

How has Kenya responded to the gendered impacts of COVID-19?



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Executive Summary

The COVID-19 pandemic has disproportionately impacted women and vulnerable groups, magnifying existing gender inequalities. To prevent inequalities from further widening, countries must urgently address and mitigate the gendered impacts of the pandemic. In this report, we outline the gendered impacts of the pandemic in Kenya, summarise measures taken by the Kenyan government to address these impacts, and offer recommendations to strengthen the pandemic response.

Our analysis of the gendered impacts of the pandemic comprises both primary and secondary impacts. Primary impacts refer to immediate, direct impacts of the pandemic, such as COVID-19 infections and deaths. Meanwhile, secondary impacts refer to longer-term social, economic, and non-COVID-19 health impacts. Through our analysis, which drew on government publications, academic journals, grey literature, and news articles, we found that:

- In Kenya, men comprised 56.4% of confirmed COVID-19 infections and 64.8% of COVID-19 deaths, as of 15 February 2022¹.
- There is no publicly available sex-disaggregated data on nationwide COVID-19 vaccinations and testing rates, nor on hospitalisations and intensive care unit admissions.
- Unvaccinated women were less likely to try to get a COVID-19 vaccine compared to unvaccinated men, even though vaccine acceptance is similar between both groups².
- Nationwide, two in three adults who lost all their income in 2020 were women, with the most affected category being women working in the informal economy and depending on daily wages³.
- The government's financial assistance for businesses, such as lower interest rates and tax relief, were targeted at the formal sector and thus did not benefit many women.
- Cash transfer programs barely reached those who needed them most. Only 5% of households in Nairobi's informal settlements received cash transfers in the first phase of the program between April and November 2020⁴.
- Over 50% of young women who were unable to meet their basic needs reported depressive symptoms⁵.
- Women disproportionately shouldered the increased care work resulting from school closures and taking care of the sick: 76% of women and only 24% of men helped to home school their children³.
- Nationally, adolescent secondary school girls were twice as likely to become pregnant and three times more likely to drop out of school because of school closure during lockdown⁶.
- Gender-based violence reported through the national helpline 1195 recorded a sharp increase of cases from 86 in February to 1,100 in June 2020⁷.
- Kenyan health care workers, the majority of whom are women, reported inadequate personal protective equipment and training on COVID-19 management, understaffing, long hours, burnout, deteriorated mental health, isolation from family, social stigma, lack of comprehensive medical cover, and inadequate risk allowance and compensation, among other grievances^{17-23,28,15}.
- Women are greatly underrepresented in COVID-19 leadership. For example, the National Emergency Response Committee on Coronavirus only included four women (19% of membership)¹⁶.



These findings reveal how women and vulnerable groups have borne the greatest brunt of the pandemic, highlighting the urgent need for a gender-responsive pandemic plan. To this end, we call on the Kenyan government to:

- Collect sex-disaggregated data on COVID-19 vaccinations, testing, hospitalisations, and intensive care unit admissions to enable better analysis of trends.
- Increase the transparency of cash transfer programs and tailor financial assistance programs to benefit the informal sector.
- Address women's increased caregiving burden during the pandemic by expanding childcare services and flexible work arrangements, as well as shifting gender norms around caregiving.
- Mandate and fund the implementation of the Interim Guidelines on Human Resource for Health during the COVID-19 response and provide mental health support to health care workers.
- Integrate mental health services into primary and community health care, and provide mental health coverage under the National Hospital Insurance Fund.
- Safeguard maternal and sexual and reproductive health services, and ensure that adolescent girls, in particular, have access to these services.
- Follow-through on the commitments in the national roadmap to advancing gender equality and ending all forms of gender-based violence and female genital mutilation by 2026.
- Ensure that children, especially girls, remain in school by addressing the gendered digital divide and burden of domestic work, and monitor the implementation of the National Guidelines for School Re-Entry in Early Learning and Basic Education, which outlines pregnant girls' right to continue their education.
- Increase gender representation within the National Emergency Response Committee on Coronavirus and other pandemic response bodies, and reduce barriers for women to get into leadership.



These measures would not only cushion women and vulnerable groups from the brunt of the pandemic, but also help build a more equitable society.

Gendered primary impacts of COVID-19

Infections and deaths

In Kenya, men are more likely to contract and die from COVID-19, compared to women. As of 15 February 2022, men comprised 56.4% of confirmed COVID-19 infections and 64.8% of COVID-19 deaths. Men with a confirmed COVID-19 diagnosis are about 42% more likely to die, compared to women with a confirmed COVID-19 diagnosis. Men above 60 years of age are at the greatest risk of dying from COVID-19, comprising about one-third of COVID-19 deaths¹. (Real-time data available here.)

Vaccinations

As of 14 February 2022, 14.8% of Kenyans have received at least one COVID-19 vaccine dose, while 12.8% have received at least two doses¹⁷ (Real-time data available here.) There are no publicly available sex-disaggregated data on nationwide vaccination rates in Kenya.

Vaccine acceptance is similar among unvaccinated men and women in Kenya, according to the Johns Hopkins Center for Communication Programs' COVID-19 Behavior Dashboard. The dashboard presents findings from a global survey conducted every two weeks from May 2021 to the present. The dashboard data shows that among respondents unvaccinated men in Kenya were as likely as unvaccinated women to say that they would definitely or probably get vaccinated (Figure 1)². Among Kenyan respondents, the top reasons for vaccine hesitancy included concerns about potential side effects and wanting to wait and see if the vaccines are safe². (Real-time data available here.)

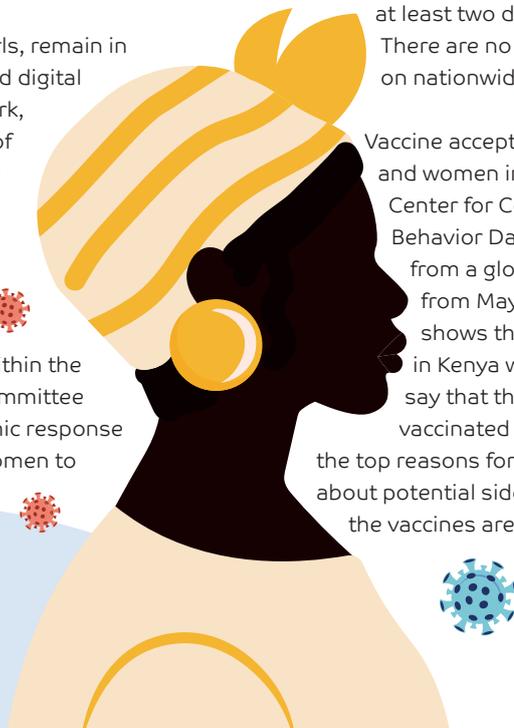
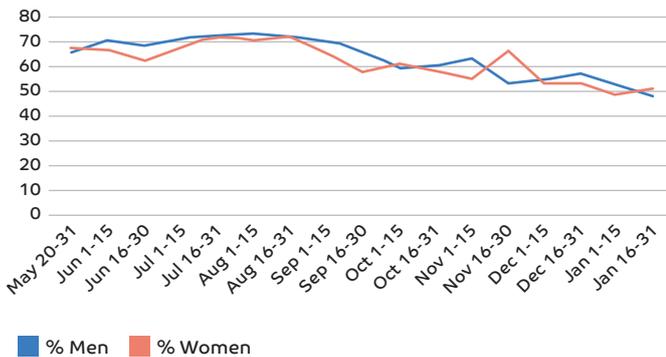


