RAPID GENDER ANALYSIS FOR COVID-19 MADAGASCAR

Cooperative Agreement No: AID-687-A-17-00002

October 2020

This publication was produced for review by the United States Agency for International Development.

It was prepared by RANO WASH

DISCLAIMER

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-687-A-17-00002 (RANO WASH), managed by Cooperative for Assistance and Relief Everywhere Inc (CARE). The contents of this document are the sole responsibility of the RANO WASH consortium and do not necessarily reflect the views of USAID or the United States Government.

ACKNOWLEDGEMENTS

This Rapid Gender Analysis (RGA) has benefitted from the valuable contributions from CARE International colleagues, consortium members, especially regional and project coordinating team of the RANO WASH project.

The views in this RGA are those of the author alone and do not necessarily represent those of the CARE or its programs, or any other partners.

Photo: Rural girls drawing water in one of the study areas

RANO WASH Project
Appartement n° 02,
Immeuble La City,
Alarobia Morarano,
101 Antananarivo,
Madagascar

CONTENTS

ABBREVIATIONS

COVID-19	Novel coronavirus 2019
CLTS	Community Led Total Sanitation
CSO	Civil Society Organization
CTTP	Center for the Triage and the Treatment of the Plague
DREAH	Direction Régionale de l'Eau, de l'Assainissement et de l'Hygiène
DREN	Direction Régionale de l'Education Nationale
DRSP	Direction Régionale de la Santé Publique
GoM	Government of Madagascar
MEAH	Ministère de l'Eau, de l'Assainissement et de l'Hygiène
MHM	Menstrual Hygiene Management
NGO	Nongovernmental Organization
PHE	Population, Health and Environment
PSEAH	Programme Sectoriel en Eau, Assainissement et Hygiène
RANO WASH	Rural Access to New Opportunities in Water, Sanitation, and Hygiene
RGA	Rapid Gender Analysis
SLC	Structure Locale de Concertation (Local Dialogue Structure)
SWA	Sanitation and Water for All
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WSP	WASH Service Provider

EXECUTIVE SUMMARY

COVID-19 is an infectious respiratory disease caused by a new coronavirus discovered in China in December 2019. On March 11, 2020, the WHO declared COVID-19 a global pandemic. Governments around the world have been taking measures to limit the spread of this pandemic, including containment, travel restrictions, cancellation of gatherings such as sporting and religious events, concerts and schools, testing and treatment of patients, tracing of contacts, and quarantine measures.[1]

Madagascar first began reporting confirmed cases of coronavirus in March 20, 2020. A state of health emergency has been established throughout the territory with preventive measures to avoid the spread of the pandemic. As of September 1, 2020, there have been 14,957 confirmed cases, including 844 cases in treatment and 195 deaths. 21 of the 22 regions are affected by COVID-19[2].

The regions most affected by the pandemic are Analamanga, Haute Matsiatra, Alaotra Mangoro and Atsinanana. Among the measures taken by the Malagasy government include movement restrictions and lockdowns, nightly curfews prohibiting traffic and activities (bar, karaoke, nightclub), the closure of national and regional borders, the closure of schools, churches and universities, stay at home orders for employees in non-essential sectors, the prohibition of all travel to and between the most affected regions and the sensitization of the population on behaviors to prevent infection and slow transmission, such as wearing a mask and practicing social distancing3.

The harmful effects caused by this pandemic have far reaching consequence on several sectors and affect girls, boys, women, and men differently. These effects are seen on psychological, health, economic and social aspects. Globally, the most important populations impacted are poor households in urban areas that depend on the informal sector. Due to their role in supervision and care of the family, women and girls are strongly involved in the health sphere. The closure of schools increases the burden of domestic and caregiving work, which in turn increases their normal day-to-day responsibilities; travel restrictions affect service sectors and informal work, in which

Key findings

- **There is high needs of water, sanitation, and hygiene materials in Madagascar at community and institutional level that needs to be urgently addressed**
- **Economic deprivation, psychosocial stress, and containment measures are leading to substantial increases in intimate partner and domestic violence and the need to expand services for survivors is critical**
- **Women in development and humanitarian settings may be employed in informal, low-wage or agricultural activities that are likely to be disrupted during the COVID-19 pandemic**
- **Movement restrictions may result in less access to food while also increasing prices – this requires a mitigation strategy**
- **Women's low involvement in decision-making spheres at the household and in the community means that they are excluded from household and assessment of community crisis management needs**
- **Weak consideration of gender in the response strategy reinforces gender inequality and requires urgent consideration**

[1] Real time updates on prevalence, mortality and recovery rates across the globe, are provided in the John Hopkins database: https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6.

[2] Rapport du Centre de Commandement Opérationnel COVID-19

[3] Decree No. 2020-359 of 21 March 2020, proclaiming a state of health emergency throughout the territory of the Republic, stipulates that, pursuant to the provisions of article 18 of Act No. 91-011 of 18 July 1991 on exceptional situations, the powers of the President of the Republic to control the movement of persons and vehicles, control supplies and control weapons are delegated to the Prime Minister

they make up the majority of the workforce; and subsequent tensions also increase domestic violence and other forms of gender-based violence.

Madagascar, like many countries in the world, faces instances of gender-based violence. One in three women aged 15 to 49 has already been a victim of violence in her lifetime. More than 73% of women survivors of violence have never tried to seek assistance or even report acts of violence4 (source ENSOMD 2012-2013). According to the MICS survey conducted in 2018, 32.4% of women reported having experienced physical violence since the age of 15, and 13.5% of women aged 15-49 reported having been a survivor of sexual violence at any time. At the marital level, 23.3% of women experienced physical violence by their husbands or partners. Approximately 10.8% of women experienced sexual violence at the hands of their husbands or partners.5

The COVID-19 crisis increases tensions within households and the risk of domestic violence for women and girls (UNFPA, 2020)6. It also increases vulnerability to gender-based violence particularly women and girls.

Although women and girls are disproportionately affected by the pandemic in Madagascar, their absence in leadership positions and decision-making spheres exclude them from household and community crisis response and management. For a more inclusive and effective response to Covid-19, women need to be given a seat at the table and a greater voice in decisions.

Key recommendations

- Increase the provision of equitable water, sanitation and hygiene services in both rural and urban areas by mobilizing the equipment and teams necessary for an effective gendered WASH response that includes the specific needs and experiences of women and girls.

- Facilitate inclusive and equitable access of households and individuals to water, sanitation and hygiene services in both urban and rural areas by engaging the private sector in the delivery of WASH products and services and recognizing women as market players and actors.

