# GENDER ALERT
# FOR COVID-19 OUTBREAK
# MYANMAR

TABLE OF CONTENTS




**MYANMAR**
**ISSUED MAY 2020**
**GENDER IN HUMANITARIAN ACTION WORKSTREAM**

## INTRODUCTION

The interim guidance Gender Alert for COVID-19 Outbreak drafted by the Inter-Agency Standing Committee (IASC) Reference Group for Gender in Humanitarian action (GiHA), provides the minimum standards for integrating gender equality into preparedness and response planning for an effective gendered response to COVID-19. The Alert includes cluster-specific tipsheets to guide mainstreaming of gender equality into programme priorities.

To make the Gender Alert more practical for the humanitarian actors in Myanmar, UN Women and UNFPA have contextualized the document as part of the efforts of the GiHA workstream to guide clusters and sectors on mainstreaming gender into design and implementation of COVID-19 response. The checklists are meant to be read in conjunction with the Gender Mainstreaming Checklists for Humanitarian Action endorsed by the Humanitarian Country Team (HCT) in March 2020.

Recognizing the extent to which the COVID-19 outbreak affects women and men differently is hugely important. Gender norms and pre-existing inequalities disproportionately impact women and girls in emergencies, including health emergencies. Gender, together with other factors including age, sexual orientation and gender identity, ethnicity, disability, education, employment, and geographical location, may intersect to further compound individual experiences in emergencies.

A majority of severe cases and fatalities caused by COVID-19 are amongst the older sections of the affected populations, and as with women and girls, the needs, rights and contributions of older people in emergencies are often neglected. Reduction in the mobility of older people can lead to their isolation and neglect; older women are more likely to have lower or no pensions and live in poverty, a manifestation of lifelong inequality and discrimination. This may exacerbate the impact of the virus, their meaningful participation and access to protective items, food, water, information and health services, as well as measures taken in response to the virus such as self-isolation.

The lessons learned from the Zika and Ebola outbreaks and the HIV pandemic demonstrate that a robust gender-integrated response is vital to strengthening the access and acceptability of the humanitarian services required to meet the distinct needs of women and girls, as well as men and boys and LGBTQI+ people. The participation and leadership of women and girls – and their respective women's networks and youth rights organizations – in responding to this crisis will be crucial to ensuring the most effective humanitarian response. In addition, the role of women and girls in the post-crisis recovery will be essential to facilitate effective social and economic changes.

## IN THE COVID-19 HEALTH EMERGENCY, A NUMBER OF GENDERED IMPACTS HAVE EMERGED, INCLUDING:

- 75 percent of the healthcare workforce in Myanmar are women, including almost all nursing professionals and over half of medical practitioners,[1] as well as a majority of support staff such as cleaners and catering personnel.

- Women have limited access to accurate, official information and public service announcements, due to limited access to public spaces, and group gatherings (e.g. through safe spaces) and outreach activities. This can contribute to increased risk of infection, as well as increased stress and protection risks.

- In Myanmar, women's representation and decision-making power in camp coordination and camp management including in camp committees or as camp leaders is limited and inadequate to advocate for women's needs. Health crises can further prevent women and girls from equally benefiting from humanitarian action and participating in and influencing humanitarian decisions.

- Norms dictate that women and girls are the main caretakers of the household. This can mean giving up work to care for children out of school and/or sick household members, impacting their levels of income and heightening risk of exposure to the virus.

- Closures of garment factories following the disruption of the importation of raw materials from China, has had a dire impact on the income of their primarily female workforce since February. Women are in general more likely to be engaged in short-term, part-time and other precarious employment/contracts, which offer poorer social insurance and are particularly at risk in an economic downturn. This can lead to women engaging in negative coping strategies, such as transactional sex and/or heighten their exposure to risks of sexual exploitation and abuse and other forms of gender-based violence (GBV).

- The closure of borders is also having a significant impact on livelihoods, most immediately for migrant workers returning through regular and irregular routes. Of the irregular returnees most have been observed to be women. Migrant returnees required to undertake quarantine in quarantine facilities may have immediate NFI needs (including sanitary materials) as well as need for information on COVID-19 prevention and protection referral pathways.

- Overwhelmed health services, reduced mobility and diverted funding will likely hamper women and girl's access to health services, including sexual and reproductive health, GBV survivor care, HIV/AIDS treatment and attended childbirth and other natal services, exacerbating preventable maternal deaths.

- During the COVID-19 outbreak, strategies of lockdowns and other movement restrictions, combined with unemployment, fear, tension and stress, may place women and girls and LGBTQI+ people, especially in non-accepting households, at heightened risk as they are confined with their abusers.

