

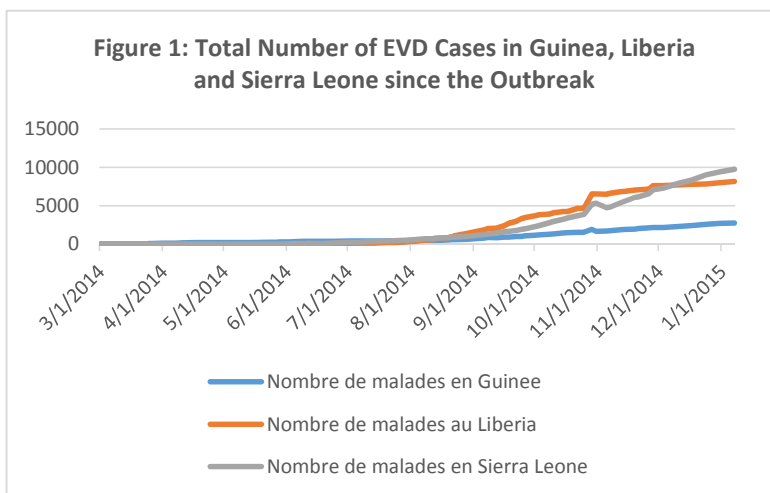
CONFRONTING THE GENDER IMPACT OF EBOLA VIRUS DISEASE IN GUINEA, LIBERIA, AND SIERRA LEONE

Nearly a year into the Ebola crisis ravaging West Africa, the deadly disease's knock-on effects are huge. Ebola has caused many deaths, stifled growth rates, reversed recent socioeconomic gains, aggravated poverty and food insecurity, and destroyed livelihoods. Buried in the aggregated impact is the plight of Ebola's voiceless victims and agents of change—women and children.

The current EVD is the most complex, longest-lasting, and largest outbreak ever.

The Ebola Virus Disease (EVD) epidemic in Guinea, Liberia, and Sierra Leone is the largest Ebola outbreak in history. What started as a public health crisis in Guinea on 26 December 2013 degenerated into development crises in the three epicentre countries in less than six months. As of January 2015, there were 20,721 EVD cases in total: 2,775 in Guinea, 8,157 in Liberia, and 9,789 in Sierra Leone. Figure 1 shows the trend between 1 March 2014 and 7 January 2015.

West African EVD is virulent; it has the highest transmission rate ever. The basic transmission rate¹ for Montserrado (Liberia) has been estimated to be 2.5, compared with 1.8 for Congo (1995) and 1.3 for Uganda (2000). Unlike the past outbreaks, which were mostly restricted to remote areas, the West African case is complex; it is geographically spread, involving small rural and large urban centres (including Conakry, Monrovia, and Freetown). Due to the high transmission rate and limited capacity to manage the epidemic at the outset, the fatality rate is also high, ranging from 35.3 percent in Sierra Leone to 64.1 percent in Guinea as of 7 January 2015. Sierra Leone has recorded the highest number of EVD related deaths, followed by Liberia (see Figure 2). Although the transmission rate has started slowing down in Guinea and Liberia since December 2014, it is yet to be under control in Sierra Leone. In contrast with past



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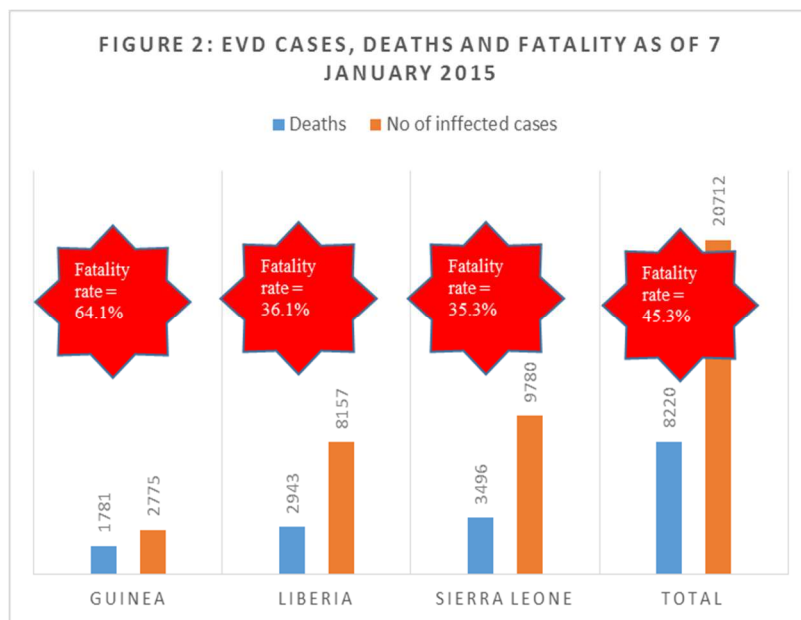
cases that were under control within a short time, the West African situation has proved to be different—the epidemic is still ravaging the region over a year after the first case was detected in Guinea.

