



Gender Analysis: Prevention and Response to Ebola Virus Disease in the Democratic Republic of Congo

[January 2020]

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Acknowledgements

This paper has benefitted enormously from the inputs of CARE International colleagues based in the DRC and elsewhere. Special thanks goes to Benoit Munsch, Françoise Lumbulumbu, Dr Eric Mukama, Eziechiel Cigoha, Alexis Kisubi, David Bisimwa, Mahamoudou Guimbayara and Sarah Slinker for the instrumental role they played in conceptualising and operationalising this research. While the many key informants and participants in focus group discussions are not named to protect their confidentiality, we acknowledge their individual and collective insights in ensuring that the specific risks and needs of women and girls, men and boys in Ebola-affected regions are more fully accounted for in present and future responses.

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Contents

Abbreviations	1
Executive Summary	2
The Operational Context:	2
Research Methodology	2
Key Findings	3
Key Recommendations	4
Introduction	5
Research Approach	5
Methodology	6
Sampling Strategy and Selection Criteria	6
Site Selection	7
Participant Profiling	8
Research Sample	9
Data Collection Tools	10
Ethical Considerations	11
Research Limitations	11
Humanitarian Context	13
Key Findings	17
Conclusions	26
Recommendations	27
Annex 1: Data Collection Schedule	30
Annex 2: Qualitative Data Collection Question Guide	31

Abbreviations

ADF	Allied Democratic Forces
CSO	Civil Society Organisation
DRC	Democratic Republic of Congo
ETC	Ebola Treatment Centre
EVD	Ebola Virus Disease
FGD	Focus Group Discussion
GBV	Gender-Based Violence
IDP	Internally Displaced Person
IPC	Infection Prevention and Control
KII	Key Informant Interview
MOH	Ministry of Health
MONUSCO	United Nations Organisation Stabilisation Mission in DRC
NGO	Non-Governmental Organisation
RCCE	Risk Communication and Community Engagement
SRH	Sexual and Reproductive Health
SRP-4	Fourth Strategic Response Plan
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation

Executive Summary

The latest epidemic of Ebola Virus Disease (EVD) in the Democratic Republic of Congo (DRC) has rapidly evolved into the second largest outbreak in history. Deployed in an operational environment characterised by ongoing volatility, EVD prevention, treatment and containment efforts have faced multiple difficulties. Mistrust of EVD responders by local communities, coupled with targeted attacks on healthcare workers and facilities, have proved to be serious operational challenges. Despite aggressive efforts to stamp out the disease across three provinces, the virus has continued to spread and is responsible for the deaths of 3,303 people to date (as of 24th November 2019) with an overall fatality rate of 67%.ⁱ

However, these casualty numbers hide the underlying characteristics of the EVD crisis. The reality is that the majority of fatalities consist of women (56%), and children (28%).ⁱⁱ Adult men constitute just 11% of EVD deaths.ⁱⁱⁱ Yet fatalities alone do not fully demonstrate the differential ways in which men, women, boys and girls are exposed and experience the immediate risks and longer-term consequences of the disease. Socially prescribed cultural norms, attitudes and practices in relation to gender and age dictate how individual women, men, girls and boys are differentially impacted by the EVD crisis. It is therefore critical to better understand the socio-behavioural underpinnings to EVD aetiology. In light of the gendered dimensions of the EVD crisis, CARE International in DRC commissioned a Gender Analysis of the EVD crisis in North Kivu in order to provide information about the different needs, capacities and coping strategies of women, men, girls and boys during the EVD crisis.

The Operational Context:

- EVD is endemic in the DRC. Yet while the current crisis is the tenth such outbreak in the country, it is the first recorded in the province of North Kivu.
- The disease is spreading in a highly enabling environment, including:
 - widespread insecurity curtailing humanitarian access;
 - community refusal, reluctance and resistance;
 - Insufficient consideration of how to address infectious disease outbreak in the context of armed conflict and corresponding humanitarian crisis.
- The present outbreak is “as much a crisis of communication as it is a health crisis.”¹ Rumours and resistance have often gone hand in hand.

Research Methodology

This research employed a mixed-methods approach, including a document review and analysis of existing quantitative data sets from secondary sources, as well as the collection and analysis of primary qualitative data at field level. Due consideration for the potential influence and intersectionality of age, gender and disability factors was also prioritised. Strongly rooted in the overriding principles of ‘do no harm’ and the ‘best interests of the child,’ full compliance with any requirements in relation to informed consent and confidentiality policies and practices were ensured. The overall sample consisted of a total of 1008 individuals, including 258 women, 274 men, 240 girls and 236 boys. Primary data collection was conducted in October/November 2019 in four health zones (Butembo, Katwa, Kayna and Mabalako), including twelve health areas. Key informant interviews also took place in the provincial capital of Goma.

Key Findings

The principal research findings have been organised thematically, helping to shed light on the most salient issue areas and identifying key levers for supporting greater gender equality in Ebola prevention and response strategies.

- **Division of domestic labour:** One of the spaces in which gender norms, attitudes and expectations are the most apparent is within the household. There are often large gender-driven disparities in how domestic chores are divided between men and women, as well as between boys and girls. Indeed, these socio-cultural determinants and drivers can often mean that women and girls are more predisposed to infection.
- **Mobility analysis:** Gender-driven differences in the division of labour are reflected in mobility patterns of different segments of the population. Day-to-day tasks including fetching water, cultivating fields and going to the market mean that many women are more likely to have wider ‘environmental ranges’ – thereby exposing them to many more people in public settings within their communities per day, including those that may be unknowingly infected with Ebola.
- **Changes in health-seeking behaviours:** Men and women, boys and girls all reported changes in health-seeking behaviours since the start of the crisis. Many research respondents explained that fear of contracting Ebola – in addition to the possibility of quarantine - kept them from seeking medical attention for other health needs. The sexual and reproductive health of women and girls have been particularly impacted.
- **Unequal access to vaccinations:** Vaccinations have played a significant role in the current outbreak, not least because it is the first time an effective vaccine has been developed and deployed as part of an overarching Ebola response strategy. However, conditions to receive vaccinal protection have been historically unfavourable to women and children.
- **Increased exposure to economic or sexual exploitation and abuse:** Ebola has brought with it specific employment opportunities, and the gendered dimensions of the disease show up in the economic sphere too. While some women have successfully secured employment, some respondents have pointed to the existence of exploitative practices when it comes to hiring and retention for such openings. The influx of Ebola responders and associated cash flow may also inadvertently have created conditions which favourise economic or sexual exploitation and abuse. The visibility and rise of such incidents is likely correlated with parallel increases in community resistance against Ebola response efforts.

“The sexual exploitation of girls can be observed in local bars, and it has increased since the beginning of Ebola activities. These girls are commonly called ‘poireaux accompagnateur de la boisson’.”
[FGD participant, Kamandi]
- **A gender gap in communication:** Ebola-related key messaging and content were perceived as being heavy or confusing. This gender gap is likely correlated with existing gender inequalities in terms of access to education during childhood years and later adult literacy levels.^{iv} Not only are women sometimes disadvantaged when it comes to accessibility and comprehension of key messages, they are also frequently hampered in their ability to respect recommendations precisely because of their gender.

- **Gender bias in research and resourcing:** The scientific underpinnings behind EVD-related policy and practice are subject to gender biases in both research and resourcing – with differential consequences on women, men, girls and boys. One key example pertains to transmission trends, particularly those that disproportionately impact women and young children. Specifically, the continued presence of the virus in seminal and maternal fluids (semen and breastmilk) amongst male and female Ebola survivors has been identified but little is known about exactly how long the virus can persist after a patient has ‘recovered.’^v Similarly, a parallel de-prioritisation was evident in research on the safe use of anti-Ebola vaccines on pregnant and lactating women, as well as, children.
- **Socio-behavioural and biological vulnerabilities of children:** In addition to adult women, children have been disproportionately affected by EVD. Children are at higher risk of infection to Ebola because it is transmitted through direct contact. They are subject to greater physical contact with caregivers, and generally have relatively poorer hand-washing practices.^{vi} While such behavioural factors partly explain the susceptibility of children to Ebola, it is also important to understand the biologically-related factors. Timely identification of cases amongst children may be hampered by the fact that many early symptoms (fever and fatigue, for example) resemble those of other commonly-found disease in sub-Saharan Africa, including malaria.^{vii}

Key Recommendations

Designing and delivering an effective response to Ebola is of paramount importance in a country where the disease is endemic. The DRC has already experienced ten outbreaks – it will almost certainly happen again. It is therefore critical that responders heed lessons that are emerging from past and present practice, in order to inform next steps for both the current and any future outbreaks.

The response to EVD today is gender-blind in many respects. There has been little or no attempt to consistently apply a gender lens to not only Ebola prevention and response efforts, but also its transmission. As a result, broader acknowledgement or acceptance of the feminisation of the current Ebola outbreak is lacking. Recommendations have therefore been formulated to enable communities to both address the gendered dimensions of the disease and to ‘build back better’ – in ways which build preparedness and resilience on a foundation of increased sensitivity to age, gender and disability dynamics.

