Chapter Thirteen

Gender Dimensions of COVID-19 and Social Policy in Sub-Saharan Africa

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Introduction

The coronavirus disease 2019 (COVID-19) pandemic is highly gendered and social policy measures that were implemented to mitigate the impact of the disease on the lives and livelihood of the affected population in sub-Saharan Africa (SSA) reveal a gendered approach by governments in SSA. Since its outbreak in 2019, the COVID-19 pandemic has undergone several phases, with cases rising sporadically in some countries compared to others. At the global level, COVID-19 cases rose from over 79 million in 2020 to over 500 million as of 2022, and reported deaths rose from over 1 million in 2020 to more than 6 million as of May 2022 (OWD, 2022). The COVID-19 pandemic is not only a health concern, it affected all areas of human life globally. In particular, the pandemic outbreak has amplified the pre-existing vulnerabilities and structural inequalities that exist in SSA, where most of the world's vulnerable to socio-economic shocks live.

As a way of curbing the spread of the disease, several policies were implemented, including the closure of borders, imposition of lockdown and movement restrictions, closure of public places, and places of means of livelihood at national and global levels. These measures, to safeguard public health, exposed people to other dimensions of distress, with implications for their sustenance. Empirical evidence has shown that although the impact of the pandemic is widely felt across nations and by different population groups, men and women are differently affected by the disease outbreak. While gender inequality has persisted in SSA, from the family settings to the workplace, the outbreak of the COVID-19 pandemic has exacerbated such inequalities. The pandemic outbreak and the containment measures disproportionately affect women's and men's access to healthcare and health services, and livelihood opportunities. Gender-based violence also increased following the lockdown because of the movement restrictions that narrowed the space between women and their abusers in the case of intimate partner and close relative violence and increased cases of non-intimate violence reported in several countries in SSA. Women in displaced people's camps also suffered the impact of the vagaries of the pandemic compared to men.

Social policy measures that were implemented in SSA in response to the pandemic outbreak have also been found to be gendered. Whether policy measures on social protection, labour markets, gender-based violence, or other forms of measures meant to reduce the socio-economic shocks of the pandemic, women were found to have less access to such opportunities than men.

The chapter, therefore, analyses the gendered dimensions of the COVID-19 pandemic and the social policy measures that were implemented to address the socio-economic impact of the pandemic in SSA, by addressing three main objectives. (1) to analyse the pandemic outbreak in SSA (2) to analyse the gender dimensions of the pandemic impact in SSA (3) to analyse the social policy responses to the pandemic outbreak in SSA. It argues that the impact of the pandemic is highly gendered

in SSA, as men and women are differently affected by the pandemic and policy responses of the governments are also gendered, with limited considerations to women's pre-existing vulnerabilities that are exacerbated by the pandemic.

The chapter uses secondary data sourced from the Africa Centre for Disease Control (Africa CDC), Our World in Data (OWD) on the prevalence and trends of COVID-19, International Labour Organization (ILO) data on social protection, and the United Nations Development programme (UNDP) Global Gender Response Tracker and International Monetary Fund (IMF) datasets. Countries with high incidences of confirmed cases and deaths in SSA are examined in the chapter. The generated data from the various sources are analysed using charts and tables to explain the dynamics of the prevalence and trends of the COVID-19 pandemic, the dimensions of social protection explored in SSA, and a gendered perspective of social protection in SSA in response to the pandemic outbreak. Articles, publications, and Internet materials are also used in the discourse. An empirical analysis of the gendered impact of the pandemic in SSA is imperative for ensuring that efforts that are geared towards mitigating the impact of the disease, especially in post-COVID-19 policies should address the gender gaps in social policy responses to affected households or individuals. The chapter provides evidence for policymakers and concerned institutions in SSA to enhance the selection of options to address the COVID-19 pandemic impact from a gendered perspective.

The rest of the chapter is divided into four sections. The first section focuses on a contextual discussion of COVID-19 in SSA, including the prevalence, trend, and containment policies of governments; the second section analyses the gender dimensions of the COVID-19 pandemic; the third section analyses the policy responses to mitigate the impact of the pandemic by governments in SSA, and the fourth section concludes the chapter with recommendations.

