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**LATIN AMERICA AND
THE CARRIBEAN RAPID
GENDER ANALYSIS
FOR COVID-19**



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Abbreviations

GBV	Gender-Based Violence
ECLAC	Economic Commission for Latin America and the Caribbean
ICT	Information and Communications Technology
IPV	Intimate Partner Violence
LAC	Latin America and the Caribbean
LGBTIQ+	Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Plus
PPE	Personal Protective Equipment
RGA	Rapid Gender Analysis
SRH	Sexual and Reproductive Health
UNW	UN Women ACRO
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization





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Executive Summary

As of May 18, the WHO was reporting 510,261 confirmed COVID-19 cases in Latin America and the Caribbean (LAC). LAC countries have varied in their responses to the crisis with the majority declaring some form of a state of emergency, and adopting preventive measures to limit transmission, throughout March and April 2020. Restrictions are set to continue in several LAC countries throughout May and June, while others began loosening restrictions by the beginning of May.

The LAC region has the highest levels of inequality in the world, with wide gaps in living standards across countries, regions, sectors, and socio-economic spheres. Access to quality health, education and employment services were therefore already limited for a large number of people. The region also faces continuous challenges related to high levels of social and political conflict, increasing rates of criminality and corruption, deterioration of human rights and several pressing humanitarian situations; all of these combined with persistent population flows and economic decelerations over the last few years.

COVID-19 could push 15.9 million more people in the region into extreme poverty, bringing the total number of people living in poverty to 214 million or 34% of the entire population in LAC.¹ Women, girls, and LGBTIQ+ people will be some of the most affected, especially those from at-risk and marginalized groups.

When also added to the persistent, pervasive gender inequality in the region the response to COVID-19 becomes immeasurably more complex. Although those most affected by COVID-19 are reportedly men, the elderly, and people with chronic diseases and weak immune systems, **women and girls are disproportionately impacted by both the disease and the public health measures to contain it.** Patriarchal gender norms place the burden of care work directly on women and girls' shoulders, exposing them to additional risk as they carry the load for caring in both the professional and domestic spheres. High rates of informal labour force participation, and workplace precarity, also mean that women and girls are disproportionately impacted by political, economic, and social containment measures as their sectors of work are the hardest hit. More than 1 in 4 households in the region are female-headed, representing the highest rate of female-headed households in the world. This further deepens the feminization of poverty and women's vulnerability to the health and economic impacts of COVID-19, especially as so many depend on informal and precarious work for their incomes.



Specific impacts seen so far for women, girls, and LGBTIQ+ people in LAC include, but are not limited to: decreased access to safe water, sanitation and hygiene (WASH); disrupted livelihoods and increased levels of labour exploitation and abuse; an overload of care work, negatively impacting psychosocial, physical, and emotional health; interruptions of life-saving sexual and reproductive health (SRH) services; interrupted essential education services for children; increased teenage pregnancies, household violence, and gender based violence; rising xenophobia and discrimination towards migrants and refugees; and growing food insecurity. All of which has a disproportionate impact on women, girls, and LGBTIQ+ people, especially those from marginalized groups such as Indigenous and Afro-descendant communities, rural, migrant, and refugee communities, and workers in informal or precarious employment.

Women's unpaid care work, and the unequal division of labour in households is further exacerbated when COVID-19 response measures close schools, public spaces, or care services. Women in LAC already spent almost 3 times as much time on unpaid care work compared to men prior to the pandemic. This invisible workload is what has sustained households, health systems, and the economy throughout the pandemic response and has been essential in backstopping national public health strategies throughout COVID-19. As public resources continue stretching to their limits as a result of the emergency, states' ability to continue providing care will further diminish when it is most needed; meaning women's caregiving role and hours spent will continue to grow.

COVID-19 therefore poses a serious threat to women's engagement in economic activities. Only 67% of women in LAC participate in the formal labour force compared to 93% of men, and over 126 million work in the informal sector. The majority are concentrated in the lower-earning care and service sectors. Additionally, they face more barriers in accessing telework options and/or generating incomes via work

outside of their homes. This means women and girls are more likely to lose income earning potential because of COVID-19 related work interruptions than their male counterparts. It also means they have less access to the social protection mechanisms or savings they need to see them through the pandemic. Domestic workers are particularly vulnerable as they face increased risk exposures in their employers' homes, as well as increased care loads.

Remittances are another significant source of income for many households in the LAC region, with a high number of women and men migrant workers and families living outside their home country providing financial support to families back home. Disruption of this source of income due to COVID-19 will have a disproportionate impact on women, and their families, who depend on these resources, affecting those living in poverty and extreme poverty the most.

Women in Latin America make up 74% of the health and social workforce. Many will come in contact with COVID-19 patients and/or those caring for COVID-19 patients and thus are at higher risk for contracting the virus. While women make up more than the majority of this sector, they hold few positions of leadership and decision making, with men occupying 75% of all leadership positions in the health sector. **Gender Based Violence (GBV) has increased in LAC during the COVID-19 crisis** as national lockdowns and self-isolation measures increase stress, economic hardship, and stop women and girls experiencing violence from leaving the places where they are being abused. Some countries have diverted limited resources to infection prevention, control and treatment, while others are investing in new digital technologies and platforms for service provision. This uneven response across contexts means that barriers to accessing GBV services will likely continue increasing in the context of COVID-19.

During the COVID-19 pandemic, access to **safe shelter** is important for everyone, but has critical impacts for intra-household gender equality. In informal settlements, conditions are crowded and **access to clean water** is limited, making social distancing and handwashing almost impossible. Families who do not have running water at home must travel outside the home to collect water, use shared toilets, and gather sufficient quantities of items to service household hygiene needs. Women's disproportionate unpaid care work in LAC means they are primarily responsible, thereby further increasing their exposure to the virus and other risks. **Women's overrepresentation in informal settlements exacerbates their lack of access to the hygiene supplies and measures needed to properly prevent COVID-19 infections. Lack of access to essential infrastructure in informal settlements also restricts women from participating in income-generating activities and/or aggravates existing time poverty².** Women and girls are also facing **increased difficulties accessing nutritious, safe food** in the wake of COVID-19. Women across the region are already reporting skipping meals, or depriving themselves of nutritious foods, so that they have more available for their children and families.



Women's overrepresentation in informal settlements exacerbates their lack of access to the hygiene supplies and measures needed to properly prevent COVID-19 infections. Lack of access to essential infrastructure in informal settlements also restricts women from participating in income-generating activities and/or aggravates existing time poverty. Women and girls are also facing increased difficulties accessing nutritious, safe food in the wake of COVID-19.

As the majority of informal workers, and the populations with less access to safe, dignified work services, women and girls are also being disproportionately impacted by economic slowdowns and work stoppages. Several states in the region are recognizing and building equity measures into relief packages so as to mitigate these inequalities, but more still needs to be done to ensure the rights of the most vulnerable are supported throughout the entire cycle of response to recovery. While there have been important advances in GBV, SRH and health services across the region as a result of COVID-19 adaptation measures, these advances need to be harnessed, invested in, systematized and scaled up. Rates of GBV and related protection issues will continue to increase as long as economic and isolation measures are in place. As countries begin lifting these restrictions, flare-ups will continue to be seen each time infection control measures need to be brought back in; requiring specific gender analysis to be part of infection control measures and decision-making moving forward. GBV and SRH service platforms will need to be part of essential packages, just as much as health measures, household support packages, and income supports. While reports indicate that gender relations are changing in some households in the region, with women's care role becoming more visible and men taking on marginally more care work, this still needs to be harnessed as an opportunity for change.

Key Recommendations

Organizations should continue to invest in gender and intersectional analysis, especially as government responses continue to evolve. Organizations should ensure that all new reports are shared widely, and that programming and policies be adapted to continual, changing needs as pandemic responses shift. These should be timed to governments' decisions to institute, or lift, new public health measures and related social, economic, and mobility restrictions. Continual up-to-date gender analysis of shifting gender dynamics in affected populations will allow for more effective and appropriate programming as responses to COVID-19 continue.

As governments begin to lift COVID-19 public health lockdowns and other measures, it will be essential that humanitarian actors and policy makers ensure a gender lens is included throughout the response and recovery process. Women, girls, and LGBTIQ+ people, especially those from vulnerable groups, will all experience the easing of public health restrictions differently, just as they experienced COVID-19 restrictions differently. It is essential that their voices, needs, experiences, and capacities are understood and included.

Recommendations include:

- 1. Conduct country specific gender and intersectional analyses** with contextualized response recommendations for diverse groups of women, men, boys, girls and LGBTIQ+ people; especially those who are currently underrepresented in the data.
- 2. Systematically collect sex and age disaggregated data** (at a minimum) in all areas relevant for the health, social, economic, and political areas of COVID-19 response.
- 3. Partner with diverse women and LGBTIQ+ organizations, and support their participation and leadership** as a cornerstone of effective COVID-19 response and recovery. Response agencies should engage a diversity of women's and LGBTIQ+ rights organizations and activists, including young women and LGBTIQ+ people as key decision makers and leaders in all planning and response efforts. This ensures effective, inclusive, action from assessment through to recovery.
- 4. Ensure all COVID-19 response and recovery activities provide trauma-informed, women-friendly, inclusive, work environments.** Responders should be aware of the increased barriers facing front

line service providers because of COVID-19 measures, especially women and LGBTIQ+ people, and ensure gender-sensitive policies address these barriers.

- 5. Recognize and address the unequal division of care work, and unpaid domestic labour, as an essential element of emergency public health and economic response.** Provide appropriate socio-economic supports for women and girls providing care work as a cornerstone of all humanitarian program design and all recovery policies, from the definition of “essential workers” (to include all paid and unpaid care work) to cash transfer programs and/or other sectoral humanitarian supports.
- 6. Build women’s and LGBTIQ+ people’s long term political and economic empowerment directly into immediate relief, and longer term response and recovery strategies** by: implementing targeted cash and income generating activities for women and LGBTIQ+ people (using a do no harm approach), including specific supports and programs for women and LGBTIQ+ people to re-orient their income-generating activities in the immediate and long term, ensuring equal or enhanced employment in predominantly female sectors, and addressing unequal burdens of care in both immediate response and recovery activities.

1. Introduction

Disease outbreaks affect people of different genders, differently. During these crises, under-resourced social protection and health systems are generally unable to keep up with the pace of need. This exacerbates pre-existing gender and intersectional inequalities, as it disproportionately impacts those who are already struggling to access resources – especially women, girls, and gender-diverse¹ people from at-risk or marginalized groups. Recognizing the different ways these disease outbreaks affect people of different genders and at-risk groups is fundamental to understanding the full impacts of health emergencies and to creating effective, appropriate, equitable responses.³



Since the declaration of the pandemic on March 11, 2020, a significant amount of information has been published globally on the gendered impacts of the COVID-19 crisis. Many of these documents have highlighted gendered health disparities in the disease, as well as the gender and intersectional implications of countries’ policies as they seek to decrease infection rates, contain virus spread, and manage the resulting socio-economic and political fallout. Many have also offered key policy, program, and governance recommendations for decision-makers as they continue facing this unprecedented crisis. CARE International and UN Women joined forces to complement this emerging body of literature in Latin America and the Caribbean (LAC).

This report is specifically targeted at the humanitarian actors, governments, and civil society organizations (CSOs) addressing COVID-19 and its impacts throughout LAC. It draws on the rich body of intersectional feminist work in the region to help humanitarian actors and CSOs deepen their

¹ The authors of this report recognize that gender diversity, and gender-diverse people, encompass an entire spectrum of experience, gender identity, and gender expression. This report addresses LGBTIQ+ people (within the larger spectrum of gender-diverse folks) because of the specific human rights violations and protection needs they are facing as a result of pre-existing inequalities and COVID-19.

analysis and response of the COVID-19 crisis. It focuses on many of the broad themes already identified by international humanitarian actors and CSOs as important for addressing the gendered impacts of COVID-19 in LAC, and then furthers this analysis by offering concrete, practical, recommendations for gender equality in humanitarian programming.

1.1 Background Information to the COVID-19 Crisis in LAC

The World Health Organization (WHO) classified COVID-19 as a pandemic on the 11th of March, 2020.⁴ Brazil reported the region's first confirmed case on the 26th of February, 2020 and as of May 18, 2020, the WHO was reporting 528,123 confirmed and presumptive cases, 29,591 confirmed deaths, and 216,507 people recovered across 54 countries and territories in the region.⁵ Brazil continued to be the most affected country at the time of writing, with 241,080 confirmed cases and 16,118 confirmed deaths while Panama, Peru, and Ecuador continued to have some of the highest incidence rates of COVID-19. The Dominican Republic also continued to be the most affected country in the Caribbean with 12,725 confirmed and presumptive cases and 434 deaths.⁶ The WHO continued to be concerned about the increasing trend in LAC countries. As in all regions around the globe, cases and deaths are underreported because of continued low levels of testing capacity.⁷

LAC countries have varied in their responses to the pandemic, adopting a wide range of measures to prevent and limit COVID-19 transmissions and to provide care for affected populations. Between March and April 2020, state actions ranged from declaring 'states of emergency' to exceptional measures⁸ such as: restrictions or cancellations of international and domestic air travel and ground transportation, prohibition of mass gatherings, closing borders and schools, preventive social isolation and social distancing, regulation of non-essential commercial activities, mandatory quarantines for travellers, and/or nation-wide lockdowns and curfews.⁹ Some locations – such as Peru,¹⁰ Panamá,¹¹ and some cities in Colombia¹² - also introduced gender-based movement restrictions as part of their public health measures.¹³ Restrictions are set to continue in several LAC countries throughout May and June, while others began lifting restrictions by the beginning of May. The response will continue to be uneven across the region as each country looks to balance public health with social and economic needs.

The “Crisis within the Crisis.”

The LAC region has the highest levels of inequality in the world, with wide gaps in living standards across countries, regions, sectors, and socio-economic spheres;¹⁴ and with access to quality public services already limited for a large number of people. The region also faces continuous challenges related to high levels of social and political conflict, increasing rates of criminality and corruption, several pressing humanitarian situations, and a continued challenge to human rights and mobility for a large swath of the migrants, refugees, and asylum seekers. These challenges already disproportionately impacted women, girls, and LGBTIQ + people – especially those from at-risk groups such as people living with disabilities or from marginalized, ethnic communities – but these were exacerbated by the crisis. For example, ECLAC predicts that more than 11.6 million jobs could be lost in the LAC region as a result of quarantine and physical distancing measures.¹⁵ These economic losses and decreased incomes mainly affect people living in poverty and those working in the informal sector, most of whom are people from already vulnerable groups.

