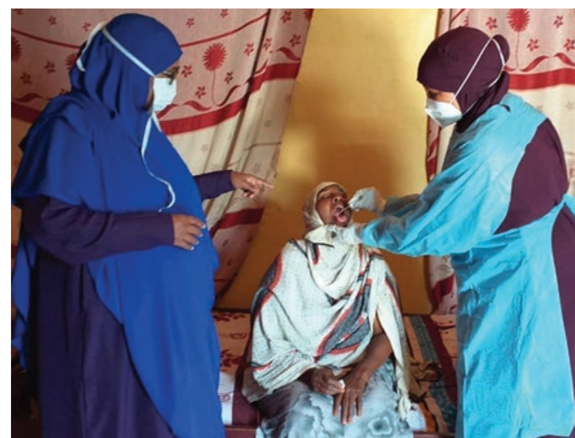
November 2020

COVID-19 information note 8

COVID-19 in Somalia: the gender gap

Since the first case of coronavirus disease (COVID-19) was confirmed in Somalia in March 2020, the country has faced a widening gap between men and women in some aspects of health, economic opportunities and well-being.



COVID-19 testing and infection: why fewer females?

Data gathered as of 10 October 2020 show that more than twice as many men as women were tested for and infected with COVID-19 in Somalia. Of a total of 23 932 samples tested, only 7574 (32%) were from females; of the 3864 positive cases, 1021 (26%) were females (Table 1).

TABLE 1: COVID-19 TESTING AND INFECTION, BY SEX, SOMALIA, 16 MARCH–10 OCTOBER 2020

Sex	Tested, no. (%)	Positive, no. (%)	Negative, no. (%)	Invalid[a]	Rejected[b]
Female	7 574 (32)	1021 (26)	6 547 (33)	3	13
Male	16 358 (68)	2843 (74)	13 502 (67)	9	4
Total	**23 932 (100)**	**3864 (100)**	**20 049 (100)**	**12**	**7**

[a]The laboratory could not determine whether the sample was positive or negative.
[b]The sample was not accepted because it was not suitable, e.g. it was a saliva sample instead of a swab.

Anecdotally, community health workers have attributed this difference to: women not visiting health facilities because of the social stigma associated with COVID-19; women's fear of being forced to isolate while they are supporting or looking after their families; and fewer women being exposed to the COVID-19 virus as they come into physical contact with others less often than men do.

Even though some tests are being conducted at home by teams of community health workers supported by the World Health Organization (WHO) and the health ministries in each region, gender differences in COVID-19 testing are also attributed to cultural barriers that impede women's access to health and health facilities. According to the Somali Health and Demographic Survey 2020[1], 34% of married women aged 15–49 years said that they made decisions on their own health care jointly with their husband. Only about 20% said they make decisions on their own health care themselves.

[1]The Somali Health and Demographic Survey 2020. Mogadishu: Directorate of National Statistics, Federal Government of Somalia; 2020: 235 (http://www.dns.org.so/wp-content/uploads/2020/04/SHDS-Report-30-04-2020.pdf , accessed 9 November 2020).

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> *It seems more men suffer from COVID-19 as they go out all time and are in contact people, whether they work or not. Women generally stay at home with children and receive our messages about COVID-19 prevention through health team visits or the radio. Also, I feel it is much easier to explain health issues to women as they are worried about supporting their families. Men generally don't follow isolation rules easily from what I have seen. When we return for a visit to check on an asymptomatic case, if it's a man, he is usually out.*

Aisha Moalim, a district polio officer in Heliwaa, Banadir, explains her observations.

COVID-19 and age: is gender a factor?

A greater proportion of younger females (up to 29 years) appear to have been infected more than their male counterparts, and women older than 80 years. In other age groups, the gender difference is smaller (Figure 1).

COVID-19 mortality: are there gender differences?

Although more deaths have occurred in males (71 deaths) compared with females (27 deaths), the overall case fatality ratio is proportionally slightly higher in females than males; 3.01% (27/897) versus 2.79%, respectively. In the age group 50–60 years, a considerably higher case fatality ratio was seen in women: 5.56% (5/90) in women versus 1.87% (5/267) in men. The reasons for this difference are not clear but cultural factors, health care access and not being able to take decisions on their health might have contributed to delay in hospitalization of severe cases in women and greater likelihood of death.

