Integrating gender and inclusion in social protection response to COVID-19: What have we learnt?

Rebecca Holmes
June 2021

COVID-19 has exacerbated existing inequalities for women and girls and persons with disabilities. Before the crisis, women were already more likely than men to live in poverty, to work in lower-paid and insecure employment, and to lack access to formal social protection (SP), savings and financial services (UN Women and WHO, 2020). Persons with disability typically have worse outcomes in education, health and experience barriers accessing employment, and are less likely to be enrolled in SP programmes, even when they are eligible (Banks et al., 2017). These inequalities and risks are multiple and compounded by diversity and intersectionality, (e.g. age, gender, disability, ethnicity, location), resulting in disproportionate impacts of the crisis.

During the pandemic, women have been more likely than men to drop out of the labour force, have shouldered an unequal burden of unpaid care work, and are facing increased threats from gender-based violence (GBV) linked to lockdowns and financial stress (UNFPA 2020; Peterman and O’Donnell, 2020, UN Women, 2020). The pandemic has also increased the risk of poverty amongst people with disabilities (Banks et al., 2021). This paper provides a snapshot of how SP responses to the COVID-19 crisis have integrated gender equality and social inclusion into programme design and implementation.

COVID-19 - What emerged across countries?

Whilst there are some good practices in inclusive and responsive programming, overall, the global response has fallen short. Since the start of the pandemic, over 1,000 new or adapted SP programmes in over 200 countries have been operationalised. However, the UN Women and UNDP Gender Tracker, set up to monitor gender-sensitive COVID-19 policy responses, found that by February 2021 only 17.4% of the SP and labour market measures recorded were “gender-sensitive”, that is, targeting women’s economic security or addressing unpaid care.

Some countries have explicitly included single-parent households, women and persons with disability in their targeting criteria to expand coverage. For example, in Nigeria and Somalia, persons with disability and women-headed households were prioritised in the eligibility criteria for expansion. In Tajikistan, a second round of COVID-19 emergency support was expanded to include already registered households with children with a disability (Sammon et al., 2021). In Burkina Faso and Colombia, cash transfers explicitly targeted women informal workers whilst in Argentina and Brazil, the expansion of SP sought to reach vulnerable, informal workers through demand-driven mechanisms (Blofield et al., 2021; O’Donnell et al., 2021). Many programmes have also included a quota for women recipients to encourage gender balance. However, many of these do so based on women’s roles within the household (e.g. targeting women to spend the transfer more effectively on behalf of the household rather than providing an individual entitlement due to lost employment (O’Donnell et al., 2021)). Moreover, gaps in eligibility persist. A study by Women in Informal Employment: Globalizing and Organizing (WIEGO), found that less than half of informal workers surveyed in 12 cities reported receiving cash or food, with those in Sub-Saharan African cities the least likely to receive support (Roever and Rogan, 2020).

A few good practices exist in providing support to meet the specific needs of women and persons with disability. Single-headed households – often headed by women - and persons with disability often face higher expenditures and have fewer coping strategies to draw on (such as savings or assets) (UN Women, WHO, 2020). Very few programmes have been designed to consider the specific needs of different households, although interesting exceptions to this include Brazil’s Auxílio Emergencial, which in the first 5 months of operation was higher than the pre-crisis transfer value of the routine Bolsa Familia programme and double that amount for single-headed households, most of whom are women (Alfers and Bastagli, forthcoming). Togo’s Novissi scheme also paid 20% more to women based on evidence that a higher share of their expenditure goes towards the household’s needs (Lowe et al., 2021).

Given the range of risks faced in the pandemic, a comprehensive approach is needed, including coordination across different services and interventions – of which social protection is just one part. In India, Kerala’s response to the first wave of the pandemic in early 2020 provides a good example where social protection programmes were part of a wider response that included food rations, community kitchens, meals for children, emergency cash transfers, social security adjustments, and expanded public works, with loans through women’s cooperatives and psychosocial support via helplines (Holmes and Hunt, 2021).

