CARE Rapid Gender Analysis COVID-19

Pacific Region

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Cover page photo: Children washing hands, Vanuatu

Image: Mark Chew

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Acronyms

COVID-19	Novel coronavirus 2019
DPO	Disabled Persons Organisations
FDPF	Fiji Disabled Persons Federation
GBV	Gender Based Violence
LGBTQI+	lesbian, gay, bisexual, transgender and queer or Intersex
MHM	Menstrual Hygiene Management
NCDs	Non Communicable Diseases
PDF	Pacific Disability Forum
PICTs	Pacific Island Countries and Territories
PNG	Papua New Guinea
PSEA	Prevention of Sexual Exploitation and Abuse
PSHEA	Prevention of Sexual Harassment Exploitation and Abuse
RGA	Rapid Gender Analysis
SOGIESC	people of diverse Sexual Orientation Gender Identity and Expression and Sexual Characteristics
SRH	Sexual and Reproductive Health
UNDP	United Nations Development Program
UNFPA	United Nations Populations Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Executive Summary

Novel coronavirus 2019 (COVID-19) is having devastating impacts globally. As of 26th March, 414,179 confirmed cases and 18,440 deaths have been recorded across 178 countries.[1] To date, the Pacific has confirmed cases in Guam[2], French Polynesia[3], New Caledonia[4], Fiji[5], PNG[6] and suspected cases in Samoa.[7]

For the Pacific, COVID-19 presents a range of contextual challenges including multiple islands, vast distances and limited resources.[8] In most Pacific countries, access to quality health services including intensive care is limited.[9] Non-communicable diseases (NCDs) including cardiovascular diseases and chronic respiratory diseases, represent the single largest cause of premature mortality in the Pacific.[10] Food security and livelihoods are particularly vulnerable to shocks due to semi-subsistence lifestyles and a high reliance on the informal sector for income.

A COVID-19 outbreak in the Pacific could disproportionately affect women and girls in a number of ways including adverse impacts to their education, food security and nutrition, health, livelihoods, and protection. Women are the primary care givers in the family and are key health care frontline responders placing them at increased risk and exposure to infection. Maternal and sexual reproductive health needs continue in an emergency but risk being de-prioritised. COVID-19 risks increasing women's workloads, caring for children as schools close and the sick. Additionally, there is a risk of increased family violence in a region where pre-existing rates of violence against women are already very high.

Men's gender roles and norms need to be taken into account in order to ensure that men are properly targeted to help reduce their vulnerability to illness and to leverage their roles as leaders and decision makers in the home and in the community to help prevent the spread of the disease.

Key Findings

- Women as primary care givers and with high domestic responsibilities including food security, will have an increased workload
- Women are key frontline responders in the health care system placing them at increased risk and exposure to infection.
- Women's engagement in decision making and leadership is low despite domestic responsibilities and role as health care providers
- Women are well placed to deliver community risk communications due to their roles, responsibilities and networks
- Women's economic status will be affected as key sectors such as tourism are impacted and quarantine measures affect the informal sector
- Gender based violence may increase with the implementation of isolation and quarantine measures

Key recommendations

Recommendation 1: Conduct Country Specific Gender, Disability and Inclusion Analyses with contextualised response recommendations

Recommendation 2: Ensure availability of sex and age disaggregated data, including on differing rates of infection, economic impacts, care burden, and incidence of domestic violence and sexual abuse

Recommendation 3: Commence COVID-19 risk communication and awareness immediately, engaging women in the development, design and delivery of risk communication and awareness materials

Recommendation 4: Ensure response teams include men, women and people with disabilities and that essential protection policies and mechanisms are in place

Recommendation 5: Ensure meaningful engagement of women and girls in all COVID-19 decision making on preparedness and response at the national, provincial and community levels, including their networks and organizations, to ensure efforts and response are not further discriminating and excluding those most at risk

Recommendation 6: Ensure preparedness and response activities target men, women, boys, girls, people with disabilities and other marginalized groups and include specific SRH and economic recovery initiatives

Recommendation 7: Prioritize services for prevention and response to gender-based violence in communities affected by COVID-19

Introduction

Background information – COVID-19 and the Pacific

First detected in China's Hubei Province in late December 2019, novel coronavirus 2019 (COVID-19) has since spread to 178 countries or regions and was declared a global pandemic on 11th March 2020. As of 24th March, over 378,041confirmed cases and over 16,365 deaths have been recorded across 178 countries or territories.[11] Numbers are expected to continue rising exponentially in the coming days, weeks, and months. Initial research indicates that older persons are most likely to suffer serious complications from COVID-19 and that men are more likely to experience higher mortality rates than women, but this analysis may change as additional COVID-19 data becomes available.[12]

Regardless, all vulnerable populations will experience COVID-19 outbreaks differently and impacts will include issues in access to water, sanitation and hygiene (WASH), disrupted livelihoods and an increase in family violence, as well as health impacts – all of which, whilst affecting all, will significantly affect women.

Until recently, the transmission of COVID-19 to the Pacific region was limited. To date in the Pacific, thirty-two cases have been confirmed in Guam[13], twenty five in French Polynesia[14], ten in New Caledonia[15], five in Fiji[16], one PNG[17] and a suspected case in Samoa.[18] Testing facilities are minimal (with the exception of Fiji[19] and New Caledonia) so samples are sent to Australia or New Zealand.[20]

In preparedness for COVID-19, numerous countries in the Pacific region are actively putting preventative measures in place to limit potential transmission through screening and travel restrictions for incoming travellers, closing borders and schools, and publishing public advisories including health promotion and social distancing messages[21] to combat the spread of the virus.