Contextual discourse of COVID-19 in SSA

The COVID-19 pandemic, which was first reported in China in 2019, was declared a global pandemic by the World Health Organization (WHO) on 11 March 2020 (WHO, 2020). The first reported case of COVID-19 in Africa was in Algeria, on 25 February 2020, and in the sub-Saharan African region, Nigeria reported the first case on 27 February 2020 (Impouma, et al., 2021). Since the first outbreak of the pandemic in SSA, the trends and prevalence of the disease have undergone various phases, with the global, regional, and national governments responding through a series of policy measures to contain its spread and impact on people.

Prevalence and Trends of COVID-19 in SSA

The prevalence and trends of the COVID-19 pandemic differ across countries and continents since its first outbreak in 2020. As of 7 June 2022, over 11 million confirmed cases, and more than 250 thousand deaths have been recorded on the African continent (African Centre for Disease Control, 2022).

In SSA, Southern Africa has the highest number of confirmed cases on the continent, with over 5 million confirmed cases, with the lowest number of reported confirmed cases in Central Africa, where less than 4 hundred thousand confirmed cases have been reported (Figure 1). Reported cases on a per-country basis indicate that South Africa has the highest number of cases, with about 4 million confirmed cases as of 7 June 2022 (African Centre for Disease Control, year).

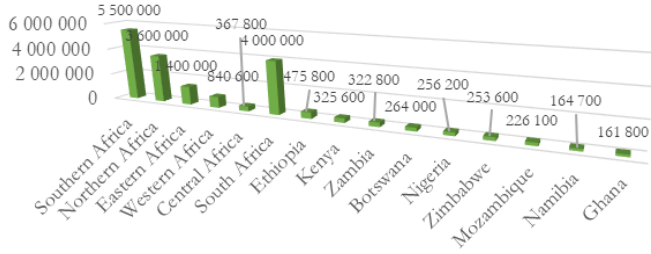

Figure 1: Prevalence of COVID-19 in Africa as of 7 June 2022. Source: Researcher's computation from Africa CDC (2022) dataset

The trends of the disease outbreak also show an increase since 2020 when the disease first broke out. For instance, in South Africa, while the number of confirmed cases was over 1 million by 31 December 2020, as of 31 May 2022, about 4 million cases of the disease had been confirmed (Table 1). Similarly in Ethiopia, with the second highest number of cases in SSA, confirmed cases increased from about 120 thousand by 31 December, to almost 500 thousand as of 31 May 2022 (Table 1). In West Africa, Nigeria had the highest number of confirmed cases of the disease, and even though this may be low compared to South Africa, Ethiopia, Kenya, Zambia, and Botswana (Figure 1), there had also been a steady increase in confirmed cases, increasing from over 87 thousand by 31 December 2020 to over 250 thousand by 31 May 2022 (Table 1).

Similarly, as observed globally, deaths associated with the COVID-19 pandemic have been on the increase in SSA. Higher death rates are reported in South Africa compared to other countries on the continent. The death rate in South Africa increased from about 28 thousand in 2020 to over 100 thousand as of 31 May 2022 (Figure 2). Comparatively, reported death rates in other countries in the sub-region have been low. For example, even though Ethiopia has the second highest number of confirmed cases, after South Africa, only about 7 thousand deaths have been reported as of 31 May 2022, while in Nigeria, recorded deaths are as low as about 3 thousand for the period under analysis (Figure 2).

Table 1: Trends of COVID-19 in selected countries in SSA

Global/Region/Country	Confirmed cases			Deaths		
	2020*	2021*	2022**	2020*	2021*	2022**
World	83,748,179	288,694,522	529,705,596	1,880,470	5,440,227	6,292,532
Africa	2,760,454	9,756,168	11,884,875	65,468	228,453	254,076
South Africa	1,057,161	3,458,286	3,957,777	28,469	91,145	101,190
Ethiopia	124,264	420,342	472,743	1,923	6,937	7,513
Kenya	96,458	295,028	324,976	1,670	5,378	5,651
Nigeria	87,607	241,513	256,028	1,289	3,030	3,143

