

SIX CONCRETE MEASURES TO SUPPORT WOMEN AND GIRLS IN ALL THEIR DIVERSITY IN THE CONTEXT OF THE COVID-19 PANDEMIC



“ [Y]OU’VE BEEN ABLE TO MOBILIZE AGAINST A KILLER EPIDEMIC, HIV, AND YOU HAVE SAVED LIVES ... THIS IS ONE OTHER EPIDEMIC. YOU ARE TESTED, YOU ARE GROUNDED, YOU KNOW HOW TO FIGHT AND HOW TO USE COLLECTIVE POWER OF COMMUNITIES TO PREVENT, TO TEST, AND TO TREAT IN THE MOST RESPECTFUL, HUMAN RIGHTS-FOCUSED APPROACH. SO GET OUT THERE AND FIGHT, USE YOUR VOICE TO DEMAND AND TAKE ACTION FOR YOUR COMMUNITIES. ”

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ADDRESSING THE IMPACT OF COVID-19 ON WOMEN AND GIRLS IN ALL THEIR DIVERSITY: A HUMAN RIGHTS IMPERATIVE

The coronavirus disease 2019 (COVID-19) pandemic is having devastating social and economic consequences worldwide. Yet the numbers of infections and deaths alone do not provide an accurate picture of the pandemic's vast gendered impact. While the available data suggest that men experience higher rates of COVID-19-related deaths (1), women and girls are bearing a disproportionate burden of the larger impacts of the pandemic and states' emergency responses (2).

This guide is designed to provide recommendations to governments to confront the gendered and discriminatory impact of COVID-19. It highlights good practices; shares lessons learned from HIV and other past public health crises; provides strategic information; calls for engagement with communities most impacted by COVID-19; and sets forth concrete immediate and forward-looking recommendations for crisis responses, policy development and investment strategies. The guide presents six key areas of concern regarding the human rights of women and girls in all their diversity during the COVID-19 pandemic—differing needs of women and girls, particularly those most marginalized; access to essential health services; the neglected epidemic of gender-based violence against women and girls; misuse of criminal and punitive laws; adolescent girls' and young women's education, health and well-being; and valuing women's work and making unpaid care work everybody's work.

The gender-specific analysis and recommendations contained here are informed by valuable insight gained from the global HIV response recognizing that many of the same structural drivers of inequality in the HIV epidemic are the same as those driving inequality in the current COVID-19 pandemic. Neither COVID-19 nor HIV can be overcome without prioritizing the most marginalized populations, and recognizing that people have diverse experiences and needs. Along these lines, we should avoid adopting uniform responses that fail to account for local contexts and guarantee the human rights of everyone affected by the crisis and its response (3).

WOMEN AND GIRLS IN ALL THEIR DIVERSITY

Women and girls are not a homogeneous group, and they face multiple forms of discrimination. While everybody is vulnerable to COVID-19, people are far from equally affected by pandemic responses. There are stark gendered disparities, and the most marginalized people are the hardest hit. Women and girls are at heightened risk of domestic violence, inadequate access of essential health care (both before and during the pandemic), COVID-19-related punishment, economic insecurity, and the imposition of unpaid and unrecognized care work. Combine this with the stigma and intersectional discrimination that marginalized women and girls (including transgender and gender-diverse people, lesbians, bisexual people, sex workers, women and girls with disabilities, women living with HIV, women who use drugs, refugees, migrants, women and girls in conflict zones, detention and humanitarian settings, indigenous women and women from other racial and ethnic minorities, and adolescent girls and young women) already face, and we can see that women and girls are undeniably being "left behind" (4, 5).

Just as HIV held up a mirror to stark inequalities and injustices, the COVID-19 pandemic will be exacerbated unless we address head-on the human rights impact on women and girls in all their diversity and their lack of access to health services, education, protection from violence, and social, economic and psychological support (6). These lessons align with the United Nations Secretary-General's call to focus on the most marginalized people (7) and to centre women and girls in COVID-19 recovery efforts (2).

UNAIDS calls on states, law- and policy-makers, key stakeholders, funders, development actors, communities and civil society to act urgently to mitigate the pandemic's impact on the most marginalized women and girls as we navigate a world overcome by COVID-19 into the post-pandemic future. All emergency measures, including their design, implementation, execution and monitoring, must include a gender perspective and take an intersectional approach that accounts for the contexts and conditions that enhance the effects of this crisis. Critical steps must also be taken to ensure advancements towards gender equality and the realization of women's and girls' human rights are not rolled back during this time.

HUMAN RIGHTS PROTECTIONS AND LIMITATIONS DURING THE COVID-19 PANDEMIC

Evidence confirms that human rights-based approaches to public health crises are most effective (8–10). The World Health Organization (WHO) has noted that as “countries identify ways to address COVID-19, integrating a human rights approach as well as rights protections and guarantees into our shared responses is not only a moral imperative, it is essential to successfully addressing public health concerns” (11).

States must comply with certain core human rights obligations during times of crisis such as the COVID-19 pandemic. They must ensure people's basic needs and rights, including for access to food, clean water, sanitation and shelter, and must refrain from discriminating against people directly or indirectly. States are further obligated to assess and address the needs of the most marginalized people who are experiencing a disproportionate impact of the crisis—in this case, women and girls in all their diversity. Specifically, states must consider how women and girls are differently affected by pandemic responses and integrate specific measures to confront gender-related inequalities, as a core obligation and a human rights mandate, and ensure women's and girls' direct and meaningful participation in pandemic planning, particularly those most affected by COVID-19.

To the extent that states can limit some rights to protect public health under international law, any restrictions must be necessary, proportionate, non-discriminatory and limited in duration, and must include key safeguards against excesses (12–14).

SIX KEY MEASURES

With the aim of bringing light to the health and human rights issues that women and girls are facing during the COVID-19 pandemic and states' responses, and to catalyse action to change course and confront these disparities, UNAIDS calls for targeted action in the following six key areas.

