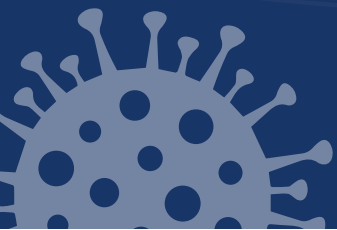




Impact of COVID-19 on Gender Equality and Women's Empowerment in East and Southern Africa



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IMPACT OF
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IN EAST AND
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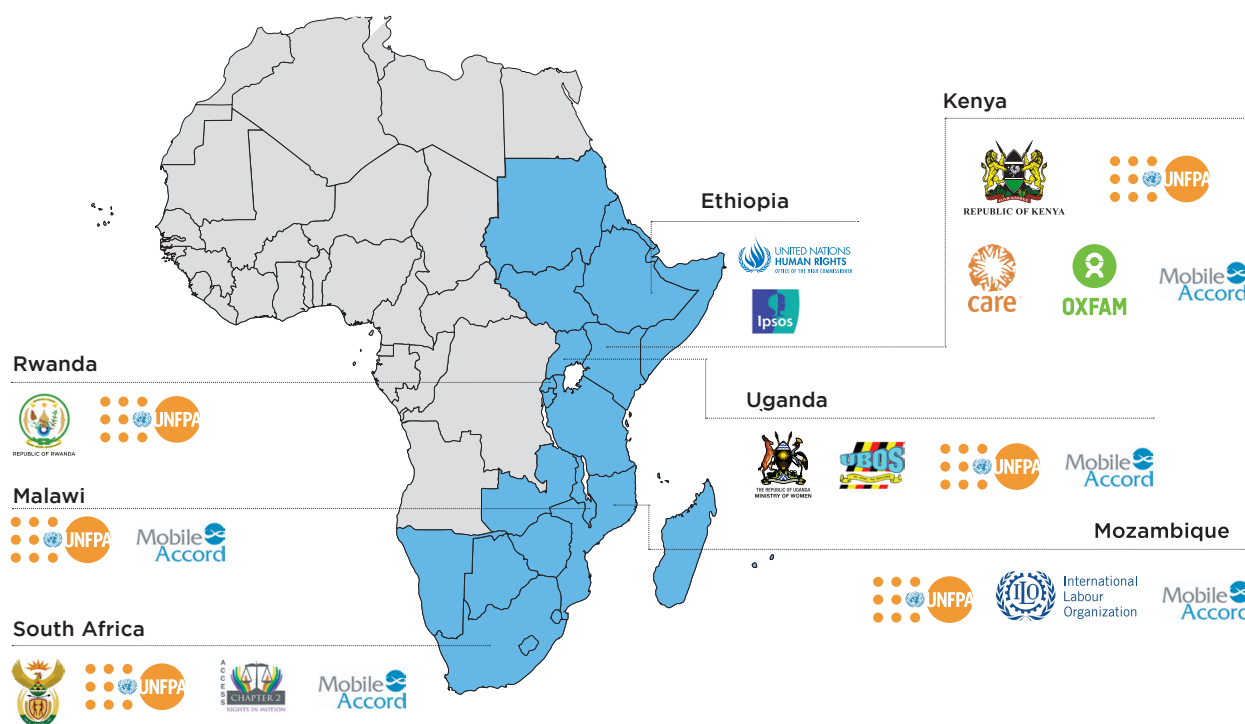
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Besides UN Women, the following agencies made technical and or financial contributions towards this report and or the Rapid Gender Assessments that provided primary data to the process:

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FOREWORD

At the onset of 2020, few of us anticipated what lay ahead. The COVID-19 pandemic declared in March 2020 caused unprecedented disruptions to all spheres of life and led to uncertainty and apprehension globally.

In East and Southern Africa, a region already beset by serious challenges on many fronts, most Governments responded quickly with efforts to contain the spread of the virus, concerned that already overburdened and fragile health systems would not be able to cope with significant increases in the demand for hospitalized care.

In part because of this decisive action, and with a few exceptions, most countries in the region continue to have relatively low levels of diagnosed infections and deaths. However, mobility restrictions due to lockdown measures to halt the spread of the virus have negatively impacted economies and led to school closures, loss of employment as well as livelihoods and incomes, the impacts of which will continue to reverberate through our region well beyond the pandemic.

The pandemic and measures put in place by governments to halt its spread have impacted women, men, girls and boys differently in the region. For instance, we have seen a significant increase in reports of gender-based violence, giving rise to the GBV ‘shadow pandemic’, while anecdotal evidence suggests that the number of child marriages and other harmful practices against girls, as well as teen pregnancies, has risen.

We are reminded that globally, women represent 70 per cent of the health and social sector workforce, and that on average, women do three times as much unpaid care and domestic work as men. This has long-term consequences for their economic security and overall well-being.

The pandemic has derailed many of the national planning processes, whether by Governments, civil society organizations, international agencies or the private sector. Responding to and reducing the impacts of the pandemic has meant a redirection in government expenditure and international aid.

As we begin to experience a downward curve in the second wave in most countries in the region – coupled with increased access to vaccines – there is a need to rethink how we will engage with, plan and budget towards interventions aimed at economic and social recovery in ways that advance gender equality and women’s empowerment (GEWE). The current context provides us with the opportunity to urgently build forward better and differently, while ensuring that women’s and girls’ needs, concerns and demands are at the centre of policy making.

UN Women and UNFPA undertook this study to understand better the gendered impacts of the pandemic and to inform national development planning for the recovery. The study highlights the impacts of COVID-19 on women and men as gleaned from research conducted during 2020, as well as the Computer Assisted Telephonic Interviews (CATI) Rapid Gender Assessments (RGAs) executed by UN Women, UNFPA and partners in seven countries in the East and Southern Africa region.

We hope that the findings of the study will contribute towards enlarging the evidence base for gender-responsive planning, budgeting and decision making, to realize women's rights and choices in the region. Even more so, it is our wish that it will translate into sustainable action that will make a difference in the lives of women in the region.



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ABBREVIATIONS AND DEFINITIONS

AfCFTA	African Continental Free Trade Area
AfDB	African Development Bank
BDI	Burundi
BWA	Botswana
COM	Comoros
DJI	Djibouti
ERI	Eritrea
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
ETH	Ethiopia
EVAW	Elimination of Violence Against Women
GBSV	Gender-based and sexual violence
GBV	Gender-based violence
GDP	Gross National Product
GNI	Gross National Income (previously known as Gross National Product)
GEWE	Gender Equality and Women's Empowerment
GWWD	Girls and women (living) with disabilities
iCCM	Integrated Community Case Management
IDP	Internally displaced people
ILO	International Labour Organisation
KEN	Kenya
LBPL	Lower-bound poverty line
LIC	Low-income countries
LMIC	Lower-middle income countries
LSO	Lesotho
MDG	Madagascar
MIC	Middle-income countries
MLW	Malawi
Morbidity	Morbidity rate indicates the proportion of population that is unhealthy
Mortality	Death rate



MOZ	Mozambique
MUS	Mauritius
NAM	Namibia
NEET	Not in education, employment or training
PHSM	Public Health Security Measures
PwD	People with disabilities
RGAs	Rapid Gender Assessments conducted in East and Southern Africa.
RMC	Regional Member Countries
RWA	Rwanda
SDGs	Sustainable Development Goals
SDN	Sudan
SGBV	Sexual and gender-based violence
SOM	Somalia
SRH	Sexual and reproductive health
SRMCNAH	Sexual, reproductive, maternal, child, new-born and adolescent health
SSA	Sub-Saharan Africa
SSD	South Sudan
STEM	Science, Technology, Engineering and Mathematics
SWZ	Eswatini
SYC	Seychelles
TZN	Tanzania
UGA	Uganda
UMIC	Upper-middle-income countries
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNCT	United Nations' Country Teams
UNDP	United Nations' Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Education Fund
UPBL	Upper-bound poverty line
VAWG	Violence Against Women and Girls
WB	World Bank
WHO	World Health Organization
ZAR	South Africa
ZMB	Zambia
ZWE	Zimbabwe

EXECUTIVE SUMMARY

Introduction and methodology

The COVID-19 pandemic has upended national development plans and is likely to derail the planned trajectories of most countries towards achieving the 2030 Agenda. Not only has it had a significant impact on the health and mental wellbeing of millions of people globally, but it has also set off a global economic crisis. UN Women, in partnership with UNFPA, has compiled an assessment of the impact of COVID-19 on gender equality in the East and Southern Africa (ESA) region.

The aim of the report is to outline the opportunities and constraints for GEWE in the post-COVID-19 recovery phase and identify the key gaps and challenges in current policies and programmes in the East and Southern Africa region. Countries¹ included in the scope of the study are Eswatini, Botswana, Lesotho, Namibia and South Africa in *Southern Africa*.¹ *East African* countries include Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Madagascar, Malawi, Mayotte, Mozambique, Réunion, Rwanda, Uganda, Tanzania, Seychelles, Somalia, Sudan, South Sudan, Zambia and Zimbabwe.

The assessment is based on a desk review of secondary data sources and publications, primarily published during 2020. Some primary data was also collected as part of the COVID-19 rapid gender assessments (RGAs) implemented by UN Women in partnership with UNFPA and various other agencies across the region. It is important to note that secondary data is not widely available for gender-specific issues in many countries in the sub-region and this is particularly true for fragile countries where the position of women is often more precarious than elsewhere. Thus, the secondary data presented as part of the regional overview provides in most cases a best, rather than worst case scenario.

The RGA data collection, using the Computer-assisted Telephonic Interview (CATI), was done in Kenya, Ethiopia, Rwanda, Uganda, Mozambique, Malawi and South Africa. It was based on a generic sample design of 2,400 women and men 18 years and older. Random digit dialling (RDD) was used for sampling purposes. Individuals were included in the sample if they met pre-determined quota requirements representative of the population by age, sex, location and household monthly expenditure prior to COVID-19. For a sample size of n=2,400, the margin of error is 32.0% at 95 percent confidence level for reporting at national level.² Due to CATI constraints on interview time, the questionnaire was divided into two modules/questionnaires applied during separate interviews of 15–20 minutes each in a demographic panel format. If a particular individual was not available for the second interview, she/he was replaced with someone with the same demographic profile. This basic methodology was applied slightly differently in the various countries and more details are available in the technical notes of the report.

¹ The UN Statistical Division's regional classifications have been used throughout the report, unless otherwise stated.

² Note that sample size calculations are not population size dependent but rather based on expected variability, and desired precision and confidence level

Demographics and the pandemic

Even though the first cases in East and Southern Africa were identified later than in other parts of the world, governments in the sub-region adopted quick and drastic lockdown measures to contain the spread of the pandemic. The main concern at the time was that the relatively weak health infrastructure would not be able to deal with the demands of the pandemic and that the financial costs would be an additional strain on already limited fiscal resources in the region.

With an estimated population of almost 513 million in mid-2020, fertility rates of 4.43 and 2.5 live births per woman respectively in East and Southern Africa, and population mean ages of 18.7 years (East Africa) and 27 years (Southern Africa),ⁱⁱ coupled with overburdened healthcare services the concern was real. The relatively young population (low mean ages) of the sub-region is considered one of the reasons that the pandemic had a lower than expected toll in Africa than elsewhere. Other reasons could also include under-reporting of cases and deaths due to limited health statistics infrastructure to measure outcomes such as for example population registers and death registration systems.

The available figures for the sub-region as of December 2020 show a somewhat mixed picture both in terms of infection rates and its differential impact on women and men. South Africa has the highest total numbers of infections in the sub-region – both of confirmed infections (1,498,766) and deaths (48,708)³. In most countries for which sex disaggregated data is available, men are overrepresented among the deaths. In South Africa and Eswatini there is near parity in the death rates by sex.ⁱⁱⁱ Higher infection rates among women could reflect their larger share among frontline healthcare workers, lifestyle choices, health-seeking behaviour or to a lesser extent a greater propensity to test for COVID-19. Estimated case fatality ratios indicate the highest rates of approximately 4% in the United Republic of Tanzania, Malawi and Comoros.^{iv} The lowest rates (less than 0.5%) have been found in Seychelles, Eswatini and Burundi.

Whilst COVID-19 has had limited impact on short-term mortality rates in East and Southern Africa during 2020, this may not continue to be the case as the second wave of the pandemic engulfs the sub-continent. It is also essential to distinguish between short- and long-term effects on mortality. Long-term effects in terms of life expectancy will only become clear in retrospect. *Given the limited access to healthcare services that the ongoing rapid gender assessments^v have detected – especially when it comes to the access to maternal and child health and health services for chronic diseases – the long-term impact on mortality and average life expectancy in the sub-region could be negative.* This is particularly true of Southern Africa which is characterised by high HIV infection rates and where a slow-down in recent life expectancy increases is expected.^{vi}

In 6 of the 16 countries in the ESA sub-region for which data is available four or more out of every ten women are not in education, employment or training (NEET) The high percentages of youth aged 15–24 that are classified as NEET has prevented the realization of the demographic dividend in ESA. Women are more likely to be in this position than men and the pandemic with its consequences of prolonged, school closures, increased drop-out rates, early marriage and reduced employment opportunities will make it even more difficult to realise the potential of the demographic dividend.

3 As of February 19

Even though women's positions in government and managerial positions have not reached equity in any country in the region, their presence in sizable numbers have led to their active involvement in planning and leadership around the pandemic in most countries in ESA. The Africa Women's Leadership network (AWLN) and grassroots women's organizations have played a significant role in this regard. Seven of the 28 countries in the region also have women as their ministers of health.

The leadership role taken by women as frontline healthcare workers, despite high risks to themselves and their households, has been noticeable.

The pandemic once again highlighted gaps in gender data and statistics. All of which are essential to fill if we are to successfully monitor progress with regards to Agenda 2030 as well as post COVID-19 recovery efforts.


The expected economic fall-out of the pandemic may increase migration streams of women and men in search of better economic opportunities in a sub-region where the net migration in most countries is already negative. Even though men are more likely to migrate than women, migration also impacts on non-migrant women as it increases their vulnerability to exploitation at home, as well as their socio-economic well-being if limited or no remittances are sent home. When women form part of a migration stream they are particularly vulnerable to economic and sexual exploitation as well as gender-based violence. Countries in the sub-region with the highest negative net migration figures^{vii} are those characterised by fragility and low incomes such as for example Sudan, Eritrea, and Zimbabwe. Eswatini and Lesotho also have high negative net migration figures due to labour migration into South Africa.

Refugees fleeing conflict and political instability have become more vulnerable during the pandemic as ever diminishing existing assistance over several years has been further reduced due to funding shortfalls and reprioritization by donor countries. Refugees in at least eleven countries in the sub-region (including Ethiopia, Uganda, South Sudan, Kenya, Tanzania, Malawi and Zambia) have been receiving rations of 80% or less than the minimum standard required to meet their needs, according to UNHCR^{viii}. The re-prioritization of resources due to the demands of COVID-19 may further exacerbate this situation.

Governance and normative frameworks

There are well established international, regional and national legal instruments, covenants and norms to protect the rights of women. Examples of international and regional legal instruments and covenants include International Bill of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) amongst others. Even though most countries in ESA are signatories to these legal instruments and protocols national legislation has not yet been fully aligned to these in all cases. An example of one of the areas in which improvement is still needed is in the area of ownership of and control over land and inheritance rights. This is especially true in countries where customary law supersedes other forms of legislation and even if the formal legal framework has been aligned to international and regional legal frameworks the actual implementation within the context of traditional law continues to impact negatively on women and impede their ability to fully participate economically. There is no doubt that the pre-COVID-19 impediments will continue to influence how women navigate the post-COVID-19 recovery phase.

In addition to legislation and normative frameworks already in place prior to the pandemic, governments across the sub-region also instituted several measures and normative frameworks



aimed at mitigating the impact of the pandemic. Unfortunately, these measures have been uneven across countries and very few are gender responsive or gender specific. According to the UN Women and UNDP Gender Response Tracker,^{ix} *29 of the 46 countries and territories analysed in sub-Saharan Africa (SSA) have adopted gender-sensitive measures in response to COVID-19.* These represent a total of 113 measures between them, reflecting the focus of the tracker, i.e. measures that address unpaid care; other labour market and social protection measures; violence against women; and measures that strengthen women's economic security.

*Some 57% of all gender-sensitive measures in sub-Saharan Africa (64 measures across 17 countries) * focus on preventing and/or responding to violence against women and girls.* Eastern and Southern African countries account for around two-thirds of VAWG measures (46 measures across 11 countries). Over half of all VAWG measures in the ESA sub-region (35 in 13 countries) aim to *strengthen services for women survivors, including through helplines and other reporting mechanisms (11 measures in 10 countries), continued provision of psychosocial support (seven measures in six countries), and police and judicial responses (seven measures in six countries).* South Africa and Uganda are the only two countries in the sub-region that implemented 10 or more gender-responsive COVID-19 response measures, while Malawi, Ethiopia and Rwanda adopted between 4 and 6 such measures each. Countries for which no gender responsive measures could be found are Botswana, Comoros, Djibouti, Eritrea, Eswatini, Lesotho, Mauritius, Namibia, Mayotte, Réunion, Seychelles, Sudan and Zambia.

General COVID-19 measures that impact both women and men include economic stimulus packages which varied⁴ between 0.2% and 10.3% of GDP^{xi} in the ESA sub-region and was the highest in South Africa where a USD 37,879 million stimulus package was adopted. The announced additional health spending in the sub-region during 2020 varied between one and 542 million USD. Most countries also adopted corporate tax deferrals and exemptions, as well as guarantees and subsidies as corporate support. These are more likely to benefit the formal sector and larger companies^{xii}, which are mostly owned by men. However, several countries in the sub-region also publicly announced the availability of cash transfers to their citizens as well as food assistance, although the extent of these has not in all cases been reported. In countries with pre-existing social safety net structures or programs, such as for example Kenya and South Africa, these have also been used to allocate more funds to vulnerable families.

Monetary policy measures such as central or national banks cutting interest rates (e.g. in South Africa this was done four times during 2020) and/or providing lending support for SMEs have also been implemented. Some of the countries, notably Seychelles, Mauritius, Uganda and South Africa have targeted the most affected sectors usually with deferrals of company taxation or allowing commercial banks to offer loan renegotiations and tax holidays to be granted on more flexible terms. In an analysis of the situation in sub-Saharan Africa, less than 16% of total fiscal, economic, social protection and jobs response (45 measures across 24 countries and territories) address women's economic security. Furthermore, of these 45 measures, 22 fall under the social protection category.

General socio-economic conditions

Even though there were differential socio-economic impacts on women and men during the pandemic, with men sometimes being more affected than women, *the evidence suggests that the already existing inequalities between women and men and between the different socio-economic groups have been exacerbated by the pandemic.*

4 As per 21 December 2020

According to World Bank estimates,^{xiii} economic activity in SSA has declined by 3.3% in 2020, causing the region's first recession in 25 years. Their estimates also indicate that the East and Southern African sub-region has been hit hardest of all the sub-regions in SSA because of the stronger output contractions of South Africa, which is the dominant economy in the region. Disruptions in the tourism industry and lockdowns have likewise caused substantial slowdowns in Ethiopia, Kenya and the island nations. The more fragile countries in the sub-region are expected to experience a strong decline in growth as COVID-19 exacerbates the drivers of fragility.


Poverty rates were already very high in many countries in the sub-region prior the COVID-19 pandemic and women were more likely than men to live in extreme poverty. Current estimates confirm an increase in the percentage of extreme poverty amongst women and men fifteen years and older as a result of the pandemic.

According to the African Development Bank,^{xiv} the COVID-19 pandemic is bound to affect the health and wider welfare of African households, and therefore their poverty levels in the following ways:

- a) COVID-19 has a direct impact on productivity as it diminishes the capacity of infected and recovering workers to work and undertake income generating activities and the expected impact of this is thought to be higher for households engaged in the informal sector of the economy with limited or no social protection. To this can be added the fact that women are predominantly found in the informal sector in the sub-region. Quarantines, closures of non-essential businesses, and curfews further impacts negatively on this business sector, which forms the backbone of economic activities in most countries in the sub-region.
- b) The pandemic also resulted in unbudgeted health expenditures that in the case of most citizens had to be paid out-of-pocket. This not only exacerbates poverty, but also increases inequality.
- c) The increased unpaid care work burden of women during the pandemic, reduced their ability to participate in productive activities, study and rest. In addition to affecting their income generation capacity it can also affect their mental and physical health negatively.
- d) The disruption of domestic and international distribution channels of inputs and outputs as well as consumer hoarding, have led to an increase in agricultural and other commodities reducing the purchasing power of households. *Food insecurity* will in particular affect women-headed households, who in most countries belong to the poorest socio-economic segment of the society.

In practically all ESA countries the average income of men is higher than that of women. According to the UNDP,^{xv} Gross National Income (GNI) per capita was on average 2,937 USD for women and 4,434 USD for men in sub-Saharan Africa in 2019. Incomes in the sub-region were highest in the middle-income countries of Mauritius, Botswana, South Africa and Namibia, which are all either resource rich and/or benefited from tourism before COVID-19 and/or have developed an industrial base. At the other end of the scale, in Burundi and Malawi, GNI per capita were well below USD 1,000 a year and only two of the countries in the sub-region – Burundi and Zambia – had GNI per capita that was higher for women than for men prior to the pandemic.

Indices measuring the economic and empowerment dimensions of development, such as for example the Africa Gender Index (AGI),^{xvi} indicate that the gaps between women and men in ESA are largest (closest to 0) in Comoros, Sudan, Eritrea, Ethiopia and Mauritius and smallest (closest to 1) in Rwanda, Seychelles, Lesotho, Namibia and South Africa.



Some countries such as Lesotho, Namibia, Zambia, Mauritius, Burundi, Kenya and Rwanda with gender inequality ratios of above 1 along the social dimension of the AGI reflect progress made by women, especially with regard to the key education indicators contained in the AGI. The gender gap in the empowerment and representation dimension of the AGI was smallest in Rwanda – the country boasting the largest share of women members of parliament in the world.

The findings of the CATI COVID-19 rapid gender assessments suggest that more than 60% of women and men in Ethiopia, Kenya, Malawi, Mozambique and South Africa experienced a complete loss or decline in personal income due to COVID-19. Decreases in the combined incomes of households were also widespread with the highest percentages reported in Ethiopia and Kenya. Men – more so than women – lost their jobs in the formal sector, while more women than men were looking for work in most countries. In all five countries, men reported decreased incomes to a somewhat larger extent than women, which may reflect the fact that they were more often found in paid employment and earned higher incomes than women. Many respondents also indicated that they were no longer able to financially help other people outside their own households, despite having previously done so, whilst others had to spread their own resources thinner through an increased support burden of non-household members during the pandemic.

Even though South Africa has spent considerable amounts of resources on social protection measures, some 53% of all respondents to the RGA reported that they did not receive any kind of assistance since the onset of COVID-19. In the other countries where the survey was conducted – Ethiopia, Kenya, Malawi and Mozambique – the share of those who had not received any assistance was even higher at 89–96%. In South Africa and Kenya, men reported receiving assistance more often than women, whereas the opposite was true in the other three countries. In those cases, when the respondents or their households had received assistance, it consisted mainly of supplies for COVID-19 prevention (gloves, masks, sanitizer, handwashing containers, soap, etc.).

Livelihoods

Low-productivity employment in smallholder agriculture is common in sub-Saharan Africa (SSA) and is one of the main reasons why 35.9% of workers in the SSA were living in *extreme poverty*, and 25.4% in *moderate poverty* in 2019.^{xvii} This affected a total number of 240 million workers. According to the ILO, this percentage is likely to increase, since poverty reduction in the sub-region is proceeding at a slower pace than elsewhere – and with the added impact of the COVID-19 pandemic may slow down even more. Whilst participation of both women (63.3%) and men (72.7%) in the labour force is high in sub-Saharan Africa, there are large differences between the countries in East and Southern Africa, and this participation is often in low-skilled and low-paid jobs. There are also marked differences between the two sexes in different countries in the region. For example, more than 80% of women participate in the labour force in Burundi, Madagascar and Rwanda, whereas some of the fragile countries like Somalia and Sudan exhibit much lower labour force participation of women (21.8% and 29.1% respectively). With the sole exception of Rwanda, men participate in clearly higher shares in the labour force than women.

Access to land and land rights have been and continue to be a barrier for women in the agricultural sector – limiting their ability to graduate from small-holder production to commercial production. The findings of the RGA suggest that some of the women and men who lost livelihoods in other sectors took refuge in agriculture during the crises.

Even though limited decent work opportunities in SSA affects both women and men, women have to deal with additional disadvantages and discrimination. The gender gap in informality is estimated at six percent (92.1% for women versus 86.4% for men). Furthermore, women (23.9%) are more likely to be underutilised than men (19.2%). Three in ten women are contributing family workers, compared to only 13.6% of men. *This reflects the fact that in many countries in the sub-region property rights are biased in favour of men, who are the main landholders.*

Most women in East and Southern Africa continue to gain their livelihoods from subsistence level agriculture, sometimes combined with informal sector micro- and small-scale businesses. According to UNDP^{xviii} (2020), the share of women in non-agriculture varies considerably in East and Southern Africa. The only countries where more than half of the non-agriculture labour force are women are Ethiopia (57.2%), Madagascar (54%) and Namibia (50.7%), where women are found in low paid service type of employment. Generally, the share of women in the non-agricultural employment tends to be higher in middle-income countries in Southern Africa, with the above-mentioned exceptions. The lowest shares of women labour in the non-agricultural labour force are found in countries characterised by fragility and conflict such as Somalia (18%) and Sudan (20%).

There are also considerable gender gaps in shares of vulnerable employment in East and Southern Africa. With the exceptions of middle-income countries such as Comoros, Mauritius, Seychelles and South Africa, vulnerable employment is more common among women than among men. In these four outlier countries the *tourism industry has largely contributed to the employment of women, but due to the COVID-19 pandemic this sector is one of the most affected sectors*, which will at least in the short term threaten women's livelihoods. The share of women in vulnerable employment is particularly high in Burundi. There are also clear discrepancies in mean wages and salaries of women and men in the period 2009–2019. *The only countries with a low gender gap^{xix} in mean salaries and wages were Djibouti, Madagascar, and Namibia*, which are all countries with small populations. Exceptionally high gender gaps in mean salaries and wages were found in Malawi and Tanzania. Even access to credit is more limited for women than men in the sub-region and this typically forms one of the main obstacles for enterprise growth. Only Malawi, Mozambique and Uganda have to an extent succeeded in closing the gender gap in access to credit. Access to credit was particularly problematic for women in Burundi, Mauritius and Somalia in light of these findings.

Likewise, all the recent CATI COVID-19 rapid gender assessments in East and Southern Africa found considerable impacts of COVID-19 on the economic activities of women and men. An overwhelming majority of respondents in Ethiopia, Malawi, Mozambique and South Africa maintained that their personal economic activity(ies) have changed after the onset of COVID-19. According to the findings of the RGA, declines in involvement in all subsectors were reported across the region. Besides Ethiopia, the percentage of individuals in the 'Not employed or unemployed' category increased in all countries. In Kenya some employment growth in the agricultural sector was observed as those who lost their jobs tended to migrate into that sector. Increases in 'Other' economic activities not classified were also reported. The number of different income-generating activities engaged in by women and men generally decreased during COVID-19, with the biggest declines observed in Malawi and Kenya.

Food security and nutrition

The impact of the COVID-19 pandemic, particularly in terms of income losses, is an important driver of food insecurity. The pandemic is taking place within the context of already fragile conditions caused by several factors such as for example conflicts, pests and weather shocks, including recent cyclones and floods in Africa. Most of these factors are affecting global and regional food production and prices. The FAO Food Price Index tracks changes in the international prices of the most globally traded food commodities and all of its sub-indices rose in November 2020. There has been great variability within and between countries in the region with regards to wholesale prices of staple foods during the past 12 months and most of it has to do with internal production conditions, reduced consumer demand and exchange rates. In most countries, prices have been largely stable, but in others especially in Southern Africa prices have increased.

The CATI rapid gender assessments conducted in the sub-region also found that most women and men reported increases in the prices of the food they normally buy. Significant numbers of respondents indicated that they didn't eat at all for a day or more or had to reduce their food intakes during the pandemic. More than 50% of respondents in Kenya, Malawi and Mozambique indicated that they had to eat less or skip a meal during the pandemic. Less than 10% of respondents in Ethiopia and around a quarter of respondents in South Africa had to eat less or skip a meal. *Women were more likely to say that they reduced their food intake in all countries except Ethiopia and Malawi.*

Both WFP^{xx} and FAO project increases in the number of people who will need food aid in the region. Prior to the onset of the pandemic in the region, the World Food Programme (WFP)^{xxi} estimated that a record 45 million people – mostly women and children – were gravely food insecure just within the 16-nation Southern African Development Community. This is the result of low rainfall and droughts, flooding in some areas and economic problems. Southern Africa has had just one normal agricultural growing season since 2015 due to temperature increases that are double that of global averages and dependence on subsistence farmers who are vulnerable to unreliable and ever decreasing rainfall. At the time, half of the population in Zimbabwe (7.7 million people), 20% of the population in drought-affected Lesotho and 10% of Namibians were considered food insecure. The FAO^{xxii} estimates that thirty-four countries in Africa (out of forty-five countries globally) need external food assistance. A preliminary WFP analysis carried out in July 2020,⁵ doubled the pre-COVID projection of people needing food assistance from 27.5 million people to 52 million people in 12 operational countries in Southern Africa.

WFP notes that there are several causes of chronic hunger in Southern Africa and the pandemic is only compounding these.^{xxiii} These underlying factors include high rates of population growth, poverty, inequality, malnutrition, HIV and environmental degradation. The damage being caused on a regular basis due to climate change (e.g. droughts and flooding) is also made worse by the pandemic. Key sources of income for families, communities and governments have disappeared or diminished significantly. As unemployment increased, remittances from migrant breadwinners in South Africa and elsewhere, have declined. These remittances are crucial for the well-being of millions of people in Zimbabwe, Malawi, Mozambique and Lesotho. In addition to this the prices of some export commodities that countries in the sub-region depend on heavily have also declined and the international tourism industry has been decimated. COVID-19 has also intensified conflict – and hunger – in northern Mozambique and in other countries in the sub-region it risks fuelling political tension and instability.

5 WFP. Available from <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>

The COVID-19 pandemic has therefore affected and will continue to seriously affect a sub-region that was already characterised by precarious food security and high levels of undernourishment due to a number of reasons, such as high dependence of traditional rain-fed agriculture, climatic conditions and calamities. According to UN Women data,^{xxiv} with the exceptions of South Africa and Mauritius, the level of undernourishment in all the other countries in the sub-region was counted in double digits already before the COVID-19 pandemic. Zambia, Zimbabwe, Madagascar and Rwanda had a more than two in five prevalence of malnutrition among their populations. Likewise, in Uganda and Tanzania, more than a third of the population suffered from undernourishment. It is noteworthy that there is no data available on the prevalence of the undernourishment in some of the most fragile countries in the region. A comparison of the gender gap in the food insecurity in ESA in 2014–2015 shows that except for Kenya, Madagascar, Mauritius and Uganda, women suffered food insecurity more often. The gender gaps in food security were especially large in Botswana, Eswatini, Malawi and Kenya.

Time use during COVID-19

Time use and time use studies are considered important within the context of women's economic empowerment and sustainable development. In addition to providing a general understanding of how women and men spend their time, such studies shed some light on how much time women spend on unpaid domestic work and unpaid care work. Time use studies have also found that women tend to spend more time on unpaid domestic and care work than men. This impacts on women in that they find it more difficult to join the labour market and gain financial independence. However, it also places a disproportionate additional burden on those who are already involved in productive economic activities. The COVID-19 pandemic once again shone the spotlight on this important dimension of Women's Economic Empowerment with more women and men confined to their homes during lockdown and greater care-burdens, vis-à-vis remote learning during school closures and caring for sick and vulnerable household members.

The RGAs carried out by UN Women, UNFPA and partners in Ethiopia, Kenya, Malawi, Mozambique, Rwanda and South Africa included a question about the person primarily responsible for domestic and unpaid care activities prior to the pandemic. The findings suggest that women were the main providers of unpaid domestic and care work prior to the pandemic. Women were also more likely than men to indicate that they were spending more time on unpaid domestic work during the pandemic across all countries. Regarding unpaid care work, men in Ethiopia, Kenya and Malawi were more likely than women to say that their unpaid care work has increased during the pandemic, and this is largely due to increased passive child-minding, teaching and providing general childcare. In all countries, except Malawi and South Africa, spouses were more likely to help with unpaid domestic and care work than anyone else. Daughters were more likely than sons to provide additional assistance during COVID-19 with these kinds of tasks.

Education

With nearly half the population under 18, people are the region's greatest resource, and this is why the closure of schools and other institutes of learning will potentially have considerable long-term impacts in the region. Prior to COVID-19, significant regional progress has been made with regard to gender equality in education. Attendance rates of boys and girls are similar and even better for girls in many of the countries for which data is available. However, in certain parts of the sub-region some serious problems persist such as for example high out-of-school rates for girls, high drop-out rates before completion of primary or lower secondary education and low graduation rates of women at tertiary level in Science Technology, Engineering and Mathematics (STEM) subjects in most of the countries in ESA.

According to UNESCO^{xxv} estimates of April 2020, a total of 124 million learners in East and Southern Africa have been affected by school closures due to the COVID-19 pandemic. Of the countries in the region, Ethiopia has the largest number of affected learners with 24,6 million, followed by South Africa with 14,6 million, Kenya with 14,3 million and United Republic of Tanzania with 13,9 million learners.

Almost all the countries in the sub-region closed their schools for 3 to 6 months^{xxvi} during the early phases of lockdown and movement restrictions. Countries where full re-opening for all grades only took place early in 2021 are Uganda, Kenya and possibly South Sudan, Eswatini and Mozambique. During school closures, distance learning measures, including distribution of printed materials, special sessions on radio and television and online platforms were put in place. Online e-learning has been primarily done using SMS, WhatsApp, Zoom or Microsoft Teams platforms or a combination of these. Online teaching methods were only used in 57% of the countries in the region. Available data not only suggests that sub-Saharan African girls are less likely to be digitally connected than boys, but women in the sub-region are also less likely than men to use the internet from any location. In addition to physical access barriers, examples set by adult women most likely also provide the role model – vis-à-vis digital technology – to young girls.

The RGAs conducted by UN Women, UNFPA and partners across the sub-region suggest that girls and boys have been facing similar problems associated with remote learning. Notable exceptions include limited access to books and printed learning materials (girls in Ethiopia); lack of a skilled instructor/parent guardian and/or do not have time (boys Ethiopia); while a lack of a conducive environment for studying was more likely to be a problem for boys than girls in South Africa.

Concerns about the potential impact of the pandemic on deepening the crisis in the sub-region around girls and boys of school-going age that were not attending school are justified and likely to increase as school closures negatively impact on continuity and motivation levels. Furthermore, increased economic hardships of households may lead to more pressure on adolescents to find work, rather than return to school during the post-COVID-19 recovery phase. The most vulnerable groups in the sub-region will continue to be rural girls and boys from the poorest income quintiles. Prior to the pandemic^{xxvii} at least eight countries had primary school completion rates of below 50% for the poorest quintiles of children (both girls and boys) living in rural areas.

Even though COVID-19 and school closures impact on both girls and boys, girls are affected in some unique ways by the pandemic. For many girls, accessing school and staying in school is difficult even under normal circumstances, but the likelihood that they will be continuing their education post-pandemic has reduced even further. *For the girl child there have also been increased and well documented safety risks associated with school closures and increased poverty in areas such as domestic violence, sexual exploitation, early marriage, and female genital mutilation. COVID-19*

may have provided opportunities for these practices to be re-enforced, contributing towards psychological and health problems and gender discrimination. Appropriate gender-sensitive responses are needed to mitigate these problems and reduce the potential compounding impact of the pandemic on the existing educational challenges on the continent.

Girls are also often expected to take on childcare responsibilities and household chores and have to act as teachers for the younger children. The time use findings of the RGAs done by UN Women, UNFPA and partners in the sub-region suggests that girls have been more likely than boys to assist adults with unpaid domestic and care work during the pandemic.

Health

Healthcare services

The COVID-19 pandemic has put additional strain on healthcare services throughout the world. One of the reasons why governments in East and Southern Africa introduced rapid and drastic measures to limit the spread of the virus was because of fears that it will completely overwhelm already fragile healthcare services in the region. During the early months of lockdown many governments focused on information and advocacy campaigns to educate the population about the risks and preventative measures that need to be applied to reduce the risks of infection. The findings of the CATI COVID-19 RGAs carried out in ESA suggest that more than nine out of ten women and men got some information about the pandemic. More than 75% of women and men in Ethiopia, Kenya, Malawi and Mozambique got their information about COVID-19 from radio/television/newspapers. Most of the other information sources were used by less than 5% of the population. Exceptions are Kenya, where 8.3% of women and 9.3% of men used the internet and social media as their main source of information. *In South Africa, the information source profile was quite different from the other countries. The internet and social media were the main sources for 23.5% of women and 25.8% of men, while 39.3% of women and 37.8% of men considered the radio/television and newspaper their main source of information about the pandemic.*

The findings of the RGA also suggest that women were more likely to be ill and less likely to be covered by medical aid than men in all countries except Malawi (where men were more likely to be ill and women more likely to have health insurance). Some form of medical aid/health insurance is most prevalent in Kenya where 47% of women and 52% of men indicated that they are covered.

Maternal and child health

In 2020, the key maternal and child health population groups in the ESA region^{xxviii} included 16 million pregnant women, 151 million women of reproductive age, 199 million young people (aged 10–24) and 19 million older persons (aged 65+). Sexual and reproductive health is therefore of utmost importance in the sub-region and any disruptions of such services will have far-reaching consequences.

Overall figures for *maternal mortality ratios* in sub-Saharan Africa prior to the pandemic remain highest in the world although showing a downward trend,^{xxix} and the sub-region also has large intra-regional disparities in terms of coverage of basic maternal health interventions like antenatal care. Southern Africa reported almost universal maternal and health coverage already in 2010, but other parts remain behind. Countries characterised by fragility and conflict – Somalia, South Sudan, Burundi and Malawi (all classified as being in a fragile situation by the

AfDB in 2020) – still face many challenges in improving maternal health. Neonatal mortality rates are particularly high in South Sudan, Somalia and Comoros, whereas the highest under-5 mortality rates are found in Somalia, South Sudan and Eswatini.

A UNFPA assessment of the Southern Africa Development Community's (SADC) regional response to the COVID-19 pandemic^{xxx} found that almost invariably all responding member states (16) had reported on average disruptions in 50% of a set of 25 tracer services. Disruptions were most common in outreach services (70%), facility-based services (61%), non-communicable diseases diagnosis and treatment (69%) and family planning and contraception (68%). Other affected services include treatment for mental health disorders (61%), and cancer diagnosis and treatment (55%). According to an African Union led assessment^{xxxi}, nearly 50% of respondents who needed care missed or delayed accessing health services, and a similar percentage said they found it difficult to access medication. Nearly a quarter attributed missed services to worrying about catching COVID-19, either while traveling to their destination, or directly from the health facility. Types of health services missed were non-communicable diseases (34%); general/routine check-up (28%); communicable diseases (26%); and reproductive, maternal, new-born and child health (16%). Malaria (15%); cardiovascular issues (10%); diabetes (8%); antenatal care (5%); care for children under 5 years (5%); and vaccinations (4%) were the conditions for which services were most likely to be missed.

COVID-19 is feared to disrupt existing and planned efforts to end child marriage and has wide-reaching consequences. *UNFPA estimates that these factors will lead to an increase of 13 million child marriages between 2020 and 2030.* This is not only due to economic hardships, often forcing parents to agree to child marriages for financial gain, but also to school closures which contributed towards early forced or consensual sexual activity (also see the education section). *Limitations caused by the COVID-19 pandemic to access family planning and safe abortions can have similar impacts.*

The pandemic has already adversely affected programmes to end child marriages, but the full impact on countries with high rates of poverty and fragile health, social welfare and governance systems is yet to be seen. Emerging evidence from the Global Programme to End Child Marriage (GPECM) from all four countries in ESA – Ethiopia, Mozambique, Uganda and Zambia – that are implementing the program^{xxxii} shows increases in violence, child marriage and teenage pregnancies are increasingly affecting teenagers. Temporary school closures and limited access to sexual and reproductive health services are considered some of the primary drivers of these problems. In Mozambique, calls to the Child Helpline showed that children made 16,244 calls from January to April 2020, doubling the number of calls during the same period in 2019. *Child marriage, abuse and neglect, and school-related problems were among the reasons children called the helpline.*

An interagency tool^{xxxiii} for monitoring continuity of essential sexual, reproductive, maternal, child and adolescent health (SRMNCAH) services has been used to analyse the situation of SRMNCAH services in 14 countries in Africa during the COVID-19 outbreak response. The analysis shows that among the most overlooked services from being included in the national essential service package are services for older persons (eight countries), ICCM (seven countries), abortion services (four countries), adolescent and youth-friendly services (three countries), and GBV and risk communication and community engagement (both two countries).

Indicators for service disruption, comparing 2019 and 2020 data in the ESA sub-region and represented by 12 countries (out of the total 14 in the study) also show some marked differences between February to April 2019 and February to April 2020.^{xxxiv} There have been large disruptions in the share of facility deliveries in Burundi, South Sudan, Kenya, Zambia

and Zimbabwe compared to the previous year. *Decreases in caesarean sections* have been particularly large in Burundi, Madagascar, South Sudan and Zimbabwe. In the same vein, the share of *unsafe abortions has increased in some countries, notably Eritrea, Madagascar, and Sudan, but decreased in Kenya, Botswana and Ethiopia*. During the same period, i.e. after the onset of the pandemic, *cases of maternal death had almost doubled* with an increase of 96% in Kenya, 28% in Botswana, and 18% in Mozambique. On the other hand, Burundi, Eritrea, Malawi, Madagascar Zambia and Zimbabwe *reported fewer maternal deaths* compared to the same time period in 2019 (which could also be due to underreporting). Likewise, *stillbirths had increased by 169% in South Sudan and also in Eritrea, Ethiopia, Malawi and Kenya*. *New-born and under-5 deaths had also clearly increased in Eritrea, Malawi, South Sudan and Zambia*.^{xxxv} Even though not documented or quantified, limitations in the access to safe abortions could also have an impact on maternal mortality.

These findings are confirmed by the ongoing CATI COVID-19 rapid gender assessments in East and Southern Africa. In Ethiopia and Kenya, child healthcare services, healthcare services for pregnant women, services relating to chronic illnesses, as well as family planning/sexual and reproductive healthcare were reported to have been affected since the onset of COVID-19. The same applies to other healthcare services. For instance, in Kenya, 58% of women and 51% men who sought child healthcare services could not get it, according to the same research. The CATI COVID-19 RGAs conducted in South Africa and Mozambique found that only 19% of women tried to access family planning and reproductive health services during the reference period.

An additional hardship for women and girls in East and Southern Africa has been that they were limited to having access or had no access to sanitary hygiene during the pandemic. Rapid gender assessments in Rwanda and Kenya^{xxxvi} found that most women and girls (over 90% in Kenya, up to 32% in urban Rwanda) reported decreased or no access to some menstrual hygiene products since the onset of the pandemic due to reduced income. This decrease in access was more prominent in informal settlements within urban areas. *In Kenya, the limited access among the girls from lower socio-economic groups was also due to school closures as the sanitary pads were mostly provided in schools*.

Mental health and psychosocial problems

The COVID-19 pandemic forms a new stress factor among populations that already present relatively low levels of subjective wellbeing. According to a Gallup 2019 survey^{xxxvii} which was conducted prior to the pandemic, the general sense of well-being across the sub-region is relatively low. On a scale of 0–10, only Mauritius reported a value above five, which signifies a relatively good state of well-being. The lowest scores (between 2 and 3) were reported in South Sudan, Malawi and Tanzania.

The results of the RGA conducted in the sub-region found that in all countries, except Malawi, women were more likely to report suffering from mental and emotional strain (more than 5 in ten) or that someone else in their household was having these kinds of problems. The most common concerns or reasons for worry were the economic impacts and fear of becoming ill with COVID-19. Men were more likely than women to be concerned about economic issues, while women were more likely than men to be concerned about becoming ill. Concerns about having enough food, children missing school, as well as fear of death also featured high in most countries.

Gender-based violence

Female genital mutilation and cutting

Female genital mutilation (FGM) and cutting remains common in some East African countries. Prevalence of FGM^{xxxviii} is as high as 97.9% in Somalia and 93.1% in Djibouti. Even Eritrea, Sudan and Ethiopia report a very high prevalence of FGM. The tradition is not widely practiced in Southern Africa and most countries therefore do not collect data about it.

Whilst some progress has been made in the East Africa sub-region on eradicating or ending FGM, the *impact of COVID-19 on ending female genital mutilation is estimated to be negative*. According to UNFPA,^{xxxix} due to COVID-19 disruptions, a one-third reduction in the progress towards ending FGM by 2030 is anticipated. Due to pandemic-caused disruptions in prevention programmes, current estimates place the occurrence of FGM over the next decade at *two million*. Lockdown measures and the effects of the pandemic on health services have limited *access to and availability of adolescents and youth-friendly SRH and GBV services*. Without such services, *increases in FGM, teenage pregnancies and violence are more likely to take place*. Results from the CATI COVID-19 rapid gender assessments point to similar results. As regards the perceived types of gender-based violence and harmful traditions since the onset of the pandemic, more than four percent of the respondents in Ethiopia and one percent in both Kenya and Uganda mentioned FGM. The long-term impact of the pandemic on FGM is yet to be seen but the preliminary findings as well as experiences from previous pandemics are not encouraging.

Perceptions and incidence of GBV

Many countries in East and Southern Africa report very high rates of gender-based violence (GBV) and the preliminary reports of some countries indicate that the GBV has increased during the COVID-19 pandemic. According to UN Women,^{xl} violence by an intimate partner was reported by more than 40% of women in Burundi (48.5%), Kenya, Mozambique, Zambia and Zimbabwe *even before the pandemic*. In the same vein, 29.9% of respondents in Uganda, 26.7% in Zambia, 27.9% in Burundi and 25.5% in Kenya reported having experienced violence in the past 12 months by current/previous partners.

Most respondents to the RGAs in the sub-region consider GBV to be a problem. Women in all three countries were more likely than men to perceive GBV to be a more serious problem. Most respondents also felt that the incidence of GBV increased during the pandemic. Nearly four in ten women (38%) and men (39%) in the sub-region knew at least one person who was a victim of GBV.

Early data from UNFPA on the impact of COVID-19 on GBV shows that there was a 777% increase in calls to national hotline pre-/post-COVID-19 in Kenya. In South Sudan, there was a 72% increase in reported cases in protection monitoring in May 2020 compared to January 2020. In addition, in Zimbabwe, 90% of calls to national hotlines were related to intimate partner violence between March 30th and May 30th, 2020. In South Africa,^{xli} a dramatic decrease in the levels of reported GBV-related cases was seen in the initial stages of the lockdown from 27th March to 31st May 2020. Furthermore, as the levels of lockdown decreased, this was accompanied by increased levels of reported violence and crime overall, including gender-based violence. Between July and September 2020, data points to a steady increase in the number of reported rapes. In 20 of the 30 top stations for cases of sexual assault, there was an increase, as compared to the previous year.

A mobile phone survey in Uganda^{xlii}, found 0.62 times perceived increases for village-level physical violence post-lockdown. These perceived increases were corroborated against an increase in arguments, a decrease in quality of life and a decrease in the economic standing of households post-lockdown.

Violence against women with disabilities^{xliii} has been found to be even higher than for other groups of women in a recent mapping in the ESA region, based on existing statistics and focus group discussions and interviews with tens of associations of people with disabilities and women's associations. *It is therefore important to look specifically at women and girls with disabilities in the COVID-19 induced lockdowns and the socio-economic impact of the pandemic situation.*

According to the UNFPA and MWCY 2020^{xliiv} research in Ethiopia, *two different cohorts of youth – those living on streets and those involved in commercial sex work – reported that their vulnerability to violence had increased significantly during the COVID-19 pandemic.* This applied to physical and sexual violence and threats by police. Police brutality had been particularly exacerbated during the initial lockdowns.

Marginalized groups

Marginalized groups: Women and young people with disabilities

A recent mapping by UN Women maintains that discrimination against women and girls with disabilities (GWWD) characterizes all the countries in the East and Southern Africa (ESA) region. *Poverty, gender, and disability are, in many ways, interconnected, rendering especially women, girls, and elderly people in the poorest countries extremely vulnerable and even in dire poverty.*

A recent study in Ethiopia^{xlv} conducted among 154 vulnerable urban and rural youth with disabilities under the COVID-19 pandemic discovered that youth with disabilities can access information about COVID-19 transmission and prevention mechanisms through the TV, FM radio on their mobile phones and in some cases – especially among youth that are men– the internet. COVID19 guidance was sometimes very difficult to follow for several reasons: social distancing is difficult for those with impairments or using wheelchairs and may have to rely on community members for their mobility. Limited access to sexual and reproductive health services and supplies are caused by access problems and long queues outside hospitals. Increased stigma associated with the disease was also mentioned by some of the respondents.

Marginalized groups: People living with HIV

As for the shares of new HIV infections pre-COVID-19 in the region, the most affected countries remain those in Southern Africa, with Botswana (7.5/1,000), Eswatini (8.0/1,000) and Lesotho (9.1/1,000) having the highest infection rates per 1,000 people.^{xlvi} On the other hand, Eritrea, Ethiopia, Madagascar, Mauritius, Somalia and Sudan and Seychelles reported only around 0.1-0.2 new HIV infections per 1,000 people before the pandemic.

As indicated in the discussion on health services, efforts are needed to mitigate COVID-19 related disruptions in health services and supplies to prevent an additional 500,000 deaths from AIDS-related illnesses.

Virtual research in rural and urban Ethiopia^{xlvii} amongst youth living with HIV found that they knew the primary transmission mechanisms, that they are more vulnerable than others due to their compromised immune systems and that they had detailed information about COVID-19 symptoms, transmission and protection mechanisms. *One of the main concerns of the Ethiopian youth was the psychosocial impacts of the pandemic, rather than physical violence in the home*

or community. These concerns primarily relate to their perceived increased risk that they should become infected with COVID-19. They were also affected by the absence of youth support groups and counselling that had played a key role in their lives prior to the pandemic.

Marginalized groups: Women and young people involved with sex work, street-connected and migrant youth

The COVID-19 pandemic has amplified pre-existing inequalities and vulnerabilities for sex workers in the region.^{xlviii} The impact on livelihoods, human rights and health has been significant, leaving many struggling to survive. Economic hardships have increased, disruption and violation of human rights – not to the pandemic itself but rather to the containment measures which governments put in place, including lockdowns, social distancing measures, curfews and quarantine measures.

Numerous challenges relating to healthcare were experienced by sex workers. Given the high HIV prevalence rates amongst sex workers, many of them could be at increased risk of higher mortality rates. *The greatest health impacts experienced by sex workers were in accessing healthcare for non-COVID-19 conditions. According to a recent UNFPA survey,^{xlix} half of the respondents reported that sex workers had problems in accessing health facilities in general, specifically, access to HIV treatment services, access to HIV prevention services and access to sexual and reproductive health services by another 21.74%. In addition, stigma and discrimination – reminiscent of HIV-related stigma – in health services were reported by 11.52%. The study also found that community-based organisations led by sex workers and providing services to them have reacted swiftly and creatively.*

Some evidence from a small sample of sex workers in Ethiopia^l suggests that workers associated with CSOs were generally better informed about COVID-19 than those who are not, while migrant youth, especially men, are more vulnerable and have less support. Due to movement restrictions and declining incomes the ability of women who are sex workers to negotiate for the use of condoms has declined.

Recommendations

General recommendations

Whilst the full impact of the pandemic and the response measures to it are yet to be seen, it is already now clear that very little of the response measures – be it by national governments or multilateral donors – have been gender-sensitive. It is important therefore that the measures that have been put in place already be assessed, and lessons learnt, and best practices shared in anticipation of possible future pandemics or other crisis situations. Such assessments should also focus on the gender impact of current response measures in ESA and plan for more gender-responsive approaches for future pandemics.

This re-emphasizes the *need for collaboration of various actors*, be it country leaders, civil society, including women's associations, development partners, women and young people in the region, as well as regional economic organizations.

There are several general measures that have been proposed by international agencies such as the IMF, World Bank and AfDB and others for the post-COVID-19 recovery phase that are presented in more detail in the recommendations section of the report. Some of the most

important of these proposed measures⁶ include continued management of the health crisis; provision of fiscal support to aid people and firms; ease their monetary stance to support growth and provide financial stability while ensuring adequate credit provisions; policy measures aimed at the labour market and informal sector such as assisting vulnerable groups, especially youth and women and the adoption of labour market policies to protect workers and their jobs; avoidance of export bans and other trade policies that fragment production and increase the costs of essential supplies for import-dependent countries; acceleration of structural reforms to rebuild Africa's productive base; address obstacles to formalizing the economy, rethinking social protection programmes for maximum coverage; continued liberalization of goods and services and the Africa Free Trade Agreements; increased Overseas Development Assistance (ODA) and the mobilization of private capital to tackle the health and other consequences of the pandemic; the adoption of digital technologies by governments, households and firms and recommending government interventions to reduce the cost of devices and services, avoiding disconnections for lack of payment, and increasing bandwidth.

Gender-specific recommendations

The study once again highlighted the gender data gaps in the sub-region and the increased need for gender disaggregated data to better measure the impact of the pandemic and post-COVID-19 recovery.

The report also makes the following gender-specific recommendations:


Governance:

- i. Very concrete action plans need to be put in place to mitigate the expected increases due to the pandemic in youth (especially women) aged 15 to 24 that are not in education or employment.
- ii. Continued and expanded support to protect the human rights of migrants and especially the rights of women and girls.
- iii. Expand support for gender responsive approaches towards the housing and integration of refugees into host populations.

Socio-economic circumstances and livelihoods

- i. The post-COVID-19 recovery period will have to focus on connecting people, especially women, to job opportunities to reduce poverty and inequality to ensure a sustained recovery.
- ii. Focus on maximizing gains made during the pandemic to transition to the digital economy by increasing efforts to expand coverage and inclusion of particularly women.
- iii. Continue strengthening access of women and youth to education and vocational training to reduce their vulnerability for future pandemics and other crises. Skills and education mismatches, especially in STEM, need continued and even greater support in the sub-region than prior to the pandemic.
- iv. Cash transfers should be prioritized to the most vulnerable households which includes households headed by women.

⁶ The specific combinations of proposed measures supported by each international organization differ and some of them are uniquely proposed by a single entity

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- v. Agriculture should not only be a last resort or subsistence livelihood activity for women but can be used as a vehicle out of poverty. Access to land and land rights have been and continue to be a barrier for women in the agricultural sector to graduate from small-holder production to more commercial modalities. Security land tenure rights for women needs continued attention.
 - vi. Women producers need to be linked to markets and create opportunities for upscaling agricultural production.
 - vii. It will be necessary to safeguard livelihoods, jobs, and businesses and create opportunities for speedy economic recovery. An important part of this will be to conduct a comprehensive economic assessment to assess economic stimulus packages that were available to SMMEs that have been affected by COVID-19. The differential needs of rural and urban residents, women, men, people with disabilities and youth. Government guarantees and subsidized loans for productive activities of women and youth. Government guarantees and subsidized loans are needed to support productive activities of women and youth.
 - viii. The gender machinery in each country needs to increase efforts to advocate for greater visibility and inclusion of issues around time use and informal economic activities in policy responses. Policy responses to ease women's unpaid domestic and care work will allow women to focus on productive activities.
 - ix. It remains important to continue to recognize, reduce and redistribute the unpaid domestic and care activities that primarily fall upon women. The pandemic has shown that when circumstances dictate, men in the East and Southern Africa sub-region do pitch in to assist with unpaid domestic and care work. It is important that through advocacy efforts this momentum be maintained to increasingly make it socially acceptable, as well expected from men in the sub-region to share these tasks with women.

Education

- i. Important lessons from pre-COVID-19 experiences that may be relevant to the post-COVID-19 recovery period include the use of cash transfers and bursaries as incentive for girls to go back to school; clear communication with and involvement of the community at all levels so that girls experience social pressure as well as support to return to school; girls need to be protected from GBV and sexual exploitation within their schools and communities; it is also important to provide pathways for girls to report and seek help if they become victims; preventing early marriage and pregnancy are important mechanisms to prevent girls from leaving school in the first place.
- ii. If a system-wide approach to school reopening is followed as recommended by UNICEF,ⁱⁱ it will automatically introduce a gender and inclusion lens into education analysis. The leadership of girls and women and their role as agents of change during the post-COVID-19 recovery phase should be recognized and prioritized. They need to be involved and integrated into consultations, planning and decision-making. It will also be important to continue to actively remove gender bias and discrimination within and across education systems needs to continue.
- iii. Countries should prioritise activities that will bring all girls back to school through targeted measures for the poorest and most marginalised girls. It is important that school reopening plans are inclusive and strive for equity, leaving no one behind.

Special consideration needs to be given to inequalities that are intersectional by nature and aggravates exclusion and marginalization.

- iv. Girls' education, health and protection need to be met in a holistic and integrated manner. It will also be important to facilitate greater cooperation between teachers, school administration, families and communities.
- v. There is a need to support cross-sectoral collaboration to ensure an inclusive and gender-responsive school reopening, safeguarding the rights of all girls and boys.

Health and well-being

It will be important to increase investments in maternal and child health, sexual and reproductive health, as well as services for the elderly, people living with HIV/Aids, people with disabilities and other vulnerable groups as the diversion of resources away from these areas will have negative long-term impacts on women, men and children.

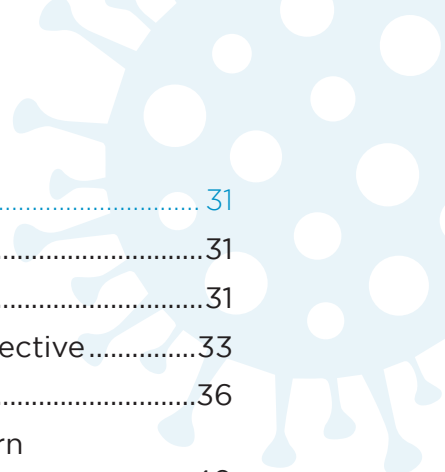
- i. Health budgets need to be prepared from a gender perspective to contribute towards more equal access to health resources in the region.
- ii. Continue emphasizing public health and safety measures (PHSM). Ensure an inclusive approach, including women, men, girls and boys, people living with disabilities, people living with HIV, refugees and IDPs. Strengthen resources of community-based organisations in providing health and social services to vulnerable groups.
- iii. Implement WHO recommended strategies to mitigate service disruptions, such as triaging to identify priorities, shifting to online patient consultations, etc.
- iv. Suspend or remove user fees, to offset potential financial difficulties for patients, in particular for the most vulnerable groups of women and men.
- v. Increased resources will be needed for maternal and child health to rectify some of the damage caused by the COVID-19 pandemic in the region, which might set back advances made so far by 2–3 years according to some estimates.
- vi. Confinement indoors and movement controls during COVID-19 may have provided opportunities for practices that present safety risks for girl children such as domestic violence, sexual exploitation, early marriage, and female genital mutilation. Appropriate gender-sensitive responses are needed to mitigate these problems and reduce the potential compounding impact of the pandemic on the existing educational challenges on the continent.
- vii. There is a need for greater cooperation between the global north and south to ensure a more equitable distribution of available vaccines between the global north and south. Governments need to prioritize frontline health care workers, the majority of which are women, to receive the COVID-19 vaccine.

Gender-based violence

- i. A lack of reliable data on GBV remains a problem and there is an urgent need to expand the coverage of standalone, nationally representative prevalence surveys across the region.
- ii. More research and research capacity is needed to identify the drivers of GBV and develop specific programs (advocacy and otherwise) at national and provincial level to address these.
- iii. Continued advocacy work is needed around GBV prevention and services; this includes amongst others increased communication around the available services.
- iv. Even though technology can be used to support reporting mechanisms for survivors of GBV, more information about the usefulness of already applied technologies and their impact will be needed before such programs are scaled up or expanded during the post-COVID-19 recovery phase.
- v. Improved services are needed for post GBV support and care. This includes but is not limited to the increased availability of safe places, mechanisms and services for victims and survivors and strengthening of referrals between service points are required. Greater cooperation and coordination between the various law enforcement and social service providers working with victims, survivors and perpetrators will greatly enhance the impacts of these services.
- vi. General human rights training of police aimed at preventing police brutality is needed across the region. The training of the police and other law enforcement agencies on how to receive and handle complaints from victims and survivors of rape and SGBV needs more attention.

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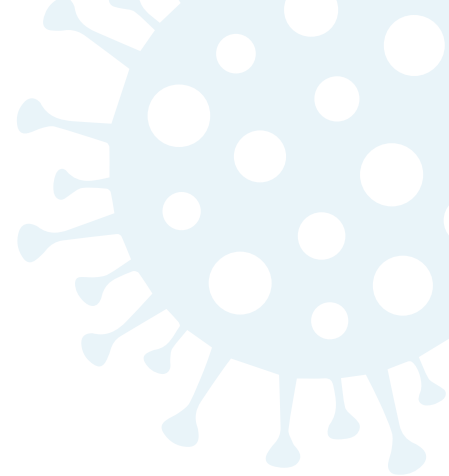
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1. INTRODUCTION



1.1 Background

UN Women is the UN agency tasked to work towards the elimination of discrimination against women and girls, the empowerment of women, and the achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action and peace and security.

Making Every Woman and Girl Count (Women Count) is UN Women's global gender data programme. The programme aims to generate more and better data to inform policies as well as monitor the implementation of the gender equality-related Sustainable Development Goals (SDGs) and other national policy priorities. The primary outcome of the program is to achieve a radical shift in the production, availability, accessibility and use of quality data and statistics for key aspects related to gender equality and women's empowerment (GEWE).

Whilst the Women Count project has led to a significant increase in the availability of gender-specific data across the East and Southern Africa (ESA) region, the COVID-19 pandemic and associated movement restrictions and social distancing have impacted on the data availability during 2020 in various ways. Whilst studies have been carried out by United Nations' Country Teams (UNCTs), national statistical offices (NSOs), the World Bank, African Development Bank and others, a gender data gap still looms large.

UN Women East and the Southern Africa Regional Office (ESA-RO), United Nations Fund for Population Activities (UNFPA) ESA and other partners have been collaborating in East and Southern Africa to fill the data gap by rolling out a computer-assisted telephone interview (CATI) for COVID-19 gender assessment in Kenya, Uganda, Ethiopia, Malawi, Mozambique, Rwanda and South Africa. The survey is expected to generate a comprehensive picture of the impact of COVID-19 on women and men across a wide range of themes.

In support of this work, UN Women ESA-RO and UNFPA ESA have been pooling financial resources to commission a Regional Gender Equality and Women's Empowerment report that is envisaged to inform development assistance policies and strategies for increasing gender equality, women's empowerment and poverty reduction.

This report summarises the findings of the study. It is divided into 11 sections as follows: after the introduction (Section 1) and methodology (Section 2), the main findings are reported from Sections 3 to 10. The third, fourth and fifth sections deal with the demographics, governance, socio-economic and livelihoods impacts of the pandemic. This is followed by time use (Section 6) and a discussion on education (Section 7). An analysis of the health impacts, gender-based violence (GBV) and other vulnerable groups (leaving no one behind) follows in sections 8, 9 and 10. Finally, the recommendations based on these findings are summarised in Section 11.

1.2 Objectives and scope of the report

The aim of the report is to outline the opportunities and constraints for GEWE in the post-COVID-recovery phase and to identify the key gaps and challenges in current policies and programmes in the East and Southern Africa region.

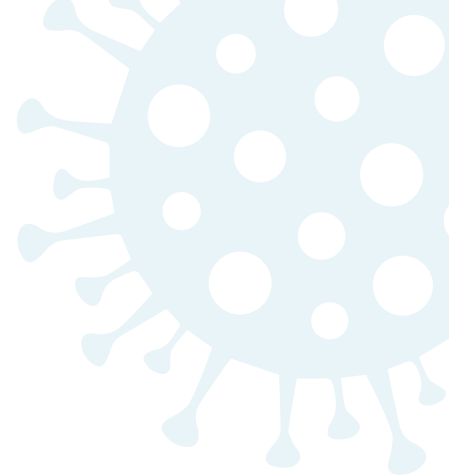
Countries included in the scope of the study are Eswatini, Botswana, Burundi, Comoros, Djibouti, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Madagascar, Malawi, Mayotte, Mozambique, Réunion, Rwanda, South Africa, Uganda, Tanzania, Seychelles, Somalia, Sudan, South Sudan, Zambia and Zimbabwe. In cases where statistical summaries are provided for East Africa and Southern Africa the UNSD SDG classification⁷ is used.

