Narrowing the 'Physical Distance' between Public Health Policies and Gender: An Analysis of Government Responses to COVID-19 in Zimbabwe and South Africa

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Abstract

COVID-19 has lifted the veil covering some deep-seated vulnerabilities existing in the forms of class, race, disability, and gender. During this phenomenon, the term "physical distance" has been used to encourage people to minimise contact with each other to curb the spread of the virus. This was one of the governments' responses to COVID-19. Consequently, it meant the closure of all learning institutions, small to medium enterprises, and the closure of marketplaces amongst others. Current evidence suggests that men, the elderly, and those with pre-existing health conditions bear the brunt of morbidity and mortality attributed to COVID-19. However, the evidence from previous pandemics highlights that the gendered roles and cultural norms often leave women and girls more vulnerable in terms of their health, social and economic well-being in the context of a pandemic. This article interrogates the implications of the government responses on the livelihoods of women, those working in the informal sector as well as those working in the frontlines. It argues for the need to narrow the gap between public health policies and gender through the adoption of a gender-lens in health policymaking and implementation. The article also argues that COVID-19 presents an opportunity to further the discourse on public health and gender in South Africa and Zimbabwe.

Keywords: Public health. COVID-19. Gender. South Africa. Zimbabwe.

Introduction

COVID-19 is an unprecedented event that has highlighted some existing social, economic, gender and health inequalities on a global scale. The virus was declared a pandemic by the World Health Organisation (2020) and since then, governments world over have put in place measures to mitigate the transmission of the virus. These measures have included heavy-handed lockdowns to restrict the movement of people within countries, encouraging physical distancing, the compulsory wearing of masks and most importantly encouraging good personal hygiene. The South African and Zimbabwean governments also implemented their 21 days of lockdown in March, with President Cyril Ramaphosa and President Emmerson Mnangagwa making the lockdown announcements in their respective countries (DoH, 2020; Nyoka, 2020).

Whilst the lockdowns in previous pandemics such as the Ebola pandemic proved to be effective in controlling the spread of the virus, in the current pandemic there are growing concerns on the social and economic implications that the heavy-handed lockdowns might have on the citizens in different countries. Key to note is how COVID-19 has exacerbated inequalities faced by marginalised groups which include women and girls. This article uses an evaluative lens to highlight the implications of the COVID-19 pandemic government responses on the livelihoods of women and girls living in Zimbabwe and South Africa.

For the methodology, a literature search was conducted in consultation with different search engines. These were: Google, Google Scholar, JSTOR and Semantic Scholar. These search engines were used to retrieve publications and "grey literature" on public health and gender. Key words were identified and used to guide the search (some words were combined). The keywords were: public health, COVID-19, gender, South Africa, Zimbabwe, health policies, gender-based violence, and governments. The combined search terms were public health and gender, public health policies and COVID-19, COVID-19 responses in South Africa and Zimbabwe, and gender-based violence and COVID-19. In general, the resources included in this article addressed the nexus between public health policies and gender within the context of the COVID-19 pandemic.

The presentation of search findings, i.e. the structure of the article is as follows: a summary of the gendered impacts of COVID-19, the isolated impacts of the mandatory lockdowns, an analysis of public health policies, aligning public health and gender and lastly, the concluding remarks.

Gendered impacts of COVID-19

Before delving into some of the gender dimensions of COVID-19, we are going to provide a brief overview of the public health understanding of COVID-19. This background is important as it lays the foundation in understanding some of the gender-related challenges in the government pandemic response. Providing the gender dimensions of COVID-19

illuminates some of the issues that governments might potentially have overlooked in their COVID-19 responses.

COVID-19 is a disease that is said to have started in Wuhan, China in December 2019 (CDC, 2020a). Many of the cases that were first recorded were directly associated with the Huainan Seafood Wholesale Market in the Jianghan District of Hubei Province (ITPC, 2020). The causative agents of this disease are the coronaviruses, which are a large family of viruses in animal and people whose name originates from the crown-like spikes on their surface that are observable under an electronic microscope (CDC, 2020a). The viruses are spread through droplets, aerosols, and contact. Understanding how a virus spreads informs the measures that will be taken in preventing the spread of the virus (CDC, 2020b). To prevent the spread, it is important to wash hands thoroughly, observe physical distance from those coughing or sneezing, avoiding touching one's hands or nose or mouth and the wearing of masks when going into public spaces (A. CDC, 2020). Those who are sick are advised to self-isolate themselves as a way of preventing the spread of the virus to uninfected persons.

