More men die from COVID-19 in Nepal, but who suffers most?

More men catch and die from COVID-19 in Nepal, just as elsewhere, writes ***Keshab Giri (University of Sydney)****. But the pandemic's impact on women has been devastating. We need to look beyond case numbers and mortality rates when we assess the effects and how to tackle them.*

More men catch and die from COVID-19 than women, and Nepal is no exception. Nonetheless, the pandemic's impact has been devastating for women living there. Various work on previous public health emergencies shows that women are more vulnerable to catching disease. Women represent 70 percent of workers in the healthcare and social care sector, making them particularly vulnerable. Yet according to the data we have, in Nepal and South Asia in general, men catch and succumb to COVID-19 at a higher rate than women. Four factors may explain this.

- Nepal is a deeply patriarchal society. Women face inequality in accessing health care, and we do not have the data to know whether they are being tested at the same rate as men.
- The spike in COVID-19 cases in Nepal coincides with the return of Nepalese migrant workers because of the pandemic-induced economic slump. The latest data shows that more than four million Nepalese received approval for overseas employment (excluding about 1.5 million Nepalese working in India's informal economy). Patriarchal societies restrict the mobility of women, and the government pursues a policy of restricting women's employment overseas. Men therefore make up a disproportionately high proportion of the migrant workers returning home with COVID-19.
- Many studies have sought an explanation for how gender contributes to various comorbidities that increase the risk of catching and dying from COVID-19. People with pre-existing health conditions like diabetes, asthma, lung diseases, heart diseases, and obesity are more likely to die from the virus. Men are more likely to smoke and drink than women, while women are more hygiene-conscious than men.
- Finally, some scientists have come up with biological explanations (chromosomes, hormones, and proteins) for the higher fatality rate in men.

Maternity services are suffering

Public health emergencies often prevent women from accessing vital healthcare such as maternity services, resulting in many avoidable deaths. After the HIV, Ebola, and Zika outbreaks maternity and reproductive health services endured a tremendous knock-on effect. The maternal mortality rate doubled in Liberia, Guinea, and Sierra Leone after the Ebola outbreak.

Social distancing at Tilganga, Nepal. Photo: Krishna Gopal Shrestha and IAPB/Vision 2020

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The current statistics on maternal and reproductive health in Nepal also echo the situation in Western African states. Since the imposition of lockdown in Nepal on 24 March, pregnant women across the country are having a hard time visiting health facilities for regular check-ups, thereby losing access to supplies of iron, calcium, folic acid pills, and recommended vaccine shots. A recent article in the Lancet shows that the number of births in a medical facility decreased by 52.4%; neonatal deaths increased from 13 per 1000 livebirths before lockdown to 40 deaths per 1000; and stillbirths in medical facilities increased from 14 to 21 per 1000 of all births. Similarly, in the first two months of lockdown 24 women died of childbirth-related complications, compared to 80 deaths in all of 2019 – an almost 200 percent increase in the maternity mortality rate.

Rates of suicide are up

COVID-19 has also triggered a higher suicide rate in Nepal. In the first four months of lockdown, 2,218 people killed themselves, 25 percent up on the suicide rate in the previous year. What is even more disturbing is the rising suicide rate among women, including pregnant women, in Nepal. Cases of domestic violence against women in Nepal are soaring; natural disasters have wreaked havoc; and more Nepalese are losing their jobs at home and abroad at the same time Nepal is reeling from the pandemic. As more women take precarious jobs in the informal economy than men, they are particularly susceptible to the economic impact.

Case and death data alone is not enough

The statistical data on COVID-19 is often incomplete and unreliable. In the case of Nepal, it doesn't include information on ethnicity, caste, class, occupation, geographical location within the district, and existing comorbidities. This leads to skewed knowledge, muting the voices of the marginalised and rendering their suffering invisible. A narrow focus on cases and deaths misses the secondary impacts of the pandemic: psychological, socio-economic and political. We need intersectional data that can help tailor the response to the needs of different populations. Diseases and pandemics should be studied holistically rather than through a narrow epistemological lens.

This post represents the views of the author and not those of the COVID-19 blog, nor LSE.

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