

August 2020



Driving the development paradigm in the post COVID-19 world

Gender inclusivity in
response and recovery



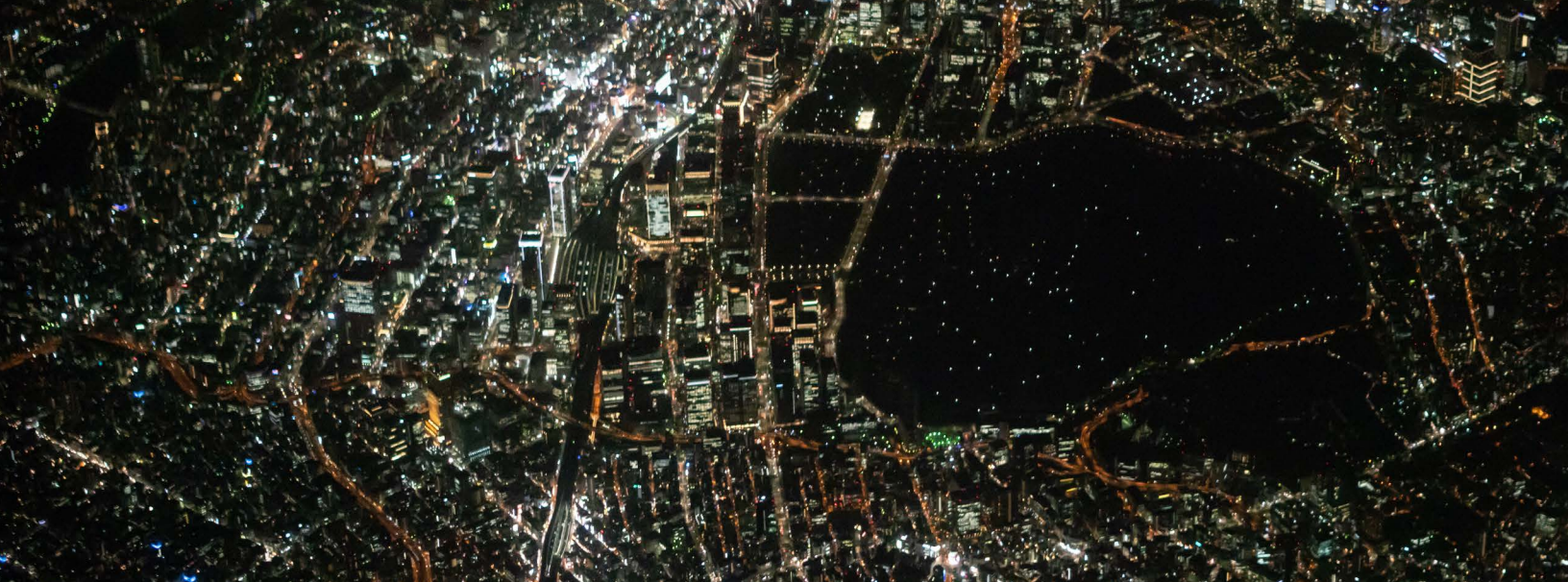
Introduction

The COVID-19 pandemic has led to an unprecedented health crisis in India. At the same time, measures to respond to COVID-19 (including social containment measures such as lockdowns and curfews, physical distancing and restrictions on mobility) have had a profound social, and economic impact on the lives of people across the country. Further, evidence shows that COVID-19 affects the population neither equally nor in the same way, with risks and vulnerabilities determined by a complex intersection of factors. In many ways, COVID-19

has exacerbated various inequalities and inequities that existed long before the current health crisis, with many groups – including adolescents, women, persons with disabilities (PwDs), and displaced persons – at the threshold of marginalisation.

As the country gradually unlocks, it becomes imperative to analyse the widening gender gap caused by the pandemic in order to make rehabilitation efforts more inclusive and gender sensitive.





1. Gendered impact of the COVID-19 pandemic in India

Research on previous global health crises such as SARS and Ebola has shown that both epidemics and policy responses impact people of different genders differently.¹ In the emerging discourse around COVID-19, researchers, activists, and implementers have all brought out the gendered dimensions and impacts of the crisis. Further, the risks of being adversely impacted by COVID-19 do not differ based on gender alone – but also due to various other factors such as identity (including caste, class, religion), location and disability. A wider lens brings into

relief the ways in which these various factors intersect with gender – and each other – to produce unique vulnerabilities, and further locates these vulnerabilities within the complex web of power relations that structure the world and societies we live in.² These realities are particularly harsh within the patriarchal context of India, where research has shed light on the various gendered concerns and impact that women and girls face across education, health, economic, security, etc.