Whilst everyone is at risk of contracting the virus, there are some groups with higher risks than other people. These include people who have encountered with someone who has the virus, frontline workers without adequate personal protective equipment (PPEs), the elderly, and those with pre-existing health conditions (WHO, 2020). According to a report by the Secretary-General of the United Nations, COVID-19 affects everyone, everywhere but it affects groups of people differently and exacerbate the existing inequalities (UN, 2020b). Although current evidence suggests that men bear the brunt of morbidity and mortality attributed to COVID-19 compared to women, the findings from previous pandemics highlight that the gendered roles and cultural norms often leave women and girls more vulnerable in terms of their health, social and economic well-being in the context of pandemics (Wenham, Smith, Davies, et al., 2020).

Evidence from the Ebola outbreak 2013-16 in the West African countries of Guinea, Liberia, and Sierra Leone, shows that women were more likely to contract the virus as they were primarily responsible in the provision of care to those infected with the virus (UN, 2020a). From the Ebola outbreak, it was also noted how women were less likely than men to have power in decision making around the time of the outbreak, and their healthcare and economic needs remained largely unmet (Davies & Bennett, 2016). Another outbreak which highlighted the unmet needs for women in times of crises was the Zika outbreak in Latin America of 2015-2016 where the differences in power between men and women meant that women did not have autonomy over their sexual and reproductive well-being (Pitanguy, 2016).

In the context of the COVID-19 pandemic, it has also heightened the challenges faced by women and girls in different societies. The conditions that are necessary in combating this disease, as earlier-mentioned: isolation, social distancing, and restriction of movement are

perversely the same conditions that feed in the hands of abusers who then use the dire circumstances to unleash abuse on their victims (de Paz, Muller, Boudet, & Gaddis, 2020). Some authors have highlighted that the spike in the number of cases of GBV could be attributed to women spending longer periods locked inside their homes with their abusers (Ghoshal, 2020).

In South Africa where gender-based violence (GBV) is rampant, GBV has been cited as an epidemic within a pandemic during COVID-19. In 2019, before the pandemic, an estimated 25000 women and children were reported to have been maimed and murdered weekly. During the first week of the South African lockdown, the South African Police Services received about 87000 gender-based violence calls, which is more than thrice the 2019 estimates (Udo, 2020). A similar trend was observed in Zimbabwe, where a notable spike in the number of cases was observed. According to Msasa women, during the first month of the Zimbabwean lockdown, there was an increase in the number of sexual violence cases reported. Where they would normally get 500-600 cases reported in a month, they received more than this number of cases in a space of 11 days (UNFPA, 2020b).

Unfortunately for the victims, the lockdown restrictions make it difficult for them to escape to safety neither can they call for help in the presence of their perpetrators. Some of the victims of sexual violence and abuse often find solace in their social groups (attending church services and community events) but with the restrictions on movement, attending such social gatherings was rendered impossible. The closure of schools following the emergence of COVID-19 has also left girls vulnerable as they are now spending a lot of time at home with close relatives, who have been cited as potential abusers (UNFPA, 2020a). Whilst GBV is not a foreign phenomenon, evidence has shown that economic insecurity can lead to sharp rises in intimate partner violence, whilst also exposing adolescent girls to sexual harassment and exploitation (UN, 2020b). According to a report by the World Bank (2020), there is a higher risk of adolescent girls dropping out of school, spikes in forced early girl-child marriages, and an increase in the number of unwanted pregnancies following the pandemic.

Sexual violence and abuse are not only observed in households. Consequent to some of the measures introduced to curb the spread of the virus, the quarantine centres where people undergo self-isolation after travel have also become centres where reports of abuse have been made from. In Zimbabwe, the Gender Commission highlighted some of the unmet sexual and reproductive health needs of women in quarantine facilities which included the unavailability of adequate sanitary wear as well as running water facilities (ZGC, 2020). In other instances, these quarantine facilities have been said to be less than ideal because of the massive breaches in infection prevention and controls, including the sharing of amenities and the difficulties in observing physical distance (Murewanhema, 2020). There were also alarms raised by some women in quarantine facilities on the insufficiency of the condoms and other methods of contraception availed in the facilities.

This could potentially expose women to an increased risk of sexually transmitted infections, and unwanted pregnancies amongst others (ZGC, 2020).

