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ECOSOCC RESEARCH STUDY

Assessing the Impact of Covid-19 Response Measures on Women and Girls in Africa

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List of Abreviations

APSP	Africa Platform for Social Protection
AU	African Union
COVID-19	Corona virus disease
CSG	Child Support Grant
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
ECOSOCC	Economic, Social and Cultural Council
ECD	Early Childhood Development
ESA	East and Southern Africa
EU	European Union
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender Based Violence
GDP	Gross Domestic Product
GGRT	Global Gender Response Tracker
HFPS	High Frequency Phone Survey
ILO	International Labour Organization
IPA	Innovations for Poverty Action
IPV	Intimate Partner Violence
LSMS	Living Standards Measurement Survey
MDB	Multilateral Development Bank
MS	Member States
OECD	Organisation for Economic Co-operation and Development
PWD	Persons with Disablities
RGA	Rapid Gender Assessment
SOP	Standard Operating Procedures
SP	Social Protection
SSA	Sub Saharan Africa
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UPE	Universal Primary Education
VAW	Violence Against Women
WASH	Water, Sanitation and Hygiene

Definition of Key Terms

Social protection:

This study adopts the World Bank's definition of social protection that encompasses three aspects of social assistance, social insurance, and labour market interventions[1]. Social assistance programmes have included conditional and unconditional cash transfers, public works, in-kind support, and utility support for social assistance. Social Insurance schemes take the form of paid sick leave, health insurance, social security subsidies/waivers and unemployment benefits. Finally, labour market interventions are classified as either wage subsidies, labour regulation adjustments and shorter work time benefits.

Gender Response Policy Measures:

Gender Response Policy measures are classified as gender-sensitive if: (i) they address violence against women and girls in the COVID-19 context; or (ii) the social protection, labour market, economic and fiscal measures taken in response to COVID-19 target women's economic security, address unpaid care, or provide support to female-dominated sectors of the economy[2].

Gender-Based Violence (GBV):

Gender-Based violence are acts that that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life[3]. These acts can endanger the victim, and may intend to coerce her or any other person related to her to meet any unlawful demand for valuable security.

Unpaid Care Work:

Unpaid care work refers to all unpaid services provided within a household for its members, including care of persons, housework and voluntary community work[4]. These include all unremunerated domestic activities that include childcare, elderly care, cleaning and cooking, as well as collecting water and firewood.

1 Gentilini, U., M. Almenfi., J.Blomquist et al. (2021) "Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures". Living database, version 15.

2 UNDP-UN Women (2021) COVID-19 Global Gender Response Tracker.

3 United Nations (1993) Declaration on the Elimination of Violence against Women: General Assembly resolution 48/104 of 20 December 1993.

4 Elson, D (2000). "Progress of the World's Women 2000", UNIFEM Biennial Report, United Nations Development Fund for Women, New York.

1. Introduction

COVID-19 has had substantial impact on the African continent. By March 2022, over 11.6 million persons from 54 AU Member States had tested positive for the disease, and more than 250,000 had died[5]. Beyond the direct health impacts of morbidity and mortality, the COVID-19 pandemic has affected Africans due to the containment measures adopted to halt the disease's spread. Governments on the continent introduced drastic measures to prevent the virus's spread, ultimately restricting economic activity because of reduced physical interactions. The containment measures adopted included state-level lockdowns in Nigeria, a ban on motorised travel except for cargo (Uganda), dusk to dawn curfews (Democratic Republic of Congo), quarantines (South Africa), social distancing (Egypt), and school closures (implemented in some form in 53 AU member states). In some Member States, actions only entailed partial lockdowns—targeting specific geographical areas—especially urban areas (Ghana). Other countries required a combination including quarantine measures, social distancing and the mandatory wearing masks (Kenya and Malawi). Overall, the adoption of COVID-19 standard operating procedures (SOPs) reduced the demand for goods and ultimately affected livelihoods, such as the deterioration of food security status in Nigeria[6].

The measures adopted have had gendered impacts, including affecting the protection environment and risks women and girls face. For example, the extended school closures have exposed millions of adolescent girls to early marriages, severely threatening their futures. Even with the re-opening of economies and lessening movement restrictions in 2021 and 2022, girls out of school are less likely to resume schooling. Indeed, early estimates show that school closures will hit the girls the hardest[7]. Access to vital health services (e.g. family planning, antenatal and childbirth services) was constrained at the height of the lockdowns. This threatened to compromise the lives of mothers and those of their unborn children.[8]

The lockdown and stay-at-home measures adopted to contain the spread of COVID-19 disproportionately affected informal workers—most of whom are women—as very few informal sector jobs could be performed at home.[9,10]

Lost direct income opportunities increased the vulnerabilities women faced, including resorting back to depending on men exclusively. The containment measures also harmed young girls introducing unintended behaviour among minors as adolescents spent more time unsupervised. For example, girls affected by school closures in Kenya were more likely to report undesired first sex during COVID-19 lockdowns.[11] Furthermore, many young girls have been sexually abused during the COVID-19 pandemic leading to a rising rate of teenage pregnancies on the African continent.[12] Several media reports also indicate that some measures adopted increased opportunities for assault by GBV perpetrators. Furthermore, the measures initiated affected access to essential protection services such as health services and hotlines/call centres required in response to GBV exposure.

5 https://www.worldometers.info/coronavirus/

6 Amare, M., K.A.Abay., L.Tiberti., J. Chamberlin (2020) COVID-19 and Food Security: Panel Data Evidence from Nigeria" Food Policy Vol 101: No 102099.

7 UNDP. (2020). Socio-economic impact of COVID-19 in Uganda: Short, medium, and long term impacts on poverty dynamics and SDGs using scenario analysis and system dynamics modelling. COVID-19 policy brief #1, prepared by United Nations Development Programme (UNDP-Uganda), April 2020.

8 Shapira, G., et al. (2021). Disruptions in Essential Health Services During the First Five Months of COVID-19: Analysis of Facility-Reported Service Volumes in Eight Sub-Saharan African Countries.

9 Casale, D. and Posel, D. (2020) 'Gender and the early effects of the Covid-19 crisis in the paid and unpaid economies in South Africa'. National Income Dynamics (NIDS) – coronavirus Rapid Mobile Survey (CRAM) Wave 1. Working Paper 4

10 Schwettmann, J (2020) COVID-19 and the Informal Economy: Impact and Response Strategies in Sub-Saharan Africa. Fredrich Ebert Stiftung.

11 Zulaika, G., M. Bulbarelli, E. Nyothach et al (2022) Impact of COVID-19 lockdowns on adolescent pregnancy and school dropout among secondary schoolgirls in Kenya. BMJ Global Health 7:e007666. doi:10.1136/bmjgh-2021-007666.

12 Peterman, A. and O'Donnell, M. (2020). COVID-19 and violence against women and children: a third research round up for the 16 Days of Activism. Center for Global Development.

Whereas governments instituted several responses to cushion the adverse impact of the pandemic, the responses were, most times, not gender-sensitive. Several constraints affected the delivery of interventions, including the delay in enrolling beneficiaries, that included children born during the pandemic to existing social protection schemes.[13] The stay-at-home measures also increased the amount of time required for domestic activities, and these unpaid duties disproportionately fell on women and adolescent girls. A significant proportion of women on the continent reported a significant increase in child care and elderly care with limited support from spouses or sons.[14]

Against this background, the Economic, Social and Cultural Council (ECOSOCC) commissioned an in-depth study assessing the impact of COVID-19 response measures on women and girls in Africa.

The specific objectives of the study are:

a. Investigate, based on authoritative evidence, the potential nexus between COVID-19 lockdown measures and an increase in gender-based violence (GBV) in African Union Member States;

b. Evaluate the economic impact of COVID-19 response measures on women in regular and irregular employment;

c. Examine the impact of COVID-19 response measures on women's access to quality reproductive health care;

d. Assess the impact of COVID-19 response measures on girls' education and the resultant incidents of child marriage and unwanted pregnancy;

e. Review international best practices for a gender-sensitive response to public emergencies;

f. Formulate evidence-based proposals to policy makers for a gendered response to public emergencies in Africa;

g. Develop, based on the research findings, a 5-page policy brief to be submitted to the policy makers at the national and continental levels

The rest of the report is organised as follows:

Section 2:
Details the study's approaches used to undertake the assessment.

Section 3:
Provides details of the impact of the COVID-19 pandemic on GBV, employment opportunities, unpaid care work and access to essential health services.

Section 4:
Provides the AU Member States' response to the crisis, how response measures affected women and girls and the best practices that other developing countries have implemented.

Section 5:
Conclusions and recommendations

13 Gelb, A. (2020) 'Covid-19 G2P cash-transfer payments country brief: South Africa'. World Bank Group.
14 UN-WOMEN (2020) Rapid Gender Assessment on the Socio-Economic Impacts of COVID-19.

2. Study Approach and methods

A desk review of literature on how AU Member States have addressed the gendered impacts of the COVID-19 pandemic was performed. The desk review included both the grey literature as well as published academic studies focusing on women and girls. These included studies examining how the pandemic exacerbated violence and affected access to response services.[15] The desk review provided the pathways through which the pandemic has resulted in gendered impacts and information on how governments have responded to mitigate the impacts of the pandemic. To get a comprehensive understanding of the Member State's efforts to address the adverse effects of the COVID-19 pandemic, the information in policy-tracker databases was analysed. Such databases provide data on the Government's COVID-19 response efforts. The first is the COVID-19 Global Gender Response Tracker (GGRT), created by the United National Development Programme (UNDP) in collaboration with UN Women.[16] This database monitors policy measures enacted by governments in the 54 AU Member States to tackle the COVID-19 crisis and highlights responses that have integrated a gender lens.[17] Other databases included the World Bank's "Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures" tracker. The focus was on differentiated gender impacts of the announced social protection interventions.

Secondary data analysis of available national surveys conducted during the COVID-19 pandemic was performed. The primary data source was the Living Standards Measurement Survey (LSMS) customised high-frequency phone survey of African households (HFPS-HH) undertaken by the World Bank and national statistical agencies in 12 AU Member States.[18] The surveys capture whether a household had access to health services, including pre-natal and post-natal health services. Finally, the surveys capture whether a household member tried to access health services in the past month before the survey and the reasons for failing to receive services sought. The surveys also captured the effects of the COVID-19 pandemic on education.[19] The high-frequency surveys collect information on whether children in primary or secondary school have been engaged in any education or learning activities since the schools were closed. Also, the type of education or learning activities children have engaged in during school closures is captured.[20] The high-frequency surveys were analysed to generate information on girls' current situation in response to the COVID-19 interventions and identify the gaps in the design and implementation programmes initiated during the pandemic for girls.

2.1 Limitations

Given the ongoing COVID-19 pandemic—especially the recent outbreak of the Omicron variant and associated restrictions on movement and stated timelines in ToRs, this study is predominantly a desk assessment with no primary data collection.

15 UN-WOMEN (2021a) "Impact of COVID-19 on Gender Equality and Women's Empowerment in East and Southern Africa"; UNFPA (2020) "Daring to Ask, Listen and Act: A snapshot of the impacts of COVID-19 on women and girls rights and sexual and reproductive health"; Awofeso, A., L.McDougal., Y.Chi et al (2021) "COVID-19 and Women and Girls' Health in Low and Middle-Income Countries: An Updated Review of the Evidence" CGD Policy Paper No 234; Holmes, R and A. Hunt (2021) "Have social protection responses to COVID-19 undermined or supported gender equality?: Emerging lessons from a gender perspective" ODI Working Paper No 611.

16 UNDP-UN Women (2021) COVID-19 Global Gender Response Tracker.

17 As of November 2021, the GGRT dataset contains 842 measures implemented in Africa divided into four different policy categories: (i) Social protection measures; (ii) Labour market measures; (iii) Fiscal and economic measures; and (iv) Violence against women and girls (VAWG) measures.

18 These are nationally representative surveys tracking the same families for six months starting in June 2020. Household heads complete phone-based interviews every four weeks. As of November 2021, the following AU member states had high-frequency surveys, Burkina Faso, Chad, Djibouti, Ethiopia, Kenya, Malawi, Mali, Nigeria, Sao Tome and Principe, Somalia, Uganda and Zambia.

19 For example, for some countries with several completed survey rounds, e.g. Round 3 for Malawi—undertaken during August 2020 before the resumption of schools captures information on whether households will be sending back children to school and the reasons for or not sending children back to school. On the other hand, Round 4, conducted in September/October when schools had re-opened—captures information on whether children returned and the reasons for those who did not return to school. The stated reasons for not returning to schools include (i) concerns regarding the safety of schools due to the coronavirus and (ii) financial challenges due to the unavailability of jobs

20 The possible alternatives include whether children: (i) completed assignments provided by the teacher; (ii) used mobile learning apps; (iii) watched educational TV programme; (iv) listened to education programmes on radio, or (v) held a session/meeting with lesson teacher.

3. Impact Of The COVID-19 Crisis On Women And Girls In Africa

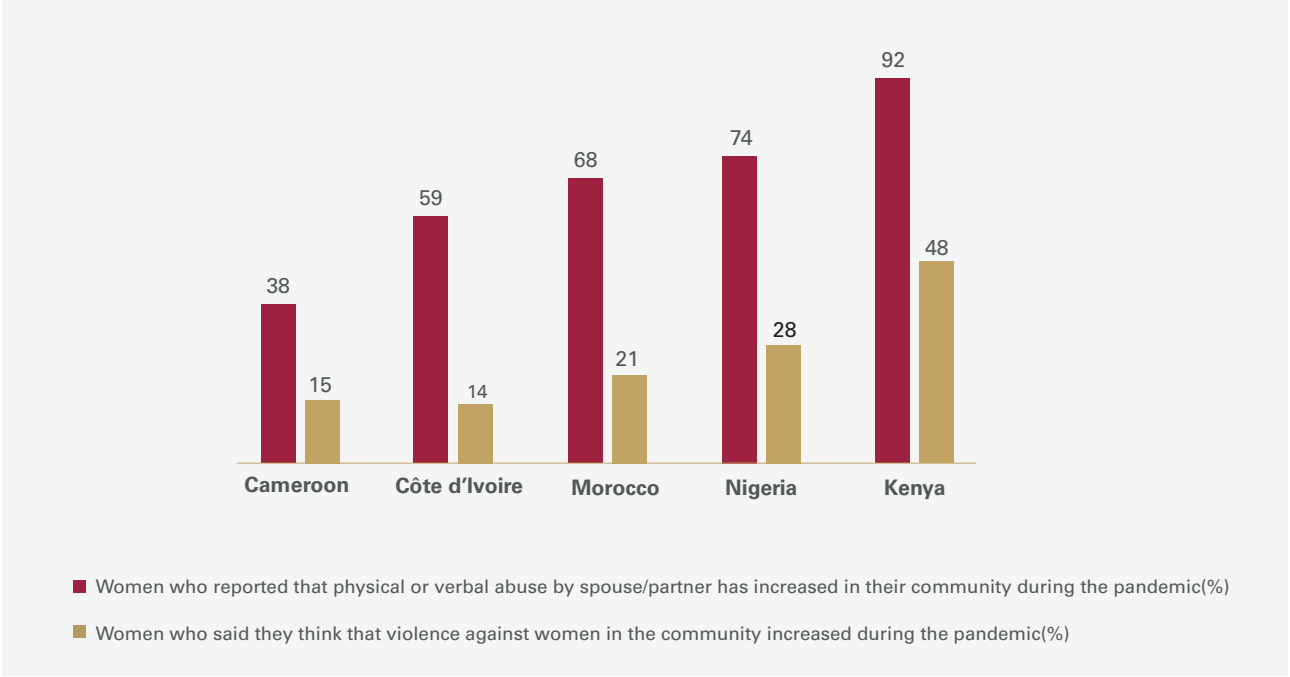
3.1 Increase in Gender-Based Violence (GBV).

There is extensive evidence to show that the stay-at-home measures imposed and the associated labour redundancies constrained movements of most men, making women susceptible to violence. This is explained by the fact that access to income-earning opportunities improve emotional well-being and economic security and reduces intrahousehold conflict. On the other hand, the school closure measures adopted exposed children to violence at home while access to violence prevention and response services was severely disrupted, as earlier noted. Many young girls were sexually abused during the COVID-19 pandemic leading to a rising rate of teenage pregnancies on the continent. Below we detail how the pandemic affected the rates of GBV faced.

Cross-country evidence

There is significant evidence to show that VAWG increased during the pandemic. From April to September 2021, UN-WOMEN conducted a Rapid Gender Assessment (RGA) to measure the shadow pandemic regarding experiences of VAW in 13 low-income countries, 5 of which were from Africa, i.e. Cameroon, Côte d'Ivoire, Kenya, Morocco and Nigeria. In each country, about 1,200 women were interviewed over the phone. Figure 1 shows that most women surveyed think that physical or verbal abuse by a spouse increased during the pandemic in their community. The rates range from a very high of 92% in Kenya to the lowest of 38% in Cameroon. Beyond experience VAW from the spouse, Figure 1 shows that a sizable proportion of women think VAW increased within the community—ranging from a low of 15% in Cameroon to a very high of 48% in Kenya.