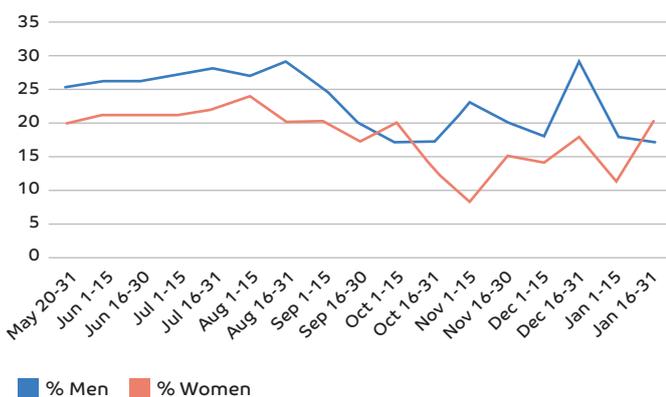
Figure 1. Percentage of unvaccinated men and women respondents who said they would definitely or probably get vaccinated (20 May 2021 - 31 Jan 2022)



Source: Johns Hopkins Center for Communication Programs' COVID-19 Behavior Dashboard

While vaccine acceptance was relatively similar among unvaccinated men and women, unvaccinated women were less likely to try to get a vaccine (Figure 2)². This suggests that structural barriers, rather than vaccine hesitancy, are likely driving the gender difference in vaccine seeking. The top structural barriers to getting a vaccine cited by respondents included difficulties traveling to vaccination sites, difficulties leaving work or school, lack of vaccine appointments, and the inability to obtain one's preferred vaccine type². (Real-time data available here.)

Figure 2. Percentage of men and women respondents who tried to get a vaccine (20 May 2021 - 31 Jan 2022)

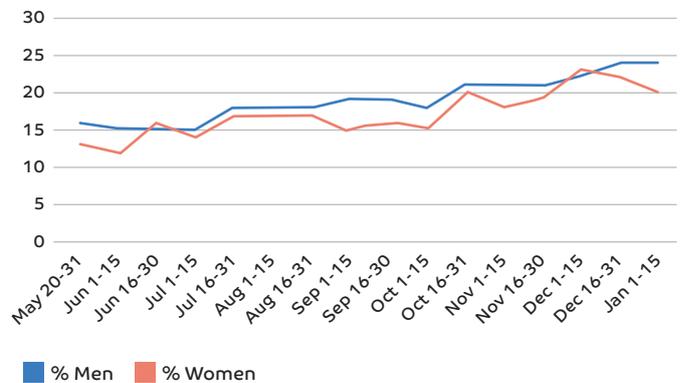


Source: Johns Hopkins Center for Communication Programs' COVID-19 Behavior Dashboard

Testing and treatments

There are no publicly available sex-disaggregated data on nationwide COVID-19 testing, hospitalisations, and intensive care unit admissions in Kenya. However, the COVID-19 Behavior Dashboard showed that respondents from Kenya who were men were marginally more likely to have tested for COVID-19 in the past two weeks, compared to women (Figure 3)².

Figure 3. Percentage of men and women respondents who tested for COVID-19 within the past 14 days (20 May 2021 - 31 Jan 2022)

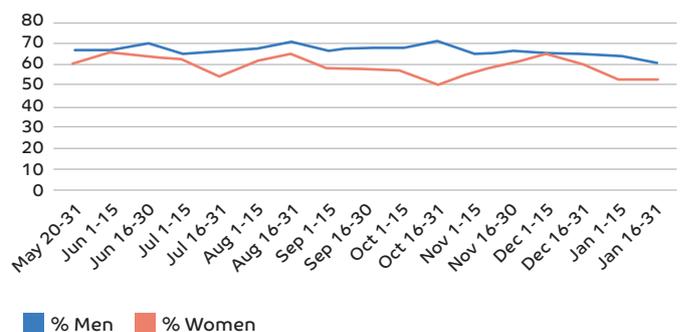


Source: Johns Hopkins Center for Communication Programs' COVID-19 Behavior Dashboard

Health information

Men also have greater access to information on COVID-19 compared to women. The COVID-19 Behavior Dashboard shows that male respondents in Kenya were more likely to be exposed to COVID-19 information from government health authorities, compared to women (Figure 4)².

Figure 4. Percentage of men and women respondents who were exposed to COVID-19 information from government health authorities (20 May 2021 - 31 Jan 2022)



Source: Johns Hopkins Center for Communication Programs' COVID-19 Behavior Dashboard



Risk perception and preventive behaviors

Women and girls are more likely to perceive the risk of COVID-19 compared to men and boys. In a survey of 1217 youth ages 16–26 in Nairobi from August to October 2020, 95.5% of women respondents who had not contracted COVID-19 reported being “very concerned or concerned” about contracting COVID-19, compared to 84.2% of men respondents¹⁸.

Mask wearing in Kenya is low, with men being marginally less likely to wear masks compared to women. In an observational study from August to September 2020 of 9533 people in the Ugunja sub-county, 9.2% of men were observed wearing face masks, compared to 12.1% of women¹⁹.

Recommendations

- Collect sex/gender and age-disaggregated data on COVID-19 vaccinations, testing, hospitalisations, and intensive care unit admissions to enable better analysis of trends.
- Address concerns around the potential side-effects of vaccines to increase vaccine acceptability.
- Improve the accessibility of vaccination sites by expanding transportation options and increasing the proximity of these sites.
- Encourage employers and education institutions to provide time-off for vaccinations.
- Run health promotion programs targeted at men to encourage preventive behaviors such as mask-wearing.
- Increase women’s access to COVID-19 information by disseminating information in multiple languages and various channels.

Gendered secondary impacts of COVID-19

This section highlights the secondary impacts of COVID-19 and covers the following focus areas: livelihood and social protection, unpaid care work, the health workforce, mental health, sexual and reproductive health, gender-based violence, education, and participation in decision making.

