

Have social protection responses to Covid-19 undermined or supported gender equality?

Emerging lessons from a gender perspective

Rebecca Holmes and Abigail Hunt

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Social protection responses to Covid-19 and beyond



Key messages

The impacts of the Covid-19 crisis have exacerbated gender inequalities. The crisis has increased women's care responsibilities, disproportionately affected women's jobs and livelihoods, and increased the risk of violence against women and girls.

Social protection has been a key policy response to the crisis, but the extent to which these measures have recognised and addressed the gendered impacts of the crisis remains far from adequate.

Without an explicit gender-informed approach, programme choices may further exacerbate gender inequalities, including risking women's own entitlement to social protection through restrictive eligibility criteria, and exploiting and exacerbating women's unpaid work.





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About the authors

Rebecca Holmes

Research Associate at ODI, specialising in gender equality and social protection within the Equity and Social Policy programme.

Abigail Hunt

Research Fellow at ODI, specialising in gender, work and social protection within the Equity and Social Policy programme.

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Acronyms

ASHA	Accredited Social Health Activist (Kerala)
CPI-M	Communist Party of India (Marxist)
CSG	Child Support Grant (South Africa)
DSD	Department of Social Development (South Africa)
GBV	gender-based violence
GoK	Government of Kerala
ISI	Indian Statistical Institute
KII	key informant interview
LSGD	Local Self Government Department (GoK)
M&E	monitoring and evaluation
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NGO	non-governmental organisation
PDS	Public Distribution System (Kerala)
PMBEJD	Pietermaritzburg Economic Justice & Dignity Group
SASSA	South African Social Security Agency
SEWA	Self Employed Women's Association (India)
SRD	Social Relief of Distress (Covid-19 SRD) grant (South Africa)
SPII	Studies in Poverty and Inequality Institute (South Africa)
TERS	Temporary Employee/Employer Relief Scheme (South Africa)
UIF	Unemployment Insurance Fund (South Africa)

Executive summary

This paper draws on two case studies – South Africa and Kerala, India – to discuss the gender implications of social protection responses to Covid-19 in 2020. The impacts of the crisis have been strongly gendered. The rapid onset of the crisis in early 2020 severely disrupted livelihoods, and these impacts were strongly mediated by existing gender inequalities in the labour market, gendered roles and responsibilities around care work, and also household composition. The high number of female-headed households in South Africa, for example, and the role of women as the main providers of food and household care and well-being, meant that women shouldered a disproportionate burden of the crisis. This has been further compounded by the fact that women typically have fewer coping strategies in terms of savings and access to other support compared to men.

The paper finds that, despite the strong evidence on the gendered impacts of the crisis, the social protection measures put in place as crisis response in 2020 have varied significantly in their approaches to addressing gendered needs. Both case studies showed that pre-existing delivery systems were critical to the fast roll-out of benefits (top-up or new benefits) reaching female beneficiaries, based on pre-existing eligibility criteria. For example, in South Africa, once the policy decision had been made to roll out the Caregiver Allowance, it was rapidly distributed to 7 million recipients – the majority of whom are women.

Looking beyond coverage levels, however, highlights that the level, type and duration of responses have been far from adequate, given the sheer need and multiple impacts generated by the crisis. Where positive lessons have emerged, including in Kerala's comprehensive package of support in 2020, the following facilitating factors were identified: strong political leadership at all levels, preparedness plans in place, strong coordination between multiple actors at national and local levels (including gender-responsive organisations), gender experts and gender data feeding into the response (including real-time data from the community), the availability of additional services at the local level, and the presence of a strong and engaged civil society, including women's organisations, self-help groups and unions.

This paper also looked at whether crisis responses offer an opportunity to strengthen the gender-responsiveness of the social protection system in the future. Our findings from the two case studies indicate that the extent to which social protection measures recognised and responded to gendered needs in response to Covid-19 depended on their design and implementation before the crisis. While the fact that issues of gender equality have been raised in public and policy discussions during the crisis is encouraging, this has not necessarily translated into practical programming changes. Perhaps most concerning is that potentially negative effects may take hold in future, especially in the context of shrinking fiscal space. In South Africa, for example, a key concern is that women's individual entitlements to social protection could be undermined by the restrictive eligibility criteria put in place during the Covid-19 response, effectively limiting many

women's eligibility to the Caregiver Allowance. In Kerala, a key concern arising from the pandemic response is the continued exploitation of women's voluntary or underpaid work in delivering a comprehensive package of interventions.

Looking forward, therefore, we provide a number of policy recommendations based around: (i) strengthening gender-responsive routine social protection systems, and (ii) preparing the social protection system to respond to future crises in a gender-responsive way, as follows.

Strengthening gender-responsive routine social protection systems:

- Extend social protection and ensure women's individual entitlement to social protection in their own right.
- Recognise and value unpaid (and underpaid) work through social protection system.
- Build partnerships and work with specialist organisations on gender equality and women's rights to inform, plan and implement gender-responsive social protection.
- Strengthen sex-disaggregated and gender-specific data collection and analysis to inform decisions on social protection design and implementation.

Preparing the social protection system to respond to future crises in a gender-responsive way:

- Plan and prepare for crisis response, with clear gender-equality objectives and strategies, alongside coordination mechanisms to engage with a coalition of national and local actors.
- Invest in gender-responsive and inclusive systems and implementation infrastructure to build routine social protection, and to enable rapid roll-out in crisis response.
- Identify opportunities to support women's and girls' rights and empowerment, even in crisis response, including ensuring that policy choices do not undermine gender equality, and that they are embedded as part of a broader strategy supporting women's and girls' empowerment.

1 Introduction

The impacts of the Covid-19 pandemic have been particularly devastating for the poorest populations. Covid-19 has created new vulnerabilities, but has also greatly exposed, and exacerbated, existing inequalities between men and women. While there are glimpses of positive opportunities arising from the crisis, the increasing concern is that the pandemic will set back the progress made towards gender equality and women's and girls' empowerment over the last few decades. Therefore, the choice of policy tools employed to respond to the crisis is critical in ensuring that the differential impacts of the crisis on men and women are recognised and addressed, and that the progress already made in gender equality and empowerment is supported, not undermined.

Social protection has been a key response to the crisis in many countries. However, it has also exposed the gaps and weaknesses in existing social protection systems. This includes the under-coverage of certain groups, but also challenges in existing design and implementation features such as eligibility criteria, type and levels of benefits provided, financing, implementation and monitoring and evaluation (M&E). These gaps and weaknesses are also particularly stark when it comes to mainstreaming gender. At the same time, the crisis has exacerbated gender inequalities in the areas of health, education, work and violence. The limitations of social protection programmes and systems to adequately respond to these needs in routine social protection (pre-Covid-19), and within Covid-19 response measures, have been starkly highlighted.

The aim of this paper is to examine social protection responses to the crisis from a gender perspective. The research was carried out between October and December 2020, and it draws on a brief global literature review on gender and social protection responses to Covid-19, as well as focusing on two case studies: South Africa and Kerala, India. These case studies were chosen to draw out lessons from adapting social protection in response to the crisis from a gender lens – the top-up to the Child Support Grant (CSG) in South Africa, where the majority of the 7 million recipients are women, and the relatively comprehensive and rapid support provided through the Government of Kerala in collaboration with community and women's worker organisations. This paper is based on analysis from key informant interviews (KIIs) with researchers and members of civil society organisations from South Africa and Kerala, as well as on published and grey literature on social protection responses in these two contexts. A full overview of KIIs is provided in Table A1 in Appendix 1.

Chapter 2 of this paper provides a brief overview of the gendered impacts of the crisis and how social protection responses have addressed these gendered needs. Chapter 3 discusses the findings from the case studies, focusing on assessing the effectiveness of responses in relation to timeliness, coverage, adequacy of the level of benefits, and adequacy of the type of benefits, and also identifies the enablers and blockages to the success of these responses. Chapter 4 summarises the key findings and presents policy recommendations.

2 Impacts of the crisis and social protection policy response: a gender perspective

2.1 Gendered impacts of the crisis¹

The World Bank (2020a) estimates that the Covid-19 crisis will have resulted in an additional 88 million to 115 million people living in extreme poverty in 2020. Looking at these estimates from a gender perspective also reveals some stark differential impacts. While the direct health impacts of Covid-19 have been worse for men, women and girls are bearing the brunt of both the short- and longer-term effects of the crisis (Azcona et al., 2020). Existing inequalities between men and women mean that women have lower capacities to mitigate against and absorb the impacts of the economic shock. More women than men live in poverty, women earn less than men, have fewer savings and less access to financial resources, and are more likely to be in insecure and low-paid segments of the informal economy, albeit with some regional variation (ILO, 2018; UN Women and WHO, 2020). Women also have less access to formal social protection, head the majority of single-parent households, and often experience harmful practices, violence and violations of their rights (ibid.).

The crisis has exposed and exacerbated these gendered inequalities, with data suggesting that, globally and across all country-income groups, the crisis has disproportionately affected women workers and gains made over recent decades (ILO, 2020a; see also Bastagli and Hunt, 2020). In 2020, women experienced 5.0% employment loss globally, against 3.9% for men, and across all regions women have been more likely than men to drop out of the labour force – with the International Labour Organization highlighting that the high associated risk of long-term labour market detachment for women, young people, the low-paid and low-skilled means that specific, targeted measures will be needed to ensure their long-term economic security (ILO, 2021).

With limited savings or alternative sources of income, many women and their households have suffered devastating effects of these losses, as the case study accounts below clearly demonstrate. Within the growing number of food-insecure people, pregnant and nursing women and children face heightened risks of food insecurity and malnutrition, and it is women and girls who will be more likely to reduce their food consumption in the household (WFP, 2020a). The pandemic has also exacerbated the pre-existing unequal distribution of unpaid care

1 Also see <https://data.unwomen.org/resources/surveys-show-covid-19-has-gendered-effects-asia-and-pacific> in www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-covid-19-and-the-care-economy-en.pdf?la=en&vs=407.

and associated time poverty for women, which increases with the presence of children in the household, as a result of family members falling ill, home-schooling, cooking and cleaning and a lack of formal or informal care support (ILO, 2020a; UN Women, 2020a).

