



CARE Rapid Gender Analysis COVID-19 Lao People's Democratic Republic

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Acronyms

ASEAN	Association of Southeast Asian Nations
COVID-19	Novel Coronavirus 2019
CSO	Civil Society Organisation
GAP	Gender and Power Analysis
GBV	Gender Based Violence
GoL	Government of Laos
ICT	Information Communication Technologies
KII	Key Informant Interview
Lao PDR	Lao People's Democratic Republic
LWU	Lao Women's Union
MOH	Ministry of Health
NGO	Non-governmental organisation
PM	Prime Minister
RGA	Rapid Gender Analysis
SRMNCH	Sexual, Reproductive, Maternal, Newborn and Child Health
UNFPA	United Nations Population Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WSS	Water Supply and Sanitation

Executive Summary

As of 29 June 2020, 10,280,397 confirmed COVID-19 cases and 505,145 deaths have been recorded across 213 countries and territories and 2 international conveyances.¹ To date, the Lao People's Democratic Republic (Lao PDR) has confirmed 19 cases, mainly in the Vientiane Capital. The Government of Lao PDR has acted swiftly since the first reported infection to prevent the spread of COVID-19. Since 13 April 2020, no new confirmed cases have been reported.

Although Lao PDR has been able to avoid the worst health impacts of the pandemic, prevention measures such as lockdown, closure of schools and businesses, social distancing and travel restrictions, have had significant economic and social impacts across the country. Gender roles, relations and norms within Lao society have influenced the impact of these measures on different genders. Drawing on primary and secondary data, this Rapid Gender Analysis (RGA) has found that the pandemic has both reinforced traditional gender norms as well as provided opportunities for men and women to work together to address the current crisis. This reflects broader gender roles and relations in Lao society in which forces of modernisation are challenging and changing traditional gender norms.

The main findings of this Rapid Gender Analysis are:

- **Gender roles and relations** have shaped the response within families and communities to the COVID-19 pandemic. Some traditional gender roles have been further entrenched (e.g. increases in women's childcare and domestic responsibilities due to lockdown and school closures), whilst some opportunities for more equitable relations have opened up (e.g. husbands and wives working together to implement preventive measures; husbands sharing household duties as they are home more than before etc.).
- The **economic impact** of COVID-19 has been the main concern among those interviewed. The pandemic has strongly affected economic sectors with a large female workforce (e.g. agriculture, tourism, services, healthcare, garment factories) which has increased women's economic insecurity. More vulnerable groups (e.g. marginalised urban women, remote ethnic minority women, return migrant workers etc.) are more impacted by the economic downturn due to their financial and socially precarious circumstances. The long-term effect of shutdown measures may further entrench the economic gender gap that currently exists across Laos.
- Women's role in the response to COVID-19 has mainly been information dissemination and following prevention guidelines. There have been limited opportunities for participation in **decision-making** platforms on the COVID-19 response, with variations between provinces. Patriarchal traditions also limit women's decision-making capacities within their homes and communities, although this also varies between households. Limitations in decision-making capacities (e.g. on spending family resources or seeking healthcare) can impact women's ability to manage the impact of COVID-19.

Key Findings: COVID-19 in Laos

- Some traditional gender roles have been reinforced (e.g. women's childcare and domestic responsibilities), whilst some opportunities for more equitable relations have been created (e.g. working together on prevention).
- The economic sectors with a large female workforce have been strongly affected (e.g. agriculture, tourism, services, healthcare, garment factories), increasing women's economic insecurity.
- Women's role in the COVID-19 response has mainly been information dissemination and following prevention guidelines, with limited opportunities for leadership.
- Access to services and resources, such as water, hygiene and sanitation (WASH), information, healthcare, and food, has been most difficult for women, ethnic minorities, persons with disabilities, those from lower socio-economic backgrounds and rural areas.
- Lockdown measures have made detection of GBV even more difficult.

- Access to **services and resources**, such as water, hygiene and sanitation (WASH), information, healthcare, and food, has been varied across individuals, communities and provinces. Access to services and resources has been much more difficult for women, ethnic minorities, persons with disabilities, those from lower socio-economic backgrounds, and rural communities. Some efforts have been made to reach marginalised individuals and communities, such as the translation of COVID-19 information into ethnic minority languages.
- Anecdotal evidence indicates that **gender-based violence** has increased within households during the pandemic. However, lockdown measures have made the detection of GBV difficult. Social acceptance of certain forms of GBV, which pre-existed the pandemic, have also contributed to difficulties in addressing GBV during the current pandemic.

Communities and individuals have implemented a range of **coping mechanisms** in the face of the COVID-19 pandemic. These coping mechanisms have mainly involved prevention strategies (such as handwashing, social distancing and face masks) and seeking up-to-date information on the pandemic. The strong economic impact of the pandemic has also resulted in individuals and households implementing various economic coping strategies, such as reducing expenditures, finding alternative work, spending savings and returning to their hometowns. Gender differences in coping mechanisms can be observed which fall along traditional gender roles, responsibilities and norms (e.g. women being responsible for coping mechanisms within the home and men for coping mechanisms outside the home). Interviewees also raised a range of **support** that would be helpful in coping with the impacts of the pandemic, including more supplies of items to enable them to follow government prevention guidelines (e.g. hand sanitiser, face masks), financial support during periods of low or unemployment, alternative employment opportunities, and support to obtain sufficient food, medicine and other essential items.

Key recommendations

1. Ensure COVID-19 prevention and response programming (short-term and long-term) **draws on evidence-based gender and power analyses** (such as this Rapid Gender Analysis), and is developed and implemented in a gender-sensitive manner that considers the impact on different genders and other vulnerable groups.
2. **Address the economic impacts** of the COVID-19 pandemic on diverse women and girls, including marginalised urban women, remote ethnic minority women, and return women migrants, particularly for those working in the sectors most affected by the pandemic.
3. Support women's meaningful **participation in decision making** on the COVID-19 pandemic at all levels – national, provincial, community and within the family.
4. Ensure that **community awareness and health information** reach all members of the community, including women, children, the elderly, persons with disabilities, ethnic minority communities and rural communities.
5. Ensure women and girls' **access to healthcare services**, both in relation to the COVID-19 pandemic and for ongoing healthcare needs, including sexual, reproductive, maternal, newborn and child health (SRMNCH) services.
6. Strengthen services for **GBV prevention and response** in communities affected by COVID-19, consider different ways people can access services in isolation, and how cases of GBV can be detected.
7. Ensure availability of sex, age, disability and ethnicity **disaggregated data**, including on differing rates of infection, economic impacts, social impacts, and incidences of gender-based violence.

Introduction

Background – COVID-19 and LAO PDR

As of 29 June 2020, 10,280,397 confirmed COVID-19 cases and 505,145 deaths have been recorded across 213 countries and territories and 2 international conveyances.² To date, the Lao People's Democratic Republic (Lao PDR) has confirmed 19 cases – 14 cases in Vientiane Capital, 3 cases in Luang Prabang Provinces, and 2 cases in Xaysomboun Province, with 0 reported deaths, and no new confirmed cases since 13 April 2020 (77 days to date). All 19 cases have recovered as of 9 June 2020.³ A total of 14,907 people have been tested.

On 18 March 2020, Prime Minister Thongloun Sisoulith issued a series of shutdown orders to close schools and restrict all non-essential activities and travel to control the spread of the coronavirus. The country entered a period of full lockdown from 29 March 2020 to 20 April 2020. Offices were ordered to be closed and employees were to work remotely from their homes. Civil servants and government employees remained on duty, especially frontline responders such as those working in healthcare, electricity management, water distribution and treatment, and telecommunications.⁴

Regulations were also in place for the Pii Mai Lao (Lao New Year) holidays, which took place from 13 to 16 April 2020, with a Prime Minister's (PM) order to restrict people's movement from their residences except for purchasing essential food and supplies or for medical emergencies. Inter-provincial travel was prohibited, as was international travel except for logistical purposes.⁵ A prohibition on gatherings of more than 10 people was enforced and closely monitored during the Lao New Year holidays.

The Government of Laos (GoL) has acted swiftly since the first confirmed case of COVID-19 in the country, setting up a National Taskforce for COVID-19 Prevention and Control which worked closely with the World Health Organization (WHO) and relevant agencies to manage the pandemic. The GoL and others provided consistent messaging to communities across Laos using a range of different means. A massive health information communication campaign was launched by the Ministry of Health, WHO, United Nations agencies and non-governmental organisations during April and May to raise public awareness.

The results of the full lockdown measures have been deemed effective as no new cases have been reported since 13 April 2020. However, some control measures remain in place to ensure community safety and prevent resurgence of the virus. The full lockdown measures began to be lifted on 4 May after the Prime Minister issued an order to allow certain classes in schools to resume (e.g. classes to prepare for examinations for graduation - grade levels primary 5, secondary 4, and secondary 7), employees to recommence work on a rotational basis, inter-provincial travel by land and air (from 18 May onwards), and restaurants to open for dine in but with social distancing measures and hygiene practices in place.⁶ As of 29 May 2020, the latest PM order has restored the operation of most businesses and other activities to almost normal levels of functioning, under conditions of social distancing, and all schools, private sector entities, and factories can resume to their operations. However, international travel is still limited until 30 June 2020, after which a reassessment and new announcements will take place.

Objectives and Methodology

This Rapid Gender Analysis (RGA) aims:

- To analyse and understand the different impacts of the COVID-19 pandemic on diverse genders and ages, including people with disabilities, the elderly and people with underlying health conditions, with a focus on ethnic minority women and marginalised urban women (e.g. informal workers, return migrants).
- To understand current needs and coping strategies of the above-mentioned groups.
- To inform practical programming and provide operational recommendations for Laos' response to COVID-19 to meet the different needs of women, men, boys and girls (including those with a disability and ethnic minority groups) with a focus on gender-based violence, health and nutrition, and women's economic empowerment.

The methodology used for this RGA consisted of:

- A review of existing secondary data and the most recent COVID-19 data in Laos.
- An analysis of primary data collected by CARE Laos and civil society organisation (CSO) partners in target communities, through Ministry of Health (MOH) focal points, gender-based violence (GBV) service providers and relevant health authorities.

The target communities were Luangnamtha, Phongsaly, Sekong, Vientiane Capital and Vientiane Province. Partners for data collection were Gender Development Association (GDA) and Association for Development of Women and Legal Education (ADWLE). Research tools included Key Informant Interviews (KII) (see Annex 1) (58 interviews) and the Individual Story Tool (see Annex 2) (22 interviews). The focus for the KIIs was the MOH at the provincial and district levels, Lao Women's Union (LWU), Lao Federation of Trade Unions (LFTU), and village representatives. All interviews were conducted by phone (telephone, online call) or face-to-face. Interviews were conducted from 4 May to 12 May 2020. Interviews were mainly undertaken in Lao language, with some translation from local ethnic languages (such as Akha, Khmu), and translated into English for qualitative analysis. A total of 79 interviews were conducted (50 women; 29 men). The data analysis also included initial findings from a rapid data collection (from 8 April to 10 April) with garment factories workers who are project participants in the Vientiane capital (32 women; 8 men).

Limitations

The data collection was conducted during the transition from full lockdown to eased measures (early May 2020). Hence, mixed methods for the interviews were used with remote supervision. Due to the unfamiliarity with the tools and interviewing via telephone, this resulted in the collection of some inadequate information or confusion from participants when answering questions.

Another important limitation based on CARE Laos' research experience is that some respondents may have provided answers that were seen as favourable, especially in regard to gender equality and GBV. This does not mean that statements from respondent were false. However, this needs to be taken into account during analysis, especially for data that has been gathered quickly and remotely, as this may limit the ability to understand the actual level of prevalence of gender inequality and GBV in the community.

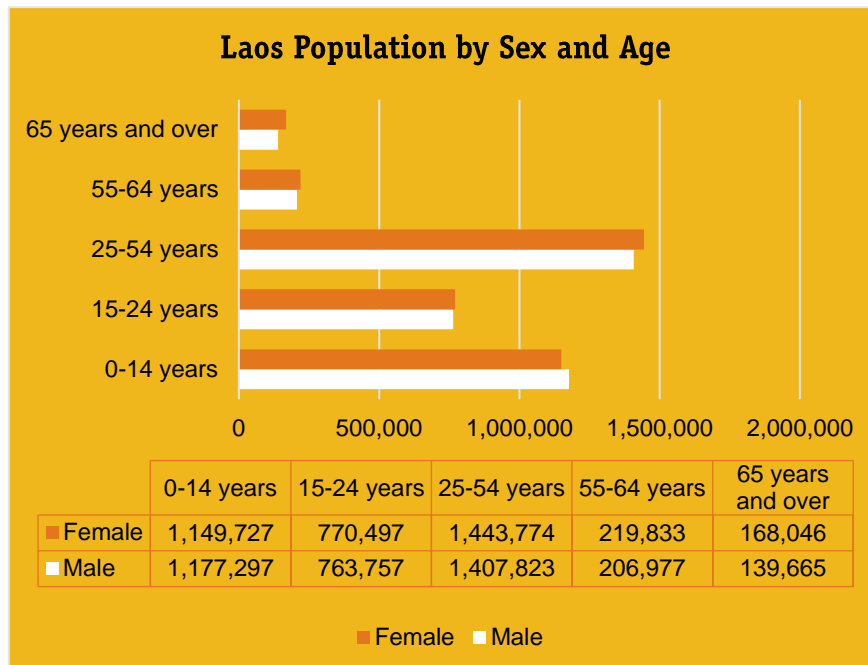
Demographic Profile

Sex and Age Disaggregated Data⁷

Population	
Female	3,237,458
Male	3,254,770
Total	6,492,228

Urbanisation	
Urban	33%
Rural	67%

Ethnicity	
Lao	53%
Khamu	11%
Hmong	9%
Other ethnic	27%



According to the 2015 Population and Housing Census, the population of Lao PDR is 6,492,228 (49.87% women; 50.13% men). Laos has a relatively young population, with 32% of the population between 0-14 years; the working age population (15-64 years) comprising 64%; and an elderly population (65 years above) of 4%. The median age is 23.5 years. The annual population growth rate has reduced over recent years to 1.45%.⁸

Laos has a 33% urban population and 67% rural population, of which 59% live in rural areas with road access and 8% without road access.⁹ The people of Lao PDR include 49 distinct ethnic groups.¹⁰ These consist of the majority Lao ethnic group (53%), followed by Khamu (11%), Hmong (9%) and many other ethnic groups (27%).¹¹

86% of households in Laos are male-headed, with 14% female-headed households. The average household size has dropped in recent years to an average size of 5.3 persons per household, alongside a declining birth rate (28 births per 1,000 population) and declining maternal mortality rate (206 maternal deaths per 100,000 births).¹²

The vast majority of people living in Lao PDR are Lao citizens (99.3%) with only a small number of foreign nationals (0.7%). On the contrary, a substantial number of Lao nationals have migrated abroad, mainly for economic reasons, with 1.3 million (around 18% of the population) living outside of Laos.¹³ There is also significant internal migration, mainly from rural to urban areas, with 4 in 10 people in Vientiane being internal migrants.¹⁴

Findings and Analysis

The impact of the COVID-19 pandemic has been different for women, men, girls and boys. The patriarchal structure of Lao society has increased women and girls' vulnerabilities during the pandemic and has potentially further entrenched some areas of gender inequality, for example, in the division of paid and unpaid labour, decision-making, access to essential services, and gender-based violence. This includes increasing labour associated with traditional gender roles, such as women's domestic and childcare responsibilities; decreased economic security, especially for marginalised urban women and remote ethnic minority women; increased barriers to accessing goods and essential services, such as food, WASH and healthcare; low levels of women's participation in developing COVID-19 prevention and response strategies; and increased risks of gender-based violence. The vulnerabilities experienced by women may be further compounded by other attributes such as ethnicity, age, disability, age, literacy, language, socio-economic background, and living in rural areas.