Several governments in LAC took immediate steps after declaring states of emergency to both contain the virus, and to protect the labour force and household incomes; attempting to “get the balance right” between managing the threat to public health and its related socio-economic costs. Social protection and economic actions included, but were not limited to, tax deferral programs, income support schemes, cash transfer programs,¹⁶ voucher programs, and food support, among others. However, when coupled with the pervasive gender inequality in the region, persistent human rights challenges, and the pre-existing economic decelerations¹⁷ already common in LAC in 2019, these containment measures and business

slowdowns made the response to COVID-19 immeasurably more complex¹⁸ for the women, girls, and LGBTIQ+ people most at risk. This complexity will continue throughout 2020 as governments tackle the need to continue “getting the balance right” between re-opening economies and the need for continued public health measures in the absence of a vaccine.

Specific impacts seen so far for women, girls, and LGBTIQ+ people include, but are not limited to: disrupted livelihoods and increased unemployment, labour exploitation and abuse; interruptions of life-saving sexual and reproductive health (SRH) services; an overload of care work, negatively impacting psycho social, physical, and emotional health; interrupted essential education services for children; increased teenage pregnancies, domestic violence and gender based violence; rising xenophobia and discrimination towards trans people, migrants and refugees; diminished access to safe water, sanitation and hygiene (WASH); and growing food insecurity. **All of these impacts are disproportionately affecting women, girls and LGBTIQ+ people particularly from groups who were already marginalized or at-risk prior to the pandemic such as those from Indigenous, Afro-descendant, rural, homeless, migrant and/or refugee communities.** People living with disabilities, in extreme poverty, and/or working in precarious situations such as domestic workers, informal workers, and women engaged in the sex industry, have also been particularly affected.



1.2 Rapid Gender Analysis: Objectives and Methodology

Rapid Gender Analysis (RGA) for COVID-19 is a tool to provide information about the different needs, risks, capacities and coping strategies of women, men, boys, girls, and gender-diverse people during the COVID-19 crisis. **This RGA is part of the iterative RGA process for the LAC region and is intended as a programming tool for humanitarian actors. The RGA will be progressively built up over the course of the crisis** using a variety of primary and secondary information sources to understand gender roles and relationships, and how they might be changing. The RGA provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls, and gender-diverse people during the crisis; ensuring we ‘do no harm’ during our response.

Research methods for this RGA focused on secondary data review of existing gender information, and the most recent publicly available COVID-19 data for the LAC region. This was augmented by internal information from CARE International and UN Women, and a limited number of key informant interviews with humanitarian personnel from both organizations in selected LAC countries. Data collection and analysis was completed in 3 phases: Initial data was collected and analyzed between April 12-24, 2020 and then updated between April 27-30 and, once again, from May 15-20, 2020. These updates were included to better reflect new data and policies being shared by national governments and the international community as the crisis unfolded. As an iterative programming tool, research will continue at both the regional and national levels as humanitarian needs continue. The RGA will be updated appropriately whenever new findings and recommendations are produced.

2. Demographic Profile

2.1 Sex and Age Disaggregated Data

LAC is a uniquely diverse region of over 648 million people,¹⁹ spanning more than 48 countries and territories² across the North, Central, South American regions and several islands in the Caribbean. Women represent 50.8% of the total population, and men 49.2%.²⁰ There are no official statistics detailing the total number of gender-diverse people in the region.

**Table 1: Sex and Age disaggregated population statistics³
from a selection of LAC Countries⁴**

Sex and Age Disaggregated Data (% and # in thousands)														
Country	Women /Men	0-14		15-34		35-49		50-64		65+		Total Women/Men		Total Population (in thousands)
		%	#	%	#	%	#	%	#	%	#	%	#	
Argentina	W	23.4	5,416	29.6	6,852	19.5	4514	14.4	3333	13.1	3032	0.51	23147	45,196
	M	25.5	5,622	31.7	6,990	19.7	4344	13.5	2977	9.5	2095	0.49	22049	
Bolivia	W	29.7	1725	34.3	1995	17.3	1005	10.7	621	8.1	470	49.8	5815	11,673
	M	30.7	1801	35.0	2052	17.1	1002	10.2	599	6.9	404	50.2	5858	
Colombia	W	21.3	5516	32.7	8470	20.4	5284	15.7	4063	9.9	2566	50.9	25898	50,883
	M	23.1	5771	34.7	8681	19.7	4920	14.3	3568	8.2	2045	49.1	24985	
Cuba	W	15.4	877	24.7	1408	19.6	1115	23.2	1322	17.2	981	50.4	5703	11,327
	M	16.5	927	26.4	1487	20.2	1139	22.3	1252	14.6	820	49.6	5623	
Ecuador	W	26.8	2363	33.4	2943	18.9	1671	12.7	1122	8.2	720	50.0	8819	17,643
	M	28.0	2470	34.2	3017	18.7	1647	12.1	1070	7.0	620	50.0	8824	
Guatemala	W	32.1	2922	36.7	3335	16.8	1527	8.8	803	5.5	502	50.7	9088	17,916
	M	34.6	3052	38.3	3378	15.3	1353	7.3	643	4.5	401	49.3	8827	
Haiti	W	31.5	1820	35.7	2062	17.3	999	9.8	567	5.7	328	50.7	5776	11,403
	M	33.5	1883	36.1	2032	16.6	933	9.2	516	4.7	262	49.3	5626	
Honduras	W	29.9	1482	37.1	1838	17.8	881	9.7	483	5.5	271	50.0	4956	9,905
	M	31.3	1548	38.2	1892	17.3	854	8.8	434	4.5	221	50.0	4949	
Peru	W	24.4	4057	32.4	5383	20.2	3347	13.8	2286	9.2	1521	50.3	16593	32,972
	M	24.9	4085	31.3	5125	21.6	3538	13.9	2275	8.3	1356	49.7	16379	
Venezuela	W	26.3	3795	30.1	4354	19.7	2850	15.1	2185	8.8	1267	50.8	14451	28,436
	M	28.3	3957	31.0	4342	19.2	2679	14.4	2007	7.2	1000	49.2	13985	

² As officially reported in the Economic Commission for Latin America and the Caribbean (ECLAC) "Statistical Yearbook for Latin America and the Caribbean, 2019" (LC/PUB.2020/2-P).

³ All statistics in this table are drawn from the Economic Commission for Latin America and the Caribbean (ECLAC) "Statistical Yearbook for Latin America and the Caribbean, 2019" (LC/PUB.2020/2-P).

⁴ Countries highlighted in this table represent countries where CARE International and UN Women have offices and/or where a selection of key informant interviews were carried out.

2.2 Demographic Analysis

Countries in LAC span a large number of ethnicities, cultural identities and languages. While Spanish is predominantly spoken, English, French and Portuguese, are also official languages, as well as some of the more than 420 indigenous languages spoken.²¹ There are close to 45 million²² Indigenous people in the region, from more than 800 indigenous groups, and approximately 130 million Afro-descendants.²³

Life expectancy in LAC is 76.1 years,²⁴ with 79.2 years for women and 72.9 for men.²⁵ Despite improvements in health outcomes, deaths by non-communicable diseases continue to represent the largest cause of premature mortality in LAC and are estimated to account for 75% of deaths of the total population.²⁶ This is a significant issue given COVID-19 related risk factors.

As reflected in the 2019 UN Women Progress Report “Families in a changing world”, women in LAC are marrying later and having fewer children while a substantial proportion of women have opted for cohabiting partnerships. Child and early marriage and adolescent motherhood remain common. Divorce and separation rates continue to rise, and the region has the highest rate of single, female headed households in the world,²⁷ with more than 1 in 4 being female headed. This varies from less than 20% in Guatemala, Bolivia and Mexico to 35% in Brazil, Uruguay and Chile.²⁸

Access to public services, including reproductive healthcare, remains constrained, particularly for women in lower socio-economic groups and rural areas.²⁹ The total fertility rate of the region is 2,³⁰ and though the rate in adolescents (15-19) has declined over the years, it is comparatively higher than other regions and 48% higher than the world average, at 63 live births per 1,000 women (2015-2020).³¹

An estimated 12% of people in the LAC region have some form of disability, representing around 66 million people.³² In over half of the region's countries, women have a higher rate of disability than men (particularly from the age of 60).³³ Only about 20-30% of children with disabilities attend school in the region,³⁴ and among 24 to 35 year-olds, the employment rate for men with disabilities is 24% lower than for men without disabilities and for women, 12% lower.³⁵ The latter is mostly due to lower female employment rates overall in the region. At the same time, while there has been some progress on the human rights for LGBTIQ+ people, significant challenges remain including for data collection related to demographic analysis.

2.3 Sex Disaggregated Data for COVID-19

Currently accessible sex-disaggregated data in LAC shows the same gender trends as in the rest of the world, with case fatality rates continuing to be higher for men than women. Despite this, interesting age trends appear compared to the rest of the world, with several countries reporting the 20-59⁵ year old age group (male) as the most affected. Interestingly, initial data at the onset of the epidemic pointed to some cases where women were presenting higher numbers of affected than men and/or almost parity.⁶ While no clear conclusions can be drawn yet as to why these variations are being seen, it underscores the need for more countries to continue systematically tracking and analyzing sex and age disaggregated data as the pandemic continues.

⁵ With, in some cases such as Haiti's, the concentration being in the 22-45 age group.

⁶ On April 17, 2020 Brazil was reporting 52% of recorded cases were women, but with 6 higher mortality rates for men and Argentina was reporting almost parity (49.8% women and 50.2% men).⁶

Table 2: Sex and Age Disaggregated COVID-19 data⁷ for a selection of LAC Countries³⁶

Sex and Age Disaggregated Data (% and # in thousands)									
Country *	Confirmed Cases	Cases (% male)	Cases (% female)	Deaths	Deaths (% male)	Deaths (% female)	Deaths among confirmed cases (male)	Deaths in confirmed cases (female)	Deaths in confirmed cases (Male:female ratio)
Dominican Republic	10,634	54	46	393	72	28	5%	2.2%	2.2
Ecuador	20,622	56	44	2,127	69	31	12.8%	7.1%	1.8
Argentina	6,034	50	50	305	60	40	6.1%	4.0%	1.5
Mexico	36,327	58	42	3,573	69	31	11.6%	7.4%	1.6
Peru	68,822	60	40	1,961	72	28	3.4%	2.0%	1.7
Colombia	11,613	57	43	479	61	39	4.5%	3.7%	1.2
Brazil	61,888	NA	NA	3,611	59	41	NA	NA	NA
Chile	25,952	53	47	294	60	40	1.3%	1.0%	1.3
Panama	8,616	59	41	249	NA	NA	NA	NA	NA
Honduras	2,006	61	42	116	NA	NA	NA	NA	NA
Haiti	596	59.6	40.4	22					

3. Findings and Analysis

Pre-existing gender and intersectional inequalities often worsen during a crisis, including public health emergencies.³⁷ Recognizing the extent to which disease outbreaks affect people of different genders in specific ways is fundamental to planning effective and equitable responses.³⁸ This section details:

- *Pre-existing* gender inequalities, and gender issues, likely affecting men, women, boys, girls, and LGBTIQ+ people in the context of COVID-19;
- Specific gender issues and differences that have arisen *as a result* of COVID-19;
- Potential *implications* of both pre-existing, and COVID-19 related, gender inequalities for response policies

3.1 Gender Roles and Responsibilities



Division of Domestic Labour and Unpaid Care Work

Globally, women perform on average 76.2% of domestic household labour and unpaid care work – more than 3 times as much as men,³⁹ and representing a 10.8 trillion dollar contribution to the annual global economy.⁴⁰ In the LAC region, this distribution remains severely imbalanced: women spent 1.7 times more on unpaid care work than men.⁴¹ In some areas of Guatemala, women report dedicating 17.8% of their total available time to unpaid work, compared to a mere 2.4% of unpaid work for men,⁴² while in Argentina almost 90% of women report doing unpaid care work in the household versus 60% of men.⁴³ Prior to the crisis, this translated to a situation where, across the region, women were already spending a total of 22

⁷ The reporting dates in each case are: 10.05.20 (Dominican Republic, Ecuador), 11.05.20 (Peru, Mexico, Argentina, Colombia, Panama), 07.05.20 (Chile), 26.04.20 (Brazil), 13.05.20 (Honduras), 19.05.20 (Haiti)

to 42 hours a week on unpaid domestic care work compared to men.⁴⁴ For example, according to the most recent data available, women in Peru spend approximately 39.9 hours a week on unpaid care work (more than 24 hours than Peruvian men), while women in Ecuador spend 37 hours a week on these tasks (27 hours more than men), and Colombian women spend approximately 32.9 hours (almost 20 hours more than men) a week on the same.⁴⁵ These disparities vary further between, and amongst, groups. On average in the region, Afro-descendant women spend more time on unpaid work than Afro-descendant men, and women's care burden is generally larger in households living in higher levels of poverty or precarity – especially with the addition of more dependents.⁴⁶ In Mexico, 64.7% of Indigenous women aged 12 and older engage in unpaid work compared to 35.3% of Indigenous men.⁴⁷



With the COVID-19 emergency, these demands on women and girls' time in caregiving are increasing multifold, exacerbating this unequal division of labour and negatively impacting women's physical and mental health. For example, in Mexico, time use surveys already indicated women dedicate 29 hours a week to caring for sick relatives (versus 13 hours for men)⁴⁸ in households with people with temporary illnesses. While some households have reported increased care contributions by male household members as a result of the crisis, overall, this unequal division of labour is growing. Most Latin American countries allocate a reduced amount of resources on long-term care for the ill and the elderly.⁴⁹ As public resources are stretched to their limits as a result of the emergency, states' ability to continue providing care will further diminish when it is most needed.

COVID-19 response measures such as closing schools, public spaces, and care services have added to this burden. As of May 18, 2020, 23 countries and 12 independent states in the region still had closed schools nationwide taking approximately 95% of 159 million children temporarily out of school.⁵⁰ While this is a decrease from March, 2020 when significantly more schools were closed in impacted countries, this has not changed the dynamics of care for the most marginalized women and girls. With large swathes of people unable to afford or access childcare or take time off work⁵¹ in the region, these school closures continue to exacerbate women and girls' pre-existing time poverty. The lack of childcare support and rigid social norms placing childcare on women's shoulders is particularly problematic for female essential workers, and for women living in poverty or engaged in precarious work, who have care responsibilities that they are struggling to maintain alongside their paid activities.

