



Women's Resilience: Integrating Gender in the Response to Ebola



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Emeka Kúpeski, 2015



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African Development Bank
Immeuble du Centre de commerce International
d'Abidjan CCIA
Avenue Jean-Paul II
01 BP 1387
Abidjan 01, Côte d'Ivoire
Tel.: (+225) 20 26 10 20
Email: d.elhassan@afdb.org
Website: www.afdb.org

Source: AfDB



Geraldine J. Fraser-Moleketi,
*VP & Special Envoy on Gender,
African Development
Bank Group*

In August 2014, the Office of the Special Envoy on Gender received a call from the First Lady of Sierra Leone urging the Bank to integrate the socio-economic recovery of Liberian, Sierra Leonean and Guinean women into our response to the Ebola epidemic. The fact that the African Development Bank's investments in public health systems in these countries were thoroughly gender mainstreamed did not quite bring about the recovery of women on the ground with the immediacy required. Thus, as the premier African development finance institution, it was important for us to think altogether differently so as not to lose the post conflict gains made by men and women in the region.

We commissioned this study to bring to light a topic that has often been discussed but never investigated concretely – did Ebola affect women and men differently? The answer is a resounding yes. We have long suspected that infectious diseases tend to exacerbate the socio-economic vulnerabilities that are present prior to an outbreak, and that knowledge has been confirmed here.

At the height of the epidemic, I visited the three countries affected. I met women and men working tirelessly to eradicate this disease. Countless lives were lost in this battle and the repercussions will be felt for years to come in terms of economic growth. For women, there was, and still is, a danger of reverting to the way things were before.

This is why it was important to ensure a signature project that focused on women's socio-economic recovery post Ebola. The AfDB has created the Post-Ebola Social Investment Fund, with a special emphasis on women and girls. This \$33 million project, which is being implemented in partnership with the governments of Liberia, Sierra Leone and Guinea, as well as the US State Department, and under the auspices of Mano River Union Secretariat, looks to support civil society organizations in the region in their efforts to reinvigorate economic empowerment and enhance the livelihood of women.

This approach highlights our thinking at the AfDB in terms of investing in gender equality for Africa's transformation – whilst mainstreaming is critical, women-focused initiatives are essential to driving real change.

Acknowledgements

The report is the result of a rich and varied collaboration, one that involved staff in most AfDB departments and field offices. The AfDB's Special Envoy on Gender, Geraldine J. Fraser-Moleketi, provided overall guidance, and Dana Elhassan, managed the publication. Chief writer, Robtel Pailey, and data specialist, Derek Powell, prepared the inception report, set up the barometers and compiled the report. Also from the AfDB, Patrick Hettinger, Senior Country Economist, and Sandy Jambawai, Social Sector Expert, gave extra data support.

The Office of the Special Envoy on Gender extends a heartfelt thanks to the President of Liberia, Ellen Johnson Sirleaf, the First Ladies of Sierra Leone, Sia Koroma, and Guinea, Djene Condé, as well as to Finda Koroma. Thanks also to the Ministers of Gender: Julia Duncan-Cassell, Liberia; Mustapha Attila, Sierra Leone; and Hadja Diakité, Guinea Conakry, who mobilized advocacy efforts for a gendered approach to post-EVD recovery efforts.

On operationalising this study and pushing for an approved project in the region, a special word of gratitude also goes out to the Resident Representative of Liberia, Margaret Kilo, and Manager of Transition States, Yero Baldeh. AfDB Gender Specialist Amel Hamza, and Director of Human Department, Sunita Pitamber and her team, Caroline Jehu-Appiah & Budali Issahaku.

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Acronyms and Abbreviations

AfDB	African Development Bank
ANC	Antenatal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DRC	Democratic Republic of the Congo
DHS	Demographic Health Survey
ETUs	Ebola Treatment Units
EVD	Ebola Virus Disease
ELWA	Eternal Love Winning Africa
FAO	Food and Agriculture Organisation
FHI	Free Healthcare Initiative
GBV	Gender Based Violence
GII	Gender Inequality Index
GoSL	Government of Sierra Leone
HCWs	Health Care Workers
IFC	International Finance Corporation
MRU	Mano River Union
NPR	National Public Radio
PPE	Personal Protective Equipment
PNC	Postnatal Care
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Executive summary

According to a 2007 World Health Organisation (WHO) report, infectious diseases tend to unmask already entrenched gender disparities in societies struggling to cope with them. When the Ebola Virus Disease (EVD) struck Guinea, Liberia, and Sierra Leone in 2014, they were ill-prepared for a massive healthcare crisis. The breakdown of pre-existing weak healthcare systems and near economic collapse across the three countries further exposed women's socio-economic vulnerabilities.

