

# THE LINGERING GENDERED EFFECTS OF THE COVID-19 PANDEMIC IN ASIA AND THE PACIFIC



## ABOUT THIS REPORT

This publication showcases the results of Rapid Gender Assessment surveys (RGAs) on the impact of the coronavirus disease (COVID-19) in seven countries in Asia and the Pacific. For some of these countries, this is the second round of RGAs and thus these findings may follow up those of “[Unlocking the Lockdown](#)”. The report is meant to be a statistical snapshot that could inform responses to the crisis but is not meant to provide policy recommendations or analyze the policy context in each country.

The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) led this study, in collaboration with the Asian Development Bank (ADB) and Ipsos, with support/consent from national statistical offices and national women’s machineries. To address the challenges related to face-to-face data collection during lockdowns and restricted mobility periods, the RGAs made use of telephone interviews. Additional resources related to the report, including methodological notes, endnotes and microdata can be found on the Women Count Data Hub at: [data.unwomen.org](http://data.unwomen.org).

## ACKNOWLEDGEMENTS

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## FOREWORD

The ongoing coronavirus disease (COVID-19) pandemic has had tremendous consequences for populations globally. For women and girls, existing gender inequalities and socioeconomic barriers have only been exacerbated. Given the commitments of UN Women and the Asian Development Bank to gender equality and our desire to create frameworks for women's empowerment, there has been an urgent need for data on the gendered effects of the pandemic. We hope this report will spur regional cooperation, inform evidence-based recovery responses and ensure that women are at the forefront of resilient Asia-Pacific economies.

This report provides data to assist government partners with the design of effective and gender-inclusive policies that will enable them to rebound from the pandemic. Further, it provides civil society organizations and other stakeholders with the necessary evidence to inform advocacy and accountability mechanisms.

This report builds on the previous research of UN Women, which quickly mobilized technological workarounds to overcome lockdown restrictions to collect real-time data on the gendered consequences of the pandemic. The findings were captured in a report entitled "Unlocking the Lockdown" – the first knowledge product of its kind since the onset of the pandemic – that provided invaluable evidence of the disproportionate effects of the crisis on women and girls. The report provided information that national governments were able to use to help women, for instance, by extending stimulus packages and changing application requirements.

The evidence presented here shows that while the health emergency continues to affect all members of the population, women and men encounter different barriers to accessing vaccinations and medical supplies. Moreover, the lingering economic and environmental effects of the pandemic are also gendered. It is becoming clear that women in Asia and the Pacific were more likely to face reduced work hours due to lockdowns, and they have borne the brunt of increased unpaid domestic and care work. When it comes to accessing financial support or government stimulus packages, women have also faced disadvantages. The data provided in this report is therefore useful for governments, civil society and international institutions to continue to design targeted programming to support women and girls across Asia and the Pacific.

We are grateful to our survey partners, and the many thousands of women and men across Asia and the Pacific who took the time to respond to the survey; to ensure that their collective voices would contribute to empower women and girls across the region.

**Samantha Hung,**

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Director, Regional Office for Asia  
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## SUMMARY OF FINDINGS

The coronavirus disease (COVID-19) pandemic continues to affect women and men across Asia and the Pacific in a multiplicity of ways. Regardless of differences in caseloads and other health effects across countries, data collected in Indonesia, Kiribati, Pakistan, Papua New Guinea, Samoa, Solomon Islands and Tonga show that the impacts are wide-ranging and multidimensional. While in countries such as Kiribati, Samoa, Solomon Islands and Tonga the survey captured mostly economic and environmental effects of the pandemic (the caseload was low at the time of the survey and thus some of the health effects were negligible), in places such as Indonesia, Pakistan and Papua New Guinea these coupled with major challenges to access vaccines and COVID-19 related information for some population groups, and substantial increases in unpaid care and domestic work driven by the pandemic. Across all countries considered, some of the effects of the pandemic that were noticeable at first have now resolved, but lingering issues remain around employment, loss of livelihoods, food hardship and increased unpaid care and domestic workloads, among others.

### INEQUALITIES IN COVID-19 VACCINATION PATTERNS

In Pacific Island Countries, women are less likely than men to have received the first two COVID-19 vaccine doses.



Vaccine availability and delays in administration are the key obstacles to complete immunization, noted by

**34%** OF PEOPLE

### SHIFTS IN THE WORLD OF PAID AND UNPAID WORK

Across most countries, the pandemic has pushed women disproportionately out of employment and into unpaid care and domestic work.



The proportion of women whose main economic activity is unpaid care and domestic work has increased in all countries, except for Solomon Islands.

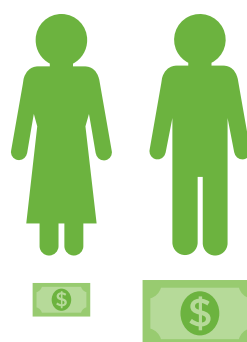
### INCOME REDUCTIONS AND LOSSES

More than

**80%** OF PEOPLE saw reductions in income since the onset of the pandemic;

**8%** OF PEOPLE lost it completely.

Women are substantially less likely than men to have access to personal income.



### CHANGES IN REMITTANCE FLOWS

**9** out of **10** PEOPLE

who received remittances prior to the pandemic and continue to do so, saw drops in the amounts received.



In Kiribati, Samoa and Tonga, more women than men stopped receiving remittances.

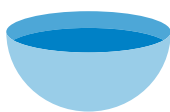
## WIDESPREAD FOOD HARDSHIP

Food hardship is widespread in some countries. In Solomon Islands

**66% OF WOMEN**

**65% OF MEN**

are experiencing it.



In Pakistan and Tonga more women than men experienced food hardship, although the gender gaps are small.

## MAGNIFIED UNPAID CARE AND DOMESTIC WORKLOADS

Women carry the heaviest unpaid care and domestic work burdens across all countries. In

**88%**

of cases women perform most of the cooking, and in

**82%**

they do the cleaning.



COVID-19 worsened these burdens:

**14% OF WOMEN**

**10% OF MEN**

saw increases in time allocated to cleaning.

**24% OF WOMEN**

**15% OF MEN**

now spend more time feeding, cleaning and providing medical care for children.



Since the onset of the pandemic

**25% OF WOMEN**

**18% OF MEN**

spend more time home-schooling children. An additional

**4% OF WOMEN**

and men initially saw increases in time but these have now resolved.

## OVERLAPPING ENVIRONMENTAL CRISES

COVID-19 overlapped with typhoons, droughts and other extreme weather; and during the pandemic,

**9% OF PEOPLE**

saw their water source compromised.



Since the pandemic began, roughly one quarter of the Kiribati population lost power, compared to rates between **15%** and **19%** in Pakistan, Papua New Guinea and Solomon Islands. Gender gaps are significant in Pakistan and rural Kiribati.

Disruptions to public transportation affected half of the population in Papua New Guinea, **36%** in Pakistan, **33%** in Kiribati and **30%** in Solomon Islands.



## BARRIERS TO ACCESSING GOVERNMENT SUPPORT

Social protection grants have been the most widespread form of government support since the onset of the pandemic, but they are not universal. In Kiribati more than **40%** of people received them, but in Papua New Guinea and Solomon Islands almost nobody did.



Food and agricultural assistance reached more than **30%** of people in Indonesia, but in most other countries they reached

**LESS THAN**

**10%.**



## INTRODUCTION

# MEASURING THE DIFFERENTIATED GENDERED EFFECTS OF THE CORONAVIRUS DISEASE ACROSS COUNTRIES AND POPULATION GROUPS

Shortly after the onset of the coronavirus disease (COVID-19 pandemic), evidence showed the consequences of the crisis spanned well beyond its direct health effects. The impacted outcomes ranged from access to health care to employment and income, and women were often at a disadvantage. The pandemic immediately impacted essential workers – such as health care workers, who are predominantly female, and essential work, such as unpaid care and domestic chores. It also revealed that existing gender inequalities translate into disproportionate effects on women in times of crises. Two years on, the pandemic continues to affect women and men, and its lingering effects are gendered. Ample evidence is now available on the negative impact of the COVID-19 pandemic on women-dominated sectors, such as tourism, and types of work, such as informal jobs. Data also point to unequal barriers experienced by women to access government support and stimulus packages for their businesses. This impacts access to food, reversing some of the hard-won progress towards eliminating poverty in all its forms.

In response to these concerns and to design effective responses to the crisis, the demand for gender data has increased. Interventions should ideally not only curb the direct effects of the pandemic, but also lead to gender transformative recovery across multiple domains, from the economy to the health sector and the environment. They should redress existing inequalities and limit their impacts across all dimensions of sustainable development. To create interventions like that, it is necessary to have precise information on those that are most affected by the pandemic and how.

As mobility restrictions and financial constraints have undermined data ecosystems and challenged face-to-face data collection, this report assesses the lingering consequences of the pandemic on women and men through evidence generated by Rapid Gender Assessment Surveys (RGAs) that used Computer Assist-

ed Telephone Interviewing (CATI). These were rolled out in seven countries in Asia and the Pacific (Indonesia, Kiribati, Pakistan, Papua New Guinea, Samoa, Solomon Islands and Tonga). Impacts across these countries were heterogeneous. With the exception of Papua New Guinea, Pacific Islands Countries (PICs) recorded lower incidence of COVID-19 related mortality, whereas in Pakistan and Indonesia the death toll was higher. The length and severity of COVID-19 waves and lockdown measures have also differed across countries, as have vaccination policies and other response programmes. Tonga, Samoa, Pakistan and Indonesia have higher vaccination rates overall. Given the high caseloads, Indonesia has been faster in setting up various forms of COVID-19 related government support, along with Kiribati, despite the country being largely spared from the health emergency. In Papua New Guinea and Solomon Islands, where the pandemic overlapped with on-going conflicts, the economic effects of the pandemic appear most devastating.

To capture the consequences of the pandemic while taking these differences into consideration, RGAs were administered in partnership with national Governments, who advised on the questionnaire design and administration. The RGAs were rolled out simultaneously in all countries in late September 2021 for eight weeks, and data were collected from a large and balanced sample of 17,845 adults of different sexes, ages, and educational levels (see Annex 1 for sociodemographic characteristics of respondents). Still, the results must be interpreted with caution in light of important cross-country differences. Some of the limitations of the study are flagged in the technical note (Annex 2), as well as others associated with the use of CATI. It illustrates the extensive quality control measures put in place to account for the statistical challenges associated with phone interviews, including conducting booster interviews among hard-to-reach population groups (i.e., less educated, rural and/or older people).

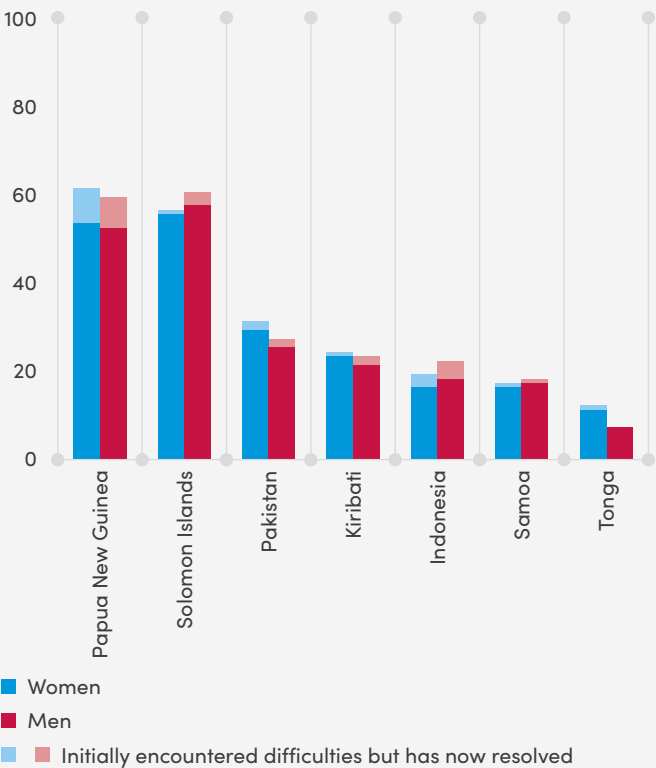
KEY INSIGHTS

THE UNEQUAL EFFECTS OF THE PANDEMIC ON THE HEALTH OF WOMEN AND MEN ALSO MANIFEST IN VACCINATION PATTERNS

The COVID-19 pandemic has had devastating health effects, but these varied greatly across the countries considered for this study. At the time of data collection, incidence of the disease (per 100,000 population) has been substantially higher in Indonesia (1,575), Pakistan (590) and Papua New Guinea (412), compared to Solomon Islands (3), Samoa (2), Kiribati (2) and Tonga (<1).<sup>1</sup>

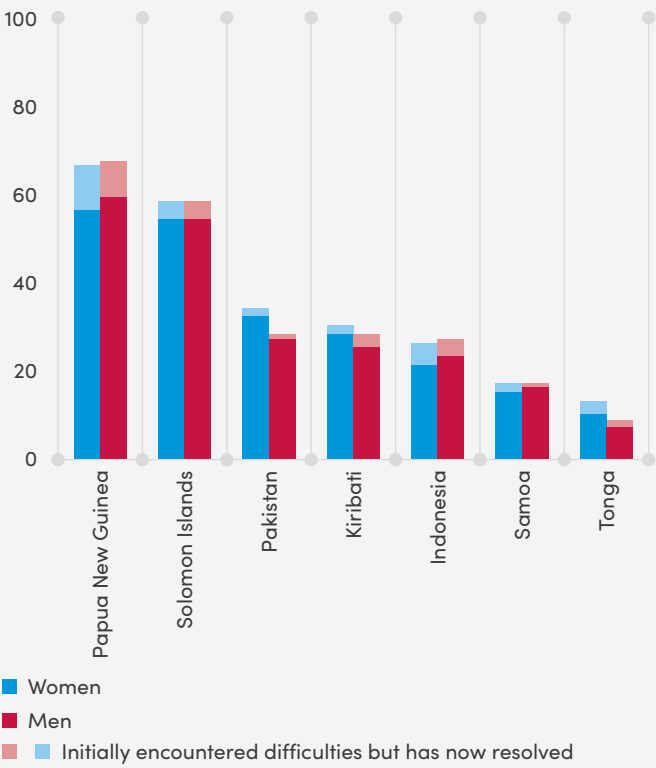
Beyond increased mortality rates directly attributed to the virus, excess mortality may be linked to barriers in accessing timely health care and medical supplies. In all countries considered, these barriers persist. Notably, in Papua New Guinea and Solomon Islands more than half of the population continues to experience challenges in accessing medical supplies and hygiene products (figure 1 and figure 2)<sup>2</sup>. Gender gaps in this regard are small.

Figure 1: Proportion of people who encountered difficulties accessing hygiene products, by sex (percentage) (n=17,845)



Note: For men and women in Kiribati, Samoa and Tonga, and women in Solomon Islands, estimates for "initially yes but has now resolved" should be interpreted with caution as the number of respondents is less than 25. "Don't know" and "Refused to answer" categories are not depicted. Gender differences are statistically significant ( $p < 0.05$ ) for "continues encountering difficulties" in Tonga ( $p = 0.01$ ) and for "initially encountered difficulties but has now resolved" in Pakistan ( $p = 0.047$ ), Papua New Guinea ( $p = 0.001$ ) and Solomon Islands ( $p = 0.03$ ).

Figure 2: Proportion of people who encountered difficulties accessing medical supplies, by sex (percentage) (n=17,845)



Note: For men in Pakistan, Samoa and Tonga, and women in Samoa, estimates for "initially yes but has now resolved" should be interpreted with caution as the number of respondents is less than 25. "Don't know" and "Refused to answer" categories are not depicted. Gender differences are statistically significant ( $p < 0.05$ ) for continues encountering difficulties in Pakistan ( $p = 0.02$ ), and for initially encountered difficulties but has now resolved in Pakistan ( $p = 0.00$ ), Papua New Guinea ( $p = 0.00$ ) and Tonga ( $p = 0.03$ ).

1 Figures refer to total number of all-time reported cases per 100,000 population. See New York Times monitor: [www.nytimes.com/interactive/2021/world/covid-cases.html](https://www.nytimes.com/interactive/2021/world/covid-cases.html) (accessed 29 December 2021).

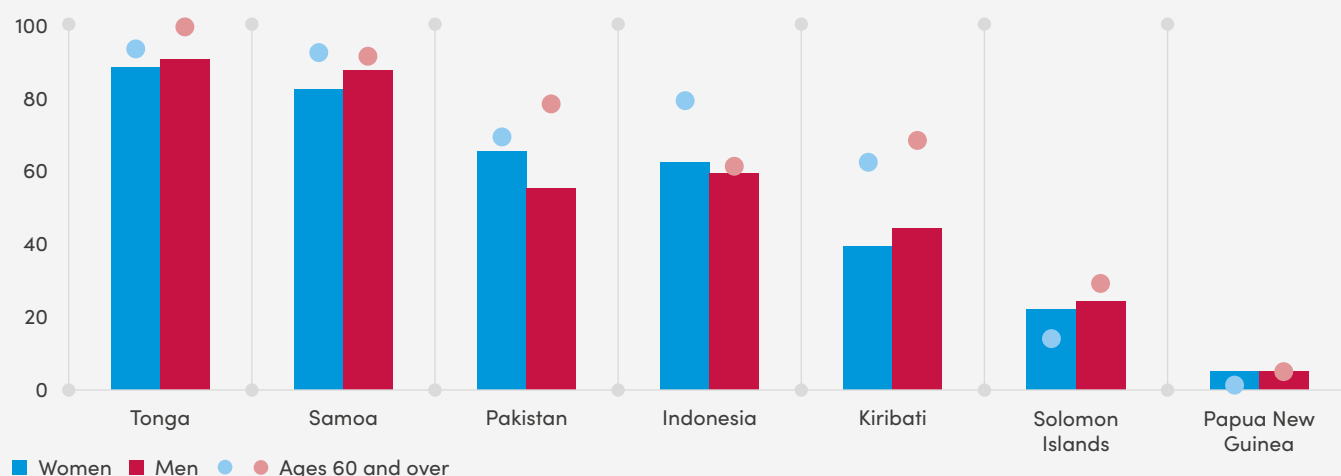
2 No specific definitions of medical supplies vs. hygiene products were provided at the time of the survey, so this was left to respondent's interpretation.