The short- and longer-term impacts on women's and girls' health, protection and education are also areas of grave concern. Lockdowns restricted access to healthcare, family planning and schools, and the financial implications of responding to the pandemic have put other expenditures at risk, including diverting funding away from maternity and sexual and reproductive health needs, and access to contraceptives (UNFPA, 2020). School closures and the impact of the economic crisis also heighten the risks of forced early marriage and pregnancy for adolescent girls. Incidents of sexual exploitation to meet basic needs have also been reported in humanitarian settings since the onset of the crisis (GPC, 2020), and reports of increased violence against women and girls, exacerbated by lockdown, school closures and economic crisis, are cause for concern (HRW, 2020; Peterman and O'Donnell, 2020).

2.2 Gendered social protection policy responses to the crisis

Given that the crisis has impacted men and women differently, a critical question to examine is whether policy responses to the crisis have adequately addressed these gender-differentiated needs. Crises are often seen as an opportune time to radically shift inequalities and power imbalances, but they also pose significant risks of undermining progress on gender equality and empowerment (UNDESA, 2020).

In December 2020, Gentilini et al. (2020) reported that there had been more than 1,000 new or adapted social protection and job responses to the crisis. Most of these are adaptations to non-contributory social assistance cash grants, and many are new programmes: 63% of cash transfer responses to Covid-19 are schemes introduced in the pandemic (ibid.). As social protection programmes were positioned in many countries as a key policy measure to provide rapid response to the developing crisis, there was a call for gender to be adequately mainstreamed in any social protection response roll-out. Some of the key features identified as a gender-responsive social protection response to Covid-19 are highlighted in Box 1.

Box 1 Mainstreaming gender equality in social protection responses to Covid-19

Calls for gender equality to be mainstreamed through social protection crisis-response measures included attention to the following design and implementation features.

Programme design

- **Eligibility** – identify those most vulnerable to the impacts of Covid-19 through targeting response measures to reach women and girls across the life course.

- **Inclusion** – actively reduce exclusion errors in rapid expansion of programmes by removing barriers to women’s participation.
- **Adequacy of benefit type, levels and duration** – consider these to meet women’s and girls’ needs exacerbated in the crisis (especially increased time on care responsibilities, gender-based violence, girls out of school, and sexual and reproductive health).
- **Linkages to other programmes and services** – to support multi-dimensional needs exacerbated by the crisis.

Programme implementation

- **Simplify enrolment and registration processes** – to facilitate women’s participation.
- **Ensure equal access to payments** – offer choice in the modality of delivery, recognising operational challenges to accessing benefits, including use of new digital technologies.
- **Establish protection and safeguarding mechanisms to reduce the risk of harm** – to programme participants, communities and programme staff.
- **Ensure access to functioning complaints and appeals mechanisms.**
- **Establish gender-responsive monitoring and evaluation indicators** and feedback mechanisms – to capture programme experiences and outcomes for women and men, and changes in gender relations.
- **Engage national and local organisations representing women and women’s groups.**

Source: SPACE (2020a; b; c)

However, despite the potential of gender-responsive social protection in the context of crisis response, and the attention that the crisis has given to gender inequalities, in practice, initial monitoring of programmes from a gender perspective indicates that there are few examples of national social protection responses paying explicit attention to gender equality in programme design and implementation. For example, at the beginning of 2021, the United Nations Development Programme (UNDP) and UN Women Covid-19 Global Gender Response Tracker² analysis measured only 18% of global social protection and jobs responses as ‘gender-sensitive’ – that is, they target either women’s economic security or address the rise in unpaid care work. While the nuances of programme design and implementation are not captured in this measurement (e.g. operational components or variations in gender-sensitive design, going beyond targeting women), this still highlights a stark gender gap.

Some of the more positive examples of gender-responsive social protection measures – through programme adjustments or the introduction of new programmes – in response to the Covid-19 pandemic include:

2 See <https://data.undp.org/gendertracker/>.

- Extending coverage of social assistance schemes, often inadvertently (rather than explicitly) benefiting women as programme beneficiaries and as recipients of cash transfers. For example, the governments of Egypt, South Africa and Turkey (among others) expanded coverage or increased the benefit value of pre-existing cash transfers (UN Women, 2020a). In Ghana, the public works scheme reduced the hours women were required to work but kept the transfer level the same (World Bank, 2020b).
- A number of countries kept school feeding going in the form of deliveries or pick-ups even when schools closed in lockdown, including Liberia, Nigeria and Cabo Verde (WFP, 2020b). This is particularly important for some groups facing specific nutritional needs, such as adolescent girls, as well as relieving stress among women when they are responsible for meeting household food needs (FAO, 2020).
- The extension of social insurance has also been implemented in several countries, in recognition of the impact of Covid-19 on informal workers. In Argentina, for example, a new cash transfer programme – the household emergency income (*Ingreso Familiar de Emergencia*) – was expected to reach 3.6 million families of informal, self-employed and domestic workers (UN Women, 2020a).
- While cash has been the predominant policy response, it has not been the only one. Women with disabilities have received sanitary supplies, while healthcare centres for children received particular attention to provide uninterrupted healthcare services in Gambia.³ The ministry in Gambia also launched a hotline to try to enable a fast response to issues of gender-based violence (GBV) (UN Women, 2020a). Several high-income countries have also taken measures to provide a minimum level of childcare (ibid.).

3 See www.socialprotection.org/discover/blog/gendered-impacts-covid-19-and-social-protection-responses-rural-areas.

3 Effectiveness of social protection response measures: case studies from South Africa and India

3.1 South Africa

3.1.1 Overview of selected social protection response measures in South Africa

South Africa's social protection response to the Covid-19 crisis was announced in several stages, with significant updates to key provisions made with each announcement. Identified as 'among the boldest in the world' (Seekings, 2020a: 2), the first major announcement was made by the Minister of Employment and Labour on 25 March 2020, introducing the Covid-19 Temporary Employee/Employer Relief Scheme ('TERS'), an employee-focused relief benefit.⁴

A presidential announcement followed this on 21 April – almost a month after the commencement of South Africa's full lockdown – announcing an emergency expenditure package of R500 billion (approximately \$25 billion or close to 10% of gross domestic product), which increased expenditure of R50 billion on social grants to include households not covered by the previously announced social insurance measures (The Presidency RSA, 2020, cited in Bassier et al., 2020a). The measures included **adjustments to existing social assistance** programmes by: increasing the benefit level of the Old Age Pension and Disability Grant; an increase in the Child Support Grant (CSG) of R300 per child for one month in May – which later became a Caregiver Allowance of R500 per month paid to the primary caregivers of CSG beneficiary children, from June to end of October 2020; a package of in-kind transfers, including food relief from mid-May to the end of June (SASSA, 2020); and the **introduction of a new programme**, the Covid-19 Social Relief of Distress (Covid-19 SRD) grant, initially for six months from June to October 2020, then extended for a further three months until January 2021. The SRD was predominantly aimed at those who were unemployed and ineligible to apply for other grants, or claim unemployment insurance or receive any other state benefit.⁵

3.1.2 The gendered impacts of Covid-19 in South Africa

Compared to other contexts, good data availability – including relevant longitudinal data – and a committed cohort of researchers, institutions and civil society organisations mean that relatively detailed insight into the immediate gendered impacts of the Covid-19 crisis is available for South

4 The directive provided for a relief benefit to be claimed where, due to Covid-19, employers are unable to pay their employees or where employees are required to take compulsory leave (KPMG, 2020).

5 For more detail on the wider Government of South Africa response to the Covid-19 crisis, see <https://data.undp.org/gendertracker/> and Gentilini et al. (2020).

Africa. The overall picture for the poorest segments during the initial lockdown was bleak, with lower-income households severely affected by the adverse effects of lockdown, including exacerbation of pre-Covid-19 mass unemployment and wider negative effects on working hours, earnings and job security (Köhler and Borat, 2020a).

Job and earnings losses were particularly prevalent among lower earners in the informal economy where women are concentrated (which also persisted after the initial lockdown), with women accounting for two-thirds of jobs lost overall and remaining well behind men in reaching their pre-Covid-19 employment levels in June 2020 (Casale and Shepherd, 2020; Casale and Posel, 2020; Rogan and Skinner, 2020). Persistent negative labour market outcomes have been identified, with a growing gender wage gap (estimated at 30% in February 2020, 52% in June 2020), as well as a lack of economic opportunities, including as a direct result of women's disproportionate and growing share of time spent on unpaid care compared to the pre-crisis period, notably due to ongoing school closures and the suspension of childcare services (Casale and Shepherd, 2020; Hill and Köhler, 2020).

Historically high rates of violence in South Africa also showed gendered patterns during the lockdown, with hospital data showing a significant increase in the proportion of female trauma cases, notably involving blunt assault and penetrating trauma perpetrated within the home (Zsilavec et al., 2020). It is worth noting that another study, based on telephone interviews, found a relatively low prevalence of domestic abuse, which authors posit may be due to the alcohol ban during lockdown (Abrahams et al., 2020). However, as discussed further below, phone interviews conducted during lockdown may not yield a full picture, including because husbands – who may be the perpetrators of GBV – may be present, highlighting that careful attention to data collection methods is critical for gaining reliable insights into gendered experiences.

