

WOMEN AND ADOLESCENT GIRLS' EXPERIENCE WITH COVID-19 IN RURAL SENEGAL

Policy Note | February 2021

Malick Dione^a, Codé Lo^b, Moustapha Seye^b, Abdou Salam Fall^b, Melissa Hidrobo^a, Agnès Le Port^c, Jessica Heckert^a, Amber Peterman^d

THE COVID-19 CONTEXT IN SENEGAL

Senegal reported its first case of COVID-19 on March 2, 2020. The government responded within two weeks, introducing preventive measures to slow the spread of the virus, including the declaration of a public health emergency, border closures, and the prohibition of intercity travel and gatherings. These measures also slowed economic activity throughout the country and disrupted food supply chains and markets, contributing to loss of livelihoods, income, and households' purchasing power.[1] Evidence suggests that globally, women have been hit harder by the COVID-19 crisis, in particular with respect to impacts on economic security, health, education, and increased caretaking responsibilities in the household.[2]

This brief presents the results of a telephone survey conducted approximately three months after the declaration of the state of emergency and shows how Senegalese women and adolescent girls living in rural areas have experienced the crisis. With 11,380 positive COVID-19 cases reported and 238 deaths as of August 11, 2020, Senegal was one of the hardest-hit countries in West Africa, behind Nigeria, Ghana, and Côte d'Ivoire.[3]

SURVEY OVERVIEW

The survey was carried out as part of an evaluation of *"C'est la vie!"*, [4] a television series screened through film clubs in 117 villages in the regions of Kaolack and Kolda. A baseline survey was conducted from October to December 2019 and collected information on a range of outcomes, including knowledge and attitudes related to gender-based violence (GBV), sexual and reproductive health and rights (SRHR), and maternal and child health. To measure the short-term impacts of the program, a telephone survey was conducted between June and August 2020. Information was also collected on experiences during the COVID-19 crisis.

The telephone survey was conducted by IFPRI-Dakar and LARTES-IFAN on a planned sample of 3,967 women and

adolescent girls, aged 14 to 35 years old, who took part in the baseline survey. A total of 3,003 women and girls were surveyed, with an overall completion rate of 77% (80% in Kaolack and 72% in Kolda (Table 1).

Table 1: Survey sample

	Planned sample	Actual sample	Completion rate (%)
Kaolack	2,029	1,614	80
Kolda	1,938	1,389	72
Overall	3,967	3,003	77

The descriptive results shown throughout this brief relate to the sample of the 3,003 women and girls contacted by telephone and their households (unless another sub-sample is specified).

Characterization of target by region

Table 2 reveals large socioeconomic differences across regions at baseline (pre COVID). For example, in Kaolack the surveyed households were predominately of Serer or Wolof ethnicity, while in Kolda they were predominately Pular. In Kaolack, woman-headed households were more common (19%) than in Kolda (10%), and the average household size was 11 people in Kaolack compared with 9 in Kolda. In terms of access to safe drinking water, regional disparities were significant, with 69% of households having access to safe drinking water in Kaolack versus only 8% in Kolda.

Although the target women were on average the same age in the two regions (23 years old), there were differences in their marital status, with target women in Kolda being more likely to be in a monogamous marriage (51%) than those in Kaolack (45%). With regard to their level of schooling, 16% were currently enrolled in school across the two regions (17% in Kaolack, 14% in Kolda), and half (51%) had ever attended school (48% in Kaolack, 55% in Kolda). Approximately 61% of target women reported owning land, and 63% reported owning cattle, sheep, or other farm animals (either solely or jointly with someone else in the household). Livestock ownership was significantly higher in Kaolack (66%) than in Kolda (60%).