"*Considering the challenges faced by the Pacific such as vast distances, dispersed and isolated islands and populations, and limited resources, even a small number of cases could quickly cause significant strain on health systems.*"

Dr. Corinne Capuano,

Director of Pacific technical support, World Health Organisation (WHO)

Globally, including the Pacific, development and humanitarian settings pose particular challenges for infectious disease prevention and control.[22] For the Pacific, COVID-19 presents a range of contextual challenges. These include multiple islands, vast distances and limited resources.[23] In most Pacific Countries, access to quality health services is limited, due to a lack of infrastructure, equipment, and qualified personnel.[24] Services are easily stretched or overwhelmed, and provision of specialised services and intensive care is limited. In the current situation, this can pose a problem of access to care if the number of infected people increases.[25] Coupled with gender inequality, which remains pervasive across the Pacific, in particular in the critical domains of leadership and decision making, access to and control of resources and gender based violence[26], the public health response to COVID-19 can become immeasurably more complex.[27]

COVID-19 is not the world's first public health emergency, nor the first to which development and humanitarian agencies have been called on to respond. Despite this, there is a marked lack of research on the implications of public health emergencies on different groups, especially women and girls.[28]

In responding to potential cases of COVID-19, population dynamics in the Pacific pose a challenge for disease control in the region. For example, based on the recent measles outbreak in the Pacific (especially Samoa), the movement of population, high-density settings, and communities where 20 people can live in one household helped build the infection tally.[29]

Public health messaging for COVID-19 has focussed on good hygiene practices such as washing hands. However, across the Pacific there is significant variation in WASH access with much lower access in rural areas. As a region the Pacific has the lowest water coverage and the second lowest sanitation coverage globally.[30] The availability of soap is challenging, especially in more remote communities. Additionally in the Pacific, women consistently raise significant difficulties with access to sanitation and their experience of violence whilst accessing sanitation facilities.[31]

The Rapid Gender Analysis Objectives and Methodology

This preliminary Rapid Gender Analysis has the following objectives

- To analyse and understand the different impacts that the COVID-19 potentially has on women, men, girls and boys and other vulnerable groups in the Pacific context
- To inform humanitarian programming in the Pacific region based on the different needs of women, men, boys and girls with a particular focus on Gender Based Violence (GBV), Health, Water, sanitation and Hygiene (WASH) and Women's Economic Empowerment.

Rapid Gender Analysis (RGA) provides information about the potential different impacts, needs, capacities and coping strategies of women, men, boys and girls and other vulnerable groups in the Pacific in light of the COVID-19 pandemic. Research methods for this preliminary RGA focus on secondary data review of existing gender information and the most recent COVID-19 data.

Demographic profile – Pacific region

Sex and Age Disaggregated Data

All of the 15 Pacific Island Countries (PICs) have small populations. PNG's population of 7.3 million is small on a global scale but from a Pacific perspective, PNG, Fiji (884,887), and the Solomon Islands (652,858) are large and together account for 90% of the total population of the 15 PICs. International migration is keeping overall population growth in the Pacific relatively low with an estimated 16,000 Pacific Islanders leaving their Island countries annually. [32]

Population figures by country[1]	Fiji[33]	Papua New Guinea[34]	Samoa[35]	Solomon Islands[36]	Tonga[37]	Vanuatu
Male	448,595 (51%)	3,772,864 (52%)	101,400 (52%)	331,948 (51%)	51,612 (50%)	138,265 (51%)
Female	436,292 (49%)	3,502,460 (48%)	93,600 (47%)	320,910 (49%)	51,585 (50%	134,194 (49%)
Total	**884,887**	**7,275,324**	**195,000[38]**	**652,858**	**103,195**	**272,459**

An estimated 17% of people in the Pacific have some form of disability. Less than 10% of children with disabilities in the region attend school, compared to 70% of children who do not have a disability. The rate of unemployment for persons with a disability in the region ranges from 50% to 90%. 15 Pacific Island Countries have signed or ratified the Convention on the Rights of Persons with Disabilities (CRPD).[39]

The average life expectancy in the Pacific is 72 years for women and 68 years for men[40] and female headed households vary from 6.5% (Solomon Islands[41]) to 23% (Tonga[42]).

Non-communicable diseases (NCDs) including cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases, represent the single largest cause of premature mortality in the Pacific[43] and are estimated to account for between 56% (PNG[44]) and 84% (Fiji[45]) of deaths with an average of those deaths being 45% female and 55% male. These statistics are of significance given that those at higher risk for severe illness from COVID-19 are those with these NCDs related underlying health conditions.[46] Approximately 27% (Fiji) to 40% (Tonga) of male adults smoke tobacco daily compared to 3% (Vanuatu) to 15% (PNG) of females.[47]

The prevalence of partner and non-partner violence is high in Pacific Island countries with lifetime prevalence rates for physical and sexual violence by partner and non-partner among Pacific Island women falling between 60 to 80 percent.[48]

[1] Note this sample of countries is shown here as they represent the countries where CARE International and its partners currently have projects

Findings and analysis

The findings and analysis from the secondary review indicate the following:

A COVID-19 outbreak in the Pacific could disproportionately affect women and girls in a number of ways including adverse impacts to their education, food security and nutrition, health, livelihoods, and protection. In the Pacific, women are the primary care givers in the family and are also the key frontline responders in the health care system placing them at increased risk and exposure to infection. Maternal and sexual reproductive health (SRH) needs continue in an emergency, but can be overlooked or deprioritised. COVID-19 risks increasing this already over-burdened workload for women with caring for children who are unable to attend school as schools close as well as caring for the sick (both at home and as workers within the health system). Additionally, as with all crises, there is the potential for an increase in family violence in a region where pre-existing rates of violence against women are already very high.

