Gender, Economic Precarity and Uganda Government's COVID-19 Response

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Abstract

Understanding the gender implications of government policy is important for effective implementation. This article examines the gender implications of the COVID-19 government response in a liberalised economy. It sought to examine the gendered effects of the Uganda government's COVID-19 response. Specifically, it interrogated the gendered experiences of males of females of the COVID-19 lockdown, how gender shaped these experiences and how gender can be mainstreamed in the COVID-19 response. Following guidance from the World Health Organisation, Uganda's COVID-19 response included lockdown, massive testing of people in quarantine and at borders, contact tracing, a national community survey and promulgation of laws to penalise non-compliance. The key method of data collection was documents review of both grey and published literature. The key findings showed that the neoliberal economic system in which Uganda's COVID-19 response was implemented cannot effectively serve the interests of all. Rather, gender, compounded with economic, social and regional inequalities converged to produce negative experiences for women and other marginalised groups in relation to health, education, justice and livelihoods. The article concludes by recommending attention to gender and context when designing crisis response strategies. Specifically, to recommends safety nets to enable the vulnerable survive crises like COVID-19.

Key Words: Gender, Gendered, Neoliberalism, COVID-19, Lockdown

Introduction

This paper examines the effects of Uganda government's COVID-19 response from a gender perspective. Specifically, it interrogates three questions: 1) How did the Uganda government's COVID19 response affect males and females?; 2) How did gender shape males and females' experiences of the Uganda government's COVID19 response?; and 3) How can gender be mainstreamed in Uganda government's COVID19 response? The COVID19 pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was identified in late 2019 in Wuhan China (Morens et al 2020). On 11th March 2020, the World Health Organisation (WHO) declared it a pandemic, providing guidelines for countries to follow (Ribeiro 2020).

The first confirmed COVID19 case in Uganda was identified on 21st March 2020 and first death due to COVID19 on 23rd July 2020. According to the Ministry of Health (MoH 2020), Uganda's cumulative COVID19 cases stand at 7,777, with 75 deaths. Uganda's COVID-19 response strategy, undertaken before the first case was detected included a phased lockdown on March 18th 2020; a hard lockdown on 20th March 2020; decongestion of schools; massive testing of people in quarantine and at borders; contact tracing and a national community survey (Olum and Bongomin 2020). Currently there has been an easing of the lockdown. However, areas of high concentration such as schools and public gatherings (churches and rallies) remain restricted.

Right from its onset, the gendered nature of the pandemic was documented, showing higher male vulnerability and mortality to COVID19 in China and Europe (Kasozi et al 2020). Accordingly, with regard to Africa, WHO predicted that women were more likely to fare worse as a result of gender inequality, inequity and extreme poverty among women. However, little was reported about the gendered experiences of the pandemic. Using an intersectional gender lens, this paper discusses how these the COVID19 response affected males and females. An intersectional gender lens considers the gender as the socially constructed attributes associated with maleness and femaleness (Phillips 2005), and how these experiences are shaped by other axes of privilege and disadvantage (Nash 2008). This understanding of gender required that beyond how individual women and men's experiences, we analyse what led to those experiences and why. The paper is divided into five main sections including: 1) the introduction; 2) situating the context; 3) Uganda government's COVID19 response; 3) gendered effects of the COVID19 response and 4) strategies for mainstreaming gender in the Uganda's COVID19 response. Given that the pandemic is ongoing and research evidence is still being collected, this article derives its evidence largely from a documents' review of grey and published literature.