1. **Improve the consistency and visibility of data disaggregation**
2. **Women are key stakeholders and their role should be front and centre**
3. **Integrate conflict-sensitive and gender-transformative approaches**
4. **Promote prevention while reinforcing reporting and referral mechanisms for abuse survivors**
5. **Tailor and target EVD-related communication efforts**
6. **Redress gender bias in scientific research**
7. **Encourage and embed child-friendly innovations**
8. **Bolster community resilience through key entry points such as schools**
9. **More spotlight on inclusive practices and programming**

Introduction

The latest epidemic of Ebola Virus Disease (EVD) in the Democratic Republic of Congo (DRC) has rapidly evolved into the second largest outbreak in history. Deployed in an operational environment characterised by ongoing volatility, EVD prevention, treatment and containment efforts have faced multiple difficulties. Mistrust of EVD responders by local communities, coupled with targeted attacks on healthcare workers and facilities, have proved to be serious operational challenges. Despite aggressive efforts to stamp out the disease across three provinces, the virus has continued to spread and is responsible for the deaths of 3,303 people to date (as of 24th November 2019) with an overall fatality rate of 67%.^{viii}

However, these casualty numbers hide the underlying characteristics of the EVD crisis. The reality is that the majority of fatalities consist of women (56%), and children (28%).^{ix} Adult men constitute just 11% of EVD deaths.^x Yet fatalities alone do not fully demonstrate the differential ways in which men, women, boys and girls are exposed and experience the immediate risks and longer-term consequences of the disease. Socially prescribed cultural norms, attitudes and practices in relation to gender and age dictate how individual women, men, girls and boys are differentially impacted by the EVD crisis. It therefore critical to better understand the socio-behavioural underpinnings to EVD aetiology.

In light of the gendered dimensions of the EVD crisis, CARE International in DRC has commissioned a Gender Analysis of the EVD crisis in North Kivu where the organisation is already undertaking response activities. Gender Analysis provides information about the different needs, capacities and coping strategies of women, men, girls and boys during the EVD crisis. It uses a range of primary and secondary information to better understand gender roles and relations and how they may have changed over the course of the crisis. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls and to ensure we 'do no harm' by minimising the potential risk of unintended negative consequences while maximising the positive impacts of proposed interventions.

Research took place in October/November 2019. The present report intends to shed light on the intersecting age, gender and power dynamics of the crisis, evaluating the current and future impact of EVD on women, men, girls and boys. By capturing both constraints and potential opportunities, as well as lessons learned and best practices from present and previous outbreaks, this analysis aims to contribute to increased gender- and conflict-sensitivity in the planning, coordination and implementation of EVD prevention and response interventions. The resulting thematic analysis provides evidence to recognise and advocate for the need for an increasingly gender- and conflict-sensitive approach to present and future EVD crises in the DRC and elsewhere.

Research Approach

Given the extreme sensitivities for EVD-affected communities, research was conducted using principled, participatory, appreciative, equitable, and rights-based approaches. The research team was, at all times, transparent about the research purpose, employing the highest possible ethical and safeguarding standards. Stakeholders at different levels were given opportunities to contribute to, and meaningfully inform, the proposed work. This was done by sharing findings and incorporating feedback, and by engaging collaboratively with a full range of stakeholders from a position of integrity, humility, and mutual respect.

Methodology

This research employed a mixed-methods approach, including a document review and analysis of existing quantitative data sets from secondary sources, as well as the collection and analysis of primary qualitative data at field level. While the analysis relies predominantly on qualitative research, available quantitative data has been used to understand scale and scope. Qualitative data, on the other hand, serves to illuminate on-the-ground perspectives from a wide variety of stakeholders. Due consideration for the potential influence and intersectionality of age, gender and disability factors was also prioritised.

- **Document review:** An initial desk-based review of existing literature related to current and past approaches to preventing and responding to EVD outbreaks in the DRC and elsewhere was undertaken. This encompassed internal organisational documents such as needs assessments and other reports from CARE, as well as published and grey material from external sources including other humanitarian actors, media outlets and academic institutions. The review helped to inform the initial research design, development of qualitative question guides, identification of key informants and sampling strategy, as well as subsequent interpretation of data and context analysis.
- **Key Informant Interviews (KIIs):** Key informants at provincial and field level were jointly identified to participate in semi-structured interviews revolving around the key research questions to gather expert insights not included in existing literature.
- **Focus Group Discussions (FGDs):** Age- and gender-disaggregated focus group discussions with approximately ten participants each were held at field level. Questions guides were developed to draw on the experiences and insights of participants to produce data relevant to understanding the gender and power dynamics underlying EVD prevention and response efforts. Where children are included in FGDs, child-friendly participatory approaches were incorporated, as well as appropriate accommodations for any children or adults with disabilities.
- **Validation and feedback:** Preliminary research findings were shared ahead of report finalisation to allow key stakeholders the opportunity to provide feedback on our initial analyses, validate principle findings and co-develop final recommendations.

Sampling Strategy and Selection Criteria

A purposive sampling strategy was employed to strike a suitable balance between the breadth and depth of research required to gain sufficient insight into the gender and power dynamics of the EVD crisis. By selecting multiple sites across the EVD-affected zone in Grand Nord Kivu for primary qualitative data collection, the proposed sample offered adequate geographic diversity to identify potentially influential variations (e.g. urban, peri-urban and rural settings). The study design also allowed for a vertical or in-depth investigation into the primary research questions, by speaking with multiple stakeholders representing different genders, ages and positions within targeted communities. Moreover, the sample size was sufficient to achieve theoretical saturation of some of the core themes explored in this study.

Site Selection

For field-based data collection in EVD-affected areas, both the location and number of sites has been determined in close collaboration with CARE DRC. It has been agreed that research will be conducted in four health zones, including 12 health areas.

The key criteria for site selection of EVD-affected areas were as follows:

- Presence of past and present EVD cases as well as duration of crisis-related interventions in the zone;
- Areas in which CARE is currently present and other areas where CARE is not present;
- Potential for diversity of responses from multiple stakeholders (age, gender, positions of power etc.) from across the range of multi-sectoral coordination and response efforts, including: Risk Communication and Community Engagement; Infection Prevention and Control (IPC); Water, Sanitation and Hygiene (WASH); Health including Sexual Health and Reproductive Health (SHRH); Education; Child Protection; and, Gender-Based Violence (GBV);
- Potential for analysing different gender approaches presently used by various stakeholders involved in EVD response;
- Potential for documentation of existing good practices that demonstrate adequate consideration for gender-sensitivity, child-friendliness, inclusion and/or conflict-sensitivity);
- Potential for understanding why past and present interventions have failed to fully integrate gender and conflict dynamics, and where lessons learned can be developed into actionable recommendations to promote a more integrated EVD response;
- Accessibility from a logistical, safety and security perspective;
- Budgetary implications;
- Time constraints.

The finalised site selection and key criteria are summarised in the table below:

HEALTH ZONE	HEALTH AREA	SELECTION CRITERIA
Butembo	<ul style="list-style-type: none"> • Mondo • Katsya 	<ul style="list-style-type: none"> • Urban setting • Contrast between use of health facilities between individual health areas • CARE present
Katwa	<ul style="list-style-type: none"> • Wayene • Muchanga 	<ul style="list-style-type: none"> • Rural setting • CARE present
Kayna	<ul style="list-style-type: none"> • Kirumba • Kamandi • Kanyabayonga 	<ul style="list-style-type: none"> • Rural setting

	<ul style="list-style-type: none"> • Mighobwe 	<ul style="list-style-type: none"> • Recently documented cases • CARE present
Mabalako	<ul style="list-style-type: none"> • Mangodomu • Mangina • Mabalako • Aloya 	<ul style="list-style-type: none"> • Rural setting • Epicentre of EVD crisis • Longest duration of intervention • No current presence of CARE • Attacks on healthcare workers and facilities

Participant Profiling

In order to gain insights into the individual experiences of different children and adults living in EVD-affected areas, as well as those working in EVD-related interventions, it was important to engage with a broad range of stakeholders of varying ages, genders and positions. For KIIs, this ranged from government representatives from relevant line ministries and agencies to humanitarian actors responsible for the coordination and implementation of interventions across different sectors. This included staff members from CARE DRC, as well as external agencies such as the UN, international and national NGOs, and local CSOs. Specific individuals within the targeted structures with whom to conduct these interviews at both provincial and field level were jointly identified.

In addition, age- and gender-disaggregated FGDs at field level offered an opportunity to engage with community members living in EVD-affected areas. In addition to gender, they were disaggregated by age as follows:

1. Girls (aged 10-14 years old)
2. Boys (ages 10-14 years old)
3. Adolescent girls (aged 15-19 years old)
4. Adolescent boys (aged 15-19 years old)
5. Young adult women (aged 20-29 years old)
6. Young adult men (aged 20-29 years old)
7. Adult women (aged 30 and above)
8. Adult men (aged 30 and above)

Age ranges were determined to fit within the CARE International impact group (aged 15-49) while also allowing the opportunity to explore further the specific risks and impacts faced by pre-adolescent children and younger adolescents. The groups were also divided to coincide with the existing disaggregation used for ongoing health-related quantitative data collection.

In order to explore the impact of the EVD crisis on the availability, accessibility and quality of sexual and reproductive health services, expectant or new mothers were also actively included alongside other girls and women. This was an opportunity to better understand issues related to perceptions and trust in health service providers vis-à-vis members of the local community. Moreover, to understand the consequences of EVD in terms of educational opportunities, including any gender-related drivers, it was necessary to target younger children and adolescents who were both in and out of schooling. Both adults and children with disabilities were also targeted, with the understanding that 'disability' is an umbrella term which encompasses a wide range of conditions, ranging from physical, intellectual, and sensorial impairments to life-long debilitating illnesses, amongst others.

Research Sample

The overall sample upon which this research is predicated consisted of **a total of 1008 individuals**, including 258 women, 274 men, 240 girls and 236 boys.

- At provincial level:
 - 7 key informants based in Goma were interviewed in person and remotely, including 5 women and 2 men.
- At field level:
 - 44 key informants including 12 women and 32 men were interviewed;
 - 957 participants in focus group discussions, including 241 women, 240 men, 240 girls, and 236 boys.

