



## Overcoming the 'tyranny of the urgent': integrating gender into disease outbreak preparedness and response

Julia Smith

To cite this article: Julia Smith (2019) Overcoming the 'tyranny of the urgent': integrating gender into disease outbreak preparedness and response, *Gender & Development*, 27:2, 355-369, DOI: [10.1080/13552074.2019.1615288](https://doi.org/10.1080/13552074.2019.1615288)

To link to this article: <https://doi.org/10.1080/13552074.2019.1615288>



Published online: 28 Jun 2019.



Submit your article to this journal [↗](#)



Article views: 3220



View related articles [↗](#)



View Crossmark data [↗](#)



## Overcoming the ‘tyranny of the urgent’: integrating gender into disease outbreak preparedness and response

Julia Smith

### ABSTRACT

This article contributes to discussions on the gender dimensions of disease outbreaks, and preparedness policies and responses, by providing a multi-level analysis of gender-related gaps, particularly illustrating how the failure to challenge gender assumptions and incorporate gender as a priority at the global level has national and local impacts. The implications of neglecting gender dynamics, as well as the potential of equity-based approaches to disease outbreak responses, is illustrated through a case study of the Social Enterprise Network for Development (SEND) Sierra Leone, a non-government organisation (NGO) based in Kailahun, during the Ebola outbreak.

Cet article contribue aux discussions sur les dimensions sexospécifiques des flambées de maladies et aux politiques et interventions en matière de préparation en proposant une analyse multi-niveaux des lacunes liées au genre, et en illustrant en particulier comment le fait de ne pas mettre en question les suppositions en matière de genre et de ne pas incorporer le genre parmi les priorités au niveau mondial a des impacts à l'échelle nationale et locale. Les répercussions du manque d'attention accordée à la dynamique de genre, ainsi que le potentiel d'approches basées sur l'équité des interventions dans les situations de flambées de maladies, sont illustrés grâce à une étude de cas du Social Enterprise Network for Development (SEND) Sierra Leone, une organisation non gouvernementale (ONG) basée à Kailahun, durant la flambée de maladie à virus Ebola.

Proporcionando un análisis de múltiples niveles sobre los vacíos relacionados con el género, el presente artículo contribuye a la discusión sobre las dimensiones de género durante los brotes de enfermedad, las políticas y las respuestas de preparación. En particular, ilustra cómo incide a nivel local e internacional el hecho de no cuestionar los supuestos vinculados al género y no incluir el género como una prioridad. Un estudio de caso de la Red de Empresas Sociales para el Desarrollo (SEND) de Sierra Leona, una organización no gubernamental (ONG) con sede en Kailahun, explica las implicaciones que tuvo descuidar las dinámicas de género durante el brote de ébola, y analiza las posibilidades de impulsar enfoques basados en la equidad en las respuestas implementadas frente a brotes de enfermedades.

### KEYWORDS

Health; gender; disease outbreak; Ebola; epidemic; policy; crisis response; care work

## Introduction

Since 2000, there have been a series of outbreaks of new, acute, or re-emerging communicable diseases that pose a threat of global spread. They have included Middle East respiratory syndrome (MERS) in Saudi Arabia and South Korea, epidemics of H1N1 and H5N1 strains of influenza, and severe acute respiratory syndrome (SARS), and the mosquito-carried Zika virus in South and Central America, as well as Ebola in West and Central Africa. The West African Ebola outbreak from 2013 to 2016 attracted particular attention to the need to address gender issues relating to the spread and control of infectious diseases. A 2015 report from the Reference Group for Gender in Humanitarian Action noted, ‘Vigilance against a repeat escalation – or future outbreak – of the disease (or any other similarly highly infectious virus) must incorporate the lessons learned on the significance of gender in the spread and control’ (2015, 1).

The gender dimensions of outbreaks are both physical and socially constructed. Some diseases by their nature affect the sexes differently: an example is the Zika virus, which may result in a relatively mild infection but is particularly risky during pregnancy, as it is linked to birth defects. Where gender roles and relations are concerned, the care roles fulfilled by women are significant as women frequently take on the majority of the burden and risk of providing health care in the home, often with little external support. Availability of health services, interactions with emergency responders, and health governance structures also all have gender dimensions.

To respond to the threat of future epidemics, a High Level Panel on the Global Response to Health Crises was set up by the United Nations (UN) Secretary-General in April 2015 to draw together the lessons to be taken from the Ebola response, and propose recommendations aiming to strengthen national and international systems to prevent and respond effectively to future health crises (UN 2016). The High Level Panel’s final report, published in 2017, included the recommendation, ‘Focusing attention on the gender dimensions of global health crises’ (Global Health Crises Task Force (GHCTF) 2017, 16). The High Level Panel noted the need to incorporate gender analysis into responses, as well as recognise the critical role played by women in responding to health emergencies. It further stated that ‘policy-makers and outbreak responders need to pay attention to gender-related roles and social and cultural practices’ (*ibid.*, 17). Responding to recommendations from the High Level Panel’s report, in May 2018, the World Health Organization (WHO) and World Bank announced the creation of a Global Preparedness Monitoring Board to:

Strengthen global health security through stringent independent monitoring and regular reporting of preparedness to tackle outbreaks, pandemics, and other emergencies with health consequences. (WHO 2018, 1)

If and how the board will integrate the recommendations related to gender remains to be seen.