Psychological distress, including depression and anxiety, increased among women during lockdown (Abrahams et al., 2020; UN Women, 2020b). Our key informants gave powerful accounts of the extreme hardship and anxiety borne by women since the onset of the crisis (see also Box 2). One explained that household and family living arrangements – in particular the high numbers of female-headed households and father absenteeism⁶ – as well as prevailing gender norms, are at the root of women's disproportionate shouldering of unpaid care and the negative effects they experienced as a result of the economic shock:

Because of the unique living arrangements in South Africa, most of the burden [of the crisis] will fall on women... So we all knew that it would fall on women when Covid-19 hit. But many women spend a lot more time on care anyway, and this also fell to women, some were doing at least four hours a day extra care – cooking, cleaning, home schooling. The government did very little to take that into account (KII, University of the Witwatersrand).

6 As of 2018, 37.9% of households in South Africa were female-headed, which amounted to a total of approximately 6.1 million households, and 43.1% of children lived with only their mother (Stats SA, 2019).

Box 2 Experiences of women living in poverty during the Covid-19 crisis

One key informant had carried out a qualitative study in the Western Cape with poor mothers living in townships and other low-income areas. She described some of her emerging findings:

This was by far the most difficult and harrowing period I have heard of... I am an experienced researcher... [but] there was utter hopelessness in those homes.

Under lockdown... there was no movement except for essential purposes such as healthcare or getting groceries, and the policing in middle-class areas and townships were very different. People in townships were scared to leave home to seek healthcare or go to the grocery store. There, people erect their own shacks, it's not brick and mortar, no yard space, so people were in one-room shacks with children, nowhere to play and ten families to a toilet, water taps right next to the toilet. These issues have always come through in research as exacerbating child health problems, but mothers had a huge sense of panic about being able to protect their children from the virus while living in these conditions...

Women's anxiety was huge. There was a lot of uncertainty about whether or how it transmits to children, so women were also worried about sending kids to school. They also carried anxiety around food provision. Even in houses with men where jobs had been lost because of the pandemic, the stress of what to do about it was entirely on the women. One woman said, 'it's my skirt that the children clutch at when they are hungry.'

These women were already poor, the child support grant was already inadequate, but they had resourceful strategies to cope with their poverty including borrowing, exchanging food with neighbours, and so on, but the pandemic and lockdown meant they couldn't access these resources. Under [restrictions] level 5 and 4 [in March and April] they were not allowed anywhere so couldn't borrow. But even later under level 3 the spaza shops or lenders wouldn't give food on credit or lend as they knew people wouldn't be able to pay it back. Women had to take the full burden but had far fewer resources to do that.

Source: KII, South African Medical Research Council

3.1.3 Performance of the Caregiver Allowance

Focusing on the Caregiver Allowance, which was an adaption to the CSG (providing a top-up of the CSG), we first discuss the performance of the response and then identify the key drivers and bottlenecks from a gender perspective.

Timeliness

There are two distinct aspects to consider in terms of the initial timeliness of response. One is the timing of decision-making, and the other is the timing of actual response and implementation reaching the targeted beneficiaries. In the case of South Africa, the timeliness of decision-making has received strong criticism in the emerging literature (e.g. Seekings, 2020b) and by our key informants alike. While social insurance measures mostly benefiting formal employers and employees had been announced in March 2020, only on 21 April 2020 – almost one month after the start of South Africa’s strict national lockdown – was an announcement on the social assistance package made, by which time the scale of destitution and hunger was huge.

Once the policy decisions had been made, the timeliness of implementing the measures was mixed. The Caregiver Allowance was implemented relatively quickly and smoothly, largely due to the existing payment infrastructure and systems in place to deliver the CSG. This is in contrast to the delays and implementation challenges faced in delivering the package of in-kind transfers including food relief⁷ and the new SRD grant – the latter was rolled out only in June 2020.

The longer-term picture is also important. Longitudinal data collected through the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) carried out in May and June 2020 showed a drastic increase in adult and child hunger in survey months.⁸ Almost half of all households had on occasion run out of money for food during April 2020 but by the second wave – when some grants had been received and limited informal economy activity recommenced – hunger and food insecurity had declined (Bridgman et al., 2020).

This provided clear evidence of the critical role of social assistance, leading many analysts to call for the new assistance measures to be extended given the protracted nature of the crisis (e.g. Casale and Shepherd, 2020). While the Covid-19 SRD grant was extended until January 2021, then for a further three months, the Department of Social Development and the South African Social Security Agency (SASSA) confirmed no similar extension would be given for the Caregiver Allowance past 31 October (Postman, 2020), despite strong objections from civil society, including a legal challenge (CALSA, 2020).

Coverage adequacy

On the basis of the announcements made, it appeared that the government had promised ‘unprecedented and quasi-universal protection’ for most households except the rich (Seekings, 2020a: 1). Indeed, the Caregiver Allowance reached 7.2 million existing recipients, the great

7 There were also allegations of corruption. In some parts of the country, government officials – notably councillors – were accused of stealing food parcels or giving them to relatives, constituents and political allies (Mahlangu, 2020), later confirmed by the Auditor General and subsequently subject to investigation by the Special Investigating Unit of the National Prosecuting Authority (Bridgman et al., 2020; Auditor General, 2020).

8 NIDS-CRAM is a broadly nationally representative panel survey of South African individuals. For more information, see <https://cramsurvey.org/about/>.

majority (almost 98%) of whom are women (Köhler and Bhorat, 2020b). While on the surface this indicates a positive gender-responsive adjustment measure, a deeper analysis looking at the coverage and objectives of the response reveals that significant gendered coverage gaps developed. This was notably through the design of the eligibility criteria for the new grants system, coupled with unclear communication about the objectives and intended beneficiaries of the Caregiver Allowance.⁹

A key challenge concerns women's individual entitlement to grants, stemming from persistent uncertainty about the objectives and rationale of the policy response, including the Caregiver Allowance. In late March 2020, a group of influential economists argued for a R500 monthly CSG top-up,¹⁰ thereby making use of existing grant infrastructure to support households vulnerable to the effects of lockdown, notably because many in these households would be working in the informal economy and so unlikely to access the Unemployment Insurance Fund (UIF)/TERS social insurance benefits during the crisis (Bassier et al., 2020b).

Because the top-up was eventually per caregiver (and thus household), rather than per child, there was confusion about whether the policy objective was aimed at supporting children or the whole family. One KII noted:

The objective was simply to get money to poor households. A number of lobbyists put forward different proposals to the Department of Social Development. The prevailing wisdom was that the CSG has a large reach among poor households, and so the strong children's lobby said that instead of looking at a universal grant they should just top up the CSG, the initial top-up came through that thinking (Representative, Studies in Poverty and Inequality Institute (SPII)).

Others posit that the Caregiver Allowance was aimed at compensating for the closure of schools and the school feeding programme (Gelb, 2020).

Nonetheless, looking at the policy response as a whole, the government did acknowledge significant coverage gaps in the existing system of UIF/TERS – which would reach predominantly formal-economy workers – and other existing assistance grants, and therefore launched the Covid-19 SRD grant. Critically, this grant targeted the unemployed who were ineligible for other grants or claiming unemployment insurance.¹¹ These eligibility criteria meant that, although women are over-represented in unemployment and job loss, they faced a double exclusion: from the UIF/UIF-TERS system, including due to their under-representation in the formal economy

9 The eligibility criteria for the existing grants also remained the same, so existing coverage gaps remained unaltered. Recent calculations show that approximately 2 million eligible children are not receiving the CSG, often due to documentation challenges (Seekings, 2020a).

10 Previously, the announcement made was an increase in the CSG of R300 per child for one month in May, which then later became an SRD Caregiver Allowance of R500 per month paid to the registered carer.

11 See eligibility criteria for the Covid-19 SRD grant here: www.sassa.gov.za/Pages/COVID-19_SRD_Grant.aspx.

(only 41% of the UIF/UIF-TERS beneficiaries in June 2020 were women), and from the SRD as the eligibility criteria meant that many women were de facto excluded from claiming the SRD due to being named as the main recipient of the CSG/Caregiver Allowance (only 34% of those paid the SRD in June 2020 were women) (Casale and Shepherd, 2020). Therefore, notwithstanding the confusion around whether the Caregiver Allowance was aimed at children and/or households, women's individual entitlement to access support was in practice limited by the design of the multiple Covid-19 response measures. As Casale and Shepherd (2020: 23) argue, the top-up should be to support the child/children in the household and 'unemployed women are effectively being penalised if they are also the main caregiver to children'.

Level/value adequacy

The CSG is a critical site of analysis to understand the gendered implications of the value adequacy of grants, being the grant most women and children are likely to benefit from, given the high share of female-headed households in South Africa and disproportionate exclusion from other cash transfers – notably linked to women's smaller share than men as UIF-TERS recipients and inability to claim the Covid-19 SRD Grant if in receipt of the CSG. Analysts have reported that, although both amendments to the original CSG were progressive, the 'per child' top-up is marginally more progressive – that is, it would have better been able to alleviate poverty as a result of the impact of Covid-19 – because more than two-thirds (66.8%) of CSG-receiving households have more than one child, meaning a higher total transfer value to the registered caregiver. The 'per caregiver' grant was chosen for fiscal reasons, and because it was assumed that top-ups to other grants and the introduction of the Covid-19 SRD grant would raise total household income (Köhler and Bhorat, 2020b). However, the majority of CSG recipients are female-headed households, suggesting that, due to the eligibility criteria restrictions, these households would not in fact be able to receive the Covid-19 SRD grant.

Rogan and Skinner (2020) point out that, in the context of the pandemic, the Pietermaritzburg Economic Justice and Dignity Group (PMBEJD) calculated the monthly cost of a basic nutritious diet for one child to be R670 and a modest household food basket to cost R3,474 as of end of April 2020 – meaning the monthly increases of R500 per family are inadequate to cover the monthly cost of basic nutrition for one child, let alone a household. Furthermore, the Institute for Economic Justice (IEJ) also paints a bleak picture of the 'per caregiver' option, resulting in one-third less support to the poorest and an additional 2 million people below the food poverty line than the 'per child' option¹² (IEJ, 2020).

