

Emergency Responses to Public Health Outbreaks

Query: An analysis of current practice on how public health responses have responded to women and girls and integrated GBV

Contents

1. Background
2. Ebola Outbreak: West Africa (2014-2016)
3. Cholera Outbreak: Yemen (2016-current)
4. Ebola Outbreak: Democratic Republic of Congo (May 2018-current)
5. Recommendations

1. Background

Outbreaks of infectious diseases such as Ebola and Cholera (both of which spread rapidly) require emergency responses to treat those affected and stem the spread of the disease. It is well-documented that such outbreaks amplify existing gender inequalities and in contexts where outbreaks coincide with conflict, this is even more severe because of the ways in which conflict impacts women but also because of the weakened infrastructure, health systems and food insecurity that impact the whole population.

This report provides a brief analysis of how public health responses have responded to women and girls and integrated prevention and response to GBV. It includes case studies from three recent, or prominent, public health outbreaks: the Ebola outbreak in West Africa in 2014-2016 (Section 2), the cholera outbreak in Yemen from 2016 onwards (Section 3), and the Ebola outbreak in the Democratic Republic of the Congo (DRC) from May 2018 onwards (Section 4). Finally, the report provides recommendations for future public health responses, drawing on lessons learned from the responses analysed and best practice guidelines (Section 5).

In both the 2014 Ebola outbreak in West Africa and the Cholera outbreak in Yemen beginning in 2016, women and girls have been disproportionately affected (African Development Bank, 2016; Nkangu, 2017; Kanem, 2017). This is due to a culmination of factors that are rooted in gender inequality: deeply entrenched gendered roles in society which puts women and girls at greater risk of exposure; lower status in the household which often means they have less decision-making power and control over household resources, impacting their ability to seek medical care when they fall sick; lack of education and literacy which impacts their ability to understand health education posters or directions on medications (African Development Bank, 2016; Nkangu, 2017; Periago, 2004). Furthermore, the ways in which women perceive disease and subsequently their help-seeking behavior differs from men. For example, studies from other countries found that women with malaria waited longer to seek treatment because

their household work was essential for the functioning of other family members and returned to work before recovering completely (Periago, 2004).

Planning and implementing emergency responses to disease outbreaks requires pre-existing knowledge and understanding of the patterns of exposure to the disease in order to identify the risk factors. As part of this, it is imperative that the humanitarian community not only understand the ways in which gender impacts risk of exposure and help-seeking behavior but also the role women can play in the prevention of future outbreaks. Recovery efforts must also consider the ways in which the outbreak impacted women and girls differently than men and boys and invest in gender-specific interventions (African Development Bank, 2016).

2. Ebola Outbreak: West Africa (2014-2016)

The Ebola epidemic that ravaged parts of West Africa from 2014-2016 was the most severe acute public health emergency seen in modern times: ‘never before in recorded history has a biosafety level four pathogen infected so many people so quickly, over such a broad geographical area, for so long’ (Margaret Chan, 26th September 2014, WHO). In addition to its overall severity, this Ebola epidemic was characterized by the significantly higher exposure of women and girls to the virus¹ and thus their greater risk of becoming ill (African Development Bank, 2016; Human Rights Watch, 2018; Nkangu, 2017). The higher exposure rate among women appears to have been the result of the roles women traditionally or disproportionately occupy – including cross-border traders, health workers, and traditional birth attendants – which put them at greater risk of coming into contact with the virus (African Development Bank, 2016; Nkangu, 2017). Furthermore, women more often cared for the Ebola victims - feeding, washing, and caring for them without basic protections such as gloves, goggles, or masks, making them extremely vulnerable to contracting the virus. Women also participated in burial rites that require handling infected bodies. Pregnant women were also at increased risk because of increased contact with health workers. Furthermore, the Ebola virus persists for seven months in the semen of men who have recovered from Ebola, putting women and girls at risk of the disease from husbands and partners, particularly given gender norms and power dynamics related to consent as well as practicing safe sex, as well as in cases of rape and sexual exploitation (Menéndez et al, 2015; Nkangu, 2017).

