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Gender and COVID-19
Considerations for West and Central Africa Response

Evidence is only just emerging, mainly from Asia and the Pacific. Much of the data is skewed in the sense that there is more information on confirmed cases because not all countries test everyone and capture information about cases with no or mild symptoms. However, there seem to be **gender differences regarding infections and mortality rates**, and COVID-19 will have **gendered impacts on everyday life, and potentially longer-term impacts.**

Infections

So far, **infection rates seem to be similar**, and are likely affected by:

- Mobility
- Patterns of travel
- Patterns of social contact
- Frontline response
- Caring for sick and elderly at home
- Uptake of protective measures

These factors are likely to differ substantially between sexes and across countries and sub regions, urban and rural areas. Generally, in our region:

- Men are more mobile and more likely to travel further.
- In urban areas, women depend more on public transport than men.
- Globally 70% of frontline workers are women - but in our region many more men are community health workers than elsewhere, e.g. only 17 per cent women in Liberia and 40 per cent in Benin.
- Women and girls are usually caring for sick and elderly in the domestic sphere.
- Women are more likely to adopt non-pharmaceutical behaviour like handwashing, face masks, avoiding public transport than men.[i]
- Women have typically less access to information than men.

⇨ **Contextual gender analysis will help understand how to target our response.**

⇨ **Implications for what, how and to whom do we communicate regarding preventive measures.**

Mortality rates

So far, **male mortality rates seem to substantially higher than female**; e.g. China CDC (Centers for Disease Control and Prevention) fatality rates: 1.7% for women vs 2.8% for men.[ii]

It is assumed that this could relate to underlying health issues as "people with pre-existing illness are more likely to get seriously ill from Covid-19"[ibid] Statistics on death rates caused by e.g. cardiovascular disease, chronic obstructive pulmonary disease or diabetes mellitus in our region show that patterns between women and men differ across countries.

⇨ **Implications for what, how and to whom do we communicate regarding screening, help seeking and response.**

Pregnancy and Breastfeeding

As per 13 March 2020, WHO guidance: [iii]

- So far, no evidence of increased risk of severe illness or fetal compromise for pregnant women or on mother-to-child transmission when infection manifest in the third trimester
- one case with positive newborn reported
- **evidence** of increased severe maternal or neonatal outcomes **uncertain and limited to infection in the third trimester**
- some cases of premature rupture of membranes, fetal distress and preterm birth reported
- immunosuppressed may present with atypical symptoms – attention to pregnant mothers who are immunocompromised (e.g. HIV positive) might be advised

⇨ ***Current evidence on this issue is still building up.*** **Updated WHO guidance is shared here.**

Impact on everyday life and exacerbation of existing gender inequalities with long-term implications

Negative impact on women's economic empowerment: Crises pose a serious threat to women's engagement in economic activities, especially in informal sectors, and can increase gender gaps in livelihoods, as seen e.g. during the Ebola outbreak. **Lost income due to imposed quarantines, reduced travel to and closed businesses/markets will have significant and far reaching impact** can result in significantly negative consequences. Depending on sectors, this can affect men and women differently; e.g. women – who make up 70 percent of small-scale traders in Liberia - were more affected by domestic travel restrictions during the Ebola outbreak than men.[iv] Individuals in vulnerable employment in particular will have no safety nets or measures in place to soften the impact. Across countries in our region, **women are on average 18.5 percentage points more likely to be in vulnerable employment than men**.[v]

Increased burdens of unpaid care work. **Women and girls usually bear the main responsibility** for caring for family members and the elderly. This leads to **increased risk of infection** as seen during the Ebola crisis[vi] as well as another reduction in women's ability to participate to income generation. The latter will lead to **reduced decision-making power in households, communities and (local) governments**, which in turn reduces the chances that women's needs during this crisis are being voiced and met. In addition, being forced to stay at home has shown to lead to feelings of depression.[vii]

School closures will affect girls and boys from most disadvantaged backgrounds disproportionately. Experiences show that **more vulnerable boys and girls may not return to the education system**,[viii] which has negative long-term effects on their families and human capital contributions to their economies. School closures might also lead to spikes in **unplanned pregnancies** – analyses of school closures during Sierra Leone's Ebola outbreak showed an increase in adolescent pregnancies of between 10.7[ix] and 65 per cent[x], and **adolescent mothers are less likely to return to school**.[viii]

Interruption of routine health services affect women and girls disproportionately. This particularly applies to **HIV/AIDS continuity of care and sexual and reproductive health services, including pre- and post-natal health care**, clean and safe delivery services, complications in pregnancy, treatment of STIs (sexual transmitted infections) , clinical management of rape, and access to contraceptives. E.g. during the Ebola outbreak in Sierra Leone, a decrease in utilization of life-saving health services lead to an estimated "3600 additional maternal, neonatal and stillbirth deaths in the year 2014-15.[xi] **Resources might also be diverted from water, sanitation, and hygiene services**.[xii] Furthermore, disproportionate losses of health workers in affected areas could increase maternal mortality in the medium to longer term.[xiii]

