

CELLULE D'ANALYSE EN SCIENCES SOCIALES | CASS

Social Science Support for COVID-19: Lessons Learned Brief 2

Gender inclusiveness in COVID-19
humanitarian response operations,
evidence from social sciences outbreak
research

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Context

Since August 2018, an Ebola epidemic has continued to spread throughout the east of the Democratic Republic of the Congo (DRC), resulting in [3404 cases and over 2240 deaths](#), including many women and children. Despite cases continuing into 2020 (including new cases in April, two days before the anticipated declaration of the end of the outbreak) a new world-wide pandemic began. COVID-19, a novel coronavirus, originated in Wuhan, China, and has since spread to 213 countries, areas or territories and infected over [2.7 million people](#)¹, including healthcare workers (HCWs).

In February 2020, the first case was announced in Africa, and as of April 2020, cases have been confirmed across 52 countries.

While prediction models for the spread of COVID-19 across the continent vary, the forecasting of the [secondary impacts](#) of the outbreak on health, [poverty and stability](#) of already fragile settings are consistent. COVID-19 adds to the burden of endemic [infectious diseases and conflict](#) facing many countries in the region, with impacts compounded by conditions of limited water, sanitation and hygiene ([WASH](#)) [coverage, and population overcrowding](#). Communities and humanitarian actors working to support the COVID-19 response within these contexts are presented with the challenge of preventing the overwhelming of health systems and [diversion of resources](#) critical to addressing existing needs.

The Social Sciences Analysis Cell (CASS)

The Social Sciences Analysis Cell (CASS), established during the DRC Ebola outbreak (2018-present), is a unit set up by UNICEF, together with national and international, operational and academic partners to operate under the Ministry of Health (MoH) response lead. The Cell conducts mixed methods, operational social sciences analyses to support the response actors, strategies and interventions. The purpose of this Cell is to provide integrated analysis to facilitate understanding and monitoring of epidemiological, behavioural and perception trends as the

outbreak and its responses evolve, and together with partners, apply results of analyses to motivate real operational change and improved community health outcomes. As part of the Ebola outbreak response, the CASS **conducted 57 field studies, and together with the MoH and response actors, developed 112 recommendations**.² Following from the success of this model, the CASS aims to replicate this role across several countries in Sub-Saharan Africa, adapting to new contexts presented by outbreaks such as the current COVID-19 pandemic.

Lessons learned briefs

The CASS has drafted a set of briefing documents outlining key lessons learned from social sciences analyses during the DRC Ebola outbreak response, aiming to connect findings from the research conducted by the CASS with recommendations for supporting and improving the approach to tackling COVID-19 and its secondary impacts in Sub-Saharan Africa.

The CASS Briefs do not imply comparatives between the diseases. While the [Ebola virus has a higher mortality rate](#) than COVID-19, it is far less transmissible being a disease where a reasonable level of physical contact with a symptomatic person is required in order to contract the virus. Conversely, [COVID-19 is spread via droplets](#), up to two metres from one person to another, often before the onset of symptoms. This presents challenges for containment and prevention activities and elevates the risk of exposure to outbreak responders.

Despite these differences, the social and behavioural sciences studies, recommendations, and resulting documented lessons learned can **provide key guidance and important considerations for COVID-19 response and research teams operating in similar contexts across the continent**.

The briefs address the following topics:

Brief 1: Social Sciences Research questions we should be asking in humanitarian contexts under COVID-19

Brief 2: Gender inclusiveness in COVID-19 humanitarian response operations

Brief 3: Humanitarian programme recommendations for COVID-19 based on social sciences evidence from the DRC Ebola outbreak response

Brief 4: Social sciences evidence on barriers to healthcare seeking during the DRC Ebola outbreak

CASS research tools, raw data, presentations, analysis and monitoring of research recommendations to action (MONITO) are available online: [Ebola drive](#) and [COVID drive](#).