Disruptions in education


Adolescents (10–19 years) comprise 20.9% of the total population of India, and adolescent girls – 47% of the total adolescent population – face significant gender barriers that have been further exacerbated by the COVID-19 pandemic and nationwide lockdown.³ Schooling is a major protective factor for adolescent girls, and the closure of schools and disruption of education is expected to lead to various adverse outcomes. Nearly 96% of children in rural India are studying at government-run schools that provide cooked mid-day meals to children. The closure of schools disproportionately impacts the nutrition levels of adolescent girls, who are more likely to depend on the mid-day meal for their nutrition, given the gendered nature of food provision in households with limited resources. Similarly, girls who are dependent on their schools for access to menstrual hygiene products will face difficulties

in obtaining these products during the lockdown, particularly in the context of limited resources and mobility restrictions. Beyond provision of education, schools are also an important space for girls to make friends, express themselves, and build support networks. The prolonged disruption of school and other activities means that girls are confined within their homes, disconnected from their studies, and often bearing the burden of additional household work. In a social and economic context in which girls and girls' education are accorded less value, they are at high risk of dropping out and discontinuing their schooling even after the lockdown ends. With the loss of school as a protective space, girls may also face a heightened risk of exposure to violence, early, child, and forced marriage (ECFM), child labour, trafficking, etc.

¹ Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, *Economic & Political Weekly*, Vol. 5(22)

² Hankivsky, O. & Kapilashrami, A., 15 May 2020. Intersectionality offers a radical rethinking of covid-19, *The BMJ Opinion*

³ Ramadass, S., Sanjeev, K. G. & Baridalyne, N., 2017. Adolescent health in urban India, *Journal of Family Medicine and Primary Care*, Jul-Sep; 6(3), pp. 468-476



The United Nations Population Fund (UNFPA) estimates that globally, there will be around 13 million more child marriages by 2030.⁴ Additionally, a staggering 61% of children with disabilities (CwDs) in the age group of 5–19 years attend schools in India.⁵ Of these, 63% are boys and just 58.3% are girls. Responses to the COVID-19 pandemic have not adequately taken into account this

vulnerable target group. Thus, CwDs are more likely to face exclusion from education than other vulnerable categories due to given other existing structural inequalities like poverty, caste, gender and religion.⁶ Despite the number of child marriages having decreased considerably, nearly 1.5 million girls in India remain vulnerable to this social evil as per the National Family Health Survey (NFHS) 2015-16.⁷

Interruptions in health services

During a crisis, the physical and mental health and rights of women and girls are often neglected. The COVID-19 lockdown has resulted in disruptions in routine health services, with restricted access to hospitals and other medical facilities.⁸ Interruptions in key sexual and reproductive health services have emerged as a major concern, including ante-natal and post-natal childcare services, safe abortion, and other routine services such as contraception.⁹ This is particularly worrying, as the National Family Health Survey (NFHS-4) data shows that only 21% of women across the nation have received full antenatal care (ANC), and only 36.4% of mothers benefited from financial assistance under the Janani Suraksha Yojana for births delivered in a public institution.¹⁰ Significant disruption due to the lockdown for over six months could lead to 2.95 lakh unintended pregnancies, over 8 lakh live births, about 1 million unsafe abortions and over 2,000 maternal deaths.¹¹ This can be largely attributed

to the Ministry of Health and Family Welfare, Government of India's advisory, which has led to the suspension of sterilisations and provision of intrauterine contraceptive devices (IUCDs) for the time being. Additionally, curbs on movement have made access to various kinds of over-the-counter contraceptives like condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs) difficult. Further, attention and resources may be diverted from other serious health concerns (cancer, diabetes, hypertension, tuberculosis, etc.) and mental health issues, despite the pressing need to expand access to psychiatric support in times of crisis. Apart from the lurking danger of contracting COVID-19, the elderly face the double burden of vulnerability to non-communicable diseases (NCDs) and isolation, which can lead to mental health concerns. Helplines for the urban elderly and social media support groups have seen a nearly 40–50% increase in the number of distress calls after the outbreak of COVID-19.¹²

4 UNFPA, April 28, 2020, News: Millions more cases of violence, child marriage, female genital mutilation, unintended pregnancy expected due to the COVID-19 pandemic, UNFPA website

5 Sharma V., 2020, 4 January 2020. Education status poor for children with disabilities, The Tribune, Tribune News Service

6 Ramadass, S., Sanjeev, K. G., & Baridalyne, N., 2017. Adolescent health in urban India, Journal of Family Medicine and Primary Care, Jul-Sep; 6(3), pp 468–476

7 United Nations Children's Fund, 'Ending child marriage: A profile of child marriage in India', 2019, UNICEF, New York

8 Pitre, A., Menon, R. & Jairath, A., 6 April 2020. Policy Brief: Covid-19: Recommendations for a feminist approach, Oxfam India