To limit COVID-19 related deaths and reduce burdens on already-overwhelmed health-care services, [the WHO recommends full inoculation](#). High demand for vaccines coupled with supply chain limitations in some countries are posing challenges to people who want to access all necessary doses. As of November 2021, double-dose vaccination rates were highest in Tonga and Samoa at more

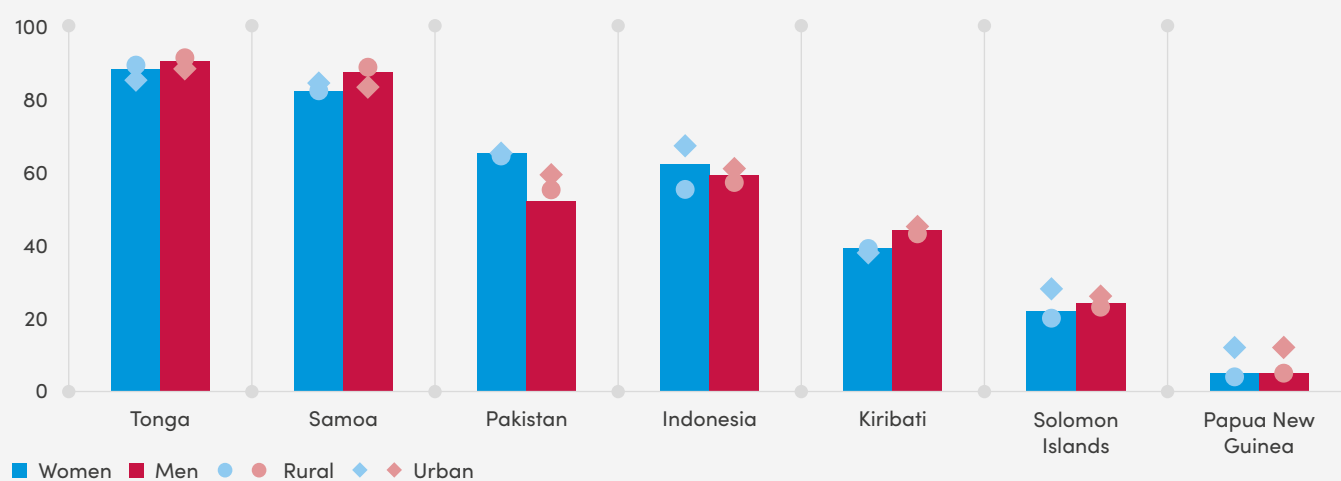
than 80 per cent of the population, followed by Indonesia and Pakistan at more than half of the population.<sup>3</sup> In Kiribati, the Solomon Islands and Papua New Guinea; vaccination rates are substantially lower. Across Pacific Island Countries, women are less likely than men to have received the first two doses (figure 3). This is particularly true among those residing in urban areas (figure 4).

**Figure 3: Proportion of people who completed two doses of COVID-19 inoculation as of November 2021, by sex and age group (percentage) (n=17,845)**



Note: For women and men aged 60 and above in Papua New Guinea, and women aged 60 and above in Solomon Islands, estimates should be interpreted with caution as the number of respondents is less than 25. Respondents who indicated they did not know if they had been vaccinated, or who refused to answer, have been considered as non-receivers of two-dose inoculation. Gender differences are statistically significant ( $p < 0.05$ ) for Kiribati ( $p = 0.01$ ), Pakistan ( $p = 0.00$ ), Samoa ( $p = 0.01$ ) and women and men ages 60 and over for Indonesia ( $p = 0.00$ ) and Pakistan ( $p = 0.02$ ).

**Figure 4: Proportion of people who completed two doses of COVID-19 inoculation as of November 2021, by sex and location (percentage) (n=17,836)**



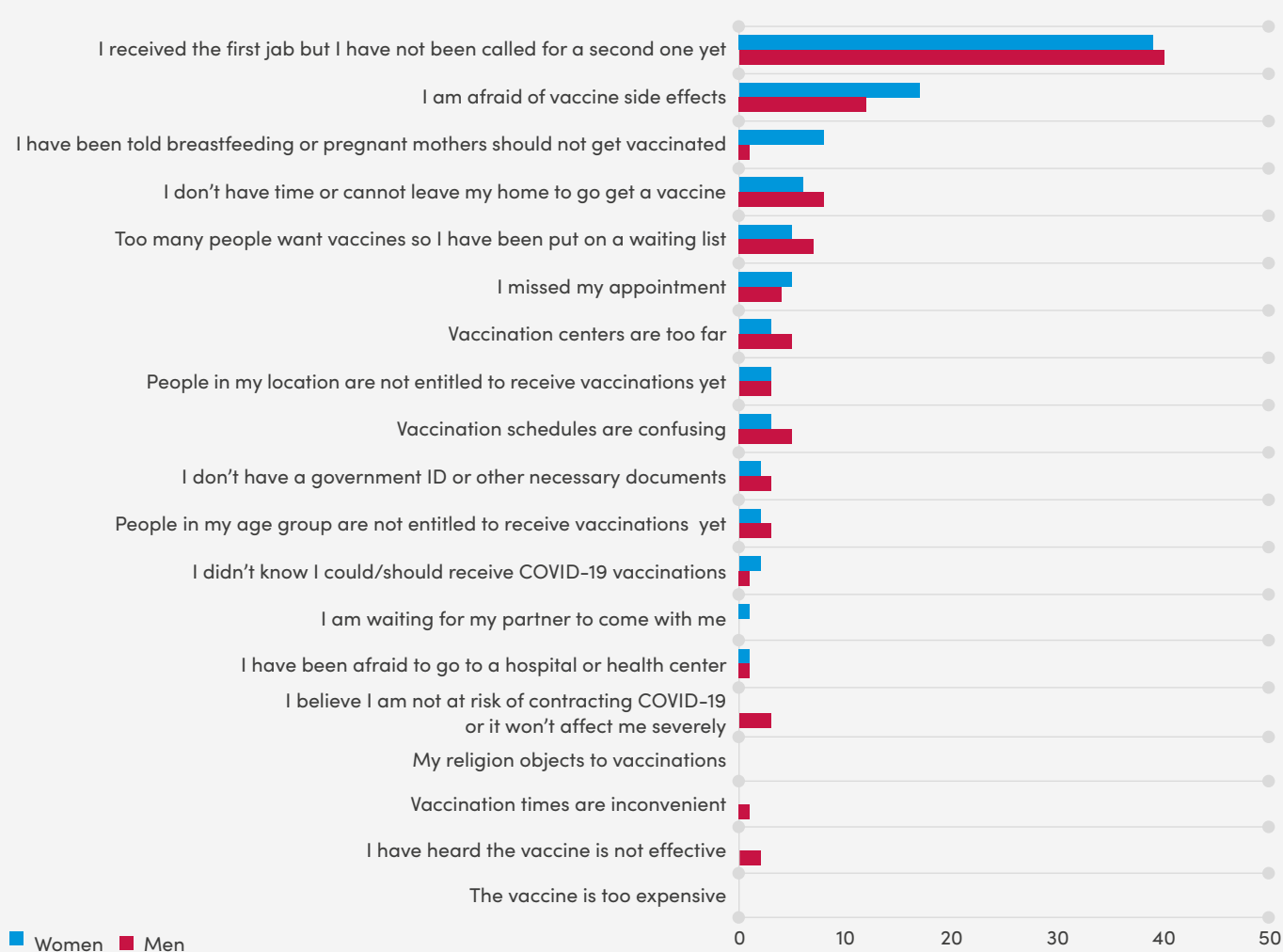
Note: Respondents who indicated they did not know if they had been vaccinated, or who refused to answer, have been considered as non-receivers of two-dose inoculation. Gender differences are statistically significant ( $p < 0.05$ ) for Kiribati ( $p = 0.01$ ), Pakistan ( $p = 0.00$ ), Samoa ( $p = 0.01$ ), rural populations of Pakistan ( $p = 0.0001$ ) and Samoa ( $p = 0.003$ ), and urban populations of Indonesia ( $p = 0.03$ ), Kiribati ( $p = 0.02$ ), and Pakistan ( $p = 0.01$ ).

3 Vaccination rates have been calculated from self-declared survey responses among adults and thus may differ from official vaccination figures from administrative data in each country.

Many who are not fully inoculated did receive a first dose of the COVID-19 vaccine (34 per cent). The most frequently noted reason for not completing the full course of vaccination was availability-related (e.g. 34 per cent of those not fully vaccinated were waiting to be called for their second dose), followed by fear of side-effects (12 per cent) (figure 5). In Papua New Guinea, however, fear of side effects was flagged as the main reason by more than half of the population. Across countries, some other reasons show-

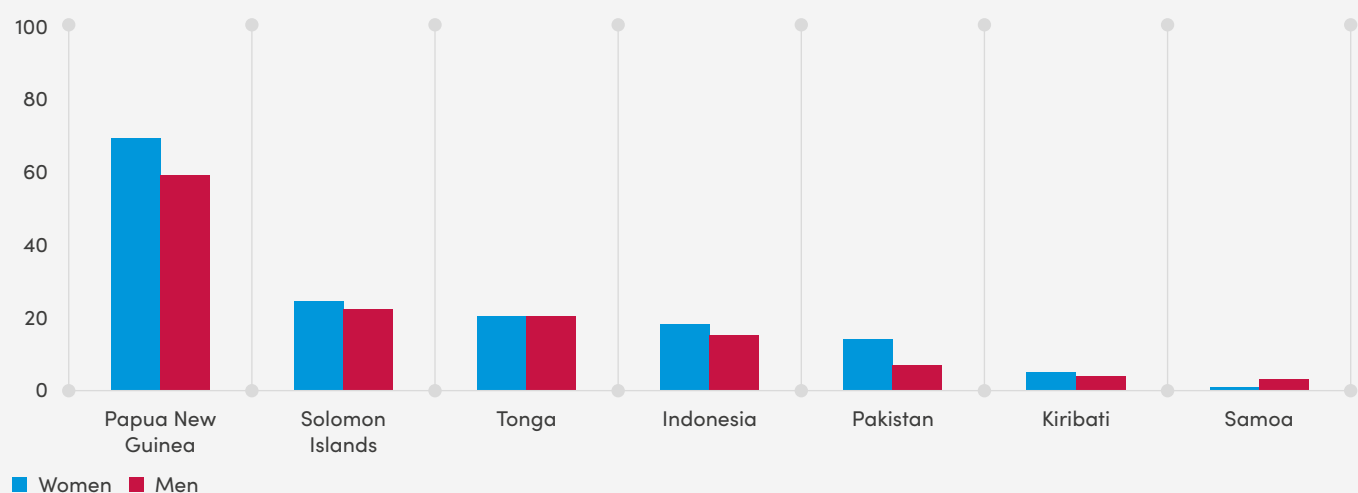
case gender differences, which should be considered for the effective roll out of vaccination programmes (figures 6 and 7). For instance, some women did not complete the full course of vaccination because of concerns about the overall effects on pregnant women or breastfeeding mothers. Men were more likely to cite appointment related reasons, such as having missed scheduled appointments, appointment locations being too far, or unavailability of appointments at convenient times.

**Figure 5: Proportion of people by main reason for not receiving a complete course of COVID-19 inoculation (seven country aggregate), by sex (percentage) (n=7,751)**



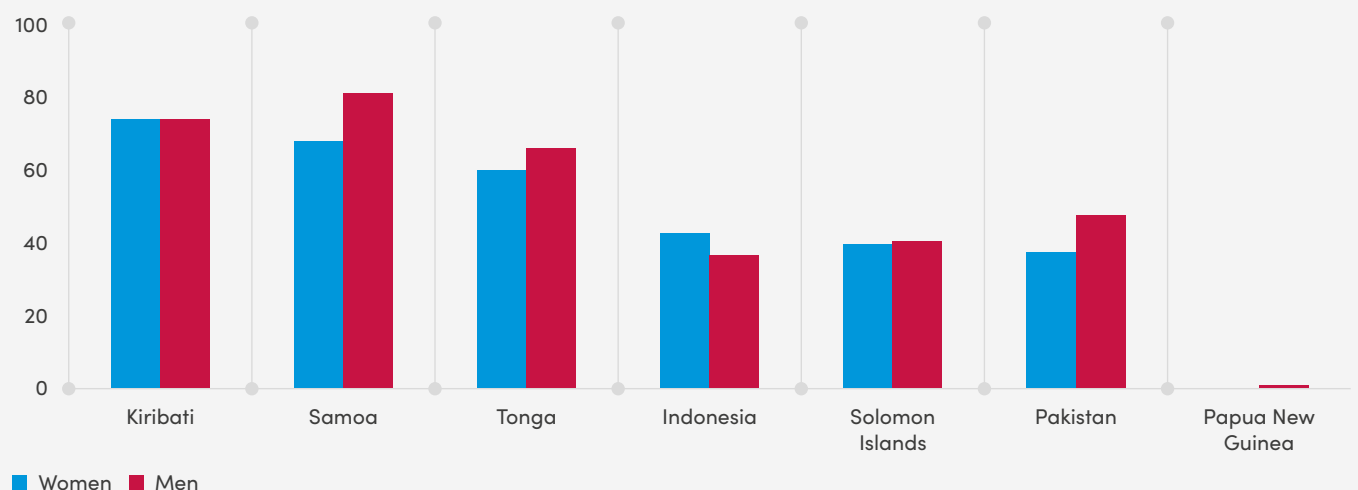
Note: Aggregates are calculated using World Population Prospects for women's and men's population ages 18 and over (2020) (available from: <https://population.un.org/wpp/>). The response "Other" was not depicted in this figure. Estimates for 1) "The vaccine is too expensive", and 2) "I am waiting for my partner to come with me", should be interpreted with caution as the number of women and men respondents is less than 25 each. Gender differences are statistically significant ( $p < 0.05$ ) for "I missed my appointment" ( $p = 0.02$ ), "Too many people want vaccines so I have been put on a waiting list" ( $p = 0.02$ ), "I believe I am not at risk of contracting COVID-19 or it won't affect me severely" ( $p = 0.02$ ), "Vaccination times are inconvenient" ( $p = 0.000$ ), "I don't have time or cannot leave my home to go get a vaccine" ( $p = 0.000$ ), "Vaccination centers are too far" ( $p = 0.000$ ), "I have heard the vaccine is not effective" ( $p = 0.02$ ), "I didn't know I could/should receive COVID-19 vaccinations" ( $p = 0.01$ ), and "I have been told breastfeeding or pregnant mothers should not get vaccinated" ( $p = 0.00$ ).

**Figure 6: Proportion of people who cited side effects as the main reason for not receiving two doses of COVID-19 inoculation as of November 2021, by sex (percentage) (n=7,751)**



Note: Estimates for women and men in Samoa and men in Tonga should be interpreted with caution as the number of respondents is less than 25. "Don't know", "Refused to answer" and "Other" categories are not depicted. Gender differences are statistically significant ( $p < 0.05$ ) for Pakistan ( $p = 0.001$ ) and Papua New Guinea ( $p = 0.01$ ).

**Figure 7: Proportion of people who cited waiting to be called as the main reason for not receiving two doses of COVID-19 inoculation as of November 2021, by sex (percentage) (n=7,751)**



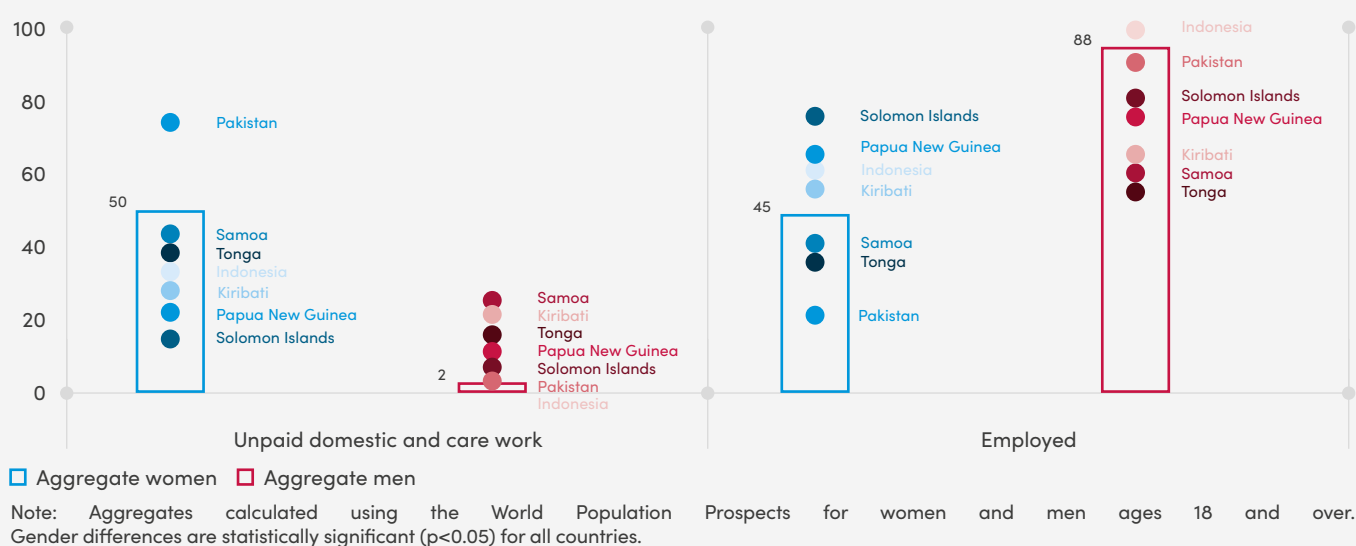
Note: Estimates for women and men in Papua New Guinea should be interpreted with caution as the number of respondents is less than 25. "Don't know", "Refused to answer" and "Other" categories are not depicted. Gender differences are statistically significant ( $p < 0.05$ ) for Pakistan ( $p = 0.000$ ) and Samoa ( $p = 0.000$ ).

## MAJOR SHIFTS IN THE WORLD OF WORK ARE TAKING PLACE AMID ECONOMIC SLOWDOWN AND INCREASED DOMESTIC AND CARE BURDENS

While some countries have weathered the health effects of the pandemic; economic consequences have lingered even in places where infection rates were low. Across countries, women are more likely than men to cite unpaid care and domestic work as their main

economic activity, and gender gaps are particularly large in Indonesia and Pakistan, where caseloads have been higher. Shifts in employment taking place since the onset of the pandemic have likely widened these gaps.

**Figure 8: Proportion of people by main economic activity, seven country aggregate and country-level results by sex (percentage) (n=17,845)**

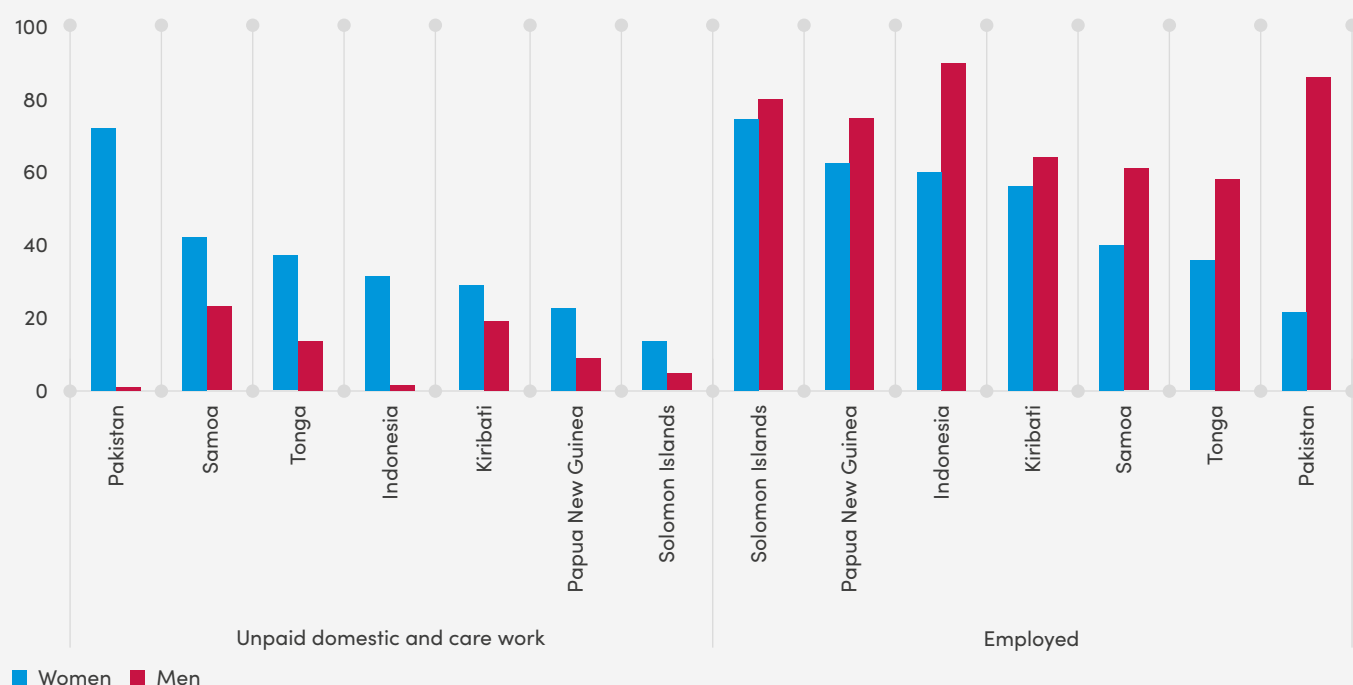


One third of respondents noted changes in their economic activity or jobs since the onset of COVID-19. While 12 per cent of people experienced temporary changes, particularly at the beginning of the pandemic; 29 per cent of respondents changed jobs permanently. In many cases, these changes were driven by shifts in demand and barriers to carry out certain jobs under COVID-19 related restrictions. For instance,

jobs in transportation and storage, accommodation and tourism, art, entertainment and recreation,<sup>4</sup> have been severely affected by the pandemic – people in these sectors were nearly twice as likely as the rest of the population to note changes in their economic activity or jobs (42 per cent of them noted changes, compared to 24 per cent of people working in other sectors).