There are specific considerations about men's gender roles and norms which need to be taken into account in relation to the COVID19 response in order to ensure that men are properly targeted to help reduce their vulnerability to illness and to leverage their roles as leaders and decision makers in the home and in the community to help prevent the spread of the disease.

The Pacific is made up of many remote communities and families which poses logistical challenges and expense getting services and critical information to remote populations. There is a reliance on informal sector for incomes (and remittances) and subsistence or semi-subsistence lifestyles are common, making many households vulnerable to the economic shocks caused by an emergency. In parts of the Pacific, women's access to or ownership of land is limited, making them particularly vulnerable as they are reliant on others for food security income generation.

All of these factors pose significant challenges for COVID-19 preparedness and response and are outlined in further detail below.

Gender Roles and Responsibilities

Division of (domestic) labour

In the Pacific, women are the primary care givers in the family and are responsible for the bulk of domestic labour. According to UN Women, globally women carry out at least two and a half times more unpaid household and care work than men.[49]

This unequal division of labour in the household will be exacerbated as COVID-19 stretches healthcare systems, resulting in care responsibilities falling onto women and girls, who usually bear responsibility for caring for ill family members and the elderly.[50] This will be of particular significance in the Pacific where healthcare systems are limited due to the unique logistical and financial challenges in designing and delivering health care across small island populations.[51]

> "*Women are playing an indispensable role in the fight against the outbreak - as health care workers, as scientists and researchers, as social mobilisers, as community peace builders and connectors, and as caregivers. It is essential to ensure that women's voices are heard and recognised.*"
>
> Mohammad Naciri,
> Regional Director,
> UN Women Asia and the Pacific

In addition to household and caring duties, the closure of schools (already announced Fiji, Samoa, Solomon Islands and Vanuatu) will further exacerbate the burden of unpaid care work on women and girls, who absorb the additional work of caring for children.[52]

Economic empowerment

Economically and socially, the Pacific is a very vulnerable part of the world.[53] Many Pacific countries are dependent on tourism and in Palau, Vanuatu and Fiji for instance, the tourism industry represents around 40% of the GDP.[54] COVID-19 is having a huge impact as borders close and cruise ships are turned away, PNG is concerned over the looming chasm in resource-based revenues, Vanuatu is anticipating thousands of job losses in the tourism sector and Fiji, which also relies heavily on tourism, will also suffer.[55]

Women are already at a disadvantage economically, as they have less time to engage in paid labour as a result of their domestic duties[56] and the closure of schools due to COVID-19 will further limit the time they have to spend on economic activities.[57] Additionally, women's economic empowerment is curtailed by social norms which limit women's control over economic resources and decision making over financial resources in the household.[58] Therefore COVID-19 poses a serious threat to women's engagement in economic activities, especially in informal sectors, and can increase gender gaps in livelihoods.[59]

These factors are important considerations to take into account when designing response interventions. A recent Cash Feasibility Study Gender Analysis from the Solomon Islands[60] noted that marital conflict and violence against women may be exacerbated when Cash and Voucher Assistance (CVA) is introduced into the household if the gender dynamics of household decision-making are not taken into account.

Men are more likely to be employed as wage earners in the formal employment sector in the family, which means they will either continue to work and be at greater risk of exposure to the disease, or find themselves suddenly unemployed due to the economic impacts. This, combined with restrictions on social participation, may have specific impacts on men's mental health, which could increase mens violence against women and children in the family. Avenues for psychosocial support for people who lose their work should be considered.

Decision Making

Decision making within the household and community

Women's engagement in decision making and leadership is very low across the Pacific from household through to national levels. At the household and community level, women typically have limited influence in decision making about expenditure and resource use. At the community level this is partially attributed to traditional governance structures which specifically exclude women, especially women with disabilities, combined with complex social norms which fail to value women's contributions.[61]

Even in Pacific communities where women hold traditional titles and where matrilineal ownership of resources such as land exists, community decision making tends to be dominated by male traditional leaders.[62] On community decision-making bodies and consultations on disaster risk management and climate change adaptation, women are often found in small numbers making them less likely to receive critical information for preparedness and to be able influence decisions. When women are excluded from decision-making their needs and priorities become invisible, resulting in preparedness, relief and recovery approaches that do not engage women nor serve them, thereby increasing the impact of disasters[63] including COVID-19.

In many Pacific countries, the community decision makers are Chiefs who are predominantly men. As the community will abide by the decisions and rulings of the Chiefs[64], they can be a powerful force in preventing the spread of the virus and must be engaged as leaders in COVID-19 awareness and prevention, including ensuring social distancing in their communities

Participation in public decision making and decision making about humanitarian services

Despite women constituting a majority of frontline healthcare workers, placing them in prime positions to identify COVID-19 trends at the local level, they continue to form only small minorities in national and global health leadership.[65] Pacific women are largely marginalised from leadership and decision making processes governing their lives. This means fewer opportunities for women to contribute to governance processes and their specific needs are often note considered. For women with disabilities, there are even less opportunities for inclusion and participation than the rest of the population.[66]

At the level of formal and national governments, women are significantly under-represented in the Pacific.[67] Globally, women comprise 23.3% of national parliamentarians (as at January 2017), but the percentage of women in Pacific parliaments is currently around 6.9%.[68] In government, women make up only 34%[69] of senior management positions. This means Government decisions about COVID-19 preparedness and response plans and resource allocations are made almost completely exclusively of women. Additionally, National Disaster Management Offices in the Pacific are entirely headed by men, and other structures such as Provincial Disaster Committees, Clusters and other response mechanisms are heavily male dominated.