Analysis of the effects of EVD on women adds substantial value to recovery efforts.

The emerging evidence points to the huge effect of the disease on women, largely because of women's wide-ranging roles as caregivers and economic agents in the agricultural and informal sectors. Analysis of the gender impacts of EVD adds value to recovery efforts and programming. Factors that render women most susceptible to Ebola and other outbreaks are not solely biological, but rather have to do with women's

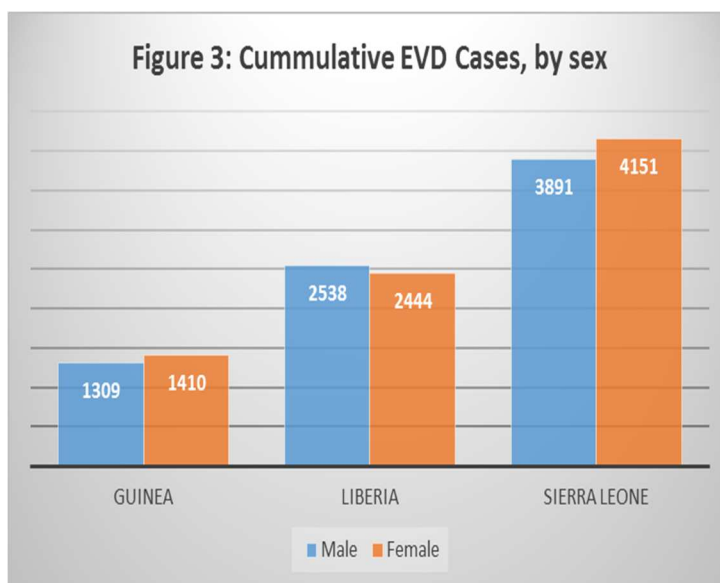
roles as frontline caregivers and care workers, cross-border traders, nurses, and mothers within the disease-stricken communities, as well as active economic agents in the informal sector. The analysis identifies entry points for designing policies that can successfully address immediate and long-term socioeconomic impacts and overcome obstacles to gender equality and sustainable development.

This policy note assesses the impact of EVD from a gender perspective in Guinea, Liberia, and Sierra Leone. It also provides insight into who is affected, why they are affected, and the policy response that is needed to address the impact of EVD on women and girls.



The toll of EVD in West Africa is greater on women than men.

As in many public health emergencies, adolescent girls and young women are among the most marginalized and at-risk populations when outbreaks occur. For example, African women have been disproportionately affected by the HIV/AIDS epidemic because of the caregiving burden placed on them by culture and traditions in the early years. Similarly, women were especially affected by the Ebola outbreaks in Congo, Gabon, and Uganda.



The impact of the current EVD on women is even more intense. The number of EVD deaths is higher among women than men in the three epicentre countries. Of the total cases of EVD in West Africa, 50.8 percent have been women, as of 7 January 2015. The gender disparity is more pronounced in Guinea and Sierra Leone; it is relatively lower in Liberia (Figure 3).¹

Guinea provides an example of the gender dimension of the EVD epidemiology. As of October 2014, the epidemic affected more women (53 percent) than men (47 percent), a disparity that could be explained by women's role in the family. As the primary caregivers for the sick, women are more exposed to infection. The situation is even worse at the regional level. For instance, in Gueckédou 62 percent and in Téliémilé 74 percent of the infected are women.ⁱⁱ

Gender roles and traditional practices make women more vulnerable to EVD than men.