9 Dasgupta, J. & Mitra, S., May 30, 2020. A gender-responsive policy and fiscal response to the pandemic, Economic & Political Weekly, Vol. 5(22)

10 Ratho, A. & Jain S., 27 March 2020, The gendered footprint of Covid19 in India, Observer Research Foundation

11 FRHS India, May 2020. Impact of COVID 19 on India's Family Planning Program, Policy Brief

12 Parul, A., 5 May 2020. Covid-19: In urban India, the elderly are grappling with hunger and fears of dying alone, Scroll.in, IndiaSpend.com



Increase in gender-based violence

Social containment measures such as lockdowns are predicated on the assumption of the home being a safe space for all. However, according to the Crime in India Report 2018 by the Indian National Crime Research Bureau (NCRB), in India, a woman is subjected to an act of domestic violence every 4.4 minutes. The WHO and UNFPA have reported a 600% rise in domestic violence cases globally, warning that a continuation of lockdowns for six months beyond May 2020 may result in an additional 31 million cases of gender-based violence (GBV).¹³ The National Commission for Women in India has witnessed a surge in domestic violence complaints and requests for support since the initiation of the lockdown, with an average of nine complaints daily in March and

April 2020 in comparison to five complaints daily in the same months last year.¹⁴ Locked in with their abusers, under the patriarchal control and surveillance of their families, women may be unable to call for help, escape or lodge complaints.¹⁵ Given the proximity of the perpetrator and lack of mobility, coupled with a fragile regulatory ecosystem, women are trapped in a complex situation. The India Child Protection Fund reported increased incidences of cyber/sexual abuse involving children (e.g. increased consumption of child pornography). With children spending more time indoors and online, often without supervision, they are more vulnerable to online sexual predators.

Economic distress

While disruptions in paid work have impacted people of all genders, women are likely to bear the brunt of this impact in the long run as they earn and save less, hold insecure and informal jobs lacking protection, and are generally more vulnerable to poverty than men.¹⁶ In both cities and rural areas, the livelihoods of 94% of the women workers in the informal sector¹⁷ (e.g. in daily-wage agricultural labour, at construction sites, home-based work) are at heightened risk. Women migrant workers in cities (e.g. casual workers, domestic help, sanitation workers) are also highly vulnerable. These women may be stranded away from their homes due to the nationwide lockdown and have been largely ignored in the discourse on the migrant crisis.¹⁸ Interruptions in remittances from male migrant workers in the family have also increased the burden of work on women.¹⁹ Transgender workers²⁰ and

women working at the margins (e.g. as sex workers) have also lost their livelihoods and will find it more difficult to resume work given the discrimination, stigma, and various other issues in a constrained job market. The overall Indian female unemployment rate was 18%. It is expected that women will witness a majority of layoffs in both the formal and informal sector during the post-COVID phase. Additionally, sectors like hospitality, entertainment, retail, beauty and wellness, and front office services, which saw higher participation from women, have been more adversely impacted. In a country where women's income is abysmally low compared to that of their male counterparts, the COVID-19 pandemic places further constraints on women's economic participation and employment opportunities.

13 UNFPA, with contributions from Avenir Health, Johns Hopkins University (USA) and Victoria University (Australia), 27 April 2020, Interim Technical Note: Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage

14 Asia/India, 2 June 2020. What India's lockdown did to domestic abuse victims, BBC News

15 Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, *Economic & Political Weekly*, Vol. 5(22)

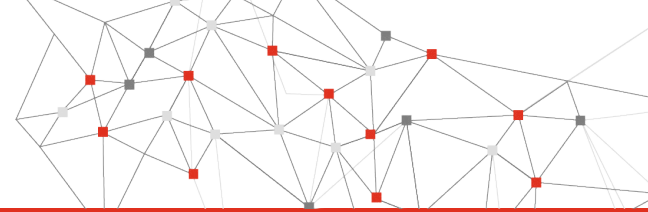
16 Shekhar D. J., April 21, 2020. The harder-hit half: Why India needs a gendered approach to Covid-19, *Forbes India Blogs*

17 Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, *Economic & Political Weekly*, Vol. 5(22)

18 Sapra I., 25 April 2020. Why don't we see the women? The untold story of Covid-19 migration, *Opinion, The Indian Express*

19 Ratho, A. & Jain S., 27 March 2020. The gendered footprint of Covid19 in India, *Observer Research Foundation*

20 Goel, I., 4 May 2020. Impact of Covid-19 on Hijras, a third-gender community in India, *Society for Cultural Anthropology*