- School closures, physical distancing and containment strategies will impact girls and boys differently, especially adolescent girls who, due to gender roles, may be expected to take on care duties thereby limiting their access to remote learning programmes.

## CAMP COORDINATION AND CAMP MANAGEMENT (CCCM)

Over 273,000 displaced people – 69 percent of whom are women and children – remain in internally displaced persons (IDP) camps or camp-like situations in Kachin, Shan, Rakhine, Chin and Kayin states, living in conditions of limited living space and limited access to WASH facilities and healthcare services. These are challenging environments to control and manage an infection outbreak and add further burden on living arrangements for vulnerable groups that have restricted movement, such as women, girls, the elderly, child-headed households and people with disabilities. An adequate pandemic response may require the redesign of camp structures and layouts to ease overcrowding and facilitate the management of infection prevention including the creation of designated areas for quarantine and isolation, and ensure the continuity of health, MHPSS and GBV service provision.

Women's leadership is limited in IDP camp management committees, which can translate to a lack of consideration for women and girls' needs in the camp management of a pandemic response. In order to respond to the risk of COVID-19 within IDP camps, the Department of Disaster Management (MoSWRR) shared an "Action Plan for the Control of COVID-19 Outbreak in IDP Camps" that mentions the establishment of "facilities to serve as quarantine centres" within camps, which includes the re-planning of IDP camps.

***Recommendations for a gender-integrated CCCM response:***

- Include women, girls and other at-risk groups including LGBTQI+ persons, the elderly, and female headed households that reside in the camps in all consultations when coordinating and planning for infection/health management, including the establishment of quarantine facilities or home-based quarantine within the camp.
- Ensure that camp management and planning include representation from women camp committee members and promote women's engagement in camp leadership to strengthen the meaningful participation of women and girls in all decision-making processes in addressing the infection outbreak.
- All resource mapping, safety audits and needs assessments of IDP camps for potential pandemic response adaptation should consult and be inclusive of women and girls, men and boys and other at-risk groups.
- Any re-planning of sites and accommodation of individuals must consider protection and rights of women and girls – including sex-segregated and safe WASH facilities, lighting, accommodation for single women and men, female-headed households, child-headed households and separated children, and ensure that quarantine facilities in the camps adhere to the aforementioned standards. A private, separate room or area for mental health and psychosocial support (MHPSS) and gender-based violence (GBV) service provision should be included in plans. Coordination with the Protection and Health clusters is important to ensure the health and safety of at-risk groups.
- All planning and construction of quarantine centres within camps should align with the complementary Gender Guidelines for Community-Based Quarantine Centres, released by MoHS Government.
- Ensure coordination between CCCM, Protection and Shelter clusters in order to effectively respond to the protection needs and rights of women and girls when planning to adapt IDP camp sites and accommodation.

## CASH-BASED INTERVENTIONS (CBI)

Health crises exacerbate pre-existing cultural and gender norms, limiting the options for women to engage in cash-for-work (CFW) activities as well as access to markets. Lockdowns, quarantine, and/or self-isolation regulations expose women and girls to greater health risks due to the potential increase in care responsibilities for ill family members. In a health crisis, women and girls are also at greater risk of experiencing gender-based and intimate partner violence.

During the design of a Cash-Based Intervention (CBI) in response to a viral pandemic, distributions have to be adaptable, innovative and implement preventative risk mitigation measures for virus transmission such as reducing crowding, enforcing physical distancing and ensuring a "Do No Harm" and "Leave No One Behind" approach. Simultaneously, changes should not increase the burden of women or make distributions less accessible. Gender and vulnerability-sensitive CBIs can relieve short-term economic pressures caused by a crisis, thereby reducing the need to rely on negative coping mechanisms such as selling off assets, accumulating debt, child labour, child/forced marriage and sex work.