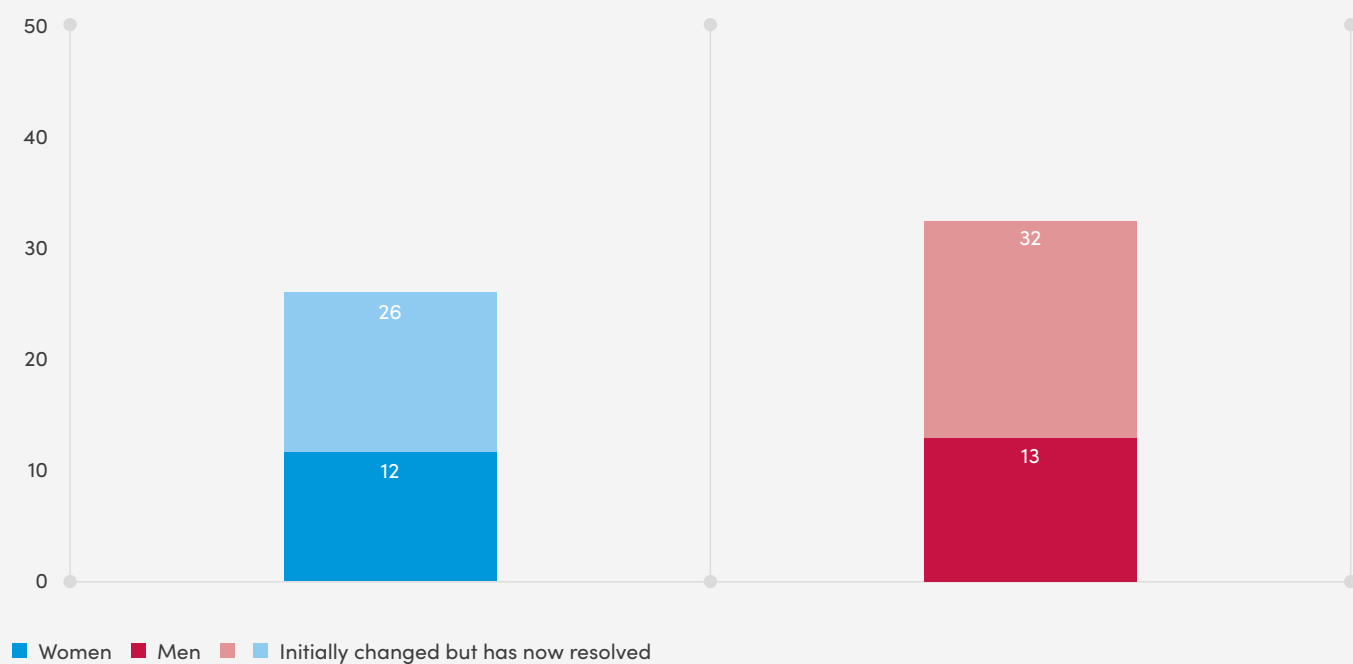
<sup>4</sup> A total of 254 respondents worked in these sectors.

**Figure 8 (continued):** Proportion of people by main economic activity, seven country aggregate and country-level results by sex (percentage) (n=17,845)



Note: Aggregates calculated using the World Population Prospects for women and men ages 18 and over. Gender differences are statistically significant ( $p < 0.05$ ) for all countries.

**Figure 9:** Proportion of people who changed their economic activities or jobs, (seven country aggregate) by sex (percentage) (n=17,478)

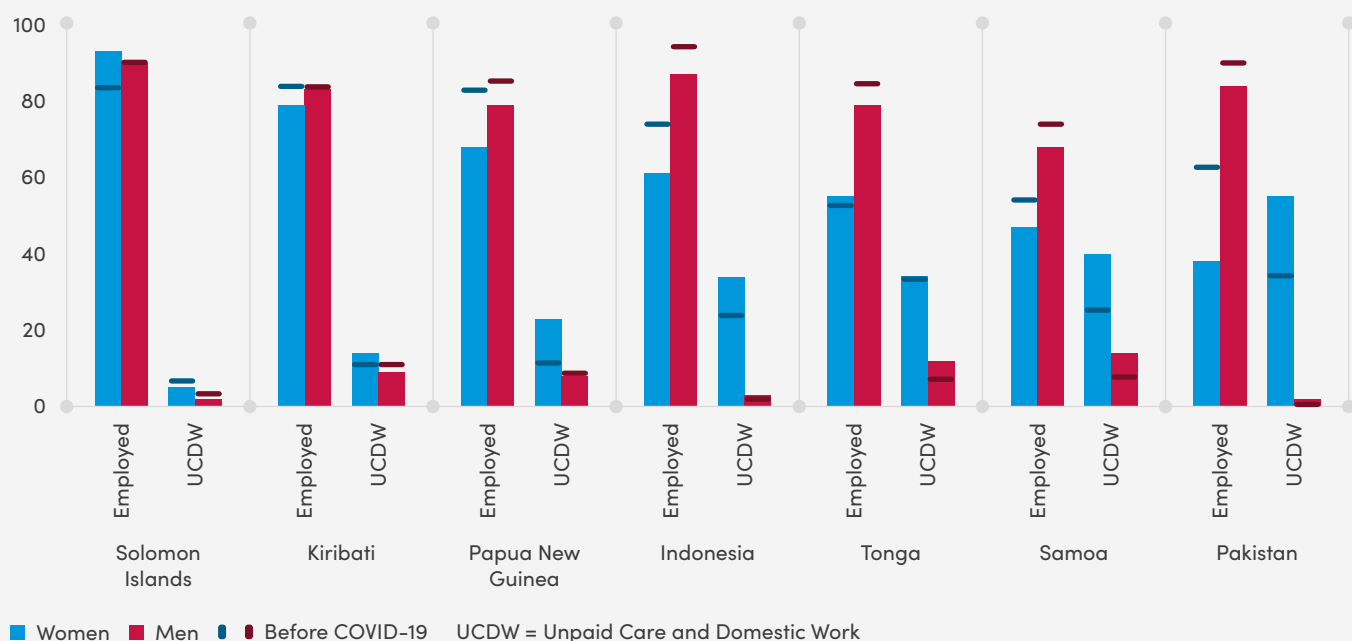


Note: Aggregates calculated using the World Population Prospects for women and men ages 18 and over. "Don't know", "Refused to answer" and "No change" categories are not depicted. All gender differences are statistically significant ( $p < 0.05$ ).

Data show that owing to global market disruptions, higher vulnerability of women's jobs and pandemic-driven rises in unpaid care and domestic work burdens, a larger share of women may have been pushed out of labour markets and into unpaid household work, which highlights that COVID-19 may be exacerbating existing

gender inequalities in the world of work (figure 10). The shifts are particularly dramatic for women in Indonesia and Pakistan, where the high number of COVID-19 cases increased unpaid work burdens and affected labor market participation substantially. Solomon Islands is the only country where this phenomenon did not take place.

**Figure 10: Proportion of people in employment and in charge of unpaid care and domestic work before COVID-19 and at present, by sex (percentage) (n=3,728 current employment; n=3,725 previous employment)**



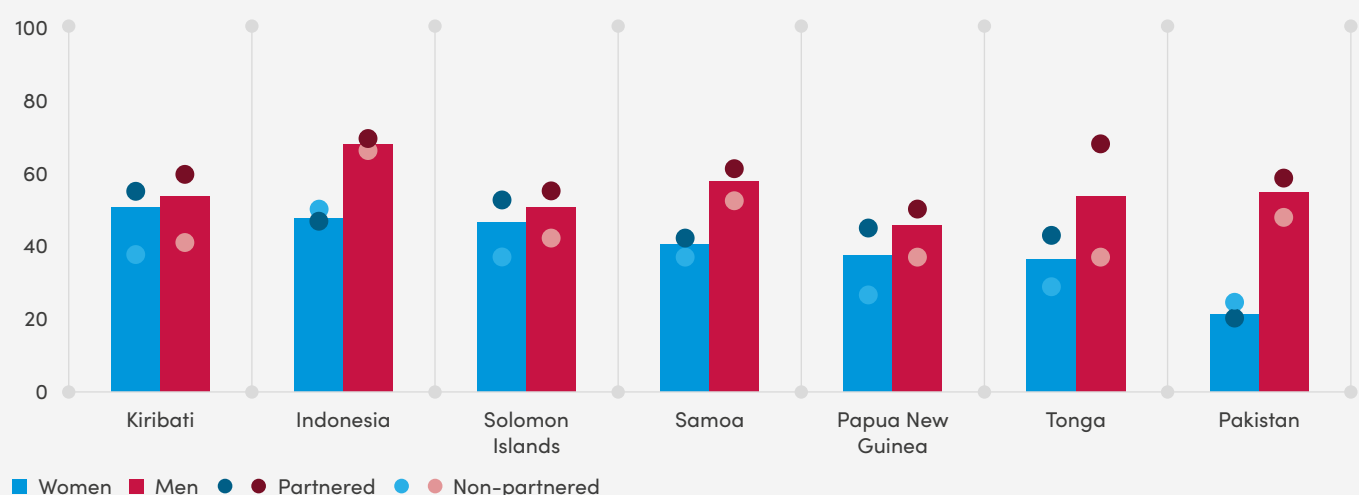
Note: Estimate for unpaid domestic and care work for 1) women and men in Kiribati and Solomon Islands, 2) men in Indonesia, Pakistan, Papua New Guinea and Tonga, and 3) men in Samoa who engaged in unpaid domestic and care work before COVID-19, should be interpreted with caution as the number of responses is less than 25 each. Gender differences across women in employment, before and after COVID-19, are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.000$ ), Pakistan ( $p = 0.000$ ), and Solomon Islands ( $p = 0.01$ ); in unpaid care and domestic work across women, for Indonesia ( $p = 0.000$ ), Pakistan ( $p = 0.000$ ), and Samoa ( $p = 0.001$ ). Before and after COVID-19 differences for men in employment are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.01$ ) and Pakistan ( $p = 0.02$ ). However, for men in unpaid care and domestic work, these differences are not significant ( $p \geq 0.05$ ) in any country.

## THE PANDEMIC IS WORSENING GENDER POVERTY GAPS, AS WOMEN ARE LESS LIKELY THAN MEN TO HAVE AN INCOME AND MORE LIKELY TO LOSE INCOME WHEN THEY HAVE IT

Previous UN Women analysis shows that the pandemic is worsening extreme poverty across countries, particularly among women in their key reproductive years. By 2030, the global gender poverty gap for people ages 25–34 will worsen from 118 women for every 100 men to 121 women for every 100 men. In South Asia and in the Pacific, the gap will worsen further to 129 and 128 women for every 100 men,

respectively. In crisis situations, access to personal income (e.g. from wages, rent, royalties, etc.) is a powerful coping mechanism against poverty, but evidence from the RGAs shows that women are substantially less likely than men to have it, particularly partnered women (figure 11). This increases their vulnerability to shocks and reduces their agency for decision-making within the household.

**Figure 11: Proportion of people who have a source of personal income, by sex and partnership status (percentage) (n=17,822)**

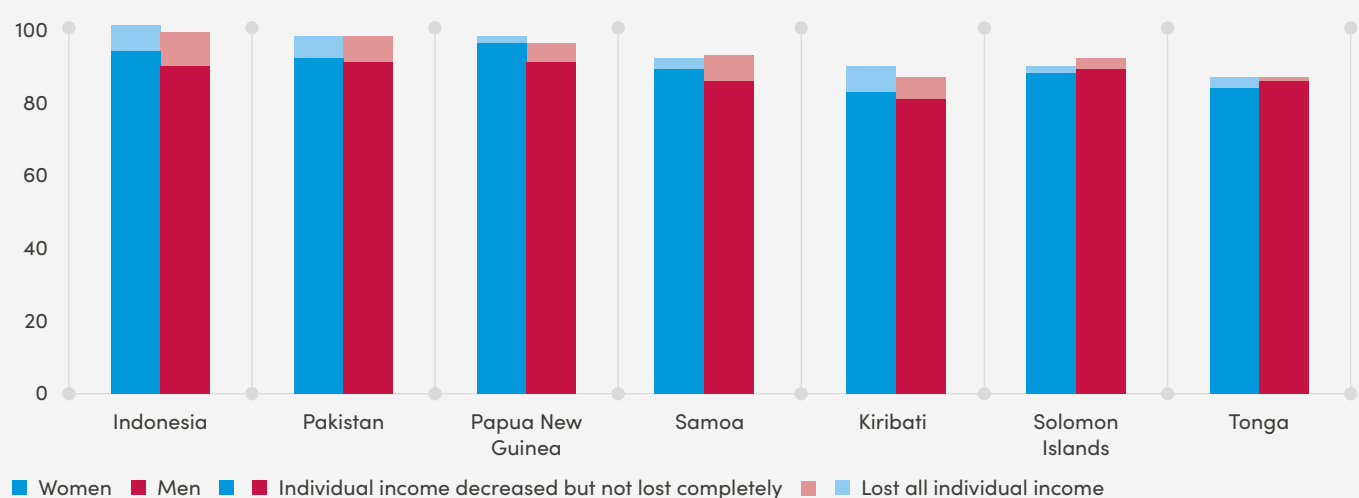


Note: Status has been classified as "Partnered" if respondents were married and "Non-partnered" if respondents were separated, widowed, divorced and single (never married). "Don't know" and "Refused to answer" categories are not depicted. All gender differences are statistically significant ( $p < 0.05$ ), except for Kiribati ( $p = 0.07$  for total and  $p = 0.10$  for partnered). Gender differences for those non-partnered are significant ( $p < 0.05$ ) for Indonesia ( $p = 0.000$ ), Pakistan ( $p = 0.000$ ), and Samoa ( $p = 0.000$ ). In the dataset, non-partnered women are overrepresented in the lower age groups, indicating that women living with their parents or pursuing studies may be the reason why non-partnered women appear less likely to have an income.

Changes in personal income since the onset of COVID-19 were experienced by both women and men (63 per cent women and 64 per cent men). Among those that saw changes, 80 per cent experienced a drop in income, while 8 per cent experienced a total loss of income. Where

differences are statistically significant, some gender differences exist. In Tonga, women were significantly more likely than men to lose all their income, while in Papua New Guinea, they were more likely to see decreases but not total loss (figure 12).

**Figure 12 : Proportion of people who saw changes in personal income since the onset of COVID-19, by sex and type of change (percentage) (n=4,459)**



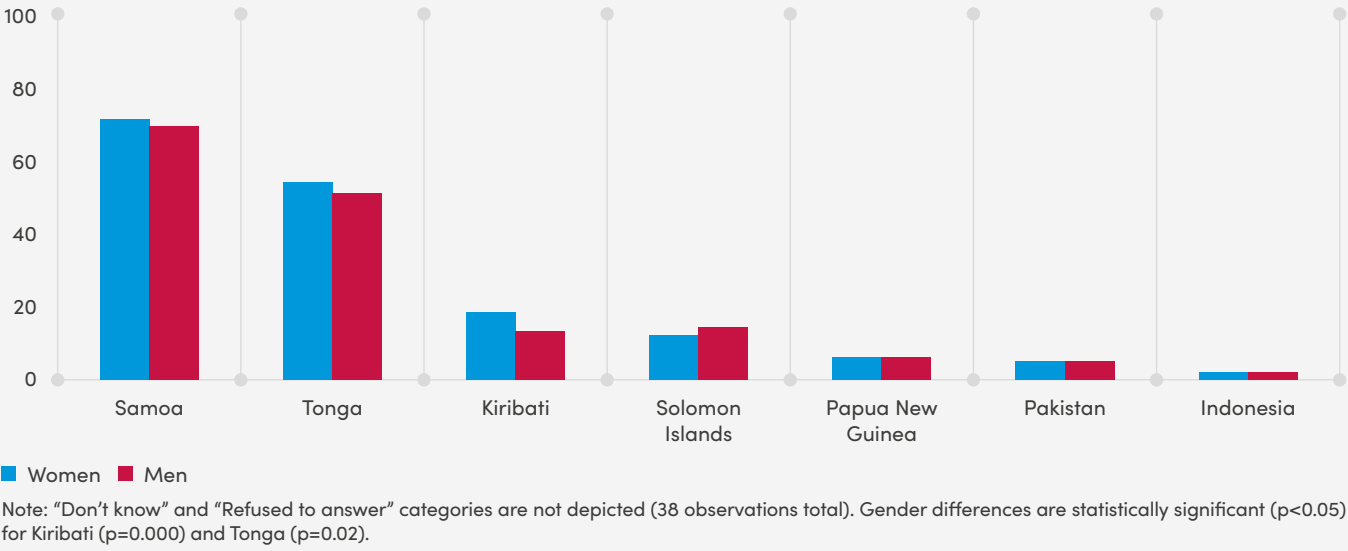
Note: The figure depicts the proportion of people who saw decreases, among those who noted any change in their personal income. People who noted their income did not change were not considered for this calculation. The proportion of people who saw increases in their income was only 7 per cent of the sample and has not been depicted. For respondents in Kiribati, Papua New Guinea, Solomon Islands and Tonga, and women in Pakistan and Samoa, the number of responds that lost all individual income is less than 25 per country, and thus estimates should be interpreted with caution. Gender differences are statistically significant ( $p < 0.05$ ) for Tonga, lost all income ( $p = 0.04$ ) and for Papua New Guinea, decreased but not lost ( $p = 0.02$ ).

# REMITTANCES ARE A LIFELINE FOR MANY, BUT THE PANDEMIC HAS SHIFTED THESE FLOWS TOWARDS MEN

Recurrent funds received from people living abroad in the form of remittances play a crucial role in keeping population groups out of poverty in many countries. In Pacific Island Countries, remittances make up a substantial amount

of people’s individual income, especially in Samoa and Tonga, where more than half of the population receive them (figure 13). Across most countries, women are slightly more likely than men to receive remittances.

