities of community groups and associations have slowed or ceased operations during the pandemic, and barriers remain to restarting these activities. Female-headed households noted specific challenges in participation due to work commitments.
- Young men and women, particularly those who are educated, were very active in the community during the pandemic, especially in urban areas. Many, especially young women, expressed a strong interest in being more active in community associations and in COVID-19 response and recovery.
- Respondents pointed to increased stress and tensions in the home due to the impact of the pandemic, and these stressors contribute to increasing domestic violence.
- Concerns persist regarding the potential economic exploitation of at-risk and vulnerable groups, whose livelihood options may already be limited.
- “Income and livelihoods” and “food and nutrition” were identified as the areas most impacted by COVID-19 and were identified by both men and women as the two greatest priority needs today.
- During the pandemic, women and young people (especially young women), took on additional roles with family businesses, including agricultural tasks on farms, adding to their already disproportionate work burden.
- While women have taken on most of the unpaid work burden, men, particularly young men, reported increased engagement in household tasks by 4 percent during the pandemic when contrasted with male engagement before the pandemic started.
- School closures have increased the unpaid work burden for girls and have increased their parents’ reluctance to send them back to school. As girls remain out of school for prolonged periods of time, the likelihood of early or forced marriages and pregnancies increases.
- Women are experiencing greater levels of food insecurity, in both male and female-led households. The likelihood of this is 7 percent greater for female heads of household, as they are more likely to adopt negative coping mechanisms to mitigate food insecurity.
- Women and men respondents from urban and semi-urban locations are reporting higher food insecurity than those in rural areas, as are female refugees. Older age groups (60+) and people who were classified as having a disability reported higher food insecurity.

Conclusion

This RGA has highlighted a range of direct and indirect impacts on the lives of men, women, girls and boys resulting from the COVID-19 pandemic, as well as the continuing shocks and crises being experienced by the countries and the wider region, which have led to wider compounding impacts. The RGA also highlighted specific impacts on particular groups and those more at risk. These included the elderly, individuals with disabilities, pregnant and lactating women, female heads of household and spouses of household heads (a group whose needs are often neglected by programmes and interventions that target the household as a whole).

Impacts on income and livelihoods are stark. While the livelihoods of many have been affected, the pandemic is disproportionately affecting those in the most insecure positions. Greater social protection is required so that families have adequate resources to eat, drink, work, travel and access health care. In the short term, stimulus packages for businesses and injections of cash and other assistance are required to enable communities to thrive. In parallel and for the longer term, more inclusive policies and labour market interventions are required to create an enabling environment for economic stabilization, combined with increased investment in building the skills of women, men and adolescents.

Food insecurity came out of this RGA as a clear concern and priority. Data showed that COVID-19 negatively influenced food insecurity to varying degrees based on the analysis of surveyed groups, and also highlighted the pre-existing insecurity pre-pandemic. This highlights the need to mitigate the impacts of the pandemic but also to consider the wider context and the other interconnecting contextual factors that are creating food insecurity. In addition to keeping the focus on rural populations, it is important for agencies to note the high levels of food insecurity faced by urban and semi-urban populations.

One of the most detrimental impacts observed across the studies has been the disproportionate burden of unpaid work carried by women and girls, leading to impacts on women's physical and mental well-being, and creating barriers for women in accessing paid work and participating in their community. Additionally, across the analyses, data revealed the critical impacts the pandemic is having on mental health as a result of food insecurity, loss of livelihoods, care and concern over the welfare of loved ones as well as the additional burdens and stresses individuals are coping with. Without adequate support and services, this will further affect the well-being and resilience of individuals in recovering from the crisis.

The return to school for girls and boys should be made a priority to ensure that school closures do not lead to

longer-term impacts on education, particularly for girls who were highlighted as being a specific concern, given the social and cultural norms that have increased barriers for women and girls even pre-pandemic. Food security and livelihood actors have a key role to play in noting the impacts of food insecurity and loss of income for girls and boys staying out of school and entering the workforce, and the risks associated with early marriage.