¹ Disaggregation by sex and age group is quite challenging. The statistics in Figure 3 does not reflect the total sex disaggregation; it only captures where sex is known for Liberia, Sierra Leone, and Guinea. See <http://apps.who.int/gho/data/view.ebola-sitrep.ebola-summary-age-sex-20150107?lang=en>





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Several factors explain the predominance of women among the victims. The sociological aspects of affected communities matter. As care providers, women are more likely to be exposed to disease transmission vectors, such as the vomit or other bodily fluids of an infected family member. Furthermore, women perform traditional practices and rituals on the deceased, which can also pose increased risk. The national study on the socioeconomic impacts of EVD in Liberia highlights the reasons why more women than men have been infected.ⁱⁱⁱ For instance, 70 percent of the respondents interviewed said that the reason was because women were natural caregivers. It is the woman's role to take care of her husband, children, and relatives should they fall ill.

This traditional role of caring for the elderly, children, and sick puts women in direct risk of contracting the virus; medical professionals are also very exposed to the virus. In Guinea, through contact tracing, it was found that patients often caught Ebola from caring for a sick relative, preparing for burial the body of a patient who had died, or assisting women during childbirth. As of August 2014, evidence from Guinea's Ministry of Health indicates that about 60 percent of the cases could be linked to traditional burials and burial practices.^{iv}

Regardless of gender, many medical professionals have fallen victim to EVD. Non-disaggregated data record a total of 318 cases of health care workers, of which 144 died, in Guinea, Liberia, and Sierra Leone as of 18 September 2014. Women's exposure to the disease is intensified by the fact that, in most cases, hospital settings in the three epicentre countries involve more female than male nurses and cleaning and laundry workers. Thus, a female working in a local hospital with Ebola patients has more frequent contacts with patients and the objects with which they come into contact.^v On the economic activity front, women dominate informal trading and are more involved in unofficial cross-border trading—a major source of contracting EVD, which further exposes women to this disease. These factors pose a serious threat to closing the gender gap in West African countries.

The gender dimensions of EVD in Guinea, Liberia, and Sierra Leone are complex.

The EVD outbreak has direct and indirect effects on the affected population groups. For women, the effects include direct impacts on their health and lives, because of their traditional roles in caregiving. In addition, the EVD outbreak has affected women through loss of livelihoods attributable to reduced productivity in agriculture, trade (including cross-border trade), small businesses, and service sector activities. Maternal deaths have increased because of reduced antenatal and neonatal care. And gender gaps in education have widened with school closures and because of girls' increased dropout rates, owing to teenage pregnancies and early marriages. The responsibility to care for the EVD orphaned children also falls on women. Toward the end of 2014, it was estimated that there were more than 30,000 Ebola orphaned children in the three countries.^{vi}



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EVD has increased women's vulnerability to loss of livelihoods and incomes.

Evidence from United Nations Development Programme (UNDP) national studies on the socioeconomic impacts of EVD in West Africa shows that the epidemic poses a serious threat to women's engagement in economic activities. Beyond being physically affected by the epidemic, women have suffered reversals in economic empowerment, because of reduced economic activity related to EVD control measures that restrict the movement of people and goods. In their role as economic providers for their families, women have experienced sharper economic impacts than men. Women in the three countries are disproportionately clustered in the least productive sectors, with 90 percent employed in the informal services and agricultural sectors. Initial economic impact assessments by UNDP, United Nations Economic Commission for Africa (ECA), and the World Bank indicate that border closures, for example, have drastically affected traders (including informal traders) and those working in agriculture and mining.

In Guinea, women are extremely economically active in the informal sector in the production and trading of agricultural and handicraft products. The reduction in trade and the border closings have negatively impacted their activities and led to a fall in incomes, thereby increasing their vulnerability to hunger and diseases. In Liberia, as community Ebola task forces were being established in most communities to monitor the movements of inhabitants and people from neighbouring villages, the movement of people between communities to trade was severely curtailed. For example, businesswomen were prevented from going to neighbouring towns and villages where they normally buy agricultural products to resell in urban areas.^{vii} Furthermore, because of the epidemic, women's main source of funding—microcredit—has dried up. Microfinance institutions have substantially reduced lending because of the uncertainty surrounding EVD (see endnote ii).

Women also play a significant role in agriculture and food security in the three countries and are mainly responsible for the production of staple crops. Restrictions in the movement of people, goods, and services in response to the crisis took place at the height of the planting season. The effects will be loss of income and livelihoods for women, further impacting food security in rural and urban areas.

