

The Gendered Impact of COVID-19 among Ugandan and Kenyan Refugees

By Grace Ndirangu and Pearl Karuhanga Atuhaire

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic, which is the highest-level classification the organization can give when a virus causes sustained community-level outbreaks across countries and regions.¹ The declaration set in motion national preparedness plans, including efforts to identify cases as efficiently as possible and minimize serious illness and deaths with proper treatment. COVID-19 has also created many socioeconomic challenges, including increased violence against women and girls.

In response, UN Secretary-General António Guterres has called on all national governments to incorporate prevention and redress of violence against women in their response plans for COVID-19. The socioeconomic impact of COVID-19 on humanitarian contexts merits particular attention. For example, increased incidence of intimate partner violence and child marriages have been reported in Cox's Bazaar in Bangladesh, which hosts thousands of Rohingya refugees.² In Jordan, Plan International reported an increase in emotional and physical abuses perpetrated by intimate partners or family members.³

Emergencies often make women and girls more vulnerable to gender-based violence, and COVID-19 has exacerbated these challenges. Women and girls in humanitarian and emergency settings also grapple with inadequate sources of livelihoods, poor living conditions, lack of social support systems, and lack of legal documentation. Impoverishment may lead refugees, particularly women, to resort to a gamut of coping mechanisms, including survival sex work, petty theft, drug abuse, and alcoholism.⁴

This policy brief examines the gender-related consequences of COVID-19 through the lens of increased violence against women and girls in refugee settings in Uganda and Kenya. Several factors—economic stress, uncertainty about the future, fears about the virus, and patriarchal gender norms—lead to increased levels of violence in many households. We propose practical solutions to address this violence so that women and girls can live in free, safe communities during the pandemic.

Refugees in Uganda and Kenya

With 1.4 million registered refugees and asylum seekers, Uganda hosts the third-largest refugee population in the world and the largest in Africa.⁵ Kenya hosts nearly half a million registered refugees and asylum seekers, with close to 90,000 living in urban areas.⁶ Most of the refugees are from neighboring Democratic Republic of Congo (DRC), South Sudan, Rwanda, Burundi, Ethiopia, Sudan, Eritrea, and Somalia.⁷

Women and children make up the vast majority (82 percent) of this population. In addition, around 56 percent of refugees are younger than 15, and 25 percent are younger than 5.⁸ In May 2020, Amnesty International reported that there were more than 10,000 displaced persons at the Ugandan border with the DRC who were waiting to seek refuge.⁹ In countries such as South Sudan and DRC, women and girls are at great risk of being taken hostage by militia groups, becoming victims of trafficking, and of being sexually exploited and abused since they cannot flee to safety across the border.¹⁰

Most refugees living in Nairobi, Kenya, reside in poor urban neighborhoods with limited resources. In Uganda, most refugees live in refugee settlements—that is, an encampment in a geographical area designated by the asylum country’s government. Refugees in settlements are given a small piece of land to farm to help achieve a measure of self-sustainability. They are also provided with basic living support, including food, water, education, health services, and other infrastructure needs. Despite this assistance, most refugees in the settlements (particularly large families) are dependent on additional humanitarian aid. Refugees living in suburbs of Kampala and other towns in Uganda that are not officially designated for refugee settlement have to find their own means to survive. Indeed, humanitarian agencies only serve refugees living in settlements.

The Pandemic and Increased SGBV

Kenya reported its first case of coronavirus on March 13, 2020. By April, President Uhuru Kenyatta had issued a series of statements and had put in place measures to curb the spread of the virus. These included restricting movement into the country, banning all public gatherings, requiring people to work from home, dusk to dawn curfews, and restriction of movement in and out of Nairobi and Mombasa counties. All land borders closed, which meant that people seeking asylum in Kenya could no longer enter.

In Uganda, which announced its first case on March 21, 2020, the government closed all refugee reception centers at the border and suspended the services of the Department of Refugees offices for 30 days starting March 25.¹¹ While these measures may have been broadly effective against the pandemic, they carried risks, particularly for vulnerable groups such as women and girl refugees.