Given the compounding challenges that households faced in 2020, without work or other income strategies, the costs of having more household members at home and not receiving school meals for children, these additional costs all effectively reduce the adequacy of the transfer. In addition, key informants also highlighted that the level of the grant did not take into account extra costs incurred in receiving it, such as bank charges (which were suspended for only a brief period at

12 Note that existing challenges in the value of the 'normal' CSG are also reported to be insufficient.

the onset of the Covid-19 crisis) and transport to the location where they could pick up the cash transferred to them, which meant that the share of the total transfer left for expenditure of the recipient was further reduced.

At the same time, the extent of poverty and lack of other income and support options meant that, although insufficient, the grants made some difference to economic stability. Making the case for the extension of the Caregiver Allowance past October 2020, several studies of longitudinal data confirm that Caregiver Allowance (along with other grants including the Old Age Pension top-up and SRD grant) ameliorate poverty, even if inadequate to keep households above the food poverty line, and are well targeted to significantly increase the incomes of poor households in relative terms – with the Caregiver Allowance being particularly pro-poor (Bridgman et al., 2020; Köhler and Bhorat, 2020a). For example, Caregiver Allowance receipt has been shown to increase per capita household income by about 63% for those in the poorest 30% of households, in contrast to the less than 3% increase for those in the richest 30% of households (Köhler and Bhorat, 2020a). Overall, though, the literature and key informants converged in the view that the social grants remained inadequate to meet basic needs.

Type adequacy

Historically, the CSG has had positive impacts on poverty and the food security of recipient households. While, as discussed above, the adequacy of the value is limited, cash transfers still helped households to meet some needs. However, interviewees for this study also mentioned that the severe implementation challenges in receiving additional support through food transfers coupled with increases in food prices meant that cash as a modality was also insufficient. One key informant explained recipients' perceptions:

In South Africa if you have little money and no income then every little helps... you can say theoretically it's not enough, but at the same time there was an appreciation for what was received.

Moreover, because of the confusion around the objectives and intended beneficiaries of the grant, there was also some confusion about intended expenditure. As one key informant explains, this confusion led to women not feeling entirely free to spend the grant to meet their own individual needs and in their own right:

None of the respondents knew the [Caregiver Allowance] was for them, the caregiver, and there was huge confusion because of the top up first then the single caregiver grant. Hostility already exists for women receiving the CSG – women need a distinction that they receive the Caregiver Allowance for themselves and not children, as there is already pressure on them to

prove the money is for children, now they have to prove they have the right to that grant? They felt guilt and shame if they bought electricity and food for everyone with the grant – now there was a confusion this money was for them and so they can spend it on anything.

3.1.4 Emerging enablers and bottlenecks to gender-responsive design and implementation

Existing digital systems and programme infrastructure

The Caregiver Allowance top-ups to the original CSG were rolled out relatively seamlessly once the announcement was made. One key challenge reported was that recipients went to cashpoints to receive their top-ups on the day they were issued (previously all on the same day), leading to huge queues that contravened social distancing. In response, SASSA then separated the payment days of different grants, and while this resulted in some delayed payments during the first month, this was quickly resolved (Seekings, 2020a). This example also points to the importance of digital payment technology in facilitating the delivery of grants – particularly when considering the long queues for in-person services, for example to receive food parcels (Gelb, 2020).¹³

While for existing programme recipients the roll-out was relatively efficient, there were significant challenges in registering *new* recipients of existing grants during the lockdown, for example obtaining CSG registration for children born during the pandemic. Most SASSA offices, where registrations take place, were closed during the lockdown and, once re-opened, operated under social-distancing requirements and with a huge backlog slowing the registration of new beneficiaries (Gelb, 2020). As one key informant explained, previous improvements in the CSG registration process were rolled back during Covid-19:

One woman gave birth in the day hospital during lockdown in May. A recent reform to ensure quicker access to CSG is that birth certificates are issued in hospitals and so people are able to register for CSG... birth registration was not being done in hospital and you have to go to the municipal office [so she] had to take a taxi at 3 a.m., ask the neighbour in the next-door shack to attend to the baby if they wakes, even though the husband was there in same room. She took a taxi to Belleville many kilometres away, to find a huge queue outside and she didn't make it to number 50 that day – home affairs only taking 50 applicants a day and there were already 50 in front of her. She had to keep going back as she was desperate for CSG money. Finally, she got the birth certificate, then had to go to SASSA – the nearby one was closed so she had to go to the regional office, and when she arrived she got given a paper to say she had to go back in one month. The CSG was backdated to date of application to SASSA when she finally got to the office, but there was a huge delay compared with the 'usual' system (KII, South African Medical Research Council).

¹³ For a stark illustration of the massive queues for food parcels, see www.bbc.co.uk/news/av/world-africa-52701571.

Communication and information

Confusion and uncertainty stemming from a lack of information was reported by key informants as a key challenge undermining the effectiveness of the CSG response. For women, as the majority of beneficiaries of the CSG, the confusion around the objectives and intended beneficiaries of the grant also resulted in some confusion about intended expenditure, potentially limiting the ability to use the new Caregiver Allowance to meet their own individual needs and in their own right.

There was also significant confusion about the longevity of grants – among experts who tried to ascertain what grants were intended for (including by writing letters to government to request clarification, but with no response) and women alike – which contributed significantly to economic insecurity and associated anxiety:

The Covid-19 SRD Grant continues but... some didn't know the Caregiver Allowance was cut off in October and had a shock when the grant was R500 less (KII, South African Medical Research Council).

Leadership and decision-making processes

Part of the confusion discussed above comes from the fact that the precise objectives of the measures were never clearly articulated. The uncertainty about the intended objectives of the Caregiver Allowance stems in no small part from the opaque decision-making process around Covid-19 response measures. Some analyses have noted that the strict lockdown led to a cessation in normal scrutiny during policy-making processes, with normal government decision-making processes suspended, rife political jostling taking place and a lack of transparency about the role and make-up of the National Coronavirus Command Council that made many decisions during early response (Seekings, 2020a; Seekings and Nattrass, 2020). The evidence base for changes in social protection design features remain unclear. Some have noted that 'the reason the South African state chose to implement the CSG June–October [2020] increase of R500 per month as a per caregiver increase... is also unknown' (Bassier et al., 2020a: 7). A lack of information about the Command Council membership and processes involved mean it is unclear whether the structures involved were gender-balanced or included individuals with gender specialisms.

Furthermore, the influence of the Department of Social Development (DSD), which would normally have led the development of social protection policy, appears to have been limited in favour of the presidency and later the treasury, which key informants felt was an indication of the government's prioritisation of fiscal concerns, rather than human rights and equality, in its response. This – in combination with the difficulties experienced by highly active civil society in influencing the policy response – may also account for the lack of overt gender-responsiveness in the approach, given the relative concentration of gender expertise in the DSD.

The lack of clarity around objectives and the decisions around eligibility criteria effectively excluding many women from individual benefits has had significant negative impacts on gender

equality and women's economic security during the Covid-19 crisis. It also has deeper practical and symbolic implications for the gender-responsiveness of the social protection system going forward. Some have lauded the introduction of the Covid-19 SRD grant, citing it as 'the predecessor of a new, permanent Universal Income Grant, a social protection legacy that would outlast the Covid-19 crisis' (Gelb, 2020: 5). Some key informants agreed that the Covid-19 SRD grant set an important precedent by putting the idea of long-term social assistance for the 18–59 age group on the government's agenda for first time, and the task at hand was now to ensure its longevity and improve its design. However, others indicated that the Covid-19 SRD Grant was a major blow to gender equality and women's rights. As one explained:

[I have] deep concern about women only being seen in terms of caregiving capacity [which is] dangerous as it perpetuates a lack of agency among women to make decisions about their own wellbeing and priorities... [So] the idea of giving cash to working-age men has taken hold, but women's right to social security was dealt a huge blow by being disqualified from the Covid-19 SRD in their own right... If anything, this has led to the idea of a basic income grant for men being more acceptable than the idea of women having social security in their own right (KII, SPII).

3.2 Kerala, India

3.2.1 Overview of selected social protection response measures in Kerala

The response of the Government of Kerala (GoK) to Covid-19 in early 2020 was quick and proactive, putting in place mechanisms to track the pandemic's emergence and commencing a state-wide response from January 2020. Building on existing emergency response infrastructure from recent floods and epidemic outbreaks, the government leveraged its relatively high expenditure on healthcare services compared to other states in India (5.5% of total expenditure in 2020/21) to strengthen its public health infrastructure to address the pandemic, including testing, tracing, and primary health service provision including government quarantine and case treatment centres (ILO, 2020b; WHO, 2020).

Comprehensive healthcare was just one component of GoK's 'all of government, all of society approach', which included local government, community networks and trade unions (ILO, 2020b). On 19 March 2020, the Kerala Chief Minister announced a 20,000 crore rupees (\$2.6 billion) emergency package focused on social protection, seven days ahead of the national relief package (Das et al., 2020a). The GoK's package included **adaptations to existing social protection measures, new programmes and links to social and economic services**. These interventions included provisions for early payments of welfare pensions, transfers to workers – including some informal workers – and a one-time payment of Rs1,000 to those not part of any pension scheme, advance payments of old age, widow or disability pensions, and loans through women's cooperatives. As Das et al. (2020b) document, key provisions also included:

- food relief, including free rations and grocery kits to existing ration-card holders
- free meal provision to those in home quarantine and others in need through community kitchens
- meals for the 300,000 children enrolled in public childcare centres (*anganwadis*) that closed during the lockdown
- expansion of the employment guarantee programme through the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)
- additional income support through loan assistance, tax relief and arrear clearance.