Burden of unpaid care work

The lockdown and presence of all family members at home have also increased the load of household work. Family members working outside the home (including migrants) and children who were previously at school are now at home. The elderly, who face a heightened risk of infection, must also be taken care of. However, given the prevailing gender norms and roles, the burden of attending to multiple needs and tasks (e.g. cooking, cleaning, fetching water, managing the household, providing physical and emotional labour) is borne disproportionately borne by women.²¹ Of the 33 economies in the OECD, India has the highest gender disparity in time spent on unpaid care work, with women doing more than six hours of this work for every 36 minutes that a man does.²² Middle- and upper-class households are facing a disruption in domestic service providers (e.g. cooks, cleaners, gardeners, dhobi) who normally carry out much of this work, with increased pressure on women to compensate for the loss.²³ Research has shown that the burden of undertaking unpaid household work is one of the key barriers to women's participation in paid work outside the home.²⁴ Many women who are working from home must

now juggle these unpaid care responsibilities in addition to their paid work, and may be forced to withdraw from the labour market unless supported by leave and flexible work arrangements. This is likely to further worsen an already low female labour force participation rate (LFPR) of 20.5% in 2019, as compared to the world average of 47.1%.²⁵

Given India's abysmal performance on the Gender Inequality Index (GII)²⁶ and indications from current trends on gender inclusion in COVID-19 response, it is important to focus on women's inclusion, representation, and rights, putting their social, economic, health, and other needs at the centre of programming to address existing gender disparities and prevent the gender gap from further widening. This calls for measures not only to bridge the long-standing inequalities but also to create an enabling ecosystem for those measures. However, despite women's presence at the frontlines of community response, they are still largely absent from decision making and leadership positions which determine the path of COVID-19 response and recovery.

21 Ratho, A. & Jain S., 27 March 2020. The gendered footprint of Covid19 in India, Observer Research Foundation

22 Madhavani, B & Mathur, S., 1 June 2020. India's painful "shecession", Southeast Asia & India at ANZ, Bluenotes

23 Deshpande, A., 28 March 2020. Protecting women is missing from pandemic management measures in India, Gendered Impacts, Quartz India

24 Ibid.

25 Madhavani, B. & Mathur, S., 1 June 2020. India's painful "shecession", Southeast Asia & India at ANZ, Bluenotes

26 Table 5, Gender Inequality Index, annual average of projected values for 2015-2020, Human Development Reports, UNDP



2. Lack of women's representation in leadership and decision making

Women on the frontline of the COVID-19 response

Although women are among the hardest hit by the COVID-19 pandemic and lockdown, they are also 'essential' workers who form the backbone of the health apparatus and constitute the crucial interface between communities and health services. Globally, 70% of frontline health workers are women²⁷ – in India, nearly half of the qualified health workforce comprises female workers, and 88.9% of qualified nurses and midwives are female. In rural India, almost 1 million female Accredited Social Health Activists (ASHAs) and 1.4 billion Anganwadi Workers (AWWs)²⁸ comprise the community-level health workforce that is engaged in various tasks, including checking up on families in their communities for symptoms and counselling community members on health advisories and precautionary measures against COVID-19. Along with the roles of ASHAs and AWWs, nursing is a highly gendered profession, reflecting the norm that

taking care of the sick is primarily women's work. This is also linked to established, gendered medical hierarchies, the devaluation of women's contribution, and disregard for their health and welfare, with reports indicating that frontline workers and nurses are struggling to get access to protective equipment and are at heightened risk of exposure to COVID-19.²⁹

In the health sector, as in many sectors, women are mostly seen as accompanists. They are nurses, midwives, frontline workers and sanitation workers, but they are neither the decision makers nor the primary beneficiaries or stakeholders.³⁰ Based on a review of 200 global health organisations, the Global Health 50/50's 2020 report³¹ highlights that organisations are failing to achieve diversity and equality in positions of power and leadership – with men comprising 70% of CEOs and health board chairs worldwide.


27 WHO/HIS/HWF/Gender/WP1/2019.1, March 2019, Equity in the health workforce: Analysis of 104 countries, Health Workforce Working Paper 1, World Health Organization

28 Ratho, A., Jain, S., 27 March 2020. The gendered footprint of Covid19 in India, Observer Research Foundation

29 Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, Economic & Political Weekly, Vol. 5(22)

30 Siganporia, S., 6 May 2020. Vogue Warriors: Meet the essential worker, who sweeps your streets and cleans the city in the middle of a pandemic, Vogue India

