



COVID-19 Bangladesh Rapid Gender Analysis



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Acknowledgements: This Rapid Gender Analysis of the impacts of COVID-19 has been a Gender in Humanitarian Action production with particular contributions from the following GiHA member agencies: UNFPA, UNICEF, CARE, World Vision, Plan International, and the Resident Representative’s Office.

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GENDER IN HUMANITARIAN ACTION (GIHA) WORKING GROUP
May 2020

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Whilst lifesaving, the COVID-19 lockdown is disproportionately impacting women as existing gender inequalities are exacerbating gender-based disparities between women, men, girls and boys in terms of access to information, resources to cope with the pandemic, and its socio-economic impact. It is therefore essential to undertake a gendered impact analysis of COVID-19.

The Gender in Humanitarian Action (GiHA) Working Group in Bangladesh has undertaken this Rapid Gender Analysis to inform national preparedness and response. Given the social distancing measures, RGA desk review contrasts pre-COVID-19 gender information and demographic data against new gender information from a multitude of surveys and qualitative sources. It examines the immediate impact of COVID-19 on pre-existing structural social and economic vulnerabilities of women, girls and diverse gender groups, and the challenges faced by these groups in accessing information and health, education, and WASH, protection and Gender-Based Violence (GBV) services as well as support for livelihoods. **The gendered impact of COVID-19 is evident in following six broad areas:**

- Increased risks and evidence of GBV in the context of the pandemic and its responses;
- Unemployment, economic and livelihood impacts for the poor women and girls;
- Unequal access to health, education and WASH services;
- Unequal distribution of care and domestic work;
- Women and girls' voices are not being included to inform a gender-targeted response; this is particularly the case for those most left behind;
- Policy response mechanisms do not incorporate gender analytical data or gender-responsive plans.

COVID-19 has a significant implication on livelihoods of women and transgender people in Bangladesh as 91.8% of the total employment of women is in the informal sector. Domestic workers, owners and workers in MSMEs, daily labourers, street vendors, cleaners, sex workers including transgender persons, and other informal

workers have rapidly lost their means to earn an income; thousands of migrant workers including women returnee migrant workers have lost their jobs with no hope for reinstatement in the near future. Even in the formal sector, massive job losses of female workers in the Ready-Made Garment (RMG) sector are being reported, although some garment factories have started opening up; in such cases the workers including the female workers safety measures remains to be a concern.

Bangladesh's health system is dominated by women, where more than 94% of nurses are female, and more than 90% of community health workers are female. They are vulnerable to infections and risk their lives. It is assumed that this crisis and its ripple effect in society and communities will continue; this means that a large number of female health workers will need support to balance the increase in workload and family obligations, e.g. child support, safety nets, mental health support.

Women are bearing the brunt of increases in unpaid care work. In Bangladesh, pre-COVID-19, women on average performed 3.43 times more unpaid domestic care work than men (BBS Gender Statistics 2018). The closure of schools and the entire family staying at home has further exacerbated the burden of unpaid care work on women, who now must absorb the additional work of constant family care duties. Where healthcare systems are overstretched by efforts to contain the pandemic; UN Women's survey result shows that in households with elderly adults, women are spending more time on unpaid adult care work activities like providing emotional care and administrative support for adults in addition to cooking, cleaning and making repairs since the spread of COVID-19. Men, on the other hand been providing increased level of physical care giving for elderly or sick adults.

Low representation of women in leadership roles at the local level results in gender insensitive approaches to the COVID-19 response; except for the number of affected cases and mortality rates there is no further sex disaggregated data, e.g. the number of men and women in isolation, institutional and home quarantine are not provided, and information about transgender people is absent.

Thus, RGA findings call for an inclusive and gender responsive COVID-19 response as follows:

- Targeted needs-based interventions for women and girls from marginalized groups, indigenous minorities, and gender diverse communities: ensuring access to health care for the most vulnerable and ensuring protection of female health workers; providing livelihood support; protection from GBV and ensuring adequate WASH services.
- Engage women leaders, diverse women's networks and organizations in decision making processes for COVID-19 response.
- Disseminate widely COVID-19 related prevention and response messages to protect women, adolescent boys and girls and other vulnerable groups. The messages should dispel and undo harmful gender stereotypes and superstitions that negatively impact women and girls.
- Collect, produce and analyze sex, age and disability disaggregated data on the COVID-19 related socio-economic impact on women, girls and LGBTIQ+ persons.
- Consult with women and adolescents from affected communities and other vulnerable groups for planning and implementation of the COVID-19 response.
- Regularly update the RGA and actively apply the findings to accurately respond to the differentiated impact of COVID-19 on these groups.
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Photo: UN Women/Mohammad Rakibul Hasan

1

INTRODUCTION

1. INTRODUCTION

1.1. Overall Context of Gender Equality in Bangladesh Pre-COVID-19

Pre-COVID-19, Bangladesh had made significant progress on gender equality in several areas. Bangladesh has been ranked the top country among its South Asian neighbors by performing the best in narrowing the gender gap. Bangladesh closed 72.6% of its overall gender gap and obtained 50th position out of 153 countries globally, the World Economic Forum said in its report titled 'Global Gender Gap Report 2020'.¹

Gender parity in primary and secondary education had been achieved through various measures like tuition free education and stipends for girls, and maternal mortality had been reduced from 574 deaths per 100,000 live births in 1990 to 172 in 2018. Bangladesh adopted a National Women's Development Policy in 1997, and has been gradually implementing it, several laws have been passed to prevent VAW, for example the Domestic Violence Act 2010, and the government has been doing gender responsive budgeting for more than 10 years now. However, significant gender gaps and persistent discrimination and violation of women's and girls' human rights remained, and these are likely to be exacerbated due to the socioeconomic consequences of COVID-19.

Girls have higher rates of dropout and grade repetition than boys. This is attributed to child marriage, early pregnancy, school facilities including the lack of facilities for appropriate menstrual hygiene management, and the fear of sexual harassment. The high rate of child marriage results in high adolescent pregnancy rates.

Women's labour force participation is only 36.3% (2017); 91.8%² of working women are employed in the informal economy and more than half of them in lower-end agriculture. Violence against women and girls remains rampant. Law enforcement and justice agencies have limited capacity to handle violence against women cases,

and the conviction rate for violence against women and children cases is very low.

Significant discrimination in laws remain which deprive women of their rights. One of the most significant issues raised repeatedly by the CEDAW Committee is the need to repeal personal status laws that treat women and men differently in matters of marriage, divorce, inheritance and child custody and adopt a uniform family code.

Presently, there is little generalizable data on the specific and gendered impact of COVID-19 on women, girls and LGBTQ+ persons in Bangladesh. We know however, that gender inequality is exacerbated and that GBV rates increase in crises, structural inequalities related to access to services (WASH, sexual & reproductive health care, prevention relating information) are widened; this RGA seeks to uncover some of these trends in Bangladesh in relation to COVID-19. It is becoming increasingly clear that many of the measures deemed necessary to control the spread of the disease (e.g. restriction of movement, reduction in community interaction, closure of businesses and services, etc.) are not only increasing GBV-related risks and violence against women and girls, but also limiting survivors' ability to distance themselves from their abusers as well as reducing their ability to access external support. In addition, it is clear from previous epidemics that during health crises, women typically take on additional physical, psychological and time burdens as caregivers.³

1.2. About Rapid Gender Analysis

A gender analysis identifies the differences between girls, boys, women, men and persons of other genders. It explains why these differences exist and how these affect the way people, community, and institutions behave and respond in certain situations. It uncovers gendered gaps, barriers and other gender inequalities. A gender analysis is done by collecting and interpreting data and information about the specific roles, responsibilities, access barriers, needs, and opportunities of girls, boys, women, men and gender diverse people. An intersectional analysis then

1 http://www3.weforum.org/docs/WEF_GGGR_2020.pdf

2 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2f1a6e0/Gender%20Statistics%20of%20Bangladesh%202018.pdf pg70

3 IASC Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response, 2020.

examines how gender intersects with age, ethnicity, class, sexuality, disability and location, to produce different degrees of vulnerabilities.

In the COVID-19 context against the backdrop of existing and exacerbated gender inequalities, it is essential to undertake and continuously update an intersectional gender analysis in order to understand and therefore design, monitor and adapt interventions to respond to the specific and growing needs and protection risks faced in particular by women, girls and gender diverse persons.