To date, as I will show in this article, gender analysis has been conspicuously absent from policy debates, documents, and processes. Instead, it is argued, outbreak responses

and policies are characterised by the ‘tyranny of the urgent’, which puts aside structural issues in favour of addressing immediate biomedical needs (Davies and Bennett 2016, 1041). For example, Sophie Harman (2016) presents a damning critique, from the perspective of women and gender issues, of the international response to the Ebola crisis. Lack of gender analysis also extends to research on outbreak responses. While health systems and policy research has begun to incorporate gender analysis, few publications have addressed gender issues relating to disease outbreaks. Sara Davies and Belinda Bennett note that, ‘The vulnerabilities of women and girls during complex emergencies are equally present during a public health emergency but are relatively underexamined in these circumstances compared to the study of gender, health and inequality during natural disasters’ (2016, 1044). In a review of the research on both Ebola and Zika outbreaks, they found that less than 1 per cent of published research discussed gender issues (*ibid.*, 1054).

In this article, I aim to reflect on the silences around gender and disease outbreaks. I do this by sharing insights gained from a literature review of scholarly and policy documentation on gender and infectious disease outbreaks conducted in 2018. The majority of my analysis draws on examples from the Ebola and Zika responses, as most of the literature focuses on these cases. However, examples from other outbreaks are also considered. In order to illustrate the gendered impacts of disease outbreaks and responses on the lived experiences of women and girls, a case study based on the work of the non-government organisation (NGO) SEND Sierra Leone is included. The case study is drawn from the reports SEND produced during and following the West African Ebola outbreak in 2014–2016.

It is important to note that, while I worked for SEND Sierra Leone as Technical Advisor during 2010–2011, I was not in Sierra Leone during the Ebola outbreak and am writing this as an academic researcher, based at a Canadian university, and from a position of privilege that means I am unlikely to be vulnerable to disease outbreaks. I recognise that there is a need to hear from those directly affected by disease outbreaks and health inequities in order to inform responses that promote equity. I hope the more academic- and policy-focused analysis that is presented here will also contribute to achieving these goals.

## Methodology and approaches

A literature review using targeted key word searches (gender OR women OR feminist\* OR masculinity OR intersectional\* AND outbreak OR epidemic OR pandemic AND policy OR response OR preparedness) was conducted in various databases.<sup>1</sup> Publications that discussed or evaluated disease outbreak policies and responses were used, including both 20 peer-reviewed articles and 18 publications by organisations engaged in global or public health.

Publications were then organised by policy level (global, national, and local) and reviewed by applying a critical gender lens informed by gender and development (G&D), feminist economics, and intersectional approaches.

*G&D literature and practice* raises awareness about how gender relations and assumptions shape humanitarian and development policies. G&D recognises that male bias is

more than just personal perception, but is also a blindness to the policies and structures ‘that operate in favour of men as a gender, and against women as a gender’ (Elson 1993, 238). This approach emphasises the need to identify and recognise conscious and unconscious bias through gender-aware and gender-visible policies. Gender bias can be exposed through questions such as: Do policies consider the differing roles and experiences of men, women, and other social groups? Do they aim to maintain the status quo or promote gender transformation?

*Feminist economics* has particularly documented how conventional approaches fail to recognise women’s unpaid labour and the economic, social, and opportunity costs women incur while fulfilling care roles (Folbre 2006). Applying a feminist economics lens, in this context, promotes questions such as: Do policies recognise how gender norms impact the health-care roles men and women fulfil during an outbreak? Do they support or exploit unpaid care work?

*Intersectionality* recognises the multiple social and identity factors – such as ethnicity, race, religion, sexuality, and disability – that shape individuals’ vulnerabilities to disease outbreaks, as well as their capacity to cope during emergencies and engage with responses (Hankivsky 2012). This research asks if and how policies and responses address multiple vulnerabilities, the rights of marginalised groups, and structural inequities, while recognising that more in-depth analysis is needed to understand fully the unique intersecting identity factors that are important in individuals’ experiences of different disease outbreaks.

### Global ‘gender gaps’ in policy documents on disease outbreaks

Analysis of global-level policy documents related to disease outbreaks reveals a notable lack of gender analysis. There is no mention of gender inequality, women’s particular needs, or ensuring the health of marginalised groups, in most high-profile policy documents.<sup>2</sup> Outbreak-specific documents also lack gender analysis. WHO’s *Ebola Response Roadmap* includes only one sentence about women (Harman 2016). The World Bank’s (2014) report on *The Economic Impact of the 2014 Ebola Epidemic* did not discuss gendered economic impacts of the epidemic. External assessments of the WHO’s response, which provide recommendations to prepare for future outbreaks, such as the report by the Harvard-LSHTM Independent Panel on the Global Response to Ebola, also fail to include any discussion of the gendered dimensions of the outbreak or response (Moon *et al.* 2015).

Documents from the Global Health Security Agenda (GHSA), a multi-sectoral and multilateral effort, established under American leadership in 2014 to accelerate progress towards disease outbreak preparedness, also do not include any degree of gender analysis. The GHSA is currently developing a framework to guide its future direction. The current draft of this framework (circulated in June 2018) does not mention gender or other equity issues (GHSA 2018b). Other GHSA publications and policy documents, such as country roadmaps (GHSA 2016) and progress reports (GHSA 2018b), also do not include gender analysis.