Those who rely on humanitarian or government assistance have been affected due to the lack of continuity of support, or the withdrawal of assistance. This stresses the need for better and more inclusive preparedness plans as the pandemic continues, as well as the need to prepare for future shocks and crises. It also requires a review of the current content of assistance packages and targeting approach. With potential economic exploitation of vulnerable groups highlighted in this assessment, it will be important to ensure at-risk groups are not in a situation where their last resort is to take employment in risky environments.

From this analysis as well as other reports, it is clear that the pandemic, combined with other contextual factors is having an impact on the risk of GBV. Food security and livelihoods programming has the opportunity to act as a key entry point to support women and at-risk groups holistically, particularly in areas where services are not available or where social and cultural norms prevent or restrict access to services of women and girls.

A key area within the analysis was the loss of social networks and community groups – be that due to COVID-19 restrictions, withdrawal of humanitarian programming, reduction in time or fear of the virus. It would be important to support communities to reconnect, which would have effects socially, economically and psychosocially, while having the potential to create longer-term opportunities for women to have a voice and increase their leadership and participation in the community.

The role of young people was well highlighted through discussions. Young men and women appear to be taking on increased roles within the home and unpaid household tasks. Young people are also mobilizing through existing community structures to respond to the COVID-19 pandemic and express interest in being integrated more in the response and recovery despite cultural limitations due to their age.

It is crucial to continue to understand the impacts of the pandemic on food security and gender inequality. Doing so requires data and information that is representative of all those in the community. Disaggregated data, an understanding of power and gender and social norms, as well as the ability to share this data widely and transparently will be key to addressing the needs, priorities and impacts of this pandemic and future crises.

Regional recommendations

Data, assessments and accountability

United Nations and governments

- Commit to greater transparency and sharing of non-identifiable data collected during the pandemic and other crises to support learning and analyses, and minimize the burden placed on communities.
- Collaborate more closely with national institutions, think-tanks and research institutes to build capacities and raise awareness around the importance of data disaggregated by relevant social dimensions (gender, age, disability and residency status), and SADD analysis to inform planning and implementation of interventions in the agricultural and rural sector and in urban/semi-urban settings.

Humanitarian actors and civil society organizations

- Actively build data collection modalities to include input, participation and validation channels for women's rights organizations and other formal and informal groups representing women, young people and persons with disabilities to better understand the needs and impacts of the crisis on affected populations.
- Ensure that data collection methodologies pay close attention to intrahousehold dynamics as well as social dimensions (i.e. rural/semi-urban/urban location, residency status, socio-economic groups and/or persons with disabilities).
- Systematically and regularly collect and share country and regional-level data and analysis, including sex-, age- and disability-disaggregated data, combined with applying a gender and power analysis to inform policy and programme development, across all sectors.

Donors

- Establish mechanisms to monitor and hold implementing agencies accountable for applying a more gender-responsive and intersectional approach that responds to age-, gender and diversity-differentiated needs and interests.

Policy and programme recommendations

United Nations and governments

- FAO and WFP to provide capacity-building support and build partnerships with national actors (i.e. national statistics offices) and relevant partners, where needed, to support the adoption of inclusive approaches and methodologies that consistently collect SADD. This will enhance capacities for assessments and analysis, including within the agricultural sector.
- Governments, with the support of FAO and WFP, to ensure national laws, policies and COVID-19 response plans apply an intersectional approach to address the needs and uphold the rights of women and marginalized groups (e.g. adult and young women refugees, working mothers, rural and urban women, small business owners, women working in the informal economy, etc.).
- Governments to adopt gender-responsive budgeting for all preparedness and response plans and frameworks at regional and country level.
- FAO and WFP to review targeted food security and livelihoods interventions to strengthen existing partnerships (e.g. in Syria and Palestine), with GBV actors to develop innovative ways of ensuring greater protection for those most at risk of GBV.
- FAO and WFP to explore partnerships with international and national organizations, WHO and the state ministries of health to integrate awareness of mental health and related interventions within their programmes, particularly in areas where services do not exist.

Humanitarian actors and civil society organizations

- Commit to integrating RGA findings into adaptive programme planning cycles and incorporating more participatory and inclusive programme design methodologies, developed in partnership with local actors and civil society organizations.
- Bridge COVID-19 recovery and preparedness initiatives with long-term community-based initiatives to address gender disparities by identifying key barriers and systematically monitoring and adapting long-term programming based on the evidence of evolving social and economic inequalities for at-risk populations.