Control of and Access to Resources and Services

Food and essential items

The potential for self-isolation or quarantine in developed countries such as Australia and the US has seen panic buying of food and essential items in supermarkets. Items such as meat, rice, pasta, canned and frozen foods, medicines, menstrual hygiene products, soap, hand sanitiser and toilet paper have been stripped from the shelves. This panic buying has also been seen in Fiji, where the news of the first confirmed case prompted panic buying in supermarkets in the island's capital, Suva.[70] Stock-piling is not only beyond the reach of the poorest, it also has the potential to make them more vulnerable as poverty makes it harder to search for supplies when they run out locally, or to pay more if there is a price surge. There is also the possibility that panic buying and increased demand in countries that export food to Pacific nations could result in limited availability of food or increased prices for the region. Because of their economic vulnerability, women have reduced capacity to build up supplies against future shortages or quarantine.[71]

In the Pacific islands context, there are significantly larger populations of subsistence farmers (e.g. 87% of PNG's population live in rural areas and grow their own food[72]) and therefore scarcity of foods may not be an issue in rural areas. Urban dwellers however, who have lost their work and do not have access to gardens are more vulnerable to shortages of food and essential items and do not have financial reserves required to stockpile. Fresh foods availability in urban areas may also be affected by government directives on self-isolation and people choosing to protect themselves. In the Pacific where women are primarily responsible for ensuring food for the household[73], the increasing scarcity of goods and pressure to perform productive labour to secure food and essential items may trigger domestic violence.

Land/house ownership

Land ownership in the Pacific is primarily patrilineal and so women's access to safe shelter for self-isolation or quarantine may be affected by property ownership.[74] Women headed households are particularly vulnerable as land ownership often is granted to male family members following the death of a husband leaving women lacking in land security. There have been reports of domestic violence affecting women's access to safe space in countries experiencing lockdown in response to COVID-19 outbreaks and reports of women being abused and kicked out of houses during the lockdown in China[75] and the USA.[76]

Mobility

With the requirement to self-isolate or quarantine, women and men's access to public spaces and services will be affected. Even in Pacific countries where there are no known cases of COVID-19, governments are requesting that people stop gathering for social events such as church, weddings, or in kava bars or night clubs and closing schools until further notice.[77] Reduced access to public spaces and services will affect both women and men and children in terms of caring for children, not being able to attend work, and not able to access health services or gain social support from friends and family.[78] Living arrangements in much of the Pacific, revolve around many people and generations in one household, and traditions built on large family and community gatherings with regular exchange of goods and other services. This makes self-isolating, quarantining or lockdowns nearly impossible or very ineffective as a preparedness or mitigation measure.

Health Services

Health care systems in the Pacific face unique logistical and financial challenges in delivering health care to small and scattered populations living in remote and inaccessible areas spread over many atolls and island groups. Many island states rely on donor support for their health systems and on average a large proportion of national health budgets are dedicated to maintaining the national hospitals.

In the Pacific, gender inequality increases women's vulnerability and inhibits their access to health care services and information. Gender norms and women's low status affect women's ability to make decisions over their own lives particularly around sexual and reproductive health and family planning and limits their access to education and health care. The most common cause of death and disability in young women is pregnancy due to too many and inadequately spaced births with limited access to skilled care.[79] Maternal mortality rates vary from 30 deaths per 100,000 live births in Fiji to 215 maternal deaths in PNG.[80] With a focus on responding

to the COVID-19 pandemic, there is likely to be considerable interruption to sexual and reproductive health services for women of the Pacific. Evidence from past epidemics, such as Ebola and Zika, indicate that efforts to contain outbreaks often divert resources from routine health services including pre- and post-natal health care and contraceptives, and exacerbate often already limited access to sexual and reproductive health services.[81] There is increased risk for pregnant women in quarantine or self-isolation who may not be able to access ante-natal care or for women in general to access contraception supplies.[82]

The Pacific has high levels of obesity among adults which is a key risk factor for non-communicable diseases such as diabetes and available data show generally higher rates among women than men.[83] Diabetes is considered a risk factor for COVID-19.

Smoking has also been identified as a possible risk factor for COVID-19 with more men than women dying of the virus in China (60% men 40% women) and in China 52.9% of men smoke compared to 2.4% of women.[84] Across the Pacific, levels of smoking are generally lower than China. However, twice the number of men smoke compared to women e.g. in PNG 48.8% men smoke compared to 23.5% women, in Samoa 38% of men smoke compared to 16.7% of women and in Vanuatu 34.5% of men smoke compared to 2.8% of women.[85] Given these higher rates of smoking, men are at a higher risk of complications should they contract COVID-19.