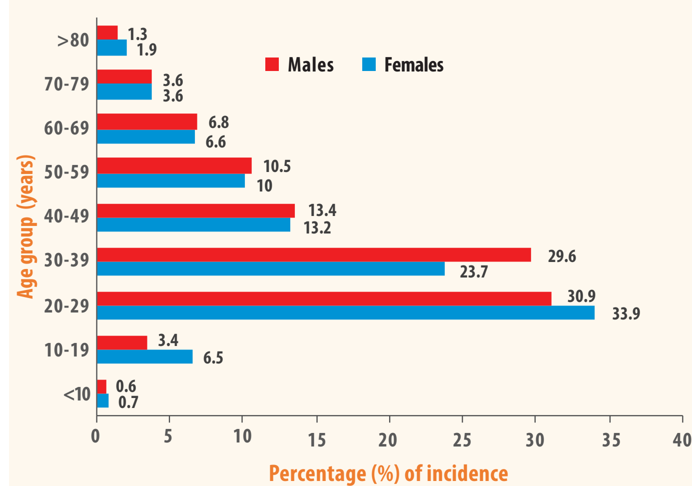

FIGURE 1: COVID-19 INCIDENCE BY SEX AND AGE GROUP, SOMALIA, MARCH–SEPTEMBER 2020

Gender-based violence during COVID-19: has it increased?

Gender-based violence is faced by many women around the world, but there are concerns about the effect of the pandemic on such violence, particularly in conservative societies where survivors have limited opportunities to seek support.

To assess gender-based violence in Somalia during the pandemic and determine ongoing services to deal with such violence and the uptake of services, the Somali Health Cluster conducted an online survey in April 2020.[2] The survey found that 92% of survivors of gender-based violence had experienced some form of physical, mental or sexual violence perpetuated by their partner and/or a family member during the COVID-19 pandemic. Furthermore, in a rapid assessment in July 2020 of 318 service providers and 756 community members, 67% of service providers said incidents of gender-based violence had increased during the COVID-19 pandemic, while 38% of the community members indicated incidents had increased, including female genital mutilation.[3] Media reports and UN agencies also indicate an increase in the numbers of girls subjected to female genital mutilation.[4,5] Service providers stated that most cases reported were of physical violence, sexual abuse and harassment, intimate partner violence and rape. More than a third (36%) of service providers further reported that COVID-19 had adversely affected the provision of services for gender-based violence.

Few services for gender-based violence are available in Somalia. The main services provided include: clinical management of rape in Puntland, Somaliland, Galmudug

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[2] The survey participants included members of the Health Cluster: fifteen nongovernmental organizations, eight international nongovernmental organizations and two United Nations agencies.

[3] GBV subcluster, Somalia. GBV/FGM rapid assessment report in the context of COVID-19 pandemic in Somalia. Geneva; United Nations Population Fund; 2020:8 (https://somalia.unfpa.org/en/publications/gbvfgm-rapid-assessment-report-context-covid-19-pandemic-somalia , accessed 9 November 2020).

[4] Girls in Somalia subjected to door-to-door FGM. Plan International; 18 May 2020 (https://plan-international.org/news/2020-05-18-girls-somalia-subjected-door-door-fgm , accessed 10 November 2020).

[5] Wallace D. Somalia sees "massive" uptick in female genital mutilation during coronavirus lockdown. Fox News. May 2020 (https://www.foxnews.com/world/somalia-female-genital-mutilation-coronavirus-lockdown-africa , accessed 10 November 2020).

and parts of South West State; psychosocial support services; and provision of risk information on gender-based violence and COVID-19. To change this situation, the gender-based violence subcluster has advocated for stakeholders to ensure that provision of services for gender-based violence is prioritized and funded to improve overall provision, including infrastructure and staffing and personal protective equipment. In addition, the Health Cluster and gender-based violence subcluster have initiated a programme that integrates gender-based violence in health programming and have secured funds through the Somalia Humanitarian Fund to facilitate integration. With support of WHO, the Health Cluster has translated into Somali the revised guidelines on clinical management of rape and intimate partner violence so more Somalis can use them.

To address the rise in gender-based violence, the Health Cluster, together with WHO, convened a focus group discussion with service providers. The service providers called for partners in Somalia to launch a joint emergency response for survivors of gender-based violence. A webinar on ensuring a multisectoral response to gender-based violence during the pandemic was also organized with experts from WHO and the Health Cluster and gender-based violence subcluster.

Effect of COVID-19: what do Somali women say?

The survey of the gender-based violence subcluster also shows that COVID-19 has affected many other areas of the community: a third of the respondents said that they thought health facilities had closed due to COVID-19, while 67% felt that people with symptoms of COVID-19 were stigmatized.[6] Furthermore, 15% of women said they had limited sources of income due to restricted movement and 12% said their household chores had increased. As regards violence, 14% of the women felt they faced increased risks of physical violence in their homes and 11% noted increased risks of intimate partner violence. Furthermore, 4% said they faced increased risk of attack when going to market or walking in isolated areas, 3% noted increased risks of any kind and 12% were more psychosocially stressed. In addition, 11% said they had limited access to gender-based violence support services, and 8% indicated that the measures to control COVID-19 introduced by the Government affected access to these services.

