

Addressing the COVID-19 Crisis's Indirect Health Impacts for Women and Girls

Carleigh Krubiner, Megan O'Donnell, Julia Kaufman, and Shelby Bourgault

Abstract

When health crises like COVID-19 emerge, the shocks to economic, social, and health systems can have different implications for women and girls, with gendered impacts across various dimensions of wellbeing. This paper focuses on how the pandemic has been affecting women's and girl's health. It begins with a conceptual framework illustrating how the pandemic, associated response measures, economic contraction and different coping strategies intersect with underlying gender norms and inequality in ways that differentially affect the health and wellbeing of women and girls. It then provides a snapshot of the existing and evolving evidence as it relates to key health services and outcomes for women and girls in low- and middle-income countries, focusing primarily on sexual and reproductive health and rights. The paper examines some ways national governments have sought to maintain provision of essential health services and reviews the extent to which donor institutions have prioritized financial, technical, and other forms of support to mitigate disruptions. It concludes by highlighting existing gaps, opportunities, and promising strategies that donors and governments should pursue to address indirect harms to women's and girl's health during and beyond the COVID-19 crisis.

Keywords: pandemic response; indirect health effects; Covid-19; gender equality; sexual and reproductive health and rights; essential health services

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Introduction

As donor institutions and governments respond to the COVID-19 pandemic and global recession, CGD's new [COVID-19 Gender and Development Initiative](#) aims to support policy and investment decisions that equitably benefit women and girls. Through this work we seek to deepen decisionmakers' understanding of the multiple and overlapping gendered impacts of the COVID-19 crisis and the public health, economic, and social policy responses to it, as well as propose evidence-based solutions to support gender-inclusive recovery. The project focuses on three distinct yet related areas of the COVID-19 response and recovery: (1) indirect health impacts of the pandemic for women and girls; (2) inclusive and equitable social protection policy; and (3) promoting women's economic opportunities and empowerment. Recognizing that much of the academic and policy dialogue around gender inequality in the COVID-19 context has largely emphasized challenges facing women and girls in high-income settings, our analysis centers on women and girls in low- and middle-income countries (LICs and MICs).¹

This paper focuses specifically on how the pandemic has been affecting women's and girl's health in order to identify solutions that can protect and promote various health dimensions in ongoing response and recovery efforts, especially focusing on what government policymakers and donors can do moving forward. This paper also draws upon our other papers addressing employment and income loss, increased household poverty and food insecurity, and increased unpaid care work—and women's and girls' coping strategies—recognizing the many ways in which social and economic interests of women and girls are interlinked with health behaviors, exposures, access, and outcomes. We have organized the paper into the following sections:

- [A Conceptual Framework for Gendered Impacts of COVID-19 on Women's and Girls' Health](#): Drawing upon the historical evidence of past crises and emerging findings specific to COVID-19, we have developed a conceptual framework illustrating how the pandemic, associated response measures, economic contraction and different coping strategies intersect with underlying gender norms and inequality in ways that differentially affect the health and wellbeing of women and girls.
- [Emerging Evidence on How COVID-19 is Impacting Women's and Girl's Health](#): We provide a snapshot of the existing and evolving evidence as it relates to key health services and outcomes for women and girls in LICs and MICs, focusing primarily on sexual and reproductive health and rights (SRHR).² To synthesize the

¹ Where research has focused on the COVID-19 crisis' impacts in lower-income countries, much of it has not focused on gender-differential impacts. See Khamis et al., *The Early Labor Market Impacts of COVID-19 in Developing Countries: Evidence from High-Frequency Phone Surveys*, World Bank Group.

² We define sexual and reproductive rights according to the 2018 Guttmacher-Lancet Commission definition: “a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity” (Guttmacher-Lancet Commission 2018). SRHR

current evidence, we draw upon various sources of data from the published and grey literature as well as databases, trackers, and reports in the public domain to summarize some of documented impacts on contraceptive use and access, maternal care, HIV services, gender-based violence, and mental health, with select country examples. We also summarize the types of gendered exposures, health behaviors, impacts on access, and aspects of gender-biased health systems documented in the context of COVID-19 to highlight gendered pathways to indirect health impacts during the crisis. (See Annex A for search methodology.)

- **Donor and Policymaker Efforts to Address Gendered Indirect Health Impacts:** This section examines some of the ways national governments have sought to maintain the provision of essential health services and reviews the extent to which donor institutions have prioritized financial, technical, and other forms of support to mitigate disruptions to health systems, including women’s and girls’ ability to access essential sexual and reproductive health services. To gauge how donors have sought to address women’s and girls’ broader health needs during of the COVID-19 crisis, we review multilateral development banks’ (MDBs) project appraisal documents and other relevant resources to shed light on the extent to which donors’ COVID-19 response efforts to date have integrated considerations of gender. While the primary focus in this paper looks at multilateral development banks, this is just a starting point to identify key opportunities to strengthen the efforts of MDBs, bilateral donors, country governments, and other influential actors to advance gender-sensitive response efforts to COVID-19 that protect and promote the health and rights of women and girls.
- **Opportunities and Preliminary Recommendations:** This section highlights existing gaps, opportunities, and promising strategies that should be pursued by donors and governments to address indirect harms to women’s and girl’s health during and beyond the COVID-19 crisis. Recognizing that gender inequality and the many shortfalls in meeting the health needs of women and girls predate the emergence of COVID-19, these recommendations reinforce and build upon past calls for gender-responsive investment, governance, health systems strengthening, evidence generation, and innovation—to help ensure women and girls are not left behind in recovery efforts and to promote resilience and gender-responsiveness in the face of future health crises.

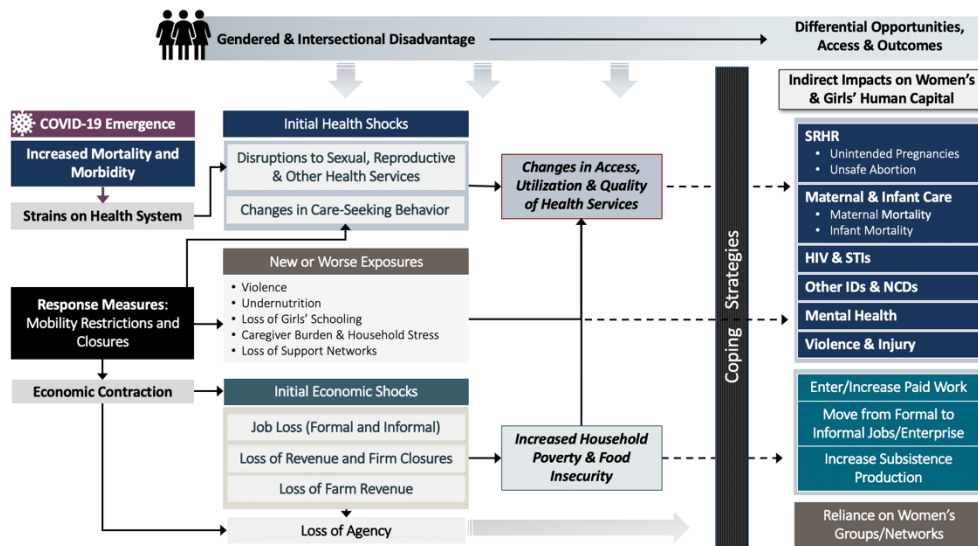
The Effects of Health Crises on Women and Girls: A Conceptual Framework

When health crises like COVID-19 emerge, the simultaneous shocks to economic, social, and health systems can have different implications for women and girls, with gendered impacts across various dimensions of wellbeing. Drawing upon the historical evidence base,

includes contraceptive access, maternal health and rights, abortion, protection against HIV and other sexually transmitted infections, gender-based violence, and discrimination and stigma (CHANGE, 2020).

we have developed a conceptual framework for the impacts of crises on women and girls and apply the framework to a growing evidence base on the effects of the COVID-19 pandemic (Figure 1).

**Figure 1. The Impact of Health Crises on Women and Girls:
A Conceptual Framework**



The conceptual framework illustrates the ways that women's and girls' lives are impacted by a health crisis, both directly and indirectly. Below, we summarize the key features of the framework to highlight how nearer-term economic and health shocks—alongside harmful exposures (e.g., violence, undernutrition, lost schooling) and differential coping strategies—can contribute to downstream gendered impacts on health and economic empowerment. For a more detailed exposition of the conceptual framework, see our accompanying paper, *The Impacts of Health Crises on Women & Girls: How Historical Evidence Can Inform Assessment and Recovery through a Gender Lens*.

A backdrop of gender inequality and intersectional disadvantage: Gender matters in explaining differential effects and coping strategies, as do intersecting demographic and socioeconomic characteristics such as age, location, household structure, and income. As underscored in the *2019 Lancet Series on Gender Equality, Norms, and Health*, there are well-documented ways in which gender and social position mediate pathways to health and wellbeing, including the types of health risks women and girls are exposed to, gendered health behaviors, access to care, and experiences within gender-biased health systems (Heise et al. 2020). Moreover, many of the risks to women and girls outlined below do not originate with the onset of crisis, rather they are magnified or compounded. It is clear from past health and economic crises that shocks do not have homogenous effects across contexts and populations. Women and girls who already faced economic hardship, violence,

undernutrition, barriers to health and social services, and other forms of marginalization often suffer disproportionately from the direct and indirect impacts of crises.

Direct impacts of health crises and response measures: Though mortality and morbidity vary across different disease threats, all health crises result in increased disease and death absent swift and effective intervention. In some instances, the burden of disease falls disproportionately on women and girls, as was the case in the 2018–2020 Ebola crisis in the Democratic Republic of the Congo where 57 percent of cases occurred in women and girls (WHO 2020b). Higher incidence of Ebola virus disease in women and girls has been attributed to greater reliance on female household members to care for the ill, gender composition of the health workforce, as well as a possible added exposure through sexual transmission (Harman 2016; Menéndez et al 2015). Although a number of countries collecting sex-disaggregated data report higher COVID-19 case fatality rates among men as compared to women, a few high-burden countries like India have documented greater fatality rates among women and girls, raising questions about the different roles of biological sex-mediated pathogenesis, gendered patterns of underlying health risks, gendered behavior, and potential bias in data collection that may be contributing to observed sex differences in burden of disease (Dehingia & Raj 2021).

Regardless of the distribution of disease burden, health crises can place enormous strain on healthcare systems, especially when containment measures are not swiftly put in place. At the same time, fear of the pandemic threat alongside government response measures—including restrictions on mobility and transportation services, schools, business operations, and income-generating activities—combine to impact economic activity. Economies are likely to contract, as businesses are forced to close and supply chains are disrupted, at least temporarily, resulting in widespread unemployment, lost income, and decreased aggregate demand for goods and services (World Bank 2020a).

Initial shocks and impacts of health crises and response measures on women and girls: As the health sector responds to the urgent epidemic threat and containment measures are imposed, women and girls may face challenges accessing essential health services, including but not limited to maternal care and contraceptive services (Church et al. 2020). Service disruptions can arise from various supply-side factors, including redeployment of health workers to the frontline response, supply chain issues, absenteeism of health workers due to fear of infection or illness, and suspension of services deemed “non-essential” or elective (Miller et al. 2018; Agarwal 2021; Kidangoor 2020; Chi et al 2020). There are also demand-side factors that can impact care-seeking behavior of women and girls (Chi et al 2020). While some of these may be directly tied to response measures and lockdowns or fear of the virus, others relate to the combined effects of reduced household income, increased demands on time for caregiving and household work, and various ways in which the pandemic context may threaten women’s and girls’ agency.

Of course, the economic shocks affect much more than women’s and girls’ ability to access health services. Economic contractions can lead to a loss of both formal and informal sector jobs, with many women-dominated sectors hit particularly hard in the COVID-19 crisis

(Finmark Trust 2020). Loss of income for wage workers, entrepreneurs, and those in the agricultural sector will increase household poverty and food insecurity (ILO 2021).