Figure 1: Changes in Domestic Violence Experiences during the pandemic

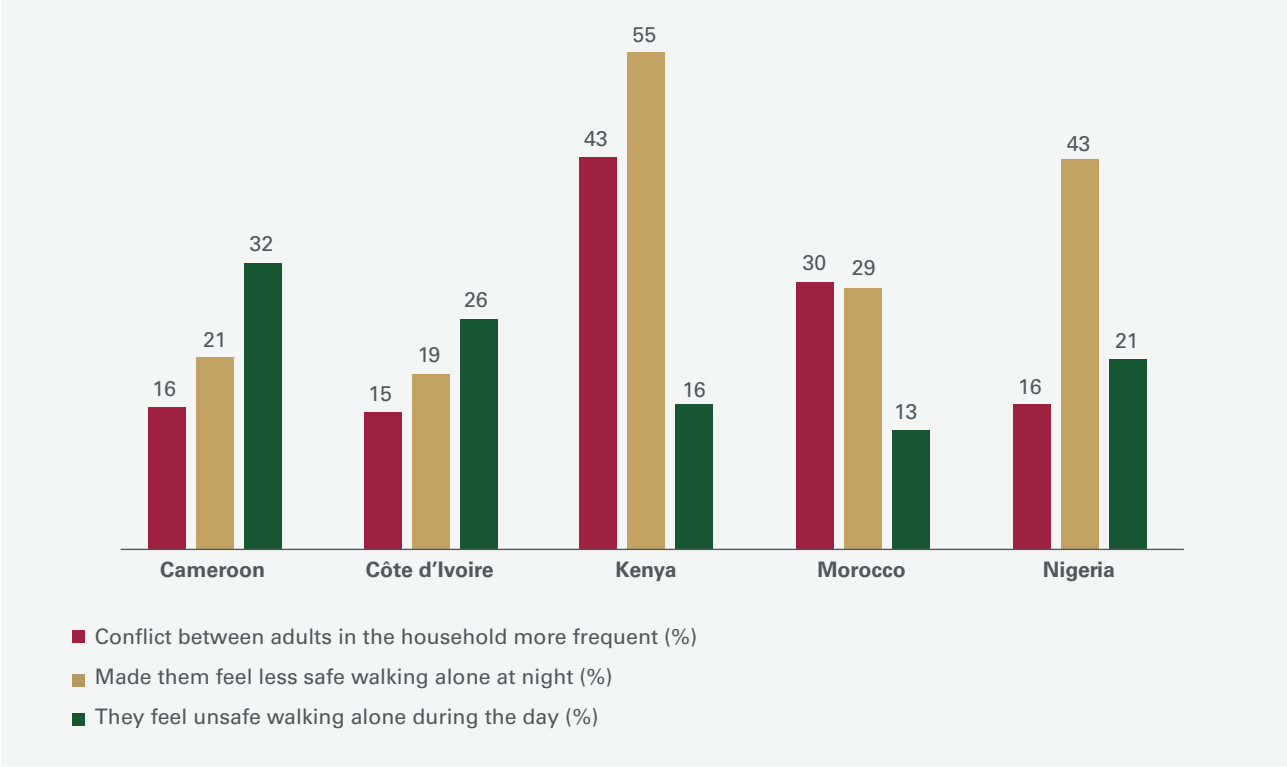


Source.[21]

21 UN-WOMEN (2021b) Measuring the Shadow Pandemic: Violence Against Women During COVID-19.

It is not only that the direct experience of physical or verbal abuse by a spouse/partner increased during COVID-19, but other forms of violence also increased. Figure 2 shows women's responses regarding the impact of COVID-19 on frequencies of conflict as well as safety concerns regarding walking alone. In Morocco, because of COVID-19, women were nearly equally to report an increased frequency of conflicts and safety concerns at night—at about 30%. In Kenya and Nigeria, at least 55% and 43% respectively of women surveyed indicated that the pandemic made them feel unsafe walking alone at night. In Cameron and Cote d'Ivoire, the largest proportion of women showed that COVID-19 made them feel unsafe during the day, i.e. 32% and 26%, respectively. In all the five countries, women considered sexual harassment in public spaces to have increased during the pandemic—ranging from 31% in Cameroon to 81% in Kenya.

Figure 2: Extent to which COVID-19 increased other violence concerns in selected AU member states (%)



Source.[22]

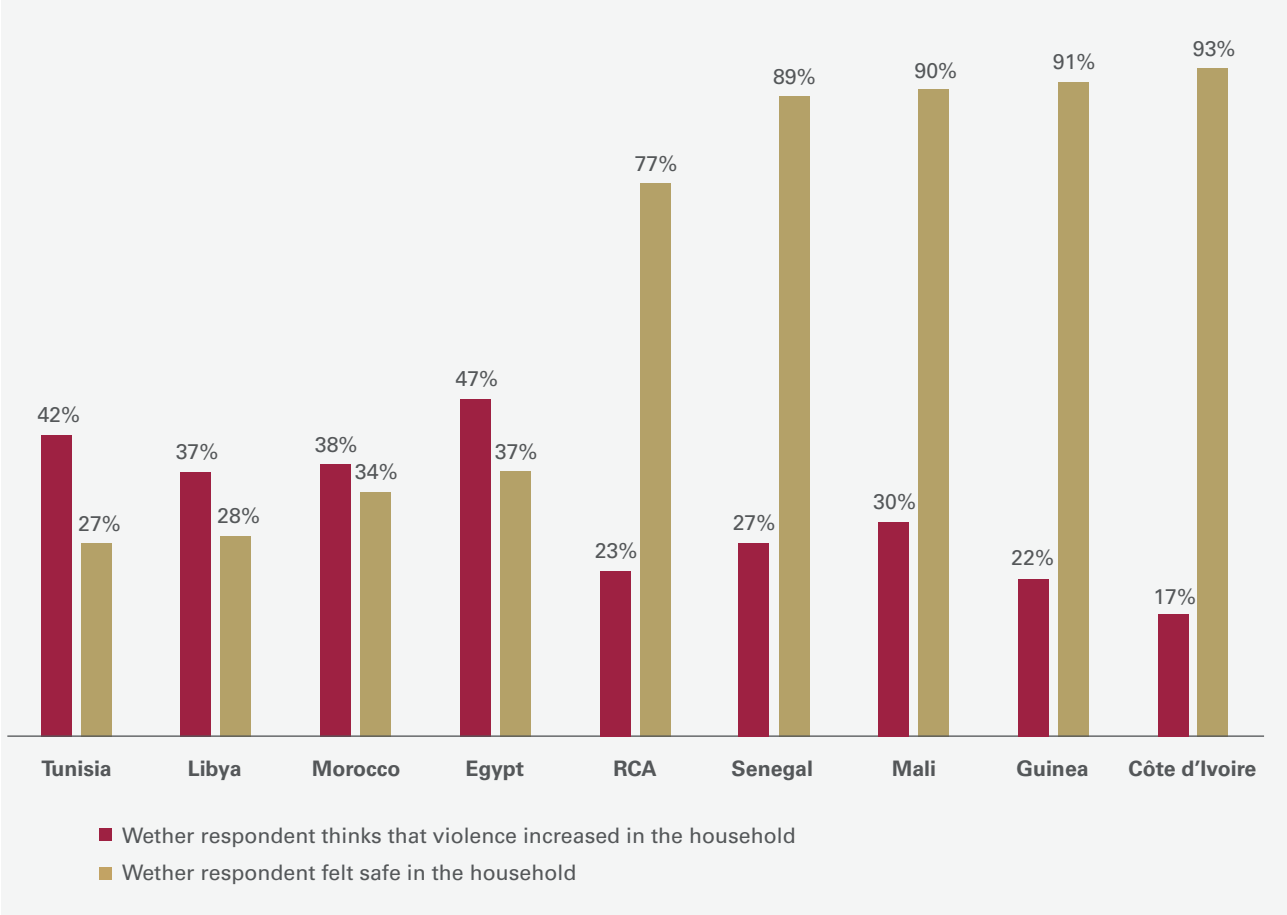
Prior to the VAWG surveys, UN-WOMEN had captured GBV experiences using Rapid Gender Assessment (RGAs) on the Socio-Economic Impacts of COVID-19. The latter surveys capture a more extensive set of AU Member States (15)—including 4 from North Africa, 6 from East and South Africa, and 5 from West and Central Africa. Figure 3 shows the results for surveyed women regarding violence and safety within the household. It is indicated that women in Egypt reported the most significant increase in violence in the family (47%), followed by Tunisia (42%).[23] Countries in West Africa reported the highest incidences of reduced safety within the households—at least 90% of the women in Senegal, Mali, Guinea, and Cote d'Ivoire reported feeling unsafe. Indeed, the more recent VAW–Rapid Gender Assessments show that a considerable proportion of women feel unsafe precisely because of COVID-19. In particular, for the 5 African countries surveyed as part of the global VAW-RGA during April-September 2021, at least 45%, 39%, 23%, 23%, and 18% of the women report feeling unsafe in Kenya, Nigeria, Morocco, Cameron and Cote d'Ivoire respectively.[24]

22 UN-WOMEN (2021b)

23 With respect to changes in GBV experiences—this information was captured only for surveys conducted in sub regions except East and Southern Africa.

24 UN-WOMEN (2021b)

Figure 3: Women's perception of violence and safety within the household



Source: UN-WOMEN (2021b)

Specific to Member States in North Africa, the RGAs inquire why women felt unsafe within the households. The following possible reasons for feeling unsafe are captured, i.e. (i) "Afraid of violence by spouse", (ii) "Afraid of violence by family member", (iii) "Afraid of being attacked by outsiders", and (iv) "Increased armed conflicts or civil unrest". The results revealed that violence within the household (either from spouse or family member) was the major reason women felt unsafe—the rates ranged from 25% in Libya to 43% in Egypt.[25] However, in Morocco and Tunisia, the dominant reason was not household-based but being "afraid of being attacked by outsiders"—at 45%. In Libya, the principal reason behind the safety concerns is the threat of armed conflict and civil unrest (61%).

It is worth noting that for women reporting a heightened risk of violence in North Africa, most of the fears were attributed to being afraid of violence by family members and not necessarily the spouse. The largest share of women reporting fear of violence from their spouses was by Tunisian women (39%), followed by Egypt (28%) and Libya (24%). Evidence from other countries also points to substantial violence from other household members. For example, in Sudan, COVID-19 restrictions increased domestic violence, particularly physical violence in the home due to limitations on movement. An analysis of calls to the GBV helpline in Sudan revealed that the dominant perpetrators of GBV cases reported to the helpline during April-August 2020 were not husbands (34%) but other male members of households (46%)[26].

25 Beyond fears due to household-based violence, the other reasons for feeling unsafe were (i) being afraid of being attacked by outsiders or Increased armed conflicts or civil unrest.

26 CVAW (2021), Sudan GBV helpline Service 2020 Annual Summary Report, Dr Abdelbasit, R.M.

That a substantial proportion of violence can come from other family members points to the precarious nature of Africa's multi-generational and extended family living arrangements. However, in other parts of the continent, spouses increased threats to violence. Based on a survey in rural Uganda, evidence shows a 30% increase in the likelihood of a significant argument among couples during the pandemic.[27]

Even studies that do not report sex-disaggregated data show a reported increase in experiences of violence—including violence that affect more girls than boys. In Uganda, sexual abuse was the third most frequently reported issue at the Uganda Child Helpline—accounting for 20% of all reported cases.[28] At the same time, the pandemic disrupted violence prevention and response services access. Previous research shows that at least 71 % and 57% of West Africa and ESA countries reported a disruption in at least one violence against children (VAC)-related service.[29]

3.1.2 Drivers of violence

Several factors are highlighted as drivers of increased VAW during the pandemic—ranging from reduced household resources to increasing vulnerabilities of certain groups as well as substance abuse. As earlier noted, COVID-19 control measures made it difficult for some men to continue to provide for their families, which increased financial pressures and stresses that typically accompany financial hardship. In North-East Nigeria, violence and threats of marital dissolution were used to divert men's breadwinner responsibilities during the pandemic.[30] Also, in the informal settlements of Kenya, women affected by food insecurity had an 8% more likelihood to report violence.[31] In Lagos, Nigeria, there is evidence to show less stable employment is correlated with intimate partner violence (IPV) during the pandemic.[32]

Also, the lockdown measures instituted to contain COVID-19 resulted in victims being in constant proximity with would-be perpetrators for prolonged periods. In Tunisia, women with a history of mental health had more severe depression, anxiety, and stress symptoms during the lockdown.[33] Furthermore, in Kenya, it was reported that girls, especially with intellectual disabilities, were increasingly being defiled at home due to having a lot of people that were just at home.[34] On the other hand, partners and relatives of persons with disabilities (PWDs) had to take on additional care responsibilities for PWDs due to the suspension of key health services. In Kenya, at least 11% of the adolescents surveyed showed increased household tension and violence—especially experiencing emotional abuse.[35]

Beyond proximity with perpetrators, social isolation and the psychological as well as the socially disruptive consequences of the pandemic led to increased substance abuse and consequently violence. In Ethiopia, women noted higher substance abuse (drugs and alcohol) among men and boys, which drove men to commit GBV[36].

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27 Mahmud, M and E. Riley (2021) "Household Response to an Extreme Shock: Evidence on the Immediate Impact of the COVID-19 Lockdown on Economic Outcomes and Wellbeing in Rural Uganda" World Development 140 (April):

28 Sserwanja, Q., J. Kawuki and J.H. Kim (2020) "Increased child abuse in Uganda amidst COVID-19 pandemic.

29 UNICEF (2020) Protecting Children from Violence in the Time of COVID-19: Disruptions in prevention and response services.

30 Nagarajan, C (2020b), 'Gender dynamics in Borno State,' British Council.

31 Pinchoff J, Austrian K, Rajshekhar N et al (2021) "Gendered economic, social and health effects of the COVID-19 pandemic and mitigation policies in Kenya: evidence from a prospective cohort survey in Nairobi informal settlements" BMJ Global Health Open 2021;11:e042749. doi:10.1136/ BMJ open-2020-042749.

32 Oguntayo, R., J. T. Oyeleke., F. Aajayi-Hutchful et al (2020). "Personal Traits, Emotional Intelligence, Socio-contextual factors, and spousal violence: The Trajectory of COVID-19 Pandemic Lockdown".

33 Sediri, S., Y.Zgueb., S. Ouanes et al (2020) "Women's mental health: acute impact of COVID-19 pandemic on domestic violence" Archives of Women's Mental Health Vol 23: 749-756.

34 UNFPA et al. (2021) The Impact of COVID-19 on women and girls with disabilities: A Global Assessment and Case Studies on Sexual and Reproductive Health and Rights, Gender-Based Violence, and Related Rights.

35 Population Council (2020a). Social, health, education and economic effects of COVID-19 on adolescent girls in Kenya: Results from adolescent surveys in Kilifi, Nairobi, Wajir, and Kisumu Counties. October 2020. COVID-19 Research & Evaluations brief. Nairobi: Population Council.

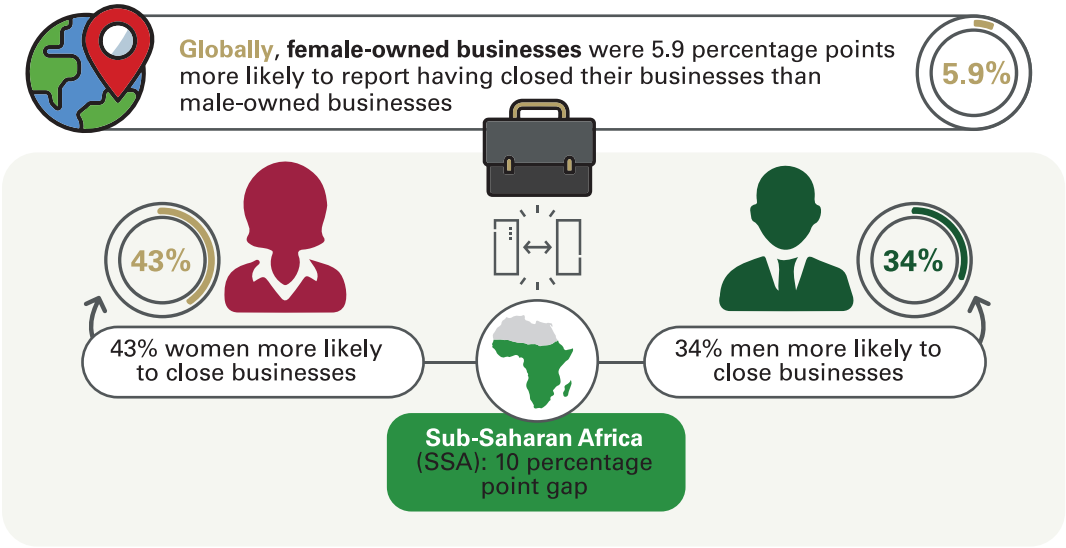
36 Care Ethiopia (2021) "A Study on The Impact of COV1D-19 on Women and Girls in Ethiopia".

Among married couples and pregnant women in the capital Addis Ababa, increased violence during the pandemic was explained by having a substance user husband—specifically abusing stimulant drugs such as khat and alcohol.[37] [38]

As the incidents of GBV experiences increased across the continent, access to GBV response services was affected due to severe movement restrictions. For example, in 3 Nigerian states, the use of Sexual Assault Referral Centres (SARCs)—centres located within hospitals—dropped during the first two months of the pandemic because of harassment and extortion related to the enforcement of the COVID-19 movement SOPs.[39]

3.2 Loss of employment opportunities and livelihoods

Government response measures adopted, including restrictions on movement, affected livelihoods forcing a sharp decline in economic activities. The standard operation procedures (SOP)s introduced disproportionately affected the informal sector employment, where women dominate. Beyond sectors of employment, increased demands for unpaid care work led to loss of income earning opportunities. Female-owned enterprises faced more closures among small businesses than male-owned ones, especially in sub-Saharan Africa (SSA). Based on the Future of Business Survey—a consortium led by the Organisation for Economic Co-operation and Development (OECD), globally, female-owned businesses were 5.9 percentage points more likely to report having closed their businesses than male-owned businesses. However, in Sub-Saharan Africa (SSA), the gap was much larger—women were more likely to close businesses —43% for women compared to 34% for men, a 10 percentage point gap.[40]



The closure of businesses resulted in long durations of inactivity and lost income opportunities. Based on high-frequency COVID-19 surveys from 25 SSA countries, the World Bank estimates that 26.4% of individuals reported work stoppages in the sub-region due to the pandemic.[41]
Even with relatively fewer work stoppages, households in SSA registered severe income losses. In particular, on average, 71% of households in the sub-region report income losses.