Since the measures were put in place, the Kenyan National Council on Administration of Justice has reported a significant rise in cases of sexual violence, including domestic violence. In April 2020, almost 120,000 women and girls in Kenya who were internally displaced and affected by floods needed services and psychosocial first aid to deal with the effects of sexual- and gender-based violence (SGBV). Among refugees living in the camps and urban areas, 61 cases of gender-based violence (GBV) were reported in March 2020, and in June 2020, 150 cases were reported. UNHCR attributed this to the government’s “stay in place” measures.¹² By June, approximately 400,000 women and girls in urban informal settlements needed access to basic household supplies and dignity kits to reduce the risk of GBV, and an additional 440,000 girls in counties with a high prevalence of female genital mutilation (FGM) required social protection and psychosocial support, including dignity kits. It was also noted that at least 2,350 women and girls across the country required shelters and safe houses for protection from GBV and FGM.¹³

Since January 2020, 1,860 SGBV incidents were recorded in refugee settlements and Kampala, with 1,725 female survivors and 135 male survivors, according to UNHCR Uganda. Of the total, 729 incidents were reported between January and March and another 1,131 between April and June, representing an increase of 55 percent in the three months after enforcement of COVID-19 lockdown measures began in Uganda. Out of 14 sites hosting refugees (13 settlements and an urban site in Kampala), 12 showed an increase in the number of SGBV incidents, with Kyangwali and Bidibidi reporting the highest rates. Through the end of June, the top three reported incidents were physical assaults (566), rape (486), and psychological abuse (396).¹⁴

In Uganda and Kenya, the governments’ closure of borders to new refugees and asylum seekers had impacts on humanitarian settings. The pandemic has exacerbated three longstanding challenges that fuel the rise in SGBV: 1) economic insecurity, 2) health and basic needs insecurity, and 3) patriarchal gender norms. Together, they have pushed some women to adopt illicit and unhealthy coping mechanisms.

Economic Insecurity

As businesses are forced to downsize or close due to COVID-19 restrictions, urban refugees are the first to lose their jobs. Before the pandemic, it was estimated that more than 70 percent of urban refugees were dependent on casual labor and daily wage work. The remainder worked in the informal economy and were already struggling to meet their basic needs.¹⁵

In Kenya and Uganda, a dusk to dawn curfew and movement restrictions reduced working hours, forcing most businesses to close earlier than usual. Some families are still restricted to their homes, and live-in help and those who offer daily services have had their work suspended in some households that seek to limit contact with strangers. Urban refugees depend on the informal market economy and run small enterprises as artisans, tailors, hairdressers, traders in precious metal and diamonds, and vendors of food and second-hand clothes.¹⁶

Most female refugees, including those living in refugee settlements, supplement the family income by working in the traditionally female-dominated informal economy by braiding hair, washing clothes, and tailoring. These sources of income have been curtailed, providing less social protection to mitigate the effects of lost livelihoods.¹⁷ Social distancing directives also affect female refugees who are no longer welcome to domestic jobs they held before the COVID-19 pandemic. One female refugee in Nairobi said:

Before this pandemic, refugee households were able to meet basic needs, but now most cannot even afford three meals a day. Our casual jobs cleaning people's homes or hawking are no longer available, and we are begging for handouts. Some of us have used our little savings and even sold assets to pay rent so that we are not kicked out of our houses.¹⁸

Indeed, restricted movements and curfews have led to closures in most Kenyan and Ugandan businesses, while some have collapsed.¹⁹ Refugees have resorted to spending their savings, and in some instances families have started selling assets. Families who once had flourishing businesses now worry about meeting basic needs, including for rent and food.²⁰ With no income or social support, sexual violence and the commercial exploitation of refugee women and adolescents for sex are almost inevitable.²¹

Halting markets and other informal trade has contributed to female refugees adopting other survival mechanisms such as survival sex work and working overtime with no pay to support their families.²² This exposes them to HIV/AIDS and other sexually transmitted infections and increases the rates of unwanted pregnancies among refugees. This is especially worrisome because both access and level of reproductive health services provided by civil society organizations and humanitarian actors have declined.²³

Livelihoods have also shrunk because of the falling away of remittances. It is estimated that the majority of urban refugees depend on remittances from relatives outside Uganda such as in Sweden and the United States.²⁴ Remittances form a crucial part of the economic well-being of many people, including refugees, in most African countries, including Kenya and Uganda.