We also know that crises can introduce or exacerbate the kinds of risk exposures women and girls face. Extended time in the home can cause excess burdens on women's unpaid care work and increase exposures to gender-based violence (Bhalotra et al. 2019). Given that, historically, women and girls are more vulnerable to undernutrition and lower educational attainment, pandemic-related food insecurity and loss of schooling—with the attendant loss of any school-based social protection programs—can contribute to gendered risk factors in the near-term, with impacts on health, wellbeing, and economic opportunity (Duryea et al. 1999; Picker 2007; Jukes et al. 2008; Hargreaves et al. 2008; Miller et al. 2017; Brown et al. 2018; Muyunda et al. 2018).

Coping strategies and downstream impacts on women's and girls' wellbeing: A pandemic can cause persistent challenges for a health system to deliver essential services, with consequences when women and girls are unable to benefit from effective treatments and services across the care continuum that would otherwise protect and promote their health and reproductive rights (Chi et al 2020). We also know from past crises that many coping strategies used to get through periods of severe economic shock leave women and their families worse-off. Reductions in girls' education and household spending on health may extend beyond the acute epidemic crisis. Continued economic pressures may result in girls being pulled or kept out of school to contribute to family income or household work (Duryea et al. 1999). Lost schooling, combined with reduced access to contraception and other sexual and reproductive health services, increases risks for adolescent girls surrounding unplanned pregnancies, sexually transmitted infections, pregnancy complications, and unsafe abortion (Jukes et al. 2008; UNESCO 2020). Household poverty associated with the economic shocks of a crisis can also adversely impact care-seeking for essential health services—especially those requiring out of pocket (OOP) payments (Alam and Mahal 2014). There is compelling evidence that adverse effects on health are much greater for girls than for boys, leading to a disproportionate loss of girls' human capital (Buvinic 2009; Friedman and Schady 2009; Baird et al. 2007).

Women's and girls' economic prospects are also impacted. Women and girls may need to explore alternative work opportunities, often with lower earning potential and fewer protections. The evidence has shown that this 'added worker effect' is sensitive to household income: low-income women join the paid workforce to insulate against the risks of household poverty and food insecurity, whereas higher-income women exit the workforce (Cerutti 2000; Humphrey 1996; Judisman and Moreno 1990; Lee and Cho 2005; Sabarwal et al. 2011; Skoufias and Parker 2006). Women who experience job loss in the formal workforce may resort to informal wage work or entrepreneurship, taking on employment with lower wages and fewer benefits and labor protections to make ends meet. Women and girls living in rural areas may turn to increased subsistence production, especially in response to rising food insecurity.

This framework illustrates the complex, bidirectional interactions between poverty and health, particularly for women and girls. The evidence also highlights how negative effects of

crisis on women and girls occur differently across the life cycle and can be intergenerational and inter-cohort, resulting in losses for future generations' health and human capital.

What Do We Know About the Indirect Impacts of the COVID-19 Pandemic, Global Recession, and Associated Policy Measures on Women's and Girls' Health?

At the start of the pandemic, considerations on how best to respond to the COVID-19 threat had an almost singular focus on how to avert cases and the direct harms of COVID-19 disease on populations. Yet, as detailed above, we know from past epidemics and the evolving evidence around the novel coronavirus that the pandemic and various response approaches carry significant indirect effects on health and well-being (Brolin et al. 2016; Elston et al. 2017; Chi et al. 2020; Krubiner et al. 2020). Below, we present the evolving evidence around select indirect health impacts for women and girls and the drivers that may be contributing to gendered collateral health impacts as countries respond to the COVID-19 threat, using the conceptual framework to examine how COVID-19 disruptions and shocks create or exacerbate gendered health impacts and inequities over the near, medium, and long term. We provide a summary of existing evidence as it relates to key health services and outcomes for women and girls, focusing mainly on family planning and maternal care, with some additional examination of HIV services, gender-based violence, and mental health.

A Note on the Nature of the COVID-19-related Evidence on Indirect Impacts

The emerging evidence on the gendered effects of the COVID-19 pandemic has a number of limitations, with myriad challenges in data access, quality, and interpretation. Much of the country-specific evidence comes from rapid response phone surveys, using a variety of sampling frames from convenience samples to random samples of specific subpopulations (e.g., in humanitarian settings), as well as some purposive samples (e.g., refugees or informal workers). Notably, these surveys do not capture data from women who do not own or have access to phones—an estimated 26 percent of women in developing economies—restricting its validity and generalizability (World Bank 2017).

Some evidence on indirect health impacts draws upon larger datasets from national routine health information systems and administrative data from vertical programs. However, many health information systems experienced disruptions and delays in data collection activities as stringent response measures were put in place. Missing data and delays in reporting pose challenges in interpreting the timing and magnitude of health care disruptions and adverse impacts on key indicators. Analytical methods also varied in reported studies, with some using direct comparison to the same period in previous years, some estimating expected utilization based on upward trends over past years, some pre-post analyses and others using interrupted time series. Like always, the analytical approach, as well as the quality of the underlying data, must be considered when interpreting findings. Drawing upon multiple data sources to triangulate findings and conducting sensitivity analyses can help improve our understanding of the timing, nature, and magnitude of indirect effects to better inform

appropriate policy responses. It should also be noted that many studies produce aggregate assessments of indirect impacts, which may be masking how the collateral impacts of COVID-19 are affecting the health and wellbeing of the most marginalized and disadvantaged women and girls, as highlighted by a few referenced studies. Moving forward, it will be important to understand the diversity of service disruption across and within countries, applying an intersectional approach and zeroing in on the risk of worsening disparities for specific regions and sub-groups, each with unique health needs and priorities.

Additionally, because we are only one year into the pandemic and both the epidemiological situation and response measures continue to evolve, the available data only provides insights into the most immediate indirect impacts of the pandemic on women and girls' health. Moreover, some harmful exposures—including undernutrition, loss of schooling, and sustained poverty—will have health impacts that extend far beyond this current pandemic crisis. Also, as noted in the context of Ebola, the strain of the pandemic on various aspects of the health system—including the disproportionately female workforce—can have long-ranging implications for maintaining gains and continuing progress on key objectives for SRHR and gender equity in health (Evans et al. 2015).

What Are the Observed and/or Predicted Indirect Health Effects as They Relate to Gender Equality?

Access to and utilization of contraceptive and abortion services

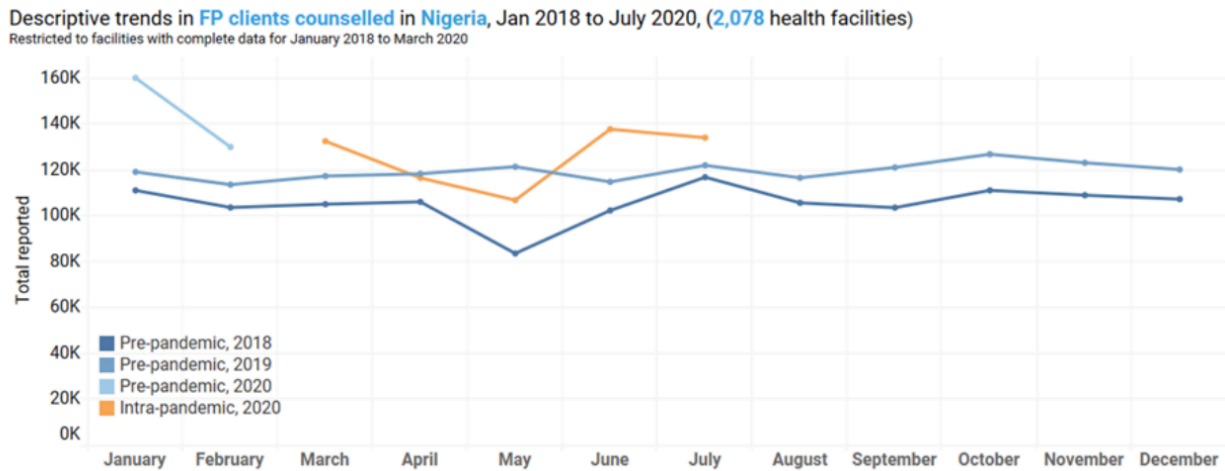
Since the beginning of the pandemic, there have been significant concerns about how COVID-19 would impact progress in the family planning space. Early projections from the Guttmacher Institute warned that a 10 percent reduction in access to short- and long-term reversible contraceptives would result in an additional 49 million women with an unmet need for modern contraception in LICs and MICs and an additional 15 million unintended pregnancies, alongside more limited access to safe abortion services (Ahmed and Cross 2020). The United Nations Population Fund (UNFPA) projected that, depending on the level of service disruption, just three months of lockdown could result in 13–44 million women losing access to modern contraceptives, with unmet need and unintended pregnancies increasing dramatically with the duration of lockdown and service disruption (UNFPA 2020a). In August 2020, Marie Stopes International cited data that 1.9 million women and girls lost access to contraception and safe abortion services during the first half of the year across 37 countries as a result of COVID-19 (Marie Stopes International 2020).

Nearly a year into the pandemic and its various response measures, documented disruptions to and impacts on SRHR show highly variable effects across national and subnational settings, with assessments relying on a variety of data sources and methods to understand the magnitude, nature, and duration of impacts since the emergence of SARS-CoV-2. A recent analysis of service volumes from January 2018–July 2020 across eight sub-Saharan countries estimated significant monthly reductions in family planning consultations in four countries, with Mali experiencing the most severe and long-lasting disruptions with a cumulative reduction of 17 percent between March and July (Shapira et al 2020). Below, we present

additional snapshots of the emerging evidence on disruptions and impacts on contraception and abortion access in select countries, recognizing that countries had highly variable epidemiological situations as well as different levels and duration of stringent response strategies:

- **India:** Data from India's health management information system (HMIS) suggest marked decreases in various contraceptive methods between December 2019 and March 2020, with the number of injectable contraception-first doses given decreasing by 36 percent, IUD insertions down 21 percent, distribution of oral contraception reduced by 15 percent, and a 23 percent reduction in condom distribution during this period (Vora et al. 2020). Safe abortions also dropped by 28 percent, which in part may be due to disrupted access to medical versus surgical abortions during the response (Vora et al. 2020). Although there were issues with some of the data collection during this period, more recent data from the HMIS continues to indicate drops in utilization when comparing the April-June period between 2019 and 2020, with a -28.2 percent drop in IUD insertions; -8.3 percent reduction in oral pill users; and -18.8 percent drop in condom users (India Ministry of Health and Family Welfare 2021).
- **Nigeria:** The Global Financing Facility (GFF) reported a greater than 10 percent decrease in family planning services in April 2020 and a 15 percent decrease in May 2020 (Global Financing Facility 2020a). Interestingly, a Performance Monitoring for Action (PMA) phone survey among women in Lagos before and during the pandemic noted modest changes in pregnancy intention and contraceptive use status, though the vast majority (67 percent) of survey participants aged 15–24 continued to be non-users of contraception (Performance Monitoring for Action 2020a). A similar survey in Kano found that 4 percent of surveyed women discontinued use of contraception during the pandemic while 7 percent started using a method, with 85 percent of women remaining non-users of contraception (Performance Monitoring for Action 2020b). While these figures underscore pre-existing barriers to contraceptive uptake, and a potential lesser role of COVID-related shocks, reported family planning visits during the early months of 2020 had been much higher than previous years, suggesting that the pandemic and lockdowns may have stalled progress on addressing previously unmet family contraceptive need (PATH 2020).