Reports from practitioners and governments indicate that GBV increased during the Ebola crisis, including sexual assault and rape, transactional sex, and domestic violence (IFRC, 2015; Aizenman and Smith, 2014). In Guinea, government data indicates a 4.5% increase in cases of GBV since before the epidemic including twice as many rapes (Caspani, 2015). In Liberia, the authorities reported that in 2014, the most commonly reported form of GBV to government entities was child rape, partly attributed to children being out of school, parents’ death, social isolation, and triggered by loss of livelihoods and increased poverty (Williams, 2015). However, caution should be exercised in the interpretation of these statistics. It has not been possible to access the original sources, which are likely to be based on reported incidents, rather than prevalence studies. The police and civil authorities became overwhelmed by the epidemic leading to an ‘atmosphere of impunity’ where GBV increased. Furthermore, survivors of GBV found it difficult to access healthcare due to closed clinics and restrictions on movement (IFRC, 2015; IRC, 2014).

In the response to Ebola, it is widely recognised that the humanitarian community failed to understand and address the particular risk factors for exposure for women, including the

¹ While disaggregated data was not systematically collected, it is estimated that close to 60% of Ebola victims across Guinea, Liberia and Sierra Leone in the 2014-2016 crisis were women (African Development Bank, 2016).

increased risk of GBV which resulted in them bearing the burden of the epidemic and its reverberating consequences (African Development Bank, 2016; Human Rights Watch, 2018; Nkangu, 2017)

3. Cholera Outbreak: Yemen (2016-current)

In war-torn Yemen, reports of confirmed cholera started in late September, 2016. The disease continues to plague Yemen today in what has become the largest documented cholera epidemic of modern times - more than a million suspected cases of cholera have been reported in Yemen from September 2016-March 2018— a country of not quite 30 million people (Camacho et. al, 2018). Cholera is often spread through contaminated food or water. Women and girls are uniquely vulnerable to the cholera outbreak because they bear most household responsibilities, such as preparing food, fetching water and cleaning latrines, and are therefore more exposed to the bacteria that cause the disease (Kanem, 2017). According to a Yemen Protection Cluster Report as of May 2017 approximately 53% of the cholera cases were women (Protection Cluster, 2017).

The conflict in Yemen has also led to significant food insecurity which has put the whole population at risk of malnutrition. Pregnant and breastfeeding women are especially vulnerable to malnutrition, and those weakened by the nutrition crisis are more prone to infections, including cholera. Pregnant women who contract cholera also have a higher risk of developing dangerous or even fatal complications (Kanem, 2017; UNFPA, 2016).

UNFPA has incorporated responses to cholera targeting women in their ongoing efforts to address the reproductive health needs of women. This had included: providing dignity kits that contain leaflets about cholera and what can be done to prevent it; supporting midwives, mobile clinics, and community outreach sessions to providing information about how to control the spread of cholera; and supporting mobile reproductive health clinics that are providing nutrition counselling, screening and referral of malnourished mothers and babies in remote and hard-to-reach areas (UNFPA, 2016).

The Integrated Response Plans for the Yemen cholera outbreak developed by the World Health Organisation (WHO), the WASH cluster and the Health cluster are absent of any reference to gender or GBV interventions. While it is possible that such interventions are happening at a local level, they are not explicitly reflected as priorities in response plans which has an impact on the strategy and funding decisions for the response. The Global Protection Cluster for Yemen did issue protection guidance in August 2017 for the cholera response which highlighted the specific vulnerabilities of women and girls both to the disease but also for increased risk of GBV given the impact of cholera on households (i.e. added stress, economic strain). For example, girls may be at higher risk for sexual exploitation or early marriage and women and married adolescent girls for intimate partner violence. It also includes recommendations for addressing the specific needs of particularly vulnerable groups (of which women and girls are included) and adopting protection-sensitive response to ensure that response activities do not create but rather mitigate protection risks. For example, the inappropriate design and location of water and sanitation facilities can provoke serious protection risks for women and girls (Protection Cluster, 2017).