According to the United Nations Development Programme and the World Bank, the remittances to Africa are expected to drop by more than 20 percent due to lockdowns and economic crises induced by the pandemic. The drop in remittances means that the flow of important sources of cash relief for poor families—including refugees and displaced people—has been affected by unemployment and salary cuts in other countries.²⁵ The fall in the wages and employment of migrant workers, who are more susceptible to loss of employment and wages during an economic crisis in a host country, has had a serious impact on the livelihoods of those most vulnerable and taken away economic safety nets.

Health and Basic Needs Insecurity

Most urban refugees live in overcrowded, unhygienic conditions that are particularly vulnerable to the spread of the virus. For example, thousands of urban refugees live in poor urban neighborhoods in Nairobi with little access to clean water, making it nearly impossible to practice regular hand washing.²⁶

In addition, as countries such as Kenya implement measures to protect the national population from the effects of COVID-19, refugees are often excluded. Owing to their lack of legal documentation, refugees are not included in national systems that provide assistance to the most vulnerable.²⁷ In Nairobi, nongovernmental organizations and other partners have provided social assistance to refugees to help them cope with the effects of the coronavirus. However, given the shortage of funds, the reduction in the amount of financial assistance given to refugees and the high costs of living in urban areas, the assistance given is not sufficient to meet the most urgent needs. While some cash assistance for refugees is distributed to the most vulnerable, less than 1 percent of the total urban refugee population in Nairobi receives financial support; the rest fend for themselves.²⁸ Those who cannot fend for themselves are advised to move to designated camp areas. Border closures and containment measures further hamper agencies' delivery of aid to areas where refugees reside. Restrictions in movement and resources being diverted to fight COVID-19 have also restricted access to reproductive health care, particularly important in the case of intimate-partner violence and also increasing the risk of maternal mortality. Other risks include an increase in sexually transmitted infections, unplanned pregnancies, and complications arising from harmful traditional practices.

Access to social services, including for reporting SGBV during the lockdowns, has been severely curtailed. Since most refugees lack government-issued identification, they are already wary of interactions with police officers or law enforcement authorities. As a result, most women and girls or survivors of violence avoid approaching police stations where they can report these incidents. In the absence of other reporting mechanisms, these incidents likely go unreported.

Uncertainty about access to food produces stress. The World Food Programme announced 30 percent cuts in its food relief effort to Uganda. Monthly cash distributions have decreased from USD \$9.00 to \$6.00 per month, according to refugee reports. Worse still, refugees cannot travel to find other sources of food during lockdown. The cut in food rations and the inability to earn income to cover basic food and nutrition needs is a huge cause for concern for refugees, especially for female heads of household, who are now more worried about going hungry than they are about the spread of COVID-19.

Patriarchal Gender Norms

Carol Pavlish, an associate professor at the University of California's Los Angeles School of Nursing, has studied life experiences of refugee women and men in the Kyaka II refugee settlement in Uganda. She found that the situation in the refugee settlements had a considerable impact on the relations between men and women. Pavlish notes that many men talked about the shame and powerlessness they felt as a result of their joblessness. Family members give the men little respect because the families feel they were not *men enough* to provide the necessary clothing and food to their families. Pavlish highlights one man's plight:

When my wife sees a neighbour ... has a new kitenge ... she says, "You can see you are not husband to me." It's very difficult for us. Sometimes we just want to remember when we could buy clothes ... but they don't understand, so they start to complain and say, "You don't have anything to do." When they start to complain like that ... you just leave and walk around all day.²⁹

The closure of markets led to loss of jobs for male refugees who previously operated as vendors and small-scale retailers. The sudden loss of work cut off income to support children and women under their care.³⁰ The pent-up frustration resulting from lockdown-induced economic hardship has increased emotional and physical violence, especially against female refugees and children.³¹

