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Letter to the Editor

Whither are we bound? Rethinking the gendered frailty during COVID-19 pandemic

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ABSTRACT

The outbreak of the novel coronavirus disease 2019 (COVID-19) has demonstrated the urgency to reconsider social behavior and the health system quality to efficiently support and improve global health. Diverse global and country-specific mechanisms to fight COVID-19 have been displayed, but the gendered analysis of these efforts still remain too little too late. A critical consideration of the brunt of health and socioeconomic crises through gender lenses can improve understanding and direction of our efforts during pandemics. We, therefore, argue that building gender responsive national policies and practices will ensure equitable and salient public health opportunities during COVID-19.

As of 12 June 2020, the 2019 novel coronavirus (SARS-CoV-2) has been responsible for over 7,600,000 infections and 425,000 fatalities worldwide. Crucially, COVID-19 is unfolding into socioeconomic, social behavior and global public health crises with profound implications for vulnerable population groups. Although some international and respective national endeavors have been gathering pace in response to the deleterious impacts of COVID-19 [1,2], the effort to unravel the gender perspectives and response to the pandemic has been limited. There is a paucity of knowledge about the gendered dimensions in the impact and response to COVID-19 pandemic particularly in sub-Saharan Africa.

The analysis of the etiology, diffusion, and the susceptibility of COVID-19 to different population cohorts could be rich and much more informative by gauging the gendered implication of the pandemic. Specifically, taking into account gender sensitivities and the respective brunt of health and socioeconomic crises of the outbreak on men and women can improve our understanding and proffer sentient efforts toward building robust and equitable public health response. Lessons from past epidemics such as Ebola and Zika [3] in the West and East African sub-regions respectively demonstrate the need for a critical interrogation into gender facet in response strategies to enhance the efficacy of health and policy interventions for COVID-19.

At the moment, COVID-19 is indiscriminately ravaging men and women of any age group. Some demographic data from various geographic regions depict certain diversities in the severity of the infection. However, the evidence on gender disparities of COVID-19 infections is highly mixed. What we do know, however, is that like adults 60 years or over, men are more likely to die from the pandemic [4]. COVID-19 thrives on people with comorbidities including older people with such conditions as cardiovascular disease, chronic respiratory/pulmonary disease, and active cancers. These chronic conditions are disproportionately prevalent in men compared to women. Salient evidence also points to the sex-induced immunology [5]. Sex hormones differ between men and women and are involved in the way the immune system triggers an inflammatory response to pathogens [6]. Men have lower innate antiviral immune responses to a range of infections including hepatitis C and HIV [7]. Studies in mice suggest that this may also be true for coronaviruses, though specific evidence on COVID-19 is lacking. Moreover, lifestyle choices such as harmful drinking, excessive smoking [8] as well as sociocultural attitudes including masculine norms, and stoic-induced reluctance to seek help [9] could potentially predispose men to COVID-19-related vulnerabilities and mortality. It is noteworthy, however, that the curve of the outbreak is yet to *flat* in many countries. Hence, it is early days yet to propose a gender-based hypothesis for COVID-19 fatalities.

The World Health Organization (WHO) has estimated that over 70% of global health care workforce constitutes women [10]. More women than men are on the frontlines of the COVID-19 response in various levels of health system and are potentially placed at a greater risk of the COVID-19 infection [10]. Very importantly, an average gender pay gap of about 28% may aggravate the vulnerability of women in times of crises such as an outbreak of an epidemic. Many preventive protocols of COVID-19 including various levels of lockdown, physical and social distancing, market closure, and travel restrictions may unleash a greater burden on women who predominantly provide informal familial caregiving and support particularly in sub-Saharan Africa. This may limit the opportunities for women in resilience and economic empowerment during and post COVID-19 outbreak. This is particularly problematic in low-income settings especially in sub-Saharan Africa where women predominate the informal sector with subsistence economic activities. In many African countries such as Ghana, Kenya, and Nigeria, various media reports have shown a growing concern of heightened domestic violence against women as a result of lockdown regulations and the concomitant socioeconomic hardships. These may not only present serious psychological, well-being, and human rights implications for women but may also negatively impact women's inevitable household management, domestic support, and caregiving roles for the vulnerable community members including children, older people, and the sickly.

Evidence from the Zika and Ebola outbreaks in sub-Saharan Africa indicates that women had limited decision-making power for epidemics [11,12]. It was also evident that most women experienced unmet care needs [3] because social and health resources were mostly diverted from crucial routine health care including reproductive health services and

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sanitary needs to make way for emergency response deliveries chiefly due to limited resources allocated for health care delivery and the fragile health systems in the region [13]. Compounded with poor access to socio-economic resources particularly for women, these circumstances may deepen the inequalities and hardship especially for older women. With previous experiences, would the COVID-19 outbreak further segregate the gender inequities in impacts and response strategies?

In the publication of *the strengthening preparedness for health emergencies*, the WHO Executive Board advocated for the inclusion and full representation of women in the decision making process at both international and national levels during outbreaks [14]. However, not much has been done to involve women in preparedness and response to COVID-19 pandemic particularly low- and middle-income settings which have been rated as vulnerable to exposing huge populations to COVID-19 pandemic and a moderate capacity to control the outbreak [15]. Indeed, the capacity of sub-Saharan African countries to provide sufficient infrastructure, personnel, clinical care and psychological counseling services to support people infected and affected with COVID-19 has been questioned vehemently [4].

Global public health security is a shared responsibility that requires a collaborative and all-inclusive response. The effectiveness in the fight against COVID-19 outbreak will largely depend upon gaining a deeper understanding of the gendered dynamics and the mechanisms that may correlate the diversity and susceptibility to the infection of the virus and management modalities among gender groups. We propose to the global health organizations, national political forces, and policymakers to conspicuously include gendered sensitivities in the analysis of impacts and response to COVID-19 pandemic. Strategic plans for preparedness must be fully grounded in a strong gendered analysis in the ambit of gender roles and norms. Strengthening the leadership and resourceful participation of women in the decision-making processes toward addressing COVID-19 outbreak and similar future epidemics will be the best way forward.

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Declaration of competing interest

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