# Gender and COVID-19 in Africa

Pandemics and their resultant effects are not gender blind and have the potential to exponentially magnify existing gender inequalities [1-4] and the plight of other vulnerable populations; such as those with disabilities, refugees, and internally displaced persons. This is especially the case for less-resourced countries where limited social protection measures are in place. The COVID-19 pandemic is no exception and has manifested itself in gendered ways, both in terms of the impact of the disease itself and the response to the pandemic. It is important to apply a gendered approach to pandemic response and preparedness to ensure effective and equitable policies and interventions [2,5].

## The gendered impact of the COVID-19 pandemic and physical distancing response measures

Current evidence suggests that men are at higher risk of dying from COVID-19 [4,6]. The reasons for this are still unclear but it has been posited to be either due to immunological sex differences or behavioral reasons e.g. that more men smoke [6]. Nonetheless, in all contexts, including Africa, women are likely to be hardest hit by the pandemic and its spill-over effects for the following reasons.

## Frontline Health Workers

Women make up a disproportionately high number of the frontline health workforce [3,7]. A 2019 analysis of 104 countries by the WHO showed that globally women make up 70% of frontline health workers in the health and social sector. Specifically, for the African region, women made up 65% of the nursing sector (but only 28% of physicians) [7]. Given the challenges that have been reported across African (and other) countries in relation to

protective personal equipment (PPE), it means that women are at an increased risk of exposure and infection in the line of duty. This subsequently puts their families at greater risk, or entails having to be separated from loved ones, including children, for extended periods of time to protect them. A recent survey undertaken in Kenya - Health Care Workers' COVID-19 Preparedness - highlighted psychosocial issues and challenges around balancing work and family life as being of importance to nurses during this period (unpublished).

## Unpaid Care Work

Even in 'normal' circumstances, women in African countries bear the burden of unpaid care work and domestic responsibilities. This is likely to be exacerbated during the COVID-19 pandemic - compounded by current school closures - due to gendered norms around caring responsibilities including care of children, the sick, and the elderly [1, 3, 8]. In addition to the physical and time-costs associated with this, caring roles put women at a higher risk of infection, as was observed in Ebola-affected countries in West Africa. These gendered roles also impact on girls' learning during the current period of school closures, as they are required to assist with caring and domestic responsibilities and subsequently have less time for home-schooling [8].

## School Closures

COVID-19 related school closures will disproportionately and adversely impact girls in Africa where girls already have lower school completion rates compared to boys [8]. Adolescent girls, in particular, face increased risk of physical and sexual abuse both from their peers and older men - sometimes resulting in unintended pregnancies - which in turn prevent girls from returning

to school post-pandemic [8]. In Sierra Leone for example, during the Ebola crisis, some communities reported a 65% increase in adolescent pregnancy, directly attributed to girls being away from the protective environment that schools provided [8].

## Domestic Violence

Across the globe, there has been an increase in reported cases of domestic violence due to pandemic restrictions (partial/total lockdowns, restricted movements, etc.) [1, 5, 9]. For example, according to a recent news report in Kenya where there are ongoing curfew restrictions and previous restricted movements, there has been a 33% increase in reported cases of gender-based violence (GBV). Implying an even higher number of cases as many go unreported. More disturbing is the heightened risk (and actual increase) of all forms of violence against children, particularly girls, including sexual violence by family members and others in the community as recently reported in one of the Kenyan dailies (Daily Nation Newspaper, 13th May 2020). In the Rift Valley region of Kenya, a non-profit NGO reported 40 cases of GBV in one month since COVID-19 restrictions were instituted, which was more than the number of cases that they dealt with in 2019 [9]. Similarly, in South Africa, a total of 2320 complaints of GBV were reported to police during the first week of a total lockdown [10]. This was 37% higher than the weekly average of GBV cases reported to police in 2019. This increase in cases is even more concerning in African settings where GBV support services are either very weak or non-existent, and affected individuals are cut off from their traditional support systems, such as extended family and friends, as a result of the movement restrictions. In Kenya

in the worst-case scenario, more than 50,000 mothers could die in the next six months alone [12]. The pandemic is also anticipated to disrupt efforts to end female genital mutilation which is still widely prevalent in certain parts of Africa [11].

## Recommendations to mitigate the negative gendered impacts of the COVID-19 pandemic and related physical distancing measures

Both short-term (immediate) and longer-term mitigation strategies will be required to ensure women are not disproportionately affected by the follow-on effects of the disease outbreak.

