Submission to the House of Commons Standing Committee on Foreign Affairs and International Development

In the context of its study on the impact of COVID-19 in crisis- and conflict-affected situations, and the role of Canadian international assistance

By CARE Canada

Nowhere will the impacts of COVID-19 be more profound than for the two billion people living in fragile and conflict-affected settings around the world. Indeed, the UN identified the increased risk of preventable disease in humanitarian settings as one of its top challenges for 2020, noting that disease outbreaks are intensifying humanitarian need in some areas. This prediction, made before COVID-19 emerged, will only gain force as the disease spreads, crippling health and food systems, and overwhelming social-safety nets weakened by years of underinvestment.

On 25th March, the UN launched the COVID-19 Global Humanitarian Response Plan (GHRP), calling on States to increase global assistance to respond to the direct public health and indirect immediate humanitarian consequences of the pandemic, particularly on people in countries already facing other crises. Updated in July, the response plan aggregates appeals from UN agencies and Non Governmental Organizations (NGOs) and calls for an initial US$10.3 billion in funding to meet needs in 63 countries from April to December 2020. As the UN Secretary-General has noted, this is a 'drop in the ocean'. Worse, at the time of writing, the GHRP is only 38% funded (USD3.62 Billion). Canada has provided just over USD$54 Million (or 1.5%) towards the plan.

It is already clear that this is not only insufficient to resource the immediate response to COVID in existing complex emergencies, but a lot more will be needed to recover from the long-term socio-economic shocks of COVID-19 globally. In many cases, the secondary impacts of the pandemic will be worse for vulnerable populations than the health crisis itself. Already, COVID-19 is amplifying inequalities and existing injustices. Women and girls are at high risk, along with the elderly, disabled people, those in poor health or malnourished, and groups such as LGBTIQ people. These risks are especially pronounced for those living in perpetually fragile contexts already affected by complex emergencies, with dilapidated health systems and no social protection. Even after COVID-19 is contained, the secondary impacts of the virus could take years to repair.

The following paper presents CARE Canada's key concerns in three key areas – healthcare, gender-based violence, and food and nutrition insecurity – and offers recommendations around the best ways for Canada to complement and build upon existing responses to COVID-19 in fragile and conflict-affected states, and to ensure its implementing partners are able to have their best impact.

// Recommendations

1. **Focus on under-served healthcare needs.** It is critical that we fill gaps in essential, underfunded and diverted services, including sexual and gender based violence and sexual and reproductive health. These areas are under-represented in Global Humanitarian Response Plans, but they are centrepieces of Canada's humanitarian policy. Gender-responsive and adolescent-friendly sexual and reproductive health services, and survivor-centered GBV prevention and response services must be treated as core elements of a non-negotiable, basic healthcare package throughout the COVID response, in line with global standards.

2. **Reach the hardest-to-reach, without delay.** Donors have directed just one-point-five percent (1.5%) of their funding toward local and national NGOs. Donors must fulfill their Grand Bargain commitment to channel at least twenty-five percent (25%) of humanitarian funding to local organizations, particularly women and girls' organizations. This needs to happen quickly, before the crisis gets worse, and before local organizations capable of doing this work disappear.
3. **Scale up support for food and nutrition security.** Immediately scale up safety net programs, including cash and voucher assistance and school feeding programs, for vulnerable rural and urban populations. Minimize disruptions to markets and agricultural activities by ensuring that smallholder farmers, especially women, can access key resources, such as inputs, information, storage, and market linkages.
4. **Help Canadian humanitarian organizations to do what we do best.** COVID-19 must be the catalyst that moves us towards locally-led, mutually beneficial partnerships. This entails adapting funding mechanisms and direction and control provisions to allow for more predictable, transparent and flexible funding through NGOs and local actors.
5. **Prioritize the collection of gender data.** It is critical that COVID-19 responses include measures to improve data and reporting standards to better understand how much humanitarian funding goes to gender equality and the empowerment of women and girls, and to women-led and women's rights organisations. Reporting standards should include tracking of gender-specific activities, expertise and outcomes, as well as systematic collection and analysis of sex- and age-disaggregated data, at a minimum.

// Healthcare: Making up for underserved needs and diverted resources

Humanitarian settings pose particular challenges for infectious disease prevention and control. Conflict often interrupts health services, results in damaged health infrastructure, and impedes the ability of health care workers to conduct disease surveillance. Systematic and targeted attacks on health infrastructure and aid workers by parties to conflicts, politicization of aid and service delivery, and restricted humanitarian access also exacerbate the spread and impact of infectious diseases.