- Continue, expand and adapt protection, psychosocial and prevention of gender-based violence services on an urgent and life-saving basis.

- Take economic measures to protect those involved in informal and insecure labor markets, such as cash and in-kind assistance.

- Ensure that women participate in leadership and decision-making regarding the response to COVID-19 at the global, regional, national and community levels by engaging men and boys in order to emphasize transforming social norms and barriers that influence leadership and decision-making. Support the WASH Cluster contingency and response plan for COVID-19 response through coordination, prevention, management of the WASH component in health centers (CSBs), continuity of WASH services and community response.

- Conduct capacity building on gender mainstreaming in emergencies for the Ministry of Water Sanitation and Hygiene and WASH cluster members

[4] ENSOMD report 2012-2013
[5] MICS survey report, 2018
[6] UNFPA report, 2020

I. INTRODUCTION

1.1. BACKGROUND

In January 2020, Madagascar began detecting suspicious cases of coronavirus and confirmed its first case on March 19, 2020 after which the President declared a state of emergency7. As of September 1, there have been 14,957 confirmed cases with 844 people "under observation" and 42 in critical care in several areas in Madagascar and a total of 194 deaths.8

Government measures include the closure of schools, universities, and churches, establishing a COVID-19 coordination operation center in Antananarivo, and setting up and supporting a special coronavirus brigade responsible for monitoring people's health status quarantined and under surveillance.

All passenger flights to and from the country have been suspended for a determinate period. In the capital Antananarivo and Toamasina (the main port of entry) additional measures have been taken, including restrictions on public transport, installation of sanitary barriers, closure of non-essential shops, and the imposition of a curfew between 8 p.m. and 5 a.m.

Public services at the ministries and municipalities are closed except for those in charge of health, justice, law enforcement, water/electricity, road services, and the media. The prices of essential commodities, such as rice, oil, and fuel will be controlled.

1.2. THE RAPID GENDER ANALYSIS OBJECTIVES

The objective of this Rapid Gender Analysis (RGA) is to facilitate the understanding of the COVID-19 crisis's effect on women, men, girls, and boys in Madagascar and formulate practical recommendations in the implementation of preventive and socio-economic support interventions. It will be to:

- Show how women, men, boys, girls, older women, older men, people with disabilities are affected by COVID-19
- Formulate recommendations for the implementation of interventions considering the gender aspect

[7] Decree No. 2020-359 of 21 March 2020, proclaiming a state of health emergency throughout the territory of the Republic, stipulates that, pursuant to the provisions of article 18 of Act No. 91-011 of 18 July 1991 on exceptional situations, the powers of the President of the Republic to control the movement of persons and vehicles, control supplies and control weapons are delegated to the Prime Minister.

[8] CCO report, September 1st 2020

II. METHODOLOGY

Rapid Gender Analysis (RGA) provides information about the different needs, capacities and coping strategies of women, men, boys, and girls in a crisis. Rapid Gender Analysis is built up progressively: using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. It provides practical programming and operational recommendations to meet the different needs of women, men, boys, and girls and ensure we 'do no harm'. Rapid Gender Analysis uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight timeframes, rapidly changing contexts, and insecure environments that often characterize humanitarian interventions.

The research was conducted from August 16 to September 7, 2020, with the support of consortium members, regional project teams, regional and national authorities, and partners. Research is continuing, and the RGA will be updated appropriately when new findings and recommendations are produced. Research methods included: The review of secondary data, and the collection of primary data was done by the gender focal points of the programs, M&E, and program managers. The primary data collection was done remotely by telephone and email through individual interviews and testimonials. The analysis was conducted in six regions of Madagascar.

Sixty people (45% women and 55% men) from rural and urban communities, national, regional, and local institutions, UN agencies, and international and national NGOs participated in the analysis.

Secondary data was prioritized; a significant proportion of data collection relied on the use of secondary data analysis. Remote primary data collection was conducted by phone.

The research had several limitations as:

• Difficulty in having statistics disaggregated by sex and age

* Primary data collection time was insufficient

* Difficulty in administering questionnaires remotely due to limited mobility

* Low involvement of other actors from the design stage

3.1. DEMOGRAPHIC ANALYSIS

Home to more than 26 million inhabitants in 2019, Madagascar is an island state in East Africa in the Indian Ocean separated from the rest of the continent by the Mozambique Channel. It is the fifth-largest island in the world. It has a very high average annual population growth rate of 3.01% and a mortality rate of 6.4 ‰. Approximately 83% of the population lives in rural areas, and 17% in urban areas. The population is extremely young, about two-thirds of the population is under 25 years old (64%), and almost half is under 15 years old (47%). The official language is Malagasy. It is a French-speaking country. However, the 22 component regions of the large island use their language according to their ethnicity[9].

The World Disability Report (2011) estimates the prevalence of people with disabilities at 15%[10] in Madagascar, i.e. 3,535,800 inhabitants[11].

[9] INSTAT/DSCVM/EHTM COVID - 19, June 2020

[10] The World Disability Report, 2011

[11] Madagascar report in disability, 2017

A household in Madagascar has, on average, 4.5 people. Malagasy households are predominantly monogamous. More than three quarters are headed by men (78%). The proportion (22%) of female heads of households has not changed over the last ten years. Households headed by women are more frequently found in urban areas (27%) than in rural areas (21%). Of the 22 regions, nine have a poverty rate above 80%. As for the financial situation of households, it appears that most Malagasy households are experiencing difficulties. Indeed, nearly 89% of households have an income lower than or, at best, equal to their basic needs.[12]

Regarding women's participation in decision making, decisions are made jointly with their husbands or partners on the following three topics: personal health care (56%), major household expenses (65%), and visits from the respondent's parents (76%). Regarding decisions about daily household purchases, the woman has the final say in 56% of cases.[13]

The lack of clear gender-oriented policies or objectives in Madagascar leads to gender-blind policies and data. Women's lack of access to participate in governance structures at different levels is alarming. i) within macroeconomic decision-making bodies, which is concerning given the issues and challenges related to women's economic empowerment, women's entrepreneurship, and regional integration; ii) decentralized and local levels, which are supposed to be closer to women and where women's empowerment can increase the provision of public goods that meet their needs (e.g., education, health, education, health care, etc.); and iii) the local level, which is supposed to be closer to women and where women's empowerment can increase the provision of public goods that meet their needs (e.g., health care, water, education, health care, etc.); and iii) associations, where they are in the best position to voice their voices/concerns (e.g. credit, GBV, gender, etc.).

