REPORT

COVID-19, gender inequality and social exclusion: imminent threats

SDDirect evidence to the IDC inquiry on COVID-19 in developing countries

Produced for: International Development Committee

17th April 2020

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1 Introduction to SDDirect

Social Development Direct (SDDirect) is a leading provider of social development assistance and research services. We are a technical firm that offers in-depth thematic expertise in conflict prevention and peace building, governance voice and accountability, girls' education, women's economic empowerment, health rights and violence against women and girls. We have a 20 year track record of providing high quality services that include technical advice and support, research, development assistance programme design, delivery and management, monitoring and evaluation. Our clients are leading international development agencies, iNGOs and Foundations.

We are a wholly owned subsidiary of Plan International UK, a leader in gender-based programming for children.

2 Overview: how COVID-19 will impact women, girls and marginalised groups

2.1.1 What we know about women and girls, marginalised groups and COVID-19

The COVID-19 pandemic is a global public health emergency affecting millions of people around the world. Over the past few weeks, as the crisis has started to unfold in low- and middle-income countries (LMICs), SDDirect has been conducting desk-based research on a number of issues related to gender and social inclusion and COVID-19, including violence against women and girls (VAWG), disability inclusion, women, peace and security, and the impact on lesbian, gay, bisexual, trans, intersex and queer (LGBTIQ) people.[1]

Our research demonstrates that women and marginalised groups are disproportionately impacted by COVID-19. Groups at the intersection of inequalities, for instance when gender inequality overlaps with other forms of exclusion including those related to age, class, disability, and sexual orientation, gender identity and expression (SOGIE), are at particular risk of adverse impacts from the COVID-19 crisis. Our research highlights that the impact ranges from greater risks of contracting the virus for some, including women and people with disabilities, to serious consequences in access to healthcare, food security, livelihoods, education and increases in violence and abuse, including in conflict zones. Barriers include inaccessible healthcare and WASH facilities, lack of access to social protection, technology, and pervasive negative attitudes, stigma and discrimination, including in the health sector. Emerging data and evidence indicate that COVID-19 is likely to exacerbate existing inequalities, worsening development outcomes, and may make it difficult to meet the Sustainable Development Goal targets. This situation is likely to be exaggerated if women and marginalised groups are not involved in the response, further damaging development gains made in the last few decades.

[1] Including:

- Fraser, E. (2020) *Impact of COVID-19 Pandemic on Violence against Women and Girls.* DFID VAWG Helpdesk. http://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf
- Meaney-Davis J., Lee, H. and N. Corby (2020) *The impacts of COVID-19 on people with disabilities.* DFID Disability Inclusion Helpdesk. http://www.sddirect.org.uk/media/1909/disability-inclusion-helpdesk-query-35-covid-19-rapid-evidence-review.pdf

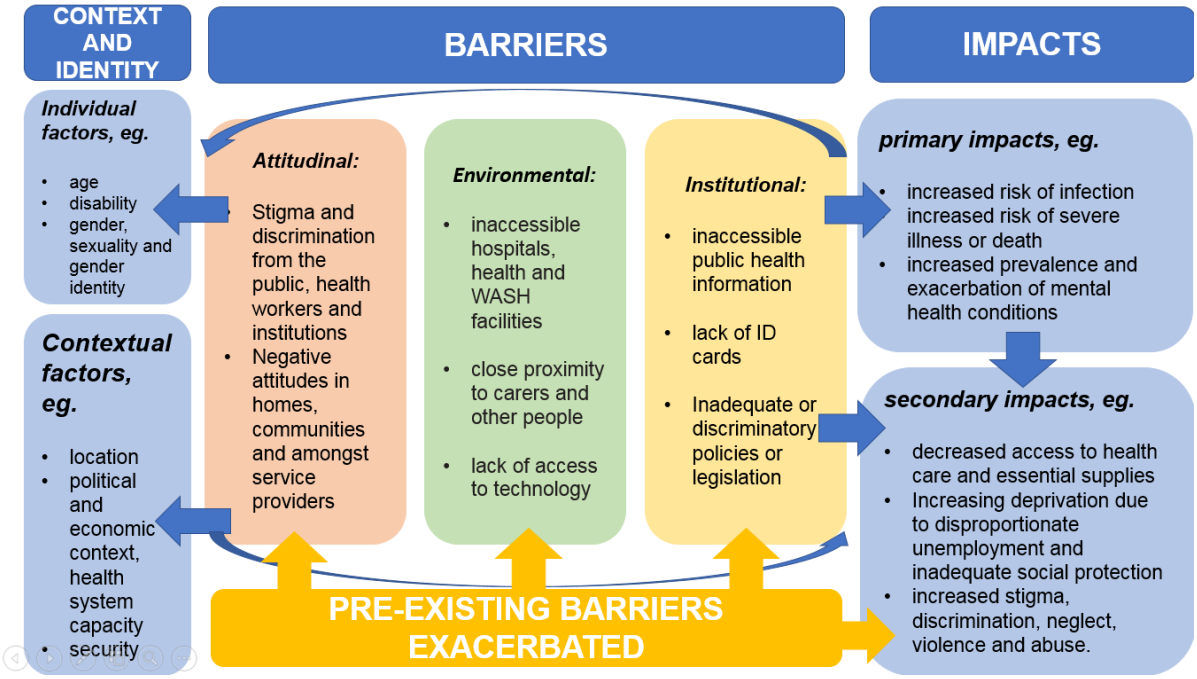
2.1.2 Availability of data and evidence on women and girls and marginalised groups in the COVID-19 crisis