The FGD participants are broken down as follows:

	BUTEMBO		KATWA		KAYNA		MABALAKO		TOTAL	
	Targeted	Reached								
Girls (10-14)	20	20	20	20	40	40	40	40	120	120
Boys (10-14)	20	19	20	20	20	20	20	20	120	119
Adolescent Girls (15-19)	20	20	20	20	40	40	40	40	120	120
Adolescent Boys (15-19)	20	17	20	20	40	40	40	40	120	117
Young women (20-29)	20	20	20	20	40	40	40	40	120	120
Young men (20-29)	20	20	20	20	40	40	40	40	120	120
Women (30 +)	20	21	20	20	40	40	40	40	120	121
Men (30 +)	20	20	20	20	40	40	40	40	120	120
										957

Data Collection Tools

The question guide that was used to conduct both FGDs and KIIs is located in the Annex II of this report. The tool was written in French and administered in Kiswahili (in field locations). Translation into local language was checked and corrected – including any necessary adaptations to the formulation of particularly sensitive research questions - as part of pilot testing of tools and debrief prior to the commencement of fieldwork.

Each FGD was facilitated by one enumerator, and notes in Kiswahili were taken by another enumerator. Transcriptions were then completed in French, under the supervision of CARE staff members. To facilitate data collation and analysis, the question guide was subsequently renumbered following pilot testing.

Ethical Considerations

This research project is strongly rooted in the overriding principles of 'do no harm' and the 'best interests of the child.' Full compliance with any requirements in relation to informed consent and confidentiality policies and practices were therefore prioritised. Specific consideration was given to:

- Confidentiality of those participating in research;
- Physical safeguards for those conducting research;
- Data protection and secure maintenance procedures for personal information;
- Age- and ability-appropriate consent and assent processes based on reasonable assumptions about comprehension of individuals involved in the research, including in the development of data collection tools;
- Child safeguarding, safety and privacy.

All field-based enumerators participated in a two-day orientation. During this training, enumerators received a detailed overview of the aims of this research, key concepts in relation to gender equity and conflict-sensitivity as well as ethical and inclusive data collection protocols. These include actions aimed at reducing any possible distress to participants caused by this research, as well as the provision of appropriate referral and reporting pathways as appropriate (in line with guidelines from the World Health Organisation). These were further refined in collaboration with CARE DRC to ensure appropriate contextualisation and respect of internal organisational policies and best practices.

27 enumerators (including 15 women, and 12 men) originating from the targeted research sites were carefully selected, with due consideration for gender balance as well as existing skills in data collection, including facilitation of focus group discussions with children, and transcription. FGDs for girls and women were conducted exclusively by female enumerators, while FGDs for boys and men were conducted by both male and female enumerators.

Appropriate formalities, wherever necessary, were undertaken by CARE DRC to ensure the research team had the required authorisations and approvals in order to commence work. Similarly, any safety and security assessments for fieldwork were overseen by CARE DRC. Given the prevailing sensitivities within the local population in relation to EVD prevention and response activities, due consideration was given to how the research team would present itself and the aims of the research at field level. In areas where there have been particularly high levels of local resistance, and widespread belief in falsehoods surrounding the origins of EVD, the research team accorded more time and attention to presenting the past and present work of CARE DRC in the area in order to increase the probability of acceptance by the local population.

Research Limitations

The strength of qualitative-focused work is that it enables us to examine questions such as 'how' and 'why' behind the differential ways in which women and girls, men and boys experience the EVD crisis. Qualitative primary data collection draws from the expertise and insight of individuals and groups who have intimate knowledge of the crisis.

One challenge is that because people experience the crisis differently - based on intersecting factors such as their position of power, gender, age, disability, geographic location – personal perspectives can vary widely between individuals. While this can be read as a limitation, this diversity of views is also a strength in that it enables a closer look at the complexities of the EVD crisis vis-à-vis children, adolescents and adults of varying backgrounds.

Another challenge is the possibility of a positive response bias. In other words, there may be little incentive for respondents to speak critically to researchers working on behalf of CARE DRC if they have benefitted from CARE interventions in some capacity (e.g., services, employment, partnership, etc.). It was therefore pertinent for researchers to stress the overall aim of this assessment, as well as the importance of informed consent and confidentiality.

Within the existing study parameters, it is difficult to conduct research with findings that can be generalised across the current (and/or any future) EVD-affected zone. However, by conducting in-depth work across selected sites, and by developing a data collection plan that aimed to arrive at conceptual saturation of key themes, the findings provide valuable insights and actionable recommendations which can be applied transversally when appropriately contextualised.

Finally, the limited timeframe and financial constraints may have affected the fieldwork strategy from time to time. For example, if a selected key informant was unavailable during scheduled presence in the field. Adequate preparation prior to fieldwork was therefore necessary to maximise the possibility of research participants' availability at scheduled times. Any gender-related considerations were also accounted for in scheduling appointments, including particular times of day or locations that were more suitable to meet with participants depending on their age and/or gender.

Humanitarian Context

EVD is endemic in the DRC. Yet while the current crisis is the tenth such outbreak in the country, it is the first recorded in the province of North Kivu. The disease has spread at alarming rates from its epicentre across one of the country's most populated provinces – with over 8 million inhabitants.^{xi}

The deadly Zaire Ebola Strain responsible for the present outbreak is known to have the highest fatality rates of all EVD strains.^{xii} However, protracted armed conflict, coupled with a near-constant state of political crisis, has created conditions in which the disease is particularly difficult to eradicate. Although there are over 100 armed groups – both local and foreign – operating in the area, one in particular has repeatedly terrorised communities situated in and around Beni town and territory - areas which are now synonymous with Ebola. At the time of writing, the Allied Democratic Forces (ADF) were responsible for two weeks of nearly nightly killings, resulting in the death of at least 77 civilians – only the latest wave of a chilling track record of attacks by the ADF over the past five years.^{xiii}

As a direct result of ongoing conflict, North Kivu has become characterised by high levels of population movement and pendular displacement patterns, resulting in huge numbers of internally displaced persons (IDPs) without access to clean water, food, sources of income, nor the protection of a cohesive family or community. The estimated 1.5 million IDPs in North Kivu alone present an additional risk factor which cannot be ignored.^{xiv} The province is surrounded by 4 other provinces (Ituri, South Kivu, Maniema and Tshopo) and shares borders with both Uganda and Rwanda. There is potential for the outbreak to extend beyond its current confines, with devastating consequences.

In reality, the disease is spreading in a highly enabling environment. When the Congolese Health Minister first announced an Ebola epidemic on 1st August 2018,^{xv} an administrative strike of nursing staff had been ongoing since 31st June 2018. This was marked by a suspension in data sharing and vaccination activities, and a refusal to receive supervisory visits at provincial level.^{xvi} This situation contributed to the late detection of the epidemic in North Kivu.

Moreover, the DRC has consistently ranked as the worst conflict zone in the world for women and children,^{xvii} and the latest outbreak of Ebola has only exacerbated existing challenges. Since the beginning of 2019, attacks against healthcare workers and facilities, including Ebola Treatment Centres (ETC), have multiplied across Grand Nord Kivu especially in Beni, Butembo and Lubero territories.^{xviii} In many cases, members of local Mai-Mai militia have been presumed to be responsible. In some instances, local actors have used these attacks as a pretext to foment continued resistance to Ebola response activities amongst the local population.^{xix}

Both the deployment and efficacy of the EVD case management infrastructure has been severely hampered by such attacks. Targeted attacks have happened with frightening regularity. In both February and April 2019, for example, *Médecins Sans Frontières* (MSF) was obliged to suspend operations following attacks on their Ebola Treatment Centres (ETCs) in Butembo and Katwa health zones.^{xx} The April attack led to the death of two Ebola patients.^{xxi} The same month, an WHO epidemiologist was killed during a different attack at Butembo University Hospital.^{xxii} At times, such attacks have triggered the displacement of confirmed EVD patients – sometimes to areas that are inaccessible to EVD responders due to security constraints – allowing the disease to spread further.^{xxiii} As recently as November 2019, the base of the UN stabilisation mission,

MONUSCO, was attacked in Beni as part of wider community backlash.^{xxiv} Several key UN actors, including WHO, UNICEF and WFP, have since temporarily relocated non-essential staff due to security concerns.^{xxv}

In fact, rumours and resistance have often gone hand in hand. The present outbreak is “as much a crisis of communication as it is a health crisis.”^{xxvi} Rumours regarding the origins of Ebola, and the motivations of responders, have run rampant. The outbreak coincided with DRC’s presidential electoral cycle, leading to politization of the disease. In some pockets of the population, people believed that Ebola was imaginary – an invention of politicians, drug companies or humanitarians.^{xxvii} Others have believed that the vaccination campaign was actually a trial of experimental drugs on unsuspecting participants, or indeed that the vaccine itself causes Ebola.^{xxviii} The influx of foreign actors – from UN agencies, international NGOs, media outlets and private sector companies – has only further exacerbated misperceptions. With mistrust so widespread and deeply rooted, dispelling myths and misinformation has become a critical component of efforts to combat EVD.

Doubts have also been raised about the World Health Organisation’s (WHO) ability to combat infectious disease in an active conflict zone.^{xxix} While the WHO has shown leadership in controlling Ebola elsewhere, the current crisis presents a unique operational and organisational challenge. Indeed, the failures of response strategies to date are telling. Jointly developed by the Congolese Ministry of Health (MOH), WHO and UNICEF, the fourth national Strategic Response Plan (SRP-4) – a self-proclaimed “final push” to “definitively defeat the epidemic”^{xxx} – has proved ineffective thus far.^{xxxi} New cases of EVD continue to be detected, including reappearances in zones previously thought to be under control.^{xxxii}

In summary, the primary and prevailing contextual conditions which favour the spread of disease in North Kivu include:

- Widespread insecurity curtailing humanitarian access
- Community refusal, reluctance and resistance
- Insufficient consideration of how to address infectious disease outbreak in the context of armed conflict and corresponding humanitarian crisis

These realities have had a persistent and deleterious impact on the efficacy of the EVD response. However, this impact has not been equally felt across all segments of the population. In both the immediate and long-term, women and children are the most likely to bear the brunt – a fact which is directly tied to their standing in society and the traditional gender-driven roles assigned to them. It is therefore imperative to better understand pre-existing gender norms in the DRC, as well as the ways in which they have intersected with the Ebola outbreak.