More specific objectives of the study include:

- Conduct an in-depth gendered analysis of gender equity during COVID-19 in East and Southern Africa. The specific dimensions included in the analysis are socio-economic circumstances and livelihoods, governance, demography, education and health and health-seeking behaviour, morbidity and mortality profiles, maternal and child health and gender-based violence in the East and Southern Africa region;
- Identify key issues affecting the status of women in the sub-region with respect to the thematic focus of the study and those hindering their access to resources, opportunities and full participation;
- Evaluate regional normative frameworks from a gender perspective and identify gaps and best practices that can be scaled-up;
- Consolidate data on key gender indicators available from existing sources for various sectors and from UN and country level official data sources; and
- Provide concrete recommendations for accelerating the advancement of gender equality through the various sectors involved in the thematic areas covered by the study.

⁷ United Nations Statistics Division (SD) SDG regional categorization. Accessed in October 2020. Southern Africa countries are: Namibia, Botswana, Eswatini, Lesotho and South Africa, while the remainder of the countries are classified as East Africa.

2. METHODOLOGY



2.1 Introduction

The study is primarily based on a desk review of secondary data sources, focusing on information published during 2020. Primary data, using CATI methodologies and conducted by UN Women in partnership with the UNFPA and various other international agencies and national partners across the region, are also included where appropriate and referenced as such.

2.2 Desk review

Desk review of publications, statistical and other information on gender, health, poverty, socio-economic development and livelihoods, and governance issues in the ESA sub-region was carried out. Information available on the internet and relevant websites from 2020 or latest available years prior to COVID-19 pandemic was gathered and compared with research and information gathered after the onset of the pandemic. The search focused on publications by international agencies, international and national civil society organizations (CSOs) and other non-governmental organizations (NGOs) and papers and publications produced by academic institutions.

Key words used for the search included women, men, gender, COVID-19, Africa, East and Southern Africa, governance, demographics, socio-economic impacts, livelihoods, health, maternal and child health, gender-based violence, education, school closures and time use, amongst others.

2.3 CATI rapid gender assessment methodology

2.3.1 Background

Even though it has been generally acknowledged that women are disproportionately feeling the impact of COVID-19 because of pre-existing intersectional inequalities and gender norms,⁸ restrictions on movement and social interaction during the periods of lockdown made it difficult to collect data about these differences. Face-to-face surveys – particularly those conducted by national statistical offices (NSOs) – came to a halt in the sub-region during this time due to the potential risks posed to respondents and data collectors. Limited internet connectivity in most of the sub-region as well as access further limited the kinds of data collection modes that could be employed as alternatives to face-to-face collection. One of the few alternatives that did not significantly restrict access and could still be used within the context of social distancing was computer-assisted telephone interviewing (CATI) survey methods. These were employed by the UN Women Country Offices in Kenya, Ethiopia, Rwanda, Uganda, South Africa, Malawi and Mozambique to collect data on the differential

8 E.g. UN Women – Women Count (2020) Spotlight on Gender, COVID-19 and the SDGs. Will the Pandemic Derail Hard-won Progress on Gender Equality?

impacts of the pandemic on women and men for use in consultations, planning and decision-making during and after the height of the pandemic.

2.3.2 Approach and methodology

Questionnaire

The generic question global and regional question omnibus was used by the Kenya Country Office (CO), in partnership with UNFPA and other partners to develop a CATI survey questionnaire for use in Kenya. This questionnaire was field tested and served as the model for the questionnaires that were subsequently developed for other countries in the region. The complete survey covers a broad range of topics. Since each interview had to be restricted to 15–20 minutes, the content was split between two questionnaires administered at different times.

1. **Questionnaire I**, covering demographics, economic activities, agriculture and education.
2. **Questionnaire II**, which includes demographics and contextual questions related to gender-based violence (GBV) such as changes in economic activities and income, health, human rights and safety and security.

The questionnaires were translated into various local languages in all countries where the study was conducted.

Rwanda and Uganda each only deployed one questionnaire with the focus in Rwanda on socio-economic matters and in Uganda on health and gender-based violence. These had been identified as priority areas by the respective country teams and government stakeholders. The study in Rwanda also employed CATI but did not make use of random digit dialling (RDD) and instead did purposive sampling in vulnerable communities.⁹ For this reason Rwanda is excluded from comparative tables and graphs. However, where appropriate, the findings are quoted in context.

Sample

The generic design of the study was based on a sample of 2,400 women and men 18 years and older. By developing sampling quotas that were representative of the population by age, sex, location and household monthly expenditure prior to COVID-19, the design mitigated the potential bias of mobile ownership which is skewed in most countries in the sub-region towards men and youth. The sample size of $n=2,400$, generates a sample for which the margin of error is 32.0% at a 95 percent confidence level for reporting at national level. Sampling was not based on a sampling frame as the service providers used random digital dialling (RDD) in all countries. However, as indicated earlier sampling quotas reflective of the sex, age and location distribution of the general population in each country were used to increase the representativity of the study. Once someone answers the phone, a set of filter questions were applied to establish whether they fall into a desired quota and whether they need to be included or not in the survey. In some countries it was difficult to fill certain location, age and sex quotas using RDD. For example, in Ethiopia RDD was supplemented by random selection from existing mobile phone sampling frames, which affected less than five percent of the sample.

⁹ The data collection was carried out in twelve districts selected in the four districts and the city of Kigali. Out of these districts twenty-four administrative sectors were identified based on criteria such as the incidence of GBV cases and teenage pregnancies. Source: MIGEPROF – UN Women – UNFPA (2020) Final report. Rapid Gender Assessment (RGA) on the Impact of COVID-19 on Women and Men in Rwanda.

The realised sample sizes per country are summarised in the table below. These were adjusted during benchmarking to conform to the original sample size and the quotas corresponding with the demographic profiles of each country, but clearly could only reach individuals who own or have access to mobile phones.

Table 1: Number of interviews conducted per country and mobile phone ownership

Country	Number of interviews	Number of mobile phones per 100 people in the population, 2019 ¹⁰
Ethiopia	2,410	36.2
Kenya	3,054	103.8
Malawi	2,481	47.8
Mozambique	2,464	47.7
Rwanda	2,400	76.5
South Africa	2,641	165.6
Uganda	3,001	57.3
Total	16,051	-

In addition to sample sizes, Table 1 shows the estimated mobile phone ownership as per the latest available information from the World Bank. Even though the mode of data collection was chosen because of lockdown, with movement and social distancing measures in place during COVID-19, using this mode clearly has limitations, especially in Africa. Examples of commentaries on the potential applications and weaknesses of CATI during COVID-19 can be found a recent publication by Grantz et al., some academic institutions and the World Bank. There are also accounts indicative of an increase in the acquisition and ownership of mobile phones in some countries during the pandemic.

This same basic methodology was applied in the countries included in the study, albeit with slight modifications. A demographic panel design was used in Ethiopia, South Africa, Malawi and Mozambique. Firstly, Questionnaire I was administered to the sample of 2,400 individuals. Those who were interested were then interviewed for a second time after a one- to two-week interval to cover the contents of Questionnaire 2. In several instances the service provider interviewed more respondents in some of the age and sex quotas due to greater availability and the realized sample exceeded 2,400 individuals. Quotas were adjusted accordingly using weights after data collection was completed.

In Kenya there were enough resources available to oversample to ensure that the final dataset only consisted of individuals who were willing to complete both questionnaires.

The Rwanda survey had the same sample size as in the other countries but did not follow the same sampling methodology. The service provider e-contacted local authorities of the selected enumeration areas to provide a list of respondents following the sample specification based on the previous household survey (proportion of each sex by age group, quintile category, urban/rural settings). This is one of the reasons why Rwanda has been excluded in most of the comparative tables and graphs on CATI COVID-19 assessment results.

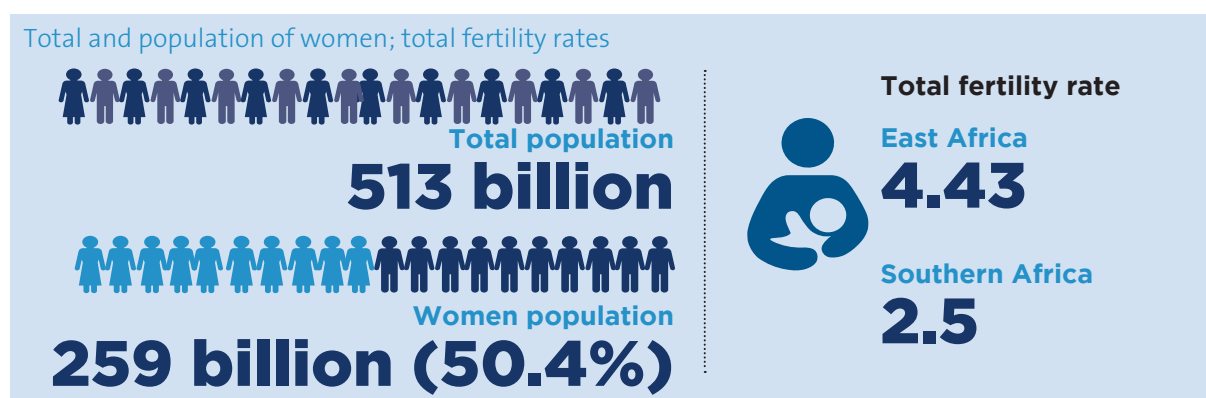
¹⁰ Data bank: World Bank development indicators, <https://databank.worldbank.org/reports.aspx?source=2&series=IT.CEL.SETS.P2&country=>, Accessed 10 February 2021.

3. DEMOGRAPHY

3.1 Population and fertility rates

The total population of East and Southern Africa was almost 513 million in mid-2020, with women constituting more than half of this figure, or roughly 259 million.

With on average 4.43 live births per woman, total fertility rates remain very high in several countries in Eastern Africa, especially in Burundi, Somalia and Uganda, although lower than the corresponding figure for whole sub-Saharan Africa (4.72). In Southern Africa, the fertility rate is clearly lower with 2.5 live births per woman, reflecting the higher standards of healthcare and better access to birth control in the latter area, where most countries belong to the middle-income group (this is still higher than the replacement level fertility, i.e. 2.1 live births per woman).



It is noteworthy, that especially in East Africa the population pyramids of countries in the sub-region are heavily concentrated on younger age groups. The mean age for East Africa is only 18.7 years, with lowest mean ages found in Somalia, Uganda, Burundi and Zambia. In Southern Africa, the mean age is almost 10 years higher – 27 years – with South Africa, Botswana and Lesotho having the highest mean ages in the sub-region.

Mean age per country

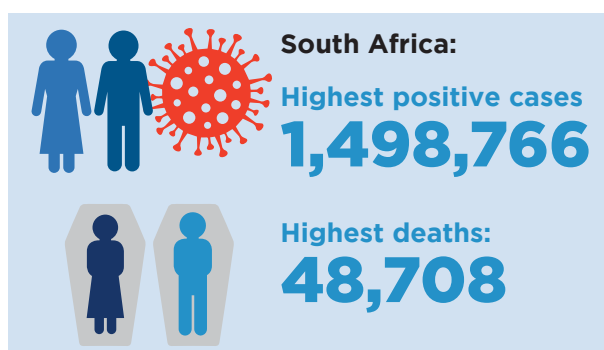
One of several explanations about why the pandemic had a smaller impact in Africa than in other regions is the relatively young populations.



3.2 COVID-19 infections and mortality

The pandemic and associated mortalities will have an impact on the demographic profiles and population pyramids of some countries, especially those that experienced high death rates amongst their older populations. Life expectancy is likely to be affected if younger age groups predominate in deaths. Globally, men account for 53% of confirmed cases of COVID-19 and the available data also shows higher mortality among them, according to UNFPA (2020) and UN Women (2020). Women, however, account for more than 63% of cases in the 85+ age cohort and this can probably be attributed to their generally longer lifespans. Many questions remain unanswered due to limited or incomplete data. According to The Lancet, it is vital to understand the primary and secondary effects of COVID-19 on different individuals and groups to create effective and equitable policies and interventions. Understanding the differential impacts on women and men is an example of such an approach.

Latest available figures for Africa show a somewhat more mixed picture, according to information compiled by the WHO. E.g. in South Africa, which has the highest total numbers in the sub-region – both of confirmed infections and deaths – women form a majority among confirmed infections, but men form the majority among the deaths. The higher infection rates among women could reflect their larger share among front line healthcare workers, or to a lesser extent a greater propensity to test for COVID-19. The same applies to neighbouring Eswatini. In Botswana, Uganda, Somalia and South Sudan, on the other hand, men clearly form a majority among both confirmed infections and deaths.



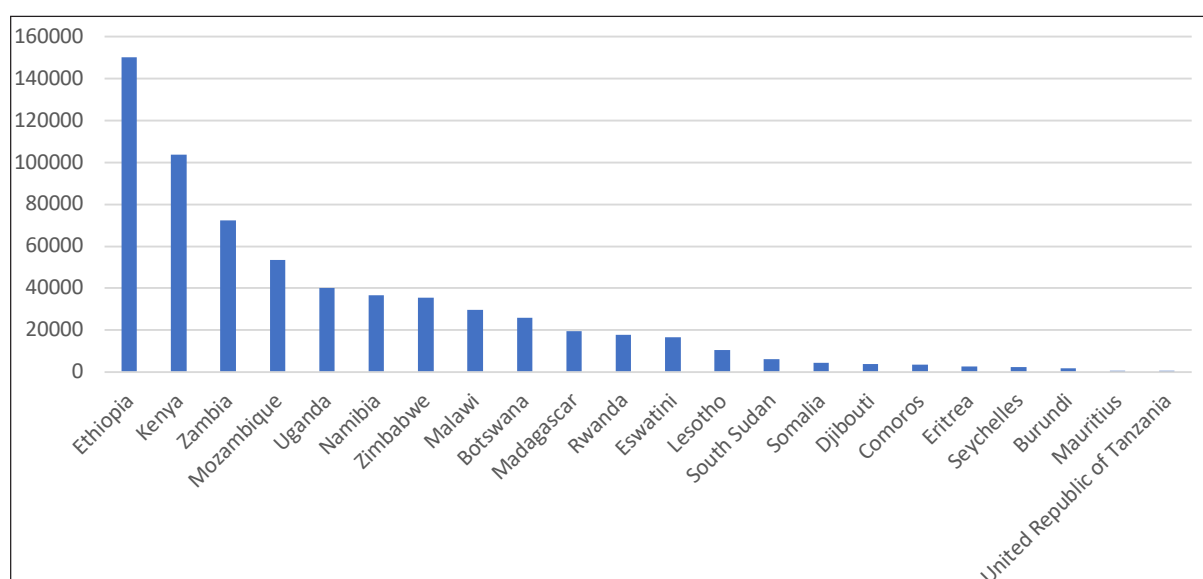
It is important to note that the total infections registered per country (Figure 1) do not necessarily reflect total infections as it is largely influenced by the following main factors:

- 1) Extent of testing and availability of testing services
- 2) Policies around testing—for example, is testing focused on individuals presenting symptoms or severe symptoms tested or only when referred by a medical practitioner?
- 3) Costs of testing may exclude poor individuals
- 4) Nature and quality of reporting systems related to the pandemic

Ideally this should be expressed as infections per 100,000 in the population, however because of differences in testing regimes as described above, and relatively small case numbers in some countries rates would be extremely small and difficult to interpret for most countries in the sub-region.

Furthermore, our understanding of the pandemic in the sub-region is seriously hampered by a lack of data. For example, an analysis of transmission patterns and risk factors will require several contextual variables, such as for example the ages, co-morbidities, socio-economic status, ethnicity and locations of those who are infected and have died. Unfortunately, the available data on infections do not have a lot of contextual variables and ‘sex’, which is one of the most important contextual variables that we need is only available for six of the 28 countries in the region.

Figure 1: Total number of COVID-19 infections per country in ESA, 19 February 2021



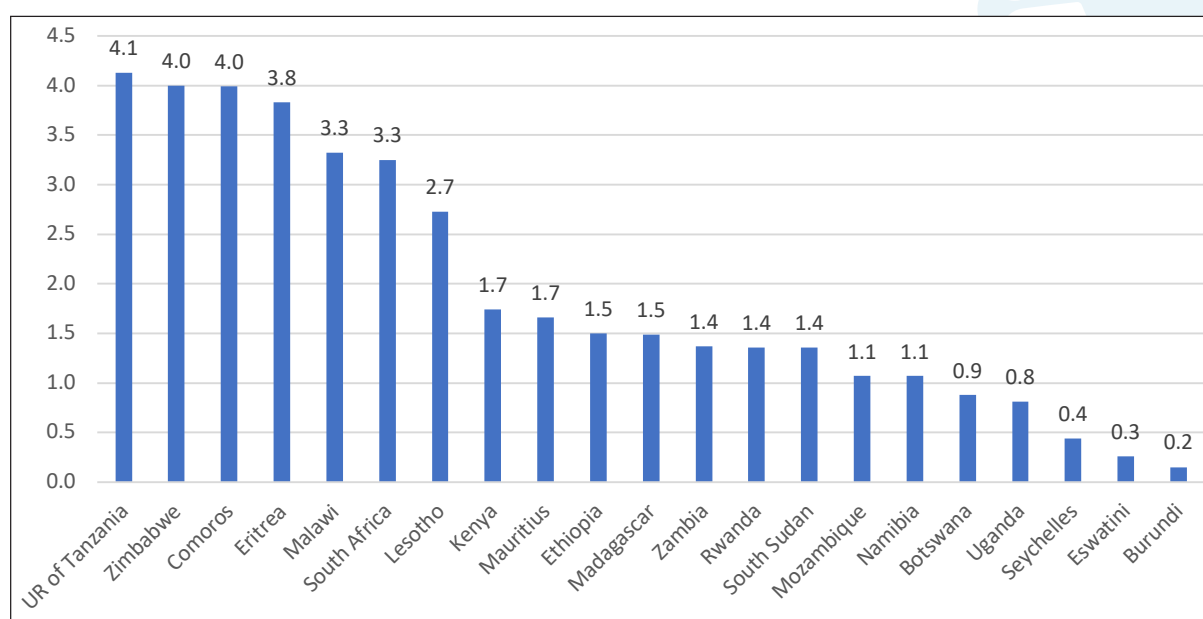
Source: Total accumulated infection and death rates, CFR: WHO Africa (2021) Dashboard, Accessed on 19 February 2021

Mortality data due to COVID-19 is generally under-reported, not diagnosed or misdiagnosed and that is why many countries calculate so-called excess deaths compared to the same period in 2019 to provide a more accurate estimate of how many people may have died due to COVID-19. South Africa is the only country in ESA that can calculate excess deaths reasonably accurately because of the compulsory and relatively good death registration system in the country.

Estimated case fatality ratios indicate the highest rates of approximately 4% in the United Republic of Tanzania, Malawi and Comoros. The lowest rates (less than 0.5%) have been found in Seychelles, Eswatini and Burundi.

In several countries with high mortality rates due to COVID-19, the population distributions have been impacted by especially deaths in the 60 years and older age cohorts. Mortality rates for women and men in ESA sub-region in 2015–2020 show that in all countries, other than Zimbabwe and Seychelles, men display higher mortality rates than women. In Seychelles, the figures are the same for both women and men, whereas in Zimbabwe they are clearly higher for women, which possibly reflects the high migration of working age men from Zimbabwe to South Africa and elsewhere.

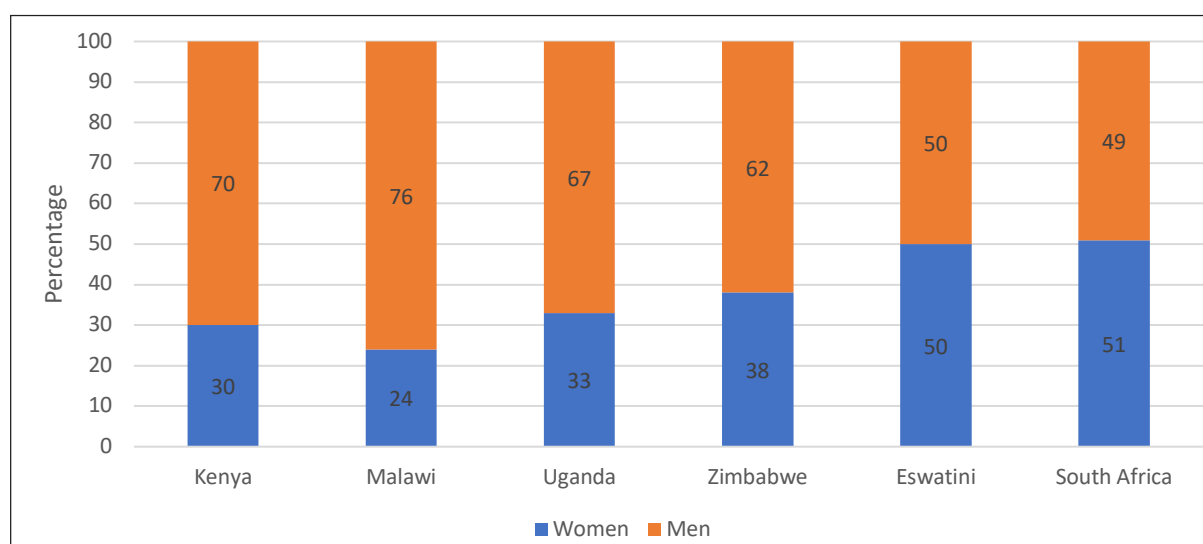
Figure 2: COVID-19 case fatality ratio (%) per country, February 2020



Source: Total accumulated infection and death rates, CFR: WHO Africa (2021) Dashboard, Accessed on 19 February 2021

In the same way, *mortality in COVID-19* shows a clear gendered pattern with men's fatality rates exceeding those of women in all those countries where such data is available and with near parity in Eswatini and South Africa. There are various reasons for this but is most likely due to differences in lifestyle and health-seeking behaviour.

Figure 3: Gender differences in COVID-19 mortality rates per country, February 2020



Source: Globalhealth5050.org. Accessed on 19th February 2021.

Healthcare workers – many of whom are women – are on the frontlines of the COVID-19 pandemic. Therefore, their exposure risk is heightened. Lack of protective and preventive equipment has turned out to be a considerable problem in many countries especially in the beginning of the pandemic. According to WHO information dating from the end of October 2020, a considerable number of healthcare workers have been infected by COVID-19. These varied between 27,360 healthcare workers infected in South Africa to 0 reported cases in Eritrea, Seychelles and Rwanda. However, it's possible that many such infections have remained undiagnosed due to lack of testing possibilities.

While COVID-19 had limited impact on short-term mortality rates in East and Southern Africa in 2020, it is essential to distinguish between short- and long-term effects on mortality. Long-term effects in terms of life expectancy can be seen only in retrospect. Given the limited access to healthcare services that the ongoing rapid gender assessments have detected, e.g. in Ethiopia and Kenya, especially when it comes to the *access to maternal and child health and health services for chronic diseases*, it is to be feared that the long-term indirect impacts on mortality and average life expectancy could be negative. Damage to vital organs sustained in serious cases of the disease may cause other health problems later on in life and could also reduce life expectancy. In Southern Africa where there are comparatively high HIV infection rates these added risks may further slow- down recent improvements in life expectancy.

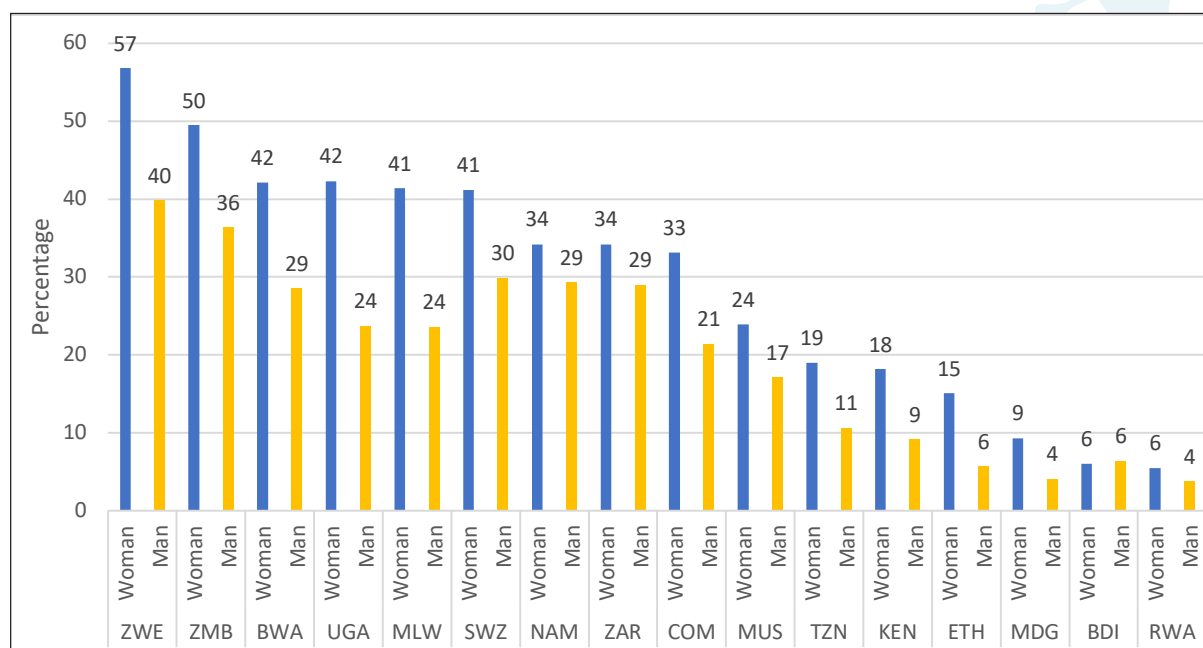
3.3 Demographic dividend and COVID-19

The demographic dividend is a term used in demography to refer to the benefits accruing to a society if they have a well-educated and predominantly youthful population who can drive economic growth and support older members of society who may be unable to do so themselves. In section 3.1 we have seen that the mean age in East Africa is 18.7 years and Southern Africa is 27 years, which places both sub-regions in a position to benefit from the demographic dividend. However, for the demographic dividend to truly pay off these youthful populations have to be educated and economically active. The proportion of youth that are in education and or employment therefore gives an indication of the extent to which the special characteristics of a youthful population is being harnessed to propel a country's development forward. SDG indicator 8.6.1 (see Figure 4) was developed for this purpose and reflects the inverse of having a well- educated and economically active youth.

According to the most recent statistics for the sub-region young women are much less likely than young men to be either engaged in education or employment activities. This is true for all countries in ESA, except Burundi. Countries with the most significant gaps between you women and men are Botswana, Malawi and Zimbabwe.

More than four in ten women aged 15–24 in Botswana, Eswatini, Malawi, Uganda, Zambia and Zimbabwe are neither in education, employment or training.

Figure 4: Percentage of youth (aged 15–24) not in education, employment or training, by sex (SDG 8.6.1), most recent year



Source: UNSD, SDG databank. Available from: <https://unstats.un.org/sdgs/indicators/database/>

The pandemic is unlikely to directly or even negatively impact the age profile of most countries in the sub-region and the potential of a demographic dividend will therefore still be there after the pandemic has been brought under control. However, we can see from Figure 4 that even prior to the pandemic high NEET levels reflected an under-utilized demographic dividend in the region.

Efforts to build human capital and expand learning have received a serious setback due to school closures which have affected nearly 253 million students in the region. With nearly half the population under 18, people are the region's greatest resource, and the temporary closures of schools and other institutes of learning resulted not only in lost learning hours, increased education inequalities and drop-out rates (Also see Section 7). This may therefore potentially have considerable long-term impacts in the region. Some estimates in South Africa predict that the long-term effects of the 2020 school closures will continue to affect children for the next 10 years.

Thus, the secondary effects of the pandemic on especially education through time lost due to school closures and expected higher drop-out rates – coupled with increased unemployment and competition in the job market – are likely to further constrain the already limited extent to which the potential benefits of the demographic dividend have been harnessed and realized in the region.

3.4 Migrants, internally displaced, refugees and COVID-19

3.4.1 Migration

Net migration rates from Africa is negative, i.e. more people leave Africa than move there, but there are also clear differences between the countries in the region.¹¹ It is expected that the economic hardships precipitated by the pandemic may stimulate increases

in cross-country migration. The countries with the highest negative net migration figures prior to COVID-19 were those characterized by fragility and low incomes such as Sudan, Eritrea, and Zimbabwe. Even Eswatini and Lesotho are characterized by high negative net migration figures due to pull factors provided in the form of their powerful neighbour, South Africa, the uncontested economic powerhouse of the region. Figure 5 provides the net migration figures for ESA in 2015–2020. The main reason for migration are economic hardships, instability and conflict and increasingly also climatic change.¹² Younger population pyramids in ESA as compared to ageing populations elsewhere lead to these migratory streams¹³ both inside East and Southern Africa and to other continents.

Economic hardships that are a consequence of COVID-19 pandemic and lockdowns could further stimulate migration from hardest hit areas to those where more economic opportunities are available. It should not be forgotten that parts of ESA have also been hard hit by locusts during the past year.

Even though intra-regional migration has been the norm within sub-Saharan Africa, oil-producing countries in the Gulf Cooperation Council (GCC) also attract migrants from East Africa, particularly the horn of Africa.¹⁴ During the pandemic many migrant workers in GCC countries had to return to their countries of origin or have no longer been able to travel to work due to lockdowns. This reduced migrant remittances, which further contributes towards the deepening poverty experienced by families and communities in East Africa. On average globally, migrant workers send home between USD 200–300 every one or two months, or 15% of what they earn.¹⁵ The World Bank projected in April 2020 that global remittances were likely to reduce by approximately 20 percent in 2020 due to the economic crisis induced by the COVID-19 pandemic and shutdown.¹⁶ Should the remittances supporting nutrition, health, education and income dwindle out in the longer term, setbacks in many of the sustainable development goals (SDGs) are to be expected in the migrants' original home countries.

In addition, living and hygiene conditions are often disastrous in migrant and refugee settings, which can hinder them adhering to recommended measures to prevent the transmission of the

11 United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, Online. Edition 1. Accessed in December 2020. UNSD, World Population report, 2020. Available from <https://www.un.org/development/desa/pd/>. Accessed on November 20th 2020, www.migrationdataportal.org. Accessed in December 2020.

12 Migration data portal. www.migrationdataportal.org. Accessed in December 2020.

13 Typical for source countries for migration is low mean age, e.g. in the case of Somalia only 16,7 years. In the region, South Africa, Uganda and Botswana receive more migrants than the other countries. Whilst in the case of Uganda the conflict in South Sudan (negative net migration rate of 15.9%) has led to refugees pouring into the country, in the case of South Africa and Botswana – both middle income countries with higher mean age than in their neighbouring countries – perceived better economic opportunities function as pull factors. Especially men labour force from Lesotho and Eswatini has migrated to South African mines for several decades. Eritrean and Sudanese refugees constitute since several decades a large part of asylum seekers also to Europe.

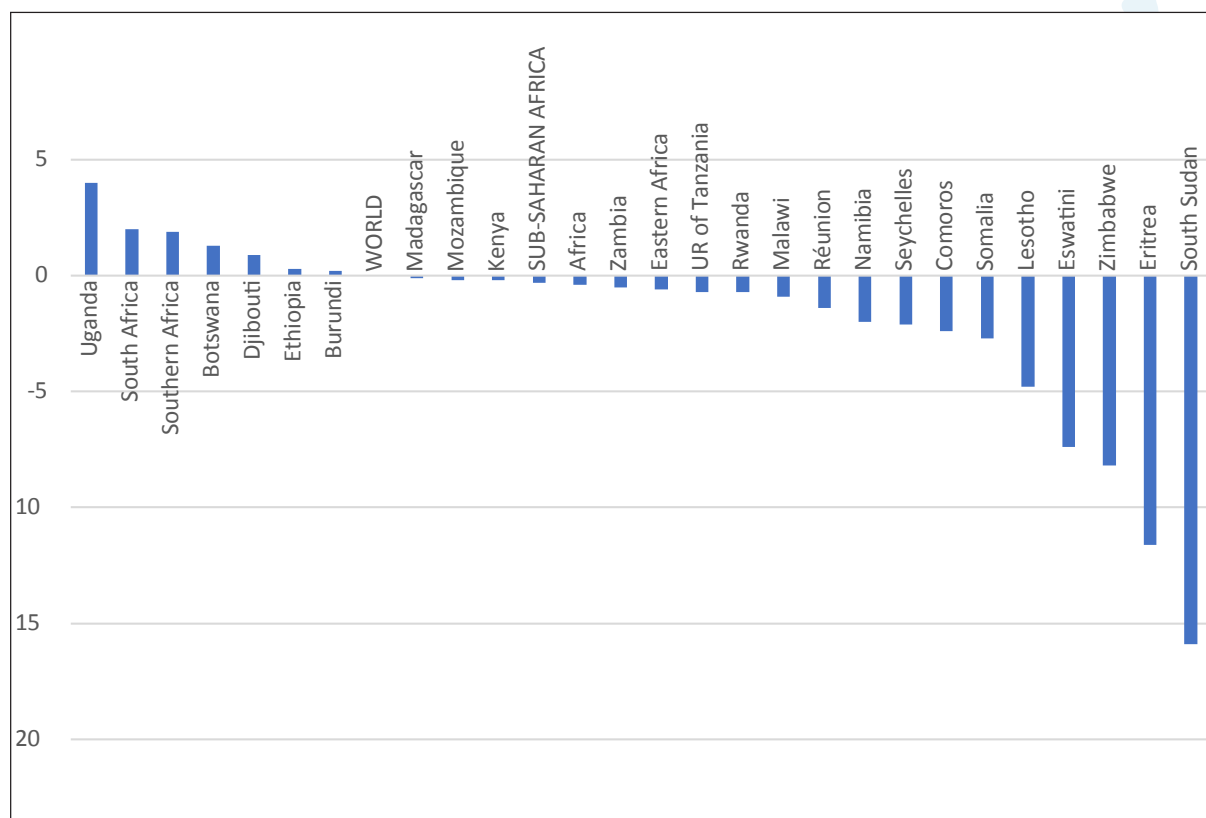
14 Migration data portal. www.migrationdataportal.org. Accessed in December 2020.

15 United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, Online. Edition 1. Accessed in December 2020.

16 World Bank. Available from <https://www.worldbank.org/en/news/press-release/2020/04/22/world-bank-predicts-sharpest-decline-of-remittances-in-recent-history>. Accessed February 2021.

virus and other diseases.¹⁷ The vulnerability of migrants and refugees is further exacerbated by their weaker access to health services, which was found to be the case with more than a third of migrants and refugees interviewed in Kenya (46% women) and Somalia (35% women) by a recent Mixed Migration Centre study.¹⁸

Figure 5: Net migration rates (per 1,000 in the population) in East and Southern Africa, 2019



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, Online. Edition 1. Accessed in December 2020.

3.4.2 Refugee and internally displaced populations

Another particularly vulnerable group in the sub-region are refugee and internally displaced populations (IDP). According to UNHCR,¹⁹ displaced populations were disproportionately more negatively impacted by the pandemic due to their already limited experience of human rights and dependence on humanitarian assistance and/or informal and unprotected work. Displaced people are seldom able to access social assistance supported provided by governments to their citizens.

In Africa, the pandemic has exacerbated an already fragile situation where existing assistance has been reduced globally due to funding shortfalls over the past few years. Refugees in at least eleven countries (including Ethiopia, Uganda, South Sudan, Kenya, Tanzania, Malawi and Zambia) are receiving rations of 80% or less than the minimum standard required to meet their needs, according to UNHCR.

¹⁷ Mixed Migration Centre www.mmc.org. Accessed in December 2020.

¹⁸ Ibid.

¹⁹ UNHCR (2020) Renewed Appeal 2021.

Refugee populations are often stateless²⁰ which increases their vulnerability even more. Some of the main reasons for statelessness in Southern Africa include: colonial history, border changes, migration, poor civil registration systems and discrimination based on gender, ethnicity and religion²¹. In the case of Eastern Africa most of these causes are also relevant, but internal conflicts and wars also play a role in triggering displacement and increases in refugees. Women and children are particularly vulnerable to statelessness²².

A recent rapid UN Women²³ and other agencies assessment among refugee populations in Uganda found that:

- Women and girls' unpaid care work has increased significantly. Girls and women aged 18–24 report an approximate 50 % increase in unpaid care work.
- Women and girls feel less safe in the home and the community than men and boys. More than 30 % of girls and women aged 18–24 have not been feeling safe in their own homes since the onset of COVID-19 and 31.8 % of girls also do not feel safe in the community.
- While men and boys more frequently reported a decrease in income, women and girls have been less able to save money through Village Saving and Loan associations (VSLAs) since the onset of COVID-19.
- Health workers and sexual and gender-based violence (SGBV) actors report an increase in gender-based violence, mainly domestic violence.
- Refugee girls and boys face a myriad of challenges to continue learning since the closing of schools. 37.1% of refugee children do not have learning materials or have stopped learning altogether. The need to carry out household chores affected the learning of 27 % and 13 % of boys.
- 80.6 % of the key informants interviewed agree that COVID-19 negatively impacts refugees' mental health.

20 The legal definition for stateless persons as individuals who are not considered citizens or nationals under the operation of the laws of any country. Source: The 1954 Convention relating to the Status of Stateless Persons, Available from https://www.unhcr.org/ibelong/wp-content/uploads/1954-Convention-relating-to-the-Status-of-Stateless-Persons_ENG.pdf.

21 ISS. Statelessness- an old problem with new threats. Available from <https://issafrica.org/iss-today/statelessness-an-old-problem-with-new-threats#:~:text=Statelessness%20in%20Southern%20Africa%20is,of%20gender%2C%20ethnicity%20and%20religion.&text=Even%20where%20the%20legal%20provisions,there%20are%20often%20practical%20impediments>.

22 UNHCR. Available from <https://www.refworld.org/pdfid/50f674c42.pdf>.

23 UN Women (2020) Rapid Gender Assessment of Refugees in Uganda.

4. GOVERNANCE DURING THE PANDEMIC

4.1 Introduction

This chapter provides an overview of the general legislative and normative contextual framework in the sub-region prior to the pandemic, as well as direct response measures to the pandemic that were put in place by governments in the region. Other non-direct measures taken by the national governments as well as (multilateral and bilateral) donor inputs will also be briefly discussed from a gender perspective. Even though leadership by women in times of crises is considered an essential ingredient for gender inclusive and sensitive decision making, limited evidence is available on their specific roles during the pandemic. The report will however, take a closer look at the pre-pandemic representation of women in parliament based on the assumption that political leadership will enhance the access of women to decision making processes and platforms.

A vital ingredient of good governance is evidence-based decision making. There is little hard evidence, backed up by data and statistics that can be used to measure the gendered impact of various normative and regulatory measures taken in response to COVID-19.²⁴ One of the main purposes of this review is therefore to collate available evidence and identify the evidence gaps that continue to exist.

One of the best sources of data on policy responses to the pandemic is the COVID19 Global Gender Response Tracker.²⁵ This tracker was developed by UNDP with technical and advisory support from UN Women and it monitors national and subnational government initiatives dealing with the pandemic and identifies whether these initiatives are gender responsive. Data obtained from this tracker forms the basis of a lot of the analysis presented in this chapter.

4.2 Gender gaps in legal and normative frameworks in East and Southern Africa

In general terms, most of the countries in the sub-region continue to have features in their legislation that discriminate against women, according to the World Economic Forum report.²⁶ These have mostly to do with the ownership of and control over land, where women in many countries continuously have weaker rights than men. Even in cases where the national, formal legislation would grant such rights, customary law might rule supreme and women could lose all their land assets in case of widowhood or divorce.

24 UN Women Ethiopia (2020) Assessment of the Gender Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia

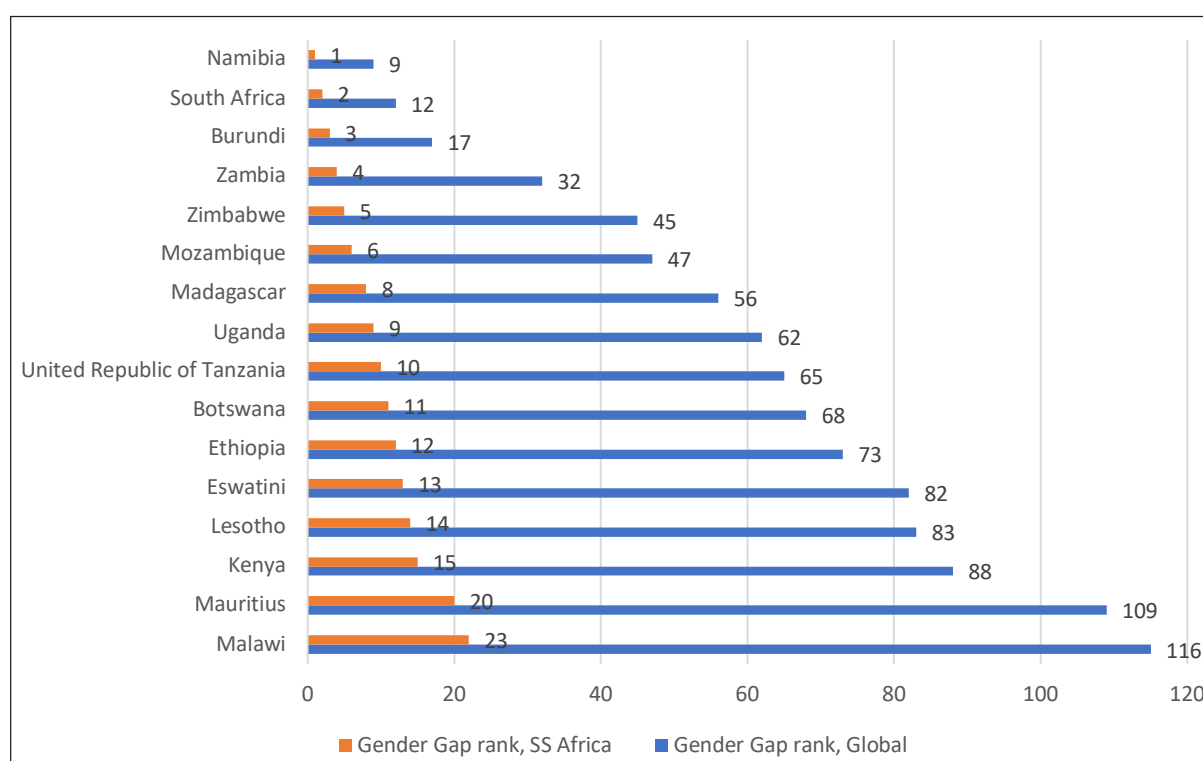
25 UN Women and UNDP (2020) COVID-19 Global Gender Response Tracker. Factsheet: Sub-Saharan Africa. Available from <https://data.undp.org/gendertracker/>, accessed in January 2021

26 WEF (2020) Global Gender Gap Report

The World Economic Forum (WEF)²⁷ has estimated the gender sensitivity of the legal framework in several East and Southern African countries (Figure 7). According to this classification, Uganda and Eswatini have most obstacles for women's access to land use and control among all the countries covered. Botswana and Kenya have also considerable obstacles whereas all the remaining countries, for which data has been analysed, have relatively fewer legal obstacles for women's access to land use and control.

Based on a variety of social, economic and representation aspects as reflected in legal and regulatory frameworks, the WEF created a global gender ranking system.²⁸ This is presented in Figure 7 where both the global and sub-Saharan Africa rankings are summarized (Figure 6). Out of these, Rwanda stands first, followed by Namibia and South Africa. The countries with lowest gender ranks in the sub-region are Malawi, Mauritius and Kenya. Rwanda also boasts the 9th place on the Global Gender Rank, that includes 154 countries, again followed by Namibia (12th) and South Africa (17th out of 154).

Figure 6: Gender-sensitive legal and regulatory frameworks, women's gender gap rank according to the World Economic Forum – regional (sub-Saharan Africa) and global (out of 153 countries), 2019



Source: World Economic Forum (2020) Global Gender Gap Report.

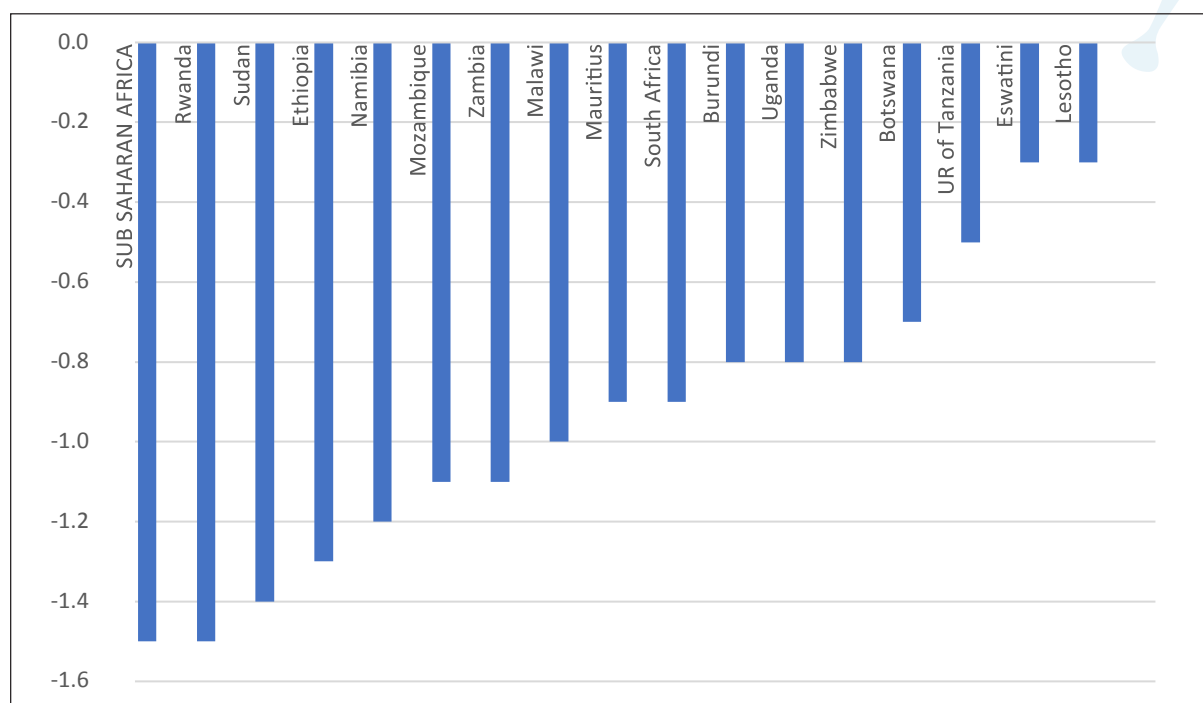
Another global measure of gender equality from human development and socio-economic sustainability perspective the UNDP (2020) Gender Inequality Index (GII) as contained in the Human Development Report (HDR). It presents a composite measure of gender inequality using three dimensions: reproductive health, empowerment and the labour market. Figure 7 provides the annual compound change rate of the Gender Inequality Index value over 2005–2019. It is one of the indicators used in the HDR dashboard to reflect socio-economic sustainability. The biggest negative value in the chart represents the biggest annual compound decline in the gap between women and men for the reference period. Figure 7 shows that

27 WEF (2020) Global Gender Gap Report

28 Ibid.

based on this index some progress has been made between 2005 and 2019 in reducing gender inequality in East and Southern Africa. Unfortunately, these gains are at risk of being eroded due to the COVID-19 pandemic as will be seen in later chapters.

Figure 7: Annual compound change rate of the Gender inequality index, 2005–2019



Source: UNDP (2020) Human Development Report 2019.

4.3 Fiscal and monetary responses to the COVID-19 pandemic in East and Southern Africa

Globally governments have adopted measures seldom used before to protect society and contain the spread of the pandemic. The exact nature of these measures has varied from country to country but, overall, the measures have very similar characteristics. When the pandemic expanded globally, most African countries also announced either an economic stimulus package or more healthcare spending in direct response to COVID-19.²⁹

For instance, in Eritrea,³⁰ the first positive COVID-19 case was reported on March 21, 2020. The government immediately announced containment measures that included placing restrictions on and quarantining international travellers who came from or transited through countries with reported COVID19 cases. A high-level task force on COVID-19 was also convened to function as the central coordinating mechanism for Eritrea's response to the pandemic. Stringent legal measures were also announced to discourage individuals and commercial enterprises from hoarding or hiking prices of essential commodities. Eateries, bars and entertainments places were closed and court sessions were postponed. The government also mandated physical distancing in commercial units and centres.³¹ All institutions of learning and non-essential commercial enterprises were also closed. A 'nation-wide 21-day stay-at-home policy' was also instituted early in April to contain the spread of COVID-19.

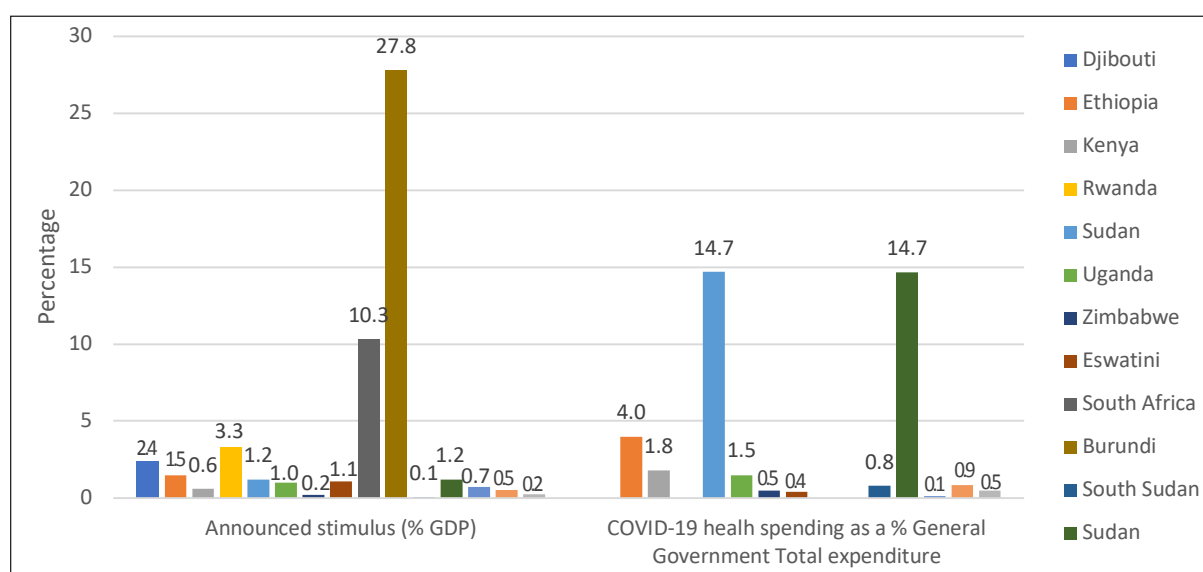
29 Milken Institute. Available from <https://covid19africawatch.org/africa-policy-monitor/>. Accessed January 2021

30 UNDP (2020) Rapid Assessment. The Socio-economic Impacts of COVID-19 in Eritrea. Preliminary Findings. May 2020

31 Ibid.

In South Africa, President Cyril Ramaphosa announced that the National Coronavirus Command Council was introducing a nationwide lockdown on March 26, 2020.³² On 1 May, the government commenced a risk-adjusted strategy to ease the country's lockdown restrictions over five levels. In addition, the government introduced **an R500 billion fiscal support packages** totalling about 10% of GDP, the biggest stimulus package in the country's history. The largest contributions were allocated to the Credit Guarantee Scheme (200,000 M Rand) and job creation and support for SME and informal businesses (100,000 M Rand). In addition, the South African government allocated funds to measures for income support, such as tax deferrals, support to vulnerable households for six months, wage protection, health and other frontline services as well as support to municipalities.

Figure 8: Fiscal response to COVID-19 in ESA, 2020



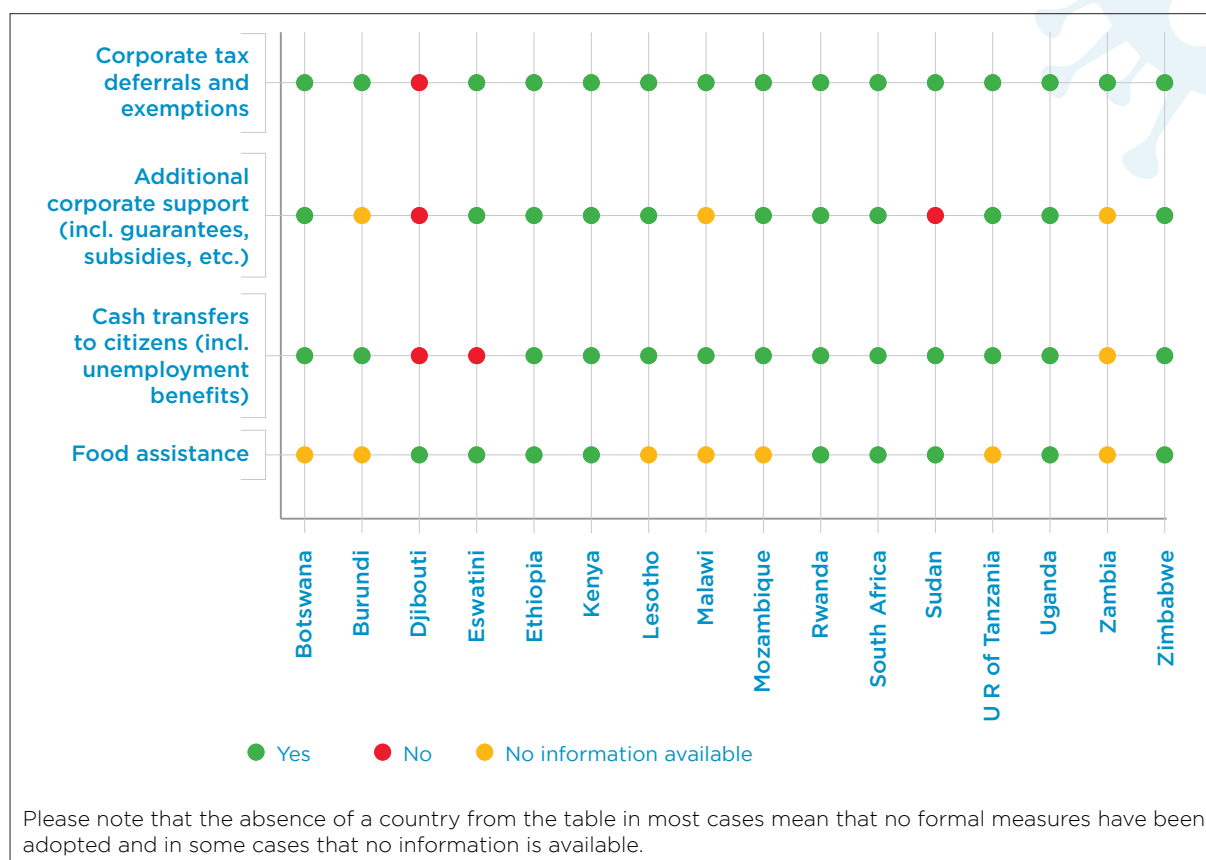
Source: Milken Institute, COVID-19 policy watch, <https://covid19africawatch.org/africa-policy-monitor>. Accessed in January 2021.

Figure 8 compares the available information on spending announcements across countries in East and Southern Africa.³³ These are converted to US dollars and displayed as a percentage of GDP. New healthcare spending is also included and expressed as a % of general government total expenditure. As can be seen from the Figure 8, the announced stimulus packages (by 21 February 2020) varied between 0.1% (South Sudan) and 27.8% (Burundi) of GDP in ESA. In terms of total expenditure commitments South Africa stood in a class of its own, with a USD 37,879 million stimulus package. Also announced health spending varied between USD one million to 542 million. Most countries also reported corporate tax deferrals and exemptions, as well as guarantees and subsidies as corporate support. These probably have benefited solely or mostly formal sector, larger companies which are mostly owned by men. However, several countries in the sub-region also publicly announced the availability of cash transfers to their citizens as well as food assistance, although the extent of these is not reported. See Figure 9.

³² Milken Institute, COVID-19 policy watch. Available from <https://covid19africawatch.org/africa-policy-monitor/>. Accessed February 2021.

³³ Ibid.

Figure 9: Fiscal and other measures in response to COVID-19 pandemic in countries with available data, 2020



Source: Milken Institute, COVID-19 policy watch, <https://covid19africawatch.org/africa-policy-monitor> Accessed February 21st 2021.

Monetary policy measures have also been taken by several countries. These typically consisted of cutting policy interest rates by central or national banks. In South Africa, the Reserve Bank de facto cut the repo rate four times due to COVID-19. Some countries (e.g. Somalia and Uganda) have also introduced lending support for SMEs. Some of the countries, notably Seychelles, Mauritius, Uganda and South Africa have targeted the most affected sectors usually with deferrals of company taxation or allowing commercial banks to offer loan renegotiations and tax holidays to be granted on more flexible terms. Thirteen of the sixteen countries in the sub-region have adopted measures that involved cash transfers to the most vulnerable groups in society. In countries with pre-existing social safety net structures or programmes, such as for example South Africa and Kenya, these systems have been used to allocate more funds to vulnerable families. Eight the countries in the sub-region also reported increasing food aid.

Even though most of these measures were generically applied across the population and theoretically could benefit both women and men, very few of these response measures were particularly gender responsive, focussing on the differential needs of particularly women. The next section takes a closer look at this.

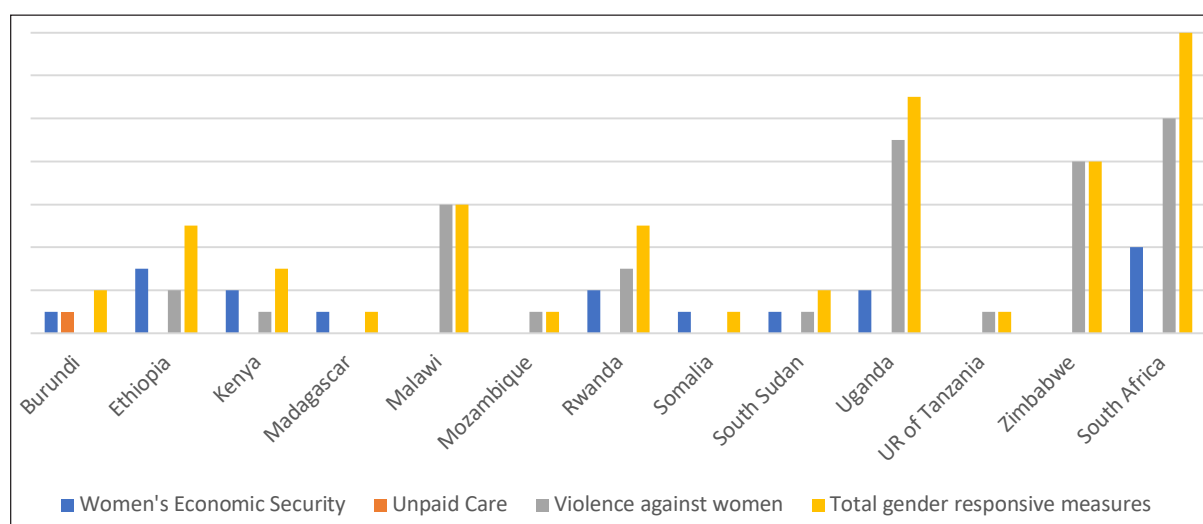
4.4 Gender-responsive measures to mitigate COVID-19 in East and Southern Africa

According to UN Women and UNDP Gender Response Tracker, 29 of the 46 countries and territories analysed in SSA have taken a total of 113 gender-sensitive measures in response to COVID-19. Gender-sensitive measures are a subset of all measures that seek to directly address the specific risks and challenges that women and girls face due to the pandemic, including:

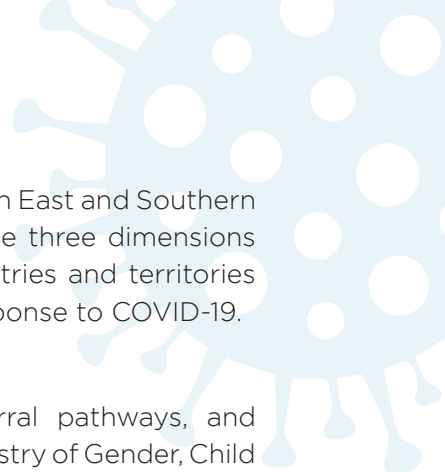
- All violence against women measures is categorized as gender-sensitive by default.
- Social protection and labour market measures are defined as gender-sensitive if they target women's economic security or address unpaid care needs.
- Fiscal and economic measures are defined as gender-sensitive if they provide support to sectors of the economy dominated by women, on the assumption that this is likely to protect women's employment and thereby their economic security. The assessment is conducted based on the available information about policy design. An assessment of the implementation or gender impact of these measures is not included. Most of the measures adopted in the sub-Saharan Africa address violence against women (64 measures in 17 countries), followed by measures to ensure women's economic security (45 interventions across 24 countries). The lowest number of measures were found to be those that address unpaid care work (four measures across three countries).

Figure 10 displays these measures for East and Southern Africa. In East and Southern Africa the picture does not look much different. Uganda (11) and South Africa (14) had the highest number of gender responsive policy measures in place. Once again, of the 13 countries for which information is available, 10 had one or more Violence Against Women measure in place. Countries without any VAW measures were Burundi, Madagascar and Somalia. Burundi is the only country with any unpaid care related policy responses.

Figure 10: Number of gender-sensitive policy response to COVID-19 in East and Southern Africa, 2020



Source: UN Women & UNDP (2020) COVID-19 Global Gender Response Tracked. Factsheet: Sub-Saharan Africa. Available from <https://advocacyaccelerator.org/product/fact-sheet-covid-19-global-gender-response-tracker-sub-saharan-africa/>. Accessed in January 2021.



Due to the lower number of measures to address unpaid care, no country in East and Southern Africa had a holistic response to COVID-19 with measures that span the three dimensions (violence, economic security, unpaid care). Moreover, 13 out of 28 countries and territories analysed in the sub-region adopted no gender-sensitive measures in response to COVID-19.

Some of the examples in ESA are as follows:

- In Malawi, guidelines were developed to assist mapping of referral pathways, and community complaint mechanisms were created. Furthermore, the Ministry of Gender, Child Development and Community Development received 940 bicycles and 60 motorcycles from the UN's Spotlight Initiative for use by VAWG service providers in communities. They are expected to ease efforts to reach out to marginalized groups in hard-to-reach areas.
- The Federal Supreme Court of Ethiopia announced that it will prioritize 'domestic violence' cases as well as opening up and full operationalization of women and children benches at courts.
- In Mozambique, the Ministries of Interior and Health made national helplines available 24/7, partnering with telecommunications companies, as a means for women and girls to report safely.
- During Level 4 of the lockdown in South Africa, the courts prioritized cases involving serious violent crimes, robbery, murder, corruption, sexual offences, gender-based violence and femicide, as well as the violation of COVID-19 regulations.
- National helplines have been launched in South Sudan to assist gender-based violence survivors 24/7 by providing information and linking them to the nearest service-providers, including Family Protection Centres (VAWG one-stop centres).
- In Uganda, Standard Operating Procedures (SOPs) were developed to ensure continuity of gender-based violence, sexual and reproductive health and HIV services during the pandemic. The Ministry of Health can use these to prioritize integrated services in COVID-19 case management.
- Further south in Zimbabwe, domestic violence cases continue to be treated as urgent by courts, the Victim Friendly Unit is operating, and services such as shelters continue to function.

The second most common type of measure taken in the sub-region was *awareness-raising and campaigns* (14 measures in 12 countries). Many of these efforts have been innovative and collaborative.

In Hawassa City, Ethiopia, Safe City messages on prevention and response to domestic and sexual violence have been shared with religious authorities for community outreach.

Source: UN Women and UNDP (2020) COVID-19 Global Gender Response Tracker. Factsheet: Sub-Saharan Africa. Available from <https://data.undp.org/gendertracker/>, accessed in January 2021.

Only Kenya, Malawi, South Africa, Uganda and Zimbabwe in ESA sub-region have taken seven measures to improve the collection and use of violence against women data within the COVID-19 context.

Services to respond to and prevent VAWG should be treated as essential services and an integral part of national and local COVID-19 response plans. However, according to the tracker, only South Africa, Uganda and Zimbabwe in the ESA sub-region have taken this step. The tracker did not identify any measures to address online violence in the sub-region and very few measures to reach the most marginalized of women.

In Kenya, the President ordered an investigation into rising reports of violence against women and girls – including rape, domestic violence, female genital mutilation and child marriage – as a result of COVID-19 restrictions.

Source: UN Women and UNDP (2020) COVID-19 Global Gender Response Tracker. Factsheet: Sub-Saharan Africa. Available from <https://data.undp.org/gendertacker/>, accessed in January 2021.

Out of the *more than 40 countries and territories in sub-Saharan Africa*, only 45 measures across 24 countries and territories address women's economic security – amounting to less than 16% of the total fiscal, economic, social protection and jobs responses. Of these measures, 22 fall under the social protection category. The main social protection programmes that sub-Saharan African governments have used to strengthen women's economic security in the context of COVID-19 are cash transfers (11 measures in eleven countries) and food assistance or other forms of in-kind support (six measures in six countries) that prioritize women as the main recipients.