Female-headed households seem to have more advantage than male-headed households in terms of access to drinking water, while sharp disparities persist between rural and urban areas: the population's access rate to improved drinking water remains low (28%, 77% of which are urban versus 18% of the rural population) and amplifies the challenge faced by the rural population. The relative advantage of female-headed households with access to improved drinking water (32% compared to 27% of male-headed households) can be understood by the sensitivity of women to water quality and the greater decision-making autonomy of women heads of household.[14]

[12] INSTAT, Recensement général de la population et de l'habitat (RGPH), 2016
[13] INSTAT, Recensement général de la population et de l'habitat (RGPH), 2016
[14] UNFPA, Madagascar Population et développement, 2013

III. FINDINGS AND ANALYSIS

Many observed and recorded findings led to the following analyses.

3.2. GENDER ROLES AND RESPONSIBILITIES

Control of resources

In rural areas, resources, assets, and savings characterized as collective are the cultivation fields, rice fields, farming, poultry, and crafts. Goods are considered household appliances such as radio, mobile phones, sewing machines, and kitchen utensils. According to the respondents' categorization, all the family members, i.e.: the father, the mother, and the children, as well as the grandmothers and grandfathers who live with the family nucleus, have access to these resources and goods. Regarding the allocation of responsibilities for each resource, it is noted that the responsibility for goods or resources of low value goes to the woman. As for control, almost all the resources and all the family goods are under the control of the man, or the husband, except the kitchen utensils. If men are more likely to control radios and other means of communication, women's access to information is difficult during the pandemic.

Even the sewing machine that the woman uses is under the control of the husband because it is of high value[15]

The current trend shows that the domestic chores' burden is very unevenly distributed between men and women within households. Under normal circumstances and prevailing social norms, women and girls assume responsibility for maintaining the home and caring for family members. On average, they spend 3 to 4 hours a day (24 hours) on unpaid domestic chores (OECD statistics, ESARO Region). And with the closure of schools and the increased need for care within the household, women are thus more likely to have to leave their jobs when teleworking is not possible to care for children and the family, especially if there are sick family members. All of this again leads to economic impacts on women and girls that could be long-term and widespread as their participation in the labor market faces many challenges.

Social norms that remain male-centered: these are reflected in their most visible form through the persistence of the traditional division of labor within the household, assigning executive roles and responsibilities to women and control/decision to men, a trend that is found in all regions, in the workplace and in the associative world.

Division of domestic labor

Women are the main caretakers of the home. Women collect water, firewood, shop for food, cook, clean, wash clothes, take care of the children, and work in the fields. Mothers ensure food hygiene and housekeeping, help their husbands work in the field, find food when fathers do not have money, and ensure the family's health. Men generally spend the day working in the (rice) field. Fathers, most of whom are farmers, combine other "small livelihoods," give money for medication, keep part of the wife's income, and guarantee the

Gender roles and responsibilities

"*Since I am forced to stay in the village because travel outside the commune is limited due to lack of transportation, due to lockdown, I have more time to take care of household needs, I was able to repair our latrine, and I was able to build a small shower cubicle for my family*," said a male head of household.

[15] Gender analysis RANO WASH report

household's food. Grandmothers give advice but are not expected to contribute to physical tasks. Sons and daughters shell rice wash the dishes and the laundry and help collect water. It is the women's responsibility to treat water, protect it, and monitor its quality by covering it. Children fetch water, especially girls, who often support their mothers. Boys participate more in cleaning the house and the compound.

The division of roles and responsibilities in the household shows that women are the main caregivers for the family's different members. However, when it comes to seeking health services like treatment, most respondents believe that men are the main decision-makers. Usually, the woman can give her opinion about the type of care based on what she knows, but in fact, the decision power does not belong to her, in a sense where the care requires costs that are quite expensive for most women.

The current trend shows that domestic chores' burden is very unevenly distributed between men and women within households. Under normal circumstances and prevailing social norms, women and girls assume responsibility for maintaining the home and caring for family members. On average, they spend 3 to 4 hours a day (24 hours) on unpaid domestic chores16. And with the closure of schools and the increased need for care within the household, women are thus more likely to have to leave their jobs to care for children and the family, especially if there are sick family members. All of this again leads to economic impacts on women and girls that could be long-term and widespread as their participation in the labor market faces many challenges.

According to the Secretary General of the United Nations, at the global level, "the pandemic has strongly affected women: their standard of living has declined, their exposure to the virus is higher, their domestic workload has increased as well as the violence they are survivors of. »17

Since confinement has not led to an awareness within households of the unequal distribution of domestic tasks between men and women, messages to the general public advocating an equitable sharing of household tasks between women and men would be relevant in this confinement period. perception femme

Earning income

In rural areas, the main activities of the population are agriculture and animal husbandry. Some agricultural products are sold at the neighborhood market, and another part is exported outside the region. This sale of local products mainly conditions household income. Both men and women are involved in agriculture, but men have a larger market share. Women practice small-scale merchandising of green vegetables or seasonal fruit. In terms of daily expenses, women provide income for daily household expenses, including soap and salt. Given the various restrictions on movement and crowding due to Covid-19 prevention measures, the local market is closed, and local products' transfer is difficult. Depressed economic activity causes a drop in income at the household level, which leads to more increased food insecurity within the household. Many households have borrowed money from relatives, others use their savings. Women also have limited access to credit. Despite its rapid growth, microfinance has a low penetration rate and a high concentration in urban areas. The low national rate of women's access to credit (3.8% in 2013; rural: 3%; urban: 7.5%), despite their high proportion (48% in 2016) among the beneficiaries of credit from all financial institutions is due to the low penetration rate of financial institutions, particularly in rural areas.[18]

[16] OECD statistics, ESARO Region

17 Perception des femmes sur les impacts de la pandémie COVID-19 et les violences basées sur le genre à Madagascar, UNFPA et MPPSPF, Juillet 2020

[18] Situation démographique de Madagascar, 2015

In urban areas, a total of 10.1% of households have lost a job since the lockdowns were imposed. This represents a total loss of 7.7% of all jobs. Four types of economic activity are mainly affected: Restaurants and Accommodation (61%), Transportation (38%), Processing and Manufacturing (13.8%) and Trade (12.8%). The restriction of movement between regions has hindered workers' mobility and inevitably has an adverse effect on employment. More specifically, salaried workers in both the formal and informal sectors have been the most affected by job loss.[19]

Decision making within the household

At the household level, decision-making on family care is more for the woman but with prior consultation with the man. Decision-making on family expenses goes to the woman for less expensive expenses, such as buying spoons or cups, because she knows the family's needs. Decision-making regarding finance is generally assigned to the man or the head of the family and will only be made by the woman if she is the family's head. Certain decisions are made by mutual agreement between the man and the woman, mostly concerning choices in the children's education and long trips[20].