Nonetheless, the COVID-19 pandemic has also created some opportunities for forging more equitable relations, such as men and women within a household working together on prevention or men sharing household responsibilities as they are spending more time at home. These nuances reflect broader gender roles, relations and norms in Lao society, in which traditional gender roles and expectations are being challenged and changed by forces of modernisation, migration and marketisation.

Gender Roles and Responsibilities

Gender Roles and Relations

The impact of COVID-19 on gender roles and relations varies for different individuals, groups, and communities. Gender norms, roles and relations across Laos are complex, diverse and evolving. The modernisation of Lao's economic profile, with increased internal migration to urban areas, has uprooted traditional social systems and challenged traditional gender norms, particularly around women's mobility and economic independence. Lao's growing regional integration and the migration of Laotian workers across borders has also brought Laos into greater contact with other cultures. Increased access to foreign entertainment, particular Thai TV, has exposed Laotians to gender roles and relations which are different to Lao traditions and these have started to shape values, norms and behaviours, particular among young people.¹⁵ As well as forces of modernity and regional integration, gender roles and relations also vary across Laos. There remain stark differences in gender norms between rural and urban areas, and between Laos' diverse ethnic communities. The experience of gender also varies depending on other intersecting factors such as age, socio-economic status, sexual orientation and disability.

Gender roles and relations are shaped by strong social norms surrounding marriage, and these can affect the roles of men and women during the COVID pandemic. Gender relations between married partners can vary depending on matrilineal, patrilineal or bilocal traditions. In matrilineal traditions, more common among the majority Lao Tai group, the husband moves to live with or near the wife's family, giving women higher status and authority.¹⁶ On the contrary, in patrilineal traditions, which are more common among ethnic minority cultures, the wife moves in with the husband's family and has less access to family resources and decision-making (see Decision Making below).¹⁷ Although there are significant variations in practice, some minority ethnic communities also observe polygamy, bride price and more commonly practice early marriage, which can impact women's authority and status within the household (see 'Remote Ethnic Minority Women' below). However, whilst traditional gender norms remain, modernisation has affected gender roles and relations in both majority and minority ethnic communities.

The complexity of gender roles, and interplay of traditional and evolving gender norms, can be seen in communities' responses to the COVID pandemic. Around one third of interviewees spoke of women and men having the same responsibilities or working together in preventing COVID-19. For example, respondents said "both men and women have the same tasks (e.g. social distancing, handwashing, following the news)", "we discuss with each other", "we work together", and "both men and women have the same responsibility for prevention." On the other hand, others discussed the different roles that men and women have adopted during the pandemic. For example, women's roles have centred around staying home, keeping the house clean, ensuring sanitary meal preparation, and caring for children, whereas men's responsibilities have included going to community meetings to receive information about COVID-19, advising family members on prevention (e.g. handwashing, mask wearing, social distancing) and, if a trip outside the home is necessary, this is often the husband's role (e.g. going out to buy essential items). A number of interviewees also highlighted that women have shown more concern and diligence over implementing preventive measures, whereas men have shown a lower level of concern and compliance. For example, some interviewees have said "men are not doing good on prevention, always gathering for drinks with others. Women are following instruction by washing their hands and not going out" and "women are doing more practically than men, such as wearing masks and not going out. Men still don't care about prevention. All prevention methods are the same [for men and women] but the difference is the level of caring." In terms of obtaining preventative items (e.g. hand sanitiser, face masks), sometimes this has been the responsibility of the woman, other times the man, or it has been the wife's role to tell the husband to purchase these items. In enforcing lockdown, a number of women have raised concerns that they are unable to do so ("Women... could not stop their family from going outside"), whereas in some families, men have had the authority to do so (e.g. "Men will be the person stop everyone to go out"). This may reflect men's greater authority within the household to control other family member's mobility, including women and children.

Different responses have been provided by women and men when asked about the main causes of stress, tension, or anxiety in relation to COVID-19. The main concern raised by male interviewees were fears around becoming infected, followed closely by reduced or loss of employment/income and the financial stress brought on by the pandemic. This included concerns over financially supporting their families, buying food and other essentials items, and potential medical costs. However, a similar number of men responded that the pandemic had not created any concerns or worries for them. A smaller number of men raised mental health impacts (e.g. stress) and fear of infection of their families. On the other hand, female respondents raised a different set of concerns and many listed multiple concerns together. For women, the mental health impacts of the pandemic (e.g. stress, fear) and the risk of infection of their families (e.g. husband, children) were their main concerns, followed by a fear of infection for themselves. Women also raised concerns about the impact on pregnant women (e.g. risk of infection, health of the fetus/baby, access to healthcare); family finances (e.g. reduced or loss of employment/income); increased unpaid labour (e.g. housework, childcare); and the impact on children (e.g. schooling). Compared to men, a smaller number of women stated that they had no worries or concerns related to the pandemic. Hence, men's traditional role in the public sphere (e.g. as the main income earner) and women's role in the private sphere (e.g. as the main caregiver) are reflected in the concerns that COVID-19 had created for the women and men interviewed by CARE.

Gendered Division of Unpaid Labour

Across Laos, there is still a strong gendered division of unpaid labour and the impact of the COVID-19 pandemic may further entrench these gendered divisions. On average, women spend significantly more time on unpaid domestic labour and caregiving (an average of 4 hours per day) compared to men (30 minutes per day). This increases notably for families with children in which, on average, women spend over 6 hours per day on unpaid labour, compared to men who spend an hour per day.¹⁸ Women and girls are also more likely to be 'unpaid family workers' (64% of economically active women and girls; 27% of economically active men and boys) in which they undertake income generating work in family businesses without receiving payment.¹⁹ Combined with unpaid domestic labour, this increases women and girls' unpaid work burdens even further.

The interviews conducted by CARE confirmed that the COVID-19 pandemic has exacerbated the burdens of unpaid labour. Many reported that women's unpaid labour had intensified, including increased housework, childcare and general caregiving. One interviewee observed that more time was now spent cleaning inside and around the home due to the fear of contracting COVID-19. However, some interviewees also reported that both women and men were sharing household responsibilities, including domestic chores and childcare, and a small number of interviewees reported that men were taking on more housework and childcare than before as they were now spending more time at home due to lockdown measures. Several respondents mentioned that men's roles included attending meetings on COVID-19 and sharing the information with their families. However, some also mentioned that some men were no longer attending community meetings due to a fear of contracting COVID-19.

In rural areas, the demands of women's unpaid work can be even more onerous due to the lack of infrastructure such as water and electricity. Domestic labour can be time-intensive and physically demanding, such as walking long distances to fetch water and fuel.²⁰ Particularly among ethnic communities, there are strong social norms associated with 'women's work' and women often have little choice in the type of labour and overall workload that they undertake.²¹ Women who do not meet their responsibilities may be punished, including through the use of violence.²² Higher socio-economic status can bring some flexibility, usually through employing the labour of a poorer woman to support domestic duties.²³ Some husbands may also support women during specific times, such as pregnancy, but if this occurs, it is often kept hidden from others due to social disapproval and to avoid appearing 'weak'.²⁴ Children from ethnic minority households are often socialised into their gender roles from a young age, with girls helping their mothers with 'women's work' from 3 or 4 years old, such as collecting water, sweeping and taking care of younger siblings.²⁵

Interviews by CARE in the provinces of Luangnamtha, Phongsaly and Sekong found that women's unpaid workload had increased during the COVID-19 pandemic. In addition, women's labour on smaller family gardens had continued during lockdown as these gardens, located near the family home, were still accessible. Adolescent girls and girl children also reported needing to undertake more domestic work, including caring for ill parents, and the accompanying stress of this increased unpaid labour (alongside their concerns of being unable to attend school). On the contrary, no adolescent boy or boy child reported an increase in household work. Instead, adolescent boys mainly cited the inability to attend school, to socialise with friends, the lack of food, and fear of contracting the virus as the main issues related to the COVID-19 pandemic.

Gendered Division of Paid Labour

Paid labour is strongly gendered in Laos and, as such, the effect of COVID-19 on the economy will also have gendered impacts. Whilst labour force participation is roughly equal (79.5% for women; 81% for men),²⁶ the types of labour undertaken is distinctly gendered and largely an extension of gender roles and norms. The largest sector in Laos is agriculture, which employs about 68% of the population (69% women; 66% men).²⁷ Following agriculture, 15% of women work in the service sector and 6% of women work in factories, predominately garment factories.²⁸ Within the agricultural sector, women often undertake 'light' but tedious and time consuming tasks (such as planting, weeding, harvesting, tending to smaller livestock, and collecting non-timber forest products) and men perform short term but energy intensive work (such as ploughing, constructing bunds, tending to larger livestock, and hunting).²⁹ An impact of COVID-19 on women highlighted by those interviewed was the closure or lack of access to markets. This has affected women's ability to sell their crops and non-food items, such as handicrafts and charcoal, putting women and their families in a state of financial distress. However, the majority of interviewees stated that the pandemic has affected both women and men in regard to the loss of work and income, and economic difficulties was one of the main concerns raised by almost all interviewees.

The paid work sectors predominately occupied by women puts them at unique risk during the COVID-19 pandemic. For example, many women work in the healthcare sector, which can be seen as an extension of women's caregiving roles. Approximately two-thirds of nurses in Laos are women.³⁰ Nursing staff can have close and prolonged contact with patients, particularly seriously ill patients who require intensive caretaking. This close and prolonged contact significantly increases women's risk of contracting COVID-19 from diagnosed patients. Women in Laos also occupy management positions within the healthcare sector on par with men (49.3% women; 50.7% men).³¹ This is a positive development and may lead to the representation of women in the management of the pandemic within the healthcare sector.

Healthcare workers interviewed by CARE raised several issues brought on by the pandemic, including concerns over both their physical and mental health. Healthcare workers talked about experiencing stress and anxiety around contracting the virus, and the lack of protective equipment that was placing health workers at risk. As one interviewee explained "[we are] worried about our safety because we don't have the protection kits and there are many people coming into the health center." The National Taskforce Committee for COVID-19 Prevention and Control has highlighted the need for more medical equipment, including protective equipment, ambulances and medicines, to prevent and treat the COVID-19 pandemic in Laos.³²

Tourism is the fastest growing sector in Laos and also predominately staffed by women, both in the formal and informal sector.³³ The gendered division of labour in tourism puts women at greater risk of COVID-19. Women are mainly employed in hotels and guesthouses, food service, bars, travel agencies, and tour companies.³⁴ This may be a reflection of women's gender roles that puts them at the service of others, particularly through the provision of food, drink and 'home' needs. Women also sell handicrafts and other small goods to tourists and operate informal food and drink stalls.³⁵ In addition, home stays for tourists have become increasingly popular and the labour of caring for guests in the home is usually undertaken by women.³⁶ In these service roles, women come into frequent and close contact with tourists and others, often interacting face-to-face and at a close distance, which presents a key transmission risk for COVID-19. In contrast, men in the tourism industry generally occupy roles in management, transportation and repair services.³⁷ These roles have less direct and intimate contact with tourists, which reduces the risk of infection.

Women also dominate the sex industry in Laos. Although data is difficult to obtain due to the illegal nature of prostitution, most women and girls in the Laos sex industry come from poor rural areas and ethnic minority communities. For example, the Khmu have been reported to predominant the lower echelons of the sex industry.³⁸ Significant numbers of Laotian women also migrate across the border to Thailand to work in the sex industry.³⁹ CARE's research in Laos has found that sex workers can have little control over their bodies and often

need to submit to their pimp, mamasang or client.⁴⁰ As most come from and continue to live in impoverished conditions, women in the Laos sex industry can be under financial pressure to 'service' many clients.⁴¹ These working conditions make sex workers more vulnerable to contracting the coronavirus. Although it is culturally acceptable within Laos for men to pay for sex, women sex workers face high levels of stigma and discrimination.⁴² Alongside the illegality of their work, this presents significant barriers for women in accessing healthcare and other services if they were to become ill with COVID-19. The potential negative economic impact of the pandemic more broadly may also drive more women, particularly from poorer backgrounds, into the sex industry and create conditions that are conducive to human trafficking.

For more on the economic impact of COVID-19, including on garment factory workers and return migrant workers, see the section on 'Women's Economic Empowerment' below.