For example, in ESA the following examples of fiscal and economic, *social protection and labour market measures* are of relevance:

- In Kenya, the *National Safety Net Programme* prioritizes giving cash to women in beneficiary households. More than one million *Inua Jamii* beneficiaries have started receiving KES 8,000 (USD 74) each as a safety net against the effects of COVID-19. The scheme targets older persons, orphans and other marginalized members of society.
- The government of Rwanda is making the most of their well-established community-based structures to implement their *social protection response*. It started with the in-kind distribution of food and other essential items to 20,000 families, partly targeting women-headed households. Committees covering 15–20 households and operating at the lowest local administrative level, identifies potential beneficiaries. However, households in need of food can also self-report to these committee members or through a dedicated toll-free number.

Finally, 11 countries in the SSA announced a total of 19 fiscal and economic measures to support feminized sectors of their economies – i.e. sectors that absorb a higher proportion of women's employment compared to that of men. These measures account for 20 % of all fiscal and economic measures analysed in the region.



In South Africa, the Department of Tourism made an additional ZAR 200 million (USD 12 million) available to assist MSMEs in the hospitality and tourism sector across all nine provinces and various tourism subsectors. Preference will be given to small and medium enterprises in rural areas and townships and those owned by women, young people and persons with disabilities.

Source: UN Women & UNDP (2020) COVID-19 Global Gender Response Tracked. Factsheet: Sub-Saharan Africa. Available from <https://advocacyaccelerator.org/product/fact-sheet-covid-19-global-gender-response-tracker-sub-saharan-africa/>. Accessed in January 2021.

Another four measures in three countries in SSA aim to address women's economic security *through labour market measures*, but none of the countries in ESA have adopted these kinds of measures.³⁴

Measures to support *unpaid care in the COVID-19 response* include the *provision of paid family leaves, cash-for-care programmes, flexible and shorter work-time arrangements or continued provision of childcare services, including for essential workers*. Such measures are extremely scarce in sub-Saharan Africa, accounting for around two% (four measures in three countries) of the total 189 social protection and labour market measures in the region. Six out of the 42 countries and territories analysed in sub-Saharan Africa have not taken any measures to address unpaid care at all. Exceptions in ESA include *Burundi, where food and hygiene kits were provided to care centres for vulnerable people*.

The case of Ethiopia (Box 1) shows how targeted measures and using existing administrative and programme frameworks can be an efficient tool in providing gender-sensitive measures in response to COVID-19 Pandemic also in low-income countries.³⁵

³⁴ UN Women & UNDP (2020) COVID-19 Global Gender Response Tracked. Factsheet: Sub-Saharan Africa. Available from <https://advocacyaccelerator.org/product/fact-sheet-covid-19-global-gender-response-tracker-sub-saharan-africa/>. Accessed in January 2021.

³⁵ Ibid.

BOX 1 Case Study of Ethiopia


According to UN Women and UNDP COVID-19 Gender Impact Tracker,³⁶ Ethiopia has taken a total of 10 measures in response to COVID19, of which five are gender sensitive. While limited in number and scope, the gender responsive measures that have been taken address women's economic security (three) and violence against women (two), with indirect benefits for women's unpaid care work. While Ethiopia recorded relatively low numbers of COVID19 cases in the first half of 2020, since July the country has seen growing numbers of confirmed cases, and a death toll of over 1,000. As part of the COVID response, the country announced a five-month state of emergency on 8 April, with physical distancing measures and restrictions on community gatherings, school closures and mandatory quarantines for travellers. Ethiopia is one of the only examples of where a country has taken measures that grant paid leave to beneficiaries of public works programmes, with direct benefits for women's economic security and indirect support for their unpaid care work. This is through the Urban Productive Safety Net Project (UPSNP), which partly targets women headed households and foresees the provision of both community based childcare services and reduced working time for women with children. Before and after childbirth, the programme enables women to receive direct support without work requirements. During COVID 19, beneficiaries of the UPSNP will receive an advance of 3 months' payment while on leave from their public work obligations. Those who benefit from UPSNP may withdraw 50% of their savings for use for expenses that are the result of the COVID-19 emergency. Other low-income citizens who are not benefiting from UPSNP will be covered by the project and will receive 3 months' advance payment. Citizens across 16 cities who have a high risk of being exposed to COVID-19 and harm and who need assistance will also receive 3 months' payment. The Rural Productive Safety Net Project has also been adjusted in response to COVID 19: since the start of April the public works requirement has been waived and from July 2020 the project was scaled up horizontally and vertically for 3 to 6 months. The estimated scale-up caseload was 1 million people, with an estimated cost of USD \$50–70 million and benefits would include both cash and food.

In Harari State specifically, paid sick leave has been implemented for government employees who are at a higher risk of COVID19 (older persons, pregnant women, those with underlying conditions). These groups have been permitted to stay at home while continuing to receive their salaries, ensuring that higher risk groups are able to maintain social distancing measures while remaining secure in their income.

Moreover, to address violence against women in Ethiopia, the courts have continued to hear domestic violence cases with minimal interruption during COVID19. In addition, in Hawassa City, "Safe City" messages on prevention and response to domestic and sexual violence have been shared with religious authorities for community outreach.

Source: UN Women & UNDP (2020) COVID-19 Global Gender Response Tracked. Factsheet: Sub-Saharan Africa. Available from <https://advocacyaccelerator.org/product/fact-sheet-covid-19-global-gender-response-tracker-sub-saharan-africa/>. Accessed in January 2021.

36 UN Women & UNDP (2020) COVID-19 Global Gender Response Tracked. Factsheet: Sub-Saharan Africa. Available from <https://advocacyaccelerator.org/product/fact-sheet-covid-19-global-gender-response-tracker-sub-saharan-africa/>. Accessed in January 2021.



A more detailed country specific analysis of the Gender Assessment on the of the Gender Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia³⁷ found that almost none of the organisations interviewed – government, CSOs or international organisations – focus on women’s economic empowerment and very little information was forthcoming on the topic. At the same time, respondents recognized *economic challenges as a priority area* going forward along with the need for significant strengthening to mount an effective response and recovery from COVID-19 impacts. Some of the findings of this assessment were the following:

- Women are often engaged in informal work arrangements and have experienced loss of jobs and income without benefits or any other resources.
- For women business owners (from micro-enterprises such as a trader selling bread to larger businesses employing 10 or more other women), there are reduced economic opportunities during COVID-19. Women feel the weight of not only supporting their own families, but also their women employees and their families.
- Access to finance has become constrained, and pre-existing loans have become difficult to pay off. Even when women take loans, they often end up losing the money due to economic challenges and have to repay without regular income.
- Being a single parent in a women-headed household puts immense burden on women to provide all the needs of children and the household, with few options to earn and in some cases not being eligible for social protection or charitable handouts.
- In order not to lose a school spot (and remote learning may at least be theoretically in effect), women must keep paying school fees to ensure their children’s future prospects.
- During lockdown and due to the economic impacts of the pandemic, labour migrants may return/are returning to their rural homes where without jobs they will again contribute directly to household economic activities (often in agriculture).

District-level offices, wards and neighbourhood associations often favour women that they know in terms of social transfers and government handouts, according to the UN Women Ethiopia Assessment.³⁸ Labour migrant returnees and Persons with disabilities (PwD) have been reported as examples of being left out and not benefiting from government programs. In the case of labour migrants from rural areas, government officials may require identification cards, when registering people for financial support. Such identification cards are not necessarily available for especially illegal migrants and or returnees who may be registered in another sub-region or country.

Another example from ESA sub-region highlights some of United Nations International Children’s Education Fund (UNICEF’s) work as follows (Box 2):

³⁷ UN Women Ethiopia (2020) Assessment of the Gender Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia.

³⁸ Ibid.

Box 2 UNICEF approach in Burundi

At the onset of the pandemic in Burundi, UNICEF and partners initiated a large communication campaign to encourage handwashing with soap to stop the transmission of the virus. One of the most immediate problems was how will it be possible to practice hand hygiene when many cannot afford to buy soap. Nearly 90 percent of Burundi's 12 million population live below the international poverty line of US\$1.90 and more than half live on less than US\$0.90 per day. Since a standard bar of soap cost around US\$0.16, purchasing soap for handwashing is not affordable to many.

As part of the solution to this problem UNICEF requested SAVONOR, the biggest industrial soap producing company in Burundi, to reduce its profit margin in soap production, and UNICEF would further subsidize the production. This reduced the price of soap in the country by half and SAVONOR used its distribution system to make the soap available across Burundi. The soap, is named Bururu in the local language Kirundi, is similar to any other soap manufactured by this company. It only differs in color (blue) and the recommended retail price (150 BIF or US\$0.08) carved on each bar.

Source: www.unicef.org/pressreleases/ (Accessed in January 2021)

4.5 Women in positions of leadership and decision-making

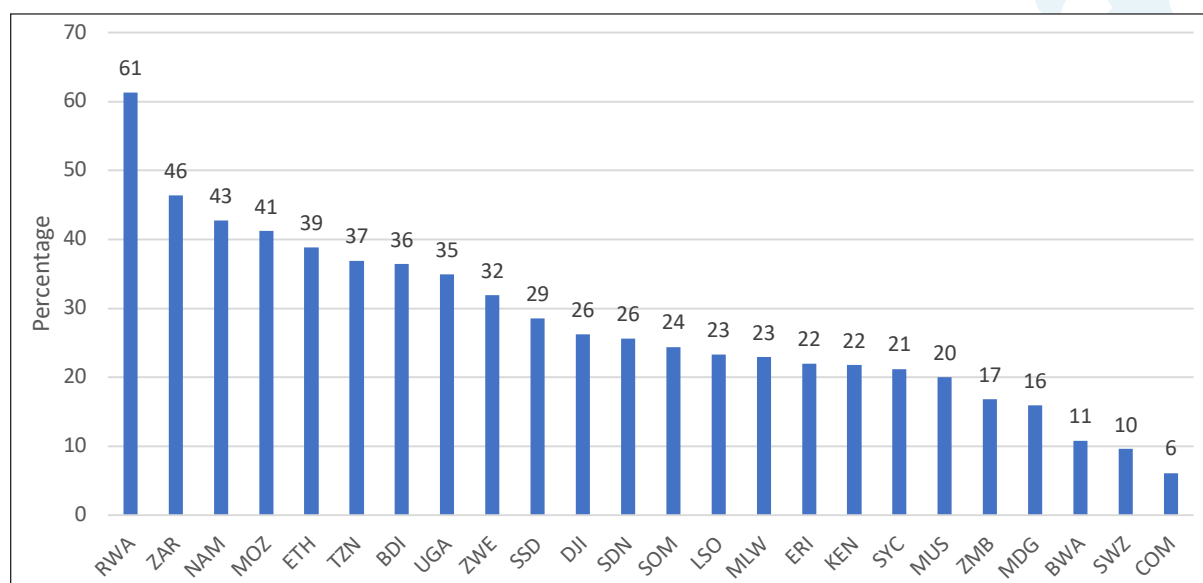
The pandemic has impacted on political processes, institutions and policies due to social control and movement restrictions. It changed the way national and local leaders went about their interactions and decision-making processes for women and men. The active leadership and participation of women during times of crises are considered important not only to ensure that planning and budgeting are more gender responsive and responsive, but also to increase inclusivity, effectiveness and diversity.

Prior to the pandemic the sub-region has made some progress with the representation of women in national parliaments as can be seen from Figure 11. Even though gender equity was not achieved in any country in ESA, at least four countries have come close. In Rwanda six out of ten seats in the national parliament are held by women and in South Africa (46%), Namibia (43%) and Mozambique (41%) more than two in five members of parliament were women. The lowest levels of representation are found in Botswana (11%), Eswatini (10%) and the Comoros (6%). The progress made with regards to women's representation in the sub-region has contributed towards the greater visibility and inclusion of women in decision-making processes during the pandemic.

Not only women in parliament have influenced the nature and course of the responses to the pandemic. In Africa existing mechanisms and institutions aimed at gender equality, such as for example gender equality commissions have been harnessed as part of their government's response to the pandemic. Examples of their involvement include the development of gender responsiveness guidelines and advocacy efforts.³⁹

39 UN Women, African Union and ECA (Economic Commission for Africa). "Meeting of African Ministers in Charge of Gender and Women's Affairs." 12 May (virtual).

Figure 11: Proportion of seats held by women in national parliaments (% of total number of seats), (SDG 5.5.1), 2020⁴⁰



Source: UNSD, SDG databank. Available from: <https://unstats.un.org/sdgs/indicators/database/>

In 2020, a significant number of consultations and high level meetings have been conducted on the Impact of COVID-19 on Gender Equality and Women's Empowerment (GEWE). These have been led by institutions including but not limited to the African Union Commission – Women, Gender and Development Directorate (AUC-WGDD), Gender Is My Agenda Campaign (GIMAC), African Women Leaders Network (AWLN), UNDP, UN Women etc., to identify gaps, provide recommendations and offer a space for strategic engagement with Member States, between/among CSOs and other key stakeholders.

In June 2020, the African Women Leaders Network (AWLN), held a virtual consultation to provide an opportunity for women to exchange experiences, knowledge and viewpoints and to get a better understanding of the impact of COVID-19 on women in Africa. This was considered important to craft action during the pandemic as well as begin to plan action for the post-COVID-19 recovery phase. Placing women's leadership in the spotlight was also considered a way of advancing the position of women in leadership.⁴¹

The AWLN also engaged its already established 25 chapters, which in turn shared the ground-breaking efforts they are leading to advance gender equality at all levels during the pandemic as well as their perspectives of its impact on women. National consultations were held in October/November 2020 by the AWLN Young women caucus in collaboration with national chapters in order to engage young women at national level in paving the way to the retreat and advocate for enhanced leadership of young women in governance and leadership especially in the COVID 19 context. A consultation guide/toolkit was developed to facilitate in country engagement and tailored based on national contexts and needs.

An inter-generational retreat was also held in November 2020 which brought together young and seasoned leaders, governments, civil society, private sector, bilateral and multilateral partners and institutions across Africa and the diaspora. Among the objectives of the retreat was

⁴⁰ The indicator value for Sudan is for 2011 and for Eritrea for 2019.

⁴¹ Africa Union Press release. Available from <https://au.int/en/pressreleases/20200602/advancing-women-leadership-during-and-post-covid-19-pandemic>. Accessed February 2021.

to leverage the role of intergenerational dialogue and mentoring to address the current political, social and economic affairs in the context of COVID 19 and beyond. At the same time it provided a digital space for inter-generational dialogue and the discussion of strategies to strengthen young women's leadership in governance, women peace and security, global health, global health security, as well as their role as front line leaders in the Covid19 response and beyond.

In East and Southern Africa, women have been prominent in the response to the pandemic not only as health-care workers, carers at home and community leaders and mobilizers, among other roles but also as government ministers tasked with dealing with certain aspects of the pandemic. The most direct involvement of women in national leadership positions during the pandemic has been in health ministries. Six of the sub-region's countries have ministers of health who were leading the fight against COVID-19 and most of them are medical doctors themselves. This includes the health ministers in Eritrea, Somalia, Tanzania, Eswatini, Ethiopia and Uganda.⁴² Other examples of women in ministerial positions who led the fight against the pandemic include ministers tasked with the management of prevention and control ministers. For example, in South Africa, Dr Nkosazana Dlamini Zuma, Minister of Cooperative Governance and Traditional Affairs, was the minister responsible for the proclamation of regulations around lockdowns and movement restrictions to prevent COVID-19.

In 2019 28% of the medical doctors in Africa and 65% of the nurses were women.⁴³ As frontline healthcare workers have played a significant role in fighting the pandemic and given that women primarily work as nurses their risk of exposure to COVID-19 is higher.⁴⁴ However, this also placed them automatically in very powerful positions as caregivers and protagonists in one of the most important areas of the fight against the pandemic.

Grassroots women's organisations have also played a critical role in filling gaps in essential services during the pandemic, especially with regards to the procurement and production of supplies such as masks and sanitizers and the provision of preventative and health care information. Women's organizations in Lesotho, Sudan and Uganda have for example used social media and reached out directly to women and girls to share information about the pandemic and how transmission of the virus can be prevented.⁴⁵

4.6 Gender data and statistics

The importance of gender data and statistics for evidence-based decision making, planning, monitoring and evaluation cannot be over emphasized. With regards to the measurement of the SDGs and pre-COVID-19 gender data and statistics, several countries in the region still have considerable data gaps. Ironically many of these are also countries where the GEWE agenda is relatively neglected.

Data2X investigated the availability of 104 gender-relevant⁴⁶ SDG indicators across 15 sub-Saharan African countries, 11 of which were in East and Southern Africa. The study found that none of the countries published data on all 104 gender-relevant indicators. In the available

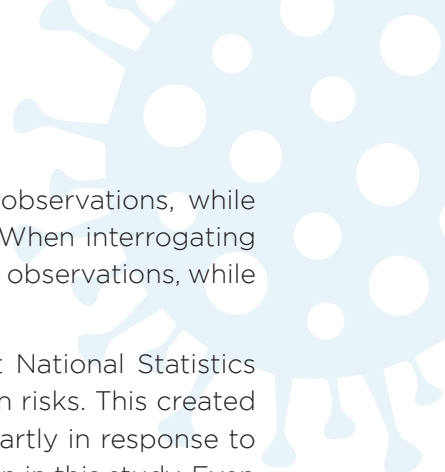
42 COVID-19 and gender monitor. Available from <https://data.unwomen.org/resources/covid-19-and-gender-monitor>. Accessed December 2020.

43 WHO 2019. Gender equity in the health workforce. Available from <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WPI-2019.1-eng.pdf>, Accessed February 2021. WHO Spotlight on statistics. Available from: https://www.who.int/hrh/statistics/spotlight_2.pdf. Accessed February 2021.

44 WHO Situation Report, October 22 2020. Available from https://apps.who.int/iris/bitstream/handle/10665/336181/SITREP_COVID-19_WHOAFRO_20201021-eng.pdf. Accessed February 2021.

45 UN Women, COVID-19 policy brief. Available from <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-covid-19-and-womens-leadership-en.pdf?la=en&vs=409>. Accessed February 2021.

46 Gender-relevant indicators measure the status and welfare of women and girls, or, when the indicators are sex-disaggregated reveal pertinent differences between men and women.



international databases Tanzania has the highest number of non-zero observations, while South Africa reported with the highest frequency for countries in ESA. When interrogating national databases the study found that Zambia had the highest non-zero observations, while South Africa had the highest reporting frequency.

During the initial phases of lockdown and movement restrictions most National Statistics Offices (NSO's) stopped with data collection to reduce virus transmission risks. This created a vacuum of data and statistics at a time when it was greatly needed. Partly in response to this UN Women, UNFA and partners embarked upon the RGAs reported on in this study. Even though it shed some light on what has been happening in the region, the remaining data and statistics gaps are still significant.

A recent study conducted by UNECA⁴⁷ found that the pandemic has increased the existing challenges faced by member states to produce, disseminate and use gender statistics. In cases where data was still produced the data was not analysed disaggregated by sex and consequently could not be used for decision making. Despite various efforts made by countries in the sub-region to address the COVID-19 related gender data gaps, a lack of financial support and limited capacity to use the modern data collection tools and technologies required by the pandemic continue to hamper their efforts. The report recommends that partnerships be promoted between National Statistics Offices and other role players in the data eco-system, including the private sector. The latter has an important role to play to provide technical and financial support to this process of technological transition.

Another recommendation of the survey was for ECA to compile guidelines to assist member States in the production, analysis and dissemination of COVID-19-related gender statistics in order to increase the availability of COVID-19-related gender data.

4.7 Donor approaches

The international donor community, international agencies and civil society organizations made a significant effort to ensure that existing and new development aid be re-allocated to the COVID-19 response.

The UNFPA country offices work in close coordination with governments, UN agencies and civil society partners, to advance UNFPA's mandate in the national COVID-19 response plans. The UN regional offices have formed a "migration working group" that is working with countries and regional economic communities to address the plight of migrants and refugees. Agencies are deploying their regional and country assets to influence the national COVID-19 task forces and include migrants in response plans. UNFPA chairs the regional "continuity of essential health services" working group. The group carries out the routine tracking of disruption of essential health services using quantitative, qualitative and anecdotal reporting tools, including media monitoring within the region. UNFPA is also involved in other regional humanitarian coordination forums to ensure a continued focus on the ongoing humanitarian crises. The regional GBV working group is supporting countries to focus current programmes to respond to COVID-19 and address GBV programme implementation challenges occasioned by the pandemic as well as a continuity of SRH interventions, including the protection of health workforce.

47 Unpublished report. Impact of COVID-19 on gender statistics activities in African countries. December 2020.

The Regional Office and the Country Offices have supported the continuity of essential SRH services by:

- Advocating for continuity of essential SRH services at national and sub-national levels.
- Monitoring the disruption of SRH services and providing technical support to overcome the bottlenecks in service delivery.
- Strengthening operational and logistical support to national supply chains, including providing personal protective equipment (PPE) to health workers, and facilitating additional supplies of modern contraceptives and other SRH commodities.
- Supporting capacity-building efforts for frontline SRH workers and health facility optimization for COVID-19 through virtual training platforms and mentorships.
- Supporting risk communications and community engagement initiatives aimed at reducing the risk of COVID-19 transmission, while addressing communities' growing reluctance to attend health facilities out of fear of becoming infected, especially among women and girls.
- In partnership with WHO, UNICEF and UNAIDS, the Regional Office has developed mechanisms to track the disruption of SRH services and utilization, brought about by COVID-19. This is intended to complement existing strategies in the sub-region and continent, including the African Health Observatory, Demographic Surveillance Sites and existing national health management information systems in countries.

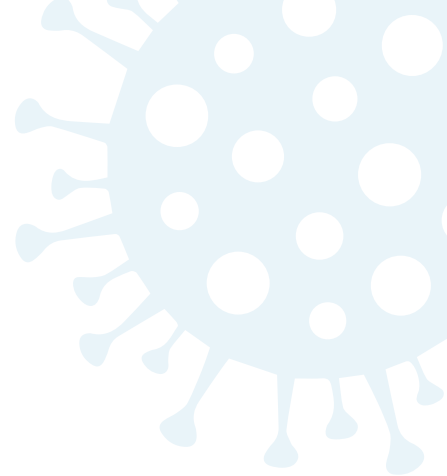
Specific responses by UN Women's country and regional offices include amongst others:

- The gender-based violence response focuses on social mobilization and awareness raising as well as the provision of essential services.
- Support to economic recovery mechanisms to alleviate women's burden of care.
- Mobilization and training of women to participate and influence the on-going response and planned recovery interventions.
- Supported leadership networks to ensure women's involvement in leadership processes related to the pandemic.
- Awareness creation, social mobilization and media engagements on gender and COVID-19 have been undertaken in all the countries.
- Advocated for gender mainstreaming in national coordination and data efforts
- UN Women advocated for and supported the inclusion of gender responsive measures in UNCT COVID-19 response plans.

With regards to data and research some examples of UN Women's responses include: UN Women developed a COVID-19 Gender Response Tracker jointly with UNDP; UN Women, UNFPA and other partners conducted CATI surveys follow up on the gendered impact of COVID-19 through CATI COVID-19 rapid gender assessments in seven countries in ESA; UNECA developed a website with a designated COVID19 portal serving the needs of the sub-region for access to information and materials related to the pandemic in general, but also gender-specific knowledge products and data.

Agencies such as for example the Food and Agricultural Organization (FAO), World Food Program (WFP), donors such as European Union (EU), World Bank (WB), African Development Bank (AfDB) also made some significant contributions to the COVID-19 response in the sub-region and more details of their activities can be found in Annex IV.

5. SOCIO-ECONOMIC STATUS AND LIVELIHOODS



5.1 Introduction

Section 5 deals with the impact of COVID-19 on the socio-economic circumstances of women and men. In ESA, as elsewhere, the socio-economic circumstances of the most vulnerable – women, youth, informal sector workers, people with disabilities (PWD), refugees and internally displaced people (IDPs) – are bound to be affected more than the population in general. Intersectionality of different vulnerabilities is moreover an important factor in the exposure to the negative socio-economic consequences of the pandemic.

5.2 Economic growth and poverty

Whilst most of the sub-Saharan African (SSA) countries – with the notable exception of South Africa – have so far managed to keep the COVID-19 virus under control with a relatively low number of cases, the pandemic continues to take its toll on African lives and economies. This affects women and men, but women who generally had poorer socio-economic statuses than men prior to the pandemic are likely to be even more affected. The World Bank⁴⁸ estimates that economic growth throughout SSA will contract from 2.4% in 2019 to between -2.1 and -5.1% in 2020, causing the region's first recession in 25 years. Some of the challenges introduced by the pandemic include billions of USD in estimated output losses in 2020, reduced agricultural productivity, weakening supply chains, increasing trade tensions, limited job prospects, and exacerbated by political and regulatory uncertainty. The containment measures introduced to slow the spread of the virus reduced domestic consumption and investment and the resultant downturn in economic activity could cost the sub-region at least an estimated \$115 billion in output losses in 2020. One of the consequences of the economic slow-down could be a reversal in progress made during the past five years in reducing poverty with up to 40 million people falling into extreme poverty.⁴⁹

East and Southern Africa boasts some of the world's richest natural resources.⁵⁰ Agricultural products are the main export commodity in most East African countries. Ethiopia and Uganda lead the sub-region in coffee exports, while Kenya is the largest tea exporter. Precious metals and minerals are among the most important exports for countries in Southern Africa. This includes amongst other primary resources gold and diamonds from South Africa and Botswana and platinum from South Africa and Zimbabwe.

48 World Bank (2020) www.worldbank.org, Accessed in January 2021.

49 Ibid.

50 World Bank (2020) www.worldbank.org, Accessed in January 2021.

According to World Bank estimates⁵¹ the East and Southern African sub-region has been hit hardest of all the sub-regions in SSA. This is mainly because of the stronger output contractions of South Africa, which is the dominant economy in the sub-region. Disruptions in the tourism industry (which is sector dominated by women in several countries in East and Southern Africa⁵²) and lockdowns have, likewise, caused substantial slowdowns in Ethiopia, Kenya, and the island nations. The more fragile countries in the sub-region are expected to experience a strong decline in growth as COVID-19 exacerbates the drivers of fragility.⁵³

The economic impact of the pandemic on poverty and incomes has been uneven across the sub-region and also within countries. The prices of exports that some countries heavily depend on, such as for example copper for Zambia, have declined sharply. The sub-region's crucial tourism industry has all but ground to a halt. COVID-19 has intensified conflict – and poverty – in northern Mozambique. Elsewhere, it risks fuelling political tension and instability.⁵⁴ In South Africa⁵⁵ there are relative “winners” and “losers” among the different economic sectors due to the pandemic: The winning sectors are those designated as essential, including the health sector, the food and agriculture sector, financial and insurance service sectors and telecommunication services sector. The losing sectors include textiles, glass products, footwear, education services, catering and accommodation (which contains tourism as per the United Nations System of National Accounts classification), beverages and tobacco sectors.

Despite the COVID-19 related economic shocks, the ESA sub-region is likely to rebound in 2021, but growth is expected to vary across countries.⁵⁶ South Africa is expected to experience a weak recovery, but overall growth in the East and Southern Africa is expected to average 2.7%. Some uncertainty is being fuelled by concerns around the current second wave, new mutations of the virus as well as a regional context of relatively high population growth rates, chronic poverty, inequality – both economic and gender-based – as well as environmental hazards linked to climatic change.⁵⁷

Some of Africa's most protracted conflicts are also present in East and Southern Africa, especially in Somalia, Darfur and in Southern Sudan, rendering many of its countries fragile. Even though most of the population lives in rural areas, East and Southern African cities continue to grow, creating preconditions for faster spread of the COVID-19 and other infectious diseases.⁵⁸ Urban growth has, moreover, not led to poverty reduction and significant gaps in education, health, and skills development continue to keep the region's population from reaching their full potential. All these factors create formidable development challenges, impact heavily on the lives and livelihoods of people⁵⁹ and are likely to influence the post COVID-19 recovery agenda.

51 World Bank (2020) www.worldbank.org. Accessed in January 2021.

52 ILO (2020) World Employment Report.

53 World Bank (2020) www.worldbank.org. Accessed in January 2021.

54 WFP. <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>.

55 UN-South Africa (2020).

56 Ibid.

57 WFP. Available from <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>. Accessed January 2021.

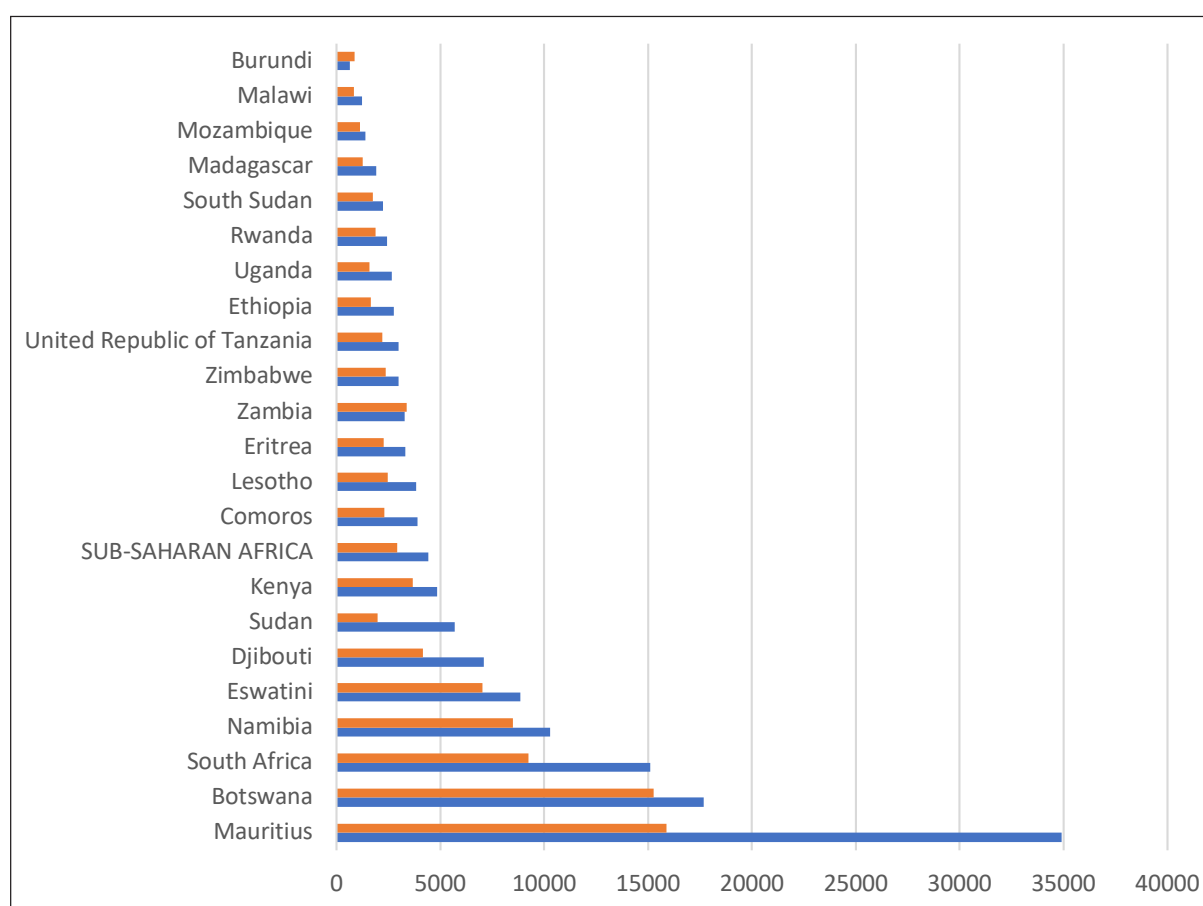
58 UN. Policy Brief. Available from https://unsdg.un.org/sites/default/files/2020-07/sg_policy_brief_covid_urban_world.pdf. Accessed January 2021.

59 World Bank (2020). Available from www.worldbank.org. Accessed in January 2021.

5.3 Economic growth and poverty from a gender perspective

In practically all the countries of East and Southern Africa men have on average clearly higher incomes than women.⁶⁰ According to the UNDP, Gross National Income (GNI) per capita, was on average 2,937 USD for women and 4,434 USD for men in sub-Saharan Africa in 2019. Figure 12 shows the GNI per Capita by sex (in 2017 PPP \$) in the sub-region. Incomes were highest in the middle-income countries of Mauritius, Botswana, South Africa and Namibia, which are all either resource rich and/or benefited from tourism before the COVID-19 and/or developed industrial base. At the other end of the scale, in Burundi and Malawi, incomes per capita were below USD 1,000 a year. GNI per capita is also much higher for men than for women in most countries in the region. In only two of the countries – Burundi and Zambia – was GNI per capita higher for women than men. The differences between women and men were particularly pronounced in Mauritius, South Africa and the Sudan (information is unfortunately missing for Somalia and Seychelles).

Figure 12: Estimated Gross National Income (GNI) per capita, by sex in 2019 (in 2017 PPP \$), 2019



Source: UNDP (2020) Human Development Report 2019.

Despite considerable progress towards overcoming gender gaps in East and Southern Africa, women continue to lag behind men also in other economic and empowerment dimensions of development.⁶¹ Figure 13 below displays the Africa Gender Index and Component Indices

⁶⁰ UNDP (2020) Human Development Report 2019.

⁶¹ African Development Bank & UN Economic Commission for Africa (2020) Methodological & Statistical report. Bridging the Gender Gaps: The Africa Gender Index Report 2019.

Gaps in the Economic and Business Dimension, Social Dimension, Empowerment and Representation as well as the gender gaps in land and or house ownership. As can be seen from the visualization, gaps in the Gender Index are largest (closest to 0) in Comoros, Sudan, Eritrea, Ethiopia and Mauritius. Smallest gender gaps (closest to 1) are found in Rwanda, Seychelles, Lesotho, Namibia and South Africa.⁶²

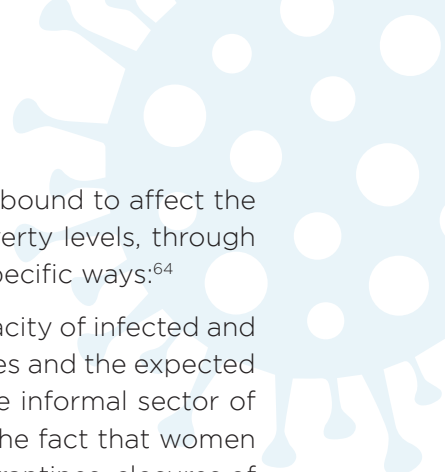
Figure 13: Africa Gender Index and Component Indices Gap,⁶³ 2019

Country	Africa Gender Index value 2019	Economic and Business Dimension 2009-2019	Social Dimension 2009-2019	Empowerment and Representation	Asset Ownership Gap (land/house) 2009-2019
Namibia	0.797	0.792	1.294	0.494	0.056
Lesotho	0.776	0.790	1.281	0.463	0.144
South Africa	0.768	0.686	1.062	0.621	0.233
Rwanda	0.761	0.662	1.064	0.626	0.269
Seychelles	0.738	0.832	1.071	0.451	0.232
Zimbabwe	0.676	0.693	0.986	0.452	0.203
Mozambique	0.649	0.640	0.955	0.447	0.185
Madagascar	0.630	0.795	1.089	0.289	0.200
Zambia	0.624	0.645	1.072	0.351	0.165
UR of Tanzania	0.618	0.507	0.965	0.482	0.272
Uganda	0.613	0.663	0.916	0.379	0.240
Burundi	0.538	0.527	1.071	0.275	0.237
Botswana	0.537	0.886	0.988	0.177	0.460
Malawi	0.524	0.661	0.800	0.273	0.247
Kenya	0.522	0.703	1.001	0.203	0.247
Ethiopia	0.487	0.542	0.863	0.247	0.763
Mauritius	0.455	0.654	1.223	0.118	0.345
Eritrea	0.412	0.476	0.888	0.166	0.266
Somalia	0.387	0.472	0.980	0.125	0.140
Sudan	0.316	0.389	1.054	0.077	0.264
Comoros	0.240	0.633	0.943	0.023	0.253

Source: African Development Bank & United Nations Economic Commission for Africa (2020) Africa Gender Index Report 2019.

62 Different dimensions display the strengths and bottlenecks or shortcomings in each country. Whilst the countries reporting smallest gaps in economic and business dimension were Botswana, Madagascar, Namibia and Lesotho, the social dimension indicated gender gaps that in fact favoured women (above 1) in Lesotho, Namibia, Zambia, Mauritius, Burundi, Kenya and Rwanda. In these countries, women have made considerable progress especially in education. The gender gap in the empowerment and representation dimension was smallest in Rwanda - the country boasting the largest share of women members of parliament in the whole world. Finally, when it comes to the gender gaps in asset (house and land) ownership, interestingly, this was smallest in Ethiopia, that has made considerable progress in registering land titles for women in the recent years.

63 The Africa Gender Index measures gender equality at national and regional level. It is a joint publication of the African Development Bank Group (the Bank) and the United Nations Economic Commission for Africa (ECA) and brings together data from 51 of 54 countries in Africa. Available from <https://www.afdb.org/en/documents/africa-gender-index-report-2019-analytical-report>. Accessed January 2021.



According to the African Development Bank, the COVID-19 pandemic is bound to affect the health and wider welfare of African households, and therefore their poverty levels, through several main channels and that women are likely to be affected in very specific ways:⁶⁴

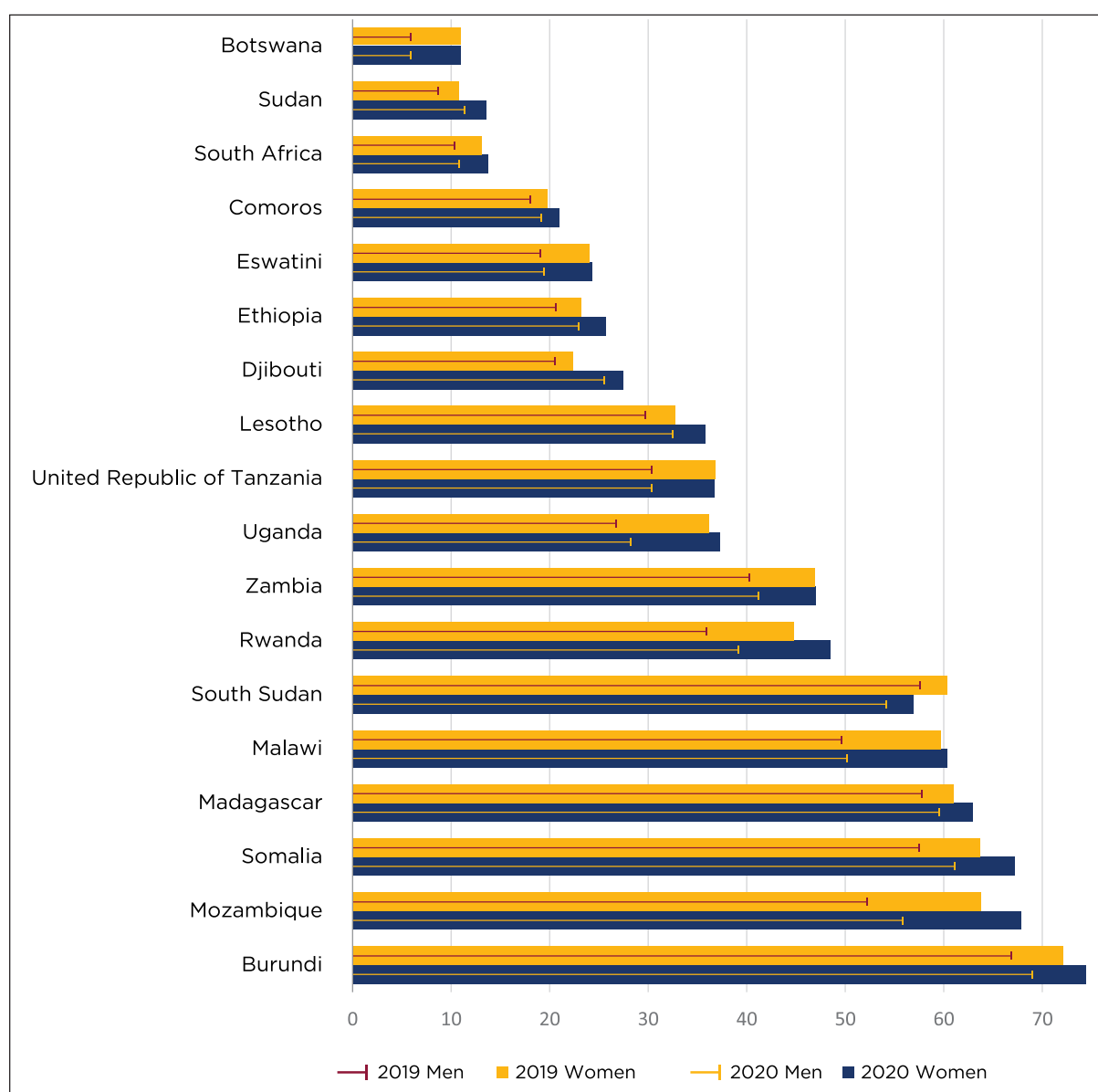
- a) COVID-19 has a direct impact on productivity as it diminishes the capacity of infected and recovering workers to work and undertake income generating activities and the expected impact of this is thought to be higher for households engaged in the informal sector of economy with limited or no social protection. To this can be added the fact that women are predominantly found in the informal sector in the sub-region. Quarantines, closures of non-essential businesses, and curfews further impacts negatively on this business sector, which forms the backbone of economic activities in most countries in the sub-region.
- b) The pandemic also resulted in unbudgeted health expenditures that in the case of most citizens had to be paid out-of-pocket. This not only exacerbates poverty, but also increases inequality.
- c) The increased unpaid care work burden of women during the pandemic, reduce their ability to participate in productive activities, study and rest. In addition to affecting their income generation capacity it can also affect their mental and physical health negatively.
- d) The disruption of domestic and international distribution channels of inputs and outputs as well as consumer hoarding, have led to an increase in agricultural and other commodities reducing the purchasing power of households. *Food insecurity* will in particular affect women-headed households, who in most countries belong to the poorest socio-economic segment of the society.

According to Figure 14 extreme poverty rates were very high in many countries in the sub-region already before the COVID-19 pandemic and women were more likely to live in extreme poverty than men. Current estimates also indicate that the percentage of women and men living in extreme poverty have increased during the pandemic, with the gaps between women and men remaining approximate equal. In Madagascar, Malawi, South Sudan, Zambia, Zimbabwe, Eswatini, Lesotho and South Africa more than half of the population were classified as living below the national poverty line.⁶⁵

64 AfDB (2020b) African Development Bank (2020b) African Economic Outlook – supplement Performance and Outlook Amid COVID-19

65 UN Women (2020) Progress of African Countries towards SDGs.

Figure 14: Percentage women and men living in extreme poverty, 2019 and 2020⁶⁶



Source: UNWomen COVID-19 gender monitor. Available from <https://data.unwomen.org/resources/covid-19-and-gender-monitor>. Sourced 22 November 2020.

5.4 Food security and nutrition

*The pandemic is considered an important driver of increased global food insecurity.*⁶⁷ Personal income losses and other economic shocks have resulted in job losses and reduced migrant remittances⁶⁸ contributing towards increased poverty, reduced ability to buy inputs and decreased consumer demands. This is further exacerbated by a context of conflicts, pests (e.g. locust plagues) and weather shocks (e.g. cyclones, floods and droughts).

66 Covid-19 gender monitor. Available from <https://data.unwomen.org/resources/covid-19-and-gender-monitor>.

67 FAO. Available from www.fao.org/new. Accessed in January 2021.

68 Relief Web. Available from <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>.

All these compounding factors have led to global food commodity prices rising sharply in November 2020 to their highest levels in nearly six years. All the sub-indexes of the FAO Food Price Index⁶⁹ rose in November 2020 and the index itself averaged 105 points during November.⁷⁰ This is an increase of 3.9% from October and 6.5% compared to November 2019. It represents the sharpest increase since July 2012, putting the index at its highest level since December 2014. FAO has also further lowered its forecast for global cereal production in 2020, which now stands at 2 742 million tonnes. In January 2021, the wholesale prices of basic commodities such as maize and sorghum in East Africa⁷¹ were constant or in decline due to low domestic demand and expenditure. The exceptions were the Sudan and South Sudan where prices were exceptionally high due to a limited supplies and serious macro-economic difficulties. In contrast to this wholesale prices of maize in Southern Africa⁷² mostly increased during the last part of 2020 and early 2021. This is ascribed to different reasons in the different countries: spill-over effects due to a global shortage during December 2020 to January 2021 (South Africa); sustained increases since mid-2020 due to reduced domestic supplies ascribed to overall weak currency and poor harvests in the previous two years (Zimbabwe); adequate supplies through most of 2020, but with inflationary pressure exacerbating the seasonal price increases of maize in January 2021 (Zambia); comparatively steeper rates during the last months of 2020 and early 2021, driven by a weak currency (Mozambique); in Malawi prices were well below their January 2020 levels due to increased domestic supplies (Malawi).

Currently the presence of La Niña heightens the risk of above-average rainfall in particularly Southern Africa, while parts of East Africa are expecting reduced rains, conditions that may result in adverse production shocks. Additionally, locust swarms have already ravaged crops and jeopardized food security across East Africa, including Kenya, Somalia, Tanzania and Uganda. The Horn of Africa, which already has 22 million severely food insecure people and more than 12 million internally displaced persons, is therefore facing a critical food security emergency. Damages and losses could amount to as much as \$9 billion in 2020 according to the World Bank estimates.⁷³ Mozambique is an example of a country in the sub-region where several of these challenges are present. Agriculture is the primary source of livelihood for more than 80 percent of Mozambique's rural population and contributes to about 2% of the national GDP.⁷⁴ In 2018 Cyclone Kenneth destroyed over 50,000 ha of cropland as well as fishing boats and equipment, which impacted on more than 300,000 people in the sub-region.⁷⁵ Two more cyclones struck the east coast of the country in January 2020, with damages still being calculated. A worsening armed conflict in the north of the country threatens their recovery, with over 560,000 people internally displaced.⁷⁶

The FAO estimates that thirty-four countries in Africa (out of forty-five countries globally) need external food assistance.⁷⁷ In Zimbabwe, 7.7 million people – half of the population – was seriously food insecure *already in the beginning of 2020*; the same applies to 20% of the population in drought-stricken Lesotho and 10% of Namibians.⁷⁸ A preliminary WFP analysis carried out in

69 The FAO Food Price Index tracks changes in the international prices of the most globally traded food commodities.

70 FAO. Available from www.fao.org/news. Accessed in January 2021.

71 FAO. Available from <http://www.fao.org/giews/food-prices/regional-roundups/detail/en/c/1373992/>. Accessed February 2021.

72 FAO. Available from <http://www.fao.org/giews/food-prices/regional-roundups/detail/en/c/1373990/>. Accessed February 2021.

73 World Bank (2020). Available from www.worldbank.org. Accessed in January 2021.

74 FAO. Available from www.fao.org/en/news. Accessed in January 2021.

75 FAO. Available from www.fao.org/en/news. Accessed in January 2021.

76 FAO. Available from www.fao.org/en/news. Accessed in January 2021.

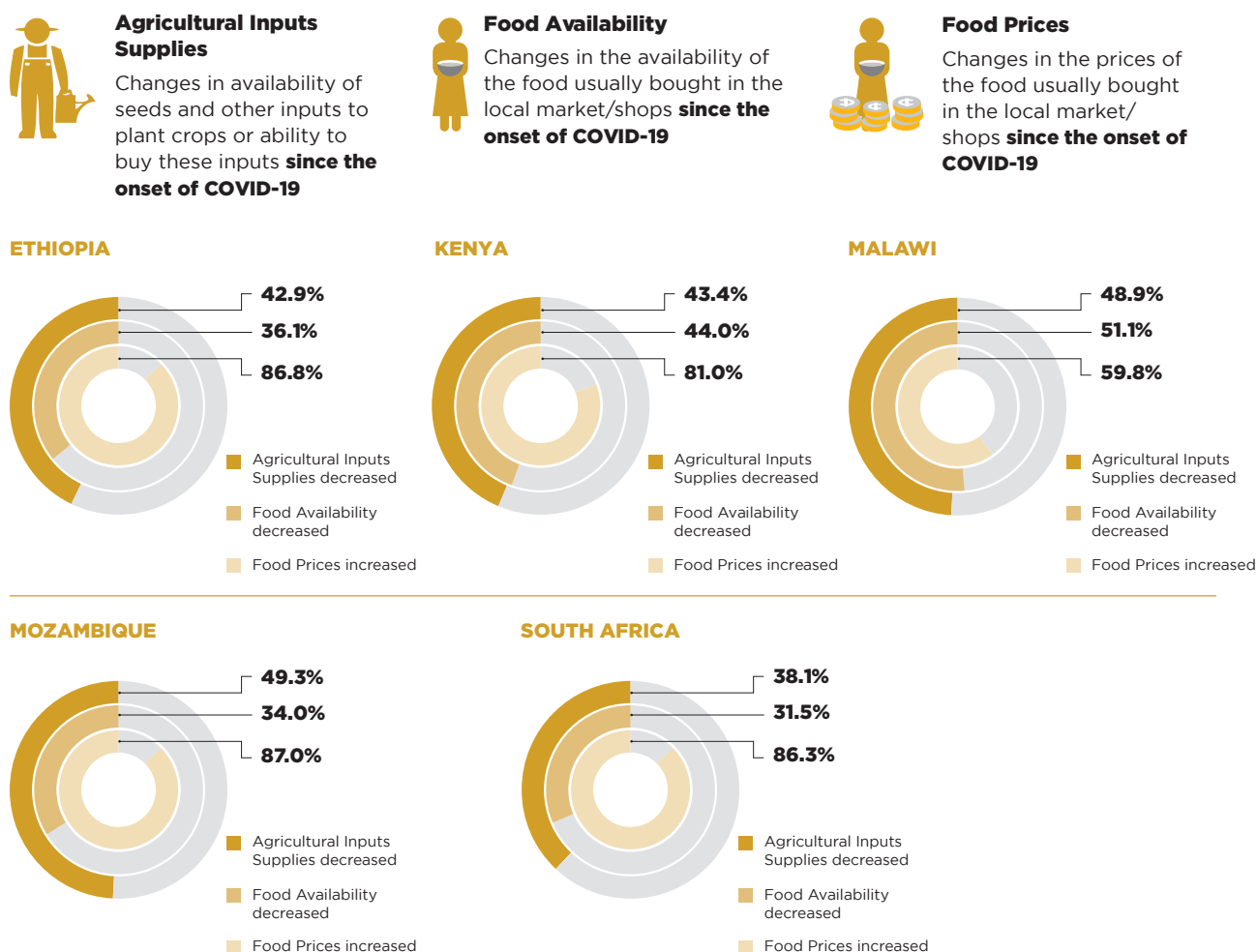
77 FAO. Available from www.fao.org/new. Accessed in January 2021.

78 FAO. Available from www.wfp.org/news/southern-africa-throes-climate-emergency-45-million-people-facing-hunger-across-region. Accessed November 2020.

July 2020,⁷⁹ doubled the pre-COVID projection of people needing food assistance from 27.5 million people to 52 million people in 12 operational countries in Southern Africa.

The findings of the Rapid Gender Assessment (Figure 15) shows that most respondents experienced increases in food prices and that a third or more of food producers indicated that the agricultural inputs they use have been less available or affordable since the pandemic started.

Figure 15: Changes in availability of agricultural inputs, food and food prices, 2020



Source: UN Women, UNFPA and partners (2020) CATI COVID-19 rapid gender assessments (Unpublished data) Accessed in December 2020.

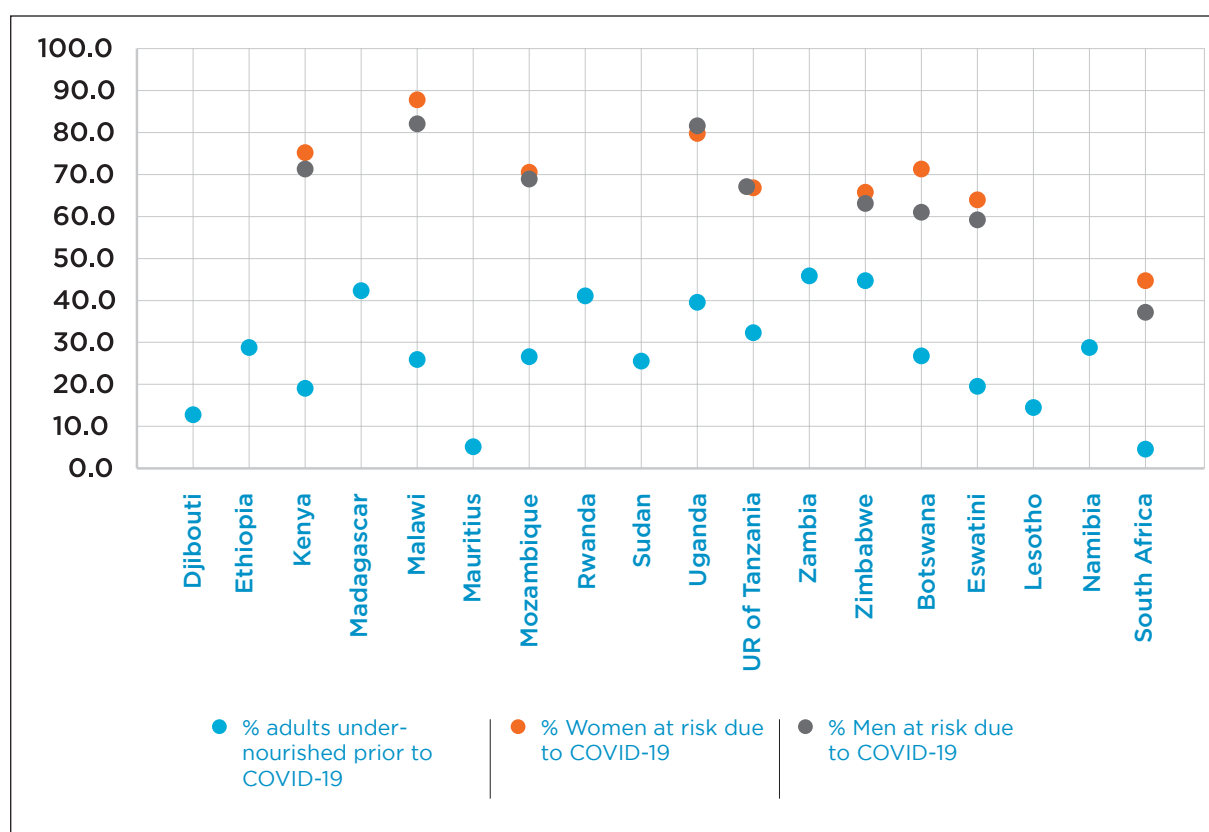
The CATI rapid gender assessments also found that most women and men reported increases in the prices of the food they normally buy. Significant numbers of respondents indicated that they didn't eat at all for a day or more or had to reduce their food intakes during the pandemic. More than 50% of respondents in Kenya, Malawi and Mozambique indicated that they had to eat less or skip a meal during the pandemic. Less than 10% of respondents in Ethiopia and around a quarter of respondents in South Africa had the same challenge. *Women were more likely to say that they reduced their food intake in all countries except Ethiopia and Malawi.*

79 WFP. Available from <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>.

The COVID-19 pandemic has hence hit hard a sub-region that was already characterized by precarious food security and high levels of undernourishment due to several reasons, such as high dependence of traditional rain-fed agriculture, climatic conditions and calamities.

According to UN Women data,⁸⁰ with the exceptions of South Africa and Mauritius, *the level of undernourishment in all the other countries in the sub-region was counted in double digits already before the COVID-19 pandemic.* Zambia, Zimbabwe, Madagascar and Rwanda reported a more than 40% prevalence of malnutrition among their populations. Likewise, in Uganda and Tanzania, more than 30% of the population suffered from undernourishment. It is noteworthy that some of the most fragile countries in the sub-region had not reported on the prevalence of the undernourishment. A comparison of the gender gap in the food insecure in ESA in 2014–2015 shows that except for Kenya, Madagascar, Mauritius and Uganda, women suffered clearly more often of food insecurity. Figure 16 displays the figures on undernourishment prior to COVID-19. The gender gaps in food security were especially large in Botswana, Eswatini, Malawi and Kenya.

Figure 16: Undernourishment prior to the COVID-19 pandemic and risk due to COVID-19 (SDG 2.1.1), by sex, 2020



Source: UN Women (2020) Progress of African Countries towards the Sustainable Development Goals (SDGs). UN Women - Women Count (2020) The COVID-19 pandemic and the impact on women and girls. 1 October 2020, Africa Region Briefing.

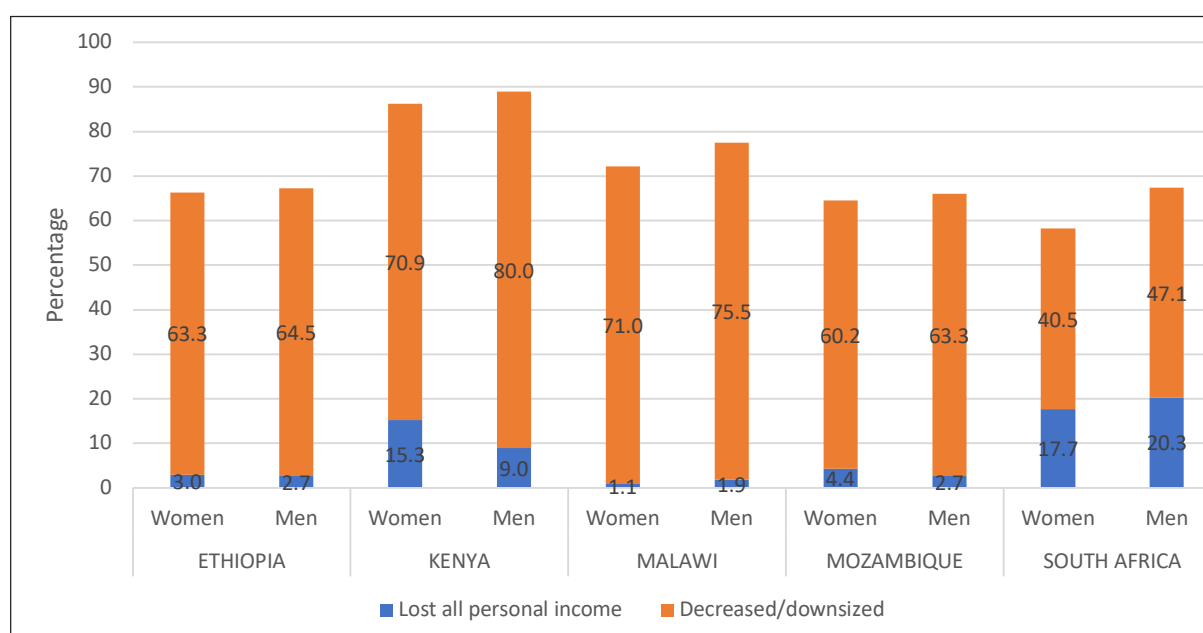
80 UN Women (2020) Progress of African Countries Towards the Sustainable Development Goals (SDGs).

5.5 Impact of COVID-19 on incomes in East and Southern Africa

Against this backdrop of widespread poverty and deep gender inequality in the region, COVID-19 has had a clearly negative impact on incomes – both personal and for the household. An Africa Union-led survey⁸¹ on the COVID-19 secondary impacts in 18 member countries discovered that seven in ten respondents reported that their household income in the previous week was smaller compared to the same time the previous year. The same proportion also reported problems in accessing food in the previous week.

This is consistent with the findings of the CATI COVID-19 rapid gender assessments that have been carried out throughout the sub-region.⁸² An overwhelming majority of respondents (more than six in ten) in Ethiopia, Kenya, Malawi, Mozambique and South Africa – both women and men – reported that their personal incomes have either been totally lost or have decreased due to COVID-19. Decreases in combined household incomes were also experienced with more than 7 in 10 respondents in Ethiopia and Kenya indicating decreases in household incomes. A further 6 in 10 Mozambican and 5 in 10 South African respondents reported decreases in household incomes. Figures 17 and 18 summarise these changes. In all the five countries, men reported decreased incomes to a greater extent than women, which probably reflects the fact that they are more often found in paid employment and earned higher incomes than women. Likewise, in Rwanda,⁸³ changes caused by COVID-19 on individual and household incomes were generally negative, especially so for men. These developments were reported in all age groups.

Figure 17:⁸⁴ Changes in personal incomes, by sex, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

81 PERC (2020) Responding to COVID-19 in Africa: Using data to Find a Balance. Part II.

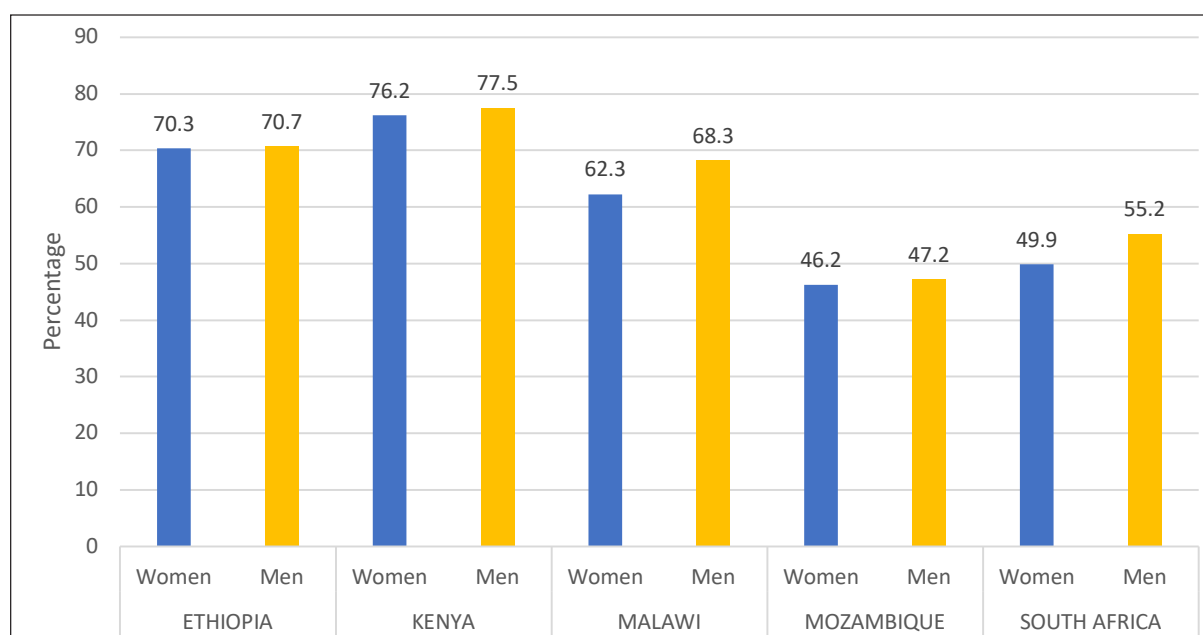
82 UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

83 Migepro-UNWomen and partners (2020). Final Report. Rapid Gender Assessment (RGA) on the Impact of COVID-19 on Women and Men in Rwanda.

84 UN Women, UNFPA and partners Rapid Gender Assessment conducted in Rwanda (September to October 2020).

Given the decreases in individual and household incomes one would expect some households, especially those without savings or other support networks to experience financial difficulties. Most women and men in the countries where the Rapid Gender Assessments were conducted indicated that they were experiencing financial difficulties. In Kenya 9 in 10 women and men said they are experiencing financial difficulties, whilst in Mozambique 8 in 10 and South Africa 7 in 10 women and men were similarly affected. Women and men in Ethiopia were the least likely of the countries surveyed to report having experienced financial difficulties (approximately 5 in 10).

Figure 18:⁸⁵ Decreases in combined household incomes, by sex, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

In the same vein, many respondents in CATI COVID-19 RGAs⁸⁶ reported that they were no longer able to financially help other people outside their own households, despite having previously done so. There is a risk, therefore, that the socio-economic impacts of the COVID-19 pandemic can have larger developmental consequences in terms of harming or slowing down sustainable development goals in different communities, regions and countries.

Moreover, the socio-economic impact of COVID-19 is likely to *exacerbate the already existing inequalities between women and men and between the different socio-economic groups*. For instance, in South Africa, the UN-South Africa recent socio-economic impact assessment⁸⁷ of COVID-19 pandemic at the household level shows that households headed by women are more likely to fall into poverty than households headed by men. The report models two scenarios: an optimistic and pessimistic scenario. Under the optimistic scenario, the percentage increase in the number of women who fell below the Lower-bound Poverty Line (LBPL)⁸⁸ is 0.39% (equivalent to about 117 000) compared to 0.24% (equivalent to about 69 072) for men. If the Upper-bound Poverty Line (UBPL) is used for the same model the percentage increase of women is 0.33%

⁸⁵ UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

⁸⁶ Ibid.

⁸⁷ United Nations in South Africa (2020) Covid-19 In South Africa Socio-economic Impact Assessment.