Children faced disruptions in school attendance, increased psychosocial stress, less play and socialization time, an increased likelihood of having to work or manage household chores, and increased risk of physical, sexual or gender-based violence.

[6]GBV/FGM rapid assessment report in the context of COVID-19 pandemic in Somalia. Geneva; United Nations Population Fund; 2020:7 & 16 (https://somalia.unfpa.org/en/publications/gbvfgm-rapid-assessment-report-context-covid-19-pandemic-somalia , accessed 9 November 2020).

Mothers with COVID-19 missing out on time with their children

Two days after she met a friend who had flu-like symptoms, 35-year-old Halimo Mohamed Warsame started to experience a headache, weakness and what felt like a cold. She took sick leave from her job to rest and eat nutritious food. Even though the rest made her feel better, after 3 days, Halimo had lost her sense of smell and taste. This prompted her to get tested for COVID-19. When she learnt she had COVID-19, Halimo decided to isolate herself from her family, following advice from her friend from WHO, who explained how best to isolate.

"My biggest challenge was that my children couldn't understand why I was avoiding them, even though I knew I was doing it for their sake. For 3 weeks, I isolated in my room far from them, without being able to touch and take care of them. It was a difficult time for me and my children."

Effects of COVID-19: how are Somalis coping?

COVID-19 has adversely affected people's mental health, causing women, men and children a considerable stress, fear and anxiety. To keep healthy, it is important for people to manage these emotions.

According to the rapid assessment conducted in July 2020, 17% of the service providers indicated that Somalis have

adopted a number of coping mechanisms to deal with the threats they face related to COVID-19 (Table 2).

TABLE 2: COPING MECHANISMS TO DEAL WITH POTENTIAL THREATS DURING COVID-19[7]

Men	Women	Girls	Boys
• Consulting community elders on the way forward • Following security measures put in place by the government • Reciting the Quran and praying regularly • Producing home-made masks to sell	• Walking in groups with other female friends when going to the market and to fetch water and firewood • Asking a male relative to escort her to a distant or remote location • Staying at home and avoiding social interaction • Seeking support from service providers • Attending available psychosocial support services • Using hotlines to report cases of violence • Seeking help from community centres	• Staying at home and avoiding social interaction • Using safer routes and walking in groups when going to the market or to collect firewood • Avoiding being outdoors at odd hours (after dark and before dawn)	• Engaging in paid labour to generate income

Source: UNFPA/GBV subcluster for Somalia

Frontline heroes: community health workers

Because of cultural preferences, women have easier access to households and other women at home. As a result, more women than men have been serving in community rapid response teams, visiting households and addressing the COVID-19 situation in Somalia. Nonetheless, from a survey conducted on 191 health workers in main health facilities in the country in August 2020, more male health workers have had COVID-19 than their female counterparts: 150 (79%) males compared with 41 (21%) females.

[7]GBV/FGM rapid assessment report in the context of COVID-19 pandemic in Somalia. Geneva; United Nations Population Fund; 2020:20 (https://somalia.unfpa.org/en/publications/gbvfgm-rapid-assessment-report-context-covid-19-pandemic-somalia , accessed 9 November 2020).

Why males are infected more: a young doctor's observations on COVID-19

Twenty-eight-year-old Dr Muna Mawlid Bade has worked in the Daryeel Hospital in Hargeisa for a year now. As with many other health professionals of her age, she has never seen anything like the COVID-19 pandemic before.

"Fortunately, most cases were mild or moderate, but severe cases, required constant care which meant no rest and working three shifts. Our main challenge was the lack of doctors. We were only three doctors working in three shifts. At the beginning of the outbreak, I remember that some days I didn't go home for days. We had to take some difficult decisions. One day, we three doctors were treating a severe case and another COVID-19 patient suddenly fell and was injured. We decided to reduce the number of admissions and only admit very severe patients, as we do not have the capacity to treat all patients".

Dr Muna observed that almost 70% of the people infected with COVID-19 were male, which she attributes to their social behaviour. "Men are more socially active and attend large gatherings of people. Many policemen and men working in the military have also been infected with COVID-19, probably because their jobs require them to mix with many people.

My main message to Somali communities is to stop stigmatizing people with COVID-19 and give them support instead, and to get themselves tested as soon as they feel sick and isolate themselves until they get the results to prevent spreading the disease further. I would also like the Government to continue supporting public health facilities with supplies, including personal protective equipment, and food for health workers and patients.

I am grateful to WHO for the personal protective equipment they provide to the health ministry, and for their guidelines as some of us have not had training on case management. I am happy every regional hospital and laboratory has the capacity to detect COVID-19 since every region now has polymerase chain reaction testing or GeneXpert."

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