ADDRESS THE DIFFERENT NEEDS OF WOMEN AND GIRLS, PAYING ATTENTION TO THE MOST MARGINALIZED

As the COVID-19 pandemic exposes entrenched inequalities and gendered power dynamics, marginalized women and girls are experiencing the greatest health and human rights impacts. Their disparate experience is related not only to the virus but also to existing discrimination and gender stereotyping; economic inequality; lack of equal access to food, clean water, housing and health services; and stigma and discrimination based on sex, sexual orientation, gender, gender identity, race, age, caste, class, religion, HIV status, disability, indigenous identity and immigration status. States' emergency responses, which in some cases are overly broad, vague and not evidence-based, contribute to the unequal experiences of women and girls and fail to promote their health and human rights. At risk are the hard-fought gains towards gender equality and women's and girls' human rights.

EXAMPLES OF URGENT NEEDS THAT COVID-19 RESPONSES MUST ADDRESS

- Women as a whole are experiencing increasing levels of violence (15), unpaid domestic and caretaking work, economic insecurity, and diminishing access to essential health services.
- Women and girls with disabilities who lack accessible information (e.g. sign language, easy-to-read captions) about the virus and protection measures face worsening conditions and lack of protection in institutions and are virtually absent in response planning (16).
- Indigenous women may need access to information in their own languages on COVID-19 prevention and access to services (17).
- Adolescent girls and young women may be increasingly susceptible to violence, child and early marriage, and trafficking amidst school closures, coupled with lack of access to comprehensive sexuality education, contraception and abortion, as has been the experience during Ebola outbreaks and other public health crises (18–20). Young women are facing a disparate impact of job losses, particularly in informal markets (21, 22).
- Rural and poor women may lack access to clean water at home, creating an increased burden of collecting water in crowded public spaces, putting them at higher risk of exposure to the virus (23).
- Migrant women working as domestic or informal care workers, especially those who are undocumented, may lack job security and protection (24).
- Sex workers, lesbians, bisexual and transgender people, women living with HIV, and women who use drugs are experiencing worsened conditions, including being subjected to humiliating treatment if found violating public health orders (25, 26); lack of access to social safety nets, financial support schemes (27), antiretroviral medicines, and drug treatment and harm-reduction supplies; and discriminatory treatment and violence by landlords, families and local officials (28).

- Women in prison are more susceptible to acquiring the virus because prisons keep people in confined spaces, with limited options for physical distancing (29). Prison populations already have a weaker health profile than the broader community, and many prisons do not provide adequate health care. Where prison health-care services are available, women, being a minority, often have poorer access, and their sex-specific needs remain largely neglected (30).

ADDRESSING THE SPECIFIC NEEDS OF WOMEN AND GIRLS LIVING WITH OR AFFECTED BY HIV

Many women living with HIV have other comorbidities and require regular access to health care, which can hinder their ability to comply with COVID-19 prevention precautions. Women living with HIV who have underlying cardiac or respiratory conditions and older women living with HIV may be at higher risk of acquiring the coronavirus and developing more serious symptoms (31). To date, few states have focused on the specific needs of people living with HIV in emergency response plans or prioritized ongoing HIV prevention. Condoms have not been regarded as essential commodities or included in contingency planning for COVID-19 in most countries (32), and harm-reduction centres have closed in many places (33). Continuity of services for women who are on or who need pre-exposure prophylaxis is essential during this time. Without adjusting programmes to meet current circumstances, women may be deterred or delayed from seeking antiretroviral therapy because hospitals are busy treating people with COVID-19, reduced clinic hours are inconvenient, or they fear acquiring the virus (34). Women may also be deterred from seeking treatment at HIV clinics due to fear that they will be compelled to reveal their HIV status to the police as a condition for leaving their home, in violation of their medical privacy. HIV treatment and supplies may be disrupted as resources are diverted or repurposed towards COVID-19. It is essential that antiretroviral therapy stocks and prevention supplies are prioritized (35).

GOOD PRACTICES

The United Nations Office on Drugs and Crime has provided furniture and medical equipment for a newly created women's centre at the Windhoek Correctional Facility in Namibia to meet women's specific health-care needs while in detention, including for HIV and sexual and reproductive health (36).

The United Nations Population Fund (UNFPA) is distributing much needed menstrual hygiene supplies and information on how to prevent the spread of COVID-19 to women in quarantine centres and prisons in El Salvador (37).

On the Venezuelan borders, where people are returning due to COVID-19, UNFPA and UNAIDS offer women in compulsory quarantine contraceptive methods (medroxyprogesterone acetate (MPA) injections, condoms) and voluntary HIV testing. Women also receive dignity kits including personal hygiene items and information papers on gender-based violence and HIV (38).

The Khawaja Sira Society is working with the most marginalized transgender people in Pakistan to promote their knowledge about HIV and COVID-19 prevention. Many transgender people are in precarious employment situations and have lost employment and income due to COVID-19 measures, live in cramped conditions (making physical distancing difficult), cannot access food aid that is contingent on presentation of national identity cards, or are illiterate, making public health campaigns and information inaccessible. The Khawaja Sira Society and UNAIDS Pakistan are disseminating information on hygiene, preventive measures and physical distancing on social media. The Khawaja Sira Society is also working with provincial governments to ensure people living with HIV can have multi-month refills of antiretroviral medicines delivered to their homes (39).

Women living with HIV who use drugs, transgender women and sex workers may be at higher risk of contracting the coronavirus due to lack of housing, poverty, or lack of continued access to prevention and harm-reduction measures. Continuity of care for people who use drugs is strained further due to staff shortages, clinic closures and quarantines, and clean drug use equipment may be reallocated to COVID-19 treatment efforts, thus reducing access to drug substitution therapy (40). Homeless women and girls may be unable to physically distance in public and may lack access to resources and the ability to manage their personal hygiene, including menstrual hygiene.