Figure 2. Trends in family planning clients counselled in Nigeria, Jan. 2018–June 2020



Source: HMIS/DHIS2, Nigeria Federal MoH and GFF

Note: 2,078 health facilities total; restricted to facilities with complete data for Jan. 2018–June 2020

- Uganda:** A phone survey noted that 15 percent of health personnel delivering family planning services were reassigned to COVID-19 activities and that 5 percent of facilities suspended services altogether—the majority for a month or longer (Performance Monitoring for Action 2020c).
- Ethiopia:** Data from a referral hospital in the northeast region of the country reported that although facility-based deliveries remained relatively stable during the first 4 weeks of strict prevention measures, family planning visits decreased by more than 95 percent in the same period (Abdela et al. 2020). Another case study from a tertiary referral hospital in Addis Ababa observed a 27 percent decline in patients presenting for family planning services as well as reductions in safe abortion services and comprehensive abortion care by 16.4 and 20.3 percent, respectively, when comparing March–May 2020 utilization data to the same time in 2019 (Belay et al. 2020).
- Kenya:** Preliminary analysis of data from Kenya’s routine health management information system (KHMIS) from January 2019–June 2020 used an interrupted time series to examine changes in aggregate family planning coverage due to the pandemic, with no statistically significant effects on coverage for women of reproductive age (Barasa et al. 2021). Analysis of UNICEF administrative data also indicated less than a 10 percent drop in family services when comparing the third quarter of 2020 to 2019 (PATH 2020). Another analysis of KHIS data looked at utilization of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services from March–June 2020 as compared to the same period the previous year, showing no significant changes in mean hospital visits for family

planning services or post-abortion care (Shikuku et al. 2020). However, there were significant differences in family planning service utilization when disaggregating by repeat contraceptive users versus new clients, with repeat visits up from 53.0 to 56.6 percent ($P < 0.0001$) and new client visits dropping from 47.0 to 43.3 percent ($P < 0.0001$). There were also significant differences in utilization of different contraceptive modalities, with increases in use of injectables (58.2 to 62.3 percent) and combined oral contraceptive pills (13.6 to 14.0 percent) and decreases in use of emergency contraceptive pills (1.7 to 1.6 percent), intrauterine devices (5.9 to 4.2 percent) and implants (16.5 to 13.0 percent).

Access to and utilization of maternal health services

Globally, around 200 million women are pregnant each year, with 90 million giving birth in health facilities. Early on in the pandemic, media reports from several countries—including China, Ethiopia, and Uganda—gave rise to concerns that women’s access to safe and respectful maternal care could be jeopardized as a result of COVID-19 and various response measures (Stevenson 2020; Marks 2020; Biryabarema 2020). The Guttmacher Institute estimated that a 10 percent reduction in service coverage of essential pregnancy-related and newborn care could result in an additional 28,000 maternal deaths, 168,000 newborn deaths, and millions of major obstetric and newborn complications (Riley et al. 2020).

Emerging country-level data are mixed in reported impacts (Baral et al. 2021). There is reason to be hopeful that the impacts are not as bleak as initially projected, with some countries reporting facility-based deliveries as relatively stable or only experiencing modest or short-lived declines before rebounding. For instance, administrative data from HMIS/DHIS2 systems in India and Nigeria suggest many delayed or forewent first antenatal care visits (ANC), with steep declines during the early lockdown months before utilization bounced back to normal or higher levels in subsequent months (PATH 2020). However, other reports show moderate to more dramatic reductions in ANC visits, attended births, quality of intrapartum care, and rises in adverse pregnancy outcomes. A recent analysis of service volumes from January 2018–July 2020 across eight sub-Saharan countries found significant reductions in institutional deliveries in four countries, ranging from 2 percent reductions in DRC to more sustained reductions in Nigeria and Mali between 7 and 11 percent (Shapira et al 2021). Seven of the countries experienced significant declines in antenatal care initiation and attendance at first and fourth visits. Reduced utilization of antenatal care may have further downstream implications on pregnancy complications, as well identification and management of women’s other health needs, including timely diagnosis of HIV and initiation of treatment and prevention of mother to child transmission.

- **Kenya:** One analysis of KHMIS data from January 2019–June 2020 showed no significant changes in facility-based deliveries or ANC visits associated with COVID-19 (Barasa et al. 2021). Another analysis looking at utilization between March and June 2019 reported no significant changes in hospital attendance for antenatal care (ANC) or facility-based deliveries but noted a reduction in hospital attendance in April 2020 for all hospital services followed by a sustained increase in

May and June 2020 for antenatal care, returning to pre-COVID levels (Shikuku et al. 2020). While the overall maternal mortality ratio was not significantly different from the prior year, there was a statistically significant increase in the proportion of adolescent maternal deaths, rising from 6.2 to 10.9 ($p=0.009$). Various counties have also experimented with innovative strategies to overcome transport barriers for pregnant women to ensure they are able to access assisted deliveries, particularly at night while curfews were in place (Wangamati and Sundby 2020).

- **Nepal:** A large-scale prospective observational study followed over 20,000 pregnant women between January–May 2019 and found a 52 percent decrease in institutional births coupled with increased neonatal mortality rates and reduced quality of intrapartum care during COVID-19-related restrictions (KC et al. 2020). A number of these observed impacts were unequally observed for disadvantaged ethnic groups.
- **Myanmar:** Surveillance data reported by the Ministry of Health and Sports (MoHS) provides evidence on coverage of antenatal care registration and immunization of pregnant women for April and May 2020 relative to January 2020 (prior to any COVID-19 restrictions) (Headey et al. 2020). The data show sizeable reductions in antenatal care registration in April 2020, with a recovery to normal levels by May. Immunization for tetanus-diphtheria during pregnancy reduced substantially, with very limited recovery in May—suggesting that antenatal care visits may have been delayed or foregone, with broader implications for missing maternal immunizations and antenatal folic acid supplementation.
- **India:** A retrospective analysis of pregnant women across four tertiary hospitals in western India during the 10 weeks after lockdown as compared to 10 weeks before lockdown reported significant increases in in-hospital mortality among pregnant women (0.20 percent post-lockdown vs 0.13 percent pre-lockdown; $p=0.01$) and late intrauterine fetal death and stillbirth (3.15 vs 2.25 percent; $p=0.02$). Additionally, the reduced hospitalizations of pregnant women for labor and delivery at tertiary facilities suggest increases in unattended deliveries (Kumari et al. 2020). Another prospective observational study at a tertiary facility in Jodhpur reported a 45.1 percent drop in institutional deliveries ($P<0.001$), a 7.2 percent increase in high-risk pregnancies, and 2.5-fold rise in ICU admission of pregnant women, comparing the period of April 1–August 31, 2020 to the pre-COVID-19 figures between October 2019–February 2020 (Goyal et al. 2020).

Access to and utilization of HIV services

Early reports of disrupted access to HIV testing and treatment gave rise to concerns about how COVID-19 could set back hard-fought gains in the HIV response. Some modelling projected that severe disruptions in antiretroviral therapy (ART) in high-burden settings could increase HIV deaths by 10 percent over the next 5 years (Hogan et al. 2020). The HIV Modelling Consortium estimated that severe and prolonged treatment disruptions in sub-Saharan Africa could lead to an additional 296,000 HIV deaths within a year (Jewell et al. 2020). While recent UNAIDS data suggests disruptions to HIV treatments services may not

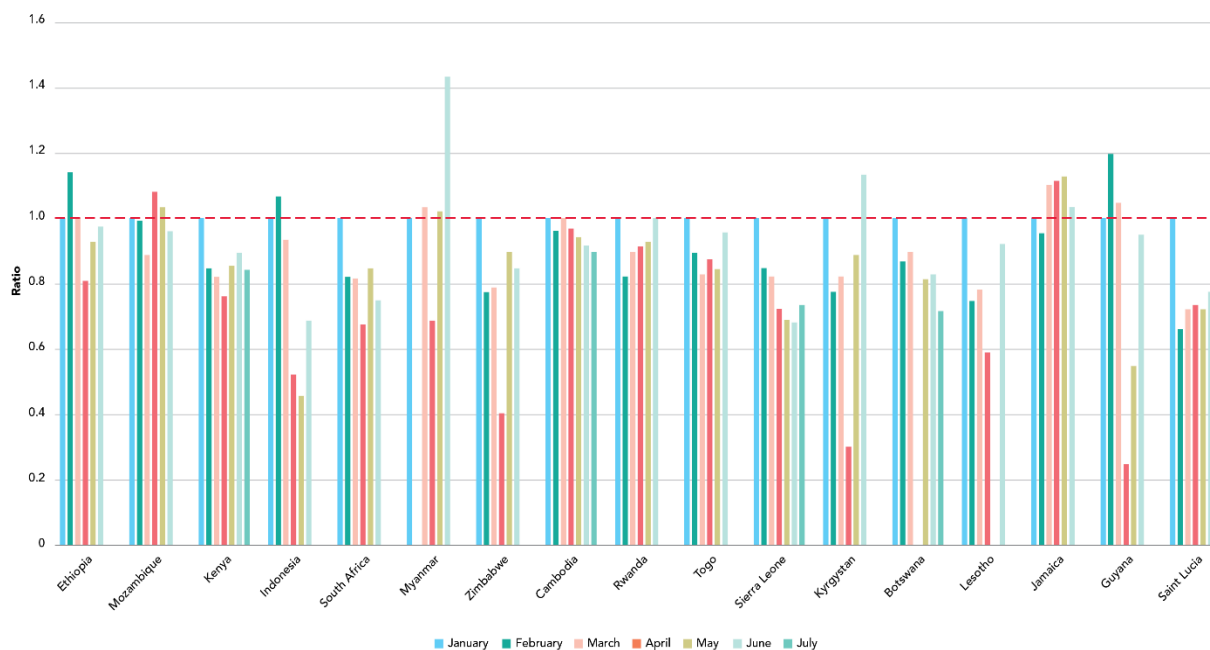
be as severe as initially predicted³—particularly in places that had adopted multi-month dispensing prior to or during the pandemic—monthly reports on diagnostic services showed significant declines in HIV testing across almost all countries with available data (UNAIDS 2020a; UNAIDS 2020b). This has particular relevance for young and adolescent girls, who already accounted for one out of every four new infections in sub-Saharan Africa in 2019 despite making up only 10 percent of the total population (UNAIDS 2020c). The combination of new exposures to sexual violence and increased economic pressures to engage in transactional sex during the COVID-19 pandemic, alongside delays in HIV diagnosis and care, pose especially concerning threats to women and girls living with or at risk of contracting HIV.

Additionally, there are related concerns where antenatal care is delayed or foregone, given that antenatal care visits are a core part of the strategy to diagnose HIV in pregnancy, initiate treatment for women as well as for prevention of mother-to-child transmission (PMTCT), and connect HIV-negative pregnant women with preventive services. As of August 2020, UNAIDS, the World Health Organization and United Nations Children's Fund had collected data on the prevention of vertical transmission of HIV from 43 countries, of which 17 countries had sufficient data to analyze trends (UNAIDS 2020d). The report noted that *“All countries except Mozambique and Jamaica experienced declines in women tested for HIV at their first antenatal clinic visit in April compared to January. By June or July, 14 of the 17 countries were back to the February level of testing (all except Indonesia, Botswana and Sierra Leone). Among the 15 countries reporting on treatment among pregnant women living with HIV, all but five have recovered to the February numbers of women receiving treatment (except Botswana, South Africa, Sierra Leone, Togo and Guatemala).”* (See figure below for country data on HIV testing in antenatal care between January and July 2020.)

With regard to prevention services, one study in South Africa examined impacts of COVID-19 lockdowns on the utilization of pre-exposure prophylaxis (PrEP) among pregnant and post-partum women (Davey et al. 2020). When examining study visits and prescription refills among the 414 women who had initiated PrEP, the investigators found that whereas 34 percent of women missed visits before lockdown, this figure rose to 57 percent during lockdown [OR 2.36; 95 CI 1.73–3.16].

³ The report calculated treatment disruptions by calculating the ratio of people on treatment as compared January 2020 levels. Because many countries use a three-month lost-to-follow-up definition, those who lost access to treatment in April or May would still be counted as on treatment until July or August. This may be masking short-term disruptions in treatment access and undercounting treatment disruptions that occurred later in the observation period.

