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NOTES FROM THE FIELD

Covid-19 and Gender in LMICs: Potential Lessons from HIV Pandemic

Eusebius Small[1] · Bonita B. Sharma[2] · Silviya Pavlova Nikolova[3]

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The Novel Coronavirus (SARS-COV-2) caused by severe acute respiratory syndrome is a public health concern that has resulted in over 4.6 million cases globally, with more than 311,000 deaths as of May 2020 [1]. The impact of COVID-19 on low-income and middle-income countries (LMICs) is still unknown but could be catastrophic [2]. Already crippled by weak economies and a history of HIV, COVID-19 could be a devastating blow to the fragile healthcare systems of these countries. Kenya, for example, is a country with a population of 50 million people and only 200 intensive care (ICU) beds countrywide [1]. In comparison, the United States (US), with 34 ICU beds for every 100,000 people, has been overwhelmed by COVID-19 [1].

We highlight the strain that the outbreak could impose on LMICs, which are already burdened by a 30-year history of fighting HIV/AIDS. Approximately 38 million people are currently living with HIV globally [3]; 70% of these people live in the SSA region [4]. COVID-19 has impacted all continents, with over 90% of deaths occurring in the wealthiest countries [5]; however, a disturbing trend observed in the US is that the poor and minority populations are disproportionately impacted [2]. Similar trends were observed in the HIV transmissions over the years [6]. Without enough kits and proper surveillance networks to trace and quarantine infected people, many LMICs will struggle to contain this pandemic. We outline four ways that COVID-19 may be devastating for SSA, which has borne the brunt of infectious diseases, including tuberculosis, malaria and AIDS. Drawing from the current literature, we suggest solutions in COVID-19 mitigations for LMICs.

Structural Inequalities and Disease Burden

The intersections between infectious diseases, including HIV and structural inequalities, cannot be overstated. HIV disproportionately impacts women [7] and is often concentrated in socially marginalized and disenfranchised communities [8]. COVID-19 is affecting women disproportionately; they are “essential workers" taking the strain as food service industry workers, janitors, cashiers, and stockers. Many live in densely populated areas that have no proper sanitation [7]. The social distancing and lockdown measures have impacted nearly 81% of the world’s labor force, mostly women [7]. According to the World Bank, almost 24 million fewer people will escape poverty in East Asia and the Pacific because of the financial impact of COVID-19 in 2020 [9]. Already half of the world population cannot access healthcare services, and large numbers of households are poor because of healthcare costs [9]. The emergence of COVID-19 may widen the gender inequality gap to an unprecedented level and threaten women’s health. For example, many HIV infected women will lack the essential antiretroviral therapy (ART) drugs, or pre-exposure prophylaxis (PreP) because of disruptions in the supply chain. As a consequence, many will develop an unsuppressed or uncontrolled viral load that will weaken the immune system making them susceptible to COVID-19 [10].

COVID-19 and Essential Services

COVID-19 will exceedingly impact women in SSA, who already face food security challenges [11]. One in every five people in Africa, nearly 250 million, did not have enough food before the COVID-19 outbreak [12]. The long-term

✉ Eusebius Small
esmall@uta.edu

Bonita B. Sharma
bonita.sharma@utsa.edu

Silviya Pavlova Nikolova
silviya.p.nikolova@mu-varna.bg

[1] University of Texas at Arlington, School of Social Work, 211 S. Cooper St., Bldg. A, Arlington, TX 76019, USA

[2] University of Texas at San Antonio, College for Health, Community, and Policy Department of Social Work, 501 W, Cesar Chavez Blvd., San Antonio, TX 78207, USA

[3] Medical University of Varna, 55 Marin Drinov Street, Varna 9000, Bulgaria

consequences are unknown; however, micronutrient deficiency and anemia are likely, which will worsen HIV/AIDS disease for HIV patients. Women are the caregivers and service providers who are 2.5 times more likely to do unpaid domestic work than men [13]. However, COVID-19 responses have not been poverty or gender-sensitive to the needs of women [14, 15]. In LMICs, women are the frontline workers, community health workers, and community engagement personnel; they are easily susceptible to COVID-19 infections. Without proper personal protective equipment (PPE), and as they work in environments with no water or sanitation, many of these workers could be exposed to COVID-19 outbreaks [16]. Although recommendations and obligatory hand hygiene have been emphasized as requisite to avoid COVID-19 [16], these recommendations are impervious to the social environments of the poor. Millions of people in the world have no access to clean water or soap; asking them to wash their hands to prevent infections is insensitive to the plight of the poor. Such recommendation parallel those made during the early days of HIV pertaining to safe sex practices. However, many populations could not afford condoms, and adequate guarantees were not put in place to acquire them [17].