In accord with patriarchal societal norms, women and girls must seek male approval to get medical attention. Women and girls who contract COVID-19 will most likely be the last to seek medical assistance, therefore putting them at more risk of developing complications. Older women, nursing mothers, women with chronic conditions, or expectant women are at even greater risk.³²

In both Uganda and Kenya, the closure of schools, an overwhelmed health system, and requirements for social distancing have created conditions conducive to the resumption of female genital mutilation (FGM) and early marriage. In one report from Kenya, at least 79 girls aged 9-12 in local and refugee communities combined were found to have undergone FGM since schools closed in March 2020.³³

Many of these harmful practices have been practiced clandestinely. Family members' movements are restricted, making reporting of FGM difficult. Young women who have undergone FGM are incapacitated and cannot leave the house for some time. One refugee woman reported that some FGM survivors have their phones taken away so that they cannot even report to their friends and other family members. Moreover, they fear reprisals from close family members or will not submit reports that might cause their families trouble. Children face greater peril because they cannot go to police stations. Community leaders are more likely to report an issue with child marriages than the children themselves.

As in past epidemics, such as the Ebola crisis in Uganda, there are clear signs that women bear the brunt of emergent risks to public health, safety, and human rights. With schools closed to contain the spread of the virus, women and girls take on more household chores, which limits their economic opportunities. Women often also shoulder the greater burden of caregiving for old and sick members of their households.³⁴ Where such women are also heads of households, loss of livelihoods due to the pandemic leads to increased poverty and food insecurity.

Because most refugees have limited or no access to savings, they cannot afford to go without employment for long periods. Containment measures render women unable to take care of their households. As a result, most will turn to negative coping mechanisms such as sex work to survive. In some cases, refugees must work despite quarantine measures, risking not only contracting the virus and infecting family members but also risking arrest.

Additional Barriers to SGBV Prevention

The challenges described above have led to increased violence against women and girls, particularly domestic and sexual violence. Three additional barriers in Uganda and Kenya stand out:

Underrepresentation of female police officers at police stations and other key response service centers. In Kenya and Uganda, most police officers are male, and although all police stations are required to have a gender desk, the desk is not always staffed by a female officer. In most cases, the gender desks are inactive, especially during the pandemic.³⁵ Women and girls are hesitant to approach police stations because they fear facing a male police officer to report cases of rape and other forms of SGBV. Similarly, women are largely underrepresented in other service centers such as the hospitals and courts and even at community leadership levels such as local councils.

Lack of data. Data can play a critical role in the response and prevention of violence against women and girls.³⁶ Data can improve understanding of how and why pandemics might lead to an increase in this violence, help identify risk factors and emerging needs, and reveal impacts on the availability and access to formal and informal services for women survivors of violence. Data enable organizations and other key partners to improve their programs to better help women access support and services.

Some organizations lack the resources and skills to be data driven. But most face added challenges to effective use of data during the COVID pandemic. They must decide if online platforms are a safe space for women to report abuse without alerting perpetrators, if it is ethical and acceptable to survey by telephone, and how social media can be used to collect data on increased gender-based violence.³⁷ The pandemic also affected the way in which service-based data are collected and stored, particularly if services are being provided remotely. Especially if survivors of violence are confined with the perpetrators, lack of privacy makes remote data collection difficult.

Limited access to information and language barriers.

Language barriers limit many refugees' access to information. This language barrier exacerbates their vulnerability not only to COVID-19 but also to other forms of discrimination and violence.³⁸ Because most refugees do not understand English and major local languages, they do not get firsthand, timely information about COVID-19.³⁹ Urban refugees in Kenya and Uganda speak mainly Arabic, French, and Swahili. This limits their comprehension of governmental directives and public health messages as well as general information, education, and communication messages.⁴⁰ Thus they are at increased risk of getting inaccurate information from peers and networks about COVID-19 and SGBV prevention and response. The language barrier also presents a challenge in police stations, where translation services are not available. In some refugee communities, female survivors of rape avoid disclosing the crime to other community members for fear of ostracism. During the lockdown, female survivors of violence may be restricted from leaving the house, making it difficult to report cases of violence. Most women and girls also share mobile phones with other members of the household, including their male partners or spouses. This lack of privacy compounds the problem. Women cannot report incidents through available hotlines for fear that perpetrators may overhear their conversations.