¹ Updated case number statistics are provided daily by the [World Health Organisation](#)

² For a complete list of all CASS Studies conducted during the Ebola outbreak response, please consult the study tracker ([LINK](#))

Brief 2: Gender inclusiveness in COVID-19 humanitarian response operations, evidence from social sciences outbreak research

This brief was developed for actors working “on the ground” in outbreak response in humanitarian programmes and contexts. It **focuses on the importance, reasons and recommendations for how to ensure gender inclusivity in outbreak response, based on evidence and lessons learned from CASS studies undertaken during the Ebola outbreak in the DRC (2018-present).**

Evidence from the DRC Ebola outbreak: gaps in gender mainstreaming and inclusiveness

1. Data inclusiveness

In the first months of the Ebola outbreak surveillance and contact tracing data did not systematically include pregnancy or breastfeeding status. When this information was collected, it was considered a single status (“breastfeeding/pregnant”) as opposed to being two separate categories.

Furthermore, data for vaccinations was not provided or disaggregated by sex and overall epidemiological information lacked systematic recording of social factors (socio-economic status, profession, education). This lack of holistic information limited the understanding of potentially critical risk factors for disease exposure and infection.

2. Impact, risk and infection amongst women

Women were more at risk

A [briefing note](#) written by the CASS in March 2019 suggests that women felt under-represented in the response, despite being at higher risk of contracting Ebola³. In the DRC and globally, women tend to play the role of [carer for children and sick relatives](#) and make up a [considerable proportion](#) of both formal and informal health service personnel. These roles did not change with the onset of the Ebola outbreak, which potentially left women more exposed to infection, often with limited access to protection and prevention measures. Until June 2019, pregnant and lactating women were not eligible for the Ebola vaccine⁴. As literacy and education levels are generally lower among Congolese women, [studies](#) found they were less likely to understand Ebola information in French and written Congolese Swahili, and more likely to feel they lacked information to keep themselves and their families safe. [Nande-speaking women](#) interviewed in [Beni](#) claimed they would not seek care if they had possible Ebola symptoms for fear that French- and Swahili-speaking medics would misunderstand and misdiagnose them.

of gender mainstreaming to ensure women’s needs are being met by response interventions. [WASH interventions](#) did not appropriately take into consideration women’s menstrual health needs, and interventions on [condom usage](#) (in order to prevent sexual transmission, and unwanted pregnancies) amongst Ebola survivors and sexual and reproductive health rights (SRHR) in general were minimal.

Access to sexual and reproductive health (SRH) services was limited

A study conducted by IRC on [the impact of Ebola on access to sexual and reproductive health \(SRH\) services](#) found that SRH needs were not prioritised in the Ebola response, and existing SRH programmes were unable to sufficiently adapt to changes in the response. Women experiencing pregnancy complications were particularly affected, as the Ebola outbreak created additional delays in care seeking, leading to adverse outcomes. For example, pregnancy complications can include “unexplained bleeding” and “spontaneous abortions”. Since these conditions meet the existing Ebola case definition, some women would delay seeking care for fear of being transferred to an Ebola treatment centre. In [the IRC study](#) participants generally agreed that it was optimal to avoid pregnancy during the Ebola outbreak, however, contraception was difficult to access outside of private pharmacies and choices were inadequate. Specifically, amongst Ebola survivors, no contraception options, other than condoms were provided at ETCs.

Response activities did not meet the needs of women

Quantitative CASS [studies](#) conducted during the DRC Ebola outbreak demonstrated that women felt that they require distinct, gender-specific information on disease transmission and prevention. A [qualitative study](#) looking at confirmed Ebola cases amongst children under 5, also suggested that many mothers lacked information about the appropriateness of breastfeeding and weaning if they themselves were a contact⁵ and felt responsible for infecting their children through breast milk. Other qualitative studies from the CASS demonstrate the importance

Spouses of and Ebola survivors reported similar in a CASS study on [perceptions and usage of condoms](#). The study participants reported variation in the number and the brands of condoms provided to survivors at ETCs, as varying individual perceptions

3 [As of April 19th, 2020](#) women represent 1873 of the 3404 cases (55%)

4 To date, there remains no sex and age disaggregated vaccination data, limiting the understanding of the role of vaccination in protecting women

5 [WHO guidance](#) recommends that women who have become contacts, continue to breastfeed unless they begin to show symptoms.

of the risks of sexual transmission of Ebola, and the potential preventative role of condoms.