1.3. Objectives of this Rapid Gender Analysis (RGA)

The specific objectives of this RGA are to:

- Identify immediate impacts of COVID-19 on pre-existing structural social and economic vulnerabilities of women, girls and diverse gender groups.
- Identify the challenges faced by women, girls & gender diverse persons in accessing information and health services, education, livelihoods, WASH and protection from GBV.
- Identify the various coping mechanisms and capacities of women, girls and gender diverse persons against COVID-19.
- Provide over-arching and sector-specific recommendations to address increasing gender inequalities and gendered protection risks as a part of the COVID-19 response.

1.4. Methodology

The RGA is primarily a desk review that contrasts pre-COVID-19 gender information and demographic data against new COVID-19 related data and information from government and non-government sources, gender information from a multitude of surveys, media monitoring, and qualitative information. The RGA draws on recent survey data from the UN Women regional office, NAWG, and relies on key informants from existing programs and partners and the CSOs from the Gender Monitoring Network having access to information from the grassroots rights holders.

Due to the COVID-19 lockdown and the social distancing measures at the time of conducting this RGA, it's been difficult to gather first-hand data especially from women and girls since there is a gender-gap in literacy and access to mobile phones. Most COVID-19 surveys undertaken have not been successful thus far in reaching equal or representative numbers of women and girls; a survey run by the RCCE pillar to assess the knowledge and understanding on COVID-19 only yielded a 17% response rate from women.

An important aspect of rural and urban contexts and the difference in vulnerability for women could not be reflected, e.g. risks due to challenges in over-crowded urban slums with lack of water for basic hygiene, non-hygienic water points, crowded situation at the water points etc., which is quite different from rural settings.

The RGA is guided by the 'Do No Harm' principle and seeks to ensure the safety and confidentiality of individuals and considers that partners and staff in many cases are under pressure. Given the potential risk of answering GBV-related questions for women and girls who are locked up with their perpetrators, no such interviews have been done for the purposes of this RGA.



Photo: UN Women/Mohammad Rakibul Hasan

2

EXPOSURE TO DIFFERENT VULNERABILITIES AND RISKS IN COVID19

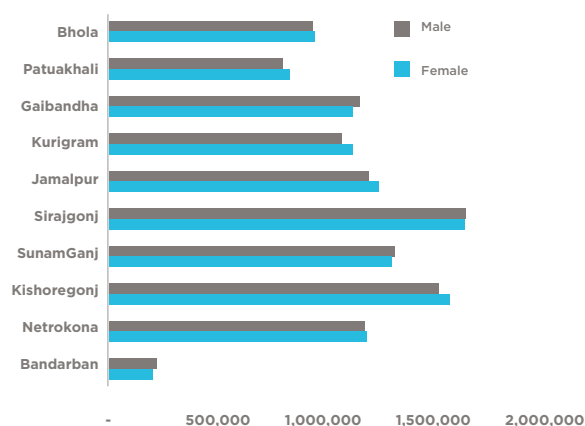
2. EXPOSURE TO DIFFERENT VULNERABILITIES AND RISKS IN COVID-19

2.1. Demographic Data

TOTAL POPULATION BY SEX, AGE

According to the Bangladesh Bureau of Statistics, the total population in Bangladesh was 162.7 million in 2018. Out of the total population, 81.3 million are women and 81.4 million are men which translates into a ratio of 100.2.⁴

FIGURE 1.
Total population by sex in each of the priority districts



The Need Assessment Working Group in the Multi Sectoral Anticipatory Impact Analysis and Needs Assessment report identified 10 top priority districts considering their risk of exposure to COVID19, demographic and social vulnerability, economic and physical capital, and historical disaster vulnerability.

4 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2f1a6e0/Gender%20Statistics%20of%20Bangladesh%202018.pdf

Total 21.95 million people (50.27% female, 49.73% male) live in these 10 prioritized districts.

SEX AND AGE OF CONFIRMED CASES

According to the IEDCR dashboard on 27 April 2020, the total number of confirmed cases for COVID19 is 10,143; out of the total cases, 32% are women and 68% are men, while of the deaths 73% are men and 27% women.⁵ At the time of compilation of this data, the total death has been 152. There is no sex-disaggregated information for number of tested, isolated or quarantined persons, or the number of people recovered. Information about transgender people is completely missing.

The table below shows that the population composition in the broad age group in Bangladesh is higher for the reproductive age group 15-49 for both women and men. The age for confirmed cases is higher for age group 21-50; with age group 21-30 counting 26% (27 April, IEDCR dashboard).⁶ It indicates that confirmed cases are skewed towards youth in Bangladesh which is quite different from European countries and USA.

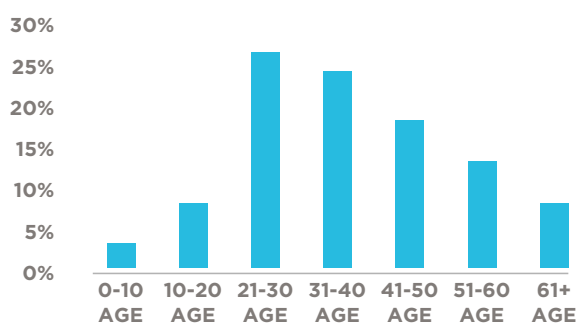
FIGURE 2.
Showing population composition

AGE	Female	Male	Total
0-14 years	29.2	29.5	29.3
15-49 years	54.8	54.1	54.4
50-59 years	8.3	8.2	8.3
60+ years	7.7	8.2	8.0
Total	100	100	100

Source: Bangladesh Sample Vital Statistics 2011-2017, BBS

5 <https://iedcr.gov.bd/>

6 <https://iedcr.gov.bd/>



Source: Bangladesh Sample Vital Statistics 2011-2017, BBS

GEOGRAPHICAL LOCATION AND CONFIRMED CASES

Dhaka and its surrounding districts (Narayanganj, Gazipur, Kishore Ganj and Narsingdi) rank the top on the list for confirmed cases.⁷ Dhaka district ranked top with 54.09% in terms of number of confirmed cases. Out of 54.09% confirmed cases in Dhaka, Dhaka City Corporation has 52.26%. These areas are mainly growth centers of formal and informal industries specifically for RMG where women constitute the majority of the workers, and it is likely that there will be direct and indirect health (higher infection rate), social, economic and psychological impacts on women and girls in these areas.

District	Total Confirmed Cases	Percentage	Total Death	Total Recover
Dhaka	2,812	54.09%	79	77
Narayanganj	699	13.44%	39	25
Gazipur	315	6.06%	-	1
Kishanganj	191	3.67%	1	-
Narsinghdi	142	2.73%	1	1
Other Districts	1,040	20.00%	32	27

Source: IEDCR Dashboard, 27 April 2020

7 <https://iedcr.gov.bd/>

2.2.

Gender & Intersectionality

WOMEN HEADED HOUSEHOLD

According to BBS data, about 14.2% of all households in Bangladesh are women headed households.⁸ Most women headed households (WHH) are in Dhaka, Chittagong, Sylhet & Rangpur division. According to the Assessment by NAWG, most people in home quarantine are in Dhaka, Chittagong, Khulna, Sylhet and Mymensingh Division. The WHHs in those areas are potentially more vulnerable to socio-economic impacts of COVID-19 if the crisis deepens and the lockdown situation prolongs. Women from these WHHs are responsible for food security, caregiving for children and elderly on top of the household chores. Given the lockdown and halt in economic and livelihood activities, the challenges of meeting the ends as well as workload at HH level for these women increases exponentially. According to the UN Women's survey WHHs spend 45% of their time in cooking compared to 35% of time spent for the same by married women. Also, the WHHs are more vulnerable to exposure to COVID-19 due to unavailability of materials to maintain hygiene (water, soap, etc.) due to lack of income. Mental health might become an issue for women in WHHs due to increased uncertainty of income, food security and access to services like health and hygiene and increased care work burden.

WOMEN & GIRLS WITH DISABILITY

Of the total population, 8.8% are persons with disabilities and among them 8% are women and girls.⁹ Protection concerns related to the multiple layers of discrimination due to gender inequality, social exclusion, stigma and social attitude can indeed hinder these women and girls' access to information, health services and response facilities. In a rapid survey of 100 persons with disabilities, Innovision found that 79% of women with disabilities had completely lost their income over the shutdown period, compared to 69% of men with disabilities.¹⁰

8 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2fia6eo/Gender%20Statistics%20of%20Bangladesh%202018.pdf

9 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2fia6eo/Gender%20Statistics%20of%20Bangladesh%202018.pdf

10 http://innovision-bd.com/covid-19/COVID-19_Digest-5_PWD.pdf

ADOLESCENT GIRLS

Adolescent girls are one of the most vulnerable groups who are prone to negative coping mechanisms such as higher family care/household chores leaving them with no time for learning and limited educational opportunities. Child marriage is likely to be on the increase as a consequence of the COVID-19 crisis induced economic instability that might only be aggravated in the coming days.