^a International Food Policy Research Institute, ^b Institut Fondamental D'Afrique Noire Cheikh Anta Diop Laboratoire De Recherche Sur Les Transformations Economiques Et Sociales, ^c Institut de Recherche pour le Développement, ^d University of North Carolina

Table 2: Baseline (pre-COVID) characteristics of women and adolescent girls by region

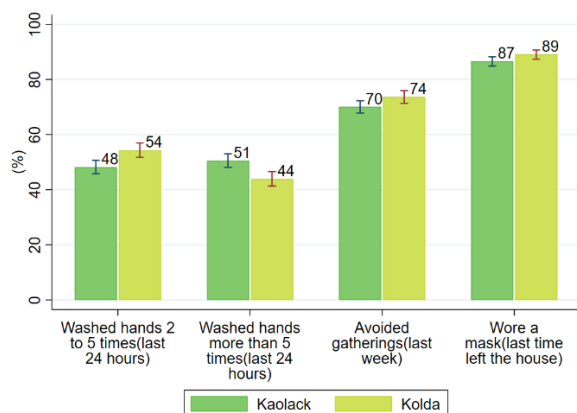
	Overall (%)	Kaolack (%)	Kolda (%)	p-value
Target female baseline characteristics	22.7	22.9	22.6	0.213
Average age (years)				
Marital status: Never married	26.7	28.6	24.6	0.098
Marital status: Married, monogamous	47.8	45.2	50.8	0.049
Marital status: Married, polygamous	21.2	20.4	22.2	0.464
Marital status: Other (divorced, separated, widowed)	4.3	5.8	2.4	0.025
Relationship with head of household: Head of household herself	3.6	4.6	2.4	0.008
Relationship with head of household: Spouse	33.0	27.9	38.9	0.000
Relationship with head of household: Daughter/Daughter-in-law/ Stepdaughter	42.3	45.1	39.0	0.008
Relationship with head of household: Other relationship	20.3	21.8	18.6	0.052
Ever attended school	50.9	47.6	54.7	0.104
Currently enrolled in school	15.5	16.6	14.3	0.328
Household baseline characteristics				
Household head is female	14.9	19.1	10.1	0.000
Household head's ethnicity: Wolof	32.1	46.7	15.2	0.000
Household head's ethnicity: Serer	42.1	14.5	74.1	0.000
Household head's ethnicity: Pular	16.9	31.2	0.3	0.000
Household head's ethnicity: Other	8.9	7.6	10.4	0.406
Owns land for agriculture (solely or jointly)	61.0	58.4	64.1	0.109
Owns cattle, sheep, other farm animals, or chickens (solely or jointly)	62.8	65.7	59.6	0.015
Household size	10.2	10.9	9.4	0.000
Access to drinking water at home	41.1	69.4	8.2	0.000

N=3,003 and represents the sample of women re-interviewed June-August 2020 (during the COVID-19 period) via phone survey; data are in percentages, with the exception of age and household size. *P*-values are calculated from Wald's tests of equality of averages between regions for each variable.

1) Preventive measures

Public and private gatherings are very common in both regions due to a strong communal culture that underpins religious, cultural, social, and economic life. The importance of the informal economy plays a major role in the tendency to gather publicly. Nonetheless, 72% of women reported having abstained from all gatherings of more than 10 people in the week prior to the survey (Figure 1).

Figure 1: Preventive measures and behaviors of women and girls (%)



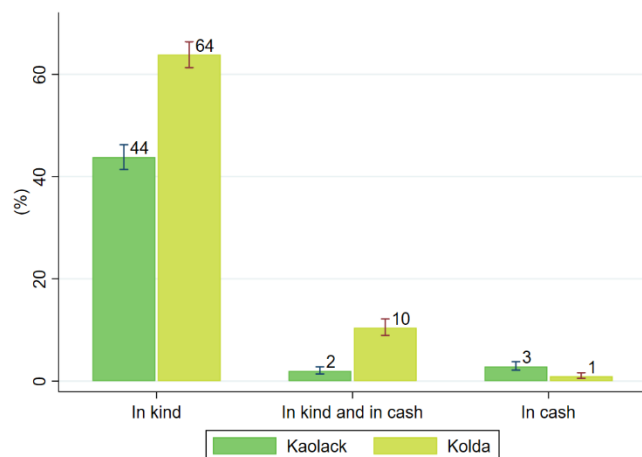
Handwashing, as a means of containing the spread of the virus, has been one of the most intensively promoted

preventive measures. As a result, almost all women reported handwashing with hand sanitizer or soap: 99% of women and girls reported washing their hands at least twice the day before the survey. Similarly, the majority of women and girls reported wearing a mask or nose and mouth covering the last time they left the house.