### *Gender and security during humanitarian crises – an example of global policy failure*

The failure of global policies to include gender reinforces a policy context that ignores how women, men, and other groups experience outbreaks and responses differently. For example, the GHSA particularly promotes greater engagement of the security sector in disease outbreak preparedness and responses, offering ‘a framework and umbrella under which defense departments can collaborate on threat reduction’ (2018b, 1). Its policy suggestions reveal the assumption, embedded in other disease outbreak preparedness policy documents as well, that security-sector engagement will improve disease outbreak responses for all concerned. Yet Fionnuala Ní Aoláin writes, ‘one has to start any conversation about security with an interrogation of the assumption that women’s security and men’s security are identical’ (2010, 19). She notes that, ‘women’s security in times of humanitarian crises requires a broad conception of security that encompasses physical, social, economic, and sexual security’ (*ibid.*, 21).

Yet the security sector – including the police and the army – is shaped by societal norms, including gender norms, which often position women at a structural disadvantage and potentially vulnerable to gender-based violence and abuse. Research indicates that the deployment of security forces, on humanitarian as well as conflict missions, corresponds to an increase in gender-based violence (Tripp *et al.* 2013). Hence the security sector is rarely well-positioned to uphold and ensure that everyone in a community can realise all of their securities.

Security sectors in many contexts are characterised by the dominance of hypermasculinity; ‘a masculinity in which the strictures against femininity and homosexuality are especially intense and in which physical strength and aggressiveness are paramount’ (Ní Aoláin 2010, 15). Research on peacekeeping and humanitarian responses has documented how hypermasculinity dominates other masculinities in times of crisis, where responders are largely men and those suffering the effects of crisis are feminised due to their disempowered position and reliance on security personnel for access to necessities such as food and health care (Tripp *et al.* 2013). While there is no apparent research on hypermasculinity and disease outbreak responses, communities that have experienced the use of security forces to conduct disease outbreak surveillance note these roles are dominated by men and report feeling fearful of excessive use of force and of violence (Abramowitz *et al.* 2015).

Global responses promoting security-sector engagement also fail to recognise that as security sectors across the world remain male dominated, and that those in the higher ranks often represent dominant social groups (such as those who identify as heterosexual white males in Western contexts), decision-making rarely includes the perspectives of women and marginalised groups (Ní Aoláin 2010). Sophie Harman (2016) argues that the military actors involved in the Ebola response in Sierra Leone had the tendency not only to overlook issues of gender difference in how men and women experience disease, but also to reproduce gender norms in masculinised spaces of decision-making and implementation. The uncritical promotion of security-sector engagement in disease outbreak responses at the global level reinforces a specific type of masculine dominance in decision-making and may exacerbate insecurity for women and marginalised groups.

## Limiting national policies

The International Health Regulations (IHR) provide legally binding regulations on how WHO member states prepare for, report on, and respond to health emergencies. Within the IHR, gender only appears in terms of accounting for the concerns of travellers with regard to their gender, ethnicity, religion, and sociocultural factors. In addition, only formal health-care work is considered, neglecting any recognition of how the bulk of care work during an emergency is conducted by women (discussed further below).

Under the IHR, state parties are required to meet core capacity standards, which are measured according to the Joint External Evaluation of Core Capacity Framework (JEE), a standardised tool used to assess country preparedness across 19 technical areas (WHO 2016a). While there is much debate about JEE components, processes, and effectiveness (Wilson *et al.* 2010), a feminist reading highlights the lack of gendered targets and indicators. No targets refer to gender or other inequities, and none of the technical questions – which guide assessment of progress towards the targets – request gender-disaggregated data. For example, the target related to Workforce Development does not ask about the gender composition of the health workforce or about supports for informal care work. There is only one target that mentions marginalised groups; the immunisation target is for ‘a functioning national vaccine delivery system – with nationwide reach, effective distributions, access for marginalised populations, adequate cold chain, and ongoing quality control – that is able to respond to new disease threats’ (WHO 2016a, 29). Yet none of the technical questions follow up on how delivery systems might reach marginalised populations.

Under the target related to preparedness for zoonotic diseases (diseases that can be transmitted from animals to people), a technical question asks, ‘Is there a plan in place to address factors which might prevent farmers/owners from reporting animal disease (may include lack of familiarity with reporting process, lack of indemnity, social stigma)?’ (WHO 2016a, 17). While this question recognises that stigma can impact surveillance effectiveness, the JEE does not include questions regarding if there are policies in place to protect individuals, particularly those already at risk, from stigma (e.g. legislation that prohibits evicting tenants or firing workers based on health status). While the JEE could be a tool to encourage state policies to consider the gendered dynamics of outbreak preparedness, it instead maintains androcentric, or male-centred, assumptions that purely technocratic responses are adequate.

There is widespread consensus that a primary gap in disease outbreak preparedness, by both recipient and donor states, is inadequate investment in health system strengthening (HSS) (Regmi *et al.* 2015). However, HSS not only requires resources, it also must include specific policies to address gender and other inequities. Sarah Payne writes:

Health systems that are ‘gender blind’ – that is, where gender differentials in health services are not recognised – may maintain and/or reinforce gender inequalities and gender inequity in wider society, both in their day-to-day operation and in their development of health policies. (2009, 4)

As there is substantial research on the need to, and how to, integrate gender and other equity issues into HSS, it will not be repeated here (Morgan *et al.* 2016). What



is particularly relevant is that HSS efforts related to disease outbreak preparedness have largely failed to address equity issues. For example, the Vaccine Alliance's (GAVI) HSS programme does not incorporate specific goals, targets, or supports related to gender (GAVI 2016).