Situating the Context

This section highlights the peculiarities of the Ugandan society, which informed the COVID-19 lockdown and its gendered effects. Uganda is a landlocked country found in Eastern Africa. It attained independence from the British in 1962. Its economy is largely agricultural. However, its tourism and services sectors are growing (African Development Bank – ADB 2020). Its post-independence history has been characterised by civil war, diseases such as HIV and Ebola, poverty, neoliberal economic reforms and poor social economic indicators. Neoliberal economic reform was especially important in shaping the state's development trajectory and consequently its response to the COVID19 pandemic. The neoliberal economic reforms, guided by the World Bank and International Monetary Fund (IMF) emphasised the free market and private sector led growth, consequently downsizing the public sector, with significant negative impact on social services (Ssali 2018). The health sector engendered by neoliberalism was more elitist, urban based, highly diagnostic and expensive for many, while the state provided health services continue to suffer logistical challenges (Ssali 2018). The social security services that emerged, from pensions, retirement benefits, worker's compensation, maternity leave and national health insurance all favour the employed, leaving the majority (about 87% of the population is unemployed) reliant on personal and family based safety nets (Nystrand and Tamm 2018). Although the government introduced the Senior Citizens Grant (SGC) to avert old age poverty, the meagre allowance of UGX25,000 (USD7), coupled with the dependence burden means this money largely benefits their young dependents than the old people themselves (Gelders and Athias 2019). Agriculture production and industry declined, most entrepreneurship remains small to medium scale, short term, highly speculative and operating quick return commercial and consumer service ventures (Asiimwe 2018).

Uganda's COVID-19 Response Strategy

The Uganda government's COVID-19 response included 35 measures introduced between 18th March and 1st June 2020 (Media Centre 2020). In broad terms, they included a lockdown, massive testing of people in quarantine and at borders, contact racing and a national community survey (Olum and Bongomin 2020). In addition, four new acts of parliament were promulgated, including: STATUTORY INSTRUMENTS 2020 No. 57 - The Public Health (Control of COVID - 19) (Amendment) Rules, 2020; STATUTORY INSTRUMENTS 2020 No. 55 - The Public Health (Control Of COVID - 19) Rules, 2020 Arrangement Of Rules; STATUTORY INSTRUMENTS 2020 No. 56-The Public Health (Prohibition of Entry into Uganda) (Amendment) Order, 2020; and STATUTORY

INSTRUMENTS 2020 No. 58 - The Public Health (Control of COVID - 19) (No. 2) (Amendment) Rules, 2020.

The lockdown was phased and communicated through different sequential Presidential announcements or speeches. The lockdown started partially on March 18, 2020, followed by a full lockdown on March 22, 2020. The specific policies included: the closure of education institutions for one month; suspension of public transport for 14 days; closure of non-essential offices and businesses (shopping malls, arcades, hardware shops, lodges, salons, non-food stores, non-food markets and garages) for 14 days; prohibition of gatherings of more than five people, parties, bars, communal weddings, churches, political rallies and events, to decongest and promote social distancing; a night curfew between 7:00pm and 6:30 am; and enforcement of stay at home measures (Ahimbisibwe 2020a). Essential services allowed to operate included food markets, supermarkets, construction sites, factories, pharmacies, vet shops, agricultural stores, banks, the Judiciary, media houses, private security companies, garbage collection services, fuel stations, water departments, Kampala Capital City Authority (KCCA), telecommunications, door to door delivery, cleaning services, and medical centres (Ahimbisibwe 2020a). Later, these were eased to allow public transport and malls to operate, albeit with some standard operating procedures (SOPs) (Media Centre 2020). Some social protection measures including: providing food relief for the urban poor; suspending all disconnection of utilities during the period of the lockdown; suspending seizing of property due to non-loan payment; suspending closing down businesses for non-payment of taxes were announced. Landlords were asked to tolerate tenants with rent arrears. Uganda's COVID-19 response were praised by many, including the WHO. However, the gender implications of this strategy were yet to unfold, as discussed below.

Gendered Effects of the COVID-19 Lockdown

This section discusses the gendered effects of the COVID19 response undertaken by the Uganda government. Gendered effects refer to, in the context of this paper, the effects of the COVID19 response impacted on males and females differently, influenced by the economic and social-cultural gender ascriptions. The gender focus of this paper therefore considers both individual males' and females' experiences and their structural drivers. In so doing, particular attention was be paid to those areas that generated the greatest reported gendered effects, namely health, education, livelihoods, care work, justice and sexual and gender-based violence. Health Care

There were several effects the lockdown that affected health care workers and health care seekers:

Declining use of Health Care Services

Declining use of health care services arose from two fundamental factors: a) restricted mobility and b) decongestion of health facilities (Sameen et al 2020). The transport ban on all vehicles except ambulances was supposed to discourage non-essential travel and support the "stay-at-home" campaign (Uganda Media Centre 2020). Any travel had to be sanctioned by the Resident District Commissioners, after assessing its urgency. Ambulances and local government vehicles were supposed to pick up ailing patients who needed to access medical facilities. However, most local governments lacked fuel for the local government ambulances and vehicles to promptly transport the sick (Ochola 2020). The commonest form of rural transportation, the motorbikes and bicycles were not allowed to carry passengers (Uganda Media Centre 2020). This posed a challenge to accessing the RDC's office to secure permission to travel, and thereafter travelling to the health facility. Those most affected were persons with disabilities and expectant mothers as explained below.