Source: Researcher's computation from Our World in Data database

**2020 and 2021 data are figures as of 31 December; **2022 data are figures as of 31 May 2022*

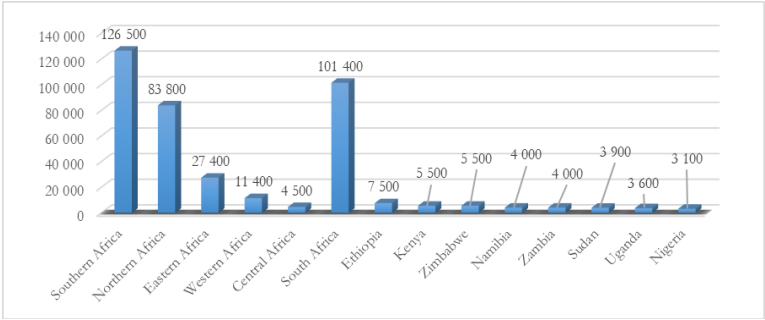

Figure 2: Sub-regional/country recorded death from COVID-19 in Africa as of 7 June 2022. Source: Researcher's computation from Africa CDC (2022) dataset

Containment Policy Measures of COVID-19 in SSA

Given the pandemic nature of COVID-19, the need for prompt policy responses in containing its spread and impact on population groups locally, nationally, and globally were explored. From the closure of national and international borders, and closure of public places, including worship centres, business places, tourism sites, schools, worship centres, etc., to restrictions of movements, imposition of curfews, and compulsory COVID-19 testing to contain the disease, were implemented in SSA, in line with global practices (IMF, 2022). The rollout of COVID-19 vaccines in 2021 has also been a key driver towards containing the spread of the disease and reducing fatalities.

While the containment measures that were imposed at the early stages of the pandemic, particularly in 2020 were understandably necessary for safeguarding public health, they also reinforced another challenge to society. The variants of lockdown and movement restriction policies that were implemented at global, regional, and national levels, affected all segments of society, to varying degrees. Primarily, means of livelihood, access to socio-economic resources, and distress mechanisms for people that are prone to violence and other attacks were seriously affected by such measures. These measures aggravated the gender gaps already evident in their

limited sensitivity to gender differences in their implementation (ILO, 2022b). Women are differently affected by the pandemic than men (ILO, 2020). Hence, where policy measures of containment and management of the impact of the disease are not sensitive to gender differences in impact, a new problem could arise, with implications for bridging the gender gap in society.

Firstly, the closure of public places and movement restrictions affect women and men differently. Even though the pandemic is a health concern, during the lockdown, women experienced challenges attending to other health needs, because the attention of most governments was tailored towards the pandemic than addressing other health challenges. There was a disruption in the women's access to routine healthcare, especially maternal care as a result of the pandemic, as most governments' attention was focused on the pandemic at the expense of other health needs of women (Aranda et al., 2020).

Secondly, the border closure that was imposed by several countries greatly affected women who derive their livelihood from cross-border trade, since the measure prevented them from accessing their means of livelihood (Zarrilli & Linoci, 2020).

Thirdly, the lockdown and closure of public places, including places where women derive their means of livelihood diminished their income, and livelihood opportunities. Hence, while the policy measures that were imposed to contain the spread of the disease appeared laudable, understanding how they contribute to gender gaps in SSA is key to situating post-COVID-19 recovery policies that will enhance gender equality in society.

Gender Dimensions of COVID-19 in SSA

The impact of the COVID-19 pandemic is highly gendered. On almost all fronts of life choices, women are at a disadvantage compared to men, even before the outbreak of the disease. The structural failures of most governments in SSA are evident in the high levels of poverty, unemployment, poor health

outcomes, and other socio-economic deprivations. The United Nations (UN) noted that women aged 25-34 are 25% more likely than men to live in extreme poverty (UN, 2020). This is expected when critical indicators of standards of living are considered, such as healthcare and employment, since pieces of evidence show that gender gaps exist in women's access to these life opportunities. It is to the extent that they can access these opportunities that the potential or actual impact of the pandemic on their lives and livelihood is understood.

The United Nations Office on Drugs and Crime (UNODC, 2020) noted that the impact of the pandemic on victims and survivors of domestic violence, homeless women, older women, and women and girls with disabilities differ and that women who are deprived of their liberty, displaced, refugees, migrants, and those living in areas that are affected by conflict are more at risk of the vagaries of the disease. This series of impacts on women is not exhaustive; however, this section will focus on the impact of the pandemic on women's access to healthcare, their livelihood opportunities, and gender-based violence.

Access to Healthcare

The impact of the pandemic on access to healthcare and services is gendered globally, with similar experiences observed in SSA. Primarily, women's engagement in the health sector predisposes them to the disease, given that most of the people employed in the sector are women. They constitute about 70% of the health sector workers, working as nurses, midwives, community health workers, caterers, cleaners, and launderers (UN, 2020). This suggests a likelihood of their higher exposure to the disease and its impacts than men.