Livelihood and Social Protection

36% and 53% of Kenyans face monetary and multidimensional poverty, respectively, with women more likely to live in poverty²⁰. Most Kenyans who live on low incomes reside in rural areas, peri-urban areas, and informal settlements⁴. As many residents living in informal settlements depend on casual employment and daily wages, they were disproportionately impacted by partial lockdown measures. 86% of respondents of a survey, conducted in five informal settlements around Nairobi in May 2020, reported a total or partial loss of income due to COVID-19²¹. 54% of households in 10 informal settlements faced severe food insecurity and only 0.9% were food secure in July 2020²². Women experienced a higher prevalence of food insecurity than men³, with women who were divorced, widowed, or separated more likely to skip a meal than married women²³.

Nationally, the pandemic increased poverty by four percentage points, increasing the number of those experiencing poverty by 2 million²⁴. The unemployment rate tripled as about 30% of Kenyans who had wage employment in January 2020 lost their employment after restrictions²⁵. Wage workers experienced a reduction in work hours and wages, with women and those in informal employment experiencing greater declines²⁵.



Women represent 50.5% of Kenya’s population²⁶ but only 35.5% of wage employment²⁷. This reflects on gendered roles and barriers to economic engagement. Unpaid care work and domestic work, for instance, limits the amount of time spent on paid work. In informal settlements in Nairobi, men spend almost double the time that women spend on paid work but less than one-third of what women spend on any care work²⁸. 26% of women are not economically engaged compared to 15% of men in Mombasa²⁹. Women-headed households (30% of all households) have lower regular income compared to households headed by men³⁰.

A majority of women workers are employed in industries most vulnerable to disruption and that were impacted by COVID-19, particularly in the service sector²⁹. Women are more likely to be unemployed (64.5%), underemployed (61.8%), seasonal (60.1%), and part-time workers (61.9%)³⁰. In June 2020, workers across all industries reported working fewer hours, with greatest decreases in the education and activities of household as employers (undifferentiated goods- and services-producing activities of households) industries; these industries employ a majority of women workers³¹.

Many women not employed in the formal sector operate small- and medium-sized enterprises. Women-operated micro- and small- enterprises represent 47.4% of all such enterprises with women operating smaller enterprises than men³². Women enterprises hence tend to be more vulnerable to shocks to supply and demand chains. In 2020, women-owned enterprises experienced higher reductions in volume of supplies compared to men³³. The pandemic continues to disproportionately affect businesses that are small and women-owned and those that had a large share of women employees³⁴.

Nationally, two in three adults who lost all their incomes in 2020 were women, with the most affected category being women working in the informal economy and depending on daily wages³. One in ten women business owners could not continue with their business during the partial lockdown³. Since women's enterprises tend to be in retail or wholesale stores, restaurants, hairstyling, and laundry and home cleaning services^{33,32}, they are dependent on close contact with clients. When more than 60% of businesses in informal settlements were closed during the partial lockdown⁴, women were more likely to be disproportionately impacted.

A survey conducted in Mombasa in May 2020, following COVID-19 curfew and cessation of movement, revealed that only 11% of women in self-employment could work from home and none of the 28% of women in casual employment had this ability²⁹. Increased unpaid care work, including home schooling, placed new demands on women's time^{3,33,35}.

Multitasking, particularly with home schooling children, was cited as one of the biggest challenges of working from home, coming second after limited access to reliable and affordable internet²⁹. These challenges are likely to impact women disproportionately due to gender disparity in unpaid care work distribution and the digital divide.



Measures taken

- In responding to the economic impacts of the pandemic, the government adopted both fiscal and monetary policies. In March 2020, the following policies were announced by President Kenyatta³⁶:
 - 100% tax relief was offered for persons earning a gross monthly income of up to Ksh.24,000
 - Reduction of the Income Tax Rate (Pay-As-You-Earn) from 30% to 25%
 - Reduction of Resident Income Tax (Corporation Tax) from 30% to 25%
 - Reduction of the turnover tax rate from 3% to 1% for micro, small, and medium enterprises
 - Reduction of VAT from 16% to 14%
 - Ksh.10 billion to the elderly, orphans and other vulnerable members through cash transfers by the Ministry of Labour and Social Protection
 - Temporary suspension of the Credit Reference Bureaus listing of any person, micro, small, and medium enterprise or corporate entity whose loan account fall overdue or into arrears
 - Reduced rates by the Central Bank of Kenya to prompt commercial banks to lower their interest rates to borrowers
- The Central Bank of Kenya additionally directed banks to provide relief to borrowers on personal loans based on individual circumstances, and assess and restructure loans held by SMEs and corporate borrowers³⁷.
- In May 2020, President Kenyatta announced³⁸:
 - An investment of Ksh.10 billion towards a national hygiene program dubbed the Kazi Mtaani Initiative set to employ 200,000 youths nationally
 - Ksh.100 million set aside for Value Added Tax refunds
 - Ksh.3 billion for affordable credit for small and medium enterprises

- Some of the initial tax measures such as the reduction of top PAYE rate, corporate income tax rate and VAT, and suspension of listing of negative credit information for borrowers were reversed effective January 2021^{39,40}. Measures on loan restructuring and classification flexibility expired in March 2021³⁹. Tax relief to those earning a monthly income of Ksh.24,000 or less was maintained⁴⁰.
- The budget for FY2021/22 allocated Ksh.23.1 billion for an economic stimulus program to cushion vulnerable groups³⁹.

Many women and members of the most vulnerable groups were not reached by these initiatives. Lower base interest rates and tax relief largely favoured those in formal employment, not benefitting women entrepreneurs who have unsteady cash flow and those in informal employment³³. Businesses in informal settlements reported not to have benefitted from affordable credit to small and medium enterprises⁴. About 20% of firms received any public support by January 2021, with smaller businesses being less likely to receive assistance³⁴. Lack of awareness about assistance programs was the main reason for firms not receiving support³⁴.

Despite the cash-transfer program prioritising residents in informal settlements and most vulnerable households - such as where the breadwinner had a disability - only 5% of households in Nairobi's informal settlements received the support in the first phase of the program between April and November 2020⁴. Due to limited transparency, many people did not register for the support, those whose applications were unsuccessful did not receive any correspondence, and some who did receive the support noted irregularity on frequency and amount received⁴. In Wajir, less than 1% of 1,322 adult respondents reported receiving assistance from



any institution⁴¹. While the government promised a 50-50 gender balance in the Kazi Mtaani program participation⁴², the nature of the program's work including unclogging drainages, bush clearing, garbage collection and fumigation is typically dominated by men in Kenya, and hence the program likely attracted mostly male applicants.

Recommendations

- Increase transparency of the cash transfer programs, by increasing awareness of the program and eligibility criteria, and notifying those who apply and don't receive funding of the reason behind this decision.
- Tailor programs to benefit those in informal employment and micro-enterprises operating in informal market spaces; and increase awareness around benefits available to medium, small, and micro-businesses.
- Create a comprehensive and transparent system of social security in the long-term with an updated database targeting vulnerable groups that might have not been reached by conventional means.