In addition to the increased burden this places on women in the household, these measures also threaten the gains made in girls' access to education.⁵² Traditional gender roles mean girls are generally expected to take on care work in the household by caring for younger siblings. As family movements are limited, and care burdens increase, this can lead to girls being given less time to invest in their remote education than their male siblings. These measures also have compounding negative impacts on single-parent families - the majority of whom are female headed in LAC, as well as low-income families, the self-employed, the precariously employed, or those without employment health rights or benefits.

The crisis is having a further differentiated impact on gender roles and responsibilities for women and girls in marginalized and vulnerable communities such as Afro-Descendant communities, Indigenous peoples, rural populations, and refugees and migrants, among others where decreased access to basic infrastructure such as running water and technologies has already increased care giving burdens. UN

Women found that prior to COVID-19 women living in poverty in 11 LAC countries already dedicated 103 more minutes/day to unpaid care and household work than their higher socio-economic female counterparts. In Bolivia, for example, only 38% of the poorest households have running water in comparison to 99% of the wealthiest households; exacerbating the time and risks related to care work.⁵³ These additional burdens are untenable, posing additional health challenges to women's wellbeing, such as a decrease in time and resources for emotional and mental health, as well as their own physical health needs.

There are clear implications for a gendered-response to the COVID-19 crisis, and the unpaid care economy must be a fundamental aspect and priority of the COVID-19 response. "Without adequate support, the long-term costs of stretching women's work to patch up the holes in social protection and public services provision can be enormous. Therefore, immediate action is needed to guarantee continuity of care for those who need it and to recognize unpaid family and community caregivers as essential workers in this crisis."⁵⁴

Income and Paid Work

Formal Labour Force Participation. LAC is the most economically unequal region in the world, hosting the largest gap between the richest and poorest wealth quintiles.⁵⁵ In 2018, 11.4% of women aged 20-59 in LAC lived in extreme poverty compared to 9.7% of men, while 26.9% of women lived in poverty compared to 23.8% of men;⁵⁶ creating essential gender differences in patterns of inequality in the region. These are further exacerbated for women, girls and LGBTIQ+ people from marginalized and at-risk groups.

Women's participation in the formal labour force has increased in LAC more than in any other region, with 67% of women aged 25-54 participating compared to 57% two decades ago. However, women's participation continues to be significantly stratified, with women from higher quintiles displaying higher levels of participation, as well as women and men from urban areas having higher rates of participation compared to those from rural areas. Men's formal labour force participation remains high, at 93%. Married and cohabiting women represent the lowest level of formal labour force participation (60.4%), with the highest rates being amongst divorced or separated women (80.7%). Men's participation rates do not appear to vary by their marital or household status⁵⁷.

Participation in the Informal Economy. Rates of informal economic participation and precarious employment are high in LAC, especially for women and girls from marginalized groups. In 2016, 53.1% of workers in LAC worked in the informal sector,⁵⁸ the majority of whom are women. Overall, 126 million women in the region work in the informal sector, mainly with low incomes and usually little to no legal and social protections.⁵⁹ In Bolivia, Guatemala, and Peru, 83% of women have jobs that do not provide them any type of paid benefits, social or legal protections.⁶⁰



In Mexico, own-account work or unpaid family work represent 57.5% of new jobs for women.⁶¹ While men are found to be higher wage earners, women between 20 and 59 years of age work 20 hours more a week in LAC than men, in low quality jobs, and learning an average of only 75% of men's salary.⁶²

These disparities are even starker for women from marginalized populations such as ethnic and/or migrant and refugee women,⁶³ who have even higher rates of participation in the informal, or independent, labour force than women from non-marginalized groups.

Given the high levels of informality of their work, women in LAC are disproportionately affected by crises and pandemics compared to men. COVID-19 particularly poses a serious threat to women's engagement in economic activities, given their high rate of participation in informal sectors⁶⁴ and personal care services. Nearly 40% of women in the region are employed in commerce, restaurants, hotels and domestic work⁶⁵. These are the sectors most affected by COVID-19 mitigation and shut down measures, as well as those that provide some of the highest risks of exposure to, and least protections from, the disease once they reopen. Women and girls also face disproportionate barriers in accessing telework options and/or generating incomes remotely, given their high rates of participation in these sectors; none of which offer easy telework opportunities. Closures and care for elderly or ill household members add additional time-burdens to women, curtailing their ability to generate income.⁶⁶ As the crisis continues, depressed economies and related job layoffs will likely disproportionately force women who are currently employed in the formal, protected, sectors to enter the informal sector as well since their areas of work are often being hit first.

“We have been locked up and I have not been able to sell my products because I have to move to the market to buy supplies and right now, we are not able to do so. The grocery store has helped us avoid going hungry these past days... but I am afraid we will not die of COVID we will starve.”

— Informal sector worker, Honduras, April 2020.

Remittances. Remittances are another significant source of income for many households in LAC, with a high number of migrant workers and families living outside their home country providing financial support to families back home.⁶⁷ For example, in El Salvador, remittances make up 1/3 of an estimated 164,000 households' income,⁶⁸ while in Guatemala 17% of national resources stem from remittances coming from the United States.⁶⁹ Women migrant workers often send home a higher proportion of their earnings, more frequently,⁷⁰ than their male counterparts though some studies show that they send smaller amounts at a time.⁷¹ This is likely due to the fact that many migrant women continue to work in underpaid, “feminized” care sectors and in precarious work. Women also tend to receive the largest share of remittances from abroad in LAC. “Research in Guatemala has shown that 63% of main remittance recipients are women, while in Colombia they make up 70% of the recipients and in Mexico a 2015 remittance study showed that women are the main group benefiting from remittances receiving almost 3 out of 4 remittances from the US.”⁷² Disruption of this source of income due to COVID-19 will have a disproportionate impact on the women, and their families, who depend on these resources; affecting those living in poverty and extreme poverty the most.

Coupled with growing inequality, COVID-19 will result in a significant increase in poverty and extreme poverty. According to ECLAC, a 5.3% drop in GDP and a 3.4% increase in unemployment could represent a 4.4% rise in poverty in 2020 compared to the previous year. This would bring the total number of people living in poverty to 214.7 million, or 34% of the LAC population. 15.9 million more people in the region might be facing extreme poverty compared to before,⁷³ most of them women and girls. Given social and economic inequalities in the region, increased unemployment as a result of COVID-19 measures will disproportionately impact the poorest and middle classes, likely increasing informal employments as a survival strategy. UN Women estimates that this will likely increase the number of children sent to work as part of household economic survival strategies; with the potential that this will particularly impact the most vulnerable girls, rolling back gains made in their health and education over the last number of decades.

3.2. Needs and Vulnerabilities of Specific, At-Risk Groups

Domestic Workers

More than 18 million people work as domestic workers in LAC, 93% of whom are women.⁷⁴ Domestic work represents as much as 14% of female wage employment in the region,⁷⁵ with more than 78% of these women working in the informal sector and therefore without access to health, social, or retirement benefits.⁷⁶ For example, in Argentina more than 95% of domestic workers are women, 75% of whom are informal or have irregular documentation and/or registration status,⁷⁷ while in Ecuador 76% of female domestic workers do not have formal contracts with their employers.⁷⁸ This forces women to carry out precarious work without access to labour rights guarantees.

A large number of domestic workers are concentrated in urban areas – often living in crowded informal settlements or impoverished areas when not in their employer’s homes. In Bolivia, for example, 88% of domestic workers are found in cities;⁷⁹ often in informal settlements or under-resourced areas. This presents additional challenges and vulnerabilities for this mostly female workforce in the face of COVID-19. While mobility restrictions are in place, this can cut domestic workers off from their primary sources of income while, simultaneously, leaving them in crowded



areas where basic infection prevention measures such as social distancing and handwashing are difficult to follow. As mobility restrictions lift, this increases their exposure to different risks. Domestic workers are often required to commute for extended periods of time to their places of employment via expensive, crowded transportation infrastructure; thereby increasing their risk and exposure level as well as those of their households. For example, prior to COVID-19 and reduced mobility measures, domestic workers in Bogota, Colombia already spent the most time daily in public transit compared to people in any other occupation,⁸⁰ while domestic workers in Medellin spend an average of 2.5-3.5 hours in public transportation daily for 14%-28% of their daily income.⁸¹ These patterns are repeated throughout the region given domestic workers’ low levels of pay and over-representation in informal settlements and under-resourced urban areas far from places of employment.

Social protection risks are also high for female domestic workers as many are dependent on informal work arrangements. This is further exacerbated for women from marginalized communities who have very limited access to support networks and increased unpaid care work in their homes. 8 out of 10 domestic workers in the region affirm they have experienced some form of violence in the workplace.⁸² For example, both Afro-descendant and migrant women are especially vulnerable to sexual harassment because of exoticization and imagined hypersexualization by host/majority contexts,⁸³ while being simultaneously cut off from their individual and communal support systems. In Haiti, a specific subset of domestic labour includes children as young as 5 years old being forced into domestic labor as *restaveks*⁸. The majority of the estimated 225,000 children *restaveks* in Haiti are female, working long hours, malnourished and

⁸ A child in Haiti who is sent by their parents to work for a host household as a domestic servant because the parents lack the resources required to support the child. Often considered ‘child slaves’.

experiencing sexual, physical violence and abuse.⁸⁴

As a result of poor work conditions and calls to mobilize, domestic workers across the LAC region have called on governments to recognize their rights and specifically, to uphold and implement the rights delineated in the International Labour Organizations's Domestic Workers Convention (No. 189 and No. 190). These efforts have been supported throughout the region by both international organizations and local civil society. As of April 2020, only 15 countries in the region had ratified Convention 189.⁸⁵

The precarious, informal nature of their work means most domestic workers face greater exposure and vulnerability to COVID-19, on a number of fronts: The increased burden of unpaid care work in their homes as a result of school closures or for household members who fall ill; increased care work and exposure in the homes of their employers when employer family members fall ill or require extra attention; decreased income and/or job loss if they cannot go to their work sites because of health reasons or restrictions to mobility;⁸⁶ decreased negotiation power and increased dependence on employers if their job status is dependent on remaining in the employers' home, thereby needing to leave their own families unattended or requiring unpaid care support from daughters, aunts, or other female household members; increases in working hours and risk exposures for live-in domestic workers without corresponding increases in pay or benefits or bio-security and protective measures. As LAC countries begin to lift and/or target specific restrictions, the precarity of female domestic workers' situations is likely to increase; requiring them to choose between earning an income, caring for their families, and protecting themselves and their households – and/or their employers – from increased risks. As economic losses become more generalized, resulting job losses might also force them to accept worse employment conditions than they had even prior to COVID-19.

♥ LGBTIQ+ People

Currently there are no reliable statistics reflecting the true dimension of discrimination suffered by LGBTIQ+ people in LAC,⁸⁷ rendering their needs invisible. While this makes it difficult to predict the specific impacts of COVID-19, LGBTIQ+ populations are among the most vulnerable in LAC.⁸⁸ LGBTIQ+ people often do not have access to health or social protection services as a result of discrimination and stigma as well as their concentration in the informal sector. In LAC countries where data is collected, trans women experience some of the highest rates of HIV prevalence; with the lowest in El Salvador (7.4%) and the highest in Ecuador (35%).⁸⁹ However, pre-existing stigma and discrimination often cuts LGBTIQ+ people off the health or social protection services they need to care for their related health needs. Some research has also shown that between 44% to 70% of transgender women in LAC have either felt forced to leave, or been expelled from, their homes⁹⁰ because of the same stigma, violence, and discrimination. Due to the same discrimination, trans people often have access to fewer educational and social opportunities than non LGBTIQ+ counterparts; often forcing them to turn to precarious, abusive, informal work including the sex industry. LGBTIQ+ populations face extremely high rates of violence, with 1,573 murders of trans people reported in LAC from 2008-2015; 78% of the total murders of trans people recorded worldwide.⁹¹ LGBTIQ+ migrants, refugees and asylum seekers also face significant risks.⁹² While progress has been made in LGBTIQ+ rights in the region, significant challenges remain for data collection, political and democratic participation, health, security and access to justice, and social and economic wellbeing⁹³.

The social and economic impacts of the COVID-19 crisis are already hitting LGBTIQ+ people hard, including by inhibiting their access to livelihoods and housing, especially where social safety nets are weak. LGBTIQ+ migrants, asylum seekers, racial and ethnic minorities are especially vulnerable. Quarantining measures are resulting in LGBTIQ+ people, particularly youth, being put in danger in hostile homes or abusive relationships.⁹⁴ With incomes decreased, and mobility restrictions leaving them unable to move between locations, many more LGBTIQ+ people are now under threat of eviction or exploitation

and unable to access legal recourse or support services. LGBTIQ+ people are already overrepresented amongst homeless populations and people living with immunocompromising situations. Increased threats of eviction, and pre-existing stigma and discrimination in access to health and WASH services, mean LGBTIQ+ people are facing more difficulties in accessing the services they need to protect themselves through physical distancing and infection prevention measures. Trans women are particularly vulnerable as they have decreased opportunities to access the social protection measures implemented by governments. It is likely that their ability to negotiate their own health - especially for those in the sex industry – will continue to be eroded. Health services and care sites such as quarantine centers will potentially expose trans people to additional risks.