The second factor blamed for declining use of health services was the drive to decongest health facilities, by restricting them to providing only emergency health care services such as deliveries, road traffic accidents, intestinal obstructions, gynaecological problems, severe abdominal pain, diarrhoea, kidney and heart failure (Nabatanzi and Kiwuuwa 2020). Patients with chronic illnesses such as groin hernia, diabetes, HIV, heart conditions cancers fractures, and prostate issues were advised to wait for the 32-day lapse or consult online. Antenatal care and family planning were not considered emergencies despite their demand. Despite Uganda's high HIV burden and the need for constant follow-up to enable adherence, this was disrupted by the transport ban and the discontinuation of peer support services which are key for supporting adherence (Gusdal et al 2011). In addition to denying people lifesaving HIV medicines, it denied many affected by HIV, especially poor females in hard to reach areas the necessary health care support to cope with HIV. The telemedicine and door to door deliveries were only in urban areas. Given women's proportionate HIV burden (Uganda AIDS Commission 2019) and predominant role in caring for the sick, this was bound to worsen their ill health as well as increase women's caring work, particularly grandmothers caring for children with HIV.

Increased Maternal Mortality

Although definitive data on the impact of COVID-19 on maternal mortality is being collected, projections conducted by Graham et al (2020), in 118 Low- and Middle-Income Countries (LMICs) including Uganda, showed a potential increase in maternal mortality by 8.3% - 38.6%. Similar projections by Robertson et al (2020) and Semaan et al (2020) showed a likely increase in maternal deaths between 12,190 and 56,700, and under-five mortality of between 253,500 – 1,157,000. In Uganda, the Women's Probono Initiative

claimed 11 mothers had lost their lives while many others had miscarried or bled to death due to the transport restrictions (Hayden 2020). The Women's Probono Initiative further claimed that the lockdown led to an increase in maternal deaths, from eight in the fifth week of 2020 to 76 in the 12th week of the 2020, right in the pandemic (Hayden 2020). While the Ministry of Health was not available to verify these statistics, health care workers in the area did not dispute the figures, focusing on their unpreparedness to deal with the situation (Hayden 2020) and the ridiculousness of the ban (Biryabarema 2020). Data from the District Health Information System showed that in Acholi sub-region alone, the total number of deliveries in health facilities reduced from 12,406 in January to 3582 in March, implying that many mothers were failing to get to the facilities due to transport challenges (Ochola 2020). Accordingly, this put the mothers at risk of experiencing complications during delivery, and even death. Hayden (2020) and Biryabarema (2020) further profiled several cases of families whose loved ones, including expectant mothers who had perished on the way to health facilities due to the transport restrictions. Often, each case involved far off health centers, unavailable or unfueled ambulances, or motorists or cyclists who could not help them for fear of the consequences of violating the transport ban (Hayden 2020 and Biryabarema 2020). Moreover, not providing antenatal care services denied providers an opportunity to identify and prevent complicated births, and consequently maternal mortality (Semaan et al 2020)

Health Worker Challenges

In addition to patients, health workers also faced challenges occasioned by the COVID-19 response. First, the transport ban and curfew also posed access challenges for health care workers, particularly midwives (Semaan et al 2020). Although the government provided stickers to enable health care workers to travel to work, this largely benefited health care workers who owned cars. Most lower cadre workers who did not own cars or who worked in facilities with no vehicles had to ride or walk to work. For example most of the nursing staff in upcountry health facilities had to canoe, ride a bicycle or walk several kilometres to work, which posed an extra challenge to female health care workers (Landman and Okereke 2020). With most health facilities not providing staff accommodation or transportation to work [resulting from the neoliberal reforms of selling off government houses], many workers had challenges getting to work and when they did, had to leave early to beat the curfew which started at 7:00 PM, leaving patients who made it to hospital hardly attended to (Semaan et al 2020). Second, health care workers suffered challenges relating to workload and lack of protective equipment. Gender studies of Uganda's health workforce have demonstrated how females tend to occupy the lower cadres, with more work and yet with less pay, incentives and protective equipment (Witter et al 2017). The emergence of COVID19 only worsened this situation, with medical workers, particularly midwives complaining of fear of infection due to lack of personal protective equipment,

increased workload and frequent changes in their schedules, leading to exhaustion (Semaan et al 2020). Moreover, nurses were also not among those to be considered for relief food (Draku 2020).