Private resources include specific resources for the man or the woman, which he or she does not share with anyone. Private property for men is especially valuable work equipment. It requires some technical capacity for its use or management, while private resources for women concern their well-being and low-value small equipment: sewing machine, hair comb and clothing including sanitary pads. This shows that men are more inclined to decisions about productive activities, and women have more decisions about welfare aspects.

3.3. Capacity and Coping Mechanisms

Livelihoods

Overall, the results show that less than a quarter of the households surveyed report having difficulty procuring basic needs, 21.3% of households have problems acquiring drugs and pharmaceuticals, and 11.8% have difficulty obtaining face-masks There are many reasons for this, but the one most mentioned by the households surveyed is the increase in prices[21].

Capacity and coping mechanisms

"I am looking for other sources of income," said one woman working for private sector who lost her job during lockdown.

"I have participated in the census activity conducted in preparation for food distribution," said one female civil servant.

Of the 43% of women in urban areas who reported learning new activities, most reported that these occurred within the private and informal sectors. Some women also indicated that they participated in the distribution of social assistance conducted by the government. In Madagascar, more than 100,000 jobs were lost during the lockdowns[22]. Those in the informal sector were the most affected, the majority of whom were women.

Although regular production activities continue in rural areas, markets are closed, and transportation is limited. Farmers are then unable to sell their produce, which leads to loss of household income and waste of local products due to lack of transport. As a coping mechanism in the aftermath of the pandemic, rural men who are engaged in activities outside their village are obliged to stay in the village.

19 Enquêtes INSTAT_ 2020
[20] RANO WASH Gender analysis report, 2018
21 INSTAT Report, Mars 2020
22 Report from Ministry of job

The fact that men are forced to stay in the village presents an opportunity to work with women to do house maintenance work, such as building latrines or showers for the family. This was not the case before.

Savings

Among important decisions to make in a family are the use of savings, which is in most cases in kind savings, the sale of agricultural products, whether in large or small quantity, and the sale of furniture and property. The involvement of both men and women is always effective for these types of decisions. However, women are often only decision-makers concerning the sale of the agricultural products, and even then, only when it is of small quantities. It is found that the man holds ultimate decision-making power for most of the decisions. In addition, women's participation in the decision-making process is limited for fear of violence in different forms: physical violence, moral violence, and verbal abuse.

The survey conducted by VIAMO on the impacts of COVID-19 on household food and economic security in six (6) countries also showed that more than 50% of households have seen their income decrease since the beginning of the pandemic in Madagascar. 1 in 5 households mentioned that this is because the current pandemic conditions did not allow them to work.

3.4. Access

Different themes dealing with the access of men, women, youth, girls, boys and people with disabilities will be presented in the following parts: mobility analysis and access to services and resources

Mobility Analysis

Restrictions on movement can prevent people from fleeing insecurity from reaching safety and prevent humanitarian and development workers from reaching those in need. Confinement also limits people's mobility. Health restrictions limit people's ability to leave their homes and as a result, only one person leaves in search of something to survive. This situation is increasingly aggravating for people with disabilities. The decision on men's mobility is restricted to men, while decisions around married women's mobility belong to their respective husbands.

> *"I'm boring because I want to go back to my village, but since there is no transportation, due to lockdown, I must stay here without having any occupation,"* said a young man doing mobile work.

On the emotional and psychological side, the survey reveals that isolation is a problem, especially among young people. Indeed, with the disruption of studies due to school closures, students are forced to stay at home. Therefore, social interactions are limited or even absent when they are alone at home, with consequences such as depressed mood.

Access to services and resources

Access to health services

In normal times, people may not have access to quality health care in both urban and rural areas, water and sanitation infrastructure may be poor, and with the increase in sick people due to the pandemic, health services are even more fragile.

> *" Since the COVID-19 pandemic, I have been afraid to go to the Health Centre for fear of being told that I am catching the disease, and I will not be able to return to my home village when I die from it. I prefer to take care of myself at home,"* said one rural woman head of household.

Of the households that needed medical care, 64% said the main reason was the onset of symptoms such as fever, fatigue or stress.

Beneficiary populations are also much less receptive and enthusiastic about the various actions carried out at the community level, particularly communication and awareness actions for behavioral change. This is linked to the fear of being contaminated by humanitarian actors, on the one hand, and given the current very fragile economic context, incomes are decreasing, investments in WASH infrastructure are less and less prioritized, especially among the most vulnerable. The population's low purchasing power and the fear of going to the health center can have negative consequences on health-seeking behavior.

Access to Education

All schools are closed to mitigate the transmission of COVID-19. The effects on women and children can also be severe. The burden of raising and caring for children at home has increased for parents and women mainly. INSTAT data show that 72% of the households had school children aged 3 years or older before the containment period. Most households adopted the best strategy by doing homework assignments at home (61%). Stress management and psychosocial support for children should be added.

> *"With the low income at home, the long period of school closure, due to lockdown, it is very doubtful that I will ever go to school again."* Said a 14-year-old rural girl in a college.

In many areas, closures negatively affect children because the school can be a reliable source of food, psychosocial support and security for some children. On the other hand, there is a huge risk that one of the basic rights of children, access to education, will be violated. Consequently, a delay in schooling and drops in school attendance are some of the effects of COVID-19. Girls are also disproportionately affected, with a higher risk of early pregnancy and dropping out of school altogether.

Access to WASH services and products

The WASH situation in Madagascar is worrying due to the lack of access to water (57% of the population does not have access to an improved water source), sanitation (40% defecate in the open air) and hygiene services (32% do not have handwashing facilities with soap and water). Handwashing with soap is essential in the fight against COVID-19. Yet 8 million people do not have handwashing facilities with soap and water at home. The situation is even worse in health facilities, where more than 90% or 9 out of 10 health facilities do not have hygiene services. Also, more than 80% of schools do not have access to safe drinking water and places where children can wash their hands. People and

children with disabilities are at a greater disadvantage due to difficulties in physically reaching institutions such as hospitals and schools. People living with disabilities described difficulty accessing water from public taps. Few had toilets, but there is concern that (new) sanitation facilities, like water facilities, would not cater to the needs of people with disabilities.[23]

The interviews highlighted some health problems such as malaria, influenza and cough that affect almost all categories of the community, children as well as adults. According to the explanation of a 35-year-old woman living with a disability, these diseases come from the unhealthy environment due to the scattering of garbage, the non-use of latrines and open defecation free. The respondents also highlighted other water, hygiene and sanitation problems: it is the lack of drinking water infrastructure because of mismanagement, the non-use of latrines, due only to habits; the unavailability of land for this purpose in the capital of the municipality; and the lack of purchasing power to buy the materials needed for the construction of latrines that are resistant to cyclones, because of vulnerability and financial difficulties.