Unpaid care work

Globally, women and girls undertake more than three-quarters of unpaid care work, representing almost 12.5 billion hours of unpaid work every day²². In Kenya, this division of labour is more pronounced in rural areas and informal settlements due to traditional social norms and gender roles²². Pre-pandemic, Kenyan women in informal settlements spent more than triple the amount of time as men on care work resulting in 'time poverty'. This reduced their opportunities to participate in "paid work, community and political life, education and self-care"²⁸. While both men and women experienced increased unpaid care and domestic work during the pandemic, women continued to do most of the unpaid care work²². Increased care work resulting from school closures and taking care of the sick was disproportionately shouldered by women: 76% of women and only 24% of men helped to home school their children³. Women were twice as likely to take on more childcare than men^{19,20}.

Measures

- The President issued a directive to encourage State Agencies to establish and implement frameworks for staff to work from home. State and Public Officers with pre-existing medical conditions and/or aged 58 years and above, servicing Jobs Group S and below or their equivalents, could take leave or work from home (Referencing circular issued to the Public Service on March 16, 2020)³⁶.

Recommendations

- Offer childcare services to essential workers, such as health care workers, in times of crisis.
- Establish longer-term working from home strategies and guidance that consider the unique needs of the home environment .
- Advocate for shifts in social norms around the division of labour at the household level to reduce the burden of unpaid care work on women.

Health workforce

Globally, women make up 70% of the healthcare workforce but only 25% of leadership roles⁴⁵. In Kenya, work in the health and social care sector is the only sector that employs more women than men at 55%²⁷. Women are more likely to occupy non-management positions which require direct contact with patients; 75.8% of nurses are women⁴⁶ while 62% of nursing faculty are men⁴⁷. The burden of women as caregivers extends to their occupations in the healthcare sector⁴⁸. Due to gendered occupational segregation in health training institutions, women are more likely to train in nursing, nutrition, and community health worker programs while men train in medicine and clinical officer programs⁴⁷.

Mirroring experiences of other health care workers globally⁴⁹⁻⁵³, Kenyan health care workers report inadequate personal protective equipment (PPE) and training on COVID-19 management, inadequate staffing, long hours, burnout, deteriorated mental health, isolation from family, social stigma, insufficient isolation and treatment facilities for health care workers who contract COVID-19, lack of comprehensive medical cover, and inadequate risk allowance and workman's compensation, among other grievances^{17-23,28,15}. Frustrations among health workers were exacerbated by delayed salaries and allegation of mismanagement of funds earmarked for COVID-19 response^{13,54-57,10,15}.

Health care workers have been vocal in raising their concerns including through industrial action. "Extremely difficult, draining, hazardous and injurious working environments" were attributed to COVID-19 related death among health workers in a strike notice by the Kenya Medical Practitioners, Pharmacists and Dentists Union in November 2020⁸. This sentiment was echoed by other union bodies representing health care workers^{13,56}. Infections among health care workers represented 4.1% of all cases in the country on 14 July 2020, with workers



at Pumwani Maternity Hospital, one of the largest maternity hospitals in the country, accounting for almost 10% of all cases among health care workers⁵⁸. Despite the lack of gender-disaggregated data, it is likely that women health care workers represented the majority of these cases. By November 2020, COVID-19 deaths among health care workers represented approximately 3% of all deaths in the country(8,59) despite them representing 0.03%⁶⁰ to 0.06%⁶¹ of the country's population.

Women healthcare workers faced the unique challenge of balancing increased caregiving for COVID-19 patients and at home, while trying to reduce the risk for their families. Studies reveal that women health care workers in Kenya experienced more burnout and worse mental health outcomes compared to men during the pandemic^{11,12}. Prevalence of self-medication among health care workers increased from 36.2% before the pandemic to 60.4% during the pandemic, primarily medicating headaches, migraines, fever, joint and muscle pains⁶². This increase represents prevalence trends among women health workers as workers who were men reported decreased self-medication⁶².

Measures taken

To address the shortage in the healthcare workforce, the President announced that Ksh.1 billion from the Universal Health Coverage budget would be directed towards the recruitment of additional health workers to support the management of COVID-19 in March 2020³⁶.

The Interim Guidelines on Human Resource for Health during COVID-19 Response published in May 2020 by the Ministry of Health offered some guidance to mitigate observed and anticipated impacts on health care workers.





Provisions in the guidelines include⁶³:

- Provision of adequate IPC and PPE supplies to workers caring for suspected or confirmed COVID-19 patients, such that workers do not incur expenses for occupational safety and health requirements.
- Training for health workers including COVID-19 care management, risk assessment and surveillance, use of PPE, infection prevention and control, community engagement.
- Arrangement of accommodation by facilities for staff involved in handling COVID-19 patients to avoid community spread.
- Maintenance of appropriate working hours with breaks.
- Right to compensation, rehabilitation, and curative services if infected with COVID-19 following exposure in the workplace, including through the provision of isolation and treatment facilities.
- Provision of mental health and counselling resources.
- Exemption from COVID-19 direct patient management duties to some health workers such as those with comorbidities, pregnant health workers, breastfeeding mothers with children under age one, and staff over 50 years old.

The Advisory on Occupational Safety and Health Measures for Healthcare Workers and other Frontline Workers Exposed to COVID-19 in Kenya (November 2020) reiterates the obligation of employers of health care workers under the Occupational Safety and Health Act in light of the increased number of deaths among health care workers.

Obligations include⁶⁴:

- Conducting occupational safety and health risk assessments and sending copies to the Director of Occupational Safety and Health Services.
- Developing, and communicating to all employees, a COVID-19 Preparedness Policy Statement including: prevention and mitigation measures against COVID-19, arrangements for dealing with suspected and confirmed COVID-19 infections, clear guidelines and requirements when healthcare workers with pre-existing conditions and those over age 58 are deployed without increasing exposure risk.

A summary of this statement is to be submitted to the Director of Occupational Safety and Health Services within 30 days from the date of advisory.

- Excluding healthcare workers who test positive for COVID-19 from service and return only after resolution of symptoms and testing negative in two consecutive tests.

These measures, however, had varied impacts. Additional staff deployed to counties as part of the Universal Health Coverage funding reported delayed salaries, contributing to industrial action by healthcare workers¹³. The Guidelines on Human Resource for Health during COVID-19 Response were not adhered to in some institutions: Some workers reported having to purchase PPE and incur the cost of COVID-19 treatment; among workers who died of COVID-19 were elderly, pregnant, and those with pre-existing conditions; and some workers were never considered for COVID-19 allowance^{13,65}. While the Guidelines were delivered as recommendations and not a policy mandate, the Advisory on Occupational Safety and Health Measures included legal obligations to employees. This, and industrial action health workers, likely contributed to comprehensive health insurance cover for COVID-19 treatment^{66,67}.