***Recommendations for gender-integrated CBI response:***

- In coordination with local health authorities and interagency coordination fora, ensure dissemination of preventive guidance and tools, factoring in gendered differences in literacy levels, access to information tools such as mobile phones and internet and to public spaces and group gatherings. This includes raising awareness on preventative measures using pictures, banners, posters, or boards posted at CBI registration, distribution points and cash and/or voucher outlets that are accessible to all in local languages.
- Assess the implications of lockdowns, quarantine, and/or self-isolation regulations in camps and camp-like settings in accessing markets and livelihoods, capturing sex-age-disability disaggregated data (SADDD).
- Analyze the composition of the affected population and identify the groups with the greatest CBI needs.
- Assess how women and other at risk-groups such as LGBTQI+, elderly, people with disabilities and female and child-headed households typically access cash and whether this may change with the characteristics of a health crisis (e.g. restriction of movement).
- Assess women's knowledge on financial management (including digital finance and financial literacy) and familiarise them with potentially more effective transfer mechanisms such as mobile phone transfers and e-payments. Explore piloting multi-purpose, gender-responsive cash programmes and provide diversified CFW options to ensure suitable and safe opportunities for women (including pregnant and lactating women), elderly and people with disabilities and guarantee equal pay between women and men.
- Ensure the design of the CBI is informed by a participatory gender and social analysis and is grounded in solid and factual understanding of who is benefitting and managing resources, ensuring women's social roles and relations will not be damaged by the interventions.
- Provide flexible schedules for women and men to participate in CBIs and offer childcare. Childcare can be provided as a CFW option for mothers bound to the domestic sphere, increasing the value of women's care work.
- In coordination with the GBV CWG/SS, Protection Sector and Protection against Sexual Exploitation and Abuse (PSEA) network, include GBV considerations in CBIs to prevent and mitigate the risk of GBV and sexual exploitation and abuse (SEA) and provide access to targeted protection services.

## COMMUNICATING WITH COMMUNITIES (CWC) AND ACCOUNTABILITY TO AFFECTED POPULATIONS (AAP)

Communicating with Communities (CwC) is crucial in ensuring accurate and reliable information on prevention and response to pandemics reaches all groups in the Myanmar population, including women, girls, LGBTQI+ people, female and child-headed households, the elderly and people with disabilities. Communities affected by conflict and disasters face multiple barriers in accessing information due to potential language barriers, low literacy levels, lack of communication devices and prevailing socio-cultural gender norms and roles. In situations of infection outbreak in states and regions with existing conflict or disaster, CwC must be adapted to reach the most vulnerable members of the population. Likewise, well-functioning feedback and complaint mechanisms for pandemic response must be easily accessible to all populations, including those with restricted movement due to prevailing social norms such as women, girls, the elderly and people with disabilities. Such mechanisms are crucial for humanitarian organisations to adjust their programming based on learnings and feedback but also to facilitate complaints of sexual exploitation and abuse (SEA), as experience from previous epidemics suggest that restrictions on movement and other contingency measures can create opportunities for SEA.

With high possibility of community transmission in Myanmar, effective and accessible communication with all groups in the Myanmar population is key to prevention and response to COVID-19. The Ministry of Health and Sports has set up a specific process to review all IEC materials related to COVID-19. The CwC Working Group in Rakhine State also regularly creates, reviews and advises on communication channels and materials adjusted to the diverse needs and vulnerabilities of the affected populations.

***Recommendations for a gender-integrated CwC and AAP response:***

- Factor in gender-based differences in literacy levels and access to information tools such as mobile phones and internet. Ensure that communication is inclusive and transmitted through multiple media options including radio, visual guides, and community mobilization, as well as in a diversity of languages, accessible formats and with use of available technologies.
- Establishment and management of community mobilization and communication strategies must have women at their core. All messaging and information on infection control must be appropriate, understandable and relayed through proven effective mechanisms, such as women's groups, adolescent youth, women with disabilities, and older people's associations.
- Provide specific advice for vulnerable groups in accessible and inclusive languages and disseminate through targeted community forums to ensure these groups are receiving information. Coordinate with WASH and Protection sectors to support with dissemination of Information, Education and Communication (IEC) resources through hygiene and dignity kit distribution.
- Ensure that the COVID-19 hotline number is shared with people who may have limited/restricted movement and access to public areas, including women and girls, the elderly, people with disabilities, and unaccompanied children. These groups should also have access to gender-based violence and sexual exploitation and abuse hotlines, in line with the protection sector.
- Ensure COVID-19 feedback and complaint mechanisms are accessible for vulnerable groups that have limited/restricted movement and access to public areas, as mentioned above.
- Community mobilization, risk communication and surveillance mechanisms should be localized with women taking a leadership role in their design and implementation.
- Follow guidance on "How to include marginalized and vulnerable people in risk communication and community engagement", developed by the Risk Communication and Community Engagement Working Group on COVID-19 Preparedness and Response in Asia and the Pacific.

## EDUCATION IN EMERGENCIES (EiE)

On 16 March 2020, in a bid to contain the spread of COVID-19, the Ministry of Education issued an order to temporarily close basic education facilities, private schools, summer courses, and new curriculum courses nationwide. It is possible that closure will continue past the beginning of the academic year starting June 2020 in Myanmar, in which case home-based learning will become relevant.