Where gender is mentioned in HSS policies related to disease outbreak preparedness, it is most often conflated with maternal and child health, reflecting assumptions that women are solely responsible for reproductive and family health (Witter *et al.* 2017). For example, Canada's Feminist International Assistance Policy commits to strengthening health systems and fighting infectious diseases primarily by funding maternal, newborn, and child health initiatives (GAC 2018). While maternal health must be a priority during outbreaks (as is discussed further below), the nearly exclusive focus on reproduction perpetuates gender norms that confine women to maternal roles, while failing to address women's marginalisation in society or the health effects of inequality (Yamin and Boulanger 2013). The focus on maternal health also obscures the roles and responsibilities of men related to reproductive health, the health needs of women unrelated to reproduction, and of the right to sexual health for people of all genders who cannot or chose not to have children.

This is not to say that comprehensive sexual and reproductive health (SRH) is a not an important priority within disease outbreak preparedness and response. Disease outbreaks can be exacerbated by and exacerbate lack of access to SRH services, which are already restricted by prohibitive laws and customs in many contexts. The South American Zika outbreak illustrates the importance of SRH services to effective disease outbreak response. In most cases Zika causes only mild infections. However, it can have severe reproductive health impacts and cause congenital syndromes in infants born to mothers infected by Zika. Consequently, family planning to ensure protective measures are taken prior to and during pregnancy is the best way to prevent this health concern (Guttmacher Institute 2018). The WHO recommends countries affected by Zika

provide equitable access to quality sexual and reproductive healthcare and services for all women and adolescent girls of reproductive age in Zika-affected areas, including access to family planning, counselling, contraceptive services, including emergency contraception, and supplies, quality prenatal care, quality obstetric care, safe abortion services (where legal), and post-abortion care. (WHO 2016b, 1)

Central and South American states affected by Zika, however, have done little to change prohibitive laws or improve access to SRH services, instead simply arguing women should avoid pregnancy. In 2017, 24 million women of reproductive age in Latin American and the Caribbean had an unmet need for modern contraception, and more than 97 per cent lived in countries with restrictive abortion laws (Guttmacher Institute 2018, 1). A recent assessment in Brazil found no increase in contraception use since the Zika outbreak, concluding this is due to continued poor access (Bahamondes *et al.* 2016). As analysis from the Guttmacher Institute notes, 'Blanket recommendations that women avoid pregnancy in several Latin American and Caribbean countries [affected by Zika] unacceptably shift the burden of responding to the crisis to individual women' (2016, 1).



Such recommendations also exacerbate existing inequities. While Zika is a threat to all pregnant women, wealthier women can often protect themselves by accessing contraception and travelling to either seek abortion services or avoid exposure to Zika while pregnant, and impoverished women cannot (Harris *et al.* 2016). Consequently, children with Zika infection-related disabilities are disproportionately born to women of low socioeconomic status (Lowe *et al.* 2018). The burden of care for children born with congenital syndromes due to Zika also falls largely on women from lower socioeconomic groups living in remote areas. Most of these women give up their jobs or studies to care for their children, and anecdotal reports suggest many become single parents (Diniz 2017).

Poor access to SRH services and restrictive laws combine with weak health systems to create a context of poor maternal health care, which is exacerbated when scarce resources are diverted to outbreak responses. During the West African Ebola outbreak, Médecins Sans Frontières (MSF) closed its obstetric and paediatric care facilities in affected areas, ‘depriving the local population of essential services’ (Stockhold Evaluation Unit 2016, 12). Across the region, the closure of NGOs and non-Ebola health services resulted in reduced access to family planning services, increasing the risk of unplanned pregnancies. Quarantine policies prevented pregnant women from accessing care and women suspected of being infected were denied care (Erland and Dahl 2017). Midwives struggled with a lack of clinic guidelines and little information on how to care for pregnant women in the context of Ebola. Maternity care was only provided in clinics after Ebola results were obtained, causing delays in care which contributed to increased foetal and maternal deaths.

Across the Ebola-infected region, the number of women giving birth in hospitals and health clinics dropped by 30 per cent and the maternal mortality rate increased 75 per cent (Davies and Bennett 2016, 1043). A midwife who cared for pregnant women with Ebola noted,

We have some kind of moral imperative, but as a global community, I don’t think we have the moral voice to be able to say: ‘yes, we did the best we could for pregnant women in Sierra Leone’ because we didn’t. (quoted in Erland and Dahl 2017, 26)

## Implications for local realities

### *The impact of outbreaks on care work*

Lack of investment in health systems at the national level has particular gendered impacts at the local level, resulting in a downloading of care responsibilities on to women, a situation which is exacerbated during outbreaks. Sophie Harman explains that the feminised unpaid reproductive care economy ‘acts as a “shock absorber” in periods of crisis ... Women absorb the burden of care through self-exploitation (leading to direct and indirect health impacts on women as a gender), reliance on family, or outsourcing care roles to poorer women’ (2016, 525).

While women often view care work as their duty and take pride in it, they also report hardships related to lack of resources, and the desire to be able to access professional services when necessary. Assessments of the care work associated with the HIV epidemic in

sub-Saharan Africa demonstrate that women providing care often sacrifice their own health, safety, and resources (Ogden *et al.* 2006).