Globally 70% of the health workforce are women. In the Western Pacific 41% of physicians are female and 59% are male whereas 81% of nurses are female and only 19% male.[86] This indicates that more women than men will be on the frontline of the response to COVID-19 in the Pacific and will therefore have an understanding of risk and solutions to the crisis. Given the low representation of women in decision-making and leadership structures, women's critical voices and knowledge are lacking when making decisions about prevention and response to COVID-19. Additionally, reports of violence against healthcare workers due to the serious stress that the pandemic places on patients, their relatives and other healthcare workers requires health services to recognise this as a risk for women health workers.[87]

Trust in and reliance on traditional medicine may complicate timely access to health systems during the pandemic due to the practice of seeking traditional or alternative medicine prior to accessing the health systems. "At the time when a Ni-Vanuatu is sick he does not go to a health facility straight away, he goes to either his traditional healer or to his pastor or his church elder".[88] In terms of COVID-19 where prevention is paramount, beliefs about traditional medicine may intensify the effect of the pandemic due to late presentation at health centres.

Some male dominated social practices in the Pacific, including drinking kava in a '*nakamal*' (a meeting place in Vanuatu where traditionally, only men are allowed to drink[89]), or the spitting of betel nut juice indiscriminately in public places, which helps transmit and spread respiratory infections.[90] These practices are hazardous in the context of a virus spread by respiratory droplets and close contact with others. Men's participation in these social settings exposes them to greater risk of contracting COVID-19 and then infecting family members. Risk communication and health promotion campaigns may need specific behaviour change communication strategies and awareness targeted at men of different ages and social groups.

Menstrual Hygiene Management (MHM)

In the Pacific, adolescent girls and women face multiple challenges to managing menstruation effectively and with dignity. In some Pacific countries, school and workplace WASH facilities are inadequate to meet menstruating girls and women's needs. Challenges include non-functioning toilets and showers, poorly maintained facilities lacking in privacy, toilet paper, safe disposal options, soap and water. Inadequate WASH facilities contribute to unhygienic practices or extended delays in changing materials.[91] With COVID-19 posing additional stresses on hygiene practice, lack of mobility due to self-isolation and quarantine as well as the reduction in income, women and girls ability to access menstrual hygiene management materials may be affected.

Many Pacific cultures maintain taboos around menstruating women touching or preparing food or that exposure to menstrual blood brings bad luck to men and boys. In a quarantine or self-isolation situation, this may exacerbate violence or the carer workload for other women in the household and could adversely affect people with a disability whose only carer is restricted by cultural norms.[92]

Another practical factor is that female health workers will need their menstruation needs met in a context of long shifts and short supply of sanitary products and has already been raised as an issue in China.[93]

People with disabilities

People with disabilities are at higher risk of contracting COVID-19 due to barriers accessing preventive information and hygiene, reliance on physical contact with the environment or support persons. Furthermore, people with disabilities may have pre-existing health (including respiratory) conditions due to their impairment, which leave them more at risk of not only contracting COVID-19, but also more at risk of developing serious illness or dying from COVID-19. Despite being part of the high-risk group, people with disabilities can inadvertently be left out of community preparedness and health messaging efforts due to inaccessible communication and other barriers.[94]

Containment measures being put in place in some countries around the world, such as social distancing and self-isolation, may be impossible for those who rely on the support of others to eat, dress and bathe, or may result in disruptions in services vital for many persons with disabilities, which may in turn undermine basic rights such as food, health care, sanitation, and communication, leading to abandonment, isolation and institutionalization. When ill with COVID-19, persons with disabilities may face additional barriers in seeking health care and also experience discrimination and negligence by health care personnel.[95]

Access to information

Women's access to information is strongly affected by gendered norms in the Pacific where men as 'household heads' will control who accesses information in their household. Men will often go to awareness sessions or go to town to receive information, with the expectation that this is shared in the family however this is not assured and messages can be incorrectly interpreted or not passed on. Women's role as care givers requires them to know, understand and pass onto others, health messages on handwashing and other prevention measures. It is important that women are directly receiving this information and in ways that suit their literacy and education levels. Technical jargon used is not understood in communities and most people prefer to face to face communication rather than through written health education materials.[96] Higher levels of men are literate than women in societies such as PNG.[97]

The primary communication systems of radio and mobile text messaging are not always available to all, particularly women, vulnerable people such as those living with disability and people living in remote communities. Globally women have 10% less access to mobile phones and the internet than men[98]. Access to mobile phones in remote and rural communities is lower for women than men. In patrilineal Western Highlands province of PNG there is a 25.7 percent point difference in phone ownership between men and women compared to matrilineal East New Britain Province with a 10.8 percent point difference in phone ownership.[99] Relative social and economic status of women in the two provinces is reflected in phone ownership rates. Phone use by women within a family often is used as a rationale for violence.

Access to WASH services

90 per cent of the total population in the Pacific have access to an improved drinking water source but this rate is significantly lower in rural areas. Access to improved sanitation is uneven in the Pacific region with Kiribati, Solomon Islands and Vanuatu hosting 81 per cent of the population without access. Unimproved sanitation facilities used in the Pacific include shared toilets, pit latrine without a slab, flush/pour to anything other than septic tank or sewer[100]. Women and girls are disproportionately affected by the lack of access to basic water, sanitation and hygiene facilities, due to their needs during periods of increased vulnerability to infection around menstruation and reproduction. Women and girls also have a larger role relative to men in water, sanitation and hygiene activities, including in agriculture and domestic labour.[101] With increased need to self-isolate and the increased need for hand washing and good hygiene practice during the response to COVID-19, women and girls may face higher security risks in collection of water and when accessing sanitation facilities.