IMMEDIATE ACTIONS NEEDED

Governments should:

- Recognize women's resilience, innovation and roles as critical change agents necessary for effective COVID-19 responses.
- Ensure women's equal representation, meaningful participation and decision-making power in national COVID-19 response and recovery planning, implementation, monitoring and evaluation, and in governance and decision-making processes regarding public health and emergency responses moving forward.
- Identify, with communities representing the wide and diverse experiences of women and girls, the needs of the most marginalized, and ensure they are prioritized in COVID-19 response plans and budgeting.
- Incorporate a gender perspective in all policy responses to COVID-19, as social norms and cultural patterns can lead to a differentiated impact for men and women. Take targeted action to avoid exacerbating existing inequalities. Specifically account for the circumstances of women and girls, including based on sex, sexual orientation, gender, gender identity, HIV status, race, age, caste, class, religion, disability, indigenous identity and immigration status, in all COVID-19 responses.
- Ensure ongoing access to critical health information and commodities such as antiretroviral medicines, condoms and lubricants, modern contraception (including emergency contraception), pre- and post-exposure prophylaxis, other post-rape care, and harm-reduction services such as needles and syringes, opioid substitution therapy and overdose prevention. To maintain safety and accessibility for all women and girls, states should provide differentiated services, including multi-month dispensing, community service delivery and self-care interventions. Anticipate and address supply-chain disruptions, and ensure ongoing compliance with medical privacy regulations in all pandemic responses (41).
- Collect age-, gender- and disability-sensitive evidence to create more equitable solutions to the disproportionate impacts of COVID-19 and responses on women and girls in all their diversity, and promptly share good practices and lessons learned in this regard. Longer term, ensure disaggregation of data is mainstreamed into outbreak and emergency response planning and preventive measures.
- Guarantee all women and girls can access health and social services, accommodation, protection from violence, and justice without fear of arrest, deportation or discrimination by service providers.

RECOGNIZE AND GUARANTEE ACCESS TO ESSENTIAL HEALTH SERVICES

As with the general population, women and girls are facing decreased access to essential health services during the pandemic (11, 42, 43). The consequences of reduced access to critical sexual and reproductive health care are particularly severe for women and girls. WHO has identified reproductive health care, including care during pregnancy and childbirth, as a high-priority essential service that states should prioritize to maintain continuity of service (42). The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee has similarly issued guidance that calls on states to ensure “confidential access to sexual and reproductive health information and services such as modern forms of contraception, safe abortion and post-abortion services and full consent must be ensured to women and girls at all times, through toll-free hotlines and easy-to-access procedures such as online prescriptions, if necessary free of charge” (44).¹

UNFPA has reported that more than 47 million women could lose access to contraception during the pandemic, leading to 7 million additional unintended pregnancies (45). In many countries, sexual and reproductive health-care funding and supplies are not included in emergency health frameworks or financing schemes. Existing sexual and reproductive health supplies and providers are also being diverted to COVID-19 efforts. For example, some African governments have moved funds regularly earmarked for reproductive health care to combating COVID-19, and at least 447 mobile clinics in the region have been shut (46). Marginalized women who use drugs, engage in sex work or live in poverty are at particular risk of acquiring COVID-19, and yet they may lack access to health care due to fear of discrimination, harassment or potential criminalization.

CASE STUDIES

A woman in the Philippines died after giving birth at home because she was denied emergency services to remove the placenta. She was turned away from various hospitals due to lack of blood, available rooms, medical personnel and surgical equipment. Hospitals also asked for advance payment for services and personal protective equipment, despite her critical condition (47).

Amidst rising anti-Muslim sentiment in India, a pregnant Muslim woman in Rajasthan was turned away from a public hospital allegedly because of her religion, resulting in the loss of her pregnancy (48).

Disruptions in supply chains for antiretroviral medicines, condoms and contraceptives have severe implications for women and girls. Their ability to protect their health, avoid unwanted pregnancies, and prevent or manage HIV and other sexually transmitted infections is impeded. Combined with increasing economic insecurity and gender-based violence, this may lead to increasing rates of unwanted pregnancies and unsafe abortions, and thus rising incidences of preventable maternal mortality and morbidity (49). Some governments have also increased restrictions on sexual and reproductive health services, such as comprehensive sexuality education (50, 51) and abortion (52). State efforts to reduce COVID-19 transmission, including mobility restrictions, geographical lockdowns and curfews, have impeded women and girls from attending clinics for necessary sexual and reproductive health care. Even where countries have deemed sexual and reproductive health care as essential, barriers such as transportation and mobility bans prevent patients and providers from travelling to clinics (46).

¹ See also the 2020 statement by the United Nations Working Group on Discrimination against Women and Girls: “Restrictions on the provision of health services essential to women and girls, such as pre- and post-natal care, termination of pregnancy and the availability of contraceptives, imposed in many countries to address the excessive demands on health services caused by the pandemic, also affects women’s and girls’ health disproportionately” (23).

GOOD PRACTICES

In the United States of America, the Telehealth Services were launched, a virtual health-care service that allows people to access a range of sexual and reproductive health services, including contraception, emergency contraception, trans/non-binary hormone therapy, and treatment for sexually transmitted infections, by video conferencing and telephone (53).

In Kyrgyzstan, the National AIDS Centre is providing three-month supplies of antiretroviral medicines to all people living with HIV who are on treatment. Hospitals in Thailand are dispensing supplies of antiretroviral medicines to cover three to six months for people whose condition is stable, in line with WHO guidance, to prevent people from running out of medicines and to reduce the need for routine visits during the pandemic (54).

The Eurasian Women's Network on AIDS, with support from UNFPA Eastern Europe and Central Asia, launched a dedicated hotline to help people living with HIV and key populations who have difficulties accessing antiretroviral therapy services, reproductive health services, and gender-based violence counselling and services due to the pandemic and associated quarantines, border closures, lockdowns, and disruptions in supplies chains and service provision (55).

England, France and Ireland are allowing remote consultations with patients seeking abortions (56). The Government of France is ensuring continued delivery of the contraceptive pill to women, even if they are unable to renew their prescriptions (57).