Previous experience in crisis settings show that adolescent girls are less likely than boys to return to school after a prolonged absence.[1] Closure of schools can also heighten their protection risks with no supervision during the day, which can lead to sexual abuse and exploitation (SEA), gender-based violence (GBV) including child marriage, and risk of engaging in high-risk sexual activity potentially leading to pregnancy and contraction of sexually transmitted infections (STIs).

The closure of preschools and any future closure of schools will increase the care duties of women – and those women who do continue to work, including female teachers, will be faced with a double burden of both income generation and care for children. In conflict-affected states, female teachers have also been subjected to sexual violence in the past, and continue to be at risk of GBV.[2] The starting monsoon season, in addition to the present conflicts, creates a risk of a multi-hazard context that will increase vulnerabilities and subsequently such concerns even further.

***Recommendations for a gender-integrated EiE response:***

- Put in place preventative measures to minimize the risk of students dropping out of school permanently, especially among girls, who are often at higher risk due to the increase in their care responsibilities and other factors. Advocate for equal sharing of domestic and care duties among all household members including male and female siblings.
- Promote equal participation of girls and boys during school closures when alternative, remote learning initiatives are implemented. Careful focus should be placed on monitoring the participation of girls in these initiatives and addressing reasons that are hindering girls' participation in coordination with other clusters where relevant.
- Provide support to caregivers to assist their children in home-based learning and encourage both parents and elder siblings where available to participate in this assistance.
- Take preventive measures to reduce girls' exposure to protection risks when educational activities are suspended. Communicate zero tolerance for SEA and strengthen community mobilization and advocacy as part of preventive efforts. Ensure access to GBV referral mechanisms.[1]
- Any educational facilities, including temporary/alternative ones, must have safe and sex-segregated WASH facilities (including lighting and functioning locking mechanisms from the inside and supplies for the prevention and control of COVID-19).
- Where schooling is not suspended, teach students about sanitation, hygiene and other COVID-19 prevention as well as protection considerations tailored to both girls and boys.
- If the location, timing, or alternate educational activities are changed, girls and boys cannot be placed at additional risk while commuting to school (due to check-points or other accessibility challenges) nor should these changes cause a drop in attendance for girls (due to distance or care responsibilities which may be expected at a certain time of day).

1 COVID-19 Addendum to the Humanitarian Response Plan (2020)
2 Statement by United Nations Special Representative of the Secretary-General on Sexual Violence in Conflict Zainab Hawa Bangura, Thursday, 29 January 2015

## FOOD SECURITY

Even though women produce more than half of the world's food globally, they are more likely than men to suffer from food insecurity, and comprise 70 percent of the world's hungry.[3] In Myanmar, high food insecurity is particularly prevalent in isolated zones of Chin, Kachin, Northern Sagaing and Shan, mainly populated by ethnic minorities.[4]

The country's proneness to natural disasters not only leads to regular displacement but also to destruction of livelihoods, crops and resources.[5] In crisis settings, female-headed households are generally more at risk of food insecurity, due to the fact that there are few work opportunities for women. In populations where women are responsible for food security within the household, food shortages and increased food insecurity places them under heightened pressure and could expose them to intimate partner violence or reliance on negative coping mechanisms, such as resorting to transactional sex, sexual exploitation and abuse (SEA) or even entering girls into child marriage.

Restrictions of movement decreases access to food markets and increases prices and competition for food, which negatively affects women and girls and increases the risk of malnutrition, as in many places they are not prioritized in the intrahousehold level. In terms of distributions, COVID-19 control measures can make distributions less accessible for women, if distribution times are made shorter or locations are more restricted to reach.

**R*ecommendations for a gender-integrated food security response:***

- The food security response must ensure that women and child-headed households, other at-risk groups as well as small-scale producers and traders, especially in quarantined, locked-down locations or self-isolation, are identified and targeted for food assistance, including in-kind and agricultural inputs distribution and cash-based transfers.
- Food assistance, emergency agricultural support and agricultural livelihood-saving interventions should be designed, delivered and monitored with the engagement of women, men, girls and boys from different socio-economic and indigenous groups in the affected populations.
- All employment made available through food distributions should, where feasible, be made available on a gender parity basis.
- Food security and nutrition-related responses should understand and address unpaid care and domestic work of women and girls and include women-targeted interventions for the most vulnerable women and girls.
- Food distributions and emergency agricultural support should not put women and girls at additional risks, including long waits at distribution points and difficult journeys to and from distributions. Distributions must be planned considering restricted movement of women and girls due to sociocultural norms or isolation, including women and girls with disabilities, the elderly, and female-headed households. It is paramount that measures are taken to reduce risks of gender-based violence (GBV) and SEA due to distributions.
- Regulate and schedule food distributions to avoid large groups congregating to avoid viral spread.
- Establish alternatives to communal cooking areas in camp/settlement settings, such as increased distribution of cooking stoves, cooking fuel and utensils. Strategies to support women's agricultural productivity and marketing activities will be essential, to reduce the detrimental effects on the wellbeing of rural people and ensure the provision of food to urban and peri-urban areas.