Apart from their direct involvement in the health workforce, women's needs for healthcare vary from that of men, especially in areas of reproductive health. Hence, the diversion of resources from primary health concerns to address the emergent COVID-19 pandemic puts women's health at further risk of the disease contagion and other associated impacts. The UN Women (2020) reported that an extended lockdown for six

months could deny about 47 million women in 114 low- and middle-income countries access to modern contraceptives. In Nigeria, there was a 50% drop in anti-natal visits in the early stages of the pandemic and a 40% decrease in available skilled birth attendants (Ameyaw et al., 2021). This means that women with maternal care issues during the peak period could be exposed to other threats when the available personnel or service required are not readily available as a result of the pandemic.

Women's access to healthcare as a result of the pandemic is also a function of the government's spending in the health sector in SSA. The expenditure for the health sector has been persistently low for most countries in SSA, ranging from 9.3% in Malawi, 8.2% in South Africa, on the high side to as low as 3.9% and 3.2% in Nigeria and Ethiopia respectively in 2018 (UNDP, 2020). With such low commitment to the health sector, the preparedness for eventualities like the COVID-19 pandemic and the emergency required to curtail the spread of the disease implied neglect of other health needs of the populace, especially women's health concerns.

Conclusively, the gendered dimension of access to healthcare was relatively poor in some countries in SSA, and while the health expenditure is generally low, its effect on women's healthcare, particularly on the ANC during the pandemic, was far-reaching.

Livelihood Opportunities

The livelihood of households was seriously affected by the pandemic, especially because of the lockdown and closure of places of livelihood opportunities that were adopted globally to manage the spread of the pandemic. The impact of the pandemic spreads across almost all sectors of socio-economic means of livelihood, with a gendered dimension to the impact on livelihood.

Labour Force Participation

Before the outbreak of the pandemic, gaps exit in labour force participation globally and in SSA. According to the UNDP (2020),

a gender gap exists in the participation in the labour force globally, reporting a 94% participation of men between the ages of 25 and 54 in the labour force compared to 63% of women. In SSA, while the female labour force participation in countries like Ethiopia, Kenya, and Malawi has been persistently high over the last decade, as high as 70% in 2019, for countries like Nigeria and South Africa, the female labour force participation was 47.87% and 49.61% respectively in 2019 (UNDP, 2020). In contrast, the male labour force for Nigeria and South Africa in 2019 was 57.9% and 62.7% respectively in 2019 (ibid). With the pandemic, fewer women became employed in Malawi, Nigeria, Uganda, and Ethiopia, which was more pronounced in Uganda and Ethiopia where more women than males lost their jobs as a consequence of COVID-19 (Weber et al., 2020). This implies that with the lockdown and associated containment measures, the impact of the disease on women's participation will be further reduced. Hence, with women disproportionally more in the informal sector and giving more hours than men to unpaid work at home, their access to livelihood opportunities is largely distorted by the pandemic.

Informal Employment

The informal sector accounts for the majority of the labour force globally, also, reflecting a gendered situation. An estimated 740 million women work in the informal sector globally (ibid), dominating the sector, with an estimated 42% of women employed in the sector compared to 32% of men (ILO, 2020). The informal sector is reported to be the most affected by the pandemic (Nguimkeu & Okou, 2020). In Nigeria, more than 90% of women work in the informal sector, and with the imposition of the lockdown, the livelihoods of such women are automatically affected for the period of the lockdown (Nguimkeu & Okou, 2020).

The services sector remains a key employer of most people in the informal sector. In countries like South Africa, Nigeria, and Ghana, there is a high proportion of people employed in the services sector. The UNDP (2020) data showed that in South Africa and Nigeria, for example, 72.4% and 52.0% of the total

population are employed in the services sector respectively. The services sector is also dominated by women, accounting for 84% and 63.57% in South Africa and Nigeria in 2019 respectively (UNDP, 2020). Their higher rates of employment in the services sector also confirm the likely differential in the impact of the pandemic on women's livelihood. The containment measures that prevented them from accessing their livelihood during the peak periods of the lockdown in SSA, put their livelihood survival and that of their dependents at risk.