IMMEDIATE ACTIONS NEEDED

Governments should:

- Designate sexual and reproductive health care, including condoms, pre- and post-exposure prophylaxis, antiretroviral therapy, diagnosis and treatment of sexually transmitted infections, safe abortion where legal,² contraception, and maternal and newborn care, as essential care for all women and girls, including women in prisons and other places of detention (59).
- Guarantee preventive and curative health care for women and girls in all their diversity, and all recommended COVID-19 services, with particular attention being paid to the most marginalized women and girls, and ensure sexual and reproductive health information, supplies and care are integrated into all current and future emergency health frameworks and financing schemes moving forward, along with plans for accessibility during public health crises for all women and girls in all their diversity.
- Implement communication and engagement between law-enforcement and health and social services where appropriate so that people can access health care and essential services without any fear of law enforcement, including deportation and punishment. Allow for self-care and telemedicine counselling and treatment, where practically and medically feasible.
- Prevent and prohibit reassignment of sexual and reproductive health resources and staff without ensuring appropriate and acceptable alternatives, and ensure uninterrupted access to essential sexual and reproductive health information, supplies and services for all people without discrimination, allowing people to travel for (or be transported

² "To the full extent of the law, safe abortion services should be readily available and affordable to all women" (58).

to) services, including maternal health care, abortion, reproductive cancer diagnoses and treatments, hormone treatment, condoms, contraception, including emergency contraception, antiretroviral therapy, pre- and post-exposure prophylaxis, and treatment of sexually transmitted infections, allowing for multi-month prescribing and dispensing, and where feasible through mail and with telemedicine counselling.

ADDRESS THE NEGLECTED EPIDEMIC OF GENDER-BASED VIOLENCE AGAINST WOMEN AND GIRLS

It is estimated that globally 243 million women and girls aged 15–49 years have been subjected to sexual and/or physical violence perpetrated by an intimate partner in the past 12 months (60, 61). With half of the world's population on lockdown during the pandemic, gender-based violence is increasing due to strains on mental health, security and income and cramped living conditions. For example, there has been a 30% increase in cases of domestic violence in France since the country's lockdown began on 17 March 2020. Calls to helplines in Cyprus and Singapore have reportedly risen by 30% and 33%, respectively (60). In Brazil's Sao Paulo state, which has been hard hit by the pandemic, there has been a 45% jump in cases of violence against women where police were dispatched in the past month, compared with a year earlier. In Colombia, domestic violence calls to a national women's hotline increased by nearly 130% during the first 18 days of the country's quarantine (62). In some countries, domestic violence reports have almost tripled, but there are few shelters and only limited capacity in those that do exist (23).

For women living with HIV, gender-based violence can impede HIV prevention and access to services (6). Violence, and the fear of violence, makes it especially difficult for women to decide whether they will have sex (and with whom) or to negotiate safer sex (63, 64). Violence, or the potential for it, discourages many women living with HIV from disclosing their HIV-positive status to their partners, families and health providers, making it more difficult for women and girls to stay on HIV treatment (65, 66).

Women and girls may face specific risks of violence due to their gender identity or sexual orientation. Such violence may be at the hands of their families, partners or communities; this is particularly so for adolescents forced to co-isolate in hostile family homes or neighbourhoods (67). These situations are compounded in countries where some forms of sexual orientation and gender identity and expression are criminalized, limiting access to justice or support due to fear of prosecution (68, 69). Criminalization can likewise increase violence against sex workers and women who use drugs (70, 71). Women and girls with disabilities are also facing disruptions to support networks that are essential for their survival, increasing their vulnerability to violence (72).

Lifesaving support for women who experience violence, such as clinical management of rape, urgent medical care, and psychosocial support (43), may be disrupted when health-service providers are overburdened. Even where essential services are maintained, physical distancing and a collapse in the coordinated response between law enforcement, health and social services providers and justice actors mean that sectors will be challenged to provide meaningful support to survivors (60).

Where women and girls have access to technology, online violence is increasing. Before the pandemic, 1 in 10 women in the European Union reported having experienced cyber-harassment after the age of 15 years, including unwanted, offensive or sexually explicit emails or text messages, or offensive inappropriate advances on social networking sites (73). During the COVID-19 pandemic, the use of online platforms has increased. Some have seized on this opportunity to groom young people into exploitative situations (74). According to Europol, online activity by people searching for child abuse material is increasing (75).

GOOD PRACTICES

FIDA-Kenya, a women's rights organization in Kenya, has launched a hotline to provide free counselling and legal aid services for people experiencing gender-based violence during the pandemic (76).³

UNFPA has supported the creation of a gender-based violence and mental health and psychosocial support hotline through a local partner in Tripoli, Libya. More than 470 phone calls have been received, including calls related to medical consultations, COVID-19 and other issues.

The Ministry of Women's Affairs in Tunisia, with support from UNFPA, has set up a new temporary shelter for survivors of gender-based violence, and supported three existing shelters with personal protective equipment products (77).

In France, women can discreetly report violence to pharmacists by using a code word. The French Government has created a 24-hour platform for confidential reporting of sexual and gender-based violence (78). The Government has also agreed to pay for 20 000 nights in hotel rooms for survivors of domestic violence, to open pop-up counselling centres at supermarkets (79), and to promptly issue legal protection orders for women and children.

UNAIDS is working with civil society networks in Thailand to monitor and report cases of violence and other human rights violations among key populations and people living with HIV during the pandemic. Using an online tool, community members can report to a crisis response team human rights abuses and other forms of discrimination, including physical violence, disclosure of HIV status, being tested for HIV without consent, and discrimination in workplaces and schools. The team consists of a multidisciplinary group of people such as community health workers, health-care providers, social workers, lawyers and police officers, and can provide immediate assistance, including social and health support, mediate with management in workplaces and education institutes, and arrange for volunteer lawyers to support survivors in court.

³ See also <https://twitter.com/fidakenya/status/1251113908238200832>.