Although men, the elderly, and persons with compromised immune systems may at be greatest risk of fatality from COVID-19, the greater caregiving role that women and girls are expected to perform may expose them to other consequences. Women comprise more than 75 percent of the health care workforce in many countries.[1] This increases the likelihood that they will be exposed to infectious diseases. In addition to the caregiving burden, social norms in some contexts dictate that women and girls are the last to receive medical attention when they become ill, which could hinder their ability to receive timely care for COVID-19.

Evidence suggests that during past public health emergencies, resources have been diverted from routine health care services toward containing and responding to the outbreak.[2] These reallocations constrain already limited access to sexual and reproductive health (SRH) services, such as clean and safe deliveries, contraceptives, and pre- and post-natal health care, and lead to disruptions in mental health

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[1] Human Resources for Health (HRH) Global Resource Center, "Resource Spotlight: Gender And Health Workforce Statistics," HRH, accessed March 14, 2020, https://www.hrhresourcecenter.org/gender_stats.html

[2] GiHA, "The COVID-19 Outbreak And Gender," GiHA.

and psychosocial support services.[3] Adolescent girls, who have unique SRH needs, may be particularly affected.

Another key issue is the rise of mis-information, with health systems in many contexts being falsely accused of spreading COVID-19. This is preventing people in many fragile contexts from attending health clinics for routine immunizations and medical procedures, with potential long-term consequences. During the 2014–16 West Africa EVD outbreak, for example, fear of contracting the disease resulted in fewer women attending health clinics.[4] Coupled with resource diversion from primary health care services and prevailing social norms, this led to a decrease in vaccination coverage[5] and a 75 percent increase in maternal mortality in three of the affected countries.[6]

Outbreaks could also result in disruptions to mental health and psychosocial support services (MHPSS), putting the individuals participating in them at risk. Psychosocial wellbeing is a major issue for adolescents exposed to conflict, displacement, or violence, which is not uncommon in humanitarian settings.[7] Moreover, MHPSS caseloads will likely increase during COVID-19 outbreaks, as frontline health workers, women and girls with caregiving burdens, and community members fearful of becoming infected or infecting others may all experience stress and trauma relating to the outbreak.[8]

// The GBV "Shadow Pandemic"

Crises exacerbate age, gender, and disability inequalities and place women, girls, and other vulnerable populations—such as LGBTIQ GBV) and intimate partner violence (IPV). In fact, IPV may be the most common type of violence that women and girls experience during emergencies,[9] resulting in profound physical and psychosocial harm. The UN estimates that for every three months that lockdown measures continue, an additional 15 million gender-based violence cases could occur. It also estimates than an additional 13 million child marriages could take place that otherwise would not have occurred between 2020 and 2030.

In the event of COVID-19 outbreaks in humanitarian settings, IPV incidents may surge if movement restrictions or quarantine measures are put in place.[10] Venezuela reported a sixty-five percent (65%)

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[3] Little is currently known about the effect of COVID-19 on pregnant and lactating women, making continued SRH services even more important. See UN Population Fund (UNFPA), "As COVID-19 Continues To Spread, Pregnant And Breastfeeding Women Advised To Take Precautions," UNFPA, March 5, 2020, https://www.unfpa.org/news/covid-19-continues-spreadpregnant-and-breastfeeding-women-advised-take-precautions

[4] Davies & Bennett, "A Gendered Human Rights Analysis," International Affairs

[5] ACAPS, "Beyond A Public Health Emergency," ACAPS, February 2016, https://reliefweb.int/sites/reliefweb.int/%20files/resources/a-potential-secondary-humanitarian-impacts-of-a-large-scale-ebola-outbreak.pdf%20

[6] Davies & Bennett, "A Gendered Human Rights Analysis," International Affairs.

[7] For example, internal CARE research found that 27 percent of adolescent girl participants in a project in conflict-affected areas of Somalia were suffering from depression and 29 percent from severe anxiety.

[8] IASC, "Briefing Note," IASC.

[9] International Rescue Committee (IRC), "Private Violence, Public Concern," IRC, January 2015, https://www.rescue.org/sites/default/files/document/564/ircpvpcfinalen.pdf

[10] Zhang Wanqing, "Domestic Violence Cases Surge During COVID-19 Epidemic," Sixth Tone, March 2, 2020, http://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic

increase in femicides in April 2020 compared to April 2019.[11] Zimbabwe's national GBV Hotline reported a seventy percent (70%) increase over pre-lockdown trends.[12] Somalia has seen a rapid rise in Female Genital Mutilation.[13] However, at the time when many women and girls need GBV and IPV services more than ever, evidence suggests that those services are likely to decrease as resources are diverted to dealing with the health crisis.[14]