"Since COVID-19, rural families use more soap in the household for hand hygiene," said a women local WASH manager.

As regards **water**, in rural area, the fathers are responsible for digging the wells and all the required installations: setting up the pit cover, making the brick masonry inside the inner wall of the well, and setting up the pulleys facilitating water extraction. The siting of wells is under the control of men, who usually are the landowners, generally following the right of inheritance or by purchasing the land itself. In addition, most mothers recognize that maintenance and advice on water use and management is the father's responsibility. In urban areas, because of lockdown measures. The time to get water from communal water points is limited because of the confinement that restricts egress from the house, so some groups of people thus tend to reduce their hygiene practices, which makes them more susceptible to the disease. Long lines form around places with supply of drinking water, women, pregnant people, young children (especially girls), elderly people, and persons with disabilities face the greatest difficulties, which increases their risk of infection because queuing at the water point puts them at risk of becoming infected with the virus if the protective measures are not properly followed. As it takes a long time to collect drinking water, people tend to collect large amounts and ration the water collected throughout the day to reduce time-use on water fetching.

Referring to **sanitation**, in rural areas, the father does the hard work of digging latrine pits. An old grandmother who lives alone explains that having no latrine presents an obstacle for her children and grandchildren who visit from the city. Thus, as the grandmother is limited in her physical strength, she hired a man from the village to dig the latrine pit and make small carpentry works for 30000 Ariary (equivalent to $8). Most mothers recognize that maintenance and counseling on latrine use is the responsibility of mothers and their children. Women are also the first to encourage men to build infrastructure for water, sanitation, and hygiene.

In rural as in urban areas, people congregate at community water supply points, such as the drawing points for shared water connections or the public toilets and washtubs. The users of these places are primarily women and people of lower social strata, as well as persons with disabilities who must rely on handholds or handrails and thus face an increased risk of infection with COVID-19. Bodily hygiene practices can be limited during lockdown because of the lack of mobility, increasing the risk of domestic violence. Also, some households cannot pay the cost of water; people thus tend to reduce their hygiene practices, making them more susceptible to the disease.

[23] RANO WASH summary response to COVID-19

For **hygiene**, in rural areas, fathers encourage their children to wash before going to school and to wash their hands before eating. On the other hand, mothers help the children wash themselves, sometimes showing them how to wash. Also, women do laundry with help from female children. According to a married woman with three children, "the laundry is always done at the river, we dry clothes near the place of the laundry, and we do not return to the house until the clothes are dry". Since COVID-19, handwashing with soap has become more convenient at home, or in public places with handwashing devices installed. In urban areas, the situation has become more and more difficult.

"There are more handwashing facilities installed at the village level, since raising awareness to fight against COVID-19," said a Municipal supervisory officer.

There is a limited number of households with showers, mostly in areas where programs carry out sensitization and increase access to WASH facilities. The lack of security and safety measures at WASH services supply places (toilets, showers, etc.) increases the risk of gender-based violence against women and young girls, especially in times of lockdown.

Declining household income, increased competition for hygiene resources, such as soap, and disrupted supply chains can reduce household access, especially of women and girls, to adequate hygiene products and sanitation facilities. As a result, their ability to carry out disease prevention efforts at the household level or to meet their own hygiene needs may be compromised.

For **menstrual hygiene**, in many societies, menstruation remains a taboo. Madagascar is no exception because even the denomination of menstruation, "fadim-bolana" ("fady", meaning "taboo"), is a perfect illustration of this. During their menstruation, women and girls are considered "impure", sometimes putting them in a situation of isolation such as not attending school during the menstrual period or participating in daily activities due to the taboos associated with menstruation. It has long been taught in girls that they should not talk about "menstruation" with others, especially with "olom-pady", like their brothers, their father or the elderly. There are barriers among men in relation to "menstruation," including a discomfort or a refusal to face everything related to the issue. So many reasons to break taboos, say the actors in the water, hygiene and sanitation sector.[24] Apart from the problems encountered by women and girls in the management of menstrual hygiene, this situation is worsening due to the pandemic. Women's and girls' access to hygiene and sanitary materials may be reduced. Women and girls face a limited supply of sanitary towels during menstruation[25].

"We also make masks in addition to the sanitary pads that we have already made and put on sale. This activity brings more income for our profession and members." Said a woman member of a VSLA group.

Since COVID-19, the men and women sewing local sanitary pads have been developing their trade by making local masks. This activity presents an economic opportunity for women and men.

[24] http://www.midi-madagasikara.mg/societe/2016/05/27/hygiene-menstruelle-finir-tabous/

[25] UNICEF Brief | Mitigating the impacts of COVID-19 on menstrual health and hygiene, April 2020

3.5. PARTICIPATION

The involvement and integration of women in an association can help improve their social status. At the national level, just over four out of 10 women (43%) reported being members of a faith-based association, while only 5.5% were members of a political or civic association. In terms of position held, only 4.6% of women members of an association held the position of President or vice-president, 4.7% held secretary, and 5.1% held other positions. It should be noted that almost all (85.0%) of the women aged 15-49 affiliated to any association are simple members.[26]

Regarding decision-making at community level, women and those living with a disability may attend meetings, but this depends on the reason for convening the meeting, the location of the meeting, and the age limit. When subjects involve men more than women, such as safety, water management for crop fields, more men attend the meeting. When the subject rather affects the health of the family, it is mainly women who attend. A decision by mutual agreement is made between the man and the woman.

Participation

"*As a woman, society does not trust my leadership* " said a woman president of the association.

"Strengthening women's participation in decision-making means making their voices heard and demonstrating a willingness to reach out to the different groups that make up society."

3.6. PROTECTION

Gender Based Violence

46% of respondents reported that the COVID-19 pandemic caused aggressive behavior in family members; most perpetrators (63%) were fathers or husbands. 43% of women reported observing family members showing signs of depression. The analysis shows that 40% of the respondents experienced aggression or conflict within the families. 15% of respondents reported that family members behaved physically aggressively towards other household members, 10% observed sexual assault behavior. 13% of respondents reported no change in behavior of family members during the confinement period.