⁸⁸ The 2019 upper-bound poverty line (UBPL) indicates an income of 1,268 Rand (\$74.00) per month and the lower-bound poverty lines indicate incomes of 810 Rand (\$48.85). Source: Statistics South Africa. Available from: <http://www.statssa.gov.za/publications/PO3101/PO31012020.pdf>.

compared to 0.24% for men. As expected under the pessimistic scenario the percentage increase of women and men that fall under the poverty lines is higher: in the case of women it becomes 0.56% and for men 0.48%; and for the UBPL, the respective figures for women is 0.48% and for men 0.36%.

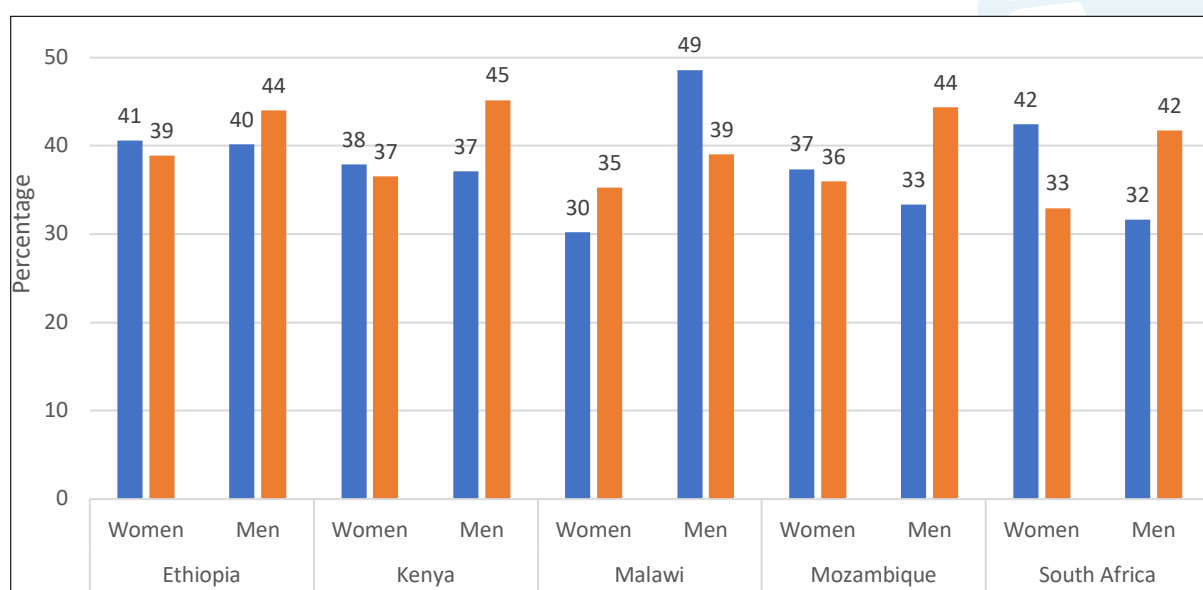
These findings are even more significant due to an overwhelming majority of respondents in all the five countries reporting that *they or any member of their household had not received any kind of social assistance from public authorities to tie them over during the pandemic*.⁸⁹ Only in South Africa, some 54% of all respondents reported that they had not received any kind of assistance since the onset of COVID-19, but in the other countries – Ethiopia, Kenya, Malawi and Mozambique – the share of those who had not received any assistance was 88–96%. *In South Africa and Kenya, men indicated receiving assistance more often than women, whereas the opposite was true in the other three countries.* In those cases, when the respondents or their households had received assistance, it consisted mainly of supplies for COVID-19 prevention (gloves, masks, sanitizer, handwashing containers, soap, etc.). In Ethiopia, 9.4% and in Mozambique, 5.5% had received such assistance. *The only exception is South Africa where 8.0% had received food aid and 0.6% medication, less than three percent had received either food aid or medication in the other four countries.* The survey data does not provide an indication of how these differences in support received impacted health.

As for the decision about how money is spent in the household, most of the respondents in CATI COVID-19 Surveys in all countries – Ethiopia, Malawi, Mozambique, Kenya and South Africa – maintained that men and women in the household decided jointly. These findings were similar also in Rwanda. It is, nevertheless, worthwhile noticing that men were more likely than women to maintain that decisions were made jointly. The definition of what constitutes a joint decision is of course subjective.

Whilst most of the respondents in Ethiopia, Kenya, Malawi, Mozambique and South Africa maintained that they usually had some money or income on their own that they decided alone, there were marked differences between women and men in this respect. In all the five countries a larger share of men than women reported being able to decide themselves about their income. Figure 19 shows the results for each country. This corroborates with the earlier mentioned fact that only in the middle-income Southern African countries and Rwanda women display more economic autonomy in terms of having their own bank accounts. It can also be an indication of increasing economic inequality between women and men due to COVID-19.

89 UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

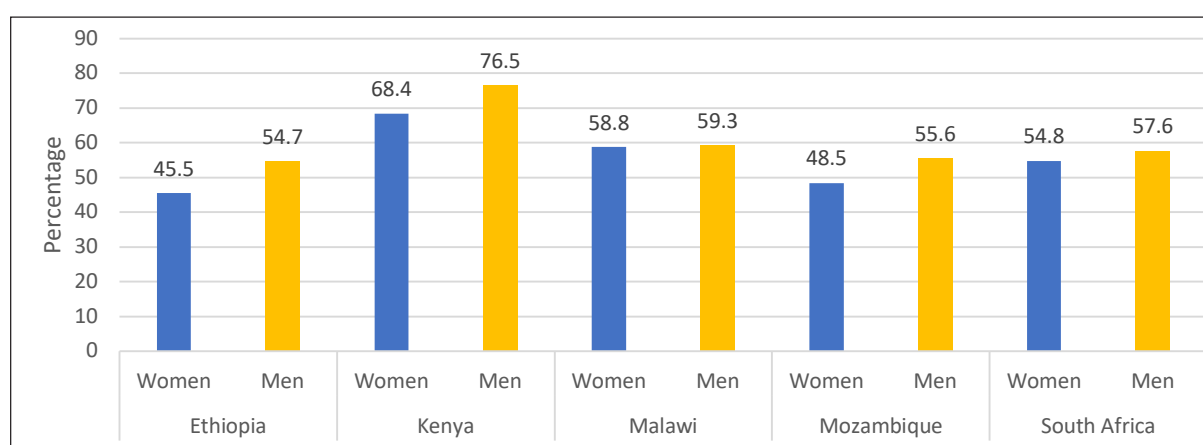
Figure 19: Decision-making about use of money/income in the household, by sex, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Whilst most of the respondents in Ethiopia, Kenya, Malawi, Mozambique and South Africa maintained that they usually had some money or income of their own that only they decide how to use, there were marked differences between women and men in this respect. In all the five countries a larger share of men than women reported being able to decide themselves about their income. Figure 20 shows the results for each country. This corroborates with the earlier mentioned fact that only in the middle-income Southern African countries and Rwanda women display more economic autonomy in terms of having their own bank accounts. It can also be an indication of increasing economic inequality between women and men due to COVID-19.

Figure 20: Percentage respondents who have some money about which they alone decide, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

5.6 Labour markets prior to the onset of COVID-19

Labour markets in sub-Saharan Africa (SSA) countries have some features which make it particularly vulnerable to COVID-19.⁹⁰ Firstly, the labour force is *characterized by widespread low-productivity employment in smallholder agriculture, which is considered by the ILO as one of the main reasons why 35.9% of workers in SSA were living in extreme poverty and an additional 25.4% in moderate poverty in 2019.*⁹¹ In total, the number of workers living in poverty was 240 million. This share is according to the ILO projected to rise, since poverty reduction in the sub-region is proceeding at a slower pace than elsewhere⁹² – and with the added impact of COVID-19 pandemic. Secondly, even though sub-Saharan Africa has relatively low unemployment rates, higher *labour underutilization* (estimated at 21.5% in 2019) due to underemployment and a lack of decent work opportunities. A lack of decent work is also reflected in the high combined share of own-account and contributing family work (74% in 2019).⁹³ The third general characteristic of the SSA labour market that increases vulnerabilities during COVID-19 is that workers transition from smallholder agriculture into low skill service industries rather than into high value-added manufacturing. Finally, 89.2% of workers in sub-Saharan Africa are employed in the informal sector and even if those employed in agriculture are excluded, more than a quarter of the workforce are in the informal sector (76.8%).⁹⁴

Almost half of the countries in the ESA sub-region have estimated unemployment rates below 5% although notably in South Africa, Namibia and Eswatini the unemployment rate exceeds 20%. Unemployment rates are also not equally distributed across various sub-groups of women and men. Young people and especially young women are particularly vulnerable to limited access to the labour market as is evidence in high NEET rates. More than four in ten women aged 15–24 in Botswana, Eswatini, Malawi, Uganda, Zambia and Zimbabwe are neither in education, employment or training (Figure 4). In South Africa,⁹⁵ 61.7% of young women (15–24 years) are unemployed.⁹⁶

Countries in ESA have similar unemployment profiles to the rest of SSA, with relatively low unemployment rates, but high levels of informal employment. This reflects economic activities borne of necessity rather than opportunity, as high poverty rates and low levels of social protection force women and men to engage in any kind of economic activity to survive. Figure 21 highlights the disparities in unemployment rates in ESA between women and men and shows that in all countries except Burundi, Namibia and Seychelles, women are more likely than men to be unemployed. The biggest percentage point gaps between women and men exist in Botswana and Mauritius (6 percentage points) and four percentage points in South Africa.

Whilst the participation of both women (63.3%) and men (72.7%) in the labour force is high in sub-Saharan Africa, there are large differences between the countries in East and Southern Africa⁹⁷ (Figure 22). Whereas more than 80% of women participate in the labour force in Burundi, Madagascar and Rwanda, some of the Muslim majority and fragile countries like Somalia (21.8%) and Sudan (29.1%) exhibit much lower labour force participation of women. With the sole exception of Rwanda, men have higher labour force participation rates than women.

90 ILO. World Employment and Social outlook Report 2020. Available from <https://www.ilo.org/global/research/global-reports/weso/2020/lang--en/index.htm>. Accessed January 2021.

91 ILO. World Employment Report 2020. Available from <https://www.ilo.org/global/research/global-reports/weso/2020/lang--en/index.htm>. Accessed January 2021.

92 ILO. World Employment and Social outlook Report 2020. Available from <https://www.ilo.org/global/research/global-reports/weso/2020/lang--en/index.htm>. Accessed January 2021.

93 ILO World Employment and Social outlook Report 2020. Available from <https://www.ilo.org/global/research/global-reports/weso/2020/lang--en/index.htm>. Accessed January 2021.

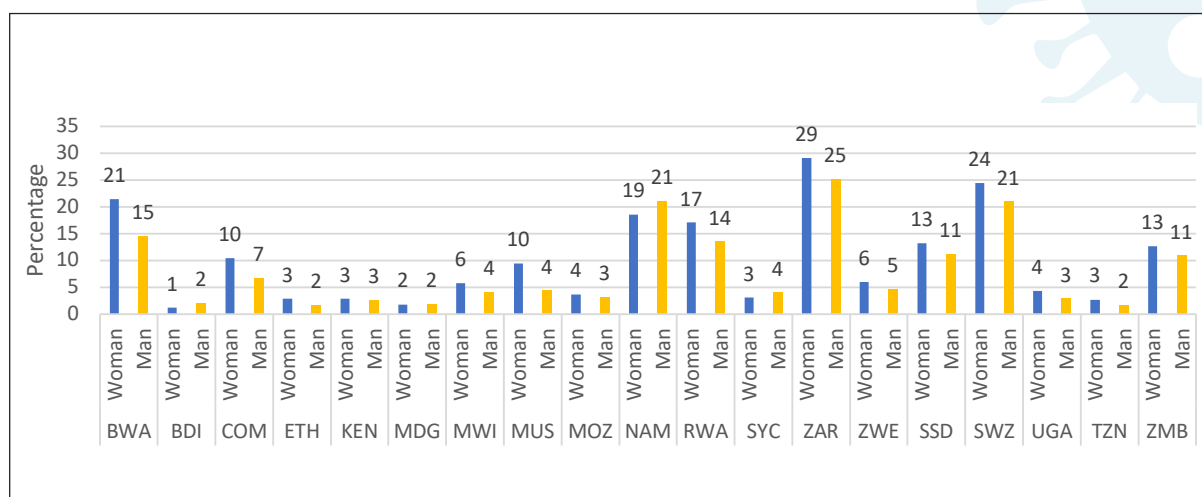
94 ILO 2020. Available from ilostat.ilo.org. Accessed in December 2020.

95 ILO 2020. Available from ilostat.ilo.org. Accessed in December 2020.

96 ILO 2020. Available from ilostat.ilo.org. Accessed in December 2020.

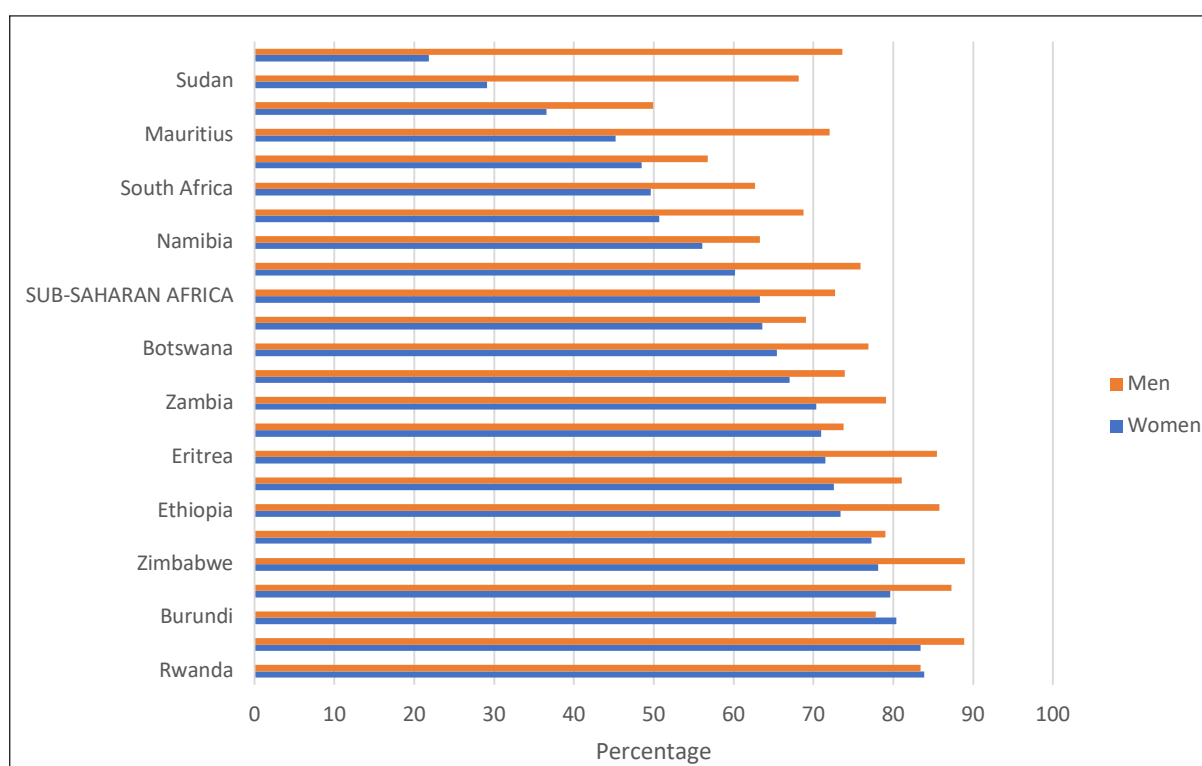
97 UNDP (2020) Human Development Report 2019.

Figure 21: Unemployment rate for individuals 15 years and older, by sex (SDG 8.5.2)⁹⁸ (%)



Source: UNSD, SDG databank. Available from <https://unstats.un.org/sdgs/indicators/database/>

Figure 22: Participation in the labour force (% aged 15+) latest available year, 2019



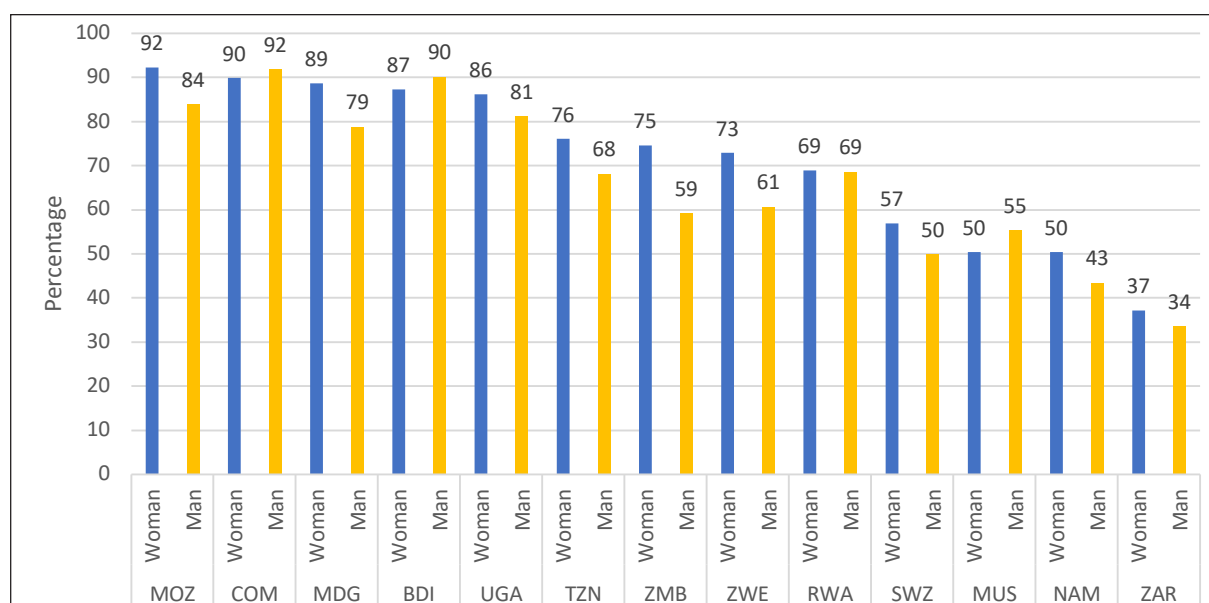
Source: ILO. Available from ilostat ilo.org/data/country-reports.

98 Most recent year is as follows: Botswana (2010), Burundi (2014), Comoros (2014), Ethiopia (2013), Kenya (2016), Madagascar (2015), Malawi (2013), Mauritius (2018), Mozambique (2015), Namibia (2018), Rwanda (2018), Seychelles (2018), South Africa (2018), Zimbabwe (2011), South Sudan (2008), Eswatini (2016), Uganda (2012), United Republic of Tanzania (2014), Zambia (2017).

In most countries in the region, women are more likely than men to be employed in the informal sector (Figure 23). The exceptions where the reverse is true are Burundi, Comoros and Mauritius.

The countries with the biggest percentage point gaps between women and men with regards to informal employment in the non-agricultural sector (i.e. women more likely to be in the sector than men) are Zambia (16 percentage points), Zimbabwe (12 percentage points), Madagascar (10 percentage points), Mozambique (8 percentage points), United Republic of Tanzania (8 percentage points), Namibia (7 percentage points),

Figure 23: Percentage of informal employment in the non-agricultural sector, by sex (ILO harmonized estimates) (SDG 8.3.1) (%)⁹⁹



Source: UNSD, SDG databank. Available from: <https://unstats.un.org/sdgs/indicators/database/>

5.9 Gender gaps in labour markets in East and Southern Africa

Whilst the general lack of decent work opportunities affects both men and women in sub-Saharan Africa, women do face additional disadvantages and discrimination, the ILO points out.¹⁰⁰ The sub-Saharan gender gap in informality amounts to 6% (92.1% for women versus 86.4% for men), and the combined rate of labour underutilization is lower for men (at 19.2%) than for women (at 23.9%). Almost a third of women (30.0%) are contributing family workers, compared with only 13.6% of men. *This reflects the fact that in many countries in the sub-region property rights are biased in favour of men, who are the main landholders.*¹⁰¹


Hence, a large majority of women in East and Southern Africa continue to gain their livelihoods from subsistence level agriculture, combined with informal sector micro- and small-scale businesses. According to UNDP¹⁰² (2020) the share of women in non-agriculture varies considerably in East and Southern Africa. The only countries where more than half of the

99 Most recent years are - Burundi (2014), Comoros (2014), Eswatini (2016), Madagascar (2015), Mauritius (2018), Mozambique (2015), Namibia (2018), Rwanda (2018), South Africa (2018), Uganda (2012), UR of Tanzania (2014), Zambia (2017), Zimbabwe (2014).

100 ILO 2020. World Employment and Social Trends Report 2020.

101 Doss et al. (2015) in ILO (2020).

102 UNDP (2020) Human Development Report 2019.



non-agriculture labour force are women are Ethiopia (57.2%), Madagascar (54%) and Namibia (50.7%), where women are found in low-paid service type of employment. Generally, the share of women in the non-agricultural employment tends to be higher in middle-income countries in Southern Africa, with the above-mentioned exceptions. Lowest shares of women labour in the non-agricultural labour force are found in countries characterised by fragility and conflict such as Somalia (18%) and Sudan (20%), where their share in general labour force is also relatively low. Figure 24 provides the figures for all countries in East and Southern Africa.

Sex segregation of occupation is combined with other discriminatory practices. The increasing level of education of women has not resulted in employment opportunities in high-end positions for women, according to the African Development Bank and UN Economic Commission for Africa Gender Index report.¹⁰³ Women's work is often undervalued, and they are overrepresented in clerical work and elementary occupations, which are poorly remunerated. Women's unpaid care and domestic responsibilities also have huge implications for women's labour market outcomes, as they are mostly found in the informal sector of economy, which allows them to combine childcare and paid work.

At the household level, the fact that women in East and Southern Africa are mainly responsible for unpaid care work of children, sick and elderly relatives, as well as the general household chores is a major factor contributing to women's weaker socio-economic status. With less time to study, work in paid employment or rest, women suffer of considerable time poverty in different parts of East and Southern Africa. According to the UNDP 2020 Human Development Report, women in Ethiopia spent 19.3% of their time in unpaid domestic and care work in a 24-hour day during 2008–2018. In South Africa, the corresponding figure at the same time was 15.6%. In other words, this meant that that women to men ratio in unpaid domestic and care work was 2.9 in Ethiopia and 2.4 in South Africa. Also see Section 6 for more information on unpaid domestic and care work during the pandemic.

Likewise, UN Women Ethiopia Gender assessment¹⁰⁴ notes that in Ethiopia, before the pandemic, women spent much more time on unpaid household work than men. For example, the amount of time women spent collecting water and firewood (71% and 54%, respectively) was double that of men (29% and 28%). However, it does appear from early reports that women who have or had paid employment do not see childcare and household responsibilities as an issue standing in the way of employment – it is rather the job loss due to COVID-19 itself which is the bigger concern.

According to the AfDB & UNECA Gender Index Report,¹⁰⁵ there are also considerable gender gaps in shares of vulnerable employment in East and Southern Africa. With the exception of middle-income countries Comoros, Mauritius, Seychelles and South Africa, vulnerable employment is more common among women than men. In the four outlier countries, the *tourism industry*, that employs large shares of women, *has largely contributed to their employment, but due to the COVID-19 pandemic this particular area is one of the most threatened sectors*, which will at least at the short term threaten women's livelihoods. Share of women among vulnerable employment in particularly high in Burundi.

According to the same report,¹⁰⁶ there was a clear discrepancy in the mean wages and salaries of women and men in the period 2009–2019. The only countries with a low gender gap in mean salaries and wages were Djibouti, Madagascar, and Namibia, which are all countries with

103 AfDB & UN ECA (2020) Methodological and Statistical Report. Bridging the Gender Gaps: The Africa Gender Index Report 2019.

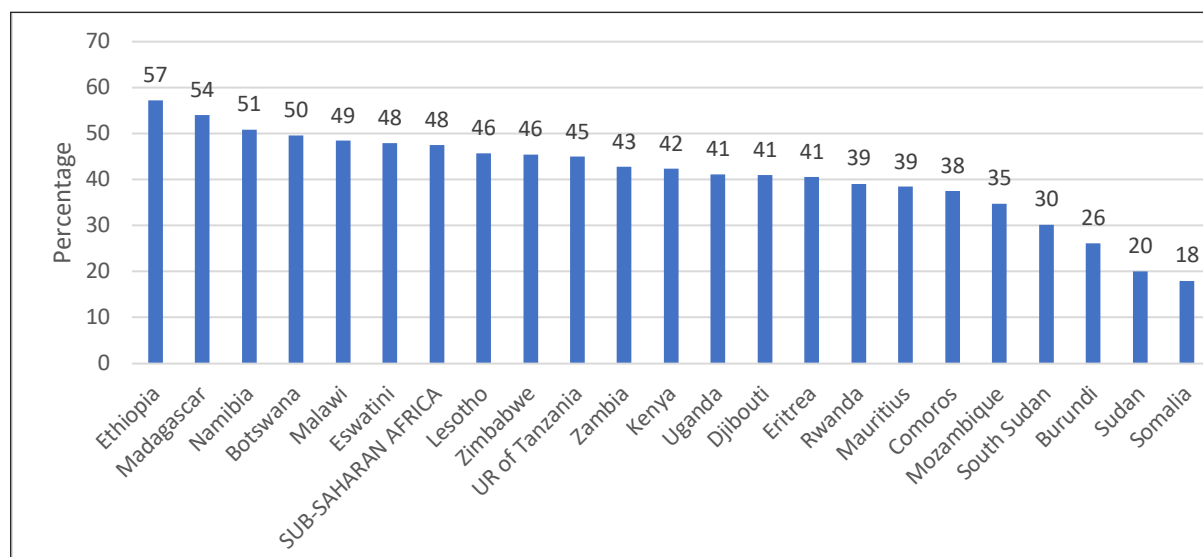
104 UN Women Ethiopia (2020) Assessment of the Gender Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia.

105 AfDB & UNECA (2020) Statistical and Methodological Report. African Gender Index report 2019.

106 AfDB & UNECA (2020) Statistical and Methodological Report. African Gender Index report 2019.

small populations. Exceptionally high gender gaps in mean salaries and wages were found in Malawi and Tanzania. Even access to credit is clearly more limited for women than men, which forms one of the main obstacles for their enterprise growth. Only Malawi, Mozambique and Uganda had more or less succeeded in closing the gender gap in access to credit. Access to credit was particularly problematic for women in Burundi, Mauritius and Somalia according to the African Development Bank and UN ECA African Gender Index Report 2020.¹⁰⁷

Figure 24: Share of employment of women in non-agricultural employment, 2019



Source: UNDP (2020) Human Development Report 2019

Women are in the minority in senior and middle management positions in all the East and Southern African countries, but the least populous ones, namely Eswatini, Namibia and Seychelles. It is therefore possible, that in these countries, the lower number of people in general and hence also graduates has benefitted women and contributed to their better access to senior and middle management posts. It also appears that countries with small populations tend to better use better all their available human resources, both women and men. In the most populous country in the region, Ethiopia, with its approximately 120 million inhabitants, women make only 21.2% of senior and middle management.¹⁰⁸

There is clear polarisation in the percentage of women with an account at a financial institution or with a mobile service provider. This accounts for only 35.9% women in sub-Saharan Africa. Only in the middle-income Southern and East African countries – Namibia, South Africa, Mauritius and Kenya – more than 70% of women have such accounts. In the low-income countries Burundi and Djibouti – less than 10% of women enjoy such economic autonomy. This lack of an account at a financial institution or with a mobile phone service provider, therefore also may have limited the ability of women in some countries where cash transfers were provided to reduce the impact of the pandemic.¹⁰⁹

¹⁰⁷ Interestingly, the access to credit and gender gaps in participation in business do not directly correlate. Women's participation in entrepreneurship was according to the AfDB & UN ECA report highest in Kenya, Zambia and Botswana, where the gender gap in access to credit was relatively large. This is probably explained by the fact that much of women's entrepreneurship in East and Southern Africa is created by necessity, as a last resort, rather than by choice. Very large gender gaps in the participation in business were found in Eritrea, Mauritius and South Africa.

¹⁰⁸ AfDB & UNECA (2019) African Gender Index Report.

¹⁰⁹ These labour market challenges may become even more problematic in future because Africa's youth labour force is growing very strongly in absolute numbers, but the creation of employment opportunities and especially decent work does not keep pace with demand and informality remain the most important type of employment for young workers in Africa, affecting 94.9% of them, 56.4% in Southern Africa.

5.10 Impact of COVID-19 on livelihoods and economic activities in East and Southern Africa

Globally, the socio-economic impacts on women due to COVID-19 are extreme, as illustrated by statistics collated by the Coalition for Women's Economic Empowerment and Equality:¹¹⁰

- An estimated 195 million jobs could be eliminated globally due to the pandemic, mostly in sectors predominated by women.
- Women predominates in the informal sector and as low-wage workers, often lacking any protection against exploitation and harassment. An estimated 740 million women globally find themselves in this sector making them particularly vulnerable to the social containment measures and movement restrictions during the pandemic.
- Global estimates show that women experience wage gaps when compared to men for both identical roles and different occupations of equal value. Women are also estimated to earn 24% less than men do.
- Women comprise on average 43% of the agricultural workforce in developing countries. An estimated two-thirds of the world's 600 million poor livestock keepers are women.
- Women are 14% less likely to own mobile phones than men and 43% less likely to engage online. This therefore excludes many women from accessing critical cash transfers and other financial services via digital platforms prioritized by governments due to social distancing measures.

An important finding of the UN-South Africa socio-economic impact assessment ¹¹¹ is that high levels of education of the household head are associated with lower probabilities of households falling into poverty. Employment is also vital for poverty transition. Households who experience more secure employment have a lower probability of falling into poverty. The study also found that self-employed household heads who are women are more likely to transition into poverty than those headed by men. This confirms the ILO's global findings that were discussed earlier in this chapter.

The UN-South Africa 2020¹¹² study also found that black Africans and households with many dependents have a higher likelihood of being poor and that individuals living in poverty and extreme poverty have increased due to the pandemic. Furthermore, poorer households are more negatively affected by the pandemic mainly through the unskilled labour and wage reduction compared to the richer households - further deepening already high levels of inequality. The analysis also suggests that the stimulus package may not be sufficient, given the estimate that households may lose as much as 40% of their income. The study found that the hardest hit workers were those with relatively low levels of education and doing unskilled and semi-skilled work.

In the same way, the preliminary results of UNDP Rapid assessment of the socio-economic impacts of COVID19 impact in Eritrea concluded that *a strong correlation would be expected between reduced economic activities in the country,¹¹³ less work time, lower income and unemployment for certain occupations due to business closures and the 'stay-at-home' regulation.* The study highlighted that the measures adopted to reduce the spread of the pandemic were likely to disrupt essential production and supply chains; interrupt movement of basic social services personnel;

¹¹⁰ Consortium for Women's Economic Empowerment and Equality Brief cited in UN Women Ethiopia (2020) Assessment of Gender Impacts of COVID-19.

¹¹¹ UN South Africa (2020) United Nations in South Africa (2020) Covid-19 In South Africa Socio-economic Impact Assessment.

¹¹² UN South Africa (2020) United Nations in South Africa (2020) Covid-19 In South Africa Socio-economic Impact Assessment.

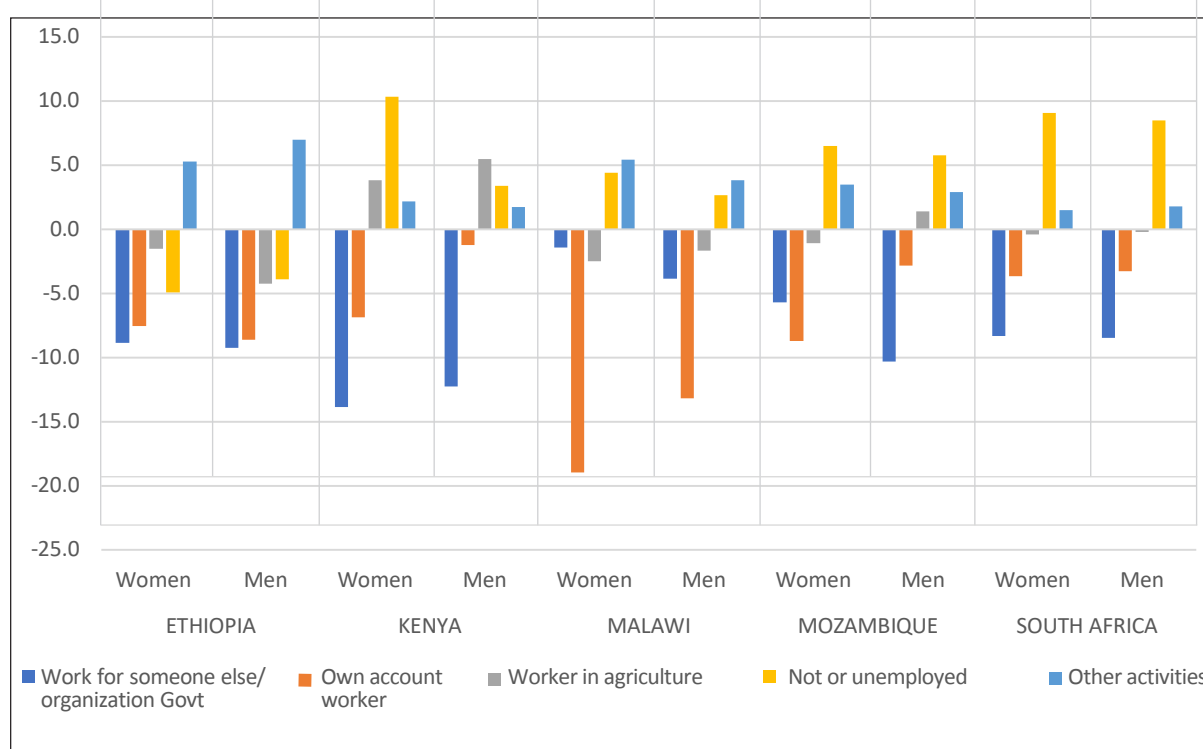
¹¹³ UNDP Eritrea (2020) Rapid Socio-Economic Assessment of COVID-19 Impact in Ethiopia.

reduce government revenue and public spending; and overall, severely impact the life of the most vulnerable population. The report specifically highlights the plight of vulnerable women and children, refugees, people living with HIV-AIDS and other chronic illnesses, and disabled people.

Likewise, all the recent CATI COVID-19 rapid gender assessments¹¹⁴ in East and Southern Africa witness of the considerable impacts of COVID-19. The impacts on incomes were already described above (Chapter 3, Figures 17 and 18). In addition, an overwhelming majority of respondents in Ethiopia, Malawi, Mozambique and South Africa maintained that their personal economic activity(ies) had changed from February 2020 (before the onset of COVID-19). Figure 25 displays these results. The figure represents the difference in the percentage points of women in men who were involved in each sector prior to the start of the pandemic (February 2020) and the survey (September -December 2020).

According to the findings of the survey, declines in involvement in all subsectors were reported across the region. Besides Ethiopia, the percentage of individuals in the 'Not employed or unemployed' category increased in all countries. In Kenya some employment growth in the agricultural sector was observed, whilst increases in 'Other' economic activities not classified were also reported.

Figure 25: Percentage point changes in individual economic activity(ies) since February 2020, by sex, 2020

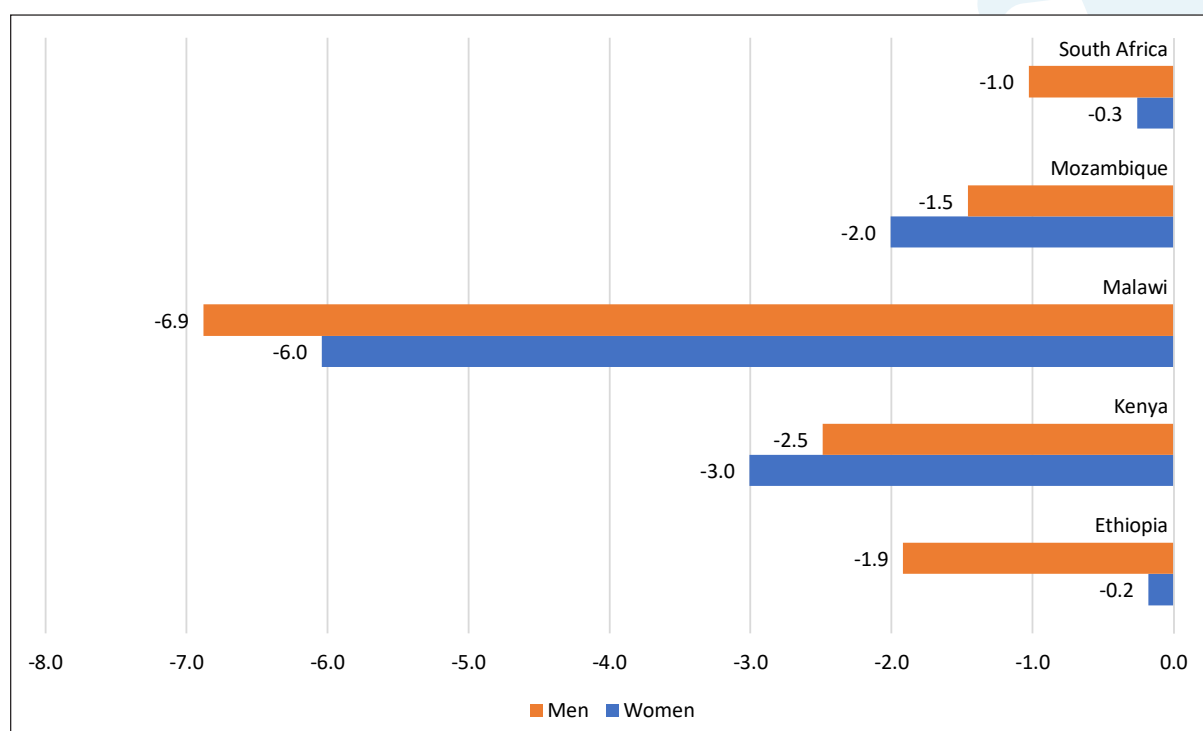


Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Not only did the nature of economic activities change, but also the number of different activities in which the respondents engaged. Changes in the number of activities in Malawi were the most pronounced when compared to other countries. In Malawi, Ethiopia and Southern Africa women were less likely than men to experience declines in their average number of activities, while women in Kenya and Mozambique were more likely to experience declines in the average number of activities they were doing than men.

¹¹⁴ UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020) Accessed in December 2020.

Figure 26: Impact of COVID-19 on number of income-generating activities, by sex 2020











Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

Changes were biggest in the sectors of working for salary or wages for others as well as own-account work with or without other employees. The category unemployed¹¹⁵ or not employed refers to individuals who were actively looking for work as well as women and men who were not economically active by choice or because they were studying, busy with unpaid domestic and care work, etc. Declines were biggest for women who were own-account workers in all countries except Ethiopia, while in the category of working for a salary or wage men were generally more affected than women in all countries except Kenya. Declines in involvement in all subsectors were reported across the region. Besides Ethiopia, the percentage of individuals in the 'Not employed or unemployed' category increased in all countries. In Kenya some employment growth in the agricultural sector was observed, whilst increases in 'Other' economic activities not classified were also reported.

Most of the economic activity transition for women took place from own-account work to not-economically active/unemployed and or men from paid employment into the not-economically active/unemployed category.

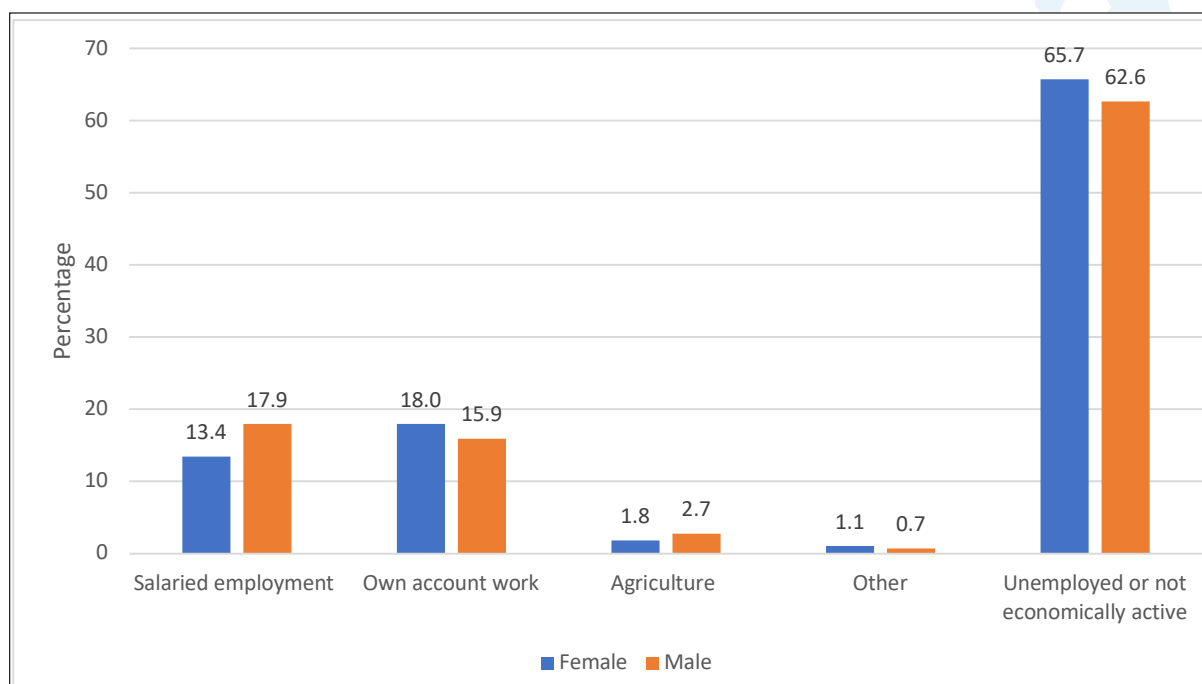
¹¹⁵ The CATI rapid gender assessments did not use the standard ILO employment questions due to restrictions on the number of questions that could be included. The employment related questions were designed to give a general idea in layman's terms what women and men's economic activities were like before and during the pandemic.

Figure 27: Percentage of women and men in each economic activity category before COVID-19 (Q1) at the time of the study (Q4), 2020

		ETHIOPIA		KENYA		MALAWI		MOZAMBIQUE		SOUTH AFRICA	
		Before COVID	During COVID	Before COVID	During COVID	Before COVID	During COVID	Before COVID	During COVID	Before COVID	During COVID
Women	 Work for someone else/organization Govt	38	29	22	8	13	11	20	14	35	27
	 Own account worker	30	22	32	25	61	42	32	23	18	15
	 Employer or worker in agriculture	3	2	23	27	26	24	34	33	2	1
	 Not or unemployed	26	21	19	30	5	10	15	22	40	49
	Other activities	8	14	9	11	11	16	10	13	7	8
Men	 Work for someone else/organization Govt	45	36	28	16	22	18	37	26	44	36
	 Own account worker	35	26	39	38	55	42	31	28	24	21
	 Employer or worker in agriculture	11	7	22	27	32	30	27	29	2	2
	 Not or unemployed	14	10	14	17	3	5	11	17	29	38
	Other activities	6	13	7	9	8	12	7	10	5	6

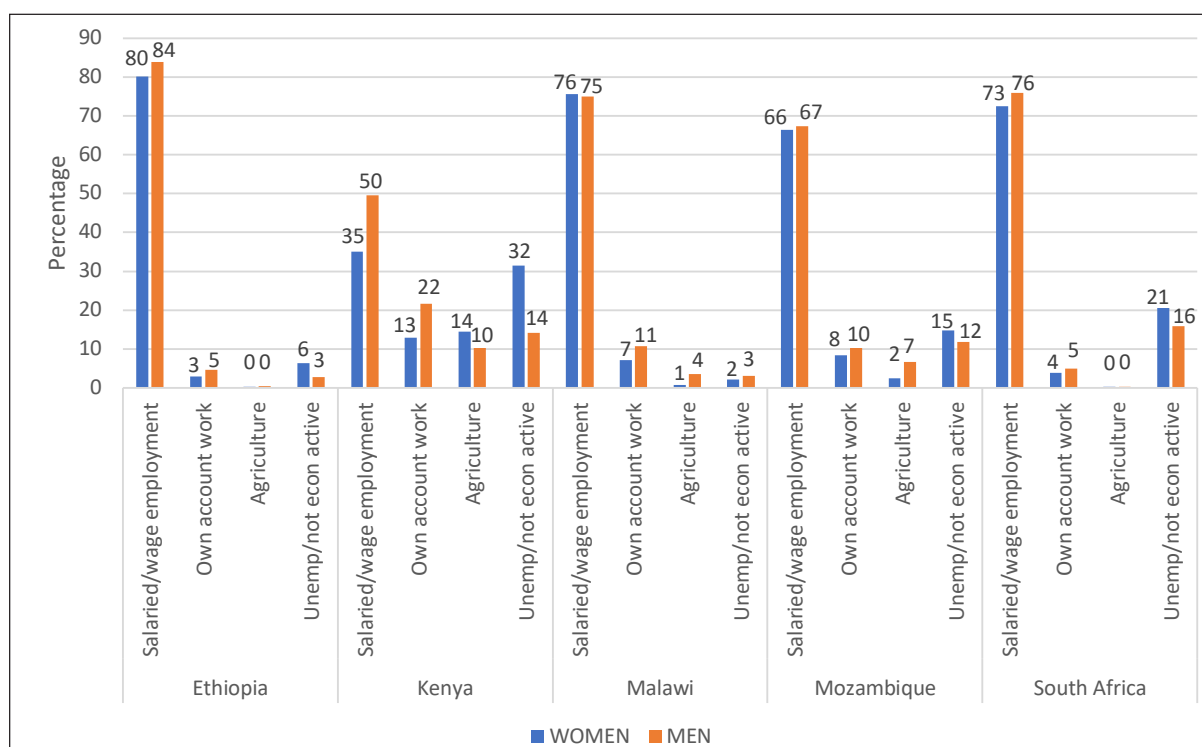
Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

Figure 28: Sector of employment prior to COVID-19 (February 2020) if unemployed or not employed in Q4 of 2020 (%)



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

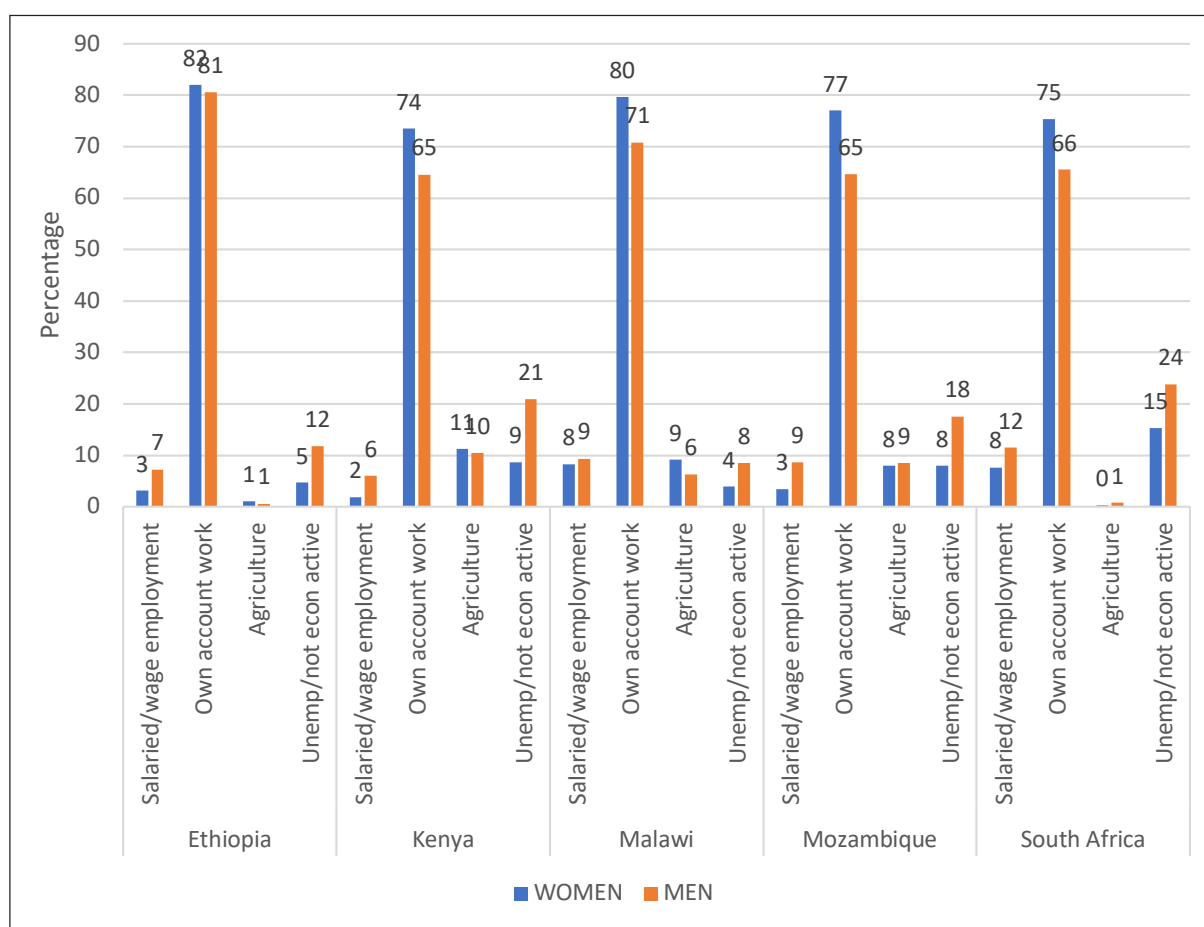
Figure 29: Respondent in salaried/wage employment before COVID-19. Economic activity after COVID-19



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

Women and men who were in paid employment prior to the pandemic were least affected in Ethiopia, Malawi and South Africa and most affected in Kenya. More than 80% of women and men in Ethiopia who were in the salaried/wage employment category prior to COVID-19 were still there in Q4, whilst 70% or more in Malawi and South Africa could say the same. In Kenya only 35% of women and 50% of men who were in salaried/wage employment prior to the pandemic were still in that position at the time of the survey. In the case of Kenya and Mozambique those who were no longer employed transitioned into own-account work, agriculture and the unemployment/not employed category.

Figure 30: Economic activity during COVID-19 if respondent in own-account employment (with or without workers) before COVID-19 (February 2020), 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

Women who were in own-account employment prior to COVID-19 were more likely to still be there during the pandemic than men across all countries in the region, with the smallest differences in the survival rates in the sector between women and men in Ethiopia. Some notable transitioning into agriculture took place for women and men in Kenya, Malawi and Mozambique for those who were no longer own-account workers at the time of the survey. In South Africa and Malawi there was also some movement into the salaried/wage employment category especially for men. Men were also more likely than women to move from own-account work into the 'unemployment/not economically' active category than women in all countries but with bigger gender gaps in Kenya and South Africa.

6. UNPAID DOMESTIC AND CARE WORK DURING COVID-19

6.1 Introduction

Time use and time use studies are considered important within the context of women's economic empowerment and sustainable development. All the recent CATI COVID-19 rapid gender assessments¹¹⁶ in East and Southern Africa are witness of the considerable impacts of COVID-19 in time use. An overwhelming majority of respondents in Ethiopia, Malawi, Mozambique and South Africa maintained that their personal economic activity(ies) had changed from February 2020 (before the onset of COVID-19).

In addition to providing a general understanding of how women spend their time, time use studies shed some light on how much time women spend on unpaid domestic work and unpaid care work. Studies conducted prior to the pandemic have consistently shown that women tend to spend more time on unpaid care and domestic work than men.¹¹⁷ This increases the general workload of women who are already involved in productive economic activities and may prevent some to engage with the labour market and becoming financially independent, but it also places a disproportionate.¹¹⁸ The role of unpaid care work in women's economic empowerment is considered so important that it was included as a target and indicator in the Sustainable Development Agenda 2030. Target 5.4 encourages the recognition and valuation of unpaid care and domestic work so that governments can provide the necessary public services, infrastructure and social protection policies, and promote unpaid domestic and care work as a shared responsibility within the household and the family.

Care work¹¹⁹ can be defined as the provision of personal, face-to-face services to meet the physical and emotional needs of a person in such a way that it enables them to function at a socially acceptable level of capability, comfort and safety. Within households, care work is usually unpaid and are accompanied by other unpaid domestic work such as for example cleaning, cooking etc. To date, very few countries in East and Southern Africa have conducted any official large-scale time use studies and once conducted they are not repeated at regular time intervals. What we do know about unpaid domestic care work in East and Southern Africa based on these surveys, is that women have been spending much more time than men on unpaid domestic and care work.

116 UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

117 Charmes J. Time Use Across the World: Findings of a World Compilation of Time Use Surveys. Available from <http://hdr.undp.org/en/content/time-use-across-world-findings-world-compilation-time-use-surveys>. Accessed November 2020.

118 Razavi, S. Redistributing unpaid care and sustaining quality care services: A prerequisite for gender equality. <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2016/un-women-policy-brief-05-redistributing-unpaid-care-en.pdf?la=en&vs=2644>.

119 Himmelweit Susan. The Prospects for Caring: Economic Theory and Policy Analysis, February 2007, Cambridge Journal of Economics 31(4):581-599.

6.2 Unpaid domestic and care work prior to COVID-19

The pandemic arrived in Africa a little later than in Asia, Europe and the Americas and the first cases were only identified in East and Southern Africa in March 2020. Most countries acted swiftly by instituting strict lockdowns and/or some form of movement controls. These resulted in businesses and other places of employment closing and workers either continuing working from home or becoming unemployed. Informal workers were equally affected, especially those working in informal markets and on the streets, as were learners at education institutions. With very little notice everyone found themselves homebound and this led to significant shifts within households, not only regarding the amounts of time spent together, but also in relation to the division of labour. One category of home-based work that was significantly impacted, especially during lockdown was unpaid domestic and care work.

In Figure 31, the differences between women and men in time spent on unpaid domestic and care work as percentage of total time are summarized. This is based on the SDG indicator 5.4.1 definition.

Figure 31: Proportion of time spent on unpaid domestic and care work, by sex most recent year (SDG 5.4.1)

Country	Most recent year(s)	Type of survey	Indicator value (percent)	
			Women	Men
Ethiopia	2013	Standalone	59	6
Madagascar	2001	Subsample of household survey	49	17
Mauritius	2003	Module of household survey	71	9
South Africa	2010	Standalone	64	18.8
Tanzania	2014	Module of labour force survey	55	16
Uganda*	2016	Stand-alone survey	7 hours per day	5 hours per day

Source: Charmes except Uganda for which the SDG country report indicator values were used. The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-use Surveys. Jacques Charmes. ILO, 2019. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_732791.pdf

*The Uganda data is not available in SDG 5.4.1 indicator format – only the average in number of hours per day was reported.

Even though at an anecdotal level awareness grew of these changes in work burdens, very few studies were conducted to quantify these and the studies which did, did not focus or report on differences between women and men, for example the study conducted by Gershuny et al.,¹²⁰ amongst others. Neither did any quantitative studies cover Africa or the East and Southern Africa sub-region.

Given the scarcity of pre-COVID-19 data on unpaid domestic and care work prior to the pandemic, the RGAs carried out by UN Women and partners in Ethiopia, Kenya, Malawi, Mozambique, Rwanda and South Africa included a question about the person primarily responsible for domestic and unpaid care activities prior to the pandemic. Women were the most likely to be identified as responsible for cooking and cleaning in all countries except in Kenya, where women and men were more likely to share these tasks. As with unpaid domestic work, women were more likely than men to take responsibility for the physical care responsibilities of children and passive care of children, rather than any of the other unpaid care activities across countries for which data is available. The relative burden of women in

¹²⁰ Gershuny et al. A New Perspective from Time Use Research on the Effects of Lockdown on COVID-19 Behavioral Infection Risk. Available from <http://ftp.iza.org/dp13599.pdf>. Accessed October 2020.

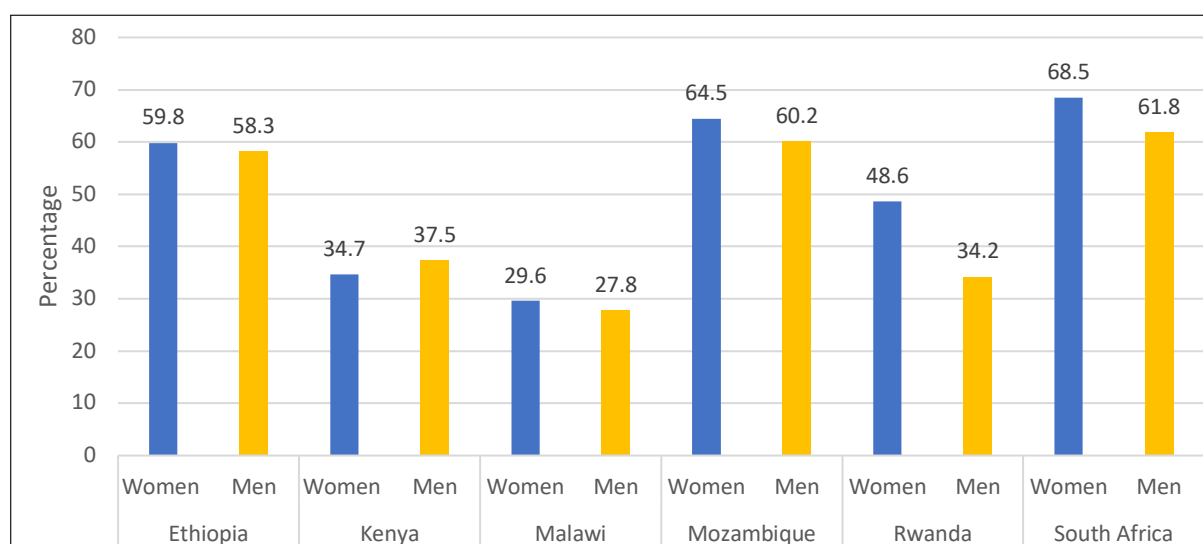
Kenya is less than in other countries because of a relatively high share of activities being jointly carried between women and men and the contribution of men towards overall unpaid domestic and care activities.

6.3 Changes that took place in unpaid domestic and time use during COVID-19

UN Women, based on rapid gender assessments (RGA) done globally in 38 countries during the pandemic, has found that women and men have been carrying an increased burden of unpaid domestic and care work. According to the available data at the time of the study, 28 percent of women and 16 percent of men indicated that the intensity of their domestic work has increased.¹²¹ Also see Table 1 in Annex 2.

Even though women were more likely than men to spend time on unpaid domestic and care work prior to the pandemic, both sexes reported spending more time on these activities during the pandemic. The statistics only reflect changes for individuals who are involved in these activities. The unpaid care activities included in the study were divided into care activities related to children and adults. For children the activities included: Minding children while doing other tasks (e.g. paid work); playing with, talking to and reading to children; instructing, teaching, training children; and caring for children, including feeding, cleaning, physical care. Unpaid care activities that involve adults included: Assisting elderly/sick/disabled adults with medical care; feeding, cleaning, physical care; assisting elderly/sick/disabled adults with administration and accounts; and affective/emotional support for adult family members.

Figure 32: Percentage of women and men indicating that the time they spent on one or more of the unpaid domestic activities (cooking, cleaning and shopping) has increased during the pandemic, 2020



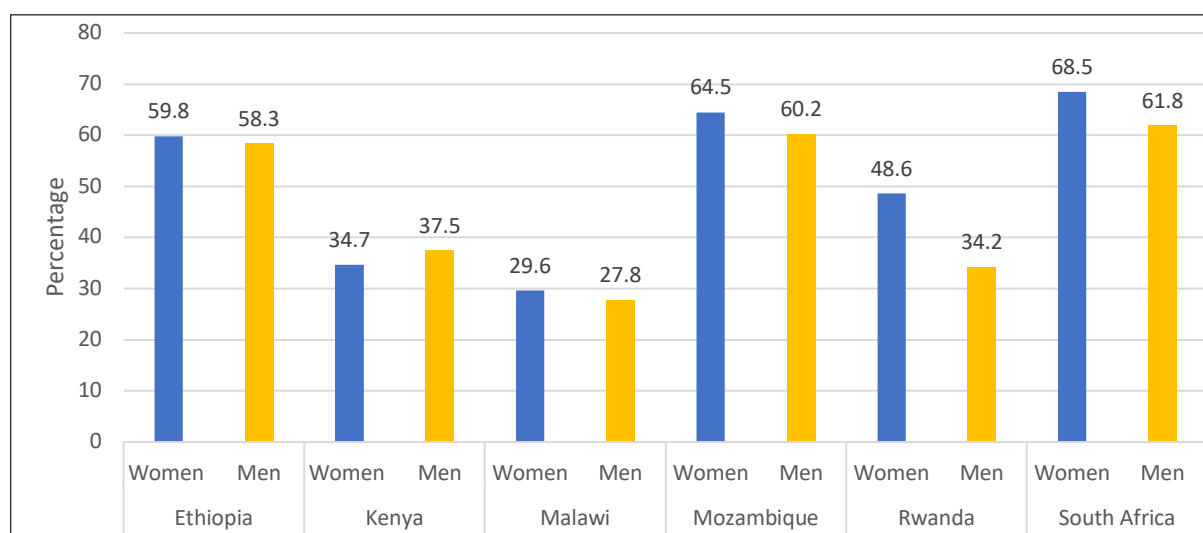
Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Women were more likely than men to indicate that they were spending more time on unpaid domestic work across all countries. With regard to unpaid care work, men in Ethiopia, Kenya, and Malawi were more likely than women to say that their unpaid care work has increased during the pandemic, and this is largely due to increased passive child-minding, teaching and

¹²¹ UN Women. Whose time to care? Unpaid care and domestic work during Covid-19. UN-Women https://data.unwomen.org/sites/default/files/inline-files/Whose-time-to-care-brief_0.pdf.

providing general childcare. In Mozambique and South Africa, women were still more likely than men to report that they participate in unpaid domestic and care work.

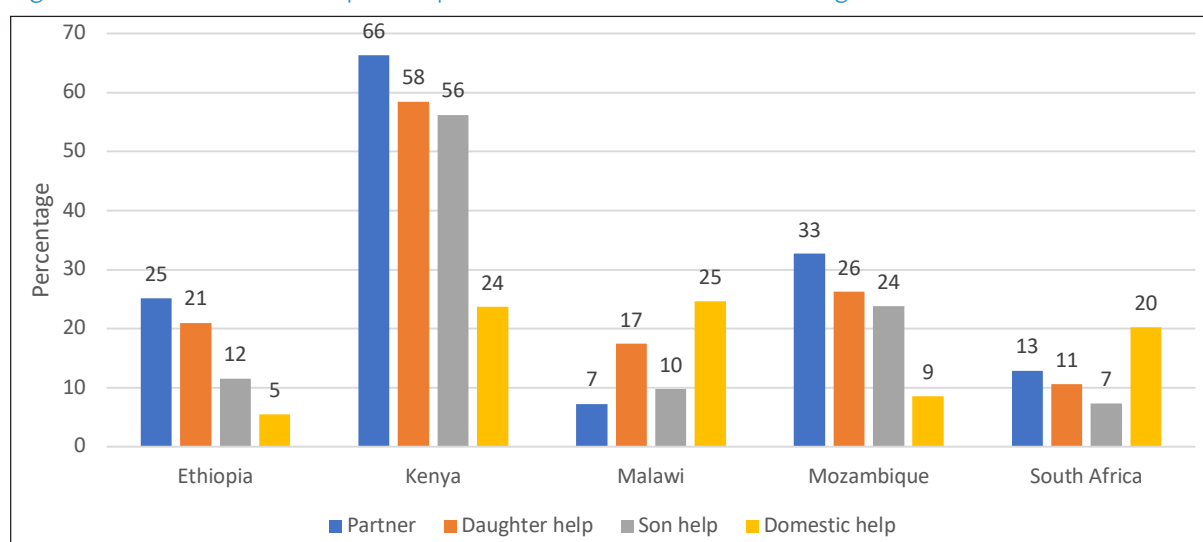
Figure 33: Percentage of women and men indicating that the time they spent on one or more of the unpaid care activities has increased during the pandemic, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Figure 33 shows that women and men were equally likely to experience an increase in activity levels in at least one of the unpaid care work activities included in the study. There are also definite gender differences in terms of who were most likely to provide support during the pandemic. Generally, women and men received assistance from their spouses/partners during the pandemic. Both women and men in all countries indicated that they received more help for unpaid domestic and care work from their daughters than their sons.