Although data and evidence are just emerging in many of these areas, there are clear trends in media, human rights, and VAWG service provider reports on the disproportionate impacts of COVID-19 on women, girls, people with disabilities, LGBTIQ groups and women and girls in conflict. The following suggestions for data collection and research would help us to understand these impacts better:

- Mixed methods research using accessible media.
- Disaggregating data by age, gender and disability at the very least and considering intersections between these factors, including gender identity, sexuality and disability, in analysis. Disaggregation and analysis is also needed by ethnicity, migrant/asylum status and socioeconomic status.
- Monitoring the participation of representative and human rights groups in response and recovery efforts.
- Mapping barriers and understanding impacts across different contexts drawing on existing models of intersectionality (see diag 1)

We believe that attitudinal, environmental and institutional barriers, together with a lack of data and evidence which considers the gender and social dimensions of the crisis, including the impact on women, girls and marginalised groups, are a threat to an effective COVID-19 response and recovery, meaning in some cases that governments and communities may leave behind the very people they are most trying to protect. The below sections summarise the research we have conducted in these areas.

Diagram 1: intersectionality and COVID-19



2.1.1 Recommendations for an inclusive COVID-19 response and recovery

Concerted efforts are needed to ensure response and recovery are inclusive, opportunities are not lost to “build back better” and we are more prepared for the next global pandemic. In order to do this, it is critical that the international community:

- Involves women and marginalised groups and their representative organisations, including as leaders and decision makers, in the COVID-19 response and recovery.
- Seeks to understand the drivers of marginalisation and the changing context during COVID-19 through ongoing gender and social analysis. This is critical to identify opportunities and minimise risk to marginalised groups.
- Ensures the continuation of an effective and unconstrained civil society, through continued support for rights organisations (e.g. women's rights organisations, disabled peoples' organisations, LGBTQI+ organisations) and civil society organisations, and commitments to transparency and accountability throughout the pandemic and recovery.
- Considers the intersections between age, gender, disability, SOGIE, ethnicity, migrant/asylum and socioeconomic status and other relevant individual and contextual factors which may have influence on the experience of the COVID-19 crisis, including both response and recovery.
- Collects disaggregated data, builds the evidence base and gathers lessons learned.

3 Impacts on people with disabilities

While publicly available data on COVID-19 has so far not been disaggregated by disability status, disturbing reports are emerging on the severe and disproportionate impacts on people with disabilities, including primary impacts of the COVID-19 virus itself, and secondary impacts of the response to the pandemic, including on health, food security and livelihoods.

3.1.1 Immediate threats and risks

- **Greater risks of contracting COVID-19 due to a range of barriers** for example, inaccessible public health information campaigns (Qualitative, 2020; Nkhoma, 2020; Ansah, 2020; AlterPresse, 2020); inaccessible water, sanitation and hygiene facilities (WHO, 2020); unfeasible social distancing and self-isolation measures for some people with disabilities who rely on carers (OHCHR, 2020; ITV, 2020; Bernhard, 2020); and close proximity to others in residential institutions or humanitarian contexts, sometimes in unsanitary conditions, and relying on carers or officials for support (LaVoz, 2020; Cappa, 2020; Salamancartvaldia, 2020; Il Fatto Quotidiano, 2020; Tribune News, 2020; Minkowitz, 2020; Mad in Asia, 2020; UNOCHA, 2020).

