CARE International in Uganda

COVID-19 RAPID GENDER ANALYSIS

Omugo Settlement, Palabek Settlement,

Gulu Municipality, Arua Municipality, Moyo District, Lamwo District

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The views in this RGA are those of the authors alone and do not necessarily represent those of CARE Uganda or its programs, or the government of Uganda and any other partners involved in CARE Uganda's work.

Cover page photo: CARE community work

Image: – CARE Uganda staff

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Abbreviations

CARE	Cooperative for Assistance and Relief Everywhere
CBO	Community-Based Organization
COVID-19	Novel Corona Virus Disease 2019
DPC	District Police Commander
DV	Domestic Violence
DRC	Democratic Republic of Congo
EMB	Engaging Men and Boys
FNS	Food, Nutrition and Security
GBV	Gender Based Violence
GoU	Government of Uganda
IGA	Income Generating Activity
INGO	International Non-Governmental Organization
IPV	Intimate Partner Violence
KII	Key Informant Interviews
LCV	Local Council 5
NGO	Non-Governmental Organization
PLW	Pregnant And Lactating Women
PPE	Personal Protective Equipment
PSS	Psychosocial Support Services
RDC	Resident District Commissioner
RGA	Rapid Gender Analysis
SACCO	Savings and Credit Co-Operative
SRH	Sexual and Reproductive Health
SRMH	Sexual, Reproductive, and Maternal Health
UNHCR	United Nations High Commission for Refugees
VSLA	Village Savings and Loans Associations
WASH	Water, Sanitation and Hygiene
WAY	Women and Youth Project
WAYREP	Women and Youth Resilience Project
WFP	World Food Program
WHO	World Health Organization
WRO	Women's Rights Organization
YSLA	Youth Savings and Loans Associations

Executive Summary

The novel corona virus disease 2019 (COVID 19) pandemic has been widely reported to have distinct gendered implications in countries around the world.[1] This rapid gender analysis (RGA) seeks to explore the implications of COVID 19 in specific areas in northern Uganda to inform current CARE Uganda programming in the region, as well as to serve as reference to any other stakeholders working in the area and with similar target groups. The specific locations this RGA covers are: Omugo settlement, Palabek settlement, Gulu municipality, Arua municipality, Moyo district and Lamwo district.

This study looks at how COVID 19 is affecting men, women, boys and girls, from refugee and non-refugee backgrounds, in the urban, rural and settlement contexts. It follows earlier RGAs[2] conducted prior to the outbreak of the pandemic and seeks to identify where there have been changes of note as a result of the pandemic. On this basis, it provides a number of recommendations to donors and for implementing organisations.

Key findings:

1. **GBV is on the rise** and **GBV services are less accessible** to survivors due to the constraining and strenuous conditions associated with lockdown measures.

2. Together with GBV survivors, women of childbearing age and pregnant and lactating women (PLW) are struggling to access essential **GBV and SRMH services**.

3. The pandemic has considerably **increased women and girls' unpaid care burden** as they are now looking after children out of school and household members out of jobs, at home. The **higher and more frequent demand for water** that accompanies COVID-19 hand washing precautions exacerbates this situation and means that women and girls are spending even more time on water collection.

4. **Access to food** was found to be a **major concern**, slightly more so for women than men. Urban and settlement populations are facing high levels of food insecurity. Refugees in settlements are in a distinctly dire situation because their food rations have been reduced and because they can no longer travel to host communities to find alternative sources of food.

5. The pandemic has had a **severe impact on livelihoods** because of the closure of markets, businesses and key trading routes. The worst affected are those that work low paid, insecure jobs in the informal sector, which tend to be women and girls. Of note is the **suspension of informal financial groups** such as Village Savings and Loan Associations (VSLAs), which affects women and girls in particular, as they constitute the majority of members.

6. The **suspension of Y/VSLAs has implications** beyond the financial realm particularly for women and girls, who depend on their Y/VSLA group gatherings for **peer support and access to information**, including COVID risk and prevention information.

7. COVID decision-making platforms – e.g. COVID task forces - are comprised in majority of men and **women's voice is marginalised.**

[1] https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19_Full_Paper.pdf

[2] For example: the Inter-agency Rapid Gender Analysis and GBV Assessment – DRC Refugee Influx, Uganda, the March 2017 RGA in Rhino and Imvepi settlements and the March 2019 RGA on Power in Omugo setttlement, CARE Uganda West Nile.

Key recommendations:

1. The **gendered implications of COVID 19** must be actively acknowledged by governments, donors, and implementing organisations alike, and **integrated in all COVID 19 prevention and response plans** as well as long-term resilience and recovery programming.

2. More gender analyses need to be conducted as the pandemic unfolds and as more and new information becomes available to ensure that findings are updated and responses are kept relevant and do no harm.

3. The **safe, effective and sufficient provision of healthcare services particularly in SRMH and GBV must be prioritised** to meet rising needs in these services in the communities. Services must include psychosocial support.

4. The **consequences of the pandemic on livelihoods and household income,** and associated survival needs, **must also be addressed as a priority**. This is most urgently the case for nutrition needs. **Capital and economic recovery packages** must be made available to women and men who have lost their jobs or suspended their business and income generating activities (IGAs), in order to help re-establish pre-pandemic sources of income, including in the informal sector and VLSAs.