4. Ebola Outbreak: Democratic Republic of the Congo (May 2018 – current)

In May 2018, the Ministry of Health (MOH) of the Democratic Republic of the Congo declared an outbreak of Ebola virus disease in Equateur Province (WHO, May 2018) which was declared over at the end of July 2018 and considered a successful response that prevented a

public health crisis. A new, unrelated outbreak of Ebola was declared in August 2018 in North Kivu and Ituri provinces and is considered higher risk because of the region's proximity to border countries and the ongoing conflict which has resulted in large internal displacement of populations, displacement of Congolese refugees to neighbouring countries, and due to insecurity could hinder the implementation of response activities (WHO, August 2018).

The most recent WHO External Situation Report released on September 4th shows that of the 122 cases, women account for a slightly higher number than men. However, women tend to fill some of the same entrenched gender roles and gender inequality as in the countries impacted by the West Africa Ebola outbreak. Furthermore, sexual violence has been pervasive in the conflict in North Kivu and the overall insecurity and displacement that has resulted from the conflict has had significant impact on the health and livelihoods of women and girls (SRSG for SVIC, 2018). These circumstances combined with the learning from the 2014 West Africa outbreak should put the humanitarian community on high alert for the increased risk of exposure women and girls face during this outbreak.

Thus far it is not clear if and how the DRC's MoH, the WHO and the international community are incorporating the particular risks for women and girls into their emergency response. The WHO's Emergencies Programme developed a document specifically for the response to the Ebola outbreak in the DRC that is intended to be used to guide risk communication and community engagement work which is central to stopping the outbreak and preventing its further amplification: *Risk Communication and Community Engagement (RCCE) Considerations: Ebola Response in the Democratic Republic of the Congo*. While the document does refer to women as an overall 'vulnerable group' in the DRC and identifies some of the specific risk factors women may face primarily related to their role in burial rites, it does not discuss the many other risk factors unique to women nor how to engage women differently than men in communication strategies. However, it is worth noting that the WHO recently began including disaggregated data on cases in the external situation reports for the North Kivu outbreak - which it had not done previously. And some of the situation reports indicate engagement with women's groups, particularly women's trade associations.

As this response continues, it is important that the humanitarian community continue to advocate for an approach that uses a gender-lens and provides the appropriate resources to do so.

5. Recommendations

Based on the learning from the responses to the outbreaks discussed as well as research from other responses, the following are recommendations for ensuring that public health emergency responses address the particular vulnerabilities of women and girls are accountable to their needs.

Preparedness

- ***Institutionalise existing theory/frameworks.*** Over a decade ago, the WHO developed a framework that outlines the parameters of a gender approach for understanding the differential impact of communicable on women and men (Periago, 2004). The framework includes many social determinants of infectious diseases, such as domestic and social roles and responsibilities, cultural norms affecting exposure, available support networks, social stigmas, use and quality of health services, and decision-making power within the household and community. This can help practitioners apply a gender lens to understand disease exposure patterns, treatment

options, and prevention methods and should inform all health emergency responses from the outset.

- **Training and capacity building.** Since the West Africa Ebola outbreak, the WHO has produced a significant amount of training materials and technical guidance for those who are part of an Ebola outbreak response which are available on their website. There is an opportunity to ensure that these materials are infused with an explicit gender lens and that the training first responders receive has this lens at its core.
- **Ensure that global response plans explicitly address the vulnerabilities and needs** of women and girls, including what will be done to mitigate their risk of GBV. The IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action should be used to guide these elements of response plans.