The holistic GoK response also included the provision of psychosocial support, counselling and advice through tele-portal and phone lines for frontline workers in the Covid-19 relief effort, as well as for people with mental illnesses or hearing impairments, children with anxiety or special needs, migrant labourers, elderly people living alone and pregnant women. A huge public information and awareness campaign, ‘Break the Chain’, aimed at stopping the spread of Covid-19 and providing information about available help, was implemented by community groups including *kudumbashree* women’s self-help groups and through the ‘GoK Kerala’ mobile app, phone lines and dedicated information sessions in multiple languages accessible to local and migrant populations (WHO, 2020).¹⁴

The main objectives of the package of measures was to provide relief from the impacts of the pandemic and restrictive measures put in place to control the virus, for poor and vulnerable families and individuals. Some measures were targeted at specific populations, such as school-meal replacement for children and provisions for migrants in Kerala (WHO, 2020; KIIs). When announcing the package, the Chief Minister noted that the early disbursement of the social security pension was aimed at ‘getting money into people’s hands when commercial activity in the state is partially paralysed because of the coronavirus scare’ (Nidheesh, 2020). A number of gender-sensitive features were apparent, including the widespread coverage of the response which benefited women, loans to women implemented through *kudumbashree*, and the range of services provided, including the psychosocial measures.

3.2.2 The gendered impacts of Covid-19 in Kerala

While comprehensive and up-to-date data on the gendered impacts of the crisis in Kerala is hard to locate, experts and frontline workers identify a range of negative impacts, with women and girls deeply affected. A small-scale survey carried out by the Self Employed Women’s Association (SEWA) in April 2020 during lockdown, including women in Kerala, indicated that respondents’ primary concerns revolved around food and work, due to limited income and savings. Other key challenges included isolation from social and professional networks leading to mental stress and frustration, and uncertainty stemming from changing lockdown and social-distancing rules (SEWA, 2020a). However, it has also been noted that getting a true picture of women’s lives, challenges and needs during the Covid-19 crisis has been challenging: lockdown and distancing

14 For more detail on the initial GoK response, see Das et al. (2020b).

have meant reliance on phone surveys, which do not always yield a full picture. This is because digital divides mean that many women are inaccessible (expenditure on women's mobile phone credit was shown to be one of first to go during the crisis), and due to the presence of husbands during interviews (Alvi et al., 2020).

Therefore, the accounts of frontline workers and those connected to women's groups are critical. Professor Eapen, a Member of the Kerala State Planning Board, describes the economic fall-out, with employment losses widespread in sectors in which women are concentrated (including retail services, manufacturing, tourism, construction, domestic work, home-based manufacturing), as well as severe income losses during the initial lockdown through MGNREGA activities and micro-enterprise trade stopping, including those run through *kudumbashree* and other cooperatives, as well as for independent own-account workers.¹⁵ She further describes impacts on women's economic security due to their over-representation in the most precarious sectors of the informal economy and associated lack of access to protections. To illustrate, according to our key informants, more than 70% of domestic workers lost work at the start of the pandemic (KII, SEWA), while only a few employers continued to cover workers' salaries until the end of March 2020 once the partial lockdown was announced on 15 March (SEWA, 2020b). As one key informant explained:

This is the same in other sectors, such as for street vendors. The streets were empty in lockdown so there was no trade. Uncertainty was the main experience (KII, SEWA).

At the same time, women's work has intensified – many frontline workers including health, care and community workers have seen increased workloads due to the pandemic, but their family have spent extended periods at home – notably children due to school and childcare closures, and husbands, many of whom lost work – yet women continue to be responsible for looking after aged and sick family members, leading to increased demands on women's time to generate income and continue their unpaid care role (KII, SEWA and Professor Eapen).¹⁶

A third critical area is the significant rise in GBV. One expert has explained that official data suggesting cases have reduced is misleading because lockdown and subsequent reduced mobility as a result of social distancing means women have been less able to go to police stations to report. However, a WhatsApp group of women organised by the Kerala Women and Child Development Department has identified a high rate of violence during the pandemic, which has been corroborated by frontline workers as well as several key informants (Professor Eapen).¹⁷

15 Professor Eapen, a member of the Kerala State Planning Board.
See <https://focusweb.org/video/covid-and-impact-on-women-the-kerala-response/>.

16 See footnote 15.

17 See footnote 15.

3.2.3 Performance of the policy response

In this section we focus on the adaption of existing social protection programmes and the introduction of new in-kind (food) programmes, as well as social-protection programme links to social services, where data is available.

Timeliness

There is broad agreement that timeliness has been an important attribute of the GoK response to the pandemic, with measures taken proactively and ahead of other Indian states (WHO, 2020; KIIs). The main GoK relief package was announced ahead of the first lockdown and seven days before the national relief package, with GoK announcing a state of ‘calamity’ on 23 March and imposing a state-wide lockdown the following day – a day before the national lockdown. Community kitchens were operational by 30 March. Importantly, Keralan women themselves have positive assessments in surveys about the speed of their state government’s approach and its proactive response to getting rations out to communities in need (SEWA, 2020a).¹⁸ Similarly, an expert key informant felt that the GoK’s response was timely, and lauded the government’s leadership:

Many other states followed things Kerala did when public pressure built up. But in Kerala it was initiatives led by the state’s government (KII, ISI).

At the same time, the speed of the response was made possible by the distinctive Kerala collaborative model of healthcare, statutory and community groups. Two well-established networks, in particular, have been identified in the literature and by our key informants as central to the quick response, with women at their core. First, Accredited Social Health Activists (ASHAs) – mostly women – have long played an important role in Kerala’s public frontline healthcare services. They have been credited with carrying out meticulous data collection of every household including on their mobility and health indicators, and having in-depth and current insights into the challenges faced by the communities they serve – both of which have proved a critical resource to inform the state’s Covid-19 strategy as it was developed and implemented (Prasad and Arathi, 2020).

Second, literature and key informants highlight the key role of *kudumbashree* and other women’s groups in rapidly establishing community kitchens to provide meals to those in need during the first lockdown, including migrant workers (e.g. IWWAGE, 2020). As one key informant explained:

18 SEWA spoke to members across 12 states in April 2020, including Kerala, to better understand the gendered consequences of the national lockdown aimed at preventing the spread of Covid-19, and to see if there were significant differences across states in the experiences of women.

they were mobilised [by the GoK] and got the dry provisions to cook the food. So instead of locking themselves at home they came out and cooked... It all happened within a few days in March and continued for about two months (KII, ISI).

Coverage adequacy

Determining the adequacy of the measures taken in Kerala in terms of population coverage is challenging due to a lack of easily accessible, up-to-date and sex-disaggregated data. Overall, key informants were largely positive about the measures taken, and noted several key groups to whom coverage had been expanded – such as migrant workers in Kerala. Yet, several key shortcomings from a gender perspective were identified.

Cash transfers were a major component of the GoK's Covid-19 response, and were provided through three main means.¹⁹ First, extra payments were made to existing social security pensions recipients, of which there are reportedly more than 50 lakh (5 million) beneficiaries across various categories. Second, payments of Rs. 1,000 were made to 11 lakh (1 million) members through Welfare Fund Boards.²⁰ We understand that coverage remained the same in these cases, although the third 'pillar' of cash transfer saw coverage expanded through a one-time payment of Rs. 1,000 for family subsistence to those outside social security pension schemes – notably families below the poverty line who are not part of any pension scheme, and which reached an estimated one crore (10 million) individuals (V. Kurian, 2020; Nidheesh, 2020; The Hindu, 2020).

Some key informants spoke positively about the cash support given in Kerala, particularly in comparison to other Indian states, highlighting that the existing social protection framework in Kerala is more comprehensive than in other parts of the country, with the Covid-19 response measures similarly far-reaching. One key informant highlighted that in Kerala several key industries in which women are concentrated as workers are linked to social pension benefits, such as the production of coir mats and *beedi* cigarettes, as well as processing coconut, cashew nut and other agricultural products. In addition, women also fall under the remit of some welfare boards, meaning they would receive payments.

However, analysis of existing welfare-board provision suggests that gendered gaps are likely to remain, given pre-Covid-19 inadequacies in provision through welfare boards in female-dominated sectors. For example, the Kerala Unorganized Workers Social Security Board was formed in 2016 to provide minimal social security coverage to domestic workers and four other unorganised-sector occupational groups, with domestic workers registered since 2018. However, unlike welfare boards for construction workers and toddy tappers, among others, the Unorganized Workers

19 We are still trying to find sex-disaggregated data on these.

20 Welfare Fund Boards are statutory agencies, generally operating at sectoral level, which collect employer and employee social security contributions, and which can be spent on diverse benefits for registered beneficiaries (and sometimes their families) such as cash transfers or services to improve education, nutrition, employment opportunities or community services. For more information on current boards in operation, see <https://kerala.gov.in/welfare-fund-boards>.

board does not receive employer contributions, meaning it is less well-resourced and able to provide adequate social security benefits to registered workers (IDWF and WIEGO, forthcoming). In this context, low payment levels mean workers are likely to remain largely insecure in the longer term, despite the short-term government Covid-19 top-up as the labour market impacts of the crisis persist.

Moreover, while Kerala has a long history of extending protections to informal-economy workers, a long-standing lack of gender-responsiveness has persisted in the Covid-19 response, with negative impacts on women's coverage and entitlements. For example, GoK announced support to the fishing industry (Das et al., 2020a), but key informants advocating on behalf of informal women workers explained that a lack of gendered understanding of the industry's operations – and associated lack of recognition of women's role as workers and therefore individual welfare recipients – was also reflected in the Covid-19 response:

men are typical fisherfolk going and doing the fishing, and women will process and sell fish and such like. So there is a tendency to consider women as subsidiary workers – but we make the case that without the women the process cannot be complete so both men and women should get equal right to social security. If fishing is a husband-and-wife team, both should have a right as individuals. Men often have the social-welfare-scheme book, with women considered dependent... we advocate women should have entitlements. [We also did this] kind of work during the time of the crisis (KII, SEWA).