37 Tadesse, A. W., S. M. Tarekegn, G. B, Wagaw, et al (2020) Prevalence and Associated Factors of Intimate Partner Violence Among Married Women During COVID-19 Pandemic Restrictions: A Community-Based Study Journal of Interpersonal Violence 1–19.

38 Teshome, A., W. Gudu., D. Bekele et al, (2021) "Intimate partner violence among prenatal care attendees amidst the COVID-19 crisis: The incidence in Ethiopia" International Journal of Gynecology and Obstetrics Vol 153 Issue 1: 45-50.

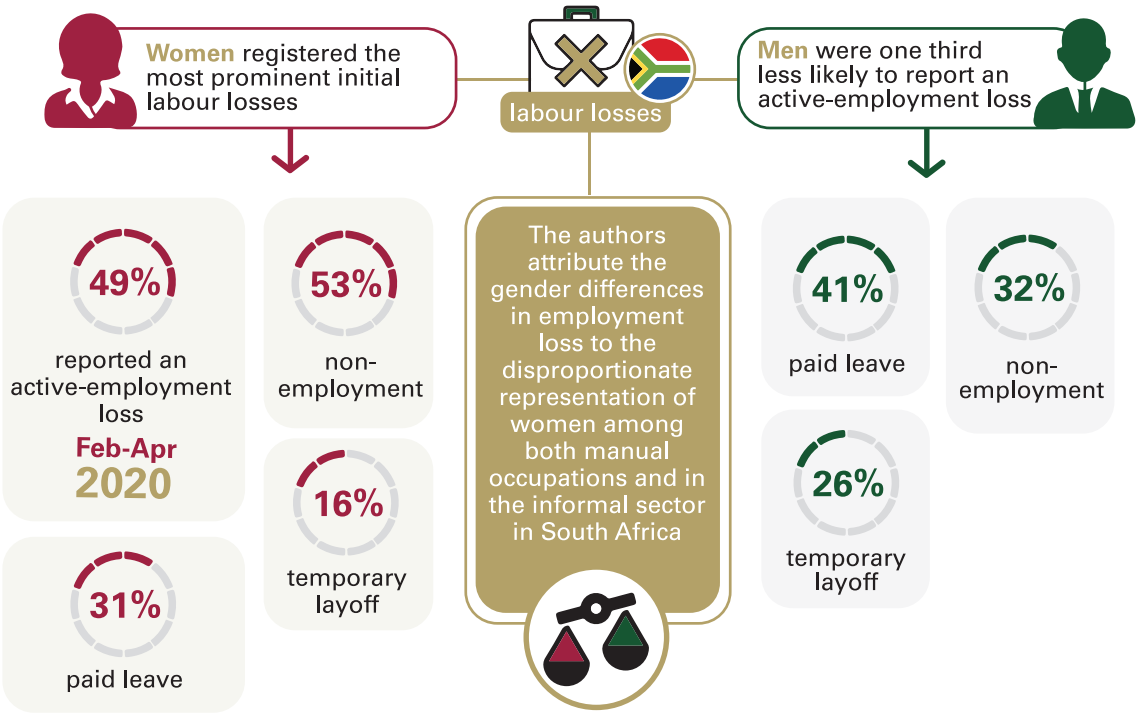
39 Nagarajan, C (2020a), 'COVID-19's Impact in Northeast Nigeria,' British Council.

40 Facebook, OECD and World Bank (2020) Global State of Small Business Report

41 World Bank. (2022). Global Economic Prospects, January 2022. Washington, DC: World Bank

Furthermore, recovery from the lockdown took a longer duration for women. In South Africa, by March 2021 (one year after the first lockdown), men's employment and working hours returned to pre-COVID-19 levels, while women's employment and working hours remained below the February 2020 rates.[42] With several COVID-19 waves and accompanying lockdowns registered in 2020 and 2021, the risks of women's long term unemployment in Africa remains high, given the possibility of skills depreciation in an environment of extended durations out of employment.

For South Africa, women registered the most prominent initial labour losses.[43] Specifically, 49% of women reported an active-employment loss during the February-April 2020 period.[44] The most significant losses were attributed to non-employment (53%), with the rest accounted for by paid leave (31%) or temporary layoff (16%). On the other hand, men were one third less likely to report an active-employment loss, and when it occurred, it was mainly attributed to paid leave (41%) rather than non-employment (32%) or temporary layoff (26%). The authors attribute the gender differences in employment loss to the disproportionate representation of women among both manual occupations and in the informal sector in South Africa. In Mozambique, stopping the train system—as one of the COVID-19 measures—eliminated women's livelihoods; they could no longer travel to bigger settlements to purchase wholesale to sell locally.[45]



42 Casale, D and D. Shepherd, (2021) The Gendered Effects of the COVID-19 Crisis and Ongoing Lockdown in South Africa: Evidence from NIDSCRAM Waves 1 – 5.

43 Jain,R., J. Budlender, R. Zizzamia et al (2020) "The labor market and poverty impacts of covid-19 in South Africa" CSAE Working Paper WPS 2020/14

44 Active employment loss is a labour status defined as either "not employed", "temporarily laid-off", or those on "paid leave".

45 Kraus, J.E., I. Athur., D. Brockington et al. (2022) "To prevent this disease, we have to stay at home, but if we stay at home, we die of hunger' – Livelihoods, vulnerability and coping with Covid-19 in rural Mozambique" World Development Vol 151, March 2022, 105757.

Women dominate sectors such as retail, hospitality, food service, and the garment industry, which have been affected by lockdown conditions required to control the spread of COVID-19. These sectors are also highly informal. Measures in some countries entailed banning the sale of alcohol, and this threatened the livelihoods of women traditionally involved in brewing traditional beverages.[46] In South Africa, women accounted for two-thirds of the overall job losses due to their over-representation in the informal sector.[47] The significant decline in early childhood development (ECD) services in South Africa—services typically run by women as either subsistence entrepreneurs or as a part of micro-social enterprises shows how the pandemic affected informal employment. ECD attendance declined from 38% in 2018 to 5% in July 2020 due to a combination of reduced household income and COVID-19 safety concerns for children.[48]

Declining economic activities forced more women to migrate back to rural areas. For example, in Ethiopia, declining opportunities in garment factories forced more women to return to rural areas as they suffered from changes in the world demand for their products.[49] Before the pandemic, gender gaps in labour force participation (LFP) in Ethiopia had reduced due to the proliferation of industrial parks in Ethiopia, which have focused on female-dominated trades (e.g., textiles); the garment industries had limited barriers to entry based on educational qualifications and as such increased employment of young women. The female-male gap in LFP rates has narrowed over time, reducing from 22 percentage points in 1999/00 to 11 percentage points by 2013/14.[50]

3.2.2 Increase in poverty and declining livelihoods

Figure 4 shows the difference in probability of income losses between the bottom 40 % and the top 60 % of the income distribution for selected African countries with HFPS. A positive estimate suggests that the bottom two quintiles were more likely to lose income than the top three quintiles. The chart shows that the losses were mixed—the number of AU Member States where the top 60 % had a greater probability of experiencing income losses is the same as that where a higher possibility of losses for the bottom 40% are registered (i.e., 5). Although the direction of distribution is maintained between rural and urban areas, urban areas have relatively larger magnitudes of change (not shown in the chart).
Concerning expected changes in extreme poverty, Figure 5 shows that, on average, the pandemic is expected to increase extreme poverty by 1.3% compared to only 0.9% globally. Hence, due to the structure of economies, SSA is projected to suffer most from the pandemic despite the relatively lower share of deaths and morbidity from disease. Increased poverty has several development challenges, including exacerbating girls' protection issues. For example, in Nigeria, child marriage is more common among the poor than well to do households—80% of young women from poor households marry in childhood compared to only 10% from the non-poor.[51]

46 Kraus et al., (2022)

47 Casale, D. and Posel, D. (2020)

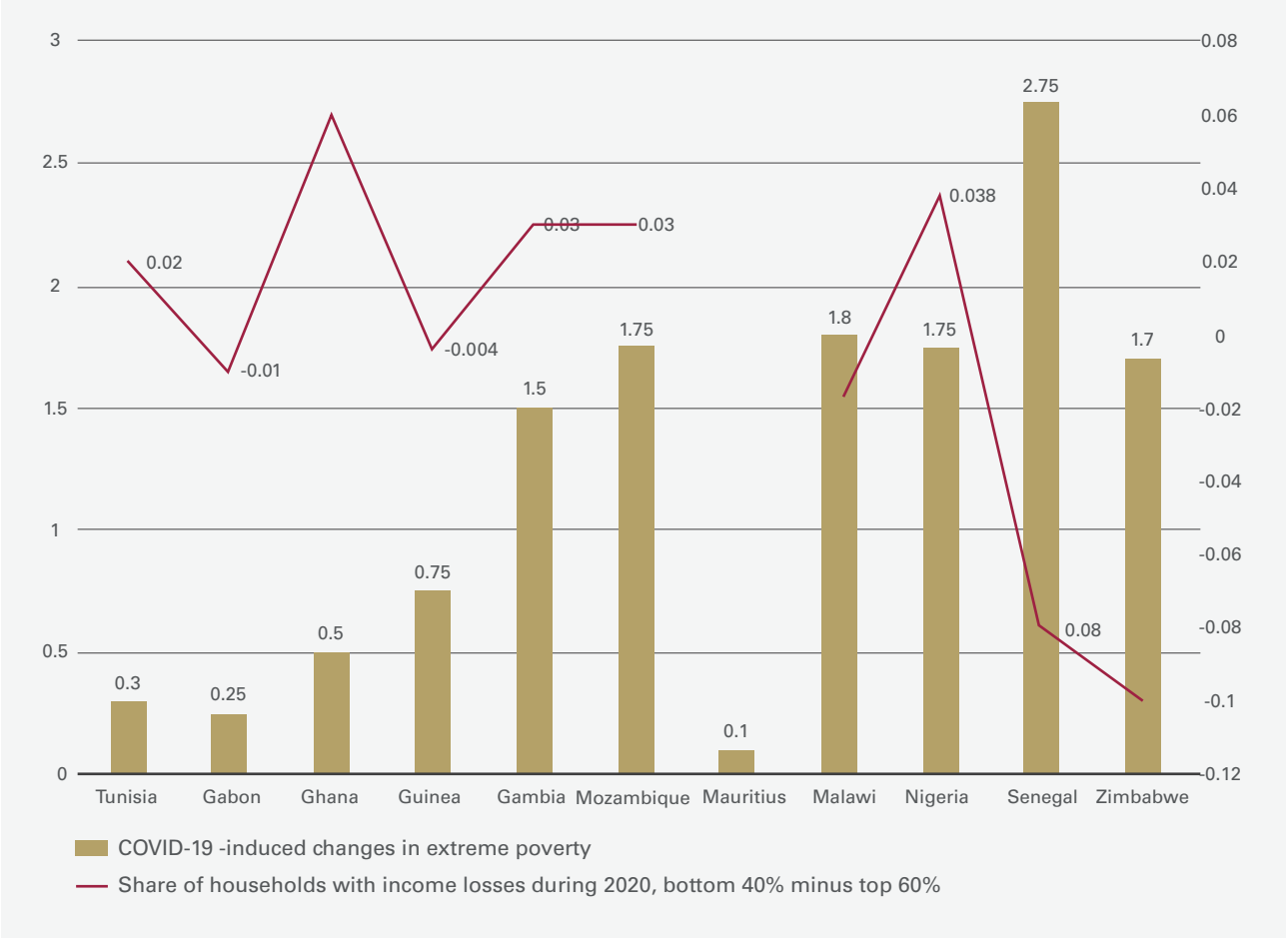
48 Wills,G., J.Kotzé, and J. Kika-Mistry (2021) "A Sector Hanging in the Balance: Early Childhood Development and Lockdown in South Africa" RISE Working Paper No 20/055.

49 Meyer, C., Hardy, M., Witte, M., Kagy, G., and Demeke, E. (2021). The market-reach of pandemics: evidence from female workers in Ethiopia's ready-made garment industry. World Development, 137(2021).

50 International Labour Organization (2020) Labour market assessment Market trends and opportunities in Ethiopia and the Gulf.

51 Ujam,N. A (2019) Child marriage in Nigeria: wedded to poverty

Figure 4: Projected changes in extreme poverty in selected AU member states



Source[52]

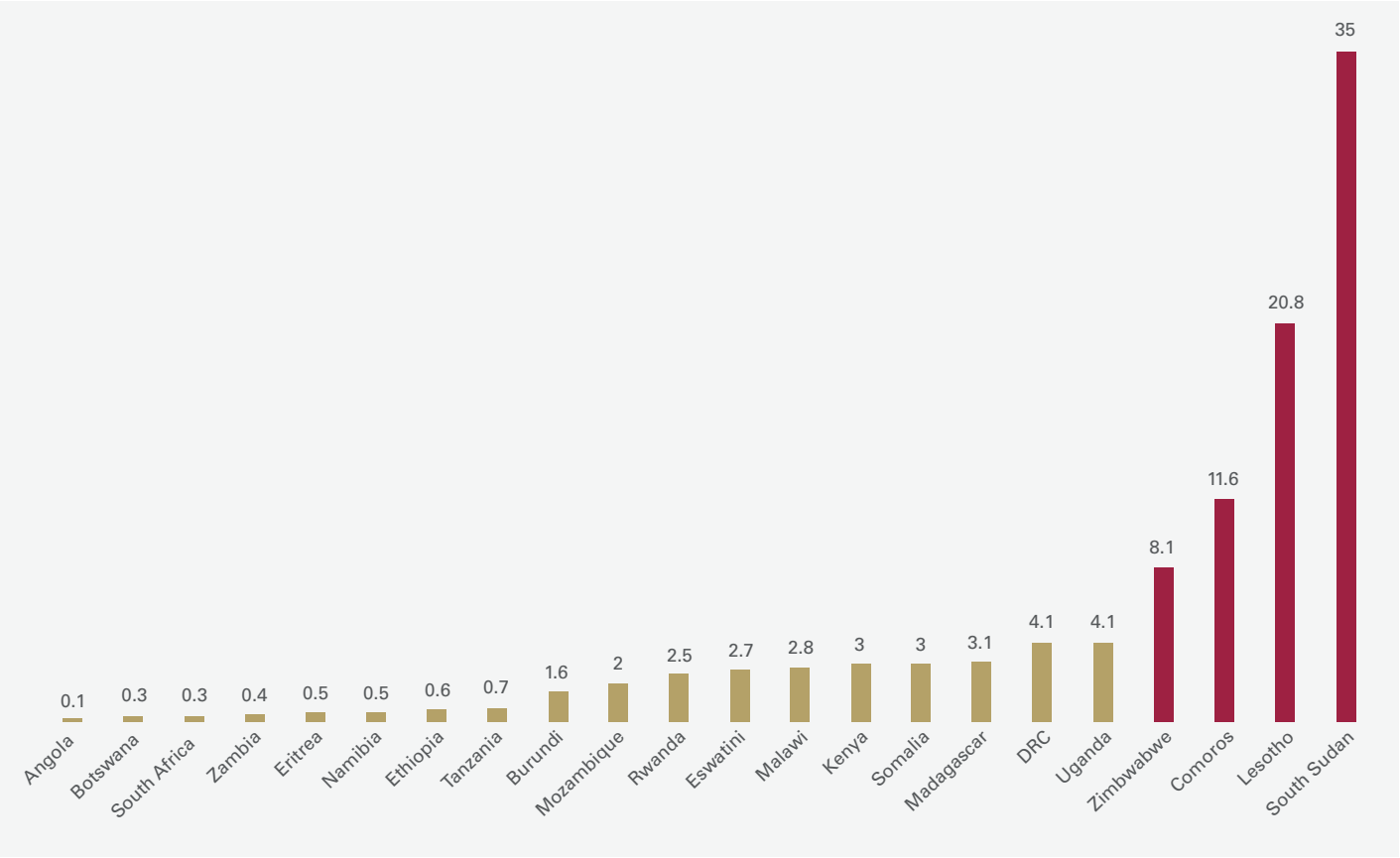
Besides job losses, another significant source of household's livelihood—notably remittances—were lost due to the pandemic's economic downturn. According to the World Bank, due to both the health crisis and unemployment risks, remittances to SSA are projected to decline by 9% in 2020 from US$ 48.8 Billion in 2019 to US$ 44 Billion in 2020.[53] Worse still, remittances in SSA are projected to decline further in 2021 by another 6%. Before the pandemic, AU Member States heavily depended on remittances. Figure 5 shows that remittances make up 35% of the gross domestic product (GDP) in South Sudan, 21% of GDP in Lesotho, 12% in Comoros and 8% in Zimbabwe.[54]

52 World Bank. (2022). Global Economic Prospects, January 2022. Washington, DC: World Bank

53 Ratha, D., S. De, E.J. Kim and S. Plaza (2020) "Migration and Development Brief 33: World Bank (2020).

54 The share of remittances in GDP reflects the extent of a country's population that is in the diaspora and the use of formal channels e.g., banks and money transfer services to send back remittances.