5. **Information on COVID 19 needs to reach all parts of the population**, including women and girls and other vulnerable groups who may not have access to news or to their usual sources of information. Ensuring that information on COVID 19 management reaches all parts of the population is crucial.

6. The finding that men dominate decision-making at home and at the community level is not new, but t**he exclusion from of women's voice from COVID 19 management must be addressed as a priority** in order to increase the chances of developing more effective and responsive solutions to the crisis. CARE and other development actors should advocate for an immediate increase in the participation of women in the COVID-19 community decisions-making platforms.

Introduction

Background

First detected in China's Hubei Province in late December 2019, COVID-19 has since spread across 215 countries and territories, with 3 634 172 confirmed cases globally, and 251 446 deaths as of 7th May 2020.[3] On 30 January 2020, the World Health Organization (WHO) declared this first outbreak of novel coronavirus a 'public health emergency of international concern'. On 11 March 2020, the Director General of the WHO declared COVID-19 a global pandemic.[4] Globally the pandemic has led to the death of tens of thousands of people, left many more in fear and disrupted economies and the provision of services, including essential services. Numbers of COVID cases are expected to continue to rise in the coming months. Initial research indicates that older persons and persons with pre-existing medical conditions are most likely to suffer serious complications from COVID-19 and that men are more likely to die from the disease than women. The outbreak of COVID-19 in the fragile development and humanitarian context is likely and proving to have disproportionate effects on women and girls, as well as at-risk and vulnerable groups. It is also likely the virus could exacerbate pre-existing gender and intersectional inequalities.

On a global level, the implications of the pandemic for women and girls present a fairly consistent pattern.

- The majority of primary care givers and frontline health workers are women and this alone exposes them to **greater risk of infection to the virus**.
- The closure of schools and measures of confinement have **increased the burden of women and girls' unpaid care work** and added to women's time poverty.
- The context of higher levels of stress arising from this health crisis in combination with conditions of confinement at home is **increasing gender-based violence (GBV) risks**, namely domestic violence (DV) and intimate partner violence (IPV).
- **GBV services** are in **limited supply and becoming harder to access** because resources are being diverted to other urgent pandemic response services[5] and because of survivors' restricted movements, respectively.

As at 7th May 2020, Uganda had registered 100 positive cases of COVID 19 and no deaths, with over 3,000 high risks travellers identified according to the Ministry of Health.[6]

Confirmed COVID-19 cases in Uganda, disaggregated by age and sex[7]

	Confirmed Cases	# of deaths
Female	23	0
Male	67	0
Total	55	0

- Uganda confirmed its first case of COVID-19 on 21st March 2020.
- As of 7th May 2020, this number has risen to 100 cases.
- Of the confirmed cases, 67% are men.
- Most cases are in the 20 - 39 year old age group.
- The cases were reported from the districts of Kampala, Wakiso, Jinja, Iganga, Lwengo, Masaka, Masindi, Hoima Adjumani, and Rakai

[3] https://www.who.int/emergencies/diseases/novel-coronavirus-2019
[4] https://www.ecdc.europa.eu/en/novel-coronavirus/event-background-2019
[5] For example, to cover the costs of greater police time and presence to monitor the enforcement of the lockdown measures, like curfews.
[6] https://www.health.go.ug/covid/
[7] https://covid19.gou.go.ug/

In efforts to contain the spread of virus in the country, the government of Uganda (GoU) put in place measures of restriction of movement and physical distancing such as closing schools, borders, non-critical businesses and services (e.g. tourism), as well as introducing a curfew. Moreover, the GoU announced a range of strict guidelines and restrictions such as banning vehicle movements unless they have special authorisation from relevant line ministries, restricting motorcycle movements, limiting the number of passengers in vehicles, confining people to their homes and banning of gathering of more than 5 people.[8] The GoU did this early on, on 18th March 2020, before the country had even confirmed a COVID case in the country.

While most of the COVID-19 cases have been recorded in urban areas, the outbreak's implications have reached all parts of the country, including Uganda's refugee and asylum seeker population, which, as of March 2020, comes to 1,423,377.[9] The restrictions on movement mean that new asylum seekers cannot come into Uganda, nor can they return to their country of origin. It also means that refugees in settlements cannot venture out of the settlements to supplement insufficient food rations or other resources and service. Most Non-Governmental Organizations (NGOs) have reduced their activities in the refugee settlements to the essential ones and the United Nations High Commissioner for Refugees (UNHCR) has suspended its resettlement of refugees. The risk is that this reduced support together with the restrictions on movement to find alternatives, could create fertile ground for negative coping mechanisms and exploitative practices within the refugee population, in the settlements.

COVID-19 presents an unprecedented global crisis with unique challenges for humanitarian and development actors, who have had to scale back essential services and activities at a time when they are most needed. NGOs are currently working to adapt their programming, exploring new ways of reaching their most vulnerable constituents in an effort to continue supporting them. An important part of this effort is to identify and understand the implications the crisis has on different parts of the population, and particularly women and girls and other vulnerable groups. This is not only because of the disproportionate impact emergencies typically have on these groups but also because of the centrality of women and girls' empowerment and wellbeing in CARE's work.