Transgender people are also being more exposed than ever to discrimination, police harassment and lack access to courts in countries where the pandemic is putting additional pressures on security and judiciary institutions.⁹⁵ Gender-based mobility provisions adopted by some states further increase LGBTIQ+ people's risks as in some cases they have led to acts of violence and discrimination⁹⁶ by public authorities policing people's movements based on perceived gender-identification.⁹⁷

Indigenous and Afro-Descendant Women and Girls

Women and girls – particularly Indigenous and Afro-descendant women and girls – are often disproportionately affected by epidemics and other crisis in LAC. They are nearly three times as likely to be living in extreme poverty, with limited access to resources, than their non-Indigenous counterparts.⁹⁸ More than 23 million Indigenous women already faced discrimination⁹⁹ and unequal access to education, labor, land, and participation in LAC prior to COVID-19. For example, in Brazil, 63.8% of self-declared Indigenous people lived in rural areas and 57.7% live in officially demarcated Indigenous land¹⁰⁰ with restricted access to drinking water and information on public health. Afro-descendant women are also less likely to have access to safe water. In Mexico, 78.2% of the Indigenous population has no social security, which means that they have no protection against unemployment, illness or disability.¹⁰¹ In Bolivia, 58% of the population in the lowest income strata are Indigenous and mostly concentrated in under-served rural areas. In this sense, Indigenous women in low- and middle- income countries are less likely to be medically insured or have access to health services, as they also continue to face the fatal health impacts of environmental degradation and extractive industries, notably resulting in the pollution of water resources.¹⁰²



Other dimensions of inequality affecting Indigenous and Afro-descendant women and men in LAC include high rates of informal or unpaid work and increased gender gaps in unpaid care. In Colombia, workers in the Pacific region – who are mostly Afro-descendants – have the highest rates of informal employment compared to the national average. In Bolivia, 75% of the Indigenous population carries out activities in the family economy, where women and girls are generally unpaid. In Peru, 10% of Afro-descendant women have not completed any level of education compared with 4.2% men and in just 8 countries in the region, Afro-descendant women represent 63% of 4.5 million domestic workers.¹⁰³ Afro-descendant and

Indigenous women have also been affected by multiple forms of gender discrimination, racism, and xenophobia and are at great risk of falling into poverty, and/or to be the most affected by unemployment. In Ecuador, for example, 71.8% of Afro-Ecuadorian women and 64% of Indigenous women have experienced at least one incident of violence during their lives.

The impact of the pandemic on Indigenous and Afro-descendant communities, especially women and girls, is therefore significant given these pre-existing inequalities. Quarantine restrictions are particularly affecting Indigenous communities with high rates of participation in the informal sector, as they have lost their ability to travel to cities or rural areas to work.¹⁰⁴ Access to information and resources are limited because of a lack of outreach and translation into Indigenous languages as well as lower levels of internet and information and communication technology (ICT) access. Women and girls in Indigenous and Afro-descendant communities face additional barriers to accessing health care, safe and clean water, hygiene and food than their non-Indigenous counterparts, thereby exacerbating the impacts of COVID-19 on their health and livelihoods.

While there is still little data available disaggregated by both sex and ethnicity, in Brazil, the Ministry of Health reported that as of 9 April, 37.4% of patients admitted in hospitals for treatment for Acute Respiratory Syndrome were Afro-descendants, representing 45.2% of deaths at that time¹⁰⁵. This points to the inequalities in access to health services and information for these populations, as 80% of Brazilians from Afro-descendant communities rely solely on the public health system for care. Fatality rates suggest these cases are mostly men, but lack of dually-disaggregated information continues to point to the need for additional intersectional analysis.

3.3 Decision-Making, Participation, and Leadership

Although the LAC region had the highest proportion of women in parliaments in the world in 2019, only 31.6% of parliamentary seats were held by women.¹⁰⁶ Various countries in LAC have laws establishing minimum gender quotas or parity requirements. However, due to other regulations, electoral results do not always meet the percentage of women established by these affirmative actions. Significant challenges still remain for women's political participation in the region. At the time of writing, only 4 countries in the region (Barbados, Grenada, Trinidad & Tobago and Bolivia) had female heads of state or heads of government and only 12 countries have specific reference to equality between men and women in their constitutions. To date 13 countries have less than 20% of female parliamentarians and only 15% of local female mayors.¹⁰⁷ Additionally, only 38.4% of management positions in the region are held by women.¹⁰⁸ Gender gaps in leadership and participation in decision-making are widespread in all sectors, including health.



Despite the fact that women make up 74% of the health workforce in LAC, only 31% of Ministries of Health are headed by women.¹⁰⁹ These disparities and levels of under-representation are even starker for women from Indigenous and Afro-descendant communities, LBTIQ+ people, and young and/or rural women and girls.

Previous health emergencies show that women and girls often provide the first, and longest-lasting, forms of humanitarian support and recovery to their communities, often at their own expense as part of unpaid care work. Recognizing these existing responses – as well as women and girls' leadership in providing for their communities' needs – is essential to effective, gender-sensitive response and recovery efforts. These

informal networks and support systems are often overlooked in humanitarian action and must be recognized and supported as part of an essential pillar of response.

Examples of “caremongering”⁹ and women’s leadership in community response to COVID-19 have arisen across the region. In Colombia, host community, displaced, and refugee, women and girls have been providing additional support and public health messaging for their communities as they are no longer able to access formal political spaces because of COVID-19 restrictions.¹¹⁰ In Brazil, Peru, Guatemala, and Ecuador among others,¹⁰ local women’s organizations have partnered with Civil Society Organizations (CSOs) to identify families in need, collect donations and distribute basic food items to marginalized communities. These actions have particularly benefitted Afro-descendant and Indigenous communities, as well as workers whose vulnerabilities have been exacerbated because of social isolation measures including domestic workers, fishers and seamstresses/tailors.¹¹¹ Information is still limited concerning women’s specific frontline responses, but should be mapped, collected and supported, as the crisis continues to unfold.

Ensuring women’s leadership and participation in the COVID-19 response is fundamental to achieving effective results and ensuring sustainability in the recovery phase. This requires women’s equal representation in all COVID-19 response planning and decision making. According to the Secretary General of the UN “Evidence across sectors, including economic planning and emergency response, demonstrates unquestioningly that policies that do not consult women or include them in decision-making are simply less effective, and can even do harm. Beyond individual women, women’s organizations who are often on the front line of response in communities should also be represented and supported.”¹¹² This requires specific, and targeted, measures to recognize women’s leadership in community level response and bring them to the public policy decision making table throughout COVID-19 health and social-protection decision-making.

"The only thing that gives me strength is to be able to help the people that is sick and their families, when we are able to give them strength to keep fighting. Makes me feel like we are winning the virus. We see people recovering and it gives me energy. We need to continue fighting and find our strength within ourselves."
— Leader of the Domestic Workers Union, Ecuador.

3.4 Health, Including Sexual and Reproductive Health and Rights (SRHR)

🏥 Health

The LAC region has seen progressive gains in health over the past few decades. Specifically, increases in health financing in several countries in the region have improved health coverage and have had significant effects on increased preventative care, contraceptive use, and maternal health services including deliveries by skilled attendants.¹¹³ While these efforts have improved some health indicators and

⁹ Spontaneous, crowd-sourced, community-based movements organized to provide care for those who are the most isolated and impacted by COVID-19; i.e ensuring community action to deliver meals, provide economic supports, check on seniors' health, share food or information resources, etc.

¹⁰ The authors of this paper would like to highlight that women’s organizations are organizing and responding to COVID-19 across the region. The countries named here are those where UNW and CARE offices directly identified examples during interviews for this report. This does not represent the entirety of locations where women’s organizations are formally, and informally, responding in the region.

reduced some inequalities in the region, challenges remain in accessibility and availability of health services for vulnerable and marginalized groups such as migrant, refugee and displaced people, Indigenous and Afro-descendant women and girls, LGBTIQ+ populations, and those residing in rural areas.



An estimated 30% of LAC's population is unable to access health services due to financial barriers, and 21% are unable to access services due to geographic barriers.¹¹⁴

Under resourced development and humanitarian settings pose particular challenges for infectious disease prevention and control.¹¹⁵ In countries like Venezuela, Haiti and Honduras, the ratio of hospital beds to patients is less than 1 per 1,000 patients and in Colombia, Peru and Mexico this ratio is less than two beds per 1,000 patients.¹¹⁶ Although those most affected by COVID-19 are reportedly men and people with chronic diseases and weak immune systems, women are bearing disproportionate impacts, given their overrepresentation in care work in both the domestic and paid work spheres.¹¹ Although there is not reliable evidence yet to identify significant risk to pregnant women and newborns, both groups are often vulnerable to infectious diseases.¹¹⁷ Similarly, people living with HIV/AIDS in the region are also at significant risk as crises often disrupt supply chains, leaving this population without critical medications such as antiretrovirals and supplies. There are currently 1.9 million people living with HIV in Latin America, while the Caribbean has the second highest prevalence after sub-Saharan Africa.¹¹⁸

The Zika outbreak in LAC demonstrates the significant ways public health emergencies can exacerbate existing gender inequalities in the region; especially given that many women do not have full autonomy over SRH and health decision-making compared to their male partners and counterparts. The Zika crisis further demonstrated that health emergencies are further compounded by already significant barriers to accessing care, including insufficient financial resources to pay for travel to facilities or payment of services.¹¹⁹ During the Zika outbreak, some women reported fear of assault as a barrier to not seeking healthcare services. This was the case in the Dominican Republic where 73% of women assumed they had the Zika virus but did not seek care as they were afraid of becoming victims of abuse or psychological violence in health facilities.¹²⁰



Women as Health Workers

Globally, women comprise 74% of the health workforce and are more likely to be front-line health workers, especially nurses, midwives and community health workers. They are also the majority of health facility service-staff – such as cleaners, laundry, catering – and as such they are more likely to be exposed to the virus¹²¹. While women represent 74% of the health and social workforce in LAC,¹²² men occupy 75% of all leadership positions in the health sector,¹²³ with some countries having even higher rates. In Mexico, 79% of health workers are women, with the majority being in nursing and support positions, while men continue to make up the majority of medical staff.¹²⁴ In Argentina (Buenos Aires), women make up only 25% of hospital management while male physicians continue to earn almost 20% more per month than their female counterparts;¹²⁵ further limiting women's input into health related decision-making.

As cases continue to increase, many frontline health and support workers continue working in extreme conditions: working long hours without the necessary personal protection equipment (PPE) and supplies.¹²⁶ These critical supplies are increasingly unavailable in under-served areas, exacerbating pre-existing disparities; especially amongst Indigenous, Afro-descendant, migrant, refugees and displaced women and girls.¹²⁷ It is worth noting that a lot of PPE equipment is incorrectly designed for women's

¹¹ See previous sections for details

bodies, as they were often modeled on the average European male. Scarcity of these needed supplies, and/or poor fits, will continue to exacerbate potential exposure rates, burnout, and vulnerabilities especially for the female work force members and their entire households.

Women's overrepresentation as front line health workers means they are taking on higher risks of exposure and infection to COVID-19 even as the pandemic, and government responses to it, continues to evolve. This includes larger emotional and physical costs related to lower-paid, longer, exhausting and extended shifts away from their families. Female workers' double-burden of caring for those in their workplace and households, including children or ill household members,¹²⁸ as they try to manage these extenuating circumstances, on smaller and more precarious salaries. This will continue to limit their own access to social support and health-seeking behavior and¹²⁹ will continue being of particular importance wherever lifted mobility restrictions lead to a resurgence of infection rates as the pandemic evolves.

Sexual and Reproductive Health

While decades of progress in the LAC region have resulted in significant declines around maternal mortality, the total fertility rate, and increased use of contraceptives, many challenges remain that can be further exacerbated by COVID-19. LAC has the second highest adolescent pregnancy rate in the world and maternal mortality remains a top cause of death among women aged 15-24 in this region.¹³⁰ Many pregnancies in girls under the age of 15 are a result of sexual violence. Gender norms often inhibit adolescents' access to services and information to prevent unwanted pregnancies,¹³¹ and other health crises such as Ebola have shown increases in the rate of adolescent pregnancy.¹³² These disparities are worse for marginalized communities where limited access to sexual and reproductive health is evidenced by low contraceptive prevalence rates. For example, in Guatemala only 40% of Indigenous women use any contraceptive method, while in Colombia, Paraguay and Peru prevalence is approximately 70%.¹³³

Recent experience with the Zika epidemic and its significant outbreak in LAC indicates that in times of crisis, resources are often diverted from existing health services to support response efforts.¹³⁴ Existing sexual and reproductive health (SRH) services could be diverted and deprioritized due to COVID-19 response. Uninterrupted access to these services is especially critical for vulnerable populations, including migrants, refugees and displaced women and girls, whose increased protection risks during crisis result in significant SRH needs.¹³⁵ In Colombia's border areas with Venezuela, **reports of increased xenophobia and discrimination against Venezuelans falsely accused of spreading COVID-19 are adding additional barriers for this population to access health services.**¹³⁶

3.5 Access to Services and Resources

Human Mobility

LAC hosts one of the fastest growing migrant and refugee movements in the world,¹³⁷ with more than 5.1 million Venezuelans having left their homes,¹³⁸ as well as significant movement from Haiti to the Dominican Republic and South American countries,¹³⁹ and heavy regional migration in Central America towards the United States; especially from Honduras, Guatemala and El Salvador.¹⁴⁰ Migration patterns in the region demonstrate specific gender dynamics, as do the impacts of COVID-19 on migrant, refugee and displaced populations. Globally, women account for 48% of the 272 million migrants in the world and half of the 19.6 million refugees.¹⁴¹



The situation in LAC is characterized by women and men known as the “caminantes,” often moving from one country to another within the region; with each group presenting specific dynamics. For example, the majority of initial migrants and refugees leaving Venezuela were unaccompanied men, seeking safety and/or improved income earning opportunities. This was followed by a gender swap where more women were migrating, accompanied by family members and young children, for family reunification or for their own safety and income earning opportunities.¹⁴² In Mexico, 22.8% of the traffic flow from Central America, and repatriated by the Mexican authorities, were women many of whom had to migrate due to gender issues.¹⁴³ Upon arrival in host countries, migrants, especially irregular migrants, largely report undertaking informal jobs, with women being mostly employed as domestic workers and in the informal economy, with little access to social protection¹⁴⁴ and incomes well below the poverty line. Partial or complete family separation, irregular status, the loss of support networks, and ongoing insecurity further aggravate risks for women, girls, and LGBTIQ+ people in these contexts.