ELDERLY WOMEN

Of the total population, 8 % are older people and among them 7.7 % are women.¹¹ Among this group, age, poverty and gender intersect to negatively impact access to humanitarian information and services for many elderly women due to very limited mobility, low literacy rate and lack of access to mobile phones, and networks.

INDIGENOUS WOMEN AND GIRLS

Due to limited access to information, poor access to health services, higher rates of communicable diseases like malaria, TB, inadequate sanitation, clean water, hygiene facilities and other essential services, indigenous women and girls are at higher socio-economic vulnerability in this crisis. They are also at increasing risk of different kinds of abuse/ exploitation and trafficking now. The situation of these indigenous women, who are often the main providers of food and nutrition to their families, is even greater.

WOMEN MIGRANT WORKERS

A total of 121,940 women migrant workers currently work overseas, with the most from Dhaka (13,438) followed by Narayanganj (7,382), Gazipur (5,532) and Manikganj (5,432).¹²

Many women migrant workers who were employed in service sectors in the Middle East specifically in Saudi Arabia, Italy, Spain and other European countries have lost their jobs since COVID-19 took hold and have returned home. There are still many more stranded abroad who may be returning soon as host country governments are pressing the Government of Bangladesh to repatriate

the migrant workers¹³ Kuwait, Maldives, Bahrain, Oman and Saudi Arabia have been insisting the Bangladesh government should bring back the illegal migrant workers: 50 per cent of over 15 lakh Bangladeshi workers in Saudi Arabia lost their jobs on expiry of job permits; 60,000 workers were undocumented in the Maldives ; 20,000 Bangladeshi became undocumented in Kuwait; 72,000 in Bahrain and 51,000 in Oman.¹⁴

The Gender Monitoring Network consultation revealed that some of these women who have returned are being left out from relief support since they do not have a Voter ID card for the location that they are currently in or other identification proof.¹⁵

"I have to survive and live my life as a regular human being. I need to go back overseas again. But right now, I cannot even get out of my home because of social pressure. When I got back here, my health condition was good. Still, the neighbours are suspicious about me, they think I will spread the virus. I don't know when this will end and when will I be able to move freely."

- Julekha Begum, from Bogra District, is one of the migrant workers who returned from Saudi Arabia at the end of February and doesn't know when she can go back to work.

WOMEN READY-MADE GARMENT (RMG) WORKERS

Bangladesh's RMG sector has 4 million workers¹⁶, 65% of whom are women who have been hit hard by the COVID-19 pandemic due to initial closures of 1,904 export oriented RMG factories and an estimated 2,138,778 RMG jobs lost between 19-31 March 2020, according to the Department of Inspections for Factories and Establishments (DIFE).¹⁷ RMG factories are mostly located in the most affected areas: Dhaka, Narayanganj, Gazipur and thus women RMG

11 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2f1a6e0/Gender%20Statistics%20of%20Bangladesh%202018.pdf

12 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2f1a6e0/Gender%20Statistics%20of%20Bangladesh%202018.pdf

13 <https://thefinancialexpress.com.bd/national/three-gulf-nations-pile-pressure-on-bd-to-take-back-migrants-1586141774>, accessed on 5 May 2020

14 <https://www.newagebd.net/article/103936/5-countries-want-bangladesh-to-take-back-illegal-migrant-workers>

15 22 April, hosted by UN Women, Bangladesh

16 http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/b343a8b4_956b_45ca_872f_4cf9b2f1a6e0/Gender%20Statistics%20of%20Bangladesh%202018.pdf

17 <https://www.ilo.org/global/topics/coronavirus/country-responses/lang-en/index.htm#BD>

workers who are the majority of the workers are more vulnerable to exposure to COVID-19 as the factories are gradually reopening with OSH¹⁸ measures introduced by BGMEA; many factories have been reopened more hastily than planned, risking the health of RMG workers.

WOMEN DOMESTIC WORKERS, DAY LABORER

The domestic workers have lost jobs en masse and are experiencing extreme hardship; many have returned to their villages who are likely facing severe food shortages, especially the ones living in remote villages, since the food distribution of the government and other parties are mostly happening in urban, municipal and Upazila HQ areas and their peripheries according to the Gender Monitoring Network consultation; also some husbands are forcing women to call NGOs to receive relief and other services as they think that women will get priority in receiving relief and services from the NGOs. These women are facing challenges both at home and while stepping outside.¹⁹

“Today, I cooked only rice and vegetables for my family. I cannot manage fish or any other food.” said Rani Begum, from Mohammadpur, Dhaka, one of the millions of women in the informal economy, working as a part-time domestic worker in three households; her husband is a rickshaw puller. She relies on her wage to pay rent—BDT 6000 (USD 71) every month. Since the COVID-19 outbreak, they have no work, and many mouths to feed. (in an interview with UN Women)

TRANSGENDER WOMEN

According to NAWG’s report, approximately 3,350 Hijra community members and 8,533 floating Hijra are affected by COVID-19. An already marginalized population group who lives on the fringe due to discrimination, and earns a living on the streets in normal times is experiencing acute food shortage now.²⁰ A small rapid impact assessment survey by Innovision on the third gender community in Bangladesh, found that 82% of the 51 persons surveyed had not earned a single penny in the past two weeks, and

that 86% did not have any savings.²¹ Existing social stigma is making it much harder for them to access services, particularly health services, and relief.

FEMALE SEX WORKERS

According to the NAWG’s report, approximately 4,500 female sex workers (FSWs) are residing in 11 brothels in 8 districts. In Jamalpur, the 5th in priority ranking for COVID response as per NAWG’s Anticipatory Impact Assessment report, there are 212 sex workers in brothels in need of food assistance as they have lost their incomes. A large number of children and their elderly parents are also living with the FSWs in these brothels fully dependent on the earnings of the FSWs.

The Government has distributed some food aid to brothel-based sex workers, but it has not been nearly enough.²² In a recent consultation with the Gender Monitoring Network hosted by UN Women, it was revealed that government handouts in the brothels are often quite small (lesser quantity of food) than handouts to other people due to discrimination. It was also revealed that due to internal hierarchies in the brothels, food supplies do not always reach the women and their dependents who are lowest in the hierarchies.

The Sex Workers Network has reported that in Dhaka alone 20,000 sex workers have become jobless because there are no customers, and at least 8,000 of them have become homeless and have no place to take shelter despite the government orders to stay at home.²³ Approximately 40,000 street based/floating female sex workers across the country are also at higher risk exposure to COVID-19 as well as violence. According to Gender Monitoring Network members that work closely with sex workers, there have been incidences of sex workers being subjected to physical violence by LEA personnel; they are facing harassment while attempting to go out to earn their livelihoods to feed their families, in some cases beaten by law enforcement agencies or locals.

18 Occupational safety and health measures

19 22 April, hosted by UN Women, Bangladesh

20 <https://www.dhakatribune.com/health/coronavirus/2020/04/18/coronavirus-your-transgender-neighbour-sleeps-on-an-empty-stomach>

21 Innovision (2020). Digest: Economic Impact of COVID-19 crisis on Third Gender Community in Bangladesh http://innovision-bd.com/covid-19/COVID-19_Digest-2_Third-Gender.pdf

22 <https://www.theguardian.com/global-development/2020/apr/06/bangladesh-sends-food-aid-to-sex-workers-as-industry-goes-into-lockdown>

23 <https://www.dhakatribune.com/health/coronavirus/2020/05/01/covid-19-renders-8-000-sex-workers-homeless-in-dhaka>



Photo: UN Women/Saikat Mojumder

3

Specific Gender Differentiated Impact and Needs

3. SPECIFIC GENDER DIFFERENTIATED IMPACT AND NEEDS

3.1. Health Services for Women and Women Health Workers (Health Cluster)

Prevailing gender inequalities are exacerbated and are resulting in gaps in access to health services. According to a survey conducted by UN Women in April 2020²⁴, 61% of women in Bangladesh reported being unable to seek medical care when they needed it, and only 1% of women reported being covered by health insurance. The same survey reveals a concerning proportion of both women and men reporting difficulties finding medical supplies (78% and 61%, respectively). Results from the survey underline that a total of 62% of women reported that their mental and emotional health has been affected.