- **Greater risks of developing serious illness or dying from COVID-19** due to the risk of exacerbating underlying health conditions (WHO, 2020) and barriers such as physically inaccessible healthcare facilities, a lack of capacity amongst health workers to treat people with disabilities, and stigma and discrimination (WHO, 2020; WHO, 2011; Kuper and Heydt, 2019). Many countries have introduced guidelines that may lead to discrimination as they permit the de-prioritisation of treatment for people with disabilities and underlying health conditions when health systems have reached capacity (SIAARTI, 2020; Booth, 2020; Disability Rights UK, 2020; NICE, 2020a; NICE 2020b). This practice would contravene the UN Convention on the Rights of Persons with Disabilities.

- **Exacerbation of pre-existing mental health conditions and psychosocial disabilities** as a result of fear and anxiety about contracting COVID-19, economic and financial pressures, long periods of social isolation, family pressures and conflict (Williams and Saxena, 2020; Kirton, 2020; Yuhong et al., 2020; Hamel et al., 2020; Long and Fowers, 2020; Torres, 2020).

- **Decreased access to healthcare, food, medications and housing** due to increased pressure on healthcare systems, markets and supply chains, made worse by pre-existing accessibility challenges and deficiencies in many health systems (Henriques-Gomes, 2020c; IDA, 2020; Enabled.in, 2020; Ryan and Marsh, 2020; Lee and Westcott, 2020; Disability Rights Fund, 2020; Al-Issa, 2020; Tribune News, 2020).

- **Increased and disproportionate impacts on livelihoods** as a result of containment measures that restrict movement – this impact may be especially severe in low and middle-income countries where people with disabilities are more likely to be in informal work or self-employed, with less access to labour protections (IDA, 2020; UNDESA, 2019).

- **Limited access to or inadequate social protection**, as many social protection schemes are already inaccessible to or inadequate for people with disabilities, and increased pressures on social protection schemes may intensify the economic and social exclusion of persons with disabilities (Allam, 2020; Henriques-Gomes, 2020b; Enabled.in, 2020; TVC News, 2020; Kidd et al., 2019).

- **Increased stigma, discrimination, neglect, violence and abuse.** Risks for people with disabilities include: being devalued in public messaging about COVID-19 (Ryan, 2020; Kukla, 2020; Ekstrand, 2020); being falsely associated with COVID-19 infection (Chacha, 2020); being left behind by carers and communities who are quarantined or fearful of infection (BBC News, 2020; IDA, 2020; Disability Rights Fund, 2020; Thompson, 2020); or being abused by family members, carers or community members in close confinement (IDA, 2020; Fraser, 2020; Fraser et al., 2019; Dunkle et al., 2018).

4 Impacts on violence against women and girls

Evidence on the impact of COVID-19 is at an early stage, however there are clear trends emerging from numerous countries including a number of HICs and India[2], Brazil[3] and Kenya,[4] showing an increase in VAWG, particularly IPV (Fraser, 2020). This emerging evidence suggests that the COVID-19 outbreak and the stay-at-home orders issued by Governments around the world may inadvertently trigger a "shadow pandemic"[5] of violence against women and girls.

4.1.1 Immediate threats and risks

- **Before the COVID-19 crisis, data on violence against women shows that one in three women will experience physical or sexual violence in the course of their lifetime**, and intimate partner violence (IPV) is the most common form (World Health Organization, 2020; Murray, 2020).

[2] https://qz.com/india/1838351/indias-coronavirus-lockdown-leads-to-more-violence-against-women/
[3] https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence
[4] https://www.hrw.org/news/2020/04/08/tackling-kenyas-domestic-violence-amid-covid-19-crisis
[5] https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic

- **The COVID-19 crisis is likely to exacerbate the known drivers of IPV, including increasing poverty, food insecurity, household level tension and exacerbating mental health issues** (Gibbs et al., 2020; Gibbs et al., 2017; Meaney-Davis et al., 2020).

- **Sexual exploitation, harassment and abuse (SEAH) is likely to increase,** perpetrated by security & justice actors who are deployed to enforce lockdowns and by humanitarian actors (Spearing & Clugston, 2020).