Other issues arising in Zimbabwe in light of COVID-19 include the unfortunate incidents of women delivering their babies from home because of the difficulties in accessing the health facilities, increasing the risk of complications, maternal and infant mortality (Chikwanda, 2020). Fortunately, there has not been any evidence that supports vertical transmission from mother to child (WHO, 2020). One of the women interviewed by a local newspaper in Zimbabwe raised concerns about going to the health facility for her routine check-up because of the letter requirements by the law-enforcement officers (Dzobo, Chitungu, & Dzinamarira, 2020). Some women also expressed the discomfort that they experienced in having to disclose their human-immunodeficiency virus (HIV) status to law-enforcers to be allowed passage to the health centres to collect their antiretroviral drugs (ARVs) (Stiegler & Bouchard, 2020). For women living with disability, the restrictions on movement also meant that women who require rehabilitation services could not access these much-needed services. From this background, it can be said that COVID-19 has limited access to healthcare for women and consequently, their ability to protect their bodies and their health (Akseer, Kandru, Keats, & Bhutta, 2020).

Another factor which could increase the exposure to COVID-19 for women and girls in both South Africa and Zimbabwe is that of gendered roles (Dzobo et al., 2020). Traditionally, women typically shoulder a great burden of care by assuming the role of caregiving to children, the elderly and even the ill. This caregiver-burden is three fold in public health emergencies like COVID-19 (Ghoshal, 2020). With everyone mandated to stay at home or work from home, this translates to formal sector employees having to balance between preparing more meals, doing more laundry, childcare and other house chores which often fall as the responsibility of women and girls in many households (UN, 2020a). Roles such as caring for an infected individual, which are often assumed by women typically put these women at risk of contracting the infection.

Women do not only care for the sick at home but also as frontline workers in the healthcare system. Over 70% of the frontline workers are women (Gausman & Langer, 2020; UN, 2020a). In South Africa, which to date is leading in the number of COVID-19 tests conducted in Africa, the country's frontline workers have reported anxiety over contracting the virus and also the possible risk of transmitting the virus to their loved ones (Chersich et al., 2020). This has resulted in some of these frontline workers living separately from their families in constant fear of spreading the virus. Another concern similar to what has been raised in the previous pandemics (e.g. the West African Ebola outbreak) is the stigmatisation that is faced by frontline workers because of their proximity to COVID-19 patients (Rajkumar, 2020).

In the case of the frontline workers in Zimbabwe, the female frontline workers expressed concerns over the inadequacy of personal protective equipment (PPE) (Makurumidze,

2020). For those that received the PPEs, they had to wear over-sized garments because only the larger sizes were available. There was also a strike by the frontline workers where they were demanding that they receive risk-allowance if they were to care for the COVID-19 patients (Dzinamarira et al., 2020). They each then received US$37 from the government to cater for their needs, which as one might note does not seem like a lot. It goes without saying that while COVID-19 is a public health concern, it has also presented some economic challenges at country-level, family level and individual level. Some of these challenges ensued because of certain decisions or non-decisions by the different governments in curtailing the spread of the virus.

Lockdown vs Livelihoods

As the virus continues to rampage in Africa, governments are forced to make tough decisions to mitigate the spread of the virus. The African governments are grappling with whether they should prioritise mitigating the spread of the virus through lockdowns or prioritise the livelihoods of people whilst risking losing lives to COVID-19 (Changachirere, 2020). The African health system is one that has been characterised as poor because of the brain drain of human resource for health, unmotivated health workers, inadequate equipment, drugs, and technologies amongst others (Gilson, 2012). Against this background of weak health systems in Africa, the South African and Zimbabwean governments (along with other African governments) opted for the implementation of the lockdown. Whilst such an approach made sense in curbing the spread of the virus, and building health system resilience, what is undisputed are the economic implications that these lockdowns imposed.

To cushion the citizens from the economic connotation of the pandemic, the South African government introduced safety nets for those who were most affected by the pandemic (Stiegler & Bouchard, 2020). These included a solidarity fund financed mainly by voluntary donations, a temporary employee relief scheme for employees of companies in distress and a tax subsidy for low-income private-sector workers. The Motsepe, Oppenheimer and Rupert families each donated R1 billion to assist in dealing with the crisis (WIEGO, 2020). Unfortunately, those in the hard to reach communities, those living with disabilities, and those who are not formally employed (domestic workers, and farmworkers), are often disadvantaged when it comes to accessing these services (Ndhlovu & Mhlanga, 2020).