Figure 5: Remittances as a share of GDP in 2019 (%)



Source[55]

The decline in remittances due to COVID-19 will affect food security and increase poverty in several AU Member States. In Ethiopia, the drop in remittances is projected to reduce household consumption by 3.1% within the first six months of the pandemic.[56] The urban poor in Ethiopia were projected to register the largest decline in consumption of 5.6% despite accounting for only 4% of remittance beneficiaries in the country—due to the decline in informal employment opportunities. Changes in remittances receipts and economic livelihood loss will affect overall food consumption. In Zambia, women were about five percentage points more likely than men to report reducing the frequency of meals during the pandemic.[57] In Sierra Leone, female-headed households encountered greater food insecurity than their male-headed counterparts.[58] In Mozambique, women frequently mentioned food insecurity and hunger as an issue of concern during the pandemic than men.[59]

3.3 Increase in unpaid care work

Because of traditional gender norms, women and young girls shoulder a heavy burden of unpaid care responsibilities on the African continent. As earlier mentioned, duties performed include cleaning and cooking, childcare, elderly care, collecting water and firewood. The heavy burden of unpaid care work affects women's wage employment opportunities. It forces them into low-paying informal sector employment activities, easily aligned to unpaid care responsibilities.

55 World Bank (2020) World Development Indicators

56 Beyene, S and T. M. Gebrewolde (2020) "Pass-through shocks and income: The impact of COVID-19 on remittances in Ethiopia".

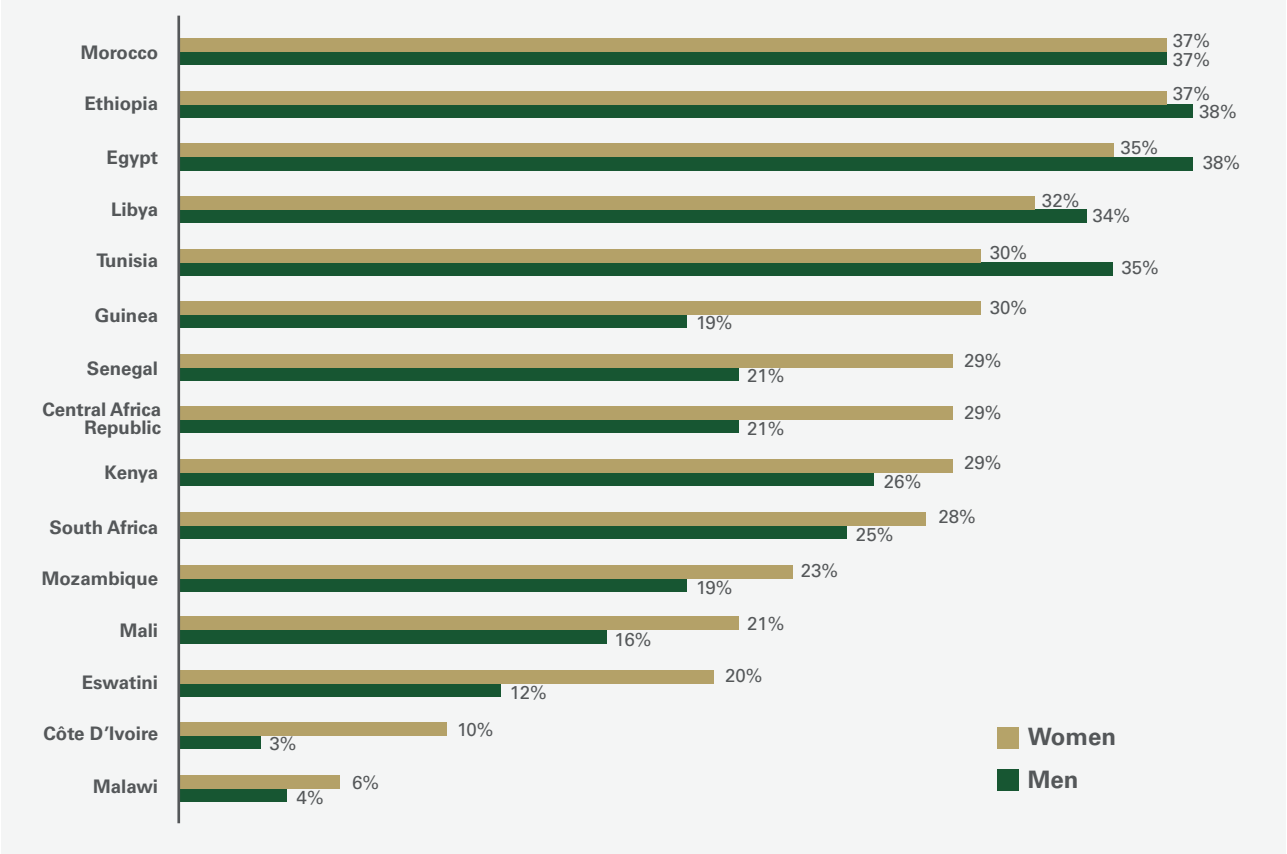
57 IPA. (2020). RECOVR Survey and hunger analysis. Innovations for Poverty Action.

58 Levine, M et al (2021) "How Is COVID-19 Affecting Gender Inequality in Low-Income Countries? Insights from Sierra Leone." IGC (blog).

59 Kraus et al., (2022)

The RGAs conducted in 15 AU Member States revealed that both men and women reported increased domestic responsibilities. Figure 6 shows a reported increase in the intensity of unpaid domestic work, defined as performing at least three domestic activities—women report a 26% increase compared to 23% for men. In SSA countries, women were more likely to report an increase in child and elderly care and at the same more likely to report not receiving support from the spouse for domestic and care activities. It is mainly in North Africa, where men and women spend more time on unpaid care work in similar proportions. The increased unpaid care workload affected labour allocation to income-earning opportunities.

Figure 6: Reported increase in at least three domestic activities among selected AU member states (%)



Source[60]

Urban areas on the continent registered some of the largest domestic duties increase. A rapid assessment of young urban women in 7 centres in 3 African countries reported an increase of more than four hours of additional work of 17 % in South Africa, 18% in Ghana, and 50 % in Kenya.[61]

The stay-at-home measures and school closures adopted during the COVID-19 pandemic disproportionately increased unpaid care work demands on women and young girls. In Ethiopia, adolescent girls faced substantial demands on their time due to unpaid care work responsibilities, which affected their ability to study from home.[62]

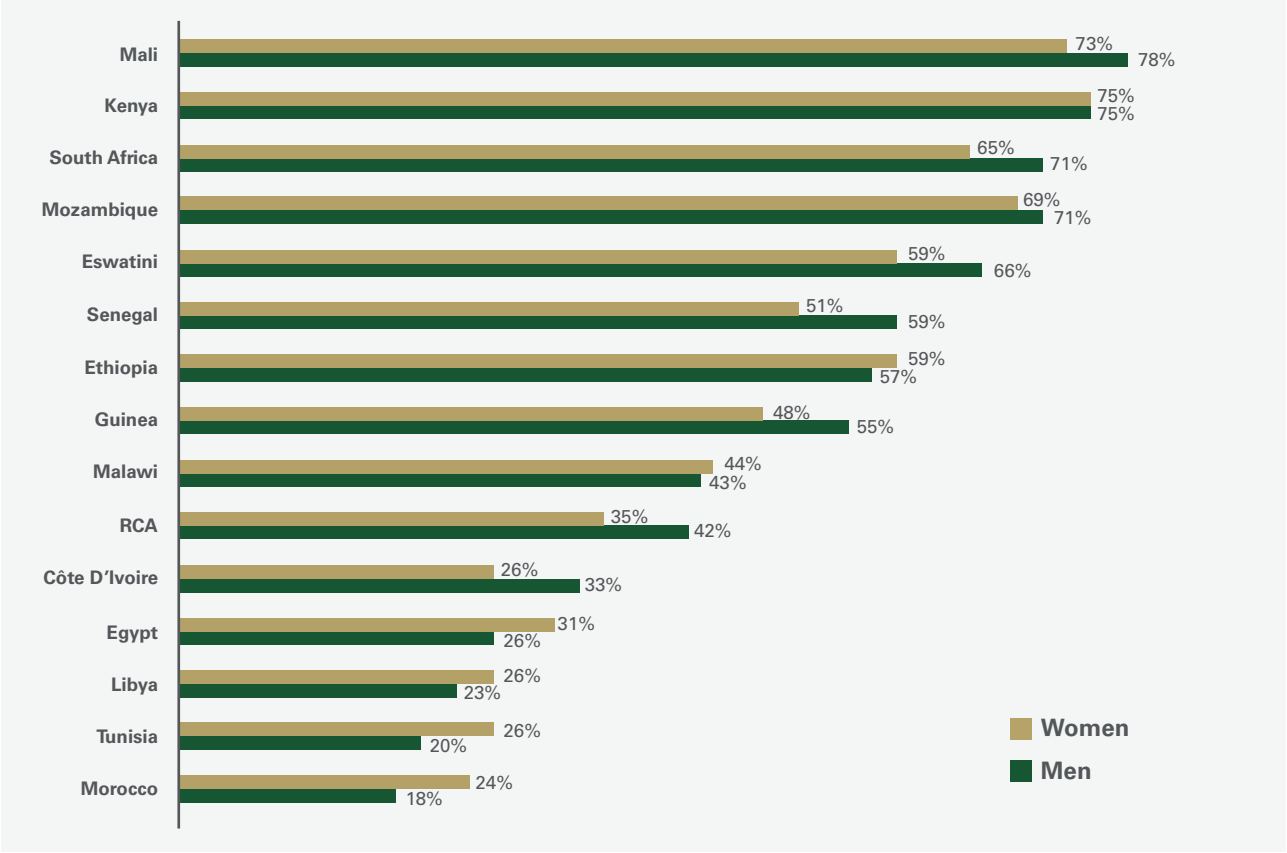
60 UN-WOMEN (2020)

61 Chakma, T. (2020). Impact of COVID-19 on young women: a rapid assessment of 14 urban areas in India, Kenya, Ghana, and South Africa. ActionAid.

62 Baird, S et al (2021) "Adolescent Well-Being in the Time of COVID-19." Adolescent Well-Being: Background Papers for Multi-Stakeholder Consultations. Geneva: Partnership for Maternal, Newborn & Child Health.

Some of the largest increases in unpaid care work were registered for activities concerning child care. Figure 7 shows the reported increase in at least one childcare activity for 15 AU Member States based on RGA. The rise in child care ranges from a very low of 18% in Morocco to a very high of 78% in Mali for both women and men. For 8 of the 15 countries listed, women report a higher increase in child care. It is mainly in North Africa, where women report a lower increase in child care than men.

Figure 7: Reported increase in at least one childcare activity



Source[63]

Women also lost employment opportunities due to extended closure of schools and unequal sharing of unpaid care responsibilities. In South Africa, the pandemic forced women to allocate a disproportionate share of time spent on unpaid care due to school closures and the suspension of childcare services.[64] Evidence from South Africa and Kenya suggests that fewer child care centres remained open during the pandemic due to fears of contracting the virus and the increased cost of operations to meet instituted SOPs.[65] The neglect of child care in Africa appears to be historical—pre-dating the COVID-19 pandemic. The review of Multilateral Development Banks' Investments in Childcare shows that during 2000-2021, Africa accounted for 27% of all 348 projects implemented by MDBs with a child care component.[66] However, among the projects dedicated to child care specifically, the continent accounted for only 6% of the global total (69 projects) compared to 52% for Latin America.

63 UN-WOMEN (2020)

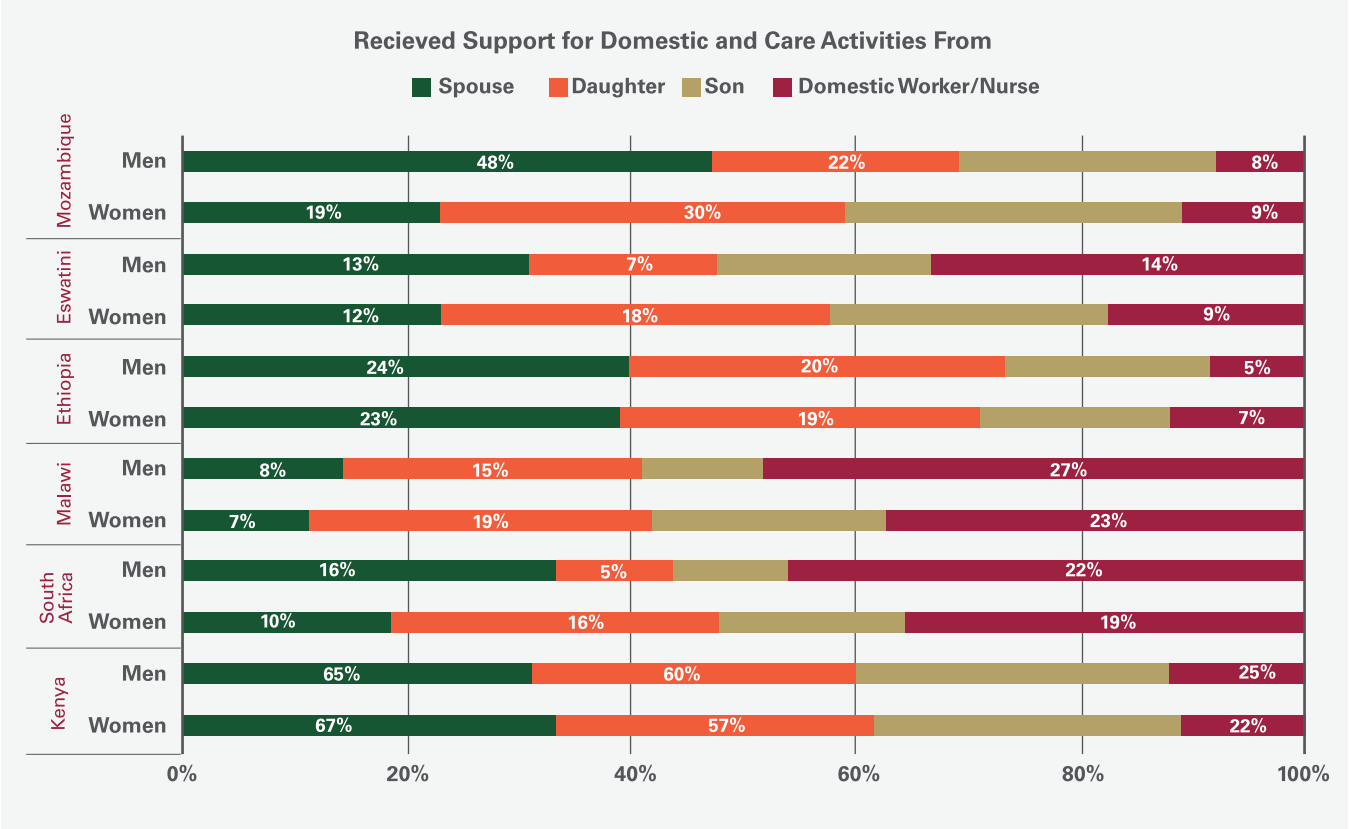
64 Hill, R. and Köhler, T. (2020) 'Mind the gap: analysing the effects of South Africa's national lockdown on gender wage inequality'. National Income Dynamics Study (NIDS) –Coronavirus Rapid Mobile Survey (CRAM) Wave 2

65 Grantham, K., Rouhani, L., Gupta, N., Melesse, M., Dhar, D., Mehta, S., and Kingra, K. (2021). Evidence review of the global childcare crisis and the road for post-COVID-19 recovery and resilience. International Development Research Centre.

66 O'Donnell, M., K. Ross, and S. Bourgault (2021) "A Review of Multilateral Development Banks' Investments in Childcare" CGD Policy Paper 223

Given the gravity of the pandemic, support for domestic activities could be expected from spouses, children, other family members or domestic workers/nurses. For the 10 countries that respond to the question of receiving support from the spouse, as expected, women report receiving less support from spouses than men for nearly all countries, except Kenya. The largest gender gaps in receiving support are in Mozambique and Egypt, where the women-men gap is 29% and 16%. It is only for countries in ESA where questions were asked regarding the source of support beyond the spouse. Figure 8 shows the distribution for the source of support for the 6 countries from ESA. It is indicated that men are more likely to report receiving support for domestic activities from spouses, on average 33%, followed by domestic workers (26%) and then daughters (23%) and sons (18%). On the other hand, women are more likely to report receiving support from daughters (32%), followed by spouses (25%), sons (23%) and domestic workers (20%).