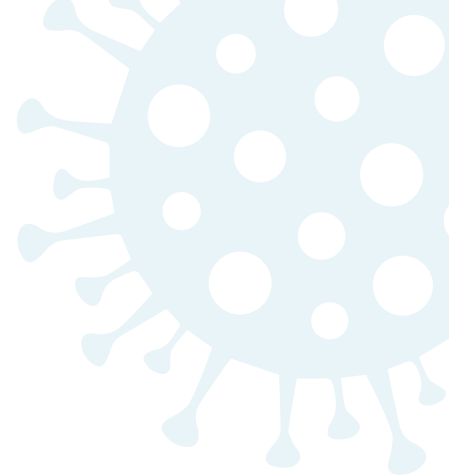
Figure 34: Source of more help for unpaid domestic and care work during COVID-19, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

In all countries, except Malawi and South Africa, spouses were more likely to help with unpaid domestic and care work than anyone else. Daughters were more likely than sons to provide additional assistance during COVID 19 with these kinds of tasks.

7. EDUCATION



7.1 Introduction

‘Education for all’ as per Goal 4 of the sustainable development agenda is not only an end, but also an important enabler for the achievement of most of the other Agenda 2030 goals. It is considered one of the cornerstones of human development and has been a priority for many governments in East and Southern Africa for several decades as reflected in government expenditure on education in 2018. Between 18 to 20% of national budgets have been spent on education in countries such as for example, Burundi, Kenya, Madagascar, Mauritius, Mozambique, and South Africa.¹²² Countries with notably lower expenditure on education in relation to total budgets are Uganda (10.9%), Rwanda (10.8%) and South Sudan (0.9%).

Prior to COVID-19, significant regional progress has been made with regard to gender equality in education. Attendance rates of boys and girls are similar and even better for girls in many of the countries for which data is available.

Despite the comparatively high expenditure on education, the education sector is still beset by several problems. These include, amongst others:

- A third or more children and adolescents of primary and lower secondary school age are out of school in Djibouti (43%), Eritrea (44%), South Sudan (61%) and the United Republic of Tanzania (33%). Countries where out-of-school rates for girls¹²⁵ continue to be worse than that of boys include Eritrea, Ethiopia, Mozambique, and South Sudan.
- Less than 7 out of 10 learners are likely to complete primary education in 47% of the 19 countries for which this data is available. Completion rates are worse for girls¹²³ than boys in Eritrea, Ethiopia, Mozambique, and Sudan.
- In 57% of 14 countries with data, less than half of the learners completed their lower secondary education. Completion rates are lower for girls than boys in Burundi, Ethiopia, Malawi, Uganda, UR of Tanzania and Zambia.

The gender equality challenges in education go beyond attendance and completion rates. If gender equality is to be achieved in and through education, gender-related concerns of the whole education system need to be addressed. Some of the gender-based problem areas within the school system, as well as the wider societal context that need to be addressed include inequalities related to access, progression, participation, learning outcomes, systemic problems such as for example linking education interventions to system wide reform and gender-responsive education sector planning, social cultural norms that do not support gender equality, as well as political and cultural structures.¹²⁴ The gender gap in especially

¹²² UNESCO figures for 2018. Available from <http://data.uis.unesco.org/>. Accessed 13 October 2020.

¹²³ This pertains to children and adolescents of primary and lower secondary school age; data is only available for 13 of the 28 countries in the region, UNESCO figures for 2018. Available from <http://data.uis.unesco.org/>. Accessed October 2020.

¹²⁴ Global partnership. Available from <https://www.globalpartnership.org/sites/default/files/2019-07-kix-gender-final-english.pdf>. Accessed November 2020.

Science, Technology, Engineering and Mathematics (STEM),¹²⁵ continues to be significant and of concern, especially within the context of the fourth industrial revolution that is irrevocably changing the way the global economy and societies function.

7.2 Education sector response during the pandemic

The role of children in spreading COVID-19 is not yet fully understood, but children of all ages can potentially spread the disease to others.¹²⁶ Emerging scientific evidence suggests that children do not act as super-spreaders with limited health risk reasons for the children as well as their families in support of keeping schools closed.¹²⁷ However, a recent contact tracing study conducted in India amongst nearly half a million people found that children do transmit the virus, especially to their peers.¹²⁸

What we do know about the pandemic¹²⁹ is that children are less likely than adolescents to get the disease, while both groups are significantly less likely than adults to be infected. When they are infected, they are also less likely to develop symptoms and complications. Just like adults, children with underlying conditions are at greater risk than other children to become ill and develop other complications.

Even though the scientific knowledge base about COVID-19 is growing, during the early months of the pandemic relatively little was known about COVID-19 and its potential impact on the population and more especially children. The highly contagious nature of the pandemic and concerns about the risks of overwhelming the already fragile health systems in the sub-region led to the institution of early and strict measures related to social distancing and movement controls. Most countries in the sub-region closed all schools and ceased face-to-face tuition in March 2020. The only exceptions were Mauritius, where schools closed in mid-April as well as Burundi where vacation dates were changed, but no formal school closures took place.

Figure 35 summarises the number of learners who were affected by these school closures across the sub-region by sex. According to the UNESCO estimates¹³⁰ of April 2020, a total of 124 million learners in East and Southern Africa have been affected by school closures due to the COVID-19 pandemic. These figures represent enrolments at the start of 2020 and reflect pre-primary, primary, secondary as well as tertiary levels. In the East and Southern Africa sub-region, this represents 61 million girls/women and 64 million boys/men with a gender parity ratio of 0.96.

Of the countries in the region, Ethiopia has the largest number of affected learners with 24.6 million, followed by South Africa with 14.6 million, Kenya with 14.3 and United Republic of Tanzania with 13.9 million learners (Figure 35). Countries with less than a million learners that were affected in total are: Eritrea, Djibouti, Comoros, Mauritius, Seychelles, Botswana, Eswatini, Lesotho and Namibia.

125 The gender gap in STEM fields: Theories, movements, and ideas to engage girls in STEM, July 2018. Journal of Journal of New Approaches in Educational Research 7(2):148-153.

126 What we know about COVID-19 transmission in schools. Available from https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update39-covid-and-schools.pdf?sfvrsn=320db233_2. Accessed October 2020.

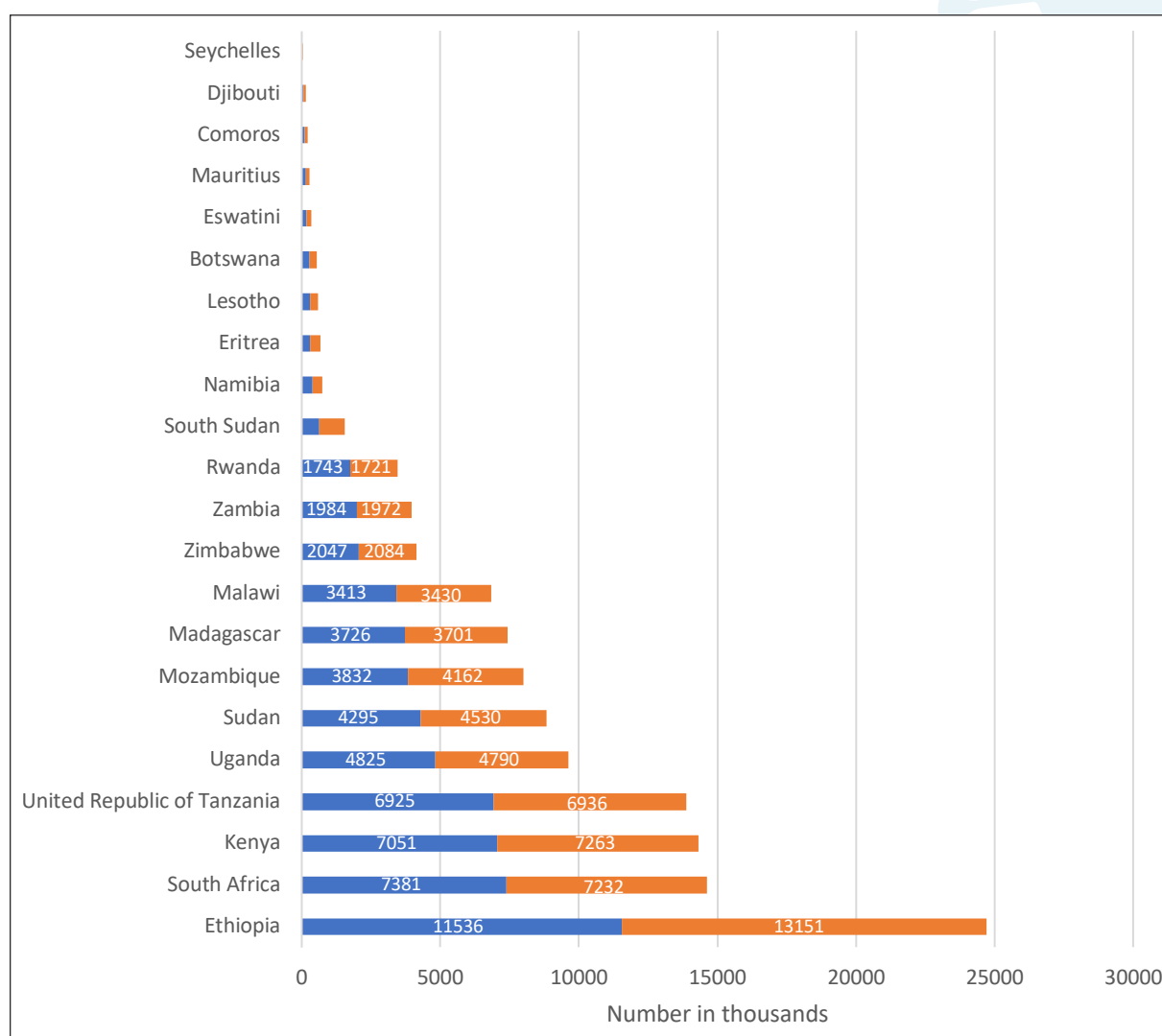
127 Arch Dis Child. 2020 Jul;105(7):618-619. doi: 10.1136/archdischild-2020-319474. Epub 2020 May 5. Children are not COVID-19 super spreaders: time to go back to school.

128 Princetown News. Available from <https://www.princeton.edu/news/2020/09/30/largest-covid-19-contact-tracing-study-date-finds-children-key-spread-evidence>. Accessed October 2020.

129 What we know about COVID-19 transmission in schools. Available from https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update39-covid-and-schools.pdf?sfvrsn=320db233_2. Accessed October 2020.

130 UNESCO figures for 2018. Available from <http://data.uis.unesco.org/>. Accessed October 2020.

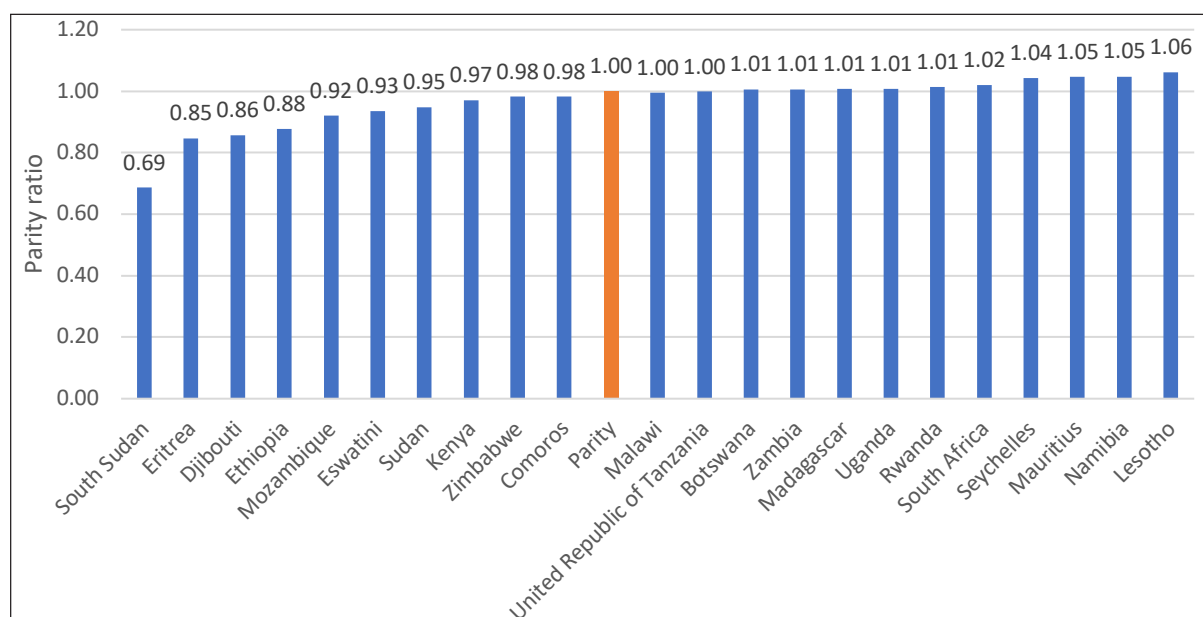
Figure 35: Number of learners affected by COVID-19-related school closures in the ESA region, by sex, 2020



Source: UNWomen/UNESCO, <https://data.unwomen.org/resources/covid-19-and-gender-monitor>
Labels are not displayed for countries with less than one million girls or boys affected.

Figure 36 not only illustrates the gender parity ratios per country for learners affected by school closures, but per implication, due to the nature of the data source used, also the gender parity ratios of enrolments. Countries with gender parity ratios of 1 had approximately the same number of boys and girls enrolled and therefore similar numbers of boys and girls affected by school closures. Small parity ratios, i.e. those with values below 1, indicated more boys relative to girls attend school and were affected by school closures. Normally variations of 0.05 below or above 1 are not considered serious disparities. However, parity ratios below that demonstrate significant differences between the two sexes. South Sudan, Eritrea, Djibouti, Ethiopia, Mozambique and Eswatini had the biggest differences between girl/women and boy/men enrolments, whilst in Seychelles, Mauritius, Namibia and Lesotho the number of girls/women attending and affected by COVID-19 were marginally more than the boys/men.

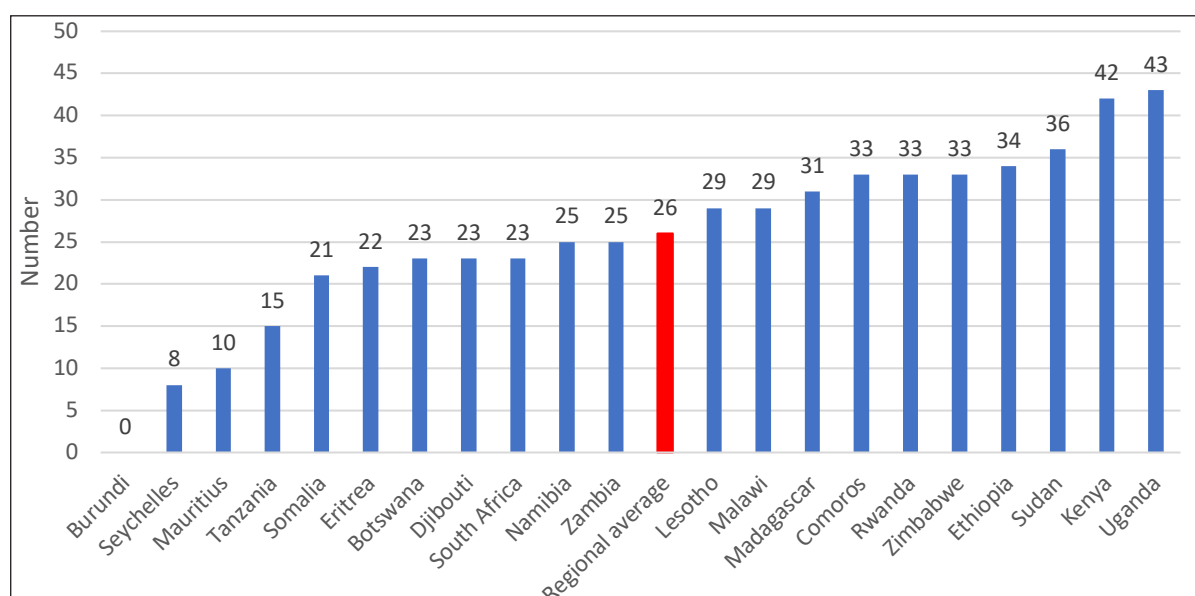
Figure 36: Parity ratios for enrolments/numbers of learners¹³¹ affected by COVID-19-related school closures in the ESA region, 2020



Source: UNWomen/UNESCO, <https://data.unwomen.org/resources/covid-19-and-gender-monitor>

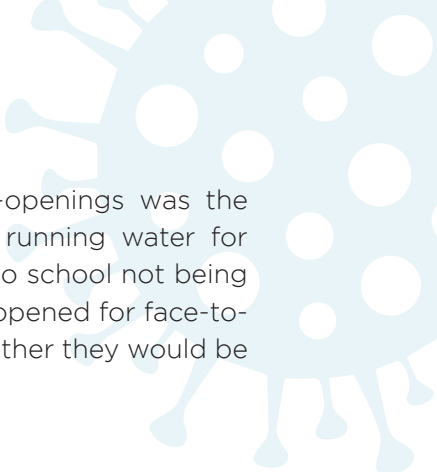
As already indicated previously, all countries in the sub-region closed their schools. The only exception is Burundi, where school holiday dates were brought forward but schools resumed normally after that. Since then, most schools have partially or fully re-opened. Countries where full re-opening for all grades will only take place early in 2021 are: Uganda, Kenya and possibly South Sudan, Eswatini and Mozambique. Figure 37 summarizes the total duration in weeks of school closures for countries with available data. Note that full re-opening in Uganda, Kenya and South Sudan will only take place in January 2021, whilst no information is available for Mozambique.

Figure 37: Number of weeks between school closure and full re-opening, 2020



Source: Centre for Global Development and UNICEF, UN Women calculations

¹³¹ Enrolments are for pre-primary, primary, secondary, tertiary levels as reflected in the UNESCO database and age ranges will vary between countries depending on what the admission ranges are for those institutions.



An important consideration about the timing and reach of school re-openings was the availability of water and sanitation in schools, as many do not have running water for regular handwashing. This, amongst other factors, resulted in the return to school not being mandatory in many countries, even after all the schools were partially re-opened for face-to-face learning. In those cases parents were given the leeway to decide whether they would be sending their children back to school or not.

7.3 Managing during school closures

After school closures and the cessation of face-to-face learning, most countries globally opted to institute remote learning programs to mitigate the impact of the closures on learners. In a global survey conducted by UNICEF, 94% of ministries provided at least one type of remote learning. However, only in 60% of the cases were activities put in place for pre-primary learners.¹³⁴

In East and Southern Africa all countries with school closures put distance learning measures in place. A combination of strategies were employed in all cases. This included the distribution of printed materials for learning from home, special sessions on radio and television and online platforms that learners could attend to. Online e-learning has been primarily done using SMS, WhatsApp, Zoom or Microsoft Teams platforms or a combination of these. According to CGD and global partnership data only Djibouti, Ethiopia, Kenya, Uganda and Zambia used all five these methods, while Botswana, Comoros, Madagascar, Malawi, Rwanda, South Africa and Zimbabwe used four of the five methods. Online teaching methods were only used in 57% of the countries in the region.

An ANDEA report on the impact of COVID-19 on Africa's education and learning¹³² reported mixed results and varying levels of success for these learning strategies from home. This is confirmed by other sources, such as the World Bank¹³³ with some studies suggesting access to remote learning opportunities on the continent as low as 4% and with most of these using television.¹³⁴ At the root of this is poor access to electricity, televisions, mobile devices and the internet especially for poor children and children living in rural areas.

Figure 38 provides household level data and more specifically information on access to computers and internet at home. The ITU database only had data available for 10 of the 28 countries in the sub-region and it can be assumed that those without data probably had similar or perhaps worse access than the countries listed. According to Figure 38, internet access was possible in 50% or more of households in Botswana, Djibouti, Mauritius and South Africa, while in the remaining countries less than 25% of households had access to internet at home. Computer access at home was even lower with all countries except Djibouti, Botswana and Mauritius having access in more than 25% of households. According to UNICEF, further estimates 49% of students (pre-primary to upper secondary) in East and Southern Africa could potentially not be reached by digital and remote broadcast learning.¹³⁵

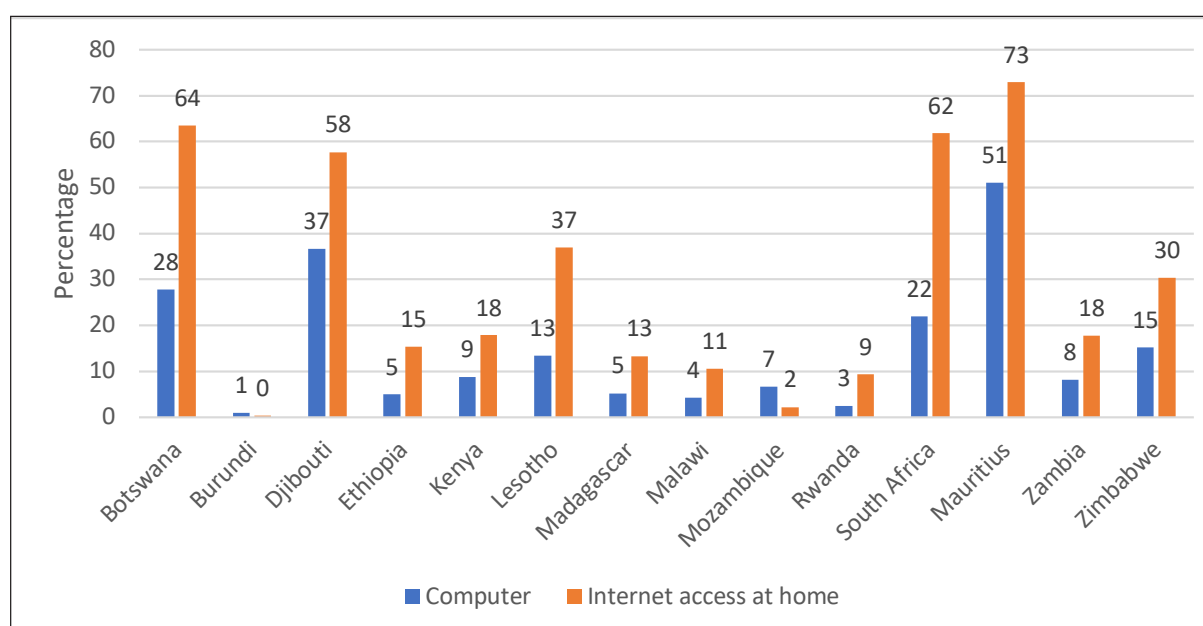
132 ADEA. Available from http://www.adeanet.org/sites/default/files/report_summary_covid-19_impact.pdf. Accessed October 2020.

133 World Bank. Available from <https://blogs.worldbank.org/education/learning-equity-during-coronavirus-experiences-africa>. Accessed October 2020.

134 CGDEV. Available from <https://www.cgdev.org/blog/why-covid-crisis-not-edtechs-moment-africa>. Accessed October 2020.

135 UNICEF. Available from <https://data.unicef.org/resources/remote-learning-reachability-factsheet/>. Accessed October 2020.

Figure 38: Households with access to computers and internet at home, 2019



Source: International Telecommunications Union, <https://www.itu.int/en/ITU-D/Statistics/Pages/stat/default.aspx>

Device access is problematic to girls for remote and other kinds of learning¹³⁶ due to social norms and constructs which associate technology use with boys/girls and sometimes create imaginary access barriers for girls. Available data not only suggests that sub-Saharan African girls are less likely to be digitally connected than boys,¹³⁷ but women in the sub-region are also less likely than men to use the internet from any location.¹³⁸ In addition to physical access barriers, examples set by adult women most likely also provide the role model vis-à-vis digital technology to young girls. Even in households with access to devices such as mobile phones and computers, sharing between different household members of different ages would have been a problem as well. In South Africa, 9.4% of the responses for the girls and 10.2% of responses for boys highlighted this problem.¹³⁹ Technology-based solutions to school closure may therefore have had limited reach and impact in the sub-region and is likely to have deepened already existing inequalities between girls and boys along rural/urban and rich/poor divisions.

A recent study conducted by UN Women across the sub-region suggests that girls and boys have been facing similar problems associated with remote learning. Notable exceptions include limited access to books and printed learning materials (girls in Ethiopia); lack of a skilled instructor/parent/guardian or do not have time (boys Ethiopia); while a lack of a conducive environment for studying was more likely to be a problem for boys than girls in South Africa. In Kenya, on the other hand, multiple roles of the parent/guardian had no significant correlation for boys, though significant for girls. This indicates that girls support parents/ guardians in unpaid care work. This is depicted in Figure 39.

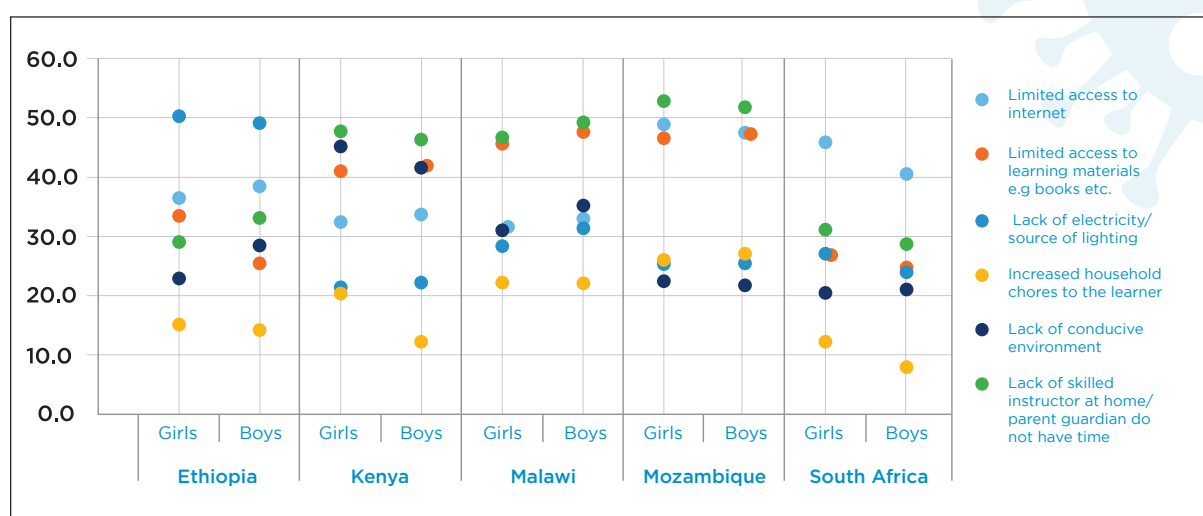
¹³⁶ OECD, "Bridging the Gender Divide: Include, Upskill, Innovate," 2018.

¹³⁷ UNICEF. COVID-19 and education: The digital gender divide among adolescents in sub-Saharan Africa, 2020.

¹³⁸ ITU World Telecommunication/ICT Indicators database. Available from <https://www.itu.int/en/ITU-D/Statistics/Pages/stat/default.aspx>. Accessed October 2020.

¹³⁹ UNWomen, UNFPA and partners. Rapid Gender Assessment, South Africa.

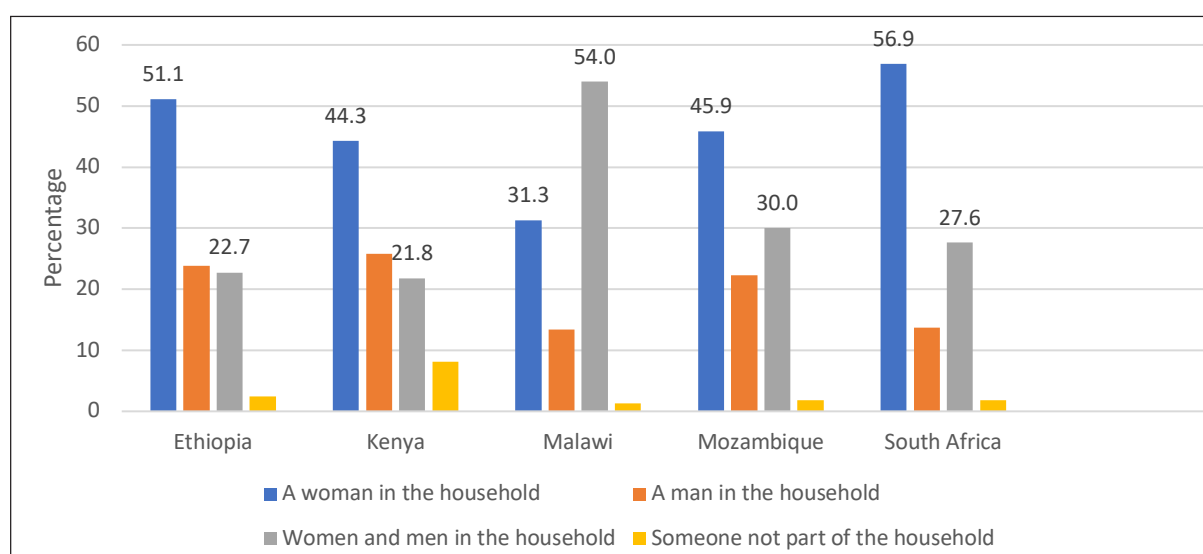
Figure 39: Problems experienced by girls and boys during school closures¹⁴⁰



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

The results from the rapid gender assessments done in the sub-region indicate that prior to the pandemic women were more likely than men to assist with the teaching of children in most countries. In Kenya and Malawi the task was shared between women and men.

Figure 40: Division of teaching tasks before COVID-19 between women and men, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

¹⁴⁰ Respondents could identify multiple responses and percentages are calculated as a percentage of total responses. In Ethiopia age bands were 7-14 years; Mozambique, South Africa, Malawi 7-18 years; Kenya - all school-going children including tertiary education.

During COVID-19 a significant proportion of women and men indicated that the time they spent on teaching children increased. Four out of ten women and men in Ethiopia, Mozambique and South Africa indicated that the time they spent on teaching children increased. In Kenya the ratios of respondents who said they have been spending more time on teaching children during COVID-19 were close to five in ten and Malawi three in ten.

7.4 Potential impacts of the school closures and pandemic on girls and boys

Even though COVID-19 and school closures impact on girls and boys, there are very specific impacts that primarily affect girls and many of these can have far-reaching consequences well into their futures. Figure 41, as developed by CGD, summarizes these potential impacts as well as their interlinkages.

As was seen in the introduction, a third or more children and adolescents of primary and lower secondary school age were out of school in Djibouti, Eritrea, South-Sudan and the United Republic of Tanzania even before the onset of the pandemic. Concerns about the potential impact of the pandemic on deepening the crises in the sub-region around girls and boys of school going age that were not attending school are justified and likely to increase as school closures negatively impact on continuity and motivation levels. Furthermore, increased economic hardships of households may lead to more pressure on adolescents to find work,¹⁴³ rather than return to school during the post-COVID-19 recovery phase. The most vulnerable groups in the sub-region are likely to be rural girls and boys from the poorest income quintiles.¹⁴¹ Prior to the pandemic, at least eight countries¹⁴² had primary school completion rates of below 50% for the poorest quintiles of children (both girls and boys) living in rural areas.

The COVID-19 pandemic, with associated school closures and movement restrictions has created additional problems for especially vulnerable children, e.g. children who are poor or have disabilities, and girls. For many, accessing school and staying in school is difficult even under normal circumstances, but the likelihood that they will be continuing their education post-pandemic has reduced even further.¹⁴³ For girl children the safety risks revolve around domestic violence, sexual exploitation,¹⁴⁹ early marriage, and female genital mutilation.¹⁴⁴ COVID-19 may have provided opportunities for these practices to be re-enforced,¹⁴⁵ contributing towards psychological and health problems and gender discrimination. Appropriate gender-sensitive responses are needed to mitigate these problems and reduce the potential compounding impact of the pandemic on the existing educational challenges on the continent.

141 The COVID-19 Pandemic Impact on Kenyan Education Sector Learner Challenges and Mitigations. George Areba.

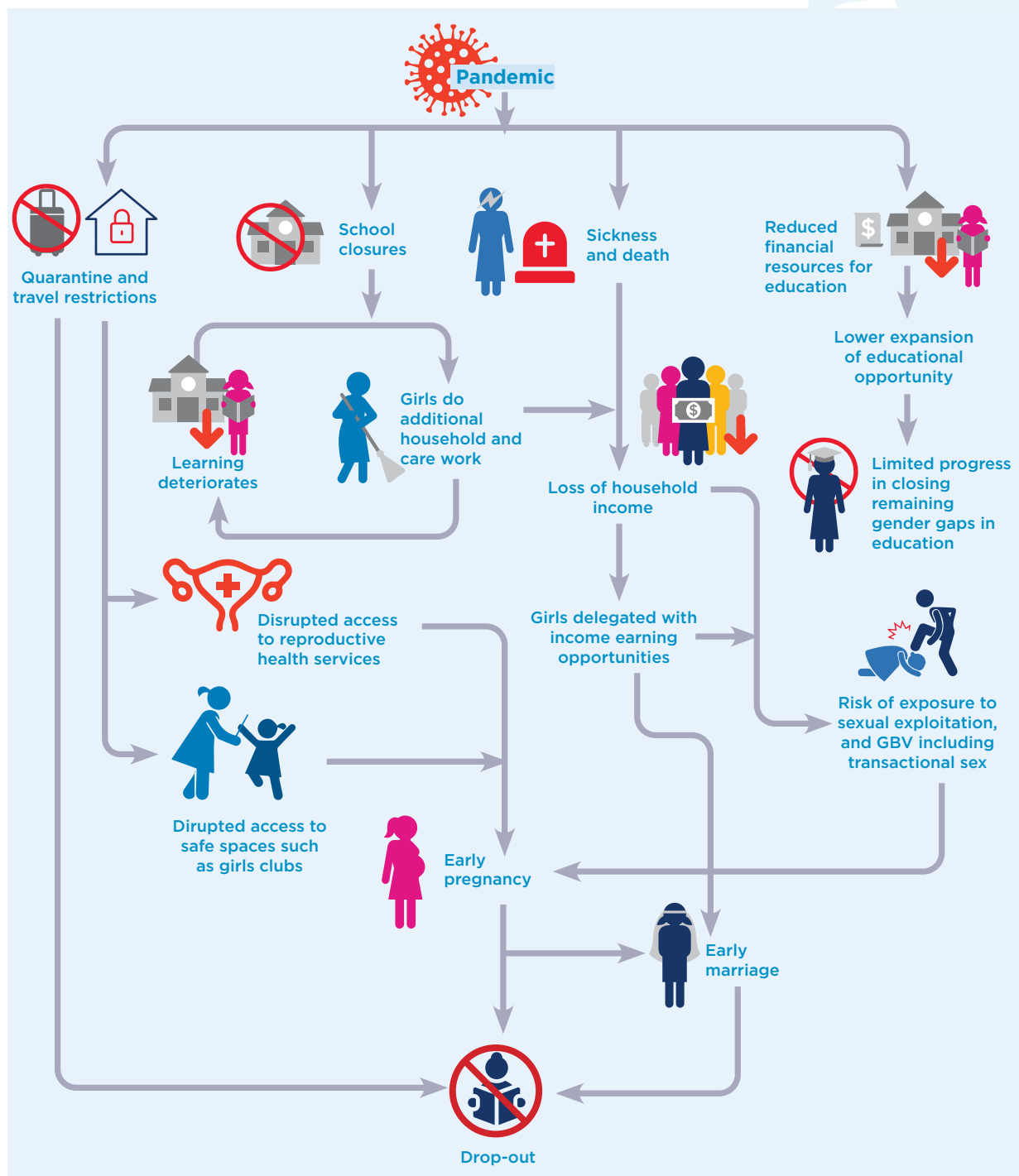
142 Madagascar, Uganda, Ethiopia, Malawi, Burundi, Rwanda, Zambia and Sudan.

143 World Vision International. Available from https://www.wvi.org/sites/default/files/2020-08/Covid19%20Aftershocks_Access%20Denied_small.pdf. Accessed October 2020.

144 Girls at greatest risk as COVID-19 threatens to leave a generation of African children behind, Relief Web, 2020.

145 ADEA. Available from http://www.adeanet.org/sites/default/files/report_summary_covid-19_impact.pdf. Accessed October 2020.

Figure 41: Potential impacts of the pandemic on girls' education



Source: Reproduced and adapted from Centre for Global Development October 2020.¹⁴⁶

¹⁴⁶ Centre for Global Development, Available from <https://www.cgdev.org/blog/covid-19-and-girls-education-what-we-know-so-far-and-what-we-expect-happen>. Accessed October 2020.

A multiplicity of factors associated with the pandemic has increased the risk for girls to engage in risky sexual behaviour, as well as to become victims of sexual violence and exploitation. School closures during the pandemic resulted in girls spending more time with boys and adult men, often in confined spaces. Some sources suggest that girls visiting their friends are harassed by the friends' fathers and uncles.¹⁴⁷ Limited social and reproductive healthcare services, child marriage, well-being and risks and increased poverty and insecurity further acerbates these risks and vulnerabilities of particularly girls.¹⁴⁸

A lack of time and sometimes skills on the part of parents and guardians to tutor at home, create difficulties for both girls and boys; however, boys seem to be able to access assistance from teachers easier than girls. Examples are available of older girl students, needing tuition finding it difficult to go to a male teacher's home for assistance, whereas boys do not face social sanction or such great risk, and many would rather desist than go.¹⁴⁹ Girls are often expected to take on childcare responsibilities and household chores and have to act as teachers for the younger children.¹⁴⁹ The time use findings of the rapid gender assessments done by UN Women in the sub-region suggest that girls have been more likely than boys to assist adults with unpaid domestic and care work during the pandemic (Also see Section 6 in the report).

147 Human Rights Watch. Available from https://www.hrw.org/sites/default/files/media_2020/08/Discussion%20Paper%20-%20Covid%20for%20ACERWC.pdf. Accessed October 2020.

148 World Vision International. Available from https://www.wvi.org/sites/default/files/2020-08/Covid19%20Aftershocks_Access%20Denied_small.pdf. Accessed October 2020.

8. HEALTH SERVICES



8.1 Introduction

In this section, general access to healthcare prior to and during the pandemic is discussed. Special attention is paid to family planning, share of live births, share of births attended by skilled attendants, share of C-sections and access to birth control as well as maternal, neonatal and under-5 mortality trends.

According to the UNFPA,¹⁴⁹ the key population groups in the ESA sub-region included 16 million pregnant women, 151 million women of reproductive age, 199 million young people (aged 10–24) and 19 million older persons (aged 65+) in August 2020. Sexual and reproductive health is therefore of utmost importance in the sub-region and any disruptions of such services will have far-reaching consequences.

8.2 Health and health-seeking behaviour

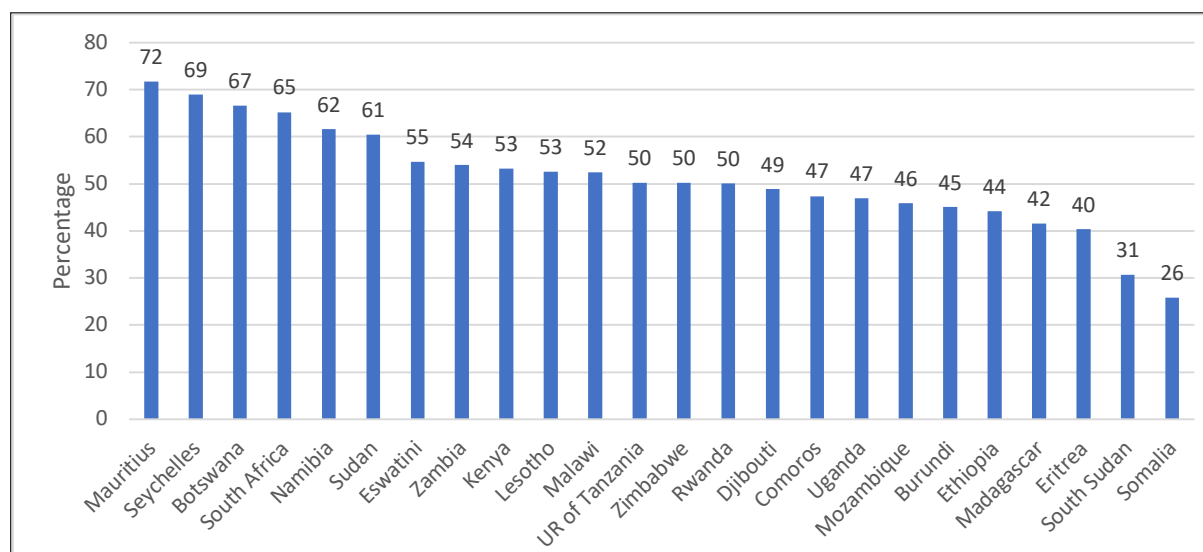
The COVID-19 pandemic has put additional strain on healthcare services throughout the world. One of the reasons why governments in East and Southern Africa introduced rapid and drastic measures to limit the spread of the virus was because of fears that it will completely overwhelm already fragile healthcare services in the region. During the early months of lockdown, many governments focused on information and advocacy campaigns to educate the population about the risk and preventative measures that need to be applied to reduce the risk of infection. The findings of the CATI COVID-19 RGAs carried out in ESA suggest that more than 75% of women and men in Ethiopia, Kenya, Malawi and Mozambique got their information about COVID-19 from radio/television/newspapers. Most of the other information sources such as the internet and social media were used by less than 5% of the population. Exceptions are in Kenya where 8.3% of women and 9.3% of men used the internet and social media as their main source of information. In South Africa the information source profile was quite different from the other countries included in the survey. The internet and social media were the main sources for 23.5% of women and 25.8% of men, while 39.3% of women and 37.8% of men considered the radio/television and newspaper their main source of information about the pandemic.

Universal health coverage remains quite low in many countries of the sub-region, especially in East Africa.¹⁵⁰ Figure 42 provides the summary measure of coverage of essential health services, which is computed for each country by averaging service-coverage values across 16 trace indicators on reproductive, maternal, new-born and child health, infectious disease, non-communicable diseases, service capacity, access and health security. According to this composite measurement, the middle-income countries in Southern Africa (except Lesotho) as well as Mauritius, Seychelles and Sudan have values above 60 on a scale of 0–100. At the other end of the scale, Somalia and South Sudan have values between 25–30.

¹⁴⁹ UNFPA (2020) East and Southern Africa Region. COVID-19 Situation Report No. 8.

¹⁵⁰ UN Women (2020) Africa SDG Index and Dashboards Report 2019.

Figure 42: Coverage of essential health services (trace indicators), 2020



Source: UNFPA (2020) East and Southern Africa region. COVID-19 Situation Report No 8.

According to the CATI COVID-19 rapid gender assessment¹⁵¹ in Ethiopia, only 18.2% of households were currently covered by public or private health insurance, with men twice more likely to access a national insurance. In Kenya 49.2% of the households had a national health insurance and the remainder (50.8%) a private insurance, with men again somewhat more likely to access a national insurance, probably reflecting their larger share in formal labour force.

An assessment¹⁵² of the Southern Africa Development Community's (SADC) regional response to the COVID-19 pandemic revealed that almost invariably all responding member states (16) had reported on average a disruption in 50% of a set of 25 tracer services. The most commonly reported disruptions were in outreach services (70%), non-communicable diseases diagnosis and treatment (69%), family planning and contraception (68%), treatment for mental health disorders (61%), facility-based services (61%), and cancer diagnosis and treatment (55%).

In the same way, an African Union-led assessment¹⁵³ of the COVID-19 impact in 18 member countries conducted in August 2020 discovered that the secondary impacts of COVID-19 on public health service have been significant. The assessment found high support for public health services measures, such as wearing a mask, washing hands, and watching their distance from others. However, reported adherence to measures to public gatherings and limiting economic activity were much lower, which was to be expected, as many governments had loosened these measures after June 2020. According to the same assessment,¹⁵⁴ nearly *half of respondents* in need of care missed or delayed health services, and a similar percentage had problems getting access to medication. Nearly one in four attributed missed services to being worried that they will catch COVID-19, either while travelling to the facility, or directly from the health facility. Types of health services missed were non-communicable diseases (34%); general/routine check-ups (28%); communicable diseases (26%); and reproductive, maternal, new-born and child health (16%). The specific disease/conditions that the respondents missed

151 UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

152 SADC (2020) SADC Regional Response to COVID-19 Pandemic. With Focus on Health, Law Enforcement and Security; and Food, Nutrition Security and Livelihood Sectors. Bulletin No. 14.

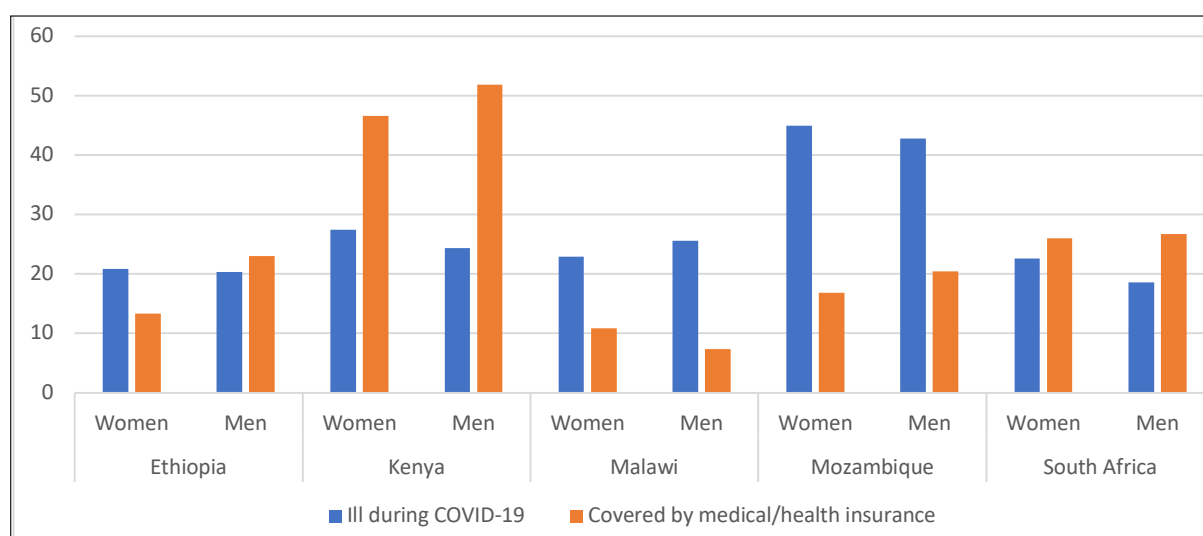
153 PERC (2020) Responding to COVID-19 in Africa: Using Data to Find a Balance. Part II.

154 Ibid.

services for were malaria (15%); cardiovascular issues (10%); diabetes (8%); antenatal care (5%); care for children under 5 years (5%); and vaccinations (4%).

According to Figure 43 women were more likely than men to be ill during the COVID-19, but more men were covered by medical/health insurance than women in all countries except Malawi. Some form of medical aid/health insurance is most prevalent in Kenya where 47% of women and 52% of men indicated that they are covered by a national health insurance, and the remainder by a private insurance. In Ethiopia, on the contrary, 87% of women and 77% of men reported not being covered by any kind of health insurance.

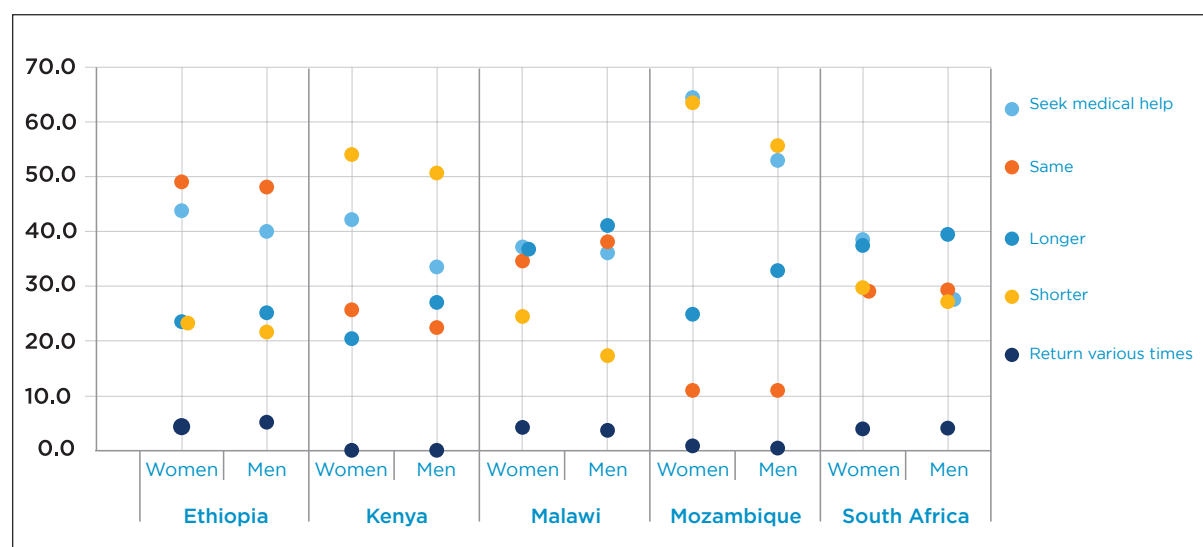
Figure 43: Percentage of respondents who were ill during the pandemic and covered by health insurance, by sex, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Except for respondents in Mozambique, less than half of the women and men who were interviewed during the CATI COVID-19 RGAs personally sought healthcare services during the reference period (March to survey date) (Figure 44). Women were more likely than men to seek medical help. In terms of the waiting times while waiting for services, experiences varied across the region. For women and men in Ethiopia, waiting times were mostly the same, while most women and men in Kenya and Mozambique spent less time waiting. In Malawi and South Africa waiting times were generally shorter. No additional information was collected on reasons for longer or shorter waiting times.

Figure 44: Percentage of women and men who sought medical help during the pandemic and waiting times compared to pre-pandemic waiting times, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

8.3 Maternal and child health

According to the WHO,¹⁵⁵ *maternal health* refers to the health of women during *pregnancy, childbirth and the postpartum period*. Maternal morbidity, which is still a risk associated with childbirth could, occur as a result of a haemorrhage, infection, high blood pressure, unsafe abortions, and obstructed labour. Increased access to safe, affordable and effective methods of contraception has provided individuals with greater choices and opportunities for responsible decision-making in reproductive matters. Increased funding in maternal health services is also a key to achieving the 2015 Millennium Development Goals, according to the WHO.

The achievement of sexual and reproductive health is also a human rights issue¹⁵⁶ and if this kind of healthcare is neglected it can negatively impact on other health outcomes such as for example infant and child mortality rates and the prevention and care of HIV.

Access to family planning is limited in many countries in East Africa due to cultural and economic reasons. Less than half of the demand for family planning was satisfied by modern methods in countries like Burundi, Djibouti, Madagascar, Mauritius, Sudan, and Uganda, whilst information is missing from many fragile countries in the region. Contraceptive use by any methods was at its lowest in 2020 in Eritrea, South Sudan and Somalia. Middle-income countries in Southern Africa were clearly better placed, with only Kenya, Malawi, Seychelles, Zambia and Zimbabwe in East Africa meeting similar level of family planning supply with modern methods. Figure 45 displays figures for all the countries in the region.

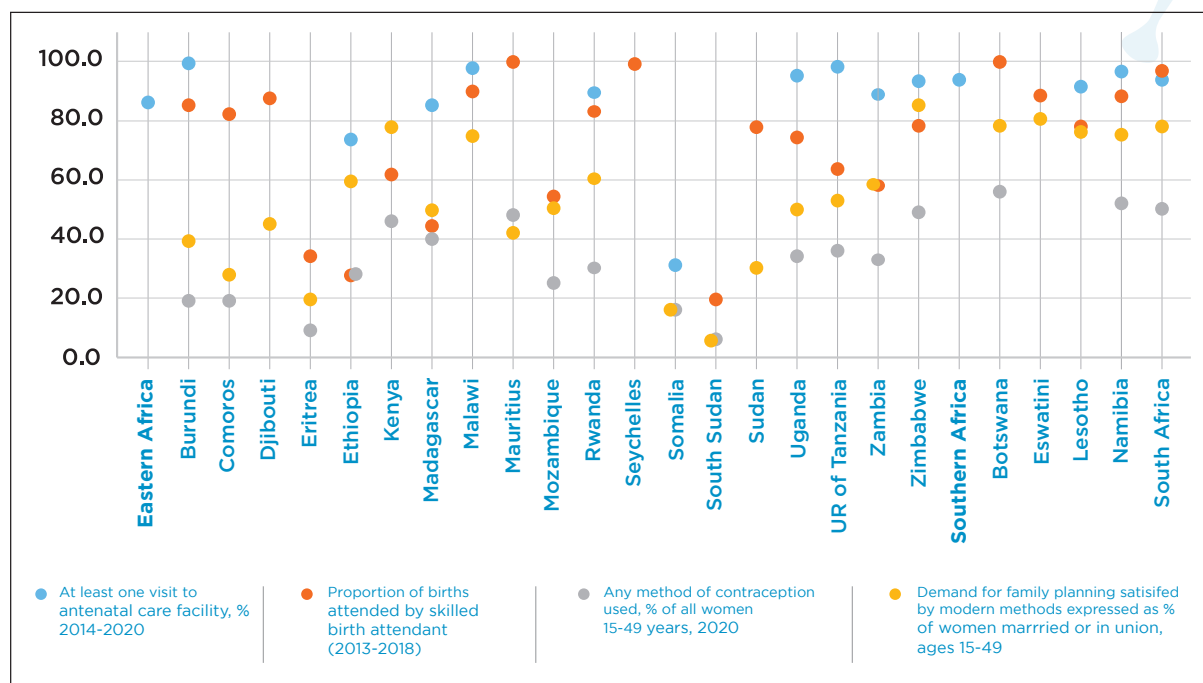
Similar patterns can be observed in the proportion of births attended by skilled health personnel, with countries like Eritrea, Ethiopia, Madagascar and South Sudan lagging clearly behind the others. In these countries less than half of the births were attended by skilled personnel in the period 2013–2018, whilst in most of Southern Africa, Mauritius, Comoros, Djibouti, Rwanda, Seychelles, Burundi and Comoros the figure was over 80%.

¹⁵⁵ WHO. afro.who.int. Accessed November 2020.

¹⁵⁶ Ibid.

The CATI COVID-19 RGAs conducted in South Africa and Mozambique found that only 19% of women tried to access family planning and reproductive health services during the reference period.

Figure 45: Reproductive health and family planning, 2020



Source: WHO. afro.who.int. Accessed November 2020

Child marriages (defined as % of women aged 20–24 who were married by age 18) remain common in several countries in East and Southern Africa. In fact, in Mozambique and South Sudan more than half of women aged 20–24 had been married before turning 18. Likewise, in Eritrea, Ethiopia, Somalia Madagascar, Malawi, more than 40% of young women in the same age group had married before turning 18. The percentage of girls aged 15–19 who were already married in 2020 was highest in Mozambique and Malawi,¹⁵⁷ but the figures were missing for many of the countries in the region. Figure 46 displays the latest figures for all the countries where such information is available.

Child marriage inevitably leads to early child births which are associated with increased health risks for both the mother and her child, lower educational attainment and poverty. The Eastern and Southern Africa sub-region has approximately 120 births per 1,000 adolescent women, which is one of the highest globally.¹⁵⁸

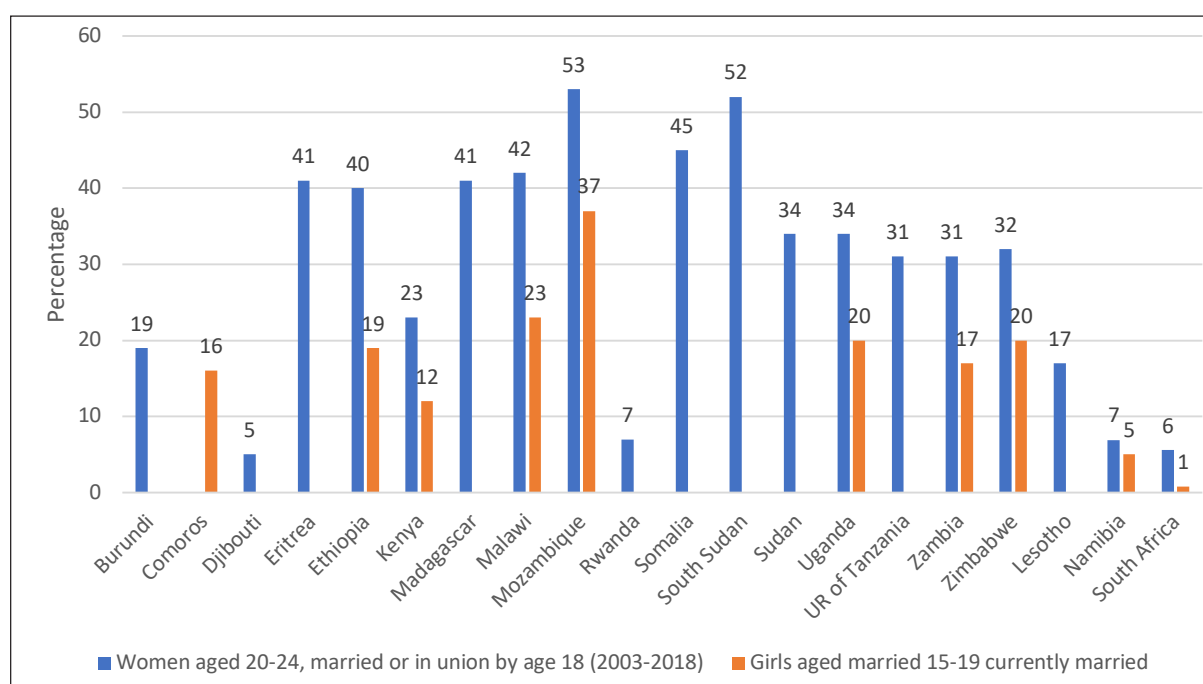
Adolescent fertility rates have remained high also in most of the countries in East and Southern Africa where more than half of the women in the age group 15–19 had given birth in 2011–2016.¹⁵⁹ In some of the countries, notably in Madagascar, Malawi, Mozambique, Somalia, Uganda, Tanzania, and Zimbabwe, there had been already multiple births in the same age group. Only in Djibouti, Mauritius, Rwanda and Botswana had less than one-third of women below 19 giving birth.

157 UNFPA. unfpa.org/data/dashboard/adolescent-youth (accessed in December 2020).

158 Ibid.

159 UN Women. UNWomen.org/data (accessed in November 2020).

Figure 46: Child marriages (SDG 5.3.1), most recently available date



Source: unfpa.org. data/dashboard/adolescent-youth (accessed in December 2020)


The impact of COVID-19 on child marriages and family planning

It is against this backdrop that UNFPA¹⁶⁰ expects the impact of COVID-19 pandemic on *ending child marriage* to be very negative. The COVID-19 pandemic is feared to have disrupted existing and planned efforts to end child marriage and with wide-reaching consequences. *UNFPA estimates that these factors will lead to an increase of 13 million child marriages between 2020 and 2030.* This is not only due to economic hardships, often forcing parents to agree to child marriages for financial gain, but also school closures which contributed towards early forced or consensual sexual activity (also see the education section). Limitations caused by the COVID-19 pandemic to access to family planning and safe abortions services could have similar impacts.

According to a recent UNFPA-UNICEF¹⁶¹ study, COVID-19 has already adversely affected programmes to end child marriages and its impact in countries characterised by extreme poverty and fragile health, social welfare and governance systems has not yet been determined. The Global Programme to End Child Marriage (GPECM) was designed around a package of evidence-based interventions designed to reduce child marriage. In all the four countries in ESA – Ethiopia, Mozambique, Uganda and Zambia – that are implementing GPECM, there is some evidence that adolescent girls have been experiencing more violence, child marriage and teenage pregnancies. These have been driven especially by school closures and limited access to sexual and reproductive health services. For example, in Mozambique, calls to the Child Helpline showed that children made 16,244 calls from January to April 2020, doubling the number of calls during the same period in 2019. Child marriage, abuse and neglect, and school-related problems were among the reasons children called the helpline.

¹⁶⁰ UNFPA (2020). Interim Technical Note, 27.04.2020.

¹⁶¹ UNFPA - UNICEF (2020) Child Marriage in COVID-19 contexts: Disruptions, Alternative Approaches and Building Programming Resilience.



UNFPA (2020) estimates that some *47 million women in 114 low- and middle-income countries will not be able to use modern contraceptives* where lockdowns continue for six months or more. The number of unintended pregnancies is therefore projected to increase in lockdown situations and if service disruptions are extended. According to UNFPA,¹⁶² a number of reasons including lack of time from staff occupied with the COVID-19 response; closing down or limited services in health facilities; women limiting or refraining their visits to health facilities due to COVID-19; supply changes disruptions in availability of contraceptives; product shortages; and lack of access to trained providers or clinics are reportedly contributing to disruptions in meeting family planning needs due to the emergence of COVID-19.

Whilst children appear largely spared from the direct health and mortality impacts of COVID-19, UNICEF estimates that the indirect effects stemming from strained health systems and disruptions in life saving health services – immunization and antenatal care in particular – could lead to devastating increases in child deaths.¹⁶³ Additional maternal and child deaths have been attributed by a recent study¹⁶⁴ to indirect effects of the COVID-19 pandemic. The estimates vary between the low scenario of 8.3% (24,400) to high 38.6% (113,400) additional maternal deaths in low-income and middle-income countries. As for the projected additional child deaths, the estimates vary between 9.8% (506,900 additional child deaths) to the high scenario of 44.7% or a staggering 2,313,900 additional child deaths. These scenarios are based on coverage reductions in family planning services, antenatal, childbirth and postnatal care services, and early child vaccination, preventive and curative services.

Overall figures for the *maternal mortality rates* (Figure 47) in sub-Saharan Africa remain highest in the world although showing a downward trend.¹⁶⁵ From 878 maternal deaths per 100,000 live births in 2000, the figure had dropped to 542 by 2017. The African sub-region also has large intraregional disparities in terms of coverage of basic maternal health interventions like antenatal care.¹⁶⁶ Southern Africa reported almost universal coverage already in 2010, but other parts remain behind. Especially in the countries characterised by fragility and conflict – Somalia and South Sudan – the rates of maternal mortality remain very high, reflecting the impact of ongoing conflicts on women's health. In the same vein, also Burundi and Malawi, both classified as being in a fragile situation by the AfDB (in 2020) still face many challenges in improving maternal health. Access to prenatal care remains very precarious in the same countries further exacerbating problems in maternal and child health. Neonatal mortality rates (Figure 48) remain particularly high in South Sudan, Somalia and Comoros, whereas the highest under-5 mortality is reported in Somalia, South Sudan and Eswatini.

¹⁶² UNFPA (2020). Interim Technical Note, 27.04.2020.

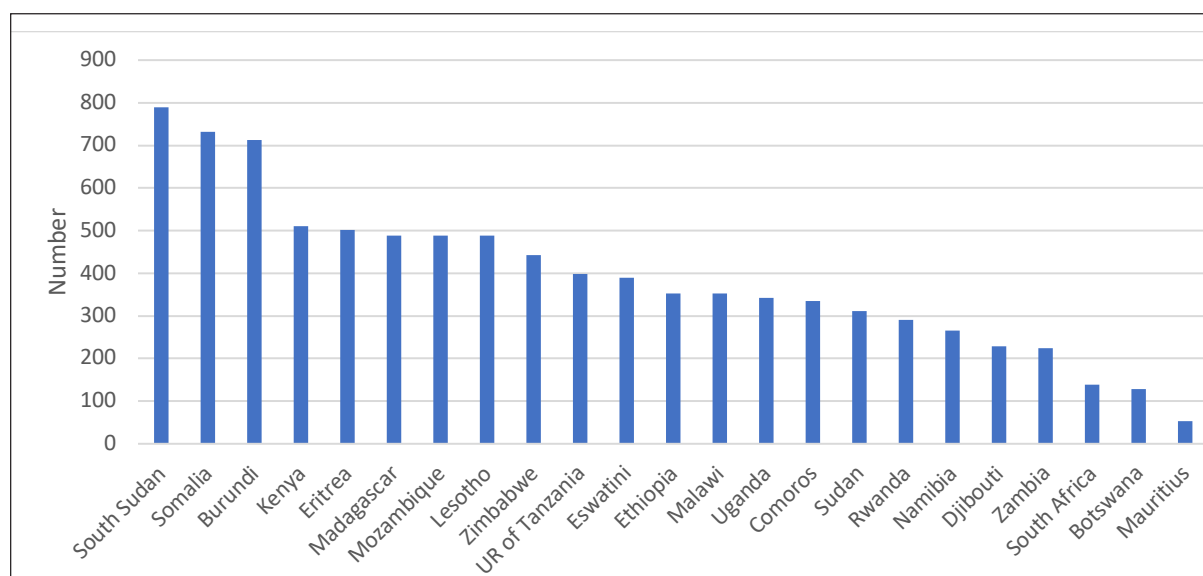
¹⁶³ Robertson et al. (2020), www.unicef.org (accessed in November 2020).

¹⁶⁴ Robertson et al. (2020), Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality.

¹⁶⁵ WHO. afro.who.int. Accessed in November 2020, UN Women – Women Count – United Nations (2020) Progress on the Sustainable Development Goals. The Gender Snapshot 2020.