[8] http://www.statehouse.go.ug/media/press-releases/2020/03/30/more-guidelines-covid19-preventive-measures-need-shut-down-president
[9] https://data2.unhcr.org/en/documents/download/75455

Rapid Gender Analysis objectives

The RGA explores the impact of COVID19 on vulnerable men, women, girls and boys in humanitarian and development settings in the selected districts of Arua, Moyo, Lamwo, and Gulu where CARE Uganda is currently implementing programmes. The RGA gathers information on how the COVID 19 pandemic has affected women, men, boys' and girls' day-to-day lives in terms of:

- **Roles and responsibilities**
- **Needs and coping mechanisms**
- **Livelihoods**
- **Access to resources**
- **Gender based violence**

In doing so, it provides an analysis of the gendered impact of COVID-19 in humanitarian and development settings across selected districts in which CARE is operating. It pays most attention to any changes observed in the above themes compared with pre-COVID 19 RGAs and studies. Based on these findings, the RGA provides recommendations for all stakeholders working in COVID 19 response and recovery in Uganda, or any other locations where similar findings might exist.

Methodology

Due to the tight time-frame, rapidly changing context and insecure work environment, the RGA team has had to work very quickly and adapt RGA tools and approaches to capturing data in the most pragmatic and safe way possible. Restrictions on movement and social distancing meant that typical data collection sources and methods such as focus group discussions were not possible and that others, such as key informant interviews, had to be limited in number and / or conducted over remote means.

This RGA collected both primary and secondary qualitative data using standard CARE RGA tools[10] and, for the most part and due to the current COVID restrictions on movement and gatherings, remotely, via email and phone.

The core tools for data collection were key informant interviews (KIIs), individual stories and desk review of secondary literature. KIIs obtained information on people's opinions, beliefs and practices relating to the crisis and on any changes within the community as a result of the COVID -19 crisis in terms of supply and access to services and current protection concerns. The team shortlisted 30 stakeholders for key informant interviews mostly via the phone. All KII responses were recorded in the KOBO application on digital handheld tablets. All interviews were conducted in compliance with the presidential guidelines on social distancing and according to standard ethical considerations for GBV research.

Individual stories were collected through telephone using the Story of Change tool bringing out participants' reflections on changes to gender roles in the household, the community and day-to-day life since the start of the pandemic. The teams in the different locations worked with the community structures in place to identify individuals from the various households with phone numbers, ensuring they had the consent from the respondent or their guardian for the case of minors. Finally, the team reviewed existing data on gender and GBV in particular, in the relevant locations. This includes past RGAs that were conducted in the settlements as well as in the Arua and Gulu municipalities prior to the pandemic. Please consult Annexes 1 and 2 for a list of secondary data reviewed and stakeholders and respondents consulted in KIIs for this RGA.

[10] https://insights.careinternational.org.uk/in-practice/rapid-gender-analysis?highlight=YToxOntpOjA7czozOiJyZ2EiO30=

Findings and analysis

Emergencies such as the COVID-19 pandemic affect women, girls, boys and men differently. Overall, from a gender perspective, women and girls are disproportionately affected in crisis situations and particularly so for girls and single women, female heads of households, pregnant and lactating women (PLW). Gender implications of the COVID-19 pandemic in terms of roles and responsibilities, needs and coping mechanisms, livelihoods, access to resources (namely health care and information) and gender based violence (GBV) are explored in this section.

Roles & Responsibilities

Decision-making

Household level

Uganda's 2016 Demographic and Health Survey (DHS) reveals that most married women participate in household decision-making and only a minority of households (9%) have men as the sole decision-makers, including on decisions concerning their wives' own earned income expenditure. The survey further reveals that the majority of surveyed women (74%) make decisions regarding their health and significant household needs (64%). Women's decision-making is positively correlated with age and income: the older they are and the more they earn the more influence they have in decision-making.[11] A minority of women (13%) do not have any decision-making influence at all, including with regard to their own health.

Key decision-making issues at the household level in the COVID-19 context are on how food and finances are managed. Women are currently supporting their families with their VSLA and SACCO savings, and through their subsistence farming, in the case of rural households. Nevertheless, respondents[12] for this RGA report that current household decision-making is still dominated by men. One male community leader (55) from Lamwo district shared the extent of his decision making, which reaches his children's spending behaviour and his wife's mobility: '*In my household, as much as there is involvement of my wife in decision making, I am still the sole and final decision maker in all matters concerning my household. My sons burnt charcoal and it fetched them 200,000 UGX (52 USD) but before they could use the money, they sought my permission and approval. My wife wanted to leave the trading centre and move to the village for a few days, but I told her not to go anywhere at the moment. She listened and stayed back'.*

Some respondents did report that spending more time together at home had introduced some changes to usual parental collaboration at household level. Men are spending more time with their children, spouses are collaborating more in their parenting roles.

Community level

COVID-19 coordination platforms have been established across the country at national, regional and district level to steer the prevention and response to the pandemic. The table below shows a breakdown of the task force membership in the five locations the analysis was conducted.