31 2020 Global Health 50/ 50 Report, 2020

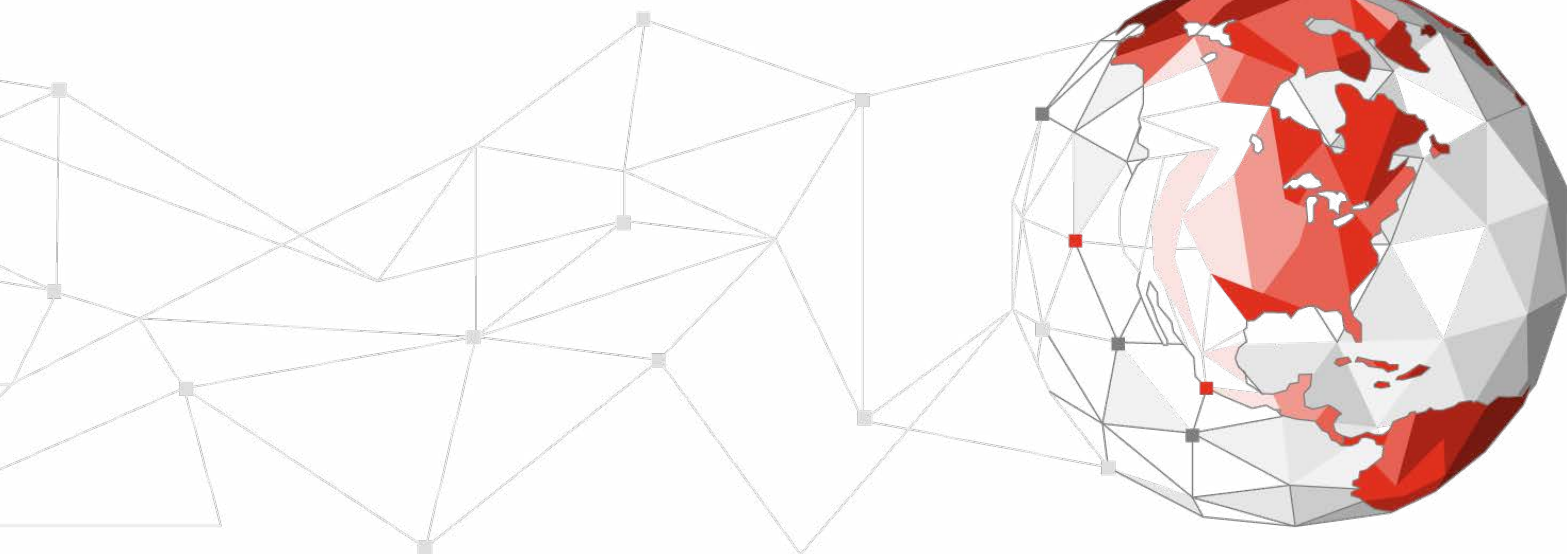


The importance of having women in positions of leadership – particularly during a crisis such as COVID-19³² – has emerged in the global discourse, with women-led countries such as Denmark, Finland, Germany, Iceland, New Zealand, Norway, Taiwan and New Zealand performing better at fighting the pandemic. In India, there is limited representation of women in key positions of leadership for planning and decision making on COVID-19 response and recovery. The national COVID-19 Economic Response Task Force is headed by the Finance Minister, Nirmala Sitharaman, who is a woman. However, there are only two women on the 21-member Committee for Public Health Experts on COVID-19 constituted by the Indian Council for Medical Research.³³ Similarly, very few women are a part of the 11 Empowered Groups formed under the Disaster Management Act to ensure a comprehensive and integrated response to COVID-19.³⁴

Women's role in leadership and decision making

Lack of women's participation in policy and planning not only limits women's inclusion within larger dialogues and schemes that impact them, but also leads to gendered concerns and issues faced primarily by women being neglected. For instance, menstrual hygiene products like sanitary napkins were initially not included within the list of essential items released by the Government.³⁵ Additionally, within health facilities, policies do not take into account the issues faced by menstruating health workers when working long shifts in protective equipment. As protective equipment is expensive and cannot be removed before a shift is complete, women health workers cannot use the washroom even if they are experiencing discomfort and need to change their menstrual hygiene product.

More broadly, lack of policies and provisions for women health workers, domestic workers and other women migrants, and those facing domestic violence are just a few examples that reflect the absence of women from dialogues and decision making, and an overall lack of gender inclusion in COVID-19 response. The limited presence of women in the upstream ecosystem has always had a slow downstream impact on their inclusion in both social and economic spaces. Thus, with regard to the process of growth and stability equation, the need for inclusion of women in decision and policymaking has assumed greater importance for development efforts to have a sustainable impact.