To address mental health challenges among health care workers, the Ministry of Health published a Comprehensive Guide on Mental Health and Psychosocial Support During the COVID-19 Pandemic in April 2020. This practical guide highlighted signs of mental unwellness, including burnout, and offered coping strategies such as getting sufficient rest and respite during work or between shifts, eating sufficient and healthy food, engaging in physical activity,

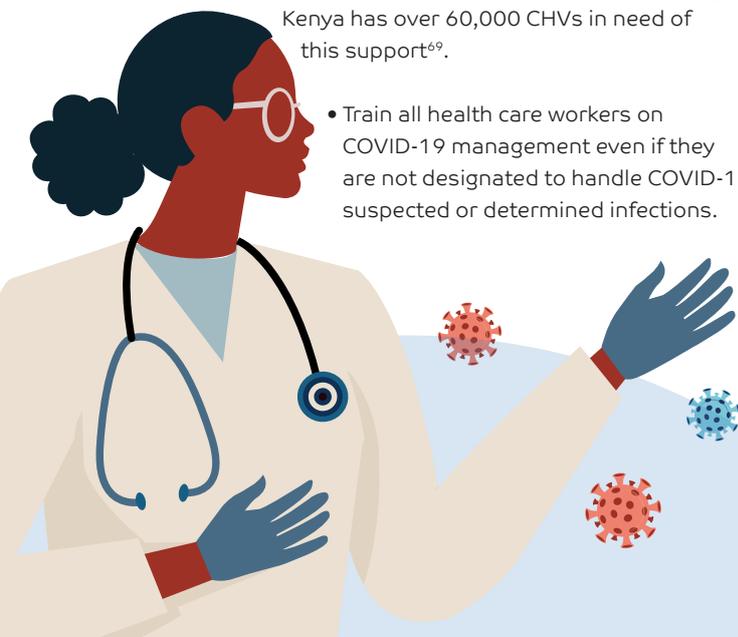


staying in contact with family and friends, avoiding the use of drugs to cope, and implementing a buddy system among health workers. Although providing practical guidance, the document places the coping burden on health workers and fails to share this burden with health facilities which would be well placed to also address some drivers⁶⁸.

Recommendations

- Guidelines such as the Interim Guidelines on Human Resource for Health during COVID-19 Response, should be a policy mandate and budgeted for, and not recommended guidelines.
- Provide clear mandates and guidelines to all health workers, including community health volunteers (CHVs). This should be preceded with, or accompanied by, transparent and thoughtful conversations around risks to reduce anxiety and misinformation while building trust.
- Frontline health workers should be effectively represented in decision-making circles with consideration of the gender gap in leadership opportunities.
- Provide formal and informal mental health support to health workers such as counselling, exercise, and meditation. Studies have shown a positive correlation between exercise and positive mental health outcomes among health care workers⁵⁰. Those in isolation wards present higher rates of psychological stress⁵⁰, hence the need for formal psychological support.
- In accordance with the Kenya Community Health Policy 2020-2030 and the Utilizing the Community Health Strategy to Respond to COVID-19, train and offer similar protections as health care workers, to community health volunteers (CHVs) who go into communities for reasons that might not be related to COVID-19 but are vulnerable to the pathogen; Kenya has over 60,000 CHVs in need of this support⁶⁹.

- Train all health care workers on COVID-19 management even if they are not designated to handle COVID-19 suspected or determined infections.



Mental health

Mental health in Kenya is underfunded at only 0.01% of total expenditure on health and lacks a separate budget allocation at the national and county levels⁷⁰. 75% of Kenyans don't have access to mental health care⁷⁰. Mental health is not integrated into primary and community health systems, and the one dedicated national referral mental health hospital is underfunded. Most Kenyans have to pay out-of-pocket to access related services because of a lack of insurance cover for mental health services. Health caregivers are not trained to recognise mental health challenges. For example, postpartum depression, affecting 18.7% of women attending maternal and child health clinics in Nairobi, goes untreated due to lack of training⁷⁰.

The mental health of women, healthcare workers, and youth was disproportionately impacted by COVID-19. As highlighted earlier, healthcare workers experienced a deterioration of their mental health in responding to the pandemic, with women health workers being more impacted^{11,12}. This gendered impact is reflected in the general public nationally - mental health decline was higher among women compared to men³. Separation from family and friends as a support and social network, for instance, was reported to be more challenging to women (32%) than men (14%)²⁹.

Among youth, one in four reported symptoms consistent with depression in November 2020, with the highest report among young women who were in formal economy prior to COVID-19 restrictions⁵. The economic impact of the pandemic and the inability to meet basic needs were important drivers. Over 50% of young women who were unable to meet their basic needs reported depressive symptoms⁵. Mental ill-health also took a toll on adolescents. Almost all adolescents reported feeling threatened or anxious when they think about Coronavirus, with half reporting depressive symptoms between June and August

2020⁷¹. Younger adolescents were worried about the virus while older adolescents were more concerned about the social and economic impacts of the pandemic⁷².

Increased mental health impact across the country was exacerbated by limited support due to measures that restricted social contact and the closure of community spaces and mental health facilities. To adhere to restrictive measures earlier in the pandemic, Mathari Mental Hospital halted its in-patient services and weekly clinic session earlier in the pandemic, and instead set up a hotline number to offer psychological support. It is estimated that these measures affected about 500,000 patients, placing the burden of care on many families^{73,74}. While mental health was later prioritised, the lack of a mental health surveillance system limited the ability to design evidence-based interventions⁷⁵.

Measures

- In April 2020, the Ministry of Health published a psychological first aid guide, which was used to train health care workers and the general public to mainstream mental health support in health care services⁷⁶.
- The Comprehensive Guide on Mental Health and Psychosocial Support During the COVID-19 Pandemic further offered guidance to health care workers on how to identify and assist those facing mental health challenges during the pandemic, including other healthcare workers⁶⁸.
- In May 2020, the Ministry of Health listed mental health services as an essential service and provided guidance on the provision of outpatient services, in its interim guidance on continuity of essential health services during the COVID-19 pandemic. However, inpatient services were not addressed⁷⁷.



- The Interim guidance on continuity of mental health services during the COVID-19 pandemic subsequently offered comprehensive guidance on provision of both inpatient and outpatient mental health support during the pandemic⁷⁸.
- The standard operative procedures for psychologists and counsellors was published to standardised delivery of mental health support during the pandemic⁷⁹.

Recommendations

- Update the Kenya Mental Health Policy 2015-2030 which provides a policy framework around funding, human resources, a mental health information system, and integration of mental health services and other health services⁸⁰.
- Develop a mental health surveillance system to allow for the development of evidence-based mental health priorities and policies.
- Integrate mental health care into basic medical or health care training, including training of Community Health Volunteers.
- Promote widespread awareness about mental health in the community to reduce stigma and increase uptake of services.
- Integrate diverse mental health services into primary and community health care services.
- Increase the budget for mental health, with specific allocations at both national and county level.
- Comprehensively cover mental health services under the National Hospital Insurance Fund (NHIF) on which most middle- and low-income households depend to access health care.