Increasing gender-based violence (GBV) and protection risks. There is ample evidence that increasing **insecurity and tensions in the household as a result of crises place women and girls at heightened risk of domestic violence**. Increased domestic violence through COVID-19 specifically has already been reported e.g. in China.[xiv] Other forms of GBV such as **sexual exploitation and violence due to increased economic vulnerabilities and dependencies** are exacerbated too – as seen during the 2013-2016 Ebola outbreak in West Africa.[xv] Another concern, particularly in our region, is the **risk of increasing rates of child marriage** – also documented during the Ebola outbreak, e.g. in Sierra Leone and Liberia.[xvi]

Female headed households are at greater risk of poverty. This in turn relates to lower levels of consumption, lesser access to services and lesser access to adequate shelter, which **further exacerbate risks of illness**[xii] **and gender-based violence**. Up to 39 per cent of households were headed by women across the region, and the majority of those were lone parents with children under the age of 15.[xvii]

Building on learning and achievements over the last years, more gender-responsive systems will be a step further towards building back better, with stronger health systems and more favourable outcomes for women, families and children.

Recommendations to mainstream gender into the COVID-19 response – actions for organizations working on COVID-19[xviii]

Disaggregate data **related to the outbreak by sex, age, disability, socio-economic background and location.** Analyzing disaggregated data allows a better understanding of gendered differences in vulnerabilities, exposure and treatment and thus to better design differential preventive measures.

Conduct gender analysis to inform country strategic plans for preparedness and response, taking into account gendered roles, responsibilities, and dynamics.

Measure the impact. Understanding which population groups are experiencing the greatest hardships and which industries are failing is essential to providing assistance.

During the Ebola epidemic 2014-2015, phone surveys were used in Sierra Leone and Liberia to gather real-time information on the impacts of ill health and behaviour on households and business.[viii]

Communicate risks, prevention and response approaches clearly to women and men in age-appropriate and accessible ways to ensure that information about prevention and response can be received and understood.

Expand meaningful participation, leadership and decision-making of women and girls in planning and response, including women frontline workers in health and other sectors that can inform and improve health security surveillance, detection, and prevention mechanisms against the COVID-19 outbreak. Women's networks and youth groups can be important partners in communication, planning and response.

Target all groups with gender-sensitive and age-appropriate services, taking into account disability, education, and socio-economic status, as well as local infrastructure. Provide support to frontline workers: technically, emotionally and with enough resources to provide quality care.

Pay particular attention to adolescent girls **as one of the most vulnerable group.** Particularly vulnerable to lacking access to services, early pregnancies, school dropouts, child marriage and other forms of gender-based violence before the outbreak, these risks are likely to increase further.

Contain and expand mitigation measures to take account of and address the burden of unpaid care work to women and girls. It leaves them at higher risk of infection, reduces their ability to contribute to income generation and thus decision-making power, and increases their risk of poverty and GBV. Attention needs to be paid to single-mother, and multi-generational household structures which are very prevalent in our region. In the medium to longer-term, governments and private sector should be supported to provide childcare and put in place family-friendly policies.

Expect increased gender-based violence risks **and respond in all communication, service provision, containment and mitigation measures.** Health workers must have basic skills to respond to disclosures of GBV in a compassionate and non-judgmental manner and know whom to make referrals to for further care. GBV referral pathways should be updated where they deviate from before the outbreak. First responders should receive psychosocial support. **Psychosocial support should also be available for GBV survivors.**

Continued access to good-quality sexual and reproductive health services, including pre- and post-natal healthcare, as well as HIV/AIDS response and prevention services should be a priority together with COVID-19 response and prevention.

Psychosocial support should be provided to all who may be affected by the outbreak **- women and girls, men and boys.** Being affected – even indirectly - by an outbreak of an infectious disease can be traumatic. This will help reduce trauma for women and girls who are also at greater risk of GBV, as well as reduce risk of outbreak-induced domestic conflict which is the biggest source of violence against women and children.

Strengthen the safety net for the most vulnerable households, **e.g. through cash transfer, and develop targeted women's economic empowerment strategies**, to mitigate the impact of the outbreak and its containment measures including supporting them to recover and build resilience for future shocks.

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[v] Based on ILO estimates, unweighted average, 2018
[vi] https://www.graphic.com.gh/international/international-news/why-more-women-than-men-are-dying-in-the-ebola-outbreak.html
[vii] As seen in currently in South Korea: https://www.bbc.com/news/world-asia-51705199
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