IMMEDIATE ACTIONS NEEDED

Governments should:

- Integrate violence prevention and support into all emergency response planning, allocating sufficient supplies and resources for this purpose (80), and including women and girls in all their diversity in the development and implementation of such plans, and incorporate anti-violence messages and available resources and social, psychological, health and legal services available for survivors into mass media and social media campaigns.
- Ensure women's centres, shelters, domestic violence helplines, police protection, legal aid and other critical services are identified as essential services, and continue to operate and identify safe spaces where women and gender-diverse people can report abuse without alerting perpetrators. Include exceptions in lockdown and confinement orders for survivors who seek assistance outside the home, and enable safe passage when fleeing violence.
- Scale up and leverage online and virtual support networks. Where such options do not exist, bolster existing women's rights organizations and collectives to lead in-person support and provide necessary protective equipment and training for them to do so safely.

- Prioritize legal rights and awareness programmes to empower women and girls living with HIV who are criminalized or otherwise stigmatized with knowledge of the law, their rights and entitlements, and information on how to access legal aid.
- Longer term, adopt a whole-of-government approach to ending gender-based violence, to coordinate and unite entities to prevent and eradicate violence, including through implementing a well-resourced national strategy that outlines roles and responsibilities, assessment indicators, and a risk-based approach that can be applied before, during and following crises.

STOP MISUSE OF CRIMINAL AND PUNITIVE LAWS

In a bid to combat COVID-19, many states are resorting to aggressive policing, punishments, criminal law and other conduct in the name of public health (81). In general, states are enforcing traditional public health measures such as periods of quarantine alongside criminal sanctions and criminalizing COVID-19 exposure and transmission, in a manner that resembles HIV criminalization. Women can get caught up in punitive law enforcement during the pandemic when fleeing violence, seeking access to critical health services, including sexual and reproductive health services, or leaving home to work to feed their families and survive (82, 83).

Criminalized populations, including lesbians, transgender people, sex workers, migrants, and people who use drugs, may experience a compounded human rights impact. They can face multiple forms of policing and punishment, deterring them from obtaining COVID-19 testing and treatment, protection from violence, or essential sexual and reproductive health care, including HIV prevention, testing and treatment. Without appropriate safeguards, new electronic contact-tracing technology may pose a great risk to criminalized people living in fear of police apprehension, as their movements and health status can be tracked (84). The application of these technologies raises questions regarding compliance with privacy rights standards, including medical privacy, which need to be addressed.

CASE STUDIES

Sex worker-led organizations are reporting systematic exclusion from financial and social protection schemes, particularly where sex work is criminalized. As a result, sex workers are forced to put their health and safety at risk to earn money (85). Twenty-four sex workers and six of their clients were arrested in Kenya for violating COVID-19 directives (86). Sex workers in South Africa report police brutality if found in the streets, when they are simply working to survive (87). Sex workers in Uganda are being targeted with violence, blackmail and arrest by police. Many of these women and their families have also been denied food aid by local government officials, and sex workers living with HIV and their children are struggling to get HIV treatment refills, pre-exposure prophylaxis, treatment for sexually transmitted infections, and contraception due to poor government planning (88).

Although states are permitted to restrict human rights in some cases, including to protect public health, their power is not unlimited. States' restrictions must have a legitimate purpose and be strictly necessary and proportionate. They must also be limited in duration, reviewable by a court and non-discriminatory. Exceptions to punitive regulations should be made for particularly marginalized populations who, due to their circumstances and existing inequalities, cannot comply with regulations. Research confirms that criminalizing people who violate public health regulations can do more harm than good (89).

As the HIV epidemic has shown, criminalization disproportionately impacts the most marginalized people. People with economic security, housing, healthy food and clean water can more easily stay home to protect their health, but people living in poverty, who have lost their jobs or housing, and who have no social security may struggle to comply with public health orders. Women also experience a disproportionate impact of punitive COVID-19 measures, given increasing gender-based violence and their overrepresentation in informal economies. Women and gender-diverse people seeking to escape violent situations or continuing to work to survive can get caught up in criminal law enforcement for violating movement restrictions. In some contexts, transgender people cannot leave their homes without facing punishment under gender-segregated quarantine measures. For example, a transgender woman health outreach worker in Panama was detained by police for being out on the “wrong day” (90). Authorities have been reported to check individuals’ official documents to confirm their gender identity when enforcing the rule. Similar gender-specific quarantine regulations have been rolled out in Bogotá, Colombia.

IMMEDIATE ACTIONS NEEDED

Governments should:

- Ensure COVID-19 responses, as well as general emergency responses moving forward, are legal and have a legitimate aim (i.e. promoting public health), are necessary, are proportionate, are non-discriminatory, are limited in duration and reviewable by a court, and avoid punishing people who cannot comply with public health orders due to their health, socioeconomic status or existing inequalities.
- Issue a moratorium on laws that criminalize individuals’ consensual sex, reproduction, gender expression, personal use or possession of drugs, and HIV exposure, non-disclosure and transmission, and work to repeal such laws moving forward. Refocus law-enforcement measures on ensuring public safety and referring marginalized groups to health and social services.
- Immediately release people who have been arrested and detained for non-violent charges. Moving forward, consider alternatives to pre-trial detention and commutation or temporary suspension of certain sentences for minor non-violent offences.
- Exercise caution when developing and relying on electronic contact-tracing tools as they may have implications for privacy rights and the potential of unintended consequences and discriminatory use.
- Avoid the introduction of new legislation or the application of existing legislation to criminalize exposure, non-disclosure or transmission of viruses and communicable diseases, and limit punishment to rare cases where intentional conduct can be demonstrated by evidence.

GOOD PRACTICES

In New Zealand, where sex work is decriminalized and treated as work, sex workers are easily able to access emergency wage subsidies during the pandemic (available to all by providing a national identity number and basic personal information) and are immediately eligible for jobseekers' benefits (91). Although some have needed help with obtaining identity numbers and bank accounts, officials have provided assistance. Some support for sex workers in New Zealand is still needed, but the situation appears to be much less dire and sex workers are better equipped to comply with public health orders.

Afghanistan, Chile, India, Indonesia, the Islamic Republic of Iran, South Africa and Thailand have released from prison large numbers of people sentenced for non-violent offences, and many more countries are releasing people in pre-trial detention in a bid to limit the spread of COVID-19 in places of incarceration.