District	Number of Women	Number of Men	Total
Moyo	**2**	**23**	**25**
Arua	**7**	**11**	**18**
Gulu	**3**	**15**	**18**
Lamwo	**18**	**52**	**70**

[11] Uganda Bureau of Statistics (UBOS) and ICF.2018. *Uganda Demographic and Health Survey 2016*. Kampala, Uganda and Rockville, Maryland:UBOS and ICF

[12] Urban context: 7 out of 15; Rural context: 5 out of 12; Settlement context: 11 out of 21

As the numbers show, these task forces are male-dominated, and men occupy the most influential positions. If women's voice is excluded from decision-making platforms, it is very unlikely that women and girls' distinct needs will be expressed, let alone addressed. Women constitute the majority caregivers in public health emergencies, which means that they have direct insights into how the crisis is playing out on the ground, and affecting different parts of the population. Women's inclusion in decision-making will therefore lead to more responsive and more effective solutions to the pandemic and on a global level, it has become apparent that women have shown very promising leadership[13] in handling the COVID 19 response.

Too few women are included in COVID-19 decision-making at community level and this can have serious consequences on their health and wellbeing. Without women's voice, decision-making spaces will not be able to address urgent and pressing needs that women typically face, for example, adapting the provision of GBV and Sexual and Reproductive and Maternal Health (SRMH) services in the context of lockdown and restricted movement and transport. A female respondent (35) from Gulu district described one experience which illustrates the urgency of this issue:

"*This crisis has already caused death to one of the pregnant mothers who died of labour pain after bleeding for a long time without being attended to at home. She died not because of negligence, only that there was no transport to take her to the hospital since by that time all the public transport means had been blocked due to the danger of COVID"*

Division of labour

In Uganda, women are typically responsible for all unpaid care and household chores such as childcare, cooking and cleaning. In rural communities, women spend most of their time on household chores with little to no source of income. In urban and refugee settlement contexts, women typically engage in petty trade or other informal income generating activity (IGA) in addition to their household responsibilities. Men in all three contexts – urban, rural and settlement - are typically responsible for earning household income and typical income sources include driving boda-bodas[14], practising carpentry, and engaging in mechanical work in garages.

The outbreak of COVID-19 has increased women's burden of care[15], both at home and in the community.*"* The closure of schools and businesses means that women are spending more time looking after children and other household members, during what would usually have been school or working hours.

In addition, the greater and more frequent demand for water resulting from COVID-19 prevention measures (i.e. frequent hand washing) also has direct implications on women and girls' time. Women and girls are typically responsible for water collection, which means that they now spend more time carrying out this ongoing, time-consuming and often dangerous[16] task.

[13] https://www.forbes.com/sites/avivahwittenbergcox/2020/04/13/what-do-countries-with-the-best-coronavirus-reponses-have-in-common-women-leaders/#152ce6083dec

[14] Boda bodas cannot carry passengers but are permitted to continue operating for shopping and other errands until 5pm

[15] As stated in a UN policy brief on the impact of COVID-19 *"unpaid care work has increased, with children out-of-school, heightened care needs of older persons and overwhelmed health service.* https://reliefweb.int/sites/reliefweb.int/files/resources/policy-brief-the-impact-of-covid-19-on-women-en.pdf*s*

[16] 2019 RGA found that water collection routes and points were frequent hot spots for GBV

Needs & Coping Mechanisms

Food, Nutrition and Security (FNS)

Accessing and affording food is a prevailing need and priority for respondents, particularly women in the urban and settlement contexts. [17] Restriction of movement, closure of markets, loss of jobs and income all contribute to making food harder and more expensive to find and buy. The need for food is directly related to the COVID-19 context and was not mentioned as a priority concern in a RGA conducted prior to the outbreak[18] by respondents sharing a very similar profile to those consulted for this RGA (status, location, age groups). The priority need before COVID-19 was access to livelihoods and income, which was equally expressed as a priority need for this RGA, mostly by men.

Women in rural communities are less worried about food reserves given their self-sufficiency in this respect through their own subsistence farming. However, there are still challenges for the rural community. In Lamwo and Moyo districts for instance, respondents explained that they could not access seeds, farm tools and fertilisers due to lockdown restrictions. This is particularly problematic at this time as it is planting season. One male respondent (44) in Lamwo explained:
''I have experienced a change in the costs of acquiring say for instance hoes, gumboots, axes etc. are very expensive and buying them also is not easy - We are not able to buy the necessary seeds needed for the season due to the ban on public transport by the government after we had cleared the fields".

Refugees in the refugee settlements are particularly worried about the availability and access to food. The World Food Program[19] (WFP) announced cutting its food relief effort to Uganda by 30% and refugees also report that cash distributions have decreased from 9 to 6 USD per month. To make matters worse, lockdown measures prevent refugees from travelling to host communities to find other sources of food. The cut in food rations and the inability to earn income to cover basic food and nutrition needs is a huge cause for concern for refugees in Uganda who are now more worried about going hungry than they are about the spread of COVID-19. [20]

Families are coping by drawing on their own food reserves, namely flour and beans, and by starting to grow their own food through subsistence farming in preparation for long-term lockdown and depleted food reserves. This applies to urban respondents as well, who report growing vegetables, ground nuts, cassava and other fast maturing crops. One respondent shared: "A*s a family right now, we have engaged other members of the family into small scale farming specifically digging and am happy that we have planted green vegetables, g nuts and cassava as well. This is going to help us survive the aftermath of COVID-19 because I strongly believe that by God's will this Corona virus will go away and our crops shall definitely be the source of our livelihood'.*

Respondents also reported eating smaller portions or fewer meals per day, and prioritising children's nutritional needs over theirs, in order to make the reserves last as long as possible.