During the West African Ebola outbreak, the majority of care was provided by women, many of whom continue to suffer from the psychological trauma of being solely responsible for the ill and from the fear of contracting and passing on the virus, particularly to their children (Abramowitz *et al.* 2015). Noting the sensitive nature of care work, Fionnuala Ní Aoláin writes that ‘humanitarian assistance and other forms of crisis intervention should not increase women’s vulnerability, neither by undermining their coping strategies nor by reinforcing damaging coping strategies’ (2010, 13). In other words, the care work provided by women should be supported, while providing alternatives that empower women.

While there are numerous examples of programmes run by states and NGOs providing supports to home-based care providers in non-emergency contexts, these remain reliant on the unpaid care work of women, are usually poorly resourced, and are ill-equipped to deal with outbreaks. For example, during the 2008 cholera epidemic in Zimbabwe, home-based care providers lacked access to basic essentials such as oral rehydration salts (Mason 2009). Reports from Zimbabwe’s 2018 cholera outbreak suggest the situation remains much the same if not worse (Burke 2018). During emergencies, inadequate support for home-based care is exacerbated. Existing programmes are often cancelled as organisations suspend operations out of fear of infection, and outbreak responses rarely include support for home-based care providers.

Emergency response organisations also frequently fail to consider gender roles, such as those relate to care work, when designing communications materials. MSF notes the effectiveness of its health promotional materials during the West African Ebola outbreak was limited by lack of understanding of local gender norms (Stockholm Evaluation Unit 2016). Public health materials, such as posters and radio advertisements, advised against touching and cleaning up after those who appeared sick. Such isolation messages were irrelevant to women responsible for caring for family members at home. As Sharon Abramowitz *et al.* reflected, ‘Don’t touch messages do not recognise that women have to touch to give care’ (2015, 11). Isolation messages can also indirectly stigmatise those required to provide care by highlighting their potential role in transmission. Instead, gender-sensitive communications would answer questions like, ‘How do I manage a family of children, including infants and toddlers, in quarantine?’ (*ibid.*, 11).

### A case study: SEND Sierra Leone

Sierra Leone, bordering Liberia and Guinea, ranks 184 (out of 189) on the Human Development Index, and Kailahun District is one of the poorest regions of the country (UNDP 2017). Only 32 per cent of the adult population is literate in Sierra Leone, and less than 20 per cent of women in Kailahun can read and write (SEND Sierra Leone 2018). The maternal mortality rate – 83.3 per every 1,000 live births (UNDP 2017, 1) – is among the worst in the world.

The Social Enterprise Network for Development (SEND), a West African-based NGO, began operations in Kailahun in 2008. SEND Sierra Leone's mission is to 'work to promote good governance and equality for women and men in Sierra Leone' (SEND Sierran Leone 2018, 1). It implements Livelihood Security, Women in Governance, and Accountability in the Health Sector projects. In addition to mainstreaming gender within its activities, SEND facilitates, as part of the Women in Governance project, the Kailahun Women in Governance Network (KWIGN). The network includes over a hundred women's groups across the district which engage in district-level policy processes, conduct gender audits of political parties, support female candidates during elections, co-ordinate microfinance savings groups, and host weekly radio shows.

Kailahun was the region most affected by the West African Ebola outbreak. Health systems collapsed, and markets and schools closed. Trade and travel disruptions resulted in food shortages and rising prices of essential items. Those in affected households destroyed their possessions out of fear of contagion, and in some cases houses were burnt to the ground. By July 2014, the district was recording an average of 30 confirmed Ebola cases per day (Ayamga 2014, 2). In one community where the KWIGN co-ordinates a microfinance project, six out of 35 women from a savings group died; in another, nine out of 35 died within a few days of each other (Kamara 2015, 1).

SEND's reports during the epidemic share the stories of those affected: a single mother died, leaving three children to be cared for by their disabled grandmother; another grandmother lost seven members of her family and was left caring for the remaining two children; a 22-year-old woman lost both parents, becoming responsible for six younger siblings (Kamara 2015). A SEND evaluation found that women were providing the vast majority of care to orphans and faced the additional hardship of stigma. The report notes, 'In situations where the husband and wife were infected, and the wife survived, the in-laws would accuse her to have bewitched the deceased husband. She will be rejected in the community, as well as evicted from her marital home' (Kohteh 2015, 5).

SEND staff observed that the majority of the national and international response efforts were primarily directed at health service delivery and failed to address the contextual and cultural factors causing the disease to spread (Kohteh 2015). While these included denial and traditional practices, they were also related to a lack of access to water, low literacy rates and the need to travel to find food as local markets were closed. Remote communities in the district were not receiving any services or supports. Because sensitisation activities did not specifically reach out to women, women were not participating to the same degree as men.

To respond to the immediate needs of those affected, SEND developed a relief programme with support from partners such as CORDAID Netherlands and Christian Aid UK. Funds provided 250 families affected by the outbreak with household goods, food, and a monthly stipend to meet basic needs. The KWIGN co-ordinated a community foster parent programme for Ebola orphans, and used its radio show to speak out against stigma, providing education about how Ebola spread and how to care for those who were ill while avoiding infection. The radio show was particularly crucial in reaching remote communities where no other information services were being provided (Kohteh 2015).

While SEND did not have the capacity to contribute to the emergency health response, it set a goal of improving health systems to respond to those concerns that were being neglected and to protect against future outbreaks. Along with international partners, SEND helped connect the district hospital to the municipal water supply, renovated peripheral health units, provided supplies – such as blood pressure machines of health units – bought motorbikes for health staff, and trained staff on how to use mobile technology.