32 Taub, A., 18 May 2020. Why are women-led nations doing better with Covid-19? The New York Times

33 Ratho, A. & Jain S., 27 March 2020. The gendered footprint of Covid19 in India, Observer Research Foundation

34 Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, Economic & Political Weekly, Vol. 5(22)

35 Muralidharan, A. & Mahajan, T., 17 April 2020. A reminder: Periods don't stop during a pandemic, The Wire



3. Global and national response initiatives addressing gendered inequities and vulnerabilities in light of COVID-19

Initiatives taken by governments and other agencies worldwide are currently focusing on immediate response interventions by leveraging existing resources, programmes and infrastructure. Governments are increasingly recognising the gendered risks and vulnerabilities that have been exacerbated by the COVID-19 crisis. However, the lens still largely remains myopic and centred on programmatic initiatives rather than systematic and policy-level introductions.

For instance, countries in South and Southeast Asia like Malaysia, Indonesia and Cambodia have gone the extra mile to ensure inclusivity through their response and recovery efforts. Some of these initiatives include digital mentorship of girls and women entrepreneurs for continued education and skill enhancement,


augmentation of violence helplines, and improved sanitation for women health workers.³⁶

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In Costa Rica, the government has reduced all interest rates for credit to cooperatives and for business projects that target priority sectors of the population, including youth, women, older adults, indigenous, afro-descendant, peasant, migrant and disabled people.”

Policy Brief: The Impact of COVID-19 on Women, United Nations, April 2020

³⁶ Naciri, M., April 2020. Putting women, girls at heart of COVID-19 response and recovery in ASEAN: Turning challenges into opportunities, The Jakarta Post



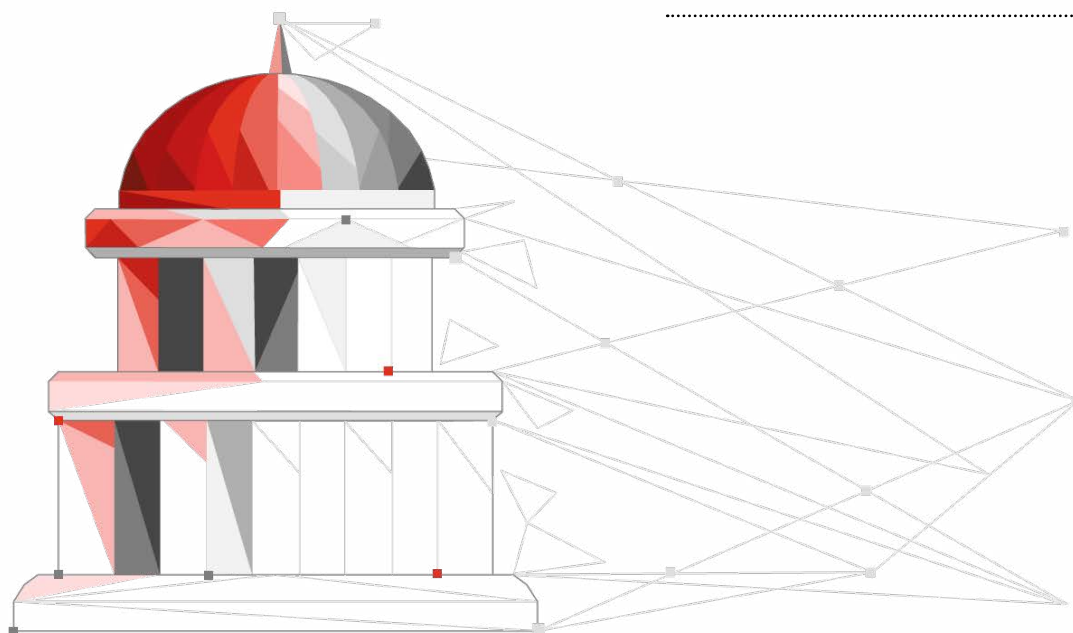
In India, self-help groups (SHGs) run by women have risen to the extraordinary challenge of the pandemic. They have started producing masks and other personal protective equipment (PPE) like sanitisers to meet the supply shortage. In addition, they are running community kitchens and fighting misinformation by spreading knowledge through community gatherings, besides providing assistance with banking and financial transactions in remote communities. These initiatives are spread pan-India and are often a consequence of the downstream impact of a multi-lateral bank grant programme or extension of state-run traditional programmes. Today, the World Bank's National Rural Livelihood Mission (NRLM) and Bank Sakhis in the state of Jharkhand are some of the pioneering initiatives that are keeping the spirit of women-led entrepreneurial initiatives alive.³⁷ Kerala's COVID-19 response, which centred on the role of women's collectives, has been hailed as a major success, with financial assistance made available to needy families through the Kudumbashree network.³⁸ Kudumbashree has been effective in empowering women through collectivisation and has acted as a space to foster women's leadership.