On August 14, the Washington Post reported that across Guinea, Liberia, and Sierra Leone, collectively 55 to 60 % of those dead were women. Although there is a dearth of evidence-based reporting on multifaceted implications of EVD for women in Guinea, Liberia and Sierra Leone, there is also sufficient anecdotal evidence to indicate that they have been disproportionately impacted by the outbreak. The reduction in health services has increased maternal, infant, and child mortality rates. According to reports across the three countries, women farmers, marketers, and cross-border traders have lost their livelihoods due to declines in agricultural productivity, imposed quarantine measures, and closed borders. Women employed in the private sector across the sub-region are in hospitality/food service, insurance, air-transport, and shipping, sectors that have been severely hit by the Ebola virus. In addition to a loss of livelihoods, women have had limited access to healthcare services, and have been overburdened by their roles as caregivers in the home. While women have spent countless hours tending to the sick, they have exposed themselves to contagion and disengaged from productive work to sustain livelihoods.

For the purposes of this report, particular attention is paid to women's labour force participation (or lack thereof), as well as their access to financial services, land tenure, healthcare, and decision-making in both the home and nation. This report suggests that the EVD crisis in Guinea, Liberia and Sierra Leone has most likely impacted women in the following ways: i) increased infection rates among women because of their traditional roles as caregivers, cross-border traders, and marketers; ii) compromised the livelihoods of women marketers due to the closure of community and national markets; iii) compromised the livelihoods of women who dominate the agricultural, retail trade, hospitality and tourism sectors; iv) stigmatised women who work in hospitals and Ebola Treatment Units (ETUs); v) barred widows from accessing their deceased husband's land because of discriminatory inheritance laws; vi) increased abuse, sexual and gender-based violence because of the pressures of EVD, as well as reduced access to justice mechanisms; and vii) reduced the number of women accessing health care, including reproductive, child, and pregnancy related health services due to the closure of facilities across the three countries. Women who fall within special categories of vulnerable groups, such as (mentally and physically) disabled or elderly women, will more than likely have been doubly or even triply impacted.

AfDB research indicates that:

- It is impossible to build resilience to Ebola and future infectious disease shocks in households and communities without also addressing systemic gender inequality. Factors that entrench vulnerability for the entire population must be addressed in the immediate response, medium- mitigation and long-term intervention.
- Gender effects of Ebola in the region are influenced by the skills and strategies used prior to the outbreak, and the mechanisms individuals used to cope and adapt **differ**. Gender-differentiated coping mechanisms often have both direct and indirect consequences that place individuals and their households at greater risk to future shocks such as food crisis.
- **The lack of gender disaggregated data should not limit interventions** and all efforts must be expended in order to collect the relevant information to combat this disease now. These insights may not only be of value in dealing with other epidemics but also prevent further outbreaks.

Just as macro-economic indicators attributed to Ebola are speculative at best, a comprehensive analysis about the socio-economic implications of EVD on women cannot be pursued in totality until the three Mano River Union countries are declared Ebola-free.

AfDB recommendations

To adequately integrate gender in the response to Ebola, AfDB recommends that:

- A **regional Social Investment Fund is established** in order to mitigate the economic losses of women during the pandemic and to position them for economic recovery and eventually, economic empowerment in the aftermath of the pandemic. As the AfDB Special Envoy of Gender, Mrs Geraldine Fraser-Moleketi indicated, "...the affected economies need to ensure that women are empowered to help them rebuild [as the] current nature of the on-going Ebola outbreak requires an increasingly multi-disciplinary approach to provide an integrated response"¹. The needs of women farmers, cross border traders, SME owners must be addressed so as to bolster their resilience.
- **Research is commissioned to conduct cross-country quantitative and qualitative analyses** on the socio-economic impact of EVD on women, in order to inform policy decisions about how to mitigate challenges post-Ebola.
- As part of preparedness, greater partnership is needed among donors to contribute towards **reducing the infrastructure gap** which contributed to the slowed response
- For long-term interventions, **post-Ebola governments should establish bilateral scholarships specifically tailored for women healthcare workers** who want to specialise in epidemiology, public health, infectious diseases, or who want to be trained as medical doctors.