Sexual and Gender Based Violence

Domestic Violence

The Domestic Violence Act (2010) notes that domestic violence constitutes any acts or omissions which harass, harm, injure or endanger the health, safety, life, limb or wellbeing (mental or physical) of the victim. Accordingly, domestic violence can be physical, sexual, emotional, psychological and economic abuse. While the Uganda Domestic Violence Act (2010) acknowledges that any member of the household can be a victim of domestic violence, the commonest victims are female spouses (Heise et al 2002). Domestic violence was a prominent feature of the COVID-19 lockdown (Masaba 2020). Omona (2020) notes that domestic violence grew from 46% to 56% in the first week of the lock down and was expected to rise as the lockdown continued. This was reiterated by Hon. Tumwebaze, the Minister of Gender, Labour and Social Development, who observed that 3,280 cases of domestic violence and 283 cases of violence against children had been reported to the police between March 30 and April 28 2020 (Huaxia 2020). So prominent was it that the President mentioned it in his 8th address to the nation, prompting the Uganda Police Force instituted a hotline for any seeking redress (Media Centre 2020). While several factors advanced for this increase in domestic violence, the common ones included women being stuck at home with violent partners (Omona 2020); men's failure to work and provide for the family, and having to stay at home, which they were not used to (Mwiine 2020). Traditional gender roles allocate males the role of domestic provisioning, failure of which one's masculinity is challenged (CARE 2020). Men's resort to violence to assert their masculinity in situations of crisis such as the COVID-19 lockdown validates the view that crises reinforce the social cultural factors which perpetuate violence against women (Stark et al 2010).

Sexual Violence

Beyond brutality and domestic violence, there were increased cases of sexual abuse of females, particularly teenage girls in rural areas. Uganda's Penal Code (Amendment) Act 2007 prohibits sex with persons under 18 years (Section 129). Further, the Domestic Relations Bill (2003) prohibits marriage of persons aged under 18 years (Section 14). Yet with the lockdown, several cases of teenage pregnancy were reported. According to Kugonza (2020), Police recorded 4,442 cases of defilement between March and April 2020. Accordingly, 600 of these cases were in Luuka District, 800 in Buliisa district, with Ankole

and West Nile also reporting higher figures. Furthermore, Kugonza (2020) observed that early marriages in Buliisa alone were 17% while early pregnancy stood at between 25 – 30%. In refugee camps such as Bidibidi refugee camp, World Vision (2020) registered 19 cases of teenage pregnancy, 6 cases of child marriage, 5 defilement cases, 4 child-to-child sex cases and 2 cases of forced marriage between March and July 2020. Accordingly, in Buliisa the reason for early marriage was attributed to being out of school while in Bidibidi it was attributed to defilement and early pregnancy which are considered taboo in Sudanese culture, forcing parents to marry off their pregnant daughters to their abusers. This shows that the potential of crises such as COVID 19 to erode gains of years of female activism to keep girls in school and against teenage pregnancy and early marriage, despite existing legislation. UNICEF argues that keeping girls in school, especially secondary school level leads to a decline in child marriages, maternal mortality, child mortality and child stunting (UNICEF 2020). Unfortunately, with the indefinite closure of schools, girl children became vulnerable to early pregnancy and marriage. Moreover, with the transport ban and partially closed courts, (Kasule 2020), it was not easy to successfully prosecute such sexual offences or preserve the evidence until the courts open. For many of these girls, even when school begins, it is unlikely that they will resume school.