Remuneration is an essential motivation for services rendered or jobs performed. The gender gap that existed before the outbreak of the pandemic also implies that women may earn less for alternative means of livelihood to cushion the impact of the pandemic in the face of the lockdown and closures of their primary places of livelihood. The gender pay gap implies that women are generally paid less for similar services rendered. According to the UN (2020), the gender pay gap is about 16%, with women paid about 35% less than men in some countries. As in the case of Uganda, Ethiopia, Malawi, Nigeria (Weber et al., 2020), and some other SSA countries, alternative means of livelihood paid women less than men during the outbreak of the pandemic. This means that women's ability to cope with family needs during the COVID-19 lockdown period dwindled compared to men.

Gender-Based Violence

Gender-based violence was tagged "the shadow pandemic" by the UN (2020) following its growing prevalence as a result of the pandemic and the lockdown that predisposes victims to their abusers. UNODC (2020:2) reported that housing individuals or families in proxy for an extended period increased the rate of violence against women. The movement restrictions and enforced 'stay at home' measures led to situations of crowded homes, substance abuse, limited access to services, and reduced peer support, situations that expose women from abusive families trapped with their abusers (Dempster et al., 2020).

Instances of gender-based violence were reported in several parts of SSA during the lockdown. The UN (2020:8) reported that the disruptions to health care services were also predicted to contribute to an additional 7 million unintended pregnancies, including those emanating from rape cases. In a similar report, the UNDP (2020) indicates that 38.8% of women in Ethiopia and 35% in Liberia experienced physical or sexual violence in a twelve-month period. Though the report for Nigeria is as low as 11% (UNDP, 2020), apart from sexual and physical abuse during the lockdown, instances of young women who were sexually abused and killed by the perpetrators during the lockdown were widely reported in Nigeria. In another report, the UN Women (2020) reported that gender-based violence cases increased from 314 in March to 781 in April 2020 alone, in Nigeria.

Social Policy Responses to the Impact of COVID-19 in SSA

Broad policy measures that are used globally in addressing societal needs range from policies that address labour markets, economic, financial, and fiscal support for businesses and entrepreneurs, social protection, and violence against women (UNDP, 2020). In response to the pandemic, governments in SSA responded to the pandemic outbreak using similar measures to address the health impact of the pandemic and mitigate the impact on the livelihood and welfare of various segments of society. Some of the measures that were announced include special allowances or grants, food and nutrition protection, and health protection, with several covering various measures including housing or basic services benefits, income or job protection. Selected country situations of policy measures to combat the pandemic in SSA are highlighted.

Policy Responses in Selected Countries in SSA

The response to COVID-19 was complex and ongoing on a worldwide scale. International efforts to battle the epidemic were effectively coordinated and facilitated by the UN and

the WHO. National and regional governments, as well as international institutions, received directives from the UN and WHO. This was essential in order to effectively combat the epidemic, as the UN and WHO highlighted the need for worldwide cooperation and solidarity. To stop the spread of the virus, numerous nations and organisations worked together on research, data sharing, and resource allocation, by guaranteeing equitable access to vaccinations, diagnostics, and treatments, the WHO collaborated on the Access to COVID-19 Tools (ACT) Accelerator with organisations including the Global Alliance for Vaccines and Immunization (Gavi) and the Coalition for Epidemic Preparedness Innovations (CEPI). The COVAX effort, sponsored by Gavi, the WHO, and the CEPI, sought to give COVID-19 vaccines fair and equitable access, particularly to low- and middle-income countries.

Beyond the global response to COVID-19, state or country responses were significant to mitigating the spread and impact of the pandemic on people. Below are some policy responses from selected countries.

As part of the multi-sectoral policy response to the pandemic in Ethiopia, an estimated $635 million (0.6% of the country's GDP – gross domestic product) was allocated to food distribution to 15 million people that are vulnerable to food insecurity who are not covered by the rural and urban Productive Safety Net Programme (PSNPs) (IMF, 2022). An additional $293 million (0.3% of GDP) was allocated to the agricultural sector support, nutrition, protection of vulnerable groups, etc. (IMF, 2022). An exemption from personal income tax withholding for four months was allowed for firms that continue to pay employees' salaries during the lockdown (IMF, 2022). This measure further enhances the social security of employees in the country. Following the roll-out of the COVID-19 vaccine in 2021**,** Ethiopia received 2.2 million vaccine doses in March 2021, with a target of vaccinating 20% of the population by the end of 2021 (IMF, 2022). However, as of 14 June 2022, only 0.3% of the more than 120 million people in the country have been fully vaccinated (African Centre for Disease Control, 2022).