Response

- **Ensure that women are able to get information about how to prevent and respond to the epidemic in ways they can understand.** Women play a major role as conduits of information in their communities. Thus, reaching women and educating them on the disease is crucial to tackling the spread. Furthermore, women as the main caregivers in most households often take responsibility for their children's health and thus have a significant role to play in preventing exposure of their children to the disease as well as decisions about medical care and treatment.
- In humanitarian responses, safe spaces are often established for women and girls and serve as places where they come together for information, support and recreational activities. Such safe spaces, if they exist in outbreak areas should be utilized as excellent ways to engage and communicate with women. In addition, engage women leaders and women's associations from the outset to inform strategies for communication about the outbreak.
- **Reduce the likelihood of exposure to the disease through the caretaking role women play.** Women are considered caregivers and take on the role of "nurses" in their homes. The need for such caretaking is especially acute in rural communities where there are few health clinics and there are significant cultural and financial barriers to access health services. While humanitarian actors should be careful not to reinforce such gender stereotypes, it could be helpful to providing the necessary equipment and training to women to carry out their caretaking of the sick in the household in a safe manner may make it is possible for them to continue their role as caretakers without being exposed to and spreading the disease. Before using this strategy it is critical to speak with women and girls about whether this would be a helpful approach or not. Furthermore such a strategy, if implemented, should be paired with providing opportunities for women to take on decision-making and leadership roles in the response (see recommendation below).
- **Engage women at the community and national level in shaping the response to the crisis.** Many responses seek to work with community leaders but because men are largely in leadership positions within community and religious structures, women are not consulted. At the community level women should be actively consulted about things like the location of boreholes, water distribution points and distribution of hygiene supplies to ensure they will be safe and accessible.
- **Mitigate women's obstacles to obtaining care.** While this is linked to longer-term interventions that address gender inequality, specific short-term strategies can be developed to address the cultural barriers women face by engaging male community leaders and members and educate them on the importance of allowing women to

access care. Furthermore, eliminating fees for medical treatment can help facilitate women's (as well as the entire community's) access to care.

- **Put women on the frontlines.** Employ women as primary distributors of emergency rations and medical supplies and ensure there is female staff presence at service points so that they are accessible to women and girls. This may also help facilitate disclosure of GBV and mitigate risks for sexual exploitation and abuse.
- **First responders must be trained on how to handle disclosures of GBV.** Health workers who are part of an outbreak response must have basic skills to respond to disclosures of GBV in a compassionate and non-judgmental manner and know to whom they can make referrals for further care or bring in to treatment centres to provide care on the spot.
- **Psychosocial support should be available for women and girls who may be affected by the outbreak and are also GBV survivors.** Related to the previous point --being affected—whether directly or indirectly by an outbreak of an infectious disease—can be traumatic as can be an experience of GBV. Recognizing that these may be co-occurring for some women and girls is incredibly important and requires that psychosocial support be available and accessible for women and girls in general..
- **Disaggregate data related to the outbreak by sex.** One of the significant problems related to the West Africa Ebola outbreak is that confirmed, probable, and suspected infections and fatalities were not systematically disaggregated. Data related to outbreaks and the implementation of the emergency response must be disaggregated by sex and analysed accordingly in order to understand the gendered differences in exposure and treatment.

Recovery. Recovery programs should also ensure a focus on women and girls and address the unique ways in which they are affected by such epidemics. For example, with the Ebola virus in West Africa, women farmers, marketers, and cross-border traders lost their livelihoods due to declines in agricultural productivity, imposed quarantine measures, and closed borders. Women employed in the private sector across the sub-region are in hospitality/food service, insurance, air-transport, and shipping, sectors that were severely hit by the Ebola virus (African Development Bank, 2016). In recognition of this, the African Development Bank launched a project that focused on women's socio-economic recovery post-Ebola by supporting civil society organisations in the region to reinvigorate economic empowerment and livelihoods interventions for women and girls. Furthermore, prevention and response programming for GBV should be integrated into recovery programs. For example: recovery programs that may focus on providing psychosocial support to Ebola survivors should be prepared to handle disclosures of GBV and know service providers to whom women and girls can be referred for help.

Lastly, further research should be done to explore the links between public health outbreaks and increased risk of GBV for women and girls as well as to identify any emerging good practices with respect to how public health responses to outbreaks have a) included targeted GBV programming, and b) integrated GBV risk mitigation measures across all sectors of the response (in line with the IASC GBV Guidelines).²

Bibliography

² www.gbvguidelines.org

African Development Bank (2016). *Women's Resilience: Integrating Gender in the Response to Ebola*.

Aizenman, N and Smith, G (2014) 'The Prostitutes Are Not Happy. Neither Are Brides. Sex, Love And Ebola', NPR, December 31 2014.

