

Tracking the Gender Impact of COVID-19: An Indicator Framework

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It is known that the coronavirus pandemic is not gender-blind; it affects men and women differently and may exacerbate gender inequalities. Yet our knowledge of the gender impact of COVID-19 — and the varied ways it directly and indirectly affects different demographic groups — is incomplete due to data gaps across economic, education, health, and social dimensions.

We also know that gender roles will help shape adaptive responses to the pandemic, but it is unclear whether we have the necessary granular information (on regions, sectors, coverage, and severity) to design effective, gender-informed mitigation and recovery policies. To better understand what data exist, and where there are key gaps, Data2X and Open Data Watch have launched a joint, ongoing review of the principal international databases to understand how well we can track the gender impacts of the coronavirus pandemic.

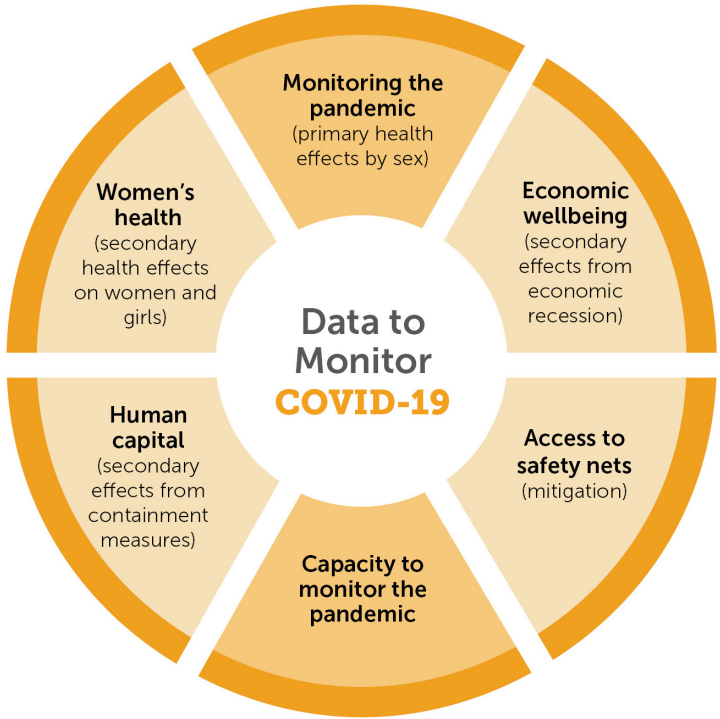
METHODOLOGY

We identified possible primary and secondary gender effects of the pandemic based on analyses of gender impacts of past pandemics and other aggregate shocks such as disasters, economic crises, and violent conflicts. The pandemic has primary effects on health and secondary effects on health, social, educational, and economic dimensions resulting from the containment measures implemented and the ensuing economic contraction across the globe. It is important to note that effects will vary with sex, age, and race, as well as other characteristics of socially excluded groups (Figure 1).

We selected 28 basic indicators to track the primary and secondary effects alongside mitigation and adaptive responses, and we searched the principal international databases maintained by the United Nations, WHO, ILO, UNESCO, UNICEF, and the World Bank for the availability of sex-disaggregated data by country.

These sources are highly standardized, and the available data generally conform to well-documented methodologies, making the data comparable across countries and

Figure 1: Indicators of COVID-19 impacts on gender measures



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over time. For most of the secondary effects, trends over time (before and after the pandemic) are needed to assess gender differentials, so we also assessed the frequency of years with data since 2015 to be able to compare the effects of the pandemic with “before” trends that are recent enough.

SUMMARY OF INITIAL FINDINGS

- 1 The data to track primary health effects by sex on cases and deaths is incomplete for the majority of the global population, non-existent for low-income countries, and unavailable for health care workers, except for a handful of countries. Even upper-middle and high-income countries such as Brazil and the United States have trouble reporting infection rates by sex (although they report deaths by sex).
- 2 The lack of recent data is a problem for most indicators to track secondary effects, as is the regularity with which they are reported since 2015.
- 3 There is adequate data to track secondary health effects on maternal health and adolescent births but inadequate data to document effects on [domestic violence](#) and the wellbeing of girls. The data on women’s mental health has adequate coverage and frequency but is based on estimates with large gaps in underlying data.
- 4 The economic indicators are less than adequate to track the secondary effects of the pandemic on economic wellbeing by gender. Neither job losses nor increases in unpaid care work by sex can be fully monitored with the available data. In contrast, sex-disaggregated education indicators are most abundant with available time series.
- 5 Indicators like social protection coverage, personal ID coverage, and mobile phone ownership, which can monitor whether short-term mitigation measures exacerbate pre-existing gender inequalities, have been incorporated only recently into international datasets and have low coverage. This is a significant data gap in need of immediate attention.
- 6 Gaps in frequency and timeliness for the majority of indicators we selected to track the gender effects of the pandemic are greater for rich than for poor countries, constraining rich countries’ abilities to monitor the effects of the pandemic on gender inequalities.