All healthcare workers require psychosocial support and other protection mechanisms, such as robust health insurance, to protect themselves and their families. Women in particular, require additional childcare support as they may be spending extended periods of time away from their families while battling the pandemic on the frontlines. This additional support could be in the form of extra allowances to enable them to hire additional domestic help (or compensate relatives who might be assisting with childcare). Furthermore, it is paramount that governments ensure sufficient personal protective equipment (PPE) is available to protect all frontline healthcare workers (who are predominantly women). This can be achieved by, for example, exploiting existing locally available capacity and resources, as has been observed in countries like Kenya where local textile factories are now bulk-producing (previously imported) PPE such as masks. Additionally, although healthcare is delivered by women, it is predominantly led by men (both globally and in African countries) [7, 13]. It is crucial that more women are involved in the policy and decision-making space (both now and in the longer term) as their perspectives and expertise are

for instance, although there is a national GBV helpline, there is only one state-funded shelter (countrywide) - launched in June 2020 in Makueni County - where survivors of violence can go to seek temporary protection.

### Economic Impact

Movement restrictions also have a disproportionately adverse economic impact on women who are over-represented in the informal economy such as small-scale trade in open-air markets and domestic paid work [1, 3, 5]. This increases their vulnerability to increased poverty, particularly for female-headed households, and in the context of minimal or absent social protection services. In contexts of already extreme poverty and economic vulnerabilities, this can result in forced early marriages where families marry off daughters in the hope of gaining economic and other protection, as was observed in Ebola affected countries such as Sierra Leone [8].

### Access to Health Services

Movement restrictions (and potential increased poverty) also impact on women's ability to access much needed gender-specific health services, such as those related to family

planning, maternity care, and sexual and reproductive health. The United Nations Population Fund (UNFPA), for example, estimates that this year alone tens of millions of women (including from low- and middle-income countries (LMICs)) will not be able to access modern contraceptives due to COVID-19 restrictions; in turn resulting in an estimated 1 million unintended pregnancies [11]. In Kenya's Rift Valley an NGO that provides mobile family planning services to women in the area stated that they have had to reduce their services by 40% due to the pandemic restrictions – this is an area where many women have up to eight children and survive on less than $1.50 a day [9]. During the Ebola crisis, it was reported that more women and girls died of obstetric complications than the infectious disease itself [5]. There have been anecdotal reports (e.g. in Kenya during curfew hours) of women experiencing emergency obstetric issues during the current pandemic restrictions, but not being able to get to health facilities in time due to lack of transport systems in the context of weak or absent ambulance and emergency services in some African countries. Early estimates on the indirect effects of COVID-19 on maternal mortality in LMICs suggest that

both empowering and could improve the public health emergency response, thus helping to save lives [13].

The leaders of African countries need to advocate for gender transformative norms that, for example, challenge the current inequitable division of domestic labour that curtail girls' and women's educational attainment and ability to engage in meaningful income-generating activities. This includes partnering with and investing in women's rights organisations [5] and raising awareness of the importance of both men and women contributing to childcare and domestic responsibilities [8]. There are exemplars that countries can learn from such as the achievements of Uganda's Raising Voices SASA! Project [14] – a groundbreaking community mobilisation approach that tackles both HIV prevention and violence against women by addressing the root causes of these inequities. In addition, and specific to GBV, governments must institute holistic multi-sectoral measures to tackle the issue and ensure coordinated, timely, and effective multi-agency responses that include: national toll-free helplines (with the required infrastructure to sustain these numbers), establishment of shelters and safehouses, specialised (free) emergency medical and police services. This would also include successful mental health, social, and legal services. Successful examples of this have been observed in Gujarat State of India [15] – also an LMIC. In the shorter term, boarding schools and hotels that are currently empty due to the COVID-19 restrictions, could be used as temporary shelters for GBV survivors (just as they are being used as quarantine centres in countries such as Kenya).

Given the gender-specific risks of school closures, education responses must prioritise the needs of girls, particularly adolescent girls. This requires a community approach that includes all necessary stakeholders, such as the youth (to ensure youth-friendly messaging), and leverage teachers and community members to raise awareness and sensitise communities to the need to protect girls and support them to continue with home learning. This could be achieved by: (1) not overburdening them with domestic responsibilities or asking them to leave studies to take up income-generating activities to support the family; (2) ensuring appropriate and flexible distance-learning options using digital media (such as radio and internet where available); and (3) teachers sending reading and writing materials home where digital methods are not an option [5,8]. In the context of Ebola, in countries such as Sierra Leone, villages that established 'girls clubs', i.e. safe spaces where girls could go to during school closures, reported that fewer girls experienced adverse effects and were more likely to continue their learning [8]. Special attention must also be paid to other vulnerable groups such as young boys from impoverished families who might drop out of school entirely to engage in income-generating activities, such as working in the public transport industry including motor-bike riding; or get caught up in drug and alcohol use.