SEND also co-ordinated Village Ebola Watch Committees to provide sensitisation and support to those communities not reached by other programmes. The committees included KWiGN members and Christian and Muslim leaders. SEND found that including religious leaders resulted in local acceptance of the committees' messages, and that including KWiGN members increased women's participation in sensitisation workshops. The committees also worked with security personnel, deployed by the government to conduct surveillance and monitor travel, acting as a liaison between security forces and community members.

KWiGN members continue to participate in surveillance activities at the 53 border checkpoints between the district and neighbouring Guinea and Liberia. At some of the more remote locations they are the only health monitors presents; in others, they work alongside security personnel (SEND Sierra Leone 2018). An evaluation of SEND's Ebola responses programmes finds, 'The organization employed a community-based approach that puts local community members (particularly women) and local authorities at the heart of their programming and this has made their projects very successful over the years' (Kohteh 2015, 4). It further notes, 'The collaboration between SEND and KWiGN contributed to the project's high acceptance rates among the local populations' (*ibid.*).

This case study demonstrates both the gendered impacts of the Ebola outbreak and the potential of responses that aim to promote gender equity. Importantly, SEND established equity goals at the onset of its programmes, building capacity through its development initiatives that it was then able to capitalise on when the Ebola outbreak occurred. While the KWiGN was initiated to advance women's leadership, it responded to the crisis by transforming into an outbreak response team that provided gender-sensitive care, sensitisation, and surveillance. KWiGN's leadership capabilities and networks enable SEND to build partnerships with other actors, such as religious leaders. While SEND provided supplies and stipends to those providing care, KWiGN members also took on roles in addition to care-giving, such as within Village Ebola Watch Committees. Through these activities, women's needs were prioritised and the position of women leaders was reinforced, putting them at the centre of the response. SEND's response did not choose between addressing immediate practical needs or structural inequities – it did both.

## Lessons learned

There seems to be an unspoken agreement – demonstrated by the lack of gender analysis in global-level policy documents – that gender is not relevant to global-level processes. Yet global policies influence local health outcomes (indeed, if they did not, we would have to

ask what the point is of all those very expensive meetings at global institutions!). The securitisation of outbreak responses puts military personnel in local communities, potentially leading to increased rates of gender-based violence. The failure of the IHR to consider gender allows assumptions that all people benefit equally from one set of policies to trickle down to state outbreak preparedness planning. The lack of investment in HSS at the global and national level contributes to failures to provide comprehensive SRH services, and continued reliance on, but lack of recognition of, the care work conducted by women during outbreaks. Lack of consideration of gender roles by health organisations translates into public health messages that are irrelevant and potentially stigmatising.

Global policy responses can learn from examples such as SEND Sierra Leone. SEND did not include a gendered approach in its response as an afterthought; it was at the heart of the response because SEND had an established gender strategy. The emergency context of disease outbreaks makes it essential to include gender in preparedness policies, as addressing structural issues, such as gender inequality, require foresight and planning. At the global level this could be achieved through greater recognition of the gendered and other social dimensions of the IHR, which could then influence national policies through the development of JEE indicators and targets reflective of an intersectional approach. These could be developed through consultation with feminist activist and social movements, an approach that has proven successful within Global AIDS Response Progress (GARP) reporting processes, where civil society organisations have worked with the UNAIDS Monitoring and Reference Group to develop indicators on gender-based violence, stigma, and the rights of marginalised groups (Smith *et al.* 2017).

Another key lesson from the Ebola case study is that the leadership role of the KWiGN was essential in reaching out to other women, communicating effectively, and building partnerships with other actors, such as security personnel. Evidence from other sectors demonstrates that gender and related rights issues will be neglected if there is not a designated responsibility for inclusion. There needs to be concerted efforts to engage women and members of marginalised groups in all levels of disease outbreak policymaking and response. For example, the Disease Outbreak Preparedness Monitoring Board could include a gender focal point to solicit input from those most affected by disease outbreaks. Davies and Bennett (2016) advocate a greater role for the Special Rapporteur on the Right to Health within disease outbreak policymaking. National and local-level policy processes need to innovate to create spaces for greater engagement with women and marginalised populations.

All levels of response need specific policies in place to ensure comprehensive sexual and reproductive health at all times. One option would be to adoption of the Minimum Initial Service Package (MISP) for Reproductive Health, a co-ordinated set of priority activities for decreasing SRH-related morbidity and mortality during an emergency, to infectious disease outbreaks. Programming and policy responses similarly need to first recognise the care work conducted largely by women in such situations, and then find ways to support such work without relying on it. This includes strengthening health systems to provide health-care options and providing opportunities for women in all aspects of the response, whether it be through formalised work in the health sector, decision-making, or security.

While it may not be clear when and where the next major outbreak will occur, we unfortunately do know that it will occur. In order to overcome the ‘tyranny of the urgent’, there is an immediate need to incorporate gender-based analysis, the voices of women and marginalised groups, and feminist perspectives in disease outbreak preparedness and responses.

## Notes

1. These databases consisted of Google, Google Scholar, PubMed, and Eldis.
2. These include the *Global Monitoring of Disease Outbreak Preparedness: Preventing the Next Pandemic* published by the Harvard Global Health Institute (2018) and *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises* published by the National Academy of Medicine (2016).