3 UNFPA (2016) *10 Things You Should Know About Women and the World's Humanitarian Crises*
4 WFP (2020) *Myanmar Country Brief*
5 Ibid.

## HEALTH

In Myanmar, women constitute 75 percent of the healthcare workforce, with almost all nursing professionals and over half of medical practitioners being women,[6] as well as a majority of the support staff such as cleaners and catering. It is essential that women frontline healthcare workers are protected from infection through adequate prevention and control measures, as well as stigma and discrimination, through enhanced community engagement and other relevant support.

For crisis affected, stateless and internally displaced people In Chin, Kachin, Kayin, Rakhine and Shan states, access to adequate healthcare is limited and will likely be further constrained if the virus spreads to these areas. Pandemic can draw resources away from other life-saving needs including sexual and reproductive health services (SRHS), mental health and psychosocial support services (MHPSS), and clinical care for survivors of gender-based violence (GBV). Further, fear of infection can also prevent women and girls, including GBV and intimate partner violence (IPV) survivors, from accessing life-saving health care. It is essential that wherever feasible, standard health services are continued, albeit with the necessary infection control measures in place – including healthcare services for older men and women, GBV survivors, antenatal, postnatal care and delivery services including emergency obstetric and newborn care.

***Recommendations for gender-integrated health response:***

- The health response should ensure that all data gathered is sex, age, and disability disaggregated (SADDD), and includes pregnancy status, thereby analyzing the composition of the affected population and identifying the most vulnerable groups.
- The healthcare response must ensure that protective training, provision of women-friendly personal protective equipment (PPE), and clear measures should be in place to prevent and mitigate harassment, abuse or other forms of GBV towards female frontline workers.
- All healthcare workers should be trained to safely handle disclosures of GBV and abuse of older people, and be familiar with existing multi-sectoral support mechanisms, referral pathways for GBV and psychosocial support, health, legal assistance, and case management: see the following link for GBV support services: https://sites.google.com/unfpa.org/myanmar-gbvcwg/national
- In health crisis-affected communities and quarantine/isolation facilities, women from marginalized groups including female-headed households, older persons, widows, women with disabilities, and pregnant and nursing women should be prioritized in the provision of medical supplies, food, care, social protection measures and psychosocial services.
- Facilitate the development and dissemination of targeted messaging on preventive, protective and care-seeking behaviors and available health resources that are responsive to the different contexts and concerns of women, men, girls and boys. Gendered differences in levels of literacy must be taken into account - especially amongst women and girls. It is important that messaging is relayed through appropriate materials and channels that are accessible and understandable by all.
- Preparedness actions should be taken to ensure continuity of services, including distribution of dignity kits, condoms, and increased supplies of contraception for women and girls.
- Provide messaging recommending that pregnant women and girls should continue with natal care and seek out assisted deliveries. Such messaging should also advise them on precautionary measures they must take relating to their pregnancy. These messages should be conveyed by healthcare workers and social mobilizers.
- The healthcare system must ensure the continuity of care for reproductive health services as well as management of clinical care for GBV survivors in both virus-affected and non-affected areas, where most healthcare workers face burdens to respond to the health crisis response and many health services/facilities have limited capacity to respond to other health issues.

[6] Myanmar Human Resources for Health Strategy (2018-2021) MOHS

## NON-FOOD ITEMS (NFI)


When a health crisis spreads unpredictably, it presents a growing risk to crisis-affected people and internally displaced persons (IDPs) in camps and camp-like settings, particularly during distributions. In addition, opportunities for female community members to influence decision-making regarding non-food items (NFI) interventions are limited due to women's lack of representation in camp management committees in Myanmar.

Stockpiling of protective materials by private individuals, including hand sanitizer, gloves and face masks should be advocated against. All healthcare providers, regardless of gender, seniority, or role, should have access to the protective materials they require to reduce their risks at work. Dignity kits and sanitary materials must be made freely available to populations under quarantine or self-isolation strategies. They should also be made available to women and girls currently undergoing treatment and/or in recovery.