In response to the pandemic, the government of Kenya budgeted Ksh40 billion (0.4% of GDP) for COVID-19-related expenditures, including the health sector, social protection (including cash transfers and food reliefs), and funds to maintain cash flow for businesses (IMF, 2022). In the 2021 budget cycle, the government also released a Ksh56.6% million (0.5% of GDP) economic stimulus package that covers a new youth employment scheme, provision of credit guarantees, increased funding for cash transfers, etc (IMF, 2022). Tax relief for persons earning below the equivalent of $225 per month, reduction of VAT from 30% to 25%, reduction of corporate income tax from 30% to 25%, etc., and in the 2022 budget, an additional Ksh45 billion (0.4% of GDP) was also allocated to cover amongst other, vaccines, access to affordable healthcare, economic stimulus programme for vulnerable groups (IMF, 2022). The vaccination plan in Kenya was initially targeted at vaccinating 30% of the population by mid-2023 (IMF, 2022), however, as of 14 June 2022, only 3.7% of the over 56 million people in the country have been fully vaccinated (African Centre for Disease Control, 2022).

One of the first responses of the Nigerian government following the outbreak of the pandemic was a ₦500 billion (0.3% of GDP) COVID-19 intervention fund, which covered health expenditures (including tests, supplies, and facilities) and a public works programme to support vulnerable households (IMF, 2022). The social register of poor and vulnerable households was also increased by 1 million, from the initial 2.6 million beneficiaries to 3.6 million households (IMF, 2022). Also, the Central Bank of Nigeria provided ₦73.7 billion ($139 million) in targeted credit facilities to support households and small- and medium-scale enterprises (IMF, 2022). The Nigerian vaccine policy was initially planned to vaccinate 40% of the population in 2021 and an additional 30% in 2022 (IMF, 2022), however, this is far from reality, because as of 14 June 2022, only 9.8% of the over 200 million people in Nigeria have been fully vaccinated (African Centre for Disease Control, 2022).

The South African government provided funding from the Unemployment Insurance Fund (UIF) to assist companies and

workers up to April 2021 in response to the pandemic outbreak (IMF, 2022). Funds were also made available for the health sector, workers with an income below a certain threshold were given tax subsidies for four months, and the most vulnerable families were given temporary higher social grants (IMF, 2022). A temporary COVID-19 grant was also provided to cover unemployed workers who were not covered in the UIF benefits, food parcels distributed and funds allocated for public works programmes, small and medium-sized enterprises (SMEs) under stress, small-scale farmers in the poultry, livestock and vegetable sectors, etc. (IMF, 2022). The South African government planned a strategic vaccination that targeted 67% of the population by the end of 2021 (IMF, 2022). However, as of 14 June 2022, only 1.6% of the over 60 million people in the country have been fully vaccinated (African Centre for Disease, 2022). Be that as it may, some government responses have been instrumental in managing the impact on well-being and livelihood. Nigeria became the first African nation to sequence the SARS-CoV-2 genome on March 4, and as of July 1, South Africa was rated 19th globally, thereby leading the continent in testing per capita with 27,485 tests per million people (Travaly & Mare, 2020). A National COVID-19 Modelling Consortium was proactively established by the South African government to serve as the main repository for all COVID-19-related projections.

Dimensions of Social Protection Policies in Response to COVID-19 in SSA

Beyond the general policies that were implemented to mitigate the impact of the pandemic on citizens in SSA, social protection has been recognised as a means of reducing the impact or effect of socio-economic shocks on poor and vulnerable households. Social protection measures are categorised based on their functions to include measures to improve health, children and family welfare, maternity services for women, unemployment, work injury, disability, old age, contribution to pension, and vulnerability (ILO, 2022a). In response to the outbreak of the pandemic, the UN (UN, 2021) reported that 51 out of 55 African countries announced a total of 227 social protection measures

between February and November 2020, which undoubtedly span the critical periods or the first phase of the disease outbreak in most countries in SSA.