Figure 8: Source of support for domestic and care activities during the pandemic in East and Southern Africa (%)



Source[67]

3.4 School closures

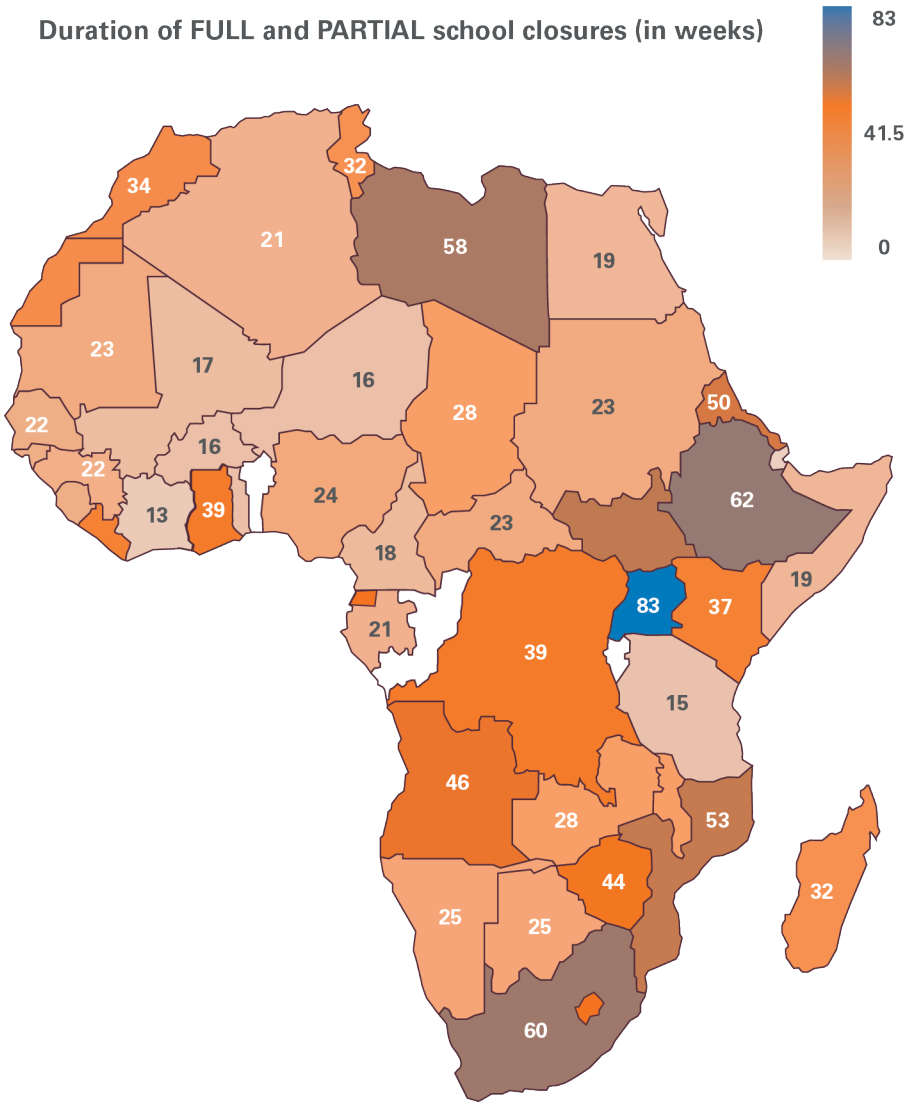
Lockdown of schools increased the risks to child protection. Globally, AU Member States registered the most prolonged duration of school closures. Figure 9 shows the map showing the duration of closure registered between March 2020 and November 2021. It is showed that the period ranged from 0 weeks in Burundi to the highest 83 weeks in Uganda. On average, AU Member States registered about 19 and 13 weeks of full and partial school closure, respectively.[68]

67 UN-WOMEN (2020)

68 Full school closures refer to situations where all schools were closed at the nationwide level due to COVID-19. On the other hand, Partial school closures refer to school closures in some regions or for some grades or with reduced in-person instruction.

Schools on the African continent were closed for about 50% of the expected instruction time for 2020. Between March 2020 and February 2021, schools were fully closed for 101 days in Eastern and Southern Africa, 90 days in North Africa, and 77 days in West and Central Africa.[69] At least 13 countries registered closures that cost students more than an entire school year.[70] With the extended closure of schools, school dropout rates are expected to increase, especially for adolescent girls at risk of child marriage, teenage pregnancy, and domestic work.

Figure 9: Map showing duration of School Closures in AU member states in 2020 and 2021(weeks)



Source[71]

Several Member States offered alternative forms of learning to children while at home—using radios and televisions, newspapers, and the internet. However, these alternative forms of learning did not provide a worthy substitute for school attendance. In Kenya, three out of every four girls could not do any school work during the 2020 school closures.[72]

69 UNICEF (2021) COVID-19 and School Closures: One Year of Education Disruption.

70 Based on the assumption that a regular school year runs for about 40 weeks, the following countries lost more than one year of schooling: (1) Uganda—83 weeks, (2) Ethiopia—62 weeks, (3) South Africa—60 weeks, (4) Libya—58 weeks, (5) Eswatini—57 weeks, (6) South Sudan—54 weeks, (7) Mozambique—53 weeks, (8) Rwanda—51 weeks, (9) Eritrea—50 weeks, (10) Seychelles and (11) Angola—46 weeks, (12) Zimbabwe—44 weeks, and (13) Lesotho—43 weeks.

71 UNESCO (2021) UNESCO global dataset on the duration of school closures

72 UNICEF and SHUJAAZ INC (2021) Barometer: Tracking the impact of Covid-19 on adolescent girls in Kenya

Due to schools' closure and the loss of livelihoods by parents/guardians, child protection concerns increased. At least one out of every five children in the East and Southern Africa reported experiencing violence at home during the pandemic.[73] Child helplines registered a surge in reported cases of sexual abuse. The closure of schools, which also act as safe spaces for children, meant limited access to trusted adult figures who could detect early signs of abuse and help children cope. Previous research also shows that child abuse incidents increase when families face financial hardships.[74]

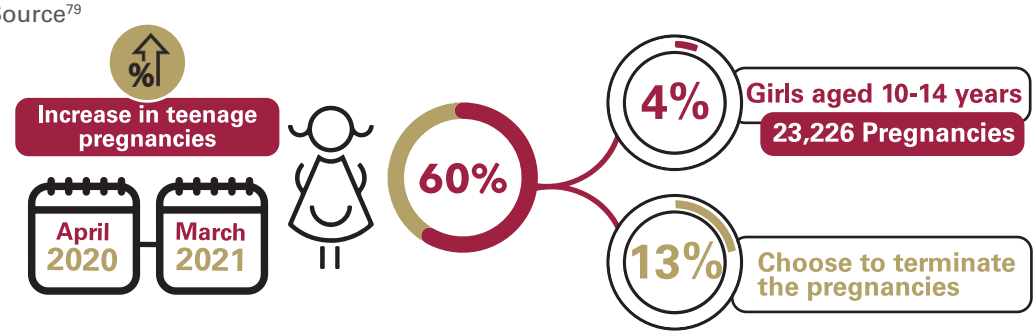
With schools closed, a lifeline for girls to report child abuse through teachers was closed throughout SSA.[75] Furthermore, in some instances, the most disadvantaged girls are worst affected by closed schools. For example, in North West Nigeria—where educational attainment is poorest for girls, and the area is child marriage-prone, the lockdown measures decrease girls' school attendance by roughly 10 percentage points relative to boys aged 12 to 18 years.[76] Lower school attainment for girls could affect women's future labour participation prospects.

Projections indicate that sustained lockdowns or disruptions of at least 6 months will delay the implementation of initiatives to end female genital mutilation (FGM). Specifically, UNFPA projects that 2 million cases of FGM will occur in the next decade due to disruptions occasioned by COVID-19.[77] For example, in Ethiopia, the National Roadmap to End Child Marriage and female genital mutilation/cutting (FGM/C) was only launched in 2019, and the pandemic and associated school closures threaten the roadmap. Early results following within four months of the pandemic in Ethiopia pointed to increased arranged marriages due to the closure of schools.[78] Similarly, teenage pregnancies jumped 60% in South Africa during the pandemic (Box 1). On the other hand, young mothers are not guaranteed readmission to school if they choose to continue their education; some have been blocked from readmission due to the stigma associated with childbirth, as illustrated in Box 2 below.

Box 1: Teenage pregnancies increase by 60% during the pandemic

> The Gauteng Province—which accounts for at least 25% of South Africa's population, registered a 60% increase in teenage pregnancies between April 2020 and March 2021. At least 4% of the 23,226 pregnancies registered were attributed to girls aged 10-14 years. Only 13% of the girls choose to terminate the pregnancies. Beyond statutory rape and SGBV issues, the exceptionally high deliveries were attributed to limited access to contraception during the pandemic or the option of safe abortion.

Source[79]



73 Ritz, D., O'Hare, G. and Burgess, M. (2020), The Hidden Impact of COVID-19 on Child Protection and Wellbeing. London, Save the Children International.

74 Ataguba, J.E (2020) "COVID-19 Pandemic, a War to be Won: Understanding its Economic Implications for Africa" Applied Health Economics and Health Policy Vol 18: 325-328.

75 African Child Policy Forum and Plan International (2020) Under Siege: Impact of COVID-19 on Girls in Africa.

76 Dessy et al, (2021). COVID-19 and Children's School Resilience: Evidence from Nigeria World Bank Policy Research Paper No 9736.

77 UNFPA (2020)

78 Jones, N., Y. Gebeyehu, K.Gezahegne, et al. (2020) Child marriage risks in the context of covid-19 in Ethiopia

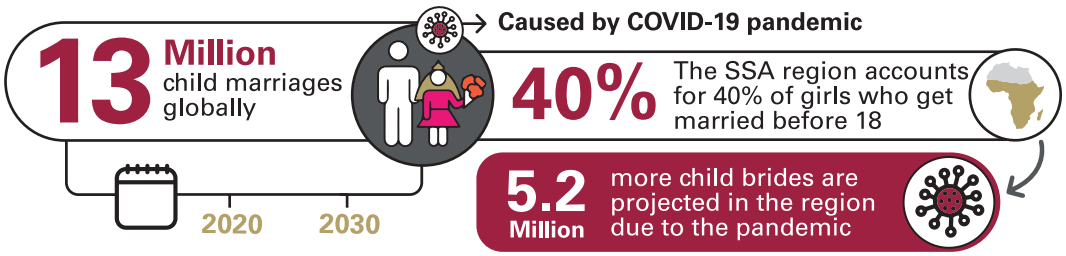
79 Save the Children (2021) https://www.savethechildren.net/news/teen-pregnancies-south-africa-jump-60-during-covid-19-pandemic

Box 2: Uganda: Resuming school after teenage pregnancy remains a challenge

In January 2022, Uganda re-opened all its schools after 83 weeks of school closure. Prior to the re-opening, the Ministry of Education issued a directive to allow back girls who ended up pregnant or gave birth during the lockdowns. On the other hand, upon re-opening, religious groups (which are the founding bodies to a substantial number of publically funded schools) decreed that pregnant and breastfeeding children be blocked from readmission due to perceived fears of providing a "bad example" to other school-going children as early pregnancy was considered an act of indiscipline. This was the case regardless of the circumstances that led to the early pregnancy, including sexual gender-based violence.

Source[80]

Projections by UNFPA also indicate that the COVID-19 pandemic would cause over 13 million child marriages globally during 2020-2030.[81] The SSA region accounts for 40% of girls who get married before 18, and at least 5.2 million more child brides are projected in the region due to the pandemic. Furthermore, the pandemic increased the risk of young girls engaging in transactional sex with dire consequences. For example, in Ethiopia, the pandemic forced street-connected adolescents to engage more in transaction sex to meet food security needs, led to increased stigmatisation about the prospects of transmitting COVID-19 by highly adolescents and also increased substance abuse as a means to deal with the psychosocial impacts of the pandemic.[82]



3.4.1 Gender and school performance after lockdowns.

Box 3: Challenges faced by learners upon lifting of school closures and the risk of female school dropouts in Uganda

In March 2021, the Uganda National Examination Board (UNEB) tested the proficiency of Primary 6 pupils who had reported back to school after the first COVID-19 lockdown in the country (March-October 2020). The tests were conducted in 500 primary and 200 secondary schools spread across Uganda and entailed FGDs with the students at school, interviews of teachers, and telephone interviews for parents whose children had failed to report back to school after the lifting of school closures. The results revealed a decline in literacy proficiency among the Primary 6 cohort from 32% in 2017 to 27% in 2021, while that of mathematics declined from 55% in 2017 to 41.2% in 2021. The decline in learning achievement was attributed to the limited time for learning while the students were under lockdown. In at least half of the primary schools, learners reported that they never had sufficient time to study and felt tired at the end of the day's work because of engagement in home chores and casual labour.

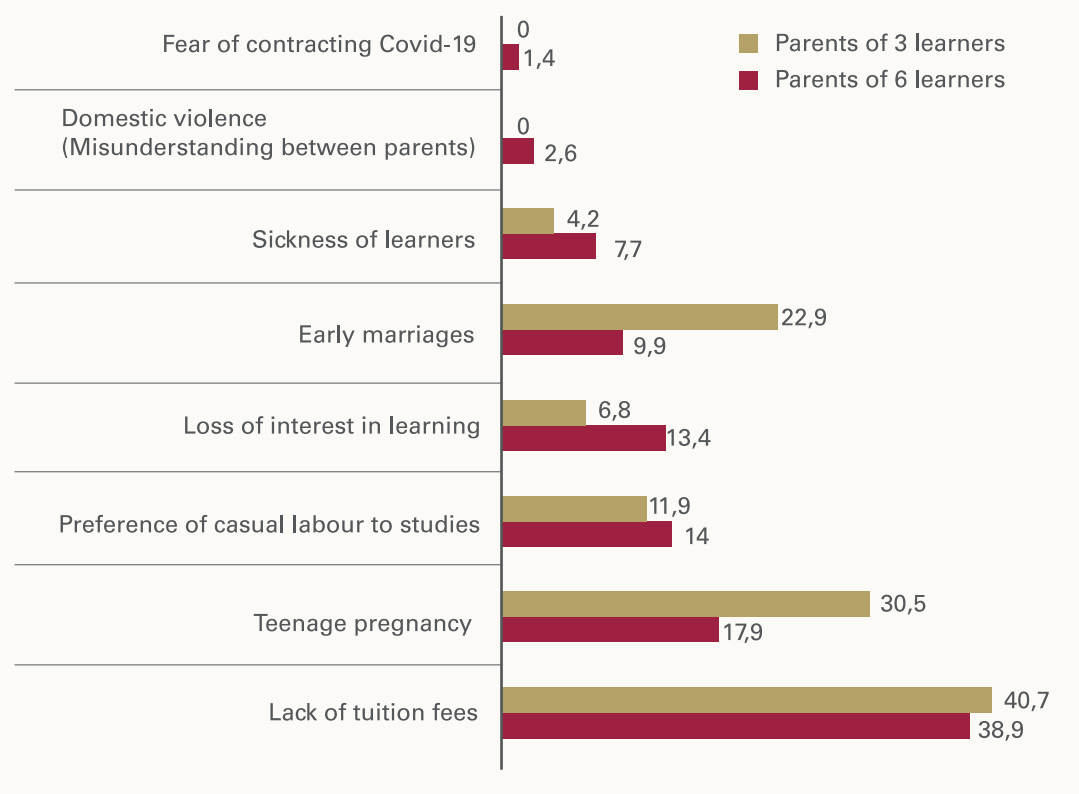
80 Daily Monitor January 10, 2022 "Block pregnant girls from church schools, Ugandan bishop tells teachers" https://www.theeastafrican.co.ke/tea/news/east-africa/block-pregnant-girls-school-bishop-uganda-3677514.

81 UNFPA (2020).

82 Amdeselassie, T., G. Emirie, A. Iyasu, et al (2020) "Experiences of vulnerable urban youth under covid-19: the case of s treet connected youth and young people involved in commercial sex work" UNFPA August 2020.

At least 10% of the expected pupils in the primary schools did not report back. The main explanation why children did not report back to school after the lockdown was the lack of tuition fees (about 40% for each level of schooling). However, teenage pregnancy affected 18% of Primary 6 and 30.5% of Senior 3 girls who did not return to school. Early marriages hindered 10% of Primary 6 and 23% of Senior 3 learners who did not return to school.[83] Furthermore, only 20% of the Primary 6 and 29% of the Senior 3 parents whose daughters got pregnant planned to take them back to school after delivery. Given the extended duration of the second lockdown, i.e. from June to December 2021, one would expect a much larger share of children dropping out of school due to pregnancy-related challenges.

Figure 4: Uganda: Reasons why children did not return to school after the lockdown (%)



Another challenge mentioned that learners faced during the COVID-19 lockdown was child labour. Child labour was the most frequently cited challenge faced by learners during the lockdown (77% for Primary 6 teachers and 80% for Senior 3 teachers). At least 14% of Primary 6 parents and 12% of Senior 3 indicated that preference of causal labour instead of studying was why children did not report back to school. Based on the FGDs, the surveyed learners reported that they were over-worked (got tired) and called for enforcement of regulations regarding the amount of domestic work given to them.

Source[84]

83 The number of parents reporting were 352 for primary kids and 118 for secondary students. Also, reported reasons are not mutually exclusive.

84 Uganda National Examination Board (2021) Effects of COVID – 19 Pandemic on Teaching and Learning at Primary and Secondary Education levels in Uganda.