¹ www.afdb.org/en/blogs/measuring-the-pulse-of-economic-transformation-in-west-africa/post/ebola-the-need-for-a-gendered-approach-13472

Introduction and Background

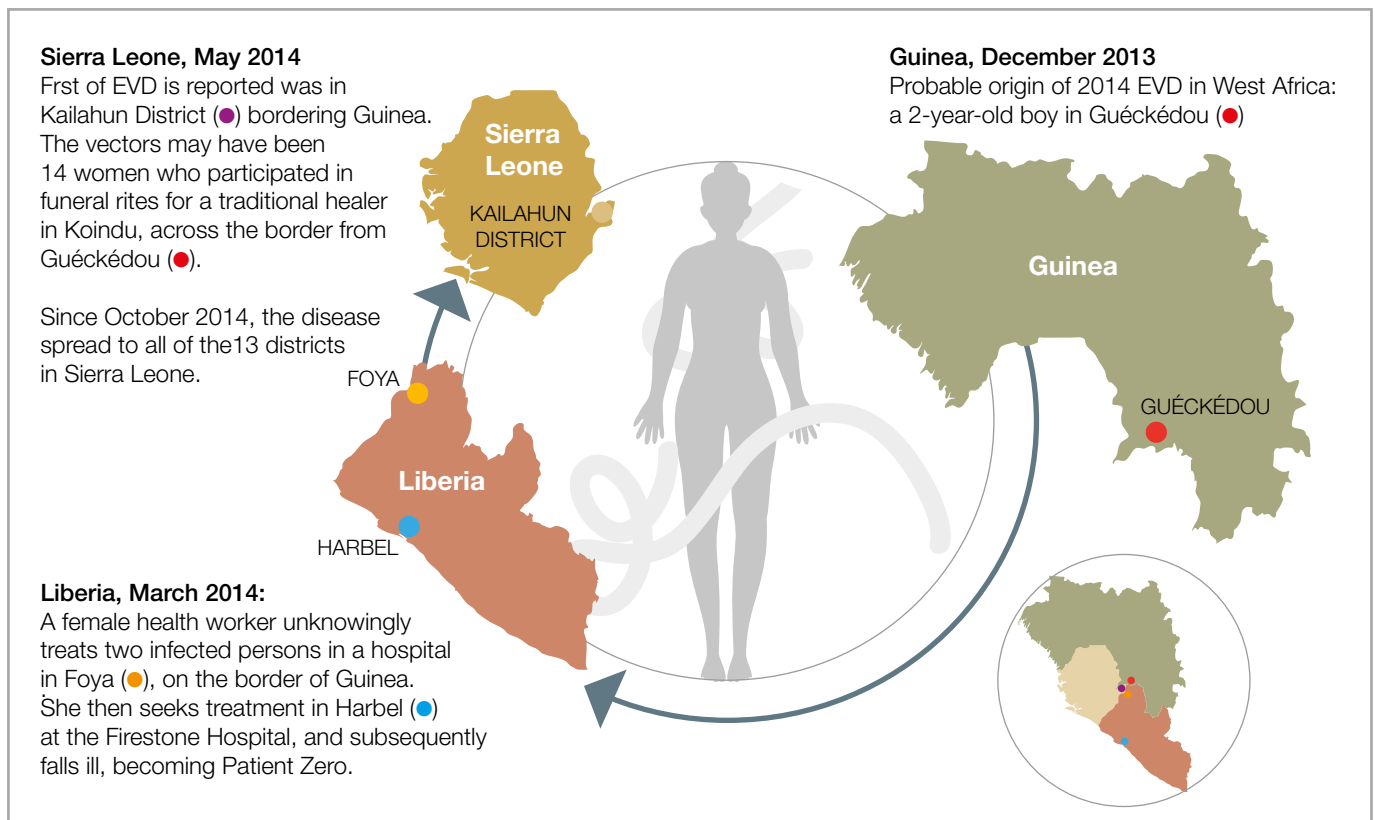
Despite having recently recovered from protracted armed conflict and regional political instability, Guinea, Liberia and Sierra Leone “remain extremely fragile, with low per capita incomes, low levels of human development, high gender inequalities, and a relatively high disease burden.”² According to the 2014 African Economic Outlook, 55.2 percent, 57 percent, and 53 percent of Guineans, Liberians and Sierra Leoneans, respectively, live below the national poverty line. Lacking strong healthcare systems and sufficient personnel trained in infectious diseases, the three Mano River Union (MRU) countries were the perfect breeding ground for Ebola to spin wildly out of control.