Other key informants felt that, while the coverage was comprehensive overall, other previously excluded groups were likely to remain excluded in the Covid-19 response – for example those in geographically isolated tribal areas. While coverage was extended during the crisis to previously excluded groups, such as migrants, only some of their needs were met. We suggest this requires further research, including from an intersectional perspective to understand the implications for marginalised groups of women experiencing multiple forms of discrimination and/or inequality.

The GoK food-relief effort in Kerala took several forms, and its comprehensiveness can be seen as a critical support to women during the crisis, given their responsibility for food provision. First, food items additional to the national government's allowance under the Public Distribution System (PDS) were provided in two lots in April and July 2020 to all households with a national ID card (*Aadhaar* card) and others in need. On 1 April 2020, shortly after the lockdown began, the Chief Minister announced the commencement of the free ration scheme, with 14.5 lakh persons (1.45 million people) covered and 21,472 tonnes of rice distributed on that day alone.²¹ The GoK employed several approaches to ensuring comprehensive coverage, including mobile apps and the engagement of police, *kudumbashree* members, ASHAs and other volunteers to identify those in need and arrange provisions for families quarantined and under health surveillance (Das, 2020a; KIIs). Efforts were

21 See <https://twitter.com/CMOKerala/status/1245410785318170625?s=20>.

made to ensure the coverage of specific groups, including transgender people and migrants, who were provided with food, as well as in some cases more comprehensive support through setting up and hosting these groups in residential camps (Das et al., 2020a; The Hindu, 2020).

The second key pillar of food relief was meals provided to labourers, those in quarantine or isolation, destitute people and other persons in need – such as older people living alone – through community kitchens (GoK, 2020). Community kitchens were organised through the GoK Local Self Government Department (LSGD), and predominantly operated by *kudumbashree* groups, with a far smaller share operated by the LSGD itself as well as other cooperative and voluntary organisations, among others (ibid.).

Level/value adequacy

While data exists on spending commitments and the level of cash transfers to key groups, the impacts of cash transfers allocated as part of the Covid-19 response and the extent to which they alleviated the negative gendered impacts of the Covid-19 crisis remains under-investigated. Indeed, while key informants in this study attested to the overall generosity of the GoK income-support response, notably relative to other Indian states, we were unable to ascertain in-depth insights into the level/value adequacy of the transfers.

However, key respondents felt strongly that the food relief was generous in Kerala and helped mitigate food insecurity, which was sharply exacerbated during lockdown by loss of earnings, food price increases, and inadequacies in the national PDS distribution system. The PDS system achieves only around 50% coverage in urban households, and provides food inadequate to meet all nutritional needs (IFPRI, 2020, cited in IPC-IG, 2020). Furthermore, the provision of food had strongly gendered impacts, given gender norms which mean that the responsibility to provide meals for families falls to women, and the high levels of stress and anxiety experienced by women during the crisis as a result (see SEWA, 2020a).

One key informant, a specialist in food security, explained that both forms of food relief (rations and meals provided through food kitchens) were generous in Kerala, and helped meet the exacerbated demands placed on women to provide food to their families due to schools shutting, husbands and other family members being at home, including returned migrants, and doing so in a contexts of increased food prices: ‘Women had to manage with less food and make more meals so this was important’ (KII, Indian Statistical Institute (ISI)). The same informant further suggested that the GoK’s provision of food relief can be seen as a positive response to demands of the women’s movement in Kerala and more widely in India, which highlighted the negative impacts of food insecurity on women:

The most strong demands [for food relief] have come from women's movements in India as its quite gendered and women have the burden of managing food, cooking and cleaning. If there is less food, women eat last so their nutrition suffers – women's movements have long advocated around this. In terms of food distribution, Kerala was generous (KII, ISI).

Type adequacy

The integrated package of measures implemented in Kerala has been lauded by analysts, who highlight its comprehensiveness in meeting the additional needs created by the crisis, including those experienced by some marginalised groups such as migrants and transgender people (Menon et al., 2020; WHO, 2020). However, a gender analysis is largely missing from much of the assessment to date.

Our findings suggest that the ways in which the response was conceptualised and implemented is likely to have had mixed effects from a gender perspective. On one hand, the holistic nature of the measures taken looks well-placed to meet – at least by design – some of the existing needs exacerbated by the crisis and new needs created. For example, key informants confirmed that the provision of both mental and physical health support via a tele-portal is critical in a context of increased GBV, as well as during a time of heightened stress and anxiety experienced by women. A specialist telephone helpline named 'Disha', for pregnant women to seek medical advice, and a counselling service, 'Balamitram', aimed at helping parents address children's anxieties, are likely also to benefit women, given women's predominant role in childcare at household level. However, key published information, for example nearly real-time data on psychosocial support provided on the GoK Covid-19 dashboard, does not provide sex-disaggregated data on users of these services, nor information on the share of calls providing support to victims/survivors of violence or pregnant women, for example.²²

At the same time, our research has identified a significant risk of critical unintended effects of the GoK approach, which relies on women's labour – notably through their participation in *kudumbashree* and as ASHAs, as well as through other volunteer and community roles. This has two key implications.

First, as discussed above, the disproportionate unpaid care loads already shouldered by women have been exacerbated during the crisis as a result of school closures, additional cooking and housework due to family members spending more time in the household, and caring for sick and quarantining family members. While this challenge has been recognised by frontline workers, including key informant experts we interviewed, it appears to have received minimal attention in the policy response, or by some of those monitoring and measuring the effects of the crisis. For example, we could not identify the collection of time-use data in surveys or other studies exploring the effects of the crisis. This appears a critical gap, given that the success of the response has been attributed to the work of women, who appear to have made significant

22 See <https://dashboard.kerala.gov.in/psycosocial.php>.

contributions to the state response in addition to their unpaid care work in the home and, when the initial lockdown eased, starting to engage in income-generating activities again. Given the well-documented negative effects of women's time poverty on women's health and well-being (e.g. Chopra and Zambelli, 2017), their integral role being a key design feature of the GoK's response is of critical concern.

Second, care workers globally are often undervalued and subject to low wages and lack of comprehensive protection (see ILO, 2018; Bastagli and Hunt, 2020), with evidence of the same among Kerala's ASHAs. ASHAs are officially considered volunteers and appointed through the national Ministry of Health and Family Welfare (MoHFW), although they receive some performance-based compensation. Some states have increased ASHAs' remuneration above the state's basic provision – including in Kerala, where ASHAs are paid between Rs8,000 and Rs8,500 a month (Prasad and Arathi, 2020).

The GoK has recently been accused of gendered labour exploitation towards ASHAs by relying on them during the pandemic response but without granting them full recognition as workers of the state and associated income security and protections – notably when many have taken on extra work during the pandemic without proportional remuneration – and of being negligent by not providing adequate protective equipment to ASHAs while working, to protect them from Covid-19 (Prasad and Arathi, 2020; Raman, 2020). While some efforts were made by the GoK to further increase Kerala's ASHAs' remuneration during the crisis, for example by announcing an extra Rs1,000 honorarium to ASHAs in the state from March to May 2021, in recognition of their exemplary work during the Covid-19 crisis, their earnings remain significantly less than the minimum wage of Rs18,000 a month demanded by ASHA unions across the country to meet the cost of living and to correct the ongoing undervaluation of women's care roles (Prasad and Arathi, 2020; Varma, 2020).

These challenges appear to mitigate some of the more promising gender-responsive features explicitly built into Kerala's response, with both examples providing evidence of significant gendered effects of the GoK's approach in practice. It is clear that women's historic disproportionate responsibility for unpaid care and undervaluation in (semi-)professional paid care roles, including as ASHAs, have been exacerbated during the Covid-19 crisis, signalling the critical need for a structural shift in the care economy to address deeply entrenched inequalities.

3.2.4 Emerging enablers and bottlenecks to gender-responsive design and implementation

Strong political leadership and institutions – from top to bottom

Strong leadership (including women leaders) at all levels has been identified as a clear contributing factor to Kerala's rapid and comprehensive response, from the proactive approach taken by the Chief Minister and others at state level to the active leadership and participation of district administrators and elected *panchayat* leaders at local levels (WHO, 2020; KII, ISI). This

combination ensured high-level commitment behind the development, implementation and financing of GoK's Covid-19 response strategy, as well as a strong grounding in the needs and priorities of people at community level through local leadership, notably at *panchayat* level.

Women were strongly represented at the local leadership level, notably as a result of the gender quota adopted in 2009, which ensures women hold at least 50% of seats in *panchayats* and other local government institutions. Coordination at all levels between these entities and those with close insight into women's lives, including *kudumbashree*, ASHAs and women's organisations, was also felt to be strong, with established channels to feed into higher-level decision-making at the state level, as discussed further below. Yet the exact relationship between women's leadership roles, and influence over decision-making and the ways in which these shaped the gender-responsiveness of the Covid-19 response, remains unclear. Given mixed evidence of the empowerment and influence in practice of women *panchayat* members in Kerala before Covid-19 (e.g. Ban and Rao, 2008; Chathukulam and John, 2000), we suggest this as an area for further investigation.

Critically, key informants explained that GoK is one – if not the only – state in India to have a full-time planning board, of around 12 members with different expertise, including a gender expert, which provides evidence and policy advice to the GoK, including supporting development of annual plans and budgets.²³ The inclusion of a gender expert has meant that the planning board has increasingly integrated gender into its research and analysis, for example by increasing the collection and use of sex-disaggregated data, and in a recent report on the impact of the Covid-19 pandemic and lockdown on Kerala's economy that contained a chapter on impacts on women's employment (KSPB, 2020). As a key informant noted about the planning board's work:

There are many problems faced by women in Kerala as elsewhere in the country but [in Kerala], first, there is more awareness and attention paid to the problems, and second, efforts are being made to address these problems (KII, ISI).