2) Aid and assistance

Social assistance has been promoted as a key factor in managing the economic shock associated with the pandemic. One major national policy action has been to distribute food to vulnerable households throughout the country. Thus, almost 61% of the households surveyed received some assistance — either in-kind (53%) or cash (2%) or both (6%) — during the two months preceding the survey (Figure 2). A higher percentage of households in Kolda received assistance compared to those in Kaolack. The Senegalese government was the main source of assistance, accounting for 93% of assistance received.

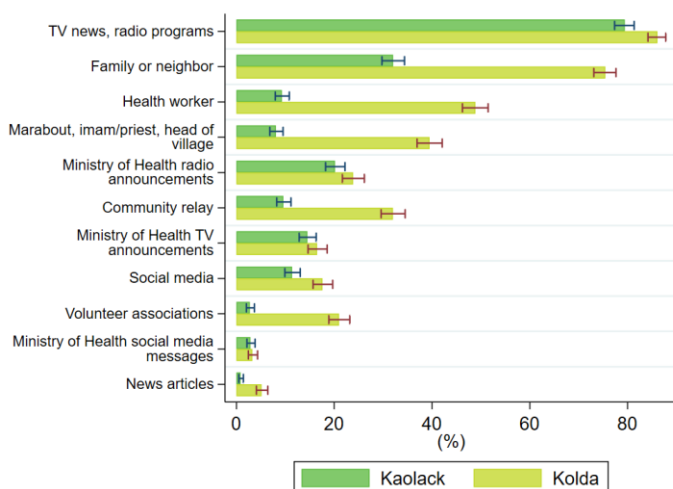
Figure 2: Aid or assistance received by households in the last two months (%)



3) Information and perceptions

Information on COVID-19 was disseminated widely across the country within the first three months of the pandemic in Senegal. Almost all women (99%) had heard of COVID-19 as a disease with symptoms of fever, coughing, and breathing difficulties.

Figure 3: Sources of information on COVID-19 (%)

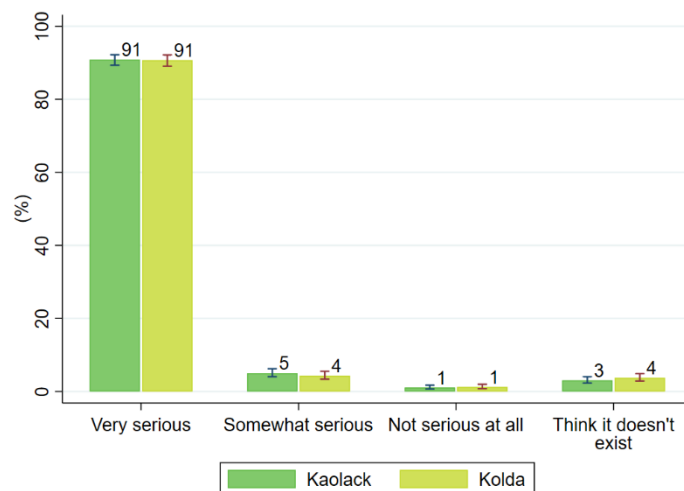


Several actors or channels that disseminated information on COVID-19 were identified by respondents (Figure 3). Of the women and girls who had heard about the disease, 83% had received information on COVID-19 through radio or television news programs. Across all sources, more women and girls in Kolda reported receiving information than in Kaolack. For example, 75% of women in Kolda reported being informed of the disease by family or neighbors compared with 32% in Kaolack. Health workers and community outreach workers played an important role in communication about the disease in Kolda, cited by 49% and 32% of the sample, respectively,

compared with 9% and 10% in Kaolack. Likewise, 40% of women and girls in Kolda reported receiving information from religious or community authorities (e.g., Marabout, Imam, priest, or village chief), compared with 8% in Kaolack. A small percentage of the sample reported receiving information through social media.

Perceptions around the severity of COVID-19 are a primary concern in management of the response strategy and stopping the spread of the disease. Among the sample, 96% considered COVID-19 to be very or somewhat serious; 1% believed that the disease is benign; and 3% believed that the disease does not exist (Figure 4).