The Girl Child

As part of lockdown measures issued on 29 March 2020, Laos schools have been closed across the country. The closure of schools with little notice has impacted the ability of educators to support students, resulting in students from poorer backgrounds struggling to continue their education.⁴³ In particular, students from poorer or rural communities who lack computers, smart phones, the internet, and sometimes even electricity, have not been able to keep up with their education as learning has moved online.⁴⁴ This has exacerbated the urban/rural divide in education, which was already significant in Laos pre-pandemic, with only 28.5% children from rural backgrounds attending secondary school, compared to 64% children from urban backgrounds.⁴⁵

As school closures were lifted, with schools recommencing on 2 June 2020, care must be taken to not further entrench gender disparities in education. Although, in Laos, the gender gap is closing for attendance at primary school (89.9% boys; 89.4% girls) and secondary school (37.6% boys; 38.6% girls), girls continue to face gender-related barriers that impact on their education.⁴⁶ Girls from rural, poor and minority ethnic communities are the most vulnerable to not being able to attend and complete school due to the gendered division of household labour (e.g. helping their mothers with cooking, cleaning, and caring for younger siblings), engaging in unpaid family work (e.g. farming), financial constraints (e.g. uniforms, school supplies), physical access (e.g. distance, lack of roads), insufficient school infrastructure (e.g. shared toilets, inability to manage menstruation), and language barriers (i.e. ethnic minority girls and women are less likely to speak Lao (the language of educational instruction) than ethnic minority men).⁴⁷ Girls also face social and cultural barriers such as lack of parental support, cultural practices like child marriage, limitations in mobility as girls are less likely than boys to travel long distances to attend school, and safety concerns such as sexual harassment and gender-based violence.⁴⁸ The economic impact of COVID-19 (such as on family finances) may affect girls' ability to return to school now that schools have been reopened. For example, families struggling financially – a concern that was raised repeatedly in interviews conducted by CARE – may not be able to afford sending girl children back to school or may prioritise the education of boy children if family resources are limited. Before the pandemic, girls aged 15-19 are more likely to be working (40%) compared to boys (28%), due boys being more likely to be in school.⁴⁹ The impact of COVID-19 may exacerbate this trend, with more girl children being required to work to support family finances.

Girl children are also at risk of early marriage. Laos has one of the highest rates of early marriage in the region.⁵⁰ Rates of early marriage are higher in rural areas (38.9% of girls are married before age 18) compared to urban areas (21.4%), and early marriage is practiced more frequently among minority ethnic communities. Early marriage increases the risk of other harms to girls, such as sexual and gender-based violence, limited education, limited access to health services, low levels of contraceptive use, and unintended and early pregnancies.⁵¹ The economic stress placed upon households due the COVID-19 pandemic may increase the use of early marriage as a 'coping mechanism' for families.

In Laos, child disciplining methods involving physical or psychological violence are also practiced. Only 22.9% of boys and 25.1% of girls are disciplined using methods that are non-violent.⁵² Boy children are slightly more likely to be disciplined with violence than girl children (70.4% boys; 67.5% girls), such as through the use of

psychological aggression (66.9% boys; 64.7% girls) and physical punishment (36.2% boys; 30.9% girls), including severe physical punishment (5.5% boys; 3.8% girls).⁵³ The lockdown measures imposed across Laos, which has seen children remain at home instead of attend school or social activities, may put children at risk of violent disciplining methods, particularly as stress within households increases due to financial pressures, fear of infection, or the close confinement of family members over an extended period of time.

Remote Ethnic Minority Women

There is great diversity in gender roles and relations among the many ethnic minority communities across Laos.⁵⁴ The experience of gender is also affected by other factors such as age, social status, economic status, disability, education, etc. In general, minority ethnic communities tend to have more rigid gender roles and relations, particularly those that are more isolated geographically.⁵⁵ In the gendered division of both paid and unpaid labour (see above), men undertake work that is of greater economic and social value.⁵⁶ This creates gender inequity as it elevates men's social standing and provides them with more economic opportunities.⁵⁷ There is also a strong 'son preference' among many ethnic minority communities. In some ethnic minority cultures, the birth of a son is accompanied by a special celebration ceremony and women who produce sons 'will be better loved by their husbands'.⁵⁸

As well as greater value placed on men's roles, some traditional practices can serve to further disempower women. Whilst marriage customs and practices varying among ethnic minority cultures, some practices that can contribute to women's disempowerment include early marriage, polygony and bride price. Bride price involves the husband's family making a payment to the wife's family upon marriage. As a result of this payment, the woman is 'obligated' to the man and his family, which includes undertaking household responsibilities, submitting to her husband, and providing sex upon demand.⁵⁹ During the COVID-19 pandemic, women's limited decision-making authority and bodily autonomy may result in them being unable to refuse situations that place them at greater risk of contracting the virus or being able to manage their health if they become ill with COVID-19. Some ethnic minority groups also practice polygamy, in which the husband may take a 'Mia Noi' (second/small wife).⁶⁰ Having a second wife, with whom the man may father more children, can divert resources away from the first wife and her children.⁶¹ During the COVID-19 pandemic, in which economic resources may become strained, the practice of polygamy may further stretch familial finances, placing both wives and their children in a more precarious situation.

Despite the continuation of traditional practices, ethnic minority communities are also 'in a state of flux' through forces such as modernisation, marketisation and migration.⁶² The desire for 'modernisation' has been fuelled by increased access to media and TV, and the promise of wealth.⁶³ Shifts in traditional gender roles and relations are also evident as minority ethnic communities come in increasing contact with the majority Lao Tai culture.⁶⁴ Migration and modernisation are bringing changes to traditional belief systems, as some ethnic communities are moving from an animist (spiritual) to an empirical (medical) way of thinking.⁶⁵ Interviews conducted across Luang Namtha, Phongsaly and Sekong provinces, which reached members of the Hmong, Khmu, Akha and Thai Dam community, showed a range of responses reflecting both traditional and evolving gender roles. Most interviewees described household responsibilities in response to COVID-19 falling along traditional gender roles. For example, women are responsible for cleaning the home and caring for children, and men are responsible for attending community meetings on COVID-19 and providing community leadership on preventative measures. However, a number of interviewees also stated that they have the "same tasks" in the prevention of COVID-19 and that they "help each other work at home" including housework and childcare. Hence, the response to COVID-19 reflects both the persistence of traditional gender roles within ethnic minority households, as well as evolving gender relations that may see a greater sharing of responsibilities.

Women with Disabilities

According to the 2015 Census, the prevalence of disability in Laos is 2.8% of the population, a total of 160,881 people. This includes a disability rate of 2.5% for urban areas, 2.9% for rural areas and 3.3% in rural areas without roads. The prevalence of disability was similar among men and women (50.2% and 49.8% respectively), and increases with age, reaching 18.4% for those 60 years and over. For people living with a disability, more than half reported a mild disability (1.9%), followed by moderate disability (0.6%) and severe disability (0.3%).⁶⁶ Prevalent causes of disability in Laos include poor immunisation and healthcare access, inadequate transportation infrastructure, and the detonation of unexploded ordnances (UXO).⁶⁷ People with disabilities in Laos face higher levels of poverty and often have more limited opportunities for accessing education, health, suitable housing and employment.⁶⁸ Women with a disability are significantly more at risk of experiencing violence, including sexual violence, as is the situation globally.⁶⁹ This violence can be perpetrated by their partners, family or carers, and caregivers and family members may prevent women from reporting the abuse to authorities.⁷⁰

During the COVID-19 pandemic, women with disabilities can be at higher risk of contracting the virus due to reliance on physical contact with the environment or with their carers. Preventative measures, such as social distancing and handwashing, may not be possible. People with disabilities might also not have access to health information on COVID prevention and treatment. Furthermore, lockdown measures may place women with disability at greater risk of violence and act as an additional barrier to seeking help.

In interviews conducted by CARE, respondents spoke of the difficulties faced by women with disabilities during the COVID-19 pandemic. This included effects on their mental health (including increased stressed), fear of contracting the coronavirus, fear of more severe symptoms if they do contract COVID-19 due to underlying health conditions, barriers to accessing services, and difficulties travelling. In addition, interviewees mentioned that women with disabilities can face additional stressors if their families were not able to support them or even hostile towards them. Discrimination from the broader community was also a source of stress for women with disabilities.

Women's Economic Empowerment

The COVID-19 pandemic has significantly impacted economies globally, nationally and domestically, including in Lao PDR. The World Bank has reported that Laos' economic growth in 2020 is projected to be between negative 1% to negative 1.8% due to the pandemic, with downturns in tourism, trade and investment, commodity prices, and remittances.⁷¹ As discussed above under 'Gender Roles and Responsibilities', the division of paid labour in Laos is largely gendered, with women occupying sectors and roles that reflect prevailing gender norms. Most women (69%) in paid labour are in the agricultural sector, which is the largest sector in Laos,⁷² followed by the service sector (15%) which includes tourism, entertainment and hospitality, and factory work (6%), predominately garment factories.⁷³ Hence, economic downturns in sectors with a large female workforce will impact the economic security of women.

The pandemic also risks further entrenching the economic gender gap across Laos. Prior to COVID-19, Laos enjoyed strong growth as the second fastest growing economy in ASEAN.⁷⁴ This growth was largely fuelled by the exploitation of natural resources (e.g. hydropower, mining).⁷⁵ Other sectors, such as agriculture, were generally lower in productivity and the manufacturing sector is still a small part of the economy.⁷⁶ The natural resources sector, however, is a strongly male-dominated sector and, hence, the strongest growing sector of the Lao economy largely excluded women.⁷⁷ On the whole, female workers in Laos earn lower average salaries, wages and other kinds of remuneration than male workers, partially due to the concentration of women in lower paying industries (e.g. garment industry).⁷⁸ In addition, women occupy lower paying jobs within the same industry,

with women often employed in administrative or lower skilled roles, and men employed in technical roles or positions of authority.⁷⁹ This contributes to the higher rate of poverty among female headed households compared to male headed households, even after controlling for education, household composition, and other factors.⁸⁰ Hence, the more precarious economic circumstances faced by women can make them more vulnerable to the economic impacts of COVID-19.

In interviews conducted by CARE, almost all respondents raised financial difficulties as an impact of the pandemic. Many interviewees commented on the economic impact affecting both men and women, or the entire family. For example, the pandemic has “effected the family as there was a stable income but now there are only expenditures” and has “effected both men and women who get paid daily”. The economic impacts highlighted by interviewees included unemployment, reduced income, financial problems, downturns in small businesses, lack of customers/clients/buyers, the need to work harder, having no other sources of income, needing to find alternative sources of income, the inability to sell produce/products, travel restrictions interfering with the ability to work, and the health risks of going to work due to the pandemic. In short, “life is harder than before”. Interviewees working in some sectors, such as the health sector and public servants, have continued to work during the pandemic and raised other concerns, such as needing to manage increased caring responsibilities from children being at home (see above section on ‘Gender Roles and Responsibilities’ for more information on health workers and on the gendered division of unpaid labour).

Whilst most respondents spoke about the economic impacts on both men and women, some highlighted the gendered differences of these impacts. For example, women have had reduced opportunities to sell their handicrafts and produce as the pandemic has affected access to village markets and buyers. Women’s availability to engage in paid labour has also been reduced due to increased demands for unpaid labour (e.g. childcare, domestic duties) from school closures and family members being at home during the lockdown. However, due to the greater physical mobility enjoyed by men, their roles during the pandemic have included traveling further distances to seek alternative forms of work and income, which has been seen as putting them at greater risk of contracting the virus. In addition, due to the gendered division of paid labour, men who are employed by larger scale farms or in industries such as construction may have had reduced or no income as these sectors have closed down. However, women who are assigned to work in smaller family gardens close to their homes may still have access to these gardens and are able to grow subsistence level produce or modest additional produce to sell, if they are able to find buyers.

Garment Factory Workers

The garment and textiles sector is the largest manufacturing sector in Laos, employing more than 20,000 people in over 100 factories. Most garment factory workers are young (17-25 years old), female (85%) and have migrated to urban centres from rural areas.⁸¹ Female workers are mostly hired into unskilled and semi-skilled roles, such as cutting, sewing, packing and ironing, whereas men are more likely to be hired as professional or technical staff, or as skilled workers.⁸² Many women workers coming from rural areas consider factory work to be an opportunity to earn extra income for their families and consider the work to be temporary.⁸³ However, many have limited understanding of their contractual and labour rights.⁸⁴ Many also live in factory dormitories which are often small and overcrowded.⁸⁵ Both their working conditions (long hours, cramped factory floors) and living conditions can expose them to increased risk of contracting the coronavirus.

In response to the COVID-19 pandemic, the Laos Government issued lockdown measures effective as of 30 March 2020. These measures included the shutdown of garment factories. However, some garment factories made requests to continue operations to fulfill previous orders which were granted on the condition that they implement COVID prevention measures.⁸⁶ Although the lockdown has now been lifted and garment factories were able to resume operations on 18 May 2020, the closure of garment factories over the past months has impacted the livelihood of garment factory workers, many of whom are young women already in financially precarious

circumstances. In addition to loss of work, there have been reports that garment factories have failed to pay workers for wages previously earned in March before shutdown measures, or delayed payments, which has created financial distress.⁸⁷ There have also been reports that some factories have not followed government regulations to close and have continued to operate, putting workers at risk of COVID-19.⁸⁸ The Ministry of Labour and Social Welfare has recently issued special instructions to factories to pay their employees their normal wages if they have not done so or, if they face serious financial hardship, to pay their employees at least 50% of their wage.⁸⁹ The Ministry's instructions also included directions on terminating contracts or labour agreements and unemployment benefits.⁹⁰

During the time that CARE conducted its interviews, respondents confirmed that many garment factories had closed for the government lockdown, with 90% of interviewees currently not working. Interviewees' financial situations were mixed, with 37.5% still receiving their full income, 7.5% receiving reduced income (generally 50% of their income), and 15% receiving no income. However, most respondents (40%) were unsure about their factories plans to pay them and whether they would receive full, partial or no pay. Some interviewees mentioned that they had been paid a week in advance, whereas others said their payments were late. A lack (or potential lack) of income was the main concern of most respondents. Their plans for alternative forms of work or income included moving into other sectors (e.g. construction, food delivery), returning home and taking up previous forms of work (e.g. weaving, animal husbandry), and making money online (e.g. selling things). Some interviewees had no plans or were unsure of what to do. Interviewees also mentioned other difficulties, such as the lack of unemployment insurance, uncertainty about when the factory will resume operations, concerns about decreases in orders which would affect how much work the factory can offer its employees, the termination of workers' contracts, and workers not having sufficient resources to return to their hometowns. Some women workers mentioned that increased childcare responsibilities from school closures meant that they were unable to spend time finding other forms of work. Respondents also expressed fear about the coronavirus spreading through factories. Some interviewees have needed to take out loans to survive financially.