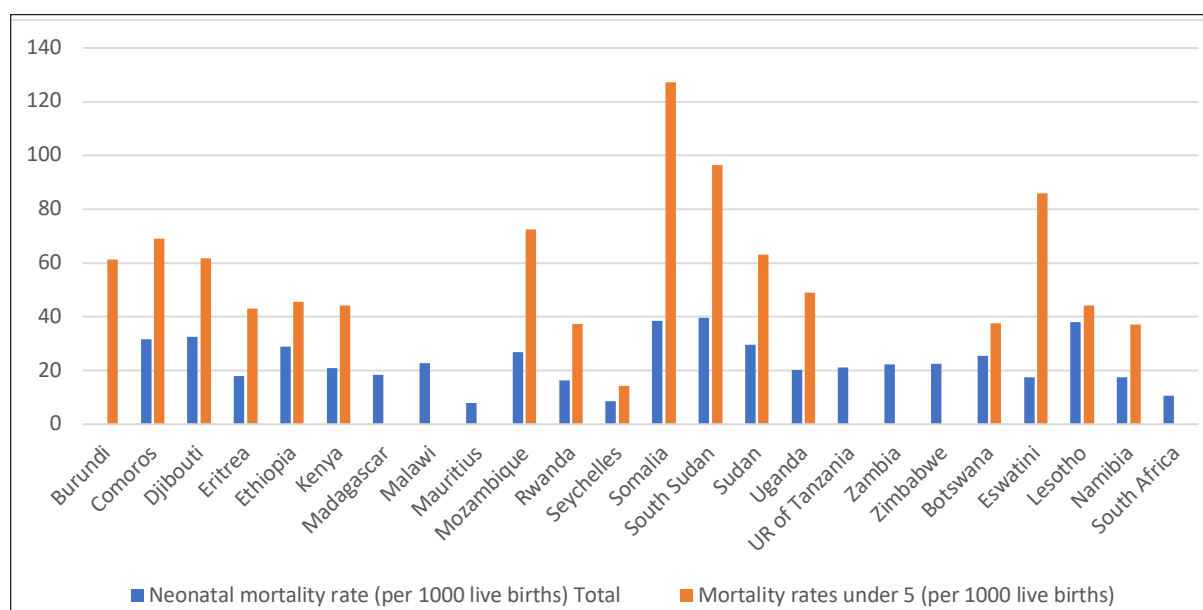
¹⁶⁶ WHO afro.who.int. Accessed in November 2020, UN Women – Women Count – United Nations (2020) Progress on the Sustainable Development Goals. The Gender Snapshot 2020.

Figure 47: Pre-COVID-19 maternal mortality rates per 100,000 live births, 2019



Source: WHO. afro.who.int. Accessed in November 2020, UN Women – Women Count – United Nations (2020) Progress on the Sustainable Development Goals. The Gender Snapshot 2020.

Figure 48: Pre-COVID-19 neonatal mortality rates and mortality rates for children under 5 years, 2019



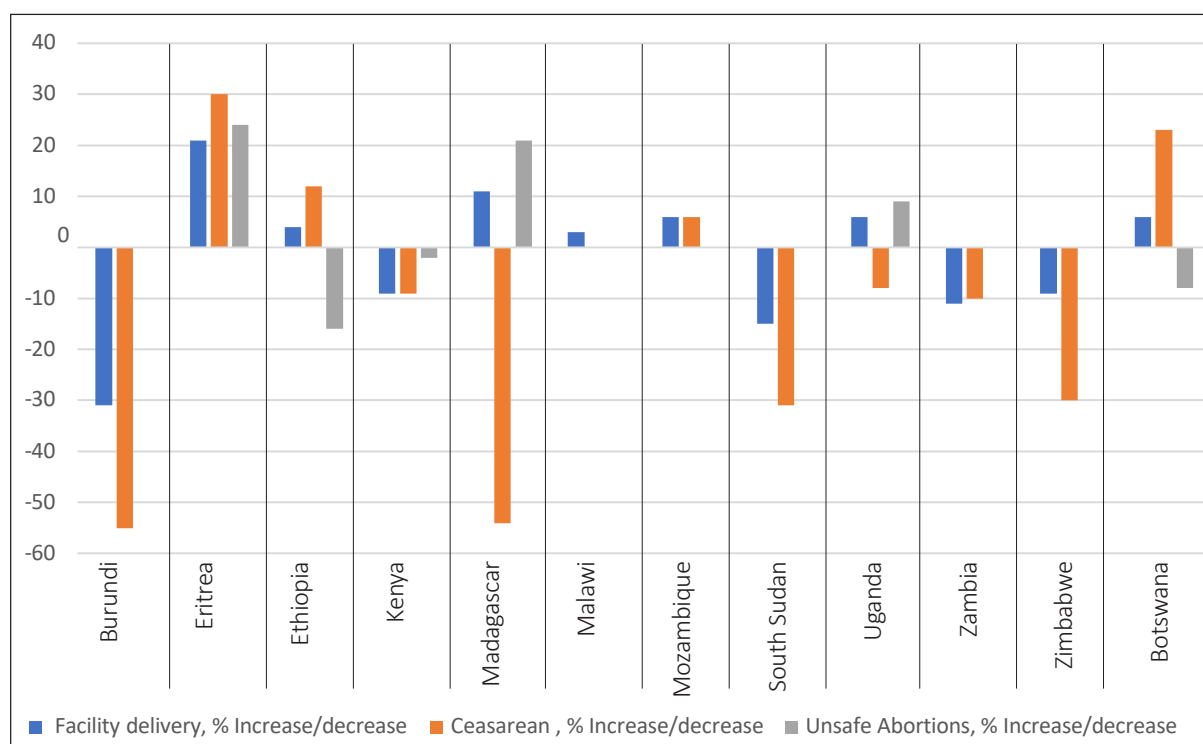
Source: WHO. afro.who.int. Accessed in November 2020, UN Women – Women Count – United Nations (2020) Progress on the Sustainable Development Goals. The Gender Snapshot 2020.

An interagency tool¹⁶⁷ for monitoring continuity of essential sexual, reproductive, maternal, child and adolescent health (SRMNCAH) has been used to analyse the situation of SRMNCAH services in 14 countries in Africa during the COVID-19 outbreak response. The analysis shows that among the most overlooked services from being included in the national essential service package are services for older persons (eight countries), ICCM (seven countries), abortion services (four countries), adolescent and youth friendly services (three countries), GBV and risk communication and community engagement (both two countries).

¹⁶⁷ World Health Organization – UNFPA – UNICEF Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa (2020).

Indicators for service disruption, comparing 2019 and 2020 data in ESA sub-region and represented by 12 countries (out of the total 14 in the study) also show some marked differences between February – April 2019 and February – April 2020.¹⁶⁸ There have been large disruptions in share of facility deliveries in Burundi, South Sudan, Kenya, Zambia and Zimbabwe compared to the previous year. Decreases in caesarean sections had been particularly large in Burundi, Madagascar, South Sudan and Zimbabwe. In the same vein, the share of unsafe abortions had increased in some countries, notably Eritrea, Madagascar, and Sudan, but decreased in Kenya, Botswana and Ethiopia. Figure 49 displays changes in essential SRH services since the onset of COVID-19.

Figure 49: Essential SRH services overlooked or disrupted in ESA since the onset of COVID-19, 2020



Source: World Health Organisation – UNFPA – UNICEF Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa (2020).

During the same time-period, i.e. after the onset of the pandemic, cases of maternal deaths had almost doubled (increase of 96%) in Kenya, 28% in Botswana, and 18% in Mozambique.¹⁶⁹ On the other hand, Burundi, Eritrea, Malawi, Madagascar Zambia and Zimbabwe reported fewer maternal deaths compared to the same time period in 2019 (which could also be due to underreporting). Likewise, stillbirths had increased with a staggering 169% in South Sudan and also in Eritrea, Ethiopia, Malawi and Kenya. New-born and under-5 deaths had also clearly increased in Eritrea, Malawi, South Sudan and Zambia.¹⁷⁰ Even though not documented or quantified, limitations in the access to safe abortions could also have an impact on maternal mortality.

These findings are confirmed by the ongoing CATI COVID-19 rapid gender assessments in East and Southern Africa.¹⁷¹ In Ethiopia and Kenya, child healthcare services, healthcare services for pregnant women, services relating to chronic illnesses, as well as family planning/sexual and

¹⁶⁸ World Health Organization – UNFPA – UNICEF Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa (2020)..

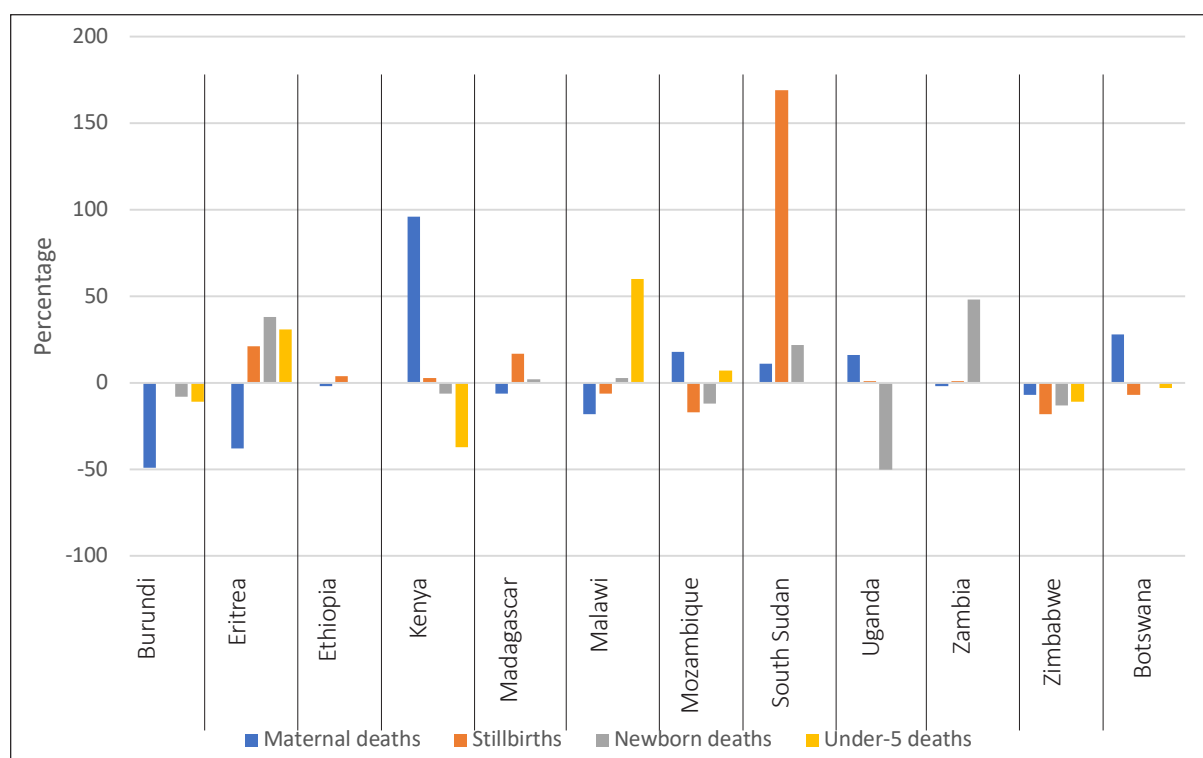
¹⁶⁹ WHO-UNFPA-UNICEF, 2getehr 4SRHR (2020) Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa. Accessed December 2020.

¹⁷⁰ Ibid.

¹⁷¹ UN Women – UNFPA (2020) CATI COVID-19 Rapid gender assessments in ESA. Unpublished Data. Accessed December 2020.

reproductive healthcare were reported to have been affected since the onset of COVID-19. The same applied to other healthcare services. For instance, in Kenya, 58% of women and 51% men who sought child healthcare services could not get it, according to the same research.¹⁷²

Figure 50: Increase/decrease in maternal deaths, stillbirths, new-born deaths and under-5 deaths since the onset of COVID-19, 2020



Source: WHO-UNFPA-UNICEF, 2getehr 4SRHR (2020) Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa (Accessed in December 2020).

An additional hardship for women and girls has been limited or lacking access to sanitary hygiene for many women in East and Southern Africa during the pandemic. Rapid gender assessments in Rwanda and Kenya¹⁷³ found that most women and girls (over 90% in Kenya, up to 32% in urban Rwanda) reported decreased or no access to some menstrual hygiene products since the onset of the pandemic due to reduced income. This decrease in access was more prominent in informal settlements within urban areas. In Kenya, the limited access among the girls from lower socio-economic groups was also due to school closures as the sanitary pads were mostly provided in schools.

8.5 COVID-19 vaccines

Since the onset of the pandemic, the development of vaccines has been a top priority for Governments and pharmaceutical companies globally. At least seven different kinds of vaccines have been developed and tested thus far and the first mass vaccination programme started in early December 2020¹⁷⁴. By February 15th 2021, 175.3 million doses of vaccine have

¹⁷² Kippra. The Kenya Institute for Public Policy Research and Analysis (2020). An Assessment of the Gendered Effects of the COVID-19 Pandemic on Households in Kenya.

¹⁷³ UN Women - UNFPA (2020) CATI COVID-19 rapid gender assessments in ESA (unpublished data. Accessed December 2020).

¹⁷⁴ WHO COVID-19 vaccines update. Available at: [https://www.who.int/news-room/q-a-detail/coronavirus-disease-\(covid-19\)-vaccines?adgroupsurvey={adgroupsurvey}&gclid=Cj0KCQiAhP2BBhDdARIsAJEzXIE_K9R-RwOU6UEfK4-Avoxyt37XLA-J7p5Q8q4ZuiJHscYLWss6DhJOaAtSgEALw_wcB](https://www.who.int/news-room/q-a-detail/coronavirus-disease-(covid-19)-vaccines?adgroupsurvey={adgroupsurvey}&gclid=Cj0KCQiAhP2BBhDdARIsAJEzXIE_K9R-RwOU6UEfK4-Avoxyt37XLA-J7p5Q8q4ZuiJHscYLWss6DhJOaAtSgEALw_wcB). Accessed February 2021.

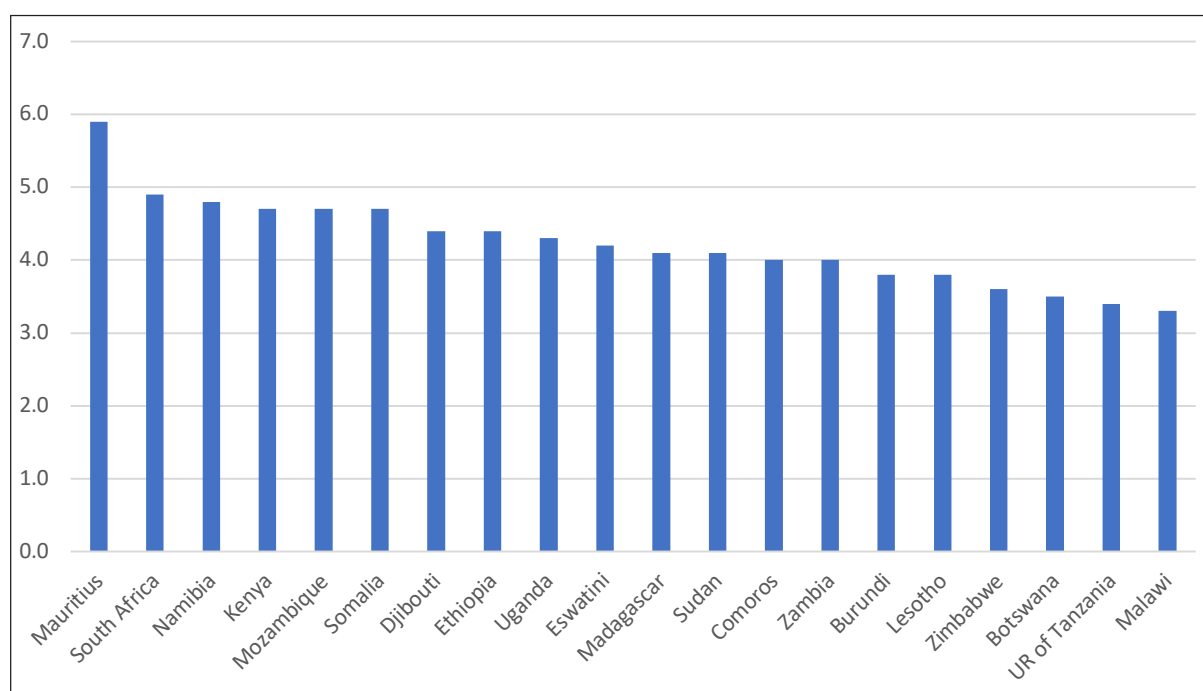
been administered. The WHO¹⁷⁵ has been working closely with partners around the world to ensure that the vaccine roll-out is done in a safe and equitable manner.

The first vaccine roll-out in Africa took place in South Africa on February 17th 2021¹⁷⁶, where healthcare workers were prioritized. This was followed by similar campaigns at the beginning of March in Ghana and Ivory Coast¹⁷⁷. Other countries in the region have also developed plans towards the acquisition and roll-out of the vaccine. Kenya¹⁷⁸ for example has a vaccine administration plan stretching into 2023.

8.6 Mental health and psychosocial problems

The COVID-19 pandemic forms a new stress factor among populations that already present relatively low levels of subjective wellbeing, according to a Gallup 2019 survey.¹⁷⁹ On a scale of 0-10, only Mauritius reported a value above five. Lowest scores – between two and three – were reported in South Sudan, Malawi and Tanzania. Figure 51 shows these values.

Figure 51: Subjective well-being per country, Index value (1-10) latest available year, 2019



Source: Gallup (2019) in UN Women (2020) Africa SDG Index and Dashboards Report 2019.

Feelings of mental and emotional strain appear to have increased in several countries due to the pandemic. These are caused by movement and social distancing restrictions as well as economic consequences. The results from CATI COVID-19 rapid gender assessments indicate that most

175 WHO COVID-19 vaccines update. Available at: [https://www.who.int/news-room/q-a-detail/coronavirus-disease-\(covid-19\)-vaccines?adgroupsurvey={adgroupsurvey}&gclid=Cj0KCQiAhP2BBhDdARIsAJEzXIE_K9R-RwOU6UEfK4-Avoxy37XLA-J7p5Q8q4ZuiJHscYLWss6DhJ0aAtSgEALw_wcB](https://www.who.int/news-room/q-a-detail/coronavirus-disease-(covid-19)-vaccines?adgroupsurvey={adgroupsurvey}&gclid=Cj0KCQiAhP2BBhDdARIsAJEzXIE_K9R-RwOU6UEfK4-Avoxy37XLA-J7p5Q8q4ZuiJHscYLWss6DhJ0aAtSgEALw_wcB). Accessed February 2021.

176 Reuters. <https://www.reuters.com/article/us-health-coronavirus-safrica/south-africa-to-give-first-covid-19-vaccine-doses-to-president-health-workers-idUSKBN2AH150>. Accessed February 2021.

177 UNICEF. Available from <https://www.unicef.org/press-releases/first-covid-19-covax-vaccine-doses-administered-africa>. Accessed February 2021.

178 The conversation. Available from <https://theconversation.com/the-ins-and-outs-of-kenyas-covid-19-vaccine-rollout-plan-156310>. Accessed February 2021.

179 Gallup (2019) in UN Women (2020) Africa SDG Index and Dashboards Report 2019.

women and men experienced increasing levels of anxiety and stress due to the epidemic. Women were more likely than men in all countries except Malawi to have experienced mental or emotional strain during the pandemic. In Ethiopia and Kenya more than 60% of women and 55–57% of men reported that their mental or emotional health (e.g. stress, anxiety, confidence, etc.) had been affected negatively since the onset of the pandemic. South African women and men nearly equally likely to experience emotional strain (approximately 50%), while in Malawi men were more likely than women to report such concerns (59% for men vs. 52% for women). Figure 52 displays these results.

Figure 52: Percentage of respondents who experienced mental strain and anxiety during the pandemic, 2020

	Women	Men
Mental health of the respondent affected		
Ethiopia	63.6	57.1
Kenya	60.0	55.7
Malawi	52.2	59.0
Mozambique	53.2	49.3
South Africa	50.5	49.2
Mental health of someone else in the household affected		
Ethiopia	62.0	56.1
Kenya	57.6	53.2
Malawi	53.1	59.1
Mozambique	45.4	42.5
South Africa	50.5	44.7

Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

The main reasons for anxiety and stress were concerns about economic and financial problems, fears of becoming infected with the Corona virus, or death and other health issues (Figure 53). These were reported by between a third and half of respondents in countries where the survey was conducted and by both men and women, with women reporting slightly higher figures. However, worries about the economic situation, income generation and access to food and medicines were also very prominent among the sources of worry. Men, more often than women, expressed worries about their economic situation.¹⁸⁰

In Ethiopia, Kenya and Mozambique, three in ten respondents in the CATI COVID-19 survey reported feeling less safe to violence or threats of violence during the pandemic than before. Whilst there were no marked differences between women and men in these three countries, women living in semi-urban areas in Ethiopia¹⁸¹ were significantly more likely (40%) than respondents in all other age and location cohorts to feel unsafe from violence or threats of violence. Men were more likely than women to have personally experienced violence or threats of violence in their communities during the pandemic. Countries where men were most likely to have experienced this were Mozambique (18.9%) and Malawi (17.2%). Experiences of discrimination were also highest in these two countries with 16.3% and 13.4% respectively.¹⁸² Feelings of safety at home



























¹⁸⁰ Gallup (2019) in UN Women (2020) Africa SDG Index and Dashboards Report 2019.

¹⁸¹ UN Women and partners (2020) CATI COVID-19 Rapid Gender Assessment in Ethiopia. Accessed November 2020.

¹⁸² UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

also deteriorated for some. In Ethiopia three in ten and in Mozambique two in ten individuals felt less safe at home during the pandemic. For more information on feelings of safety, experience of violence and discrimination please consult Table A5 in Annex II. The fact that increasing crime rates and violence were perceived as a growing problem was also mentioned by youth with disabilities in another study,¹⁸³ which will be discussed in Chapter 10.

Figure 53: Type of worries experienced by respondents by sex

	ETHIOPIA	KENYA	MALAWI	MOZAMBIQUE	SOUTH AFRICA
 Death	 Women 33	7	16	13	14
	 Men 27	7	15	11	13
 Becoming infected with COVID-19	 Women 60	48	61	38	29
	 Men 55	46	59	36	28
 Other health issues	 Women 24	4	3	12	5
	 Men 20	5	2	11	4
 Economic situation and other income related issues	 Women 47	51	42	38	28
	 Men 52	56	48	42	33
 Access to food	 Women 25	18	17	28	10
	 Men 21	13	17	26	10
 Access to medicine	 Women 24	3	4	11	3
	 Men 22	3	5	11	3
 Missing school	 Women 34	20	19	19	8
	 Men 29	14	16	14	6
 Safety	 Women 17	8	9	13	10
	 Men 18	12	7	14	10
Others	 Women 4	11	7	11	10
	 Men 4	10	7	12	10

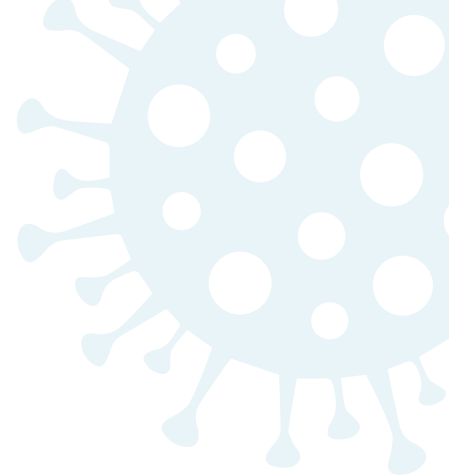
Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

183 UNFPA-CAGE (2020).

Impact of COVID-19 on alcohol consumption and smoking

Findings from the UN Women rapid gender assessment in five countries in ESA indicate that there has been some decrease in the abuse of alcohol, drug and substance abuse among household members of the respondents. In Mozambique, South Africa and Kenya, such a decrease was reported by between seven to up to almost 20% of some groups of the respondents. These decreases could be related to temporary bans in the sale of alcohol that took place in South Africa as well as decreasing incomes of most respondents or their households. In Ethiopia and Malawi, perceived changes were less significant.

9. GENDER-BASED VIOLENCE



9.1 Introduction

Gender-based violence can be defined as ‘violence directed against a person because of that person’s gender or violence that affects persons of a particular gender disproportionately’.¹⁸⁴ The *Declaration on the Elimination of Violence against Women* (A/RES/48/104) defines violence against women as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’.¹⁸⁵ This includes but is not limited to: sexual harassment, physical abuse, FGM, sexual abuse, with-holding resources, online bullying, emotional abuse, denial to communicate with others and child marriage.

GBV is driven by several factors including amongst others poverty and hunger, power imbalances in access to and control over resources, insecurity, war and conflict, blaming HIV infection on women partners, HIV related stigma and discrimination, alcohol and substance abuse, low levels of education, patriarchy, gender inequalities, harmful gender norms, etc.¹⁸⁶ The COVID-19 pandemic and the response of governments in the sub-region to the pandemic, created conditions under which many of the drivers of GBV thrived. For example, during lockdown with limitations on movement and other restrictions women and girls were often secluded with their abusers in the same location; stress and insecurity related to changed economic circumstances, increased poverty and other consequences of the pandemic; re-affirmation of patriarchal and socio-cultural values that support and encourages GBV and increased alcohol and substance abuse during and after confinement may have exacerbated the problem further.

According to UNFPA,¹⁸⁷ the COVID-19 pandemic is likely to undermine efforts to end gender-based violence through two different ways. These are, firstly, due to reduced prevention and protection efforts, social services and care, and, secondly, increasing incidence of violence.

184 European Commission. Available from https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/gender-based-violence/what-gender-based-violence_en. Accessed February 2021.

185 United Nations. Violence Against Women. Available from <https://www.un.org/womenwatch/daw/vaw/v-over-view.htm>.

186 Bukuluki et al. Perceptions of the Drivers of Sexual and Gender Based Violence in Post Conflict Northern Uganda. *International Letters of Social and Humanistic Sciences* Vol. 10 (2013) pp 84-102. Available from https://www.researchgate.net/publication/279742991_Perceptions_of_the_Drivers_of_Sexual_and_Gender_Based_Violence_in_Post_Conflict_Northern_Uganda/link/5641d93b08aeacfd8937c147/download.

Concern Worldwide. Drivers of GBV. Available from <https://www.concernusa.org/story/causes-of-gender-based-violence/>

Government of Kenya. Kenya’s response to the special rapporteur on violence against women, it’s causes and consequences. Available from <https://www.ohchr.org/Documents/Issues/Women/SR/Celebrating25Years/Kenya.pdf>.

SIDA, Gender based violence and education. Available from <https://publikationer.sida.se/contentassets/a3950e8788e-c48a78218358a0457fa63/genderbased-violence-and-education.pdf>

UNHCR. Action sheet 4. Gender-Based-Violence. Available from <https://www.unhcr.org/4794b3512.pdf>.

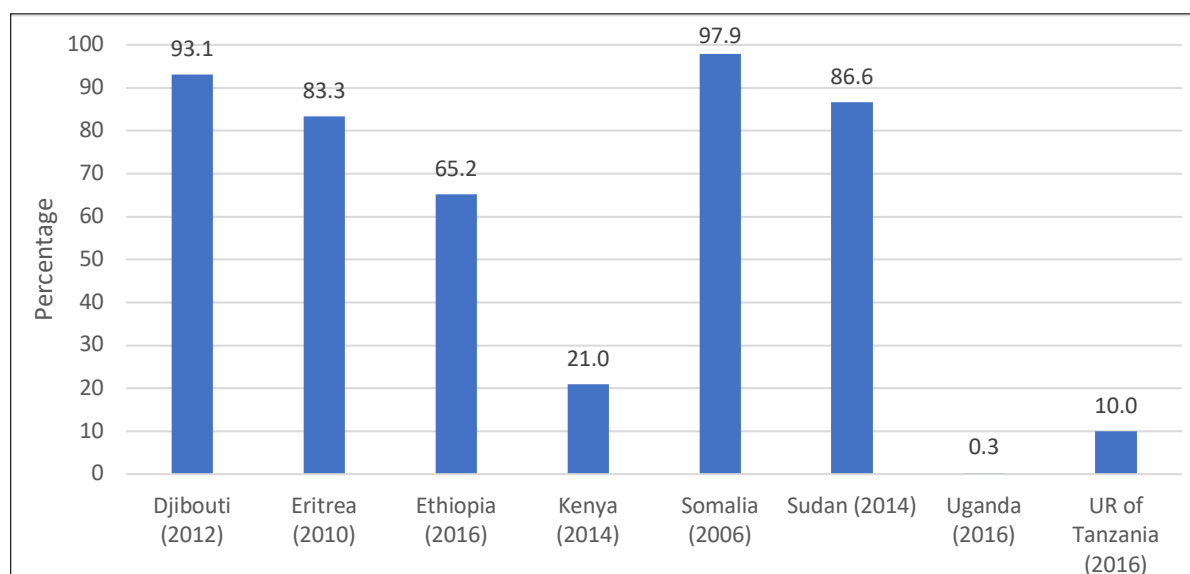
187 UNFPA (2020) Interim Technical Note, 27.04.2020.

The reduction and elimination of gender-based violence (GBV) and especially violence against women, is one of the primary focal areas of Goal 5 and the Gender Equality and Women's Empowerment (GEWE) agenda. Section 9 takes a closer look at the available evidence regarding the perceptions and attitudes towards GBV during the pandemic, as well as perceived changes in the incidence of GBV. Most of the available evidence can be gleaned from the CATI COVID-19 RGAs that were conducted in East and Southern Africa between September and December 2020.

9.2 Female genital mutilation and cutting

Female genital mutilation (FMG) and cutting remains common in some East African countries. The prevalence of FMG is a staggering 97.9% in Somalia and 93.1% in Djibouti. Even Eritrea, Sudan and Ethiopia report a very high prevalence of FMG. The tradition is not widely practiced in Southern Africa and most counties therefore do not collect data about it. Figure 54 displays the latest available figures for the region.

Figure 54: Prevalence of FGM/cutting among girls and women (% of girls and women aged 15–49) (SDG 5.3.2), latest available year



Source: UNSD SDG database, accessed December 13th 2020.

Whilst some progress has been made in the East Africa sub-region on eradicating or ending FGM, the *impact of COVID-19 on ending female genital mutilation is estimated to be negative*. According to UNFPA,¹⁸⁸ due to COVID-19 disruptions, a one-third reduction in the progress towards ending FGM by 2030 is anticipated. Due to pandemic-caused disruptions in prevention programmes, *it is to be feared that two million FGM cases could occur over the next decade*. The impact of COVID-19 on the health sector has been significant in many countries – as described in the preceding sections – and this combined with lockdown measures, has limited the availability and access of adolescents and youth to friendly SRH and GBV services, which will no doubt contribute towards an increase in FGM, teenage pregnancies and violence.¹⁸⁹

¹⁸⁸ UNFPA-UNICEF (2020). COVID-19 Disrupting DG 5.3. Eliminating Female Genital Mutilation. Technical Note. April 2020.

¹⁸⁹ UNFPA (2020) Child Marriage in COVID-19 contexts: Disruptions, alternative Approaches and Building Programme Resilience.

The CATI COVID-19 rapid gender assessments¹⁹⁰ found that when the respondents were presented with a list of types of GBV, which includes FGM, a small percentage of them knew at least one person who experienced this during the pandemic. Respondents were the most likely to know someone who has been exposed to FGM during the pandemic in Malawi (women (9.3%) and men (7.6%)) and Mozambique (women (4.0%) and men (3.4%)). The long-term impact of the pandemic on FGM is yet to be confirmed, but the preliminary findings are not encouraging.

9.3 Perceptions about GBV

Many countries in East and Southern Africa report very high rates of gender-based violence (GBV) and the preliminary reports of some countries indicate that GBV has increased during the COVID-19 pandemic. The CATI RGAs included several questions measuring the perceptions of women and men about GBV.

More than 90% of women and men in Malawi and South Africa believe that GBV is a big problem in their country (Figure 55). More than 7 out of ten women in Ethiopia, Mozambique and Uganda feel the same way. Men in Ethiopia (58%), Mozambique (70%) and Uganda (68%) were less likely than women in their countries to believe that GBV is a big problem.

Figure 55: Perceptions about the seriousness and frequency of GBV, 2020

Percentage of respondents who believe GBV is a big problem in their country		
	Women	Men
Ethiopia	71.55	57.96
Malawi	98.04	97.14
Mozambique	73.46	69.94
South Africa	94.91	93.01
Uganda	75.91	68.13
Percentage of respondents who believe GBV happens very often in their country		
	Women	Men
Ethiopia	58.19	42.53
Malawi	88.88	86.47
Mozambique	58.84	55.48
South Africa	92.85	91.2
Uganda	68.28	62.89

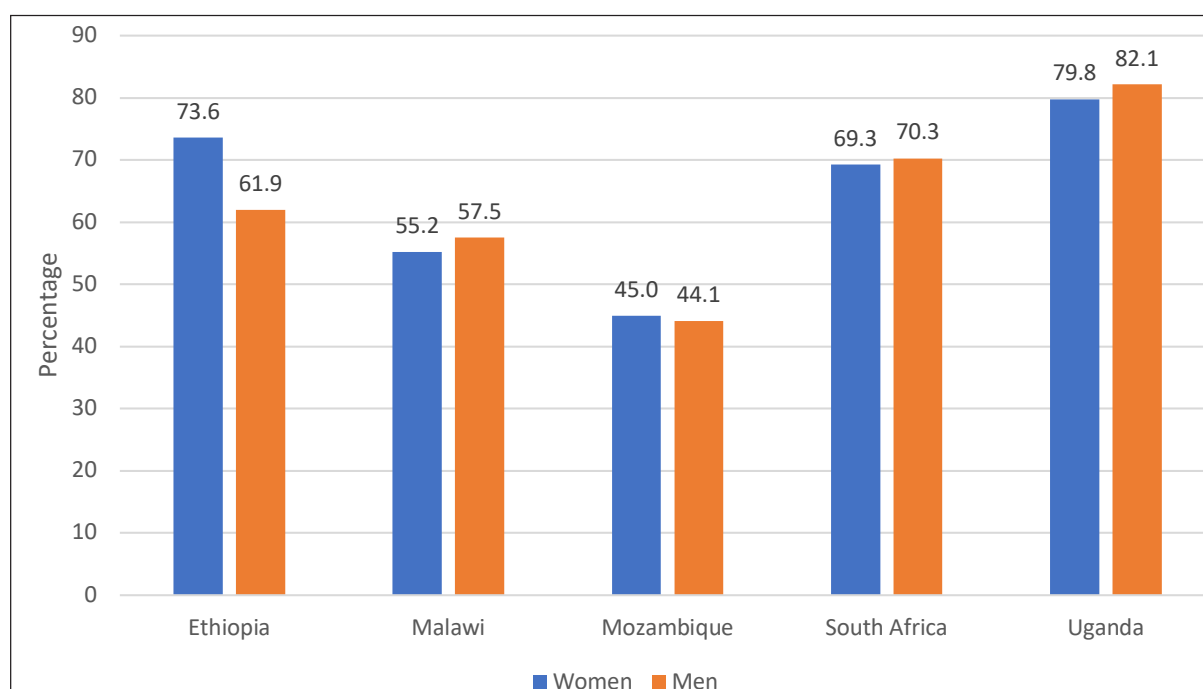
Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Also, according to CATI COVID-19 rapid gender assessments, 67% of the respondents in Ethiopia and 81% in Uganda thought that the violence had increased since the onset of the pandemic.¹⁹¹ Again, clearly women more often than men reported an increase in GBV. Likewise, a clear increase was reported in Kenya. Figure 56 displays the results in different countries.

¹⁹⁰ UN Women, UNFPA and partners (2020) CATI COVID-19 Rapid Gender Assessment, extracted from harmonized regional database.

¹⁹¹ UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

Figure 56: Percentage who believe GBV increased during COVID-19, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Moreover, in rural Uganda, using data from 1,386 women collected via mobile phones¹⁹² found a perceived increase of 0.62 times of physical violence after lockdown at village level. This increase was corroborated against the same study by a reported increase in arguments, decrease in quality of life and decrease in households' economic well-being during lockdown.

Violence against women with disabilities may be even higher than for other groups of women based on a recent mapping done in the ESA region,¹⁹³ based on existing statistics and focus group discussions and interviews with tens of associations of people with disabilities and women's associations. It is therefore important to look specifically at women and girls with disabilities in the COVID-19 induced lockdowns and the socio-economic impact of the pandemic situation (Chapter 5.9).

According to the UNFPA& MWCY 2020 research¹⁹⁴ in Ethiopia, two different cohorts of youth – those living on streets and those involved in commercial sex work – reported that *their vulnerability to violence had increased significantly during COVID-19 pandemic*. This applied in particular to physical and sexual violence and threats by police. Police brutality had been particularly exacerbated during the initial lockdowns.

192 Mahmud and Riley 2020, working paper cited in Center for Global Development (2020) CGD Note. COVID-19 and Violence against Women and Children.

193 UN Women (2020) Mapping of Discrimination Against Women and Girls with Disabilities in East and Southern Africa.

194 UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020.

9.4 Incidence of GBV

Prior to the pandemic, data on the incidence of intimate partner violence as part of SDG reporting (SDG indicator 5.2.1) was only available for 12 countries in the region.¹⁹⁵ The most recent indicator values for women aged 15–49 who have ever been victim of intimate partner violence are:

- Burundi (2016–2017) – 27.9%
- Ethiopia (2016) – 19.8%
- Kenya (2014) – 25.5%
- Malawi (2015–2016) – 24.3%
- Namibia (2013) – 20.2%
- Rwanda (2015) – 20.7%
- Zimbabwe (2015) – 19.9%
- Uganda (2016) – 29.9%
- United Republic of Tanzania (2016) – 29.6%
- Zambia (2014) – 26.7%

Even though no GBV prevalence data based on large sample surveys during COVID-19 is available in the region, data from CSOs and police records give an indication of the extent of the problem, but also how it changed during various phases of lockdown. Early data from UNFPA¹⁹⁶ on the impact of COVID-19 on GBV during the pandemic shows that there was a 775% increase in calls to national hotline pre-/post-COVID-19 in Kenya. In South Sudan, a 72% increase in reported cases in protection monitoring in May 2020 compared to January 2020. In addition, in Zimbabwe, 90% of calls to national hotlines were related to intimate partner violence between March 30th and May 30th, 2020. In South Africa,¹⁹⁷ a dramatic decrease in the levels of reported GBV-related cases was seen in the initial stages of the lockdown from 27th March to 31st May 2020. According to the police, the decrease in various categories of violent crime was well above 70% during lockdown compared to a similar period in 2019. This is attributed to the heightened visibility of law enforcement agents and the prohibition of liquor. At the same time, data from the civil society helplines showed a 67% increase in GBV related calls between late March and early April, as compared to the same period in 2019. Furthermore, as the levels of lockdown decreased, this was accompanied by increased levels of reported violence and crime overall, including gender-based violence. Between July and September 2020, data points to a steady increase in the number of reported rapes. In 20 of the 30 top stations for cases of sexual assault, there was an increase, as compared to the previous year.

The RGA also included questions about the incidence of GBV. However, given the risks associated with CATI surveys and repeated victimization if the perpetrator hears responses to the CATI interview or hear about the survey in another way, it was decided to restrict questions on specific types of GBV to a format that asks whether the respondents know someone who has been a victim of GBV. The follow-up questions were also phrased in such

¹⁹⁵ UNSD. SDG Indicator database. Available from <https://unstats.un.org/sdgs/indicators/database/>. Accessed February 2021

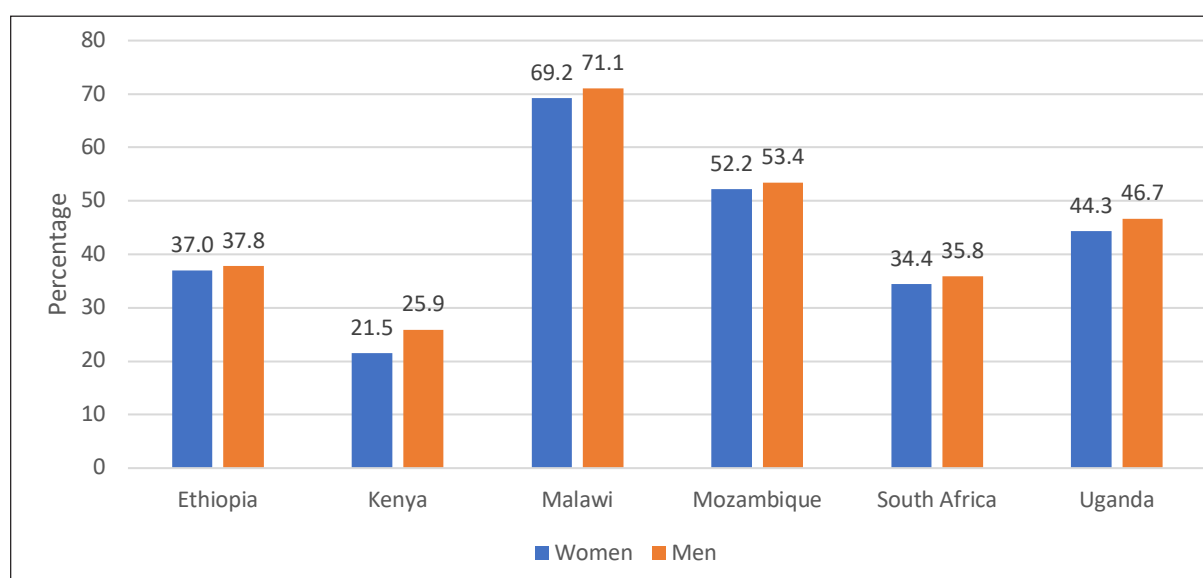
¹⁹⁶ UNFPA (2020) Gender-Based Violence AoR - Global Protection Cluster East and Southern Africa: Regional GBV Trends in East and Southern Africa during the COVID 19 pandemic, June 2020.

¹⁹⁷ UN in South Africa – Department of Women, Youth and People with Disabilities (2020) The Shape of the Shadow. COVID and Gender-based Violence in South Africa. December 2020.

a way that only yes/no responses were possible. Furthermore, enumerators were sensitized during training to identify warning signs of repeat victimization and they were provided with information for referral to a local helpline if needed.

In South Africa and Ethiopia about a third of women and men personally knew at least one person who has been a victim of GBV during the pandemic. In Mozambique, 5 in 10 and in Malawi, 7 in 10 respondents knew at least one victim of GBV.

Figure 57: Percentage of respondents who personally know someone who has experienced at least one kind of GBV since the onset of COVID-19, 2020

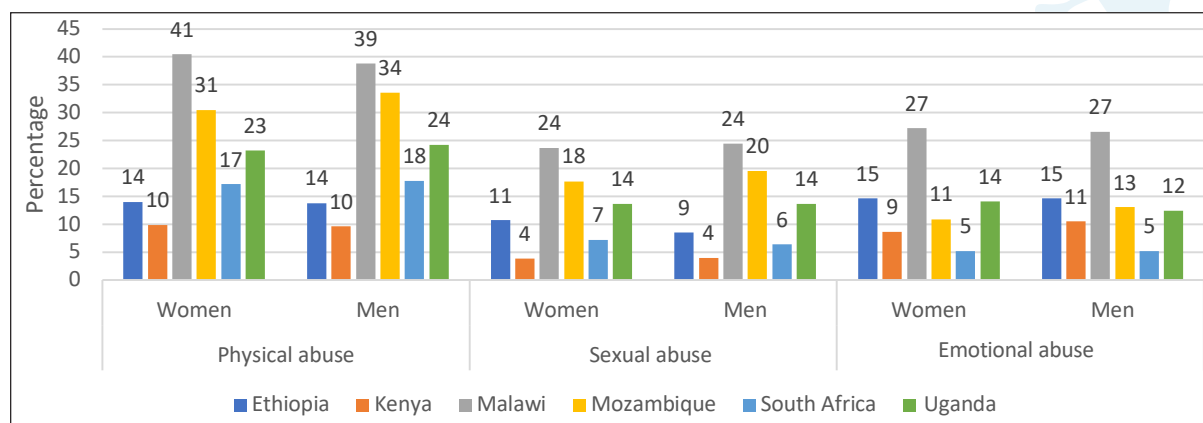


Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Men were slightly more likely than women to report in the CATI COVID-19 RGAs that they know at least one person who was a victim of GBV during COVID-19. Differences between men and women varied between 4.4 percentage points in Kenya and 2.4 percentage points in Uganda to the smallest difference which was found in Ethiopia at 0.8 percentage points. Women and men in Malawi (69.2% and 71.1%, respectively) and Mozambique (52.2% and 53.4%, respectively) were more likely than their counterparts in other countries to know at least one person who is a victim of GBV. In Malawi this is primarily due to high incidences of child marriage, sexual harassment and physical abuse, whilst in Mozambique the most common forms of abuse known of are physical abuse, forbidding someone to talk to others and sexual abuse. Both these countries were on the lower end of the scale in terms of considering GBV a problem or thinking it occurs frequently yet these were also the two countries where the respondents were most likely to know someone who has been a victim during the pandemic.

Slightly more than a third of respondents in South Africa (34.4% women and 35.8% men) and Ethiopia (37.0% women and 37.8% men) knew at least someone who was a victim of GBV during the pandemic. With regard to the kinds of GBV most likely to be mentioned in South Africa, physical abuse and forbidding someone to talk to others were the most common, while in Ethiopia women and men were most likely to mention sexual harassment, physical and emotional abuse. The dominant forms of abuse in Kenya are emotional and physical abuse as well as sexual harassment.

Figure 58: Percentage of respondents who personally know someone who has experienced physical, sexual or emotional abuse during the pandemic, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Women and men in Uganda were most likely to mention physical and emotional abuse, as well as withholding resources. Five out of ten women and men in Malawi knows someone personally who experienced child marriage during the pandemic.

Figure 59: Percentage of women and men who personally know someone who experienced specific kinds of GBV during the pandemic, 2020¹⁹⁸

	Ethiopia	Kenya	Malawi	Mozambique	South Africa	Uganda
Sexual harassment						
Women	17.4	3.1	36.1	16.3	7.1	10.2
Men	16.5	4.7	34.5	16.0	8.3	11.3
Physical abuse						
Women	14.0	9.9	40.5	30.5	17.2	23.2
Men	13.8	9.6	38.8	33.6	17.8	24.2
FGM						
Women	2.6	1.0	9.3	4.0	1.0	1.2
Men	2.7	1.5	7.6	3.4	1.1	0.9
Sexual abuse						
Women	10.7	3.8	23.7	17.7	7.2	13.6
Men	8.5	4.0	24.4	19.6	6.4	13.6
Withholding resources						
Women	6.3	3.8	18.3	13.3	10.4	14.4
Men	5.5	4.5	21.5	12.2	9.2	14.1
Online bullying						
Women	5.5	2.1	17.8	6.9	3.7	3.1
Men	5.8	3.7	19.5	6.7	2.8	3.8
Emotional abuse						
Women	14.6	8.6	27.2	10.9	5.2	14.1
Men	14.6	10.5	26.6	13.1	5.2	12.4

¹⁹⁸ For a more detailed explanation of what was meant with each kind of GBV please consult the questionnaire in Annexure 1 where specific examples are provided under each of the main GBV types

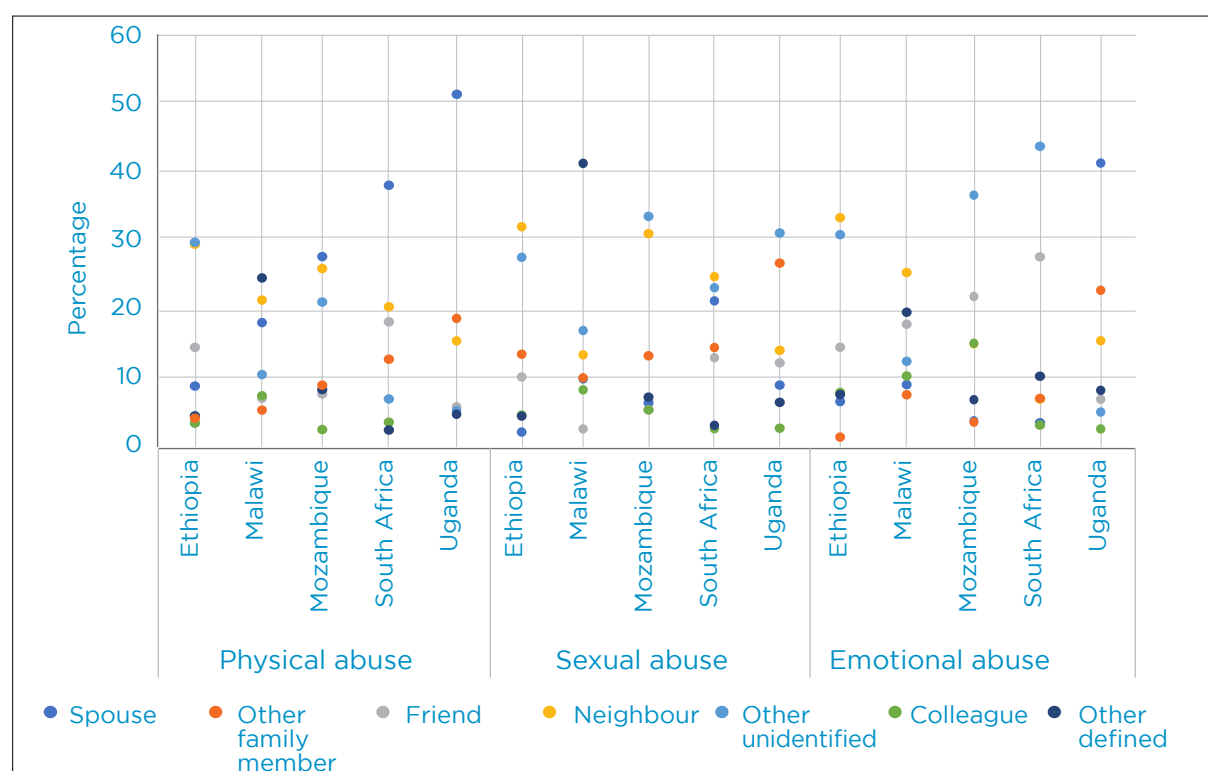
	Ethiopia	Kenya	Malawi	Mozambique	South Africa	Uganda
Denial to communicate with others						
Women	6.0	4.3	12.8	22.5	13.9	5.7
Men	4.7	2.8	11.6	21.4	15.3	4.4
Child marriage						
Women	7.8	2.9	49.4	11.9	4.7	11.8
Men	8.7	4.0	51.1	9.5	5.7	13.1

Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

9.5 Perpetrators and help-seeking behaviour around GBV

The question in the CATI COVID-19 RGAs which asked whether the respondent 'knows someone who was a victim of GBV during the pandemic', was followed by a request to identify the most recent case. Based on the most recent case some follow up questions were then asked. These were: what the identity of the perpetrator was and also whether the victim sought help after the event. Based on the cases where the identity of the perpetrator was known, GBV perpetrators during the pandemic were most often either neighbours, spouses or other family members and friends. There were some differences between responses from Ethiopia and Uganda, as well as between women and men as to the perpetrators of the most recent GBV events. Women were more likely than men to report a spouse as the perpetrator of especially physical and sexual violence. For more information on perpetrators of other kinds of GBV please refer to Table 3 in Annex II.

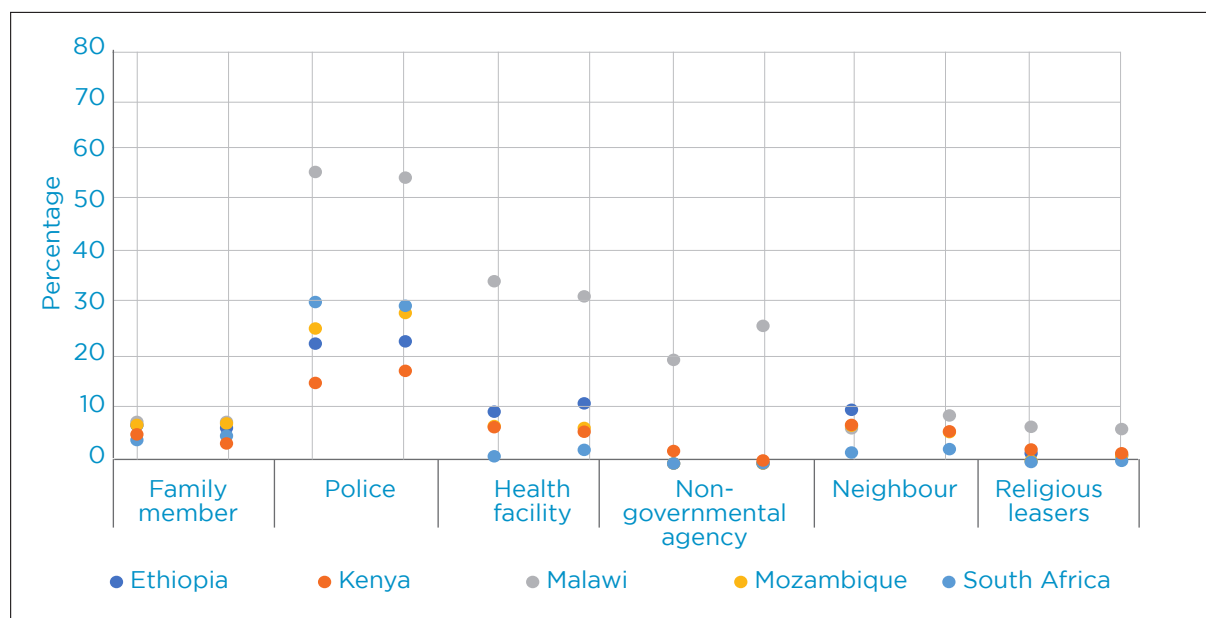
Figure 60: Perpetrators of different kinds of GBV here known to the respondent, 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020)

Figure 61 summarizes the most common support services used by survivors of Gender Based Violence. The first point of call in most countries was the police. This is closely followed by health facilities and family members. In Malawi, victims are more likely than in any other country to go to the police, health facilities and non-governmental agencies. For more information on support services used by survivors of other kinds of GBV please refer to Table 4 in Annex II.

Figure 61: Most common support services used by survivors of GBV where the information is known to the respondent, by sex of the respondent 2020



Source: UN Women, UNFPA and partners Rapid Gender Assessments conducted in East and Southern Africa. Harmonized regional dataset (September to December 2020).

10. LEAVING NO ONE BEHIND

10.1 Introduction

One of the central tenets of Agenda 2030 is the principle of ‘leaving no-one behind and specifically targeting the marginalised and vulnerable in interventions. Women as a group can clearly be identified as the marginalized. However, with further disaggregation it becomes evident that within the bigger group there may be certain sub-groups that are more vulnerable than others, and by targeting those specific sub-groups of women or men, the specific interventions can be more impactful.

Section 10 covers special sub-populations of vulnerable groups and specifically looks at evidence around the impact of COVID-19 on women and young people with disabilities, persons living with HIV and women and young people involved in sex work, and street-connected and migrant youth.

10.2 Women and young people with disabilities

The above-mentioned recent mapping by UN Women maintains that discrimination against women and girls with disabilities (GWWD) characterizes all the countries in the East and Southern Africa (ESA) region. Only the level and intensity of such discrimination varies. This discrimination takes place at home, in access to education, social and health services, employment, and inheritance as well as in social relations. Fewer public buildings and modes of transport are accessible to people with disabilities (PWDs). Poverty, gender, and disability are, in many ways, interconnected rendering especially women, girls, and elderly people in the poorest countries extremely vulnerable and even in dire poverty.

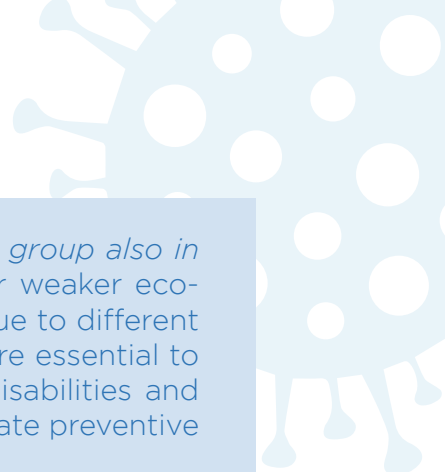
Countries seen as having a relatively higher socio-economic status, such as South Africa, Botswana, Namibia, and Kenya, also have more developed legal and regulatory frameworks and practical measures in support of persons with disabilities, including women with disabilities.

Discrimination of girls and women with disabilities starts at home and can, in extreme cases, lead to infanticide, chaining up or caging children, denying them food, or hiding them. Having a child with a disability is often seen as a ‘shame’ or a ‘curse’ and often leads to their father abandoning their mother.¹⁹⁹

Access to education is more limited for girls than boys with disabilities in all the countries in ESAR. School buildings are not always accessible, and lack of accessible and gender-disaggregated sanitation facilities adds up to the problems of girls with disabilities. Sexual abuse and forced sterilizations are not unknown in special boarding schools for children with disabilities.²⁰⁰

¹⁹⁹ UN Women (2020) Mapping of Discrimination Against Women and Girls with Disabilities in East and Southern Africa

²⁰⁰ Ibid.



Women and girls with disabilities form a particularly vulnerable group also in COVID-19 pandemic, for several reasons. These consist of their weaker economic status, lack of education, lack of access to information due to different types of disabilities as well as their limited mobility. It is therefore essential to undertake special efforts to reach women and children with disabilities and together with these groups and their associations plan appropriate preventive measures.

The probability of people with disabilities, and particularly women and girls, attending and successfully completing their education remains very low. They are thus at the highest risk of remaining illiterate than their counterparts. Weak educational background, stigma, and negative social attitudes lead WWDs to unemployment and extreme poverty, including begging and destitution.²⁰¹

Access to health services, including sexual and reproductive health, is also limited for several reasons, such as accessibility and social attitudes, towards persons with disabilities. The fact that women and girls with disabilities suffer from higher risks of sexual and gender-based violence renders considerable urgency to improving awareness, prevention and treatment of sexually transmitted diseases, including HIV/AIDS for women and girls with disabilities, as well as knowledge of their sexual and reproductive rights among healthcare givers and judiciary, including the police force.

In the same vein, people living with disabilities are more likely to report finding healthcare providers' skills inadequate to meet their needs and report being poorly treated and hence building the capacity of healthcare workers in providing quality, affordable and required services to women and girls living with a disability is essential.²⁰²

A recent study in Ethiopia²⁰³ among 154 vulnerable urban and rural youth with disabilities under the COVID-19 pandemic discovered that generally, the youth with disabilities have reasonable access to information about COVID-19 transmission and prevention mechanisms through the TV, FM radio on their mobile phones and in some cases – especially among youth that are men– the internet.

However, in terms of practice, many young people with disabilities emphasized that the COVID-19 guidance was very difficult to follow for several reasons.²⁰⁴ To these belonged the difficulties in social distancing for those with figure impairments or those in wheelchairs who typically would have to rely on community members for their mobility. Because of the fear of virus, fewer people were willing to assist them. For many respondents, economic constraints also hindered the use of soap, alcohol, sanitizers and masks and several had no running water supply. Sharing toilets formed a particular risk for people with physical or figure impairments. Poor access to water and sanitation facilities characterised the very low-cost housing where especially many migrant youths with disabilities lived. Several young people also mentioned that they were mocked for wearing masks and labelled as “cowards”.

201 UN Women (2020) Mapping of Discrimination Against Women and Girls with Disabilities in East and Southern Africa.

202 Ibid.

203 UNFPA GAGE (2020) COVID-19 Series. Ethiopia. August 2020. Experiences of vulnerable urban youth under COVID-19: the case of youth with disabilities

204 Ibid.

In terms of access to sexual and reproductive health services and supplies, many of the disabled youth in the study²⁰⁵ emphasized that they often have problems to access health facilities. These barriers had become even more exacerbated during COVID-19 due to queues outside hospitals. Key informants anticipated that adolescent girls would become more vulnerable to sexual assaults following the pandemic.

Youth included in the above-mentioned study²⁰⁶ in Ethiopia expressed a number of fears about violence on the streets, both from the police who are trying to clean the streets because of social distancing guidance, as well as from youth gangs. Some attributed growing violence at streets to increasing substance abuse due to school enclosures and loss of jobs.

A dominant theme among the youth with disabilities was, however, the psycho-emotional toll of the pandemic.²⁰⁷ Due to social distancing measures adopted in urban centres, they were experiencing a higher degree of stigma in the streets, cafes, restaurants and shops. The closure of schools and universities was also considered especially problematic for youth with disabilities, as these had been places where they had been able to socialise on regular basis before the pandemic. Some youth with disabilities received stipends prior to the pandemic and the suspension of these made youth more vulnerable and dependent on handouts from their relatives.

10.3 People living with HIV

As for the share of new HIV infections pre-COVID-19 in the region, the most affected countries remain those in Southern Africa, with Botswana (7.5/1000), Eswatini (8.0/1000) and Lesotho (9.1/1000) having the highest infection rates per 1,000 people.²⁰⁸ On the other hand, Eritrea, Ethiopia, Madagascar, Mauritius, Somalia and Sudan and Seychelles reported only around 0.1-0.2 new HIV infections per 1,000 people before the pandemic.

UN Women²⁰⁹ highlights the intersection of gender, COVID-19 and HIV/AIDS and it highlights the concern that individuals may not be able to obtain the anti-retroviral medicines used to manage their disease, due to travel and other restrictions. There is no evidence that HIV/AIDS is a risk factor for the severity of COVID-19. However, there has been increasing trade of antiretrovirals in parallel markets based on speculations that they could prevent COVID-19.²¹⁰ This could potentially reduce the supply of antiretrovirals for people with HIV. It is also estimated that there is a need *to mitigate COVID19 related disruptions in health services and supplies to prevent an additional 500,000 deaths from AIDS-related illnesses.*²¹¹

Youth living with HIV and COVID-19²¹²

Rapid virtual research from rural and urban Ethiopia indicates that youth living with HIV had detailed information about COVID-19 symptoms, transmission and protection mechanisms. They were also aware that given their compromised immunity, their HIV-positive status means that they could be at heightened risk if they contracted the COVID-19 virus. In terms

205 UNFPA GAGE (2020) COVID-19 Series. Ethiopia. August 2020. Experiences of vulnerable urban youth under COVID-19: the case of youth with disabilities

206 Ibid.

207 Ibid.

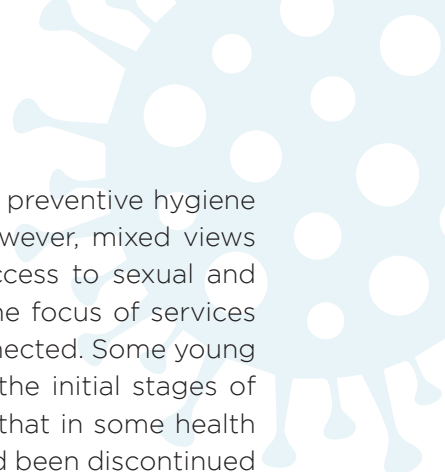
208 UN Women (2020) Africa SDG Index and Dashboards Report 2019.

209 UN Women (2020) Spotlight on Gender, COVID-19 and the SDGs.

210 Ibid.

211 Ibid.

212 UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020.



of practice, respondents emphasized that they were strictly adhering to preventive hygiene measures, including using masks and social distancing. There were, however, mixed views about the respondents about the impact of the pandemic on their access to sexual and reproductive health services and supplies. Key informants noted that the focus of services was on those HIV-infected youth who were also destitute and street-connected. Some young respondents had struggled to access their antiretroviral medication in the initial stages of the pandemic, but that had been resolved over the time. Others noted that in some health facilities and NGO free services and trainings for HIV-positive patients had been discontinued during the pandemic.

Vulnerability to violence within the home and in the community was raised as a concern among only a minority of respondents living with HIV.²¹³ Given the virtual interview methodology, this could represent underreporting. At the community level, there were concerns about decreasing safety on streets as violent crime was reportedly escalating. The main concern among these Ethiopian young people living with HIV was, however, the psychosocial impacts of the pandemic. *This was in particular as the respondents perceived their heightened risk should they become infected with COVID-19.* Likewise, they keenly felt the absence of youth support groups and counselling that had played a key role in their lives prior to the pandemic.

10.4 Women and young people involved in sex work, and street-connected and migrant youth

According to a very recent UNFPA²¹⁴ scoping assessment in East and Southern Africa, the COVID-19 pandemic has amplified pre-existing inequalities and vulnerabilities for sex workers in the region. The impact on livelihoods, human rights and health has been devastating, leaving many struggling to survive. Respondents to the study attributed the tremendous impact of COVID-19 on sex workers – such as widespread hardships, disruption and violation of human rights – not to the pandemic itself but rather to the containment measures which governments put in place, including lockdowns, social distancing measures, curfews and quarantine measures.