The IRC study also showed that compared to other services, HIV and STI services were less impacted by the Ebola outbreak, possibly because of the free health care initiative⁶. Access to safe abortion care⁷, however, remained low, and was generally unavailable at Ebola treatment centres or most public healthcare

facilities, possibly related to the limited knowledge amongst HCWs of the legality of induced abortion in DRC.

This study also showed that survivors of sexual and physical violence who may have experienced vaginal bleeding were less likely to seek care at healthcare centres for fear of being referred to an Ebola treatment centre as a suspected case as a result of presenting bleeding (symptom of Ebola).

3. Women's influence and involvement in the DRC Ebola outbreak response

Women were underrepresented in response teams

Throughout the DRC Ebola outbreak response, women were under-represented as paid response workers. The majority of workers including in supervisory and management positions in government commissions and NGOs were male, and in many organisations, including the UN fewer than 30% of individuals in response teams were women. This limits women's voices and influence in response strategies and interventions, and limits opportunities for women within communities to interact with women in the response.

Further, as men are the primary owners of hotels, restaurants and [car rental businesses in the DRC](#), it can also be estimated that the majority of the [economic investment](#) from the response was [directed towards men](#) within the general population. This limits women's opportunity to benefit from the financial and economic investments of the response.

Why gender inclusiveness is key in COVID-19 humanitarian response programming

Women often play the role of [un-paid workforce](#) and carers at home, and worldwide, women make up around 70% of health and social service workers; high risk roles in the current context. The risk is compounded by generally lower literacy, health literacy, and non-native language skills among women, disadvantaged in access to education. This impedes their access to information on prevention and treatment if it is not specifically geared to their needs. Additionally, these articles by [IFRC](#) and [IRC](#) show that during emergencies (such as an epidemic) access to other essential health services is often impeded; this includes SRH services. An [article by UNFPA](#) explains:

"In the 2015-2016 Zika outbreak, women faced significant barriers to health care due to lack of autonomy over their own sexual and reproductive health, inadequate access to health services, and insufficient financial resources. During the 2014-2016 West African Ebola outbreaks, women were more likely to be infected due to their predominant roles as caretakers and health workers."

Although women are not thought to be the most bio-medically at risk of COVID-19, they are at greater risk of the socio-economical (secondary) impacts of COVID-19. Articles printed in the [Lancet](#) and by [UNIDIR](#) have expressed the need for a gender gap analysis, and indicate an increasing risk of social vulnerability and violence against women in the current pandemic. COVID-19 IPC measures in place in many countries (self-isolation, confinement, physical distancing) could also increase existing disparities by placing those in abusive relationships at higher risk and burdening women more domestic labour. Gender mainstreaming at all levels of this response could ensure that existing disparities are not deepened, and the needs of men and women are addressed appropriately. This includes the need for specific programmes responding to women and adolescent girls' priority needs in childcare, education and household materials and WASH facilities to meet menstrual health and hygiene needs (either in cash or kind depending on what is most appropriate), exploring remote-learning opportunities for girls out of school to reduce risks of teenage pregnancy, safeguarding measures for heightened SGBV risks and supporting older women through isolation.