Protection

Gender Based Violence (GBV)

The prevalence rates for violence against women in the Pacific region are some of the highest in the world with 60-80 percent of women aged 15 to 49 years experiencing some form of partner violence in their lifetime.[102] Women and girls in the Pacific are more susceptible to sexual and gender based violence, recording one of the highest rates globally in the aftermath of a disaster.[103] Studies show that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than women with no disabilities and they also experience different forms of violence from women without disabilities such as the denial of food or water, and forced sterilization and medical treatment[104]. Violence prevention work in the Pacific is highly challenging and requires significant investment in changing the attitudes and behaviours of women and men.

Experiences have demonstrated that where women are primarily responsible for procuring and cooking food for the family, increasing food insecurity as a result of the crises may place them at heightened risk of intimate partner and other forms of domestic violence due to heightened tensions in the household.[105] In response to COVID-19, domestic violence service providers have warned of a possible increase in domestic violence cases if people are forced to self-isolate at home. China has already seen domestic violence reports nearly double[106] as people were forced to stay indoors.[107] In China, 90% of the causes of violence are related to the COVID-19 epidemic believed to as a result of fear and anxiety from the extended quarantine, as well as the economic strain put on many families.[108]

Women and girls living with disability are even more at risk as their social isolation, exclusion and dependency increase the extent of abuse they are subjected to and limit the actions they can take.[109]

Additionally, some Pacific countries experience 'sorcery' related violence.[110] It is possible that symptoms or deaths caused by a novel virus such as COVID-19, when not well understood by communities, could be blamed on sorcery, which is often gendered, resulting in violence perpetrated against the accused sorcerer or woman.

In the Pacific, access to justice and support services for victims of violence vary from country to country. Without a comprehensive or integrated approach to legislative reforms, the implementation of laws and functioning of justice and police systems remains lacking.[111] In PNG for example, GBV survivors are reluctant to report and the police are generally not seen as a resource for support on GBV.[112] In 2012, MSF highlighted the critically high rates of gender based violence in PNG, similar to rates found in protracted conflict countries. Critical gaps in the treatment of survivors of domestic and sexual violence place thousands of women at serious physical and psychological risk in PNG, even without the added pressures of a disaster.[113]

Counselling services for survivors of GBV are available in all Pacific countries, though the quality and access varies because of a lack of funding and supervision as well as difficult access for remote locations.[114] However, at the time when many women and girls need GBV services more than ever, evidence suggests that those services are likely to decrease as resources are diverted to dealing with the COVID-19 health crisis.[115]

Child Protection

Previous crises in Pacific countries have found several serious child protection issues including instances of neglect, separation, abandonment, abuse, economic exploitation, illegal adoption and trafficking, physical, sexual and other forms of violence.[116]

Recent research conducted by ECPAT International on the sexual exploitation of children in the Pacific[117] found that it was more common than previously thought. Findings noted that about one-third of victims are boys and two-thirds are girls with 93% of offenders being male and 32% of 'enablers' being female. Offenders were most likely to be from the child's extended family, including grandparents, uncles/aunts, cousins, and siblings. Parents/step-parents and community members were the next most common categories of perpetrators. The research noted a strong stigma attached to being a victim of sexual exploitation, cultural taboos around discussing sex and the fear of further judgement by communities and other family members as limiting children's ability to speak out and report offending against them. COVID-19 presents a risk of exacerbating these risks to children, as schools close and they are left home, and possibly alone, if their mother is working in health care. Additional risks are posed if families are forced to self-isolate.

Sexual Exploitation and Abuse

An overall economic downturn can result in a spike in sexual exploitation and abuse, where at-risk groups (particularly woman, child heads of households and single women living in poverty, widows, adolescent girls, sex workers, LGBTQI+ populations, and disabled men and women among others), who are struggling in terms of income and employment opportunities, may be forced or coerced to provide sex in exchange for food.[118] Emerging evidence suggests that the COVID-19 pandemic has the potential to increase the risks of sexual exploitation and violence[119] as women and girls may be forced to exchange sexual services for essential goods, something which is not uncommon in the Pacific even in non-crisis times.

Safety

Public health messaging for COVID-19 has focused on good hygiene practices such as washing hands. However, across Pacific Island Countries and Territories (PICTs) there is significant variation in the coverage of drinking water and sanitation with much lower WASH coverage in rural areas and in comparison to global figures, PICTs have the lowest water coverage and the second lowest sanitation coverage.[120] Additionally, women in the Pacific, women consistently raise significant difficulties with access to sanitation and their experience of violence whilst accessing them.[121]

Capacity and Coping Mechanisms

Livelihoods and Agriculture

In the Pacific, women tend to be highly active in small-scale income generation and agriculture. In the Solomon Islands, for example, women generate income through vegetable production, weaving and sewing, and often need permission from their husbands to do so. Women are also expected to engage in market activity;[122] a 2009 study found that women make up 96% of open-air vendors catering for tourists.[123] These income-generating activities could be threatened by pandemic prevention measures, particularly social distancing, if markets are slowed or shut down and people are encouraged to self-isolate in their homes. In this case, women will also bear the responsibility of finding alternative income while maintaining their responsibilities in the home. One vulnerability study found that even as women made an effort to raise income and increase cash flow within the household, they were still not considered equal in household financial decision-making processes.