Figure 13: Proportion of people who currently receive remittances, by sex (percentage) (n=17,807)

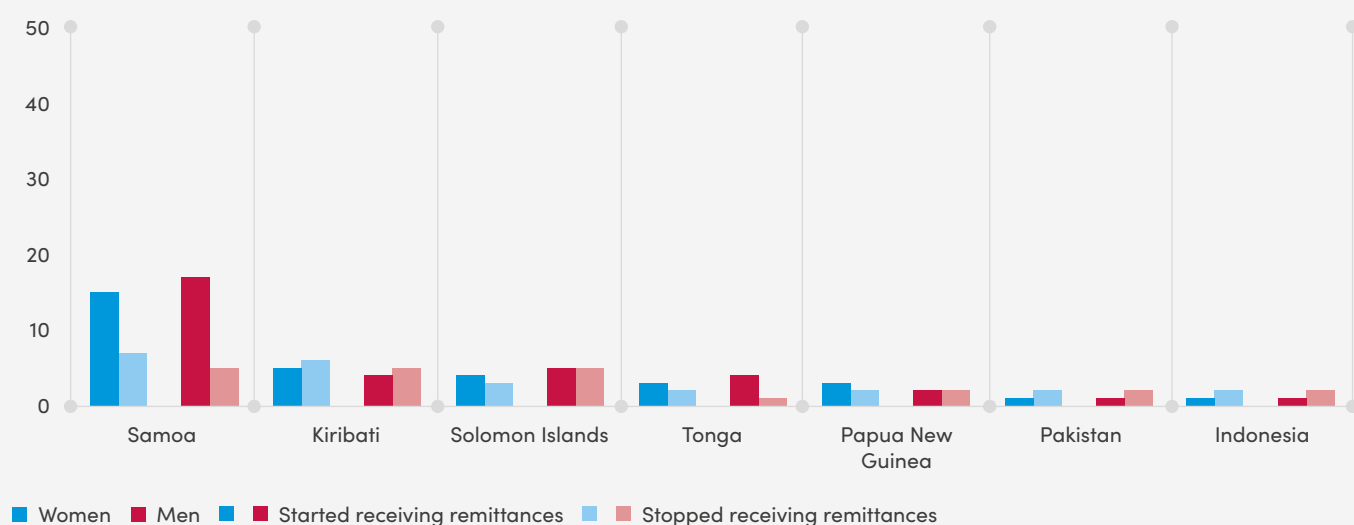


The pandemic has had a substantial effect on the availability and amount of remittance flows. Since the onset of COVID-19, some women and men stopped receiving remittances (figure 14). Although in other countries the gender gaps are not significant, in Tonga some of those flows may have been re-directed to

men, as more men receive remittances now. In addition, most people who received remittances prior to the pandemic and continue to do so have seen drops in the amounts received – an estimated 92 per cent of women and 88 per cent of men noted these decreases (figure 15).

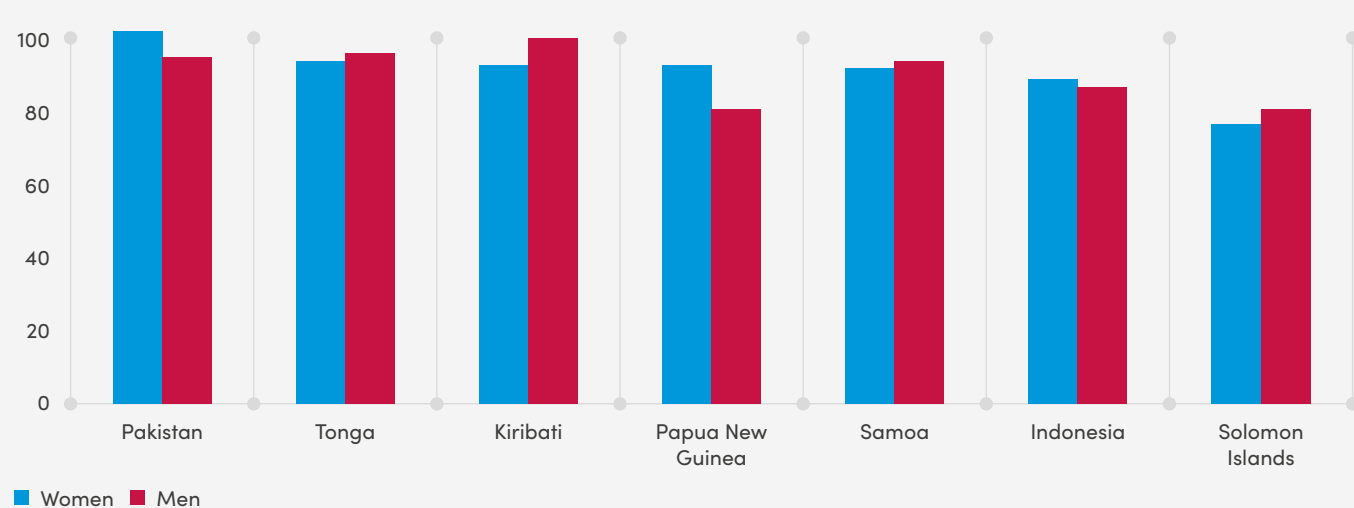


**Figure 14: Proportion of people who stopped/started receiving remittances since the onset of COVID-19, by sex (percentage) (n=17,834)**



Note: Respondents who refused to answer have not been included. All estimates for women and men in Indonesia and estimates for women who started receiving remittances in Pakistan, as well as estimates for women and men in Tonga who stopped receiving remittances amount to less than 25 observations each and thus should be interpreted with caution. Gender differences are statistically significant ( $p < 0.05$ ) in Tonga.

**Figure 15: Proportion of people who received remittances prior to the COVID-19 pandemic and noted a decrease in the amount received, by sex (percentage) (n=1,495)**



Note: Less than 25 women and men in Indonesia received remittances but noted drops. As such, these estimates should be interpreted with caution. Gender differences are statistically significant ( $p < 0.05$ ) in all countries.

# CHANGES IN HOUSEHOLD INCOME AND OTHER FACTORS ARE RENDERING WOMEN MORE VULNERABLE TO FOOD HARDSHIP

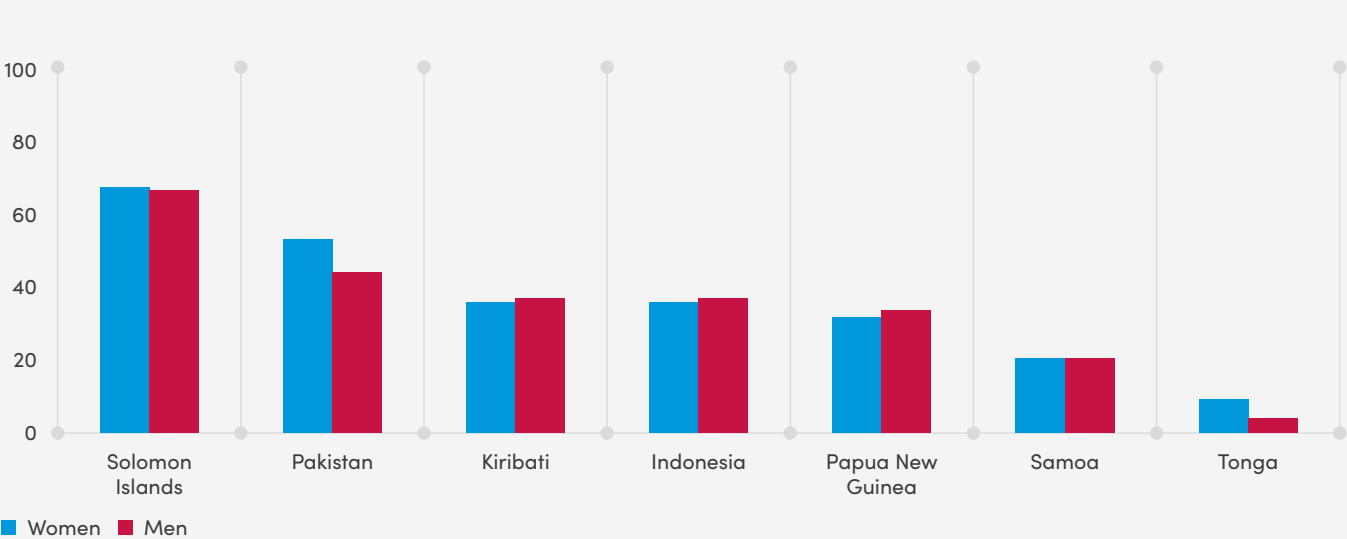
Beyond personal income, women are also suffering from changes in household income triggered by the pandemic, as they are particularly vulnerable if they lack personal earnings or decision-making power over shared resources. Evidence shows that, across the countries considered, 66 per cent of women and 62 per cent of men saw the income in their households drop since the onset of the pandemic. Of these women, 64 per cent had no personal income, compared to 39 per cent of men.

Reductions in income, in many cases, were accompanied by food hardship. In Pakistan, Tonga and, to a lesser extent, Samoa and Solomon Islands, the proportion of women experiencing constraints in accessing sufficient food was higher than that of men; while the opposite

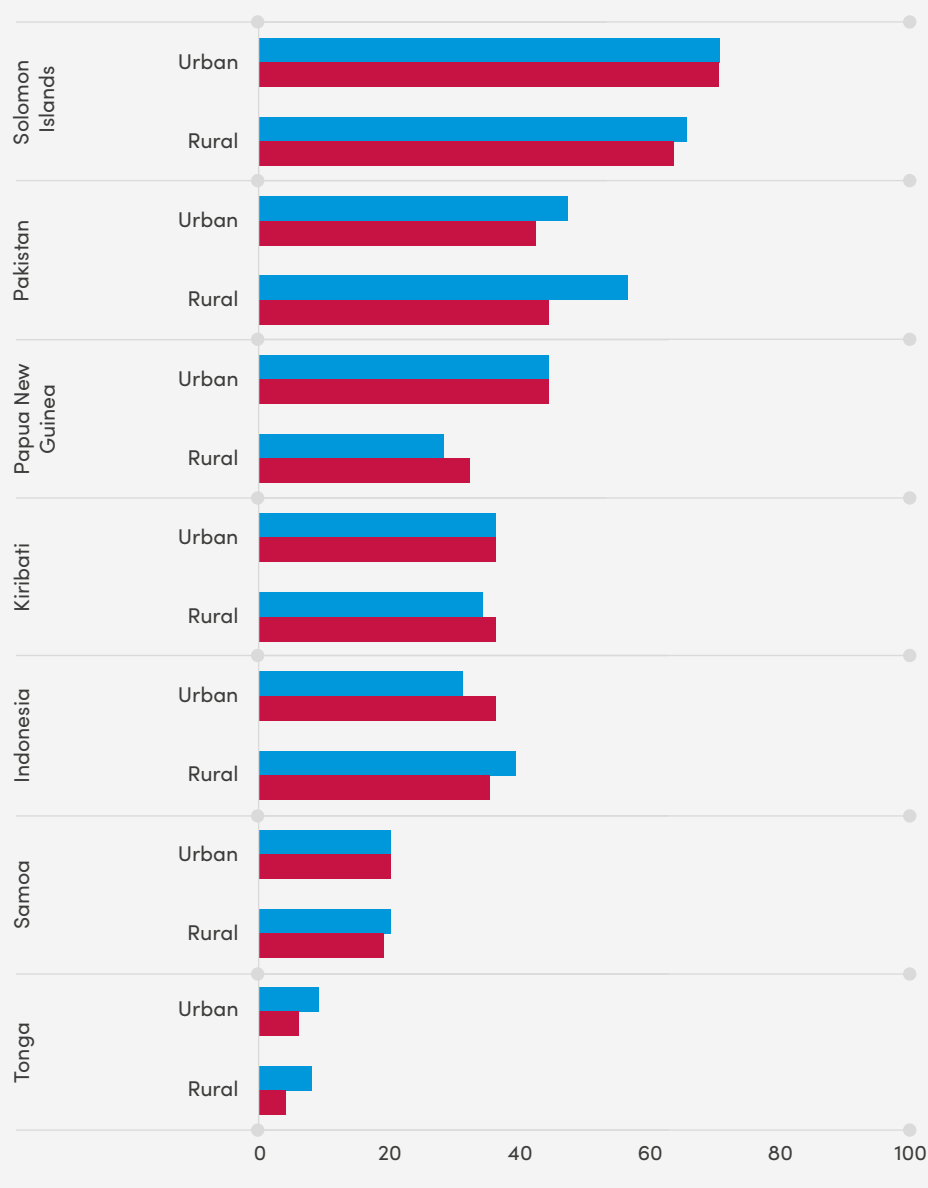
was true in Kiribati, Papua New Guinea and Solomon Islands (figure 16). In rural Kiribati and Solomon Islands, however, women experienced more food hardship than men (figure 17). It is important to note that, due to sample size limitations, some of the urban–rural differences depicted are not statistically significant.

Even though food hardship is very low in Tonga (less than 7 per cent of adults), Tonga also has the largest gender gaps among countries considered in this study, with women almost twice as likely as men to experience hardship. This pattern is present in both urban and rural areas.

Figure 16: Proportion of people experiencing food hardship, by sex (percentage) (n=17,845)



Note: Food hardship measures the lack of access to food in enough quantity or quality. For each of the seven countries, data were collected using the Food Insecurity Experience Scale questionnaire sequence of the Food and Agriculture Organization of the United Nations (FAO) and were analysed using the Rash model to assess the performance of the scale. In all countries the data passed the statistical validation tests, and the raw score (the number of affirmative answers to the eight questions) can be considered as an ordinal measure of food security. Therefore, an individual is considered as experiencing food hardship if its raw score is higher or equal to four (except in Tonga where this threshold corresponds to 5). At this raw score the probability of experiencing food hardship is greater than 50 per cent. When considering margins of error with a design effect of 2 and confidence level of 90 per cent, some of the gender differences are not statistically significant.

**Figure 17: Proportion of people experiencing food hardship, by sex and location (percentage) (n=17,845)**

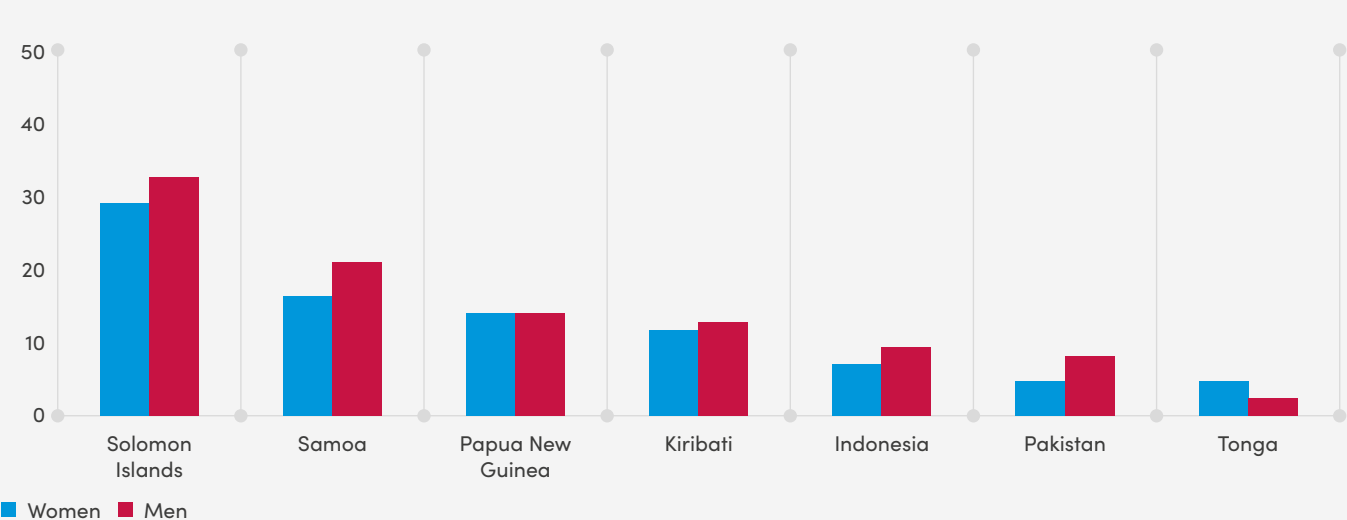
Note: Food hardship measures the lack of access to food in enough quantity or quality. For each of the seven countries, data were collected using the Food Insecurity Experience Scale questionnaire sequence of the Food and Agriculture Organization of the United Nations (FAO) and were analysed using the Rasch model to assess the performance of the scale. In all countries the data passed the statistical validation tests, and the raw score (the number of affirmative answers to the eight questions) can be considered as an ordinal measure of food security. Therefore, an individual is considered as experiencing food hardship if its raw score is higher or equal to four (except in Tonga where this threshold corresponds to 5). At this raw score the probability of experiencing food hardship is greater than 50 per cent. When considering margins of error with a design effect of 2 and confidence level of 90 per cent, most differences are not statistically significant.

# COVID-19 MULTIPLIED UNPAID CARE AND DOMESTIC WORKLOADS, BUT REDISTRIBUTION OF TASKS DID NOT TAKE PLACE

Restricted mobility, limitations in gatherings, recommendations for heightened hygiene and other COVID-19 related measures in the beginning of the pandemic increased the time people spent at home and multiplied care and domestic workloads. Women, who were already more likely to provide these essential services, were also burdened with the provision of homeschooling, unpaid medical care and increased cleaning to ensure

a safe environment. In many countries, the onset of the pandemic brought about domestic migration as well (figure 18), with many people returning from urban to rural areas following job losses. Although this may have provided opportunities for redistribution of unpaid care and domestic work, in many cases it translated into additional burdens of unpaid care work linked to increased household size.

**Figure 18:** Proportion of people who migrated to a different geographic area within the same country since the onset of COVID-19, by sex (percentage) (n=17,843)



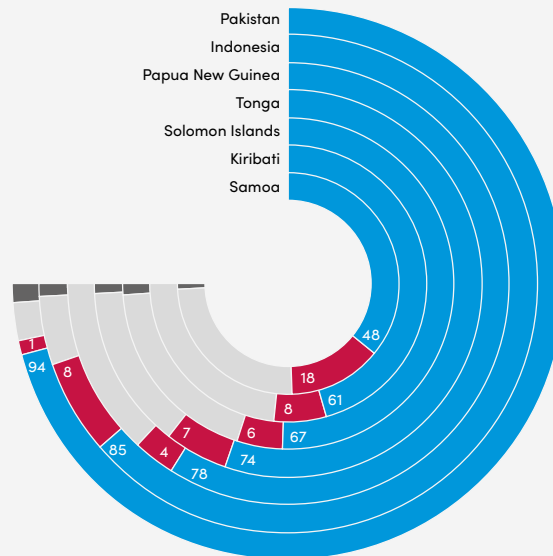
Note: Respondents who refused to answer have not been included (2 observations total). Gender differences are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.02$ ), Pakistan ( $p = 0.000$ ), Samoa ( $p = 0.012$ ), and Tonga ( $p = 0.03$ ).

Data indicate that domestic work activities, such as cooking, cleaning and shopping, continue to be largely performed by women across countries (figure 19 and

figure 20). Less frequent activities, such as decorating, making repairs and managing bills are a bit more evenly distributed between women and men.