In the subsequent analysis, we delve into our findings in more detail.

Health

PRIMARY HEALTH EFFECTS

The primary effects of the pandemic are measured by infection rates and death rates for the general population and separately for health care workers — disaggregated by sex, age and other features of social exclusion.

- The data to track these primary health effects by sex are incomplete for most of the global population and unavailable for health care workers.⁴ There are complete data (with infection cases and deaths) for only 39 countries, representing 42.1 percent of the global population (Table 1). Another 33.8 percent are represented by data that show infections (cases) or deaths (but not both) for men and women.

⁴ Except for data from Global Health 50/50 for Germany, Italy, Spain and the USA

- There are no sex-disaggregated data on primary health effects for low-income countries, and upper-middle income and high-income countries, such as Brazil and the US, are particularly bad at reporting infection rates by sex (although they report deaths by sex).⁵
- The sex-disaggregated data that exist are also disaggregated by age for a quarter of infection cases and slightly more than half of all deaths. These data are not available by other group-based characteristics such as race or disability.

Table 1: Countries reporting COVID-19 data with sex-disaggregation

	Number of countries reporting	Share of global population (%)
Countries with sex-disaggregated data	39	42.1
Countries with partial disaggregation	28	33.8

Source: [Global Health 50/50 COVID-19 sex-disaggregated data tracker](#); authors' calculations

SECONDARY HEALTH EFFECTS

- 1 Reduced access to reproductive health care results from shifting resources to address the health emergency alongside an overall shrinking of health resources from the economic contraction. The consequences are unwanted pregnancies, increased maternal morbidity and mortality ([D. Evans 2020](#)), and negative impacts on child health ([Sabarwal et al 2010](#)). Adolescent girls and young women are particularly at risk, partly because of school closings that remove institutional protections, and because of more free time — often spent with men — which can lead to risky behaviors and the unwanted pregnancies mentioned above ([Bandiera et al 2018](#)).
- 2 A rise in intimate partner violence is a secondary consequence of health emergencies ([Peterman et al 2020](#)) and other shocks such as natural disasters and violent conflicts, partly resulting from the “stay at home” orders to contain the pandemic.
- 3 When exposed to traumatic events, women have a greater risk than men in developing post-traumatic and depressive symptoms ([Buvinic et al 2013](#)).

We identified nine indicators to track these possible secondary health effects — the majority of which have acceptable coverage and recent data, but five have only one observation since 2015.

Table 2: Women’s health: secondary (or indirect) health effects

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Adolescent birth rate (women aged 15-19 years)	220	9	2	2000	2018
Prevalence of anxiety disorders	195	28	3	1990	2017

⁵ See Table 7 below.

(Table 2 continued)

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Prevalence of anemia among pregnant women	187	17	2	2000	2016
Maternal mortality ratio	185	18	3	2000	2017
Proportion of women of reproductive age who have their need for family planning satisfied with modern methods	130	2	1	2000	2018
Proportion of ever-partnered women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months	107	1	1	2000	2017
Height-for-age <-2 SD (stunting)	110	3	1	2000	2018
Weight-for-height <-2 SD (wasting)	110	3	1	2000	2018
Proportion of mothers who had postnatal contact with a health provider within 2 days of delivery	91	1	1	2010	2018