The COVID-19 crisis is impacting migrants, refugees and IDPs in specific ways, especially women and young girls who are heads of households. While some countries – such as Brazil – report covering migrants and refugees under cash transfer schemes, other countries are unable to provide this support, thereby excluding migrants from social protection services, especially those who do not have documentation.¹⁴⁵ This particularly impacts women and girls caring for extended families or young children. Other countries, such as Bolivia, are reporting increased numbers of returnees as a result of job and income losses abroad, resulting from COVID-19 containment measures and their related economic fallout.¹⁴⁶

Most countries in LAC closed all or part of their borders as part of containment measures at the onset of the pandemic. Protection and surveillance of border areas continues to be a challenge for armed forces and police, especially at irregular access points and porous borders, increasing specific security risks for women, men, boys, girls, and LGBTIQ+ people. Since the onset of COVID-19 measures, border closures have increased migrants’ and refugees’ passage through irregular crossings. For example, the IOM estimated there were some 20,200 border crossings by the 15th of April 2020 between the Dominican Republic and Haiti, including 2,550 returnees to Haiti.¹⁴⁷

COVID-19 related mobility restrictions have further limited migrants’ and refugees’ access to protection systems and basic services at border areas.¹⁴⁸ This has generated greater risks especially for women, girls, adolescents and LGBTIQ+ people who are more exposed to being victims of human trafficking, smuggling of migrants, sexual assault, and survival sex. Even prior to COVID-19, 88.5% of migrant, refugee, and displaced women (women in mobility) in Ecuador had experienced some form of gender-based violence. Risks of detainment, re-ouling, and/or exploitation by different actors have only increased. For example, Venezuelan refugees and migrants are returning to Venezuela in irregular movements, increasing protection and health risks, xenophobia. The emergence of clandestine transport companies using unofficial crossing points, represents an increased risk of related GBV, trafficking, smuggling risks, and survival sex¹² as vulnerable populations look to use these services.¹⁴⁹ This is particularly problematic for migrants, refugees and IDPs who do not have family and/or social networks for support. At the same time, quarantine and isolation measures at borders – such as quarantine centers in Bolivia, El Salvador, and relocations in Brazil¹⁵⁰ – also represent specific risks for women, girls, and LGBTIQ+ people, especially as populations in the centers and re-location appear to be predominantly male.¹⁵¹ Shelter closures for Venezuelan migrants, such as those in Colombia, Ecuador and Peru, also force refugee and migrants’ into the street; thereby furthering risks particularly to women, girls and LGBTIQ+ people.

¹² According to UNHCR’s Protection Monitoring, 2% of the interviewed women mentioned that they had to resort to sex for survival. Available at: https://acnur.org/5d321d124#_ga=2.229179039.2035465752.1569421762-1175617468.1560347589

“If, as a result of this disease, we the poor cannot survive, it means none of the countries are doing their job correctly. That is why I have decided to go back to my country, as I would rather die there”.

— Venezuelan migrant, April 2020.

□ Access to Information and Technology

Measures to stop the spread of COVID-19 have accelerated the pace at which both work and education are going digital. However, this accelerated pace of migration to digital platforms runs the risk of exacerbating existing gender inequalities. While more than 67% of the region’s inhabitants were using the internet by 2017, this varied sharply across countries, urban-rural locations, ethnic groups and income sectors, with 80% of the population in Chile, Brazil, Costa Rica and Uruguay having a mobile Internet connection but only 30% in Guatemala, Honduras, Haiti and Nicaragua (with figures varying wildly between them).¹⁵² The ECLAC Report on the economic and social effects of COVID 19, highlights that the inequalities in connectivity rates between income segments are extreme with “the gap between the richest and poorest quintiles (being) widest in Honduras (58 percentage points) and Peru (60 percentage points), and narrowest in Chile (22 percentage points) and Uruguay (17 points).”¹⁵³

While data is very limited around the intersectional gender gap in connectivity for the region, the data that does exist clearly shows that women and girls have less access to digital communications and platforms across the region compared to men. In LAC, women’s access to mobile phones and the internet is high. 86% of women in the region own mobile phones and there is only a 2% gender gap between men and women’s access. In Guatemala, there is a 13% gap between men’s and women’s mobile ownership. Despite this encouraging data, an estimated 76 million women in the region do not use mobile internet.¹⁵⁴



In 2015, women’s internet use was less than men’s in almost all LAC countries surveyed.

In households that have internet in the home, women showed slightly more use of the internet than men (in the home itself). However, internet access in the home varies wildly across countries with only 2% of women and men in Nicaragua having access, compared to 9% in Guatemala, and 17% in Bolivia.¹⁵⁵ These gender differences further vary depending on whether men and women are self-employed, salaried, or an employer, with women working as paid workers having the highest rate of access to, and use of internet, while self-employed women have the lowest rates. Those in the lowest quintile obviously had the least access, particularly for women. For example, only 14.1% (Bolivia), 8% (El Salvador), 9.5% (Honduras) and 9% (Peru) of women in the lowest quintile had access to internet, and in every case, this was lower than men’s rate of access. Both the overall situation, and the gender gap, are generally worse in rural areas.¹⁵⁶ With COVID-19, containment measures isolating people in their homes – and information dissemination going increasingly digital – this has significant implications for women and girls’ access to information.

Interviews with migrant women in Colombia demonstrate that they are already lacking in connectivity and public health information because of social distancing measures. They cannot access information physically, thereby increasing existing vulnerability and social isolation. This will continue disproportionately impacting women and girls' access to income earning opportunities, education, rights information, and services as the pandemic continues to unfold. Any initiative to re-open and recover the economy will need to ensure that women's employment sectors – which are largely informal and service based – will be able to migrate online in order for women not to be left behind. For example, as relief packages and income support continue to roll out across the region, gender gaps in official identification, and mobile technology, run the risk of leaving poor, and at-risk women and girls from marginalized groups out of mobile cash transfer or cash access platforms.

3.6 Safety and Protection

Gender Based Violence

Almost 12% of women aged 15-49 (or 19.2 million) in LAC have experienced violence by a current or former intimate partner in the last 12 months,¹⁵⁷ with an average of nearly one third of ever-partnered women reporting physical and/or sexual abuse by an intimate partner at some point in their lives.¹⁵⁸ The proportion of women who reported physical and/or IPV ranges from around 1 in 7 ever-partnered women (in Brazil, Panama, and Uruguay)¹⁵⁹ to upwards of 43% in Ecuador,¹⁶⁰ and 58.5% in Bolivia.¹⁶¹ The percentage of ever-partnered women who reported sexual violence range from 10.3% (Paraguay) to 27.2% (Haiti).¹⁶² At least 3,529 women were victims of femicide in 25 countries in LAC in 2018,¹⁶³ with the highest rates in El Salvador, Honduras, Santa Lucia, Trinidad and Tobago, Bolivia, Guatemala, and the Dominican Republic.¹⁶⁴ 23% of women aged 20 to 24 in the region are married or in unions before age 18, with 5% in unions before age 15.¹⁶⁵

GBV rates against marginalized women in the region are also higher than the average, specifically amongst Indigenous, Afro-descendant, and women with disabilities as well as refugee and migrant women. In Bolivia, departments with the highest concentrations of Indigenous peoples have IPV prevalence rates up to 5% higher than the national average. In a 2019 survey in Ecuador, Afro-Ecuadorian women were 7% more likely to experience GBV than Indigenous and 10% more than mestiza women.¹⁶⁶ Globally, women with disabilities are 2-4 times more likely to experience IPV than women without disabilities.¹⁶⁷ While data for this population is limited in LAC, one national survey in Colombia indicates that IPV prevalence rates are 4% higher among women with disabilities than women without disabilities when all kinds of violence committed by a current or former intimate partner are considered, and up to 4.5 times higher for certain sub-sets of violence such as threats of being abandoned.¹⁶⁸

While LAC is among the most progressive regions in the world in terms of legislation on GBV, important gaps remain in the implementation of laws, access to justice and support services for survivors of violence.¹⁶⁹ Helplines and support centres have been created across most countries in the region, providing legal, health, counselling and other support services for GBV survivors. However despite the existence of several national strategies to respond to the needs of GBV survivors, as well as protocols for



Conversely, as women, girls and adolescents spend more time on-line when they have Internet access, and use virtual means of communication through telecommuting, online education and activism, as well as on-line leisure spaces, there are signs that cyber violence and cyber harassment are intensifying in virtual spaces such as social networks, chat rooms, teleconferencing services and on-line games.

the care of victims of sexual violence, significant gaps remain in effective implementation in the region.¹⁷⁰ **Reporting rates remain low, with an average of 45% of victims of domestic, sexual and/or physical abuse never having told anyone nor sought institutional help because of stigmatization.** This includes feelings of shame, fear of retaliation, lack of information about services and beliefs that no-one would help.¹⁷¹ Reports suggest that Indigenous women face particular barriers where legal information and justice services are only, or primarily, available in Spanish. Similarly, particular barriers exist for women and girls with disabilities,¹⁷² as well as migrants and undocumented workers,¹⁷³ in accessing information and services.

Humanitarian crises, including public health crises, are known to further increase GBV rates,¹⁷⁴ due to compounding factors such as changes in traditional roles, economic hardships, and increased impunity for perpetrators.¹⁷⁵ This trend is evident in LAC during the COVID-19 crisis as national lockdowns and self-isolation measures increase stress, economic hardship, and prevent women and girls experiencing violence from leaving the place where they are being abused, increasing barriers to essential services: In Argentina, calls to domestic violence hotlines increased by 40% after the government established a mandatory quarantine;¹⁷⁶ in Brazil, the state hotline recorded an 18% rise in IPV reports from March 17 to 25 compared with the first two weeks of the month,¹⁷⁷ with reports in Rio de Janeiro increasing by 50 percent in the same period.¹⁷⁸ In Mexico, the Special Prosecutor's Office for Femicide and Crimes Against Women recorded a 30 to 35% increase in reported cases in the two weeks up to 23 March 2020,¹⁷⁹ with a further 60% increase in calls to shelter helplines from 23 March to 8 April.¹⁸⁰ Also, 33% of needs assessment respondents in Guatemala reported experiencing some form of violence or tension in the home as a result of the COVID-19 crisis in March alone.¹⁸¹ In Bolivia, 7 of the 34 femicides between January-April 2020 occurred since quarantine was announced on March 22nd. These are likely underestimates, as many women cannot safely contact services when confined with their abuser.¹⁸²

Evidence from previous crises demonstrates that women who already faced multiple forms of discrimination prior to the crisis are likely facing higher risks, and additional obstacles, to accessing essential services now. For example, it is important to note that official reports of GBV in some LAC countries have decreased during the pandemic, but experts believe this lack of reporting actually reflects higher levels of control by abusers living in the home, making it more difficult for women and girls to report. This is further exacerbated by women's increased economic dependence on partners as COVID-19 measures mean survivors are losing access to the essential cash resources they need to escape abusive situations. GBV response and prevention services are insufficient in the region, despite several countries' increased investment in GBV services and shelters. In some countries, limited GBV resources are being diverted to infection prevention, control and treatment, while investment is being strengthened in some others. In Haiti, numerous activities related to reproductive health and gender-based violence, including mobile clinics, have been suspended.¹⁸³ At the same time, Argentina, Colombia, Ecuador, and Chile (among others) have been able to expand and innovate service delivery, providing whatsapp and email-based services, increasing helplines, investigating new "text mining" possibilities, and instituting "code" systems survivors can use to alert service providers of immediate danger even when in the presence of abusers, and automatic renewals or extensions of protection orders due to expire during the quarantine period.

This uneven response across contexts means that **barriers to accessing GBV services will likely continue increasing in the context of COVID-19.** Restrictions on movement, closed clinics, a lack of information regarding which GBV services remain available, and fears of contracting the virus at service points, combined with existing fears of violence and mistreatment while seeking care will continue this trend¹⁸⁴ despite successful adaptations to current service models. This is also likely to continue as restrictions begin lifting. The impact on frontline services delivered by women's civil society organizations is extremely worrying as many are struggling to respond to the increase in demand for services or do not have adequate access to PPE and other essential resources to facilitate remote working and are finding

it difficult to adapt their services in response to COVID-19. For many women, accessing community-based support is preferable to reporting to the authorities so as services provided by civil society and women's organizations are scaled back this further reduced the few sources of support that women in abusive situations may have.¹⁸⁵

Human Trafficking

Sexual exploitation is the most reported form of trafficking of women and girls in LAC. 84% of victims of trafficking for sexual exploitation identified in Central America and the Caribbean in 2016 were women and girls.¹⁸⁶ The exacerbation of vulnerabilities during and after the pandemic, will bring several challenges to the effective identification of victims of trafficking,¹⁸⁷ their access to services, protections and redress, as well as prevention. Moreover, the dynamics of trafficking for sexual exploitation, particularly impacting women and children, have shifted from the more traditional forms of exploitation to various forms of trafficking online; making systemic responses even more difficult. The internal displacement in the region specially with the Venezuelan crisis and the presence of armed groups, and organized crime, have shown growth on human trafficking, which is likely to be exacerbated as borders are closed and migrants/refugees need to seek for irregular or informal border crossing.

Safety

Several countries in the region face particular situations in relation to security which have disproportionately affected women and girls. In Colombia, for example, apart from the mobility restrictions existing at the national and local levels, in some areas illegal armed groups have also imposed local control measures.¹⁸⁸ In Brazil's favelas, gangs have reportedly enforced lockdowns in certain areas.¹⁸⁹ In Central America, community leaders and internally displaced people (IDPs) have reported that organized criminal groups have been exploiting the confinement, to strengthen their control over local communities in Honduras, El Salvador and Guatemala¹⁹⁰ whereas in Haiti, the security situation has deteriorated significantly due to widespread violence perpetrated by gang-related armed clashes.¹⁹¹

At the same time, Venezuela continues to be the country with the highest rate of violence in the region with 60.3 deaths per every 100.000 inhabitants,¹⁹² even as thousands of women and men now returning from neighbouring countries.¹⁹³

The LAC region has one of the highest rates of intentional homicides, accounting for 37%¹⁹⁴ of registered homicides in the world in 2019, with El Salvador, Venezuela, Honduras and Brazil recording amongst the highest rates.¹⁹⁵ The majority of those affected were young men, aged 15-29 years old. Over 50% of all homicides in El Salvador in 2017 were from this specific male, age group.¹⁹⁶ Overall, male homicide rates in LAC are 8 to 11 times those of female rates, with a tendency to decrease as overall safety conditions improve. This is linked to the lethality of male urban violence, often between gang members.¹⁹⁷ While there are no reports as of yet that homicides of young men have increased as a direct result of the COVID-19 pandemic, there are indications this will be of particular concern as economic and social conditions continue to decline. Young male migrants, and/or those living in extreme poverty, or being held in quarantine centers, will likely be hardest hit as stretched resources may force them to increasingly turn to precarious, informal employment and/or gangs. This, in turn, fuels violence and safety concerns for the women, girls, LGBTIQ+ leaders, human rights defenders and activists mobilizing against violence, criminality, inequality and corruption in their regions. Many are young, Indigenous, Afro-descendent, and LGBTIQ+ people who are targeted because of their leadership and political activism in national and local level decision-making spaces. This results in forced disappearances, trafficking, smuggling of migrants and sexual exploitation (see previous sections).