Changes were also observed in children or youth, including aggressive emotions, signs of depression, excessive alcohol consumption, aggression and conflict. Half of the respondents reported experiencing at least one type of violence during the COVID-19 or confinement period. Women who are members of associations are less likely to be victims than non-members.

79.5% of the survivors suffered psychological violence during the period of COVID19 and confinement and 31% of the survivors suffered economic violence. Sexual violence is not automatically reported, yet a proportion of 26% was still recorded, so in reality this rate is underestimated.

Protection

Women and girls are at increased risk

Children, particularly girls, may face additional risks

Resources for protection services may be reallocated, putting women and girls at risk

[26] Perception des femmes sur les impacts de la pandémie COVID-19 et les violences basées sur le genre à Madagascar, UNFPA et MPPSPF, Juillet 2020

Women's needs in the face of COVID-19 and to combat gender-based violence.

Women have different socio-economic needs to face stressors and shocks for themselves and their families. Slightly more than 40% of the women respondents mentioned a need to strengthen awareness around protections. Almost a quarter of the women explicitly state they would like their rights to be respected. The need to educate girls and boys from an early age was mentioned by 18% of the respondents as a priority. It was mentioned by 17% of the respondents that having work and income of their own enables women to be autonomous and independent. Economic empowerment as prevention also influences power inequities that increase vulnerability to violence.

Women respondents gave their opinions on the importance of strengthening decision-making and authorities' involvement in the fight against GBV and the control of alcohol and drug use. Other women mentioned their need for security reinforcement, confidentiality and protection of women, moral support, and ensuring that men and boys don't commit violence. Overall, the effects of COVID-19 on the women sampled emphasize that awareness among women and girls in protection needs to increase.

IV. CONCLUSIONS

The impacts of COVID-19 are multidimensional in both urban and rural areas. In terms of health, all categories of people are affected by COVID-19, In September 2020, the rate of positivity of Covid-19 screening tests is 6% in Madagascar[27]. There are more deaths among men, with more than 55% are male cases[28]. The population's low purchasing power coupled with the fear of going to the health center can have negative consequences on health seeking behavior, including economic burden of health costs and not being able to return home if testing positive for COVID-19.

In urban areas, the most affected groups socio-economically are households, especially women, young men and young people who are dependent on the informal sector or involved in restaurants, hotels, and tourism. In rural areas, the halt in the production and sales chain is harmful to farmers and stockbreeders' daily lives. Some households are already using negative coping mechanisms, including reducing the quality and quantity of meals and using their limited income/capital for acute food needs.

Declining income and increased stress are risk factors for domestic violence. Violence comes in different forms that impact women and girls in different ways. An alarming rate of violence, with a rate of 78.40% of the opinions of women survivors who stated that the period of COVID-19 worsened their violence situation, was recorded during this period of crisis, which risks personal and social peace. Prevention and support services for survivors already weak before the crisis will be even more limited because of the mobility restrictions due to COVID-19.

Women have little access to decision-making spaces on the COVID-19 response strategy. Illiterate people, mostly women, need to read and communicate from reliable sources of information in the local language. This is critical in an environment where misconceptions and misinformation about COVID-19 is high. Despite their high vulnerability to the crisis, women and young people have access to the skills and networks that can enable them to become central actors in finding and implementing solutions and responses to the pandemic and its harmful effect on poverty.

The crisis is evolving very rapidly, and a multi-actor and flexible response strategy for considering WASH, health, and socio-economic needs is required. COVID-19 has also highlighted the importance of strong WASH systems and access to WASH services not just in the immediate term or as an emergency response, but as a pillar of preparedness and resilience to future infectious diseases, emergencies, and poverty alleviation. Private operators are also emerging and developing the WASH business, from small to large scale, to help Madagascar's government meet WASH targets for SDG6.

[27] CCO report, 2020
[28] Orange actu Madagascar, Sep 2020

V. RECOMMENDATIONS

The following recommendations are targeted towards humanitarian and development actors, as well as relevant government bodies in Madagascar.

5.1. OVERARCHING RECOMMENDATION

This RGA report should be updated and revised as the COVID-19 pandemic unfolds and be supplemented by country-specific RGAs in Madagascar. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, boys and girls. The crisis's impacts are continuously evolving and require regular analysis of shifting gender dynamics for more effective and appropriate response. CARE and partner organizations should continue to invest in contextualized gender analysis and guidance on prevention and response messaging for COVID-19 and widely share new reports.

5.2. TARGETED RECOMMENDATIONS

- Increase the provision of equitable water, sanitation and hygiene services in both rural and urban areas by mobilizing the equipment and teams necessary as hygiene kits, devices to enable women and girls to continuously access WASH services, special regulations, staff support for an effective gendered WASH response that includes the specific needs and experiences of women and girls.
- Facilitate inclusive and equitable access of households and individuals to water, sanitation and hygiene services by engaging the private sector in the delivery of WASH products and services by localizing production of face masks and soap and recognizing women as market players and actors.
- Continue, expand and adapt protection, psychosocial and gender-based violence (GBV) services on an urgent and life-saving basis. Safety and security around water points and toilets will be reinforced
- Take economic measures to protect those involved in informal and insecure labor markets, such as cash and in-kind assistance.
- Undertake several activities to support the WASH Cluster contingency and response plan through coordination, prevention, management of the WASH component in health centers (CSBs), continuity of WASH services and community response.
- Make available data disaggregated by age and gender of those affected, as well as those who received assistance, to prevent a gender-blind response at different levels and in different sectors.

5.3. GENDER MAINSTREAMING RECOMMENDATIONS

- Share key practices and tips that promote consideration of people's specific needs in the WASH, nutrition, health, economic sectors. These are the guides to be developed for stakeholders to adopt to prevent the spread of the disease and manage inclusive response activities.

- Energize discussions through working groups on gender in different sectors of activity at different forums at civil society, civil servant, and community level

- Support NGOs on assessing the needs and designing responsive projects for marginalized groups in their programming such as consideration of the elderly, people in boarding schools, prisons, and orphanage centers.

- Conduct capacity building on gender mainstreaming in emergencies for the Ministry of Water Sanitation and Hygiene and WASH cluster members

- Collaborate with the mass media to convey non-discriminatory messages that promote gender equality in a practical and relevant way.

5.4. GENDER SPECIFIC PROGRAMMING RECOMMENDATIONS

- Develop and implement action programs such as human rights promotion activities, provision of water and sanitation services at the institutional and community levels, and economic support for vulnerable households. The groups are concerned to reduce the gaps between men and women, urban and rural areas.