3.5 Access to essential health services

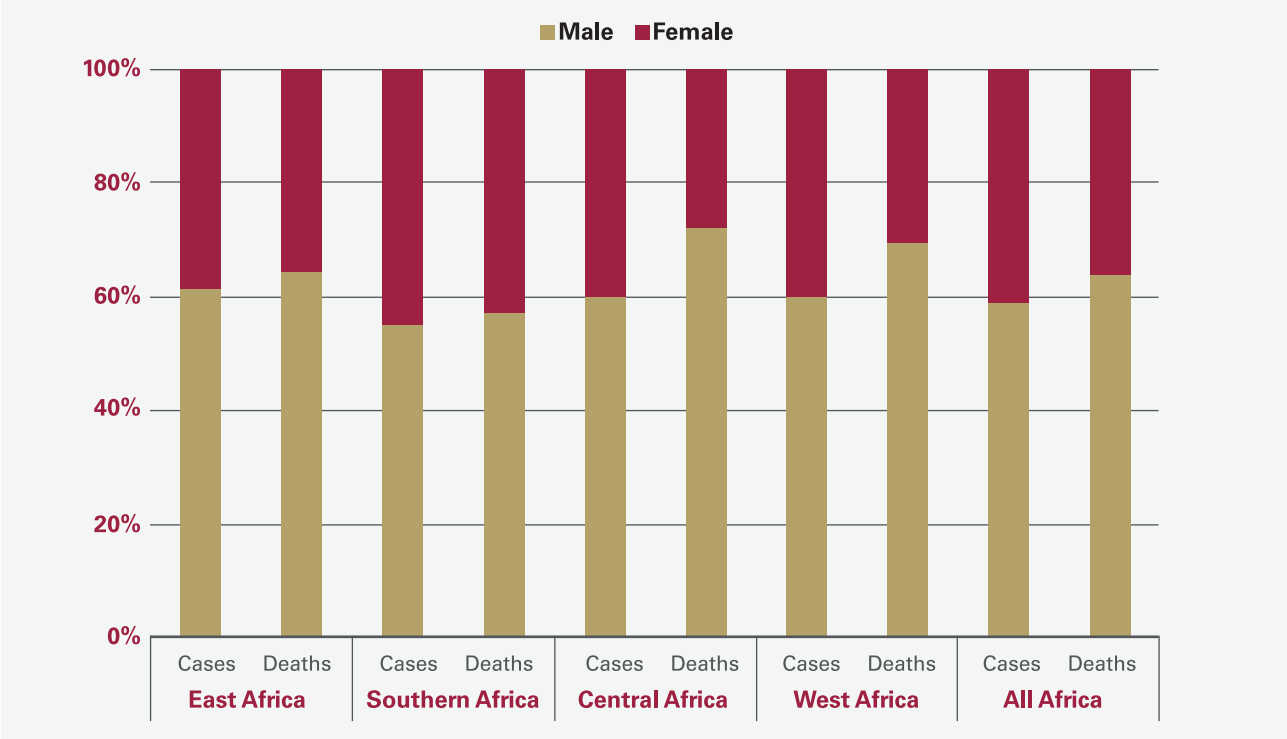
Part of COVID-19 SOPs implemented at health facilities involved changes in health protocols, including limitations on gatherings, affected particular types of vulnerable groups, e.g. those with disabilities. As a result, female PWDs visiting hospitals were denied access to family and other support teams, e.g. family care givers and sign language interpreters. On the other hand, regarding access to reproductive health services, health outreaches that provide sexual health services were discontinued during the pandemic. Finally, the focus on preventing and treating COVID-19 patients diverted substantial resources away from maternal and child health services. Below we explore the gender impacts of COVID-19 mortality, morbidity and access to health services.

Men account for a disproportionate share of COVID-19 deaths

As is the case globally, men in Africa have experienced a higher incidence of testing positive for COVID-19 and higher death rates. Across 46 AU Member States for which sex-disaggregated data were available, men accounted for roughly 59 % of all COVID-19 positive cases reported and 64 % of COVID-19 deaths (Figure 10).[85] However, there are significant gender differences by geographical region for reported COVID-19 deaths on the continent. The Central Africa region leads in having the highest share of male COVID-19 deaths (72.3%), followed by West Africa (69.8%), East Africa (64.5%), while Southern Africa has the least (57.4%). Among the 3 African countries reporting sex-disaggregated COVID-19 hospitalisations, men also dominate in at least two, i.e. 70% in Eswatini, 60.3% in Sudan, while the rate is 45% in Tunisia.[86]

Several factors have been advanced for the lower share of females among COVID-19 positive cases and deaths in low-income countries. These include positive the higher susceptibility of men to lifestyle-related behaviours and diseases such as smoking and alcohol use. Furthermore, the gender norms that restrict women's movements and labour force participation may reduce chances of contracting COVID-19. On the other hand, women face an increased risk of contracting the COVID-19 virus because of accounting for the predominant frontline staff in health facilities. In Egypt, women outnumber men by a ratio of 10: 1 among nursing staff.

Figure 10: COVID-19 cases and deaths disaggregated by sex in African Sub Regions (Dec 2021)



Source[87]

85 At least 46 AU member states report sex-disaggregated cases data while on 20 report sex-disaggregated deaths data.
86 See https://globalhealth5050.org/the-sex-gender-and-covid-19-project/dataset/ Accessed on 29 December 2021
87 HDX (2020), "Humdata", COVID-19 Sex-Disaggregated Data Tracker,

Disruptions to healthcare systems led to reduced availability and use of health services due to changes in protocols. In Ethiopia, a referral hospital registered a 16% reduction in using safe abortion services during March-May 2020 compared to a similar period in 2019.[88] There were also recorded delays in restocking family planning supplies in Nigeria. [89]The decline in family planning services in Nigeria ranged between 10-15 % within the first 3 months of the pandemic.[90]

Based on information from the health management information systems (HMIS) from 15 SSA countries[91] that were collected during March 2020 and June 2021 on health facility utilisation under the auspices of the Global Financing Facility for Women, Children, and Adolescents, estimates for low and middle-income countries show that the pandemic increased child mortality rates by 2.7% due to lower vaccination and outpatient attendance of health facilities.[92] On the other hand, at least 0.8% more maternal deaths are projected on account of lower child births in health facilities. Additionally, access to HIV/AIDS prevention services was affected; in South Africa, the proportion of pregnant women who missed scheduled pre-exposure prophylaxis (PrEP) visits increased from 34 % prior to the lockdown to 57 % during the lockdown. [93]

The pandemic also led to the diversion of health workers away from providing sexual reproductive health services. For example, in Uganda, a survey found that at least 15 % of health personnel delivering family planning services were diverted to address the COVID-19 public health emergencies.[94] On the other hand, health facilities in Nigeria and Mali registered a decline in the share of facility-based childbirths during the first 5 months of the pandemic—ranging between 7 and 11%.[95] Diversion of health resources also has the potential to affect long term maternal health status. Evidence from past pandemics shows that maternal health services are among the worst affected when health systems divert resources. Previous estimates based on the Ebola crisis show that the maternal mortality ratio increased by 110% in Liberia during the Ebola crisis as scarce resources were diverted to other uses.[96]

The pandemic also affected access to services for vulnerable women, e.g. female PWDs. Sometimes, the changes in the health care protocols were not effectively communicated, which affected women with disabilities. Changes to health protocols, including limitations on gatherings, affected access to family and other support teams, e.g. family carers and sign language interpreters, for female PWDs visiting health facilities.

In Malawi, it was noted that access to sexual and reproductive health for female PWDs was constrained by the movement restriction—especially the closure of public transportation—poor women could not afford the costs of hiring private vehicles to travel for health services.[97] Although most African countries that implemented lockdowns had exceptions to allow access to essential health services and medicine, the haphazard enforcement of rules curtailed movements. For example, certain vulnerable groups were not considered in the various fiscal stimulus and social protection arrangements, e.g. sex workers operated in challenging environments to negotiate safe sex. [98]This created barriers to HIV/AIDS prevention, testing and treatment.

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88 Belay, L., et al. (2020). Effect of COVID-19 pandemic on safe abortion and contraceptive services and mitigation measures: a case study from a tertiary facility in Ethiopia. Ethiopian Journal of Reproductive Health 12(3).

89 Nagarajan, C (2020c) Impact of COVID-19 Pandemic on Violence against Women and Girls, VAWG Helpdesk Research Report No. 311. London, UK: VAWG Helpdesk.

90 Global Financing Facility. (2020). New findings confirm global disruptions in essential health services for women and children from COVID-19. Global Financing Facility.

91 The 15 countries of Cameroon, DRC, Ethiopia, Ghana, Guinea, Liberia, Kenya, Madagascar, Malawi, Mali, Nigeria, Sierra Leone, Senegal, Somalia and Uganda account for 63% of the SSA population and 51% of Africa's population in 2021.

92 Ahmed, T., T. Roberton et al. (2022) "Indirect effects on maternal and child mortality from the COVID-19 pandemic: evidence from disruptions in healthcare utilization in 18 low- and middle-income countries" Lancet

93 Davey, D. et al. (2020). PrEP retention and prescriptions for pregnant women during COVID-19 lockdown in South Africa. The Lancet HIV 7(11), pp. e735.

94 Performance Monitoring for Action. (2020c). PMA Uganda: results from phase 1 survey.

95 Shapira et al. (2021).

96 Evans, D., M. Goldstein and A. Popova (2015), "Health-care worker mortality and the legacy of the Ebola epidemic", The Lancet Global Health, Vol. 3/8, pp. e439-e440,

97 UNFPA et al (2021)

98 UNAIDS (2021) Rights in a Pandemic: Lockdowns, rights and lessons from HIV in the early response to COVID-19.

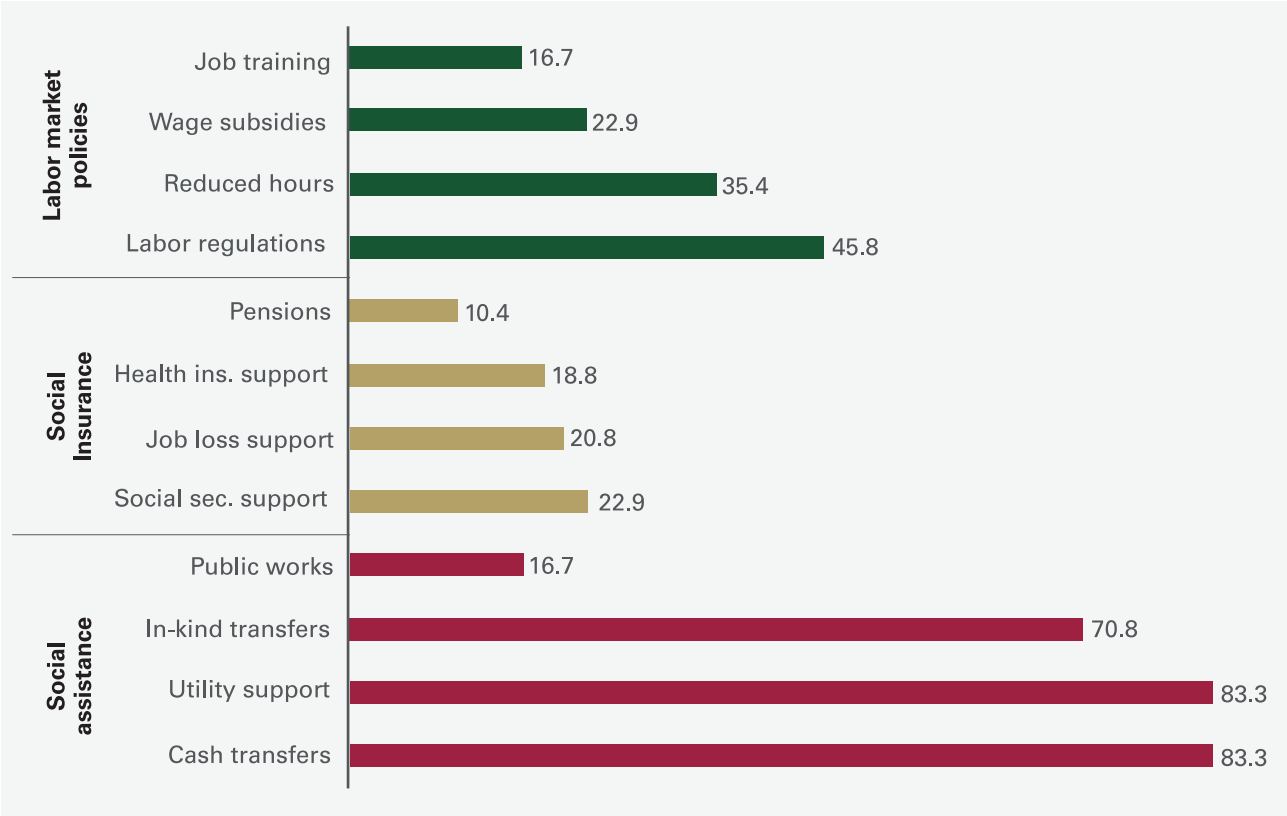
4. Gender and Government's Response to the COVID-19 crisis

4.1 Social protection measures

There was wide variation in the type of emergency social protection schemes implemented in SSA. Some of the interventions benefited women and girls either directly or indirectly. Figure 11 shows that social assistance dominated all other forms of social protection. In terms of social assistance, conditional and unconditional cash transfers were the primary interventions due to the lower cost of implementation and potential indirect market benefits.[99] Nonetheless, countries also provided in-kind transfers within social assistance due to the supply chain disruptions occasioned by COVID-19; most of this was in the form of food, e.g., in Angola (targeting children), Cote d'ivoire, Eswatini, Gambia, Senegal, and Nigeria. Other measures included control of staple food prices (e.g. Burkina Faso), provision of food to specific vulnerable groups (e.g. persons with disabilities in Sierra Leone) and livestock food to vulnerable populations affected by COVID-19 (e.g., in Mali).

The other form of social assistance has been utility support for electricity or water. For example, the governments of Eritrea and Madagascar postponed the payments for electricity and water. In Gabon, Guinea, and Mauritania, the State paid water and electricity bills for low-income families. On the other hand, the Government of Eswatini ensured that the citizens continued to access water and sanitation services—by providing water tanks and handwashing facilities. Burkina Faso, Burundi and Senegal offered subsidies on water and electricity costs.

Figure 11: Shares of countries implementing social protection measures in response to COVID-19.



Source[100]

99 Cash transfers are associated with improved dietary diversity and quality and greater household savings compared to food distribution or vouchers.

100 Gentilini et al (2021).

Regarding social insurance, interventions took the form of paid leave or unemployment benefits such as the continued payment of all civil servants employees in the parastatal and formal private sectors during the lockdown period—implemented in Ethiopia, Mozambique and South Africa.[101] Other forms of social insurance were through the provision of pension/disability benefits, e.g. in Zambia; money was allocated to public service pensions funds to enable payment of retirees or their beneficiaries. There was a 20% increase in pensions in Cameroon for those who did not benefit from the revaluation following the 2016 reform.[102]

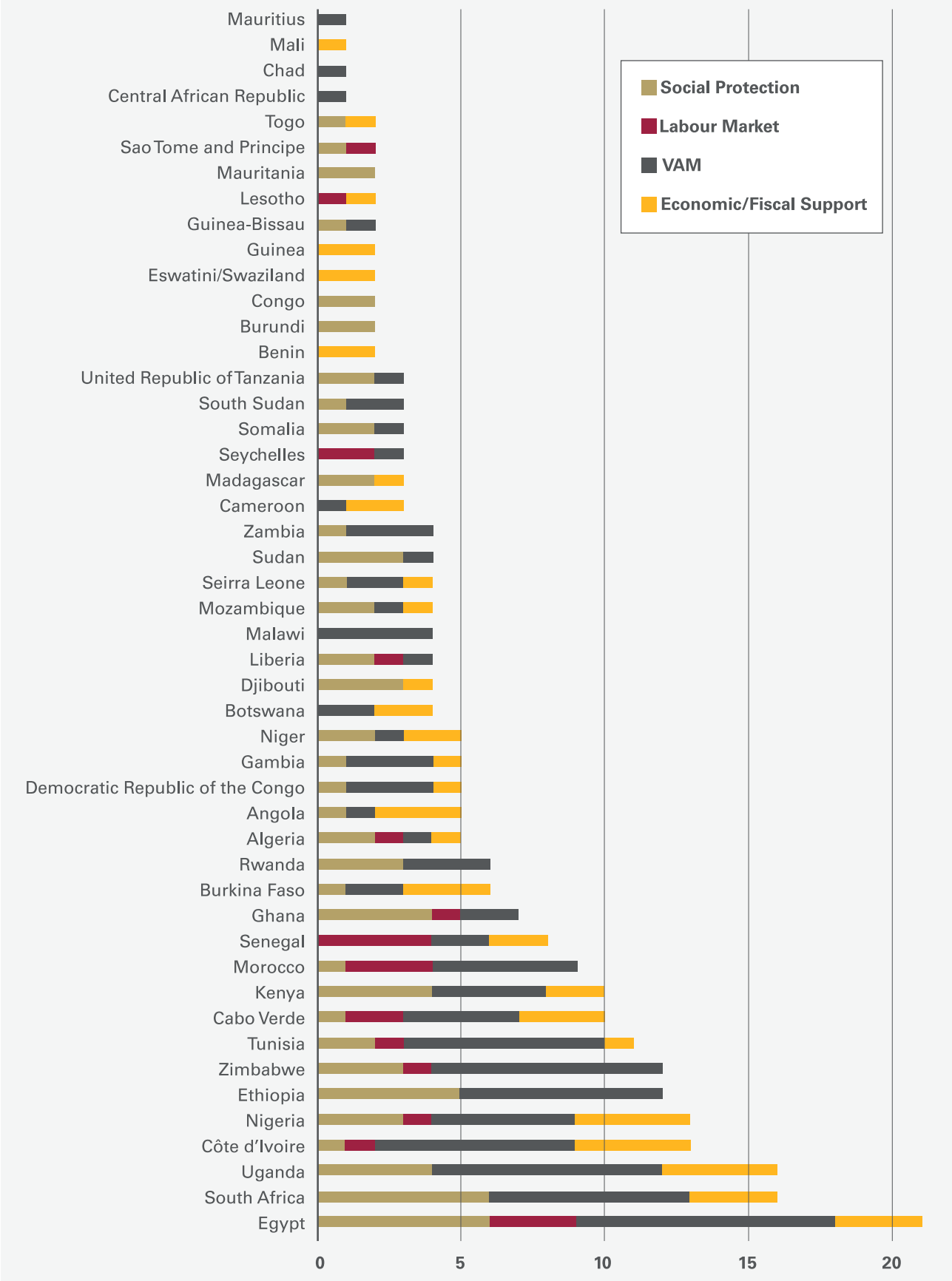
Finally, some countries implemented waivers or deferred payments for social security contributions. For example, monthly social security fund contributions were rescheduled for three months without penalty in Cameroon, Madagascar and Seychelles. Labour market interventions were in the form of wage subsidies, e.g. in Burundi, Cape Verde, Lesotho, and Mauritius.[103] There was also wage activation training, e.g. in Botswana, where the Government committed to financing a waiver on training levy for 6 months.[104] Finally, some countries implemented adjustments in labour regulations—notably in Ethiopia, where firms were prohibited from laying off workers and terminating employment.