Donors

- Require programme design and decision-making to be based on updated RGA recommendations and analysis for more effective response, recovery and preparedness efforts, and for enhancing learning and data comparability over time.

Country-level recommendations for the government, FAO, WFP and humanitarian actors

The usefulness of the data presented in this initiative combined with the effectiveness of gender and food security programming depend on the extent to which context-specific and gender-disaggregated data can be used to inform food security programming and strength-

en the relationship between gender and food security actors regionally, and more specifically in this study in Iraq and the Sudan. The boxes below highlight both immediate short-term recommendations and cross-cutting country-specific themes:



Women in Iraq preparing the foundations for a community irrigation project

Iraq: Immediate short-term response

- 1. Create opportunities for temporary employment and economic relief** through stimulus packages and/or cash transfers for mitigating negative coping strategies, designed to take into consideration the specific needs of women and at-risk groups.
- 2. Amplify advocacy for the endorsement of the anti-domestic violence law** and its implementation, recognizing the increase in GBV cases and the right to justice of survivors in times of crisis.
- 3. Ensure delivery of special permits** to those working as daily labourers or on farms in the case of curfews.



Female participant of CARE's Every Voice Counts (EVC) programme joined a Village Savings & Loans Association (VSLA) in Aljalbie village in East Darfur, the Sudan. She used her training to build a grocery store in front of her home and also now owns a donkey for transporting goods

The Sudan: Immediate short-term response

1. Mitigate barriers to existing community-based support and impacts where food assistance or livelihoods programmes have ceased or become limited due to COVID-19. Prioritize immediate programme-specific follow-up to understand these impacts through a gender-responsive and intersectional approach, and identify key needs and appropriate mitigation actions.

2. Increase interventions that support small and micro businesses, insurance services and/or cash transfers to enhance men and women's individual and household capacities to manage risks, particularly those related to food insecurity and malnutrition.

3. Revamp and reinforce informal financial groups and services (rotating savings associations), which before the pandemic served to facilitate the access of individuals (especially women in rural areas) to credit as well as social networks. Within this, identify barriers to participation for specific groups and mitigate them through tailored food security and livelihoods programmes.

Cross-cutting country-level recommendations

- **Review targeting criteria and implementation modalities of recovery and response programmes (such as cash-based transfers) and allow for adaptations that combine support on food security and nutrition with other priorities** (e.g. access to maternal and reproductive health care and WASH), particularly for those most vulnerable and impacted by COVID-19 and other shocks. This will help address some specific gender-based constraints (e.g. time and mobility constraints) and ensure that women are not having to decide between food for themselves or their families, and health care for themselves or their children.
- **Provide equal access to agricultural inputs, resources and services (including capacity building and technical training)**, the availability of which was affected during the pandemic. Attention should be paid to the provision of agricultural technologies and practices that are women friendly and save labour, and can contribute to ease the excessive work burden of women (both paid and unpaid), which has been further exacerbated as a result of the pandemic.
- **Address the immediate food-related impacts of rural girls and boys being out of school** (paying specific attention to the needs of adolescent girls of reproductive age and boys). Adjust programmes to incentivize their sustainable return and retention in school programmes, while fostering opportunities for vocational training in agriculture and agribusiness, including by investing in their digital inclusion.
- **Invest in the integration of psychosocial support services in parallel to food and livelihood programmes and services**, ensuring that all staff are skilled and informed of up-to-date resources around GBV services and referrals.
- **Foster greater sensitization around discriminatory social and gender norms**, and engage women, men and young people in identifying pathways and opportunities for shifting power dynamics and creating awareness of gender equality. This transformative approach is essential for ensuring that recovery from COVID-19 as well as other compounding shocks and crises is sustainable.