// Hunger pandemic

The COVID-19 pandemic is unfolding in a world that is already experiencing a hunger crisis, one in which 2 billion people—one in every four people—do not have reliable access to enough nutritious and safe food. At the start of 2020, 690 million people were undernourished or chronically hungry. UN agencies estimate that that figure could increase by over 130 million because of COVID-19.[15]

Since the start of the pandemic, the number of people receiving food assistance in Latin America has nearly tripled. In West and Central Africa, food insecurity has jumped 135%, and 90% in Southern Africa.[16] Hunger hotspots—such as South Sudan and Afghanistan—are already seeing exponentially accelerating food crises. Four countries – Democratic Republic of Congo, northeast Nigeria, South Sudan and Yemen - are currently on the brink of famine.[17]

A number of factors contribute to this. Business closures, mobility restrictions, and social distancing related to the pandemic are affecting every aspect of food production and distribution. Access to fields, pasture, and water sources is limited, while economic restrictions mean that resources—such as seeds and fertilizers—can be difficult to obtain. Global school closures mean that 368 million children have lost

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[11] International Rescue Committee (IRC), "IRC data shows an increase in reports of gender-based violence across Latin America," June 2020. https://www.rescue.org/press-release/irc-data-shows-increase-reports-gender-based-violence-across-latin-america

[12] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "Global Humanitarian Response Plan: COVID-19," May 2020. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ghrp-covid19_mayupdate.pdf

[13] Plan International, "Girls in Somalia Subjected to Door-to-Door FGM," May 2020. https://plan-international.org/news/2020-05-18-girls-somalia-subjected-door-door-fgm

[14] CARE's 2014 Regional EVD Strategy found that "[s]ince the outbreak, gender-based violence and sexual exploitation programming has been seriously disrupted, further raising the possibility of unreported and untreated cases during the crisis."

[15] CARE International, "Left Out and Left Behind: Ignoring Women Will Prevent Us From Solving the Hunger Crisis," August 2020. https://care.ca/wp-content/uploads/2020/09/Left-Out-and-Left-Behind_FINAL-REPORT_reduced.pdf?x23729

[16] CARE International (2020). "Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings." https://insights.careinternational.org.uk/media/k2/attachments/CARE_Gender-implications-of-COVID-19_Full-Report_March-2020.pdf

[17] IASC, "In a letter to members of the Security Council, Mr. Mark Lowcock warned that the 'First Famines of Coronavirus Era Are at World's Doorstep'," September 2020. https://interagencystandingcommittee.org/inter-agency-standing-committee/letter-members-security-council-mr-mark-lowcock-warned-first

access to school feeding programs, a crucial safety net for families worldwide.[18] In the face of mobility restrictions and lost income, people around the world are struggling to access enough food and diverse, quality diets. This lack of nutrition compromises their immune systems.

When food becomes scarce, women and girls—who are already more likely to be malnourished than men and boys— could face additional health complications quickly, including increased susceptibility to COVID-19 infection. In CARE's global Rapid Gender Analysis on the impacts of COVID-19, 41% of women said that hunger is one of their biggest challenges, compared with 30% of men.[19] While both men and women are going hungry, women reported eating even less frequently than men—they are often expected to buy and prepare all food for the family, and typically eat last and least in order to ensure the other family members have enough. In Afghanistan, for example, men reported eating fewer meals three days a week, while women are eating fewer meals four days a week.[20]

COVID-19 not only is compromising how much food people eat, but it also is forcing people to make less nutritious food choices. In Venezuela, for example, 74% of people can access cereals, but only 61% can access proteins or vegetables.[21] Women's difficulties in accessing COVID-19 support programs also make it harder to have nutritious food at home. Pregnant and lactating women and girls have specific nutritional needs that may go unmet during COVID-19.

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[18] UN (2020). "Policy Brief: The Impact of COVID-19 on Food Security and Nutrition." https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_covid_impact_on_food_security.pdf
[19] CARE International. "She Told Us So – Rapid Gender Analysis: Filling the Data Gap to Build Back Equal." September 2020. https://care.ca/wp-content/uploads/2020/09/CARE_RGA_SheToldUsSo_Sept-2020.pdf?x23729
[20] Kalkidan Lakew Yihun (July 2020). "Rapid Gender Analysis COVID-19 Afghanistan – July 2020." CARE Afghanistan. http://www.careevaluations.org/evaluation/afghanistan-covid19-rga-july-2020
[21] CARE (July 2020). "Proyecto: Responder a las Necesidades Inmediatas de los Migrantes / Refugiados de Venezuela en el Contexto del COVID-19." CARE International. http://www.careevaluations.org/evaluation/proyecto-responder-a-las-necesidades-inmediatas-de-los-migrantes-refugiados-de-venezuela-en-el-contexto-del-covid-19