Recommendations

Given the challenges we have described, we recommend the following practical steps that national and international actors should take immediately to improve the situation of refugees and internally displaced persons and reduce SGBV.

- Disseminating information in local dialects is key for refugees so they can receive accurate, relevant information. Radio announcements, posters, and leaflets in French, Arabic, and Swahili, among other local refugee languages, should be distributed so that refugees can be included fully in national preparedness, prevention, and pandemic response measures.
- Service providers must continue to raise awareness of the dangers of COVID-19 and SGBV. There must be dedicated reporting mechanisms and channels for survivors to report incidences of violence, information on identifying and responding to SGBV, and lists of available services. Such activities can bridge the gaps between service providers and the communities they serve.

- Building the capacity of pharmacists, police, community, and local administration leaders is important in raising awareness on SGBV prevention and response. Law enforcement officers should have greater capacity to identify signs of abuse, respond to emergency calls, and to handle survivors of violence who are fleeing abusive situations past curfew hours. Community and local administration leaders need the capacity and skills to address and respond to complaints of violence and abuse in their local communities. Nonmedical personnel such as pharmacists may be the first to come into contact with survivors of violence and need the capacity and skills to identify, report, and respond to those seeking assistance.
- Governments and development and humanitarian organizations should acknowledge the gendered implications of COVID-19 and put in place gender-responsive COVID-19 prevention and response plans as well as sustainable age- and sex-disaggregated resilience and recovery programs. In addition, national contingency plans should include refugees at no cost. Moreover, humanitarian workers and their services should be deemed essential and therefore allowed access to the most vulnerable refugees in settlements and urban areas so they can identify the needs of the most vulnerable individuals and families and provide real-time support. Like other vulnerable host communities, refugees should benefit from government assistance in the form of food and other essential items distributed by national COVID-19 task forces.
- Government authorities mandated to work on refugee issues, such as the Office of the Prime Minister in Uganda and the Refugee Affairs Secretariat in Kenya, should work with UNHCR and other relief organizations to ensure that refugees have continued access to services. Refugee local leadership such as traditional leaders and local council leaders should be engaged in building awareness about the available services. In refugee communities, frontline workers such as health care staff and other social workers need more training to understand the specific needs of refugees so they can deliver the appropriate pandemic protection over the short and long term. These might include psychosocial support and toll-free hotlines for information and assistance on SGBV, water sanitation and hygiene services, and other needs.
- It is also critical that accurate, disaggregated data be collected during this period. Lack of such data could hamper post-pandemic recovery efforts. Public-private partnerships will be important to design and disseminate innovative solutions such as the use of apps to deliver goods, services, and information and to collect data from survivors of violence. Such innovations could include the use of mobile apps to deliver services and commodities and employ trained counselors in call centers. The counselors could work in the call centers in the guise of customer care agents. Data collection should be done in a manner that is ethical and confidential and should protect survivors of SGBV and the research teams. Data collection should also take into consideration the needs of marginalized groups of women, including the elderly, women with disabilities, adolescent girls, and ethnic minorities.
- Governments and organizations should put refugee women at the center of solutions and recovery efforts in refugee settings. Refugee women are key resources for ensuring that recovery plans and longer-term solutions meet women's needs, yet their input is typically not valued. Their participation should be sought in decision-making processes, including but not limited to those related to violence prevention and response. Governments should work through organized refugee women groups from different communities to ensure that they leave no one behind in the prevention of SGBV and COVID-19.

Conclusion

While measures have been put in place to curb the spread of COVID-19, these measures must at the very least do no harm. It is also important that the government involve stakeholders in designing and putting in place measures that will curb the spread of the virus. These measures should include interventions that protect women, girls, and other vulnerable groups from violence, abuse, and exploitation. The engagement of men and boys is important in designing measures for SGBV prevention and response, but women and girls must also be involved in the program cycle of all interventions.

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