These findings are in line with the Anticipatory Need Assessment by NAWG, which found that 49% of women and children are unable to access health and nutrition services at the health facilities. Given that only 17% of the survey respondents were women, it is likely that the proportion is even higher. The assessment revealed that 43% of healthcare workers heard of mothers dying in their area within the last week and 25% of healthcare workers noted women are not coming into healthcare facilities.

Women and adolescent girls' access to sexual and reproductive health services are also affected by the COVID-19-induced lockdown and reallocation of health care resources. Data from the NAWG report shows that 43% of health workers reported higher risks of maternal death in the current lockdown situation given the reduced access to antenatal care (ANC) and life-saving comprehensive obstetric and newborn care (CEmONC). In a best-case scenario during the COVID-19 outbreak a 50% reduction is estimated for access to skilled birth attendants and delivery in facilities in 2020 as compared to the 2019

baseline. Pregnant women and women with gynecological issues are not in a position to go to clinics/hospitals due to lack of transportation options.

Adolescent girls' childbirth rate in Bangladesh is at 83% (MICS 2019) and is already one of the highest in South Asia. The situation will particularly have an adverse impact on sexual and reproductive health rights of adolescent girls and their ability to reach potentials. With a prevalence rate of 51.4% of women aged 20-24 married before 18 years of age, and 15.5% marrying before 15 years (MICS 2019), marriage at a young age is a persisting issue in Bangladesh. Adolescent pregnancies and childbirth have long-term negative health effects on adolescent girls and newborn children (BDHS 2014). Child brides are also more vulnerable to intimate partner violence: 43 % of married girls (15-19 years) are victims of physical or sexual violence during their lifetime (BBS 2015).

In terms of health workers, women are more exposed to COVID-19, according to MOHFW since 91% Registered BSC and Diploma nurses are women, while 94% of nurses in the country are women. In the context of COVID-19, this gendered division of labour means that women, as health workers, are disproportionately exposed to infection due to lack of adequate number of PPE; emerging media reports claim that hospitals are experiencing shortages of personal protective equipment (PPE). On 27 April 2020, the Dhaka Tribune published a report that mentioned 660 healthcare professionals have tested positive for COVID-19 since March 8, i.e. 11% of the infected people are health professionals, according to the *BMA Secretary General Ehteshamul Huq Chowdhury who said, "According to the BMA, a total of 295 doctors, 116 nurses and 249 other healthcare workers have been so far infected"*²⁵. The female health workers are sometimes required to work long hours,

24 <https://data.unwomen.org/resources/surveys-show-covid-19-has-gendered-effects-asia-and-pacific>

25 <https://www.dhakatribune.com/health/coronavirus/2020/04/27/healthcare-workers-account-for-11-of-covid-19-cases-bma>

often unpaid without sick leave/isolation leave, work entitlements, in under-resourced conditions.

3.2. Gender Based Violence in this Health Emergency (GBV Cluster)

Global data shows pandemic/disease outbreaks increase incidences of gender-based violence – particularly exposing girls and women to domestic violence, intimate partner violence (IPV) and rape; at the same time, life-saving care and support to GBV survivors are disrupted when front-line service providers and systems, such as health (physical and mental), protection (legal and police) and social welfare, are overburdened and preoccupied with handling COVID-19 cases.

Bangladesh has a dominant and harmful patriarchal societal structure with norms and practices that place females of any age at higher risks of violence. These social norms prescribe domestic violence and intimate partner violence as exclusively private matters; as a result, the actual number of cases are never known; 25.4% of women think partner (husband) violence is justified (MICS 2019), hence the under reporting. Within that context, the current lockdown and loss of livelihood would inevitably work as a trigger of domestic violence against women and girls. The NAWG's Anticipatory assessment report reveals 49.2% of women and girls feel safety and security is an issue in the current lockdown. Both a Gender Monitoring Network consultation²⁶ and a qualitative BRAC study on COVID-19 in the slums support the assumption of increased domestic violence.²⁷

There are limited multi-sectoral and survivor-centered support services for violence-survivors, including domestic violence and IPV. The social welfare system does not keep an oversight on incidences of gender-based violence and subsequent support to survivors. The existing national multi-sectoral services are typically available only on demand – that is – support only when the survivor can reach and/or communicate to certain service points. However, in the current situation where women and girls who are forced to be in the same household as their perpetrators, they may not have access to telephones or mobiles to connect to these service points. At least 33% women and girls are currently unaware of where to seek

help for abuse and/or ill treatment by anyone including family members²⁸.

Few media reports indicate fear of COVID-19 infection acting as a trigger of abuse, the target which are often women and girls. In the month of April, 19 cases of gender-based violence have been reported in media – the majority of which were rape and physical assault. Media undoubtedly is a major source of GBV incidence reporting, however, there is a general lack of visibility of domestic violence and IPV, including availability of support services to survivors, accountability of service providers in ensuring safe and ethical services to survivors etc. COVID-19 reporting is dominating media reporting sidelining issues like GBV.

Possession of essential personal health hygiene material, including GBV awareness information enhances girls and women's confidence to protect themselves. Where women's health needs in normal circumstances are often deprioritized, these items will now be first to be left out. The recent assessment indicates the same, 51.7% of women reported insufficient availability of personal health hygiene items. Female headed households are identified as facing the greatest challenges in meeting such needs.

The vulnerability of disadvantageous and marginalized groups, e.g. transgender, female sex workers, women and adolescent girls with disabilities, women living with HIV, migrant women and homeless women are heightened under the current crisis.

In the current context, there is a surge in new and non-traditional humanitarian responders, including government and UN partners. This combined with high demand and an unequal supply of food and health supplies increases risks of sexual exploitation and abuse (SEA) accompanying aid distribution. The Gender Monitoring Network consultation revealed a case where one of the GBV victim was deprived of relief assistance because the perpetrator was engaged in relief distribution and avoided giving her the assistance.²⁹ Whilst no reports of SEA have come to the attention of the RGA task team at the time of writing, it is clear that there is a potential risk of sexual exploitation and abuse. There is a need to raise awareness of PSEA.

26 22 April, hosted by UN Women, Bangladesh

27 BRAC JPGSPH, COVID-19 RAPID MINI-RESEARCH REPORTS, IMPACT OF COVID-19, *Lived Experiences of the Urban Poor in Slums during the Shutdown*, April 2020

28 Anticipatory multi-sectoral needs assessment, April 2020

29 22 April, hosted by UN Women, Bangladesh

3.3.

Women's access to income, food security and livelihood (Food Security Cluster)

Food security remains a concern for Bangladesh, which has one of the highest rates of child stunting in the world. Due to harmful social and gender norms, women and girls often eat less and last, with 45.70% of women of reproductive age with anemia³⁰. This negative coping mechanism during the COVID-19 crisis is bound to be further exacerbated. The four dimensions of food security - food availability, access to food, food utilization and food stability - are all directly or indirectly challenged due to COVID-19.

Informal sectors, and small and medium sized enterprises are often hardest hit by such emergencies. In Bangladesh, 51.7 million people are engaged in the informal sector. In rural areas, 93.3 per cent of the women are in informal employment whereas it was 87.3 per cent in urban areas (LFS, BBS 2016-17), their earnings are at stake due to the countrywide lockdown situation. Mass job losses have already started in Bangladesh, such as amongst domestic workers, RMG workers, workers in the SMEs, daily laborers, cleaners etc. wherein women representation is significantly higher compared to men.

In RMG sector 65% of employees are women (around 3 million) who are among the hardest hit by COVID-19.³¹ One-quarter of garment workers in Bangladesh have been fired or furloughed because of declining global orders amid the coronavirus crisis³². Most of the workers did not get their salary due to shut down of industries. The meager income these workers earned was barely enough to cover their living costs, and as a result, they have little to no savings set aside to deal with the current crisis. Within these laid off female workers, there are single mothers, pregnant women, lactating mothers and they will not get any support from their factory owners. In addition, many of these women face abuse at home by their husband.

UN Women's survey shows that women are likely to see job losses or their working hours reduced (83% of those in formal and 49% of those in informal employment)³³. This

is concerning as women were already more likely to report that they earn less than their partners (35%). Job losses are also an emerging concern among informal workers. This phenomenon is affecting both women (17%) and men (25%), but despite women being less likely to report job losses, they are more likely to report reductions in earnings/wages (38%).