Health Systems and Services Inequities

The impact of COVID-19 is undoubtedly felt unevenly across countries and regions [18]. Among the LMICs in sub-Saharan Africa, COVID-19 could push these countries farther into a spiral of poverty, ravaging their already tenuous health systems [2, 5]. The vast global demand for PPEs, for example, exerts substantial competition and demand for them. There is a troubling rich/poor divide, disadvantaging many LMICs who lose out to the wealthier countries that outspend and outbid them, sometimes tripling the market price for PPEs [19]. Faced with such inequity gaps, many countries in Latin America and Africa are realizing unseen pre-existing inequities and cannot find enough materials and equipment to test for COVID-19 and treat their populations [7]. The long-term impact on GDP, growth, and service delivery will be consequential as projections have already been revised downwards for most regions and countries [9]

Sexual and Reproductive Health

Sexual and reproductive health and rights (SRHR) are critical to women's health [20]. Evidence awash indicating that providing contraception to women is one of the simplest ways to reduce poverty [21]. During the HIV outbreak, a significant limited reproductive health care and family planning services were available to women. Resources to address the disease were diverted elsewhere [6]. In the era of COVID- 19, disruptions in the manufacture and distribution of critical contraceptives might contribute to unwanted pregnancies [22] and sexually transmitted diseases like HIV. According to the United Nations, an unrelated crisis impacting women worldwide are the spikes in domestic violence due to COVID-19 lockdowns [7]. Lockdowns and mandatory sheltering-in-place may be making violence in homes more frequent and severe as girls and women shelter in place with their abusers. Domestic violence and sexual abuse are significant correlates of HIV risk for women as violence has been identified as an independent risk factor for HIV infection [23]. Women who are abused may not ask their partner to use a condom, nor have the efficacy to say no to sex if their abusive partner does not want to use protection, which will put abused women at a higher risk for HIV. Additionally, women who are transgender and are living with HIV are disproportionately impacted by intimate partner violence [24], stay at home COVID-19 orders could exacerbate their wellbeing.

Gender-Sensitive Strategies to Address Covid-19 in LMICs

Following COVID-19, a renewed focus on reducing structural inequalities is needed to ensure that health is not a byproduct of privilege in any country or region. Adapting existing practices and schemes to benefit women can simultaneously reduce the viral spread of the infection [25]. For example, cash benefits using e-payments and in-kind transfers can improve economic security for women. Also, policies and programs should ensure dignified work opportunities that promote sustainable economic growth, inclusive workspaces, and decent wages for women to ensure their full economic participation. Particular attention should be paid to adolescent girls and young women and improve women's empowerment by challenging norms that increase their vulnerability in the community. The entrenched structural imbalance can dramatically weaken women's economic ability to recover from an epidemic, as evident with Ebola quarantine measures [26]. Women shoulder nearly 85% of austerity measures [27]. Thus, involving women to assess and analyze policy decisions will ensure greater equity of impact.

Engage Women in Public Health Decision-Making, and Provide Social Insurance Guarantees for Women

Addressing the social determinants of health as a broader issue should incorporate women's lived experiences because of their unique perspectives on policymaking [28]. For example, cash-transfer programs (although not common in most LMICs) should be sensitive to the women's lived reality. Women are more likely to hold informal work and have child care obligations that may prevent them from accessing aid. In South Asia, over 80% of individuals in non-agricultural jobs have informal employment; in SSA, this figure is 74%, yet social protection and consumer stimulus often depend on participation in the formal sector [29]. Additionally, ensuring maternal and reproductive health in the form of insurance coverage for routine checks, especially in rural and marginalized communities, could reduce maternal mortality, reduce adolescent pregnancies and control HIV and sexually transmitted diseases.

Design a Pandemic Response to Violence Against Women and Children (VAW/C)

Economic uncertainty, civil unrest, and disasters—including pandemics—are linked to increases in violence against women [30]. Thus, anticipating a surge in VAW/C at the outset of an epidemic to promptly prepare is necessary. Specifically, provide women (1) access to formal health/mental health services through increasing first responders, access to free mental health services, and free legal counsel. (2) increasing access to informal social support; (3) clear communication from governments on violence prevention/intervention, and steadily ease restrictions to help families reduce the financial stress that could trigger violent situations.

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