Women and young people's leadership and participation

- **Prioritize approaches that support and nurture women's and young people's leadership and decision-making power, such as CARE's Women Lead in Emergencies Approach** or the approaches tested in the Joint Programme "Accelerating progress towards the Economic Empowerment of Rural Women" (JP RWEE), jointly implemented by FAO, the International Fund for Agricultural Development (IFAD), UN Women and WFP, and the Joint Programme on "Gender Transformative Approaches for Food Security, Improved Nutrition and Sustainable Agriculture" (JP GTA), implemented by FAO, IFAD and WFP. The adoption of these approaches and methodologies is essential for promoting women's leadership in food security and agricultural interventions, and increasing decision-making by women and young people in households and communities, while engaging with men and boys to tackle the root causes of gender inequalities.
- **Build from existing interest and engagement of young people within programme areas.** Adopt approaches such as the [FAO Farmer Field Schools](#), [Farm Business Schools](#) and [Junior Farmer Field and Life Schools](#), and partner with existing young people's groups and committees (formal and informal) to better understand the diverse needs, barriers, aspirations and challenges that young people face in recovering from the pandemic, with specific attention to the young in rural areas.
- **Create participatory and inclusive strategies for sharing information about programme adaptations across diverse communities** (such as through youth ambassadors or engagement of community front line workers) to ensure all those who are entitled to assistance are aware of these adaptations and able to access assistance, as well as able to provide feedback in a safe and effective way.

Gender-based violence and mental health and psychosocial support integrated as life-saving components in food security and livelihoods programming

- **Identify opportunities via food assistance and agriculture-related interventions to create and/or restore formal and informal social protection networks**, particularly to reach those most at risk of marginalization. For example, through distributing food rations via volunteers providing home-based care,²⁶⁸ and working with partners specialized in addressing the needs of at-risk groups, e.g. persons with disabilities, migrant populations or the elderly.
- **Ensure professional staff is available around GBV and provide programme teams with the most up-to-date referral pathways and the skills** for mitigating GBV risks, sexual exploitation and abuse, as an integral part of food security and livelihoods programming for the COVID-19 response and recovery process.
- **Create safe, confidential and appropriate reporting and feedback mechanisms** (considering the digital gender divide between men, women, girls and boys, as well as between rural and urban areas), which also allows understanding and analysis of evolving trends in relation to all forms of GBV.

Gender equality as central to COVID-19 recovery and preparedness for future shocks

- **National and local task forces for COVID-19 and subsequent crises to actively seek to increase representation of women in leadership positions**, in alignment with government policy and commitments to gender parity. Active participation of women in decision-making bodies is essential for the development of policies, programmes and interventions that adequately address the needs of women, men, boys and girls.
- **Engage men, male leaders and young men in the community** to advocate for gender equitable COVID-19 recovery processes and, more broadly, for social change, particularly those who have recognized and valued the shift in gender roles as a result of COVID-19.
- **Examine the criteria and conditions for participation in livelihoods and assistance programmes**, recognizing the additional burden of unpaid work for women and girls created by the pandemic and adapting delivery modalities to facilitate their participation.
- **Digital-based solutions should be further explored**, but paying attention to those that typically face significant barriers in accessing information and services, such as people with disabilities. Digitalization has the potential to also enhance rural women's access to information, knowledge, financial inclusion and access to markets. However, for these solutions to be effective, efforts to close the persisting digital gender gaps need to be accelerated – considering that information and communication technologies prove to be key in times of crisis.

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Annex 1

Supporting methodology, field plans and further details on approach

In Iraq, a total of 601 individual surveys were administered, reaching out to 236 women and 365 men.

Governorate	District	Description
Anbar		In northern governorates, there were new displacements due to IDP camp closures.
	Amriat Al-Faluja (AAF) informal settlement (rural)	Due to camp closures in Iraq, AAF is one of the camps that has been officially closed. However many IDPs are living in this area.
	Alqayim (rural)	Returnees are the biggest community in Alqayim, many of whom are working in agriculture.
Dohuk		Duhok is a diverse community with refugee, IDP and returnee populations.
	Zakho	A large IDP population live in Zakho. Daily labour is a key livelihood activity.
	Domiz refugee camp	Refugee population live in Domiz in one or two camps.
Erbil	Darashokran refugee camp Erbil	In this governorate there will be a focus on refugee populations, as it has several refugee camps, and in Erbil IDPs and refugees are living in non-camp settings.
Ninewa	Rabea	The majority of people in Rabea are working on agricultural activities, including small-scale farming.
	Mosul	Mosul is home to populations of returnees.
Missan	Al-Majar	Focused on speaking with the host community who are working in fishing and agriculture. There are a small number of IDPs living in Al-Majar. There are a few organizations working with persons with disabilities.
	Al-Amarh	