Innovision's rapid survey on the impact of COVID-19 found that 82% of the transgender people have no income in the last two weeks. Among the respondents 59% have not received any support yet³⁴.

There are approximately 7.2 million people with disabilities in Bangladesh (as of 2015; Population Monograph Volume 5). People with Disabilities are among the lowest income earners in Bangladesh. The incidence of extreme poverty is about 15% for the severe disability group compared to 7% for the 'no disability' group (Sen, Binayak 2017). Another study by Innovision on the impact of COVID-19 on people with disabilities found that 74% of the surveyed people with disabilities do not have any income (Data as of April 13th). If compared to men (69%), more women (79%) have completely lost their income in the shutdown period.³⁵ Significant numbers of women with disabilities are living under the poverty line. Those who are engaged in livelihood options, risk becoming jobless because of the lockdown situation. Mobility and communication difficulties make the situation worse for them. Poverty and higher household costs can make it difficult for women with disabilities to ensure their food security and access to medication and hygiene products.

About 150,000 sex workers, who mostly depend on daily income for livelihood, are one of the worst hit communities of this lockdown situation³⁶. These groups are facing food crisis situations and have no income source. They are victims of social stigma and have no access to social services.

Thousands of indigenous women engaged in informal work such as beauty parlors are also faced with loss of jobs.

30 <https://www.indexmundi.com/facts/bangladesh/prevalence-of-anemia>, Accessed on 5 May 2020

31 <https://waronwant.org/sites/default/files/Stitched%20Up.pdf>

32 <http://www.workersrights.org/wp-content/uploads/2020/03/Abandoned-Penn-State-WRC-Report-March-27-2020.pdf>

33 <https://data.unwomen.org/resources/surveys-show-covid-19-has-gendered-effects-asia-and-pacific>

34 <http://innovision-bd.com/covid-19-impact-studies/#COVID-19-Third-Gender>

35 <http://innovision-bd.com/covid-19-impact-studies/#COVID-19-PWD>

36 https://www.dhakatribune.com/health/coronavirus/2020/04/25/coronavirus-hunger-grips-sex-workers-in-bangladesh?fbclid=IwAR20buPj5h33ux9_Z_XZKSAvgp40atGorMNFgkDVakZdixV_QwsyshGqico

3.4.

Access to WASH Facilities and Services (WASH Cluster)

Women and girls in Bangladesh bear the responsibility for water collection in over 90% of households³⁷ making it impossible to comply with recommendations for staying home and maintaining social distancing in many cases. This chore is potentially putting them at risk of exposure to the virus, for example via handpump handles or while queuing in crowded areas. Groups of women that are facing heightened barriers to practicing hygiene include women and girls living in hard to reach and underserved areas like Chars (Riverine islands), coastal areas, CHT and tea gardens.

People losing income and facing food crisis may be at risk of having to de-prioritize hygiene materials like soap; the NAWG's report indicates that around 42% of people do not have access to hygiene material (soap/hand sanitizer, masks). According to the MICS 2019, 74.8% of households have basic handwashing facilities, so there is a sharp decrease in the percentage of people who now have access to hygiene facilities³⁸). The scenario is almost the same whether it is city corporation, parastatal or Upazila. Slightly more than half of the population (56%) has access to some form of hygiene materials. In some urban localities and densely populated slums even water supply is meager or absent leading to utter lack of hygiene practices. Most of the people in urban slums share toilets between 5-8 families. In Rajshahi, Sylhet, Khulna and Chittagong half of the people do not have access to hygiene materials. It is relatively better in Rangpur and Dhaka city.

Women's workload has increased manifold in collecting water, maintaining cleaning, sanitizing, and health hygiene maintenance of children and male members of the households. In slum areas, there are insufficient latrines, water and handwashing facilities, this impacts women's health and security and increases the risk of violence significantly. Women and girls in the family also take the burden of nursing sick patients in the family.

According to the Gender Monitoring Network consultation, in Sunamgonj and Shatkhira households neither have sufficient drinking water nor water for frequent hand washing and showers. Women now have to spend extra time collecting water. In urban slums also, women lack

access to clean water, and hygiene items (soap, hand-sanitizer, mask, etc.) and the small living quarters make it impossible to apply social distancing.³⁹

3.5.

Impact on Unpaid Care Work

The average number of hours spent on unpaid domestic and care work in a week disaggregated by sex in Bangladesh is 24 hours for women and 7 hours for men. Lockdown and social distancing have resulted in increased burden of unpaid care work and household chores. A survey conducted by UN Women suggests little to no shift in re-distribution of domestic work as a result of the confinement. School closures during the lockdown further exacerbate the burden of unpaid care work on women who absorb most of the additional work of caring for children. Although men are at home and sharing some responsibilities like children's education or playing with children (10% as opposed to women's 5%), women's household chores have not necessarily decreased as per the survey conducted by UN Women; the most time consuming work for women under the circumstances is cleaning (38%) since household hygiene and disinfecting everything has become a norm, and cooking (25%). Shopping for the family is men's most time-consuming task (17%). The unpaid care work is more difficult for female headed households. Single mothers (identified through our analysis as unmarried/widowed/divorced female living in households with children) are particularly sensitive to the burden of unpaid domestic work. In comparison to couples that are married or cohabitating, a significantly higher proportion of single mothers report that the most time-consuming activity is cleaning or cooking.

Data from UN Women's survey shows that domestic work is increasing for both men and women with and without children, but the burden of unpaid childcare work is increasing much more substantially for mothers or female caretakers. Women with children are more likely than men to report increases in time allocated to playing, teaching and taking physical care of their children. They are also more likely to multi-task than men, as more women report minding their children while performing other activities, such as work for pay or profit. In households with elderly adults, women are more likely than men to report increases in the time spent on most unpaid domestic and care work activities. They are substantially likely to see increases in the time spent providing emotional care and administrative support for adults, as well as cooking,

37 MICS 2019

38 https://mics-surveys-prod.s3.amazonaws.com/MICS6/South%20Asia/Bangladesh/2019/Survey%20findings/Bangladesh%202019%20MICS%20Survey%20Findings_English.pdf

39 Gender Monitoring Network Consultation hosted by UN Women on 22 April

cleaning and making repairs since the spread of COVID-19. Men, in turn, have seen more rises on provision of physical care for elderly or sick adults. The majority of the 1.5 million respondents in this survey of UN Women were from the population section with secondary and higher education level.

Discriminatory social norms are a major source of persisting gender inequalities, including within the household, where women are expected to help more. As a result of the COVID-19 lockdown, about half of the women in Bangladesh report that their partners help them more with household chores and caring for the family. However, almost two thirds of the males reported an increase of such help from their partners. Furthermore, both women and men report that daughters are helping more with the housework in comparison to sons.

3.6. Women's Access to Information

According to rapid online surveys conducted by Risk Communication and Community Engagement (RCCE) group led by DGHS and UNICEF to measure the reach of COVID-19 prevention information, there is no significant variation between women and men in terms of knowledge about the virus. Of respondents, 98.1% indicated that they know about the virus. Around 90% of the respondents are aware of how to protect themselves from the disease, are aware of the symptoms and transmission factors. Of the respondents, 77% have knowledge on what to do if he or she has symptoms or complications. Only 1.5% are unaware about COVID-19. Approximately 63% of respondents thought it likely that they would become sick with COVID-19, and identified a need for more information about treatment (60.1%), at-risk groups (50.6%), actions to be taken when they observe symptoms (49%) and how to protect themselves (45%).

Social media (90%) and TV (81%) were seen by the majority of respondents as the most effective/preferred medium of communication on coronavirus, followed by newspaper (60%) and miking (37.5%). Results from the mobile phone survey conducted by UN Women also confirmed that social media and the internet were dominating media for women to access information in Bangladesh, followed by radio, television, newspapers. However, in the RCCE feedback survey, female respondents also reported relying much more on family members (42.1%) and neighbors/friends/ relatives (34.6%) compared to male respondents (28.5% and 31.4%, respectively).

It is important to note that the total number of women respondents of the RCCE survey was low (17% and 26%), which may indicate that fewer women have access to the internet to complete online surveys compared to men, or they do not have the time to participate in such surveys compared to men. The greater reliance of women on second-hand information from neighbours and family members similarly indicates that women either have limited means or time to access information directly compared to men.