The Zimbabwean economy is largely an informal economy with a soaring unemployment rate. Most of the Zimbabwean women make a living through cross-border trading and vending (Rusvingo, 2015). The closure of borders has disproportionately affected women and girls as the demographics show that this group constitutes a significant proportion of cross-border traders (DHS, 2015). The closure of the largest vegetable market (Mbare Musika) in Zimbabwe following President Mnangagwa's lockdown announcement resulted in some of the women expressing concerns that hunger would kill them before the virus

even got to them. Another group of informal workers which was affected by the lockdowns is that of commercial sex workers. In the preliminary interviews conducted by journalists at the inception of the lockdowns, the commercial sex workers raised concerns about the difficulties of going on with their trade because of the movement restrictions imposed on people by the government (Gwarisa, 2020).

With barely enough money to make it through the day, the sudden closure of markets put most families in difficult financial situations. In Zimbabwe (and South Africa), there were reported cases of people panic buying just before and after the announcements of the lockdowns. The people who were panic buying were those whose financial position allowed them to do so, which resulted in shortages for those who were less well-off (Hopman, Allegranzi, & Mehtar, 2020). To try and address these shortages, the government of Zimbabwe offered some relief packages for families most affected by the pandemic in the form of mealie-meal and other grocery items in an attempt to relieve the disruptions in people's incomes following the lockdowns (OCHA, 2020).

Not all families benefited from this government initiative, for some, the remaining option was for the women to join the long queues to buy subsidised mealie-meal where physical distancing was not always possible thereby heightening the risk of exposure to the virus (Chikwanda, 2020). The risk of heightened food insecurity and malnourishment during public health emergencies is unfathomable for women and girls because of cultural and social norms in some contexts which dictate that they eat last and least (Lokot, Avakyan, & Matters, 2020). When there are food shortages, women and girls who are already more likely to be malnourished than men and boys could face additional health complications including increased risk of contracting the COVID-19 infection (UN Food and Agriculture Organisation (FAO), 2020).

Whilst the policies introduced by the African governments were aimed at mitigating the spread of COVID-19, policies do not always achieve their intended objectives because of the people, power, and the processes involved in policymaking. The next section explores some of the public health policies that were introduced in the two Sub-Saharan African countries in response to COVID-19.

Policy and Politics

This article builds on the existing scholarship on a topical issue, that is, embedding gender in public health policies. Although gender research is no longer a terra incognita of health policy, gender sensitive approaches remain missing from, misunderstood in, and only sometimes mainstreamed into public health policies (Hawkes & Buse, 2013; Kuhlmann & Annandale, 2015). Academics have argued that public health policies and efforts have not always addressed the gendered impacts of disease outbreaks, or pandemics (Gebhard, Regitz-Zagrosek, Neuhauser, Morgan, & Klein, 2020). Yet, when adequate attention is

given to gender issues, gender-related health inequalities are reduced and healthcare can make a positive change in the lives of women and men (Kuhlmann & Annandale, 2015). Gender by definition refers to: the roles, behaviours, activities, and attributes that are expected, allowed, and valued in a woman or man in any given context (Hawkes & Buse, 2013).

Health policy refers to: decisions, plans and actions that are undertaken to achieve specific healthcare goals within a society (An, Huang, & Baghbabian, 2015). The decisions or non-decisions taken by those with influence in a policy often contribute towards the outcome of that policy (McConnell, 2010). In most policy contexts, not all policy actors formulate policies, but they can influence it through their actions, decisions, and practices (Popoola, 2016). The policy process is also one which involves contestation of power and interests of the actors involved in the policy formulation process (Ciccia & Lombardo, 2019). This process determines who gets what, when, and how they get it, and is instrumental in health policy and health equity outcomes (Hawkes & Buse, 2013).

In responding to COVID-19, the South African and Zimbabwean governments set aside Presidential task forces to lead in the COVID-19 response. These task forces were composed of leading scientists and public health practitioners. Whilst some have applauded these task forces to be high-level platforms to harness Africa's hard-earned expertise in combating public health crises, others have seen them as nothing more than political advances. Human rights organisations have expressed sentiments that authoritative regimes are taking advantage of COVID-19 to entrench their power and control by probing for interventions that further their political goals at the expense of their political opponents and the citizens. In the Zimbabwean response, some critics have said that it is the politicians and not the doctors and the scientists who are leading the COVID-19 response.