4.2 Gender - Sensitive Policy measures

To respond to adverse COVID-19's economic and social impacts, the 55 African Union (AU) Member States have implemented social protection and health improvement initiatives since March 2020. Based on the Global Gender Response Tracker, only 270 out of 842 policy measures enacted by governments to address the COVID-19 crisis in Africa are classified as gender-sensitive, i.e. targets women's economic security, directly supports unpaid care work, or address violence against women and girls. Figure 12 shows the number of gender-sensitive policy measures implemented in 49 AU Member States by country and policy type. Out of the 239 gender-sensitive initiatives implemented due to COVID-19, 42% address violence against women (VAW), 29.3% address social protection, and 20% target economic or fiscal support to entrepreneurs. Labour market intervention account for less than 10% of all measures implemented. On average, African countries have implemented five gender-sensitive interventions since March 2020. Nonetheless, there is significant variation—at least 6 AU Member States did not implement any gender-sensitive measure while the majority implemented at least four measures.[105] On the other extreme, 10 countries implemented 10 or more measures, accounting for 50% of all gender-sensitive measures implemented on the continent.

101 Gentilini et al (2021).
102 Gentilini et al (2021).
103 Gentilini et al (2021).
104 Gentilini et al (2021).
105 The 6 countries without a listed gender-sensitive COVID-19 response measure are Comoros and Equatorial Guinea, Eritrea, Gabon, Libya, and Namibia

Figure 12: Number of Gender Sensitive Measures in Africa by country and policy type



Source[106]

106 UNDP-UN Women (2021)

In several AU Member States, women dominate employment in the health sector. For example, in South Africa, there are 1.5 women for every man employed in the sector; in Zimbabwe and Ghana, women account for 65% and 62% of health workers, respectively. Consequently, several policy responses were implemented in the health sector that benefited women. In Egypt, the monthly allowance for medical professionals was increased by 75 %; similar, health workers in Algeria, Chad, Ghana and Chad received bonus payments. In Chad, the families of health workers who have died of COVID-19 were granted the deceased's usual wages until all children are 18 years old. In Malawi, Government increased risk allowances for health workers from K1,800 (USD 3) to up to K60 000 (USD 75). in Zimbabwe, the Government unfroze 4000 health sector posts and created an additional 200 to ensure a full-scale response to the pandemic.

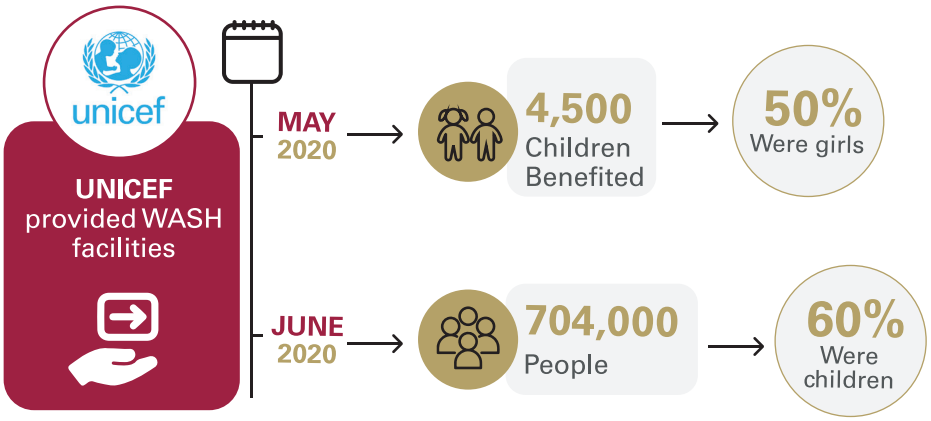
WASH Interventions to support school retention

As part of the COVID-19 response in education facilities, Water, Sanitation and Hygiene (WASH) interventions have been a significant feature of interventions implemented—partly as means to retain girls in school. For example, hygiene kits have been distributed in Guinea[107], Mauritania, Ethiopia, South Sudan, and Somalia. In addition, several countries constructed latrine blocks for girls—with a provision/room for menstrual hygiene management (e.g. South Sudan and Uganda). In preparation for school re-opening in South Sudan, school management committees were supported to undertake intensive back-to-school campaigns and provide menstrual hygiene management support through re-usable sanitary pads to young adolescent girls. In Somalia, the WASH initiatives targeted both access to water and hygiene promotion, as described in Box 4 below

Box 4: Providing critical WASH supplies to adolescent girls and women in Somalia

In May 2020, UNICEF provided WASH facilities such as hand-washing and latrines to improve hand-washing, hygiene, and sanitation practices in schools to enhance the safety and protection of learners. These facilities benefited 4,500 children, 50% of whom were girls. To address the challenges of women and girls, UNICEF supported water trucking to ensure households have access to enough water for hand-washing and women do not have to travel long distances to collect water. By June 2020, over 704,000 people—60% of whom were children—had received critical WASH supplies and services, including hygiene items and safe water supply through water trucking. During April-June 2020, UNICEF offered 30,000 women and adolescent girls menstrual hygiene management (MHM) kits to enhance their dignity.

Sources[108]



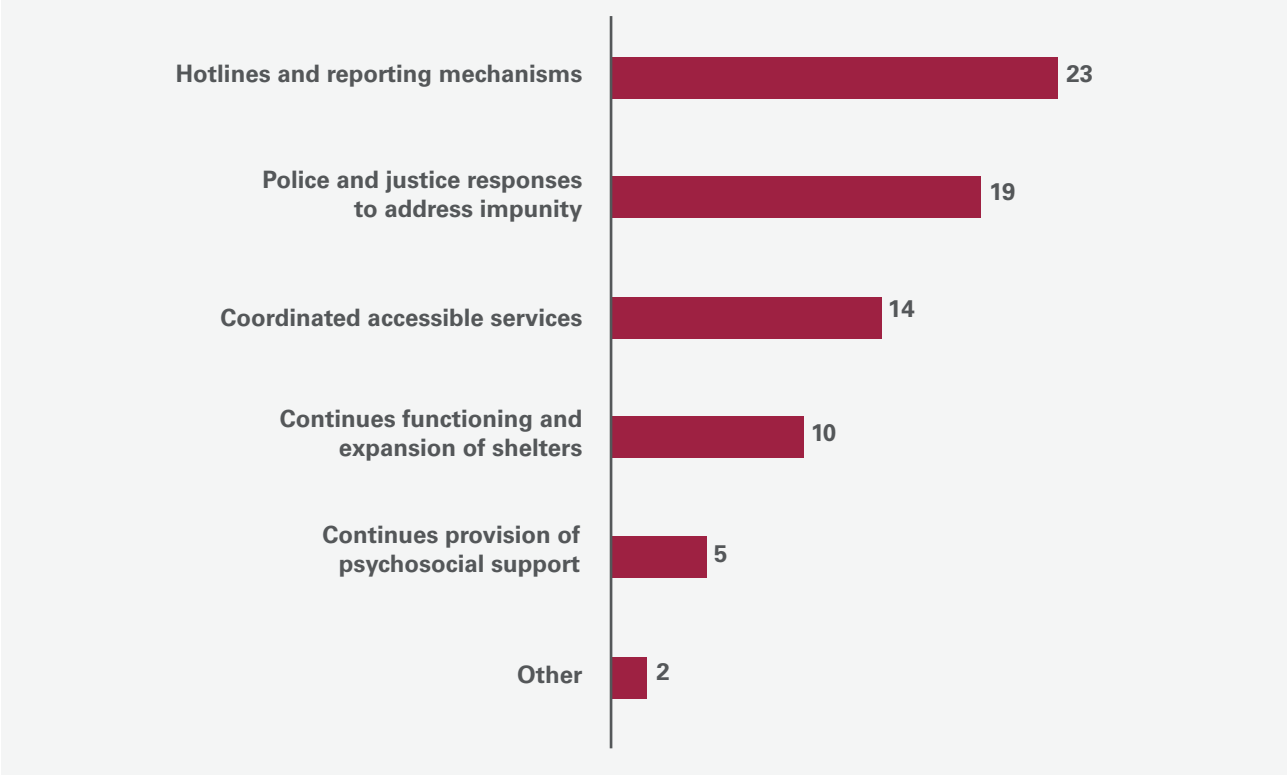
107 The target was to distribute sanitation kits to 130,900 households (more than 850,000 people).

108 UNICEF (2020)

4.3 Measures to address violence against women

Among the major policy measures addressing VAW involved the "strengthening of services"—which dominated all other VAW measures—accounting for 64% of all VAW policy measures. The other measured implemented can be broadly categorised as "Awareness-raising campaigns" (17%) and "Collection and use of data" (8%). Figure 13 shows that within the policy measure of strengthening of services, the primary sub-type measure was the launch of hotlines and victim reporting mechanisms—these accounted for more than 30% of all strengthening measures followed by Police and justice responses to address impunity (26%). It is also worth noting that at least 10 policy measures relating to the continued functioning and expansion of shelters were implemented on the continent in response to the rising of GBV.

Figure 13: Number of measures on strengthening of services to address VAW by sub-type of measure



Source[109]

Regarding establishing hotlines to respond to GBV, according to the GGRT tracker, measures were in the form of the launch of new dedicated toll-free lines (e.g. Angola, Mozambique, Sudan and Cote d'ivoire), the extension of operating hours for GBV call centres (e.g. Egypt and Tunisia), and the provision of more toll-free lines (e.g. Nigeria, South Africa and Uganda). Other relatively unique interventions in response to victim reporting included the provision of "SALAMA kits" containing protective equipment and sanitation supplies. This was done in Morocco. Other countries, e.g. Mozambique, partnered with telecommunications companies 24/7 during COVID-19 as means for women and girls to report safety concerns. On the other hand, various measures were implanted to address GBV impunity. These ranged from the operation of special courts as a response to the COVID-19 crisis (e.g. Botswana, South Sudan and Zimbabwe) to the provision of remote access to courts (e.g. in Kenya, South Africa, and Tunisia) and the enactment of new policies/regulations addressing VAW (e.g. in Liberia and Malawi).

Several innovations were implemented to address VAWG during the pandemic. Specifically, innovations were in strengthening services through hotlines and reporting as well as awareness-raising campaigns. Most of the innovations entailed using digital infrastructure, especially new hotlines or collaborations with telecommunication service providers.

109 UNDP-UN Women (2021)

For example, a free psychological support service via phone was launched in Tunisia, and video conferencing was used for hearings or the provision of testimony.[110] In Cape Verde, an alternative reporting mechanism was created in the form of a coded message—used in any pharmacy across the country by survivors of GBV. Similarly, in DRC, an online network of psychologists and social workers was set up to provide psychosocial support to GBV and COVID-19 survivors and refer them to the appropriate services.[111] Finally, in South Africa an alcohol ban was adopted during lockdown to limit risks of GBV. Other innovations have entailed repealing discriminatory policies against school re-entry for pregnant girls, as explained in Box 5 below.

Box 5: Reinforcing school re-entry policies for pregnant students and adolescent mothers

According to Human Rights Watch, by 2021, at least 30 AU Member States presently have school re-entry policies that prescribe conditions for pregnant students and adolescent mothers. However, during the COVID pandemic, several countries abolished existing discriminatory policies or re-enforced available policies. In December 2020, Uganda issued revised guidelines for preventing and managing teenage pregnancy in a school setting. Among the various provisions included the right of parents to report school administrators who refuse to enrol young mothers. In March 2020, Sao Tome removed a nearly 15-year restriction that blocked thousands of adolescent girls from secondary education. Similarly, in March 2020, Sierra Leone lifted its 10-year-old ban on public school attendance for pregnant girls and teenage mothers following an ECOWAS court ruling. In March 2021, Sierra Leone's Ministry of Basic and Senior Secondary Education adopted a policy on "Radical Inclusion in Schools" that gives pregnant girls the right to remain in class until they give birth and allows them to return to lessons as soon as they wish.

Sources[112]

4.4 Labour market measures

AU Member States implemented several other labour market interventions. Only one measure was implemented directly targeting unpaid care work. Specifically, Cabo Verde introduced reduced work time and mandated teleworking. If possessing the necessary logistical conditions, parents (mothers and fathers) of a child under 3, in consultation with their employer, could work from home to ensure the care of children under a teleworking regime (UNDP-UN Women, 2021). Similarly, South Africa introduced a comprehensive initiative to partly deal with unpaid care work through the Care Giver Allowance, implemented in April-October 2020. This was a flat top-up of R500 (about USD 30 per month) in addition to the Child Support Grant (CSG). The programme reached 7.2 million, of which 98% were women. Beyond alleviating unpaid care demands, CSG was progressively from a gender standpoint—it was more likely to be captured by women than men. In contrast, other grants, such as the Temporary Employee/Employer Relief (TEER) Scheme, were regressive (Jain et al., 2020). Burundi was among the few African countries that announced a policy measure directly addressing unpaid care—by adopting a policy on providing meals at care facilities.

Other AU Member States offered options for teleworking to ensure the continued care for children. Djibouti promulgated the Presidential decree (2020-63/PR/MTRA) to allow exceptional measures, including teleworking and partial work. Lesotho's Government[113] provided a three-month wage subsidy to over 40,000 textile and clothing industry employees.[114] In Sao Tome and Principe, the Government committed to cover up to 85% of salaries in the priority sectors affected by the pandemic, including tourism, restaurants, and hotels (UNDP-UN Women, 2021).

110 UNDP-UN Women (2021)
111 UNDP-UN Women (2021)
112 Human Rights WATCH (2021) Africa: Rights Progress for Pregnant Students
113 In Lesotho, the textiles and garment industries are of critical importance to women's employment; women account for 82% of employees in the textile and garment industries.
114 UNDP-UN Women (2021)

In Tunisia, working hours were reduced for pregnant women and persons suffering from certain diseases. In Egypt, the Ministry of Communication and Information Systems (ICT) launched an educational program for women to prepare them for the labour market, including new technological tools.[115]

Only Algeria implemented intervention for paid leave on the continent to benefit women. Specifically, an executive decree in March 2020 introduced a series of exceptional measures; under the terms of the said decree, at least 50% of the staff of each institution and public administration were placed on exceptional paid leave for the two weeks.[116] Exceptional paid leave was granted for all working mothers without exception. Pregnant women and women raising children were also priority categories for this leave. The measure was then extended to both the public and private sectors. On the other hand, the Algerian National Social Insurance fund (CNAS) extended the deadline for paying employers and independent contributions up to September 2020, including covering employees on paid leave.[117]

4.5 Fiscal and economic security measures

At least 143 measures were implemented targeting women's economic security, i.e. either through social protection, the labour market, economic, financial and fiscal support for businesses and entrepreneurs. Figure 14 shows that at least 43 of the AU Member States implemented one measure targeting economic security. The most common intervention implemented were social protection measures (dominated by social assistance) (48%) followed by equity injection by way of either public sector loans or subsidies to businesses (18%) and tax-related measures (14%) followed by labour market activation measures and enterprise development.

115 UNDP-UN Women (2021)
116 UNDP-UN Women (2021)
117 UNDP-UN Women (2021)

Figure 14: Measures of women's economic security by country and policy type

Source[118]

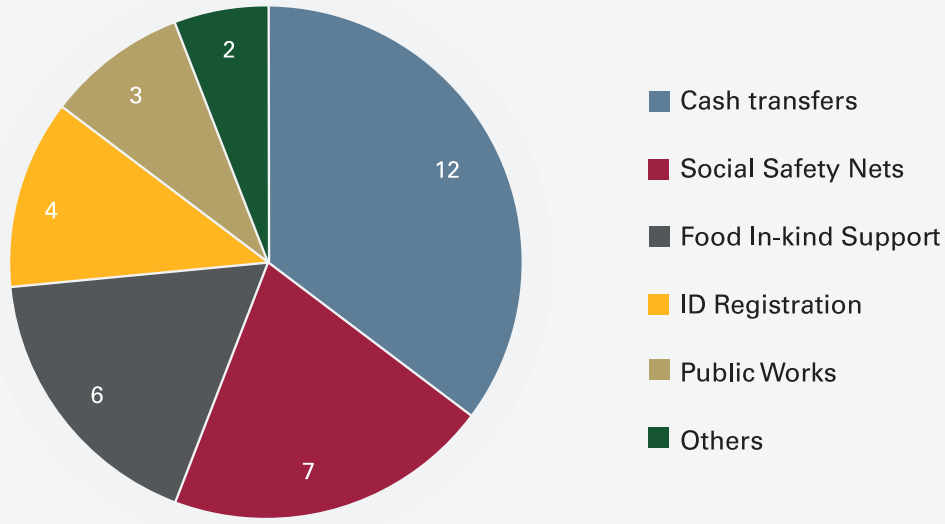
There were some innovations to address the specific challenges faced by women due to COVID-19. The innovations targeting women's economic security included tax deferral for the tourism sector (Egypt) and a state guarantee scheme for the tourism sector in Morroco. For the labour sector in Egypt, the Ministry of Manpower launched an initiative, the "Egypt is More Beautiful" initiative, to train, qualify and employ people with disabilities during the pandemic.[119] In Morocco, the Ministry of Agriculture created a digital platform for presenting and marketing local products from women's cooperatives. On the other hand, Senegal offered vulnerable households in-kind relief sourced from women farmers.

118 UNDP-UN Women (2021)
119 UNDP-UN Women (2021)

Gender sensitivity of Multilateral Development Banks (MDBs) Response

The pandemic was characterised by increased lending by multilateral development banks (MDBs) to address budget support, public health, and social protection issues. The focus of the support was mainly on the provision of cash transfers, followed by social safety to women and food/in-kind transfers (Figure 15). The chart also shows some efforts to provide ID registration to women since this appeared to constrain access to available social protection services. Table 1 in the appendix shows the extent of gender targeting in the MDBs's support by the African Development Bank and the World Bank in 27 African countries. Most gender indicators targeted were individual and as such benefited women exclusively.