Figure 3. Ratio of the number of pregnant women tested for HIV at antenatal care, subsequent months versus January



Source: UNAIDS 2020a

Violence against women and children

As of December 2020, Peterman and O'Donnell (2020) reviewed 74 papers documenting the impact of the pandemic on violence against women and children (VAW/C).⁴ Nearly half of the studies reviewed (45 percent) found an increase in violence against women during COVID-19, and another 25 percent reported mixed results with an increase in at least one measure of violence, confirming initial hypotheses around violence as a 'shadow pandemic' in the COVID-19 context, while service providers report facing additional constraints to supporting survivors (Peterman and O'Donnell 2020). Where studies observe mixed findings or decreases, underreporting, especially by children, may account for results—a cause for concern as victims are less able to report violence and seek help under lockdown conditions. Studies explore risk factors or other dynamics around VAW/C in the COVID context, highlighting economic stressors, low social support, lack of employment, substance use, poor mental health, and younger age as salient risk factors associated with intimate partner violence (IPV) and parenting stress, job loss, and lack of support and perceived control as salient risk factors associated with violence against children, in diverse settings. This evidence is consistent with how VAW/C has increased in past pandemic and crisis contexts, although to date, studies primarily rely on small and non-representative samples (Peterman et al. 2020; Peterman and O'Donnell 2020).

⁴ As of March 2021, we have collected over 130 papers on VAW/C in the COVID context. See <https://drive.google.com/file/d/1w28pmDt-lOlcI9cvaUdAMVVDzftOi1-/view>.

Impacts on mental health

In an EMERGE review of 98 studies across diverse geographic settings that compared mental health status and outcomes between men and women during the COVID-19 pandemic, over 80 percent (n=82) indicated that women were experiencing greater adverse mental health effects, (with some of these effects likely driven by the fact that women had higher risks of stress and anxiety than men prior to the pandemic) (Center on Gender Equity and Health 2021). These included higher levels of stress, anxiety, depression, and fear of COVID-19 among women than men. These findings have been corroborated by a meta-analysis of mental health outcomes examining 68 studies across 19 countries that found women had higher odds of anxiety and depression (Wang et al. 2020). These reviews also highlighted several studies indicating disproportionate mental health impacts among female health workers as compared to their male counterparts, as well as exacerbated mental health for pregnant women during the pandemic.

These findings represent only a subset of the ways in which COVID-19 is producing gendered indirect health impacts for women and girls across different areas of health and health care, relying largely on publicly available data documenting impacts on services particularly relevant to women and girls, and in rarer cases, gender disaggregated data from broader datasets.

Based on the available evidence on gendered indirect health impacts of the COVID-19 crisis, there are at least three phenomena occurring at country level for different services: (1) significant disruptions to existing services, with varying magnitude and duration of disruption; (2) minimal, short-lived, or statistically insignificant disruptions to services and utilization with relatively good coverage in the pre-pandemic period, associated with the nature and stringency of response measures as well as efforts to maintain or adapt service offerings during crisis; and (3) minimal disruptions observed due to low coverage and utilization prior to the pandemic, making the COVID-19 shock fairly minor in comparison to pre-existing access and quality issues.

To supplement the findings above, we also drew upon the *2019 Lancet Series on Gender Equality, Norms, and Health* to map various documented disruptions to the “Gendered Pathways to Health” to better understand how gender norms, biases, and inequalities may be moderating the impact of the COVID-19 crisis as it relates to differential exposures to health risks, changes in health behaviors, impacts on access to health care, gender-biased experiences within the care setting, and other gender biases in how research and data collection are being done during the pandemic (Heise et al 2019). The following presents a collective, though not exhaustive, list of cited COVID-19 impacts contributing to gendered indirect health effects:

Gender-related differences in exposures

- Disproportionate female health workforce face added psychological distress or physical abuse (Center on Gender Equity and Health 2021)
- Increased exposures to GBV (Peterman and O'Donnell 2020)
- Food insecurity and undernutrition (Fuhrman et al. 2020; Malghan and Swaminathan 2020)
- Psychosocial stress associated with social restrictions (Wangamati and Sundby 2020)

Changes in health behaviors

- Avoidance of health facilities due to fears of the virus (Vora et al. 2020; Performance Monitoring for Action 2020c; Goyal et al. 2020; Nagarajan 2020)
- Changes in pregnancy intention, sex behavior, frequency and number of sexual partners (Performance Monitoring for Action 2020a; Li et al. 2020; Kimani et al. 2020)

Impacts on access

- Limited transportation during lockdowns (Vora et al. 2020; Performance Monitoring for Action 2020c; Wangamati and Sundby 2020; Goyal et al. 2020)
- Limited human resources for health, including providers diverted to COVID-19 activities (Vora et al. 2020; Performance Monitoring for Action 2020c)
- Stockouts and supply chain disruptions (Narayan et al. 2020; FinMark Trust n.d.b)
- Reduced care-seeking due to economic constraints, often combined with increased financial dependence on males (Performance Monitoring for Action 2020a; Performance Monitoring for Action 2020b; Performance Monitoring for Action 2020c; FinMark Trust n.d.a; GFF 2020a)
- Partner disapproval of care-seeking (Performance Monitoring for Action 2020c)
- Facilities closed or hours reduced (Performance Monitoring for Action 2020c)

Gender-biased health systems

- Restrictive policies around birthing partners and departures from respectful maternal care (KC et al. 2020)
- Suspension of “non-essential” services during the epidemic, including certain SRHR services (Dutta et al. 2020)
- Reliance on disproportionate female health workforce, particularly in lower-level positions
- Women perceive or experiencing longer wait times to see a doctor and have more difficulty in accessing medical supplies and products (Performance Monitoring for Action 2020c; CARE 2020)
- Reliance on telehealth and e-health adaptations overlook gender gaps in mobile and internet use (Galle et al. 2020)

Gender-biased health research, institutions and data collection

- Lack of sex-disaggregated data for many health indicators of interest

Additionally, a recent PATH report used Premise/Ipsos survey data to examine primary barriers to accessing health services across their 5 study countries, disaggregating by sex (PATH 2020):

Table 1. Reasons respondents were not able to access needed care from March to June 2020, by sex

Reason	Burkina Faso		Ethiopia		India		Kenya		Nigeria	
	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)
Health facility closed	58.3	37.5	38.1	23.3	47.8	36.1	20.6	28.6	16.9	28.1
Turned away from health facility	16.7	20.5	14.3	23.3	17.4	20.9	14.2	14.7	13.0	12.3
Treatment or tests unavailable	12.5	13.0	14.3	16.5	10.9	13.1	11.6	26.6	11.7	18.1
Unable to access due to lockdown restrictions	0	1.0	0	4.5	6.5	7.3	6.4	5.2	7.8	6.1
No transportation	8.3	3.2	4.8	9.8	2.2	6.8	4.3	2.4	0	9.2
Lack of money	4.2	11.2	9.5	9.0	2.2	6.3	9.9	9.5	20.8	15.0
Partner or family does not approve	0	1.2	0	0	0	0.5	0.7	0	1.3	0.6

F = female; M = male.

Source: PATH (2020)

What are Donors and Policymakers Doing in Response?

Drawing upon evidence from past crises, researchers and advocates have expressed concern that policies and financing packages aimed at responding to COVID-19's health, social, and economic impacts will be gender-blind, ignoring the unique needs and constraints of women and girls and risking their exclusion from benefits (Wenham et al. 2020). In an effort to move quickly to respond to pandemics' immediate health effects, donors and governments may have placed a priority on expediency to the detriment of inclusion, in particular risking the disruption of other essential health services upon which women and girls rely. Here we seek to explore the extent to which COVID-19 response measures are designed intentionally to either mitigate the risk of or address the disruptions discussed above—those related to contraception and abortion, maternal health, HIV, gender-based violence and/or mental health.

Review of Governments' COVID-19 Response Efforts

National governments have sought to maintain the provision of essential health services through modifications that fit the COVID context. These include multi-month medication delivery and dispensing, bolstering community health worker capacity, harnessing private sector care, ensuring dedicated treatment spaces, delivering health information through digital tools, and information, communication, and education initiatives about where and how to safely seek care (Krubiner et al. 2020). For example, Kenya, Uganda, Tanzania, Zambia, and Zimbabwe have all implemented the WHO's recommendation to relax contraceptive prescription requirements and provide multi-month supplies for oral, self-injectable, and emergency contraception (Mubiru and Fischer 2020). Further, Kenya rolled out community-based distribution of pills and condoms and offered new guidance for continued provision of injectables and other methods in private drug shops. Uganda has also increased community-based distribution and Tanzania has recommended emergency contraception be available at all pharmacies.

To get a more comprehensive understanding of governments' efforts to maintain or bolster essential health services during the COVID crisis, as well as identify gaps, we rely on two policy trackers: the COVID-19 Essential Health Services Policy Tracker, created by PATH in collaboration with WHO, and the COVID-19 Global Gender Response Tracker, created by the United National Development Programme (UNDP) in collaboration with UN Women.

Findings from the PATH tracker reviewing (at least) 200 documents from 119 countries.⁵ In reviewing these policy documents, PATH categorized country efforts to maintain access to essential services along the following lines: (1) continuation of service with additional adaptation (e.g., telehealth, multi-month dosing, reconfiguring intake at facilities); (2) continuing services with Infection Prevention & Control (IPC); (3) reducing or halting health services; (4) no mention of health service. The findings are summarized in the table below, highlighting any specific adaptations mentioned in policy documents.

The policy documents reflect that many countries are continuing to offer essential services, relying on adaptations such as telehealth, reduced facility-based care or shorter hospital stays in favor of community or home-based care, use of scheduling systems to space out appointments, and multi-month dispensing of medications—with many more relying solely on IPC to reduce the COVID-19 risk. However, many countries have internal inconsistencies between different policy documents and guidelines, and adaptations are either unspecified or overly reliant on telehealth measures that may not reach populations without adequate mobile phone or internet access. Moreover, these documents do not reflect the implementation of recommended adaptations and IPC measures. Compared to maternal care and contraceptive services, guidance on provision of HIV and STI testing and care in the pandemic appear to be disproportionately overlooked in available policy documents.

⁵ Count available as of August 28, 2020. Review has likely continued to cover more countries' policies, but exact figures are unavailable.

Table 2. Country efforts to maintain access to essential health services during COVID-19

Service (# Policies)	Continue with Adaptation(s)	Continue with IPC	Reduce or Halt	No Mention
Contraception (13)	Argentina Burkina Faso India Kenya± Lesotho Zambia <i>e.g., telehealth, mobile clinics, multi-month supply</i>	DR Congo Ecuador Ethiopia Nigeria Pakistan	South Africa* * recommend postponing sterilization procedures	Botswana
Safe Abortion (16)	Burkina Faso* India± Lesotho South Africa <i>*CHWs and mobile units for counselling</i>	Argentina DR Congo Ethiopia Kenya Nepal Nigeria		Botswana Ecuador Ghana Pakistan Uganda Zambia
ANC (26)	Algeria, Argentina, Botswana, Burkina Faso±, Honduras, India±, Kenya±, Morocco, Myanmar, Nepal±, Peru, Philippines, Senegal, Sierra Leone, South Africa±, Uganda±, Zambia <i>e.g., telehealth</i>	Bolivia, Costa Rica DR Congo Dominican Rep. Ecuador Ethiopia± Pakistan		Tanzania Turkey
Labor & Delivery (29)	Algeria, Argentina, Botswana, Burkina Faso±, Costa Rica, Morocco, India, Kenya, Lesotho, Myanmar, Nepal±, South Africa±, Philippines, Uganda±, Zambia <i>e.g., shorter length of stay post-delivery, support for home births, PPE guidance</i>	Bolivia, DR Congo, Dominican Rep., Ecuador, Ethiopia, Ghana, Honduras, Nigeria, Pakistan, Senegal, Tanzania, and Venezuela		Peru Turkey
STI Testing (25)	Kenya* South Africa <i>*Appointment system</i>	Uganda		Algeria, Argentina, Chad, Burkina Faso, Cote d'Ivoire, DR Congo, Ecuador, Ethiopia, Guinea, Honduras, India, Lesotho, Liberia, Nepal, Niger, Pakistan, Peru, Sierra Leone, S. Sudan, Tanzania, Zambia, Zimbabwe