Savings

In the Pacific, access to financial services can vary. One gender analysis[124] conducted in the Solomon Islands showed that eighty-five percent (85%) of women reported saving money, with a high proportion reporting that they saved at home or via informal financial services such as savings clubs. This can be attributed largely to the significant travel time and expense required to reach a formal financial access point. Women in particular have reported a preference for services that are provided within the community because they are more convenient and accessible. Social distancing and lockdown measures could hinder women's ability to participate in their savings club, and for many, utilising a formal financial access point would be too difficult. It will be important to understand the variations in how different people access and utilise different types of informal and formal financial services as this situation unfolds.

Household capacity

A vulnerability study carried out in Vanuatu and the Solomon Islands found that traditional wealth (livestock holdings, environmental assets and social capital) acts to absorb sudden shocks and support the resilience of households.[122] In a time of social distancing measures and economic downturn, this traditional wealth could be less effective in absorbing shock. Women in Vanuatu and the Solomon Islands were found to bear a unique burden in adjusting to food, fuel and economic crises, and were more likely to report increases in food prices and increased difficulty in adjusting to these prices. This is likely to be due to women's general responsibility for procuring food for the household. Women were subsequently more likely to report reduced food consumption, concern for the health and nutrition of the family, and increased reliance on their kitchen garden in response to rising food prices.[122]

Conclusion and Recommendations

Whilst the current levels of COVID-19 infection rates are low for the Pacific, what is clear is that if more countries become exposed, there will be a public health crisis with complex contextual challenges. These include multiple islands, vast distances and limited resources[125] including access to quality health services. Based on experiences in other countries it is really important that risk communication that is gender inclusive is commenced immediately. If there is an outbreak, it will be much easier to contain if the population is already practicing good hygiene and understands the risks and the measures, such as self-isolation, that are required to stop the spread.

A COVID-19 outbreak in the Pacific could disproportionately affect women and girls in a number of ways including adverse impacts to their education, food security and nutrition, health, livelihoods, and protection. In the Pacific, women are the primary care givers in the family and are also the key frontline responders in the health care system placing them at increased risk and exposure to infection. Maternal and sexual reproductive health (SRH) needs continue in an emergency. COVID-19 risks increasing this already over-burdened workload with caring for children unable to attend school as schools close and caring for the sick (both at home and as workers within the health system). Additionally, as with all crises, there is the potential for an increase in family violence in a region where pre-existing rates of violence against women are already very high.

There are specific considerations about men's gender roles and norms which need to be taken into account in relation to the COVID19 response in order to ensure that men are properly targeted to help reduce their vulnerability to illness and to leverage their roles as leaders and decision makers in the home and in the community to help prevent the spread of the disease.

Recommendation 1: Conduct Country Specific Gender, Disability and Inclusion Analyses with contextualised response recommendations

Whilst this is a Pacific analysis, every country within the Pacific has its differences. Therefore it is important to conduct country specific analyses that take into account country specific dimensions for gender (including those for people of diverse Sexual Orientation Gender Identity and Expression and Sexual Characteristics - SOGIESC), disability, age and other marginalised populations. Analyses should look at country specific gender roles and responsibilities, access to decision making and impacts on livelihoods, WASH and health. Ideally, country specific analyses should also include collecting primary data from women, disability and LGBTQI organisations, health and violence referral services, to ensure all gender considerations are taken into account.

Response recommendations should not perpetuate harmful gender norms, discriminatory practices and inequalities and should recognize how the country specific social, culture and gender norms, roles, and relations influence vulnerability to infection, exposure, and treatment[126] for women, men, boys, girls, people with disabilities and other marginalised groups.

Response recommendations should consider how the quarantine experience can be different for women, men, boys, girls, people with disabilities and other marginalised groups, such as whether different physical, cultural, security, and sanitary needs are being met as well as recognize that the home may not be a safe place for some women, children and people with disabilities and may indeed increase exposure to intimate partner violence.[127]

Recommendation 2: Ensure availability of sex and age disaggregated data, including on differing rates of infection, differential economic impacts, differential care burden, and incidence of domestic violence and sexual abuse[128]

Given the gender dynamics of COVID-19 impacts, it is important to collect data that is disaggregated by sex, age and disability (using Washington Group Questions) and if possible also captures data on female headed households, pregnant and lactating women and people of diverse SOGIESC

COVID-19 will not only have impacts on health, and therefore data should also be collected on impacts on livelihoods, wellbeing, gender based violence and child protection. This enables the monitoring of these key societal issues which have negative impacts on certain community members.

Recommendation 3: Commence COVID-19 risk communication and awareness immediately, engaging women in the development, design and delivery of risk communication and awareness materials

We have seen from other countries that once the COVID-19 virus enters a country it rapidly spreads. Given women's role as carers (for children, the sick, the elderly and people with disabilities) and as health service providers, it is important that they are engaged and targeted with awareness measures immediately.

Women should be engaged in the design of awareness materials and imagery should depict women. Women should also be engaged in the delivery of messages. While these materials must speak to women, they are also an opportunity to promote sharing of work and mutual support in a time of crisis. Ensure imagery depicts men and women working together to share household and caring work (cooking, cleaning, caring for children) safely and hygienically to fight the spread of COVID-19.

Recommendation 4: Ensure response teams include men, women and people with disabilities and that essential protection policies and mechanisms are in place

4.1 Response teams to include men, women, people with disabilities and other marginalised groups

One way to create an environment to enable the voices and priorities of women, people with disabilities, children and other marginalised groups such as people of diverse SOGIESC, is to ensure that response teams are diverse. By ensuring a diverse response team that is represented by a cross-sector of the community, agencies will have outreach to the more vulnerable and marginalised.