## Acknowledgements

Research for this article was supported by Global Affairs Canada, and the Social Sciences and Humanities Research Council of Canada’s International Policy Ideas Challenge

## Notes on contributor

*Julia Smith* is a Research Associate in the Faculty of Health Sciences at Simon Fraser University, Canada. She has worked for health and development organisations in Africa, Europe, and North America. Postal address: c/o The Editor, *Gender & Development*. Email: jhs6@sfu.ca

## References

- Abramowitz, Sharon, Kristen McLean, Sarah McKune, Kevin Bardosh, Mosoka Fallah, Josephine Monger, Kodjo Tehoungue and Patricia Omidian (2015) ‘Community-centered responses to Ebola in urban Liberia: the view from below’, *PLoS neglected tropical diseases* 9(4): e0003706
- Ayamga, Joseph (2014) *Update On Ebola In Kailahun District, Where SEND Works In Sierra Leone*, Kailahun: SEND Sierra Leone
- Bahamondes, Luis, Ali Moazzam, Ilza Monteiro and Arlete Fernandes (2016) ‘Contraceptive sales in the setting of the Zika virus epidemic’, *Human Reproduction* 32(1): 88–93
- Burke, Jason (2018) ‘Medieval cholera outbreak exposes huge challenges in Zimbabwe’, *The Guardian*, 20 September, <https://www.theguardian.com/global-development/2018/sep/20/medieval-cholera-outbreak-exposes-zimbabwe-problems> (last checked 9 April 2019)
- Davies, Sara and Belinda Bennett (2016) ‘A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies’, *International Affairs* 92(5): 1041–60
- Diniz, Debora (2017) *Zika: From the Brazilian Backlands to Global Threat*, London: Zed Books
- Elson, Diane (1993) ‘Gender-aware analysis and development economics’, *Journal of International Development* 5(2): 237–47
- Erland, Elin and Bente Dahl (2017) ‘Midwives’ experiences of caring for pregnant women admitted to Ebola centres in Sierra Leone’, *Midwifery*, 55: 23–28
- Folbre, Nancy (2006) ‘Measuring Care: Gender, Empowerment, and the Care Economy’, *Journal of Human Development* 7(2): 183–99



- GAVI (2016)** 'Health system strengthening evaluations 2013–2015', Gavi: the Vaccine Alliance, <https://www.gavi.org/results/evaluations/health-system-strengthening-evaluations-2013-2015/> (last checked 9 April 2019)
- GHSA (2016)** *Interagency Roadmap: Sierra Leone*, <https://www.ghsagenda.org/docs/default-source/ghsa-roadmaps/ghsa-sierra-leone-roadmap.pdf> (last checked 9 April 2019)
- Global Health Crises Task Force (GHCTF) (2017)** *Final Report*, Geneva: United Nations, <https://www.un.org/en/pdfs/Final%20Report.Global%20Health%20Crises%20Task%20Force.pdf> (last checked 9 April 2019)
- Global Health Security Agenda (GHSA) (2018a)** *Global Health Security Agenda 2024 Framework PREFACE*, <https://www.ghsagenda.org/docs/default-source/default-document-library/draft-ghsa2024-framework-v2-july2018.pdf> (last checked 9 April 2019)
- Global Health Security Agenda (GHSA) (2018b)** *Implementing the Global Health Security Agenda: Progress and Impact from U.S. Government Investments*, <https://www.ghsagenda.org/docs/default-source/default-document-library/global-health-security-agenda-2017-progress-and-impact-from-u-s-investments.pdf> (last checked 9 April 2019)
- Government of Canada (GAC) (2018)** 'Canada's Feminist International Assistance Policy', [http://international.gc.ca/world-monde/issues\\_development-enjeux\\_developpement/priorities-priorites/policy-politique.aspx?lang=eng#5.2](http://international.gc.ca/world-monde/issues_development-enjeux_developpement/priorities-priorites/policy-politique.aspx?lang=eng#5.2) (last checked 9 April 2019)
- Guttmacher Institute (2018)** 'Abortion in Latin America and the Caribbean', <https://www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean> (last checked 9 April 2019)
- Hankivsky, Olena (2012)** 'Women's health, men's health, and gender and health: Implications of intersectionality', *Social Science and Medicine* 74(11): 1712–720
- Harman, Sophie (2016)** 'Ebola, gender and conspicuously invisible women in global health governance', *Third World Quarterly* 37(3): 524–41
- Harris, Lisa, Neil Silverman and Mary Faith Marshall (2016)** 'The Paradigm of the Paradox: Women, Pregnant Women, and the Unequal Burdens of the Zika Virus Pandemic', *The American Journal of Bioethics* 16(5): 1–4
- Kamara, Siapha (2015)** *SEND Ebola Update On Kailahun District: Where SEND Works*, Kailahun: SEND Sierra Leone
- Kohteh, William (2015)** *Evaluation of the Kailahun District Remote Villages Ebola Watch Capacity Building Project*, Kailahun: SEND Sierra Leone
- Lowe, Rachel, Christovam Barcellos, Patrícia Brasil, Oswaldo G. Cruz, Nildimar Alves Honório, Hannah Kuper and Marilia Sá Carvalho (2018)** 'The Zika Virus Epidemic in Brazil: From Discovery to Future Implications', *International Journal of Environmental Research and Public Health* 15(1): 96, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5800195/> (last checked 9 April 2019)
- Mason, Peter (2009)** 'Zimbabwe experiences the worst epidemic of cholera in Africa', *The Journal of Infection in Developing Countries* 3(02): 148–51
- Moon, Surei, Dev Sridhar, Muhammad Pate, Ashish Jha, Chelsea Clinton, Sophie Delaunay, Valnora Edwin, Mosoka Fallah, David Fidler, Laurie Garrett, Eric Goosby, Lawrence Gostin, David Heymann, Kelley Lee, Gabriel Leung, Stephen Morrison, Jorge Saavedra, Marcel Tanner, Jennifer Leigh, Benjamin Hawkins, Liana Woskie and Peter Piot (2015)** 'Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola', *The Lancet* 386(10009): 2204–21
- Morgan, Rosemary, Asha George, Sarah Ssali, Kate Hawkins, Sassy Molyneux and Sally Theobald (2016)** 'How to do (or not to do) ... gender analysis in health systems research', *Health Policy and Planning* 31(8): 1069–78
- Ní Aoláin, Fionnuala (2010)** 'Women, Vulnerability and Humanitarian Emergencies', *Michigan Journal of Gender and Law* 18(1): 1–23
- Ogden, Jessica, Simel Esimand and Caren Grown (2006)** 'Expanding the care continuum for HIV/AIDS: bringing carers into focus', *Health Policy and Planning* 21(5): 333–42