Figure 15: Social Protection Measures captured in MDBs lending in response to COVID-19



Source[120]

4.6 Impacts of implemented interventions

Women can be disadvantaged in several ways, including receiving less than expected COVID support. In South Africa, there was no statistical gender difference in receiving the special COVID-19 grant despite women accounting for the majority of the unemployed that this grant was targeting.[121] This is attributed to the eligibility criteria, which specified that recipients of the COVID-19 grant could not concurrently hold other grants, whereas women accounted for 85% of recipients of other grants. The same study also show that urban women were 43% more likely to apply and receive the special grant than their rural counterparts.

The significant fiscal response African governments implemented in response to COVID-19 only remotely targeted gender indicators. For example, tax policies were generally gender-neutral. However, some countries made tax policies that indirectly favoured women through reduced or deferred taxes. For example, the suspension of recovery of tax debts for hotel and catering sectors in Burkina Faso. In Burkina Faso, hotel and catering account for 7.8% of women's employment compared to 1.7% for men. In Cote d'ivoire deferred income tax payments for 3 months for tourism-related sectors accounted for 10% of female employees compared to 1% for men; IMF, 2021). In Egypt, hotel facilities were relieved of the estate tax for six months, while the payment of any dues was postponed for three months without attracting penalties.[122] In Morroco, the tourism sector received a suspension of social security contribution payments.

120 Webster, B., A. Gelb, M. O'Donnell, et al (2021) Gender in the MDB Social Protection Response to the COVID-19 pandemic. Centre for Global Development (CGD) Note: August 2021.

121 Köhler, T and H.Bhorat (2021) "Can cash transfers aid labour market recovery?: Evidence from South Africa's special COVID-19 grant" DPRU Working Paper 202108, June 2021.

122 UNDP-UN Women (2021)

5. Conclusions and Recommendations

This report sought to investigate how the COVID-19 lockdown measures and policy response to the pandemic affected GBV, women's employment and access to quality reproductive health care, and the burden of unpaid care work in African Union Member States.

From the analysis, the government response—notably lockdowns and movement restrictions—generated unintended consequences that inadvertently led to an increase in GBV prevalence. Both GBV experiences and safety concerns from walking alone during the day or at night increased due to the lockdowns. In sampled countries, GBV experience increased by at least 38%. Stay-at-home measures coupled with reduced economic activities and consequently earnings affected the mental health status of would-be GBV perpetrators. At the same time, the closures of schools exposed girls to GBV perpetrators with minimal recourse to response services—as many of the services were halted or affected by travel restrictions. School closures led to increased teenage pregnancies. On the other hand, some AU Member States responded to the increase in violence by initiating new GBV response services and innovating approaches to delivering such services in crisis settings.

Regarding women's employment, even in relatively well-developed AU Member States, e.g. South Africa and Egypt, fiscal stimulus and other rescue packages focused more on the formal and public sectors and less on the informal sector. Furthermore, policy responses to address the adverse impact of COVID on women's employment-focused on broader social protection, with only a few being gender-sensitive. The gender-sensitive measures implemented took several dimensions. First, some states offered fiscal stimulus packages (e.g. tax deferrals) for the hospitality and tourism sectors, employing a significant share of women. Such initiatives were implemented to maintain female labour participation. Secondly, several countries offered cash transfers, and in most cases, most beneficiaries were expected to be women. Third, Member States allocated new resources to female enterprises to provide wage subsidies and income replacement for self-employed women. Fourth, there were regulatory changes in the health sector, with a few governments un-freezing the ban on recruitment in the health sector—a sector disproportionately employing women. Nonetheless, given the limited resources for COVID response, more women in AU Member States lost jobs than the policy response measures could replace.

The evidence is mixed regarding response measures meeting women and girls' longer-term needs and priorities in Africa. It is worth pointing out that the requirements and preferences of women and girls are numerous, including economic security, supports for unpaid care and health care demands—some of the measures adopted to control the pandemic affected women's needs. For example, the diversion of resources away from reproductive health provision to COVID testing and treatment could affect the long term health status of women and children. Several services associated with health facilities, e.g. birth registration, were curtailed during the lockdown, raising short-term child protection concerns. On the other hand, the ban on alcohol affected household-based enterprises, given that brewing is a critical activity for ensuring economic security for women working in the informal sector. At the same time, the lockdown exacerbated the unpaid care burden faced by women and girls.

Most of the specific initiatives implemented targeted income replacement, ensuring food security, sanitary provisions, the scaling up GBV response and a few attempts to address unpaid care work. However, only a few responses were integrated to ensure an adequate gender response. Only Egypt, Ethiopia, and Zimbabwe offered paid sick leave to expectant mothers to reduce the risk of contracting COVID-19 and indirectly address unpaid care work demands. South Africa offered a Care Giver Allowance—partly to handle the surge in unpaid care as well as the closure of ECD facilities. Only Burundi offered the alternative of providing meals at care facilities. As such, whereas governments identified and responded to the economic security and partly GBV requirement of women and girls, there was a meagre response to the surge in the burden of unpaid care work.

Despite COVID-19 starting as a health crisis and the increased public spending on health, response measures severely affected women's access to quality reproductive health care. During the lockdowns, several AU Member States singled out the health sector as a priority or essential sector and issued special passes to access health facilities; however, the haphazard enforcement of rules was not balanced adequately with the health needs of women and these generally curtailed movements to health facilities.

There were also changes to protocols at the health facilities—to enforce SOPs—which further affected women who managed to move, e.g. eligibility of carers to access health facilities. As earlier mentioned, the diversion of health workers away from providing sexual and reproductive health services will have implications for the health status of children. Evidence indicates that child mortality rates will increase on the African continent due to lower vaccination and outpatient attendance during the pandemic. At the same time, maternal mortality rates are projected to increase due to fewer births at health facilities.

The school closures affected girls' education severely and consequently increased their vulnerability. A significant proportion of AU Member States lost more than one year of schooling between 2020 and 2021. Several Member States offered alternative forms of learning to children while at home—using radios and televisions, newspapers, and the internet. However, these alternative forms of learning did not provide a worthy substitute for school attendance. Due to the advent of universal primary education (UPE) programmes, nearly all children were attending schooling before the school closures; during COVID, only about 60% of the children reported any engagement in any form of learning. Worse still, teacher presence nearly vanished, with only about one out of ten students contacting a teacher after the lockdown. The children receiving no education have a higher potential dropout of school and face an early likelihood early pregnancy, in the case of girls.

Overall, rising teenage pregnancies create a risk of pushing back gains made in reducing gender gaps in education access during the implementation of UPE programmes. On the other hand, with the lifting of the school closures, child mothers face additional discrimination with the prospect of being blocked from re-enrolling into schools. Finally, there have been very few empirical estimates on the extent of teenage pregnancies on the continent—partly due to the data collection challenges faced by the pandemic.

Beyond lost human capital, the remarkably high teenage pregnancies registered during COVID-19 have implications for healthcare and the aspiration of the adolescents affected. Concerning health, adolescent pregnancies are associated with a higher likelihood of death due to childbirth complications, such as fistula. Apart from pregnancy, early sexual activity increases the risk of contracting sexually transmitted infections—especially HIV/AIDS. Finally, another significant impact of teenage pregnancy is single motherhood which compromises women's economic security.

There were some innovations to address the specific challenges faced by women due to COVID-19; nonetheless, most of the policy measures implemented relied on the traditional approaches. For example, ensuring women's economic security was addressed through social assistance—by way of cash transfers or by labour market interventions—through wage subsidies and income replacement for self-employed women. The major innovations were mainly implemented in policy responses addressing VAWG.

5.1 Recommendations

The various impacts of the pandemic and the duration of the lockdowns call for several measures that ECOSOCC can champion. We recommend the following actions beyond the COVID-emergency response.

i. Ensure that established GBV response measures are maintained post lockdown.

ii. Support studies and data collection exercise to establish the true extent of changes in teenage pregnancies due to the pandemic. The failure to collect extensive data on adolescent pregnancy could imply that the gravity of the pandemic on girls will not be fully understood.

iii. Ensure that girls who have been unfortunate to become pregnant during the school lockdowns are not blocked from re-entering into schools on religious or other grounds.

iv. Recognise the burden of unpaid care work on women and the surge in this volume of work. This includes dealing with the unintended consequences of the health crisis. In particular, the COVID-19 measures call for frequent hand washing, increasing the burden of water collection on adolescent girls.

v. Advocate for changes in gender norms, including those relating to unpaid care work child marriage.

vi. ECOSOCC should support Member States in initiating policies that address unpaid care work.

vii. Support Member States by drafting appropriate pandemic protocols, including SOPs for accessing health facilities in times of a crisis.

viii. Engage with the private sector to support initiatives that close the digital divide, given the critical role digital platforms have played in ensuring quicker delivery of response measures.

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Table 1: List of Gender Indicators Targeted in COVID support by Multilateral Development Banks to AU member states

	Country	MDB	Project Name	Project Value (Million, USD)	Social Protection?	Gender Target?	Indicator	Indovidual or Household
1	Burkina Faso	World Bank	Burkina Faso COVID-19 Crisis Response Development Policy Financing	100	Yes	Yes	Total number of personnes indigentes (inc. internally displaced persons (IDPs)) to whom an identity credential adapted to the foundational ID platform has been issues (target 50% women);	Individual
2	Cabo Verde	AfDB	Cabo Verde - Covid-19 Crisis Response Support Programme (CCRSP)	36.3	Yes	Yes	Expansion of the Social Inclusion Income Programme for vulnerable households (incl. women headed) -8,000 with at least 40% headed by women (2020).	Household
							Creation of Solidarity Income and food assistance schemes for vulnerable (incl. women) - Scheme approved (with 50% female target) (2020).	-
3	Cameroon	AfDB	Cameroon - Covid-19 Crisis Response Budget Support Programme (PABRC) - Appraisal Report	108	Yes	Yes	Vulnerable households covered by social safety nets (30% of them headed by women).	Household
4	Central African Republic	AfDB	Central African Republic - Crisis Response Budget Support Programme (PABRC)	14.4	Yes	Yes	Households receiving food kits in the context of the fight against COVID-19 (target 50% women headed households).	Household
5	Central African Republic	World Bank	AF for COVID-19 Response under the Service Delivery and Support to Communities Affected by Displacement Projects	16	Yes	Yes	Female direct project beneficiaries (target 50%).	Individual
							People provided with improved urban living conditions (Number)(of which female)(Percentage)(target 50%)	Individual
							Beneficiaries of safety net programs (Number); of which female (Percentage)(target 50%)	Individual
							Female direct recipients of cash transfers (Percentage) (target 50%).	Individual
							Beneficiaries of safety net programs affected by COVID19 (Number); of which female (Percentage)(target 50%);	Individual

							Beneficiaries of safety net programs affected by climate related issues (Number); of which female (Percentage)(target 50%);	Individual
							Person-days of employment created (Number); of which female (Percentage)(target 30%)	Individual
6	Comoros	AfDB	Comoros- Covid-19 Crisis Budget Response Support Programme for Programme for the Union of the Comoros (PABRC) - Project Appraisal Report	20.55	Yes	Yes	10,000 households will recieve food kit (3,000 headed by women);	Household
							200 women will receive financial and material assistance for lost income	Individual
		World Bank	Additional Financing Comprehensice Approach to Health System Strengthening	5	No	Yes		
7	Congo	World Bank	Republic of Congo Lisungi Emergency Response COVID-19 Response Project	50	Yes	Yes	Beneficiaries of social safety net programs - Female (CRI, Number)(target 50%)	Individual
8	Côte d'Ivoire	AfDB	Côte d'Ivoire - Covid-19 Response Support Programme	92	Yes	Yes	Number of vulnerale households benefiting from money transfers (taret 40% women)	Household
9	Dem. Rep. Congo	AfDB	Multinational - Special and Urgent Operational to Support Memeber States of the Central African Economic and Monetary Community (CEMAC) and Democratic Republic of the Congo (DRC) to Fight the Coronavirus Pandemic (Covid-19)	1.95	No	Yes		
10	Ethiopia	AfDB	Covid-19 Crisis Response Budget Support Programme	164.4	Yes	Yes	Vulnerable households benefitting from the scale up of safety net programs (least 60% headed by women).	Household
		World Bank	Strengthen Ethiopia's Adaptive Safety Net	2283.7	Yes	Yes	Percentage of females who own and operate electronic accounts (Percentage)(target 50%)	Individual
							Beneficiaries of social safety net programes - Female (CRI, Number)(target 51%)	Individual

11	Ghana	AfDB	Ghana - Covid19 Response Support Programme - Project Appraisal Report	68.1	Yes	Yes	Number of vulnerable households benefiiting from food supplies - 400,000 (of which 35% headed by women) by end of July 2020.	Household
							INDICATOR 2.2 Number of households benefiting from free water and electricity - 3,000,000 households by end of June 2020 (of which 20% headed by women)	Household
		World Bank	Ghana Accountability of Learning Outcomes Project Additional Financing	44.8	No	Yes		
			Ghana COVID-19 Emergency Preparedness and Response Project Additional Financing	130	Yes	Yes	Number of women and children who have received basic nutrition services (CRI, umber)(target 50% women).	Individual
			Ghana: etransform Ghana Project Additional Financing	115	No	Yes		
			Ghana: Jobs and Skills Project	200	No	Yes		
12	Guinea	World Bank	Emergency Response and Nafa Program Support Project	70	Yes	Yes	Beneficiaries of emergency cash transfers for Covid-19 response - Female (Percentage)(target 30%)	Individual
							Beneficiaries of regular cash transfers under the Nafa program - Female (Percentage)(target 90%)	Individual
13	Kenya	AfDB	Covid-19 Emergency Response Support Program	227.5	Yes	Yes	Percentage of vulnerable population (individuals) covered by social safety nets (including%women)(at least half women);	Individual
14	Madagascar	World Bank	Support for Resilient Livelihoods in the South of Madagascar Project	100	No	Yes	Number of beneficiaries of caash transfer programs (including Tosika Fameno) disaggregated by gender and youth status;	Individual
							Number of workers benefiting from training disaggregated by gender	Individual
15	Malawi	World Bank	Financial inclusion and Entrepreneurship Scaling Project	86	No	Yes		
16	Mozambique	World Bank	Mozambique Covid19 Response DPO	100	Yes	No	New mobile transaction accounts opened by women due to social transfer scale up;	Individual

17	Niger	World Bank	Governance of Extractives for Loacal Development & Covid-19 Response Project	100	No	Yes		Individual
18	Nigeria	AfDB	Covid-19 Response Support Program	288.5	Yes	Yes	Number of vulnerable households (including female headed) benefiting from cash transfers (50% of which are women);	Household
							Number of people enrolled in the Public Works Program (50% of which are women).	Individual
		World Bank	Nigeria Covid-19 Preparedness and Response Project	114.3	Yes	Yes	It is expected that at least 150,000 beneficiaries will receive their social transfers via electronic payment means, 60% of whom will be women.	Individual
19	Rwanda	AfDB	Rwanda - Covid-19 Crisis Response Budget Support Program (RCRBS)	97.3	Yes	Yes	New vulnerable households due to Covid enrolled in Labour Intensive Public Works (LIPWs)(target 60% women);	Household
							Vulnerable people supported in basci health insurance (50% women).	Individual
20	Sao Tome and Principe	AfDB	Pandemic Crisis Response in the SADC Region and Sao Tome and Principe - Appraisal Report	0.7	No	Yes		
21	Senegal	AfDB	Senegal - Emergency Covid-19 Response Support Programme (PUARC)	106.5	Yes	Yes	Income stabilisation of poor households (including% of female headed households. - 40% of households covered by social protection programmes, 20% including women	Household
22	Sierra Leone	AfDB	Sierra Leone - Proposal for utilisation of savings from emergency humanitarian relief assistance to flood victims project towards emergency covid-19 relief assistance for water, sanitation and hygiene improvement	0.23	No	Yes		
23	Sudan	World Bank	Sudan Family Support Project	400	Yes	Yes	Number of families receiving cash/income support (Number) of which females are heads of families (Percentage)(target 2.4%);	Household
							Number of beneficiaries of SFSP (Number) of which female (target 50%)	Individual
							Gender - focused behavioral science integrated into the community strategy for SFSP in areas where women are not designated primary beneficiaries (Yes/No)	-

24	Tanzania	AfDB	Tanzania - Covid-19 Crisis Response Budget Support Program (TCRBSP)	49.2	Yes	Yes	Persons and households vulnerable to Covid-19 benefitting from the PSS None - year temporary conditional cash transfers program (target 25% women-headed households)	Household
							Vulnearble people supported to access improved community health fund (target 40% women).	Individual
25	Togo	World Bank	Togo Emergency Covid-19 DPO 2021	70	Yes	Yes	Share of women with mobile money accounts (percentage)(target 23%)	Individual
							At least 50% of cash transfer beneficiaries will be women.	Individual
26	Uganda	AfDB	Covid-19 Crisis Response Support Program	31.6	Yes	Yes	Proportion of poor and vulnerable families, including 31% female headed households, that have consumed ongoing food and nutritional support	Household
		World Bank	Uganda Covid-19 Economic Crisis and Recovery Development Policy Financing	300	Yes	Yes	The program will aim to have at least 50% women as beneficiaries	Individual
			Additional Financing for Uganda Reproductive, Maternal and Child Health Services Improvement Project	15	No	Yes		
			Covid-19 Emergency Education Response Project	14.7	No	Yes		
27	Zimbabwe	AfDB	Zimbabwe - Covid-19 Response Project (CRP)	15.22	No	Yes		

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