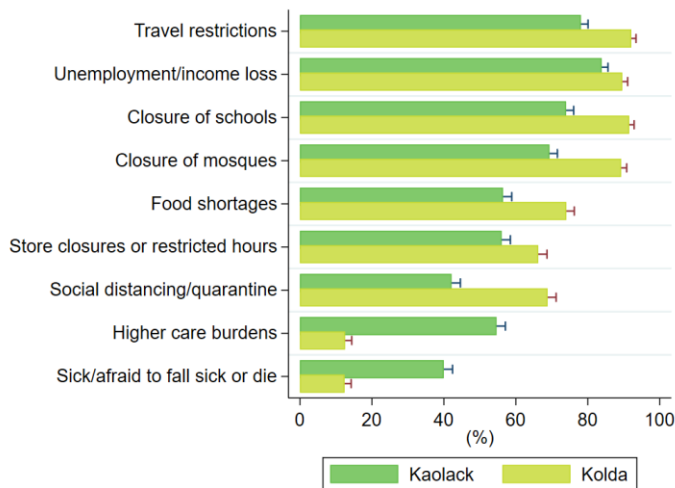
Figure 4: Women and girls' perceptions of the severity of COVID-19 (%)



4) Consequences of COVID-19

Adverse consequences related to the pandemic were reported by women and girls across a wide range of economic and social domains (Figure 5). Approximately 87% of women and girls interviewed reported that someone in their household had become unemployed or suffered income loss; 65% reported food shortages; 61% had been affected by store closures; and 85% reported restricted mobility due to travel restrictions. In addition, 55% of women reported enforcing physical or social distancing measures; 82% were affected by school closures and 79% by the closure of mosques and other places of worship. Finally, 27% reported that the pandemic had aroused fear of falling ill and dying, revealing a possible negative psychological effect. For the most part, these consequences were reported more frequently by women in Kolda than by those in Kaolack, with the exception of higher care burdens and fear of falling sick.

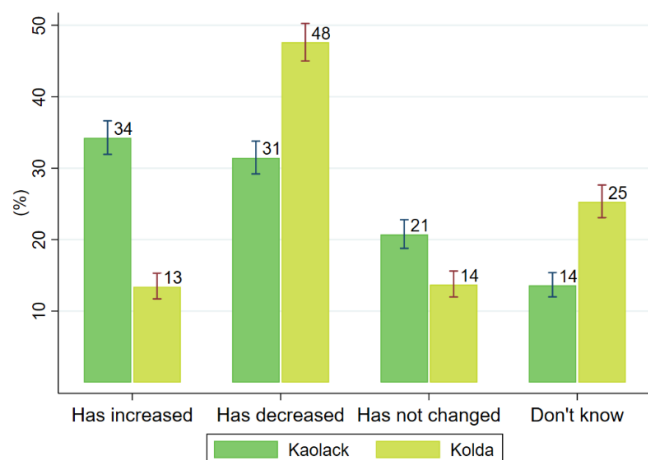
Figure 5: Self-reported consequences of COVID-19 for women/girls and households (%)



Moreover, it is likely that the loss of employment and compliance with COVID-19 response measures resulted in competition among members of the same household for living space during the crisis. The forced proximity, coupled with economic insecurity has been recognized in various parts of the world as a possible source of increased risk for conflict and violence inside the home.[5]

Although women and girls in Kaolack appear to have been less affected by the crisis, 34% reported an increase in intimate partner violence in their communities due to COVID-19 compared with only 13% in Kolda (Figure 6). Somewhat fewer women and girls in Kaolack (31%) reported a decrease in intimate partner violence; however, this figure was substantially larger (48%) in Kolda. These results suggest a

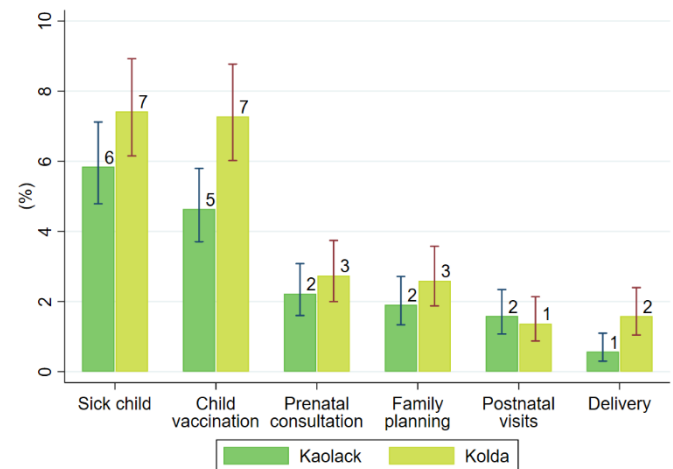
Figure 6: Perceived change in intimate partner violence in the community due to COVID-19 (%)



decline in community-level intimate partner violence perceived by women in Kolda. While this may seem counter-intuitive, it highlights important regional differences in trends.