- **Lockdown, quarantine and social distancing measures may make it more challenging for women to access support services.** Women at risk of IPV find themselves trapped and cut off from people, networks and organisations that might otherwise be able to spot signs of abuse and support them.

- **There are reports of frontline women healthcare workers being subject to verbal and physical abuse** (Fraser, 2020). Women represent 70% of workers in the paid health and social care sectors. The fear and anxiety caused by COVID-19 pandemic can expose healthcare and social care workers, the majority of which are women, to violence perpetrated by patients and or/their relatives.[6]

- **There are also fears that school closures and economic pressures might result in increased sexual abuse and exploitation, child/early and forced marriage and early pregnancy in low-income countries**, including as negative coping mechanisms, as witnessed in the recent Ebola outbreak in West Africa (Plan International, 2014; UNICEF, 2020).

- **The COVID-19 crisis may hinder the delivery of critical, life-saving support to women and girls affected by IPV (Yaker, 2020).** Women who disclose IPV require compassionate care and a coordinated response from service providers, including clinical care and accommodation/ housing. The surge in COVID-19 infections and lockdown measures may hinder the ability of service providers to handle disclosures face-to-face and coordinate and facilitate referrals to different service providers.

- **Women with disabilities are at greater risk of experiencing intimate partner violence than non-disabled women and also face a range of barriers accessing GBV services during the COVID-19 pandemic (Pearce, 2020).** Women with disabilities may be less likely to leave their homes due to inaccessible infrastructure and lack of support.

- **The reliance by some service providers on the use of phone, internet and email services to provide support to women at risk can alienate women and girls in low-income countries who do not have access to a mobile phone or the internet (UN Women, 2020).** While mobile phone ownership has increased globally, women and girls are still less likely to own a phone than men and boys, and even less likely own a phone which facilitates access to the internet (Plan International, 2020).

[6] Though not yet evidenced, there is a risk that stigma attached to contracting COVID may be a trigger for VAWG as seen in the HIV/AIDS pandemic (e.g. blaming women for infections, or abandoning women and girls who are ill). See Colombini et al., 2016: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4819069/

5 Impacts on LGBTQI+ groups

Gender disaggregated COVID-19 data and analysis is commonly based on a binary understanding of gender. There is limited evidence that considers the impact on lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people. Despite this blind spot, there are increasingly reports from LGBTIQ and human rights organisations shedding light on how COVID-19 is affecting sexual and gender minorities. The evidence is so far mainly based on news and local organisations and activists reports.

5.1.1 Immediate threats and risks

- **Impact on health and access to health services:** LGBTIQ people face negative attitudes, are often denied care and treatment, and fear being reported to authorities in countries that criminalise sexual and gender minorities (Social Development Direct, 2017a). These challenges threaten to block LGBTIQ access to COVID-19-related healthcare, and puts LGBTIQ people at risk of serious illness or death from COVID-19 (Human Rights Watch, 2020).

- **Globally, LGBTIQ people are at high risk of experiencing mental health issues as well as substance dependency** (Social Development Direct, 2017a). The LBTI Caucus warns that circumstances such as social isolation and risk of family harassment and abuse during the COVID-19 crisis, risk exacerbating mental health issues and substance use among LGBTIQ people (LBTI Caucus, 2020).

- **Exclusion from crisis response and services:** Previous crisis response have showed that LGBTIQ people are often excluded (Knight, 2016). For example, *Sanggar Swara*, a transwomen's organisation in Indonesia, warns that trans people will not be able to access food and sanitation assistance from local governments as most of them lack ID cards that match their gender identity (ASEAN SOGIE Caucus, 2020).

- **Increase in violence, harassment and abuse**: LGBTIQ organisations across the world warn that lockdown measures put LGBTIQ people at a high risk of violence and abuse (Barkawi, 2020). LGBTIQ organisations in the Middle East warn that lockdown measures are having adverse effects. The closure of face-to-face support services have led to an increased demand for online and phone-based services to support LGBTIQ people who are isolating with abusive families (Barkawi, 2020). Lockdown measures risk exacerbating safety risks trans people face in public. In Panama, the government has imposed a quarantine schedule that allows men and women to leave home on different days. Human Rights Watch reports that a transwoman was detained and forced to pay a fine for being out on "women's day" (González Cabrera, 2020).