Liberia, Guinea and Sierra-Leone, in spite of recent progress in economic and political terms, remain extremely fragile, with low per capita incomes, low levels of human development, high gender inequalities, and a relatively high disease burden. In socio-economic terms, the most devastating impact of the EVD is the negative impacts on livelihoods—in both urban and rural areas. Households directly affected suffer immensely, as the disease is capable of

wiping out whole families. However, the disease, by disrupting the entire economic framework, has important indirect or second round effects on communities and the whole country.

The Ebola epidemic continues to cripple the economies of Guinea, Liberia, and Sierra Leone. Since mid-2014 all three economies have seen flat or negative income growth (and large resulting fiscal needs). All three were growing briskly in the first half of 2014. But full-year 2014 growth in Guinea collapsed to an estimated 0.5 percent from a rate of 4.5 percent expected before the crisis. Full-year growth for 2014 in Liberia fell by more than half to an estimated 2.2 percent from 5.9 percent expected before the crisis. Full-year 2014 growth in Sierra Leone fell by more than half to 4.0 percent from 11.3 percent expected before the crisis. All three of these rates imply shrinking economies in the second half of 2014. The total fiscal impact felt by the three countries in 2014 was over half a billion dollars, nearly 5 percent of their combined GDP. Second-round effects and investor aversion make 2015 growth estimates sober: -0.2 percent in

Figure 1.
Women’s involvement in the evolution of the Ebola virus



² Brief entitled “Impact of the Ebola Disease: Short, Medium and Long-term Perspectives” by staff of the African Development Bank (AfDB), Abidjan, October 2, 2014.



Source: CERD, AfDB

Guinea, 3.0 percent in Liberia, -2.0 percent in Sierra Leone (down from pre-Ebola estimates of 4.3 percent, 6.8 percent, and 8.9 percent, respectively: Figure 1). These projections imply forgone income across the three countries in 2015 of about \$1.6 billion (about \$500 million for Guinea, \$200 million for Liberia, and \$900 billion for Sierra Leone: Table 1), more than 12 percent of their combined GDP³.

According to a report⁴ in the *New England Journal of Medicine*, the 2014 Ebola Virus Disease (EVD) in West Africa may have originated from a 2-year-old boy in the town of Guéckédou, Guinea, in December 2013. It is suspected that the virus spread further when a female health worker unknowingly treated two infected persons in a hospital in Foya, Lofa County, on the border of Guinea, in March 2014. She then travelled to Harbel in Margibi County to seek treatment at the Firestone Hospital, subsequently falling ill. This woman became Liberia's patient zero, the first reported EVD case in the country. Across the border in Sierra Leone, the first reported case of EVD was in May 2014 in Kailahun District bordering Guinea, and the vectors may have been fourteen women⁵ who participated in funeral rites for a traditional healer in Koindu, a diamond-mining town across the border from Guéckédou. Since October 2014, the disease spread to all of the country's thirteen districts.

It is unsurprising that women signify central figures in this most recent Ebola narratives. In Muslim burial practices across the sub-region, women prepare corpses for funerals although there is little to no empirical evidence proving a correlation between burial practices and increased EVD transmission rates. Women are also disproportionately the caregivers in homes across the MRU. They represent the largest share of marketers, cross-border traders, and small-scale farmers. Similarly, women dominate the healthcare sector, primarily as nurses, midwives and traditional birth attendants, although statistics on the number of female nurses in the three most affected countries could not be found at the time of writing this report. The quarantine of markets and residential areas, or restrictions of movement, as measures to stop the spread of EVD, have also devastated income generation—especially in the informal sector, where female household heads and other women predominate.

...examining who is most adversely impacted by infectious diseases “shows you who has power and who doesn’t. In a way, it holds a mirror to society. And it shows societies how they treat each other.”

³ The Economic Impact of Ebola on Sub-Saharan Africa: Updated Estimates for 2015 – WB prepared for the World Economic Forum 2015.