Some programmes have adapted delivery systems to support equality and inclusion. In Senegal, for example, the government announced links between the equal opportunity card (disability) registry and the unified social registry to ensure that persons with disabilities would have...
access to in-kind relief (Barca et al., 2021). In the Dominican Republic, strengthening the unique beneficiary registry data to include households with children with disabilities before the crisis allowed rapid scale-up of support to households with children with disabilities at the onset of the pandemic (Sammon et al., 2021). And in Somalia, the Baxaano programme shifted to mobile payments during COVID-19, but recognising that women were less likely to own mobile phones, SIM cards were distributed to ensure they could receive the payments. The programme also strengthened safeguarding processes to reduce protection risks through awareness-raising and establishing referrals to GBV services (McLean, forthcoming).

What hindered or promoted more inclusive and equitable responses?

**Attention to gender equality and disability-inclusion in SP design and implementation pre-crisis.** The pandemic required decisions and trade-offs across programme design and implementation, in the context of time pressures and resource constraints. Programmes that did not already have an existing gender-responsive and inclusive design in place were unlikely to introduce this in the context of the crisis. Those with existing infrastructure were better able to expand or adapt programmes quickly, including providing disability benefits or reaching women recipients. In South Africa, the COVID-response Caregiver Allowance was rapidly distributed to 7 million recipients already receiving the child grant - the majority of whom are women. Conversely, in the Republic of Congo, limited pre-existing SP infrastructure delayed the disbursement of assistance to informal workers in urban areas by months (Government of Congo 2020).

**Availability of disaggregated data by sex, gender, age, disability and ethnicity.** The use of real-time surveys, technological innovations and long-term panel data have all been leveraged in the crisis, but the extent to which this has been used to inform gender and inclusive programme design in terms of the adequacy and comprehensiveness of support provided, or the ways a programme is implemented to ensure equitable access to benefits, remains relatively limited. An exception to this is an example from Kerala, India, when in early 2020 real-time data was collected from community health workers and local organisations highlighting important gender-related issues arising from the crisis and how this changed over time. Mechanisms were put in place to then use this data to inform state-level response. However, in many contexts a lack of attention to gender and inclusion in monitoring means that issues faced by specific groups or individuals may not be acknowledged. This is not just relevant to coverage (e.g. the number of women/men that receive benefits), but includes appropriateness of design in meeting needs, ensuring equitable access to grievance redress mechanisms, to programme information and policy coherence in terms of access to different types of interventions.

**Policy attention to specific gender and inclusion issues.** COVID-19 has highlighted the importance of specific gender and inclusion issues. An example has been increased policy attention to GBV resulting in more SP programmes recognising the need to put in place institutional safeguards, identify and mitigate risks, such as ensuring staff capacity and skills and referring SP recipients to GBV services.

**Preparedness plans and coordination across actors.** Gender-responsive and inclusive considerations are often relegated in the urgency of rapid responses. Organizations of informal workers in India and Argentina worked with governments to reach member-based workers, sharing information about government programmes, and acting as a last-mile bridge between the government and intended recipients (SPACE, 2020). Many COVID-19 responses also relied on local level actors, including many led by or representative of women, informal workers, and persons with disability. However, actors were often not adequately funded or provided with appropriate PPE and rarely involved at a strategic level to inform programme design and implementation decisions. The lack of diversity at the policy table, therefore, becomes reinforced through homogenous “one size fits all” responses, which may not adequately reflect the context or experiences of those most in need.

What lessons have we learned for the future?

**Develop a costed gender equality and social inclusion (GESI) strategy for SP.** Clear strategies articulating the ambition for gender and inclusion, and how it is to be achieved through programme design /implementation, are needed to achieve consistent, inclusive, and equitable outcomes and to inform programme choices/trade-offs in the context of a crisis. This needs to be in place before crises and also as part of crisis response.

**Invest in the collection and analysis of disaggregated data** to monitor and evaluate the benefits of SP measures by sex, gender, age, disability, and other as relevant, linking this into preparedness and SP planning through inclusive information systems.

**Invest in partnerships and multi-disciplinary teams,** engaging with local organisations to co-design and implement programmes. Establishing a common strategy across multiple stakeholders can also work towards common gender equality and inclusion goals, and draw on different strengths. A response team with gender and inclusion skills is critical.

**Look for opportunities to embed transformative objectives to support longer-term progress on agency and empowerment.** An SP programme can build on what already exists, even outside of the SP sector. Coordinating and working with the health, education, and livelihoods sectors, and linking SP recipients to relevant services, skills, social norm change interventions and GBV services.