Response teams should ensure everyone has equal rights to access to awareness messaging and humanitarian assistance and that no form of discrimination (i.e. giving preferential treatment to recipients based on family connections or anything else), abuse (i.e. Maltreatment of people) or sexual exploitation (i.e. giving aid in return for sexual favours) will NOT be tolerated.[129]

4.2 Ensure that essential protection policies and mechanisms are in place for the protection of community members and responders

Response agencies should also ensure child safeguarding, Prevention of Sexual Harassment Exploitation and Abuse (PSHEA) policies are in place and refreshers provided for front line responders. Community feedback mechanisms should be established or strengthened to enable reporting of any issues relating to staff or volunteer conduct.

Recommendation 5: Ensure meaningful engagement of women and girls in all COVID-19 decision making on preparedness and response at the national, provincial and community levels, including their networks and organizations, to ensure efforts and response are not further discriminating and excluding those most at risk.[130]

Response agencies should engage local women organisers, not just as recipients of the support but as leaders in the response, facilitating their collective agency. Responders should ensure equal voice for women in decision making in the response and long-term impact planning by reaching out to women's organisations, networks and women leaders in the community. Decision-makers and those coordinating response efforts should use existing gender analysis and include gender, GBV and SRH specialists at regional, national and local levels to inform decision-making processes and preparedness and response planning. Better inclusion of women frontline workers in health and other sectors (e.g. GBV) in all decision-making and policy spaces can improve health security surveillance, detection, gender GBV patterns and prevention mechanisms.[131]

Responding agencies should also provide priority support to women on the frontlines of the response, for instance, by improving access to women-friendly personal protective equipment and menstrual hygiene products for healthcare workers and caregivers, and flexible working arrangements for women with a burden of care.

Given women's front-line interaction with communities and their participation in much of the care work, they face a higher risk of exposure. With such proximity to the community, women are also well placed to positively influence the design and implementation of prevention activities and community engagement.[132]

Recommendation 6: Ensure preparedness and response activities target men, women, boys, girls, people with disabilities and other marginalized groups and include specific SRH and economic recovery initiatives

6.1 Ensure that public health messages properly target men, women, people with disabilities and the most marginalized[133]

Whilst **women** are the key care givers for children, sick, elderly and people with disabilities, and hold the bulk of domestic responsibilities, due to social and cultural norms they do not always have access to necessary preparedness information. **People with disabilities** can also inadvertently be left out of community preparedness and health messaging efforts due to inaccessible communication and other barriers.[134]

Given women's domestic and caring responsibilities, it is imperative that messaging reaches women to enable the mitigation of COVID-19 spreading. Messaging should be in a variety of formats to take into account literacy and visual or hearing disabilities. Written communication materials should be provided in plain language, easy read, Braille, high contrast, and large print formats. Community events must consider the need for provision of sign language interpreters. Any mass media campaigns using videos must use captioning and on-screen sign language interpretation.[135] Outreach should include working through Disabled Persons Organisations, health, and violence referral services due to their community networks and knowledge of vulnerable groups.

Specific activities should also be implemented targeted to **men,** focussing on risk communication and behaviour changes strategies recognising specific male dominated social practices (e.g. kava) and norms which may increase their exposure to the disease and which leverage their role in prevention

6.2 Protect essential health services for women and girls, including SRH services[136]

Sexual and reproductive health and rights is a significant public health issue that requires high attention during pandemics. Safe pregnancies and childbirth depend on functioning health systems and strict adherence to infection prevention. Provision of family planning and other SRH commodities, including menstrual health items, are central to women's health, empowerment, and sustainable development and may be impacted as supply chains undergo strains from pandemic response. Continuity of care must be ensured in case of severe facility service interruption or other disruption in access for women and girls of reproductive age. Obstacles and barriers must be addressed, enabling women's and girls' access to services, including psychosocial support services, especially those subject to violence or who may be at risk of violence in quarantine. [137]

6.3 Develop mitigation strategies that specifically target the economic impact of the outbreak on women and build women's resilience[138]

COVID-19 has the potential, if not already, to affect the ability for women to earn an income. This will affect a household's ability to purchase essential items including food and hygiene products and will also place additional stresses on the household which may lead to an increase in family violence. Therefore responding agencies need to consider economic recovery activities ensuring that any strategies have considered gender impacts. For example, any cash based programming should take into account the changing gender dynamics due to COVID-19 and increased GBV risk so as not to perpetuate these risks.

Recommendation 7: Prioritize services for prevention and response to gender-based violence in communities affected by COVID-19[139]

The Pacific region has some of the highest rates of GBV in the world. Referral services and response mechanisms will need to be resourced and strengthened to be able to respond to the increase in violence due to COVID-19. Women and girls may be at higher risk of GBV due to increased tensions in the household, particularly if isolation, quarantining and lock-down measures are put in place. As systems that protect women and girls, including community structures, may weaken or break down or become inaccessible due to COVID-19 impacts, specific measures should be implemented to protect women and girls from the risk of GBV[140] including ensuring that information is circulated on how to access services in the constrained environment. Gender based violence referral pathways must be updated to reflect changes in available care facilities, while key communities and service providers must be informed about those updated pathways.[141] Responding agencies and coordination mechanisms should also engage GBV service providers and protection services, such as the police, in development of IEC materials and other awareness. Funding should be ensured to continue existing services and ensure they are not disrupted due to re-allocation of resources to COVID-19.

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