The decrease in Kolda may be due to the fact that more households there received assistance (monetary or in-kind), which has been shown to reduce intimate partner violence, or it may be linked to differential impacts of the *C'est la vie!* intervention.[6]

Figure 7: Occasions when someone in household was afraid to seek health services due to COVID-19



Evidence increasingly shows that COVID-19 has resulted in a decline in health-seeking behavior and visits to hospitals and healthcare centers worldwide.[7] Among the women and girls who were aware of COVID-19, 12% said that they or other members of their household were afraid of going to the hospital or a healthcare center due to COVID-19. Figure 7 reveals that this fear was observed in situations where a child in the household was ill (7%) or was scheduled to receive a vaccination (6%), as well as for prenatal visits (3%), family planning (2%), postnatal visits (2%), and deliveries (1%). These percentages were slightly higher among women and girls in Kolda than in Kaolack, as well as among married women as compared to unmarried women.

5) Trends in food security and women's wellbeing

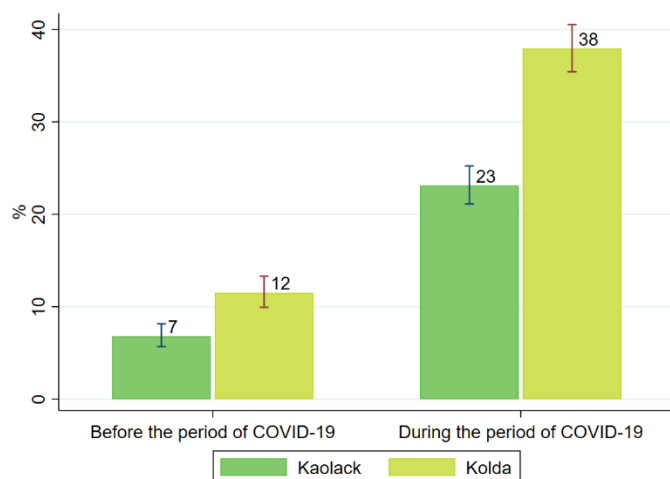
The phone survey included a series of questions related to food security and the wellbeing of women and girls, which could be compared with the baseline data for the same sample. It is important to note that averages are reported based on simple comparisons of "before" and "during" the crisis, and that trends could therefore be due to seasonal differences or other factors, rather than attributed solely to COVID-19.

Changes in food security

Food security was measured using the **Household Hunger Scale (HHS)**, which was specifically developed and validated for use at the global level.[8] The recall period for the HHS is

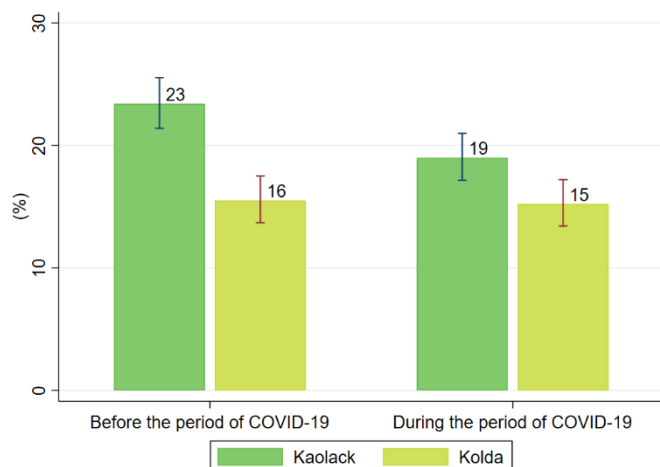
the four weeks preceding the survey. Figure 8 shows the level of moderate to severe hunger among households before and during the pandemic.