During the COVID-19 pandemic, whilst health services stayed open, they reoriented their services to gear up for the anticipated rise in COVID-19 infections, reducing all but emergency health services. The study found that numerous challenges relating to healthcare were experienced by sex workers. Given the high HIV prevalence rates amongst sex workers, many of them could be a heightened risk of increased mortality. The greatest health impacts experienced by health workers were in accessing healthcare for non-COVID-19 conditions. In the UNFPA survey, 49.28% of the respondents reported that sex workers had problems in accessing health facilities, specifically, access to HIV treatment services were reported by 52.12%, access to HIV prevention services by 21.74% and access to sexual and reproductive health services by another 21.74%. In addition, stigma and discrimination – reminiscent of HIV-related stigma – in health services were reported by 11.52%. However, according to the respondents in the UNFPA study, community-based organisations led by sex workers and providing services to them have reacted swiftly and creatively.

213 UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020.

214 UNFPA (2020) A Rapid Scoping Assessment of the Impact of COVID-19 on Sex Workers' Programmes in East and Southern Africa. (Unpublished manuscript).

The Ministry of Women, Children and Youth in Ethiopia and UNFPA²¹⁵ Ethiopia report on preliminary research among *vulnerable urban youth under COVID-19*. There are hundreds of thousands of youths who live and work on the streets in urban Ethiopia. Of these youths, it is the adolescent girls who are often sexually exploited, and many young women engage in commercial sex work due to otherwise limited options. It is estimated that up to 600,000 children across the country are street connected and there are approximately 210,967 women sex workers in Ethiopia.²¹⁶

Emerging evidence also from Ethiopia indicates that due to the COVID-19 pandemic, resources are being diverted from routine health services, reducing already limited access of many girls and young women to sexual and reproductive health services.²¹⁷ Considerable differences have been noted between street-connected youth and those involved in commercial sex work in relation to their knowledge and practices related to COVID-19. *Adolescent girls and women engaged in commercial sex work, who had links to NGOs, had in fact better knowledge about COVID-19 than other street connected youth.*

On the other hand, many migrant youths, especially men, working on the street didn't have strong linkages to NGOs and were not accessing sexual and reproductive health services, SRH, and supplies at all. Neither were they aware of having right to such services whilst many young women involved in commercial sex work spoke of regularly availing of SRH services. *However, due to declining incomes caused by COVID-19, some women sex workers noted that their ability to negotiate with their customers about condom use was reduced which can have a negative impact on spread of HIV and other sexually transmitted diseases.* It has to be borne in mind that both samples of interviewees were very small in this study.

215 UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020.

216 FHAPCO (2020:26).

217 UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020.

11. MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

11.1 Introduction

The findings of the study suggest that besides the direct health and mortality impacts, the COVID-19 pandemic is also having significant indirect consequences in the areas of socio-economic circumstances, education, time use, healthcare and more particularly, maternal and child health. This section of the report summarizes the main findings, conclusions and recommendations of the main sections of the report.

11.2 Demography

The report found the following with regards to the key demographic indicators:

- Relatively young population in the region may have contributed towards lower than expected COVID-19 infection rates and deaths.
- Inadequate health statistics information systems such as population registers and death registration systems and the consequent inability to calculate excess deaths in all countries except South Africa need to be considered when assessing the infection and mortality rates in the sub-region.
- The long-term impact on mortality and average life expectancy in the sub-region could be negative. This is particularly true of Southern Africa which is characterised by high HIV infection rates and recent increases in life expectancy increases may slow down.
- The economic slowdown in the region may increase migration streams into countries that already had net positive migration flows prior to the pandemic i.e. Uganda, South Africa, Botswana, Djibouti and Ethiopia.
- Existing and new refugee streams could follow increased civil and political unrest as a fall out to the pandemic. Women are usually one of the most vulnerable refugee groups.

The high percentages of youth aged 15–24 that are not in education, employment or training (NEET) has prevented the realization of the demographic dividend in ESA. Women are more likely to be in this position and the pandemic with its consequences of prolonged, school closures, increased drop-out rates, early marriage and reduced employment opportunities will make it even more difficult to realise the potential of the demographic dividend.

It is recommended that:

- Very concrete action plans need to be put in place to mitigate the expected increases due to the pandemic in youth (especially women) aged 15 to 24 that are not in education or employment.
- Continued and expanded support to protect the human rights of migrants and especially the rights of women and girls.
- Expand support for gender responsive approaches towards the housing and integration of refugees into host populations.

11.3 Governance and normative frameworks

Previous disease outbreaks highlighted the importance of including a gender analysis into preparedness and response efforts to improve health interventions and promote health and gender equity goals²¹⁸. At the same time, although the full impact of the pandemic and the response measures are yet to be seen, only a minority of the response measures – be it by national governments or multilateral donors – have been gender-sensitive. It is crucial that these measures will be assessed, and lessons learnt, and best practices would be shared in anticipation of possible future pandemics or other crisis situations.

The findings of this study indicate that the gender normative frameworks – especially in some of the most fragile countries – are not robust enough to withstand the impact of pandemics and associated lockdowns. Again, resources have been diverted from maternal and child health, sexual and reproductive health, as well as services for elderly, HIV/AIDS survivors, people with disabilities and other vulnerable groups risk having negative long-term impact on women, men and children in East and Southern Africa. The fact that gender-based of violence, increase in child marriages and FGM are feared to increase show that the work done so far to counteract these can be derailed.

Women are still not adequately represented in positions of leadership both at national and regional level. The strengthening of women's positions in leadership and management will contribute toward more inclusive decision-making and gender responsive and responsive outcomes during the recovery phase as well as during future pandemics. Efforts need to continue to ensure that decision making bodies are gender balanced, make use of existing gender equality mechanisms and that institutions at national level to support decision making during the pandemic. This will be even more important than during the post COVID-19 recovery phase when it will be essential to include gender equality concerns in planning, budgeting and implementation processes. The pandemic created an opportunity to revisit existing exclusionary and discriminatory social norms and practices. Efforts to remove the barriers towards women's full participation need to continue and emphasis should be placed on increasing women and women's organizations access to public information.²¹⁹

Specific recommendations include:

- More advocacy is needed to ensure that countries adopt gender specific and gender responsive norms and frameworks during the post-COVID-19 recovery phase.

218 Lancet. www.thelancet.com Vol 395 March 14, 2020.

219 UN Women policy brief, 2020. Available from <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-covid-19-and-womens-leadership-en.pdf?la=en&vs=4409>. Accessed February 2020.

- Research is needed into the effectiveness of the COVID-19 mitigation measures as they relate to GEWE, GBV and time use. This will increase the understanding about the effectiveness of these mechanisms for possible future use.
- Even though progress has been made, more women are needed in leadership positions in Government and the private sector to ensure that planning and resources allocation during events such as the pandemic is inclusive of the particular needs of women and girls.
- There is a need for more investment in the production and use of gender data and statistics not only to understand the impact of the pandemic on women and men better, but also to monitor the implementation of recovery plans.

11.4 Socio-economic factors, livelihoods and food security

As has been discussed in the previous chapters, the challenges created by COVID-19 and other threats to food security and livelihoods in East and Southern Africa are likely to be considerable and exacerbate already existing gender and socio-economic inequalities. Pre-existing inequality in terms of gender, disability status and geography, exposure to conflicts and natural calamities like floods, locust swarms and environmental hazards, have greatly increased the vulnerability – especially of women, children, people with disabilities, IDPs and refugees – to the COVID-19 pandemic.

The main findings of the study are:

- The economic consequences of the pandemic are likely to deepen poverty in a region already characterised with high levels of extreme poverty prior to the pandemic. Women have been more likely than men to live in extreme poverty prior to the pandemic and this will continue to be so during post-COVID19 recovery.
- The Rapid Gender Assessment (RGA) findings suggest significant impacts on individual incomes of men and women as well as their household incomes. More than 60% of the respondents have either lost all their income or have experienced reduced incomes since the onset of the pandemic. Men were slightly more likely than women to report reduced incomes.
- Prior to COVID-19 women in the region were more likely than men to be unemployed and have lower labour force participation rates. If they were employed, women were also more likely to be underemployed and employed in the informal sector. Wage gaps for similar work favoured men.
- According to the RGA's, women who were economically active prior to the pandemic were more likely than men to transition into unemployment/not economically active.
- The sectors hardest hit by the pandemic were individuals who were employed by others and own account workers, while the agricultural sector did not experience serious change. In some countries such as Kenya and Mozambique workers who lost their jobs or own account work transitioned into agriculture.
- Women who were own account workers prior to the pandemic were more likely than men own account workers to still be active in the sector during the pandemic. In some countries such as for example Kenya and Mozambique respondents who lost their livelihoods in other sectors moved into the agricultural sector to mitigate their loss of income.

With regards to food security and nutrition the study found that:

- Access to land and land rights have been and continue to be a barrier for women in the agricultural sector to graduate from small-holder production to more commercial production. The findings of the RGA suggests that women and men who lost livelihoods in other sectors took refuge in agriculture during the crises.
- There has been great variability within and between countries in the region with regards to wholesale prices of staple foods during the past 12 months and most of it has to do with internal production conditions, reduced consumer demand and exchange rates. In most countries, prices have been largely stable, but in others especially in Southern Africa prices have increased.
- Both the FAO and WFP predict an increase of food aid requirements in the region due to COVID-19.
- According to the RGAs more than 80% of respondents in all countries except Malawi said that the prices of the food they normally buy increased during the pandemic. This coupled with reduced purchasing power does not bode well for food security.
- More than a third of producers of agricultural produce interviewed for the RGA said that the availability of seeds and other inputs to plant crops or their ability to buy inputs have decreased since the onset of COVID-19.
- Women have been more likely than men to be at risk of malnutrition prior to and during the pandemic.

The findings point universally to increases in poverty level and decreases in economic opportunities across the region. It also re-emphasizes the *need for collaboration of various actors*, be it country leaders, civil society, including women's associations, development partners, women and young people in the region, as well as regional economic organizations. These include COMESA, EAC, SADC, and the Indian Ocean Rim Association supports countries bordering the Indian Ocean and the Intergovernmental Authority on Development which covers countries in the Horn of Africa.

General macro-economic recommendations from international agencies

At a macro level various international and regional bodies have made some macro-economic recommendations for short term and post-covid-19 recovery phase. These are briefly summarized below:

IMF (2020) proposes several policy priorities as response to the COVID-19 crisis in Africa²²⁰. According to them the priority should be to firstly manage the health crisis, provide fiscal support to aid people and firms as well as ease monetary stance to support growth, and provide financial stability while ensuring adequate credit provisions.

In the same vein, the AfDB²²¹ (2020) has proposed several policy options for a COVID-19 environment and beyond. These are broadly as follows:

- Public health responses
- Fiscal policy responses (support households, cash transfer help businesses staying afloat, etc.)

220 IMF. Available from <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>. Accessed January 2021.

221 AfDB. Africa's Economic Outlook 2020. Available from https://www.afdb.org/sites/default/files/documents/publications/afdb20-04_aeo_supplement_full_report_for_web_0705.pdf. Accessed January 2021.

- Monetary policy responses (ease financial conditions, use macro-prudential and unconventional monetary policy by central banks to support the economy, etc.)
- Labour market and informal sector responses (assist vulnerable groups, especially youth and women, pursue active labour market policies to protect workers and their jobs)
- Structural reforms (accelerate structural reforms to rebuild Africa's productive base, address obstacles to formalizing the economy, rethink social protection programmes for maximum coverage)

The *World Bank recommendations*,²²² focus on *policies and investments focussing on connecting people to job opportunities, which can help end extreme poverty, particularly post-COVID-19*. Investments in the digital economy and infrastructure are also considered important to mitigate the impact of the COVID-19 pandemic and support sustainable recovery. More and more governments are adopting digital technologies, but households and businesses in sub-Saharan Africa are trailing other regions in the world. Government interventions to reduce the cost of devices and services, to avoid disconnections for lack of payment, and to increase bandwidth will therefore be key during the recovery phase.

In addition,²²³ the World Bank emphasizes that a significant proportion of the *growing youth population* in Africa lives in rural areas. Within the context of predominantly rural populations with relatively low labour productivity and limited employment and entrepreneurial opportunities, the provision of improved employment and entrepreneurial opportunities for young workers in rural areas are important. These workers are also the face of the agri-food systems of tomorrow. Skills and education mismatches continue to be most serious policy concerns as there are many young workers whose formal qualifications do not provide the actual skills demanded by employers. This is particularly true for young women in most countries in the ESA region.

The most pressing concern in the short term according to the OECD,²²⁴ is for African governments to concentrate their activities on *preventing the spread of the virus, investing in preparedness and early-detection mechanisms, and deploy emergency relief measures, notably in highly informal sectors*. They also recommend that the OECD and other major producers of medical products avoid export bans and other trade policies that fragment production and increase the costs of essential supplies for import-dependent countries. The maintenance and increase of ODA levels, and reinforcing cooperation to mobilise private capital is also deemed important. Their recommendations also include for the short term that *fiscal and monetary measures should support increased financial liquidity of SMEs, households and informal workers, especially in the most vulnerable economies, within a coordinated global response to the crisis*. The African Continental Free Trade Area (AfCFTA) implementation and national plans to liberalise goods and services should also continue. The OECD further recommends that work in the medium to long-term governments should continue to strengthen health systems and extend health and social protection coverage with the support of the international community. Regional integration and digitalisation should support the implementation of AfCFTA, including on investment, competition policy, intellectual property rights and e-commerce. These measures are considered key to reducing vulnerability to external shocks in trade and commodity prices as well as transform production and building resilience (human, society and economic) for future global crises.

²²² World Bank (2020) www.worldbank.org. Accessed January 2021.

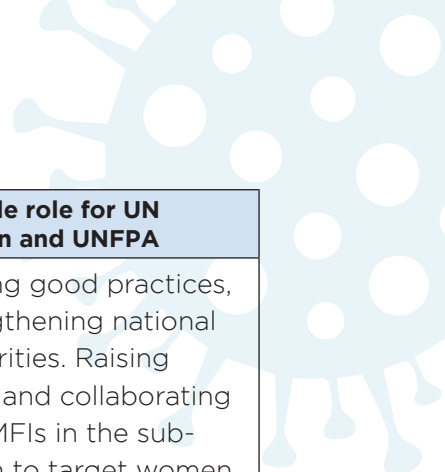
²²³ Ibid.

²²⁴ OECD (2020) COVID-19 in Africa: Regional socio-economic implications and policy priorities

Emanating from the above recommendations for larger macro-economic, fiscal and monetary responses to COVID-19 pandemic, a number of more specific gender-sensitive policy recommendations in response to the COVID-19 crisis in Africa are summarised in Table 2.

Table 2: Gender-responsive policy recommendations

Implications for gender-responsive programming	Responsible	Possible role for UN Women and UNFPA
<ul style="list-style-type: none"> Public health responses to ease women's unpaid work as primary caregivers in households will allow women to focus on productive activities. Continue to consider and plan for multiple uncertainties. Assess the gender impact of current response measures in ESA and plan for more gender-responsive approaches for future pandemics. 	National and local authorities	<p>Collect and publish results from the sub-region of the gender impact of COVID-19 and response measures, including lessons learnt and best practices.</p> <p>Strengthen the national authorities.</p>
<ul style="list-style-type: none"> Cash transfers to most vulnerable households. Continue strengthening access of women and youth to education and vocational training to reduce their vulnerability for future pandemics and other crises. 	National authorities	<p>Provide funds for national authorities.</p> <p>Share best practices and expertise.</p>
<ul style="list-style-type: none"> Safeguard livelihoods, jobs, businesses and generate the conditions needed for quick economic recovery. Execute an economic assessment towards a stimulus package that will support pandemic affected MSMEs in the form of cash, tax and non-tax or a mix. This needs to be sensitive to the unique needs of rural and urban, women, men, people with disabilities and youth. Government guarantees and subsidized loans for productive activities of women and youth. 	National authorities	<p>Share best experiences.</p> <p>Strengthen national authorities.</p>



Implications for gender-responsive programming	Responsible	Possible role for UN Women and UNFPA
<ul style="list-style-type: none"> Facilitating upgrading from informal to formal sector with promoting professional and business associations of women and tax policies, such as tax breaks or holidays in the initial stages, negotiating with entrepreneurs' associations, etc. Facilitate the access of SMMEs, also owned by women and young people to public recruitment, market information and skills and business training. Tax breaks or rebates for SMMEs. Provide women and youth-owned firms extra points in public procurement and improved access to market information. Target women, people with disabilities and youth in the informal sector of economy. Facilitate access to credits to SMMEs, ensuring that those owned by women and young people benefit. Facilitate access to financial institutes also for women. 	National authorities	Sharing good practices, strengthening national authorities. Raising funds and collaborating with MFIs in the sub-region to target women and youth.
<ul style="list-style-type: none"> Agriculture should not only be a last resort or subsistence livelihood activity for women but can be used as a vehicle out of poverty. Access to land and land rights have been and continue to be a barrier for women in the agricultural sector to graduate from small-holder production to more commercial modalities. Security land tenure rights for women needs continued attention. 	National authorities	Share best experiences. Strengthen national authorities.
<ul style="list-style-type: none"> Link women producers to markets and create opportunities for upscaling agricultural production. 	National authorities	Sharing good practices, strengthening national authorities. Raising funds and collaborating with MFIs in the sub-region to target women and youth.

11.5 Time use

The study found that prior to the pandemic women were more likely than men to be the main person in the household responsible for unpaid domestic and care work. During the pandemic both women and men experienced increases in the domestic and care work they were doing. In most countries more women than men were likely to indicate increases in unpaid domestic work, while men were as likely and sometime slightly more likely than women to say that their unpaid care work burdens have increased.

The pandemic has shown that when circumstances dictate, men in the East and Southern Africa sub-region do pitch in to assist with unpaid domestic and care work. It is important that, through advocacy efforts, this momentum be maintained to increasingly make it socially acceptable, as well expected from men in the sub-region to share these tasks with women. UN Women, in a policy brief on time use during COVID-19, highlights²²⁵ the importance of continuing to recognize, reduce and redistribute these unpaid domestic and care activities. That cannot be done without putting specific normative frameworks in place in support investments that would make it possible for women to increasingly share and delegate some of these tasks with others. A specific area that has been shown to impact immediately on women's time use in this area has been government support for increased access to child-care services, as well the provision of and extension of paid family and sick leave amongst other measures.

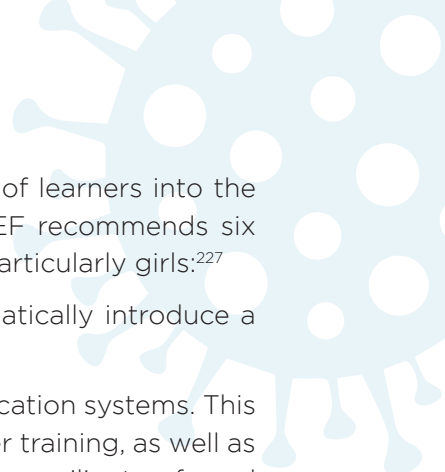
11.6 Education

The sub-region already had high out-of-school rates prior to the onset of the pandemic. Confinement indoors and movement controls during COVID-19 may have provided opportunities for practices that present safety risks for girl children such as for example domestic violence, sexual exploitation, early marriage, and female genital mutilation to be reinforced. This no doubt further contributes towards psychological and health problems and gender discrimination. Appropriate gender-sensitive responses are needed to mitigate these problems and reduce the potential compounding impact of the pandemic on the existing educational challenges on the continent.

The study illustrated the potential impacts of the pandemic on girls' education and also highlighted the associations between girls out of school and early marriage and pregnancy. During the pandemic, increases in teenage pregnancies were reported in several countries. The 'Keeping girls in school initiative' in Zambia, which is executed jointly by the government and the World Bank, has indicated that there are important lessons from the projects' pre-COVID-19 experiences that may be relevant to the post COVID-19 recovery period.²²⁶ These include the use of cash transfers and bursaries as incentive for girls to go back to school; clear communication with and involvement of the community at all levels so that girls experience social pressure as well as support to return to school; girls need to be protected from GBV and sexual exploitation within their schools and communities; it is also important to provide pathways for girls to report and seek help if they become victims; preventing early marriage and pregnancy are important mechanisms to prevent girls from leaving school in the first place.

225 UNWomen, Policy brief: Whose time to care. <https://data.unwomen.org/publications/whose-time-care-unpaid-care-and-domestic-work-during-covid-19>. Accessed November 2020.

226 World Bank. Available from <https://blogs.worldbank.org/nasikiliza/lessons-zambia-how-bring-adolescent-girls-back-school-post-covid-19>. Accessed November 2020.



In 2021, the sub-region will be challenged to support the re-integration of learners into the school system as well as catch-up for months lost in schooling. UNICEF recommends six interventions that will support such continuation for children and more particularly girls:²²⁷

- Adopt a system-wide approach to school reopening. This will automatically introduce a gender and inclusion lens into education analysis.
- Actively remove gender bias and discrimination within and across education systems. This should start with teacher recruitment and permeate through to teacher training, as well as learning curriculum and materials development. It should also guarantee resilient, safe and violence free school environments.
- The leadership of girls and women and their role as agents of change should be recognized and prioritized. This entails systematically and meaningfully integrating them into consultations, planning and decision-making on COVID-19 related education response and recovery interventions. Including when doing needs assessments to design remote learning opportunities, and other interventions to plan and monitor school reopening and promote life-long learning.
- Countries should prioritise activities that will bring all girls back to school through targeted measures for the poorest and most marginalised girls. Both returning students and those previously out of school need to be reached with these initiatives. It is important that school reopening plans are inclusive and strive for equity, leaving no one behind. Special consideration needs to be given to inequalities that are intersectional by nature and aggravates exclusion and marginalization.
- It is important to promote an integrated and coordinated approach that addresses girls' holistic education, health and protection needs in an integrated manner. Cooperation between teachers, school administration, families and communities, need to be facilitated as much as possible.
- There is a need to support cross-sectoral collaboration to ensure an inclusive and gender-responsive school reopening, safeguarding the rights of all girls and boys.

11.7 Healthcare

Preliminary research on the health impact of the COVID-19 pandemic in the ESA sub-region indicates that there have been clear and gendered consequences on women and men, girls and boys in the region. Whilst the final toll of the pandemic can only be seen in the retrospect, among the immediate impacts are the following:

- Curtailed access to many essential healthcare services such as child and maternal healthcare, including sexual and reproductive healthcare and for non-communicable chronic diseases, such as diabetes, services for people with HIV and living with disabilities.
- Due to the pandemic, resources from many essential health services and programmes for preventing child marriages, gender-based violence and child marriages have been diverted or cut down. Following such cuts, there is a risk of increasing cases of child marriages, adolescent pregnancies, HIV transmission and gender-based violence.
- Decreasing food security and access to incomes due to social distancing and curfews, leading to higher incidence of food insecurity and skipping meals due to lack of food, with women more affected than men according to preliminary findings in some countries.

²²⁷ UNICEF. Building Back Equal: Girls back to School Guide. Published 2020

- Increasing feelings of stress and anxiety, caused both by health and economic concerns by both women and men.
- Increase in GBV and decreasing feelings of safety in home and in communities in many countries.
- Increasing vulnerabilities for many already vulnerable groups in society, such as people with disabilities, refugees and IDPs, people with HIV/AIDS and in those engaged in sex work, migrants and street-connected youth.

The following key issues affect women and healthcare in the region:

- Decreasing access to child healthcare can lead to long-term problems in forms of increasing mortality, disabilities, and other health problems.
- Sexual and reproductive health needs are not fully met in most countries in the ESA sub-region and the COVID-19 pandemic appears to have set back the situation with clear downwards trends in many countries. Curtailed access to birth control including safe abortions can have a long-term impact on demographic trends, including higher levels maternal, infant and child mortality.
- Gender-based and sexual violence against women and children, in particular against women and children with disabilities remains a serious problem in the region.
- Some of the most vulnerable groups are youth living on streets – both boys and girls – and those involved in commercial sex work who can fall victims of violence and also of police brutality.
- Food security issues and impact on nutrition. The impact of COVID-19 on incomes has mostly been negative which has led to deficiencies in nutrition.
- Risk for setbacks in programmes eradicating FGM and child marriages.
- The full impact of some of the health-related issues caused by COVID-19 will be seen only in the aftermath, e.g. increase in child marriages and their impact on maternal and child health, long-term mental health issues caused by lockdowns and increased food insecurity; moreover, the long-term neurological impact of COVID-19 that has been reported from Western countries might never be fully diagnosed in the ESA region, etc.

The following recommendations, with suggested responsible actors, their priority and possible role for UN Women and UNFPA is listed in Table 3.

Table 3: Recommendations

Recommendation	Responsible	Priority	Possible role for UN Women & UNFPA
Preparing gender-sensitive health budgets to ensure more equal access to health resources in the region.	Ministries of health		Strengthening the ministries of health.
Strengthening data collection for swift, effective action. Gender-disaggregated data serves as a basis for gender-responsive budgeting and should be gathered as a routine at all levels.	National authorities	High	Strengthening the national authorities in data collection and ensuring that gender disaggregated data is collected.
Continue emphasizing public health and safety measures (PHSM). Ensuring an inclusive approach, including women, men, girls and boys, people living with disabilities, with HIV, refugees and IDPs. Strengthening resources of community-based organisations in providing health and social services to vulnerable groups.	National authorities and third sector	High	Strengthen the national authorities. Research and dissemination of research findings.
Implement the WHO recommended strategies to mitigate service disruptions, such as triaging to identify priorities, shifting to online patient consultations, etc.	National health authorities	High	
Suspend or remove user fees, to set off potential financial difficulties for patients, in particular for the most vulnerable groups of women and men.	National treasury and health authorities	High	
Increased resources will be needed to maternal and child health to rectify some of the damage caused by the COVID-19 pandemic in the region, which might set back advances made so far with 2-3 years according to some estimates.	National authorities		Raising resources.
Sexual and reproductive health services are also a long-term investment in a healthy and productive labour force and must be extended to all groups in the society, including women with disabilities, refugees and internally displaced and young peoples – including men – living on streets. Access to birth control, including safe abortions are essential for preventing increases in maternal, infant and child mortality rates.	National authorities, NGOS		Resources.

Recommendation	Responsible	Priority	Possible role for UN Women & UNFPA
Human rights training of police, prevention of police brutality. Training of police to receive and handle complaints from victims of rape and SGBV.	National authorities		Sharing international best practices.
Easing drops in income and negative impacts on nutrition needs to be addressed early on by national authorities through different social safety net measures, such as food aid, cash transfers, etc. Prioritize evidence-based measures to increase food security and economic recovery. Also providing access to land and seeds.	National authorities	High	Financial support.
Address misinformation and continue to build trust. Engaging community and religious leaders to understand and counteract misinformation that is circulating.	National authorities, community leaders		Sharing international best practices in targeting misinformation.
Ensure that needs for sexual and reproductive health, including access to family planning and safe abortions as well as access to menstrual hygiene are guaranteed even during pandemics and lockdowns.	National authorities, local authorities	High	Strengthening national authorities.
Involve women and young people, including those with disabilities, living with HIV/AIDS as well as refugees and internally displaced people as well as the elderly in planning prevention of COVID-19 pandemic measures.	National authorities, community leaders		Strengthen the national authorities. Sharing best practices.
Government and non-state actors can support community based psychiatrist services in local health centers. This should go hand-in-hand with encouraging people to seek professional psychiatrist services when they feel depressed.	Ministry of Health		Strengthen the national authorities. Sharing best practices.
Prioritize frontline healthcare and education personnel in vaccination plans	Ministry of Health	High	Strengthen the national authorities. Sharing best practices.

11.8 Gender-based violence

The study found that:

- More than half of the respondents in all countries except Mozambique felt that the incidence of GBV increased during the pandemic (Source: RGAs). Evidence from other sources and studies suggest that GBV has increased especially during lockdown as the

drivers of GBV such as for example economic strain, substance abuse and being in a confined environment became more pronounced.

- Approximately 7 in 10 women and men across the region think that GBV is a big problem in their country. Women were more likely than men to think that GBV is a big problem in their country and that its frequency has increased during COVID-19 (Source: RGAs).
- Between a quarter and three quarters of respondents to the RGAs indicated that they knew someone who had been a victim to GBV during the pandemic. The most common types of abuse were physical abuse, emotional abuse and sexual harassment (Source: RGAs).

It is therefore recommended that the following is prioritized as we move forward in our efforts to mitigate the current situation and plan for the post COVID-19 recovery:

- A lack of reliable data on GBV remains a problem and there is an urgent need to expand the coverage of standalone, nationally representative prevalence surveys across the region.
- More research and research capacity are needed to identify the drivers of GBV and develop specific programs (advocacy and otherwise) at national and provincial level to address these.
- Continued advocacy work is needed around GBV prevention and services; this includes amongst others increased communication around the available services.
- Even though technology can be used to support reporting mechanisms for survivors of GBV, more information about the usefulness of already applied technologies and their impact will be needed before such programs are scaled up or expanded during the post-COVID-19 recovery phase.
- Improved services are needed for post GBV support and care. This includes but is not limited to the increased availability of safe places, mechanisms and services for victims and survivors and strengthening of referrals between service points are required. Greater cooperation and coordination between the various law enforcement and social service providers working with victims, survivors and perpetrators will greatly enhance the impacts of these services.
- General human rights training of police aimed at preventing police brutality is needed across the region. The training of the police and other law enforcement agencies on how to receive and handle complaints from victims and survivors of rape and SGBV needs more attention.

11.9 Marginalized groups

Women and youth with disabilities, sex workers and HIV Aids sufferers were more likely to experience victimization and stigmatization during the pandemic and those not associated with non-governmental Organizations were less likely to have received preventative and other COVID-19 related support and information.

During the post COVID-19 period they are likely to be even more marginalized than prior to the pandemic as re-prioritization within the context of scarce resource takes place. It will be important to continue with advocacy for the rights and protection of women and youth with disabilities, sex workers and HIV Aids sufferers during the recovery phase to ensure that sufficient resources are channelled to them.

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ANNEXURES

Annex I: Terms of Reference



TERMS OF REFERENCE

CONSULTANCY: Consultants (2) to compile a Regional COVID-19 Gender Equality Profile

Type of contract	International Consultants	
Location of Assignment	100% virtual and desk based	
Duration of contract	25 working days spread over 2 months	
Start date	From: 27 October 2020	To: 21 December 2020
Reporting to:	Statistics Specialist - Gender	

1. Introduction

UN Women, grounded in the vision of equality enshrined in the Charter of the United Nations, works for the elimination of discrimination against women and girls; the empowerment of women; and the achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action and peace and security. To fulfil its mandate, the organization and offices work on various aspects of development with the aim of either drawing attention by providing evidence on the existence of a gender gap or directly implementing interventions geared towards closing the gender gap among other sectors, also in gender statistics.

Making Every Woman and Girl Count (Women Count) is UN Women's gender data programme, aimed at supporting countries in their efforts to generate data to inform policies and monitor the implementation of the gender equality-related Sustainable Development Goals (SDGs) and other national policy priorities. The overall objective of the programme is to affect a radical shift in the production, availability, accessibility and use of quality data and statistics on key aspects of gender equality and women's empowerment through three interlinked areas of work:

- Building a supportive policy and institutional environment for the localization and effective monitoring of the SDGs;
- Increasing the quality, comparability and regularity of gender statistics to address national data gaps and meet reporting commitments under the SDGs; and
- Ensuring that gender statistics are accessible to users in governments, civil society, academia and the private sector, to strengthen their policy and interventions.

UN Women in East and Southern Africa Regional Office (ESA-RO) continues to be committed to bridge the gender data and analysis gaps as part of the 'Leave No One Behind' commitment and collaborate closely with other UN Agencies to advance the agenda of Gender Equality and Women Economic empowerment across all areas of work of the United Nations, regional entities, national governments and other entities.

2. Background to the assignment:

One of the outcomes of the Women Count project has been a significant increase in the availability of gender specific data across ESA. However, the socio-economic impacts of the pandemic, as well as disruption caused by COVID-19 to the face to face traditional data collection efforts have impacted on data availability during 2020. Various entities such as the UNCTs in the region, National Statistical Offices, the World Bank and other producers of data have conducted studies specially adjusted to COVID-19 in the region during 2020. Even though these studies are yielded some data about the differences between men and women most do not cover the gender data gap comprehensively enough.

UN Women and UNFPA are currently collaborating in East and Southern Africa to fill this data gap by rolling out a CATI COVID-19 gender assessment in 7 countries in the region. These countries are Kenya, Uganda, Ethiopia, Malawi, Mozambique, Rwanda and South Africa. The survey is generating a comprehensive picture of the impact of COVID-19 on women and men across a wide range of themes including; economic activities, agriculture and food security, education, time use, health and health care seeking behaviours, human rights and gender-based violence.

The findings of this survey are already available in Kenya and will progressively become available for the rest of the participating countries during September and October 2020. The survey data is considered an important part of the knowledge base and contextual framework that will be required for all GEWE work in the region, regardless of implementing agency and sphere of implementation.

In support of this work, UN Women and UNFPA ESA-RO and UNFPA ESA are collaborating on the compilation of a regional COVID-19 Gender Profile that will inform development assistance policies and strategies for intensifying impact on gender equality, women empowerment and poverty reduction. The regional gender profile will focus on key gender inequalities in the region that constrain inclusive growth, identifying key gaps and challenges in current policies and programs, provide an overview of best practices and recommend strategic actions for addressing gender inequalities as the region begins to recover from the pandemic. The study will have to focus on normative frameworks, the demography of the region, economic activities, household income and other resources, agricultural activities and household food security, education, Education, access to basic services, time use, health and health seeking behaviour, basic morbidity and mortality profiles in the region, maternal and child health, human rights and gender based violence.

The evidence provided through the regional gender profile will be used for regional strategic planning, advocacy and resource mobilization during the post pandemic recovery phase and beyond.

3. Objective and scope of the assignment:

The purpose of the assignment is to conduct an analysis of inequality, poverty and impact of shocks and formulate clear recommendations on policy and programmatic changes and priorities including key communication messages that can be used during the post COVID-19 recovery phase.

The two gender experts will be required to prepare selected sections of the planned comprehensive regional gender profile for East and Southern Africa.

The specific objective of the consultancy is to prepare a comprehensive report that outlines the opportunities and constraints for GEWE in the post COVID-recovery phase and identify the key gaps and challenges in current policies and programs in the region.

The specific thematic focus areas of the report will include; demography, health and health seeking behaviour, morbidity and mortality profiles, maternal and child health and gender-based violence.

The study will be based on existing reports and secondary data that were collected in the region during 2020. Data collected through the CATI COVID-19 gender assessment currently being conducted through the UNWomen UNFPA collaboration will also be incorporated into the report.

The countries to be included in the profile are: Eswatini, Botswana, Burundi, Comoros, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Madagascar, Malawi, Mozambique, Rwanda, South Africa, Uganda, Tanzania, Seychelles, Sudan, South Sudan, Zambia and Zimbabwe.

4. Duties and Responsibilities:

Consultant 1 will focus on governance and normative frameworks, livelihoods, socio-economic circumstances and time use. The following tasks will need to be done to prepare this part of the Regional COVID-19 Gender Equality Profile:

- Conduct an in-depth gendered analysis of governance and normative frameworks, livelihoods, socio-economic circumstances and time use in countries in the region.
- Identify key issues affecting the status of women in the region with respect to the thematic focus and those hindering their access to resources, opportunities and full participation.
- Evaluate regional normative frameworks from a gender perspective and identify gaps and best practices that can be scaled-up;
- Consolidate data on key gender indicators available from existing sources for various sectors and from UN and country level official data sources;
- Provide concrete recommendations for accelerating the advancement of gender equality through the various sectors involved in the thematic areas covered by the study.

Consultant 2 will focus on demography, health and health seeking behaviour, morbidity and mortality profiles, maternal and child health and gender-based violence. The following tasks will need to be carried out to prepare this segment of the Regional COVID-19 Gender Equality Profile:

- Conduct an in-depth gendered analysis of the demography, health and health seeking behaviour, morbidity and mortality profiles, maternal and child health and gender-based violence of countries in the region.
- Identify key issues affecting the status of women in the region with respect to the thematic focus of the study and those hindering their access to resources, opportunities and full participation.
- Evaluate regional normative frameworks from a gender perspective and identify gaps and best practices that can be scaled-up;
- Consolidate data on key gender indicators available from existing sources for various sectors and from UN and country level official data sources;
- Provide concrete recommendations for accelerating the advancement of gender equality through the various sectors involved in the thematic areas covered by the study.

- Make specific reference in the analysis to the COVID-19 pandemic and how it has impacted on women in the region.

5. Reporting:

The consultants will report directly to the UN Women Regional Statistics Specialist -gender in ESA-RO, but will execute the assignment in close collaboration with the Gender specialist UNFPA ESA-RO. Both regional representatives will provide technical support where needed.

6. Outputs:

Key outputs of the consultancy are:

- Inception Report establishing the methodology for the development of the report;
- Two drafts of the reports (one for comments, the final incorporating comments);
- Creative and dynamic PowerPoint presentation summarizing the guidelines (for online advisory support).

7. Key Deliverables

- 1) One inception report per consultant establishing the data sources and report outline for the profile
- 2) One Regional gender profile report from consultant 1 of no more than 30 pages (excluding appendices) covering governance and normative frameworks, livelihoods, socio-economic circumstances and time use of the countries of interest in the region.
- 3) One Regional gender profile report from consultant 2 of no more than 30 pages (excluding appendices) covering demography, health and health seeking behaviour, morbidity and mortality profiles, maternal and child health and gender-based violence of the countries of interest in the region.

Below are the key deliverables and schedule for the assignment

Phase	Deliverables	Days
1.	Inception Report establishing the data sources and report outline for the profile	3
2.	First draft of the gender profile report	20
3.	Final draft of the gender profile report incorporating comments	2

8. Values and Competencies

Core Values:

- Respect for Diversity;

- Integrity;
- Professionalism.

Core Competencies:

- Awareness and Sensitivity Regarding Gender Issues;
- Accountability;
- Creative Problem Solving;
- Effective Communication;
- Inclusive Collaboration;
- Stakeholder Engagement;
- Leading by Example.

Please visit this link for more information on UN Women's Core Values and Competencies: <https://www.unwomen.org/-/media/headquarters/attachments/sections/about%20us/employment/un-women-values-and-competencies-framework-en.pdf?la=en&vs=637>

Functional Competencies:

- Extensive knowledge of gender statistics and its production, analysis and dissemination;
- Demonstrated experience in gender equality and women empowerment including solid understanding of linkages between gender, statistics and development;
- Strong knowledge of UN system, 2030 Sustainable Agenda and Leave No One Behind Commitment;
- Leadership and skills to work with autonomy and initiative.

9. Qualifications

Education:

Master's degree or equivalent in demography, social sciences, development studies, development economics, gender/women's studies, international relations or related field is required. PhD is a plus.

Experience:

- Minimum of 10 years of demonstrated extensive experience that combines research and programs in gender and international development at the national and international level is required;
- At least five years of experience in gender issues in Sub-Saharan Africa especially in fragile states;
- Track record of publications on gender issues in peer reviewed journals;
- Knowledge and experience in socio-cultural, economic, and geopolitical contexts of Sudan and Somalia is an advantage;
- Excellent writing and analytical skills.

Languages:

- Fluency in English is required;
- Working knowledge of another official UN language is an asset.

7. Consultancy fees

The consultants will work for up to 25 days on this assignment to be effectuated before or on 21 December 2020. Consultancy fees will be determined in accordance with UN Women Corporate Policy for consultant's remuneration.

UNWOMEN is committed to achieving workforce diversity in terms of gender, nationality and culture. Individuals from minority groups, indigenous groups and persons with disabilities are equally encouraged to apply. All applications will be treated with the strictest confidence.

Annex II: Additional Tables and Figures

Table A1: Main person responsible for unpaid domestic work in the household prior to the pandemic (per cent), 2020

Unpaid domestic and care task	Who is mainly responsible	Ethiopia	Kenya	Malawi	Mozam-bique	South Africa
Food management and preparation	Woman	73.6	16.3	64.9	78.6	62.6
	Man	14.6	17.7	10.4	4.4	13.1
	Equally women and men	5.8	37.8	23.7	15.5	23.5
	Other household member	6.1	28.1	1.1	1.5	0.8
Cleaning (e.g. clothes, house, etc.)	Woman	64.8	18.0	74.9	57.3	57.5
	Man	16.0	17.8	9.1	6.5	13.0
	Equally women and men	10.6	36.1	13.6	32.5	26.3
	Other household member	8.6	28.1	2.4	3.6	3.2
Shopping for the household	Woman	64.5	32.7	27.1	57.3	50.5
	Man	21.0	19.2	42.6	19.7	18.5
	Equally women and men	10.4	37.4	29.9	22.5	30.2
	Other household member	4.2	10.7	0.4	0.5	0.7
Person collecting water and firewood	Woman	57.1	27.1	74.0	55.4	40.3
	Man	21.5	23.3	7.5	13.4	29.1
	Equally women and men	14.4	29.6	16.4	29.0	28.0
	Other household member	7.1	20.0	2.2	2.2	2.6

Source: UN Women, UNFPA and partners rapid gender assessments conducted in East and Southern Africa, harmonized regional database (September to December 2020).

Table A2: Main person responsible for unpaid domestic work in the household prior to the pandemic (per cent), 2020

Unpaid domestic and care task	Who is mainly responsible	Ethiopia	Kenya	Malawi	Mozambique	South Africa
Minding children without doing something specific for them	Woman	58.8	35.3	55.7	62.7	60.5
	Man	17.1	28.6	8.8	8.1	10.6
	Equally women and men	19.9	20.9	34.6	28.2	26.9
	Other household member	4.2	15.3	0.9	1.0	2.1
Playing with, talking, reading to children	Woman	53.9	41.1	44.3	43.1	56.8
	Man	20.4	26.4	18.7	16.9	11.9
	Equally women and men	21.8	21.0	33.4	37.0	29.2
	Other household member	3.9	11.6	3.7	3.0	2.1
Instructing, teaching children	Woman	51.1	44.3	31.3	45.9	56.9
	Man	23.8	25.8	13.4	22.2	13.7
	Equally women and men	22.7	21.8	54.0	30.0	27.6
	Other household member	2.4	8.1	1.3	1.9	1.8
Caring for children (e.g. feeding, clothing, cleaning etc.)	Woman	61.1	32.9	69.5	67.1	66.1
	Man	13.1	24.6	6.6	6.6	7.7
	Equally women and men	22.1	23.8	22.2	24.9	24.2
	Other household member	3.7	18.7	1.7	1.4	1.9
Assisting adults with physical care	Woman	53.3	42.8	43.7	45.4	59.4
	Man	21.3	39.8	19.8	19.6	13.7
	Equally women and men	15.7	13.8	34.6	33.5	20.0
	Other household member	9.7	3.6	1.8	1.5	6.9
Assisting adults with administration and other tasks	Woman	53.4	42.5	33.6	39.2	58.0
	Man	23.7	39.6	28.2	27.0	15.4
	Equally women and men	14.8	14.3	36.1	31.8	19.9
	Other household member	8.1	3.6	2.1	2.0	6.7
Providing affective and emotional support to other household members	Woman	40.9	48.2	34.4	34.3	50.6
	Man	32.1	24.2	29.1	28.5	16.2
	Equally women and men	23.0	23.3	35.2	33.9	25.2
	Other household member	4.0	4.4	1.3	3.3	8.0

Source: UN Women, UNFPA and partners rapid gender assessments conducted in East and Southern Africa, harmonized regional database (September to December 2020).

Table A3: Perpetrators of different kinds of GBV here known to the respondent (per cent), 2020

Perpetrator	Ethiopia	Malawi	Mozambique	South Africa	Uganda
1 Sexual harassment e.g. inappropriate and unwelcome jokes, suggestive comments, leering, etc.					
Spouse	1.2	7.8	5.5	19.2	15.2
Other family member	3.1	2.3	9.2	11.1	9.8
Friend	10.8	4.9	2.1	12.9	12.0
Neighbour	24.0	25.9	25.9	24.2	21.7
Other undefined ²²⁸	45.7	23.2	28.4	11.0	31.5
Person at work ²²⁹	7.2	6.9	10.8	12.5	2.2
Other defined ²³⁰	8.1	29.1	18.1	9.1	7.6
2 Slapped, hit, kicked, thrown things, or done anything else to physically hurt the person					
Spouse	9.3	18.7	27.2	37.5	51.7
Other family member	5.1	6.2	8.7	12.4	18.3
Friend	15.3	7.9	7.5	17.8	5.6
Neighbour	30.0	22.1	25.5	20.0	15.0
Other undefined	30.4	11.4	20.7	6.8	5.0
Person at work	4.5	8.3	2.3	3.4	0.0
Other defined	5.5	25.3	8.1	2.3	4.4
3 Female genital mutilation, that is, deliberate removal of external female genitalia					
Spouse	3.1	3.2	10.1	33.9	20.0
Other family member	6.0	0.0	19.6	0.0	40.0
Friend	0.0	4.0	8.7	0.0	0.0
Neighbour	45.9	11.5	20.2	66.1	40.0
Other undefined	26.4	11.7	20.5	0.0	0.0
Person at work	0.0	15.7	10.2	0.0	0.0
Other defined	18.6	53.8	10.7	0.0	0.0
4 Make the person have sex when s/he did not want to” and “do something sexual that s/he did not want to do”					
Spouse	3.1	9.7	6.1	20.9	8.8
Other family member	14.2	9.8	12.9	14.1	26.3
Friend	11.1	2.4	5.2	12.6	11.9
Neighbour	32.6	13.1	30.5	24.2	13.8
Other undefined	28.3	16.5	33.0	22.8	30.6
Person at work	5.5	8.0	5.2	2.5	2.5
Other defined	5.3	40.6	7.0	2.9	6.3

228 In this table 'Other undefined' refers to a category 'Other' that was provided in the questionnaire (also see Annexure IV). Enumerators classified all responses which could not be found in the pre-defined list of responses into this category

229 The category 'Person at work' combines the boss, colleague and client options in the questionnaire (Also see Annexure IV)

230 The grouping 'Other defined' includes all categories that formed of the option list in the questionnaire (also see Annex IV) but for which there were relatively few responses. The types of perpetrators grouped under this category include teachers, health-workers, police and security workers, etc.

Perpetrator	Ethiopia	Malawi	Mozambique	South Africa	Uganda
5 Denial of resources/money/water/land/livestock/house/grain					
Spouse	0.0	4.7	52.8	54.1	50.3
Other family member	5.1	16.0	8.6	3.1	21.5
Friend	16.5	18.3	4.4	8.3	6.1
Neighbour	29.4	13.8	19.3	18.8	13.5
Other undefined	38.0	10.6	9.8	5.1	4.3
Person at work	5.1	7.0	1.6	3.0	0.6
Other defined	5.8	29.6	3.4	7.6	3.7
6 Online/Internet bullying e.g. physical threats, sexual harassment, sex trolling, sextortion, online pornography, Zoom-Bo					
Spouse	3.9	5.6	8.8	21.0	21.1
Other family member	2.8	3.8	8.7	15.1	15.8
Friend	33.5	16.9	5.8	0.0	5.3
Neighbour	20.0	9.1	39.0	8.0	10.5
Other undefined	25.7	24.0	20.4	22.5	31.6
Person at work	7.8	10.9	8.9	14.7	10.5
Other defined	6.4	29.6	8.4	18.7	5.3
7 Emotionally hurting someone through verbal abuse, etc.					
Spouse	6.4	8.8	3.5	3.3	40.6
Other family member	1.3	7.3	3.3	6.8	22.4
Friend	14.2	17.6	21.3	27.2	6.7
Neighbour	32.8	24.9	14.7	6.7	15.2
Other undefined	30.4	12.2	36.0	43.1	4.9
Person at work	7.7	10.0	14.7	3.0	2.4
Other defined	7.4	19.3	6.6	9.9	7.9
8 Denial to communicate with other people					
Spouse	0.0	4.8	16.9	35.5	30.2
Other family member	13.5	4.8	12.0	12.9	32.6
Friend	16.7	10.3	9.7	16.4	9.3
Neighbour	24.6	24.8	28.3	14.1	16.3
Other undefined	26.1	5.1	21.0	9.3	7.0
Person at work	4.7	15.1	4.0	7.2	0.0
Other defined	14.4	35.0	8.1	4.8	4.7
9 Child and/or forced marriage					
Spouse	1.3	10.4	6.5	37.8	19.1
Other family member	15.3	5.2	6.3	14.6	31.2
Friend	17.5	10.7	35.3	20.5	14.3
Neighbour	17.2	23.9	36.1	15.1	18.0
Other undefined	33.9	19.0	3.2	0.0	12.2
Person at work	5.0	6.2	9.4	12.0	0.0
Other defined	9.8	24.5	3.2	0.0	5.3

Table A4: Most common support services used by survivors of GBV where the information is known to the respondent²³¹, 2020

Country		Ethiopia	Kenya	Malawi	Mozambique	South Africa
Family member	Woman	10.3	7.9	10.8	10.4	7.1
	Man	9.7	6.0	10.9	10.7	7.8
Friend	Woman	12.4	4.5	8.2	4.5	5.3
	Man	13.4	4.6	6.9	5.0	7.4
Women's Affairs office	Woman	10.5	N/M	10.3	6.3	0.9
	Man	9.7	N/M	10.2	7.3	1.3
Colleague	Woman	3.8	1.3	6.4	1.6	0.0
	Man	3.4	1.3	3.8	1.4	1.0
Client	Woman	0.7	0.0	1.9	0.4	0.2
	Man	1.5	0.4	3.2	0.7	0.3
Teacher	Woman	1.4	N/M	8.5	0.6	0.2
	Man	1.0	N/M	6.1	1.0	0.5
Police	Woman	29.3	20.2	69.4	33.0	39.0
	Man	29.9	22.7	67.9	36.4	38.1
Health facility	Woman	13.6	9.9	44.2	10.5	3.0
	Man	15.1	8.8	40.2	9.6	4.4
Helpline	Woman	2.3	0.4	6.3	1.4	4.9
	Man	1.8	0.5	5.5	1.1	5.6
Social worker	Woman	5.7	2.8	4.5	4.5	6.1
	Man	3.3	2.0	3.9	3.5	7.1
Non-governmental agency	Woman	1.5	4.2	25.3	1.5	1.4
	Man	1.6	2.0	33.3	1.1	1.6
Neighbour	Woman	13.2	9.8	9.8	10.0	3.8
	Man	12.3	9.1	12.7	9.0	4.9
Religious leaders	Woman	3.8	4.6	10.1	2.2	0.7
	Man	3.3	3.8	9.4	3.2	2.0
Online platforms §(Facebook, etc.)	Woman	1.0	0.2	1.7	0.4	0.7
	Man	0.6	0.2	1.9	0.2	0.7
Other	Woman	5.0	9.5	11.9	4.9	4.0
	Man	4.5	12.2	8.4	5.7	2.5

Source: UN Women, UNFPA and partners rapid gender assessments conducted in East and Southern Africa, harmonized regional database (September to December 2020).

²³¹ Even though the question about perpetrators was asked in Kenya, it was not asked about the most recent case of GBV, but rather about all the known cases and is not directly comparable to that of the other countries

Table A5: Feelings of safety, experience of violence and discrimination during the pandemic (per cent), 2020

Country	The same feeling		Feel safer		Feel less safe	
	Woman	Man	Woman	Man	Woman	Man
Feelings of safety from violence or threats of violence in the community during pandemic						
Ethiopia	59.9	57.4	8.9	11.4	31.2	31.2
Kenya	56.9	54.1	11.7	13.1	31.4	32.7
Malawi	40.4	38.0	43.5	42.5	16.1	19.5
Mozambique	32.7	35.1	37.1	33.7	30.2	31.2
South Africa	55.9	58.8	22.0	22.7	22.1	18.5
Feelings of safety at home during the pandemic						
Ethiopia	54.2	53.6	13.9	16.9	31.9	29.5
Kenya	72.7	68.9	13.8	15.9	13.5	15.1
Malawi	48.5	49.0	44.6	42.7	6.9	8.4
Mozambique	31.5	34.4	49.3	44.2	19.2	21.3
South Africa	58.3	61.1	26.0	27.3	15.7	11.6
Feelings of safety from violence or threats of violence in the household during pandemic						
	Yes		No			
	Woman	Man	Woman	Man		
Ethiopia	4.6	11.3	95.4	88.7		
Malawi	14.8	17.2	85.2	82.8		
Mozambique	13.4	18.9	86.6	81.1		
South Africa	6.1	9.9	93.9	90.1		
Personal experience of discrimination during the pandemic						
	Yes		No			
	Woman	Man	Woman	Man		
Ethiopia	7.4	9.2	92.6	90.8		
Malawi	14.2	13.4	85.8	86.7		
Mozambique	14.2	16.3	85.8	83.7		
South Africa	6.5	8.5	93.6	91.5		
Changes in the incidence of discrimination during the pandemic						
	No, it didn't change		Yes, it increased		Yes, it decreased	
	Woman	Man	Woman	Man	Woman	Man
Ethiopia	59.8	59.2	11.7	15.6	28.6	25.2
Malawi	69.2	68.7	15.2	15.2	15.6	16.1
Mozambique	51.7	54.9	22.1	21.5	26.2	23.7
South Africa	81.2	77.1	13.2	16.4	5.6	6.5

Source: UN Women, UNFPA and partners rapid gender assessments conducted in East and Southern Africa, harmonized regional database (September to December 2020).

Annex III: Detailed technical notes CATI rapid gender assessment on the impact of COVID-19 on women and men

Ethical considerations

The study was executed in such a way that confidentiality and anonymity was guaranteed. Ethical and safety principles will be followed to ensure that no harm including no risk of further violence, risk or distress were imposed on women and men who took part in the data collection being conducted remotely. Informed consent was obtained from each participant. Regular checks were done to ensure respondents were answering the survey in a private and safe space. Referrals to support services were provided by interviewers when necessary and safe to do. The survey also ensured the safety of interviewers, that the recommended anti-COVID-19 barrier behaviours were observed amongst teams of interviewers to avoid any risk of contamination. Working hours were in accordance with curfews as implemented in each country. Some of the sources on best practices that were referenced include work done by Emerge and SVRI.

Testing

The generic questionnaire developed through the multi-agency partnership in Kenya was also tested through face-to-face interviews and as part of the initial phases of the implementation of their own CATI rapid gender survey on COVID-19. These tests influenced the phrasing of questions, response options and ordering of questions in the questionnaire. Most of the changes that were made to the questionnaire following the inputs from partners and face-to-face testing contributed towards improving the GBV module and informing the ESA survey design and tool.

Enumerator training and data collection:

Data collection was done by regionally procured service providers. Ipsos collected the data in Ethiopia, whilst Mobile Accord (GeoPoll) collected data in Kenya, Uganda, Mozambique, Malawi and South Africa. A local research agency was contracted in Rwanda.

- Training was done over three-day period in most countries.
- Enumerators needed to have the necessary knowledge and skills to ask violence-questions in a sensitive, confidential, and ethical manner; to detect risks during the interview; and to refer to violence services if necessary.
- Enumerators were trained on how to detect non-verbal clues that may indicate when respondents feel uncomfortable and how to handle situations where the interview impacts or seems to be impacting negatively on survivors of GBV.
- Special helpline numbers for GBV survivor's support specific to each country were provided to respondents where needed.

Table A5: Timelines associated with lockdowns and movement restrictions and corresponding data collection periods

	March	April	May	June	July	August	September	October	November	December
Ethiopia	School closure to full re-opening									
	Social and movement restrictions									
	Data collection socio-economic, TUS, education									
	Data collection human rights, health and GBV									
Kenya	School closure to full re-opening									
	Social and movement restrictions									
	Data collection socio-economic, TUS, education									
	Data collection human rights, health and GBV									
Malawi	School closure to full re-opening									
	Social and movement restrictions									
	Data collection socio-economic, TUS, education									
	Data collection human rights, health and GBV									
Mozambique	School closure to full re-opening									
	Social and movement restrictions									
	Data collection socio-economic, TUS, education									
	Data collection human rights, health and GBV									
Rwanda	School closure to full re-opening									
	Social and movement restrictions									
	Data collection socio-economic, TUS, education									
	Data collection human rights, health and GBV									

		March	April	May	June	July	August	September	October	November	December
South Africa	School closure to full re-opening										
	Social and movement restrictions										
	Data collection socio-economic, TUS, education										
	Data collection human rights, health and GBV										
Uganda	School closure to full re-opening										
	Social and movement restrictions										
	Data collection socio-economic, TUS, education										
	Data collection human rights, health and GBV										

Note:

Social and movement restrictions varied from country to country and continues to be adjusted as the pandemic evolves. The timelines in the table reflect the period in each country where there was the biggest restrictions on movement and economic activities

Only one questionnaire and interview per respondents was implemented in Rwanda and Uganda. The subject matter in Rwanda covered most areas covered using two questionnaires in the other countries. In Uganda the focus was only on the health and GBV modules.

Sources: Centre for Global Development, <https://docs.google.com/spreadsheets/d/1ndHgP53atJ5J-EtxgWcpSfYG8LdzHpUsnb6mWybErYg/edit#gid=0>
 UNESCO, <http://tcg.uis.unesco.org/survey-education-covid-school-closures/>
<https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>

Quality assurance and monitoring

- During interviews, monitoring and tracking data were automatically generated. This data was analyzed and used to inform learning about the usefulness and potential sensitivities around the core GBV questions in Ethiopia which has been captured in a [technical report](#). These will then be adjusted where needed for the global GBV survey.
- Through training, verification and related quality assurance processes the service providers ensured that recommended best practices with regard to GBV were followed.
- Interviews were not recorded to protect confidentiality; interviews terminated early were also assessed and investigated as one of the quality assurance mechanisms.

Analysis and regional estimates

Since the questionnaires used across the sub-region were not exactly the same, the analysis in this report is based on a harmonized dataset, where comparable questions were aligned across surveys. Due to the inconsistent use of 'Do not know', 'Refuse' and item non-response between questions and countries all of these values were set to missing and treated as item non-response. They were also excluded from the denominator during the calculation of percentages and analysis in general. Regional estimates were compiled using population estimates for 2020 as produced by the United Nations Population Division in the revised World Population Prospects 2019.

Annex IV: Additional notes on interventions by UN agencies and other international bodies in the region

Introduction

The international community has rallied in support of ESA sub-region as a response to COVID-19. Although the full impact of these measures is still to be seen, and some of the programmes have not yet been launched (especially COVAX – solidarity programme for delivering COVID-19 vaccinations to poor countries), they have provided some much-needed support to governments in East and Southern Africa. The main measures of multilateral donors are listed below, especially considering their importance for women, youth and children. In addition, a number of bilateral donors can have taken similar measures, but these are not discussed in the following. As will be explained in the following, a number of donors have addressed the pandemic in gender-blind terms. On the other hand, WFP, UNICEF, UN Women and UNFPA have all taken a clearly gender-responsive approach to dealing with the COVID-19 Pandemic.

WHO


With just two laboratories able to test for COVID-19 in sub-Saharan Africa when the outbreak began, countries – with assistance from WHO, Africa Centres for Disease Control and Prevention and other partner organizations – have ramped up testing capacities. Currently, all the 47 countries in WHO African sub-region can diagnose the virus and around 6.4 million polymerase chain reaction tests have been performed so far. More than 2.1 million test kits have been delivered to countries and 2 million more are to be shipped. A COVID-19 platform for laboratory practitioners in the WHO African and Eastern Mediterranean regions has been launched and an external quality assurance programme established to monitor countries' capacity to accurately test for the virus²³²

World Bank

According to the World Bank,²³³ the World Bank Group is taking broad, fast action to help developing countries strengthen their pandemic response, increase disease surveillance, improve public health interventions, and help the private sector continue to operate and sustain jobs. Over 15 months, the World Bank Group is making available up to \$160 billion in financing *tailored to the health, economic and social shocks countries are facing, including \$50 billion of IDA resources on grant and highly concessional terms*. On April 2, the *first group of projects* using the dedicated COVID-19 Fast-Track Facility, amounting to \$1.9 billion and assisting 25 countries, was rolled out. In addition, the World Bank is working worldwide to redeploy resources in existing World Bank financed projects, including through restructuring and use of projects' emergency components as well as contingent financing instruments designed for catastrophes, including pandemics. On May 19, the Bank Group announced its emergency operations to fight COVID-19 have reached *100 developing countries* – home to 70% of the world's population. In East and Southern Africa, the following countries have been already included: Burundi, Ethiopia, Eswatini, Kenya, Lesotho, Malawi, Rwanda, Somalia and Uganda. Gender-responsiveness is not highlighted.

²³² www.who.int.afro/. Accessed in January 2021

²³³ www.worldbank.org/eng/what-we-do/. Accessed in January 2021



However, another programme of interest for women and girls in East and Southern Africa (although predating the COVID-19 pandemic) is the World Bank *Africa Human Capital Plan* to boost Africa's potential through the health, knowledge, skills and resilience of its people, which was launched in April 2019. The plan includes a focus on empowering women and girls through more than \$2.2 billion in new World Bank-financed projects. The projects are designed to further women's agency, health, education and employment opportunities. Other areas of focus include human capital policy reforms, domestic resource mobilization and leveraging technology and innovation. Thirty-one countries have committed to advancing the human capital agenda, including Ethiopia, Eswatini, Kenya, Lesotho, Malawi and Rwanda in ESA.

African Development Bank

The African Development Bank Group²³⁴ announced in April 2020 the creation of the COVID-19 Response Facility to assist regional member countries in fighting the pandemic. The Facility is one of the measures taken by the Bank to respond to the pandemic and will be the institution's primary channel for its efforts to address the crisis. It provides up to \$10 billion to governments and the private sector. Gender-sensitivity is not mentioned in these communications.

The Facility entails \$5.5 billion for sovereign operations in African Development Bank countries, and \$3.1 billion for sovereign and regional operations for countries under the African Development Fund, the Bank Group's concessional arm that caters to fragile countries. An additional \$1.35 billion will be devoted to private sector operations.

In March 2020, the Bank launched a record-breaking \$3 billion Fight COVID-19 Social Bond, the world's largest US dollar-denominated social bond ever on the international capital market. The Board of Directors also approved a \$2 million grant for the World Health Organization for its efforts on the continent.

Several ESA countries have benefited from budgetary and other support from the AfDB, namely (in chronological order) Sudan, Comoros, Tanzania, Mauritius, Djibouti, Somalia, Rwanda, Uganda, Eswatini, South Africa, Malawi, Kenya, Mozambique, Madagascar, South Africa, South Sudan and Ethiopia. Some of these have implemented gender-sensitive measures, as discussed earlier on. In addition, the African Union COVID-19 initiative and African Water Facility have received support to fight COVID-19. This will be important for women, as they are mainly responsible for fetching water for household and subsistence farming needs in SSA.

European Union

On 8th April 2020 the EU launched "[Team Europe](#)", a package of more than 20 billion to help the most vulnerable countries, in particular in Africa and the EU's neighbourhood, in the fight against the pandemic and its consequences.²³⁵ Most of this funding comes from [reorienting existing EU funds and programmes](#). Parliament [supports](#) efforts by the European Commission for a global response by the EU. MEPs have also joined calls from the International Monetary Fund and the World Bank to [suspend debt payments](#) by the world's developing countries. It's noteworthy that gender-sensitive approaches are not mentioned at all in the communication.

"The EU's response follows a '[Team Europe](#)' approach, aimed at saving lives by providing quick and targeted support to our partners to face this pandemic. It combines resources from the EU, its Member States and financial institutions, in particular the European Investment Bank

²³⁴ www.afdb.org/response-to-covid-19

²³⁵ www.europarl.europa.org/news/en/headlines/. Accessed in January 2021

and the European Bank for Reconstruction and Development, to support partner countries and address their short-term needs, as well as the longer-term structural impacts on societies and the economy... The EU, as global actor and major contributor to the international aid system, will promote a coordinated multilateral response, in partnership with the United Nations, International Financial Institutions, as well as the G7 and the G20”.

“The European Union will continue to adapt its response to the evolving situation and focus on the most affected countries in need of health support, such as countries in Africa.... The EU's response will focus on the most vulnerable people, including migrants, refugees, internally displaced persons and their host communities and integrate its strategic objectives set out in the Green Deal and the Digital Agenda.

From the overall package of 15.6 billion, 3.25 billion are channelled to Africa, including 1.19 billion for the Northern African neighbourhood countries. In addition, the overall package includes another 1.42 billion in guarantees for Africa and the neighbourhood from the European Fund for Sustainable Development (EFSD)... another 291 million will go for the Africa, Caribbean and Pacific region.”

502 million for Emergency response actions focus amongst others, on:

- Providing immediate support to the Response Plans of the World Health Organisation and the United Nations, as well as to the appeal of the Red Cross and Red Crescent Movement to boost emergency preparedness and response in countries with weaker health systems and those dealing with humanitarian crises.
- Providing immediate humanitarian support in affected countries, in particular in health, water, sanitation and hygiene (WASH) and logistics.
- Supporting increased production in Europe of personal protective equipment and medical devices to meet urgent needs in Europe and in partner countries.
- Organising the supply of in-kind assistance to affected countries through the Union Civil Protection Mechanism.
- Providing guarantee and liquidity provisions to local banks via International Financial Institutions and European Development Finance Institutions, supported by the European Fund for Sustainable Development.
- Supporting global efforts to combat export restrictions and ensure supply chains remain intact, notably for essential medical supplies and pharmaceuticals.