The RCCE group has developed and disseminated a significant number of communication products for general awareness raising among the general public so far in the 1st phase of the communication effort. In the 2nd and 3rd phase of messaging, more attention is being given to disseminate more gender targeted messages focusing on GBV or psychosocial support for women. More messages for marginalized groups e.g. transgender/gender diverse persons, sex workers, urban slum dwellers, garments workers etc. addressing their needs and concerns remain to be developed.

3.7. Children's Access to Education (Education Cluster)

Since March 26, all education institutions have been closed as part of the Government's efforts to contain the spread of COVID-19. As of now, schools are not expected to reopen until September. The closure of primary schools means that currently 19.5 million school aged (50.7% girl students, source BANBIES) children have no or limited continuity of education.

In Bangladesh, the government, development partners and non-government organizations have invested for decades to make education accessible for millions of poverty-stricken people and ensure maximum girls' enrollment in primary school. However, the lockdown may force students coming from daily-wage earning families to drop out due to financial problems. Girls are likely to be the first to drop out, and this may lead to increases in early marriage and other negative and gendered coping mechanisms. Plan International research shows that, in crisis settings, girls live in fear of violence and are concerned about the constant presence of armed men and about gender-based violence (GBV) within families.

When schools are closed, girls are generally given more household responsibilities as compared to boys due to pre-existing gender inequalities, and gender norms⁴⁰.

Girls from marginalized and poor communities are in the highest risk group. They may discontinue their education and the number of out of school children may increase. As the schools reopen, a lot of girls will find it difficult to balance schoolwork and increased domestic responsibilities. Many of them might shift to income-generating activities to support their family.

The home quarantine during COVID-19 and the closure of schools, learning centers, Child Friendly Spaces, and protective environments will have negative impacts on the educational attainments and increased exposure to child protection risks such as sexual exploitation, child labour, neglect and physical and emotional abuse that could negatively affect child development, especially adolescent girls.

The Bangladesh government started telecasting classes for students; but many female students will remain out of reach not just because they might not have television at their homes but also due to their engagement in household chores. Furthermore, in the face of movement restrictions, gender and sexual minority youth may be psychologically impacted by the need to remain in unsupportive home environments.

3.8. Children in need of protection and care (Child Protection Cluster)

More than 1.5 billion students^{41,42} are out school, widespread job and income loss and economic insecurity among families are likely to increase rates of child labour, sexual exploitation, teenage pregnancy, and child marriage. As the death toll from COVID-19 increases, large numbers of children will be orphaned and vulnerable to exploitation.

Further, children's reliance on online platforms for distance learning has also increased their risk of exposure to inappropriate content and online predators. Girls are

more vulnerable and exposed to these risks. Growing digitalization magnifies children's vulnerability to harm. Children are rarely able to report such egregious acts. Yet, at a time of increased need, children no longer have the same access to teachers to report incidents at home, while social work and related legal and protective services for children are being suspended or scaled down.

Conversely, children in institutions and detention, including child migrants, face a different kind of vulnerability. Their continued care is easily put in jeopardy at a time of crisis. Integration of children with the family or extended families is a challenge particularly for girls which exacerbates stigma and risk of neglect and discrimination.

The fall in income of parents, particularly female headed households, eventually have negative impacts on children's overall care and development. A Financial diary from 60 low-income households in the Hrishipara neighborhood in Gazipur District captures the collapse of daily incomes when lockdown measures are introduced. Historically, the burden of such shocks on households have disproportionately been borne by girls.

It is also impacting the efforts to end child marriage in Bangladesh. Strategies being utilized to end child marriages like adolescent girls' empowerment, community mobilization to change social norms, secondary education and employability, WASH in schools and MHM, adolescent friendly health services and nutrition are in jeopardy and disrupted. Girls are likely to be offloaded by parents through early marriage in this crisis as many of the factors/drivers of child marriage are expected to increase as social structures at the family and community level break down during such emergencies.

3.9. Women's voice, leadership and decision making in the COVID-19 response

Women's participation in the political arena globally and in Bangladesh is yet to reach parity. However, the pandemic threatens to roll back even the limited gains made, and any lost progress will clearly take years to regain. In this pandemic, countries headed by women leaders have been doing better than those headed by men. Yet just 7.2% of heads of State and 6.2% of heads of Government are women, and just 18% of the world's health ministers are women. Research has shown that women are better in handling crisis on emotional intelligence, and are more empathic, considerate and humble - qualities that are often valued higher at times of crises like this pandemic. In Bangladesh, the proportion of seats held by women in

40 UN Women Rapid Assessment Survey on the socio-economic consequences of COVID-19 on women's and men's economic empowerment, April 2020

41 UN Women Rapid Assessment Survey on the socio-economic consequences of COVID-19 on women's and men's economic empowerment (23 April 2020)

42 COVID-19's Devastating Impact on Children: Governments should Mitigate Harm, Protect Most Vulnerable; Human Rights Watch, April 9, 2020

Parliament and local bodies is 20.6% and 25%, respectively,⁴³ although, the head of the Government, the Prime Minister is a woman. Of civil service employees, 37.1% in 2017 were women, a slight increase from 36.9% in 2014, and women are being increasingly appointed to senior positions outside of the capital including as chief administrators at the district and Upazila levels. The director of IEDCR, which is at the helm of the government's efforts to tackle the health crisis is a woman too. At local levels of government, however, women's participation is significantly lower: according to 2017 figures, the proportion of women chairpersons in Union parishad and Upazila parishad in 2017 was only 0.7% and 1.4%, respectively. This implies that women's official representation and decision-making power in the COVID-19 response at the local level is much lower than that of men.

In terms of the ability of civil society women's organizations to represent women's needs and concerns to shape the government response, the Gender Monitoring Network members reported that women's rights NGOs were not being consulted by authorities on the COVID-19 response, neither at national nor at local level⁴⁴.

43 UN Bangladesh Common Country Assessment 2020

44 22 April, hosted by UN Women, Bangladesh



Photo: UN Women/Mohammad Rakibul Hasan

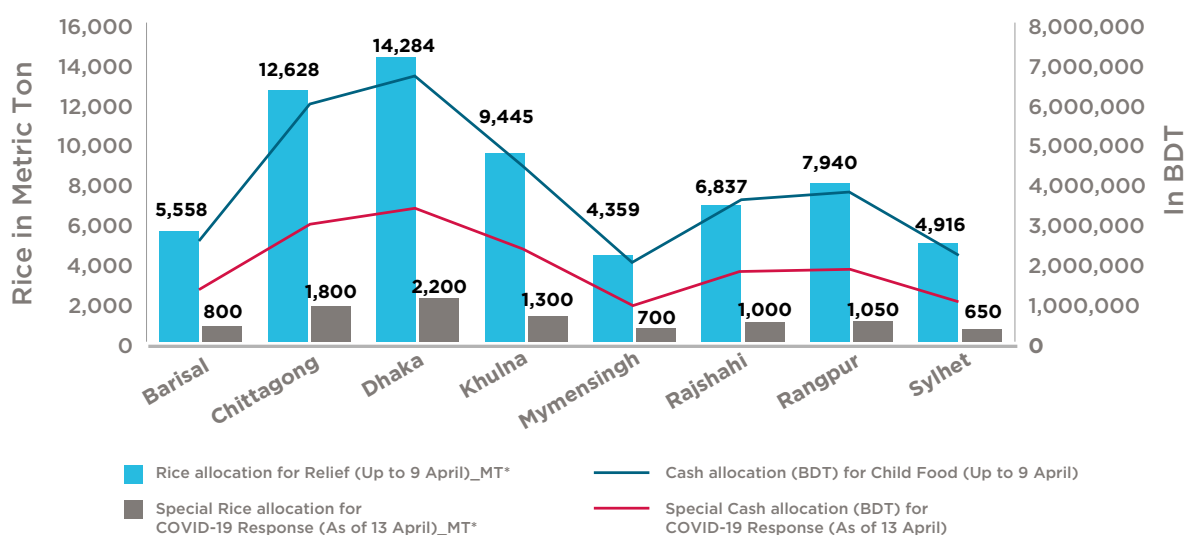
4

COVID-19 – RESPONSE ANALYSIS

4. COVID-19 – RESPONSE ANALYSIS

The Government announced a large relief, rehabilitation and stimulus package in the wake of the COVID-19 pandemic. Non-governmental organizations, the private sector, volunteer groups and individuals have come forward to support vulnerable people with food and other necessities. However, mainstream media has been reporting about irregularities and gaps in food relief and food subsidy programmes have been reported by the media.

FIGURE 3.
Government Response



Data Source: NDRCC, MoDMR

Following are problems that have been identified.