***Recommendations for gender-integrated NFI response:***

- The provision of NFI must include adequate distribution of dignity kits, sanitary materials and other materials related to reproductive health (including contraceptives) to locked down, self-isolating and/or quarantined households affected by virus and treatment centers. The selected items for the dignity kits should be based on a participatory consultation with women, girls and other at-risk groups to ensure their specific and distinct needs and requirements are addressed.
- Before and during distributions, cluster partners should explain to the people receiving the items what the packages include and how to use them properly (especially dignity kits, hygiene items and plastic sheets). Factor in gendered differences in literacy levels, access to public spaces and group gatherings, as well as access to information tools such as mobile phones and the internet.
- Distribution should be accompanied with sensitization on the safe disposal of sanitary supplies/materials to counter stigma and sanitation issues regarding menstruation.
- The distribution staff must consist of women and men to ensure that all recipients can comfortably engage with and be supported by staff, including raising issues that may be gender sensitive.
- Dignity should be maintained for persons attending quarantine/isolation facilities or/and treatment facilities - particularly for women and girls with separate water, sanitation and hygiene facilities and privacy screens, as well as safe disposal bins for used sanitary items.
- Consult with women and men on appropriate times, dates and locations for the NFI distributions to avoid large groups congregating to prevent viral spread.
- Any changes in times or locations of distribution of NFIs should be implemented only after consultation with women, men, girls, and boys in the community. In some areas, women may predominantly be responsible for collection of NFIs and it is critical that alternate locations and times are accessible for women and do not further increase their burden.
- Distribution sites should be demarcated with controlled access points, adequate space, and shade for waiting. Set up a demarcated queuing system using stakes and rope or string, with different lines for men, women, or those with specific vulnerabilities that for example affects their ability to queue in line.
- Washrooms for men and women should be marked adequately in local language in distribution centres.
- Guidance on essential actions to reduce risk and mitigate Sexual and Gender-Based Violence (SGBV) associated with the distribution of shelter, NFIs and cash can be found on the Global Shelter Cluster website: https://www.sheltercluster.org/sites/default/files/docs/site_planning-gbv_booklet_apr-2018_web_high-res_v3.pdf

## NUTRITION

Malnutrition is prevalent in Myanmar with almost one third (29.4 percent) of the under-five population experiencing stunting.[7] Women and children living in isolated and conflict-affected areas require life-saving humanitarian nutrition services.[8] In particular, young children and pregnant and lactating women are at risk of all forms of malnutrition including wasting, stunting, obesity, and micronutrient deficiency, because they require enhanced nutritional diets,[9] and also due to gender inequalities in intra-household food distribution that put women and girls at heightened risk of malnutrition.[10] These inequalities can further deepen as food scarcity and care burden increases due to mitigation measures against COVID-19. Malnutrition, in turn, may increase their susceptibility to infectious diseases such as COVID-19.

Community-level screening may be restricted due to infection control and could shift to household-level screening. Home visits, in turn, can increase risks of SEA, but can also provide an entry point for connecting survivors with GBV response services if staff are trained properly.

***Recommendations for a gender-integrated nutrition response:***

- Promote the active participation of women, girls, older female family members that provide care support, and other at-risk groups in nutrition assessment processes and use results for gender-responsive targeting and programme design.[1] Engage grandmothers and mothers-in-law, who play a key role as advisers to young women influencing maternal and child nutrition, specifically regarding pregnancy, feeding and care of infants, sick children.
- Where information sharing/gathering is done virtually or by other means, always consider the ability of women, girls, and other at-risk groups including LGBTQI+ people, elderly and people with disabilities, to access different communication technologies.
- Target malnutrition prevention and response initiatives, including nutrition support to pregnant and lactating women, children, adolescent girls, and older women. Also engage men and boys in any behavioral change communication and antenatal care programming.
- Address unequal power dynamics that affect women's nutritional intake and increased care burden at the household level, redistribute tasks and responsibilities, and promote the progressive engagement of men and boys in unpaid care and domestic work. Enhance participation of men and boys in awareness raising initiatives. Address limited nutritional understanding and socio-cultural food practices to advocate for gender-equal nutrition education.
- Where household-level nutrition visits are carried out, ensure staff are trained (via virtual platforms if needed) on safe response to disclosures of GBV and PSEA response and referral pathways. Coordinate with GBV actors any dissemination of information on available GBV services, including hotlines, and support protection needs assessments and feedback mechanisms if required. Invest in women's leadership in relation to nutrition and COVID-19 awareness raising to ensure that both men and women's needs during and after the epidemic are adequately met.