Income

The main need expressed by men is consistent with their priority need in pre-pandemic times[21], which is income. Men are concerned about the recovery of their livelihoods and businesses after the crisis, as well as how they will manage to cover their families' basic needs during the crisis. Many men have lost their jobs and do not know if they will be able to get back to them and when. While those who are self-employed have exhausted their savings and express concern about setting up again, without any capital.

[17] 27 out of 36 women consulted.
[18] The RGA was conducted in September 2019 in Arua and Gulu municipalities.
[19] https://www.theguardian.com/global-development/2020/apr/14/food-rations-to-14-million-refugees-cut-in-uganda-due-to-funding-shortfall-coronavirus-world-food-programme
[20] https://www.aljazeera.com/news/2020/04/fears-uganda-coronavirus-outbreak-refugee-settlements-200406145749564.html
[21] 2019 RGA

Respondents in urban locations are sustaining their income by continuing or taking on work that is still permitted such as selling food and boda-boda riding. Of the 15 respondents interviewed in urban locations, 5 report that they are still selling food to make ends meet. One family joined forces with their neighbours in selling chapatti and eggs in the community. Some have also taken this difficult context as an opportunity to create new businesses. For example, students at St. John Bosco Vocational Training institute in Lamwo district are producing hand sanitizers and facial masks using locally available materials.

There is a risk that some may resort to harmful coping mechanisms in this time of crisis, unfortunately. Some families may wish to marry off their girls for the bride price, or just to have fewer mouths to feed. Young women and girls may resort to commercial sex in order to cover their basic needs. Very vulnerable young women and girls such as teenage and single mothers are particularly likely to do this.

Water, Sanitation and Hygiene (WASH)

Access to clean water and washing and sanitation facilities has always been a priority for respondents, particularly women and girls, because of their sanitation needs. The outbreak of COVID 19 however has escalated and spread this need to all parts of the population due to the very widely and frequently repeated advice that hand washing is one of the most effective ways to contain the virus. Water and soap have effectively become life-saving resources and many parts of the population do not have easy or ongoing access to either.

On the one hand, this has had a positive impact and improved household hygiene. As one respondent reports *"(…) another change that has been brought about COVID-19 according to me is, there is improved hygiene in my family, as well as other families/ households in the neighbourhood, whereby all households must have a hand washing container and everyone that enters in the home must at least make sure that he/she has washed".* On the other hand, the majority of respondents consulted for this RGA cannot afford to buy soap and expressed that access to soap and water was a priority need. For example, one respondent told us "*there is a challenge of water because without water hand washing and general hygiene are problem. And with poor hygiene means higher chances of being at risk of contracting the virus".*

Access to resources

Health care – GBV and Sexual, Reproductive and Maternal Health (SRMH) services

The GoU has recognised the health sector as one of the key critical services that must remain functional during this crisis. Access to SRMH services is crucial for women and girls globally and particularly in fragile states affected by conflict and natural disasters, where there is a high rate of maternal mortality (61%).[22]

In Uganda, there are on average, 4538 births per day[23], which illustrates just how crucial SRMH services are to the country. This is even more so the case during crises, when SRMH resources are typically diverted to emergency response. Past crises have shown us that this leads to increased maternal mortality and a deterioration of SRMH outcomes.[24]

Key informants report that women of childbearing age, pregnant and lactating women (PLW), persons living with HIV/AIDS and children have the most at stake where a functional health sector is concerned as they respectively depend on SRMH services, essential antiretroviral drugs, and vaccines and immunization.

[23] https://worldpopulationreview.com/countries/uganda-population/

[24] https://gbvguidelines.org/wp/wp-content/uploads/2020/04/Interagency-GBV-risk-mitigation-and-Covid-tipsheet.pdf, p 9

Despite the fact that none of the recorded confirmed COVID-19 cases are from the RGA locations, health services in these areas have also been affected by some of the restrictive measures introduced to contain the pandemic. The restriction of movement and the suspension of transport services apply to the whole country and people are not able to reach health facilities. Pregnant women are a particularly vulnerable group in this respect, as they struggle to reach health services if they go into labour or experience any maternal health complications. Respondents for this RGA shared that some expectant mothers have opted to deliver at home which exposes them and their unborn babies to potential complications. There have already been grave losses in this respect.

Worryingly, unplanned pregnancies are likely to rise sharply in the COVID 19 context due to couples spending more time together at home and limited access to family planning services. The Archbishop of Uganda has recommended the use of contraception during lockdown. [25] However, even if couples heed to this advice, they may not even be able to access family planning services and products.

Women's GBV and SRH needs are a particularly pressing priority where access to health care services are concerned. Not only do crises typically increase rates of GBV, but the COVID-19 containment measures mean that it has become more difficult for survivors to reach the health (and other) services that they need.

Within the health facilities, there are also issues. Health workers themselves report being worried about their working conditions and not having adequate personal protection equipment (PPE) when treating potential COVID 19 patients. For community members who can reach health facilities easily, there is the concern that entering the establishment and being closer to potential COVID 19 cases could put them in danger.