Existing gender norms, power dynamics and gender-based violence in DRC

Globally, the Democratic Republic of Congo ranks near the bottom of both the Human Development Index (HDI) and the Gender Inequality Index (GII) - 176 out of 189 countries, and 152 out of 160 countries in 2017 respectively.^{xxxiii} According to the United Nations Development Programme (UNDP), GII can be broadly interpreted as the loss in human development due to gender inequality across three dimensions: reproductive health, empowerment and economic activity^{xxxiv} - all of which are well below par in the DRC. However, the vastness and diversity of the country cannot be captured by generalisations alone, and it is understood that

socially prescribed roles and relations can vary significantly across geographical regions and within communities of differing religious, ethnic or linguistic heritages.

The Constitution affords women and men the same rights and responsibilities.^{xxxv} Until only recently, the Family Code explicitly designated the role of head of household to husbands and wives are legally obligated to obey their husbands.^{xxxvi} Although the Family Code was formally amended in 2016 to promote respect for women's rights, the previous code had been in force for almost 30 years. It was a legislative framework which served to reinforce prevailing socio-cultural norms that discriminate against women, rendering them inferior to their husbands, constraining their freedom of choice in terms of where to live, work and travel.^{xxxvii} Despite changes to the legislature, overcoming deeply rooted patriarchal attitudes and transforming social norms continues to be a struggle in the DRC today.

At the household level, social relations between genders translate into gross imbalances in the fulfilment of daily domestic tasks. Where women devote 17 hours a day to productive and reproductive tasks, men only consecrate 7 hours.^{xxxviii} In reality, women and girls carry the burden of cooking, cleaning, searching and stocking water, as well as child care responsibilities.^{xxxix} Conflict-related displacement only amplifies these gender disparities, particularly as specific tasks become more difficult to accomplish (collecting water or firewood, for example).

Children also experience these inequalities, often with long-term consequences for their future educational, economic and health outcomes. While enrolment in primary school tends towards gender parity (with 84.4% for boys and 80.6% for girls),^{xl} there is a more significant difference at secondary school level, resulting in striking differences between genders. For those aged 15 to 24 years, 91.2% of males are literate compared to just 73.6% of females.^{xli} Research shows that these differences can have lasting implications in terms of men and women's sexual and reproductive health behaviours, including contraception use.^{xlii} While the educational prospects of children of all genders may be adversely impacted by displacement, it is common practice that girls abandon their schooling (before boys) in order to support their parents.^{xliii}

Despite recent advances in related legislation guaranteeing women's equal rights to microfinance, employment and remuneration, women's economic empowerment remains curtailed by persistent wage gaps.^{xliv} The traditional occupations for the vast majority of Congolese women – in both perception and reality – continue to be limited to domestic chores and subsistence farming. The disproportionate number of women in the informal sector is significant. It means that many are subject to inconsistent income with no social securities.^{xlv} The level of financial education is low across all segments of the population in the DRC, but even more so amongst women and youth.^{xlvi} This is also reflected in the lower number of women and youth who own a bank account and make regular savings.^{xlvii}

Weak economic empowerment of women is reflected in their weak political empowerment too. Very few women occupy positions of political power in the DRC.^{xlviii} Following the 2018 elections, for example, just 10% of parliamentary seats at national level are filled by women.^{xlix} More specifically, in North Kivu, the electoral districts of Goma town, Butembo town, Beni town and Masisi territory have never delegated a female parliamentarian at either national or provincial level in any of the past three elections (2006, 2011 and 2018).^l The average number of seats for women parliamentarians elected in December 2018 at both the national and provincial level in North Kivu is 7%.^{li}

Women's weak political empowerment is explained by several intersecting factors but is predicated on patriarchal norms and practices.^{lii} Women's participation and legitimacy in the public space is often undermined by discriminatory attitudes. Research by International Alert shows that participation of women in politics was frequently viewed as a 'social deviance' – one which diverted women's attention away from their assigned duties as spouses and mothers. Political participation, therefore, is relegated to women who are "willing to live outside of established social standards [of marriage]."^{liii} Women may also lack the financial means necessary to exercise political participation at higher levels. For instance, presidential electoral candidates are required to pay a USD\$50,000 non-refundable deposit.^{liv} Increased costs to ensure campaign coverage across rural communities may also be a substantive barrier.^{lv} Whatever the reasons, their absence in such spheres of influence directly affects women's ability to dictate and determine discourse and decision-making which affects them.

So many years of conflict have left lasting reverberations across a Congolese society which was already historically rooted in a kinship system with pre-existing gender inequalities. The exceptionally high levels of ongoing conflict have served to further entrench the duality of males and females, as well as the inferiority of women relative to men at both household and societal levels.^{lvi} Such sustained conflict has only exacerbated traditional socio-cultural norms, beliefs and expectations in relation to gender, resulting in a normalisation of violence in everyday life and specifically gender-based violence. In the process, sexual violence has migrated from a conflict-related issue to one which is increasingly commonplace, as demonstrated by the sheer number of incidents of a civilian nature.^{lvii} Perpetrators are no longer solely members of armed forces or armed groups, but also family members, teachers, health care workers, and religious figures, amongst others.

While survivors of sexual violence can be of all ages and genders – and despite endemic under-reporting of incidents – women and adolescent girls constitute the vast majority. Yet gender-based violence can take diverse forms, including forced marriage, sexual exploitation and abuse, as well as, intimate partner violence, amongst many others. Worryingly, 75% of Congolese women and 61% of men felt that a man hitting a woman could be justified under certain circumstances.^{lviii} Moreover, research shows that of females aged 15-24, 44% have experienced forced sex in their marriage at some point by their spouse, while another 45% of those unmarried have experienced forced sex during their first sexual encounter.^{lix}

Indeed, adolescent girls and young women face particular challenges in relation to the intersection of both their gender and age. Socio-cultural norms and beliefs in DRC dictate that once females have undergone puberty, pregnancy or marriage, they are viewed as adults no matter what their actual age. Transitions to adulthood therefore can be abrupt, and are not necessarily supported by appropriate cognitive, psychological and social interventions by peers, family or community members. In general, protracted conflict has taken its toll on social cohesion, and families have become fractured due to poverty and displacement.

Key Findings

The principal research findings have been organised thematically, helping to shed light on the most salient issue areas and identifying key levers for supporting greater gender equality in Ebola prevention and response strategies. This will help ensure that current and future programmatic approaches are cognisant of deeply entrenched norms, attitudes and expectations around gender roles and responsibilities. This is a critical first step in articulating outbreak management strategies which are increasingly responsive to structural opportunities and barriers in relation to evolving gender dynamics.

Division of domestic labour:

One of the spaces in which gender norms, attitudes and expectations are the most apparent is within the household. There are often large gender-driven disparities in how domestic chores are divided between men and women, as well as between boys and girls. Indeed, these socio-cultural determinants and drivers can often mean that women and girls are more predisposed to infection.

Specifically, the day-to-day functions of women in North Kivu encompass caring for the sick, including accompaniment to hospital if necessary.^{lx} Although burial practices vary across ethnic and tribal lines in Congo, women typically take the lead in preparing bodies for burial, with elderly women in particular tasked with the responsibility of leading funeral rites.^{lxi} Girls, especially of pre-adolescent and adolescent age, are known to support their mothers in domestic tasks. In addition to caregiving and funeral preparation, females within the household are often assigned chores such as washing clothes and cleaning. Because Ebola is spread through contact with bodily fluids, and the disease itself manifests in haemorrhagic fever with severe vomiting, diarrhoea and bleeding, these socially rooted practices can and do differentially expose women and girls to infection. This is particularly true when access to adequate WASH facilities, including sufficient supplies of water and soap, is also limited.

In fact, women and girls are also typically responsible for fetching and storing water for household use.

Prescribed IPC measures mean greater consumption of water at home, adding to their daily workload. More time spent on water collection for the prevention of Ebola is not insignificant for women and girls – it is tiresome work, and can mean less time

“Because we need more water, we’re obliged to leave our homes early in the morning or even after dark in search of water. That’s when we can be raped.” [Adolescent girls, Focus Group Discussion]

available for income generating activities, as well as more exposure to harms outside of the home. Some research respondents, especially adolescent girls, indicated that fetching water at odd times of day or at longer distances increased their level of risk to sexual violence.

Moreover, deeply entrenched patriarchal culture also means that Congolese women often have limited control over household finances, even their own income. Although they are responsible for household hygiene and sanitation, and – because of both social and biological factors – have greater needs, women and girls are not in a position to make decisions related to the purchase of soap, disinfectant or disposable menstrual hygiene products. They are poorly placed to negotiate for improved latrine or handwashing facilities in the home. This means that while their gender-driven roles and responsibilities potentially place them at increased risk of exposure to Ebola, the ability of women to take precautionary measures is also curtailed by the same gendered driving forces.

However, it is important to note that gender dynamics are not static. They can change with time. One example pertains to the evolving role of women and girls vis-à-vis the proportion of their time spent on caring for the sick and its corollary potential for risk of cross-infection. As the outbreak has progressed from its early days, there have been corresponding contextual changes, including an evolution in health-seeking and protective behaviours. While community resistance is a persistent feature of the current crisis, there have been substantive efforts to better inform and engage with the local population on all levels. Cumulatively these individual interventions – as well as the growing crisis itself - have led to greater respect of disease management protocols, especially in terms of immediate isolation and referral to health facilities. More awareness and action on the part of the population means that suspected Ebola patients are less likely to be cared for at home (by female family members) and more likely to be transferred to an ECT or health centre for appropriate medical care.

Similarly, with greater engagement and sensitization efforts, community members are increasingly aware and likely to respect recommendations regarding safe and dignified burials for Ebola victims – thereby significantly altering the level of contact (and exposure) females would have previously had with cadavers of dead relatives.