Safe childbirth is further threatened.

Pregnant women are especially vulnerable to the virus. When women infected with EVD survive to give birth, they invariably pass the virus to the baby, often resulting in the death of the new-born. The severe bleeding caused by Ebola is intensified during labour, which increases the chances and fear of contamination, and explains why pregnant women with Ebola are being turned away from care for fear of contamination.^{viii} Health care providers are often reluctant to care for pregnant women.



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Before the onset of the epidemic, expectant mothers in Guinea were at high risk of maternal death (724 maternal deaths per 100,000 live births). With the epidemic, there has been a breakdown in health services. Of the approximately 200,000 expected pregnant women in the last quarter of 2014, nearly 40,000 may not be monitored or may not have their babies delivered by a qualified person. The constraints facing health services in the delivery of maternal and reproductive health are also evident in Liberia and Sierra Leone (see endnote ii). Increased patronage of traditional birth attendants has further exposed pregnant mothers and their babies to substantial risks.

The reduction in the use and quality of services illustrates the weakening of health structures because of the epidemic. If this trend continues, maternal health indicators will worsen and the maternal health gains made since 2005 will be compromised.² In Sierra Leone, the constraints in the delivery of maternal and reproductive health services may lead to a potential spike in unplanned pregnancies. The reduction in access to health services for women means that women are often left without prenatal, obstetric, and neonatal services, which could reverse gains made on maternal and child mortality in Guinea, Liberia, and Sierra Leone. In addressing this challenge, Médecins Sans Frontières (MSF) has opened its first specialized Ebola treatment centre for pregnant women in Freetown, Sierra Leone. The results achieved so far suggest that well targeted efforts for pregnant women are likely to save lives during public health outbreaks such as EVD. An MSF expert stated that, “so far from all previous epidemics including this outbreak, there had been no recorded cases of babies being born and surviving if their mother had Ebola, but one can remain hopeful that services targeting pregnant women specifically will yield positive results.”^{ix}

EVD exposes women to gender-based violence and exploitation.

The Ebola crisis is causing high levels of psychological trauma among children and women, increased violence against women and girls, early pregnancies, and early marriage. Evidence from the United Nations Population Fund, in its report cited in the UNDP’s “Road to Recovery” study, shows that adolescent girls have been particularly exposed to EVD because of their role as caregivers in the family and community. The report also finds that the closure of schools and the displacement of families may expose girls to sexual exploitation and sexual violence. The report points out that there has been a sharp rise in teenage pregnancies in some areas. The increased poverty associated with EVD is leading to increased child labour and other forms of violence and exploitation of women and children.

These trends have implications for the education of girls and the achievement of gender parity goals in primary and secondary education. In Sierra Leone, the untimely pregnancy of young girls is ranked as the third most common reason for girls dropping out of school. The Government of Sierra Leone estimates that the poorest and those in rural locations are

² See UN, 2014, p. 55, as cited in footnote ii.



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8.5 times more likely to be out of school and less likely to complete the full cycle of education. Poverty compounded with rural location reduces the chances of girls attending secondary school. The Ebola outbreak will increase the disparity, as delays in attendance, especially among teenage girls, will lead to untimely pregnancy and consequently increase the dropout rate among girls.^x

EVD response and recovery and national development strategies must be gender sensitive in addressing the associated negative impacts on women and girls.

The following points should be included in the response and strategies.

1. ***National development plans and strategies must be pro-women.*** EVD has further exposed the structural impediments to gender equality in the affected countries. Long-term gender responsive development policy is critical. Concerted efforts should be made to contain the disease and implement recovery programmes. It is also important to pay special attention to the gender dimensions of the impact of EVD and the recovery efforts. The response should address the underlying gaps in women's representation, access to knowledge, and health, and the disruption to livelihoods, while recognizing the potential of women to act as agents of change in the recovery from Ebola. Renewed efforts should address the gender gaps in education and improved educational attainment for girls and boys, with special attention to orphans and vulnerable children impacted by EVD.
2. ***Gender disaggregation of socioeconomic data is vital.*** The challenge in getting adequate data on the gender dimension of EVD reflects some structural impediments. Hence, it is imperative to obtain more gender disaggregated data and analysis on EVD cases and deaths, to inform policy and programming.
3. ***Promoting advocacy and raising awareness of harmful traditional practices are imperative.*** Tackling harmful cultural practices that leave women and the population at large more vulnerable is not an easy task. Addressing this area must be a gradual process, involving community and religious leaders. Special advocacy and awareness-raising programmes should be established at the national and local levels.
4. ***A strong gender focus in EVD recovery plans is important.*** The lessons learned from this epidemic need to be analysed with a gendered lens, translating medical and social responses that are adequate and respond to the specific and differentiated needs of women and men.