The country is also witnessing cases of better response towards the pandemic through women's leadership. For instance, Kerala emerged as one of the frontrunners in the battle against COVID-19 and saw a flattened curve. The Health Minister of the state, KK Shailaja, received considerable praise for her work in national and international media. While this success may be attributed to some extent to the state's prior experience with viruses like Nipah, it is the overall planned, system-driven and last-mile approach leveraging ASHAs, auxiliary nurse midwives (ANMs) and nurses that deserves greater credit.

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A prominent example of strong female leadership is that of the ‘ruthless containment model’ in Bhilwara, Rajasthan, where IAS Officer Tina Dabi has promoted a strategy of isolation, aggressive screening in urban and rural areas, quarantine and isolation wards and rigorous door-to-door testing.”

Mohanty, H., 16 April 2020. Women In India & around the globe are leading the way to combat COVID-19 pandemic, Feminism in India



37 Feature story, 11 April 2020. In India, women's self-help groups combat the COVID-19 (Coronavirus) pandemic, World Bank (<https://www.worldbank.org/en/news/feature/2020/04/11/women-self-help-groups-combat-covid19-coronavirus-pandemic-india>)

38 COVID 19 - A summary of key activities by Kudumbashree, Kudumbashree, State Poverty Eradication Mission, Government of Kerala website



4. Proposed way forward for a more inclusive approach to recovery

As we slowly move towards a ‘new normal’ and with growing speculation around the virus eventually becoming ‘endemic’, we are presented with a unique opportunity to apply an inclusive and gender-transformative lens to the short-term response to COVID-19, as well as the long-term road to recovery and the ‘new world order’. Although governments across the world are under immense pressure to respond quickly to the crisis, this has often meant that comprehensive, intersectional perspectives with gender as a key lens have been often left out of the COVID-19 response and recovery initiatives.³⁹

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The ‘Aatma Nirbhar Bharat Abhiyaan’ was launched by the Government of India in May 2020 with a special economic package of INR 20,97,053 crore (equivalent to 10% of India’s GDP), with the aim of making the country independent against the tough competition in the global supply chain and to help in empowering the poor, labourers, migrants who have been adversely affected by COVID.

Ministry of Finance, 13 May 2020. Summary of announcements: Aatma Nirbhar Bharat Abhiyaan, PRS

This poses further challenges to policymakers and implementers who are working towards equitable distribution of benefits amongst men, women and vulnerable sections of society that have been deeply impacted by the pandemic. While there are opportunities for bridging the gender gap through specific announcements such as collateral-free loans for women SHGs, additional direct fund transfers to women Jan Dhan account holders and enhanced provision for jobs created under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA,) there is limited focus on addressing the gender gap through other initiatives. A study conducted across 30 countries showed that although India has announced economic reforms and support for the vulnerable, it is yet to announce any special measures to curb GBV and promote sexual reproductive health (SRH) and childcare support.⁴⁰

A three-dimensional approach is proposed as the key driver for a gender-transformative and inclusive COVID-19 response and recovery:

- evidence-based response through sex-disaggregated data and gender analysis
- bridging gendered gaps and inequities by enhancing women’s access to key social, economic and health resources
- enhancing women’s participation and leadership at all levels of response, including planning, implementation, monitoring, and accountability.

39 Women Count, June 26, 2020, COVID-19: Emerging Gender Data and why it matters, UN Women

40 Fuhrman, S. & Rhodes F., June 2020. The absence of women in COVID-19 response, Gender and Climate Change, CARE



Need for sex-disaggregated data for gender analysis

Effective policies, programmes and schemes must be evidence-based and informed by robust data. Along with other types of disaggregated data (e.g. age, location, class), sex-disaggregated data is crucial to not only capture biological, sex-based differences in various indicators, but also understand how gender norms impact the ways in which people of different genders experience health. However, the Global Health 50/50 2020 report finds that among 200 global health organisations, very few sex-disaggregate data, and even fewer use the data for gender analysis. In the case of the COVID-19 pandemic, there is an enormous gap in the availability of sex-disaggregated data on COVID-19 infections, which would be of enormous value in improving understanding and guiding prevention and response efforts. Global Health 50/50's sex-disaggregated data tracker⁴¹ is a promising initiative and aims to compile official government data from across the world to track differences in COVID-19 illness and death among women and men. However, many countries do not have accurate or up-to-date sex-disaggregated data on

COVID-19 cases, recoveries and deaths, or on testing and other indicators (e.g. hospitalisations, ICU admissions, cases and deaths among healthcare workers). At present, India does not feature in the list of countries reporting sex-disaggregated data on the GH 50/50 tracker.