Sexual and reproductive health

COVID-19 policies impacted access and uptake of sexual and reproductive health services. Factors including fear of contracting the virus, deprioritisation of related health services, economic constraints, and the psychological effects of lockdown and curfew policies reduced access⁸¹. New hospital policies, for instance, restricted women seeking maternal health services entry to health facilities, some routine services such as growth monitoring were deprioritised; and accompaniment by friends and family was prohibited⁸¹.

In addressing urgent health care needs resulting from the pandemic, health resources including workers meant for

maternal health were reallocated to COVID-19 response efforts, with some maternity wards and facilities converted into COVID-19 isolation centres^{81,82}. Health facilities also faced shortages in medical supplies and equipment including contraceptives due to the disruption of production and delivery supply chains. In addition, restricted movement of pregnant women due to night curfews resulted in reduced hospital attendance, by up to 50% in Lamu County⁸². Fear of COVID-19 transmission and enforced quarantine following health care visits unrelated to COVID-19 resulted in women delaying maternal care and reduced access to family planning options^{83,84}. More women than men either resorted to self-medication or did not seek medical care at all for fear of contracting COVID-19⁹³. A national survey revealed that more than half of young women experienced disruptions in accessing menstrual hygiene products with cost as the primary barrier⁸⁴, contributing to financially transactional sexual relationships⁸⁵.

The sexual and reproductive health of refugee women, women living in informal settlements, adolescents, rural women, and women sex workers was disproportionately impacted. Home deliveries and underutilisation of facility-based reproductive, maternal, newborn and child health services, increased among urban refugee women. This was attributed to fear of contracting COVID-19, financial constraints, and lack of migrant-inclusive health system policies⁸⁶. In addition to fear of COVID-19 and financial constraints, women in informal settlements faced challenges around the deprioritisation of maternal health services and psychosocial effects of lockdown and curfew policies⁸¹. The unmet need for contraceptives among adolescent girls and rural women further increased⁸⁷, contributing to adolescent secondary schoolgirls being twice more likely to become pregnant^{6,88}. Adolescent girls in informal settlements did not seek needed health care, including sexual and reproductive health services; a situation that was likely worse for pregnant adolescents who typically face stigma when seeking maternal care⁸⁹.

Sexual and reproductive health services among women sex workers were impacted by a reduced supply of anti-retroviral therapy (ART), family planning options and pregnancy testing kits as well as nutritional packs for HIV positive sex workers⁹⁰. Due to stigma in government clinics, sex workers depended on outreach and community clinics which were impacted by the pandemic which further limited access to health care^{90,91}. Cessation of movement and the dusk-to-dawn curfew further limited the time sex workers had to access health care and peer support as they shifted to working during the day. In addition,



due to the consequent financial impact of the public health measures, sex workers resorted to risky behaviour such as engaging in unprotected sex to get higher pay at a time when they faced challenges adhering to pre-exposure prophylaxis (PrEPs) and post-exposure prophylaxis (PEPs)⁹⁰.

As of 2014, maternal mortality accounted for 14% of all deaths to women between 15 and 49 years old⁹². Limited access to sexual and reproductive health services and delayed intervention resulted in unplanned and risky pregnancies, still births, and maternal mortality due to unsafe abortion, infection, and postpartum haemorrhage still births^{83,93}. These outcomes threaten to increase the already high maternal mortality rates in the country.

Measures

- In July 2020, President Kenyatta directed registration of pregnant adolescents so that they can access free maternity health care⁹⁴. This promised to improve access to sexual and reproductive health for adolescents below the age of 18 through the Linda Mama free maternity care program.
- Innovative measures by government and non-profit organisations were initiated to improve access to services for pregnant women. For instance, in Kakamega County, local administrators facilitated the movement of pregnant women during curfew hours by linking them with motorbike taxis. In Nairobi County, the Wheels for Life Initiative by the Ministry of Health and partners offered free medical advice and transportation services during curfew hours, after calling a toll-free number⁹². Non-profit organisations also initiated peer-to-peer outreach support through cell phones and WhatsApp for sex workers⁹¹. These initiatives, however, were limited to urban areas.





- Community health workers/volunteers (CHVs) were engaged in the distribution of contraceptives. However, they were under-resourced. They received little training on COVID-19 transmission and prevention and were not equipped with PPE during home visits⁸².

Recommendations

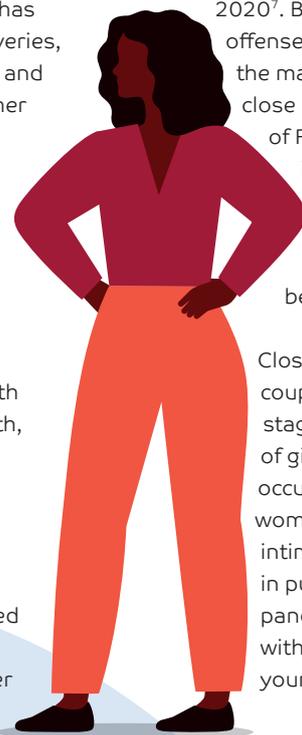
- CHVs should be trained to continue with services in times of crisis. They are well-positioned to reduce inequality in health care access between rural and urban residents and across income levels. Community health workers serve a large population of over 200 households who might otherwise not have had access to health services⁸².
- Research on the causes of maternal and neonatal mortality is needed even with the provision of free maternity hospitals. While the provision of free maternity health care has translated to an increased number of facility deliveries, it has not had an impact on the rates of maternal and neonatal mortality hence the need to address other factors contributing to these deaths⁹⁵.
- Strengthen existing community midwifery and informal community networks and establish midwifery centres closer to communities, especially in rural areas.
- Work with medical training centers, facilities, and health workers in removing stigma associated with young girls seeking sexual and reproductive health, including contraceptives.
- Increase access to quality education on sexual and reproductive health in schools.
- Maternity and SRH services and commodities need to be safeguarded even during pandemics and other crises as this is the area most likely to suffer due to service disruption.

Gender-based violence

Gender-based violence disproportionately impacts women and girls. In Kenya, over 15% of women aged 18 to 24 years experienced sexual violence in childhood, compared to 6.4% of men⁹⁶; and 14% of women and girls aged 15-49 years have ever experienced sexual violence compared to 6% of men and boys⁹². LVCT health data highlighted that 90.8% of the 4,944 cases of sexual violence reported in selected health facilities in 2014 involved women as survivors. While this indicates a disproportionate impact on women, it is also a reflection of underreporting among men: 44% of women and 27% of men report or seek assistance in cases of violence⁹². In domestic settings, 39% of ever-married women aged 15-49 report spousal physical and sexual violence compared to 9% of ever-married men⁹². Violence against girls is aggravated by female genital mutilation (FGM) and child marriage. By 2014, 21% of women aged 15 to 49 years survived FGM; and 7% of women aged 20 to 49 were married by age 15 compared to 0.2% of men and boys⁹².