- There is good country coverage and data frequency for adolescent births and both maternal morbidity (indicated by prevalence of anemia among pregnant women) and maternal mortality.
- Fewer countries (but still more than half of the countries in the world) have data on child nutritional status disaggregated by sex (indicating child health) and on women's access to modern contraception. But for these data, the frequency of observations would not allow for trend analysis — there is only one median observation per country since 2015.
- Slightly more than half the countries in the world have data on intimate partner violence, but there is only one median observation since 2015. In addition to these coverage and frequency constraints, the data required to track increases in this violence can suffer from underreporting, and reporting itself can become more difficult during health crises. Rapidly deployed surveys, using cell phones for instance, will be needed to check for underreporting and monitor urgent needs. Police reports and administrative data on support services may provide useful monitoring data if carefully evaluated.
- The two indicators to monitor child nutritional status by sex have moderate coverage (slightly more than half the world's countries) but only one observation after 2015, making it difficult to use these data to monitor the pandemic's secondary effects. This inadequacy is particularly serious since the economic contraction is causing increased poverty and food insecurity, and girls can be disproportionately affected in low-income countries and in societies where male children are more highly valued by families ([Sabarwal et al 2010](#)).
- The indicator of anxiety disorders provides a mental health measure. These data come from the highly modeled estimates produced by the [Institute of Health Metrics and Evaluation](#). As is true of the maternal mortality estimates, there are large gaps in the underlying data.
- Information on postnatal contact with a health provider for mothers as a way to detect changes in health of mothers and newborns is available for less than half of all countries. This can make it very difficult to track the effects on mothers and infants of food insecurity and lack of access to medicine that can accompany a shock like this.

Economic Wellbeing

Secondary economic effects of the pandemic are related to the severe global recession with massive job, asset, and income losses in all sectors and resulting increased poverty and food insecurity ([Daniel Gerszon et al 2020](#)).

Possible effects include:

- 1 Direct impacts on jobs and income losses in sex-segregated global and country labor markets will depend on the predominance of women or men in the different occupations that are affected. In high-income countries, where the pandemic has taken root first, job losses appear to be disproportionately affecting women's incomes (See, for example, [Gould et al 2020](#)). How direct job losses affect men and women differently in low- and middle-income countries should provide critical knowledge to design effective mitigation and recovery measures.
- 2 Adaptive responses to past economic shocks have included women from low-income groups increasing their participation in the workforce to help families weather the crisis, while women from richer families retreat from the workforce to take on unpaid housework and care work ([Sabarwal et al 2010](#)).
- 3 Women and young women everywhere share a higher burden of unpaid housework and care work. The unpaid care burden is likely to increase substantially with more sick family members to care for, more effort to purchase, produce, or process food, and children to care for more often during the day as result of school closures.

To assess the effects of the economic contraction differentially by gender, we identified five basic indicators of economic wellbeing and food insecurity. These indicators vary in their coverage, most recent observation, and frequency of observations. The food insecurity indicator has the best coverage and frequency of observations. Overall, however, these indicators are less than adequate to track the secondary effects of the pandemic on economic wellbeing by gender (Table 3).

Table 3: Economic wellbeing – secondary effects from economic recession by gender

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Prevalence of moderate or severe food insecurity in the adult population	74	3	3	2015	2017
Employed population below international poverty line, by sex and age	110	4	1	2000	2017
Informal Employment	76	3	2	1999	2019
Employment distribution by economic activity	172	28	4	1991	2018
Proportion of time spent on unpaid domestic chores and care work	91	1	1	2000	2018

- The employment by economic activity indicator has good coverage and frequency, and there are recent data to track job losses by sex. However, while there are recent data to track job losses by sex, we cannot fully monitor economic disruption and impacts on women

without more adequate data coverage on informal employment. Unfortunately, the informal employment indicator by sex has inadequate coverage (76 countries), significantly affecting the ability to track what is happening to women in low- and middle-income countries, the majority of whom are concentrated in low-paid, informal employment.

- Tracking women’s possible “added worker” effects in response to food insecurity and poverty first needs documentation of increased food insecurity which the indicator can do well (good coverage and frequency of observations) and increased poverty, which robust measures can only do at the household level. We selected a sex- and age-disaggregated indicator of the employed population below the poverty line, but this indicator has only moderate coverage and only one observation since 2015. Second, tracking needs to document changes in employment by sex and income levels since women’s responses to economic crises vary by income, which is only possible if the employment data are cross tabulated by income.
- Tracking increased unpaid work by women and girls as an adaptive response to the pandemic is difficult to do with the existing international indicator, since less than half of all countries have this information with only one median observation since 2015.

Human Capital

With school closures during crises, girls are more likely to become pregnant and report increases in unwanted sex ([Bandiera et al 2018](#)). Schooling investments in children may be affected by pre-existing gender inequalities, with impoverished families sending boys back to school first over girls, although gender differential effects on schooling have been nuanced and small in past economic crises ([Sabarwal et al 2010](#)).