- **Temporary restrictions being used to target LGBTIQ people:** In Uganda, 23 people living in a shelter for homeless LGBTIQ people were arrested in late March, accused of disobeying social distancing rules (Goshal, 2020). In the Philippines, three LGBTIQ individuals were stopped and forced by a village official to kiss and dance while being broadcasted on social media (Thoreson, 2020).

- **Impact on livelihoods:** Globally, homophobia, biphobia and transphobia prevent or limit LGBTIQ people's access to employment (Social Development Direct, 2017b). The current economic crisis risk pushing LGBTIQ people into unemployment, poverty

and homelessness. An assessment of the economic impact of the crisis on 1000 people living with HIV in Indonesia, many of them trans people, found that over 50% experience severe impact on their livelihoods (USAIDS, 2020).

5 Impacts on women and girls in conflict

To date there is limited publicly available data on the impact of COVID-19 on women in conflict zones, but the pandemic is anticipated to hit conflict-affected states significantly. Emerging testimonies and evidence from previous pandemics suggests a number of possible impacts, worsening the already disproportionate impacts of conflict on women and girls.

5.1.2 Immediate threats and risks

- **Pre-existing barriers preventing women from accessing health services, especially sexual and reproductive health services, during armed conflict are likely to be exacerbated** (Center for Reproductive Rights, 2017). Across conflict zones, health facilities have collapsed due to severe lack of funding, breakdown in supply chains, increase in demand, and direct armed attacks against health facilities and workers (WHO, 2015). Where facilities remain open, security risks, lack of transportation, and social norms restricting women's movement prevent women from accessing services (Percival et al., 2014). Over half of all maternal deaths globally occur in areas of armed conflict (World Economic Forum, n.d.). COVID-19 heightens the risk that resources needed to run essential health services for women will be redirected.

- **Limited access to personal technology devices, illiteracy and unreliable media may prevent women from accessing accurate information about methods of prevention and response to COVID-19.** Following the collapse of health services, women are often tasked with caring for sick relatives. Limited access to accurate health information leaves them vulnerable and reduces their effectiveness. Inaccurate information about how to prevent and treat COVID-19 is already pervasive in Somalia (FESOJ, 2019), including claims from religious extremists that COVID-19 is spread by the West (BBC News, 2020). While technology can offer creative solutions to information management, decision-making and engagement, it risks excluding underrepresented groups with limited access to technology (GAPS, 2020).

- **Increasing already high rates of VAWG in conflict.** IPV increases by 35% during armed conflict and health crises also prompt increases (Hanmer and Klugman, 2016). The cholera response in Syria and Yemen caused both an increase in IPV and other forms of VAWG, including child marriage (Potts, 2020). The impacts of COVID-19, coupled with conflict-related stresses, constraints and trauma, raise fears of heightened IPV prevalence with few mechanisms for survivors of violence to seek help.

- **Armed conflict increases the risk of violence against women by armed groups** (Sidebotham et al., 2016). With COVID-19 being used to justify increasingly authoritarian measures to control populations (Ratcliffe, 2020), the use of sexual violence by security forces suggests an intensified sense of impunity among those

committing these crimes (Menash, 2020). Women whose role it is to collect water due to prevailing social norms in many contexts are likely to face greater risks as more water is needed and social distancing may require women to carry out this role alone (Sidebotham et al., 2016).

- **During conflict, women are often subject to movement restrictions limiting their human rights – this is likely to increase.** For example, in areas of Yemen held by extremist groups, the practice of Mahram prohibits women from moving in public unless accompanied by a male relative (Oxfam, 2016). Female activists are also at increased risk of attack for engaging in activities deemed 'inappropriate' for women (Heinze and Stevens, 2018).

6 Impacts on women's unpaid care work

Women face a triple disadvantage in the COVID-19 crisis, firstly they are likely to be response for unpaid care work in the household due to pervasive social norms, including prevention and response to COVID-19 and so are more likely to be exposed to the virus, whilst suffering negative impacts on their livelihoods, emotional and physical health (United Nations, 2020; CARE, 2020b). Even before the pandemic, globally women did three times as much unpaid care as men. Now, women with children are having to juggle additional childcare and home-schooling on top of work. Even women without children may find they have increasing caring responsibilities for other family members, such as elders (UN Women, 2020). Evidence from the Ebola outbreak shows that women absorb the additional care burden via 'self-exploitation, (leading to direct and indirect health impacts on women as a gender), reliance on family, or outsourcing care roles to poorer women' (Harman, 2016: 525).

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