Information

During public health emergencies, sharing accurate information on detection, prevention and treatment of a disease as quickly as possible and to as many people as possible is crucial. Radio, television, internet especially social media, mobile phones and face-to-face interactions are some of the media being used to disseminate information on COVID-19. However, not everyone has access to these channels of information and communication because of cost, location, literacy or simply, because of lack of awareness that the information is available and important. Vulnerable and / or remote groups such as women and girls living in rural areas and in settlements are an example of groups that may not have access to otherwise very widely available information.

The RGA found that men tend to have more access to information given their greater mobility, higher rates of literacy and their access to social media and other media through phones and radios. Women, however, are at a particular disadvantage in their access to information in this current context. A common source of information for women is in group gatherings such as VSLA meetings or a water points, which are currently not allowed.

Some men are sharing the information that they access with their families and communities as reported by a respondent from Omugo settlement: "*My husband is a role model man who is involved in mobilizing the community and passing information on COVID. When he comes back in the evening, he calls us together and emphasizes how serious this disease is, and gives some information on how the virus is spread and how it can be avoided.*"
In addition to the means of communication by mobile public address systems in urban areas– which consists of boda boda drivers spreading messages on COVID prevention and response over a megaphone as they drive their boda bodas - respondents in the settlements also report messages being communicated through mega phones as a common communication method.

[25] https://www.theguardian.com/global-development/2020/apr/18/archbishop-of-uganda-urges-women-to-use-contraception-during-lockdown

Livelihoods

Women are mainly engaged in informal and low paid IGAs. This is not unique to Uganda. Women tend to be over- represented in informal, low paid and vulnerable employment as well as being disproportionately responsible for unpaid care work.[26]

The current restrictions on movement in Uganda has only exacerbated the fragility of these women's livelihoods. Women and men's sources of income alike have been disrupted by the crisis, as they are no longer able to access the market places where they can sell their produce and engage in petty trade. Confinement of potential consumers at home, the closure of borders and markets has removed the most essential trading opportunities, which many rely on, on a day-to- day basis, to cover their basic family needs.

Furthermore the businesses that have continued to operate mainly employ men (e.g. factories and boda bodas) while those that typically employ women (e.g. salons, restaurants and clothes shops) have been closed. The situation is all the more difficult for female heads of households who have the sole responsibility for providing for their families.

One female head of household from Lamwo district gave us an insight into her life:

"I have seen a reduction in my income earnings because I am unable to go to the public markets to sell clothes, being a widow it's really taking its toll on me and my family. I am trying to adjust as I devise other ways of making ends meet just like other equally affected people out there are managing the crisis."

Youth/ Village Savings and Loans Associations

In addition, as majority members of Youth/Village Savings and Loans Associations (Y/VSLAs) and Savings and Credit Co-Operatives (SACCOs), women are more affected than men by the suspension of these informal groups, which are key financial safety nets and support systems for them. The GoU restrictions of 18th March had a direct impact on Y/VSLA activities as they restricted group meetings to 5 people only, with strict adherence to social distancing guidelines. Given that Y/VSLA groups are normally comprised of 25 – 30 members per group, many have had to suspend their activities. Many members have therefore withdrawn their savings from these groups to cover basic needs in this time of crisis.

As one respondent from Omugo explained:
"After the outbreak of the crisis, we got all the savings from the box and stopped saving. We are now not saving because we don't have the financial support (which we would get from support from our relatives or small businesses for some members or sell part of the food ration to save). Right now we are focused on how to survive with our families and the VSLA has been paused".

According to CARE Uganda's Women and Youth Project's (WAYREP) statistics, the total membership of 44 Y/VSLA groups in Gulu and Arua municipalities and Omugo settlement comes to 1,358 of which 848 members are women and 510 are men. Based on these numbers, it is clear that the suspension of Y/VSLA activity or other type of informal financial service will impact women more than men. And not only financially as, beyond savings and loans, the groups provide a social network for the members, where they can access, peer support and information, as well as gain new skills. .

One female respondent's story represents the situation as a whole, quite well. Not only of the impact of the suspension of VSLAs but also how this has interacted with restricted movements and access to markets:
"As a woman, I have been limited in many ways, I am a member of a women's group and we used to meet every Monday and Thursday for different sessions including making baskets. This has been affected especially now that we cannot move to buy the materials we need for our business. The major means which

[26] 92% women against 87% of men in informal employment - https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_711798.pdf
https://www.unwomen.org/en/what-we-do/economic-empowerment/facts-and-figures

is boda boda was stopped yet this is what we used to move with to the lake to buy Mukene but due to the long distance my business will drop down."

Women across rural, urban and refugee contexts report the suspension of VSLA activities has reduced their ability to save money or access loans. Respondents also missed the support system they normally benefit from when participating in group meetings, and presumably the support they would need in coping with COVID 19 developments. This is particularly important to note at a time of crisis, as stress levels tend to rise and sources of communal support become all the more crucial. The suspension of VSLAs therefore has serious implications not only on the livelihoods but also on the wellbeing of their members. The majority of female respondents interviewed - 21 out of 36 - expressed the need for support to revive their businesses and re-instate VSLAs as part of the recovery measures.

Gender Based violence

It has been widely reported that the outbreak of the COVID-19 pandemic has led to a rise in gender-based violence (GBV) especially domestic violence (DV) and intimate partner violence (IPV). GBV is typically strongly correlated with situations of crisis, such as conflict, natural disasters and public health emergencies. This is most often explained by the financial strains, household tensions and psychological distress such situations often involve and the triggers they can be to GBV.