In the context of COVID-19, social distancing, quarantines and curfews have decreased the number of people on the street, resulting in a heightened risk of these gendered forms of violence; particularly for those that work in the informal sector or perform essential services. Reports indicate this has worsened for women when running daily errands or performing regular chores for supplies. Emerging data suggests that sexual violence against women and girls in public spaces continues to occur since the outbreak of COVID-19. With fewer people on the streets, there are fewer bystanders to intervene or help women who are being harassed in public spaces. Also, with shops, restaurants and businesses closed there are fewer opportunities to seek assistance, therefore impacting on women's perceptions of safety and autonomous mobility.¹⁹⁸

Xenophobia and Violence

Prior to the COVID-19 pandemic, xenophobia against migrants and refugees was already increasing. Central American and Venezuelan migrants, refugees and asylum-seekers already feared being physically attacked by other community members, coyotes, and/or national authorities.¹⁹⁹ For example, 35.6% of Venezuelans (36.6% of women, 34.6% of men) residing in Peru reported experiencing discrimination,²⁰⁰ and one survey in Peru documented that 27.8% of immigrant respondents were worried about the risk of being attacked by their host communities - with that risk being more elevated for men (32%) than women (26%).²⁰¹ 11% were concerned about the possibility of sexual harassment and/or violence - with that risk being felt more keenly by women (16%) than men (3%). In a survey among refugees and migrants in Ecuador, 56% of respondents reported having experienced some form of abuse with higher portions of women (30%) and LGBTIQ+ (50%) reporting abuse than men. This trend of concerns is also evident amongst male and female migrant populations throughout Colombia, Guatemala, and Brazil, among other countries.

As in much of the world, xenophobia increased with the arrival of COVID-19. Narratives identifying migrants and foreigners as bearers of disease are flourishing, contributing to potential increases in violence. Demonstrations in some countries, including Colombia,²⁰² and Ecuador²⁰³ have targeted migrant populations perceived to be disobeying quarantine measures or failing to use protective equipment. While there is little gendered data currently available about COVID-19 specific related increases in xenophobia, it is safe to assume women, men, and LGBTIQ+ people are all experiencing these vulnerabilities differently. Evidence from previous emergencies demonstrates that the gendered elements of violence become worse during a crisis. As vulnerability increases, and people have less access to services because of loss of income following COVID-19 containment measures, it is reasonable to assume that women who were previously victims of hyper-sexualization and vulnerable to exploitation, such as migrant or Afro-descendant women, will be facing increased pressure to pay for rents in sex and/or provide other sexual services in exchange for basic needs.

Confinement and Detainment

Institutional confinement could increase community transmission of COVID-19 unless proper social distancing and hygiene measures are in place²⁰⁴. Several forms of mass detainment and confinement - and measures to manage community transmission in those spaces - likely have severe gender implications.

Shelters and Quarantine Centers

Several countries have implemented strict border control measures that include detainment and forced returns. In El Salvador²⁰⁵ and Venezuela²⁰⁶ for example, people are being held in Quarantine Centres where there are varying health and protection standards. Recently, the Salvadoran Office for Human Rights signaled a lack of basic services such as potable water, food, information and overcrowding in these Centers.²⁰⁷

Particular risks of infection and GBV are also found in crowded shelters and transition points for those on the move. For instance, it was recently noted that only 3 of 13 shelters in Boa Vista - a northern Brazilian city through which many Venezuelans pass on their migratory route – may be considered low risk in terms of spreading the coronavirus.²⁰⁸ There is no gender data at this time to quantify the populations and GBV cases in each of these centers, thereby making it difficult to identify the specific gendered risks they're facing. However, data from previous emergencies shows that women, girls, LGBTIQ+ people, and other at-risk groups are at even *more risk* of GBV, abuse and exploitation and pressure to engage in survival sex, and they are also affected by decreased access to basic services such as food, in these situations. As countries begin to lift restrictions, it will be essential to continue ensuring these issues are tracked, and addressed, as long as quarantine centers and shelters are in place.

Incarceration

LAC has some of the world's most overcrowded prisons, with many of the prisoners in pretrial detention. Detention facilities in Haiti have an occupancy rate of 450%, with Bolivia and Guatemala at around 360%.²⁰⁹ Incarceration rates are much higher for men than women in the region, with women representing only 3% (Dominican Republic) to 10% (El Salvador) of total prison populations.²¹⁰ This means consequences of potential infections in detention facilities will be especially high for men and in particular, young men. Even before COVID-19 infections began, crowding, poor ventilation and limited healthcare meant there were increased risks of infection in prisons, especially of airborne diseases. For example, in Brazil, rates of tuberculosis among prisoners are 35 times higher than the national average. Colombia linked some of its cases in other departments outside Bogota, to prisoners transferred from a prison in Villavicencio.²¹¹ Though countries such as Argentina, Chile, and Brazil were attempting to reduce the population in their prisons to reduce risks in the context of COVID-19, conditions in the region remain concerning.²¹²

As mostly male prisoners are released, their return home will likely have knock off effects of increasing women's care burden as they reintegrate into their families and households, as well as potential exposure to trauma, violence and potential infections.

Sexual Exploitation

Global evidence shows that an overall economic downturn can cause increases in sexual exploitation and abuse.²¹³ For example, research following the Africa Ebola outbreak suggests that the COVID-19 pandemic has the potential to increase the risks of sexual exploitation and violence by state officials and armed guards,²¹⁴ as well as landlords, employers, and others in positions of power and authority. This is a particular concern for at-risk groups who may be forced or coerced to provide sex in exchange for food or other necessities. Single female-headed households were particularly at additional risk during the Ebola outbreak,²¹⁵ a pattern with the potential to be repeated in LAC.

Refugees and migrants in the region also have significant livelihood risks as many are unable to cover basic needs. 97% of Venezuelan migrant heads-of-household have reported they do not have a fixed salary.²¹⁶ Before the onset of COVID-19, many Venezuelan migrant women, especially in Colombia and Ecuador found themselves in vulnerable situations with little source of income and at risk of sexual exploitation. In Colombia, for example, Venezuelan women were already forced to resort to transactional sex as a coping mechanism prior to COVID-19.²¹⁷ Current reports indicate this has been getting worse since the onset of the crisis, with refugee and migrant women are finding themselves forced to have sex in exchange for housing, food or basic supplies as a result of income and goods shortages related to COVID-19.

3.7 Capacity and Coping Mechanisms

The majority of LAC governments have already implemented different measures to help those in the region cope with the impacts of the crisis,²¹⁸ including moves towards easing mobility restrictions and infection control related closures. The Government of Guatemala is targeting vulnerable populations in urban and rural areas, including female domestic workers, poor families in settlements, and children, with social programs funded by World Bank loans.²¹⁹ Other countries such as El Salvador, Colombia, and Peru are providing direct economic support to families through vouchers, cash transfers, and in-kind food assistance. Peru has delivered more than \$300 million to 1.23 million families,²²⁰ while Colombia is also providing cash transfers to around 3 million vulnerable households,²²¹ and Peru has announced a voucher program of \$223 for households with monthly incomes below \$340.²²²

While many vulnerable families are being reached, it is critical to emphasize the need to ensure that the most affected – especially female headed households, women in the informal sector, LGBTQI+ people, and those who lack social and legal protection for their jobs – are included in current or future economic and social stimulus packages. Migrants with irregular status should also be considered as their legal status often excludes them from receiving any support the regular population receives.²²³ Examples include Brazil's program to provide USD \$120 for 3 months for up to 2 people in the same family, with double the amount (USD 240/month) being targeted at single female headed households with at least 1 dependent less than 18 years old.²²⁴ This recognizes women's disproportionate care burden, increased care costs, and higher likelihood of economic vulnerability given the sectors affected.

3.8 Specific Sectors Issues

Shelter

Access to shelter, land, and housing had key gender differentials in LAC prior to the COVID-19 outbreak. LAC is the most urbanized region in the global south,²²⁵ with 81.2% of the population living in urban centres.²²⁶ Women are becoming a growing share of the urban population in the region, with urban sex ratios which have favored them since the 1980s. In El Salvador and Guatemala, for example, 15 more women per 100 men, and 12 more women per 100 men, aged 15 to 49 live in urban areas respectively.²²⁷ Economic differences combined with gender barriers to information, education, legal titles, access to land, incomes, credit facilities, among others,²²⁸ severely impact men and women's different capacities to address housing, land, and tenure security issues, particularly during a crisis. Quarantine and self-isolation measures demand secure housing, but the economic impacts of COVID-19 measures mean men and women's capacities to absorb these shocks and find secure housing have become increasingly limited in the face of the pandemic. This will continue even as mobility restrictions are lifted.

Informal Urban Settlements.

In 2016, more than 100 million people lived in informal urban settlements in Latin America,²²⁹ meaning 1 in 4 people in cities live in areas with inadequate infrastructure and cannot properly access basic transportation, utilities, or safe housing. These numbers have since climbed to 113 million or 1 in 5.²³⁰ In Colombia, more than 24% of the built-up areas of all cities are informal and almost 5 million people live in them,²³¹ while approximately 13 million Brazilians live in favelas.²³² In countries such as Guatemala and Haiti, there are 120 women for every 100 men living in informal settlement and settlement-like conditions.²³³ In Mexico, 15% of women live in houses with infrastructure or space deficiencies, a percentage which increases to 45% for Indigenous women.²³⁴ While current homeownership and tenure types are difficult to find by gender at the regional level, a 2007 meta-analysis identified that female headed families in LAC have a lower probability of owning their own homes (13 out of 17 countries surveyed).²³⁵ More men than women also continue to have greater access to land, legal titles, financing, and/or the assets needed to secure adequate housing.²³⁶ Data is not accessible for LGBTQI+ populations.

During the COVID-19 pandemic, access to safe shelter is important for everyone, but has important impacts for intra-household gender equality. In informal settlements, and underserved areas, housing and public space are crowded and access to clean water and hygiene items is limited, making social distancing and hand-washing almost impossible.²³⁷ **Simply put, women’s overrepresentation in informal settlements exacerbates their lack of access to the hygiene supply and measures needed to properly prevent COVID-19 infections. Lack of access to essential infrastructure in informal settlements also restricts women from participating in decision making and income-generating activities and aggravates the resulting ‘time poverty’,**²³⁸ further increasing their risks. For example, families who do not have running water at home must travel outside the home to collect water, use shared toilets, and gather sufficient quantities of items to service household hygiene needs. In Mexico, the time dedicated to housework increases 15% in houses without piped water.²³⁹ While no official statistics exist yet of the increased care burden due to COVID-19, and associated risks, it will likely be disproportionate for women and girls living in precarious housing.

Temporary Accommodation.

COVID-19 has also compounded pre-existing difficult situations for refugees, IDPs, and migrants in LAC. For example, prior to COVID-19, young male Venezuelan migrants in Peru, Ecuador, and Colombia already spent more time sleeping outside, on the streets, than their female counterparts.²⁴⁰ While the reason for this is not known, similar patterns have been seen in other areas. There is conjecture that this is because many female migrants travel with children and/or others for family reunification, whereas many men were traveling on their own as initial migrants.²⁴¹ For example, a CARE



Colombia Needs Assessment found that most families with young children found somewhere to rent in the border towns of Colombia (La Parada), but these places are inadequate and overcrowded spaces. As economic opportunities dry up, and housing costs in many areas increase as a result of COVID-19, migrants are at a higher risk than ever of evictions,²⁴² and the numbers of homeless refugees and migrants is increasing.²⁴³ Female single parents have, specifically, reported challenges due to loss of assistance from their relatives, and lone female ‘caminantes’ and children living outside are vulnerable to harassment and exploitation including offers of transactional sex for accommodation and food.²⁴⁴ In addition to formal shelters for displaced, refugee and migrant populations, spontaneous occupations have also sprung up. However, running water and wash facilities are even scarcer²⁴⁵ in these locations, likely impacting women, girls, and LGBTIQ+ people in these spaces disproportionately.

As actors set up temporary accommodation options for people affected by COVID-19 – including in hotels, through cash-for-rent programs, and decongestion isolation areas – gender dynamics around safety, care, and access to essential services need to be kept in mind. For example, reconstruction efforts in Haiti after the earthquake demonstrated that women and girls had specific safety needs for housing design such as a second door, locks, and exterior lighting.²⁴⁶ Some LAC countries are putting some form of gender-sensitive shelter policies in place as part of their COVID-19 response. These forms of support include family friendly spaces, eviction moratoriums and/or rental subsidies for women and marginalized groups especially those working in the informal and precarious employment sectors.



🚰 WASH – Water, Sanitation and Hygiene

In LAC the population using safely managed drinking water services increased from 56% to 74%, and the rate for sanitation services from 12% to 31%. Since 2000, this region has recorded the largest increase in the use of improved water sources free from contamination, however less than 50% of wastewater was treated in most countries.²⁴⁷

The COVID-19 pandemic will have impacts on current gender inequalities in access to and use of adequate, safe WASH services. Overall, the burden of water collection falls disproportionately on women,²⁴⁸ with over half of households relying on women to use sources located off premises.²⁴⁹ Women who live in households without access to potable water spend between 5 and 12 hours more a week on unpaid domestic and care work than women who live in homes with access.²⁵⁰ In Mexico, the time dedicated to housework increases 40% when they have to carry water.²⁵¹ In Honduras, only 33.34% of the women had the drinking water system located inside the home, which means that 77 out of 100 women are forced to carry water from public taps or other sources to ensure water access in their homes.²⁵²

The gendered impact on access to water and improved sanitation systems also intersects with other variables, such as poverty, that exacerbate the problem. In Bolivia, for example, only 38% of the poorest households have running water (supplied by pipelines), compared to 99% of the richest households. Up to 65.7% of rural households in Bolivia do not have access to household water and, therefore, to the basic conditions they need to prevent infection by washing their hands. This implies a greater burden of domestic work and unpaid care, as well as risks exposure, for women and girls because of limited access to basic infrastructure.²⁵³ This will disproportionately impact Indigenous women and girls, in particular as many underserved areas have high numbers of Indigenous and Afro-descendant populations. In Argentina, 75% of families in Rivadavia (Salta) and Ramón Lista (Formosa), where 70% of the population is Indigenous, do not have access to safe water,²⁵⁴ and in Brazil Afro-Descendant women are more likely to live in areas where water is scarce.