- Strengthen specific actions for example the production and supply of hygiene products, to help, support and empower people with disabilities through existing institutions and develop new guidelines

- Support men and women seamstresses to develop their business by providing additional funding to expand their WASH business and increase access to WASH services in their community by expanding productivity, as demand for face masks and hygiene products increases by finding more markets to liquidate products.

- Ensure that women participate in leadership and decision-making regarding the response to COVID-19 at the global, regional, national and community levels, by addressing the social norms and barriers, working with men and boys to challenge these norms and reinforce measures to protect against gender based violence.

- Develop mitigation plans to manage gender-sensitive emergencies and prepare for implementation, by referring to COVID-19 experiences

ANNEXES

ANNEX 1: GENDER IN BRIEF

RANO WASH GENDER ANALYSIS MADAGASCAR

EXECUTIVE SUMMARY

Under RANO WASH, CARE led a gender analysis in Madagascar in 2018 to identify and explore gender inequalities and their impacts. Research was conducted in 20 sites across regions (Alaotra Mangoro, Atsinanana, Amoron'i Mania, Haute Matsiatra, Vakinankaratra and Vatovavy Fitovinany) and employed multiple discussion and participatory tools. In total over 600 men and women contributed to the exercise.

The analysis used five key areas for addressing and analyzing inequalities: 1) Laws and policies; 2) Social norms (including Gender Based Violence); 3) Household decision-making; 4) Access and use of services (including health clinics and schools) and 5) Leadership and community participation.

MAJOR FINDINGS

1) Laws and official policies in Madagascar are reflective of gender equity. The challenge is that many policies are not yet finalized, not fully disseminated, and not implemented. There is a lot of injustice for women at the community level, people with disabilities and those who are not heterosexual.

2) Women are responsible for maintaining the home. Women have less time than men due to expectations of running the household and contributing to working in the field. Women are expected to be flexible, clean, work hard and respect men. The equality of women is now more openly discussed and is increasing in some areas.

3) Violence and harassment, although illegal, is rarely reported or punished. Fear or risk of violence against women increases during times of stress. Women may fear retaliation if they contribute opinions on decisions.

4) Household level decision-making. Major decisions are made by the man in terms of selling, purchasing, and constructing. Women may be able to influence their husband's decisions, but he has the final say. In Vatovavy Fitovinany women were discussed as being "obedient" and silent. This was not discussed as often in the Alaotra Mangoro region. People with disabilities are also expected to be silent and not contribute to conversations.

5) Access to services: Access to education, healthcare and water has improved in recent years. Now nearly all kids go to school, regardless of income. Health facilities and hospitals are now accessible and utilized.

6) People and children with disabilities are at a greater disadvantage due to difficulties in physically reaching institutions such as hospitals and schools. People living with disabilities described difficulty accessing water from public taps. Few had toilets, but there is concern that (new) sanitation facilities, like water facilities, would not cater to the needs of people with disabilities.

7) Leadership and Community participation: Men and boys are much more likely to participate in community committees and community decisions. Women and girls face several obstacles to their

involvement. Although they want to participate, they rarely find the time due to meetings being outside their village, and the expectations to be near home and to fulfil domestic duties. Additionally, there is evidence from men and women, that women's low educational achievement limits their participation in decision-making at household and community levels due to less experience expressing thoughts or speaking publicly than men.

8) Field research shows that almost all WASH activities are dedicated to women and girls, and often do not integrate men and boys due to the "home, hygiene and nutrition" focus associated with a female domestic role.

9) Women of all ages want latrines at their household. The challenge is convincing the household members, especially men that it is worth the time, effort and space. Men were reported to contribute money for soap and water treatment products, demonstrating their commitment to the family's health.

RECOMMENDATIONS

1. Enable women the freedom and opportunity to be involved. Women want to be more involved in community decisions and village development activities. This can be done by working with men and boys to assist women in household duties, have meetings or other trainings closer to home, and travel during hours where travel is easier.

2. Promote women's skills and leadership. The project must ensure that women's skills and leadership is promoted, not only with new skills, but highlighting their existing strengths so that other women have the desire and courage to join community groups. RANO WASH should work with women on describing their needs, aspirations and improving preparation (literacy, speaking skills) for more meaningful participation in community decision-making.

3. Expanding the role of men and boys. Ensure that men and boys are invited and involved in WASH activities and trainings. Men care about their kids' health, strength, education, progress, future incomes – using those angles increases the attraction of WASH trainings beyond "child handwashing." Men contribute to the purchase of soap and water treatment – RANO WASH needs to help men see that building a latrine is another way of demonstrating care and ensuring the health and dignity of their family.

4. Understand schedules. This may seem simple, but many development programs do not consider the days during the week, month or year when different community categories are available for participation in activities (meetings, training, labor and/or financial contributions).

5. Promote collaborative design. RANO WASH should incorporate the opinions of women, girls and the vulnerable (and men and boys) into program and infrastructure designs, including menstrual hygiene facilities for girls in school, and facilities for females and people with disabilities in homes and health centers.

6. Establish/strengthen feedback mechanisms. RANO WASH should develop a feedback mechanism so that program participants can easily share opinions and feedback on the program; a system for inquiring about unintended consequences or unforeseen risks to participants could support better programming for voices normally left behind and not heard.

7. Understand signs of Gender Based Violence. RANO WASH should collaborate with anti-violence against women organizations and understand the risks, signs and protocols for referring victims of violence to (external) services.

8. Streamline gender equality. RANO WASH should consider holding capacity building sessions for local partners to understand the importance, meaning and real-life application of gender equality so that all actors are using the same language and working towards similar goals.

9. Intentionally inclusive. RANO WASH needs to collaborate with and learn from People living with disabilities and other minority organizations to ensure programming is intentionally inclusive to diverse needs and perspectives

ANNEX 2: SCHEDULE OF VISITS

The field visit to collect primary data was conducted by the field team in place. They were guided remotely for the conduct. Telephone calls to the target persons were also made. It was the week of August 17.