Gendered Effects of School Closure

The foregoing section engaged with the link between schools' closure and increasing teenage pregnancy and early marriages. This section deals with the implications of the schools' closure for access to learning and caring roles. Though the first to be closed, schools remain closed, even after other sectors of the economy have been relaxed. To ensure students do not lose out on learning, the Ministry of Education and Sports (MOES) advised institutions to embark on on-line and distance education, through radio, television and newspapers (MOES Circular No.05/2020 (MOES 2020). The Ministry also developed a Framework to guide continued teaching for teachers and a boost guide for parents to support learning at home MOES 2020)

Commendable, thought this strategy maybe, online learning is likely to exacerbate rural/urban and gender inequalities in learning. First, the privatisation of the education sector in Uganda created a bifurcated system of well-resourced urban schools and dilapidated rural schools (Namusobya et al 2015). Hence, many rural children are unlikely to access the online or distance resources availed by the MOES. Furthermore, gender inequalities in education are well documented, with clear disparities and higher female dropout rates prominent from upper primary to tertiary levels (Odaga 2020). These gender disparities have persisted despite the introduction of universal primary and secondary education. These disparities are worse in rural areas, where gender inequalities in access

are compounded by fewer schooling opportunities, domestic care burden, longer distances to school and increased vulnerability of sexual abuse, teenage pregnancy and early marriages (MOES 2012).

Beyond learning, the closure of schools increased the caring roles of females. Traditionally, reproductive roles, including caring are assigned to females (Ilahi 2001, UNICEF 2016). The gender division of labour assigns females endless domestic chores compared to their male counterparts (CARE 2020). Meanwhile, the Parents' Boost Guide required parents to be constantly available to help with the children's learning, including providing them with learning materials, listening with their children to education programmes aired on radio and television and guiding the children through examples and learning packs. These roles were additional to women's already heavy workload of looking after children out of school and household members out of work (CARE 2020). In a rural area without domestic helpers, piped water and fuel wood, the girls were expected to help provide these than the boys. For example, CARE reported an increase in the women's and girls' unpaid care burden (CARE 2020). Moreover, these tasks were worsened by the COVID-19 SOPS which required frequent hand washing and hence more work collecting of water by the females. Furthermore, in Bidibidi refugee camp, World Vision reported a case of a 15 year old whose father threw a stone at her for refusing to collect water, yet she did not have a jerry can to collect the water in (World Vision 2020). As a result of the violence, she had relocated to the World Vision Centre shelter to escape father's wrath. In Buliisa, children were engaged in petty trade to fend for the home, which sometimes required them to trek long distances, as far as 30 kilometres, selling fish and charcoal from the fish landing sites, rendering the girls vulnerable to sexual exploitation (Kugonza 2020). Hence for girls in rural areas, the COVID-19 measures increased their domestic chores, limited their chances to study and exposed them to sexual exploitation (Kugonza 2020; World Vision 2020).

Unemployment, Loss of livelihoods and Strategies to Survive

The COVID-19 response strategy led to mass unemployment and loss of livelihoods for many. This section discusses the gendered nature of the job losses, their implications and coping strategies engaged in.

Gender and Job Losses

As observed in Section 2.0 above, the Uganda economy engendered by the neoliberal economic reforms was largely small scale and service oriented most of which were self-owned (Asiimwe 2018). With the lock down many of these enterprises closed either as requirement or for lack of clientele. For example, informal sector traders/crafts makers in the tourism sector no longer had business, while those employed formally were sent on

forced leave. For example, the Kampala Serena Hotel sent 350 staff on forced leave (Kwesiga, 2020), while the Hotel Africana considered halving its workforce when hotel occupancy rates dropped from 75% to 25% (Kulabako 2020). Many private education institutions (from primary to tertiary institutions) followed suit, suspending the services of their teachers until the institutions re-opened (Atulinda 2020). With the exception of the health sector and food markets, most of the essential services that remained open, such as truck driving, motor bike and bicycle riding, security, media, construction sites, were those predominated by males (Ramos 2020). Women predominated in the services sectors such as tourism, hospitality, infant educators, and in the informal sector as petty traders, market vendors, road side traders, hawkers and cleaning services (Uganda Bureau of Statistics UBOS 2019), most of which were required to shut down (Media Centre 2020). Without earnings and social safety nets (Nystrand and Tamm 2018) the situation became extremely precarious for especially female headed households (Yiga 2020a).