There is also need for gender-responsive social protection measures to boost economic resilience and address loss of livelihoods, especially for vulnerable women [5]. This could include cash transfers and social safety nets to ensure immediate needs are met; and more long-term economic empowerment programs to shield women and girls from future shocks and safeguard against potentially negative coping measures, such as sex work [5]. Furthermore, even as focus and resources shift towards battling the pandemic, there is a need to prioritise ensuring uninterrupted access to a full spectrum of high-quality care for women and girls, including contraceptives, safe deliveries and both pre- and post- natal care; that includes adolescent-friendly messaging [5, 11]. This is particularly crucial considering that complications related to pregnancy and childbirth continue to be a leading cause of death in many African countries [5]. Innovative examples of public-private partnerships such as the 'Wheels for Life' in Kenya should be emulated to particularly vulnerable groups of women to ensure they receive required healthcare services even during COVID-19 restrictions. In this particular program, the Kenyan government partnered with a range of institutions including a private taxi service provider, which (in the absence of government ambulance services), provides free transport to hospital for pregnant women requiring obstetric care during the curfew hours.

In Africa and more broadly, the impact of COVID-19 and ensuing responses are not gender-blind with women and girls being disproportionately affected. They are impacted by virtue of being at the frontline of care both within the health system and in the domestic sphere; as a result of gendered societal norms and roles that place the burden of domestic responsibilities squarely in women's domain, with knock-on adverse effects such as curtailing girls' ability to access and/or continue with their education; by increased risk of violence and limiting of access to health services and economic opportunities. It is therefore crucial that governments and stakeholders apply a gender lens in their response to the pandemic factoring in both short- and long-term consequences of the disease and its response. Beyond this, there is need to advocate for gender-transformative change that addresses the root causes of some of the issues highlighted above and that would ensure sustainable gender-responsive systems that go beyond the current pandemic.

# References:

1. Wenham C., Smith J., & Morgan R., 2020, COVID-19: the gendered impacts of the outbreak, The Lancet. DOI: https://doi.org/10.1016/S0140-6736(20)30526-2

   Also available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30526-2/fulltext

2. Morgan R. & Davies S., 16 April 2020, How gender norms play out in the COVID-19 response, Advancing Learning and Innovation on Gender Norms (ALIGN). Available at: https://www.alignplatform.org/resources/how-gender-norms-play-out-covid-19-response

3. Evans, D. 16 Mar 2020, How Will COVID-19 affect women and girls in low- and middle-income countries? Centre for Global Development. Available at: https://www.cgdev.org/blog/how-will-covid-19-affect-women-and-girls-low-and-middle-income-countries

4. BMJ Global Health Blogs, 24 March 2020, Sex, gender and COVID-19: Disaggregated data and health disparities. Available at: https://blogs.bmj.com/bmjgh/2020/03/24/sex-gender-and-covid-19-disaggregated-data-and-health-disparities/

5. Save the Children, 6 April 2020, 8 ways to ensure gender equality is at the centre of responses to covid-19. Available at: https://www.savethechildren.net/blog/8-ways-ensure-gender-equality-centre-responses-covid-19#

6. Global Health 50/50: Towards gender equality in health, COVID-19 sex disaggregated data tracker – sex, gender and COVID-19. Available at: https://globalhealth5050.org/covid19/

7. Boniol M., McIsaac M., Xu L., et al., 2019, Gender equity in the health workforce: Analysis of 104 countries – Health force working paper 1, World Health Organisation. Available at: https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf

8. Plan International, 2020, COVID-19 school closures around the world will hit girls the hardest. Available at: https://plan-international.org/blog/2020/03/covid-19-school-closures-hit-girls-hardest

9. Dandelion Africa (https://dandelionafrica.org/) cited in: Ford L., 28 April 2020, The Guardian. Available at: https://www.theguardian.com/global-development/2020/apr/28/calamitous-domestic-violence-set-to-soar-by-20-during-global-lockdown-coronavirus

10. Mazibuko N., 2020, High COVID-19 GBV statistics are no surprise, University of South Africa – Institute for Gender Studies. Available at: https://www.unisa.ac.za/sites/corporate/default/Colleges/Human-Sciences/News-&-events/Articles/High-COVID%E2%80%9319-GBV-statistics-are-no-surprise

11. United Nations Population Fund (UNFPA), 2020, Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage. Available at: https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital

12. Roberton T., Carter E.D., Chou V., et al., 2020, Early estimates of the indirect effects of the Coronavirus pandemic on maternal and child mortality in low- and middle-income countries, The Lancet. Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3576549

13. Women in Global Health, Operation 50/50: Women's perspectives saves lives. Available at: https://www.womeningh.org/operation-50-50

14. Raising Voices – preventing violence against women and children. Available at: https://raisingvoices.org/sasa/

15. Newberry J., Mahadevan S., Gohil N., 2015, Using an emergency response infrastructure to help women who experience gender-based violence in Gujarat, India, Bulletin of the World Health Organization. Available at: https://www.who.int/bulletin/volumes/94/5/15-163741/en/

## Authors

Kui Muraya, Kemri-Wellcome Trust Research Programme, Kenya

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