COVID-19 exacerbated these trends of violence. The number of GBV cases reported to the police between January and June 2020 increased by 92.2% compared with cases reported between January and December 2019⁹⁷. 71% of victims were women with the main perpetrators being men in the family or intimate partners⁹⁷. In addition, gender-based violence reported through the national helpline 1195 recorded a sharp increase of cases from 86 in February to 1,100 in June 2020⁷. Between March 19 and April 2, 2020, sexual offenses constituted 35.8% of criminal offenses, with the majority of perpetrators being partners, guardians, close relatives, and those living with survivors⁹⁸. Cases of FGM and child marriage following school closure increased in some communities as monitoring and reporting mechanisms afforded by schools were non-existent^{99,100}. In West Pokot County, for instance, 500 cases of FGM were reported between March and June 2020⁹⁹.

Closures of schools and community safe spaces coupled with stay-at-home advisory in the early stages of the pandemic increased the vulnerability of girls and women. While violence against children occurred in private residences by people they knew, women experienced violence by strangers and intimate partners both in private residences and in public¹⁰¹. The socio-economic impacts of the pandemic were a driver by contributing to tensions within households^{10,23}, economic dependence among young women^{35,102}, and child marriage¹⁰⁰.



Those who survived GBV faced barriers to seeking support and redress. The number of SGBV survivors presenting at health facilities decreased earlier in the pandemic¹⁰³. On one hand, some GBV recovery centres in county and national referral hospitals were transformed to COVID-19 treatment and isolation centres, with other centres closing or reducing their capacity¹⁰³. On the other hand, survivors faced barriers to access such as fear of infection or being quarantined, increased cost of transportation, curfew, fear of police violence, childcare challenges, move to virtual counselling, closure of community-based programmes, and lack of awareness of available complaints and protective mechanisms^{102,104}.

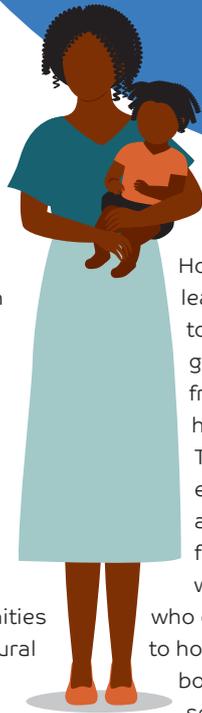
Only 31% of adult survivors reported receiving medical attention in a study engaging 80 SGBV survivors¹⁰¹. In another study engaging 26 survivors, none accessed comprehensive healthcare, including mental health services¹⁰⁴. Emergency measures and staff shortages also reduced the capacity of already understaffed and under-resourced shelters and safe houses mostly concentrated in urban areas^{101,104}. Reprioritisation of police efforts towards curfew enforcement coupled with closures and reduced capacity of courts compromised accountability for SGBV crimes^{101,103}. Survivors also reported corruption, violation of privacy, and aggravated trauma when seeking assistance from the police¹⁰⁴. One study found that only 50% of 80 participating adult survivors sought police services in the early stages of the pandemic¹⁰¹. Services such as counselling and judicial services moving online also created a barrier for marginalised women and girls¹⁰².

Measures

- Earlier on in the pandemic (March-May 2020), the 24hrs GBV national hotline 1195 was closed during the latter part of the day through the night because of a lack of clarity on whether non-medical tele-counsellors were essential workers as curfew was being actively enforced by police¹⁰⁴.
- Various GBV helplines were initiated by government and non-government actors - including by the National Police Service and the Office of the Director of Public Prosecutions. While these hotlines likely filled a service gap, they created potential confusion among survivors¹⁰⁴. Also, some survivors were unaware of the hotlines or other related support services¹⁰⁴.
- In May 2020, the Ministry of Health included services addressing SGBV among essential services in its interim guidelines on continuity of essential health services during the COVID-19 pandemic. However, no guidance was offered on how to adapt related services during the pandemic⁷⁷.



- In July 2020, President Kenyatta mandated the National Research Centre to investigate the rising numbers of SGBV, particularly its effects on girls, and for security measures to take remedial action, and immediate prosecution of suspected perpetrators¹⁰⁵. This call from the top leadership signalled the importance of prioritizing GBV.
- There was also a presidential directive for local administrators to register all pregnant school-going girls and collect information on the men responsible, with local administrators working with education institutions and healthcare institutions to monitor and report on teenage pregnancies. However, it is not clear if this information would be used for prosecution¹⁰⁴.
- In August 2020, the government announced the launch of Policare, a 24-hour one-stop shop to provide integrated services to GBV survivors, including children, at the county level. In October 2021, a corresponding policy was adopted. Having service providers such as police, health care workers, counsellors, prosecution, and judiciary providing technologically supported integrated services reduces transactional costs to victims and revictimisation (106)(107). By September 2021, two Policare centers were operational, in Nairobi and Makueni counties, and one was being set up in Laikipia county.
- In June 2021, the government adopted a national roadmap to advancing gender equality and ending all forms of gender-based violence and female genital mutilation by 2026. The roadmap highlights commitments to support GBV research, ratify the ILO Convention 190 and fund GBV initiatives, integrate services for survivors of violence into the Universal Health Coverage package by 2022 and establish GBV recovery and shelters in all counties by 2026¹⁰⁸.



- On the international front, Kenya is a co-head of the UN Women-led Generation Equality's Action Coalition to end gender-based violence hence offering an opportunity for Kenya to demonstrate leadership through action at the national level. Government response to GBV was reactive, hence the need for proactive programming moving forward.

Recommendations

- Follow-through on the commitments in the national roadmap to advancing gender equality and ending all forms of GBV and FGM by 2026, and include communities where prevalence is high such as counties where cultural beliefs still support FGM despite a legal ban.
- Increase awareness about existing services e.g., helplines, Policare centres, shelters using community-level networks such as community health workers, and phone text messaging.
- Explore alternative safe avenues for children and those at risk of GBV during emergencies, and prioritise GBV support services in times of emergencies.
- Support the implementation of pre-existing legal frameworks e.g., 2015 Protection Against Domestic Violence Act, 2019 National Policy on Abandonment of FGM.
- Update and integrate recent initiatives into the 2014 National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender Based Violence in Kenya.
- Prioritise GBV prevention and response during all emergencies.