Bearing in mind that women, who have more difficulty accessing public services, including health, education, and justice, are more vulnerable to violence and gender-based violence; and are poorer and more likely to experience poverty and health problems, they are considered a vulnerable group (UNDP, 2014). Hence, available data showed that the vulnerable in South Africa enjoy more social protection benefits compared to other countries in the sub-region (UNDP, 2020). In South Africa, the proportion of the population that enjoys at least one social protection benefit increased from 47.8% in 2016 to 49.3% in 2020 (UNDP, 2020), whereas in Nigeria, the proportion of people with at least one social protection benefit increased from 4.4% in 2016 to 11% in 2020 (UNDP, 2020). This is very low in a country where over 40.1% of the population is poor (NBS, 2023), with more people becoming vulnerable to poverty outcomes caused by the pandemic and lockdown measures. What is observable in Ethiopia is a decrease in the proportion of people with at least one social protection benefit (from 11.6% in 2016 to 7.4% in 2020), even though the country has the second-highest cases in SSA and the possibility of increased vulnerability. The diversion of funds to strengthen health systems, at the expense of the social and economic impacts of the pandemic, implies poor socio-economic outcomes for the poor and those who became vulnerable because of the lockdown.

An analysis of the coverage of social protection policies of some countries in SSA showed that most countries have not performed well in their coverage of the social protection measures. For instance, the proportion of the population with social protection coverage for maternity, which is an exclusive terrain for women, indicates that, except for Kenya and Botswana, with 30.2% and 24% coverage respectively, limited coverage was observed for countries like South Africa (7.6%), Zambia (4.1%) and Nigeria (0.1%) (ILO, 2022). For countries with high incidences of the pandemic, only South Africa and Zambia appear to have a reasonable social protection coverage

(32.4%) and (19.8%) respectively for vulnerable households, and for Nigeria, this is as low as 1.8% (ILO, 2022). The data also showed that only South Africa (11.9%) and Nigeria (7.0%) have social protection policies that cover unemployment (ILO, 2022). This is still very low, given the lockdown impact on the livelihood of households during the peak periods of the outbreak when people could not access their means of livelihood.

The low spending on social protection in SSA confirms the low coverage of social protection efforts. The ILO (ILO, 2022) data indicates that the expenditure on social protection as a percentage of the GDP is low for most of the countries, as low as 0.7% in Nigeria and 0.9% in Ethiopia, with South Africa having the highest, 5.5% of the GDP amongst the countries studied. The willingness or unwillingness to spend on social security measures is a determinant of how the pandemic will affect the lives and livelihood of citizens, especially the vulnerable like women.

Not minding the fact that several social protection policies were implemented in response to the pandemic outbreak in SSA, most of these policies are ad hoc responses that are not entrenched in the legal systems of the countries. Hence, their sustainability cannot be guaranteed beyond the critical phases of the pandemic outbreak. For instance, it is surprising that only South Africa has a social protection legislature that covers unemployment (40.2%) (Figure 3). The absence of such legislature in the select countries implies limited accountability of the government to the plight of those in vulnerable employment and those whose employment status became vulnerable as a result of the pandemic.

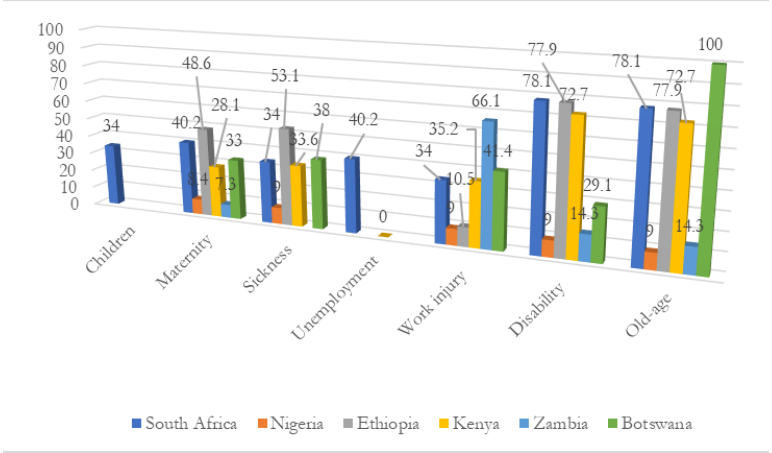

Figure 3: Legal coverage of social protection. Source: Researcher's computation from ILO (2022) dataset

Gender Dimensions of Social Protection in SSA

Given that the impact of the pandemic on different population groups is gendered, any policy measure that is implemented should be gender-sensitive its effectiveness to be ascertained. While this is the expectation, observations from SSA indicate that social protection measures that were implemented to mitigate the impact of the pandemic are limited in gender-sensitivity.