PRIORITIZE ADOLESCENT GIRLS' AND YOUNG WOMEN'S EDUCATION, HEALTH AND WELL-BEING

Approximately 89% of students worldwide are out of school because of COVID-19 closures, many without adequate solutions for remote learning, and without crucial health and social services such as school feeding programmes. This represents 1.54 billion children and youth enrolled in school or university, including nearly 743 million girls (92). Past crises show that adolescent girls are more likely to drop out after school closures, which further entrenches gender gaps in education and leads to increased rates of early and forced marriage, early pregnancy, unplanned or forced sexual activity, risk of physical and sexual abuse by peers and older men, and transactional sex to cover basic needs (92–96). Children often dropped out of school in Guinea, Liberia and Sierra Leone during the Ebola epidemic due to increased domestic and caring responsibilities and the need for income generation (92).

Although remote learning approaches have been deployed to great effect, there is a stark gender digital divide (97), which may prevent adolescent girls and young women from fully engaging in and benefiting from remote solutions. As schools scramble to develop remote curricula, there is a real risk that comprehensive sexuality education will be left behind; for example, delaying puberty education—a key component of comprehensive sexuality education—by a year could mean many girls will begin menstruating without having learned about it (98). This places adolescent girls at particular risk, as many will lose access to critical sexual and reproductive health information, and girls may be unable to leave their homes to access HIV and sexual and reproductive health services without parental consent. Similar school closures during the Ebola outbreak led to a 65% increase in adolescent pregnancies in Sierra Leone (18, 92). Past school closures have also led to increases in early and forced marriages (99), transactional sex to cover basic needs (100), and sexual abuse (101). School closures have cut off many learners from the health, nutrition and social support services typically provided in school environments. Notably, adolescent girls are more likely to face malnutrition, because the meals provided at school are an essential source of nourishment that may not be provided at home.

Pregnant girls and adolescents with children often do not return to school due to stigma, child-care obligations, economic considerations, and laws, policies and practices that limit their access to education. Quarantine measures that exacerbate already cramped and limited housing and increasing economic strains may lead to child or early marriage (102). Pregnant adolescents living with HIV are at higher risk of mental health problems, poor

treatment adherence and retention in care, and suboptimal health outcomes. They may require additional counselling, linkages to social safety nets, and postnatal care to manage their unique psychosocial stressors (103).

Disabled women and girls may be unable to work with support workers to access sexual and reproductive health services. If they must rely on a partner or family member to seek care, that dependence makes them susceptible to violence and abuse (72).

Girls' education has long been recognized as a critical tool in the fight against HIV, the advancement of gender equality, and enhancing the health and welfare of families and communities (104). Education for girls, especially secondary education, has a protective effect against HIV (105–107). Education has been specifically associated with reduced HIV infection among young women (108); when Botswana extended mandatory secondary education, for instance, it found that each additional year of schooling after year 9 was associated with a 12% reduction in girls' risks of acquiring HIV (105). By contrast, discrimination in education and economic opportunities undermines women's and girls' agency and limits their decision-making power within relationships, families and societies, heightening their risk of acquiring HIV (6, 109).

GOOD PRACTICES

The Lesotho Ministry of Health and the United Nations Children's Fund (UNICEF), through its implementing partner Help Lesotho, are providing remote health counselling, COVID-19 information and psychosocial support through teleconsultations for young men and pregnant or breastfeeding adolescent girls and women aged 15–24 years, and their children, participating in the 2gether 4 SRHR Young Mothers Programme. The consultations are done through individual WhatsApp messages and phone calls, using a modified survey that includes questions on continuity and access to maternal and child care, prevention of vertical transmission, sexual reproductive health, HIV prevention and testing, mental health, birth registration, and prevention of sexual and gender-based violence (110).

To urgently address the disproportionate impact that COVID-19 and stay-at-home orders would have on adolescent girls and young women, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has adapted the existing Let's Talk campaign.⁴ This campaign was originally created with UNFPA, SAfAIDS and Save the Children Sweden in 21 countries in eastern and southern Africa to prevent and address early and unwanted pregnancies and to keep girls in school. Using social media, the adapted campaign generates dialogue and information on how to ensure women and girls are safe at home, know where they can turn for help in their communities, and are supported to return to school once it is safe, as well as core campaign messages on education, health and rights.

The Eurasian Union of Adolescents, Teenergizer, has not only continued its support for adolescent girls and young women affected by HIV, but also expanded its services during COVID-19 lockdowns in Eastern Europe and Central Asia. The organization has transitioned to the provision of online services, which include facilitation of confidential support groups for adolescents living with HIV, internships for HIV-negative adolescents, and training for educational institutions. Website enquiries for peer-to-peer online counselling on teenergizer.com have increased four-fold since the lockdowns began. Sixty-nine per cent of the website users are girls and young women aged 18–34 years. Through a series of live broadcasts, videos and articles on social media, thousands of adolescents and young people in the region were covered by the #StaySafe campaign, received reliable information on obtaining psychological support and help with adapting to quarantine orders and security measures during the pandemic, and received sex education and information on HIV (see @teenergizer on Instagram and Facebook) (111).

⁴ <https://letstalkeup.com>.