Beyond data on COVID-19 infections, sex-disaggregated data is also important to understand the profound social, economic, health, and other effects of the pandemic. While policymakers can be guided by insights by researchers, activists, and implementers witnessing and addressing the gendered impact on the ground, it is necessary to have robust, scientific data for better, evidence-based policies, and to ensure transparency, accountability and action. Sex-disaggregated data will serve as an important record of the varied gendered impact of COVID-19 across a range of issues, including domestic violence, employment, unpaid care work and access to health.⁴² The data will also reveal how the impact of the pandemic varies across gender, class, caste, religion, etc., and will help in reaching out to the most marginalised and vulnerable groups.

Bridging gaps to enhance access


There is a need to improve women's access to not only productive labour but also basic social security privileges and services. Access to basic services like education, health and sanitation should also be viewed from the lens of gender sensitivity and equality.

For instance, when schools reopen, implementers should ensure that economic constraints are eased, including through universal fee waivers and cash for education top-ups, particularly for adolescent girls who may be at a heightened risk of dropping out. Similarly, while cash benefits are the preferred choice for reaching out to the vulnerable, implementers should also consider the feasibility of providing in-kind transfers (including bulk, storable, and fortified food, or hygiene supplies such as soap and female sanitary products), as these are often overlooked in regular programming.

More importantly, it is imperative to reach out to target groups through empathetic and two-way communication media. Public health services, including communication, treatment, and support, should be culturally and gender sensitive to ensure access for women and, where possible, ensure that medical teams are gender balanced. Further, sexual and reproductive care should be prioritised, and all women should have access to medical support through digital platforms and forums. There is a compelling need for continuous capacity building for frontline workers, social workers, law enforcement officers, health workers and other volunteers operating helplines or providing services in response to reports of GBV. Additionally, there is a need to orient and support parents to send their children to school once there is a return to normalcy, rather than pushing their children into labour or child marriage.

41 Fuhrman, S. & Rhodes F., June 2020. The absence of women in COVID-19 response, Gender and Climate Change, CARE

42 Dasgupta, J. & Mitra, S., 30 May 2020. A gender-responsive policy and fiscal response to the pandemic, Economic & Political Weekly, Vol. 5(22)



Economically, the informal sector, which makes up most of the Indian economy, is worst hit by not only the lockdown, but also limited access to international trade and exchange. As women are an integral part of the country's informal sector, the immediate response as part of an all-inclusive rehabilitation process must include targeted and gender inclusive economic policies, government bailouts and support measures. A systemic approach to lower the intersectional inequalities and thus reduce the regional disparities in terms of minimum wages, ensure basic health standards of women, social security of women and girls as well as their upskilling and reskilling in line with the emerging needs of the economy

could be some of the preliminary measures. Opportunities like including and prioritising single women as MNREGA beneficiaries can result in a more inclusive approach to scheme implementation. Further, providing subsidies to women through skill training programmes and institutions, especially for deficit skills, can promote a two-way process for economic growth. Lastly, promoting women entrepreneurs and providing them benefits, loans and subsidies can result in a more inclusive 'Make in India'.

To summarise, there is a need for interventions focused on strengthening of systems to improve access to basic services such as education, health, nutrition, employment and financial aid.

Fostering women's participation and leadership

Women's participation in planning, designing and implementing policies, programmes and schemes has been lagging. There is a need to involve women at the micro, meso and macro levels with focused and deliberate initiatives to push them into decision-making roles and build capacity and institutional support. Women should not only be provided platforms to allow them to assume leadership positions but also be included at every level of decision-making structures and have the necessary resources.

Based on past evidence,⁴³ pandemics and lockdown conditions intensify the systemic and structural gaps within the current system. It is critical for theorists, advocacy groups and planners to revisit gender-blind policies that leave women, girls, the elderly and the marginalised more affected than ever. There is an urgent need to adopt a more human-centric approach to the planning and designing of policies and programs. A more bottom-up approach would ensure that results are not only delivered till the last mile but are also need based. The use of a

mix of evidence-based and participatory methods would help in increasing inclusion of women in the planning and initiation of a programme or service. Women must also be part of the monitoring and accountability mechanisms to ensure that gender is integrated into COVID-19 response initiatives.

The public sector, private sector, civil society, media and community leaders are striving to work together during the COVID-19 crisis while considering its differential impact on women, men, boys and girls. This would require establishing targeted forums to communicate with vulnerable groups such as women while considering factors such as their literacy and technology requirements. Many civil society organisations have launched community initiatives where marginalised sections play more prominent roles and demonstrate leadership at all levels.

While a more inclusive approach is being promoted in immediate response measures, it needs to be sustained through recovery as we progress towards the new normal.

43 Fawole, I. O., Bamiselu, O. F., Adewuyi, A. P. & Nguku, M. P., Jan-Mar 2016. Gender Dimensions of Ebola Outbreak in Nigeria, US National Library of Medicine National Institutes of Health, PMC, Vol. 15(1), pp. 7-13

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