Available data on the gender-sensitivity of social policy measures in SSA indicates that South Africa announced a total of 44 policy measures in 2020, with 17 addressed to social protection. Of the 44 policy measures, only 16 them are gender-sensitive (Table 2). Nigeria announced 34 policy measures with only 11 addressed to social protection. Of the 34 measures, only 13 are gender-sensitive (Table 2). Countries like Zambia and Botswana, with high incidences of confirmed cases and death rates, announced very low social protection measures – six and three respectively, with only four of their measures being gender-sensitive (Table 2).

It is also interesting to note that only South Africa announced four policy measures that directly support unpaid

Table 2: COVID-19 Policy Measures and Gender Sensitivity in SSA

Country	Types of policy measures				Total number of policy measures	Addresses VAWG	Targets women's economic security	Directly supports unpaid care	Gender-sensitive
	Social protection	Violence against women	Labour market	Economic, financial, and fiscal support for businesses and entrepreneurs					
South Africa	17	7	2	18	44	7	5	4	16
Ethiopia	9	7	3	3	22	7	5	0	12
Nigeria	11	5	2	16	34	5	8	0	13
Kenya	12	4	6	6	28	4	6	0	10
Zimbabwe	10	8	8	0	26	8	4	0	12
Botswana	6	2	2	4	14	2	2	0	4
Zambia	3	3	4	0	10	3	1	0	4

Source: Computed by the researchers from UNDP (2020) global gender response tracker

Table 3: Legal Coverage of Social Protection by Sex

Country	Children/ family		Mater- nity	Sickness		Unemploy- ment		Work injury		Disability		Old age	
	F	M	F	F	M	F	M	F	M	F	M	F	M
South Africa	100	100	30.2	30.2	37.9	34.6	46.2			77.3	79	77.3	79
Nigeria			8.4		12.3	-	-		12.3		12.3		12.3
Ethiopia			48.6	48.6	57.7	-	-	7.7	13.3	71.4	84.5	71.4	84.5
Kenya			28.1	27	40.3	-	-	28.1	42.5	70.1	75.4	70.1	75.4
Zambia			7.3	-	9.3	-	-			7.3	21.6	7.3	21.6
Botswana			33	33	43.6	-	-	35.4	48.1	28.5	6.6	100	6.6

Source: Researchers' computations using data from the ILO (2020) World Social Protection Database.

care amongst the countries under examination (Table 2). With the lockdown and the responsibility of attending to family members, and other basic chores, women's responsibilities increased compared to men (Augustus, 2021).

A major determinant of the commitment of governments to implement any policy measure is whether such measure is backed by the legislature. Disaggregating the legal coverage of social protection policies that are implemented along gender lines, it is interesting to note that only South Africa has a legislature that is truly gender-blind for children and family, with a legal backing of the policy altogether absent in other countries under examination (Table 3). Also, across all functions of social protection, gender bias exists, with women lagging in the legal coverage across the functions (Table 3). This situation is critical for the effectiveness of social protection measures as the absence of legislation that protects the rights of women to benefits to the same extent as men, further exacerbates their vulnerabilities.

Policy measures that were implemented by the governments in the region also reveal that most of the social policies are not gender-sensitive. Given that women are differently impacted by the pandemic than men, the chapter, therefore recommends the following:

1. The differential impact of the pandemic on women and men should be considered by governments in SSA when formulating and implementing social policies, especially social protection policies that target the poor and vulnerable in the society, and ensure that women are adequately incorporated into social policies.
2. It is imperative for governments in SSA to increase legislation that ensures equal access to social protection measures for men and women. This is critical given the lopsided distribution of social policy measures, as the absence of legislation limits governments' commitments to the implementation of social protection measures.
3. Targeted approaches that deliberately incorporate social policy policies into the working processes of governments

in SSA should be considered to be well-prepared to address unexpected emergencies.

Conclusion

While the COVID-19 pandemic in SSA is highly gendered, policy responses of the governments in the region reveal limited sensitivity to the gender dimensions that are evident in the impact of the disease. As observed globally, the number of confirmed cases and deaths caused by the pandemic outbreak in SSA has been on the increase since the first reported case in the region in 2020.

In line with global containment measures, policy measures that are implemented like lockdown, movement restrictions, and closure of places of livelihood, reveal that apart from the health impact of the pandemic, other dimensions of vulnerabilities are also observed. The impact of the disease affected women's access to healthcare and employment opportunities more than men, and there were also increased cases of gender-based violence as a result of the lockdown in several countries in SSA.

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