Mobility analysis:

Gender-driven differences in the division of labour are reflected in mobility patterns of different segments of the population. Day-to-day tasks including fetching water, cultivating fields and going to the market mean that many women are more likely to have wider ‘environmental ranges’ – thereby exposing them to many more people in public settings within their communities per day, including those that may be unknowingly infected with Ebola. Gendered topographies may be another explanatory variable to be factored into an analysis of why women are more susceptible to EVD.

For younger school-going children, there are no significant differences between genders in terms of their daily mobility during the academic calendar – given that both girls and boys appear to attend school in almost equal numbers at primary level. It is in later years, that the gender disparity becomes increasingly evident, with lower completion rates for primary school and lower enrolment at secondary school amongst girls.^{lxii} Pre-adolescent and adolescent girls are more likely to accompany their mothers to support them in their socially prescribed roles. Because published data on EVD cases are not fully disaggregated by age and sex for children under 18 years old, it is impossible to know whether adolescent girls are therefore differentially exposed, partly due these distinct mobility patterns. Some research respondents also noted that adolescent boys were more likely to be participate in demonstrations, including those related to community resistance against Ebola response efforts - potentially putting them at risk to physical harm in the event that demonstrations turned violent.^{lxiii}

Changes in health-seeking behaviours:

Men and women, boys and girls all reported changes in health-seeking behaviours since the start of the crisis. Many research respondents explained that fear of contracting Ebola – in addition to the possibility of quarantine - kept them from seeking medical attention for other health needs.

However, there was a notable diversity of views in relation to the possibility of being transferred to an ECT for treatment. While many were reluctant to unnecessarily expose themselves to this possibility if presenting with related symptoms at a health centre, some respondents indicated that they had actively sought out

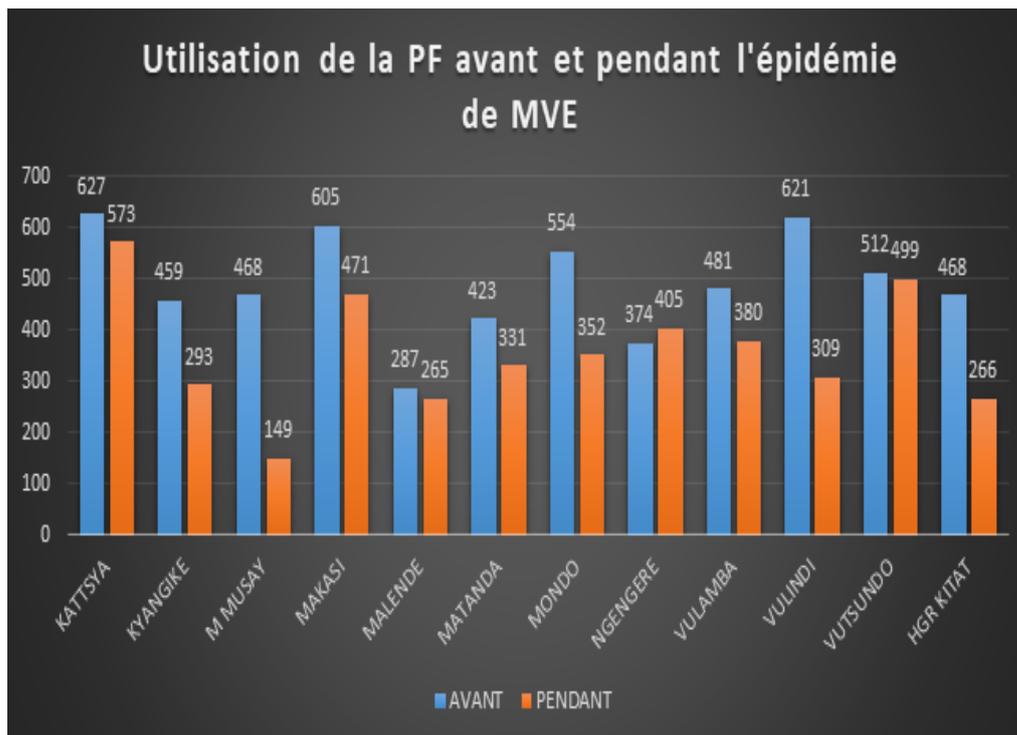
opportunities to be taken an ECT. Some had attempted to falsify Ebola-like symptoms such as fever or diarrhoea in the hopes that they would be transferred. Shelter and free food were reportedly the main factors driving this behaviour, possibly indicative of the fact that EVD-related efforts did not holistically respond to the needs of the wider population. Where interventions were limited to EVD cases, contacts and survivors, certain other members of an already fragilised community may have been obliged to take recourse in other coping mechanisms and survival strategies.^{lxiv}

Nonetheless, the vast majority reported a strong preference to avoid ECTs wherever possible. Women, especially, explained that they feared separation from their children, as well as possible stigmatisation upon returning to their families and communities. Pre-adolescent and adolescent respondents cited various fears in relation to ECTs, including family separation, isolation during 21 days, as well as, potential for both deliberate and accidental infection.

Misinformation and mistrust led many to avoid going to government operated health facilities altogether, preferring to use private dispensaries or pharmacies. Some also relied on traditional medications and other home-made solutions. Broadly speaking, there was large-scale misgivings about health workers and health centres – including fears of forced vaccinations, quarantine, hysterectomies, and abortions, amongst others. Due to potential social backlash and stigmatisation, research respondents indicated that certain chronically ill people hesitated or avoided health structures - despite needing medical care - due to the high visibility of EVD-related efforts (for example, the presence of NGO vehicles).

The sexual and reproductive health of women and girls have been particularly impacted. For some, avoidance meant limiting their access to family planning services. Interruptions in contraception protocols that require follow up (IUDs, for example) may have led to more unwanted pregnancies, although more targeted research would be required to fully explore this aspect. Adolescent girls and women, especially expectant and new mothers, reported that they preferred to forgo care than to put themselves at unnecessary risk of cross-infection or potential quarantine.

Statistics show to which extent this was the case. In Butembo health zone, for example, a significant reduction in the use of family planning services was noted between November 2018 and April 2019 at the height of the crisis, as compared to prior utilisation rates. The graph below charts this difference across the various health areas:



Driving these changes in health-seeking behaviours were several key factors. In the areas where this research was conducted, participants noted the following:

- Medical facilities were affected by the Ebola outbreak, creating fears of potential contamination for users of other services;
- Quarantine of healthcare workers in certain health centres;
- Infection of two healthcare workers with EVD and transfer to the ECT;
- Community resistance, rumours and low levels of understanding about Ebola amongst the local population.

Interestingly, in some specific health areas, utilisation of medical facilities for family planning services remained largely unaffected by the crisis. In Vutsundo and Katsya health areas, for example, attendance was relatively stable. Research respondents indicated that the following factors contributed to the maintenance and reinforcement of utilisation rates:

- Situation analysis and understanding of the locally relevant social norms and customs;
- Development of adapted messaging addressing the identified norms and customs;
- Community dialogue;
- Training and respect of standard precautions and protective measures in IPC amongst healthcare workers;
- Provision of chlorine, hand-washing stations and other necessary items to promote IPC;
- Weekly supervision sessions;

- Dissemination of information on suspected Ebola cases.

Unequal access to vaccinations:

Vaccinations have played a significant role in the current outbreak, not least because it is the first time an effective vaccine has been developed and deployed as part of an overarching Ebola response strategy. In fact, the response has been marked by not just one but two vaccines:

- The first is manufactured by Merck and has been provided free of charge to the WHO and Congolese authorities on the basis of a ‘compassionate use’ protocol despite the absence of commercial licensing.^{lxv} Thus far it has been used as part of a ‘ring vaccination’ approach, whereby ‘contacts’ and ‘contacts of contacts’ are vaccinated, alongside local and foreign frontline and healthcare workers.^{lxvi}
- The second vaccine – from Johnson & Johnson – is also experimental and has only recently been deployed in the DRC. Beginning in October 2019, authorities have started to use it on at-risk populations where there no active Ebola cases despite concerns about the possible complexities and potential misperceptions amongst local communities.^{lxvii}

In a stark reversal from past protocol, the WHO’s Strategic Advisory Group of Experts (SAGE) on Immunization declared on 20th February 2019 that pregnant and lactating women would be eligible for vaccination against Ebola.^{lxviii} At the time of this landmark decision, 57% of confirmed and probable Ebola cases were females, of which 61% were of childbearing age – representing 35% of the total caseload.^{lxix} Between 26th November 2018 and 26th May 2019, a reported 319 pregnant women and 603 lactating women were registered as contacts and were denied vaccines.^{lxx}

Yet it was not until 2nd June 2019, after a total of 2000 deaths, before the Ministry of Health confirmed amendments to the vaccination protocol by the ethics committee at the School of Public Health at the University of Kinshasa.^{lxxi} However, eligibility criteria were changed to include only pregnant and lactating women identified as case contacts, and even then only expectant mothers past their first trimester.^{lxxii}

It is clear that conditions to receive vaccinal protection have been historically unfavourable to women and children. WHO’s previous policy to exclude pregnant and lactating women was based on the fact that Merck’s product is a ‘live vaccine’ thereby posing a theoretical risk of transmission of the weakened virus through the placental barrier in pregnant women and through breastmilk in lactating women.^{lxxiii} Children under one year are still excluded.^{lxxiv}

Increased exposure to economic or sexual exploitation and abuse:

The consequences of EVD can be devastating for all those affected. However, women and girls face both immediate and long-term implications and impacts of the disease which are distinctly different from those of men and boys. Women reported facing stigmatisation by family and community members, particularly post-discharge from an ECT. Others also reportedly faced social consequences from neighbours if they were blamed for having informed local authorities of a suspected Ebola case or contact.