Return Migrant Women

There are an estimated 1.3 million Lao nationals living abroad, 54% of whom are women.⁹¹ Many of these are migrant workers who have travelled to bordering countries, in particular Thailand, in search of work. Male migrants often work in agriculture, factories and on fishing boats, whereas female migrants take up positions in domestic work, services and the entertainment industry.⁹² Most migrants come from rural backgrounds, with an average age of 21 years for men and 16.5 years for women.⁹³ The age and backgrounds of migrant women places them in a particularly vulnerable position, and there is a continuum between migration, exploitation and forced labour, as well as a risk of recruitment or coercion into the sex industry.⁹⁴

The lockdowns imposed across countries in southeast Asia, including Thailand, has resulted in many migrants returning to Laos due to loss of employment. As of early June 2020, an estimated 40,000 migrant workers have crossed the board from Thailand to Laos in an effort to return home, many of whom are women.⁹⁵ Eighty-three camps have been opened in Laos to quarantine return migrant workers.⁹⁶ Although Laos' borders were officially closed on 16 March 2020,⁹⁷ and only some are gradually reopening,⁹⁸ migrant workers have continued to return home during this time. Return migrant workers have been subject to a 14-day quarantine period before being allowed to continue home. Women and girls are particularly vulnerable during crisis situations that involve mass migration and, due to the generally younger age of migrant Lao women, returnee migrants can include significant numbers of young women, pregnant women and women with young children.⁹⁹ Women and girls are at increased risk of gender-based violence and sexual harassment, exploitation and abuse, both during their travel and at quarantine centres. Women and girls also have needs associated with menstruation and pregnancy. There have been reports of shortages in food, water and other necessities at quarantine centres.¹⁰⁰ International organisations, such as UNFPA in collaboration with the Lao Women's Union (LWU), have provided some supplies of essential sanitary kits to migrant women in quarantine.¹⁰¹

Interviews conducted by CARE found that the most common issue raised in relation to return migrant workers were financial difficulties. While some returned with small savings, many have returned with no additional resources. The 14-day quarantine period was seen by some as increasing stress levels, in particular, as 'wasted time' in which they were unable to look for other work. Once at home, some returnee migrants resumed previous forms of work, such as on familial agricultural plots or producing handicrafts, or have tried to find other work. However, many have been unable to find alternative work and remain at home and dependent on their families. Hence, the return of migrant workers has both reduced the flow of remittances and increased demand on family resources. Some returnee migrants have needed to borrow money, either from family, village funds or banks, and with uncertainty over future work prospects, these loans have created significant stress. Others have also report social stressors since returning to their home towns, such as being treated with fear or hostility. As one interviewee explained "some people said that we have COVID-19. When we went out to buy food, they didn't want to sell it to us. The villagers ignore us. We are so nervous and keep thinking about COVID-19 because we came from risky location."

For more information on other female dominated work sectors, such as healthcare (nursing), tourism and the sex industry, see 'Gendered Division of Paid Labour' above.

Remote Ethnic Minority Women

The poverty rate in Laos remains significantly higher among rural communities. Whilst in urban areas, 48% of the population occupies the top wealthiest quartile, this drops to 8.8% for rural communities, and only 0.8% for rural communities without road access.¹⁰² On the contrary, only 2.1% of the urban population lives within the poorest wealth quartile, compared to 23.2% of rural communities, and 55.2% of rural communities without road access.¹⁰³ The poverty rate is highest among minority ethnic groups who make up most of the population living in rural or remote areas.¹⁰⁴ Among these, women often have the least economic security due to gender-based barriers such as the gendered division of paid and unpaid labour (see 'Gender Roles and Responsibilities' above), lack of opportunities for education and income generation, time poverty due to higher unpaid workloads, social norms restricting women's physical and social mobility, and inheritance practices in which land ownership is transferred patrilineally. Female-headed households face additional challenges compared to male-headed households, such as less access to agricultural land, a smaller household workforce, less capacity to engage in livestock production, less access to fishing and forestry, and reduced abilities to access loans, especially formal loans to invest in income generation.¹⁰⁵ The lower levels of economic security faced by women, and female-headed households, can make them more vulnerable to the economic impacts of the COVID-19 pandemic. For example, it has been estimated that Laos' agricultural production for 2020 will be 17,500 tons lower than in 2018 due to the impacts of the pandemic and arid conditions.¹⁰⁶

Research undertaken by CARE confirmed the economic impact of the pandemic on rural ethnic communities. Many interviewees spoke about no income or reduced income from their agricultural work due to the closure of markets or the inability to sell to buyers. One interviewee explained, "women... get offers from an external dealer to [buy from their] cucumber garden, but when it grows, nobody comes to buy as promised. If we will sell it to people in the village, nobody comes to buy it". Interviewees also raised issues of decreased agricultural outputs, increased barriers to accessing agricultural plots, reduced prices of the produce that they are selling, decreased income from other sources (e.g. paid labour, small businesses), and lack of savings. This has all lead to "women [needing to] work harder than before". In addition, women's unpaid labour has increased through additional childcare and domestic responsibilities due to lockdown measures. Some interviewees have stated that women are 'more effected' due to the double burden of paid and unpaid labour. In addition, as men have reduced work from the lockdown (e.g. as men are more likely to work on larger agriculture plots or effected sectors such as construction) and families have reduced income to purchase food, the dependency on women to provide food has grown as women continue to have access to small family plots to grow food for their families.

Decision Making and Women's Participation

Decision Making in the Public Sphere

Ensuring a gender-sensitive response to COVID-19 requires the inclusion of women at all levels of decision-making and drawing on gender expertise in formulating response strategies, implementing activities, and monitoring outcomes. Laos has achieved a high level of female representation (27.5%) in national parliaments, which is above the world average,¹⁰⁷ and has met its target of women occupying 15% of management positions in state and mass organisations.¹⁰⁸ The Lao Women's Union (LWU) provides official representation of women's voices and acts as a bridge between the Lao People's Revolutionary Party, the Government, and Lao women in urban and rural areas.¹⁰⁹ In the response to COVID-19, the National Taskforce Committee for COVID-19 Prevention and Control composed of 11 people as secretariat, there are only 2 women as the members which are from Ministry of National Defence and from Prime Minister Office.

Despite the success of women's representation at a national level, this has not extended to the provincial or district levels where women's representation is still low. For example, at the provincial level, there are no women governors and only three women vice-governors.¹¹⁰ At the village level, only 1.7% of village chiefs and 7.2% of deputy village chiefs are female.¹¹¹ The significant underrepresentation of women at the provincial and village level may mean that the needs of women and girls are not integrated into COVID response strategies at these levels. It is important at the provincial and village levels, where COVID response strategies will be implemented, that all initiatives are undertaken in a gender-sensitive manner. Whilst the official role of the Lao Women's Union is to represent all women, in practice, there has been limited inclusion of women from rural areas or ethnic communities.¹¹² With the LWU's focus on women's advancement at a national level, it has also not sufficiently acted as the 'voice' of women at the provincial or village level.¹¹³ Hence, women's voice and representation is lacking at the provincial and village level, which can significant impact the effectiveness of COVID-19 response strategies for women and girls, as well as for communities more broadly.

Decision Making in the Home

At the household level, women's authority to make decisions can vary. Women's ability to make decisions, particularly around the use of family financial resources and accessing healthcare, is essential during a health pandemic. Although male-headed households predominate in Laos (86.1%),¹¹⁴ this does not necessarily determine the decision-making structure within the household. For example, it has been previously reported that in 64% of farming households, women and men make joint decisions on crop and livestock production activity.¹¹⁵

In interviews conducted by CARE, respondents reported different decision-making patterns within their households. In the Luang Namtha province, most interviewees stated that women 'keep' the money and manage daily household expenses, whereas men manage family assets such as transportation (e.g. motorbikes). On the contrary, in Phongsaly and Sekong provinces, most interviewees reported that husbands and wives manage financial resources and expenses together. Across all provinces, a small minority of households reported that the woman is the decision maker ("My mom decides everything"). No interviewees mentioned that the COVID pandemic had changed these decision-making structures within families. However, some changes in household decision-making due to COVID-19 were reported by interviewees living in the Vientiane capital. These changes were mainly related to financial pressures caused by lockdown measures. For example, interviewees mentioned that there were increased discussions between husbands and wives on how to manage their financial situation, husbands were consulting with their wives more before making purchases (which was different to before the pandemic), and there was an increased use of savings to buy food and other essential items. Overall, within the Vientiane capital, there appears to be greater levels of discussion and negotiation between wives and husbands on household savings and expenditures compared to before, whereas in rural areas, patterns of financial decision-making appear to not have change much among those interviewed.

Household decision making can also be influenced by marriage practices. In matrilineal traditions, which are practiced by the majority Lao Tai community, the husband moves in with the wife's family which often provides the wife with higher status and decision-making authority.¹¹⁶ Decisions on small daily expenditures are generally made by women, and large financial decisions are made jointly between wife and husband.¹¹⁷ As the property belongs to the woman's family, this can give her greater control over family assets and resources.¹¹⁸ On the contrary, in patrilineal traditions, more commonly practiced by ethnic minority communities in which the wife moves in with the husband, men are more likely to make decisions about daily expenditures and larger financial expenses, as well as control family land and assets.¹¹⁹ Additional practices, such as bride price and early marriage (see 'Gender Roles and Responsibilities' above), may further disempower women and their decision-making abilities. CARE's research has found that, in general, ethnic minority women often defer to their husbands for decision-making, although husbands can be receptive to their wives' input.¹²⁰ However, men ultimately make significant family decisions which can impact women's ability to manage their safety, health and well-being.

Interviews conducted by CARE during the COVID pandemic found that women generally made decisions over food consumption and household work, although a small number of interviewees mentioned that decisions about food consumption were made by both the husband and wife together. There were no households in which the husband was primarily responsible for decisions around household consumption and chores. For those interviewed, men made decisions around earning money, financial planning, raising livestock, construction or repairs, and problem solving. There was also a general pattern of women being responsible for smaller decisions, and men being responsible for bigger decisions or the 'final' decision. As one interviewee stated, "we share decision making on everything, both women and men. However, the husband would be the final decision maker". Another interviewee reflected that the "wife and husband have to discuss, but the husband still has the higher power to make the decision". Nonetheless, in a small number of households, big decisions were made jointly between the husband and wife, such as the purchasing of high value items or solving big problems. The lack of authority to make decisions about the use of family financial resources, particularly potentially high cost expenditures such as accessing healthcare or hospitals, can have significant impact on women's ability to seek treatment if they or their children are infected with COVID-19. However, the authority to make small daily decisions about family expenditures can allow women to purchase items needed for COVID-19 prevention, such as soap, hand sanitiser and masks.

In regard to decisions on accessing family planning, interviewees stated that this was either the decision of the husband or of the husband and wife together. Only in a few households (2 out of 62 interviewed) did decisions on family planning lie with women. Decisions around healthcare followed a similar pattern, although women were more active in decision-making. However, healthcare decisions were generally still made by the husband or the husband and wife jointly. Not all joint decision-making was entirely equal though, as sometimes 'joint' decision making involved the wife discussing her needs or concerns with the husband first, and the husband having greater influence over the final decision. This seemed to be related to men also often controlling family transportation (e.g. vehicles) and the wife being reliant on the husband to take her to healthcare facilities. Interviewees also mentioned a difference between rural and urban households, in which women in rural communities often sought their husband's permission to access healthcare, whereas in urban areas, decisions were more likely to be made together. During the COVID-19 pandemic, men have also had more decision-making authority over their family's mobility, including who can leave the house. Often, it has been men's role to go outside during the pandemic, except for obtaining food which was sometimes the domain of women. Hence, women's compromised abilities to make decisions concerning their own healthcare and mobility can impact the care they are able to receive during the COVID pandemic, both for ongoing healthcare issues, such as family planning, and to receive treatment if they were to be infected with COVID-19 (see also 'Access to Healthcare' below).

Decision Making within the Community

At the community level, within ethnic minority groups, the man usually represents the family at village meetings and other official events.¹²¹ Although women may be sent by their husbands to 'deputise' for them if the husband is unavailable, if this occurs frequently, the man may be seen as not taking his responsibilities seriously.¹²² Furthermore, the wife's role is not to speak on behalf of the family but rather to communicate information back to her husband.¹²³ Participating in community decision-making is not seen as women's role, sometimes even by women themselves, and is contrary to gender norms in which women are gentle, patient and self-effacing.¹²⁴ However, community meetings also often do not require the active participation of men and are often characterised by top-down information dissemination from the commune level (Kum ban) to the district level.¹²⁵ Once the information has been communicated to the male head of household, the 'duty' of community leaders has been fulfilled and there is often little follow up to ensure the information is shared with the rest of the family.¹²⁶ Previous research has found that men often do not pass on information from community meetings to their wives.¹²⁷

In interviews conducted by CARE, mixed responses were received on women's participation in community decision-making platforms for COVID-19 prevention and response. For most provinces, interviewees answered both 'yes' and 'no' when asked if women were involved in decision-making around COVID-19. The strongest positive response on women's participation in decision-making came from Luang Namtha province, in which some respondents stated that women were involved in the design, planning, implementation and evaluation of the COVID-19 response, including as members of the COVID response committee, doctors, village chief, and LWU president. Other provinces (e.g. Phongsaly, Vientiane province) said that only limited numbers of women were involved in decision making. Contradicting these respondents, almost all provinces also had interviewees who stated that women were not involved in decision-making platforms on COVID-19, by simply responding "no" or explaining that men make the "final decision... [as] it is believed that men have the most authority."

The majority of interviewees, however, explained that women's primary role in the COVID response has been to receive and disseminate information and to 'participate' by following prevention guidelines. For example, women have attended community meetings to receive information on COVID-19, participated in consultations, and obtained information from media sources such as television. Women have also disseminated information to others in the community, through women's groups, to vulnerable community members such as the elderly and children, and through social media. Some interviewees reflected that women are highly motivated to help prevent the spread of COVID-19, are more concerned about the impacts of the pandemic, and are more diligent than male community members in their responsibilities to not transmit the virus. Hence, whilst progress can be noted with the involvement of some women in decision-making platforms for COVID-19, women's role remains primarily disseminating information and following guidance that is given, rather than developing and leading the response.

Access to Services and Resources

Access to Water, Sanitation and Hygiene (WASH)

According to guidelines issued by the World Health Organization (WHO) and adopted by national governments globally, handwashing is a key strategy in preventing the transmission of COVID-19. Handwashing requires access to adequate WASH facilities. Laos has made significant progress in improving WASH,¹²⁸ including as part of its 6th National Socio-Economic Development Plan (NSED) 2006-2010 and the National Rural Water Supply and Sanitation (WSS) Sector Strategy which highlights WASH access for women and rural communities.¹²⁹ However, significant challenges remain with differences in WASH access related to gender, geography, ethnicity and socio-economic background. For example, the availability of household handwashing facilities (with water and soap) is higher in urban areas (73.3%) than rural areas (45.6%), for Lao Tai communities (66.4%) than minority ethnic communities (between 32.6% to 57.5%), and for richer households (86.6%) than poorer households (20.9%).¹³⁰ The need to share sanitation facilities is also higher among rural household (37.9%) than urban households (8.8%),¹³¹ and female headed households have less access to basic sanitation compared to male headed households.¹³² Access to handwashing facilities during the COVID pandemic is essential for transmission prevention, and lower levels of WASH access by rural, poorer, ethnic minority and female headed households puts these communities at greater risk.