STI Treatment (25)	India* South Africa <i>*3-month supply, home visits, telehealth</i>	Ethiopia Kenya Uganda	Algeria, Argentina, Burkina Faso, Chad, Costa Rica, Cote d'Ivoire, DR Congo, Ecuador, Guinea, Honduras, Liberia, Nepal, Niger, Pakistan, Peru, Sierra Leone, S. Sudan, Tanzania, Zambia, Zimbabwe
HIV Testing (26)	India± Kenya± Liberia South Africa Uganda± Zambia <i>Adaptations unspecified</i>	Burkina Faso Sierra Leone Zimbabwe	Algeria, Argentina, Chad, Costa Rica, Cote d'Ivoire, DR Congo, Ecuador, Ethiopia, Guinea, Honduras, Lesotho, Nepal, Niger, Pakistan, Peru, S. Sudan, Tanzania
HIV Treatment (27)	Cote d'Ivoire, Kenya, Peru, Sierra Leone, South Africa, Uganda±, Zambia, Zimbabwe	Burkina Faso Ethiopia India Tanzania	Algeria, Argentina, Chad, Costa Rica, DR Congo, Ecuador, Guinea, Honduras, Lesotho, Liberia, Nepal, Niger, Peru, Pakistan, S. Sudan
GBV (9)	Afghanistan± Lesotho Pakistan* Uganda± <i>*record monitoring system to link districts to provincial & federal teams</i>	DR Congo Ethiopia India Kenya Zambia	
Mental Health (19)	Afghanistan±, Algeria, Argentina±, Costa Rica, Ecuador, India±, Kenya, Nepal, Peru, Tanzania, Thailand, Zambia <i>e.g., telehealth, less inpatient services, HCW services</i>	Burkina Faso Dominican Rep. Guatemala Pakistan Uganda	Liberia, S. Sudan Suriname

± *inconsistent guidance across policy documents*

The United Nations Development Programme (UNDP), with substantive leadership and technical contributions from UN Women, is tracking the extent to which COVID-19 policy responses from national governments and territories are gender-sensitive—defined as “seeking to directly address the risks and challenges that women and girls face during the COVID-19 crisis” (UNDP and UN Women 2020). Tracked measures include those that relate to economic security and empowerment—labor market measures, fiscal and economic measures, and social protection measures—as well as those aimed at reducing the risk of violence against women and supporting survivors. To date, the tracker

has not incorporated an explicit focus on policy measures aimed at addressing the full range of the crisis' indirect health impacts, but we do see a handful of policy response measures reflected aimed at addressing these effects.

Most systematically documented are policy responses aimed at addressing violence against women and girls (VAWG). Of the 2517 measures reflected in the tracker, 704 measures across 135 countries seek to address VAWG. This constitutes 71 percent of all gender-sensitive policy measures the tracker documents (992 total across 164 countries and territories). Most of these measures (63 percent, or 447 in 121 countries) are focused on supporting survivors, whether through establishing, preserving, or expanding access to helplines and other reporting mechanisms, shelters, or police and court systems. Fewer measures aim to raise awareness about the increased risks of VAWG during the pandemic and how to seek help (126 measures in 88 countries) or to collect and harness data to inform policies to counter VAWG (41 measures across 36 countries). The tracker shows that only 55 measures across 48 countries have treated services to respond to and prevent VAWG as essential.

Measures to address other indirect health impacts are not systematically documented in the UNDP tracker, but some are reflected. For example, Algeria opted to expanded coverage of social security to deliveries in private maternal health facilities, perhaps recognizing that this flexibility would reduce risks of disruption should public facilities be overburdened. Costa Rica adapted a program that provides information regarding sexual and reproductive rights to be virtually accessible. Rwanda removed its usual 1-month waiting period for community-based health insurance to allow faster access to family planning, antenatal and postnatal care, and skilled birth attendance. Uganda's Ministry of Health established a COVID-19 Essential Services Committee and with the support of UNFPA has worked to prioritize integrated GBV/SRH/HIV services as part of the essential service package in COVID-19 case management.

Both the PATH and UNDP trackers provide valuable information on the extent to which governments are prioritizing the continuation and/or adaptation of essential health services during the pandemic. Going forward, these tools should be maintained—and can be strengthened in a number of ways. The PATH tracker, for example, could benefit from integration with a PATH framework that assesses service delivery adaptations on effectiveness, feasibility, acceptability, and sustainability (see Table 3). The framework finds that integration at point-of-care using a “one-stop-shop” model for service provision is most promising, alongside moving services closer to homes and communities and novel catch-up activities—and mapped against tracker data could shed light on the extent to which countries are adopting evidence-based approaches to ensure health systems' resilience.

Table 3. Potential impact of service delivery adaptations

	INTEGRATION AT POINT OF-CARE	HOME- AND COMMUNITY-BASED DELIVERY OF MEDICINES AND COMMODITIES	MULTI-MONTH PRESCRIBING AND DOSING	EXPANDING HOME-BASED VISITS BY CHWS AND CHVS	TELEMED
Effectiveness	High	High	High	Variable	Variable
Feasibility	Moderate	Low	Moderate	Moderate	Low
Acceptability	High	High	High	High	Moderate
Sustainability	Moderate	Low	Moderate	Moderate	Moderate

Source: PATH 2020.

The UNDP tracker can take an even more comprehensive approach to document gender-sensitive policy responses in the COVID-19 context by including an explicit focus on the crisis’ indirect health impacts and how governments are seeking to address them. At this stage, both trackers reflect governments’ policy commitments but do not include information on implementation, so additional research will be needed to gauge the extent to which policies are effectively implemented to continue/expand the provision of essential health services.

Review of Donor Institutions’ COVID-19 Response Efforts

We also review MDBs’ project appraisal documents (PADs) and other relevant resources found through a desk-based review to shed light on the extent to which donors’ COVID-19 response efforts to date sought to address the indirect health impacts of the crisis on women and girls. Overall, we find that donor institutions are working to protect and promote equitable coverage of essential health services, including sexual and reproductive healthcare, in the COVID-19 context through knowledge generation and sharing, modifying existing programs to adapt to the COVID-19 context, and launching new investments to address COVID-specific challenges.

Knowledge generation and sharing: First, donor institutions have collected and analyzed data to assess the effects of COVID-19 on women’s and girls’ health outcomes, as well as on their program operations and related resource shortfalls. To better understand women’s and girls’ health experiences, challenges, and needs in the face the outbreak, some global health institutions are leaning on their existing data systems, while concurrently undertaking new data collection efforts. For example, the GFF is helping countries to monitor service delivery levels using administrative data as well as data collected through rapid health facility phone surveys (Ahmed et al. 2020). Similarly, UNFPA launched a COVID-19 Population Vulnerability Dashboard to provide decisionmakers with access to information on at-risk

populations to target preparedness and response using census data and population estimates (UNFPA 2020b). The Global Fund’s regular COVID-19 situation reports provide updates on service delivery disruptions to HIV, TB, and malaria programs (Global Fund 2020a). Global Health 5050 compiled a sex-disaggregated data tracker with country-level data on cases, deaths, hospitalizations, and outcomes among healthcare workers—although this effort excludes gender-specific impacts of COVID-19 on non-COVID health threats (Global Health 5050 2021). The WHO also released a tool in January 2021 for analyzing and monitoring routine health information to assess impacts of COVID-19 on essential services, with recommended indicators for RMNCAH-N (WHO 2021).

One particularly important area for data and visibility to inform decision-making is resource tracking, which helps governments to identify financing gaps, efficiently allocate resources, and assess the impact of the pandemic on essential service delivery. Support for these functions can build sustainable decision-making capacities and lay the groundwork for longer-term resilience. Transparency and visibility into funding flows is important to improve the quality of external and domestic financing, including financing and programs to sustain and expand SRH and other health services for women and girls (Madan Keller et al. 2020). For example, GFF’s resource mapping and expenditure tracking (RMET) for COVID-19 leverages a prior area of technical assistance to help governments rapidly collect data on health and COVID-related operational budget commitments, disbursements, and expenditures from various financing sources and implementers across sectors (Global Financing Facility 2020b). Public information is currently available on Burkina Faso, the Democratic Republic of the Congo, and Niger (Global Financing Facility 2020c); dynamic resource mapping from Burkina Faso, for example, identifies a \$26 million funding gap for COVID treatment and care and a \$24 million gap for infection prevention and control, suggesting evidence-based prioritization of resources in these areas—alongside additional advocacy for more external support—is critical to avoid consequences of resource diversion from other areas like SRH.

While numerous platforms to share evidence and synthesize knowledge across countries have taken shape, such as GFF’s community of practice on RMNCAH service adaptations and Family Planning 2020’s convenings on how family planning programs should evolve in the COVID-19 context, more evidence is needed to determine whether knowledge generation and sharing efforts are leading to more effective adaptations in donors’ internal operations or the policy response efforts of governments (World Bank n.d.; FP2020 2020). Our early analysis (reflected below) suggests that donors can go further in ensuring that learnings translate into informed project design, and in particular concrete indicators and targets that track projects’ progress in addressing the crisis’ indirect health impacts.

Launching new investments and adapting existing ones: Donors have made efforts to modify existing programs to ensure their continuity and effectiveness in the COVID-19 context, as well as mobilize new investments to protect and strengthen health systems. To examine new investments, we review relevant documents from the World Bank, the African Development Bank (AfDB), and the Asian Development Bank (ADB) to gauge the extent to which the investments by these institutions between March and December 2020 have prioritized a focus on addressing the indirect health impacts of the crisis, particularly from a

gender perspective. Recognizing that bilateral donor governments may turn inward to address domestic health and economic crises, we prioritize multilateral development banks as institutions most likely to take a lead role in global development response and recovery efforts.

Our initial analysis is limited to projects for which project appraisal documents (PADs) or the equivalent are publicly available.⁶ We plan to supplement our early findings as more are published, recognizing the potential for gender integration to strengthen over time in COVID-19 response and recovery efforts, as well as expand our analysis to projects being rolled out by other institutions.⁷ It also will be important to track the implementation of projects over time to gauge the extent to which disaggregated data is being published and gender-specific targets are being met.

This preliminary analysis focuses on countries eligible for support under the World Bank's International Development Association (IDA), which offers concessional loans and grants to the world's poorest countries, as well as any non-IDA countries reflected as most vulnerable to the crisis from a gender perspective according to the analysis conducted by Data2X and Open Data Watch.⁸ This results in a sample of 77 countries: 74 eligible for IDA support and three additional countries highlighted in the Data2X/Open Data Watch analysis: Angola, Eswatini, and the Ukraine. Overall, we reviewed 195 projects across the three institutions that were related to COVID-19 response and approved between March 1, 2020 and December 31, 2020.

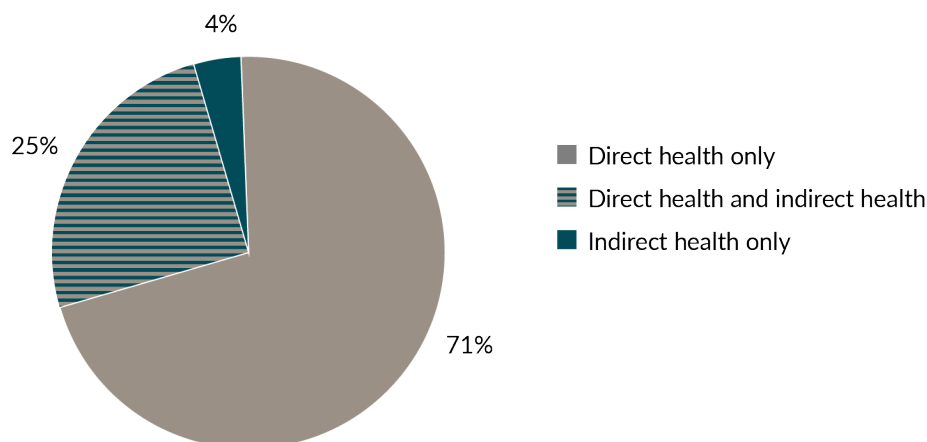
On the whole, we find that the vast majority of new projects approved by the World Bank, ADB, and AfDB in the COVID-19 context aim, at least in part, to address the direct health effects of the pandemic. Of 135 projects with health components, we identify across the institutions—84 from the World Bank, 34 from the ADB, and 17 from the AfDB, we find that the vast majority (130, or 96.3 percent) focus on the direct impacts of the crisis—including through the provision of essential medical supplies and protective equipment, hiring and compensating frontline health workers, and developing health facilities' capacity to test and treat for COVID-19.