The six sex-disaggregated schooling indicators we identified to track **secondary human capital effects** have good coverage, and both recent data and more than one yearly median observation for half of them (Table 4). A drawback of these data is that they are based on school enrollments or graduations, which are recorded once a year, and do not capture short term changes in attendance.

Table 4: Human capital – secondary effects from containment measures by gender

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Completion rate, lower secondary education	155	4	1	1996	2018
Completion rate, primary education	122	3	1	1996	2018
Completion rate, upper secondary education	155	4	1	1996	2018
Enrolment in primary education	224	37	3	1970	2019
Enrolment in secondary education	223	27	3	1970	2019
Graduates from tertiary education	211	12	3	1970	2019

- The school enrollment indicators have recent data with good coverage and frequent observations. The school completion indicators, essential for capturing the full extent of possible education effects, are less adequate since they have somewhat less coverage and not enough observations since 2015.

Tracking Mitigation Measures by Gender

Social protection and other short-term mitigation measures in response to health or economic crises can exacerbate gender inequalities ([Hidobro et al 2020](#)). To monitor that women as well as men benefit from the short-term mitigation measures that are being put in place, we identified three basic sex-disaggregated indicators. These indicators have been incorporated recently into international datasets and have low coverage (Table 5).

Table 5: Access to safety nets – mitigation

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Proportion of population covered by social protection floors/systems	94	1	1	2011	2019
Proportion of population with personal IDs by sex	30	1	1	2016	2016
Proportion of individuals who own a mobile telephone, by sex (%)	70	2	2	2013	2018

- The measure of social protection programs is based on country reports of a disparate set of programs, including maternity, unemployment, and disability cash benefits, and pension plans. Information on maternity benefits only begins in 2016.
- Coverage of the population with personal IDs and with mobile phones by sex, both instrumental to accessing emergency government cash transfers and digital financial services, is even more limited. This is a significant data gap in need of immediate attention.

Capacity to Monitor the Pandemic

To monitor a rapidly evolving public health crisis, countries must have in place reporting systems that receive and accurately compile data on new cases, deaths, recoveries, and preventative measures. We have already seen that gender-differentiated data on the COVID-19 pandemic are lacking for a large portion of the world's people.

In Table 6, we include two additional indicators. The registration of births is the first and fundamental element of a complete civil registration and vital statistics (CRVS) system. Registering all children is also important for ensuring that they are able to receive the social benefits, including health care, to which they are entitled.

Reporting on cause of death is the final step in a CRVS system. It provides important information about the incidence of disease, which is important for managing a current crisis and for retrospective studies. This indicator reports the proportion of deaths caused by communicable diseases and maternal, prenatal, and nutrition conditions as a share of all female deaths.

Table 6: Capacity to monitor the pandemic

	Countries or territories with data	Years of data (median)	Year with data since 2015 (median)	Earliest year	Latest year
Cause of death, by communicable diseases, ages 15-59	183	5	2	2000	2016
Proportion of children under 5 years of age whose births have been registered with a civil authority	177	1	1	2006	2019

- Cause of death information should come from CRVS systems, but, in practice, many countries still lack the capacity to report vital events and is supplemented by epidemiological models.
- Information on the registration of children is scattered and sparse and it is not available separately for boys and girls. This is a serious gap in an important SDG indicator.

Data availability for countries in different income groups

We have also explored the availability of our selected indicators according to the income level of countries using the World Bank country income groups.

Table 6 shows the coverage of the sex-disaggregated COVID-19 pandemic indicators provided by [Global Health 50/50 \(GH5050\)](#) with the aggregate measures available from [Our World in Data \(OWID\)](#). OWID publishes a comprehensive tabulation of COVID-19 cases and deaths (and some testing data) in 209 countries and territories that is updated daily. The data in Table 7 have been updated through May 20, 2020.

Table 7: Comparison of COVID-19 data reporting

	Total cases (OWID) (1,000s)	Total cases (GH5050) (1,000s)	Cases (GH5050/OWID) (%)	Total deaths (OWID) (1,000s)	Total deaths (GH5050) (1,000s)	Deaths (GH5050/OWID) (%)
Low income	25	-	-	1	-	-
Lower-middle income	299	134	44.8	9	5	50.1
Upper-middle income	1,295	337	26.1	53	21	39.1
High income	3,241	1,265	39.0	260	190	73.1
Total	4,861	1,736	35.7	323	215	66.7

Sources: [Our World in Data \(OWID\)](#); [Global Health 50/50 COVID-19 sex-disaggregated data tracker \(GH5050\)](#); authors' calculations

Approximately 36 percent of globally reported cases and 67 percent of deaths are available with sex-disaggregation. Although the numbers are much smaller, sex-disaggregation of cases is somewhat higher in lower-middle-income countries than in other income groups, while the proportion of deaths reported with sex-disaggregation is highest in high-income countries.