[7] Global Nutrition Report (2020) *Myanmar Nutrition Profile.*
[8] Oxfam and Trocaire (2017) *Life on Hold.*
[9] World Food Programme (2020) *Nutrition: WFP Myanmar*
[10] Global Nutrition Report: Shining a light to spur action on nutrition (2018)

## PROTECTION

Around 922,100 people in Chin, Kachin, Rakhine, Shan and Kayin states are in need of protection services due to protracted displacement, conflict, segregation, and approximately 520,000 of these are people in need of gender-based violence (GBV) protection and support.

Evidence suggests that increased tension in the household due to isolation, food and financial insecurity, and suspension of educational activities has led to increased GBV, including intimate partner violence. Women, girls and vulnerable groups such as LGBTQI+ people, the elderly, people with disabilities, and female and child headed households are at greater risk of violence due to restrictions of movement and isolation, and lockdown strategies heightening the risk of being confined with their abusers. Stigmatization and discrimination against female healthcare workers also heightens the risk of violence.

Furthermore, experience from previous epidemics suggest that restrictions on movement and other contingency measures can create opportunities for sexual exploitation and abuse (SEA) and that existing support for GBV survivors may break down during a public health emergency, further preventing women and girls from accessing support. Suspension of education activities can also increase the risks for adolescent girls of different forms of sexual exploitation and abuse, and child/forced marriage.

There is also a high risk of stigmatization and discrimination of persons with suspected or confirmed cases of the infection, particularly amongst marginalized groups and stateless persons in Myanmar, and recently returned migrants.

***Recommendations for a gender-integrated Protection response:***

- All frontline workers should be sensitized to existing and expected protection risks including GBV and elder abuse and be trained to respond to disclosures of GBV, including IPV as well as to guide individuals through the existing referral mechanisms.
- The Protection response must prepare for an increase in need for GBV response and support, identify gaps in GBV survivor-service provision, prepare to provide essential stop-gap measures where feasible. This especially applies to quarantined and/or locked down areas.
- The Protection response must endeavour to prevent household separation, including the provision of alternative care arrangements to preserve household unity (e.g. keeping siblings together, keeping elderly relatives with the family unit). Children should always be accompanied in quarantine centres or isolation sites. Planning and implementation measures should be taken for sex-segregated areas, including for the mandatory separation or isolation of individual women or girls.
- Ensure response services for GBV survivors are maintained and prioritised as life-saving interventions, and easily accessible for women, girls and other vulnerable groups that may be isolated or have restricted movement.
- Ensure safe distribution of dignity/hygiene kits so that homebound/quarantined women can access essential items for their health and personal needs as well as updated epidemic risk mitigation information and GBV referral information, especially hotline/remote support options (including for remote psychosocial support).
- The Protection response must develop community mobilisation to counter stigmatisation and xenophobia, and to assist in the reintegration/acceptance of returning migrants and/or people who have been quarantined into their communities/host communities, households and schools. Any such community mobilisation efforts should include women and women's groups.
- The protection and safety of healthcare workers, specifically frontline workers who are predominantly women, should be included in the Protection cluster's response, and preventive and mitigation measures should be implemented against abuse or violence.
- All PSEA protocols must be in place, including training and code of conduct for responders and complaint mechanisms and services for survivors.

## SHELTER

The health crisis brings additional risks to crisis-affected people and internally displaced persons (IDPs) in camps and camp-like settings. Over 273,000 displaced people – 69 percent of whom are women and children – remain in camps or camp-like situations Kachin, Shan, Rakhine, Chin and Kayin states in Myanmar.[11] The living conditions in shelters in IDP camps and camp-like settings continue to be difficult, especially for women, girls, boys and LGBTIQ+ people and people living with disabilities, due to lack of privacy as well as augmented protection concerns. Dense populations and limited access to sufficient and safe water, sanitation and hygiene facilities make preventative measures such as handwashing and social distancing particularly difficult. To that end, the role of women and girls in community mobilization, risk communications and surveillance mechanisms will be crucial.

With the release of the initial draft the 'Action Plan for the Control of COVID-19 Outbreak in IDP Camps' led by the Ministry of Social Welfare, Relief and Resettlement, the Humanitarian Country Team stresses the importance of meaningful and inclusive consultations with IDPs themselves on any potential establishment of quarantine/isolation facilities inside camps, and on possible other self-quarantine and self-isolation strategies. The different needs of women and girls should also be considered in the consultations, noting that gender norms and pre-existing inequalities result in disproportionate impacts on women and girls in emergencies, including health emergencies.