Leaders from the locations surveyed for this RGA all acknowledged that DV was on the rise as a result of the financial strains arising from the pandemic. To quote the Resident District Commissioner (RDC) of Lamwo: "There is food crisis everywhere and this is even causing violence in families". The deputy police spokesperson in Uganda also reported that there has been an increase in domestic violence in the country, and about 328 cases have been recorded during the lockdown period. 27

Indeed, our consultations with respondents in the police confirmed this rise in reported GBV cases, namely DV. The number of unreported cases is also believed to be very high. Reporting rates are usually low due to a number of factors including social stigma and costs associated to reporting. The rate of unreported cases is likely to be even higher in the COVID 19 context, as survivors face the added challenge of not being able to travel to the police station.

Respondents identified issues such as the lack of money, the loss of income and jobs and the concern over where the next meal is coming from as key triggers to the increase in GBV at household level. Studies done before the pandemic also identified the lack of resources and income, and resulting conditions poverty, as a key trigger to GBV. It is therefore not a new trigger but is perhaps more easily activated and severe during the crisis.

Men reported being under more pressure than usual to cover their family's basic needs. Many are unable or struggle to do so and this can lead to tensions and arguments at home. A female respondent from Arua municipality shared her experience:

"There is always disagreement as (a) woman and my husband due to failure to agree on some of the house hold items that have got finished because the man does not have money to provide and when he is asked, he gets angry. The lock down has also affected them psychologically as many are thinking about their businesses which was locked down, coupled with failure to provide food at home."

The lack of food is a priority need for all as mentioned earlier in this report. The confinement measures of COVID however make it ever worse as not only is food scarcer, but the fact that there are more people staying at home, for longer periods of time means that there is also greater demand for food.

[27] https://nilepost.co.ug/2020/04/17/328-cases-of-domestic-violence-reported-during-covid-19-lockdown-so-far/

Respondents also cited disagreements relating to decision making on household expenditure and negotiations around sex as triggers for GBV. When food is sold to purchase alcohol for example. Or, in the case of negotiations around sex, when families are forced to live in very small spaces, shared entirely with their children, and they cannot find the privacy for sex. Male respondents in the settlements complained about being denied sex and claim that women use excuses of hunger and being busy to deny them sex. Meanwhile, women note the pressure of their spouses' demands for sex and the challenge of finding an adequately private space for sex when families live in very small spaces and share space with their children.

The added factors of confinement, the restriction of movement and the diversion of GBV resources to COVID-19 response means that not only is GBV on the rise but that there is less help and support available to survivors. Furthermore, most organizations that were engaged in GBV prevention and response have had to suspend their work, in adherence to lockdown measures. The protection house coordinator for Action Aid in Gulu municipality reports that even though their shelter remains open for survivors of GBV, many of them cannot actually travel to the shelter due to there being no available transport services. In the settlement and hosting districts, many implementing partners have scaled down their operations, and important community structures and sources of community support such as community based facilitators, SASA! Activists and case workers.

The GBV referral pathway is currently not operational. Many GBV services are not operational and where resources are available, they tend to support COVID prevention and response. The key government structures for GBV - the Community Services department and the police's Child and Family Protection Unit – were not initially prioritised as critical services, however the Government of Uganda has since instructed them these community structures to strengthen their services and response capacity in to continue providing services. Despite these efforts and while some departments or structures are open, they are not able to reach people in need due to challenges in transport and PPE supplies. Furthermore, community members report that organisations that were previously providing support are no longer active.

Other examples of how human and material resources for GBV services have been diverted in the locations surveyed include:

- GBV prevention and response officials from the Community Development Services Department being asked to support COVID 19 awareness raising activities;
- Child and family protection officials in the police force being deployed to support the monitoring of community adherence to COVID 19 prevention measures
- GBV services staff needing to stay at home rather than be present in the health facilities because of confinement measure

These examples come as a result of the government's response to the COVID-19 crisis, namely its priority to contain the spread of the virus. It is a well-intended response but could be inadvertently increasing GBV risks.

Conclusion & Recommendations

This RGA has surveyed respondents in the Northern regions of Uganda to take stock of the gendered implications of COVID 19 on vulnerable and marginalised groups in the urban, rural and refugee settlement contexts. It documents findings on the impact of the pandemic on men and women's **roles and responsibilities**, on their **needs and livelihoods** and on **gender-based violence**, as well as how these men and women are **coping** with the crisis.

The Government of Uganda's efforts to manage and contain the spread of this virus are very commendable, with taskforces at both national, regional, and district level. Whilst the figures of confirmed COVID 19 cases in the country are still relatively low at the time of this RGA, vulnerable groups in the population are suffering from some of the consequences of the containment measures. The restrictions on movement is cutting off access to vital resources and services for the most vulnerable parts of the population. This includes GBV services, which are even more necessary during crises such as these because of the increased rates of GBV that conditions of prolonged confinement in strenuous circumstances tend to generate. In addition, the closure of markets, trade routes and trading centres are severely affecting those that rely on their day-to-day IGAs to put food on the table. Access to food is a major concern, especially to those living in refugee settlements. All respondent groups are affected by the suspension or loss of livelihoods and income that have come with the closing of businesses, markets and physical distancing measures. Women are particularly affected by the suspension of informal financial groups such as VSLAs and SACCOs not only because this affects their finances, but also because these groups are an important source of peer support and access to information for them. Meanwhile, at home, women and girls' unpaid care burden has spiked, as school and business closures mean that there are more people to look after, and the increased demand for water for hand washing means that they are spending more time collecting water for the household.