In Iraq, key informants (19 in total) included protection focal points, NGO/organization representatives working with persons with disabilities and with refugees, food security actors, health care providers, community leaders, representatives from the Ministry of Agriculture, GBV service providers, daily labourers, women's group representatives, farmers, seasonal workers, small business owners, market vendors and mukhtars. The individual stories included (21) were from young people, seasonal workers, producers, female heads of household, pregnant women, rural workers, farmers and daily labourers.

In the Sudan, three states were selected for primary data collection. Locations within the states and descriptions are displayed in the table below. A total of 606 individual surveys were collected (356 women and 250 men). In the Sudan, key informants included (25) FAO and WFP representatives, sultans, sultanas, community leaders, health officers, teachers, government employees, representatives of human rights organizations, HAC representatives, nutrition officers, medical assistants, midwives, NGO workers, market vendors, farmers, pastoralists, housewives, seasonal farmers, daily workers, small business owners and traders. Individual stories (25) were collected from young people (male and female), female heads of household, pregnant women, women's union representatives, persons with disabilities, women's group representatives and teachers.

State	Locality	Description
South Darfur	Bileel (specifically Al-Salam IDP camp)	Al-Salam is an IDP camp in a semi-urban location.
	Nyala town	Nyala town is a large urban town with a central market.
	Kass	Kass is a rural location, home to IDPs and host community residents
Kassala	Aroma	Aroma is a rural location, home to Sudanese residents.
	Kassala town	Kassala town is an urban, market area, home to Sudanese residents.
Khartoum	Umbeda (specifically Nivasha area)	The focus population here was South Sudanese refugees in the Umbeda refugee settlement.
	Khartoum North (specifically Wad Ramli)	Khartoum North is a semi-urban community of Sudanese residents, who were previously affected by the flooding.

Methodological considerations

- The sample selected is not meant to be representative of the overall population in the Sudan and Iraq, but it is representative of women and men living in the (target) areas.
- In Iraq, the sample for the individual surveys was selected from the list of beneficiaries provided by FAO and WFP country offices. The lists included beneficiaries residing in the targeted areas.
- In the Sudan, the sample for the individual surveys was randomly selected in the working areas of CARE International in the Sudan.
- Qualitative data, collected through KII and individual story telling tools, were conducted with key stakeholders and members of the community. Respondents were selected using a “snowballing strategy” with the aim to represent diverse perspectives based on gender, age, and diversity factors. Respondents were also selected based on their occupation, residency status (e.g. IDPs, host community) and role within the targeted community (e.g. community leaders, health service providers).
- In the Sudan, quantitative and qualitative data collection was entirely conducted face to face.
- Due to COVID-19 restrictions, data was collected remotely in Iraq. It must be acknowledged that telephone surveys may be biased by design because they target only those in the population with access to mobile telephones.
- Due to time constraints, quantitative and qualitative data collection took place in parallel.
- Male enumerators interviewed male respondents and female enumerators interviewed female respondents, as far as possible. This also allowed for the team to speak to other members of the household, not only to the heads of household.
- Data was always collected at the individual level, and respondents did not respond on behalf of the household.
- The analysis collected and disaggregated information by disability status. To achieve this, the Washington Group Short Set on Functioning was used during the quantitative survey and coded based on the recommended guidance.
- Respondents who identified as having a disability, as well as organizations working with persons with disabilities were explored for the qualitative data collection. Due to scope of the project, available time and sample size, further disaggregation based on types of disability were not analysed.