⁶ Equivalent documents include program documents (PGDs) for development policy grants from the World Bank, 'Report and Recommendation of the President to the Board of Directors' documents from the ADB, and project appraisal reports from the AfDB.

⁷ Future analysis will seek to explore response efforts of other MDBs and key bilateral donors in the health arena, including FCDO, GAC, and USAID, keeping in mind anticipated shifts in resource allocations (e.g., FCDO's reduced aid budget; the United States' renewed prioritization of SRHR support under the Biden-Harris administration).

⁸ In November 2020, researchers at Data2X and Open Data Watch identified 26 low- and lower-middle income countries where women and girls are likely to be most exposed to the negative effects of the COVID-19 pandemic. These countries are Afghanistan, Angola, Bangladesh, Cabo Verde, Central African Republic, Chad, Congo, DRC, Eritrea, Eswatini, Guinea, Guinea Bissau, Haiti, Malawi, Mali, Mauritania, Niger, Sao Tome e Principe, Solomon Islands, Somalia, South Sudan, Sudan, Tanzania, Ukraine, Yemen, and Zimbabwe.

Figure 4. MDBs' COVID-19 response projects with direct and indirect health components

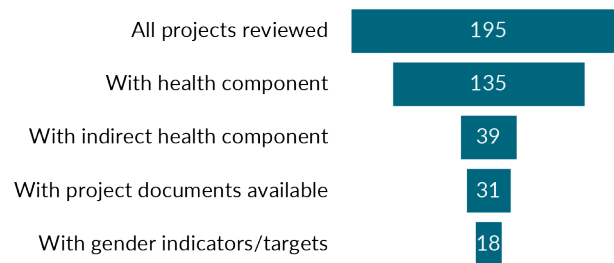


Projects focused on addressing COVID-19's direct health impacts vary in their degree of gender integration. We see that relatively few projects include gender-specific targets or indicators, in spite of the fact that women constitute the vast majority of frontline health workers—those charged with caring for patients diagnosed with the virus—and in spite of gender gaps in those more likely to contract and die of COVID-19, with global data suggesting that men are more at risk for severe cases (Peckham et al. 2020). Where we do see project documents reflecting elements of gender analysis—identifying women's predominance among frontline health workers and risks to their physical and mental health, for example—there are few accompanying indicators or targets that ensure projects will effectively address the gender-specific constraints identified. Of projects addressing direct health impacts of the crisis that have PADs available, less than half (48 percent) have gender-related indicators. This may be due to the rapid nature of response efforts from donor institutions and client countries, with a priority placed on expediency precluding a deep embedding of gender-focused results frameworks.

Only 39 out of 135 total health projects (28.9 percent) contain a component that addresses the indirect health impacts of the COVID-19 crisis, even though indirect health effects are predicted to be worse than direct effects in LICs and LMICs (Chi et al. 2020).⁹ Of these 39 projects, 25 (64.1 percent) are from the World Bank, 11 (28.2 percent) are from the ADB, and 3 (7.7 percent) are from the AfDB. We find that 31 projects (79.5 percent) have project documents available allowing us to gauge the extent to which gender and other forms of inequality have been considered in the projects' objectives, indicators, and targets.

⁹ Projects determined to address indirect health impacts include components that focus on maternal health, child health, sexual and reproductive health, and mental health, among other areas. To identify whether projects included a focus on the pandemic's indirect health impacts, and specifically those where we anticipate gendered impacts, all PADs with health components were searched for the following keywords: *sexual, maternal, MC, SRH, reproductive, contraceptive*, pregnancy, STI, STD, HIV, birth, abortion, mental, women, girl, female, gender.*

Figure 5. MDBs' indirect health projects



Of the 31 projects with project documents available for review, 18 (58.1 percent) include indicators with a gender dimension related to indirect health impacts.¹⁰ From an examination of projects' gender-specific indicators and targets, MDBs are largely tracking progress on protecting and strengthening health systems in the COVID-19 context in three main thematic areas: addressing gender-based violence, maternal health, and broader gender-sensitive health support.¹¹ See Annex B for a full list of relevant indicators and targets.

The projects aimed at addressing GBV include objectives to raise awareness about the increased risk of GBV in the COVID context (e.g., through radio and television spots in the Gambia, Mali, and Niger; radio messages in the Solomon Islands); establish telephone hotlines and other support services (e.g., a national hotline in the Marshall Islands); and those related to frontline health workers identifying GBV cases and making appropriate referrals, including in Ghana and Micronesia.

Projects including maternal healthcare components include indicators and targets focused on deliveries with skilled birth attendants (included in 3 World Bank projects in Comoros, Myanmar, and Uganda), health centers offering caesarian sections (included in a World Bank project in Uganda), and broader objectives to provide adequate, free, and/or uninterrupted maternal healthcare (included in an ADB project in Samoa and World Bank projects in Uganda and Myanmar).

Finally, there are indicators and targets framed around providing broader health support in a gender-sensitive way. For example, an ADB project in Micronesia aims to support 40 community-based COVID-19 proposals that strengthen gender-responsive preparedness in the communities. Other projects aim to ensure that hospitals have “women-friendly” facilities (ADB project in Afghanistan) or provide health (or “dignity”) kits that reach women and girls (AfDB project in Cameroon; ADB project in Marshall Islands).

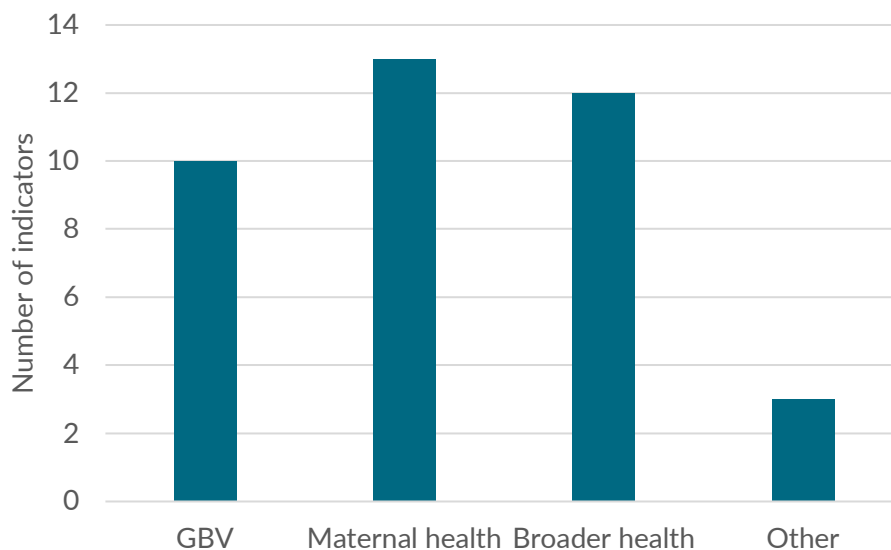
¹⁰ Of the 31 projects with project documents we examine, 10 (32.3 percent) are in countries registered as most vulnerable to the COVID crisis from a gender perspective according to Data2X and Open Data Watch. We find that 6 of these 10 projects include gender-related indicators.

¹¹ We have not included nutrition as a core focus of this initial paper but may explore the gendered dimensions of food insecurity and nutrition in later analyses. We note that 3 World Bank projects (those in Comoros, Ghana, and Myanmar) include the indicator “Number of women and children who have received basic nutrition services.”

We find just two projects that include a target specifically regarding the provision of reproductive health services. The first is an ADB project in the Kyrgyz Republic that aims to preserve the national budget allocation of \$240 million to the Ministry of Health, including for the protection of these services. The second is an ADB project in Afghanistan that aims to develop and implement a resilience strategy for infectious diseases, “including capacity development plan for effective post-COVID-19 use containing provisions to improve access for women to sexual and reproductive health services, as well as support mechanisms for gender-based violence” (ADB 2020). We find nine projects that reference mental health—whether the higher likelihood of women experiencing stress and anxiety due to increased care work responsibilities or the mental health of frontline health workers—but no projects include gender-specific indicators or targets aimed at measuring impacts on individuals’ mental health.

In mapping projects’ areas of focus against the evidence we review above on COVID-19’s indirect impacts, we note a number of gaps to fill. First, with the vast majority of gender-specific indicators and targets falling within the realm of gender-based violence and maternal health, relatively few efforts focus on access to contraception, abortion, and other sexual and reproductive health services. No projects include gender-specific indicators or targets focused on HIV or other STIs or mental health. That said, we note that these efforts may be occurring through other vertical programs, including those explicitly focused on HIV and SRHR that were not the focus of this initial review (i.e., the Global Fund, PEPFAR, UNAIDS, UNFPA). More research is needed to understand the full scope of donor efforts to address COVID-19’s indirect health impacts using a gender lens.

Figure 6. Indirect health indicators’ areas of focus



Finally, donor institutions are also modifying existing programs to ensure continuity during the crisis. For example, in partnership with World Bank and the International Finance Corporation, the GFF is providing additional grant financing and technical assistance for partner countries to prioritize service continuation, strengthen frontline delivery, and address constraints in PPE and other health commodities (Global Financing Facility 2020d). Many of the adaptations to promote resilience discussed above in our review of governments' COVID-19 policy response efforts require additional or repurposed funds from donors to implement. Donor flexibility can help facilitate a rapid response, and many donors such as Gavi and the Global Fund have allowed a small percentage of grants to be reallocated in light of COVID-19, yet other donors have not sufficiently enabled countries to quickly deploy new or existing resources. An analysis by Duggan and colleagues (2020) of World Bank lending in 2020 showed that this lending was not on track to meet disbursement commitments, curtailing the ability of low- and middle- income countries to increase social spending in response to the crisis. Countries need the fiscal space to prioritize inclusive recovery measures; we must keep sight of potential implications for essential health services and ensure that modifications (or diversions where necessary) have their intended health benefit and move us toward longer-term resilience where possible.

What Else Needs to Be Done? Opportunities and Preliminary Recommendations

Our review of the indirect health impacts of the COVID crisis, as well as an examination of the efforts governments and donor institutions have made to date to address these impacts, suggest areas of opportunity for future action. A number of our recommendations are specific to the COVID context, whereas others are perennial. Because so many of the pandemic's indirect health effects amplify pre-existing problems, the pre-COVID evidence on health systems strengthening still applies, both to provide a pathway for an inclusive recovery and for longer-term health systems strengthening to ensure women and girls are equitably reached by and benefit from reforms.

Invest in improving data collection, with explicit attention to gender and intersectional disadvantage. The many gaps and limitations of the current data landscape on the indirect health impacts of COVID-19 underscore the need for deeper investment in health information infrastructures in low- and middle-income countries, with a focus on timely, local, and disaggregated data points to inform how disruptions are being experienced, by whom, and how ongoing response and recovery efforts can address or mitigate these harms. With renewed efforts and investments in strengthening the data infrastructure, including ways to make data collection more resilient in the face of health crises, there needs to be explicit attention to gender differences in how women and girls experience different shocks, harmful exposures, and barriers to accessing care in ways that disproportionately impact near- and longer-term outcomes of health and wellbeing. This at minimum means standardizing the collection of sex- and age-disaggregated data so that women and girls are no longer “conspicuously invisible” in epidemic response efforts, but collecting data on other factors such as location, socioeconomic status, and ethnicity that can compound

disadvantage and gender inequities (Harman 2016; Heidari et al 2020; Dutta et al 2020; Pillay et al. 2020).