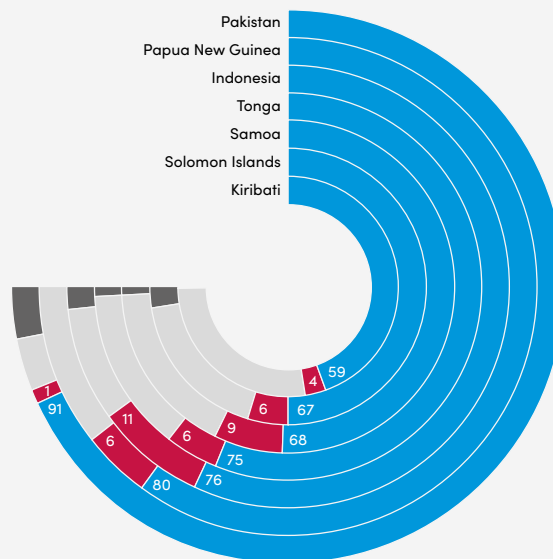
**Figure 19: Proportion of people who noted women/men in the household spend the most time performing different unpaid domestic work activities**

**Cooking and serving meals (n=17,789)**



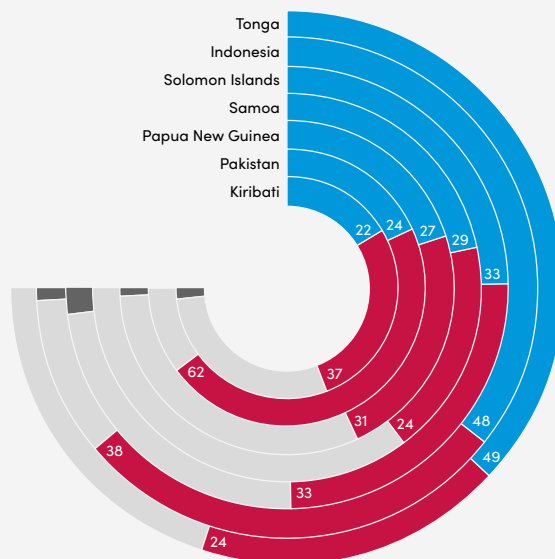
■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

**Cleaning and doing laundry (n=17,797)**



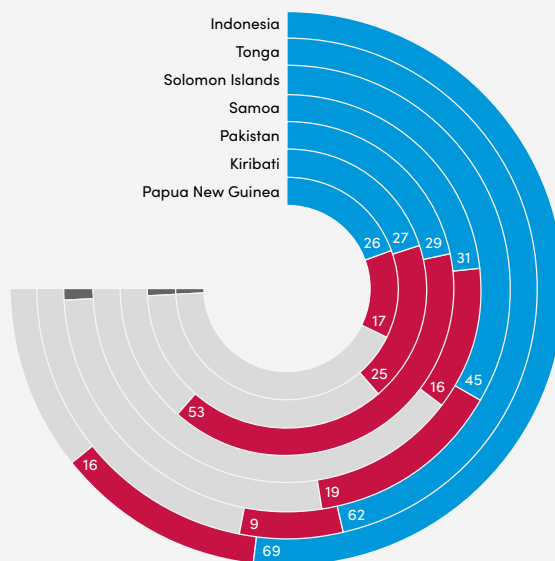
■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

## Decorating, repairing, and managing bills (n=17,305)



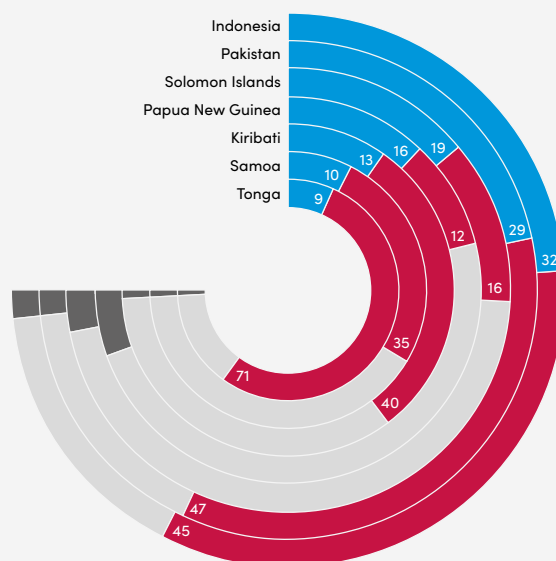
■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

## Shopping for family (n=17,698)



■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

# Pet care (n=10,451)



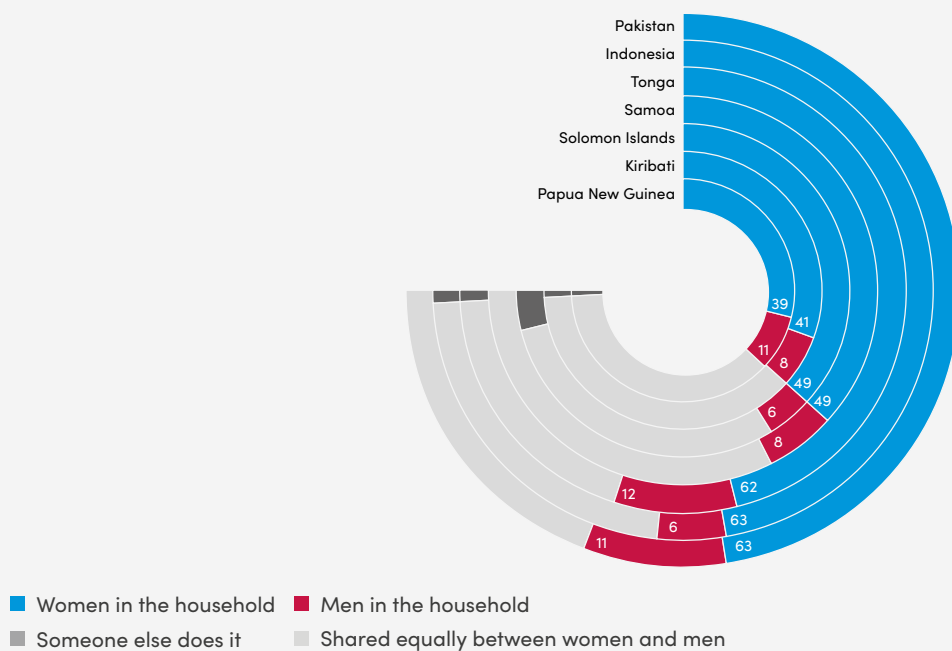
■ Women in the household
 ■ Men in the household  
■ Someone else does it
 ■ Shared equally between women and men

Note: "Women in the household" refers to a clustered category of women respondents who reported being primarily in charge of the activity and respondents of any sex who reported a female household member was primarily in charge of the activity. "Men in the household" refers to a clustered category of men respondents who reported being primarily in charge of the activity and respondents of any sex who reported a male household member was primarily in charge of the activity. "Shared equally between women and men" refers to respondents who reported an activity is equally undertaken by women and men in the household. Respondents who reported that the activity does not take place in the household, or responded "I don't know" or refused to respond have not been included.

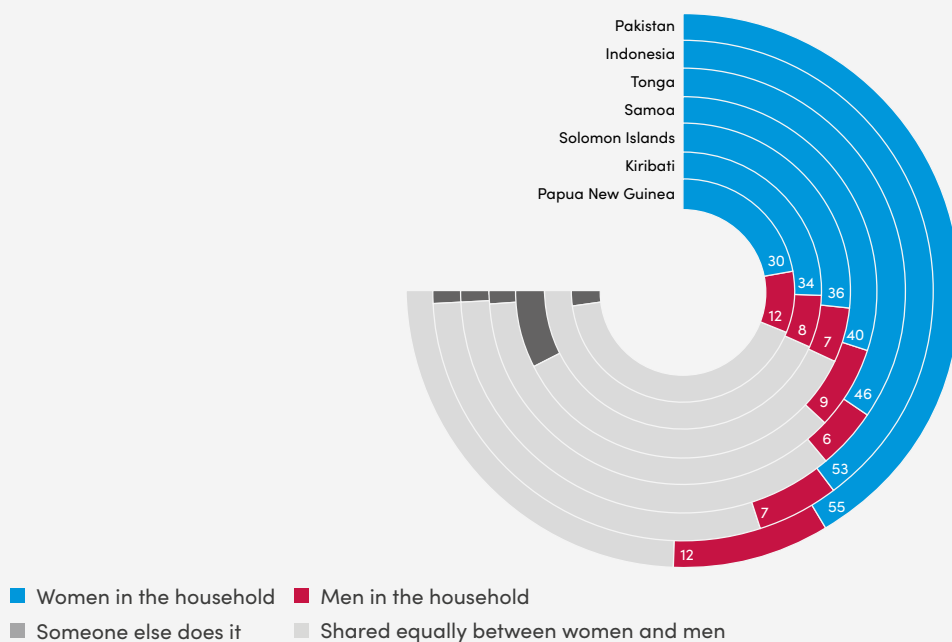
Estimates should be interpreted with caution in the following cases, as the number of response is less than 25, 1) respondents in Kiribati who indicated "Someone else does it" in the analyses of cooking and serving meals and cleaning and doing laundry; 2) respondents in Indonesia, Pakistan, Papua New Guinea, Samoa and Tonga who indicated "Someone else does it" in the analysis of decorating, repairing and managing bills; 3) respondents in Indonesia, Kiribati, Pakistan, Papua New Guinea, Samoa and Tonga who indicated "Someone else does it" in the analysis of shopping for family; and 4) respondents in Kiribati and Samoa who indicated "Someone else does it" in the analysis of pet care. All gender differences are statistically significant ( $p < 0.05$ ) for cooking and serving meals, cleaning, and doing laundry, decorating, repairing, and managing bills, and shopping for the household and family (with the exception of Kiribati,  $p = 0.35$ ) and pet care (with the exception of Solomon Islands,  $p = 0.87$ ).

**Figure 20:** Proportion of people who noted women/men in the household spend the most time performing different unpaid care work activities

**Supervising and minding children (n=14,762)**

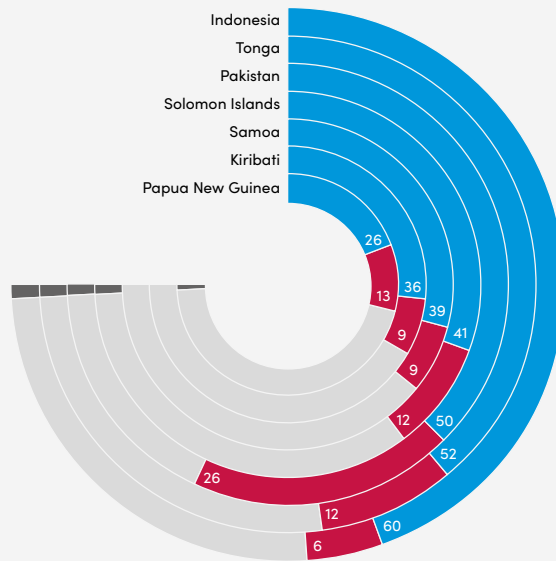


**Playing with children (n=13,640)**



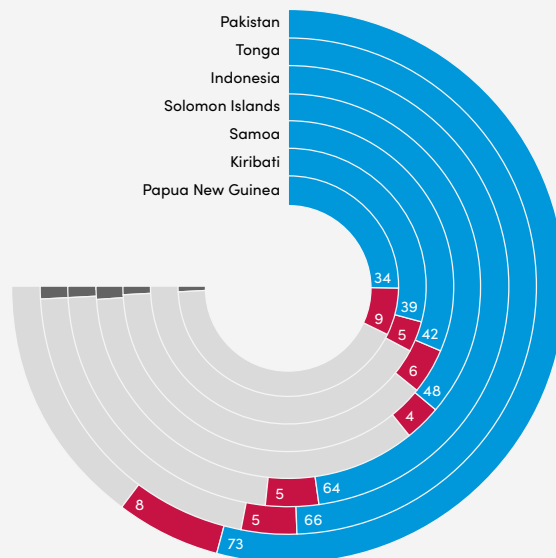


### Teaching children and taking care of arrangements with schools (n=14,354)



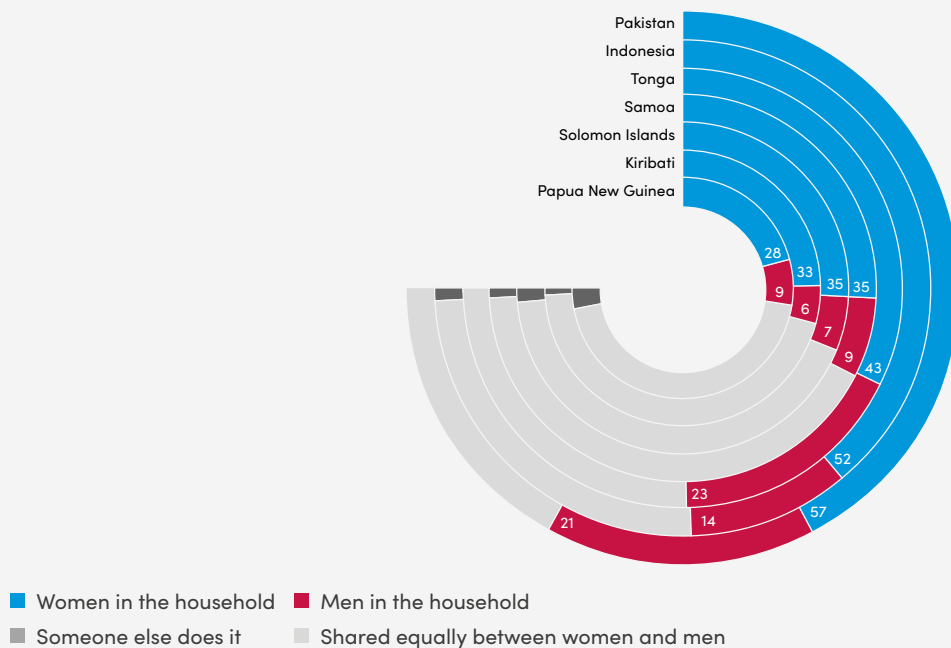
■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

### Feeding, cleaning, physical care, and medical care for children (n=14,800)

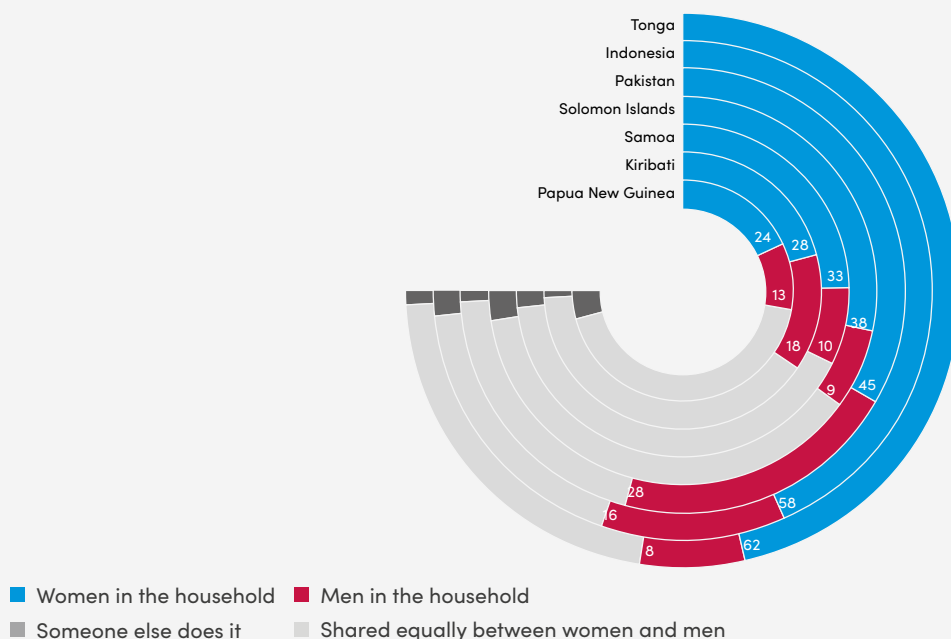


■ Women in the household 
 ■ Men in the household  
■ Someone else does it 
 ■ Shared equally between women and men

## Feeding, cleaning, physical care and medical care for dependent and non-dependent adults (n=10,627)



## Taking care of or helping adults/elderly (own household or family) (n=8,627)



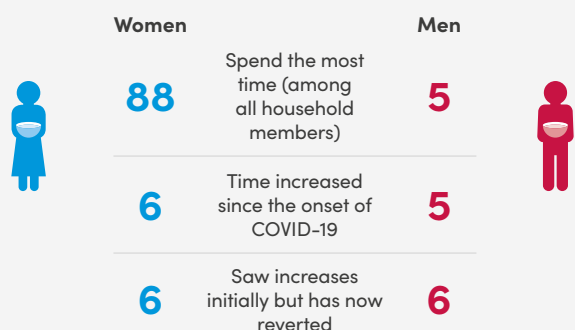
Note: "Women in the household" refers to a clustered category of women respondents who reported being primarily in charge of the activity and respondents of any sex who reported a female household member was primarily in charge of the activity. "Men in the household" refers to a clustered category of men respondents who reported being primarily in charge of the activity and respondents of any sex who reported a male household member was primarily in charge of the activity. "Shared equally between women and men" refers to respondents who reported an activity is equally undertaken by women and men in the household. Respondents who reported that the activity does not take place in the household, or responded "I don't know" or refused to respond have not been included. Estimates should be interpreted with caution in the following cases, as the number of responses is less than 25, 1) respondents in Indonesia, Kiribati, Pakistan and Tonga who indicated 'Someone else does it' in the analyses of supervising and minding children, playing with children and taking care of or helping adults/ elderly (own household or family) ; 2) respondents in Indonesia, Kiribati, Pakistan, Samoa and Tonga who indicated "Someone else does it" in the analyses of teaching children and taking care of arrangements with schools and feeding, cleaning, physical care and medical care for dependent and non-dependent adults; 3) respondents in Indonesia, Kiribati, Pakistan, Solomon Islands and Tonga who indicated "Someone else does it" in the analysis of feeding, cleaning, physical care, and medical care for children. All gender differences are statistically significant ( $p < 0.05$ ).

As a result of the pandemic, both women and men saw increases in time allocated to unpaid care and domestic work. The first months were particularly straining, but the workloads remain high; only 6 per cent of people in the

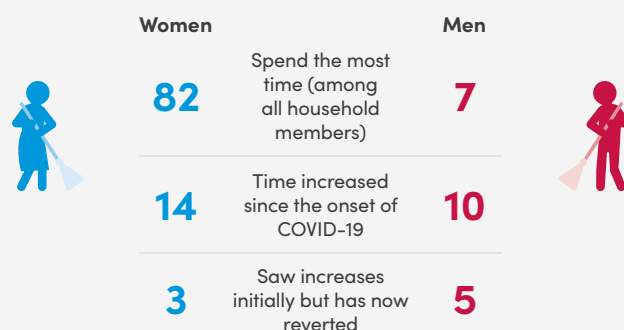
countries considered noted that the initial increases in time spent cooking and serving meals have now reverted to pre-pandemic levels, and only 3 per cent noted reversals in time spent caring for adults.