IMMEDIATE ACTIONS NEEDED

Governments should:

- Ensure gender-responsive approaches to remote learning, including through measures to bridge the gender digital divide (e.g. collect sex-disaggregated data on participation in distance learning programmes; use public–private partnerships to make gender-responsive distance learning materials and learning opportunities free of charge; and provide broadband and mobile network connections that ensure accessibility for adolescent girls and young women with disabilities). In contexts where digital solutions are less accessible, consider using low technology such as reading and writing materials and radio and television broadcasts to reach the most marginalized people. Ensure programme scheduling and learning structures are flexible, and allow self-paced learning so as not to deter girls who are disproportionately shouldering the burden of care.
- Provide feeding programmes, take-home rations and conditional cash transfers to encourage girls to stay in school or to incentivize them to return to school, and prioritize ongoing education for girls and young women. Ensure community engagement around the importance of girls' education, including sexual and reproductive health information.
- Guarantee access to non-discriminatory, evidence-based comprehensive sexuality education (using innovative and interactive methods, both digital and non-digital) for all adolescent girls and young women, including those with disabilities, both in and out of school settings, that challenges gender stereotypes and gender-based violence, including during the COVID-19 pandemic. Remove barriers to accessing sexual and reproductive health information services, such as parental consent requirements.
- Longer term, develop gender-responsive education sector contingency plans and budgets, grounded in gender analyses of roles, risks, responsibilities and social norms. These must consider mitigation and response measures for additional caregiving burdens, heightened risks of gender-based violence and early pregnancy, and other adverse impacts of the pandemic.
- Longer term, promote gender equality in and through education, including through targeted measures to support young women to complete secondary education, and through programmes designed to build women's skills for the world of work.

VALUE WOMEN'S WORK AND MAKE UNPAID CARE WORK EVERYBODY'S WORK

In the world of work, women aged 25–34 years are 22% more likely than men to live in extreme poverty (112). This economic inequality is likely to increase further during the COVID-19 pandemic and its aftermath. The global pause in the world economy is disproportionately impacting women, particularly women heads of households, who more often work in positions that lack basic social or legal protection and employment benefits, including in informal work that is more precarious, lesser paid and subject to market fluctuations.

Formally employed women work shorter hours than men, earn less and enjoy less seniority than their male counterparts (113, 114). With less status in formal labour markets, women are more likely to experience job losses, particularly in developing countries and emerging economies (115). As women often hold less wealth than men, job losses can be devastating (116, 117). Women are also disproportionately represented in informal work. There are approximately 126 million women working in informal economies, such as domestic workers, women living in rural areas and sex workers, and in other industries and sectors, who are

disproportionately affected by the pandemic. Young women are especially impacted, as 77% of young workers are in the informal economy and many are working in part-time or temporary jobs or in the “gig economy” (21). With the widespread loss of livelihoods and fewer employment opportunities, transactional sex, sex work and sexual exploitation may increase (118).

As women lose their paid employment, their unpaid care work has increased exponentially due to school closures and the burden of caring for older dependents (2). Before the pandemic, women were doing two and a half times more unpaid household and care work than men (119, 120). Occupied with cooking, cleaning, fetching water, food and firewood, and taking care of children, family members living with HIV and elderly people, women have less time to undertake paid work, or they work longer hours by combining paid and unpaid work. Compared with men, women perform on average three times as much unpaid care and domestic work, including caring for elderly or ill family members (121). While women’s unpaid work subsidizes the cost of care that sustains families, supports economies and makes up for lack of social services, it is rarely treated as “work” (122), despite it being valued to be 10–39% of the gross domestic product and to contribute more to the economy than the manufacturing, commerce or transportation sectors (120, 123).

The imposition of unpaid care and domestic work on women and girls is grounded in traditional gender roles, which are being re-entrenched during the COVID-19 pandemic. Women’s role as “caretakers” has come to the fore as increasing domestic work has been imposed on them in recent months. School closures have increased both child-care and educational tasks, again which have typically been absorbed by women (115, 124). As health-care systems become strained in high-income countries, and in low-income countries where health infrastructure is weak, health-care responsibilities are frequently loaded on to women and girls (125).

GOOD PRACTICES

UN Women launched the #HeForShe@Home campaign to highlight the unfair reality that women make up 70% of workers in the health and social sector and do 3 times as much unpaid care work at home as men, and to call on men to take on their equal share of domestic and care work (126).

The Government of Thailand is providing 3-month allowances of 500 baht (US\$ 150) to support informal workers, the majority of whom are women, not covered by social insurance, if they register with one of 3 state-owned banks or online (115).

Swasthi, a community-based nongovernmental organization in India, is distributing rice, lentils, cooking oil and small amounts of cash to transgender people and women living with HIV in Madurai during the pandemic, as most of these people are struggling to work and earn money. UNAIDS and UNICEF have been supporting networks of sex workers to develop income-generating schemes so they can compensate for the loss of income caused by COVID-19 (127).

In Bangladesh, UNAIDS has joined forces with the sex workers network and the country coordinating mechanism to support 23 community-based organizations of sex workers to procure protective commodities such as soap and masks during the initial stages of the response to COVID-19 (128).

WOMEN'S LEADING ROLE IN COVID-19 RESPONSES AND HEALTH-CARE PROVISION

As well as being the primary caretakers at home, women are also providing most of the COVID-19 care in hospitals and clinics. Women constitute almost 70% of the health workforce worldwide, but they are more often employed in lower-level positions that receive lesser pay. Research conducted in 104 countries found that women made up around 85% of nurses and midwives (115, 129). Women also make up the majority of health facility service workers, such as cleaning, laundry and catering staff, and as such are more likely to be exposed to the virus. Despite working at the frontlines of COVID-19 care responses, in some areas women have less access than men to personal protective equipment or correctly sized equipment (96). Women health-care workers engaged in the response report particular challenges around the use of personal protective equipment when they are menstruating, including lack of adequate flexibility or facilities to manage their menstruation with dignity (130).

Despite women constituting a majority of health-care workers and primary caregivers at home, placing them in prime positions to problem-solve at the local level, they continue to occupy few positions in national and global health leadership (131, 132). Inclusion of women frontline workers in health and other sectors in all decision-making and policy spaces could improve health security surveillance, detection and prevention mechanisms (115). Given women health-care workers' vulnerability to workplace violence, due to pre-existing gender roles, power dynamics, and rising tensions during COVID-19 (133), they must also be included in the design and implementation of measures to ensure their security and safety in health-care settings. Advancing women in leadership as a whole could have positive impacts. There is an emerging consensus that all of the countries that have shown the strongest leadership in this crisis are led by women (134).