Figure 8: Household levels of moderate or severe hunger before and during COVID-19



Overall, the levels of moderate and severe hunger tripled from the pre-pandemic levels, rising from an average of 10% to 30%. Figure 8 shows a higher prevalence in Kolda than in Kaolack, with 12% and 38% of households, respectively, suffering from moderate to severe hunger before and during the pandemic in Kolda and 7% and 23% in Kaolack. However, it should be noted that the pandemic period also coincides with the lean season in Senegal (June to August), which may partially account for these increasing trends.

Figure 9: Women and girls' engagement in paid work before and during COVID-19



Despite the rapid government distribution of food aid, household food security was precarious during the first few months of the pandemic in Senegal.

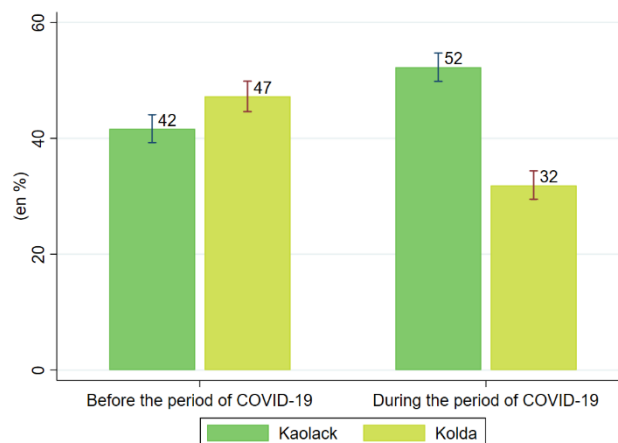
Changes in paid work

Government-mandated closure of markets took place during a period when many rural women rely on markets to sell agricultural produce from recent harvests. Overall, the number of women and girls who worked for pay in the six months preceding the survey fell slightly in Kaolack (from 23% prior to the pandemic to 19% during the pandemic) but there was no change in Kolda (<1 percentage-point drop). Restrictions in movement may have played a role in this decline, however it could also be due to seasonal differences or other factors.

Changes in emotional wellbeing

The emotional wellbeing of women and girls during the seven days preceding the survey was analyzed via a question from the Center for Epidemiological Studies Depression scale (CES-D) asking the respondent to recall the amount of time she felt depressed during the week preceding the survey.¹ Figure 10 shows an increase in reports of feeling depressed (either occasionally, sometimes, or frequently) among women and girls in the Kaolack region (from 42% before to 52% during the pandemic). In contrast, in Kolda, 47% of women and girls reported feeling depressed before the pandemic, as compared with 32% during the pandemic. It is unclear what might account for these regional differences or why emotional wellbeing improved in Kolda but not Kaolack. Potential reasons include differential impacts of the *C'est la vie!* intervention on women's wellbeing or differential impacts of

Figure 10: Share of women and girls reporting feeling depressed in the week preceding the survey, both before and during COVID-19



¹Three of the ten CES-D short-form items were included in the phone survey. Results are robust to aggregating across all three items.

COVID-19, especially with respect to continued aid, care burden, fear of falling sick, and perceived intimate partner violence.

CONCLUSION

A phone survey conducted with a sample of 3,003 women and adolescent girls (aged 14 to 35) living in rural Senegal offers a picture of the gendered effects of COVID-19. The results show that a few months into the pandemic, rural populations were well informed about the outbreak. For example, 99% of women and adolescents had heard about the disease — 83% of them through radio or television. These figures confirm the results of a national study conducted by the Center for Global Development early on, showing that nearly all respondents had heard about COVID-19.[9] In addition, there was high compliance with preventive measures, including mask-wearing, handwashing with soap or hand sanitizer, and social distancing. These behaviors are consistent with the viewpoint of nearly all women and girls (95%) that COVID-19 is a serious disease.

Household food security decreased during the pandemic, with the level of moderate to severe hunger tripling from 10% before to 30% during the pandemic. Likewise, the proportion of women and girls doing paid work in the six months preceding the survey declined (although only in Kaolack). These results justify the government provision of assistance to poor households. Approximately 61% of sample households received some government assistance in the two

months preceding the survey, including 53% in kind. With the pandemic and its economic consequences persisting into the future, it is imperative that this assistance continue.