### Infographic 1: Women bear the brunt of unpaid care and domestic work

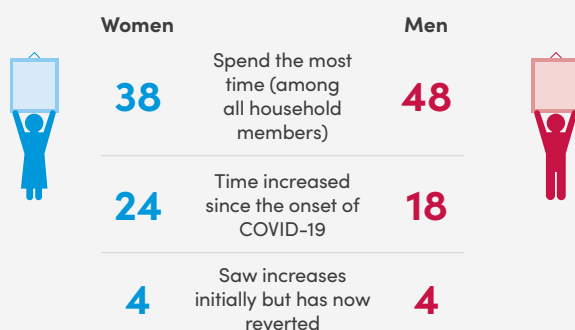
#### Cooking and serving meals



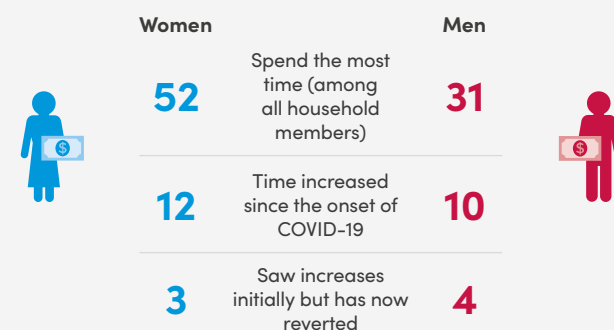
#### Cleaning and doing laundry



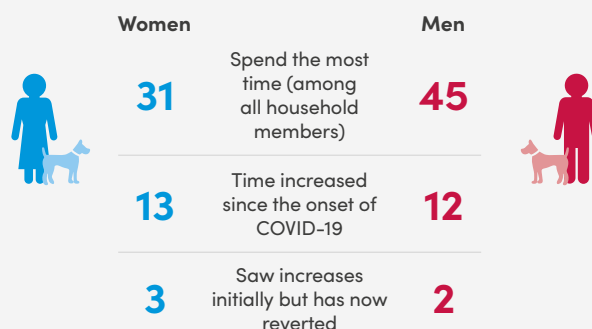
#### Decorating, repairing the house and managing bills



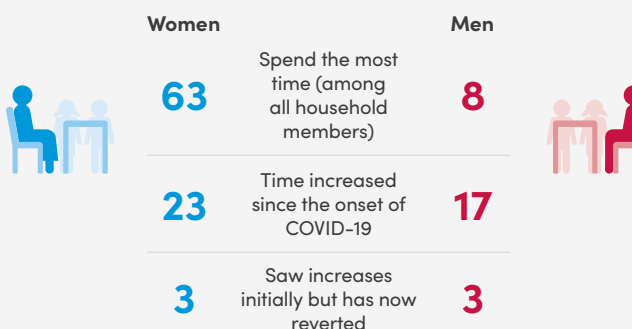
#### Shopping for the household/family

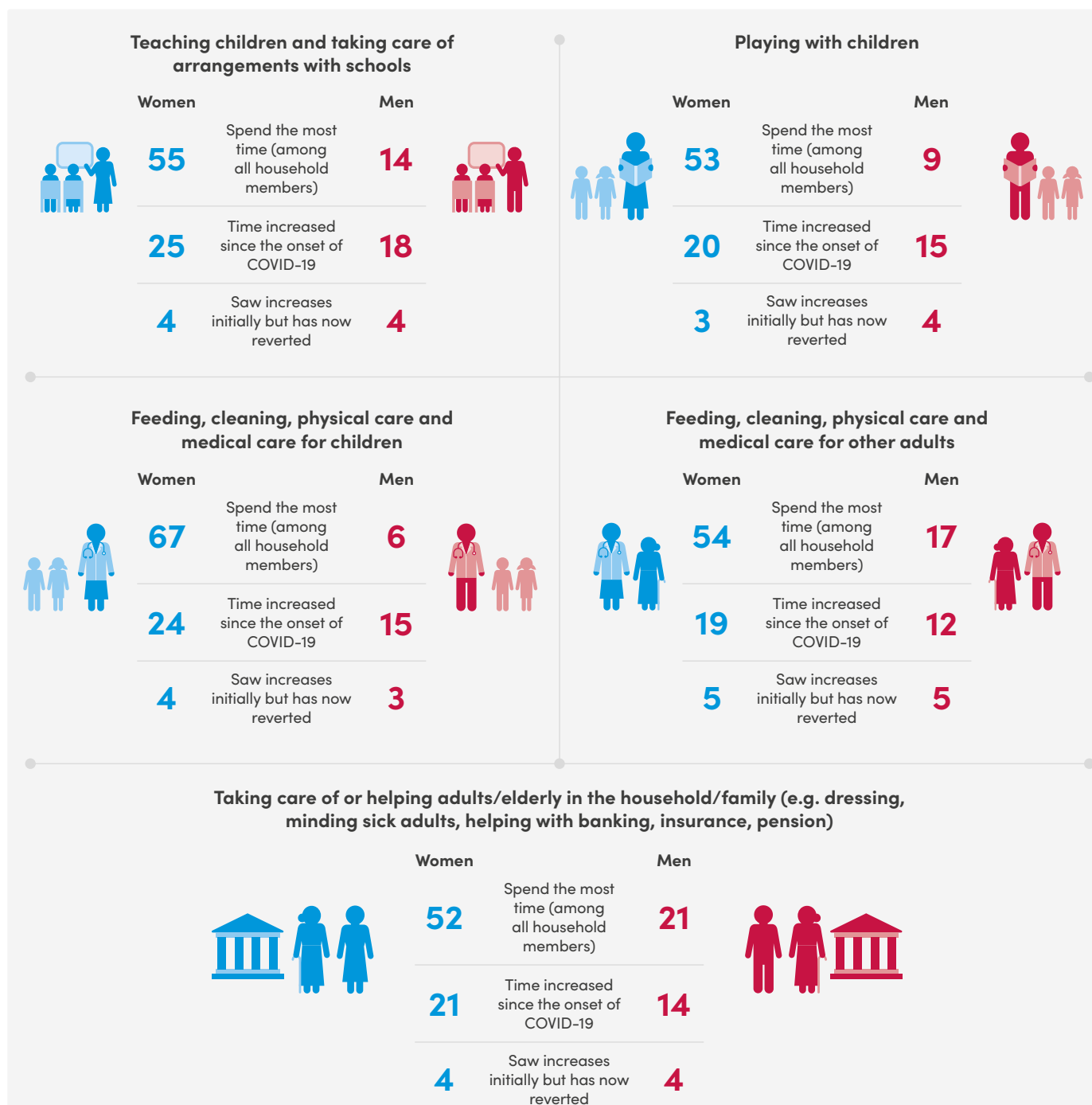


#### Pet care



#### Supervising/minding children



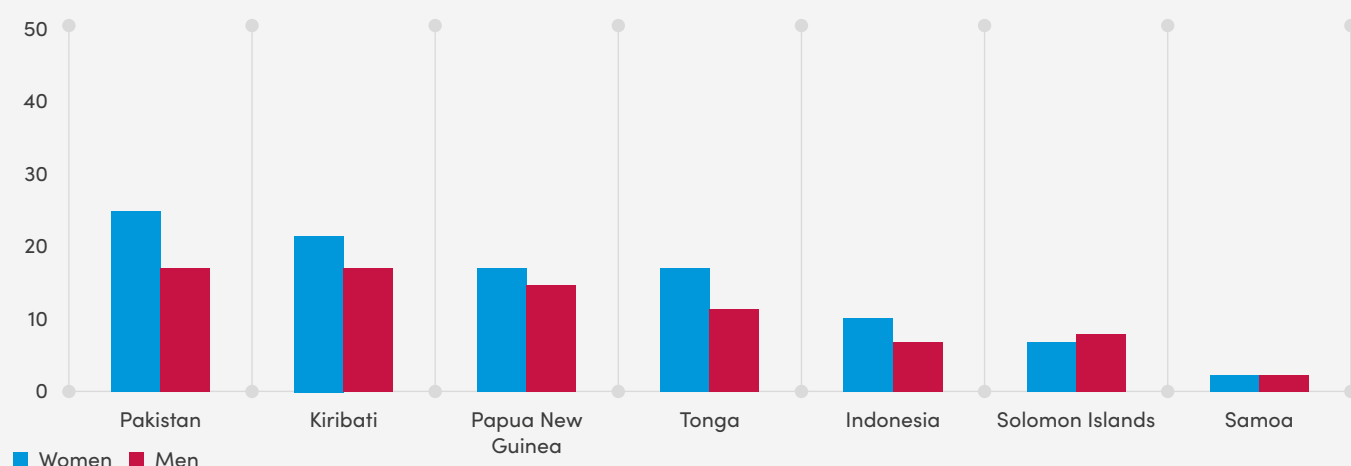


Note: Aggregates calculated using the World Population Prospects for women and men ages 18 and over. An important caveat of these data is associated with the fact that it captures perceptions. Thus, due to social desirability bias, some of these figures may be inflated. In other words, those who weren't performing unpaid care and domestic work prior to the pandemic may perceive these increases as greater or may report them as greater to appear more diligent.

A redistribution of tasks has not truly taken place despite the changes in workloads brought about by COVID-19. For instance, although women do most of the cooking, cleaning and caring for others across countries, they were also more likely to see increases in time spent on these activities as a

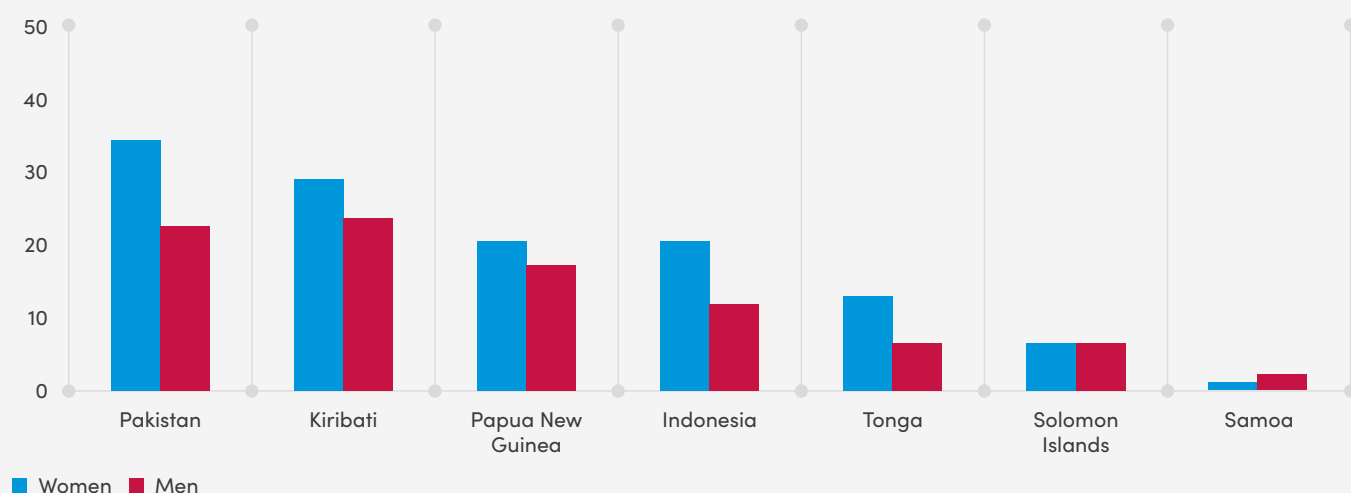
result of the pandemic. Similarly, women also saw larger increases in time spent feeding, washing and providing medical care for children, despite the fact that they were already disproportionately in charge of those tasks (figure 21 and figure 22).

**Figure 21: Proportion of people who noted their time spent cleaning and doing laundry increased since the onset of COVID-19, by sex (percentage) (n=17,773)**



Note: For women and men in Samoa, estimates for increases in time allocated to cleaning and doing laundry should be interpreted with caution as the number of respondents is less than 25. Respondents who reported "I don't know" or refused to respond have been excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) for Kiribati ( $p = 0.03$ ), Pakistan ( $p = 0.000$ ), Papua New Guinea ( $p = 0.03$ ), and Tonga ( $p = 0.000$ ).

**Figure 22: Proportion of people who noted their time spent feeding, washing, providing physical and medical care for children increased since the onset of COVID-19, by sex (percentage) (n=14,815)**

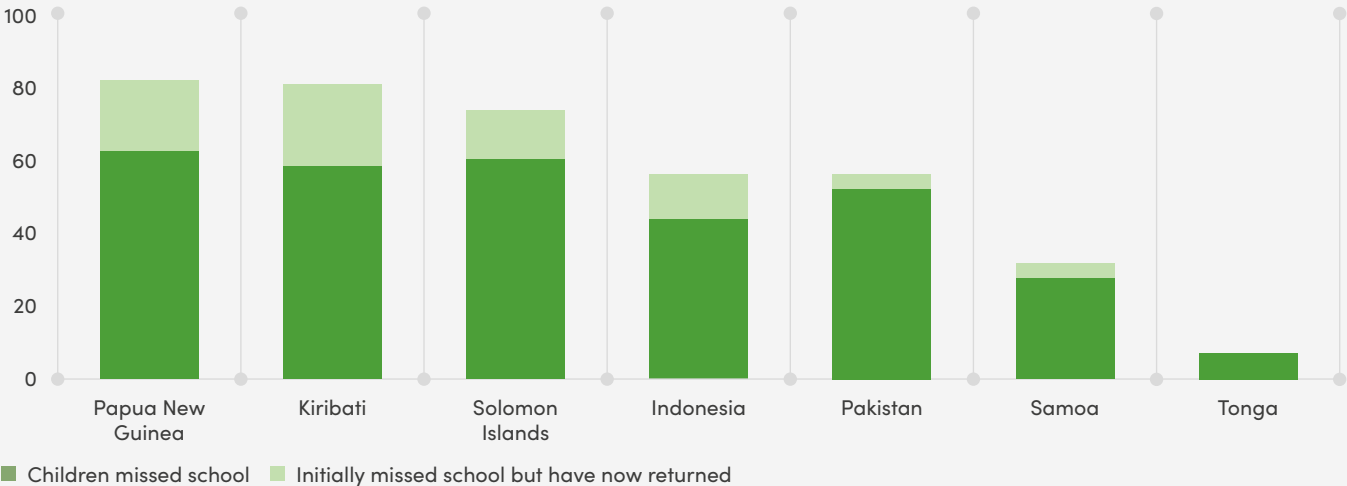


Note: For women and men in Samoa, estimates for increases in time allocated to feeding, washing, providing physical and medical care for children should be interpreted with caution as the number of respondents is less than 25. Respondents who reported "I don't know" or refused to respond have been excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.001$ ), Kiribati ( $p = 0.01$ ), Pakistan ( $p = 0.000$ ), and Tonga ( $p = 0.000$ ).

Temporary school closures in some countries and parents choosing not to send their children to school for fear of contagion have resulted in parents and other family members needing to step up to provide homeschooling. Across countries, an estimated 28 per cent of women noted increases in the time spent teaching children and taking care of school arrangements, compared to 21 per cent of men. This was particularly noticeable at the beginning of the pandemic, as 4 per cent of women

and 3 per cent of men noted that these increases have now reverted. The shift to remote learning that took place in some schools posed barriers for some children who lacked access to online technologies. Similarly, at a time when economic resources are scarce, the costs of schooling are also keeping some children out of school (figure 23). An estimated 56 per cent of people across all countries considered noted these challenges.

**Figure 23:** Proportion of people who noted that children living in the household missed school due to the lack of access to remote learning technologies or inability to pay for schooling (e.g., fees/supplies) since the onset of COVID-19 (percentage) (n=8,205)



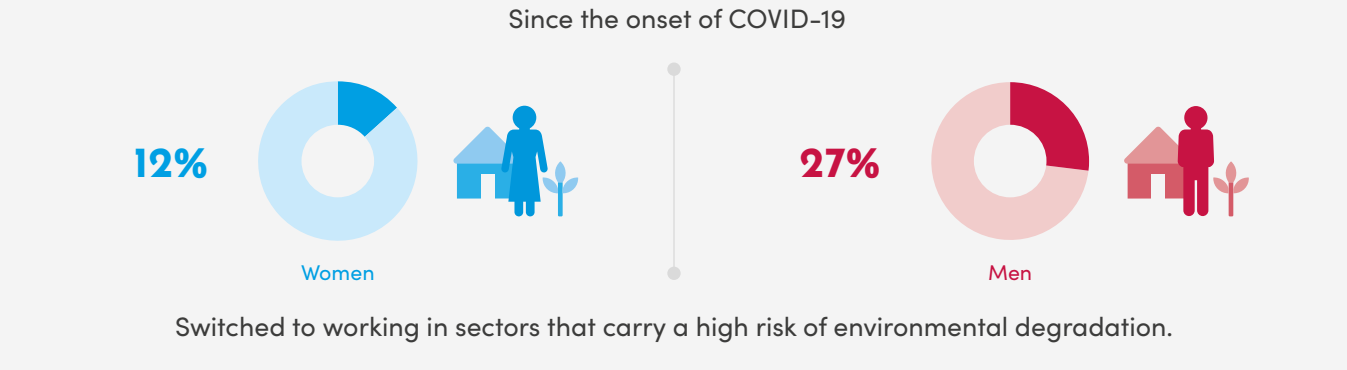
Note: Estimates for "Initially missed school but has now returned" for Tonga should be interpreted with caution as the number of respondents that chose this response category is less than 25. "Children did not miss school", "Don't know" and "Refused to answer" categories are not depicted.

# THE PANDEMIC HAS OVERLAPPED WITH ENVIRONMENTAL CHALLENGES, MAKING IT HARDER FOR WOMEN TO COPE

While the pandemic halted travel and initially reduced commerce and commutes, it also increased energy use within households, online shopping and the use of personal protective equipment at an enormous scale, with consequent effects for the environment. Disruptions to public transit and fear of contagion have driven many to use personal vehicles instead. Furthermore, the economic crisis triggered by the pandemic is being met with government support for industrial activities in many countries, including for polluting industries,

such as transportation and extractives. Even without this support, people who lost their jobs may be switching to environmentally degrading activities, such as logging or wildlife trafficking, due to limited employment options. Data indicates that, across the countries considered, 27 per cent of men and 12 per cent of women switched from other activities to working in agriculture, forestry, fishing, mining, quarrying, electricity, gas supply, steam and air conditioning supply – activities that may carry a high likelihood of environmental degradation.

## Infographic 2: Shifts to polluting jobs

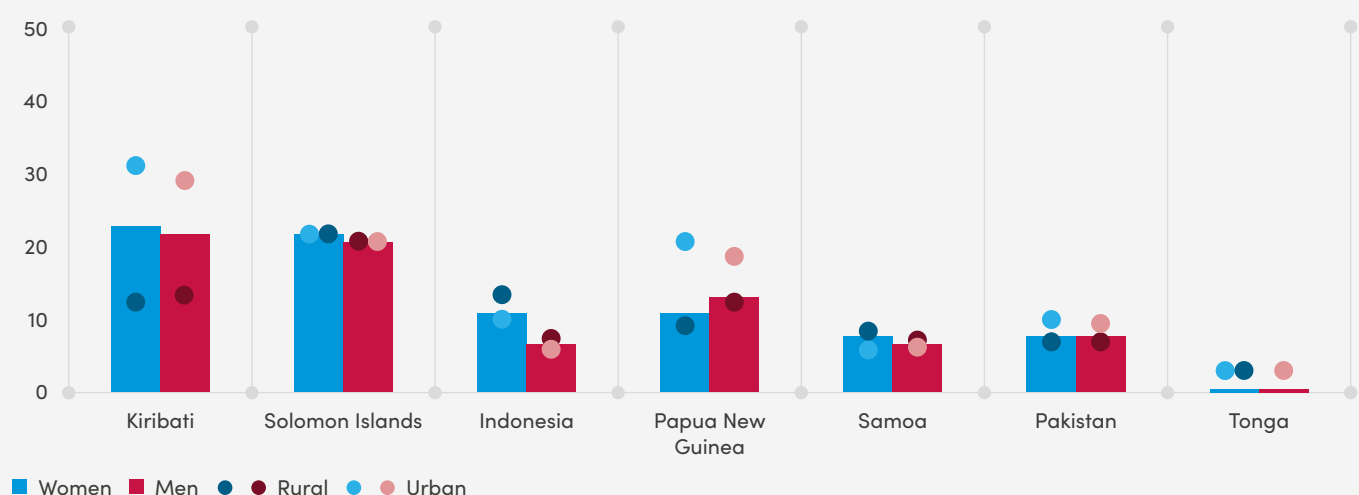


Natural hazards, such as typhoons, droughts and other extreme weather events, have overlapped with the pandemic in all countries considered.