Without dedicated efforts to collect and analyze these data, public health response measures and recovery efforts will be unable to address the specific needs of women and girls, perpetuate pre-existing gender biases that favor men as the default, while exacerbating health inequities experienced by the most vulnerable populations. A resource released by the WHO provides some helpful guidance on key RMNCAH-N indicators, how to handle missing data and co-present indicators on data completeness alongside indicators, and important ways to disaggregate along different equity dimensions to understand where the greatest vulnerabilities and adverse impacts are (WHO 2021). Donors and policymakers can ensure that these measures are routinely included in data collection instruments and reports, including those specifically designed for preparedness response plans. As countries improve their health information systems, policymakers and funding partners can ensure that data entry and inputs to centralized databases retain important disaggregated data points to guide policy.

Additionally, data on the impacts of the COVID-19 crisis in low- and middle-income country contexts must go beyond the use of mobile phone surveys to understand COVID-19's health, economic, and broader social effects.¹² Those lacking access to mobile phones are more likely to be living in poverty and may be more vulnerable to health systems disruptions, but policies and programs designed based on data that excludes them will likely be limited in effectiveness. To fill gaps in data collected through mobile phone surveys, donor institutions and the governments they support can prioritize the development and/or strengthening of partnerships with local researchers and community organizations well-positioned to provide insights into the impacts the crisis is having on local populations. There may be further opportunities to move away from paper-based records by supporting greater update of electronic records, including through various mHealth initiatives with CHWs that may simultaneously enable more real-time data collection outside facilities while offering tools and benefits to CHWs and the communities they serve (O'Donovan et al. 2020; Gopalakrishnan et al. 2020).

In the longer-term, investments in stronger data infrastructure, collection, standardization, and visibility are also crucial to hold organizations and governments accountable to using data to inform and adapt their programs and resource allocation; to facilitate shared learning and collective action between governments, development partners, and their populations; to avoid duplicative or incoherent efforts; and to deliver equity-focused support and improve equitable service access and coverage. This includes ongoing investment in routine health information systems, with available sex-disaggregated data, to capture important indicators of interest, with measures to support resiliency and real-time data collection even in the face of epidemic threats. There is also a role for greater investment in mixed methods research to

¹² For example, in partnership with local researchers and financial inclusion institutions, FinMark Trust has undertaken COVID-19 phone surveys in seven countries across Africa to elucidate the impacts of COVID-19 on livelihoods and wellbeing, including access to contraceptives and other medicines (FinEquity 2020).

better understand not just the quantitative observations and trends in service utilization and health outcomes, but qualitative information on the complex drivers of gendered health behavior and facilitators or barriers to access during crises and recovery periods.

Generate evidence on what works to mitigate indirect effects, especially integrated approaches. Despite the review of policy response measures collected by PATH and UNDP, as well as MDB project documents, stating intended plans to sustain essential health services and/or address indirect health impacts, there is still a limited understanding of the implementation of various strategies and adaptations, the cost associated, and their effectiveness. Evaluating the effectiveness of various approaches to protect essential health services amidst COVID-19 is necessary to inform future emergency responses and longer-term recovery and resilience. As mentioned above, there is an opportunity to build on the PATH and UNDP trackers currently collecting and reviewing governments' policy response efforts. These trackers should be maintained, expanded, and further integrated with programmatic evaluations to deepen collective understanding of how what governments are actually doing to address indirect health impacts and the degree to which approaches taken are evidence-based and effectively implemented.

To promote continued learning and accountability among donor institutions, there is an opportunity to build on the initial analysis reflected above through an ongoing review of project documents and a review of corresponding results documents to track implementation over time. Our preliminary analysis focused on a specific set of MDBs operating in IDA countries, but future efforts could expand to review investments made by other donor institutions, including bilateral aid agencies and UN agencies.

Ongoing assessments should evaluate effectiveness, feasibility, acceptability, and sustainability of various adaptations. Perhaps more importantly, because there are multiple, simultaneous shocks and harmful exposures during a crisis that can impact various aspects of women's and girls' health, an important area of future research includes how well programs are integrated at the point-of-service in a "one stop shop" model. One level of integration includes the extent to which services are available to address multiple health conditions or health needs of different family members—recognizing that some services like STI screening and care were less visible in documented response efforts as compared to maternal care. Another level of integration would address how well health adaptations are aligned or paired with other mitigations strategies—like cash assistance, nutritional supplementation, and GBV services and support—making it easier for women and girls to receive complementary benefits and protection that promote their health and wellbeing.

Build on the momentum of health innovations that COVID-19 has generated. The COVID-19 crisis is giving rise to a surge of new locally-adapted innovations and momentum for scale-up of existing innovations, such as self-care SRH products, telehealth platforms, and new product delivery systems—all of which have the potential to enable women and girls to more readily access healthcare conveniently and safely (Hansen Staples et al. 2020; Yadav and Glassman 2019). For example, telepharmacies like Kasha in Rwanda, MedRx in Ghana, and MyDawa in Kenya enable direct-to-consumer delivery that may improve coverage of priority health products (Impact for Health 2019). And Nivi, a digital messaging

platform currently available in Kenya, Nigeria, and India, uses artificial intelligence to provide users with information on SRH products, services, and referrals (Bellows 2020).

However, new digital models and tools need to be integrated into the larger health system to harness their full potential and avoid exacerbating existing inequities. Public financing from governments and development partners to pay for these innovations and other private services is still rare; a recent assessment of private health sector engagement in 18 LMICs found that while 78 percent of these countries contract services through the private sector, just half cover private providers through public insurance and only 28 percent regulate service pricing (Jennings 2021). Leveraging digital platforms requires strategically building pathways for marginalized groups, including adolescents and women in rural and poor urban areas, to sustainably access private options and tools available to wealthier, more educated, and urban populations—with a focus on addressing the gendered digital divide (Hansen Staples and St-Denis 2020; Galle et al. 2020; Kaufman 2020).

Blended funding flows from governments, development partners, and private sector can better connect digital tools with national health systems, potentially channeled through demand-side financing mechanisms to build healthcare around the choices, preferences, and agency of women and girls as users. For example, the MOMS Initiative—a \$50 million collaboration between Merck for Mothers, the US Development Finance Corporation, USAID, and Credit Suisse formed in 2019—provides debt and grant financing to help promising maternal health innovators in sub-Saharan Africa and South Asia to scale (Merck for Mothers 2020).

Leverage health reforms to enhance women’s and girls’ agency, choice and equitable access healthcare recipients and clients. Women’s and girls’ health needs—and importantly their agency, choice, contributions, and leadership—should be prioritized to ensure an inclusive and sustained recovery from the COVID-19 crisis, as well as equity and inclusion in broader health systems improvements. Wherever feasible, support for women’s and girls’ health initiatives should go towards national health systems as opposed to creating parallel systems at the expense of coherent, sustainable financing structures. Overly fragmented operations and funding flows, even when targeted towards specific groups of women and girls, risk undermining cost, access, and equity goals. For example, in Kenya, Linda Mama is NHIF’s reimbursement model for maternal healthcare and one of multiple user fee removal/provider reimbursement schemes. Fragmented mechanisms like Linda Mama risk hindering government efforts to implement comprehensive health system-wide policies. While budget support and the pooling of resources entails less visibility into resource allocation amongst specific products and services, it opens the door to more results-based approaches in which specific coverage, quality, and equity outcomes could be monitored and incentivized.

Given economic crises and severe contraction in public revenues, development partners should support and incentivize governments to protect public spending for—and equitable coverage of—the most cost-effective services, including SRH and contraception. Development partners should promote sexual and reproductive healthcare, including family planning, as part of the universal health coverage (UHC) agenda, as opposed to funding

services predominantly through vertical programs, which can hinder country ownership and sustainability. UHC agendas are an opportunity to advocate for service expansions and equity considerations, such as increasing access to vulnerable groups, in ways that resonate and link with broader health financing policies, especially if informed by continued improvements in local data on the costs and benefits of expansions (Silverman and Kaufman 2021).

It is important to recognize that moving towards UHC is beneficial to, but does not assure equitable, rights-based care (Witter et al. 2017). Rights-based approaches should be prioritized—and can be linked to sustainable resource allocation decisions. Development partners could also consider targeting their resources towards equity-related expansions that are more likely to become cost-effective after generating user demand, paying start-up costs, rolling out provider training, and so on, which can then be taken on by governments after marginal costs are covered (Silverman and Kaufman 2021). Leveraging UHC policies can also allow [strategic purchasing](#) and provider payment approaches to enable broader and more equitable coverage of SRHR services and the ability to link health financing to quality of care and specific results.

Given the severe economic crises facing LICs and MICs, many households will face reduced income to cover OOP healthcare expenses; 80 percent of all contraceptive spending comes from individuals purchasing supplies from private sector entities at non-subsidized prices, with significant implications for equitable access across geographies, age groups, socioeconomic levels, and other factors (Commodity Gap Analysis 2019). [Demand-side financing](#), such as [conditional cash transfers](#), [vouchers](#) and coupons, can help shift purchasing power and autonomy to women and girls as healthcare recipients and be a particularly useful way to empower vulnerable groups to access healthcare (Bowser et al. 2016). For example, a conditional cash transfer program run by New Incentives that gives monetary incentives to mothers or caregivers who vaccinate their children in Nigeria, accompanied by public awareness campaigns and vaccine stock management, has been found to increase immunization coverage (Connor et al. 2020). Further, across recent analyses of 44 LMICs, just 11 countries offer family planning financing through vouchers—despite growing evidence on their effectiveness to flexibly engage private-sector capacity (Eldridge and Hansen-Staples 2018; Bellows et al. 2016).

Specific financing modalities and service delivery approaches should be context-specific and depend on the most significant constraints to equitable service coverage and utilization, whether challenges stem from health worker supply, quality issues, lack of service utilization, or other root causes—further emphasizing the need for more data and evidence on what and where the problems and disparities are.

Prioritize support for women as leaders and providers in the global health workforce (including CHWs). There is a need for more women as leaders within the health sector and an increased valuation of their work (van Daalen et al. 2020; Bali et al. 2020; Women in Global Health n.d.). Although women constitute over 70 percent of the global health workforce, they hold only 25 percent of leadership roles (Boniol et al. 2019). As of August 2020, just 3.5 percent of 115 COVID-19 decision-making and expert task forces attained

gender parity in their membership (van Daalen et al. 2020); 85 percent are majority men. Pre-COVID, very few women worked in SRH supply chains, though initial efforts by JSI, People that Deliver, and the Reproductive Health Supplies Coalition to increase women's representation in supply chains (JSI n.d.).

Beyond ensuring women have opportunities to occupy decision-making and leadership roles in the health sector, women should be safe, supported, and appropriately compensated as healthcare workers, particularly as they are being asked to take on a greater number of tasks while facing the threat of COVID-19 exposure (Kedia et al 2020). A recent WHO report noted that women's unpaid care work comprises approximately half of the \$3 trillion women contribute annually to global health (WHO 2019). Women health workers on the front lines also need adequate protections and support, including from gender-based violence they may face while working. As the pandemic continues, health workers, especially nurses, midwives and CHWs who have been overlooked in PPE allocations, require sufficient and effective personal protective equipment to mitigate the harms they may face on the job, recognizing that some PPE such as masks and gowns may require different sizing for female health workers to be appropriate and effective (O'Donnell and Rick 2020; Nepomnyashchiy et al. 2020). To the extent that there are existing women-led social enterprises in the health space, there could be opportunities to simultaneously enhance economic opportunities for nursing and midwifery enterprises while expanding their capacity to deliver essential services for women and girls (Krubiner et al. 2016).

Elevate women and girls as members of civil society. There is an opportunity to secure a positive legacy of the COVID-19 crisis with regard to promoting open and accountable global health governance by ensuring global health policymaking is informed by the needs and perspectives of women and girls. The Global Fund has signaled that engaging with members of at-risk populations and wider civil society during the crisis is a priority, offering clear guidance on civil society engagement in Global Fund processes (although some CSOs have highlighted their struggle to access resources despite their ability to maintain relationships with vulnerable groups during COVID-19) (Global Fund 2020b; Boulanger 2021). Pre-COVID, Kenya committed to setting aside 30 percent of public procurement opportunities to women, youth, and people with disabilities, and Nigeria committed to increase the participation of women and other marginalized groups across government, but comparable commitments specifically for crisis response have not gained traction (OGP 2020).