Women have effectively led public health crisis responses in the past. For example, progress in the HIV context has hinged on greater involvement of affected communities, particularly women living with HIV, young women and women community leaders. Sustained investment in women as change agents in women's mobilization, such as support for networks of women living with HIV, has proven successful in diverse regions and settings and should therefore be prioritized (135, 136). Along similar lines, reliance on local women to raise awareness about Ebola through community networks in Liberia and Sierra Leone helped to ensure lifesaving information shared was relatable and delivered by a trustworthy source. This approach of integrating a gender-focused response that relies on local women's networks had a significant impact on the successful regional containment of the Ebola crisis (137).

IMMEDIATE ACTIONS NEEDED

Governments should:

- Take measures to reduce the risk of COVID-19 exposure for all health-care workers in clinics, hospitals, nursing homes and other care facilities, and provide appropriately sized personal protective equipment, shorter hours, more frequent breaks, adequate and appropriate menstrual health and hygiene management facilities, temporary removal from the risk and compensation if exposed, psychosocial support, and equal pay for equal work.
- Provide subsidies and vouchers for child-care services, and child and elderly care options for people working in health-care and other essential services, and ensure unpaid care work is recognized and valued as a vital contribution to the economy moving forward; and put in place legal, policy and cultural change measures to promote equal distribution of domestic and care work.
- Shift economic structures to account for and fairly remunerate informal work, and implement safe working conditions and health and economic protections for this sector.

WOMEN LIVING WITH HIV PROVIDE BOLD LEADERSHIP AND SUPPORT IN THE CONTEXT OF THE COVID-19 PANDEMIC

Networks of women living with HIV have been securing resources, documenting rights violations, and mobilizing to support women, including those from key populations, to access medicines, food and other essential supplies—in some cases, filling in where governments have failed to take action to protect women living HIV. The International Community of Women Living with HIV and AIDS (ICW) Eastern Africa is advocating for sexual and reproductive health and rights to be considered as essential services in the context of COVID-19. The network successfully lobbied the Ugandan Government to exempt pregnant women from the lockdown so they can travel to health facilities.

In Nigeria, ICW West Africa members are serving as community pharmacists to provide antiretroviral medicines.

The Association Tunisienne de Prevention Positive, ICW Costa Rica, ICW Mexico, ICW Zimbabwe, the National Federation of Women Living with HIV and AIDS Nepal, Positive Women Ukraine, and the Viet Nam Network of Women Living with HIV are delivering food packages and provisions to the most vulnerable women, including sex workers and women in conflict regions. Adolescent girls and young women in Africa are using the ATHENA Network #WhatWomenWant and #WhatGirlsWant platforms to share experiences and advocate for human rights (138).

- Include self-employed and informal workers, without discrimination, in unemployment assistance and other financial and social support programmes, ensuring access for sex workers, women who use drugs, gender-diverse women, migrant women and other groups of women at risk of exclusion. Direct financial support to hard-hit women-led enterprises and businesses, with subsidized and state-backed loans and tax and social security payment deferrals and exemptions.
- Adopt and enforce non-discrimination laws and policies in workplaces, particularly as employers reorganize and downsize, and reinforce accountability mechanisms and redress for women experiencing employment discrimination.
- Place a moratorium on evictions and allow for loan forgiveness and debt reduction for women struggling to make rent or mortgage payments. Provide emergency housing options, including access to shelters, for people without permanent housing or who face risk of abuse or violence at home.

RISE FOR ALL: THE UNITED NATIONS INITIATIVE TO LEVERAGE WOMEN'S EXPERTISE AND LEADERSHIP

Rise for All is a new women-led global advocacy effort to support the United Nations Roadmap for Social and Economic Recovery from COVID-19 (139–141), and to fully fund the United Nations Response and Recovery Trust Fund (142). It is a five-pillar initiative that is “not only measured in monetary terms, but in livelihoods, vulnerabilities and confidence in government to lead economies and societies through this process” (143). As stated by the United Nations Deputy Secretary-General: “Like no other time in recent history, women are on the frontlines of COVID-19 and bearing the brunt of this human crisis ... It is time for us to rise as women leaders, taking action to conquer the pandemic and come out stronger so as to keep the world on track to achieve the Sustainable Development Goals by 2030” (139, 140).

“When we get past this crisis, we will face a choice ... we can go back to the world as it was before or deal decisively with those issues that make us all unnecessarily vulnerable to crises.”

**António Guterres,
United Nations Secretary-General**

VISIONING THE FUTURE: LONGER-TERM CHANGE NEEDED

COVID-19 is not only a health issue, just as HIV never was. It impacts on a wide range of human rights, and although it affects all people, it does so unequally. Women and girls in all their diversity are experiencing the greatest impact of the crisis. COVID-19 has highlighted the stark inequalities across societies, with a lack of pandemic preparedness and fragile or non-functioning institutions posing graver impacts.

We must ensure that COVID-19 responses do not deepen existing structural inequalities, create new vulnerabilities, or roll back hard-fought gains in gender equality and women’s and girls’ human rights, or advancements in the removal of structural barriers to HIV prevention, testing, treatment and care. Instead, states, in collaboration with civil society, development actors and communities, including women leaders, must innovate from the ground up, creating new opportunities for a different future that is just and equitable. The most marginalized women and girls in our communities must be prioritized and included in the development of states’ COVID-19 responses and post-recovery efforts. Now is the time for significant structural reforms that protect health, including for HIV and future possible outbreaks and emergencies and promote security more broadly and yet still account for and remedy the reality that some people live in unacceptable and inhumane conditions and face discrimination.

It is time to create a new order—not “business as usual”, but a paradigm shift that ensures all people can live with dignity; have access to basic health care, protection and a safety net in times of crisis; and do not experience violence, discrimination or oppression because of who they are, where they were born, the colour of their skin, or their sex or gender. It is time to “build back better” (2).

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RESOURCES

ADDRESS THE DIFFERENT NEEDS OF WOMEN AND GIRLS, PAYING ATTENTION TO THE MOST MARGINALIZED

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RECOGNIZE AND GUARANTEE ACCESS TO ESSENTIAL HEALTH SERVICES

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