Ebola has brought with it specific employment opportunities, and the gendered dimensions of the disease show up in the economic sphere too. Some women have successfully secured employment because of their EVD status – such as female survivors working as caregivers or ‘*berceuses*’ at ECT-based nurseries.^{lxxv} Others have found work as cleaners or guards, while women have also contributed to various vaccination

and IPC initiatives. According to some research respondents, women were also more implicated in safe and dignified burials earlier in the outbreak. However, many abandoned such work due to subsequent stigmatisation.^{lxxvi}

However, some respondents have pointed to the existence of exploitative practices when it comes to hiring and retention for such openings. There are reports of economic exploitation of both men and women, including through financial kickbacks for those that

“You must always have sexual relations with agents working on the Ebola-response, even if you have a diploma. It’s very remarkable amongst women. Even for men, they will expect them to give half their salary to the one who got you the job in the first place.” [Key Informant]

were responsible for securing their employment. Although it is difficult to establish the scale of the problem, there are also many indications that men in decision-making roles have used their position of power to subject women to sexual abuse as an employment pre-requisite or prior to receiving their salary. Some

“I’ve had a patient come to me to ask for an assisted abortion. She was pregnant owing to sex she was forced to have with an Ebola responder in order to get her job.” [Healthcare worker]

respondents stated that recruitment policies were unclear, and that they worked on Ebola response activities without a formal contract or adequate follow up.

Collectively, this has led some women and girls to abandon their posts or to avoid seeking such roles

altogether, denying them the possibility of supplementing their income. While others, who were subjected to such abuses, are likely only fragilised further. Healthcare workers and local authorities disclosed confirmed cases of pregnancies resulting from sexual exploitation perpetrated by Ebola responders, while also indicating that many more cases likely exist but are not formally reported or documented.

The influx of Ebola responders and associated cash flow may also inadvertently have created conditions which favourise economic or sexual exploitation and abuse. The visibility and rise of such incidents is likely correlated with parallel increases in community resistance against Ebola response efforts.

“The sexual exploitation of girls can be observed in local bars, and it has increased since the beginning of Ebola activities. These girls are commonly called ‘poireaux accompagnateur de la boisson’.” [FGD participant, Kamandi]

The increasing prevalence of female-headed households is a direct consequence of EVD.^{lxxvii} Female heads of household may resort to coping strategies which involve sexual and economic exploitation in order to provide for their families under impossible circumstances. Some respondents indicated that women and girls were forced to commit adultery and/or accept sexual relations with potential employers in order to earn money to meet basic needs for them and their families. In certain cases, they may have led to unwanted pregnancies or early marriages. Girls who have lost their mothers to Ebola, especially the eldest, must assume greater responsibilities in terms of domestic chores and childcare of other siblings. This may lead to increased absenteeism at school or dropping out altogether,^{lxxviii} with long-term implications for their educational, economic and health outcomes for both themselves and any future children they may bear.^{lxxix}

A gender gap in communication:

Research conducted by Translators Without Borders in February/March 2019 underscores the gender gap in comprehension of Ebola-related community messages, demonstrating that women consistently scored lower than men across all forms of communication (pictorial, auditory and written).^{lxxx} While the research was conducted in Goma city, it does point to important lessons which can be applied to other Ebola-affected areas in eastern DRC. Specifically, the need for hyper-localisation of key messages to ensure comprehension by people of all genders and ages. Because linguistic diversity in such areas is high – and that even predominant languages such as Kiswahili are not standardised but rather contextualised – it is critical to cross-check that risk communication and community engagement (RCCE) interventions are being understood as originally intended.

According to research respondents, difficulties in communication and comprehension are a significant barrier. Ebola-related key messaging and content were perceived as being heavy or confusing. For example, some prevention-related communications contained images or drawings of an Ebola victim vomiting blood, while this is actually amongst the final manifestations of the disease (if at all) and therefore unhelpful when it comes to detecting EVD in its early stages. Others used terminology that was overly complicated for its intended audience, attempting to distinguish between contact cases, probable cases, infected cases, for instance.

This gender gap is likely correlated with existing gender inequalities in terms of access to education during childhood years and later adult literacy levels.^{lxxxii} Illiteracy amongst women is widespread, particularly in rural areas. Data show that one in two women is illiterate, compared to one in five men.^{lxxxiii} Amongst adolescents and adults aged 15 years and older, the literacy rate for males was found to be 85.8% compared to just 58.9% amongst females.^{lxxxiii} When viewed in the context of access and control to resources, the ability to access, understand and follow information related to Ebola prevention and response cannot be underestimated. Information is a power resource in combatting disease. If the ability of women to comprehend such information is impeded, then so is their capacity to protect themselves.

Women's economic status and livelihood activities relative to men could further impede their access to information delivered via radio. Often purchase and use of radio and batteries is dominated by men within the household. Moreover, women working outside of the home during the day (cultivating fields, for example) would miss the opportunity to listen to sensitization messages or programmes that took place during the daytime on the radio.

Not only are women sometimes disadvantaged when it comes to accessibility and comprehension of key messages, they are also frequently hampered in their ability to respect recommendations precisely because of their gender. For example, while prevention protocols dictate that contact with suspected Ebola cases should be avoided, women are typically expected to care for sick at home and/or accompany them to hospital. Women are also poorly placed to negotiate for condom use, despite the fact that safe sex is recommended for protection from Ebola. And while breastfeeding may put babies at risk for maternal transmission, new mothers may not be in a position to exercise economic decision-making regarding the purchase of breastmilk substitutes.

“Men don’t want to hear you talk about Ebola in the family. They refuse to use precautions like condoms while having sex and this creates divisions between couples.” [Female FGD participants]

Gender bias in research and resourcing:

In WHO's Director-General, Dr Tedros Adhanom Ghebreyesus's own words, "In everything we do, we are driven by science."^{lxxxiv} Yet, the scientific underpinnings behind EVD-related policy and practice are subject to gender biases in both research and resourcing – with differential consequences on women, men, girls and boys. Existing gaps in evidence highlight these – likely inadvertent – biases.

One key example pertains to transmission trends, particularly those that disproportionately impact women and young children. Specifically, the continued presence of the virus in seminal and maternal fluids (semen and breastmilk) amongst male and female Ebola survivors has been identified but little is known about exactly how long the virus can persist after a patient has 'recovered.'^{lxxxv}

Due to gender dynamics between couples which determine both control and access, women often have less individual agency and decision-making power vis-à-vis sexual intercourse or indeed the purchase and/or use of condoms. Female research participants reported being at increased risk of physical beatings and other abuse if they attempted to elicit condom use from their husbands post-discharge.^{lxxxvi} These socio-behavioural factors mean that Congolese women are exposed to the possibility that the virus be re-introduced back into their household by male survivors. Sexual transmission through male disease survivors can also predicate the spread of Ebola into new communities and regions, particularly when factored together with the prevalence of gender-based violence in eastern Congo generally and the high levels of prostitution along major trunk roads and commercial centres in Grand Nord Kivu specifically.^{lxxxvii}

Moreover, not enough is known about mother to child transmission during breastfeeding. Nursing babies may therefore be at increased risk of viral infection from their mothers, even post-discharge from an ECT. In both sexual and maternal transmissions described above, male and female survivors can unknowingly carry and infect others with Ebola.^{lxxxviii} This is a serious public health concern, yet there is no conclusive research to date on these issues.

Similarly, a parallel de-prioritisation was evident in research on the safe use of anti-Ebola vaccines on pregnant and lactating women, as well as, children. Even now, WHO's own analysis of its 'ring vaccination' approach is lacking in nuance. This common containment strategy is not deployed across a geographically contiguous area. Instead, it is reflective of a patient's social network – including 'contacts' and 'contacts of contacts.' According to the WHO, each 'ring' will typically consist of an average of 150 persons.^{lxxxix} However, there is no further unpacking of whether there are gender-specific variations in the size of 'rings' between women and men. Given what we know of the significant differences in daily mobility patterns – and therefore social networks - of women and men, there are presumably also differences in the ways in which the 'ring vaccination' strategy is implemented. Without further research – or disaggregated and in-depth epidemiological and aetiological analysis of existing data – it is difficult to draw any conclusions at present.

Socio-behavioural and biological vulnerabilities of children:

In addition to adult women, children have been disproportionately affected by EVD. Data from 28 May 2019 shows that the overall fatality rate amongst children under five years old was 77% and 57% for children over five years old.^{xc} These statistics are similar to those observed during the West Africa crisis.^{xcii}

As is the case for all infectious diseases spread through direct contact, children are at higher risk of infection to Ebola. This is because children are subject to greater physical contact with caregivers, and generally have

relatively poorer hand-washing practices.^{xcii} While such behavioural factors partly explain the susceptibility of children to Ebola, it is also important to understand the biologically-related factors. Timely identification of cases amongst children may be hampered by the fact that many early symptoms (fever and fatigue, for example) resemble those of other commonly-found disease in sub-Saharan Africa, including malaria.^{xciii} Delays in diagnosis may mean that children already have a higher viral load and more extensive internal damage to organs by the time they are brought for treatment, potentially resulting in higher probability of fatality.^{xciv}

In May 2019, WHO undertook an in-depth study of child deaths to date looking at Ebola prevalence and fatality rates amongst children under five and under one years old, as well as related health-seeking behaviours of parents and caregivers. Although the organisation claims to periodically conduct 'epidemiological analyses so that data can help reveal any gaps and drive evidence-based response improvements,'^{xcv} its own assessment of children fails to fully consider age or gender. Apart from distinguishing between under 5 and under 1 age categories, there is no further unpacking of the specific vulnerabilities of pre-adolescent or adolescent children. Moreover, there is systematic lack of visibility for gender disaggregation of child cases in WHO's public reporting, presenting instead children as a homogenous group. This is problematic as it makes further analysis of potential intersections between age and gender amongst children impossible.