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5. ***An effective social protection mechanism for heavily affected women is urgently needed.*** The safety net mechanism should be decentralized so that discharge packages for survivors and compensation for deceased families and orphans are promptly paid. In addition, the governments and UN agencies should design a comprehensive and robust programme targeting EVD orphans. Institutional mechanisms must be provided so that women in agriculture and the informal sector can access financial services to protect their livelihoods and food security.
6. ***Involvement of women in EVD response actions is vital.*** Health officials and organizations working to combat the Ebola epidemic must involve women in efforts to raise awareness about the disease, share risk mitigation measures, and discuss prevention and eradication.
7. ***Building community resilience in EVD response actions is imperative.*** It is important to strengthen local or community capacity for case management, contact tracing, and safe burial, to ease the burden on women as the primary caregivers. These efforts should include the establishment of holding centres closer to hot spots, so as to minimize the need to transport Ebola patients to distant and unfamiliar centres.
8. ***Improved health facilities and health delivery systems are urgently needed.*** This includes logistics (e.g., good roads, vehicles, and electricity), standards testing, and research laboratories. Such systems should also protect access to maternal care and reproductive services. In Sierra Leone, MSF has established an EVD treatment centre focused on pregnant women. This is a step in the right direction.

Endnotes

ⁱ The basic reproduction number is the average number of secondary infections produced by a primary infection. For the West African estimate, see Lewnard et al. (2014), Dynamics and Control of Ebola Virus Transmission in Montserrado, Liberia: A Mathematical Modelling Analysis, *The Lancet Infectious Diseases* 14: 1189–95. For Congo and Uganda, see Chowell et al. (2004), The Basic Reproductive Number of Ebola and the Effects of Public Health Measures: The Cases of Congo and Uganda, *Journal of Theoretical Biology* 229: 119–126.

ⁱⁱ For more analysis on this, see UN (2014), National Study on the Socio-economic Impacts of the Epidemic of Ebola Fever in Guinea, A Draft Report, Guinea United Nations System, December.



iii More information is available in UNDP (2014), National Study on the Socio-economic Impacts of the Epidemic of Ebola Virus Disease in Liberia, A Draft Report, UNDP Liberia, December.

iv See UN (2014), as cited in endnote ii, on how women have contracted EVD while providing care, and WHO (2015), as cited in endnote vi, for the proportion of infections associated traditional practices.

v UNDP (2014), Assessing the Socio-Economic Impact of the Ebola Virus Disease in Guinea, Liberia and Sierra Leone: The Road to Recovery.

vi WHO (World Health Organization) (2015), Global Alert and Response (GAR)—One Year into the Ebola Epidemic: A Deadly, Tenacious and Unforgiving Virus, January, <http://www.who.int/csr/disease/ebola/one-year-report/introduction/en/>.

vii UNDP (2014), National Study on the Socio-economic Impacts of the Epidemic of Ebola Virus Disease in Liberia, A Draft Report, UNDP Liberia, p. 12.

viii For more elaboration on this, see Anika Rahman, Ebola and Pregnant Women: A Tragedy to Be Addressed in Recovery Plans, *The Huffington Post*, TheHuffingtonPost.com, 7 Jan. 2015, http://www.huffingtonpost.com/anika-rahman/ebola-and-pregnant-women-b_6419368.html.

ix The MSF expert, Dr. Benjamin Black, is an obstetric doctor who was on sabbatical to MSF, researching how best to treat Ebola-affected pregnant women. See <http://www.bbc.com/news/health-30780176>.

x See UNDP Regional Bureau for Africa (2014), The Economic Impact of Ebola Virus Disease (EVD) in Guinea, Liberia and Sierra Leone, *UNDP Africa Policy Note 1* (1, 3 October 2014).