- Payne, Sarah (2009)** *How can gender equity be addressed through health systems? Policy Brief 12*, Geneva: World Health Organization, [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/64941/E92846.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/64941/E92846.pdf) (last checked 9 April 2019)
- Reference Group for Gender in Humanitarian Action (2015)** Humanitarian Crisis in West Africa (Ebola) Gender Alert: February 2015, Inter-Agency Standing Committee, <https://reliefweb.int/sites/reliefweb.int/files/resources/IASC%20Gender%20Alert%20EBOLA%2020-%20Feb2015.pdf> (last checked 9 April 2019)
- Regmi, Krishna, Ruth Gilbert and Colin Thunhurst (2015)** 'How can health systems be strengthened to control and prevent an Ebola outbreak? A narrative review', *Infection Ecology & Epidemiology* 5, no. 1. doi:10.3402/iee.v5.28877
- SEND Sierra Leone (2018)** *Strategic Plan 2019-2024: Empowering Citizens to Make Sierra Leone Work For Equity*, Kenema: SEND Sierra Leone
- Smith Julia, Chris Mallouris, Lee Kelley and Alfvén Tobia (2017)** The Role of Civil Society Organizations in Monitoring the Global AIDS Response, *AIDS and Behavior* 21(S1): 44–50
- Stockholm Evaluation Unit (2016)** *OCB Ebola Review – Summary Report, April 2016 - Guinea*, <https://reliefweb.int/report/guinea/ocb-ebola-review-summary-report-april-2016> (last checked 9 April 2019)
- Tripp, Aili Mari, Myra Marx Ferree and Christina Ewig (2013)** *Gender, violence, and human security: critical feminist perspectives*, New York: NYU Press
- UN (2016)** Protecting humanity from future health crises: Report of the High-level Panel on the Global Response to Health Crises, 70th Session Agenda item no 125, [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/70/723](http://www.un.org/ga/search/view_doc.asp?symbol=A/70/723) (last checked 9 April 2019)
- UNDP (2017)** *Human Development Report: Sierra Leone*, <http://hdr.undp.org/en/countries/profiles/SLE> (last checked 9 April 2019)
- WHO (2016a)** *Joint External Evaluation Tool IHR (2005) Monitoring And Evaluation Framework International Health Regulations*, Geneva: World Health Organization, [https://apps.who.int/iris/bitstream/handle/10665/204368/9789241510172\\_eng.pdf;jsessionid=96A8F0012A6509A22A98D837982F04D4?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/204368/9789241510172_eng.pdf;jsessionid=96A8F0012A6509A22A98D837982F04D4?sequence=1) (last checked 9 April 2019)
- WHO (2016b)** *Zika Strategic Response Plan*, Geneva: World Health Organization, <https://apps.who.int/iris/bitstream/handle/10665/246091/WHO-ZIKV-SRF-16.3-eng.pdf?sequence=1> (last checked 9 April 2019)
- WHO (2018)** 'WHO and World Bank Group join forces to strengthen global health security', <http://www.who.int/news-room/detail/24-05-2018-who-and-world-bank-group-join-forces-to-strengthen-global-health-security> (last checked 9 April 2019)
- Wilson, Kumanan, John Brownstein and David Fidler (2010)** 'Strengthening the International Health Regulations: lessons from the H1N1 pandemic', *Health Policy and Planning* 25(6): 505–9
- Witter, Sophie, Justine Namakula, Haja Wurie, Yotamu Chirwa, Sovanarith So, Sreytouch Vong, Bandeth Ros, Stephen Buzuzi and Sally Theobald (2017)** 'The gendered health workforce: mixed methods analysis from four fragile and post-conflict contexts', *Health Policy and Planning* 32 (suppl\_5): v52–v62
- World Bank (2014)** *The Economic Impact of the 2014 Ebola Epidemic: Short- and Medium-Term Estimates for West Africa*, Washington, DC: World Bank, <https://openknowledge.worldbank.org/bitstream/handle/10986/20592/9781464804380.pdf?sequence=6> (last checked 9 April 2019)
- Yamin, Alicia and Vanessa Boulanger (2013)** 'Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators', *Reproductive Health Matters* 21(42): 74–85