How to ensure inclusiveness in COVID-19 responses

Agencies including [UNICEF](#), [UN Women](#), [UNFPA](#), and [CARE](#) have published guidance on the inclusion of women and gender mainstreaming in the response. Several recommendations from these articles can be found below:

- Conduct a [gender gap analysis](#) in all intervention countries
- Budget for gender mainstreaming activities, and develop all communication materials in plain language, local languages, and accessible formats
- Ensure equal representation of women at all levels of the response, particularly including in high-level positions of influence

- Implement the Minimal Initial Service Package ([MISP](#)) to ensure continued access to SRHR services, including support for survivors of intimate partner violence or gender-based violence (including sex workers), and free and safe abortions.
- Engage women's and youth rights networks
- Care for caregivers (formal and informal), including mental health support, childcare, uninterrupted access to SRH services, cash-transfer programmes for women and girls to minimise socio-economic impact of the outbreak

6 In order to mitigate any potential decrease in the use of health facilities during the outbreak, [the government of the DRC set up free health care services in some public facilities](#).

7 Since 2018, [states have the capacity](#) to legalise abortion when necessary to protect a woman's physical and mental health, as well as in cases of rape, incest and fetal anomaly

How to measure and ensure a gender lens in social sciences research in the COVID-19 response

Social sciences analyses and evidence from the Ebola outbreak have identified key areas to ensure action and use of a gender lens in humanitarian programming:

- Train social sciences researchers on the importance and process of gender mainstreaming in research
- Ensure gender is considered in all aspects of research, including recruitment, study development, data collection and analysis
- Ensure all genders and ages are equally represented in data collection (men and women of different ages (e.g. elder women, adolescents etc.) should be consulted in all studies)
- Collect sex disaggregated data
- Hire male and female researchers in equal numbers, and ensure supervisory and management roles are filled by both men and women
- Explore research questions which address “gendered issues”, such as SGBV, maternal health, SRH, and specific needs of women relating to mental health and homelessness
- Conduct a rapid gender gap analysis to guide future research questions
- During analysis, compare results from men and women and to identify any similarities or differences
- Discuss the impact that research results could have on gender (regardless of the subject)

Indicators for measuring gender mainstreaming:

- % of female research staff
- % of female research staff in supervisory or management roles
- % of research staff trained on gender mainstreaming
- % of research studies which discuss gendered issues in the results
- % of research studies which address gendered issues as the main research question
- % of research studies that interview both men and women
- # of recommendations created that aim to improve gender disparities that are caused or exacerbated by COVID-19
- # of recommendations put into action by COVID-19 response workers that aim to improve gender disparities that are caused or exacerbated by COVID-19
- % of research budget allocated to gender mainstreaming activities

How COVID-19 humanitarian programming can apply lessons learned from the DRC Ebola response

- All data collected should be disaggregated by gender and age (regardless of the programme)
- Ensure that women are equally represented in all levels of response teams (decision making and influence)
- Include women’s associations and groups in development and design of response planning (not only in risk communication and community engagement)
- Surveillance data should:
 - Include options for (1) pregnant and (2) breastfeeding women as 2 separate categories
 - Include socio-economic indicators
- Invest in women’s socio-economic enterprises (example: supporting women in mask production, reusable menstrual hygiene management materials)
- Address socio-economic impacts of the pandemic in concordance with prevention and control in programming
- Ensure or facilitate continued access to SRHR services including comprehensive family planning, safe abortion care, SGBV/GBV support, emergency obstetric care, and routine health screenings (pre/post natal, cervical cancer screenings, etc.)

The Social Sciences Analysis Cell- CASS: contact and brief development

If you have a direct request concerning the CASS, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be included in CASS research, network, partnerships or team, please contact the CASS by emailing Simone Carter (scarter@unicef.org) and Jerome Pfaffman Zambruni (jpgaffmann@unicef.org). Key contributing CASS members include GOARN Research (nina.gobat@phc.ox.ac.uk), Anthrologica (oliviattulloch@anthrologica.com), MSF-Epicentre (Pascale.LISSOUBA@epicentre.msf.org), HHI (ppham@hsph.harvard.edu; pvinck@hsph.harvard.edu), Gillian McKay from LSHTM (Gillian.Mckay@lshtm.ac.uk), TWB (christine@translatorswithoutborders.org), ITM (WVDamme@itg.be, vvanlerberghe@itg.be), IFRC (ombretta.baggio@ifrc.org), NOVETTA (roneill@novetta.com)