Although Ebola has been widely mediatised, especially internationally, it is not the only infectious disease outbreak affecting Congolese populations. Humanitarian situation reports show that there have been recent resurgences in preventable diseases across the country. Measles, for example, has been responsible for more deaths than Ebola during the same period.^{xcvi} Children are at particular risk of preventable illnesses – even more so in conflict-afflicted and Ebola-affected Grand Nord Kivu where a number of planned immunisation campaigns have been postponed.^{xcvii} As a result of interrupted vaccination schedules, children in the area have incomplete immunisation cover against diseases like measles and polio.

Conclusions

Designing and delivering an effective response to Ebola is of paramount importance in a country where the disease is endemic. The DRC has already experienced ten outbreaks – it will almost certainly happen again. It is therefore critical that responders heed lessons that are emerging from past and present practice, in order to inform next steps for both the current and any future outbreaks.

The response to EVD today is gender-blind in many respects. There has been little or no attempt to consistently apply a gender lens to not only Ebola prevention and response efforts, but also its transmission. As a result, broader acknowledgement or acceptance of the feminisation of the current Ebola outbreak is lacking. Recommendations have therefore been formulated to enable communities to both address the gendered dimensions of the disease and to 'build back better' – in ways which build preparedness and resilience on a foundation of increased sensitivity to age, gender and disability dynamics. It is hoped that both the research results and recommendations can help inform the updated Strategic Response Plan (SRP 4.1) currently under development, as well as future EVD-related programming interventions in the DRC and elsewhere.

Recommendations

These recommendations stem directly from the findings of the present research, indicating a way forward to ensuring that Ebola crisis management efforts are tailored to the specific and different needs of women, men, boys and girls. They underscore the importance of undertaking a gender analysis and of sharing the results widely. As the crisis unfolds, gender norms, attitudes and expectations will evolve. It is important therefore that gender analysis not be viewed as something static, but rather dynamic – necessitating continual reflection and adaptation to changing needs.

Improve the consistency and visibility of data disaggregation: Targeted responses appropriately tailored to the distinct needs of different segments of the population are only possible when there is evidence to allow for this. Complete and consistent data disaggregation is therefore a cornerstone to effective programming and advocacy. Key actors in the current response continue to issue reports with statistics that eclipse the full picture. The WHO, for example, releases weekly bulletins that do not provide sex disaggregation of either children or healthcare workers affected by Ebola, let alone age disaggregation beyond adult and child. Statistics presented in this way contribute to misperceptions that children are a homogenous group, when in reality girls and boys of varying ages have unique risks, needs and expectations. Similarly, healthcare workers consist of a broad range of roles – some of which may be more predominantly occupied by women than men (such as personnel in charge of cleaning health facilities, for example). Without fuller disaggregation, it is impossible to ascertain whether women in such roles are at greater risk of inadvertent infection. Moreover, disaggregation does not presently include any attempt to capture specificities for pregnant or lactating women, nor people with disabilities – again limiting any possibility of more nuanced analysis and targeted programming. Data disaggregation by age, sex and disability should therefore be systematized during data collection, as well as reporting.

Women are key stakeholders and their role should be front and centre: Prevailing gender dynamics in the DRC have the potential to be exploited for positive outcomes too. Women are not just victims of EVD but can also be at the frontline of the response.^{xcviii} More attention needs to be paid on how to instrumentalise social customs to contain the disease, capitalising on the many and varied roles women play at both household and communal levels. Not only can women be employed as healthcare workers and technical or operational experts, they also fulfil vital functions as social mobilisers and contact tracers. Women are uniquely qualified to take a lead in information management and rumour mitigation, as well as ensuring hygiene in the home. They can also ensure the efficacy and applicability of Risk Communication and Community Engagement (RCCE) interventions.

Male domination of the EVD response infrastructure needs to be redressed through gender-sensitive hiring practices and further protective measures to curtail the use of exploitative recruitment practices. In addition, existing female humanitarian staff – and women in leadership roles at the community level – need to be given more visibility and voice, setting the tone for more diversity in the response.

Women-led civil society organisations, structures and initiatives should also be better engaged. It is these people and partners that represent the key actors who can lead on both preparedness and response in a sustainable way. Commitments made under the Grand Bargain to strengthen partnerships with local actors and to promote the participation of the people most affected must also be respected when addressing Ebola. By supporting women-led efforts, humanitarian agencies can promote greater gender representativity and integration across sectors.

Integrate conflict-sensitive and gender-transformative approaches: Ebola-related interventions must be holistic, integrating and/or reinforcing conflict-sensitive and gender-transformative approaches. Beyond 'do no harm,' conflict-sensitive interventions not only seek to minimise unintended negative consequences, but also maximise positive benefits. In the context of Ebola, this entails understanding the wider context of pervasive gender-based violence, while specifically recognising and addressing opportunities to combat sexual exploitation and abuse within the EVD response itself. Promoting protective measures and mechanisms is an important element, as is identifying entry points for transforming discriminatory norms, attitudes and practices such as working with local opinion leaders (including religious and political figures). Broader community engagement and dialogue are critical components to not just reducing resistance, but also promoting positive change. Efforts to promote gender equality must also adopt tailored engagement approaches with women, men, youth and children for structural and cultural change to take root. This should include understanding their specific needs, fears, and risks. This could encompass analysing any economic, educational, socio-cultural, normative, legislative and/or political barriers or opportunities they may face.

Promote prevention while reinforcing reporting and referral mechanisms for abuse survivors: Dedicated efforts to curtail incidents of economic or sexual exploitation abuse must be strengthened, for example, through improved recruitment processes such Code of Conduct, orientation and training sessions, and reference checks during onboarding of new humanitarian personnel. Parallel efforts to improve awareness amongst community members of the increased risk of exploitation and abuse as well as possible protective measures must also be undertaken, alongside dissemination of information related to reporting incidents, referring cases and submitting complaints. A transparent and strict 'zero tolerance' approach must be adopted by humanitarian organisations when investigating allegations and taking disciplinary actions. Suspected or reported cases must be dealt with systematically as part of a centralised reporting and referral network in the Ebola-affected zone, including a complaints mechanism. Survivors, encompassing children, adolescents and adults of all genders and varying disabilities, must have access to timely and integrated care which includes both immediate and long-term multi-sectoral support including medical, psycho-social, legal and social reintegration services.

Tailor and target EVD-related communication efforts: Initiatives to sensitize communities must analyze and account for the varying degrees of literacy amongst its intended targets. Both the content and means of communication must be adapted to ensure that all segments of the population are able to access, understand and follow key messages and recommendations. Where literacy levels are lower, especially amongst women, images are preferable compared to overly complicated text. However, these images must also be clear, corresponding to reality and not be inadvertently misleading. While radio is a useful and cost-effective tool for mass communication, particularly in rural settings, accessibility may be determined by gender. Therefore, communication initiatives must be comprehensive – for example, by offering programming during both day and evening spots to increase likelihood of fuller coverage. Radio alone should not be entirely relied upon, however, and other means of sensitization must also be employed to reach marginalised groups such as women, children, and people with disabilities.

Redress gender bias in scientific research: Sexual and maternal transmission pathways which differentially affect women, adolescent girls and young babies have not yet been fully researched or analysed. These include further information about virus persistence in seminal fluid in male and breast milk in female Ebola survivors. Where screening of survivors is complicated by insecurity and limited compliance of post-discharge protocols, more scientific research is necessary to fully understand all the programmatic implications.

Encourage and embed child-friendly innovations: Although EVD was not found to significantly influence school enrolment and retention numbers for either girls or boys at a broader level, the disease did have substantive impacts on the individual children who were isolated at Ebola Treatment Centers. Those that were treated and survived, still had to pass through a 21-day convalescence period thereafter. While the experience of Ebola and ETC may have resulted in specific psychosocial support needs, it also meant that children were unable to attend school. It is therefore recommended that the Ministry of Education be encouraged to administer exams at the ETC itself so as to limit the impact of EVD on both girls and boys of school-going age. Children should also be appropriately engaged in reading and writing activities in order to maximize their time in convalescence and minimize any adverse effects on their educational outcomes.

Moreover, some ETCs have now been equipped with nurseries, in order to allow mothers to keep their younger children nearby during their own treatment. This practice should be further systematized across all ETCs,^{xix} alongside full compliance of IPC measures to ensure these (unvaccinated) children do not become inadvertently infected themselves.

Bolster community resilience through key entry points such as schools: Given that Ebola is endemic in the DRC, it is necessary to not only deal with the current crisis but to anticipate future outbreaks by proactively strengthening community resilience. This will enable communities to better protect themselves now and in the future. Schools provide an important entry point into such efforts. Although parents and caregivers may have previously feared sending their children to school due to concerns about possible infection, schools actually furnish critical infrastructural and personnel components to overall Ebola prevention and response. Schools are important community hubs, providing a range of services. Teachers are great amplifiers and influencers. They can be used to convincingly disseminate IPC messages to children and their families.^c They can monitor for signs of EVD and contribute to early detection of symptoms, reinforcing EVD reporting and referral pathways. Teachers and schools also play an important role in the reintegration and psychosocial support of children orphaned by Ebola.^{ci}

More spotlight on inclusive practices and programming: Disability has been another blind spot in the response across almost all sectors and actors. One exception has been attempts to address mental health and psychosocial support needs both during ECT stays and post-discharge. Some agencies have also focused on the specific needs of children who have lost one or both of their parents to Ebola. However, inclusion has yet to be fully integrated across the EVD crisis management infrastructure – leaving one of the most vulnerable groups on the margins.