Education

To curb the spread of COVID-19, the Ministry of Education announced the closure of educational facilities in March 2020, interrupting the education of about 18 million pre-primary, primary, and secondary students¹⁰⁹. The impact of these disruptions went beyond access to education, affecting the most vulnerable students. Beneficiaries of the government's sanitary towel program, mostly girls in upper primary schools; 1.6 million learners who rely on the National School Meals Program; and those who depended on school guidance and counselling programming for psycho-social support were all affected¹⁰⁹.

Households coped using home schooling and self-learning, with 24.6% and 17% of households unable to learn in May and June 2020, respectively^{110,31}. More girls than boys were unable to continue with learning from home³. Children in only 10% of households had access to their teachers during school closure²⁵. There were regional differences in the continuation of education. While 92% and 91% of adolescents in Kilifi and Kisumu counties, respectively, were able to learn from home^{111,112}, most adolescents in Wajir County were unable to learn from home¹¹³. For adolescents who continued with learning, 60% faced interference due to household chores, with girls (74%) more affected than boys (46%)⁸⁸. Over 50% of adolescents in informal settlements reported spending more time on household chores since COVID-19 by June 2020¹¹⁴. Nationally, more girls (18%) and boys (11%) spent most of their time helping with housework³. In Wajir County, girls were twice as likely as boys to cite household work as the reason for not engaging in learning¹¹³.

Working to earn a living affected education of 10% of adolescents, with boys slightly more affected (13%) than girls (9%)⁸⁸. With over 40% of the girls having a parent who had lost all income, girls aged 15-19 years reported searching for work or earning income putting them at risk of dropping out of school permanently¹¹⁴. Most girls who had begun menstruating faced difficulties accessing preferred hygiene products largely due to financial limitations¹¹⁴, contributing to financially transactional sexual relationships⁸⁵. Although most adolescents (89%) were confident that they would return to school when it reopened, girls were less optimistic than boys⁷². Girls were particularly concerned about the difficulty of paying school fees^{72,114}.





As has been extensively evidenced, dropping out of school among girls increases the risk of adolescent pregnancies and early marriage further curtailing access to education¹¹⁵. In Kenya, nearly one in every five girls and women aged 15 to 19 years is a mother or pregnant with their first child, with over 50% having either no education or an incomplete primary education⁹². In Homa Bay County, 70% of girls who drop out of school do so as a result of pregnancy, with only 10% of teenage mothers returning to school after delivery¹¹⁶. With this strong correlation between school attendance and teenage pregnancy, the pandemic impacted learning opportunities for girls.

Nationally, adolescent secondary schoolgirls were twice more likely to become pregnant and three times more likely to drop out of school because of school closure during lockdown⁶. Adolescents cited school closure, increased unsupervised time, peer pressure, limited access to family planning, and financial constraints as reasons for their pregnancies⁸⁸.

Measures

- Through the Kenya Global Partnership for Education (GPE) COVID-19 Learning Continuity in Basic Education Project, the Ministry of Education initiated educational programming through radio and television broadcastings as well as availed digital learning resources through the Kenya Education Cloud in March 2020^{109,117}. While this facilitated learning for many, only 47% of students were able to access education through these channels by May 2020¹¹⁸. A national survey revealed that none of the surveyed individuals in four counties- Lamu, Nandi, Taita Taveta, and Tana River- knew of the existence of these learning platforms during the same period¹¹⁹.
- Students who resided in areas outside the broadcast range or did not have the necessary equipment, internet, or skills did not benefit from these distance learning innovations; disproportionately impacting children in rural areas and

urban informal settlements and particularly girls^{118,120}.

A gender gap in digital access saw boys significantly more likely to use a computer or tablet for education than girls⁷². A majority of girls in informal settlements reported as the most common methods of learning, reading books not provided by schools (56.9 percent), using school-issued written materials (41.7 percent), and listening to lessons on the television or radio (29.2 percent)¹¹⁴.

- Updating previous guidelines on the continuation of education for teenage mothers, the government adopted the National Guidelines for School Re-Entry in Early Learning and Basic Education in April 2020. The 1994 guidelines have been criticised for being unclear and lacking resources for implementation resulting in inconsistent application^{121,122}. The new guidelines specify the right of a pregnant student to stay in school as long as possible; of an adolescent mother to go back to school following childbirth; and of adolescent mothers who become pregnant again to re-enter school as long as they are of schooling age¹²³.

Recommendations

- Consider the gendered digital divide and burden of unpaid work, particularly, among rural and informal settlement girls, in learning innovation during emergencies.
- Continue with the provision of menstrual hygiene products in cases where children are out of school. Expand the program as even with the return to school, some girls do not have access to such hygiene products⁸⁸.
- Monitor the implementation of the National Guidelines for School Re-Entry in Early Learning and Basic Education. Provide support with childcare, not relegating it to parents.
- Implement age-appropriate sexual and reproductive health education in schools.

Participation in decision-making

The National Emergency Response Committee on Coronavirus, established according to a Presidential executive order in February 2020 to provide leadership in the country's COVID-19 response, only included 4 women (19% of membership)¹⁶. The 15-member Interfaith Council on the National Response to the Coronavirus Pandemic mandated by the President to guide protocols around religious gatherings and activities only included one woman¹²⁴. This under-representation of women mirrors global trends where women make up only 24% of members among 225 COVID-19 task forces across 137 countries included in the COVID-19 Global Gender

Response Tracker analysis¹²⁵. Human resources policies that do not support work-life balance create barriers for women's progression to positions of leadership. Studies on the health sector indicate that perception of women as child-bearers and nurturers is a barrier to women's career progression⁴⁸. In the media, women's expert voices have been marginalised, limiting opportunities to shape the COVID-19 narrative and influence government responses; earlier in the pandemic, men were quoted nearly four times more frequently than women¹²⁶. The exclusion of the unique expertise, perspectives and lived experiences of women reinforce inequitable power structures and undermine an effective pandemic response¹⁶. The exclusion of the Ministry of Public Services and Gender from the National Emergency Response Committee earlier in the pandemic, for instance, is noted to have contributed to GBV services not being deemed essential and the lack of mention of GBV in the April 2020 Community Engagement Health Strategy^{102,104}. Gender inclusion has been notable in responses such as the Policare initiative which resulted from an idea brought forward by a woman Superintendent of Police who saw the need to streamline GBV services and reduce re-traumatisation of survivors¹⁰⁷.

Recommendations

- Increase gender representation within the National Emergency Response Committee on Coronavirus and other bodies appointment by the government to develop pandemic response policies.
- Implement the constitutional requirement of at least two-thirds gender representation in elective public bodies, and expand this provision to other leadership positions within national and county governments.
- Reduce barriers for women getting into leadership by implementing gender-sensitive human resources policies such as flexible, family-friendly working arrangements, and support gender-equitable development and distribution of leaders across all public sectors.
- In realising their role in shaping the narrative and influencing policy, the media should give equal voice to men and women expertise.

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