Previous public health campaigns in Laos have demonstrated that these can be effective in improving WASH practices, such as the '3 Cleans' campaign which increased the use of latrines.¹³³ Hence, public health campaigns that have promoted handwashing to prevent COVID-19 may also be successful. This is evidenced in interviews conducted by CARE in which almost all respondents expressed knowledge of hygiene practices related to COVID prevention, including through public health information provided by government or health authorities, and half of all respondents expressly mentioned the importance of handwashing or using hand sanitiser. Despite this knowledge, if households lack WASH access, then following these directives can be challenging.

Following handwashing guidance may also increase the workload of women and girls who, in rural communities, are responsible for collecting water and maintaining household sanitation and hygiene.¹³⁴ This may involve the need to carry more water to the home from water sources and increased time spent collecting water if additional trips are needed. This may exacerbate the 'time poverty' experienced by many women (see 'Gender Roles and Responsibilities' above) and may lead to women having less time for rest or for other responsibilities (both paid and unpaid). Additionally, women and girls can face risks of sexual assault or violence travelling to or from water collection points, and may be punished if they return home with an insufficient amount water or if they are seen as spending too much time on this chore.¹³⁵ Therefore, although the preventative strategy of handwashing is sound from a medical perspective, it needs to be implemented in a gender-sensitive manner with sufficient infrastructure and social support to mitigate any potential risks to women and girls.

Whilst women are responsible for daily household water management, men have decision-making and management roles over the community's water infrastructure, such as water supply systems and the construction of latrines.¹³⁶ Women are largely excluded from participating in water policy development, water engineering, community WASH awareness raising, and financial management of WASH systems.¹³⁷ Women's exclusion impacts the design and management of WASH, and can result in WASH systems not adequately meeting women's needs (e.g. menstruation, pregnancy, childbirth; safety; accessibility). WASH facilities that are not gender-sensitive exacerbate the challenges faced by women in managing the COVID pandemic.

Those interviewed by CARE observed a number of changes since COVID-19 in regard to WASH. Both women and men have increased knowledge of hygiene and sanitation practices as it relates to the pandemic. There was a strong emphasis on drinking clean water (which is not a COVID prevention strategy per se), maintaining a clean living environment, and improving personal hygiene practices. Most interviewees were able to access water for

these purposes, although a minority did not have sufficient access to clean water. Boy children tended to be guided by their parents and some showed an improved level of personal hygiene. Girl children were more likely to have a dual role (both being taken care of by parents, plus taking care of their parents in return, such as through increase household cleaning tasks) as well as taking care of their own person hygiene. However, a small number of interviewees stated that there had been no changes in WASH practices in their households since the start of the pandemic.

Access to Information

During the COVID-19 pandemic, access to information on prevention and treatment, as well as government or other sources of support, is essential to effectively navigate both the virus and the socio-economic impact of the pandemic. This requires both access to sources of information (e.g. media, information materials) and the ability to understand the information. However, there continue to be gender-related barriers to accessing and understanding information in Laos. For example, women have lower levels of literacy than men in both urban (men 91%; women 84.6%) and rural areas (men 72%; women 51%).¹³⁸ Rural ethnic minority women have the lowest literacy rates, particularly in Lao language.¹³⁹ In interviews conducted by CARE, the two main challenges highlighted by respondents to women's access to information during the COVID-19 pandemic was illiteracy and limited understanding of Lao language (for ethnic minority women). Other prominent challenges included: the information being presented in a manner that was not understandable; not having direct access to information or knowing how to obtain information; a lesser 'role' and lower levels of participation in the public sphere where information is being disseminated; and high levels of domestic labour that consumed women's time. Although almost all interviewees (both men and women) stated that they were personally able to access information on COVID-19, interviewees reflected that more broadly "women don't have time to follow the news, but men are able to get information because they have time to watch television, use their mobiles and interact with others online", "men receive information faster than women as men can access social media and meet with friends more often", and "usually it is men who discuss prevention, less so women as some of them are illiterate".

For ethnic minority women, Lao language adds a further barrier to accessing information on COVID-19. Men from ethnic minority communities have greater opportunities to develop Lao language skills than women. For example, in the Mon-Khmer community, 63% of men compared to 45% of women are literate in Lao language.¹⁴⁰ Those interviewed by CARE confirmed that language was a significant barrier in accessing COVID-19 information. Although most interviewees themselves were able to understand the information that they had come across, interviewees stated that within the broader community, those with low literacy, the elderly, children, people living with a disability, rural communities, and poorer households may have more difficulty understanding COVID-19 information, both due to language barriers and the length and complexity of information presented. However, interviewees living in the provinces (Luang Namtha, Phongsaly, Sekong, Vientiane Province) told CARE that some COVID-19 information had been translated into local languages, presented in short and easy to understand formats, and provided pictorially for those with limited written language skills. In addition, a committee was available to support local community members to understand the information, some training had been conducted for the community, and information had been presented through a range of mediums (e.g. posters, on a news board, phone, social media, village speaker, healthcare staff, village volunteers, radio and television). Overall, for the cohort that was interviewed by CARE, more respondents provided positive examples of adapting information to suit the local community (e.g. a video was translated into Akha language and shown to the community in Luang Namtha province) compared to negative examples of inaccessible information. When asked about the contents of the information, the main information received was on prevention strategies (e.g. handwashing, face masks, social distancing), followed by news about the pandemic (e.g. infection numbers). A few interviewees also mentioned receiving information on lockdown measures, international travel restrictions, treatment and surveillance. There was little difference between women and men in those interviewed regarding access to and understanding of COVID-19 information.

Access to information also requires access to the means for obtaining information. Respondents interviewed by CARE stated that their most common means of accessing COVID-19 information was through smart phones or other devices that connected to the internet (60% of respondents). Whilst there has been a substantial increase in information communication technologies (ICT) across Laos, and both the women and men who were interviewed by CARE had access to mobile phones, there continues to be gaps in ICT access based on gender and geography (urban/rural). Patterns in ICT usage include greater access for men than women, and in urban areas than rural areas. For example, slightly more urban men (94.2%) have used a mobile phone in the past three months compared to women (94.1%), which is higher than rural men (83.6%) and rural women (72.3%).¹⁴¹ ICT usage is also correlated with education, rising steadily for those with early childhood education (46.1%) to lower secondary (87.8%) to higher education (99.2%). There are also correlations in access with ethnicity (Lao Tai 89.4%; ethnic minorities 55%-78%) and wealth (poorest quartile 41.3%; richest quartile 98.4%).¹⁴² Hence, rural, poor, ethnic minority women with less formal education have the least access to mobile phone technology. This pattern is similar for access to other types of ICT including computers and the internet.¹⁴³

The second most common means for accessing COVID-19 information for interviewees was mass media, specifically television (27% of respondents). Similar to mobile phones/internet, gender and geography gaps remain in access to mass media. For example, there are differences in access to television between urban men (92.4%) and women (90%), and rural men (79%) and women (69.7%). These patterns of access are also found for radio (urban - men 33.3%, women 25.1%; rural - men 18.7%, women 13.5%) and newspapers (urban - men 16.2%, women 15%; rural - men 5.5%, women 3.3%).¹⁴⁴ Hence, rural ethnic women again have the least access to mass media as a source of information.

Whilst interviewees also mentioned other sources of information (e.g. health workers, community speakers), the lack of access to the most common sources of information on COVID-19 can place women, particular rural, poor and ethnic minority women, at greater risk. This may impact their abilities to prevent contracting the virus and understanding options for treatment if they were to fall ill. Women may also be unable to obtain information on support services, such as for gender-based violence which tends to increase during a crisis (see 'Gender-Based Violence' below), or on financial support, such as NGO assistance or government initiatives. Furthermore, the inability to access information on COVID-19 may result in the influence of local beliefs or practices mentioned by some interviewees (such as eating boiled eggs, drinking boiled herbs, hanging bamboo in front of houses, and killing ducks, chickens or dogs) to prevent illness or deal with financial hardships. In conversations with CARE, interviewees mentioned that following traditional beliefs or practices may reduce the recommended preventative measures that community members put in place, putting them at greater risk of contracting COVID-19, and may result in added stresses, such as feeling ill after consuming certain foods or experiencing stress from not being able to obtain certain herbs. However, there were no notable gender differences in following these traditional beliefs or practices.

Access to Healthcare

Access to quality healthcare services is essential during a global health pandemic. However, there are a number of barriers to accessing healthcare in Laos, including financial barriers due to out-of-pocket costs; potentially long travel distances, including on poor roads; the cost of transportation; long wait times; and poorly staffed and under resourced facilities.¹⁴⁵ In addition, despite the 2011 Law on Hygiene Prevention and Health Promotion which prioritises women, children and rural communities, there continue to be significant gender-based barriers to accessing healthcare.¹⁴⁶ This includes restricted mobility due to social norms; domestic responsibilities; husbands' decision-making role in women's healthcare access; women not wanting to go alone; and women's concerns about communicating with healthcare providers.¹⁴⁷ These barriers to access may be further exacerbated for some women, such as marginalised urban women (e.g. migrant workers, sex workers) and minority ethnic women, due to discrimination, exclusion, and lack of appropriate services.¹⁴⁸ In previous research, 45% of women reported that financial constraints were a key barrier to accessing healthcare.¹⁴⁹ Family coping strategies

for medical costs included borrowing money, reducing consumption, taking children out of school, sending children to work, selling assets, and only some family members receiving select treatments.¹⁵⁰ Although research is lacking on the gender impacts of these coping mechanisms,¹⁵¹ it has been reported that boys were more likely to be taken to healthcare facilities to be treated for conditions such as pneumonia.¹⁵² This may have implications for COVID-19, which has symptoms that resemble pneumonia and can lead to pneumonia, if boys are more likely to receive treatment than girls.

Access to healthcare services is particularly limited in rural areas, especially for ethnic minority communities. The healthcare services available are often rudimentary and have limited resourcing and staffing.¹⁵³ Healthcare providers are commonly not from the local ethnic community and lack local language skills, and the care provided can run counter to local spiritual beliefs.¹⁵⁴ As one interviewee told CARE, there are difficulties as people “do not know and cannot answer some information in Lao, (and so they) have no [health] information.” There is also a lack of awareness of gender norms within minority ethnic communities that affect healthcare access for women and girls.¹⁵⁵ In addition, service provision often does not take into account barriers facing local communities (e.g. financial constraints, transportation, decision-making capacity).¹⁵⁶ Hence, during a pandemic, providing accessible and appropriate healthcare for remote ethnic communities can be challenging, leaving these communities particularly vulnerable to COVID-19.

CARE’s research has produced mixed findings on the impact of COVID-19 on the accessibility of healthcare services for women and men. Around half of the interviewees reported reduced accessibility and less people using healthcare services. The primary reason given was fear of contracting the virus and a loss of trust in the healthcare system, which was reported by both men and women. One interviewee explained, “people do not go to hospital because they are afraid of infection, as there are many people in the hospital and they do not know who is carrying the virus or infected.” The second most common reason was related to quarantine measures, including difficulties of being able to go anywhere and travel restrictions (e.g. “no one can travel from the infected areas”). Another prominent reason given was that it was not safe for women and girls to travel to healthcare facilities. However, whether this barrier pre-existed the pandemic or has been worsened by the pandemic was unclear. Nonetheless, a similar number of interviewees reported that there has been no change in access to healthcare services and/or that they have been able to access healthcare services during the pandemic.

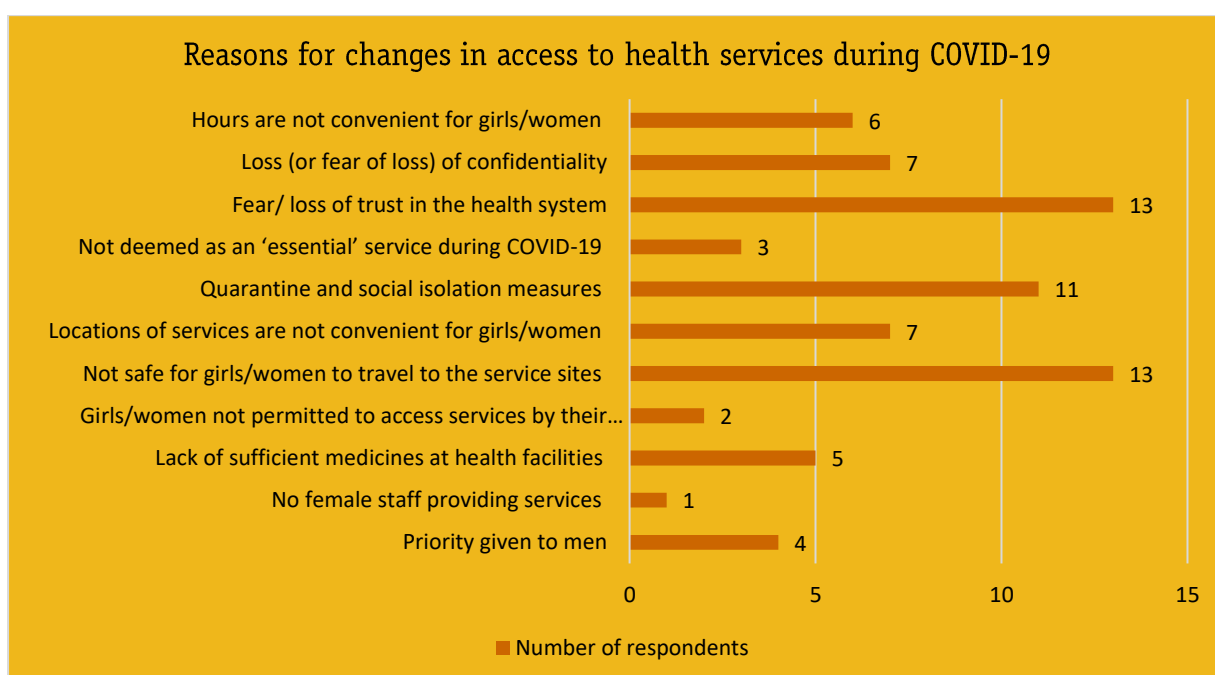


Table 1: Interview responses on reasons for changes in healthcare access

Mental healthcare services are also critical during the COVID-19 pandemic. In response to the pandemic, UNFPA, in collaboration with the Lao Women's Union and local youth organisations, have launched a telephone hotline offering psychosocial support.¹⁵⁷ Those interviewed by CARE have reported heightened levels of stress and anxiety around fears of infection and the economic impacts of the pandemic, and adolescents and children reported stress around not being able to attend school. The availability of mental health services appeared to vary between provinces. Interviewees from Luang Namtha province reported that mental healthcare services were available and that government policies supported the availability of such services. Whilst some reported that these services were available to everyone and many people can access them, others reported that only "special groups" have access, the services were not convenient, the hotline was not accessible, and some chose not to access services due to the fear of infection. In the remaining provinces (Sekong, Phongsaly, Vientiane province, Vientiane capital), interviewees reported that mental health services were generally not available, although other healthcare services may be available (e.g. general healthcare services, COVID-related healthcare services).