The challenges which often ensue when health policies are made from a political position are that some are often left vulnerable and the top-down approaches often face resistance from the people for whom the policies would have been intended for (Maynard-Moody & Portillo, 2010). This can be evidenced by the observed resistance to the lockdown in both South Africa and Zimbabwe where policies were handed down without the buy-in from the public for whom they were intended for. In such cases, this often leads to some gross human rights violations with governments trying to force people to comply with the policies. In Zimbabwe, there were reports of young women being physically assaulted because of 'defying' the lockdown restrictions (DIA, 2020). There were also reports of police officers raiding vegetable markets and burning the goods, leaving the vendors in vulnerable positions. In South Africa, one of the incidents that were reported was that of a family that sued the state for the death of Collins Khosa who passed on at the hands of the South African National Defence Forces (SANDF) and the Johannesburg Metropolitan Police Department (JMPD) (Karrim, 2020).

The government responses to COVID-19 in South Africa and Zimbabwe could be said to mirror each other. The initial lockdown in both countries included the closure of borders, mandatory two-weeks quarantine of those returning to the country, the closure of non-essential services, and restrictions for the public transport operators (DoH, 2020). The argument for the necessity in embarking on such measures to mitigate the spread of the virus is one that cannot be disputed. The South African COVID-19 economic response was divided into three phases, the first phase being that of putting in place measures to mitigate the worst effects of the pandemic on businesses, on communities and individuals, the second phase was aimed at stabilising the economy by addressing the decline in the supply and demand and protecting jobs and the third phase is an economic strategy aimed at driving the recovery of the economy post the pandemic (DoH, 2020). Like most economies, the South African economy has taken a massive knock because of months of lockdown (Arndt et al., 2020).

Whilst the measures taken to mitigate the impacts of COVID-19 were necessary in the given circumstances, it can be argued that these governments overlooked the importance of applying a gender lens in the design and the implementation of their policies. In a report by the Centre for Natural Resource Governance (2020), they argue that the thin presence of women in the Zimbabwean Presidential taskforce is an apt reflection of the lack of representation of women in the decisions made by the COVID-19 taskforce. The female leadership in Zimbabwe has been accused of not advocating for the needs of women and girls in times of disaster which is based on the reported cases of sexual exploitation during the Cyclone Idai disaster which struck in 2019 (Chatiza, 2019).

Aligning Public Health Policies and Gender

Policies in the previous pandemics (West-African Ebola Virus and Zika Virus) have not addressed the gendered impacts of disease outbreaks (Gausman & Langer, 2020). The case appears to be no different from the COVID-19 responses (UN, 2020a). Whilst there is no one size fits all approach in addressing some of the matters arising because of COVID-19, there are some questions that governments should be asking to guide their disaster preparedness plans during and after COVID-19. The policymakers need to consider why gender plays a crucial role in determining who does what in a pandemic, how the effects of the coping measures are gender-differentiated, how gender relations alter due to the unprecedented consequences unleashed by the disease, and lastly how the steps adopted to tackle the disease affect women and men differently (Gausman & Langer, 2020).

While it is expected that governments lead the COVID-19 response, the pandemic has shown that different actors, i.e., the public sector, private sector, media, civil societies and community leaders should all come together in developing strategies that are gender-sensitive and culturally appropriate. A key lesson from the COVID-19 pandemic is that effective pandemic responses are highly dependent on the levels of trust between those

in positions of authority and the citizens. As evidenced by the defiance of the citizens to stay at home during the lockdown, it can be said that heavy-handed policies deplete public trust in the government. Once trust is lost, it might be a while before the government regains the trust of the public.

From the 1990s to 2000s when Sub-Saharan Africa was grappling with the HIV pandemic, Zimbabwe was not spared. As a way of curtailing the spread of HIV, the government forged partnerships with community leaders and religious leaders in leading the HIV response as the community trusted and respected this group of people as opposed to the agents of government (Kagawa, Anglemyer, & Montagu, 2012). Constructive and persistent social dialogue between the government and other social partners is crucial in developing effective responses as evidenced by historic crises (ILO, 2020). In the context of COVID-19, all actors should, "*commit to an intersectional analysis to account for the needs of all individuals, irrespective of ethnicity, gender, nationality, or sexual orientation. These efforts should take place with the full participation of at-risk populations, particularly women and girls*"(Fuhrman, Kalyanpur, Friedman, & Tran, 2020). The World Health Organisation also indicates that for the successful implementation of programs, there should be buy-in from people, from the ground up ensuring cultural sensitisation, education, and trust in the health system (UN, 2020a).