2.8 billion to support research, health and water systems. The EU is, amongst others:

- Supporting partner countries in building resilient, responsive health and social protection systems.
- Supporting communication and awareness efforts on basic protective measures and hygiene advice to prevent the spread.
- Allowing some EU funding from global health initiatives like the Global Fund to fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Financial Facility to be used to respond to the coronavirus, while ensuring continuation of vital health programmes.
- Supporting further research on diagnostics, treatment and prevention, and once a vaccine is available, fast-tracking approval and subsidizing vaccines and their delivery in vulnerable countries.

- Supporting experts training, epidemiological surveillance and strengthening regional health organisations in Africa, Latin American and the Caribbean and Asia and the Pacific.
- Supporting equal access to health systems for migrants, refugees and host communities.

12.28 billion to address the economic and social consequences. The EU is amongst other:

- Providing direct budget support and concessional financing for partner countries to adopt reforms for socio-economic development and poverty reduction, and measures to protect workers during the crisis.
- Supporting the private sector, especially small and medium enterprises (SMEs) and the self-employed, via guarantees, liquidity provisions and technical assistance and further reorient guarantees from the European Fund for Sustainable Development towards short-term risk-sharing on loans.
- Providing public sector loans from the European Investment Bank, notably for healthcare equipment and supplies.
- Working with international organizations and European companies to build strong and resilient value chains in strategic sectors and ensure labour rights and corporate social responsibility.
- Promoting forms of debt relief considered by the IMF in affected countries.

UNICEF²³⁶

The Access to COVID-19 Tools (ACT) Accelerator is a global collaboration to speed up the development, production and equal access to COVID-19 tests, treatments and vaccines. COVAX (the vaccines pillar of the ACT-Accelerator) aims to accelerate the development and manufacture of COVID-19 vaccines, and to make sure that they reach the poorest countries in the world. UNICEF is working to support countries to prepare their immunization programmes for this historic rollout.

Through the COVAX Facility – together with Gavi, the Vaccine Alliance, WHO and CEPI – UNICEF is leveraging its unique experience as the largest single vaccine buyer in the world by working with manufacturers and partners on the procurement of COVID-19 vaccine doses, as well as freight, logistics and storage. We are also bringing the full weight of our strength in community engagement and our expansive social mobilization network to build demand and acceptance for vaccines.

UNICEF²³⁷ estimates that it could potentially transport up to 850 tonnes of COVID-19 vaccines per month in 2021, should such quantities become available, according to a new assessment. This is more than double the average weight of vaccines UNICEF transports every month.

The assessment is part of UNICEF's work to lead on the procurement and delivery of COVID-19 vaccines for 92 low- and lower middle-income countries on behalf of the COVAX Facility, in collaboration with the Pan American Health Organization (PAHO).

The UNICEF assessment looked at global airfreight capacity and transport routes to better understand the challenges of delivering COVID-19 vaccines in 2021. It found that commercial airlines will be able to deliver vaccines to almost all 92 low- and lower-middle-income countries, which are among the 190 economies participating in the COVAX Facility, at an estimated cost

²³⁶ www.unicef.org/. Accessed in January 2021

²³⁷ www.unicef.org/pressreleases/. Accessed in January 2021

of up to US\$70 million.

Comparing vaccine volume estimates against commercial and cargo routes across the globe, the assessment also found that current air cargo capacity would be sufficient to make deliveries covering 20 percent of the population for most of the 92 countries. COVID-19 vaccines are expected to be primarily shipped using existing passenger and cargo flight capacity, although charters or alternative transport options may still be needed for some small countries and others with access issues. UNICEF is working with airlines and the wider logistics industry to prioritise the delivery of COVID-19 vaccines around the world.

One major challenge in the COVID-19 vaccine operation is local cold chain capacity for vaccine storage within some low- and lower-middle-income countries. UNICEF, WHO and Gavi, the Vaccine Alliance, developed a guidance note on supply and logistics to help countries develop their supply chain strategies to receive, store, distribute and manage COVID-19 vaccines and related products. Given the range of storage temperatures required for COVID-19 vaccines, countries will continue to train logisticians and health workers on how to keep COVID-19 vaccines at the right temperatures.


As part of a programme that started in 2017, with support from Gavi, UNICEF continues to procure and support the installation of 70,000 cold-chain fridges in lower-income countries by the end of 2021, which will help in the roll-out of COVID-19 vaccines that need to be stored at 2 to 8 degrees Celsius. Almost half of these will be solar powered. UNICEF, WHO and Gavi are also working to help countries prepare and develop national deployment and vaccination plans for the large-scale roll out of COVID-19 vaccines. Currently, countries are continuing to monitor their readiness against key milestones, which include expediting regulatory approvals and putting in place ways to monitor vaccine safety.

In addition, a UNICEF meeting with more than 300 vaccine procurement experts globally, including government officials, looked at ways to procure and roll-out COVID-19 vaccines and strengthen regulatory systems and supply chains. Funding is critical. UNICEF has called for US\$410 million to help countries with the delivery of vaccines, therapeutics and diagnostic tools in 2021. Further, UNICEF estimates a funding gap of US\$133 million to cover in-country vaccine logistics and the required cold chain equipment for the poorest 92 countries.

World Food Programme²³⁸

With COVID-19 infections surging but still to peak, cash-strapped governments struggling to cope with growing hunger, and the pandemic's socio-economic consequences set to outweigh its health impacts, WFP continues working to ensure help reaches the most at-risk. WFP continues to be able to receive and dispatch food and other essentials relatively freely thanks to the support of SADC and its governments. This must continue, given that most countries in the sub-region are heavily dependent on food imports, many are land-locked (Zimbabwe, Zambia, Malawi, Lesotho and Eswatini) and WFP has limited in-country stocks to sustain key operations – notably those in Zimbabwe and Mozambique. Anticipating COVID-related supply chain disruptions, WFP has worked since the outset of the crisis to procure and pre-position up to three months of food to meet the increased needs of especially vulnerable communities. Thanks in part to the better harvests in some countries, much of the planned 70,000 tonnes of commodities has been sourced and delivered. The more pronounced hunger the pandemic and its socio-economic impacts are set to inflict presage a significant surge in WFP funding needs. WFP insists that 50% of its food aid is delivered to women.

²³⁸ <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>



Beyond assistance to the traditionally vulnerable – subsistence farming families, refugees and IDPs, among others – WFP’s scale-up includes support to millions of now destitute people in urban areas. It is also consistent with our accelerating transition to preventive, anticipatory action: building resilience to shocks before they strike. We have a solid foundation in the food-assistance-for-assets programmes already helping to propel threatened communities to self-sufficiency. In its capacity as global humanitarian logistics lead, WFP has set up a regional staging centre in Johannesburg, South Africa, for aid cargo and personnel – part of a worldwide network of dedicated COVID-19 air transport hubs. With COVID-19 infections surging but still to peak, cash-strapped governments struggling to cope with growing hunger, and the pandemic’s socio-economic consequences set to outweigh its health impacts, WFP continues working to ensure help reaches the most at-risk. As have lengthier quality controls and document processing, WFP continues to be able to receive and dispatch food and other essentials relatively freely thanks to the support of SADC and its governments. This must continue, given that most countries in the sub-region are heavily dependent on food imports, many are land-locked (Zimbabwe, Zambia, Malawi, Lesotho and Eswatini) and WFP has limited in-country stocks to sustain key operations – notably those in Zimbabwe and Mozambique.

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WFP Zimbabwe’s COVID-19 response plan envisages a more than five-fold increase, to 550,000, in the number of vulnerable people in urban areas receiving cash transfers. WFP Zambia is this month initiating a three-month cash programme for poor people in four cities – Lusaka, Kitwe, Kafue and Livingstone – starting with 37,000 households (184,000 people) in the capital. In Mozambique, WFP plans to assist up to 500,000 people in urban areas with up to three months of cash transfers (US\$46 a month per family), funds permitting. Take-home rations are being provided to school children, in lieu of hot meals. WFP Malawi’s six-month, US\$34.2 million COVID-19 response plan provides for three months of take-home rations to 600,000 schoolchildren, starting this month. Support to a government-led social protection initiative for vulnerable residents of the country’s four largest cities – Lilongwe, Blantyre, Zomba and Mzuzu – is also envisaged. As part of a three-month, US\$17.8 million COVID-19 response plan, WFP Madagascar is giving two months of cash transfers to up to 250,000 vulnerable people in three major cities: Antananarivo, Toamasina and Fianarantsoa (US\$27 per household per month). Take-home rations (cereals, pulses and vegetable oil) are being provided to 230,000 schoolchildren. In Tanzania, WFP is planning cash transfers for nearly 500,000 urban poor people in 10 high-risk locations and nutrition assistance for 45,000 vulnerable women and children. In Eswatini, 1,700 so-called Neighbourhood Care Points accommodating over 52,000 HIV/AIDS orphans and other vulnerable children have been supplied with three months of food commodities (maizemeal/rice, beans and vegetable oil). The registration of urban residents for the extension of a cash assistance programme to an additional 15,000 people is being finalised. In Lesotho, WFP is rolling out a cash assistance programme for 8,500 vulnerable urban families (34,000 people) in the capital Maseru and the districts of Maseru’s Hoek, Mafeteng, Quthing and Qacha’s Nek. WFP is also increasing, by 80% – to over 2,500 – the number of families benefiting from food-assistance-for-assets programmes.

FAO

According to FAO,²³⁹ 45 countries are in continuous need of external assistance for food. In East and Southern Africa these countries are Burundi, Djibouti, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Somalia, South Sudan, Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

²³⁹ www.fao.org/news (Accessed in January 2021)

Annex V: Example of Rapid Gender Assessment Questionnaire

Quest 1 questionnaire

Survey: Impact Assessment of COVID-19 on women's and men's wellbeing

QUESTIONS FOR A MOBILE PHONE INTERVIEW BASED SURVEY

Interviewer notes in **green**

Scripting notes in **blue**

ASK ALL

S1. Which language do you wish to proceed with?

READ ANSWERS, SINGLE RESPONSE

1. English
2. Afrikaans
3. Isizulu
4. Isixhosa
5. Sesotho

ASK ALL

A01a. What is your sex?

SINGLE ANSWER

1. Male
2. Female

A01b. To which population group do you belong?

SINGLE ANSWER

[OPERATOR: CHOOSE ONLY ONE OPTION]

1. African
2. Coloured
3. Indian/Asian
4. White

98. Do not know **[DO NOT READ]**

99. Refused **[DO NOT READ]**

ASK ALL

A02. What is your date of birth?

RECORD ANSWER IN FORMAT YY/MM

- ☐ YEAR
- ☐ _1910 1910
- ☐ ...
- ☐ _2015 2015
- ☐ MONTH
- ☐ _1 January
- ☐ _2 February
- ☐ _3 March
- ☐ _4 April
- ☐ _5 May
- ☐ _6 June
- ☐ _7 July
- ☐ _8 August
- ☐ _9 September
- ☐ _10 October
- ☐ _11 November
- ☐ _12 December

ASK IF A02 IS 98 (DON'T KNOW)

A02a. What is your age in completed years?

WRITE YEARS

__ [YEARS]

BELOW 18 BASED ON MONTH AND YEAR -> FINISH INTERVIEW

ASK ALL

A03_1. In which province do you usually live?

SINGLE ANSWER

1. Eastern cape
 2. Free state
 3. Gauteng
 4. Kwa-zulu natal
 5. Limpopo
 6. Mpumalanga
 7. Northern cape
 8. Western cape
 9. North west
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

A03_2. Do you live in a traditional leadership/tribal area, farm, township, town or city?

SINGLE ANSWER

1. Land under the control of a traditional leader/king/chief
2. Farm
3. Township/town/city
4. Other

98. Do not know **[DO NOT READ]**

99. Refused **[DO NOT READ]**

INTRO: Hello, my name is **[INTERVIEWER'S NAME]** and I am calling from Geopoll, market research agency, on behalf of UN Women and their partners. We would like to understand how the rapid spread of COVID-19 is affecting women and men, Girls and Boys. You have been randomly selected to participate in this assessment and your feedback and cooperation will be highly appreciated. In order to make the survey as inclusive as possible, each participant will be asked a set of questions once per week over a two week period and all responses will be kept strictly confidential and if there are any costs to the call, it will be covered by UN-Women.

I request for about 20 minutes of your time to ask you some questions.

You will receive **[PLACEHOLDER]** of communication credit as an incentive for the participation in both surveys.

ASK ALL

S2. Are you interested in participating in this survey, now or another time?

DO NOT READ ANSWERS. SINGLE ANSWER

1. Yes **[RESPONDENT SPEAKS NOT USING SPEAKERPHONE]**
2. Yes **[RESPONDENT SPEAKS OVER SPEAKERPHONE]**
3. Not now but another time **GO TO S3**
4. No **IF NO, TRY TO CONVINCE THE RESPONDENT BEFORE CONCLUSIVELY ENDING THE SURVEY GO TO S4**

ASK IF S2 IS 3

S3. When would be a good time to call you back?

RECORD HH/MM/DD/MM OF CALLBACK

HH/MM/DD/MM

Thank you, we will call you back at **[HH/MM/DD/MM]** you requested. Thank you again and have a great day!

ENTER CALL NOTES BELOW, WHO YOU SPOKE TO AND WHAT THEY SAID

ASK IF S2 IS 4

S4. Thank you for your time, you will be removed from today's survey.

IF S3 OR S4, END CALL

A. Demographic characteristics

ASK ALL

A03_4. How much (in Rand) on average did your household spend in total in a month, BEFORE THE COVID-19 LOCKDOWN STARTED? Please include all expenditure on rent/food/clothing/transport/vehicles, etc.

SINGLE ANSWER

1. 0-1199
 2. 1200 to 1799
 3. 1800 to 2499
 4. 2500 to 4999
 5. 5000 to 9999
 6. 10000 plus
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ELIGIBLE FOR THE INTERVIEW IF:

1. Yes **QUOTA BY REGION/AGE/SEX/LSM**
2. No: **I am sorry that you are not eligible for the survey and thank you for your time.**
-> FINISH INTERVIEW

ASK ALL

A04. Are you the head of your household? [IF NEEDED, EXPLAIN: By household we mean people who have been eating from the same pot for the past 6 months. The head of household is the person who makes most of the decisions and generally is the main earner of the household].

If no, what is your relationship to the head of the household?

SINGLE ANSWER

1. Head
2. Spouse/Partner
3. Son/daughter
4. Grandchild
5. Brother/Sister
6. Father/Mother
7. Nephew/Niece
8. In-Law
9. Grandparent
10. Other Relative
11. Non-relative

ASK ALL

A05. What is your current marital status?

SINGLE ANSWER

1. Married
2. Living with partner/Cohabiting
3. Married but separated
4. Widowed
5. Divorced
6. Single (never married)

ASK ALL

A06. What is the highest level of education that you completed?

SINGLE ANSWER

1. No formal education
 2. Some Primary School
 3. Completed Primary School
 4. Some Secondary School
 5. Completed Secondary School
 6. Technical & Vocational Training
 7. Completed University/College
 8. Completed Post Graduate
98. Do not know **[DO NOT READ]**

ASK ALL

A07. Do you live with other people? If yes, how many people live with you in your household, could you tell us by following age groups? Please include yourself

MULTIPLE ANSWER. OPEN ANSWERS FOR EACH CATEGORY. IF THERE ARE NO MEMBER OF SEPCIFIC CATEGORY PUT ZERO

I live alone **[EXCLUSIVE]**
Number of children 0-5 Yrs. ____
Number of children 6-17 Yrs. ____
Number of adults 18-34 Yrs. ____
Number of adults 35-64 Yrs. ____
Number of elderly 65 or over Yrs. ____

ASK ALL

A08. BEFORE THE ONSET OF COVID-19 did this household provide financial or in-kind support to other family members who do not live with the household?

SINGLE ANSWER

1. Yes
 2. No
98. Do not know **[DO NOT READ]**

ASK ALL

A09. Is this household currently providing financial or in-kind support to other family members that are not normally supported, AS A RESULT OF COVID-19? If yes, how many additional people are supported.

SINGLE ANSWER

1. Yes
2. No
98. Do not know **[DO NOT READ]**

ASK ALL

A10. How many women, of any age, live in your household (please include yourself)? Are there any pregnant or lactating women in your household? If yes, please specify how many pregnant or lactating women are in the household:

MULTIPLE ANSWER. OPEN ANSWERS FOR EACH CATEGORY. IF THERE ARE NO WOMEN, PREGNANT OR LACTATING WOMEN, PUT ZERO

1. Women: Number..... **NUMBER SHOULD BE LESS THAN SUM IN A07**
2. Pregnant: Number.....
3. Lactating: Number.....

ASK ALL

A11. Do you have difficulty doing any of the following?

SINGLE ANSWER

1. Walking
2. Seeing
3. Hearing
4. Remembering or concentrating
5. Self-caring
6. Communicating
7. No - you don't have difficulties
98. Don't know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

B. Household Economic Activities and Livelihoods

ASK ALL

B01a. How would you describe your personal economic activity(ies) BEFORE THE ONSET OF COVID-19 that is, as of February 2020?

DO NOT READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES. MULTIPLE ANSWER

1. Worked for a person/company/ government//household or other entity for pay
2. Own business/freelancer and I employed other people
3. Own business/freelancer, but I did not employ other people
4. Casual work/odd jobs for others (non-agricultural)
5. Farmer and employed other people
6. Subsistence farmer (own production without employing others)
7. Casual laborer in agricultural enterprise
8. Worked (without pay) in a family business
9. Did not work for pay/money, but I am looking for a job and I am available to start working
10. Did not work for pay/money, because I have to take care of household chores, my children, elderly and the sick
11. Did not work for pay/money because I am studying full time
12. Did not work for pay/money, I have a long-term health condition, injury, disability
13. Did not work as I am retired/pensioner
14. Did not work for pay/money, I was not looking for a job and I was not available to work for other reasons
15. Other

ASK ALL

B01aa. Did your personal economic activity(ies) change from February 2020?

SINGLE ANSWER

1. Yes, due to COVID-19 **GO TO B01b**
2. Yes, but not due to COVID-19 **GO TO B01b**
3. No

ASK IF B1aa IS 1 OR 2

B01b. How would you describe your CURRENT economic activities?

DO NOT READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES. MULTIPLE ANSWER

1. Worked for a person/company/government/household or other entity for pay
2. Own business/freelancer and I employed other people
3. Own business/freelancer, but I do not employ other people
4. Casual work/odd jobs for others (non-agricultural)
5. Farmer and employed other people
6. Subsistence farmer (own production without employing others)
7. Casual laborer in agricultural enterprise

8. Worked (without pay) in a family business
9. Did not work for pay/money, but I am looking for a job and I am available to start working
10. Did not work for pay/money, because I have to take care of household chores, my children, elderly and the sick
11. Did not work for pay/money because I am studying full time
12. Did not work for pay/money, I have a long-term health condition, injury, disability
13. Did not work as I am retired/pensioner
14. Did not work for pay/money, I was not looking for a job and I was not available to work for other reasons
15. Other

ASK ALL

B02. Has your personal source of income been affected SINCE THE ONSET OF COVID-19? If yes, please indicate how.

SINGLE ANSWER

1. No change in income
 2. Lost all income
 3. Increased/oversized
 4. Decreased/downsized
98. Don't know **[DO NOT READ]**

ASK ALL

B03. Have you or any other member of household received any social protection grants and/or any in-kind support from the Government and/or other non-state actors at national and/or county level - SINCE THE ONSET OF COVID-19, like food, medication, health supplies, etc.?

READ ANSWERS. MULTIPLE ANSWER

1. No **[EXCLUSIVE]**
 2. Yes - food parcels
 3. Yes - medication
 4. Yes - supplies for prevention [gloves / masks / sanitizer / handwashing containers / soap / etc.]
 5. Yes - personal hygiene supplies [menstrual supplies / baby diapers / adult diapers etc.]
 6. Yes - COVID-19 relief grant
 7. Yes - social protection grants [Safety Net Programme / Health Insurance scheme / OVC / disability] - exclude grants normally received [old age grant / Child support grant]
 8. Yes - psycho-social support
 9. Yes - support for education related activities
 10. Yes - other cash transfer
98. Don't know **[DO NOT READ]**

ASK ALL

B04. Did you regularly (six times or more per year) receive any money or goods from relatives/friends living elsewhere in the country or in another country before the onset of COVID-19?

SINGLE ANSWER

1. Yes **GO TO B04_1**
2. No
98. Don't know **[DO NOT READ]**

ASK IF B04 IS 1

1. It has become a source of income after COVID-19 started
2. It is still a source and the amounts are still the same
3. It is still a source but the amounts have increased
4. It is still a source but the amounts have decreased
5. No, it is still not a source of income
6. Used to be a source, but no longer is

B04_1. Have there been any changes in the regular receipt of money and goods from elsewhere since the onset of COVID-19?

SINGLE ANSWER

ASK ALL

B05. Have there been any changes in the combined income from all household members SINCE THE ONSET OF COVID-19? If yes, how did it change?

SINGLE ANSWER

1. No change in income
2. Increased income
3. Decreased income
98. Don't know **[DO NOT READ]**

ASK ALL

B06. Who usually decides how money is spent in your household?

SINGLE ANSWER

1. I decide alone
2. Another household member (woman)
3. Another household member (man)
4. It is joint decision between women and men household members
5. Other non-household member
98. Don't know **[DO NOT READ]**

ASK ALL

B07. Do you usually have any money/income of your own that you alone decide when and how to use?

SINGLE ANSWER

1. Yes
2. No

ASK ALL

B08: Has your household experienced any of the following SINCE THE ONSET OF COVID-19?

READ ANSWERS, RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER

1. Financial difficulties
2. Loss of employment of the head of household
3. Loss of employment of another male HH member
4. Loss of employment of another female HH member
5. Forced isolation within the household
6. Family separation due to cessation of movement/quarantine
7. Increase in alcohol or drug/substance abuse by a member of household
8. Decrease in alcohol or drug/substance abuse by a member of household
9. Did not eat at all for a day or more because of lack of money or other resources
10. Ate less or skipped a meal because of lack of money or other resources
11. Other
12. No difficulties **[DO NOT READ] [EXCLUSIVE]**
98. Don't know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

C. Food Security and Agricultural Inputs

ASK ALL

C01: Does your household usually produce any crops/livestock (fish farming/poultry/ other small stock)?

SINGLE ANSWER

1. Yes
2. No **GO TO C04**

ASK IF C01 IS 1

C02: To what extent does the food produced by the household usually provide your household food needs?

SINGLE ANSWER

1. It provides in **all** our food needs
2. It provides in **most** of our food needs
3. It provides in **some** of our food needs
4. It does not provide us with any of our food needs
98. Don't know **[DO NOT READ]**

ASK IF C01 IS 1

C03: Has the availability of seeds and other inputs to plant crops or your ability to buy these inputs changed in any way SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Stayed the same
2. Increased
3. Decreased

98. Don't know **[DO NOT READ]**

ASK ALL

C04: Has the availability of the food that you usually buy in the local market/shops changed in any way SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Stayed the same
2. Increased
3. Decreased due to movement restrictions
4. Decreased due to other reasons

98. Don't know **[DO NOT READ]**

ASK ALL

C05: Have the prices of the food you usually buy in the local market/shops changed in any way SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Stayed the same
2. Increased
3. Decreased

98. Don't know **[DO NOT READ]**

D. Education

ASK ALL

I will now ask you few questions, separately for boys and girls in your household.

ROTATE SECTION FOR BOYS AND GIRLS

ASK ALL

D0_BOY: Do you have boys aged 7 to 18 years old in the household?

SINGLE ANSWER

1. Yes
2. No

ASK IF DO_BOY IS 1

D00_BOY: Were all of the boys aged 7 to 18 old years in your household attending school or any other educational institution in February 2020 BEFORE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Yes, all were attending school
2. Some were attending some not
3. No, they were not attending

ASK IF D00_BOY IS 1 OR 2

D01_BOY: What kind of school or other educational institution were they attending in February 2020 BEFORE THE ONSET OF COVID-19?

READ ANSWERS. MULTIPLE ANSWER

1. Pre-primary
2. Primary
3. Secondary
4. Other e.g. special needs school

ASK IF D01_BOY IS 2 TO 4

D02_BOY: Are boys using any measures to continue with learning at home SINCE THE ONSET OF COVID-19.

READ ANSWERS. MULTIPLE ANSWER

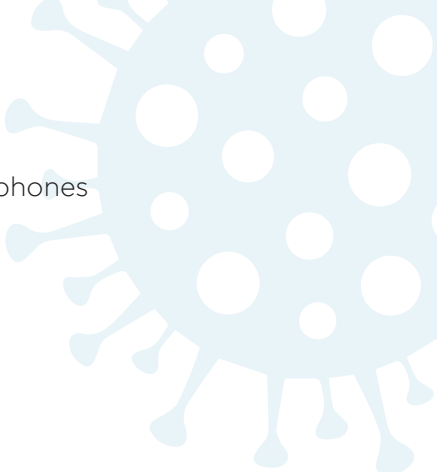
1. No measures **[EXCLUSIVE] GO TO D01_GIRL/E01**
2. Radio
3. Online learning platforms
4. TV
5. Social Media (e.g WhatsApp/SMS)
6. Print media
7. Other
98. Don't know **[DO NOT READ]**

ASK IF D01_BOY IS 2 TO 4

D03_BOY: What challenges are the boy learners in your household facing with learning at home SINCE THE ONSET OF COVID-19?

READ ANSWERS. MULTIPLE ANSWER

1. Limited access to internet
2. Limited access to learning materials e.g books etc.
3. Lack of electricity/source of lighting
4. Increased household chores to the learner
5. Lack of a skilled instructor/adult in the household
6. Lack of conducive environment
7. Multiple roles of the parent/guardian

- 
8. Sharing resources e.g. computers / tablet computers / smart phones
 9. Other
 10. No challenges
 98. Don't know **[DO NOT READ]**

ASK ALL

DO_GIRL: Do you have girls 7 to 14 years old in the household?

SINGLE ANSWER

1. Yes
2. No

ASK IF DO_GIRL IS 1

DOO_GIRL: Were all of the girls 7 to 14 years old in your household attending school or any other educational institution in February 2020 BEFORE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Yes, all were attending school
2. Some were attending some not
3. No, they were not attending

ASK IF DOO_GIRL IS 1 OR 2

D01_GIRL: What kind of school or other educational institution were they attending in February 2020 BEFORE THE ONSET OF COVID-19?

READ ANSWERS. MULTIPLE ANSWER

1. Pre-primary
2. Primary
3. Secondary
4. Other e.g. special needs school

ASK IF D01_GIRL IS 2 TO 4

D02_GIRL: Are girls using any measures to continue with learning at home SINCE THE ONSET OF COVID-19.

READ ANSWERS. MULTIPLE ANSWER

1. No measures **[EXCLUSIVE] GO TO D01_BOY/E01**
2. Radio
3. Online learning platforms
4. TV
5. Social Media (e.g WhatsApp/SMS)
6. Print media
7. Other
98. Don't know **[DO NOT READ]**

ASK IF D01_GIRL IS 2 TO 4

D03_GIRL: What challenges are the girl learners in your household facing with learning at home SINCE THE ONSET OF COVID-19?

READ ANSWERS. MULTIPLE ANSWER

1. Limited access to internet
 2. Limited access to learning materials e.g books etc.
 3. Lack of electricity/source of lighting
 4. Increased household chores to the learner
 5. Lack of a skilled instructor/adult in the household
 6. Lack of conducive environment
 7. Multiple roles of the parent/guardian
 8. Sharing resources e.g. computers / tablet computers / smart phones
 9. Other
 10. No challenges
98. Don't know **[DO NOT READ]**

E. Water and Sanitation

ASK ALL

E01: Do you have access to clean and safe water? Please also indicate whether access is sufficient or limited.

SINGLE ANSWER

1. Yes, sufficient access GO TO F01
2. Yes, but limited access
3. No access

ASK IF E01 IS 2 OR 3

E02: If you have limited or no access to water, what is the MAIN reason why you have limited or no access to clean and safe water?

DO NOT READ ANSWERS. PUT ANSWER IN RIGHT CATEGORY. SINGLE ANSWER

1. Regular / intermittent break-downs
 2. Denied by cartels
 3. Fear of covid-19 infection
 4. Harassment en-route to source
 5. Source is too far away
 6. Source closed due to covid-19
 7. Cannot afford the cost
 8. Not enough water containers
 9. Water access has always been a challenge
 10. Due to floods
 11. Poor maintenance
 12. Affordability of water
 13. Piped water supply is only available on certain days of the week
 14. Other
98. Don't know **[DO NOT READ]**

ASK ALL

E03: Do you have water piped into the house or compound?

SINGLE ANSWER

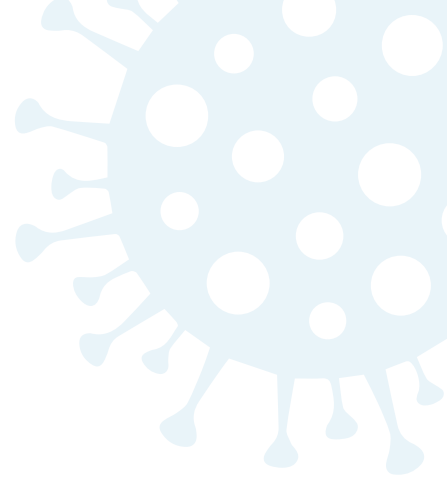
1. Yes
2. No **GO TO F01**

ASK IF E03 IS 2

E04. If no, who normally collects water in your household?

MULTIPLE ANSWER

1. Women collect
2. Men collect
3. Girls collect
4. Boys collect
98. Don't know **[DO NOT READ]**



F. Unpaid Care Work

ASK ALL

F01. BEFORE THE ONSET OF COVID-19, who in your household spent the most time doing each of the following activities?

SINGLE ANSWER PER ROW

	Me 1	Another house- hold member (woman) 2	Another house- hold member (man) 3	Equally between women and men household members 4	Someone else (not house- hold member) 5	Don't have that activity 6	Don't know 98
1. Food and meal management and food preparation (e.g. cooking and serving meals)	1	2	3	4	5		98
2. Cleaning (e.g. clothes, household)	1	2	3	4	5		98
3. Shopping for own household/ family members	1	2	3	4	5		98
4. Collecting water/ firewood/fuel	1	2	3	4	5	6	98
5. Minding children without doing something specific for them	1	2	3	4	5	6	98
6. Playing with, talking to and reading to children	1	2	3	4	5	6	98
7. Instructing, teaching, training children	1	2	3	4	5	6	98
8. Caring for children, including feeding, cleaning, physical care	1	2	3	4	5	6	98
9. Assisting elderly/sick/ disabled adults with medical care, feeding, cleaning, physical care	1	2	3	4	5	6	98
10. Assisting elderly/sick/ disabled adults with administration and accounts	1	2	3	4	5	6	98
11. Affective/emotional support for adult family members	1	2	3	4	5	6	98

ASK ALL

F02. SINCE THE ONSET OF COVID-19, how has the time you, personally, devoted to the following activities changed?

SINGLE ANSWER PER ROW

	Do not usually do it 1	Increased 2	Unchanged 3	Decreased 4	Don't know 98
1. Food and meal management and food preparation (e.g. cooking and serving meals)	1	2	3	4	98
2. Cleaning (e.g. clothes, household)	1	2	3	4	98
3. Shopping for own household/family members	1	2	3	4	98
4. Collecting water/firewood/fuel	1	2	3	4	98
5. Minding children without doing something specific for them	1	2	3	4	98
6. Playing with, talking to and reading to children	1	2	3	4	98
7. Instructing, teaching, training children	1	2	3	4	98
8. Caring for children, including feeding, cleaning, physical care	1	2	3	4	98
9. Assisting elderly/sick/disabled adults with medical care, feeding, cleaning, physical care	1	2	3	4	98
10. Assisting elderly/sick/disabled adults with administration and accounts	1	2	3	4	98
11. Affective/emotional support for adult family members	1	2	3	4	98

ASK ALL

F03. SINCE THE ONSET OF COVID-19, how has the time you, personally, devoted to help/support non-household members (e.g. community, neighborhood) changed?

SINGLE ANSWER

1. I do not usually do it
2. Increased
3. Unchanged
4. Decreased

ASK ALL

F04. Do you get help for chores and caring for family from other family members or persons outside of family? If yes, who provide you with help?

READ ANSWERS. MULTIPLE ANSWER

1. I don't usually do chores and caring for family
2. Parent(s)
3. Husband/partner
4. Daughter(s)
5. Son(s)
6. Other family member(s)
7. Person outside of family (domestic worker/babysitter/nurse)
8. I am on my own

ASK IF F04 IS 2 TO 7

F05. SINCE THE ONSET OF COVID-19, do you get more or less help for chores and caring for family from other family members or persons outside of family?

SINGLE ANSWER

1. I get more help
2. I get less help
3. The level of help is the same

ASK IF F04 IS 7

F06. You mentioned help from domestic worker/babysitter/nurse. How has the situation changed SINCE THE ONSET OF COVID-19:

READ ANSWERS. SINGLE ANSWER

1. We hired a domestic worker/babysitter/nurse
2. Domestic worker/babysitter/nurse works longer hours with us
3. Domestic worker/babysitter/nurse no longer works for us

ASK ALL

F07. This marks the end of Part I of the questionnaire. Thank you for your participation in this mobile phone survey, you will receive your [PLACEHOLDER] airtime credit on this phone 2 DAYS after the competition of the second survey.

Thank you for your participation!

Quest 2 questionnaire

Survey: Impact Assessment of COVID-19 on women's and men's wellbeing

QUESTIONS FOR A MOBILE PHONE INTERVIEW BASED SURVEY

INSERT TIMER FOR Quest2

IF CODE 1 AT Q_CHOOSE IN QUEST 1 AND QF07 IN QUEST1 IS REACHED, SELECT CODE 1 AT QSO

IF CODE 2 AT Q_CHOOSE IN QUEST 1 AND QF07 IS NOT REACHED, SELECT CODE 2 AT QSO

S0. PARTICIPATION IN QUESTIONNAIRE 1.

1. YES -> GO TO INTRO2
2. NO -> GO TO INTRO1

ASK IF S0 IS 2

S1. Which language do you wish to proceed with?

READ ANSWERS, SINGLE RESPONSE

1. English
2. Afrikaans
3. Isizulu
4. Isixhosa
5. Sesotho

ASK IF S0, PARTICIPATION IN QUESTIONNAIRE 1, IS CODE 2 (NO)

INTRO1: Hello, my name is [INTERVIEWER'S NAME] and I am calling from Geopoll, market research agency, on behalf of UN Women and partners. We would like to understand how the rapid spread of COVID-19 is affecting women and men, girls and boys. You have been randomly selected to participate in this assessment and your feedback and cooperation will be highly appreciated. The findings of the survey will be used to inform strategies and programs aimed at supporting women and girls during COVID-19. In order to make the survey as inclusive as possible, each participant will be asked a set of questions once per week over a two week period and all responses will be kept strictly confidential and if there are any costs to the call, it will be covered by UN-Women. If at any point there are any questions you do not feel comfortable answering, you can choose not to answer them. You can also choose to stop the interview at any point.

I request for about 20 minutes of your time to ask you some questions. You will receive [PLACEHOLDER] of communication credit as an incentive for the participation of the survey.

INTRO2_3: We previously called this phone number and interviewed you to understand how COVID-19 has been affecting women and men, girls and boys. Just to remind you, all responses will be kept strictly confidential and if there are any costs to the call, it will be covered by UN-Women. If at any point there are any questions you do not feel comfortable answering, you can choose not to answer them. You can also choose to stop the interview at any point.

A. Demographics

S1. Which language do you wish to proceed with?

READ ANSWERS, SINGLE RESPONSE

1. English
2. Afrikaans
3. Isizulu
4. Isixhosa
5. Sesotho

ASK ALL

A01a. What is your sex?

SINGLE ANSWER

1. Male
2. Female

A01b. To which population group do you belong?

SINGLE ANSWER

[OPERATOR: CHOOSE ONLY ONE OPTION]

1. African
2. Coloured
3. Indian/Asian
4. White
- 98 DON'T KNOW
- 99 REFUSED

ASK ALL

A02. What is your date of birth?

RECORD ANSWER IN FORMAT YY/MM

- ☐ YEAR
- ☐ _1910 1910
- ☐ ...
- ☐ _2015 2015
- ☐ MONTH
- ☐ _1 January
- ☐ _2 February
- ☐ _3 March
- ☐ _4 April
- ☐ _5 May
- ☐ _6 June
- ☐ _7 July
- ☐ _8 August
- ☐ _9 September
- ☐ _10 October
- ☐ _11 November

□ _12 December

ASK IF A02 IS 98 (DON'T KNOW)

A02a. What is your age in completed years?

WRITE YEARS

_ _ [YEARS]

BELOW 18 BASED ON MONTH AND YEAR -> FINISH INTERVIEW

ASK ALL

A03_1. In which province do you usually live?

SINGLE ANSWER

1. Eastern cape
2. Free state
3. Gauteng
4. Kwa-zulu natal
5. Limpopo
6. Mpumalanga
7. Northern cape
8. Western cape
9. North west
98. Don't know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

A03_2. Do you live in a traditional leadership/tribal area, farm, township, town or city?

SINGLE ANSWER

1. Land under the control of a traditional leader/king/chief
2. Farm
3. Township/town/city
4. Other
98. Don't know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

A04. Are you the head of your household? [IF NEEDED, EXPLAIN: By household we mean people who have been eating from the same pot for the past 6 months. The head of household is the person who makes most of the decisions and generally is the main earner of the household].

If no, what is your relationship to the head of the household?

SINGLE ANSWER

1. Head
2. Spouse/Partner
3. Son/daughter
4. Grandchild
5. Brother/Sister
6. Father/Mother
7. Nephew/Niece
8. In-Law
9. Grandparent
10. Other Relative
11. Non- relative

ASK ALL

A05. What is your marital status?

SINGLE ANSWER

1. Married
2. Living with partner/Cohabiting
3. Married but separated
4. Widowed
5. Divorced
6. Single (never married)

ASK ALL

A06. What is the highest level of education that you completed?

SINGLE ANSWER


1. No formal education
2. Some Primary School
3. Completed Primary School
4. Some Secondary School
5. Completed Secondary School
6. Technical & Vocational Training
7. Completed University/College
8. Completed Post Graduate
99. No answer/Do not know **[DO NOT READ]**

ASK ALL

A07. Do you live with other people? If yes, how many people live with you in your household, could you tell us by following age groups? Please include yourself.

MULTIPLE ANSWER. OPEN ANSWERS FOR EACH CATEGORY. IF THERE ARE NO MEMBER OF SEPCIFIC CATEGORY PUT ZERO

1. I live alone **[EXCLUSIVE]**
2. Number of children 0-5 Yrs. ____
3. Number of children 6-17 Yrs. ____
4. Number of adults 18-34 Yrs. ____

- 
5. Number of adults 35-64 Yrs. _____
 6. Number of elderly 65 or over Yrs. _____

ASK ALL

A08. How many women, of any age, live in your household (please include yourself)? Are there any pregnant or lactating women in your household? If yes, please specify how many of each:

MULTIPLE ANSWER. OPEN ANSWERS FOR EACH CATEGORY. IF THERE ARE NO WOMEN, PREGNANT OR LACTATING WOMEN, PUT ZERO

1. Women: Number..... **NUMBER SHOULD BE LESS THAN SUM IN A07**
2. Pregnant: Number.....
3. Lactating: Number.....

ASK ALL

A09. Do you have difficulty doing any of the following?

SINGLE ANSWER

1. Walking
2. Seeing
3. Hearing
4. Remembering or concentrating
5. Self-caring
6. Communicating
7. No - you don't have difficulties
98. Don't know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

B. Household Economic Activities and Livelihoods

ASK ALL

B01a. How would you describe your personal economic activity(ies) BEFORE THE ONSET OF COVID-19, that is, as of February 2020?

DO NOT READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES. MULTIPLE ANSWER

1. Worked for a person/company/government/household or other entity for pay
2. Own business/freelancer and I employed other people
3. Own business/freelancer, but I did not employ other people
4. Casual work/odd jobs for others (non-agricultural)
5. Farmer and employed other people
6. Subsistence farmer (own production without employing others)
7. Casual laborer in agricultural enterprise
8. Worked (without pay) in a family business
9. Did not work for pay/money, but I am looking for a job and I am available to start working

10. Did not work for pay/money, because I have to take care of household chores, my children, elderly and the sick
11. Did not work for pay/money because I am studying full time
12. Did not work for pay/money, I have a long-term health condition, injury, disability
13. Did not work as I am retired/pensioner
14. Did not work for pay/money, I was not looking for a job and I was not available to work for other reasons
15. Other

ASK ALL

B01aa. Did your personal economic activity(ies) change from February 2020?

SINGLE ANSWER

1. Yes, due to COVID-19 **GO TO B01b**
2. Yes, but not due to COVID-19 **GO TO B01b**
3. No

ASK IF B1aa IS 1 OR 2

B01b. How would you describe your CURRENT economic activities?

DO NOT READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES. MULTIPLE ANSWER

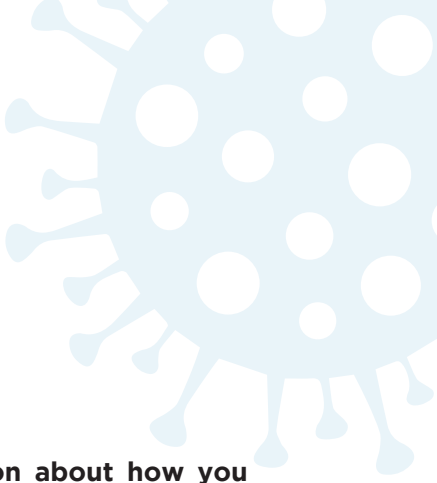
1. Worked for a person/company/ government/household or other entity for pay
2. Own business/freelancer and I employed other people
3. Own business/freelancer, but I do not employ other people
4. Casual work/odd jobs for others (non-agricultural)
5. Farmer and employed other people
6. Subsistence farmer (own production without employing others)
7. Casual laborer in agricultural enterprise
8. Worked (without pay) in a family business
9. Did not work for pay/money, but I am looking for a job and I am available to start working
10. Did not work for pay/money, because I have to take care of household chores, my children, elderly and the sick
11. Did not work for pay/money because I am studying full time
12. Did not work for pay/money, I have a long-term health condition, injury, disability
13. Did not work as I am retired/pensioner
14. Did not work for pay/money, I was not looking for a job and I was not available to work for other reasons
15. Other

ASK ALL

B05. Have there been any changes in the combined income from all household members SINCE THE ONSET OF COVID-19? If yes, how did it change?

SINGLE ANSWER

1. No change in income

- 
2. Increased income
 3. Decreased income

98. Do not know **[DO NOT READ]**

C. Health

ASK ALL

C01. SINCE THE ONSET OF COVID-19, have you received information about how you can protect yourself against COVID-19 (including the associated risks, recommended preventive action, recommended coping strategies? If yes, what is your main source of information regarding COVID-19?

READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES.

MULTIPLE ANSWER

1. Internet & social media
 2. Official Government websites or other communication channels
 3. Radio/Television/Newspaper
 4. Public announcement/speaker
 5. Phone (text or call)
 6. Community, including family and friends
 7. Community health worker /volunteer
 8. NGO/Civil Society organization
 9. Other
 10. No, I have not received information about COVID-19 **[EXCLUSIVE]**
98. Don't know **[DO NOT READ]** **[EXCLUSIVE]**

ASK ALL

C02. Have you or any other household member(s) been/is ill, any kind of illness, SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Yes
2. No

98. Do not know **[DO NOT READ]**

ASK ALL

C03. Has your own mental or emotional health (e.g. stress, anxiety, confidence etc.) been affected negatively SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Yes
2. No

98. Do not know **[DO NOT READ]**

ASK ALL

C04. Has the mental or emotional health (e.g. stress, anxiety, confidence etc.) of any of your household members been negatively affected SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. Yes
2. No
3. I live alone

98. Do not know [DO NOT READ]

ASK ALL

C05. Have you been worried about anything SINCE THE ONSET OF COVID-19? If yes what are your MAIN worries?

READ ANSWERS.

MULTIPLE ANSWER

1. Death
2. Becoming infected with COVID-19
3. Other health issues
4. Economic situation and income-generating activities
5. Access to food
6. Access to medicine
7. Missing school
8. Safety (related to the crisis specifically)
9. Others
10. I haven't been worried [EXCLUSIVE]

98. Don't know [DO NOT READ] [EXCLUSIVE]

ASK ALL

C06. Are you or your household currently covered by health insurance or medical aid?

SINGLE ANSWER

1. Yes
2. No

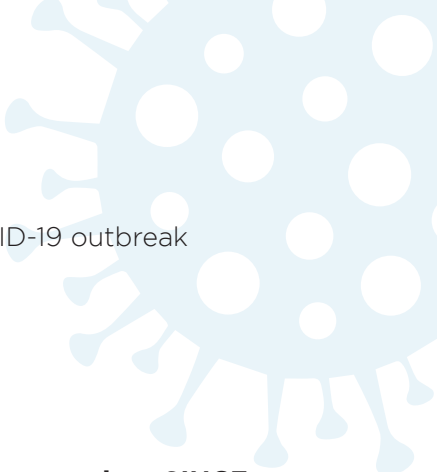
98. Don't know [DO NOT READ]

ASK ALL

C07. Did you personally seek any healthcare service/visit doctors SINCE THE ONSET OF COVID-19? If yes, what has been your experience in the time it took to receive healthcare services/visit doctors?

SINGLE ANSWER

1. Same waiting time as before COVID-19 outbreak
2. Longer waiting time as before COVID-19 outbreak

- 
3. Shorter waiting time as before COVID-19 outbreak
 4. Had to go repeatedly as doctors are not available during COVID-19 outbreak
 5. Did not seek/need medical care
 6. Self-medication for fear of getting infected with COVID-19
 98. Don't know **[DO NOT READ]**

ASK ALL

C08. Have you or any other household member tried to access healthcare services SINCE THE ONSET OF COVID-19. Were you able to access them?

SINGLE ANSWER

1. Yes, we tried and were able to access healthcare facilities
2. Yes, we tried but were not able to access healthcare facilities
3. Yes, we tried and were able to access some, but some we couldn't
4. No, we didn't need any healthcare services **[EXCLUSIVE]**
98. Don't know **[DO NOT READ]**

ASK IF C08 IS 2 AND 3

C08a. Which of the following healthcare services did you try to access SINCE THE ONSET OF COVID-19 but have been UNABLE to?

READ ANSWERS. MULTIPLE ANSWER. RANDOMIZED ANSWERS

1. Family planning/Sexual and reproductive healthcare services (including menstrual hygiene etc.)
2. Healthcare services for pregnant mothers/maternal healthcare services
3. Child healthcare services
4. Clinical management of sexual violence
5. HIV healthcare services
6. Other chronic illness related services
7. Cancer related healthcare (Oncology)
8. Medical imaging (radiology/x-ray) services
9. Lack/scarcity of medicine for chronic illnesses
10. Other healthcare related services
98. Don't know **[DO NOT READ]**

ASK ALL

C09. Has your household been using alternative sources of healthcare services? Please specify.

DO NOT READ ANSWERS. PUT ANSWERS IN APPROPRIATE CATEGORIES. MULTIPLE ANSWER

1. No need to seek alternative healthcare **[EXCLUSIVE]**
2. Visiting herbalists
3. Procuring medication from pharmacies
4. Praying for healing
5. Using mid-wives
6. Calling personal /family doctor for consultation and prescription over the phone

7. Other
98. Don't know [DO NOT READ]
99. Refused [DO NOT READ]

D. Protection and Security

ASK ALL

D01. Have your feelings of safety in your community from threat of violence or violence itself changed SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. The same feeling
2. Feel safer
3. Feel less safe
98. Don't know [DO NOT READ]
99. Refused [DO NOT READ]

ASK ALL

D02. Have you personally experienced violence or threats of violence by the police or security agents in the context of implementing restrictions to respond to COVID-19 (movement restriction, curfew, closure of certain premises)?

SINGLE ANSWER

1. Yes
2. No
98. Don't know [DO NOT READ]
99. Refused [DO NOT READ]

ASK ALL

D03. Have you personally experienced any form of discrimination against you SINCE THE ONSET OF COVID-19? Discrimination happens when you are treated less favourably compared to others or harassed because of your sex, age, disability, socio-economic status, place of residence, political opinion or any other characteristics

SINGLE ANSWER


1. Yes
2. No
98. Don't know [DO NOT READ]
99. Refused [DO NOT READ]

ASK ALL

D04. Do you feel that discrimination, prejudice or racism in the county/area where you live has changed SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

1. No, it didn't change
2. Yes, it increased

- 
- 3. Yes, it decreased
 - 98. Don't know **DO NOT READ]**
 - 99. Refused **[DO NOT READ]**

ASK ALL

D05. Have your feelings of safety in your home changed SINCE THE ONSET OF COVID-19?

SINGLE ANSWER

- 1. The same feeling of safety GO TO INTRO_GBV
- 2. Feel safer GO TO INTRO_GBV
- 3. Feel less safe GO TO D06
 - 98. Don't know **DO NOT READ]** GO TO INTRO_GBV
 - 99. Refused **[DO NOT READ]** GO TO INTRO_GBV

ASK IF D05 IS 3

D06: Why do you feel less safe SINCE THE ONSET OF COVID-19?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER

- 1. Live in densely populated area and children play and move around making even your home unsafe during COVID-19
- 2. Crime has increased
- 3. Others in the household hurt me
- 4. Other adults in the household are hurt
- 5. Children in the household are being hurt
- 6. There is substance abuse (e.g. alcohol and drugs) in the household
- 7. I fear discrimination and being side-lined at home due to the nature of my work (health worker, COVID-response frontline workers)
- 8. I am stigmatized for having been infected with COVID-19
- 9. Other
 - 98. Don't know **DO NOT READ]**
 - 99. Refused **[DO NOT READ]**

E. Gender Based Violence and harmful practices-FGM and child marriages

INTRO_GBV

I am now going to ask you a series of questions about gender-based violence, please answer based on your knowledge of the experiences of you and your community (family and friends). By gender-based violence we have in mind violence committed primarily against women by men, but we would also like to learn about violence that may be perpetrated by women against men. This violence can be any physical, sexual or psychological violence (such as harassment), in both public and private spaces.

DISCLAIMER

Kindly only answer to this part if you feel confident and safe enough to do so. Should you require information or further support in regard to gender-based violence (GBV), kindly call the national GBV toll free-helpline 6388- Setaweet and 8044- Marie Stopes. It's free for everyone.

You can also refer your family, friends, neighbours or someone who needs support. We commit to ensure that the survivor's right to safety, confidentiality, dignity and self-determination, and non-discrimination.

In cases of sexual violence, the team should be prepared to facilitate access to lifesaving health services within the appropriate time period (72 hours for HIV post-exposure prophylaxis and 120 hours for emergency contraception).

NOTE TO INTERVIEWER: SHOULD YOU FIND A SURVIVOR WHO NEED SUPPORT, THEN REFER THEM TO 1195 (GBV HELPLINE) AND/OR 116 (CHILDREN'S HELPLINE). DO NOT TRY TO COUNSEL THE SURVIVOR, BE CALM AND OPEN WITH THEM. LISTEN CALMLY AND SEEK THEIR APPROVAL TO LINK THEM TO SOMEONE WHO CAN PROVIDE GUIDANCE AND SUPPORT TO THEM. IT IS VERY IMPORTANT TO RESPECT SOMEONES DECISION AS TO WHETHER THEY WILL CALL THE HELPLINE OR NOT. THE TOLL FREE-HELPLINE IS 6388- SETAWEET AND 8044- MARIE STOPES

ASK ALL

E01. To what extent do you think that gender-based violence is a problem in South Africa?

SINGLE ANSWER. REMIND RESPONDENT THAT THIS VIOLENCE INCLUDES: PHYSICAL, SEXUAL, PSYCHOLOGICAL (SUCH AS HARASSMENT), IN BOTH PUBLIC AND PRIVATE.

1. A lot
2. Somewhat
3. A little bit
4. Not at all

98. Do not know **[DO NOT READ]**

99. Refused **[DO NOT READ]**

ASK IF 1-3 AT E01

E02. How often do you think that gender-based violence occurs in South Africa?

SINGLE ANSWER.

1. Happens very often
2. Happens sometimes
3. Does not happen very often
4. Never happens

98. Don't know **DO NOT READ]**

99. Refused **[DO NOT READ]**

ASK ALL

E03. Do you think gender-based violence in South Africa has changed SINCE THE ONSET OF COVID-19? If yes, how did it change?

SINGLE ANSWER

1. Yes, increased
 2. Yes, decreased
 3. No, stayed the same
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

E04. Do you know anyone who have experienced any of the following types of gender-based violence SINCE THE ONSET OF COVID-19?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER. RANDOMIZED ANSWERS

1. Sexual harassment e.g inappropriate and unwelcome jokes, suggestive comments, leering, unwelcome touch/kisses, intrusive comments about their physical appearance, unwanted sexually explicit comments, people indecently exposing themselves to them (the range of sexual harassment)
 2. Slapped, hit, kicked, thrown things, or done anything else to physically hurt the person.
 3. Female genital mutilation, that is, deliberate removal of external female genitalia
 4. Make the person have sex when s/he did not want to" and "do something sexual that s/he did not want to do".
 5. Denial of resources/money/water/land/livestock/house/grain
 6. Online/Internet bullying e.g. physical threats, sexual harassment, sex trolling, sextortion, online pornography, zoom-bombing among others
 7. Emotionally hurting someone through verbal abuse etc.
 8. Denial to communicate with other people
 9. Child and or forced marriage
 10. I Don't know anybody with these types of experiences **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**
98. Don't know **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**
99. Refused **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**

Ask if E04 = any code between 1 to 9

E04a. Which one of the types of gender-based violence listed in the previous question is the most recent one that you became aware of?

ASK ONLY FOR ANSWERS SELECTED IN E04. SINGLE ANSWER

1. Sexual harassment e.g inappropriate and unwelcome jokes, suggestive comments, leering, unwelcome touch/kisses, intrusive comments about their physical appearance, unwanted sexually explicit comments, people indecently exposing themselves to them (the range of sexual harassment)

2. Slapped, hit, kicked, thrown things, or done anything else to physically hurt the person.
3. Female genital mutilation, that is, deliberate removal of external female genitalia
4. Make the person have sex when s/he did not want to" and "do something sexual that s/he did not want to do".
5. Denial of resources/money/water/land/livestock/house/grain
6. Online/Internet bullying e.g. physical threats, sexual harassment, sex trolling, sextortion, online pornography, zoom-bombing among others
7. Emotionally hurting someone through verbal abuse etc.
8. Denial to communicate with other people
9. Child and or forced marriage
98. Don't know **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**
99. Refused **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**

ASK IF ANSWER TO E04a IS 1 TO 9

E05. I would ask you few more questions in relation to the MOST RECENT case of gender-based violence you are aware of.

Who was the perpetrator/offender of the action?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER. RANDOMIZED ANSWERS


1. Spouse/partner
2. Other family member
3. Friend
4. Boss
5. Colleague
6. Client
7. Teacher
8. Neighbour
9. Health worker
10. Community leader
11. Religious leader
12. Security agent
13. Other member of the community **[ANCHOR TO THE BOTTOM]**
14. Other **[ANCHOR TO THE BOTTOM]**
98. Don't know **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**
99. Refused **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**

ASK IF ANSWER TO E04a IS 1 TO 9

E06. Again, in the MOST RECENT case you are aware of, Do you know if the affected person looked for help? If yes, who did they contact?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER. RANDOMIZED ANSWERS.

1. Family member
2. Friend
3. Women's Affairs office

- 
4. Colleague
 5. Client
 6. Teacher
 7. Police
 8. Health facility
 9. Helpline
 10. Social worker
 11. Non-governmental agency
 12. Neighbour
 13. Religious leaders
 14. Online platforms (Facebook, etc.)
 15. Other **[ANCHOR TO THE BOTTOM]**
 16. No, did not seek help **[ANCHOR TO THE BOTTOM, EXCLUSIVE]**
98. Don't know **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**
99. Refused **[DO NOT READ] [ANCHOR TO THE BOTTOM, EXCLUSIVE]**

ASK ALL

E08. If you or someone you know experienced gender-based violence or harmful practices, do you think they would seek help?

SINGLE ANSWER

1. Yes
 2. No
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

E09. Do you know where to find help if you or someone else is exposed to gender-based violence? If yes, where would you find help?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER. RANDOMIZED ANSWERS.

1. Call for access to friendly spaces for children in the community
 2. Seek support from family
 3. Seek religious leader
 4. Access to centres for women/men
 5. Approach community leaders
 6. Talk with friends
 7. Call helpline
 8. Call/go to police
 9. Go to health facility
 10. Seeking support from civil society/NGOs
 11. Other, specify_____
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

ASK ALL

E10. What types of information, advice or support would you say is needed in this community to prevent gender-based violence and harmful practices from happening DURING THIS COVID-19 PERIOD?

READ ANSWERS. RESPONDENT SHOULD ANSWER ONLY WITH YES AND NO. MULTIPLE ANSWER. RANDOMIZED ANSWERS.

1. Information about security/crime prevention, referral linkages
 2. Practical help such as shelter/food/clothing
 3. Someone to talk to
 4. Psycho-social support
 5. Help with insurance/compensation claim
 6. Protection from further victimization/harassment
 7. Help in reporting the incident/dealing with the police
 8. Medical support
 9. Financial support
 10. Legal support
 11. Comprehensive, one stop services where the victim can get all support
 12. Other
98. Do not know **[DO NOT READ]**
99. Refused **[DO NOT READ]**

Thank you for your responses so far. We have one last question to ask before the end of this interview.

ASK ALL

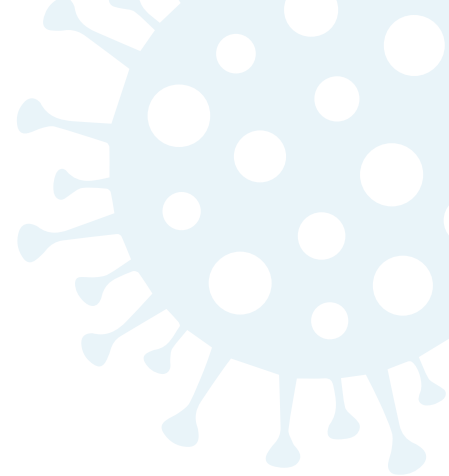
E11. What are currently, during COVID-19, are the top three priority needs for you and your household?

READ ANSWERS. MULTIPLE ANSWER

1. Health care
 2. Food
 3. Water
 4. Sanitation – Hygiene
 5. Shelter and household items
 6. Being sure that you can continue to live in your current place (security of tenure)
 7. Education
 8. Earning a living/getting an income/working
 9. Safety and Security
 10. Other
98. Do not know **[DO NOT READ]**


E12. This marks the end of the questionnaire. Thank you for your participation in both parts of this mobile phone survey. You will receive your **[PLACEHOLDER] airtime credit on this phone within the next 2 days.**

ENDNOTES



- i United Nations Statistics Division (SD) SDG regional categorization
- ii According to UNSD SDG regional definitions East Africa include the following countries: Burundi, Comoros, Djibouti, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Madagascar, Malawi, Mayotte, Mozambique, Réunion, Rwanda, Uganda, Tanzania, Seychelles, Somalia, Sudan, South Sudan, Zambia and Zimbabwe. Southern Africa consist of Botswana, Eswatini, Lesotho, Namibia and South Africa
- iii WHO Regional Office for Africa (2020), COVID-19 Situation update for the WHO Africa Region, External Situation Report, 21.10.2020, WHO Regional Office for Africa dashboard (Accessed 12 December 2020)
- iv WHO Regional Office for Africa (2020), COVID-19 Situation update for the WHO Africa Region, External Situation Report, 21.10.2020, WHO Regional Office for Africa dashboard (Accessed 12 December 2020)
- v UN Women - UNFPA (2020) CATI COVID-19 Rapid Gender Assessments in ESA (unpublished data, accessed in December 2020).
- vi AFIDEP webinar series. Available from <https://www.afidep.org/programme/seminar-series-demography-and-covid-19-in-africa/>. Accessed February 2020
- vii World Population prospects 2020. Available from <https://population.un.org/wpp/>. (Data Accessed 10 December 2020)
- viii UNHCR. Renewed Appeal 2021.
- ix Africa Gender development Index, AfDB. <https://www.afdb.org/en/news-and-events/press-releases/african-development-bank-and-partners-roll-out-comprehensive-report-state-gender-equality-africa-39648>, accessed 16 December 2020
- x UN Women and UNDP (2020) COVID-19 Global Gender Response Tracker. factsheet: Sub-Saharan Africa (Accessed in January 2021)
- xi <https://covid19africawatch.org/africa-policy-monitor/>
- xii AfDB. Unleashing women's entrepreneurship through strategic partnerships. Available from: https://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/AFAWA_-_Unleashing_women%E2%80%99s_entrepreneurship__en_.pdf. Accessed February 2021
- xiii World Bank (2020) www.worldbank.org (Accessed in January 2021)
- xiv AfDB (2020b) African Development Bank (2020b) African Economic Outlook – supplement Performance and Outlook Amid COVID-19.
- xv UNDP (2020) HDR 2020
- xvi UNDP (2020) HDR 2020
- xvii ILO (2020) ilostat.ilo.org (Accessed in December 2020)

- xviii UNDP (2020) HDR 2020
- xix AfDB & UNECA (2020) Statistical and Methodological Report. African Gender Index report 2019
- xx <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>
- xxi www.wfp.org/news/southern-africa-throes-climate-emergency-45-million-people-facing-hunger-across-region
- xxii FAO. Available from www.fao.org/en/news. Accessed in January 2021
- xxiii <https://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Southern%20Africa%20-%20COVID-19%20Situation%20Report%20-%202020%20July%202020.pdf>
- xxiv UN Women (2020) Progress of African Countries Towards the Sustainable Development Goals (SDGs)
- xxv UNWomen/UNESCO, <https://data.unwomen.org/resources/covid-19-and-gender-monitor>
- xxvi Centre for Global Development and Unicef, UNWomen Calculations
- xxvii UNESCO figures for 2018. <http://data.uis.unesco.org/>. Accessed 13 October 2020
- xxviii UNFPA (2020) East and Southern Africa Region. COVID-19 Situation Report No. 8
- xxix Ibid.
- xxx SADC (2020) SADC Regional Response to COVID-19 Pandemic. With Focus on Health, Law Enforcement and Security; and Food, Nutrition Security and Livelihood Sectors. Bulletin No. 14
- xxxi SA PERC (2020) Responding to COVID-19 in Africa: Using Data to Find a Balance. Part II.
- xxxii UNFPA - UNICEF (2020) Child Marriage in COVID-19 contexts: Disruptions, Alternative Approaches and Building Programming Resilience
- xxxiii World Health Organisation – UNFPA – UNICEF Interagency Tool for Monitoring Continuity of Essential SRMNCAH Services in East and Southern Africa (2020)
- xxxiv Ibid.
- xxxv Ibid.
- xxxvi UN Women – UNFPA (2020) CATI COVID-19 Rapid Gender Assessments in ESA (unpublished data, accessed in December 2020)
- xxxvii Gallup (2019) in UN Women (2020) Africa SDG Index and Dashboards Report 2019
- xxxviii UNSD SGD database, Available from <https://unstats.un.org/sdgs/indicators/database/>. Accessed December 13th 2020
- xxxix UNFPA-UNICEF (2020). COVID-19 Disrupting DG 5.3. Eliminating Female Genital Mutilation. Technical Note. April 2020
- xl [UN Women.org/data-portal/vaw](http://UNWomen.org/data-portal/vaw) (Accessed in December 2020)
- xli UN in South Africa – Department of Women, Youth and People with Disabilities (2020) The Shape of the Shadow. COVID and Gender-based Violence in South Africa. December 2020
- xlvi Mahmud and Riley 2020, working paper cited in Center for Global Development (2020) CGD Note. COVID-19 and Violence against Women and Children

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- xliii UN Women (2020) Mapping of Discrimination Against Women and Girls with Disabilities in East and Southern Africa
 - xliv UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020
 - xliv UNFPA GAGE (2020) COVID-19 Series. Ethiopia. August 2020. Experiences of vulnerable urban youth under COVID-19: the case of youth with disabilities
 - xlvi UN Women (2020) Africa SDG Index and Dashboards Report 2019
 - xlvi UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020
 - xlvi UNFPA (2020) A Rapid Scoping Assessment of the Impact of COVID-19 on Sex Workers' Programmes in East and Southern Africa. (Unpublished manuscript)
 - xlvi UNFPA (2020) A Rapid Scoping Assessment of the Impact of COVID-19 on Sex Workers' Programmes in East and Southern Africa. (Unpublished manuscript)
 - I UNFPA and Ministry of Women, Children and Youth (2020) COVID-19 Series. August 2020
 - li UNICEF. Building Back Equal: Girls back to School Guide. Published 2020



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