Coordination and preparedness

Kerala's 'all-of-government, all-of-society approach' to tackling the crisis has seen close attention paid to both the economic and social impacts of the crisis in addition to the core health response, which has been made possible in practice through good communication and involvement of civil society partners and other stakeholders at all levels (ILO, 2020b; Swaminathan and Johnson, 2020; Gupte et al., 2021). This has been underpinned by learning from previous epidemic outbreaks informing strong coordination between intergovernmental and external teams. When the pandemic emerged, 24/7 control rooms were instituted, mandated to coordinate the multi-sectoral response, alongside state-level committees, rapid response teams and external expert groups which met twice daily with ministerial attendance (Das et al., 2020a).

23 For more information about the Planning Board, its members and work, see <https://spb.kerala.gov.in/>.

At the ward level, committees of political party members and elected representatives, community members and resident associations, police, *kudumbashree* and other women's group representatives, health workers, ASHAs and other key stakeholders met regularly to plan, based on local community needs (Prasad and Arathi, 2020). This coordination at multiple levels and convening diverse stakeholders was identified by key informants as a key attribute of Kerala's response.

Strong and engaged civil society, including women's organisations, self-help groups and unions

Civil society – notably NGOs and labour unions – has played a critical role in Kerala's Covid-19 response, with women's organisations and self-help groups and unions supporting women workers playing a particularly important role. These groups have improved the gender responsiveness of the measures taken across key stages of the response, including informing design, advocacy and communications, and implementation.

First, the connectedness and ongoing communication between these groups and their constituencies allowed them to rapidly collate information on women's realities, needs and priorities as the impacts of the Covid-19 crisis emerged, and provide them with critical support. Second, civil society organisations have played an ongoing role in informing statutory agencies of the situation on the ground and carrying out advocacy for a gendered response. One example is the SEWA, whose 'last-mile' model of decentralised governance has been active during the pandemic, and through which grassroots leaders known as *aagewans* have played a critical role in strengthening networks to build a broader coalition for lobbying government to respond to women's needs (SEWA, 2020c). Third, civil society – along with state institutions, volunteer groups and the private sector – has played a key role in implementing the Covid-19 response as part of the GoK's integrated response strategy (O.C. Kurian, 2020; Menon et al., 2020).

Political economy and social contract

The unique political economy of Kerala has been identified in the literature as contributing to its strong crisis response. Key factors include: a strong political leadership from the Communist Party of India (Marxist) (CPI-M), linked to a long-term political strategy and grassroots activism; comprehensive and timely information-sharing from GoK; long-term investment in health and social policies as part of a social democratic welfare model; high levels of public trust in the government, which helped initiation and compliance with social distancing and quarantine; and a history of participatory politics contributing to the rapid mobilisation of initiatives such as community kitchens (Jenkins and Ram, 2020; O.C. Kurian, 2020).

A strong history of 'community activity for social good' also led to a huge volunteer contribution to the relief effort, carrying out tasks including awareness-raising, sanitation and transport of meals to homes and people to health facilities, among other tasks. One key informant highlighted the large mobilisation of volunteers from student and youth organisations affiliated to the CPI-M, notably through the Democratic Youth Federation of India (DYFI). In addition, a new volunteer corps was formalised during the Covid-19 crisis through the SannadhaSena 'Social Volunteer

Force', a registration portal and mobile app-based training process developed as part of the Covid-19 response by the State Disaster Management Authority, based on learning from past disasters in the state.

However, available data points to a challenge in how volunteer efforts have been tracked. Volunteer shares are one of the only sex-disaggregated datapoints on the GoK Covid-19 data dashboard, and as of 30 November 2020, 276,994 men, 86,905 female and 58 transgender volunteers were registered (GoK, 2020). However, the dashboard tracks only volunteers registered through the SannadhaSena site, and not through *kudumbashree*.²⁴ Nonetheless, the willingness to volunteer remains a key feature of Kerala's response to the Covid-19 crisis, and of many Keralan citizens' experience of it. As this key informant summarised:

We had a major flood in 2018 – that brought us together like nothing else; people learnt that if they had to stay alive, they had to depend on others. This was the same thinking but on a much wider scale (KII, Amrita Institute of Medical Sciences and Research Centre).

24 For more information about activities carried out by *kudumbashree* groups during the Covid-19 crisis, see www.kudumbashree.org/pages/830.

4 Emerging lessons and policy recommendations

4.1 Emerging lessons

This paper asks whether social protection responses have undermined or supported gender equality in the context of Covid-19. By examining two case studies, we have found that, even when social protection responses to the crisis have to some extent been gender-sensitive in their design, the complexities around gender, women's multiple roles, and the acute deprivation experienced within many households mean that often this approach was not sufficient. In this concluding section we first summarise the key findings around the effectiveness of the crisis response from a gender perspective, highlighting the implications of the adjustments for longer-term gender-responsive social protection systems (see Bastagli, forthcoming), and then provide some policy recommendations.

4.1.1 Effectiveness of the crisis response from a gender perspective

The two case studies offer insights into the effectiveness of social protection responses to Covid-19 in early 2020 – both case studies draw on examples of programme adaptation, as well as linkages to services in the case of Kerala. Both cases clearly illustrate the gender-specific impacts of the crisis. The rapid onset of the crisis severely disrupted livelihoods, and these impacts were strongly mediated by existing gender inequalities in the labour market, gendered roles and responsibilities around unpaid care and domestic work, and household composition. The high number of female-headed households in South Africa, for example, and the role of women as the main providers of food and household care and well-being, meant that women shouldered a disproportionate burden of the crisis. This was further compounded by the fact that women typically have limited coping strategies in terms of savings and access to other support.

In terms of **programme design**, the case studies show that existing **eligibility criteria** (and thus enrolment of beneficiaries) enabled a fast roll-out of benefits to female recipients in South Africa and Kerala. Once the policy decision had been made, South Africa's Caregivers Allowance rapidly reached 7 million recipients – the majority of whom are women. In Kerala, the state has been lauded for its pre-existing progressive and inclusive social protection policies, particularly by including women working in the informal economy and who are elsewhere typically excluded from social protection benefits.

In South Africa, the top-up to the CSG in the form of a temporary Caregiver Allowance was a welcome support in the face of the severe impacts of the crisis, especially for single-female-headed households, and evidence shows that the Caregiver Allowance contributed to ameliorating poverty. However, **the level, adequacy and duration** of the top-up has not been

sufficient to meet the basic needs of many households, nor to meet the specific gendered needs created and exacerbated by the crisis. There are several reasons for this. First, many factors effectively reduced the value of the transfer, including the choice of the ‘per caregiver’ model rather than ‘per child’ (66.8% of CSG households have more than one child), as well as the associated costs of receiving the transfer (bank charges were only temporarily suspended). And second, the sheer financial impact of the crisis on CSG-beneficiary households – the majority of whom are single-adult-female-headed households – in the context of lost income opportunities and more household members at home, meant that the transfer level was insufficient. In recognition of the relatively low transfer, there was an assumption that households would receive more than one type of support. However, implementation challenges meant inadequate food and in-kind distribution in practice, and the restrictive eligibility criteria for other cash support meant that women receiving the Caregivers Allowance were disproportionately excluded from the other cash transfers. For the majority of the CSG single-adult-female-headed beneficiary households, this resulted in limited receipt of other support to the household. A key challenge identified in the design of the Caregivers Allowance was that there was little consideration of these specific gendered needs in the calculation of the benefit levels. The urgency of quick decision-making at the start of the crisis, coupled with fiscal space constraints, all contributed to the final decision on the level of transfer, rather than it being based on an informed calculation of need.

In contrast, the Kerala case study illustrates an example of a relatively **comprehensive approach** to the pandemic response, including early payments of welfare pensions and other social grants, loans, in-kind support – notably extensive food relief – and linkages to psychosocial support services. The widespread coverage of the response helped to support women’s economic and social needs. The design of the response was influenced by a number of interconnecting factors, including learning from recent crises, strong political leadership and the inclusion of women’s representation in local- and national-level leadership positions (e.g. a gender expert on the Planning Board), and the use of sex-disaggregated data and real-time monitoring at the community levels feeding into programme design. Importantly, both studies show the importance of **data and how data is collected** for providing comprehensive insights into the short- and longer-term impacts of the crisis and how they differ between men and women. For example, the rapid collection of data enabled insights into the real-time impact of the crisis, such as through telephone interviews, or through community workers or civil society. Caution was highlighted, however, in relying on telephone interviews for accurately collecting sensitive data. Longitudinal studies also provided important insights on the impacts of the crisis on women and men with the benefit of looking back at their situation pre-crisis, the impacts of the crisis, and being able to identify longer-term effects of the crisis in the future.

In terms of **systems and implementation**, a number of key lessons also emerged from the case studies. As has been well noted in discussions on social protection crisis response, the **existing system infrastructure** is critical to ensuring a rapid roll-out of programmes in the crisis (O’Brien et al., 2018). Existing digital payment technology in South Africa, for example, facilitated the quick delivery of the grants to millions of pre-existing beneficiaries. However, during the lockdown,

a backlog of processing new applicants for the routine CSG occurred because hospital-based registrations at the time of birth ceased, and some government offices were closed – this is a cause for concern especially when payments start only when the child is registered and cannot be backdated before that, so caregivers effectively lose out on some of the previously available entitlement.