Annex 2

Demographic breakdown of respondents

Iraq demographics of survey respondents

Table 1: Disaggregation by sex

Sex of respondent	Count	Percentage
Female	236	39%
Male	365	61%
Total	601	100%

Table 2: Disaggregation by age

Age of respondent	Count	Percentage
18–24	89	15%
25–35	188	31%
36–49	206	34%
50–59	78	13%
60–69	25	4%
70+	15	2%
Total	601	100%

Table 3: Type of household

Type of household	Count	Percentage
Female-headed household (with a partner/married)	9	1%
Joint headed household (husband and wife)	105	17%
Male-headed household (with a partner/married)	359	60%
Single female-headed household (without a partner/unmarried)	111	18%
Single male-headed household (without a partner/unmarried)	9	1%
Other	8	1%
Total	601	100%

Table 4: Respondents by governorate

Respondent breakdown by governorate	Count	Percentage
Anbar	137	23%
Duhok	161	27%
Erbil	96	16%
Missan	76	13%
Ninewa	131	22%
Total	601	100%

Table 5: Relationship with household head

Relationship with household head	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Household head	375	62%	132	22%	243	40%
Spouse of household head	100	17%	62	10%	38	6%
Brother/sister	5	1%	3	0%	2	0%
Father/mother	66	11%	11	2%	55	9%
Father-in-law/ mother-in-law	1	0%	1	0%	0	0%
Son/daughter	48	8%	21	3%	27	4%
Son-in-law/ daughter-in-law	2	0%	2	0%	0	0%
Other	4	1%	4	1%	0	0%
Total	601	100%	236	39%	365	61%

Table 6: Residency status

Residency Status	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Host community	111	18%	25	4%	86	14%
IDP	304	51%	122	20%	182	30%
Refugee	48	8%	12	2%	36	6%
Returnee	138	23%	77	13%	61	10%
Total	601	100%	236	39%	365	61%

Table 7: Type of location

Location type	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Rural	129	21%	57	24%	72	20%
Semi-urban	94	16%	33	14%	61	17%
Urban	378	63%	146	62%	232	64%
Total	601	100%	236	100%	365	100%

The Sudan demographics of survey respondents

Table 1: Disaggregation by sex

Sex of respondent	Count	Percentage
Female	356	59%
Male	250	41%
Total	606	100%

Table 2: Disaggregation by age

Age of respondent	Count	Percentage
18–24	68	11%
25–35	158	26%
36–49	162	27%
50–59	111	18%
60–69	66	11%
70+	41	7%
Total	606	100%

Table 3: Type of household

Type of household	Count	Percentage
Female-headed household (with a partner/married)	99	16%
Joint headed household (husband and wife)	37	6%
Male-headed household (with a partner/married)	356	59%
Single female-headed household (without a partner/unmarried)	82	14%
Single male-headed household (without a partner/unmarried)	29	5%
Other	3	0%
Total	606	100%

Table 4: Respondents by state

Respondent breakdown by governorate	Count	Percentage
Kassala	186	31%
Khartoum	242	40%
South Darfur	178	29%
Total	606	100%

Table 5: Relationship with household head

Relationship with household head	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Household head	284	58%	111	39%	173	84%
Spouse of household head	96	20%	87	31%	9	4%
Brother/sister	8	2%	7	2%	1	0%
Brother-in-law/ sister-in-law	6	1%	6	2%	0	0%
Father/mother	10	2%	6	2%	4	2%
Father-in-law/ mother-in-law	2	0%	2	1%	0	0%
Son/daughter	50	10%	37	13%	13	6%
Son-in-law/ daughter-in-law	21	4%	16	6%	5	2%
Grandchild	2	0%	2	1%	0	0%
Grandfather/ grandmother	5	1%	5	2%	0	0%
Other	5	1%	5	2%	0	0%
Total	489	100%	284	100%	205	100%

Table 6: Residency status

Residency Status	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Resident (urban)	160	26%	90	25%	70	28%
IDP	113	19%	69	19%	44	18%
Refugee	119	20%	71	20%	48	19%
Resident (rural)	214	35%	126	35%	88	35%
Total	606	100%	356	100%	250	100%

Table 7: Type of location

Location type	Count	Percentage	Count	Percentage	Count	Percentage
	Overall		Female		Male	
Rural	327	54%	195	55%	132	53%
Semi-urban	119	20%	71	20%	48	19%
Urban	160	26%	90	25%	70	28%
Total	606	100%	356	100%	250	100%

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