The impact of COVID-19 on the healthcare system may include a diversion of resources to address the pandemic. This may reduce the resources available for other healthcare needs, particularly for women and girls, such as sexual, reproductive, maternal, newborn and child health (SRMNCH) services. Although recent progress has been made, Laos still has one of the highest adolescent birth rates in the region (94 births per 1000 girls aged 15-19) as well as a high maternal mortality rate (206 per 100,000 births).¹⁵⁸ The fertility rate is higher for women from ethnic minority communities, lower socio-economic backgrounds, rural communities, and with lower levels of formal education.¹⁵⁹ Before the pandemic, there were still significant unmet healthcare needs, with one in five women (23%) reporting difficulties accessing SRMNCH services, particularly young women (aged 15-19).¹⁶⁰

Interviews conducted by CARE during the pandemic produced mixed responses in regard to access to sexual, reproductive and maternal healthcare. Many respondents reported increased difficulties in accessing SRMNCH services and that less women and girls were using SRMNCH services. Whilst some said that this was due to lockdown measures, most stated that fear of infection was the main barrier to accessing SRMNCH services. For example, interviewees said that women are "afraid to go to the hospital for treatment, checks or follow up on their pregnancy", "less people go to hospital [for SRMNCH services] because we are afraid of getting infected so we don't go to hospital if not necessary" and there was "difficulties accessing [SRM] health services because of increasing nervousness and stress". Nonetheless, other respondents stated that there were little or no changes to access (e.g. "pregnant women still go to see doctors", "we go to hospital for check-ups and vaccines").

Related to accessing healthcare, previous research has found low rates of healthcare-seeking behaviour among both men and women in Laos. Estimates range from 10% to 31% of women and men who seek care for temporary health problems.¹⁶¹ The reasons given for low healthcare-seeking behaviours included that the illness was not considered serious (84.2%), difficulties accessing healthcare facilities (7.8%), financial constraints (1.7%), low quality healthcare (0.6%) and belief that there is no cure (5.5%). Furthermore, those living in urban areas are more likely to engage in healthcare-seeking behaviour, as are women, and members of the Lao-Tai ethnic group.¹⁶² The primary reason given – that the illness is not serious – may affect the rate of seeking treatment for COVID-19, as the majority of cases (81%) of infected persons may only present with mild to moderate symptoms.¹⁶³ However, ensuring that all infected persons are tested and diagnosed is important in tracing the spread of the virus and preventing transmission to more vulnerable persons. As mentioned above, interviews conducted by CARE have found that fear of infection is a key barrier to accessing health services during the COVID pandemic. This may further decrease the level of healthcare-seeking behaviour within the community during the pandemic. As one interviewee told CARE, "we don't go to hospital (during the pandemic) even when we feel sick." A low level of healthcare-seeking behaviour may be particularly dangerous during COVID-19 as it may conceal infection rates, increase virus transmission, and delay the discovery of outbreaks until they become widespread.

Another risk factor which has been identified in contracting and increasing the severity of COVID-19 is smoking.¹⁶⁴ Laos has one of the highest rates of smoking across the Asia Pacific,¹⁶⁵ with 43.5% of men and 7.2% of women having used a tobacco product. The rate of tobacco use is higher in rural areas among both men (rural 48.3%; urban 33.4%) and women (rural 9.8%; urban 1.9%). Alongside men's lower rate of health-seeking behaviour, this places them at a higher risk of contracting and becoming seriously ill with COVID-19.

Access to Food

The COVID-19 pandemic has the potential to create or deepen food insecurity across Laos, such as through disruptions to the food supply chain, downturns in the local or global economy, or the impacts of containment measures (e.g. travel bans, closures, lockdowns and social distancing). Despite recent progress, with a reduction from 33% to 23% in poverty-related hunger in the past decade,¹⁶⁶ the 2019 Global Hunger Index still defines the situation in Laos as “serious”.¹⁶⁷ Food insecurity is more prevalent among the poorest households, rural households, and ethnic minority communities such as the Mon-Khmer.¹⁶⁸ In rural communities, access to communal land is a significant source of food security, especially among the poorest.¹⁶⁹ Reduced access can result in women needing to spend more time on food or income generating activities and men needing to travel further to find alternate sources of income.¹⁷⁰ In response to the COVID-19 pandemic, the Ministry of Agriculture and Forestry is developing a response plan to provide direct assistance to farmers, such as through seeds, home gardening kits, animal healthcare items and technical support.¹⁷¹ Ensuring this assistance is developed and implemented in a gender-sensitive manner and reaches all members of the family, including women and children, and is essential to producing equitable outcomes.

Women and children in Laos face significant levels of malnutrition. In the poorest households, 29% of women have short stature, compared to 8.2% of the richest households.¹⁷² During pregnancy and postpartum, women’s increased nutritional needs may not be met. For example, during pregnancy women may not be able to increase or diversify their food intake, and post-pregnancy, women may be expected to follow certain food restrictions related to traditional beliefs.¹⁷³ In urban areas, 75% of pregnant or postpartum women’s food intake meets the minimum dietary diversity, which drops to 33.2% and 19.5% in rural areas with and without roads, respectively.¹⁷⁴ Women also face cultural barriers to food access. For example, in the Makong ethnic community, women are not permitted to eat with their in-laws and must eat on a separate table, and in the Katang community, pregnant daughters-in-law are not allowed to join the family meal, although some of these practices are changing.¹⁷⁵ There is also a significant rate of malnutrition among children, with 21.5% of urban children and 37.2% of rural children classified as ‘stunted’ (34% boys; 32% girls).¹⁷⁶ Only 13% of young children in rural areas have access to a minimally adequate diet¹⁷⁷ and 40% of young children have both moderate anaemia and Vitamin A deficiency.¹⁷⁸ However, greater dietary diversity has been found to be correlated with higher levels of education, particularly the education level of the head of household.¹⁷⁹

Difficulties in accessing food during the COVID-19 pandemic was raised repeatedly during interviews conducted by CARE, particularly for families with lower socio-economic resources. For example, interviewees stated that “we are facing money problems and we do not have enough food” and “we need more dry food during times when we cannot go out or are under home quarantine”. The primary reason given for insufficient food supplies were reduced incomes due to the pandemic. Some families have needed to sell their resources and assets to buy food, as one interviewee explained “we can’t earn money for our family, so we have to sell our assets to buy food for the family.” Other reasons for increased food insecurity included the need to divert financial resources to buy other goods (e.g. hygiene-related products) and financial strain from illness within the family. Despite government regulations that prohibit increasing the price of essential consumables, such as rice, food, water, masks, soap and medicine,¹⁸⁰ some of those interviewed by CARE reported that consumer products had increased in cost. Similarly, despite government lockdown measures allowing people to leave their homes for necessary circumstances, such as buying food or going to the hospital, interviewees reported that lockdown measures have made obtaining food more difficult. Due to the gender- and age-related barriers to accessing food mentioned above, the increased food insecurity brought on by the COVID-19 pandemic may have disproportionate effects on women and children.

Gender-Based Violence (GBV) Prevention and Response

Many studies have indicated that there is a level of acceptance of gender-based violence in Laos, which can be seen in both the legal framework and in social norms and attitudes. Previous research has found that 29.5% of women aged 15-49 years believe that a husband is justified in beating his wife for a range of reasons, while 16.2 % of men in the same age range believed the same.¹⁸¹ Young people said that violence against women and girls was justified when traditional Lao society gender roles and responsibilities were not adhered to, such as the way a woman should dress, acceptable sexual relations, and fulfilling domestic responsibilities such as food preparation and childcare. In a qualitative study complementing the 2014 national survey on violence against women and the Laos Social Indicator Survey II of 2017, it was discovered that traditional gender norms, roles and relations contributed to gender-based violence. For example, partner violence could arise due to a wife's inability to fulfil her domestic household duties. Both male and female participants in focus groups frequently stressed that alcohol, infidelity and financial difficulties in the household were key triggers for violence. Moreover, these factors may also interact as multiple causes leading to an act of violence.¹⁸² Ethnic minority backgrounds and living conditions were also important factors in terms of exacerbating violence, as the study found that women in rural areas in the northern region tended to agree with the statement that a good wife obeys her husband even if she disagrees (38.9%), while 35.4% the women from the central region and 30.2% of the women from the southern region agreed with same statement.¹⁸³ From a range different studies, women reported that the most common type of violence was psychological violence. This was characterised by yelling at the woman, or belittling her with comments that she is stupid or cannot do certain types of work because she is a woman. This type of violence was reported to occur every day.¹⁸⁴

The acts that can constitute of GBV are not commonly understood by both men and women. In a previous study be CARE, women report that domestic violence was shameful to talk about outside of the family, and might only be deemed 'serious' and problematic if there are physical injuries. This response was similar for men, especially for men in positions of authority such as village chiefs or elders, who reported that physical violence was common between husbands and wives and that taking action is usually only considered when there are physical injuries.¹⁸⁵

The support systems for women who experienced gender-based violence can include formal and informal mechanisms which can address and prevent further acts of violence. In Laos, the process to address GBV in the community is comprised of three systems: the customary system, the semi-formal justice system and the formal justice system. The customary system involves seeking help from family or village elders, the semi-formal justice system consists of the Village Mediation Units, and the formal system involves the police and courts.¹⁸⁶

However, in reality, many women who experience GBV do not tell others nor seek any support as they know that their case will most likely go through the customary system via family and friends first and later to the semi-formal system through local authorities or local leaders. For formal services, such as social services, police stations, courts and mediation units, there has been some GBV sensitisation training to provide staff with the skills to respond to GBV cases. However, health facilities have lagged behind in this respect. Nonetheless, sensitisation training has yet to translate into direct service provision to women survivors. Very few facilities provide an extensive range of services, and referrals to other facilities and services remain virtually non-existent. Since 2017, the LWU has provided counselling services at the national and village level. There have been 11,668 people (71.8% women and 28.2% men) who have used the LWU counselling centres nationwide. The range of topics covered by the counselling service include legal, health and psychological issues related to gender-based violence.

Most of those interviewed by CARE did not report cases of GBV or related violence. In part, lockdown and travel restrictions, as well as interviewees not being based at the village level, made it difficult for respondents to have observed or heard reports of GBV during the pandemic. Most of the concerns raised by interviewees related to the stress generated from lockdown measures and health concerns related to COVID-19 which, for women, more commonly involved concerns about the health of their families rather than themselves. On the other hand,

men were mainly concerned about their own health and the economic impact of the pandemic including their ability to provide for their families. However, the interviews produced limited insight into the prevalence of GBV during the lockdown. Anecdotal reports through partners organisations and working groups meeting have indicated that there are tensions within some households related to increase household work, financial pressures, stress, and fear from infection, which may have contributed to increased cases of GBV. In mid May 2020, the LWU with support from UNFPA launched a hotline to provide psychosocial support to the community. It aimed to target women who were experiencing violence to enable them to call and receive support. However, the call centre is in the Vientiane capital and has a limited number of trained staff. Very few of the interviewees were aware of existing support systems for GBV survivors, and most of the interviewees responded that the cases can be solved within the family or with village chief. There were some mentions of the Village Mediation Unit, but interviewees were not able to expand further. In the resolution of GBV cases, most interviewees referred to obtaining justice rather than supporting the physical or psychological health of survivors, despite the fact that 40% of interviewees were healthcare workers or from the LWU. This reflects the limited capacity of service providers to respond adequately to GBV cases and that more investment in GBV training is needed.

Capacity and Coping Mechanisms

Capacities and coping mechanisms in response to the COVID-19 pandemic have been implemented by individuals and communities across Laos. In interviews conducted by CARE, a range of coping mechanisms were highlighted:

- **Prevention:** The majority of respondents mentioned preventative strategies as a key coping mechanism. This included handwashing, using hand sanitiser, staying at home, social distancing, avoiding large crowds, and wearing face masks. As interviewees explained, “we seriously follow the rules: wear masks, wash our hands with gel... Both men and women do same tasks” and “we follow the right ways to keep us safe from COVID-19, such as washing our hands with soap and wearing mask when go out.”
- **Information:** The second most common coping strategy was staying up to date with information on COVID-19 prevention and news on the spread of the virus. Information and news is obtained through mass media (e.g. television), government announcements, village authorities, and healthcare workers. For example, respondents have said that “we get information from doctors... and we always follow the news of this situation” and “we follow the situation of COVID-19 through the TV and from the village chief.”
- **Economic coping strategies:** Interviewees listed a range of economic coping strategies. The most common strategies were reducing expenditures. For example, one interviewee is “planning and reducing the amount of food we are consuming, reducing expenses, reducing the resources we are using, and reducing the amount of electricity we are using.” Another common coping mechanism was looking for other forms of work or income, for example, respondents have said: “our next goal is to make money by burning charcoal but eventually we will go back to our job because we can make more money from it,” “we have different talents so my husband will go out to hunt wild animals” and “some days I help my mom clean the guest house so we can make money and pay for daily food.” Other economic coping mechanisms mentioned by interviewees included spending their savings; consuming food that they are able to grow or gather themselves; selling belongings; taking out loans; saving dry food; and returning back to their home villages.
- **Gendered coping strategies:** Whilst most respondents spoke about women and men coping together (e.g. discussing together, making plans together, undertaking the same preventative measures), a few gender differences were raised. These differences mainly reflected gender roles, relations and norms, such as women being responsible for keeping the house clean and men ensuring that family members do not leave the house during lockdown; men obtaining information on COVID-19 and sharing this with their families; women taking care of children and teaching them about COVID-19 prevention; and men hunting animals and women harvesting vegetables for food.