***Recommendations for gender-integrated shelter response:***

- Include representation from women and other at risk-groups such as LGBTIQ+, elderly, persons with disabilities, female-headed households into gender-segregated focus group discussions in all coordination and planning efforts by the government and local authorities to prepare and respond to health crises.
- Ensure that Camp Management Committees (CMCs) consult with women residents of the camps and include the most urgent and differing needs of women, girls, men, and boys in implementing the response strategies**.**
- Community mobilization, risk communication strategies and surveillance mechanisms should be localized with women taking the active role in their design and implementation. All messaging, information on health crisis and monitoring mechanisms must be relayed through proven effective mechanisms, such as women's groups, adolescent youth, women with disabilities, and older people's groups.
- Any communication and information sharing initiatives must take into consideration the literacy levels and language requirements of all community members. Initiatives utilizing technology, including mobile phones, must consider those who do not have access to such resources, including women and older people.
- Any re-planning of sites and/or additional temporary shelters for individuals must consider protection and rights of women, girls, female-headed households and unaccompanied children. Installation of additional WASH resources in densely populated areas must consider safety and protection concerns for women and girls, including locks, lighting, accessibility. and sex-segregation must be integral to their design.
- Ensure the facilities to serve as quarantine/isolation facilities provide minimum standards for creating safe quarantine spaces for women, children and adolescents with available separate rooms (or separated areas with curtains or other dividers allowing physical distancing or separate sex-disaggregated quarters) where feasible, and use separate water, sanitation and hygiene facilities with functioning locking from inside and lighting.
- In collaboration with the Protection cluster, continue protection monitoring, individual assistance, and referrals for vulnerable IDPs, and provision of gender-based violence and child protection case management and psychosocial support services.

[11] Myanmar Humanitarian Needs Overview 2020.

## WATER, SANITATION AND HYGIENE (WASH)

Washing hands and maintaining good hygiene is central to preventing and controlling the spread of COVID-19, but many IDP camps do not have readily available soap and water or WASH facilities that would be easily and safely accessible by women and girls. Only 4.1 percent of households in Myanmar have piped water into the dwelling[12] and, particularly in some rural/semi-rural areas, water collection requires women and girls to walk long distances, putting a time burden upon them and exposing them to gender-based violence (GBV) risks on the journey. Women and girls, particularly adolescent girls, can also be exposed to GBV when accessing any communal WASH facilities, which will be frequented more than normal due to COVID-19 control measures, hence the positioning and design of facilities is crucial in ensuring safe use by everyone.

Women and girls are also often an untapped source of knowledge regarding cultural WASH practices, which must be understood in order to effectively promote public health through hygiene[13] and combat COVID-19. Encouraging the participation of women as leaders in WASH service provision by assigning public health outreach roles to the most suitable persons can improve both the quality of programming and the health of households.

***Recommendations for a gender-integrated WASH response:***

- Creation of any new WASH facilities should be developed in consultation with women, girls, men and boys in the community. Facilities should be sex-segregated, well-lit, with functioning locking systems from the inside and generally safe and accessible to all and especially older women, adolescent girls, and women and girls with disabilities to reduce risk of GBV in accessing these facilities.
- Ensure women and girls have access to information about COVID-19, including the likely symptoms and how to protect themselves and their dependents by good hygiene practices and physical distancing.
- Understanding the respective needs of women, girls, men and boys helps promote access to, and the appropriate use of, facilities. For example, appropriately designed WASH facilities with privacy and safety measures increase the acceptability of the facilities for women and girls to use them. Facilities specifically designed for younger girls and boys e.g. with a lower washbasin, also encourage use.
- Distribute soap and sanitizer products through community mobilization initiatives. Ensure women and girls including marginalised or vulnerable groups such as women and girls with disabilities and elderly women are included as recipients and in the distribution process. Distribute extra hygiene kits on a monthly basis until the outbreak has been contained, ensuring that WASH interventions should prioritize menstrual health and hygiene management, including supplies and age-appropriate information for adolescent girls, also in quarantine centres to women and girls.
- Use inputs and feedback from women, girls, men and boys in a participatory manner to encourage measures such as hand-washing in ways that resonate with the community. Utilize women's and girls' potential in community mobilization and hygiene promotion.
- Consider the distance and route that women and girls take to collect distributed water, and adapt if this increases time burden and potential protection risks. Regulate and schedule water distributions to avoid large groups congregating to prevent viral spread and reduce risks of GBV.

[12] WHO: UN Water Global Analysis and Assessment on Water and Sanitation - Glaas (2015)
[13] IASC (2017) Gender Handbook for Humanitarian Action – WASH Chapter