Recommendations

General:

1. As the COVID 19 crisis unfolds, the RGA should be updated to take into account new information and data on gendered implications of the crisis in these regions of the country.

2. The GoU and development and humanitarian organisations must acknowledge the gendered implications of COVID 10 and put in place gender-responsive COVID 19 prevention and response plans as well as design long-term resilience and recovery programming, based on the collection and analysis of sex age disaggregated data.

Gender based violence:

3. Safe, effective and sufficient SRMH and GBV services must be provided by the health sector and implementing organisations. Concrete actions could include for:
    a. GBV coordination platforms to update the GBV referral and share it widely to key stakeholders (e.g. health workers, NGOs, local leaders);
    b. COVID task forces to include and address GBV issues in COVID prevention and response plans.
    c. CARE and GBV service providers to build capacity of community structures to provide GBV services remotely e.g. through phone services. This should include the provision of psychosocial support (PSS);
    d. CARE to advocate for the inclusion of GBV caseworker in health facilities, to deal with any GBV needs and / or provide information on key GBV services.
    e. CARE to sensitise local council leaders on GBV and SRMH needs, and gain their support in addressing them in their communities by helping spread awareness and information on support and services in GBV and SRMH.

Livelihoods:

4. Vulnerable groups at risk of going hungry need support in accessing food. The GoU, donors and implementing organisations such as CARE must address this need as a priority, both in the short

term, by distributing more food to those in need, particularly in the refugee settlements, and providing more long term sustainable support, such as with the provision of seeds or support in subsistence farming or to IGAs.

5. Capital and economic recovery packages must be made available to women and men who have lost their jobs or suspended their business and income generating activities, in order to help re-establish pre-pandemic sources of income, including in the informal sector and VLSAs

6. Development and humanitarian actors must support the re-establishment of VSLAs and consider providing capital and adapting the VLSA cycle to make up for the lost savings and operational disruption of the suspension of these groups.

Information dissemination:

7. CARE and other implementing organisations should ensure that information on COVID 19, prevention and containment reaches all people, including marginalised communities, women, disabled and the elderly. This could involve:
    a. Developing relevant IEC materials and disseminating them widely through local partners and various media such as radio, social media and public address systems (e.g. boda boda)
    b. Engaging men to share information that they manage to have access to with their families and wider communities.
    c. Working with VSLA groups to ensure that women also participate in information dissemination

Decision Making:

8. The finding that men dominate decision-making at home and at the community level is not new, but the exclusion from of women's voice from COVID 19 management must be addressed as a priority in order to increase the chances of developing more effective and responsive solutions to the crisis. CARE to advocate for the inclusion of women and women's rights organisations (WROs) in COVID 19 decision-making structures, namely the COVID task forces.

Annexes

Annex 1: Desk Review Literature

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Annex 2: Key Informants

	Name	Title	Location
1	Amaku Ratib	Clan /Cultural leader	Arua Municipality
2	Ayikoru monica	Women group leader	Arua Municipality
3	Not given	Community Development Officer	Arua Municipality
4	Not given	Association Leader	Arua Municipality
5	Acan Paska	Deputy Chairperson – Main Market	Gulu Municipality
6	Not given	Women group leader	Gulu Municipality
7	Not given	LOCAL COUNCIL 1 (LC1	Gulu Municipality
8	Not given	Women group leader	Gulu Municipality
9	Ikaaba Mohamad	District Internal Security Officer – Covid19 taskforce	Gulu Municipality
10	Emmanuel Mafundo	District Police Commander- Covid19 taskforce	Gulu Municipality
11	Mrs. Pauline Lukwayi	Deputy Mayor – Gulu	Gulu Municipality
12	Filda	Centre manager – RHU	Gulu Municipality
13	Benard Joe Okello	Radio Presenter	Gulu Municipality
14	Patrick Albert Issamat	District Police Commander- Covid19 taskforce	Lamwo District
15	Not given	Community Development Officer	Lamwo District
16	Hon Doreen Lakomakech	District LC5 Vice Chairperson	Lamwo District
17	Not given	Resident District Commissioner	Lamwo District
18	Komakech Richard Cyrus	District Production Officer	Lamwo District
19	Not given	Gender Focal person	Lamwo District
20	Not given	Community Development Officer	Moyo District
21	Not given	Community Development Officer	Moyo District
22	Not given	Community Development Officer	Moyo District
23	Not given	Community Development Officer	Moyo District
24	Not given	Project Officer	Moyo District
25	Not given	UNHCR staff	Moyo District
26	Not given	Police Officer	Omugo Settlement
27	Gilbert Alioni	Project Coordinator	Omugo Settlement
28	Mazu William	Gender and Protection Officer	Omugo Settlement
29	Rebecca Nabukeera	Programme Officer-Nutrition	Omugo Settlement
30	**Not given**	Women's group leader	Omugo Settlement

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