According to UNICEF²⁵⁵, approximately 1.8 billion girls, women, and LGBTIQ+ people menstruate, though millions do not have access to basic services to manage their monthly cycle in a dignified, healthy way. The lack of water and sanitation also affects their ability to practice adequate menstrual hygiene, a lesser

explored implication that is central to guaranteeing the well-being and equal participation,²⁵⁶ mobility, work, safety and health of those who menstruate. It is possible that supply chain disruptions will increase costs for essential menstrual products, thereby adding additional costs of living for those who menstruate; forcing them to choose between essential items and services such as food and menstrual products. Additionally, women and girls who do not have sufficient access to adequate water, sanitation and hygiene facilities might be exposed to violence and health hazards, such as gastrointestinal illnesses, respiratory and skin infections,²⁵⁷ and the spreading COVID-19 and others virus. For example, in Guatemala, 80% of households surveyed as part of COVID-19 needs assessment activities reported a lack of access to clean water. A total of 86.7% of women and girls in those households identified their urgent needs as food, followed by personal hygiene products and services including clean water and menstrual hygiene products.²⁵⁸ These needs are likely to persist even after countries begin to lift COVID-19 restrictions as supply chains continue to be disrupted and women and girls already living on the edge, continue to use their scarce resources for other household needs.

Food Security

Gender differences in food security in LAC are more pronounced than the global averages.²⁵⁹ While 31.1% of the regional population (187 million people), experienced moderate or severe food insecurity in 2016-2018,²⁶⁰ 69 million were adult women (29.9%) compared to 55 million men (24.8%). High levels of inequality exacerbate the vulnerability of children, women and individuals of Indigenous and ethnic minority backgrounds, preventing them from accessing a healthy diet.²⁶¹ Additionally, rural women are responsible for more than half of food production in the region, but hold only 30% of land titles and receive only 10% of credit.²⁶² Gender disparities in food security are even more pronounced for people with intersectional identities such as Indigenous and Afro-descendant women, rural women, women living with disabilities, refugees and migrants, and others.

Sales of processed foods are extremely high in the region, increasing exposure – especially of those in low-income areas – to excessive amounts of sugar, salt, fat²⁶³ and related health issues such as diabetes and obesity. Almost 1 in 5 children under five in the region are malnourished or overweight while,²⁶⁴ 59% of the 105 million adults in the region living with obesity, are women.²⁶⁵ While research is still on-going regarding co-morbidities, and underlying risks related to pre-existing conditions for COVID-19, current evidence suggests that diabetes and obesity are 2 of the key risk factors for the disease.²⁶⁶ This will impact women in LAC more significantly than their male counterparts given their higher rates of these pre-existing risk conditions.

Women and girls are also facing increased difficulties accessing nutritious, safe food in the wake of COVID-19, due to the closure of food services in schools and communities, food shortages, disrupted supply chains, decreased income, and movement and quarantine restrictions. This will likely continue even after restrictions have started to lift given longer term impacts on supply chains. In Central America's dry corridor, where consecutive seasons of drought have destroyed harvests and depleted reserves, farmers are hesitant to plan for fears of COVID-19 infection or of being detained by police. At the same time, rice and wheat prices were already rising in April.²⁶⁷ The World Food Program received requests for support to 800,000 people affected by the COVID-19 crisis in Colombia, in addition to the regular monthly support provided to 300,000 individuals.²⁶⁸ In Haiti, active malnutrition screening was suspended at the community level, and outpatient malnutrition activities are limited due to low attendance by malnourished children and their parents.²⁶⁹ In Central America, 3.2 million people need food assistance in Honduras,²⁷⁰ 60,000 households have been identified for food assistance in El Salvador, and a CARE needs assessment in Guatemala found that 64% of families, across 95% of the communities assessed do not have sufficient economic resources to meet basic food needs in the context of COVID.²⁷¹

This level of increasing food insecurity is bad news for women, girls, and people from vulnerable groups. Evidence from previous crises shows that food insecurity can lead to harmful coping mechanisms and situations, such as the changes in diet, decreasing consumption and sexual exploitation.²⁷² For example, a CARE Needs Assessment in Guatemala found that 93.3% of households surveyed lost their income as a result of unemployment and economic shut downs due to COVID-19 and 56% of the families surveyed decreased the quantity and quality of food intake, as well as other basic product consumption, as a coping mechanism.²⁷³ Women across the region are reporting skipping meals, or depriving themselves of nutritious foods, so that they have more available for their children and families.

Additionally, 85 million children benefit from school feeding programs in LAC, and schools represent one of the most reliable sources of daily meals for about 10 million of these children.²⁷⁴ School closures and the related suspension of feeding programs during the pandemic therefore pose risks to the food security and nutritional status of many children, with risks being particularly elevated for girls and children from vulnerable groups. As schools have begun to re-open throughout the next time period, it is essential that girl children continue to be given equal priority and that school feeding programs resume. Previous crises have shown that at-risk groups include pregnant and breastfeeding women, women in rural areas, children under 5,²⁷⁵ and other groups facing intersectional vulnerabilities such as homeless people, LGBTIQ+ people, and ethnic minority women living in poverty.

5. Conclusions

Women, men, boys, girls, and LGBTIQ+ people in LAC are being differentially affected by COVID-19. While case fatalities, and total cases, still appear to be primarily affecting older, men from marginalized groups, women and girls are likely being the most impacted in the longer term by the social, economic, political, and public health measures being put in place. Women, and girls' unpaid care work is the backbone of national public health responses, as women take on the burden of providing additional household and social care services in the absence of sufficient public systems. Pre-existing structural inequalities are being deepened, exacerbating vulnerabilities and limiting women's income security and autonomy; leaving them increasingly less time for income-generating and decision-making activities.

As the majority of informal workers, and the population with less access to safe, dignified work services, women and girls are also being disproportionately impacted by economic slowdowns and work stoppages. Several states in the region are recognizing and building equity measures into relief packages so as to mitigate these inequalities, but more still needs to be done to ensure the rights of the most vulnerable are supported throughout the entire cycle of response to recovery. While there have been important advancements in GBV, SRH and health services across the region as a result of COVID-19 adaptation measures, these advancements need to be harnessed, invested in, systematized and scaled up. Rates of GBV and related Protection issues will continue to increase as long as economic and isolation measures are in place. As countries lift these measures, flare ups will continue to be seen each time infection control measures need to be brought back in, requiring specific gender analysis to be part of infection control measures and decision making moving forward. GBV and SRH service platforms will need to be part of essential packages, just as much as health measures, household support packages, and income supports. While reports indicate that gender relations are changing in some households, as women's caring role become more and more visible as an essential service, and men take on marginally more care work, this still needs to be harnessed as an opportunity for change.

Ultimately, women, girls, and LGBTIQ+ people – particularly from at risk groups – are facing disproportionate health, economic, and social risks from the COVID-19 pandemic. Women and girls are on the frontlines, doing the majority of the paid care work in the health sector and the unpaid care work at home. Effective short- and long-term responses will require equity measures be built in at all steps of intervention design, recognizing women, girls, and LGBTIQ+ people's leadership and agency, as well as

men and boy's capacity for transformational change. Humanitarian actors and CSOs should, ultimately, partner with and provide support to local agencies and local women's organizations leading the response on the ground.

6. Recommendations

A Rapid Gender Analysis is designed to be updated as the situation evolves, and new information becomes available. This is particularly important given the continued lack of gender and intersectional data currently available on the different impacts of COVID-19 as well as continually evolving health research to better understand, and combat, the disease.

Overarching Recommendation

It is recommended that **organizations continue to invest in gender and intersectional analysis, that new reports are shared widely, and that programming and policies be adapted to continual, changing needs, even as response moves into a longer-term phase.** Continual up-to-date gender analysis of shifting gender dynamics in affected populations will allow for more effective and appropriate programming as responses to COVID-19 continue.

It is further recommended that humanitarian actors and CSOs advocate for, and support the provision of, free, immediate, adequate and timely access for women, girls, migrants and refugees and LGBTIQ+ people to legal, psychological, health care, as well as counselling, education, water and sanitation, housing, childcare, employment, protection, and access to justice and reparation, in accordance with international standards.

Priority Recommendations

1. Conduct country specific gender and intersectional analyses with contextualized response recommendations for diverse groups of men, women, boys, girls and LGBTIQ+ people; especially those currently underrepresented in the data: While many agencies have already conducted sectoral gender analyses, it is important to:

- a. Ensure these studies disaggregate for intersectional identities such as gender, ethnicity, migratory status, disability, and other factors.
- b. Privilege data collection about, and in support to, groups who are underrepresented in current gender analysis information, but who are the most vulnerable and disenfranchised – i.e. LGBTIQ+ people, homeless and/or migrant, refugee and/or displaced women, Indigenous and Afro-descendant women and girls, men and women in prisons, quarantined migrants and refugees who identify as LGBTIQ+, young domestic workers, etc.
- c. Use existing gender analysis and secondary data to inform initial prevention and response efforts at local level; while developing inter-agency, multi-sectoral gender-analyses as soon as relevant data is available, and sharing widely to ensure gender-responsive COVID-19 interventions.

2. Systematically collect sex, and age, disaggregated data (at a minimum), and ethnically disaggregated data wherever safe and possible, in all areas relevant for the health, social, economic, and political areas of COVID-19 response: COVID-19 related risks are not only health issues. It is therefore important to:

- a. Systematically collect the sex and age disaggregated data (and for at risk groups) throughout all stages of assessment, response and monitoring, including:

- b. Health - Rates of infection, co-morbidities, treatments, and social determinants related to risks of COVID-19.
- c. Economic and social impacts of COVID-19 response policies – livelihoods, nutrition, well-being, job security, mobility, migration, care burdens, social protection, and GBV.
- d. Invest in remote data collection technologies that support informed consent, safety, and privacy of respondents – both to protect them from potential harm, and to respond to gendered barriers to connectivity.
- e. Systematically include gender and inclusion indicators in all sectoral assessments and response for COVID-19²⁷⁶ to assess the impacts and trends of the virus on different groups, and to ensure effective programming and advocacy. See the [CARE COVID-19 Policy Paper](#), the [IASC Gender Alert for COVID-19](#), and [UN Policy Brief: The impact of COVID-19 on women](#), for specifics.

3. Partner with diverse LGBTIQ+ and women’s organizations, and support their participation and leadership, as a cornerstone of effective COVID-19 response: Response agencies should engage a diversity of women’s organizations and LGBTIQ+ organizations and activists in all planning and response efforts – from local to national and regional levels – as key decision-makers and leaders. This ensures effective, inclusive, action from assessment through to recovery. To achieve this:

- a. Map, identify, and partner with local community capacities and networks – such as women’s groups, community groups, civil society organizations – as well as national women’s rights organizations.²⁷⁷ Ensure these networks include a diversity of women and experiences.
- b. Coordinate with existing national and local women’s rights mechanisms, and the participation of women’s and feminist organisations and movements, including those of Indigenous, Afro-descendant, rural and community-based organisations.
- c. Provide core organizational support – including administration costs, communications and internet infrastructure, transport and salaries – when lack of access to those can otherwise be barriers to participation or response; especially for marginalized, smaller organizations representing vulnerable or minority groups.
- d. Increase investment in women’s community-based and civil society organisations as well as human rights defenders, so that they can continue to develop local and community support networks and promoting the participation of women in the decision making and in public policy.²⁷⁸
- e. Recognize women’s unpaid labour as an essential element of COVID-19 response and provide relevant financial and logistical support for organizations’ activities related to this, as well as their work as first responders.
- f. Provide women and LGBTIQ+ leaders and their organizations with guaranteed, safe, access to data and internet so they are not excluded from on-line coordination, participation, and planning mechanisms.
- g. Partner with diverse local women, LGBTIQ+ people, and local civil society organizations, to ensure all programmatic and public health messaging is localized, evidence-based, safe, dignified, clear, and grounded in positive, social norm change. Ensure it also recognizes, understands, and uplifts women’s traditional knowledge, especially in Indigenous communities.
- h. Ensure coordination and decision-making bodies are gender-balanced and inclusive, creating specific seats for marginalized and disenfranchised groups such as LGBTIQ+, Indigenous women, migrants and refugees women, women living with disabilities, and others. Where necessary, use quotas, targets, and other mechanisms at global, national, and local levels.²⁷⁹

4. Recognize and value the care economy – paid and unpaid – including household and paid sector activities. Care workers – both paid and unpaid – should be recognized as essential workers and supported to carry out their work safely. To do this:

- a. Exempt caregivers from mobility restrictions, when they are in place, and provide them with all required information and security equipment.
- b. Recognize, and support the reduction and redistribution of unpaid work taking place at home, as part of basic humanitarian intervention and program design.
- c. Provide specific, targeted, cash support and interventions to people with care responsibilities, for both paid and unpaid care work, ensuring access to health and income.
- d. Provide childcare services, particularly for the children of essential workers, as a standard part of all humanitarian and pandemic actions – especially while daycare centers are closed. Enable flexible working arrangements and reductions in working time for non-essential workers with care responsibilities to reduce double burdens and maintain an adequate standard of living.
- e. Prioritize access to food and basic services to alleviate unpaid care and domestic work as part of critical strategies for containing the spread of the virus and reducing the unpaid care and domestic work burden on women. Support continued school feeding programs as much as possible.
- f. Encourage greater sharing of care responsibilities between women and men, through advocacy and media campaigns to encourage more men to engage in domestic work and to fathers to do their fair share of childcare.

5. Actively adjust all COVID-19 response activities and expectations to provide trauma-informed, women-friendly, Inclusive, work environments: Responders should be aware of the increased barriers facing front line service providers because of COVID-19 measures, such as: working under quarantine, working under precarious conditions, increased time poverty and care burdens, increased transportation and connection barriers, and potentially decreased safety both in the home and where providing services. To address this, donors, governments, and agencies should adjust organizational management practices to address these barriers:

- a. Adapt response proposal, planning, due diligence, and related funding and reporting procedures to ease the burden on responders, so they have more time for emergency community and family activities.
- b. Be aware of women and girls' specific needs as ways of working continue to shift; For example, GBV survivors are not only found in affected populations, but also in responding agencies. It is important to understand that workers may be facing more violence in their home and may need different leave policies, or work hours, without being able to openly articulate why (because the abuser is present).
- c. Provide priority support to women and marginalized groups providing front line services, for example 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.
- d. Ensure all materials, programs, messaging, are widely accessible to all audiences, specifically by: publishing them in all languages spoken, engaging in grounded translation processes, offering multiple engagement methods that do not just depend on someone being able to see or hear (i.e. teleworking options are not always accessible for people living with disabilities), and others.