<https://www.npr.org/sections/goatsandsoda/2014/12/31/374057299/the-prostitutes-are-not-happy-neither-are-brides-sex-love-and-ebola?t=1536234620339>

Camacho, et. al (2018). *Cholera epidemic in Yemen, 2016–18: an analysis of surveillance data*. The Lancet, 6:6.

Caspani, M (2015) 'Violence against women rises in Ebola-hit nations: ministers: TRFN', Reuters, <https://af.reuters.com/article/topNews/idAFKBN0MF0L320150319>

Human Rights Watch (2018). <https://www.hrw.org/news/2018/06/06/dr-congo-ebola-outbreak>

International Federation of Red Cross and Red Crescent Societies (IFRC) (2015) *Unseen, unheard: Gender-based violence in disasters*, IFRC: Geneva.

https://www.ifrc.org/Global/Documents/Secretariat/201511/1297700_GBV_in_Disasters_EN_LR2.pdf

International Rescue Committee (IRC) (2014) '*9 Unexpected Consequences of the Ebola Crisis on Women and Girls – and 3 Creative Solutions*', 10 December 2014.

Kanem, N. (2017). *Yemen's Cholera Epidemic Puts Pregnant Women at Greater Risk than Ever* <https://www.newsdeeply.com/womenandgirls/community/2017/08/08/yemens-cholera-epidemic-puts-pregnant-women-at-greater-risk-than-ever>

Menéndez, C et al (2015) 'Ebola crisis: the unequal impact on women and children's health', *Lancet*. 3(3): e130.

Nkangu et al (2017). *The perspective of gender on the Ebola virus using a risk management and population health framework: a scoping review*. *Infectious Diseases of Poverty*, 6:135.

Periago MR, Fescina R, Ramón-Pardo P. (2004) Steps for preventing infectious diseases in women. *Emerging Infectious Diseases*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3329005/#R8>

Protection Cluster (2017). *Protection guidance for the Cholera Response in Yemen*. <https://reliefweb.int/report/yemen/protection-guidance-cholera-response-yemen-august-2017-enar>

Special Representative to the Secretary General for Sexual Violence in Conflict (2018) <https://www.un.org/sexualviolenceinconflict/countries/democratic-republic-of-the-congo/UNFPA> (2017). *Yemen's Deadly Cholera Outbreak Puts Pregnant Women in Danger*. <https://www.unfpa.org/news/yemens-deadly-cholera-outbreak-puts-pregnant-women-danger>

WHO (May 2018). EBOLA VIRUS DISEASE Democratic Republic of Congo: External Situation Report 1. <http://apps.who.int/iris/bitstream/handle/10665/272509/SITREP-EVD-DRC-20180511.pdf?ua=1>

WHO (2018). *Risk Communication and Community Engagement (RCCE) Considerations: Ebola Response in the Democratic Republic of the Congo*. <http://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf?ua=1&ua=1>

WHO (August 2018). *EBOLA VIRUS DISEASE Democratic Republic of Congo: External Situation Report 1*.

http://apps.who.int/iris/bitstream/handle/10665/273640/SITREP_EVD_DRC_20180807-eng.pdf?ua=1

[Williams, W \(2015\) 'Liberia: Raped amidst Ebola – Girl, 12, Bleeds to Death as System Fails', All Africa, 20 January 2015. https://allafrica.com/stories/201501200894.html](https://allafrica.com/stories/201501200894.html)

About GBViE Helpdesk Short Research Reports: The GBViE Helpdesk is funded by UNICEF, contracted through the UNICEF Gender Based Violence in Emergencies team. Helpdesk Short Research Reports are based on three days' work per query.

GBViE Helpdesk services are provided by roster of humanitarian and GBV experts, under the leadership of Social Development Direct. Expert advice may be sought through this roster, as well as from SDDirect's broader in-house and network of expertise. Any view or opinions expressed do not necessarily reflect those of UNICEF, the GBViE Helpdesk, or any of the contributing experts.

For any further request or enquiry, contact enquiries@gbviehelpdesk.org.uk .