- Limited reach to remote areas:** Distribution of food relief is taking place mostly in the urban and sub-urban areas and Upazila and Union level reach is low. Limited support is reaching the peripheries e.g. char land, river erosion affected areas, hill-tracts, Haors.
- Migrants excluded from relief due to voter requirements:** Internal migrants, for example garment workers, sex workers, domestic workers who are not registered voters of the area they currently reside in are being left out from the local relief support. A Gender Monitoring Network organization reported that a domestic migrant worker living in Shyamoly slum in Dhaka reached out to the ward commissioner but was refused any relief as she was not a registered resident of the local ward.

- Exclusion of the most vulnerable:** Indigenous ethnic minorities including Vedas, Harijans, Kayaputra, dalit, rishis, munda, garo, people from tea plantation communities, Bihari, marginalized groups e.g. sex workers, LGBTIQ+ community, bede, bonojibi, cleaners and sweepers are not properly targeted and enlisted for relief support. In the relief distribution (priority) list, there is no category for women-led households to be prioritized. As a result, these women-led households and single parents are struggling with receiving relief.
- Lack of information and transparency:** Most of the people who are eligible to receive relief are not aware of the process to be enlisted for relief services. Clear messaging and information dissemination regarding relief efforts is lacking. There are reports on irregularities and corruption in relief distribution meant for the poor amid the evolving coronavirus situation.



Photo: UN Women/Fahad Kaizer

5

Recommendations and Conclusions

5. RECOMMENDATIONS AND CONCLUSIONS

5.1.

General Recommendations

- It is important to ensure that at the grassroots level, women are accessing relief services and relief packages.
- Engage diverse women leaders, women's networks and organizations, including women-led organizations of persons with disabilities, in decision making and planning processes for COVID-19 response.
- Disseminate widely COVID-19 related prevention and response messages to protect women and other vulnerable groups. The messages should dispel and undo harmful gender stereotypes and superstitions that impact negatively on women and girls, including to address stigma and discrimination against returning women migrant workers.
- Collect, produce and analyze sex, age and disability disaggregated data on the COVID-19-related socio-economic impact on women, girls and gender diverse persons. Regularly update the RGA and actively apply the findings to accurately respond to the differentiated impact of COVID-19 on these groups.
- Collect, produce and analyze sex, age and disability disaggregated data on COVID-19 spread, quarantine and isolation measures and the impact on women, girls and gender diverse persons.
- The massive relief operations undertaken by the government cannot be delivered satisfactorily unless the whole operation is effectively coordinated centrally as well as at subnational and local levels.
- Child marriage is going to be a consequence of COVID-19 so it is critical to mitigate immediate and long-term impact of COVID-19 on child marriages. A comprehensive multisectoral response will be needed beyond protection measures to prevent and respond to child marriage in terms of access to education, psychosocial support, SRHS and social protection measures.

5.2.

Cluster-Specific Recommendations

5.2.1. SHORT TERM RESPONSES (NEXT 3 MONTHS)

- **Health:**
 - » PPE, especially PPE designed for and in sizes for women, safety and security of frontline female health workers and doctors need (social protection, safety nets, mental health, child care, transport) to be ensured.
 - » With the sharp rise of violence against women during the COVID-19 crisis, treatment of victims of violence needs to be focused and resourced; online based counselling support needs to be enhanced and need to a set minimum care standard for this service.
 - » Online based counselling support needs to be enhanced and needs to set a minimum care standard for this service.
 - » Access to mental health and psycho-social support for women and children needs to be enhanced.
 - » Pregnant women's accessibility to ANC and PNC services and other SRH services needs to be ensured.
- **GBV:**
 - » Make prevention of and response to VAWG/GBV an integral part of COVID-19 response plans, particularly for the most vulnerable and marginalized groups.
 - » Health staff and facilities needs to be equipped/trained to address GBV related issues and be linked to the protection mechanisms and collect data on the treatment of GBV survivors.
 - » Strengthen multi-sectoral services for survivors through wider dissemination of information about the available services online (hotlines of MoWCA and other organizations and NGOs) on the OSCC of GOB and GBV response centers of other agencies.
 - » Strengthen quality of multi-sectoral services to survivors of GBV including quality of psychosocial and legal online/telephone support.
 - » Strengthen, and where missing, set up referral pathways for survivors of GBV and ensure that first responders are oriented on referral pathways.

- » Design targeted content and disseminate messages and IEC material for domestic violence and other forms of GBV prevention.
 - » Develop entry points for GBV prevention through cash (multipurpose cash grant), food, WASH and other social safety net interventions.
 - » Promote multi-purpose need-based dignity kits as a key GBV risk mitigation tool.
 - » Advocate for the adoption of prevention of sexual exploitation and abuse (PSEA) codes of conduct in quarantine and isolation centres.
 - » Support and resource women's organizations, particularly community-based organizations, to prevent and respond to VAW.
 - » Ensure comprehensive measures to protect girls from child marriage.
- **Child Protection:**
 - » Identify available child protection actors at community level and their level of access to target groups and ensure coordination with Health actors for sensitization of children and their caregivers on prevention against COVID-19 and for the protection and safeguarding children in quarantine (tipsheet is being prepared)
 - » Advocate for the provision of personal protective equipment (PPE) for CP staff, where visits are still possible
 - » Identify and prioritize children who are more likely to be at greater risk due to the implications of COVID-19 pandemic (IDPs, children on the move, children in conflict with the law, children in institutional care, survivors of sexual abuse and exploitation, children with disabilities, child labor, children working and/or living in the streets, etc.)
 - » Promote distance learning and continued capacity strengthening options for MHPSS and case management staff related to MHPSS and Psychological First Aid within the COVID-19 context; and strengthen capacity in MHPSS, referrals, communication with children, caregiver for Child Helplines: 1098 & 109 and strengthen the link between 1098 & 109 lines.
 - » Ensure that all child protection actors i.e. frontline workers are well trained on child protection measures; and also they have signed a Code of Conduct in line Protection from Sexual Exploitation and Abuse (PSEA) and child safeguarding.
 - » Strengthening messaging on child marriage and harmful practices to families & community leaders through platforms accessible to girls and women
- » Conduct a rapid assessment of the child marriage situation in the COVID-19 crisis, and Continue to update the assessment
- **Food Security, Income and Livelihoods:**
 - » Food relief packages should consider extra nutritional supply for the HH with PLW and children to maintain nutritional needs of those vulnerable groups.
 - » Distribute Multi-Purpose Cash Grants (MPCG) with protection as the centrality in the response, to the most vulnerable groups like FHHs, sex workers, transgender women, women returnee migrant workers, female tea garden workers, female day labourers including domestic helpers, sex workers, ethnic minority women. Ensure digital outreach such as mobile cash transfers directly to women for cash support where relevant, and ensure women are familiar with and have access to the technology.
 - » Start emergency employment creation schemes for vulnerable women through creation of temporary jobs: cash-for-work to produce goods essential to mitigate COVID-19, e.g. producing masks, PPEs, etc, taking into account safety and potential needs for provision of childcare.
- **WASH**
 - » Distribute hygiene kits for women and girls, prioritizing menstrual hygiene management and sexual and reproductive health care needs.
 - » Install hand-washing stations at workplaces, e.g. at RMG factories; inside and around the slums, tea garden and public water points where mostly women and girls gather to collect water.
 - » Ensure safe water supply in urban areas as well as some of the coastal districts where there is water scarcity to ensure that women, girls and other vulnerable groups are able to practice frequent hand washing, cleaning and other hygienic practices.
 - » Water points should be safe and accessible for the vulnerable groups.
 - » Behavior change communication to prioritize women and girls to introduce handwashing before water collection to minimize contamination through hand pump handles.
 - » Prioritize poor and vulnerable households including female headed households and households with people with disabilities when distributing soap/sanitizer and water purification tablets.
 - » Prioritize poor and vulnerable households including female headed households and households with people with disabilities when distributing soap/sanitizer and water purification tablets.

- **Unpaid Care work**

- » Create messaging through social media and mainstream media that promotes sharing of household chores and unpaid care work at home.
- » Make COVID-19 safe child-care facilities available for female essential workers such as nurses and community health workers.

- **Access to Info**

- » Target methods for distributing messaging on COVID-19 to women, girls and gender diverse groups; expand geographical coverage reach with channels accessible to marginalized groups.
- » Engage religious leaders in disseminating messages related to GBV prevention and sharing of unpaid care work and gender-equal household dynamics and reducing social stigma around women.
- » Reduce discrimination and social stigma around women and closely monitor messaging, images and approaches/ methodologies/tools to ensure they are not reinforcing gender discrimination.