Table 8 provides a comparison of country coverage for the indicators of the secondary health, economic well-being, and human capital indicators by income level.

Table 8: Data availability by country income level

Proportion of countries with data in one or more years	Low income n=31	Lower- middle income n=47	Upper- middle income n=60	High income n=80
Enrolment in primary education	100.0	100.0	98.3	91.3
Enrolment in secondary education	96.8	100.0	98.3	91.3
Adolescent birth rate (per 1,000 women aged 15-19 years)	100.0	100.0	98.3	90.0
Graduates from tertiary education	93.5	95.7	93.3	90.0
Prevalence of anxiety disorders (%)	100.0	100.0	95.0	75.0
Prevalence of anemia among pregnant women	96.8	100.0	93.3	67.5
Cause of death, by communicable disease, ages 15-59	100.0	97.9	90.0	65.0
Maternal mortality ratio	100.0	100.0	90.0	66.3
Proportion of children under 5 years of age whose births have been registered with a civil authority	96.8	97.9	83.3	61.3
Employment distribution by economic activity	80.6	91.5	78.3	71.3
Completion rate, lower secondary education	93.5	89.4	73.3	50.0
Completion rate, upper secondary education	93.5	89.4	73.3	50.0
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	96.8	93.6	80.0	10.0
Completion rate, primary education	93.5	89.4	70.0	11.3
Height-for-age <-2 SD (stunting)	93.5	87.2	61.7	3.8
Weight-for-height <-2 SD (wasting)	93.5	87.2	61.7	3.8
Employed population below international poverty line	83.9	87.2	65.0	5.0
Proportion of ever-partnered women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months	64.5	70.2	38.3	37.5
Proportion of population covered by social protection floors/systems	16.1	51.1	38.3	52.5
Proportion of mothers who had postnatal contact with a health provider within 2 days of delivery	80.6	76.6	45.0	5.0
Proportion of time spent on unpaid domestic chores and care work	19.4	36.2	51.7	45.0
Informal Employment	54.8	61.7	43.3	5.0
Prevalence of moderate or severe food insecurity in the adult population	32.3	31.9	30.0	38.8
Proportion of individuals who own a mobile telephone	12.9	36.2	38.3	32.5
Proportion of population with personal IDs	22.6	23.4	20.0	0.0

Table 8 shows that country coverage is significantly greater in low- and lower-middle-income countries than in upper-middle-income countries and, especially, high-income countries for a majority of indicators across domains. This is true even for widely reported indicators, such as school enrollment rates by sex. The exceptions are the time spent on unpaid care work, food insecurity, social protection programs, and owning a mobile phone where coverage is better in high-income countries than in low-income countries. The better country coverage in low-income countries reflects the efforts of the international agencies to assist poor countries in collecting the data required first by the MDGs and then the SDGs. While upper-middle-income and high-income countries have significantly more data capacity, the gaps in frequency and timeliness remain and can constrain efforts to track the effects of the pandemic on gender inequalities in these countries.

Conclusion

Our initial analysis demonstrates that we have insufficient data to inform our understanding of the gendered implications of the pandemic and of the gender-informed approach needed for effective mitigation and recovery efforts.

This finding — that we have inadequate data on the gender impacts of COVID-19 — is not new, but we believe our analysis identifying the specific areas where internationally comparable data exist and are missing is a critical new contribution to the conversation on data, gender, and COVID-19. Our hope is that it will help stimulate efforts to fill data gaps and ensure communities have the resources they need to respond to COVID-19.

The next steps for this collaboration are to use the insights above to find solutions to COVID-19 gender data gaps. Stay tuned!

Appendix: Data Sources

Calculations of data availability were based on data downloaded from the SDG Global Database or, for non-SDG indicators, from the international agency responsible for compiling the indicator.