Amongst the group of international actors proffering solutions for achieving gender-sensitive responses to COVID-19 which governments can adopt is the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). The UN Women encourages that governments should ensure that the needs of female frontline workers are integrated into all aspects of the response efforts (Bhatia Anita, 2020). Part of addressing the needs of the female frontline workers includes ensuring that menstrual hygiene products such as sanitary pads are availed to them together with PPE (Fuhrman et al., 2020). They also highlight the importance of ensuring that in times of disaster, services for victims of domestic abuse are kept open and that law enforcements are sensitised to the need to be responsive to calls from the victims (Ghoshal, 2020). UN Women also urges governments to provide stimulus packages which reflect an understanding of women's special circumstances in times of disaster (Bhatia Anita, 2020). The governments should also pay attention to what is happening in people's homes in terms of the shared burden of care between women and men. Another key dimension in gender-sensitive responses is that of finding ways in which women are included in the response and recovery decision-making (Wenham, Smith, & Morgan, 2020). Whether this is done at the local level, municipality or even at the national level, bringing in the voices of women will result in targeted and better health-outcomes.

The disproportionate manner by which women and girls are affected by pandemics is a topic that has emerged persistently during the COVID-19 pandemic and has been raised in the previous pandemics. Pandemics shed the light on existing inequalities and force local governments and international bodies to pay closer attention to those issues. The impacts

of COVID-19 can reverse some of the progress made globally in achieving a more gender-equal world (Alon, Doepke, Olmstead-Rumsey, & Tertilt, 2020). However, the silver lining is that it also offers an opportunity to further the discourse on the challenges around achieving a more gender-equal world. The steps indicated above as suggested by UN Women would indeed go a long way in assisting governments adopting a gender-lens in their responses. The importance of taking this route is one that cannot be emphasised enough. Governments must also develop holistic, country-specific, and sustainable solutions to provide social protection, greater equality for the vulnerable groups in their countries (Dutt, 2020). They should have the capacity to implement policies and programs that address gender inequities and efficiently allocate resources for health equity goals (Marmot et al., 2008).

The call to governments is for them to strengthen their health systems in ways that they can absorb the shocks from unprecedented events such as pandemics (De Savigny & Taghreed, 2009). They can also consider offering interventions which ensure that adequate protection systems exist to address violence and harassment against female health workers and other women and girls who are at risk of succumbing to the different forms of abuse (Ghoshal, 2020). More importantly, seeing that gender-based violence is rampant in South Africa, the government and other key stakeholders should conduct further research on the drivers of this phenomenon and find ways in which the root cause can be tackled. The South African government must also strengthen its efforts in raising social awareness and responses to this phenomenon. Adopting this approach has the potential to protect women and girls from violence. In the Zimbabwean context where there are a plethora of humanitarian problems, including food insecurity, recurring droughts, a weak health system and a collapsing economy, the government has more to do in ensuring that the needs of women and girls are met. Health system strengthening would be a priority, increasing fiscal space, creating employment opportunities, raising awareness on the need for the social protection of children and finding ways in which the economy can be stabilised. All these efforts as already indicated would require collaborative efforts from the public sectors, private sectors, non-governmental organisations, and civil societies.

Conclusion

We began this article by drawing attention to the gendered-dimensions of the COVID-19 pandemic for women living in South Africa and Zimbabwe. We highlighted that even before the pandemic, the marginalisation of women and girls is visible in terms of their health, social, and economic well-being. We assert that for the COVID-response to be effective, it is urgent that governments adopt a gender-lens in the design and implementation of their pandemic response (Gausman & Langer, 2020). This includes facilitating the representation of women's voices in the COVID-19 responses at local, municipality or even at the national level. Governments and other key stakeholders should utilise the opportunity to further the discourse on how to incorporate gender into public health

policies. Whilst some efforts have been made by governments to mitigate the impact of COVID-19 on the livelihoods of women and girls, some have been rendered vulnerable due to the methods adopted by governments in curtailing the spread of the virus.

The notion of the importance of adopting a gender-lens in health policymaking and implementation is one which has been stressed on different accounts by national governments as well as the international bodies. As evidenced by the accounts of women in Zimbabwe and South Africa, the failure of governments to recognise the needs of women and girls in their responses exacerbates their plight when disaster strikes. In conclusion, we strongly recommend that given the extent to which gender cuts across all sectors and spheres, there is a growing need for those in positions of authority to pay attention to the gender dimension in the design and implementation of policies. They must ensure that existing health services which support women's needs are not neglected during cataclysmic events.

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