This, coupled with social distancing measures and changes in the availability of public services as a result of the pandemic, affected women's and men's access to natural resources as well. An estimated 9 per cent of people in

the countries considered noted that their access to water sources was compromised since the onset of COVID-19 (figure 24). In Indonesia, the only country where the gender gaps are statistically significant, women are worse off. Although this was a temporary change for most, access to water sources continues to be compromised for 8 per cent of people.

**Figure 24: Proportion of people whose water source was compromised since the onset of COVID-19 and continues to be, by sex and location (percentage) (n=17,764)**

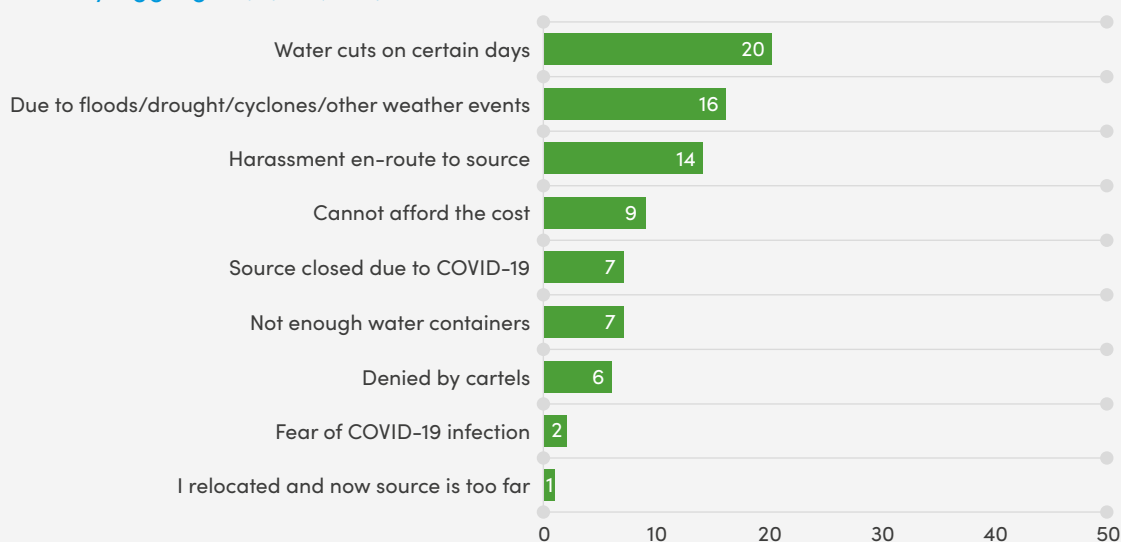


Note: All urban estimates for Samoa, and both urban and rural estimates for Tonga should be interpreted with caution as the number of respondents with compromised water sources is less than 25 in each case. Gender differences are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.001$  for total and  $p = 0.004$  for urban areas).

Across countries, the most common reason behind the continuing lack of access to drinking water sources since the onset of COVID-19 had to do with piped water now being available only on certain days (figure 25). In all countries except for Indonesia, Papua New Guinea and Tonga, women were more likely to experience this challenge. In addition, in Papua New Guinea, Samoa, Solomon Islands and Tonga, a substantial share of the population noted not being able to afford the cost of water since the onset of the pandemic, with women at a disadvantage in Papua New Guinea, Solomon Islands and Tonga. At a time when hygiene and cleaning are essential measures to combat COVID-19, limited access to water can have serious consequences.

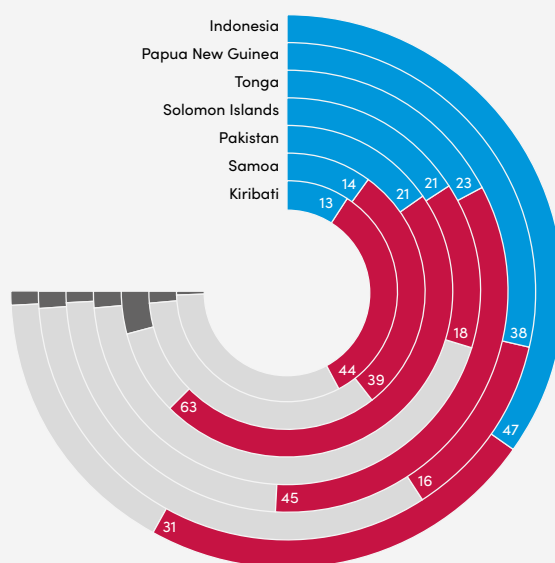
When water is not available at home, people must bear the burden of fetching it. In the countries considered, men are more likely to be in charge, a trend that differs from the global aggregate (figure 26). As the pandemic has exacerbated water collection burdens across the board, many women and men noted increases in the time they spend on this task (figure 27). Women noted larger increases in Indonesia, Kiribati and Pakistan. This may have been a result of increases in female unemployment, among other factors, as newly unemployed family members and children out of school are now able to take on some of these chores.

**Figure 25: Main reasons why access to water supply was compromised since the onset of COVID-19, by sex (seven country aggregate) (n=2,068)**



Note: Aggregates calculated using UN Population Prospects for population ages 18 and over (2020). (Available from: <https://population.un.org/wpp/>). Respondents who reported they did not know the reason why their water source was compromised or refused to respond were excluded from the analysis.

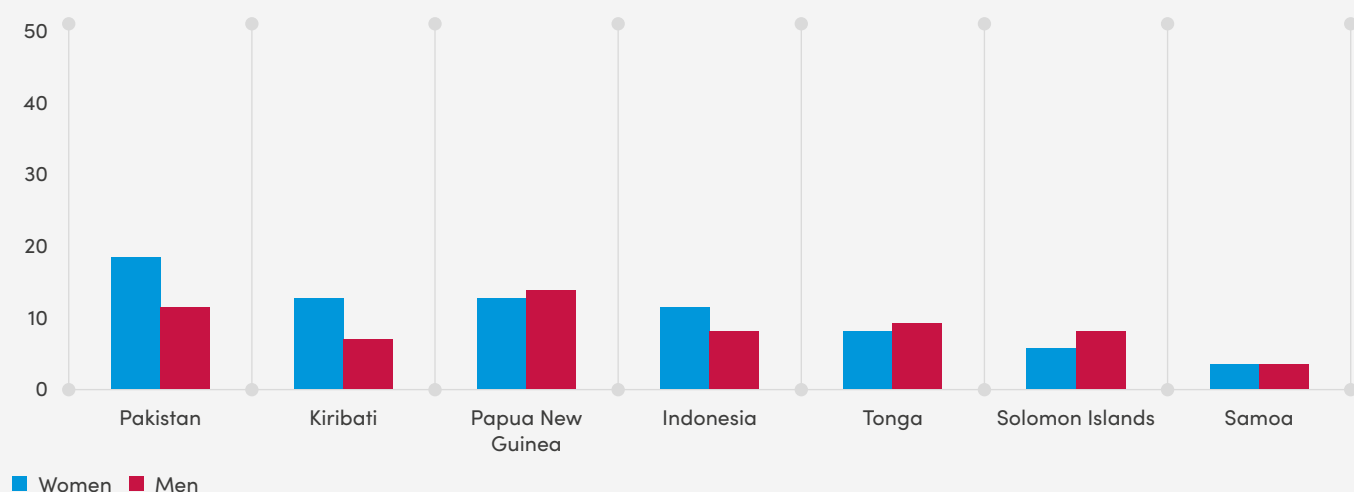
**Figure 26: Proportion of people who noted women/men in the household spend the most time fetching water (percentage) (n=13,063)**



■ Women in the household ■ Men in the household ■ Shared equally between women and men ■ Someone else does it

Note: "Women in the household" refers to a clustered category of women respondents who reported being primarily in charge of the activity and respondents of any sex who reported a female household member was primarily in charge of the activity. "Men in the household" refers to a clustered category of men respondents who reported being primarily in charge of the activity and respondents of any sex who reported a male household member was primarily in charge of the activity. "Shared equally between women and men" refers to respondents who reported an activity is equally undertaken by women and men in the household. Respondents who reported that the activity does not take place in the household or responded "I don't know" or refused to respond have not been included in the analysis. Estimates for "Someone else does it" in Indonesia, Kiribati, and Samoa should be interpreted with caution as the number of respondents that chose this response category is less than 25. Gender differences are statistically significant ( $p < 0.05$ ) for all countries except Indonesia ( $p = 0.62$ ).



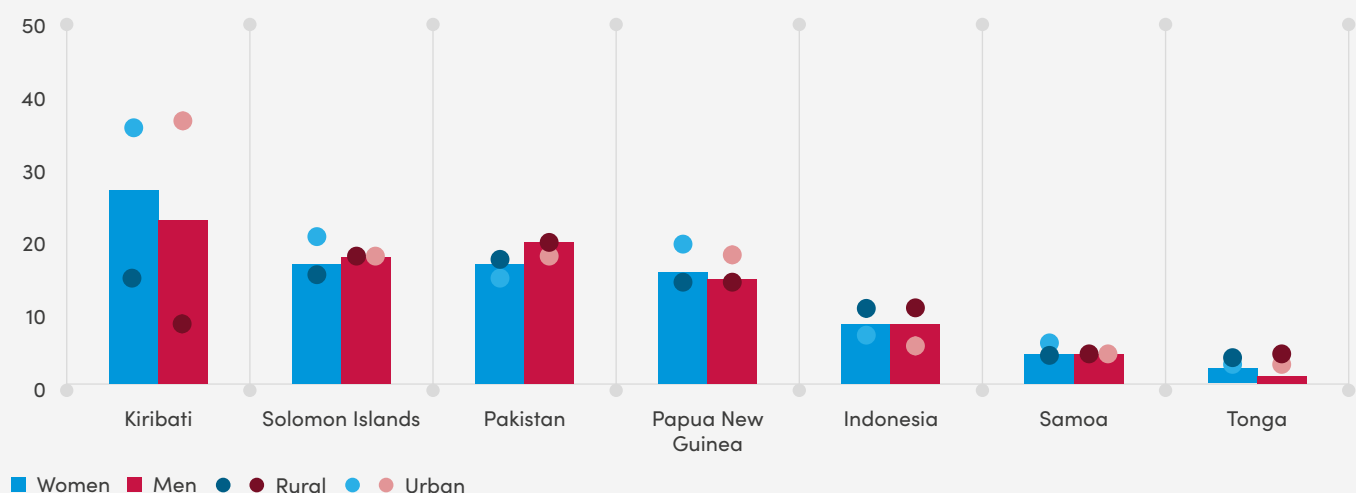
**Figure 27:** Proportion of people who noted an increase in time spent collecting water since the onset of COVID-19, by sex (percentage) (n=13,159)

Note: For women and men in Samoa, estimates should be interpreted with caution as the number of respondents that chose this response category is less than 25 in each case. Respondents who chose "I don't know" or refused to respond have been excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.01$ ), Kiribati ( $p = 0.003$ ) and Pakistan ( $p = 0.01$ ).

Several typhoons, droughts, floods and other severe weather events have battered some of the countries included in this analysis since the onset of COVID-19. From cyclone Harold in Solomon Islands and Tonga to cyclone Seroja in Indonesia, floods in Kiribati, Indonesia and Pakistan, and landslides in Papua New Guinea and Pakistan, severe weather has challenged the capacity of women and men to cope with the ongoing pandemic and related economic crisis. In places where grid electricity is overground or unstable, severe weather may have resulted in power losses. Furthermore, increasing energy costs and limited economic resources may have resulted in many people losing access to power for extended periods. In Kiribati, Pakistan, Papua New Guinea and Solomon Islands this has affected many people. Almost

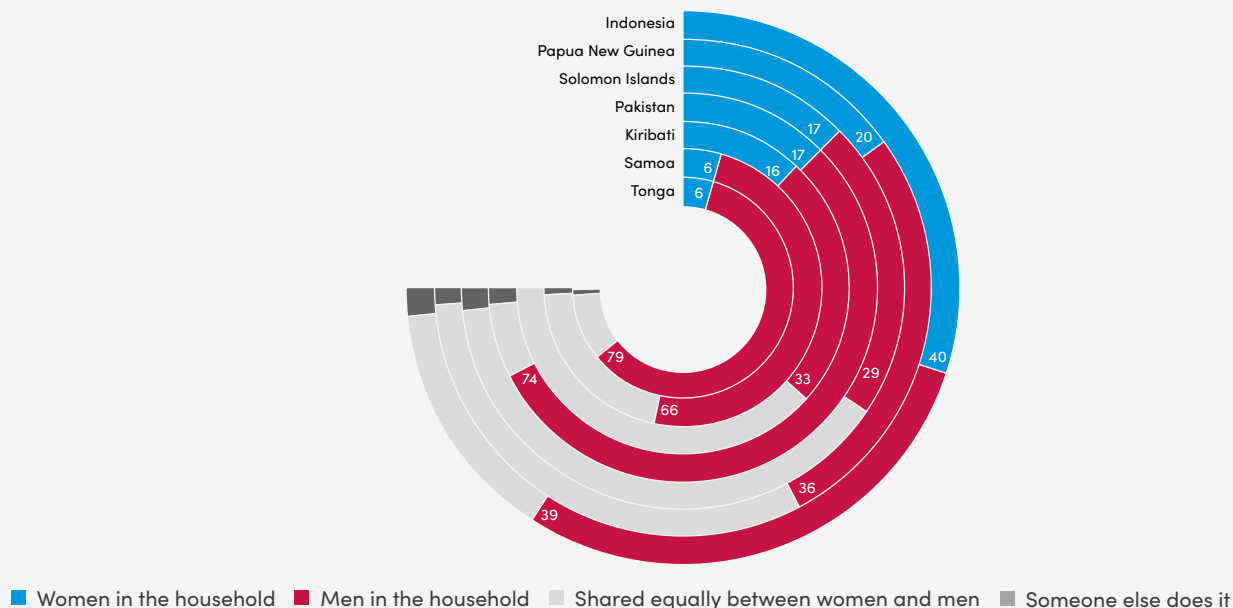
a quarter of the population noted losing power since the beginning of the pandemic in Kiribati, while in Pakistan, Papua New Guinea and Solomon Islands the figures range between 15 and 19 per cent, excluding those who initially lost power but have since had it restored (figure 28). The phenomenon is more widespread in urban than in rural areas of Kiribati, Papua New Guinea and Solomon Islands, while it extends across both areas in Pakistan and is more prevalent in rural areas of Indonesia. Although most gender gaps are insignificant, lack of access to power carries gendered consequences, from women's safety at night, to increased unpaid domestic burdens for cooking, washing clothes or cleaning, which are activities typically performed by women.

**Figure 28:** Proportion of people who lost access to their power supply since the onset of COVID-19 (and continue without power), by sex and location (percentage) (n=17,801)



Note: The sample size for the analysis by location is found to be 17,792. Urban estimates for Samoa, and all estimates for Tonga, should be interpreted with caution as the number of respondents is less than 25. Respondents who refused to respond to this question were excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) in Pakistan ( $p = 0.02$ ) and rural Kiribati ( $p = 0.01$ ).

**Figure 29:** Proportion of people who noted women/men spend the most time collecting fuel/firewood for the household (percentage) (n=13,723)

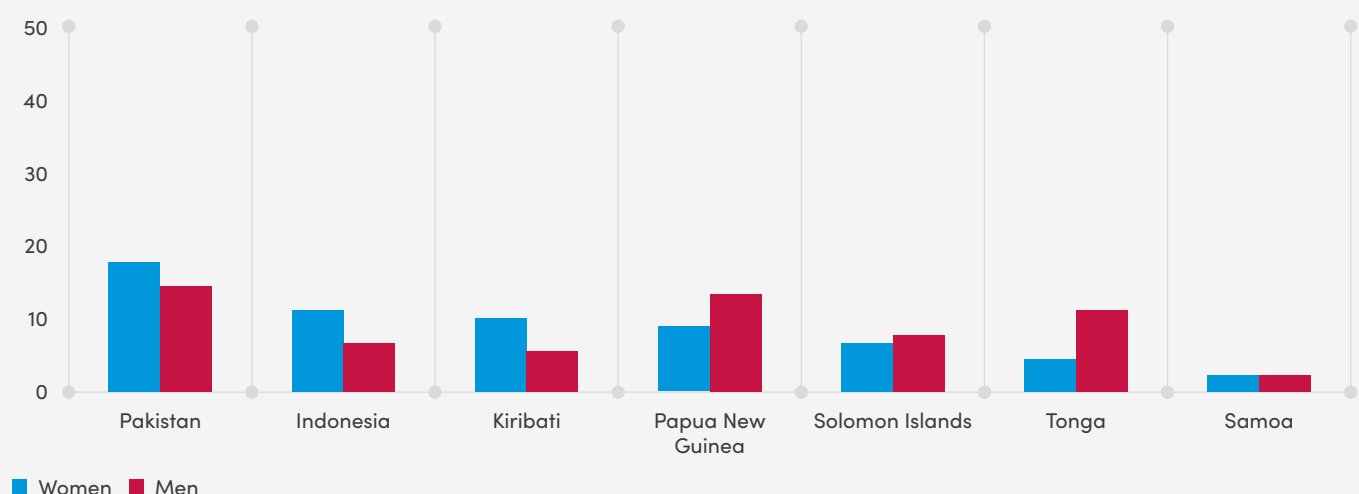


Note: "Women in the household" refers to a clustered category of women respondents who reported being primarily in-charge of the activity and respondents of any sex who reported a female household member was primarily in-charge of the activity. "Men in the household" refers to a clustered category of men respondents who reported being primarily in-charge of the activity and respondents of any sex who reported a male household member was primarily in-charge of the activity. "Shared equally between women and men" refers to respondents who reported an activity is equally undertaken by women and men in the household. Respondents who reported that the activity does not take place in the household or responded "I don't know" or refused to respond have not been included in the analysis. Estimates for "Someone else does it" in Kiribati and Samoa should be interpreted with caution as the number of respondents that chose this response category is less than 25. Gender differences are statistically significant ( $p < 0.05$ ) for all countries except Solomon Islands ( $p = 0.15$ ).

In most of the countries considered, fuel collection chores are shared between women and men. However, in households where this does not happen, men are disproportionately in charge (figure 29). Since the onset of the pandemic, women in Indonesia, Kiribati and Pakistan saw the largest increases in time allocated to fuel collection. Increased fuel collection burdens have been widespread, experienced by as many as 85 per cent of men and 19 per cent of women in Tonga and 69

per cent of men and 26 per cent of women in Pakistan. In many countries, initial burdens have now returned to pre-pandemic levels, but the proportions of the population who continue to see heightened fuel collection times remains substantial across the board. With more people spending time at home and cooking-in, loss of access to clean fuel can substantially impact well-being, including safety and the time spent cooking, among other outcomes.