Indicator name	Source	URL
Employed population below international poverty line, by sex and age (%)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of population covered by social protection floors/systems, by sex	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Prevalence of moderate or severe food insecurity in the adult population (%)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Maternal mortality ratio	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (% of women aged 15-49 years)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Adolescent birth rate (per 1,000 women aged 15-19 years)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of ever-partnered women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months, by age (%)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of time spent on unpaid domestic chores and care work, by sex, age and location (%)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of individuals who own a mobile telephone, by sex (%)	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of children under 5 years of age whose births have been registered with a civil authority	SDG Global Database	https://unstats.un.org/sdgs/indicators/database/
Proportion of population with personal IDs by sex	World Bank ID4D Global Dataset	https://id4d.worldbank.org/global-dataset

Indicator name	Source	URL
Prevalence of anxiety disorders (%)	IHME Global Burdens of Disease 2017	http://ghdx.healthdata.org/gbd-2017
Employment distribution by economic activity (by sex)	International Labour Organization ILOSTAT	https://ilostat.ilo.org/topics/
Informal Employment by sex (as % of emp by sex)	International Labour Organization ILOSTAT	https://ilostat.ilo.org/topics/
Completion rate, lower secondary education, female (%)	UNESCO Institute for Statistics	http://uis.unesco.org/
Completion rate, primary education, female (%)	UNESCO Institute for Statistics	http://uis.unesco.org/
Completion rate, upper secondary education, female (%)	UNESCO Institute for Statistics	http://uis.unesco.org/
Enrolment in primary education, female (number)	UNESCO Institute for Statistics	http://uis.unesco.org/
Enrolment in secondary education, female (number)	UNESCO Institute for Statistics	http://uis.unesco.org/
Graduates from tertiary education, female (number)	UNESCO Institute for Statistics	http://uis.unesco.org/
Height-for-age <-2 SD (stunting)	UNICEF Malnutrition Data	https://data.unicef.org/resources/dataset/malnutrition-data/
Weight-for-height <-2 SD (wasting)	UNICEF Malnutrition Data	https://data.unicef.org/resources/dataset/malnutrition-data/
Prevalence of anemia among pregnant women (%)	World Health Organization Maternal, Newborn, Child & Adolescent Health Data Portal	https://www.who.int/data/maternal-newborn-child-adolescent/maternal-and-newborn-data/maternal-and-newborn---morbidity
Proportion of mothers who had postnatal contact with a health provider within 2 days of delivery	World Health Organization Maternal, Newborn, Child & Adolescent Health Data Portal	https://www.who.int/data/maternal-newborn-child-adolescent/indicator-explorer-new/mca/proportion-of-mothers-who-had-postnatal-contact-with-a-health-provider-within-2-days-of-delivery
Cause of death, by communicable disease, ages 15-59	World Bank Gender Data Portal	https://datatopics.worldbank.org/gender/indicators

Appendix: List of Covid Indicators and Categories

PRIMARY INDICATORS

Monitoring the pandemic (primary health effects)

- COVID-19 infection and death rates
- COVID-19 testing rates
- COVID infection and death rates for health workers

Capacity to monitor the pandemic

- Cause of death, by communicable disease, ages 15-59 by sex
- Proportion of children under 5 years of age whose births have been registered with a civil authority by sex

SECONDARY INDICATORS

Economic Wellbeing (secondary effects from economic recession)

- Employed population below international poverty line by sex
- Employment distribution by economic activity by sex
- Informal Employment by sex
- Prevalence of moderate or severe food insecurity in the adult population by sex
- Proportion of time spent on unpaid domestic chores and care work by sex

Human capital (secondary effects from containment measures)

- Completion rate, lower secondary education by sex
- Completion rate, primary education by sex
- Completion rate, upper secondary education by sex
- Enrolment in primary education by sex
- Enrolment in secondary education by sex
- Graduates from tertiary education by sex

Women's health (secondary health effects on women and girls)

- Adolescent birth rate (per 1,000 women aged 15-19 years)
- Height-for-age <-2 SD (stunting) by sex
- Maternal mortality ratio
- Prevalence of anemia among pregnant women
- Prevalence of anxiety disorders (%) by sex
- Proportion of ever-partnered women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months
- Proportion of mothers who had postnatal contact with a health provider within 2 days of delivery
- Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
- Weight-for-height <-2 SD (wasting) by sex

Access to safety nets (mitigation)

- Proportion of individuals who own a mobile telephone by sex
- Proportion of population covered by social protection floors/systems by sex
- Proportion of population with personal IDs by sex