In addition to the adverse consequences for food security and work, 12% of women and girls reported that they or someone else in their household feared visiting health facilities for illness or preventative care.[9] The effect of this fear on health-seeking behavior could lead to harmful consequences in vulnerable populations (children, pregnant women) in the short and long term.[10]

Rural women and girls are key pillars in community and household health and wellbeing, and the adoption of transmission prevention and mitigation strategies should involve women from the outset. The experience in Senegal demonstrates that it is possible to turn the crisis into a driver of sustainable behavioral change, helping to contain the spread of the pandemic and potentially preventing other communicable diseases. In addition, the findings make a case for continuing and expanding interventions to assist households during and after the pandemic. Finally, targeted communication encouraging women to continue attending health and preventive care services despite fear of COVID-19 is essential now more than ever. Further research should investigate longer-term and intrahousehold effects of COVID-19 and associated measures for rural women and girls, including economic insecurity, school drop-out rates, care burdens, and intrahousehold conflict.

References

- [1] United Nations Sénégal. 2020. *Plan de préparation et de réponse au covid-19 du système des Nations Unies au Sénégal*. April–December. https://senegal.un.org/sites/default/files/2020-05/pnupr_covid-19_final.pdf
- [2] World Bank. 2020. “Gender Dimensions of the COVID-19 Pandemic.” Policy Note, April 16. Washington, DC. <http://documents1.worldbank.org/curated/en/618731587147227244/pdf/Gender-Dimensions-of-the-COVID-19-Pandemic.pdf>
- [3] Ministère de la Santé et de l’Action Sociale. 2020. *Plan de contingence multisectoriel de lutte contre le Covid-19*. Dakar.
- [4] *C’est la vie!*. 2018. Season 1 (video). <https://www.youtube.com/channel/UCrxIWNRo2vNWOMw7XvgK2pA>
- [5] Peterman, A., A. Potts, M. O’Donnell et al. 2020. “Pandemics and Violence Against Women and Children.” CGD Working Paper 528. Washington, DC: Center for Global Development <https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children>
- [6] Buller, A. M., A. Peterman, M. Ranganathan, A. Bleile, M. Hidrobo, and L. Heise. 2018. “A Mixed-Method Review of Cash Transfers and Intimate Partner Violence in Low- and Middle-Income Countries.” *World Bank Research Observer* 33 (2): 218–258.
- [7] World Health Organization. 2020. *Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic*. Interim report, Aug. 27. Geneva.

[8] Ballard, T., J. Coates, A. Swindale et al. 2011. "Household Hunger scale: Indicator Definition and Measurement Guide." FANTA III and USAID. Washington, DC: fhi360. <https://www.fantaproject.org/sites/default/files/resources/HHS-Indicator-Guide-Aug2011.pdf>

[9] Le Nestour, A., and L. Moscoviz. 2020. "Five Findings from a New Phone Survey in Senegal." Center for Global Development blog. <https://www.cgdev.org/blog/five-findings-new-phone-survey-senegal>

[10] Headey, D. D., and M. T. Ruel. 2020. "The COVID-19 Nutrition Crisis: What to Expect and How to Protect." In *COVID-19 & Global Food Security*, eds. J. Swinnen and J. McDermott, Chapter 8, 3841. Washington, DC: International Food Policy Research Institute (IFPRI). https://doi.org/10.2499/p15738coll2.133762_08

Funding for this work was provided by an anonymous donor. This publication has been prepared as an output of the *C'est la vie!* impact evaluation and has not been independently peer reviewed. Any opinions expressed here belong to the author(s) and are not necessarily representative of or endorsed by IFPRI.

INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

A world free of hunger and malnutrition

IFPRI is a CGIAR Research Center

1201 Eye Street, NW, Washington, DC 20005 USA | T. +1-202-862-5600 | F. +1-202-862-5606 | Email: ifpri@cgiar.org | www.ifpri.org | www.ifpri.info

© 2021 International Food Policy Research Institute (IFPRI). This publication is licensed for use under a Creative Commons Attribution 4.0 International License (CC BY 4.0). To view this license, visit <https://creativecommons.org/licenses/by/4.0>.