Livelihood Strategies

Women coped differently with the COVID-19 lockdown. Two categories worth mentioning here, albeit with different results, were the market vendors and street hawkers. One condition the President gave for food markets to remain operational was for the vendors to practice social distancing and to sleep in the markets in order to avoid taking the disease to their families (Uganda Media Centre 2020). While male and female food vendors alike slept in the markets, female vendors had an extra burden of childcare in the markets. Mothers with young babies opted to sleep with them in the markets, while others had to leave their children at home unattended to for weeks. For example, Ann [not real name] slept in the market with her eight-month-old breast-feeding baby because as a widow with eight other children, not working would lead to her family starving (Mukhaye 2020a). However, sleeping in the market with such a baby posed a risk to the baby's health given the limited social amenities and extreme cold of rainy season then. Hence, the vendors like Ann had their caring roles increased (CARE 2020). But unlike the market vendors whose sleeping in the markets was praised as a heroic and patriotic act, female street food vendors who attempted to work were beaten by security personnel (Mukhaye 2020b). Apparently, selling food was restricted to formal food markets and supermarkets. Most poor women with limited capital cannot afford market dues and resort to hawking and roadside trading (Mitullah 2003). Such were the women beaten on Kampala's and Gulu's streets during the lockdown (Mukhaye 2020b). Those in Gulu even had an additional charge of violating the curfew since they were found operating in the evening. While officials from the Uganda People's Defence Force (UPDF) apologised, the injury had been done (Mukhaye 2020b). Other females such as attendants and sales personnel of supermarkets, cleaners and cooks in public offices and construction sites that remained open had additional challenges of transport. These staff cadre, who had previously

travelled by public transport were expected to walk to work or encamp at their workplaces. Walking to work, especially at dusk during curfew time came with a risk of sexual and gender-based violence. Although they were advised to camp at their workplaces, most places did not have that facility while camping at construction sites with predominantly male staff came with the risk of gender-based violence. While this section has dealt with the gender dynamics of employment and loss of jobs, the subsequent section focuses on the implications job loss had for males, especially violence and suicide.

Men, Masculinity and Suicide

Because the relationship between job loss and domestic violence was examined earlier, this section will focus on the increasing rate of suicide among men, which has been associated with job loss (Matovu 2020). From the onset, mental health experts warned that measures such as stay at home, self-isolation, coupled with fear and the economic downturn would lead to a rise of mental health challenges such as anxiety, stress and suicide (Sher 2020; Ribeiro 2020). The WHO published a guide on supporting mental health issues arising from the pandemic (Ribeiro 2020). While the full picture on how COVID19 affected suicide rates is still forming, Uganda has registered many cases suicide by men, which have been attributed to the COVID-19 lockdown. For example, in April, a male secondary school teacher hanged himself after failing to find food (BaBa TV, 2020). In May 2020, a 30-year-old man from Kabale District reportedly hanged himself for failure to raise 1000UGX (0.27USD) to buy salt for the family (Nayiga 2020). Similarly, a 54-year-old primary school teacher in Bududa District hanged himself over accumulated debts and failure to feed and look after his family during the lockdown (Nakhaboya 2020). On July 2, 2020, a 20-year-old motorbike transporter killed himself in the Masaka District Police Station after failing to raise 100,000UGX (27.07USD) required to release his motorbike that police impounded for violating COVID19 restrictions (URN 2020a). In August 2020, a 32-year-old primary school teacher from Kamuli District reportedly hanged himself over COVID19 debts (URN 2020b) and another secondary school teacher in Wakiso District set himself on fire and died due to financial hardships occasioned by the lockdown (Tinka 2020). UNHCR and partners registered 59 suicide attempts and 10 completed suicides in refugee settlements housing Sudanese refugees in the first four months (UNHCR 2020). Overall, the Uganda Police noted that the country had recorded a 22.7% increase in suicide, that is 275 cases of suicide between January and June 2020, compared to 224 cases recorded for the same period in 2019 (Matovu 2020).