- 6. Build women’s political and economic empowerment into both immediate relief, and longer term response and recovery, strategies by addressing unequal burdens of care:** There is a deep understanding in LAC of the cost and contribution women’s care work brings to the economy, national health, and family well-being as well as its role in backstopping national public health during the COVID-19 response. Leverage this for effective short term response and long term transformation of unequal care burdens:
- a. Support and promote the work and leadership of women at the community level as an important element of the prevention and response to the pandemic.
 - b. Systematically include sex and gender disaggregated time-use, and care burden, data in all agency, inter-agency and multi-sectoral needs assessments. Where possible and safe for respondents, further include ethnically disaggregated data as well.
 - c. Design and implement a coordinated system, for accessing and using, time-use and care burden data. Consider using interactive technology, dashboards, and other real-time visualization tools to track the impacts COVID-19 related care, and humanitarian activities, have in contributing to women’s time poverty and associated health factors.
 - d. Recognize care-burden changes and consider cash schemes and/or social safety net programs to support these activities.
 - e. Twin economic supports (such as humanitarian cash transfers, small and medium business grants, tax relief, one time grants, transportation subsidies, and other such actions) with specific incentives to institute gender and inclusion measures (such as offering specific support services for domestic workers advocating for safe working conditions, or offering additional incentives to small businesses to bring in daycares, gender/inclusion hiring equity, and/or flex hours as part of their HR practices).
- 7. Ensure women, girls, and LGBTIQ+ people are systematically included in all COVID-19 response planning and decision making, in the short, medium, and longer term.** When countries in the LAC region begin to lift Covid-19 public health lockdowns and other measures, it will be important to ensure a gender lens is still included throughout the decision-making process. Women, girls, and other vulnerable groups will experience the easing of public health restrictions differently, just as they experienced current COVID-19 responses differently. It is essential that their needs, experiences, and capacities are understood and included.

Sectoral Recommendations

₹ Health, including Sexual and Reproductive Health and Rights

1. Enable access to healthcare services for women and girls, and the most at-risk groups (including refugees and migrants), by eliminating the cost of COVID-19 prevention, treatment and care where those costs create barriers. This includes the indirect costs related to associated, increased, care burdens; i.e. older girl children for siblings, young women caring for elder parents, and others.
2. Strengthen health systems and guarantee universal access to testing, medication and treatments, especially for women and members of marginalized groups.
3. Provide support for female health workers’ health, psychosocial needs and work environment of frontline female health workers, including midwives, nurses, community health workers, as well as facility support staff; including the supports needed to offset the additional burden of household management and care duties, and essential hygiene and sanitation items, particularly for particularly those quarantined for prevention, screening and treatment.
4. Ensure Personal Protection Equipment is the appropriate size and design for women.

5. Ensure existing funding is maintained for all life-saving health services including SRH and mental health, particularly where primary health resources are diverted to the COVID-19 response.
6. Ensure any and all telehealth services plans take the gender data gap into account and include specific messaging, campaigns, data support plans for reaching women and marginalized people who do not usually have internet access or smart phones.
7. Include women health frontline workers in all decision-making and policy spaces to improve health security surveillance, detection, and GBV response and prevention mechanisms.

Gender Based Violence

1. Ensure GBV services are considered essential throughout the pandemic response – both before and after mobility restrictions are imposed; specifically ensure that quarantine regulations and movement restrictions contain exception clauses for GBV survivors, their children, and/or their caregivers and other dependents.²⁸⁰
2. Increase investment in funding for GBV prevention and response as part of essential COVID-19 interventions, including essential health, socioeconomic, legal and psychosocial services for survivors; both during and after the pandemic. This includes but is not limited to the clinical management of rape, psychological first aid, case management, and shelters/refuges. Develop guidelines and resources for family members, friends, neighbours and other witnesses to create a culture of zero tolerance, including campaigns and messages aimed at men.²⁸¹
3. Strengthen the identification of, and support to, GBV within health sector responses; including understanding clinical care – and support for – child, LGBTIQ+, women and male survivors.
4. Collaborate with grassroots women’s groups and civil society women’s organizations to ensure alternative community-based mechanisms are put in place for survivors who do not have access to internet or smart phones.
5. Classify technology and communications as essential life saving protection services – such as access to internet, data, smart phones, and related costs – and provide them as part of the basic package of services to survivors.
6. When appropriate, use cash transfers as part of GBV survivor case management and for those at risk for GBV. Transfer values will be determined by the needs of the survivors and may vary across the gender groups and their household compositions.
7. Specifically target and support shelters, safe spaces, and organizations for LGBTIQ+, disabled, Indigenous, migrant, and other vulnerable populations disproportionately impacted by increases in violence as a result of COVID-19. Recognize that mixed-group services may not always be safe for marginalized women and men, or LGBTIQ+ populations and invest in additional, specific, services and spaces for them.
8. Capitalize on high levels of access to mobile phones to continue building digital access to GBV and Protection services through free phone and virtual channels; ensuring sufficient support and investment into required digital platforms and outreach mechanisms and noting the gender disparities in access to technology. Ensure updated referral pathways are regularly disseminated to reliably bring information to at-risk groups.

Protection

1. Advocate for gender-based lockdown and pass systems to be removed; thereby avoiding prescriptive gender-identity ideas that can increase the risk of stigma and violence. Ideally, base these on the number of days and people that can be moving about instead of any identity-based system (gender, age, migratory status, etc.) that can inadvertently create barriers or cut vulnerable people off from the services they need.
2. Specifically target confined groups at-risk of infection and/or discrimination – such as prison populations – to provide support, including services such as cash and housing if released. This should be part of a dual GBV prevention and Protection Assurance strategy.
3. Collect quantitative and qualitative data on GBV and all forms of violence during the crisis to inform solutions, prevention and support measures during and after the crisis.²⁸²
4. Adopt measures that ensure access of migrant women and refugees to health services, employment, and food to mitigate protection risks with particular attention to gender-based violence, trafficking of women and girls, and the promotion of social cohesion.
5. Expand protection systems to reach the under-employed or self-employed, youth, women, children and the elderly.
6. Partner with LGBTIQ+ organizations to research, and develop, education and awareness raising campaigns to address stigma and barriers to accessing services.

Livelihoods and Income Generation

1. Develop intervention strategies that both target the immediate economic impact of the outbreak on women and at-risk groups, and build longer term resilience:
 - a. Where feasible, appropriate and safe, use cash and voucher assistance to meet the immediate needs of women and LGBTIQ+ people. Do this by developing gendered-market analysis as part of CVA interventions and considering CVA for small business grants, to facilitate documentation, and for gender friendly livelihoods development.
 - b. Consider targeting cash transfers directly to women and vulnerable groups who might face barriers to formal supports, such as undocumented migrant workers, domestic workers, women head of households, women only dedicated to unpaid care work, LGBTIQ+ people, and others.
 - c. Provide direct compensation to informal workers, including health workers, domestic workers, migrants, and the sectors most affected by the pandemic, so that most affected women can maintain income generation and livelihoods.
 - d. Prioritize sectors with high levels of women's participation, and which are heavily affected by the crisis, such as teaching, nursing, hospitality, food and tourism sectors.²⁸³
2. Ensure gender-sensitivity in use of cash and vouchers: The process of how CVA is delivered matters. When deciding on the selection of modalities, potential vendors, delivery mechanisms, women and other vulnerable genders must be considered in the design phase.
3. Ensure GBV mitigation when using CVA: In a region with such a high prevalence of GBV, it is incumbent on agencies to mitigate as much as possible any risks that could be associated with CVA.

Water, Sanitation and Hygiene

1. Ensure WASH messaging for infection control and safety is localized and appropriate for different

social norms, languages, and cultures – including the different norms and health seeking behaviours for men compared to women (i.e. around hand washing).

2. Work with health providers, municipalities, and women's networks and organizations to ensure women's different water and hygiene consumption needs are included in COVID-19 response planning, including:
 - a. Accurately provisioning for the increased quantities of water they need to access and consume for their care, as well as for elder and child care (given the weight of unpaid care burden women in LAC carry).
 - b. Implementing positive social norms change messaging to encourage male partners and other household actors who do less care work to take on more of the load.
 - c. Properly consulting and siting WASH facilities with women, girls, and vulnerable groups such as LGBTIQ+ people and women with disabilities in quarantine and containment centers, as well as shelters and temporary clinics or health provision service points.
3. Provide an appropriate number of safe water points, showers, latrines and washing points are supplied in communities that do not have them. Ensure they are located in safe and illuminated places, accessible to people with disabilities, older adults, boys and girls, and LGBTIQ+ people, without discrimination. Ensure facilities are safe (generally separated by sex, and by children/adults), offer privacy, and include hygienic spaces for transgender people.
4. Ensure awareness messages, images, and products related to care for the sick, and infection control, do not continue to exacerbate existing stereotypes of women's role as caregivers. Ensure all images and messages include women from diverse backgrounds, as well as men from all diverse backgrounds.
5. Identify women and girls' menstrual hygiene as a key essential service and provide free access to menstrual hygiene products. Ensure households can access sufficient water for proper hygiene practices that are both culturally appropriate and safe, regardless of location and water source.

Food Security

1. Include measures to address women and girls' unpaid care and domestic work of women in messaging, service schedules, service offers, and supports provided (i.e. transportation, service siting, childcare, clinic and nutrition program hours, etc.)
2. Nutrition facilities and nutrition schedules should include people who are at higher risk of malnourishment, with a focus on private support to women who are breastfeeding or lactating. They may have higher nutritional needs and may need to maintain their supply of milk while separated from their children.
3. Ensure nutrition facilities, services and messaging are culturally appropriate, safe, and use specific easy-to-understand language.
4. Consider programming (in-kind distributions, cash and voucher assistance) while strong social distancing measures are in place, specifically and intentionally targeting both those vulnerable to COVID-19 as well as the women, girls, LGBTIQ+ people and marginalized people who run the risk of being harassed in those spaces. Consider including additional targets for women and girls whose care burdens mean they cannot go to markets to meet basic food needs (ie single women who cannot leave children or elders home alone, women (or men) who are solely responsible for child education in their off hours, etc.)

5. Provide increased training and support to nutrition and health care staff in order for them to recognize the signs of violence and abuse so that they can offer first-point-of-contact for affected women and at-risk groups who may not have access to other safe space.
6. Design gender, and culturally sensitive, nutritional messages and campaigns offering adapted information for maintaining health, given the knowledge that many women will continue to deprive themselves of food so their families can have more.

Shelter

1. Well-ventilated homes reduce the risks of respiratory diseases. Existing shelter programs should focus on meeting urgent shelter needs – while prioritizing protection and access to household level WASH inside homes as these tasks often fall to women.
2. Shelter material distributions (e.g. tarpaulins) can assist families in constructing internal partitions / isolation booths for infected family members. Having sufficient household items such as kitchen sets, stoves, blankets, mattresses for different household members to use rather than sharing can also help to reduce transmission of the virus as well as reduce protection risks.
3. In collective shelters/centers ensure that families can have separate living units and are not sharing sleeping areas. Whenever possible, families should be accommodated together as a family unit, with the caveat that people who report domestic violence must be moved to a safe place or protected in some other way (for example, by staying with another family).
4. For tenants (especially displaced women, migrants and refugees and LGBTIQ+ people) who are at risk of eviction, partner with women's groups, community organizations, and others to offer rental subsidies, family housing allocations, or other housing support measures as costs continue to increase. This can be part of a cash-for-shelter program approach but must be done in collaboration with livelihoods support and with an exit strategy as it is not a sustainable activity.
5. Explicitly target women, girls, and vulnerable groups such as trans women, domestic workers and migrants for shelter support and moratoriums and eviction support.
6. Partner with women's groups, community organizations, and others to offer rental subsidies, family housing allocations, or other housing support measures as costs continue to increase. Cash for rent may also allow some families to rent more space or improved healthier accommodation.
7. Conduct regular, systematic, safety audits of any informal settlements, spontaneous shelter spaces, and surrounding neighbourhoods for women, girls, and at-risk groups. Include analyses of transit patterns, and transit modes, that assess both physical risks as well as emotional and health risks. Build these into community programs for shelter allocation or re-allocation.
8. In transit or collective centers, lone women and unaccompanied children should be allocated safe spaces that are monitored by trained, female staff, including women and children who are in isolation for COVID-19.
9. Provide ongoing information on services, programs and spaces available for women, girls, and LGBTIQ+ people in temporary shelters, taking into account appropriate means of information, literacy levels and language.
10. Advocate for the rights of refugees or IDPs living in substandard shelter conditions and formulate decongestion strategies in housing and settlements. Government and local stakeholders may consider to free up land around settlements, and donors can help fund infrastructure and shelter improvements to reduce risk of transmission. Specifically advocate for women, girls', and LGBTIQ+ people's particular needs to be included in these strategies.

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Acknowledgements

This RGA has benefitted from the valuable contributions of CARE International and UN Women colleagues throughout Latin America and the Caribbean, including members of: The CARE International Gender in Emergencies team, the CARE International Regional Management Unit, UN Women ACRO Teams on Peace and Security and Humanitarian Action; Economic Empowerment; Governance and Participation; Violence against Women and Communications. CARE Country Offices in Colombia, Cuba, Ecuador, Guatemala, Haiti, Honduras, Peru, and UN Women Country Offices in Argentina, Brazil, Bolivia, Colombia, Ecuador, Guatemala and México. The authors would also like to acknowledge the substantial contributions and inputs provided by Tamah Murfet, Francisca Vigaud Walsh, Melissa Ekdor-Delorme, Ada Zambrano, Amelia Rule, Catalina Vargas, Cecilia Alemany, Raquel Coello, Paula Narvaez, Yeliz Osman, Elisabeth Diaz, Gerald Mora, Denize Santana, Gianluca Giuman, Tamara Jurberg, Ana Claudia Jaquette, Belen Zamora, Bia Albernaz, Carolina Tejada, Juliette Bonnafe, Natalia Calero, Ana Grace Cabrera, Delfina García, Alexandra Guerrón throughout the RGA process.

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