Annex 1: Data Collection Schedule

Field-based qualitative data collection was conducted by three separate teams of enumerators, each one supervised by a staff member of CARE International. Due to logistic and contextual specificities, each team followed a slightly different schedule, as summarised below:

QUALITATIVE DATA COLLECTION		OCTOBER 2019										
		17	18	19	21	22	23	24	25	26	28	29
BUTEMBOIKATWA	• Training of enumerators	X	X									
	• Pilot testing of field tools for quality assurance			X								
	• Field-based data collection				X	X	X	X				
	• Translation and transcription								X	X	X	X
KAYNA	• Training of enumerators	X	X									
	• Pilot testing of field tools for quality assurance			X								
	• Field-based data collection				X	X		X	X			
	• Translation and transcription						X			X	X	X
MABALAKO	• Training of enumerators	X	X	X								
	• Pilot testing of field tools for quality assurance				X							
	• Field-based data collection					X	X	X	X			
	• Translation and transcription									X	X	X

Annex 2: Qualitative Data Collection Question Guide

Introduction

- ✓ *Qui sommes-nous ?*
- ✓ *Que ferons nous aujourd'hui ensemble et pourquoi ? Que planifions nous faire avec les informations que nous récoltons ? Parler de la confidentialité des données.*
- ✓ *Combien de temps prendra la discussion ?*
- ✓ *Rappeler que certains sujets de discussions peuvent être difficiles à aborder. Ils ne doivent pas avoir l'impression de sentir une pression de parler de leurs expériences personnelles si c'est difficile ou très personnel pour eux si cela semble trop difficile ou bouleversant.*
- ✓ *La confirmation de votre consentement verbal à participer volontairement (consentement/assentiment + enregistrement audio/prise de photo) peut être retiré ou stoppé quand vous le voulez*
- ✓ *Brise-glace ; une activité selon l'âge et pour mettre tous les participants dans le bain*

Discussion Questions

I. Nous cherchons à comprendre qui est plus dans le besoin et quel est le besoin spécifique des femmes, hommes, garçons et filles pendant la crise causée par la MVE.

1. Selon vous, est ce que les femmes, filles, hommes et garçons courent au même niveau le risque de contacter la MVE ? (Note : cette question nous permet de comprendre les perceptions communautaires sur le risque de contamination à la MVE et les potentiels dimensions liées au genre)
2. a. S'il y a une différence, quelles sont ces différences des risques de contamination aujourd'hui entre les hommes, femmes, filles et garçons ?
b. Pensez-vous que dans l'avenir le niveau de risque peut changer pour les femmes, hommes, filles et garçons ? (Note : Quels sont les vulnérabilités auxquelles les femmes/filles/hommes/garçons font face aujourd'hui et quelle pourrait être la situation dans l'avenir ?)

En se basant de ce qui n'a pas été discuté dans les questions générales au-dessus., les questions supplémentaires peuvent être posées sur les secteurs spécifiques :

II. Moyens de subsistance :

1. Comment la MVE a affecté les moyens de subsistance (opportunités économiques) pour les hommes et les femmes ? (Note : Comment pour les personnes vivant avec handicap)
2. a. Avant la MVE qui contrôlait les ressources entre l'homme et la femme au niveau de ménage ?
b. Pendant la crise de la MVE, qui contrôle les ressources entre les hommes et les femmes dans le ménage ?
c. Pourquoi ?
3. a. Comment la MVE influence le temps que des femmes, hommes, filles et garçons passent dans le travail non payant (reproduction et communautaire) ? (Note : Approvisionnement en eau, préparer la nourriture, recherché de bois pour la cuisine, prendre soin des maladies, prendre soin des enfants orphelins de la MVE, laver les habits, préparer les funérailles etc.)

III. Santé/ SSR (santé sexuelle et de reproduction) :

1. a. Quel est l'impact de la crise MVE sur l'accès aux soins des femmes, hommes, filles et garçons ?
b. Quel est l'impact de la crise MVE sur la capacité de différents groupes à suivre les recommandations médicales ? ? (Note : protocole d'hygiène et de sécurité, traitement de complication des grossesses sans se limiter aux avortements à risque, planification familiale, les infections sexuellement transmissible y compris le VIH, épidémies spécifiques causés par la crise)
2. a. Les femmes, hommes, filles et garçons ont-ils toujours confiance aux structures de santé ?
b. Si non, quelles sont les causes ?
3. a. Comment la crise MVE a affecté la fréquentation des femmes, hommes, filles et garçons aux structures de santé.
b. Quel sont les autres le défis (difficultés) spécifiques majeurs auxquels les filles adolescentes et femmes enceintes/allaitantes font face depuis le début de la crise MVE ?
c. Quelles sont les difficultés spécifiques pour les enfants et adultes en situation d'handicap/vivant avec handicap ?

4. a. Quelles croyances, attitudes et pratiques locales influencent la manière dont la santé des femmes/filles et des hommes/garçons est affectée par la crise EVD ? (Sonde : planification familiale, grossesse et accouchement, soins aux malades, élimination des cadavres, lavage des mains, aller chercher de l'eau et utilisation)
5. a. Les femmes et les hommes parlent-ils et/ou reçoivent-ils des informations sur la prévention et la réponse aux EVD

IV. Eau, hygiène et assainissement

1. a. Comment les pratiques d'eau, hygiène et d'assainissement ont changé depuis la crise MVE ?
- b. Y va-t-il une différence entre les hommes, les femmes, les filles et les garçons ?
2. a. Est-ce que les pratiques socio culturelles (normes, coutumes, religions) influencent l'accès à l'information aux femmes, filles, hommes et garçons ?
- b. Le suivi des recommandations relatives aux mesures d'hygiène et de prévention de la MVE ?

V. Éducation :

1. a. Comment la crise MVE a affecté l'accès aux filles et aux garçons à l'école ?
- b. S'il y a des différences d'accès pourquoi ? (Sonde : absentéisme, abandons, insuffisance des enseignants ou fermeture d'école...et voir la différence entre les jeunes écoliers et autres adolescents)
2. Quels sont les conséquences à court terme et dans l'avenir pour les filles et les garçons à ne pas aller à l'école ? (Explorer : augmentation à l'exposition aux abus et exploitation sexuelles/économiques, à l'alcool, à la drogue, augmentation des grossesses des adolescentes/mariages précoces.)

VI. Protection et PSEA :

1. a. Pensez-vous que les femmes, hommes, filles, garçons courent les mêmes risques de protection pendant la crise MVE ? (Sonde : les abus et exploitations sexuelles, les viols, les agressions physiques, être utilisé pour participer dans les manifestations de contestations, tueries, conflits dans la communauté, vols etc.)
- b. Quels sont les risques que courent spécifiquement chaque catégorie ?
2. Quels sont les mécanismes de réponse et de prise en charge de victimes en cas d'abus et exploitation sexuels ?

VII. Nous voulons vous demander comment les femmes, hommes, filles et garçons font face à la crise MVE ?

1. a. Quelles sont les différents mécanismes et stratégies que les femmes, hommes, filles et garçons mettent en place pour faire face à la crise MVE ?
- b. Il y a-t-il une différence dans les stratégies entre les hommes, femmes, filles et garçons ? (Sonde : Exploitation économique/sexuelle des enfants/adolescents non scolarisés, Éviter les centres de santé/prise en charge, Éviter les responsabilités de prise en charge des malades de MVE/préparation des funérailles ?)
2. a. Quelles sont les différentes capacités, opportunités que vous comme hommes, femmes, filles, garçons possédez et mettez à la disposition de la communauté pour contribuer positivement à la prévention /lutte contre la MVE ? (Sonde : gestion des risques et message communautaire/mobilisation et sensibilisation)
- b. Comment la communauté humanitaire peut appuyer ces efforts dans le futur ? comment peut-elle renforcer la confiance en leur appui dans la communauté (Sonde : comment les humanitaires peuvent construire la confiance dans l'appui à la lutte contre la MVE ?)

Conclusion

- ✓ *Rappel de ce à quoi ces informations recueillies vont nous servir.*
- ✓ *Disponibilité pour du soutien supplémentaire, des références et/ou des discussions individuelles avec eux qui ont quelque chose dont ils aimeraient discuter davantage.*
- ✓ *Merci !*

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CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water, basic healthcare and education and create opportunities for people to build a better future for themselves.

We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives.

We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 65 million people around the world.

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^x By 'adult men' it is understood that this does not include those otherwise categorised as 'healthcare workers' which constitutes 5% of Ebola fatalities (and for which no sex disaggregation is publicly available). See: WHO, Ebola Virus Disease, Democratic Republic of Congo: External Situation Report 69/2019 (published 24 November 2019). Available at: <https://www.who.int/emergencies/diseases/ebola/drc-2019/situation-reports>.

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^{xxi} As reported by key informant.

^{xxii} As reported by key informant.

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^{xxxiii} Human Development Report 2019, Inequalities in Human Development in the 21st Century: Democratic Republic of Congo. Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/COD.pdf.

^{xxxiv} Human Development Report 2019, Inequalities in Human Development in the 21st Century: Democratic Republic of Congo. Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/COD.pdf.

^{xxxv} Article 12 of the Constitution of the Democratic Republic of Congo states that "All Congolese are equal before the law and entitled to equal protection under it."

^{xxxvi} Articles 444, 448, 450, 454 and 497 of the Democratic Republic of Congo's original 1987 Family Code stated that a husband is head of the household and a wife must obey him, a wife must obtain her husband's permission to provide a personal service and for all legal actions, a husband determines the family residence, and a husband can assume control over his wife's property.

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^{lxxv} As reported by key informant.

^{lxxvi} As reported by key informant.

^{lxxvii} While it is difficult to accurately assess the number of additional women-headed households as a result of the Ebola crisis, it is assumed that EVD fatalities amongst adult men have resulted in an overall increase in women-headed households. Existing research from

North Kivu shows that female-headed households generally are the poorest – and even more so in rural and semi-urban areas. 61.15% of households headed by women live below the poverty line compared to 54.32% of households headed by men. See: the Alternative report for the Committee on the elimination of all forms of discrimination against women, Report on violence against women in North and South Kivu, in the Democratic Republic of Congo (July 2013): https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/COD/INT_CEDAW_NGO_COD_13432_E.pdf.

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^{lxxxvi} As reported by FGD respondent.

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