Health multilaterals and national governments have the opportunity to prioritize civic participation in efforts to ensure essential services are available to all who need them. Governments and multilaterals should create space for civil society input so that the perspectives and preferences of those most marginalized and affected by the policies themselves are incorporated, potentially building on the Open Government Partnership's recommendations to apply a gender and inclusion lens to COVID-19 response and recovery through gender analysis, intersectional demographic data, digital citizen engagement, protections against gender-based violence, and other measures that place transparency, accountability, and participation at the forefront (OGP 2020). Longer-term, civic participation and engagement can help hold governments accountable to analyze data

disaggregated by gender and other demographic characteristics and use findings to inform service delivery and resource allocation. The 2021 Generation Equality Forum, and especially its action coalition on bodily autonomy and SRHR, offers an opportunity for donor institutions and governments to engage with civil society and formulate concrete commitments collaboratively.

Conclusions

- **COVID-19 amplifies existing vulnerabilities and inequities and stalls progress.** Direct and indirect harms of the pandemic disproportionately affect populations that were previously worse off, often through multiple simultaneous shocks to economic opportunities, health access, and new harmful exposures. This occurs not just at the individual level but also at the systems level, where health systems and facilities with the fewest resources pre-pandemic are least equipped to respond to increasing demand and diverted resources. Building back better will require not just preparedness for next crisis but strengthening systems in the interim and addressing areas with previously unmet need, ideally in ways that will improve equitable coverage and resilience in the face of emerging epidemic threats.
- **There are opportunities to leverage innovation and adaptation to better meet the broader health needs of women and girls, during the COVID-19 crisis and beyond.** As countries experiment with new ways to deliver services during the pandemic and donors explore flexible financial and technical support, there are opportunities to learn what types of adaptations support equity and efficiency in meeting the health needs of women and girls who may be most vulnerable to shocks. Some promising features of integrated service offerings, delivery in community settings, and programs that simultaneously address multiple economic, social, and health shocks in a crisis should be explored further to inform comprehensive solutions that promote women's and girls' wellbeing over the long run. Leveraging these innovations may help resume and accelerate progress on the Sustainable Development Goals related to health and well-being (SDG 3) and gender equality (SDG 5).
- **More and better evidence is needed.** While it is clear that health service disruptions and new exposures occurred as a collateral impact of COVID-19, including those most central to women and girls' health and rights, these effects seemed to vary across contexts and health areas. Moreover, there are a number of limitations on what conclusions can be drawn from different types of evidence, including the extent to which evidence captures the experience of the most marginalized and vulnerable women and girls. There are opportunities to gather better evidence over time, to harmonize indicators and analytical methods across settings, and explore which interventions and service adaptations supported more resilient health service provision and access during the COVID-19 response.

- **Some initial recommendations.** Amid calls to align global health security with UHC, there is also an opportunity to integrate SRHR into UHC to promote efficiency, equity and inclusion while safeguarding against political de-prioritization. Various approaches to demand-side financing can help facilitate choice while addressing economic barriers to access. There is also a clear need to have more women occupying leadership roles and have greater voice in decision-making across the health landscape—as policymakers, providers, patients, and in civil society—to bring a gender lens to various aspects of the epidemic response strategy, supply chain issues, appropriate service provision and adaptations with an eye to gendered effects.

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Annex. Search Methodology for Indirect Effects

The review of the empirical literature entailed systematically combing through relevant academic journals, organizational publications, impact evaluations, policy documents, and meta-analyses for the latest evidence on indirect health impacts relevant to the COVID-19 context (or relevant historical contexts). Some program and case study materials were included as rigorous evidence is scarce at this early stage. The search for resources was conducted in four phases:

1. The search terms listed below were used in the databases listed below. The total number of search results was recorded per database. For databases that do not support long strings of search terms, the list was simplified.
2. In the second round, titles and abstracts were screened for relevance.
3. Finally, the remaining papers were read in full and underwent a final round of screening for relevance. They were excluded if they were not directly linked to the indirect health impacts of COVID-19.
4. The results of the systematic search were also supplemented by resources sent by other researchers and partners or resources found through other bodies of work that had relevance for this review.

Databases/resources searched:

- Gender and COVID-19 Working Group
- JSTOR
- Science Direct
- Director of Open Access Journals
- PubMed
- Google Scholar
- Social Science Research Network
- Wiley Online Library
- World Bank
- WHO
- Cochrane Library
- The CGD Indirect Health Effects Inventory
- FHI360
- GFF
- PMA
- Marie Stopes International
- PSI

Search terms:

(“Women” OR “female” OR “men” OR “male” OR “gender” OR “girl” OR “adolescent”)

AND

(“COVID-19” OR “COVID” OR “coronavirus” OR “pandemic” or “health crisis” or “outbreak”)

AND

(“Women’s health” OR “girls’ health” OR “children’s health” OR “adolescent health” OR “reproductive health*” OR “sexual health*” OR “sexual and reproductive health*” OR “SRH*” OR “contraception” OR “contraceptive*” OR “unintended pregnanc*” OR “unplanned pregnanc*” OR “unwanted pregnanc*” OR “family planning” OR “unmet need” OR “LARC” OR “long-acting reversible contraception” OR “birth control” OR “abortion” OR “HIV*” OR “AIDS” OR “STI*” OR “STD*” OR “sexually-transmitted*” OR “gender-based violence” OR “GBV” OR “intimate partner violence” OR “IPV” OR “domestic violence” OR “violence against women and girls” OR “VAWG” OR “violence against children” OR “maternal” OR “maternal health*” OR “newborn” OR “newborn health*” OR “maternal and newborn health*” OR “primary health*” OR “primary service*” OR “nutrition” OR “immunization” OR “service delivery” OR “service disruption*” OR “indirect health effect*” OR “indirect effect*” “collateral damage” OR “paused services” OR “secondary impact*” OR “unintended consequence*” OR “crowding out” OR “crowding-out” OR “interrupted access” OR “suspended service*” OR “health supply chain*” OR “medical supply chain*” OR “healthcare” OR “health care” OR “healthcare workers” OR “health care workers” OR “healthcare provider*” OR “health care provider*” OR “nursing” OR “nurse*” OR “doctor*” OR “medic*” OR “service provider*” OR “vaccine” OR “clinical trial” OR “treatment*” OR “PPE” OR “personal protective equipment” OR “health funding” OR “healthcare funding” OR “resources for health*” OR “crowd out” OR “collateral” OR “indirect health”)

Annex B. Indicators and Targets Focused on Indirect Health Impacts

Donor	Country	Project	Indicator/Target	GBV	Maternal health	Broader health	Other
World Bank	Central African Republic	Consolidation and Social Inclusion Development Program: Supplemental Financing	Number of health facilities offering free health care for pregnant women, breastfeeding women, children under five years and gender-based violence (GBV) victims	✓	✓	✓	
World Bank	Comoros	Additional Financing Comprehensive Approach to Health System Strengthening	Number of deliveries attended by skilled health personnel (CRI, Number) (target 16,500)		✓		
World Bank	Ghana	COVID-19 Emergency Preparedness and Response Project Additional Financing	GBV cases identified by frontline health workers and referred to appropriate departments for additional support	✓			
World Bank	Myanmar	Additional Financing for Essential Health Services Access Project	Deliveries with skilled birth attendant (Percentage)		✓		
World Bank	Myanmar	Additional Financing for Essential Health Services Access Project	Deliveries which are followed by adequate postnatal care within 2 days of birth		✓		
World Bank	Myanmar	Additional Financing for Essential Health Services Access Project	Number of deliveries attended by skilled health personnel (CRI, Number)		✓		
World Bank	Myanmar	Additional Financing for Essential Health Services Access Project	People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number) (target 29%)			✓	
World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	Birth (deliveries) attended by skilled health personnel (Percentage)		✓		
World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	Pregnant women who received IPT2		✓		
World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	Pregnant women receiving the first antenatal care within the 1st trimester		✓		

World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	Health centers offering caesarian section	✓
World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	Reported maternal deaths that are audited	✓
World Bank	Uganda	Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	People who have received essential health, nutrition, and population (HNP) services - Female (target 20%)	✓
World Bank	Yemen, Republic of	COVID-19 Response Project	To the extent possible, data collection and monitoring will be done in a gender- and age-disaggregated manner to contribute to a better understanding of the demographic profile of the affected population	✓
World Bank	Zambia	COVID-19 Emergency Response and Health Systems Preparedness Project	Implementation of the project's activities will consider gender as needed and project indicators will be disaggregated by gender, where feasible	✓
ADB	Afghanistan	Emergency Assistance for COVID-19 Pandemic Response	At least 40% of provincial hospitals have expanded services for infectious diseases and critical care, and include women-friendly and culturally sensitive facilities	✓
ADB	Afghanistan	Emergency Assistance for COVID-19 Pandemic Response	At least 15 hospitals constructed and equipped with all the essential amenities, such as power generators and waste incinerators, and have dedicated wards for female patients and separate offices and lounge spaces for women doctors and nurses	✓
ADB	Afghanistan	Emergency Assistance for COVID-19 Pandemic Response	At least five hospitals and medical facilities rehabilitated following the "build back better" principle and include women-friendly and culturally sensitive facilities	✓

ADB	Afghanistan	Emergency Assistance for COVID-19 Pandemic Response	Resilience strategy for infectious diseases developed and implemented, including capacity development plan for effective post-COVID-19 use containing provisions to improve access for women to sexual and reproductive health services, as well as support mechanisms for gender-based violence	✓	✓
ADB	Kyrgyz Republic	COVID-19 Active Response and Expenditure Support Program	Government protects national budget allocation of \$240 million for Ministry of Health, to ensure that current health programs such as maternal and child health programs, and provision of reproductive health services will continue even during the pandemic	✓	✓
ADB	Marshall Islands	Health Expenditure and Livelihoods Support Program	At least 700 dignity kits distributed to women and girls from vulnerable households		✓
ADB	Marshall Islands	Health Expenditure and Livelihoods Support Program	New national GBV telephone hotline—with supporting standard operating procedures for domestic violence services during lockdown—operational	✓	
ADB	Micronesia	Health Expenditure and Livelihoods Support Program	By September 2021, requirements for clinical management of rape and intimate partner violence in place in eight health clinics	✓	
ADB	Micronesia	Health Expenditure and Livelihoods Support Program	By September 2021, at least 40 community-based COVID-19 proposals (e.g., awareness, sanitation, GBV) funded to strengthen gender-responsive COVID-19 preparedness in the communities	✓	✓
ADB	Samoa	Health Expenditure and Livelihoods Support Program	Free maternal health care maintained without any reductions	✓	

ADB	Samoa	Health Expenditure and Livelihoods Support Program	Free health care for the elderly and children below 15 and free maternal health care maintained without any reductions (FY2019 baseline: free health care for the elderly and children below 15 and free maternal health care)	✓	✓
ADB	Solomon Islands	COVID-19 Rapid Response Program	By December 2020, gender-based violence COVID-19 referral pathways are in place in all provinces	✓	
ADB	Solomon Islands	COVID-19 Rapid Response Program	By December 2020, at least 500 public awareness messages on gender-based violence and COVID-19 are delivered on national radio	✓	
ADB	Vanuatu	COVID-19 Fiscal Response Program	5 GBV centers upgraded to include additional handwashing facilities	✓	
AfDB	Cameroon	Covid-19 Crisis Response Budget Support Programme (PABRC)	Persons benefiting from health kits (at least 30% of them women)		✓
AfDB	Dem. Rep. Congo	Special and Urgent Operation to Support Member States of the Central African Economic and Monetary Community (CEMAC) and the Democratic Republic of the Congo (DRC) to Fight the Coronavirus Pandemic (Covid-19)	In total, the project will directly benefit about 145 million people in the Central African region, more than 50% of whom are women		✓
AfDB	Gambia, The, Mali, Niger	Exceptional Emergency Project to Support Ecowas Low Income Member Countries and Strengthening the Health Systems to Combat the Covid-19 Pandemic	Gender-sensitive radio/television spots including spots to combat GBV	✓	