To support the coping strategies of communities and individuals, interviewees mentioned a range of supportive measures (from local and national authorities) that would be useful. Whilst, in general, the provision of information and guidance on prevention was sufficient, interviewees raised the need to support the implementation of this guidance, particularly through the supply of items such as hand sanitiser and face masks. Respondents also wanted support to cope with financial pressures due to low or unemployment, as well as alternative employment opportunities. As one interviewee explained, “we need support from the government for the local community to be able to survive during the lockdown as we have no jobs.” Many interviewees also raised that support was needed to obtain sufficient food, medicine and other essential items, which have been difficult to obtain due to reduced financial resources, increased commodity prices or lockdown measures and travel restrictions. For example, respondents have stated that “we need support and contributions for basic needs (such as food) for poor families and those who cannot go out,” and “we need contributions towards essential products for the household as during lockdown people are not allowed to go out, some shops have increased the price of products, and some shops are closed so people do not know where to buy products.”

Conclusion and Recommendations

Laos has been able to avoid the worst health impacts thus far, with lower reported infection rates than many other countries in the region. However, the successful prevention strategy enacted by the Laos government, including a two-month lockdown and travel restrictions, has had significant economic and social impacts across the country.

The COVID-19 pandemic has both reinforced traditional **Gender Roles and Responsibilities** (e.g. in the division of paid and unpaid labour, such as increased domestic responsibilities and childcare for women) but also provided small opportunities for men and women to work together in the home and in responding to the pandemic (such as undertaking preventative measures).

Women’s Economic Empowerment has been affected by the pandemic due to economic downturns in the sectors which employ a large female workforce, including agriculture, tourism, garment factories and services. This threatens to further entrench the economic gender gap, in which women were already in a more economically precarious situation than men before the pandemic.

Whilst there has been some involvement of women in **Decision-Making** platforms for COVID-19, women’s role has remained primarily disseminating information and following guidance that is given, rather than developing and leading the response. Women’s decision-making within the home was also mixed, with some households sharing decision-making whilst, in others, the husband continuing to be the main decision maker. This can affect women’s abilities to manage contracting the virus and seeking healthcare, if needed.

There continue to be gender-related barriers in **Access to Resources and Services**, such as WASH, information, healthcare and food. In particular, women from rural areas, ethnic minority cultures, and lower socio-economic backgrounds had the most difficulties accessing resources and services.

Anecdotal evidence indicates that **Gender-Based Violence** has increased within households during the pandemic. However, lockdown measures (as well as social norms accepting some level of GBV and regarding it as a private matter) has made the detection of GBV difficult.

A range of **Coping Mechanisms** have been implemented, mainly around COVID-19 prevention and obtaining up-to-date information. The economic impact of the pandemic has also resulted in various economic coping strategies, such as reducing expenditures and finding alternative work. Gender differences in coping mechanisms can be observed which fall along traditional gender roles, responsibilities and norms.

Recommendations for COVID-19 Programming

1. Ensure COVID-19 prevention and response programming (short-term and long-term) draws on evidence-based gender and power analyses (such as this Rapid Gender Analysis), and is developed and implemented in a gender-sensitive manner that considers the impact on different genders and other vulnerable groups.

All response efforts to the COVID-19 pandemic, whether short-term assistance or longer-term programming, needs to be based on gender and power (GAP) analysis to ensure that efforts are inclusive of women, girls and other vulnerable groups, does not further entrench disadvantage, and mitigates gender-based risks. This RGA has found that the gendered dimensions of the COVID-19 pandemic in Laos can be nuanced, such the level of women's participation in the decision-making platforms on the COVID-19 response varying between provinces. This RGA has also found that the impact of the pandemic has been different not only based on gender, but also geography (urban/rural), ethnicity, age, disability, literacy, socio-economic background and other factors. To ensure that programming is effective, all COVID prevention and response efforts need to take into account the different impacts on diverse genders and other vulnerable groups. In addition, due to the rapidly changing nature of the pandemic, it is also important to continue to update this Rapid Gender Analysis (or other GAP analysis) to ensure that information remains current.

2. Address the economic impacts of the COVID-19 pandemic on diverse women and girls, including marginalised urban women, remote ethnic minority women, and return women migrants, particularly for those working in the sectors most affected by the pandemic.

The economic impact of the COVID-19 pandemic was the main concern raised consistently throughout the interviews conducted by CARE. The pandemic has particularly affected several sectors in which women predominately work, including agriculture, tourism, entertainment, services, healthcare (nursing), and garment factories. Compared to men, women are often in more economically precarious situations, including in lower paid sectors/positions and less stable forms of employment, and may have less economic decision-making abilities within the family. The economic impact of COVID may further entrench the economic inequality and disadvantage already faced by many women. COVID-19 programming efforts need to address both the short-term and long-term economic impact of the pandemic by taking a gender-sensitive or gender-transformative approach which builds women's economic empowerment and mitigates potential gender-based risks.

3. Support women's meaningful participation in decision making on the COVID-19 pandemic at all levels – national, provincial, community and within the family.

Gender norms and roles in Laos have impacted women's abilities to engage meaningfully in the COVID-19 response, from developing high-level national strategies, to participation in village meetings, and making decisions within the family on COVID prevention. Although the level of participation in decision-making varies across provinces and families, this RGA has found that women's role has largely centred around following guidance on COVID prevention and sharing information. Women need to be supported to meaningfully participate in decision-making platforms on the COVID-19 pandemic to ensure that women are represented and their needs are addressed. The active participation of women will also improve the effectiveness of COVID response strategies and plans by ensuring that they reach all members of the community.

4. Ensure that community awareness and health information reach all members of the community, including women, children, the elderly, persons with disabilities, ethnic minority communities and rural communities.

Government and healthcare workers should be encouraged to continue providing COVID-19 information in accessible formats, including translation into ethnic minority languages and pictorial communication materials, and to ensure that these become standard practice. All COVID-19 programming should design information materials and dissemination methods that reach all members of the community, taking into account the different accessibility of various sources of information (e.g. social media, internet, mass media, print) based on gender, age, literacy, language, location (urban/rural), disability, and socio-economic background, etc.

5. Ensure women and girls' access to healthcare services, both in relation to the COVID-19 pandemic and for ongoing healthcare needs, including sexual, reproductive, maternal, newborn and child health (SRMNCH) services.

The COVID-19 pandemic has placed additional stress on Laos' healthcare system and created further barriers to access, such as increased financial strain and fear of infection. The pandemic may also result in the diversion of resources away from essential services, such as sexual, reproductive and maternal healthcare, which is already in low supply. Responses to the COVID-19 pandemic need to advocate for the continued funding of SRMNCH services as essential services. COVID-19 programming also needs to address the barriers to accessing healthcare services that have been created or worsened by the pandemic, such to practical barriers (e.g. financial constraints, transportation, literacy/language), gender-based barriers (e.g. decision making within the family), and other barriers (e.g. low healthcare seeking behaviours, avoiding healthcare services due to fear of infection).

6. Strengthen services for GBV prevention and response in communities affected by COVID-19, consider different ways people can access services in isolation, and how cases of GBV can be detected.

The prevalence of gender-based violence is known to increase during times of crises and rates of increased GBV have been reported across numerous countries affected by COVID-19. This RGA has found that lockdown measures have made it difficult to detect cases of GBV in Laos, alongside social norms which tolerate certain forms of GBV. It is important that during the pandemic, services to prevent and response to GBV continue to operate and are adapted to be accessible to women and children in isolation. All those who may be required to support survivors of GBV (e.g. police, justice system, social services, healthcare workers) need to be adequately trained to respond in an effective, survivor-centred manner, including understanding how to respond under the restrictions imposed by COVID-19.

7. Ensure availability of sex, age, disability and ethnicity disaggregated data, including on differing rates of infection, economic impacts, social impacts, and incidences of gender-based violence.

All COVID-19 programming should collect data that is disaggregated by sex, age, disability and ethnicity. As COVID-19 does not only impact health, data should also be collected on impacts on paid and unpaid labour, decision-making, women's economic empowerment, access to essential services, and gender-based violence. This will enable the monitoring of key issues which will impact women, their families and their communities in the short-term and long-term, and enable the adaption of COVID prevention and response strategies to meet the needs of all members of the community.

Annex

Annex 1

Rapid Gender Analysis: Assessment Tools

Key Informant Interview – Non-Community Member COVID-19

NOTES to interviewer:

- Self-introduction and read full introduction for interview. Then seeking for verbal consent before start the interview.
- Ask permission for record and audio record, just in case you may miss recording
- Note taking the answers that response to the question guide
- Encourage to further digging out or probing for more interest information
- Summary the answers of each question, in bullet points is acceptable and type it up. If you interview for more than one person at the same target group, summarize their answers into just one answer sheet.
- Send your summary answer a day after you completed the interview

Introduction

1. Thank the participant(s) for the interview
2. Explain the objectives and expectations of the interview
3. Outline the amount of time interview will take
4. Obtain the informant's informed consent to record / write notes from the interview

Introduction for interviewer

Sabaidee and thank you for your time. My name is _____. I am working for CARE International in Lao PDR. CARE is conducting a Rapid Gender Analysis to learn more about the different impacts that COVID-19 may have on women, men, girls, boys, and other vulnerable groups such as garment factory workers and migrant workers who recently returned, focusing on Gender Based Violence, Sexual Reproductive Health, and women economic empowerment. The result of this assessment will inform humanitarian programming intervention and provide recommendations for organization on organizational preparedness for COVID-19, including policies and practice (e.g. Child safeguarding and Prevention of Sexual Exploitation and Abuse). Your contribution are really important and helping us to understand more about the situation and inform our programming. Your answers are kept in confident, no name or identification is appear in this report. I have some questions for this interview, this may take about 30 minutes.

Do you allow me to do the interview?

☐ Yes ☐ No

Interviewer Name:	
Date:	
Time:	From: To:
Geographic Location	

Method of interview e.g. ☐ phone call, ☐ App call ☐ face to face

Other Note: _____

A: personal information of key informant	
Question	Answer
1. Locality	Province: _____ district: _____ village: _____
2. Age	<input type="checkbox"/> under 18 year <input type="checkbox"/> 18-35 years <input type="checkbox"/> over 35 years
3. Gender	<input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Other: _____
4. Ethnic Group	<input type="checkbox"/> Akha <input type="checkbox"/> ThaiDam <input type="checkbox"/> Hmong <input type="checkbox"/> Khmu <input type="checkbox"/> Lanten <input type="checkbox"/> Lao-Lum <input type="checkbox"/> Lahou <input type="checkbox"/> Mouseu <input type="checkbox"/> Others: _____

5. Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> In a relationship not married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Other: _____
6. Role in the community	<input type="checkbox"/> village chief <input type="checkbox"/> LUW <input type="checkbox"/> village volunteer <input type="checkbox"/> Other: _____
7. Education level (if not complete secondary school, tick ✓ completed primary school)	<input type="checkbox"/> No schooling <input type="checkbox"/> Not yet completed primary school <input type="checkbox"/> Completed primary school <input type="checkbox"/> Completed Secondary school <input type="checkbox"/> Completed vocational training, college <input type="checkbox"/> Completed university or higher degree <input type="checkbox"/> Other: _____
8. Can you read and write, in your first language?	<input type="checkbox"/> No <input type="checkbox"/> Can read only <input type="checkbox"/> Can limited read and write <input type="checkbox"/> Can read and write
9. Specific situation of the individual	Disability status: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what difficulty do you have? _____ <input type="checkbox"/> return migrants workers <input type="checkbox"/> other: _____

B. Gender Roles and relations

10. Since COVID-19, what has there been a change for women and men are engaged in paid and unpaid work?

Probe: Have there been any economic, social, physical or psychological impacts of these changes?

On paid work (for examples, earning incomes, types of economic activity)

On unpaid work (household chores, social activity)

11. What new coping mechanisms are individuals / families adopting, to fulfill their roles and responsibilities? What are the difference between women and men?

12. In your observation, what are the family asset& resources during the COVI-19? Is it different before?

13. Who has access to and control over family resources and assets during the COVID-19 situation?

- ☐ Husband ☐ Wife ☐ Girls ☐ Boys ☐ Grandmother ☐ Grandparents
☐ Other relatives in the household

Can you explain more about the change?

Probe : you can ask about specific assets that are accessed and control by different people (for examples, motorbike might be only used by husband, but it changes now. Or wife is controlling the money during this time only.

To what extent economic empowerment is being affected in the family/community by the COVID-19? Are there different impact for men and women? Please explain

Note: please choose which is relevant to the interviewee

For Rural areas, ask about

Economic and income generation activities, livelihood and agriculture, savings and loans, migration

For urban areas (factory worker, services sector), ask about job security, alternative income generation, taking leave/quitting jobs/arrangements for child care, work hours, savings and loans , termination of contracts, work hours, other benefits

For return migrants: job security, alternative income generation, taking leave/quitting jobs/arrangements for child care, work hours, savings and loans

14. What are the coping strategy in economic opportunities- short term, mid-term , long –term ? how is it different between women and men ?

15. How are people/ adapting to follow COVID-19 prevention / health care seeking practices? Is it different between men and women

Note for interviewer: e.g. Wash hands frequently with soap and water; Maintain Social Distancing, at least 1.5-2 meters; If you have a fever, cough and difficulty breathing seek medical care early)

C: Access to Basic Services and information to COVID-19

16. Have there been changes in women, men, boys and girls safe access to services in the community since COVID-19?
(Prompt: specifically for health, WASH, SRHR and GBV services, clean water, equipment for COVID-19 prevention)

Groups		Health	Water, sanitation, hygiene	Sexual reproductive health	Maternal and child health	Mental health	GBV	others
Women (probe for: pregnant women, lactating mothers, unmarried women, single mothers..etc)								
Men (probe for single father, unmarried men)								
Adolescent	boys							
	girls							
children	boys							
	girls							
People with Disability	Women							
	Men							
Elderly	women							
	Men							
Others:								

17. If yes, can you describe why? (Prompt: use the following options as prompts; do not read out. For each reason given, please specify the service the respondent is referring too and the group it affects e.g. men, women, persons with disabilities etc)

- ☐ Priority is given to men
- ☐ No female staff providing services
- ☐ Lack of sufficient medicines at health facilities
- ☐ Girls/women not permitted to access services by their families
- ☐ Not safe for girls/women to travel to the service sites
- ☐ Locations of services are not convenient for girls/women
- ☐ The Government/Authorities have put in place quarantine and social isolation measures
- ☐ The service is not deemed an 'essential' service since COVID-19 and is therefore limited/restricted
- ☐ Fear/ loss of trust in the health system
- ☐ Loss (or fear of loss) of confidentiality when accessing services (e.g. due to greater/increasing restrictions on movement)
- ☐ Hours are not convenient for girls/women
- ☐ Other: _____

18. How (if at all) is COVID-19 impacting levels of stress, tension and anxiety levels of men and women, adolescent boys and girls, and children (boys and girls) in the community? Is this impacting certain group over others?

impacting certain group		Please describe the impacts
Women (probe for: pregnant women, lactating mothers, unmarried women, single mothers..etc)		
Men (probe for single father, unmarried men)		
Adolescent	boys	
	girls	
children	boys	
	girls	
People with disability	women	
	men	
Elderly	women	
	men	
Others:		

19. Is there safe access to mental health and psychosocial support services? And if so can everyone access them during the COVID-19 crisis? Please describe?