	Profile Individual or authority Interview	Nb/region	ALM	ATS	AMM	HM	VAK	V7V
1	Elderly (women and men)	1H, 1F		Fabien				
2	Persons with disabilities (women and men)	1H, 1F	Estele	Rossi	Mirana			Judith
3	Youth (women and men)	1H, 1F	Manda					
4	Pregnant Women	1H, 1F		Landrika				
5	Breastfeeding women / women with a child under 6 months of age	1H, 1F	Claudia		Laurent			
6	Female or male heads of household (single-parent household)	1H, 1F					Prisila	
7	Caregiving staff	1H, 1F	RD Sand	RD	Ifaliana	Raissa	RD	RD
8	Authorities	2H, 2F	SE Ckeil	SE	SE	SE	Iarivola	SE Rolland
	Total	8 X 6 =48 +2 ⇨ 100						

ANNEX 3: TOOLS AND RESOURCES USED

Tools used are individual interview at household level, and authority interview. A lot of observation was also used to understand the situation, at the household level, at the level of public interaction and at the level of the societal environment.

Rapid Gender Analysis: Assessment Tools COVID-19

Individual Interview

Region: **District:** **Commune:**
Name:

Date interview:

Interview method: face to face or by phone

Introduction

Gender				Age	Situation				Observations
W	M				Married	Householdhead	Handicap		

Key informant interview questions

CHANGES IN GENDER ROLES AND RELATIONSHIPS DURING THE CRISIS

1.What changes have you experienced since the VIDOC-19 crisis?	
Who has access to and control over family resources and assets? Have there been any changes since the VIDOC-19 crisis?	
What changes have you experienced specifically as a woman/man/boys/girls? Or belong to a specific group (insert if applicable)	
Have there been any economic, social, physical or psychological impacts of these changes?	
2.Which of these changes is the most important and why?	

COPING MECHANISMS OF AN AFFECTED FAMILY OR HOUSEHOLD

Coping strategies: How do different family/household members cope with COVID-19? How do people adapt to follow COVID-19's prevention/health care-seeking practices?	

Vulnerabilities: Who is vulnerable in the context of COVID-19 and why? What are the different vulnerabilities of women, men, boys and girls? As well as different age groups and different groups of people (e.g., pregnant women, people with disabilities or chronic health problems, LBGTI).	
Decision-making: How does the household make decisions? Who in the household decides about education, access to health services, household income, and travel outside the home? Who is consulted? Who is not consulted? How does this affect women, men, boys and girls in the household since COVID-19?	

NEEDS AND CONCERNS

What are your needs since the COVID-19 crisis?	
What are the needs of other family members (Explore: What are the main needs of women and girls, men and boys, and other groups)?	
Do you have specific concerns related to the crisis?	
Do you have all the support you need to deal with COVID-19? What support is missing?	
What suggestions do you have on how local or national leaders / authorities could better respond to your needs?	

RAPID GENDER ANALYSIS: ASSESSMENT TOOLS COVID-19

Interview with authorities

Region: **District:** **Commune:**
Name:

Date interview:

Interview method: face to face or by phone

Introduction

Gender				Age	Sector				Observations
W	M				WASH	Health	Protection		

Key informant interview questions

Gender roles and relations

1. Since COVID-19, has there been a change in the working hours of women and men in paid and unpaid work? Please describe the change? Have there been any economic, social, physical or psychological impacts of these changes?	
2. Who has access to and control over family resources and assets? Has there been any change since the VIDOC crisis? 19.	
3. What new coping mechanisms are individuals/families adopting to fulfill their roles and responsibilities?	

Access to Basic Services

1. What services are safely available to men, women, boys and girls in this community?	
2. Have there been any changes in access to services for women, men, boys and girls in the community since COVID-19 (specifically for health, WASH, reproductive health and GBV services)?	
3. If so, can you explain why?	

Decision-making and leadership

1. What changes (if any) have occurred with respect to household members who make/influence decisions about family/individual access to health care?	
2. What social/cultural structures does the community use to make decisions? How do women and men participate? How have these structures been affected by COVID-19?	
3. How are women and men and at-risk or minority groups involved in the local and national (formal) preparedness and response mechanisms for COVID-19? What are the main obstacles to meaningful participation of women in these forums ?	

Protection Concerns

1. Has there been an increase in safety and security concerns/incidents since VIDOC-19? Do you feel comfortable describing what types of concerns/incidents and who is affected?	
2. Who can community members turn to for help when they have a safety or security concern or are victims of violence?	

REFERENCES

- Real time updates on prevalence, mortality and recovery rates across the globe, are provided in the John Hopkins database: https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6.
- For further details on ranking, please refer to: https://www.ghsindex.org/
- https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd
- WHO Covid-19 National Response Plan - March 2020
- WHO (2019). Gender equity in the health workforce: Analysis of 104 Countries
- Ministry of Social Welfare, Gender and Children's Affairs, UN Women, Oxfam, Statistics Sierra Leone (2014). Report of the Multisector Impact Assessment of Gender Dimensions of the Ebola Virus Disease in Sierra Leone.
- ASC (2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Food Security and Agriculture.
- UNGA A/70/723. Protecting Humanity from Future Health Crises: Report of the High Level Panel on the Global Response to Health Crises.
- UNGA A/70/723. Protecting Humanity from Future Health Crises: Report of the High-Level Panel on the Global Response to Health Crises.
- Measure Evaluation (2017). The Importance of Gender in Emerging Infectious Diseases Data.
- Smith, Julia (2019). Overcoming the 'tyranny of the urgent': integrating gender into disease outbreak preparedness and response, Gender and Development 27(2).
- Gender analysis, RANO WASH project, 2018
- UNICEF Brief | Mitigating the impacts of COVID-19 on menstrual health and hygiene April 2020
- Perception des femmes sur les impacts de la pandémie COVID-19 et les violences basées sur le genre à Madagascar, UNFPA et MPPSPF, Juillet 2020
- INSTAT/DSCVM/EHTM COVID - 19, Juin 2020
- UNICEF Brief | Mitigating the impacts of COVID-19 on menstrual health and hygiene April 2020
- Résultats de l'enquête MICS conduit par INSTAT/DSCVM/EHTM COVID - 19, Juin 2020
- Implications of COVID-19 Outbreaks in Development and Humanitarian Settings, par CARE International – May 2020
- COVID-19 Survey on Food Security, Economic impacts, VIAMO
- Gender-Based Violence (GBV) and Risk Communication and Community Engagement (RCCE) in COVID-19 Response, UNICEF
- Femmes et hommes ne sont pas égaux face au coronavirus, CAREN GROWN et CAROLINA SÁNCHEZ-PÁRAMO, Banque Mondiale - 20, avril 2020
- Partage du Cluster Protection Madagascar – Juin 2020
- Impact du COVID -19 sur les conditions de vie des ménages, Enquête à Haute Fréquence par téléphone auprès des ménages (EHTM)
- Situation COVID- Septembre 20