Institutional coordination between a wide range of actors in Kerala was identified as a critical factor facilitating the crisis response. Good levels of communication and involvement of civil society and other actors was learnt from previous crises – intergovernmental and external teams were mandated to coordinate the multi-sectoral approach, meeting twice daily. At the local level, committees of political party members and elected representatives, community members and resident associations, police, *kudumbashree* and other women’s-group representatives, health workers, ASHAs, and other key stakeholders met regularly to plan based on local community needs. This enabled feedback from the community monitoring to inform programme design, based on local community needs.

A strong and engaged civil society, including women’s organisations, self-help groups and unions, has also been recognised as a key part of the inclusive and multi-sectoral approach in Kerala. Not only did local organisations’ connectedness with their constituencies inform policy on women’s realities, needs and priorities, as the impacts of the Covid-19 crisis emerged, but civil society organisations also played an ongoing role in carrying out advocacy for a gendered response. Civil society actors – along with state institutions, volunteer groups and the private sector – also played a key role in implementing the multi-sectoral Covid-19 response as part of the GoK’s integrated response strategy.

4.1.2 Implications of adjustments for medium–long-term system strengthening

In addition to the effectiveness of the crisis response, we are also interested in the implications of the policy response for system strengthening in the future (Bastagli, forthcoming). These include the implications for: embeddedness in national policy; attention to coverage and adequacy gaps; implementation and delivery capacity; capacity for financing; and the social contract.

Both South Africa and Kerala provide examples of adjustments to existing social protection programmes already **embedded in national policy and legislation**. However, the programme adjustments were intended to be only short term in nature. In South Africa, the earlier end to the Caregivers Allowance compared to the extension of the Covid-19 SRD Grant has been subject to fierce public debate, and was linked to a legal case presented by civil society (which was rejected).

Filling **coverage and adequacy gaps in the longer term** has also been a key point of discussion. In Kerala, for example, while the food relief efforts aimed to reach all those in need, the cash-based assistance was not increased beyond already eligible beneficiaries. As such, the pre-existing levels of exclusion from the cash-based schemes were highlighted as a problem, particularly for women.

In South Africa, the eligibility criteria tied to the Covid-19 SRD Grant disadvantaged women who were receiving the Caregivers Allowance. Those receiving the existing social assistance grants were not able to access the Covid-19 SRD grant. This has sparked a key policy debate around women's future individual entitlement to social protection. While some have lauded the introduction of the Covid-19 SRD grant, citing it as the predecessor of a new, permanent Universal Income Grant for those of working age that would outlast the Covid-19 crisis, gender advocates cautioned that this could be a major detriment to women's rights as it gave credit to the idea of giving cash to working-age men, but women were disqualified from the SRD in their own right if they were receiving the CSG.

In terms of **implementation and delivery capacity**, both case studies highlighted the importance of having existing systems and delivery infrastructure already in place to facilitate the rapid roll-out of benefits when the crisis hit. The advantages of digital payment systems for adaptations were particularly noted in South Africa. The Kerala example also highlights the importance of being prepared, investing in the coordination of gender-responsive actors for a multi-sectoral approach, and utilising sex-disaggregated and community data on the realities of women's lives to inform gender-responsive programme design. While this approach was already largely embedded in Kerala's systems and infrastructure, it was highlighted as a key area for improvement going forward in South Africa. Key informants emphasised the need to plan responses based on a holistic understanding of families' lives.

Another area of caution for the future system was identified in the Kerala case study. The crisis response relied heavily on *kudumbashree* members and care workers (ASHAs) to deliver the response. ASHA workers – the majority of whom are women – are not fully recognised as workers of the state and do not enjoy full income security and protection. In addition to the fact that women shouldered a disproportionate increase in care loads in the household as a result of the crisis, many ASHAs took on extra work during the pandemic without proportional remuneration or benefits, and at times without basic protections including personal protective equipment. This highlights a critical need for a structural shift in the care economy to address deeply entrenched inequalities, which the crisis response may have further exacerbated.

The **financial sustainability** of Covid-19 responses was identified as a key constraint for extending the crisis response measures in both case-study contexts. Financing strategies have important implications for the focus of programmes on gender equality, yet it looks unlikely that the Covid-19 responses will result in any longer-term commitment to gender-responsive social protection systems in the two case studies discussed here. Indeed, key informants raised concerns that in the context of fiscal constraints, there is a risk that future budgets will prioritise reinvestment in male-dominated sectors, with negative impacts for women's livelihoods and economic recovery.

Both the South African and Keralan case studies demonstrate the importance of pre-existing strong civil society activism for holding governments to account and in service provision in

the delivery of the response. However, it is unclear the extent to which the **social contract** will be strengthened going forward. The Kerala example highlights how trust in institutions and the mobilisation of civil society was a key part of the successful response – and women’s organisations and women were a key part of this. However, it also highlights the importance of building non-exploitative state–citizen relations. The South African example also highlights the need for transparent and accountable decision-making, especially when the usual decision-making processes appear to have been disrupted in the urgency of crisis response.

4.2 Policy recommendations

The **extent to which social protection measures recognise and respond to gendered needs in crisis depends on how they are established in times of relative stability**. Here, we focus on key recommendations related to: (i) strengthening gender responsiveness in routine social protection systems, and (ii) how social protection systems can be better equipped and prepared to respond to future crises in a gender-responsive way.

4.2.1 Recommendations for strengthening gender-responsive routine social protection systems

Extend social protection and ensure women’s individual entitlement to social protection in their own right. Gaps in social protection provision from a gender perspective are well reported. The Covid-19 crisis has highlighted the urgent need to extend social protection to previously under-covered groups, including informal workers. Just as importantly, and as the South Africa case study illustrates, women must be able to access social protection benefits in their own right, and not only tied to their caregiving roles. This means that eligibility criteria across different programmes must not discriminate against women if they are the named recipients of social protection aimed at child or care support. Social protection systems must be built to promote women’s rights and dignity that contribute to women’s economic independence and agency.

Recognise and value unpaid (and underpaid) work through social protection systems. A critical issue highlighted by the Kerala case study in this paper is the important role that women have played as frontline workers in the success of the crisis response. However, at the same time, women continue to face exploitation in the workforce (including low pay and limited social protection benefits) and shoulder the additional responsibilities of unpaid and domestic work. This requires a shift in the system to recognise women’s labour and its intrinsic value and seek to redress the historical undervaluation of care work – and associated undervaluation and underpayment of paid care work. Ways to do this include:

- ensuring the access of essential workers, including paid care workers, to decent working conditions

- supporting the development of strong care systems that share the costs of care with society as a responsibility of all (such as including support to unpaid carers by supporting family caregivers with paid leave and pension credits and expanding affordable quality care services for children, older persons and persons with disabilities) (UN Women, 2020a).

Build partnerships and work with specialist organisations on gender equality and women’s rights to inform, plan and implement social protection. In order for social protection systems to respond to gender inequality and the gendered patterns of poverty and vulnerability, it is important to build longer-term relationships with national and local organisations specialising in gender equality and women’s rights. This includes providing more formal spaces for their expertise and advocacy and for women’s leadership in policy decision-making, planning and implementation, as well as ensuring sustainable and comprehensive funding for their organisations and programme work.

Strengthen sex-disaggregated and gender-specific data collection and analysis to inform social protection design and implementation decisions. Social protection measures can contribute to gender equality, and, if well designed and implemented, they can also support progress on women’s and girls’ empowerment and transformation across their lives. However, these outcomes are not guaranteed nor are they automatic; rather, approaches to gender equality need to be explicit in programme design and implementation, and need to be informed by gendered monitoring and assessment of data to feed into programming (O’Donnell et al., 2021). For longer-term system strengthening, it is essential that context analyses, as well as programme M&E systems, collect and analyse data at individual levels through sex- and age-disaggregated data – and also identify gender-specific needs and their intersections with other areas of risk and inequality (such as disability and ethnicity). Moreover, increased capacity is needed to use this data to better inform decision-making on social protection.

4.2.2 Preparing the social protection system to respond to future crises in a gender-responsive way

Plan and prepare in advance. Planning and preparing in advance for shocks, including learning from the Covid-19 experience, is critical for future response. There are a number of ways in which attention to gender equality can be better integrated into preparedness plans. A key example is collecting and analysing sex-disaggregated and gender-specific data related to ongoing poverty and vulnerability assessments, as well as anticipating how different crises may exacerbate or create new inequalities between men and women across the life course. Other steps include establishing full-cost-recovery partnership agreements with organisations delivering gender-responsive services, establishing common strategies and information-sharing across multiple actors, and establishing coordination mechanisms with local and national women’s organisations.

Invest in gender-responsive and inclusive systems and delivery. Inclusive systems are critical for routine social protection but also for enabling rapid crisis response. Investments in inclusive

and gender-responsive systems – through, for example, the collection of gender-responsive data, the inclusion of gender expertise in design and delivery teams, and strengthening staff capacity – are critical for responding to gender needs and supporting a transition towards systems that support broader empowerment (Holmes, 2019; Barca et al., 2021).

Identify opportunities to support women’s and girls’ rights and empowerment. Even where crisis response interventions may be short term, it will be important for gender-responsive social protection responses to be embedded as part of a broader strategy to support women’s and girls’ empowerment, and to assess the options to ensure that programme choices do not undermine gender equality and women’s rights. This may include, for example, setting out a gender-responsive strategy within a preparedness plan and identifying partnerships and programme linkages with specialist gender organisations and services that respond to women’s needs. This can include services outside the social protection sector, such as those focused on protection, psychosocial support and economic inclusion.

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Appendix 1 Key informants overview

Table A1 Overview of key informant interviews

Country	Key informant organisation
India	Amrita Institute of Medical Sciences and Research Centre
	Indian Statistical Institute (ISI), Bangalore
	Self-Employed Women's Association (SEWA)
South Africa	Black Sash Trust
	South African Medical Research Council
	Studies in Poverty and Inequality Institute (SPII)
	University of the Witwatersrand