- **Education:**

- » Support the education continuity plan of the Ministry of Education and Ministry of Primary and Mass Education, technically led by Access to Information(azi), ICT division.
- » Engage with teachers and parents to ensure that the Amar Ghare Amar School (my school at my home), televised every day for primary and secondary, is accessed by the majority of the school going children, especially girls.
- » Utilize multiple platforms like mobile phone, radio, internet and other TV channels to maximize the reach and make them interactive and engaging for learners, parents/caregivers and teachers.
- » Activate the ELCG/ development partners' platform to support the Government for ensuring learning continuity for all children including those with disabilities.
- » Community sensitization should continue as part of distance learning to ensure that parents, leaders and other community members are aware of the importance of girls' education.
- » Consult with girls to design and telecast, in social media and mainstream media, educational entertainment programmes for children to enhance their knowledge about prevention of COVID-19 spread.

- **Women's Voice and leadership**

- » Include women, women's organizations and networks in decision making processes of COVID-19 response across all sectors; at least 30%.

5.2.2. MID-TERM RESPONSE (SUBSEQUENT 6 MONTHS)

- **GBV**

- » Ensure quality protection services in the existing shelter homes for GBV survivors.
- » Set up/ run standard shelter homes, with appropriate public health measures in the COVID-19 context, for victims of sexual and other forms of violence including for single women who are driven out of homes through stigmatization and other human rights violations. With increased uncertainty and economic recession and job losses, domestic violence might continue to be on rise; hence the need for shelters for abused women and girls in mid-term as well.
- » Develop national protocols to run emergency shelters for GBV survivors under the COVID-19 crisis.
- » Develop / strengthen standard operating procedures on case management of GBV survivors that can be adopted nationally.
- » Support and resource women's organizations, particularly community-based organizations, to prevent and respond to VAW.
- » Advocate for continuous upholding of prevention of sexual exploitation and abuse (PSEA) codes of conduct in quarantine and isolation centres as well as gender responsive policing.
- » Build capacity through virtual trainings on GBV and COVID-19 to frontline workers from other sectors.
- » Prepare and implement child protection advocacy plan highlighting the impact of COVID-19 on children including adolescents and their families for the attention of government.
- » Advocate and support key actors to make community-based complainants and feedback mechanisms child friendly considering different needs and barriers of boys and girls of different ages and disabilities.

- **Child Protection:**

- » Analyze context and identify priority groups and their specific needs (for example: children in institutional care, children separated from caregivers due to death or isolation, children with pre-existing mental health conditions, etc.); identify resources and gaps in the existing MHPSS responses out of COVID-19.

- » Identify what role local actors such as women groups, faith-based networks, youth groups and communities can play in protecting children and families affected by COVID-19, and prevent child marriages
 - » Prepare and implement child protection advocacy plan highlighting the impact of COVID-19 on children including adolescents and their families for the attention of government.
 - » Advocate and support key actors to make community-based complainants and feedback mechanisms child friendly considering different needs and barriers of boys and girls of different age and disability
 - » Develop new ways of providing information and support to adolescent girls: broaden the use of mass media, community radio and digital media to provide adolescents and their communities with access to information and communication tool, as well as share their experiences and concerns, communicate with their peers and access sources of support
 - » Partner with youth organizations to support and build the capacities of adolescent girls and boys as educators, facilitators, and communicators
 - » Establish safe, trusted and confidential channels for girls to report child marriage
 - » Partner with local women's organizations and youth organizations/networks to provide continued services for girls at risk of child marriage
 - » Advocate for social protection to soften the impact of the pandemic and mitigate negative coping mechanisms like child marriage. Use existing social protection schemes to provide support to vulnerable adolescents and their families. Strengthen the child protection and mental health systems at the community level through social welfare services, and support to police, education and health services. Develop new ways of providing information and support to adolescents through partnership with local women's organizations and youth organizations/networks to provide continued services for girls at risk.
- **Food Security, Income, Livelihoods**
 - » Provide financial support to women owned small businesses and micro-enterprises to recover the loss incurred and restart their businesses; support government and financial institutions in setting up specific products for the purpose.
 - » Provide technical support to women SME entrepreneurs including skills development and market linkages.
- » Create skills training and apprenticeship programmes for newly unemployed women in diverse areas.
 - » Review existing social assistance and cash transfer programmes to include newly vulnerable women.
- **WASH**
 - » Ensure safe water supply in urban and coastal districts where there is water scarcity to ensure that women, girls and other vulnerable groups are able to practice frequent hand washing, cleaning and hygiene practices.
- **Education**
 - » When schools reopen, pregnant girls, married girls and young mothers should be fully supported to return to education. This might involve flexible learning, catch-up courses and accelerated learning opportunities. It may also involve checking school enrolment lists to identify and follow up with those girls who have not returned to school.
 - » Provide access to distance education through television, radio or online learning and virtual platforms keeping in mind the gender digital divide and the most marginalized with low tech solutions.
 - » Monitor school dropouts of girls and ensure their return to school.
 - » Invest in evidence building on what is happening during the crisis in order to address the drivers of child marriage during the pandemic and beyond to prevent child marriage.
 - » Strengthen the child protection and mental health systems at the community level through social welfare services, and support to police, education and health services.
- **Access to Information**
 - » Develop new ways of providing information and support to adolescent girls: Broaden the use of mass media, community radio and digital media to provide adolescents and their communities with access to information and communication tools.
 - » Create online opportunities for adolescent girls, to share their experiences and concerns, communicate with their peers and access sources of support.
 - » Partner with local women's organizations and youth organizations/networks to provide continued services for girls at risk.
 - » Establish safe, trusted and confidential channels for girls to report child marriage.

- » Partner with youth organizations to support and build the capacities of adolescent girls and boys as educators and facilitators, communicators and mentors, as well as to provide support in their communities.

5.3. Conclusion

The RGA supports the assumptions that female healthcare workers and vulnerable groups with lack of access to information and health services, ability to implement appropriate hygiene measures, and apply social distancing are disproportionately at risk of being directly affected by COVID-19. A majority among these vulnerable groups are women and children. Further, the RGA strongly supports the assumption that the far-reaching socio-economic impact of COVID-19 is indirectly affecting most of the population in varied degrees, but women, girls and gender diverse persons are disproportionately at risk and affected. Poverty, migration status, disability, age, sexuality, occupation and location all intersect with gender to create pockets of extreme vulnerability and protection risks. These factors combine to increase the risk and incidences of GBV among women; create barriers to access sexual and reproductive health care, relief support, COVID-19 information and services; and exacerbate the care burden.

This RGA has primarily relied on pre-COVID-19 national data and local secondary data sources including media reports, surveys, and qualitative accounts from a consultation with CSOs that represent rights holders at the grass-roots level. It has also relied on the vast expertise of colleagues and partners in the humanitarian community in Bangladesh, many with extensive experience of responding to the gendered dimensions of humanitarian crises as a result of floods and cyclones in the country. The RGA will be updated periodically to capture the gendered impact of COVID-19, to absorb new data and information, and to incorporate previously insufficiently explored areas. In forthcoming versions of the RGA, the task team anticipates being able to fill in the data gaps and expand the analysis in areas as new information and evidence emerges. This may include women's leadership and decision-making power in the COVID-19 response and recovery efforts; women and gender diverse persons' different capacities and coping strategies; the impact of social isolation and related stress on women's mental health and well-being; and the gendered impact of COVID-19 on boys.

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UN Bangladesh Common Country Assessment 2020

The Gender in Humanitarian Action (GiHA) working group, under the Humanitarian Coordination Task Team, is comprised of focal points of each of the ten thematic clusters, and a few gender experts from other national and international NGOs. The aim of the group is to support the realization of gender responsive programming by mainstreaming gender equality in the work of each of the thematic clusters, inter-cluster working groups and the overall joint response and preparedness efforts throughout the humanitarian action phase (emergency response preparedness, assessment, analysis, strategic planning, resource mobilization, implementation, monitoring, review and lesson learning).

The focus areas of the GiHA WG are: Coordination, Technical Advice and Guidance, Advocacy, Assessment, Analysis and Monitoring, Information Sharing and Management. It is chaired by the Director General of Department of Women Affairs of the Ministry of Women and Children Affairs and co-chaired by UN Women.



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