From this chronology of events, most who have committed suicide were males and predominantly teachers. Teachers were most affected because the private schools they worked for decided to suspend their services and monthly pay as long as the schools

remained closed (Atulinda 2020). With privatisation of the education sector, many teachers in private schools do not have security of tenure as their counterparts in government schools (Namusobya 2015). While government warned employers not to lay off staff in the COVID19 crisis, employers still suspended their services with no sanctions from government. Hence in each of the cases, lack of wages was cited as a key factor in the deceased's indebtedness and failure to provide basics such as food and salt, which triggered the suicide. Moreover, the government food relief distribution started in Kampala, the capital city and never reached the rural settings. Without social safety nets, owing to the highly privatised society, those who could not cope opted for suicide. This view was validated by the Police Spokesperson, Ms Polly Namaye who attributed this to poor living conditions occasioned by the COVID19 lockdown, particularly joblessness, business collapse, poverty, frustration, stress, rejection by family members and denial of justice among others (Matovu 2020). This highlights the crisis the COVID19 restrictions placed on men's ability to perform their gender roles of family provisioning, challenging their very essence of masculinity (Mwiine 2020).

Court Closure and Implications for Justice

Two trends relating to denial justice in the COVID19 era was the creation of new laws and hence new crimes, as well as the closure of courts. Earlier, the article noted that to control the COVID19 pandemic, government enacted four new Acts, to make violating the SOPS a punishable offence in law (See section 3.0). These rules, together with Presidential addresses, created crimes out of previously normal activities such as using motorbike transportation, jogging, being out of one's house after 7:00PM, spitting and hawking one's merchandise on the street in the evening. Many poor people, especially poor women were often considered culprits and suffered the wrath of the forces. For example, several people were reportedly brutalised for being found outside their homes, violating the curfew or engaging in petty trade when their services were not among those considered essential. A seven months pregnant woman was brutalised for violating the curfew when actually she was sheltering from rain (Odeng and Mubiru 2020). In Amuru District, women and men were frog matched while naked (Kiva and Kitara 2020). In Kampala, over 200 elderly disabled, and juveniles were apprehended for violating the curfew and remanded to Kitalya prison for two weeks (Yiga 2020b). Even those who were unable to operate their own wheelchairs were remanded, even when it was clear they were dependant.

The above situation was worsened by the restricted operation of courts. With the COVID19 lockdown, the Chief Justice issued a circular restricting courts to attend to applications and urgent matters (Judiciary Press Release 2020). Criminal proceedings were restricted to plea taking while most operations, including delivery of rulings, were migrated to the online

platform Zoom. However, this had several negative implications for women's pursuit for justice. First, prioritising criminal proceedings over civil matters under which women's matters are commonly reported denied prompt justice to women (Mugenyi 2020). Furthermore, the closure of courts, in a context of growing sexual and gender-based violence denied women access to justice. Some abuses such as sexual abuse rely on quick judicial processes to secure the evidence and prosecute offenders. However, with courts closed indefinitely, coupled with transport restrictions, successfully prosecuting such cases was impossible. Third, given the gender digital divide, which is ranked as 17% for mobile phone ownership and 48% for mobile internet use in favour of men, accessing online justice was another gender inequality introduced by the judiciary (Mugenyi 2020). Lastly, the court closure was allegedly used to deny people justice. For example Athumani (2020) argues that the court restrictions were used to imprison and deny members of the LGBT community justice. All in law, the developments in the judiciary reinforced the patriarchal nature of the law, where gender concerns are not taken seriously (Barzilai 2004).

Refugees' Livelihoods and Coping Strategies

This section focuses on relief efforts for refugees. Uganda government hosts the third largest refugee population in the word, after Turkey and Pakistan (Watson and Figueras 2020). Uganda's progressive refugee policy settles refugees in settlements as opposed to camps (Hovil 2018). While this enables them to continue subsisting, it can create challenges in crises such as the COVID-19 lockdown. During the lockdown, the relief food provision was strictly for urban poor Ugandans. Refugees were excluded though they were no longer working. Urban refugees could no longer engage in trade (Khan 2020) while the rural ones could no longer access their gardens due to movement restrictions (Otto 2020). Moreover, the World Food Programme had started reducing their food rations and financial support even before the crisis (Otto 2020). For example before the crisis, refugees were getting 2Kg of beans, 12Kgs of maize and cooking oil per person. Then they would find charcoal or firewood at 1,000UGX. However, with the global restrictions of movements interrupting the entire relief effort, food rations were reduced by 5kg and for those receiving cash, it was reduced from 31,000UGX to 22,000UGX. This situation impacted especially on women, who continued to care in difficult circumstances (Watson and Figueras 2020). Apparently despite displacement and refugee status, gender relations continue to determine men's and women's roles and experiences. Women refugees, who predominate among Uganda's refugees populations still remain responsible for reproductive and caring roles (CARE 2020; World Vision 2020). The COVID-19 crisis therefore compounded the gender inequality among refugees, saddling women with more reproductive and caring roles in a context of scarcity, forcing many to cry out for lack of relief (Otto 2020).