How do the **health workers** access to to mental health and psychosocial support services? If so, can everyone access them during the COVID-19 crisis? Please describe?

20. Do you have access to information about COVID-19?

IF YES, how do you normally get information about COVID-19,

- ☐ TV ☐ Smart phones/devices that connect internet
- ☐ Village Volunteers
- ☐ Radio ☐ Community loud speaker ☐ Village leader
- ☐ Health workers ☐ Project staff)
- ☐ Other:.....

The information that you receive via the means above (in no.22) is easy to understand?

- ☐ Yes.....
- ☐ No.....

Can you explain?

Probe: ask languages of the messages, graphics, easy to understand , or the messengers explain more?

.....

21. Are there groups of people who cannot access information through these forms of technology? (Prompt: e.g. men, women, adolescent girls/boys, children, single female parent HHs, elder and persons with disabilities)

22. Do women and men talk about and/or receive information about health differently? How about adolescent boys and girls? Has there been a change since COVID-19?
☐ Yes..... ☐ No.....

If yes, please share

23. Do women and men talk about and/or receive information about government policy, announcement? How about adolescent boys and girls? Has there been a change since COVID-19

Probe : ask for specific announcement on work/employment opportunities, tax issues, logistics

☐ Yes..... ☐ No.....

If yes, please share

24. Are there specific local beliefs and practices that impact how messages around COVID-19 are being received by the community? (prompt: for example influences from non-traditional health workers, religious leaders)

☐ Yes..... ☐ No.....

If yes, please describe

25. Has this impacted health-seeking behavior of men, women or specific groups? (Prompt. For example beliefs and practices related to marriage, family planning, pregnancy and birth, menstrual hygiene management, disposal of dead bodies, hand washing, water use and management). Are any of these harmful for women, men, girls or boys?

☐ Yes..... ☐ No.....

If yes, please describe

Decision-making, participation, and leadership

26. Who in the household makes/influences decisions on family/individual access to healthcare (including family planning and maternal health)

Probe: for what kind of decisions, and who make the final say?

List of decisions : general healthcare, sexual reproductive healthcare, family planning, maternal health, mental health

.....

Made decision by whom	What decision?
Wife (women)	
Husband (men)	
Together (wife & husband)	
Girls	
boys	
Grandparents	
Others.....	

27. Who in the household makes/influences decisions on family/individual plan for after the crisis ?
Probe for what kind of decisions, and who make the final say?

List of decisions : Usage of income, asset, getting loan, saving money, employment, types of work

Made decision by whom	What decision?
Wife (women)	
Husband (men)	
Together (wife & husband)	
Girls	
Boys	
Grand parent	
Others.....	

28. In what ways do women and girls participate in the decision-making platform in the community in regard to COVID-19 prevention and response?

Probe: information consultation, design, planning, implementation, evaluation, through which platforms (community meetings, informal gathering, telephone etc)

29. Are there challenges for women and girls to access information and participate into decision making regarding Covid-19 prevention and response activities.

Probe: literacy and language barriers, accessibility, domestic workload

30. What informal groups or networks were present in the community pre-crisis? Are these still active now? Are they (and how are they) adapting to different ways of interacting/communicating? (prompt: for example, women's groups, civil society groups, social movements).

31. Any suggestions for improvement that we should consider in terms of participation?

GBV and protection

32. Has there been an increase in safety and security concerns / incidents since the COVID-19? Do you feel comfortable describing what types of concerns or incidents and who is affected (men, women, boys, girls, specific groups, without giving personal details of anyone involved)? (Note for facilitator, not to be read out: e.g. violence in the home, sexual exploitation, violence at water points or health facilities etc.)

☐ Yes.....

☐ No.....

If yes, please describe

Who is affected?	What types of concerns?
Women	
Men	
Girls	
boys	
Elder	
People with disability	
Others.....	

33. Who can community members go to for help, when they have a safety concern or experience violence? (both individuals and services). Are these still accessible since COVID-19, e.g. with the restrictions on movement?

Who?	What concerns or violence experience?
Village chief	
Village LWU	
Lao front	
Health center	
Hospital	
Police	
Others.....	

34. Do you think the new coronavirus disease is increasing stigma against specific people? If yes, which group is being discriminated in your community because of the new coronavirus disease?

☐ Yes..... ☐ No.....

If yes, which group?

☐ Women ☐ Men ☐ Elderly ☐ Girls ☐ Boys ☐ disability ☐ others

35. What are the main rumours/beliefs, concerns, questions you hear in your community? (For facilitator: if asking this question it will be important to have up-to-date messaging to dispel myths and rumours, or to answer questions from the respondent).

.....

36. Do migrant workers (person from risk areas) arriving to your villages/ location were put in quarantine or isolation? Do they comply with that? Why? Who advise on this?

☐ Yes..... ☐ No.....

If yes, why and who advise on this?

Why	Who advise on this	Where for quarantine or isolation

37. Do you hear or know about increase of reporting of incidents, or increase in numbers of cases or stories about this? If yes, Please explain more

Probe: Gender based violence (domestic violence, sexual harassment and abuse) , sexual exploitation in exchange of services, human trafficking

.....

38. If there are women who needs help on accessing GBV services (reconciliation, police, place to stay, physical health care, psychological/mental health support) , how are they getting support ? what are the differences for each groups to access (women, men, girls, boys, elders)

.....

39. Are there increase in early marriages, child marriage in your community during the COVID-19? If yes, can you explain more? Or why do you think it happens?

.....

40. How can Government, NGOs support the community?

.....

41. Any suggestions, comments?

.....

THANK YOU!

Annex 2

Rapid Gender Analysis (RGA): Assessment Tools

Individual Story – COVID-19

Purpose: Understand the impact of the crisis from the perspective of an affected individual woman, man, boy or girl or from an individual from a vulnerable or at-risk group within the COVID-19 crisis.

Tool Notes: This tool uses story telling alongside semi-structured interview questions. It is important not to lead the story telling – the hope is that this tool will help to raise issues which may not have been anticipated in designing the assessment. There may be repetition between the information that comes up in the story and some of the interview questions, but ask the interview questions anyway. Remember to get informed consent from your interviewee and ask whether they wish to remain anonymous.

Note for the facilitator: It will be useful to have information regarding support services that you could provide to the responder following the interview

Introduction

1. Thank the participant(s) for the interview
2. Explain the objectives and expectations of the interview
3. Outline the amount of time interview will take
4. Obtain the informant's consent to record the interview

Introduction for interviewer

Sabaidee and thank you for your time. My name is _____. I am working for CARE International in Lao PDR. CARE is conducting a Rapid Gender Analysis to learn more about the different impacts that COVID-19 may have on women, men, girls, boys, and other vulnerable groups such as garment factory workers and migrant workers who recently returned, focusing on Gender Based Violence, Sexual Reproductive Health, Dignify Works, Inclusive Governance, and Education. The result of this assessment will inform humanitarian programming intervention and provide recommendations for organization on organizational preparedness for COVID-19, including policies and practice (e.g. Child safeguarding and Prevention of Sexual Exploitation and Abuse). Your contribution are really important and helping us to understand more about the situation and inform our programming. Your answers are kept in confident, no name or identification is appear in this report. I have some questions for this interview, this may take about 30 minutes.

Do you allow me to do the interview?

☐ Yes ☐ No

Interviewer Name:		
Date:		
Time:	From:	To:
Geographic Location		

Method of interview e.g. ☐ phone call, ☐ App call ☐ face to face

Other Note: _____

A: personal information of key informant	
Question	Answer
1. Locality	Province: _____ district: _____ village: _____
2. Age	<input type="checkbox"/> under 18 year <input type="checkbox"/> 18-35 years <input type="checkbox"/> over 35 years
3. Gender	<input type="checkbox"/> Man <input type="checkbox"/> Women <input type="checkbox"/> Other: _____
4. Ethnic Group	<input type="checkbox"/> Akha <input type="checkbox"/> ThaiDam <input type="checkbox"/> Hmong <input type="checkbox"/> Khmu <input type="checkbox"/> Lanten <input type="checkbox"/> Lao-Lum <input type="checkbox"/> Lahou <input type="checkbox"/> Mouseu <input type="checkbox"/> Others: _____
5. Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> In a relationship not married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Other: _____
6. Role in the community	<input type="checkbox"/> village chief <input type="checkbox"/> LUW <input type="checkbox"/> village volunteer <input type="checkbox"/> Other: _____
7. Education level (if not complete secondary school, tick ✓ completed primary school)	<input type="checkbox"/> No schooling <input type="checkbox"/> Not yet completed primary school <input type="checkbox"/> Completed primary school <input type="checkbox"/> Completed Secondary school <input type="checkbox"/> Completed vocational training, college <input type="checkbox"/> Completed university or higher degree <input type="checkbox"/> Other: _____
8. Can you read and write, in your first language?	<input type="checkbox"/> No <input type="checkbox"/> Can read only <input type="checkbox"/> Can limited read and write <input type="checkbox"/> Can read and write
9. Specific situation of the individual	Disability status: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what difficulty do you have? _____ <input type="checkbox"/> refugee/IDP <input type="checkbox"/> other: _____

B: Story of Change: Affected individual reflects on changes to gender roles since the crisis

Please ask the individual to tell the story, you can ask these questions as the interviewee is telling the story

- What changes have you experienced since the COVID-19 crisis?
 - Probe: How were things before the crisis, and how are they different? ○ Probe: What changes have you experienced specifically as a woman/man/boy/girl? Or being from a specific group (insert as relevant).

.....
- Of those changes, which is the most significant and why?
 - Probe: Why do these changes matter?

.....

Network Analysis: Coping mechanisms of an affected family or household

Who do you know that has been affected by COVID-19, both directly or indirectly? How have they been affected? (prompt: this can be social, economic, health-related impacts)

.....

- What resources are the family/household members relying on during this time? What are the different capacities and skills of each member of the family? How are these skills and capacities helping the family/household plan for, cope with and respond to COVID- 19?
.....
- How are different family/household members coping with COVID-19? Can you tell about your plan? Short, medium and long term?
.....
- Who is vulnerable within the context of COVID-19 and why? What are the different vulnerabilities of women, men, boys and girls? As well as different age groups and different groups of people? (e.g. pregnant women, persons with a disability or chronic health conditions)
.....
- How does the household make decisions? Who within the household decides about education, access to health services, household income, and movement outside the home? Who is consulted? Who is not consulted? How is this impacting women, men, boys and girls in the household since COVID-19?
.....

C: Needs and concerns

- What are your needs since the COVID-19 crisis happened?
.....
- What are the needs of other members of your family? (*Probe: What are the main needs of women and girls, of men and boys and other groups?*)
.....
- Do you have any specific concerns related to the crisis?
.....
- Do you have all the support you need to cope with COVID-19? What support is missing?
.....
- What suggestions do you have about how local or national leaders/authorities could better respond to your needs?
.....

Endnotes

- ¹ Worldometer (29 June 2020) 'COVID-19 Coronavirus Pandemic', <https://www.worldometers.info/coronavirus/>
- ² Worldometer (29 June 2020) 'COVID-19 Coronavirus Pandemic', <https://www.worldometers.info/coronavirus/>
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- ⁴ <https://www.tilleke.com/resources/laos-imposes-sweeping-covid-19-lockdown-measures>
- Laos Imposes Sweeping COVID-19 Lockdown Measures, March 30, 2020
- ⁵ <https://laotiantimes.com/2020/03/29/laos-to-enter-full-lockdown-starting-march-30/> Laos To Enter Lockdown Starting March 30
- ⁶ <https://laotiantimes.com/2020/05/15/laos-to-resume-domestic-flights-schools-other-restrictions-eased/> Laos to Resume Domestic Flights, Schools, Other Restrictions Eased, 15 May 2020
- ⁷ Results of Population and Housing Census 2015; https://lao.unfpa.org/sites/default/files/pub-pdf/PHC-ENG-FNAL-WEB_0.pdfhttps://theodora.com/wfbcurent/laos/laos_people.html
- ⁸ Results of Population and Housing Census 2015; https://lao.unfpa.org/sites/default/files/pub-pdf/PHC-ENG-FNAL-WEB_0.pdfhttps://theodora.com/wfbcurent/laos/laos_people.html, p.12 & 33
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- ¹⁰ GENDER AND ETHNICITY IN LAO PDR WITH A FOCUS ON THE TALIENG ETHNIC GROUP, ROBIN MAUNEY, CARE LAO PDR, APRIL 28, 2020, p.8
- ¹¹ Results of Population and Housing Census 2015; https://lao.unfpa.org/sites/default/files/pub-pdf/PHC-ENG-FNAL-WEB_0.pdfhttps://theodora.com/wfbcurent/laos/laos_people.html, p.12
- ¹² Results of Population and Housing Census 2015; https://lao.unfpa.org/sites/default/files/pub-pdf/PHC-ENG-FNAL-WEB_0.pdfhttps://theodora.com/wfbcurent/laos/laos_people.html, p. 12 & 13
- ¹³ IOM, UNESCO, UNDP, UNHabitat, Overview of Internal Migration in Lao PDR, <https://bangkok.unesco.org/sites/default/files/assets/article/Social%20and%20Human%20Sciences/publications/laos.pdf>, p.3
- ¹⁴ IOM, UNESCO, UNDP, UNHabitat, Overview of Internal Migration in Lao PDR, <https://bangkok.unesco.org/sites/default/files/assets/article/Social%20and%20Human%20Sciences/publications/laos.pdf>, p.3
- ¹⁵ Lao PDR Gender Profile 2018, Lao Women's Union, p.17
- ¹⁶ http://www.fao.org/gender-landrights-database/country-profiles/countries-list/customary-law/en/?country_iso3=LAO
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- ¹⁸ World Bank, *Toward Gender Equality in East Asia and the Pacific: A Companion of the World Development Report, 2012*, p.47 <http://documents.worldbank.org/curated/en/270511468246373406/pdf/734380PUB0Box30ward0gender0equality.pdf>
- ¹⁹ ADB Gender Assessment p.39
- ²⁰ ADB Gender Assessment, p.37
- ²¹ Gender and Power Analysis for Remote Ethnic Groups (REG), Suzie Albone, Women's Health Advisor, CARE International in Lao PDR, June 2011, p.10
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