**Figure 30: Proportion of people who noted an increase in time spent collecting fuel/firewood since the onset of COVID-19, by sex (percentage) (n=13,752)**

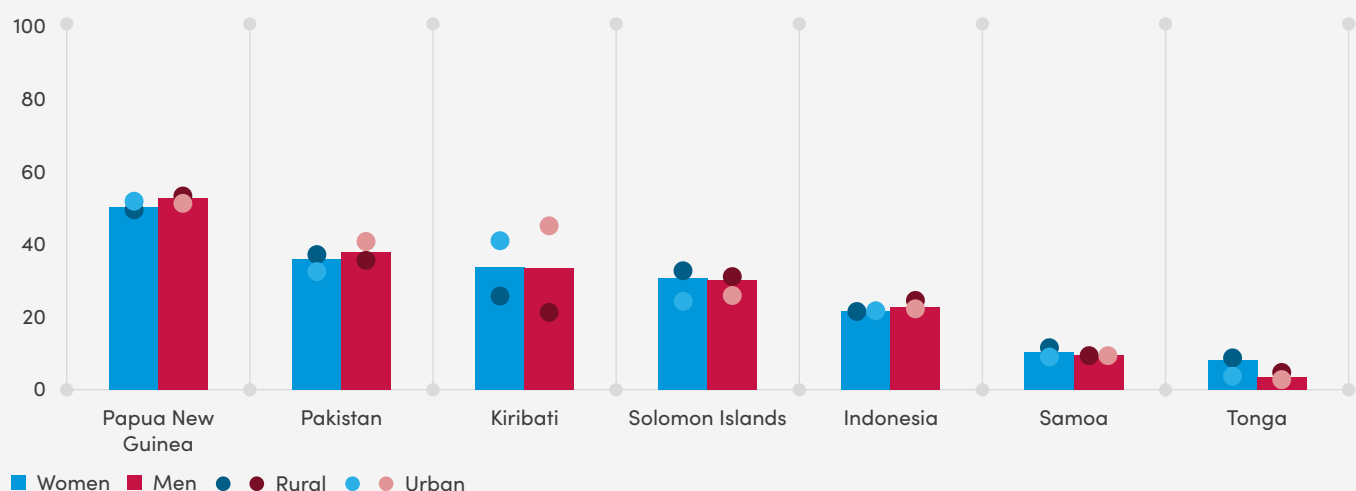


Note: For women and men in Samoa, estimates should be interpreted with caution as the number of respondents is less than 25. Respondents who reported "I don't know" or refused to response have been excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) for Indonesia ( $p = 0.01$ ), Kiribati ( $p = 0.01$ ), and Tonga ( $p = 0.000$ ).

To respect social distancing and encourage people to stay at home, many countries limited the availability of public transportation services. Disruptions in public transit can limit access to essential services, pose challenges to access the workplace and even impede disaster recovery efforts. In the context of COVID-19, even when public transportation was available, some people shifted to alternative forms of transportation to stay away from crowds. Although for smaller distances this may have translated into increased shares of the population choosing to walk over public transit, for longer commutes it is expected that most people who lost access to public transportation may have shifted to individual vehicles, such as cars and motorbikes, with

consequent environmental impacts. In Papua New Guinea, for instance, about half of the population lost access to public transportation since the onset of the pandemic; the proportion was also high in Pakistan (36 per cent), Kiribati (33 per cent) and Solomon Islands (30 per cent). In places such as Tonga and Samoa, where the spread of the virus has been limited (one confirmed case in Tonga and two in Samoa as of December 2021), losing access to public transportation has not been an issue (figure 31). In Kiribati, which had seen no COVID-19 cases at the time of this survey, the loss of access may have been caused by weather events or other phenomena and affected urban areas disproportionately.

**Figure 31: Proportion of people who lost access to public transportation since the onset of COVID-19, by sex and location (percentage) (n=17,842)**



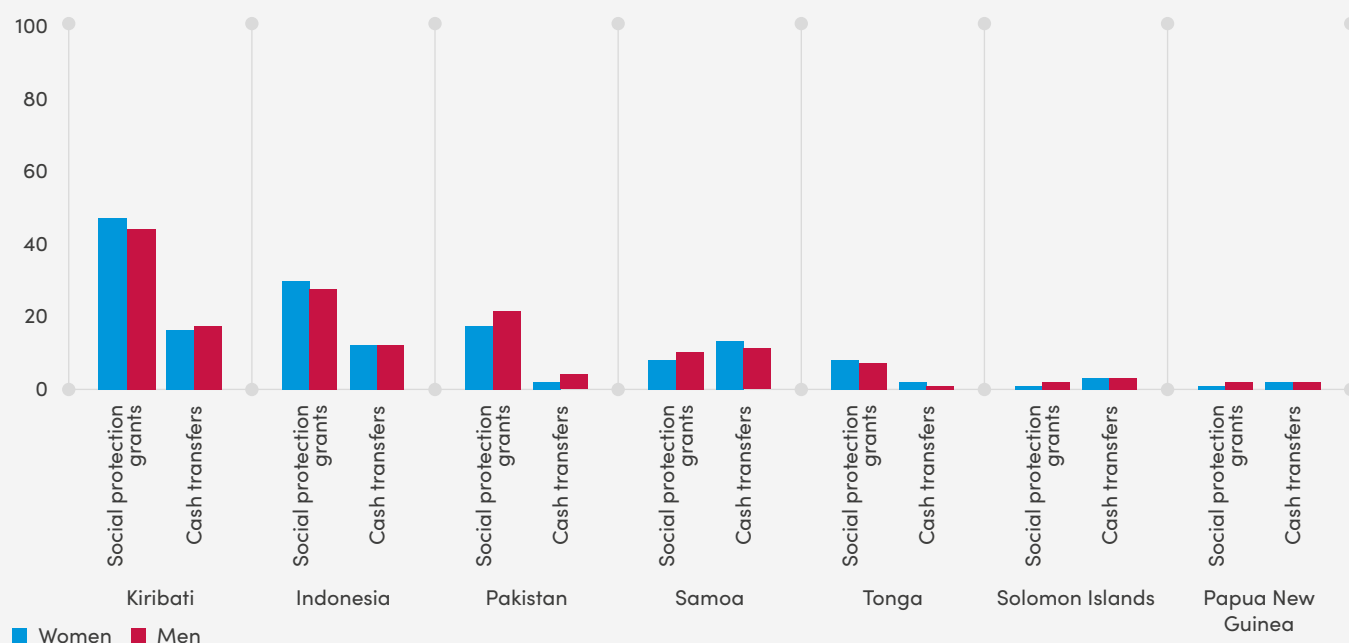
Note: For rural and urban men in Tonga, estimates should be interpreted with caution as the number of respondents is less than 25. Those who refused to respond have been excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) in Tonga ( $p = 0.000$  for total,  $p = 0.04$  for rural, and  $p = 0.05$  for urban) and Pakistan ( $p = 0.000$  for urban).

## GOVERNMENT SUBSIDIES AND OTHER SUPPORT ARE INACCESSIBLE TO MANY

The COVID-19 pandemic affected the livelihoods of people around the world, including in countries where the virus did not spread. Its effects on tourism, transportation, manufacturing and many other industries continue to translate into unemployment and income loss. In response to the pandemic, many governments set up subsidies, in cash or in kind, to support the most affected populations; and they provided stimulus packages and other plans to support businesses. However, access to these benefits has been limited, with gender differences in some cases.

Social protection grants, among all types of government support, have reached the most people by far, although there are wide differences across countries. While in Kiribati almost half of the population received social protection grants, in countries such as Papua New Guinea and Solomon Islands almost nobody received such benefits (figure 32). Across countries, these grants have targeted the most disadvantaged population groups. In the absence of wealth data, an analysis by educational attainment shows that people with lower levels of education have been more likely to access them (figure 33).

**Figure 32: Proportion of people who received government support since the onset of COVID-19, by sex and type of support, (percentage)(n=17,800)**



Note: For "Cash transfers" n=17,731. For social protection grants among women in Papua New Guinea and Solomon Islands and for cash transfers among men and women in Tonga, estimates should be interpreted with caution as the number of respondents that chose this response category is less than 25. Respondents who reported "I don't know" or refused to respond were excluded from the analysis. Gender differences are statistically significant ( $p < 0.05$ ) for Pakistan ( $p = 0.001$ , social protection grants and  $p = 0.001$  for cash transfers).

**Figure 33: Proportion of people who received social protection grants from the government and/or non-state actors since the onset of COVID-19, by sex and educational attainment (percentage) (n=17,740)**

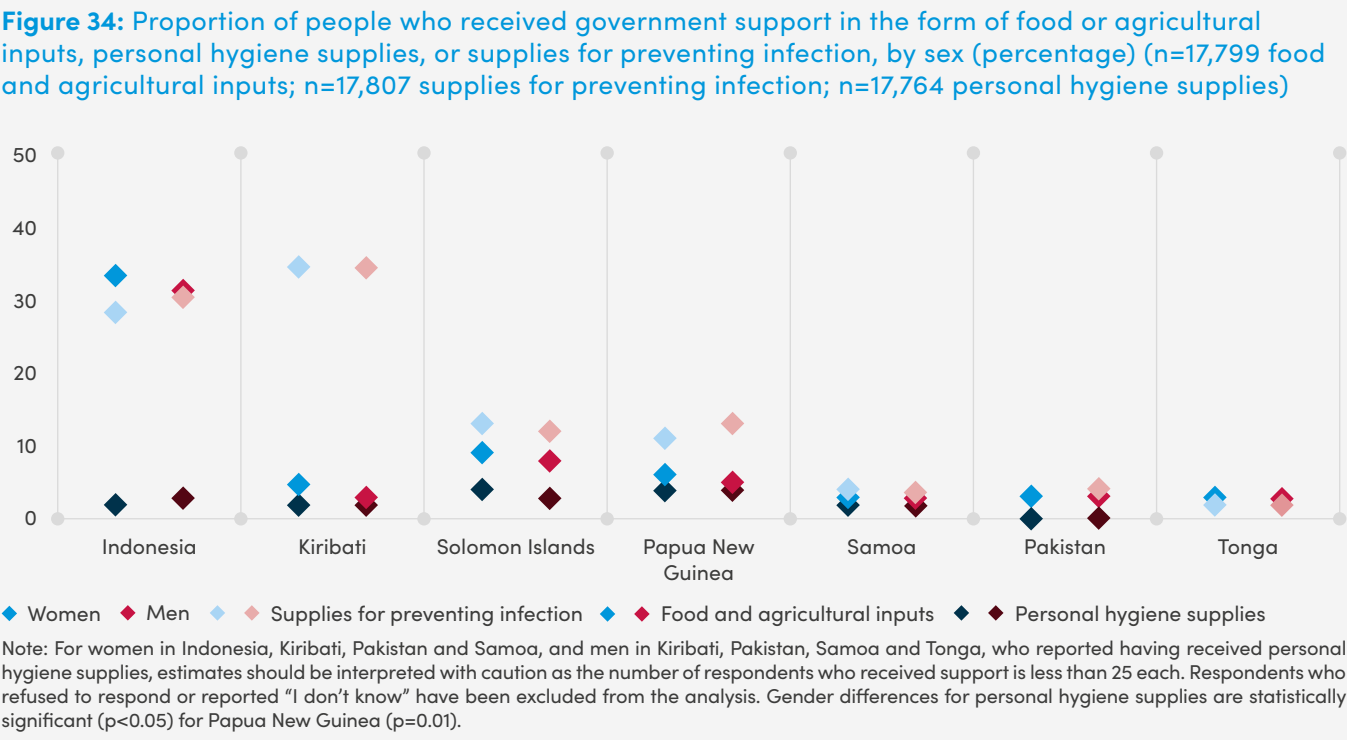


Note: Estimates for 1) "primary or less" for women and men in Papua New Guinea, Samoa, Solomon Islands and Tonga, 2) "secondary" for women and men in Papua New Guinea and Solomon Islands, 3) "Higher than secondary" for women and men in Papua New Guinea, Solomon Islands, women in Pakistan and men in Tonga, should be interpreted with caution as the number of respondents for each is less than 25. Education levels have been classified into three categories, "Primary or less" includes all respondents who received no formal education, some primary education and those who completed primary school. "Secondary" includes all respondents who received some secondary education and those who completed secondary school. "Higher than secondary" includes all individuals who received technical & vocational training, some university/college education, some post-graduate education and those who completed university/college education and post graduate education. "Don't know" and "Refused to answer" categories are not depicted. Gender differences in secondary and higher than secondary are only statistically significant ( $p < 0.05$ ) for Pakistan ( $p = 0.01$  and  $p = 0.05$ , respectively).

Besides grants, governments of some countries have also provided cash transfers, although they only reached 17 per cent of the population in Kiribati, and 12 per cent of the population in Indonesia and Samoa, with small gender gaps.

Other measures taken by governments to support people's livelihoods since the onset of the pandemic include the distribution of food or agricultural inputs, supplies of personal protective equipment and distribution of hygiene products. Food and agricultural assistance reached more than 30 per cent of people in Indonesia,

the country with the most widespread distribution of these supplies; but in most other countries less than 10 per cent of the population received these inputs. Personal protective equipment to prevent infections reached an estimated 34 per cent of people in Kiribati and 29 per cent in Indonesia, while in other countries these rates ranged between 2 and 13 per cent. Gender gaps were overall statistically insignificant (figure 34). Finally, personal hygiene products were also supplied in some countries, although these reached less than 5 per cent of people in all countries considered.



## ANNEX 1. SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Proportion of population age 18 or older, by sex, selected sociodemographic characteristics and country (unweighted, n=17 845)

Sociodemographic characteristic	Indonesia		Kiribati		Pakistan		Papua New Guinea		Samoa		Solomon Islands		Tonga	
	n=2 364		n=2 032		n=3 636		n=3 089		n=2 142		n=2 315		n=2 267	
	W	M	W	M	W	M	W	M	W	M	W	M	W	M
<b>Total</b>	49	51	49	51	48	52	44	56	50	50	44	56	52	48
<b>Residence*</b>														
<b>Urban</b>	56	56	71	66	68	58	63	58	32	34	53	51	55	47
<b>Rural</b>	44	44	29	34	32	42	37	42	68	66	47	49	45	53
<b>Age group</b>														
<b>18–28</b>	28	28	38	38	36	37	41	36	28	31	42	34	28	30
<b>29–39</b>	26	26	29	27	28	26	32	30	27	25	31	29	24	24
<b>40–50</b>	27	26	19	18	22	21	18	21	22	22	18	21	20	21
<b>51–61</b>	14	14	10	12	10	10	6	10	14	12	7	11	14	14
<b>62+</b>	5	7	4	6	4	7	2	4	10	9	2	5	14	11
<b>Marital status</b>														
<b>Married</b>	75	72	72	71	74	73	57	63	71	65	58	64	57	61
<b>Married but separated</b>	1	1	2	1	1	1	4	2	1	1	4	2	1	0
<b>Widowed</b>	7	1	3	1	7	1	3	1	4	2	4	1	10	4
<b>Divorced</b>	2	3	1	1	1	0	1	1	1	1	2	1	1	0
<b>Single (never married)</b>	15	23	22	26	18	26	35	33	23	32	32	31	32	35
<b>Education</b>														
<b>Some primary education</b>	4	5	4	7	40	32	17	18	4	5	16	11	9	10
<b>Primary education</b>	25	23	3	5	10	7	12	12	3	3	9	9	4	5
<b>Secondary education</b>	49	52	79	75	27	37	40	34	50	50	46	48	61	56
<b>Vocational/ college</b>	7	7	11	11	8	11	22	26	23	25	16	19	19	23
<b>Tertiary education</b>	15	13	3	3	15	13	9	9	20	17	13	14	7	7
<b>Disability</b>														
<b>Self-reported</b>	21	13	23	23	40	23	15	18	20	15	29	29	16	11

\* Urban/rural location is self-declared. Population who noted they reside in cities or towns have been considered urban dwellers or the purpose of this analysis. This classification may differ from that used in official statistics in each of the countries.

## TECHNICAL NOTE

The RGAs were rolled out in September 2021 among people aged 18 and over in Indonesia, Kiribati, Pakistan, Papua New Guinea, Samoa, Solomon Islands and Tonga. The country selection was informed by data gaps and possibilities for trend analysis. In particular, for Indonesia, Pakistan and Samoa this is the second round of RGAs; while for the remaining countries, important gender data gaps existed in this context. To comply with COVID-19 safety protocols, Computer Assisted Telephone Interviewing (CATI) was used for data collection. In each country, Random Digit Dialling was implemented using numbering plans from national telecommunications agencies, which excluded commercial numbers and business registers. Prior to data collection, the sample was pulsed (a signal was sent to the randomly generated number to verify its existence). No landlines were considered for this exercise. Information on the sociodemographic characteristics of the respondents was unknown prior to dialling, and thus screening questions were used to achieve sex, age, region and education quotas. The quotas were calculated using national household survey and population census data. For groups where insufficient number of individuals were reached after completing all interviews, booster calls were performed for an additional 10 days.

A key limitation of these surveys has to do with coverage errors associated with CATI (e.g. only people using phones can be interviewed), and low response rates associated with this method. As mobile phone penetration varies across countries, cross-country differences in estimates may, in some cases, be artefacts of the methodology. Mobile phone coverage, however, was greater than 70 per cent in most countries considered, with differences based on sex, age, educational attainment and location. In view of the sample sizes achieved (Indonesia (2,364), Kiribati (2,032), Pakistan (3,636), Papua New Guinea (3,089), Samoa (2,142), Solomon Islands (2,315) and Tonga (2,267)), caution should be used when interpreting results for populous countries such as Pakistan and Indonesia.

With an average length of 16 minutes, the interviews comprised 19 questions asked to all respondents and

20 follow-up filtered questions. These were designed through stakeholder consultations with national and international experts. In August 2021, cognitive interviews and a pilot test were conducted among 1,900 respondents (pooled sample), administered through CATI. Cognitive interviewing tested whether participants understood and interpreted the questions correctly. Emphasis was put on assessing potential recall bias for the reference period (many questions refer to behavioural changes since the onset of the coronavirus disease (COVID-19) pandemic). Professional translation and back translation were performed prior to administering the survey in each country's main national language.

Country teams consisted of 30 interviewers, 3 supervisors and 1 operations manager each, all of which received training in early September 2021. Both men and women carried out interviews, with almost 80 per cent of women interviewers in Pakistan, Indonesia and Tonga. Enumerators all had previous experience in data collection and a minimum of a high school degree. A dedicated team performed random checks for quality assurance (e.g. listening to audio recordings and checking how the questions were administered and responses recorded), and a central research team performed consistency checks (e.g. missing data in line with script logic, refusals, length of interviews, etc.). An estimated 10 per cent of interviews were flagged for quality issues in the Pacific Island Countries considered, compared to 21 per cent in Indonesia and 30 per cent in Pakistan. As quality checks were performed progressively, these issues were addressed through call backs.

This report presents estimates weighted using iterative proportional fitting, more commonly referred to as raking, whereby iterative adjustments were made until the sample distribution aligned with that of the population for sex, age, location and education. Weight efficiency was considered (to avoid affecting the power of the estimates) and improved by trimming (to reduce the impact on the variance of the final weight) or by merging weighting categories. The estimates generated by RGAs are not meant to replace official statistics or to be used for monitoring the Sustainable Development Goals.







**TWO YEARS ON**  
**THE LINGERING GENDERED EFFECTS OF THE COVID-19 PANDEMIC**  
**IN ASIA AND THE PACIFIC**