Conclusions and Recommendations

This article set out to examine the gendered effects of the Uganda government's COVID-19 response. Specifically, it examined how the Uganda government's COVID19 response affected males and females; the role of gender in shaping males and females' experiences of the response and how gender can be mainstreamed therein. So far, the article has demonstrated the following:

1. The resilience of gender inequality in crisis situation, to the detriment of women and poor males. Gender inequality will ride on disrupted social and economic systems to frustrate all efforts (educational, legislative, and socio-economic) to overcome it.
2. The level of poverty, absence of safety nets, economic system, disability, location and being a refugee are significant confounders of gender inequality with the capacity to compound gender disadvantage.
3. Context matters in the implementation of disease control mechanisms; however global and universal the pandemic may be.
4. That a neoliberal economy, without safety nets cannot ably respond to crises and safeguard the interests of the most vulnerable in society.
5. That privatised health care systems cannot ably respond to disease outbreaks and serve the most vulnerable such as women, children, disabled and the poor.
6. Without social safety nets, strategies for disaster prevention such as COVID-19 control risk undermining the welfare of those they sought to protect.

Based on the above, the paper suggests the following recommendations:

Robust and Gender Sensitive Health Care System

The COVID-19 has exposed the dire state of health care systems, particularly in developing countries (Paintsil 2020). A functional health care system would ably respond to crises and ensure good health for all by addressing both prevention and curative aspect of health. Strategies to improve disease prevention would emphasise basic social services including improved housing, water and sanitation, food security and livelihoods. Strategies to cure ill health would emphasise a functional health care system with proper referral and well-coordinated transport systems for patients and health workers, clinical equipment, water, special personal protective gear. They would also pay attention to mental health and non-communicable diseases and develop telemedicine. Health care workers would have to be better equipped with

research and information for protection and facilitated with food, accommodation, transport and protective equipment, unlike now where they had to cry out for food and protective equipment or have a whole facility with no water as is the case with Iganga Hospital (Bita and Asiimwe 2020). Such a system would better address gender concerns than the existing elitist system.

Pro-Poor Interventions

The provision of food relief and multiple methods of distance learning was an attempt to be inclusive. However, their inadequacy revealed gaps in the country's disaster relief response in a context of poverty. The SGBV, caring roles and other gender relations entailed in frustrating females benefit from the online learning revealed the persistence and pervasiveness of gender inequality in contexts of adversity, as well as the limits of a liberalised economy in responding to shocks. This highlights the need for social safety nets for the most vulnerable in society, even in a liberalised society. The performance of the senior citizens' grant could be evaluated with a few to growing into a relief fund with systems of access especially for the most vulnerable such as single mothers, children and refugees. Beyond relief, government needs to seriously consider pro-poor interventions which enable the poor and vulnerable such as women, youth and the disabled to thrive (Tayebwa 2020; Byanyima 2020). Examples of such strategies would include waiving network fees to cheapen the cost of network transactions (Pillai 2020); restructuring loans and reducing interest rates; prioritising women's businesses and informal sector activities in the post COVID-19 economic projects. With regard to education, this strategy would ensure e

Strategies to combat GBV

Increasing cases of GBV has been a key factor in this crisis. Yet, with limited mobility and partially closed judicial systems, victims of gender-based violence, most of who are females, cannot easily report and seek justice in real time, be it at the community level or beyond. One strategy to overcome this would be to provide hotlines where women would promptly report cases of domestic violence. There is also a need to classify SGBV cases as priority cases whose prosecution should never be suspended. Furthermore, there is need to make courts more friendly to all who need their services, by investing in platforms that work for all. Given the level of illiteracy, a blend of on-line and physical would address all. Sensitisation against SGBV is important. There is also a need to strengthen community surveillance and grievance handling mechanisms as well as the police stations to maintain the family protection desks and to rapidly respond to cries for help.

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