⁴ www.nejm.org/doi/pdf/10.1056/NEJMoa1404505

⁵ www.nytimes.com/2014/08/29/health/ebola-outbreak-in-sierra-leone-is-tied-to-one-funeral.html

It is clear that infectious disease outbreaks tend to expose already entrenched disparities and inequalities within national populations, particularly with respect to gender. According to a Foreign Policy Magazine article⁶ published in August 2014, Columbia University epidemiology professor Wafaa El-Sadr argues that examining who is most adversely impacted by infectious diseases "... shows you who has power and who doesn't. In a way, it holds a mirror to society. And it shows societies how they treat each other." Indeed, the 2014 Ebola outbreak in Guinea, Liberia, and Sierra Leone may have exacerbated women's socio-economic vulnerabilities, though apart from a few isolated empirical studies conducted to date evidence of this is generally anecdotal. For instance, Liberia's Minister of Gender, Children and Social Protection, Julia Duncan-Cassell, has been particularly vocal by illustrating the nature of women's disease burden:

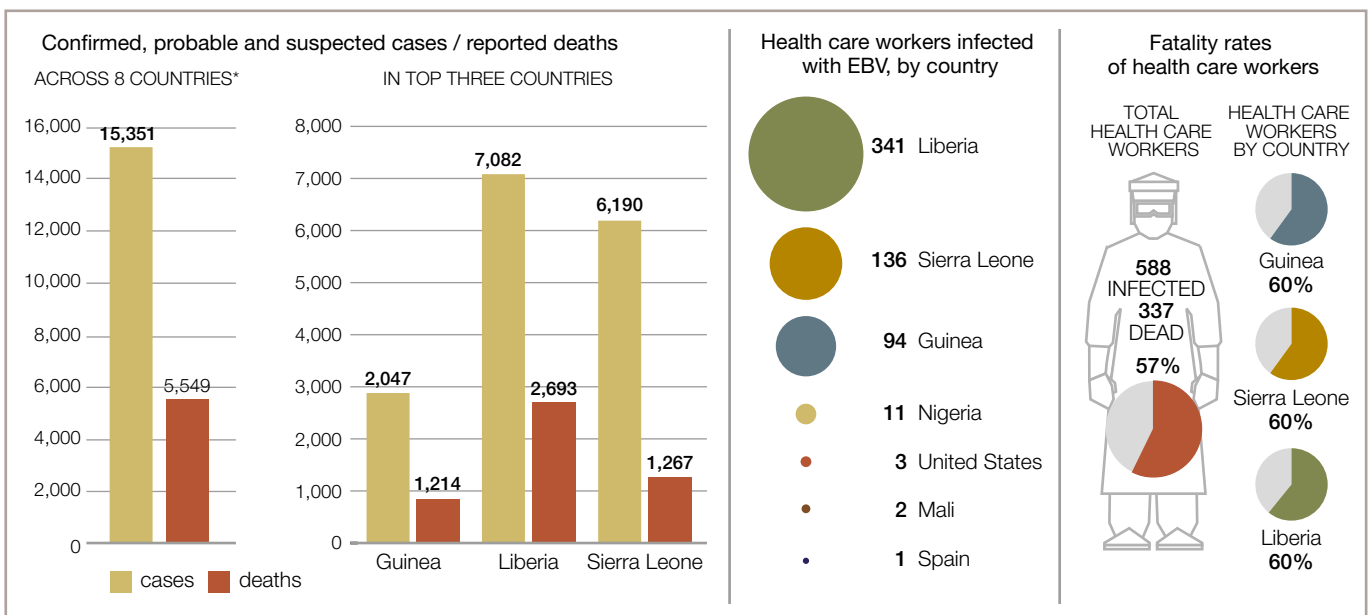
"At the beginning of the outbreak [in Liberia], 65 percent of those infected were women. That's now reduced slightly. Women are losing their husbands, they are losing their sons and their daughters. Women are often both caregivers and breadwinners. They go to the market, they do farming. Most nurses in Liberia are female. Directly or indirectly, they are taking the brunt of this".⁷

Duncan-Cassell's appeal not only emphasises the need for gendered analysis, but also for data accuracy and reliability. Some have argued that the psycho-social trauma has been so enormous that the toll from Ebola might become heavier than the toll of armed conflict.

In the same way that there had been limited to no research on finding a cure for Ebola in its 40-year life cycle before this latest outbreak, and comprehensive qualitative and quantitative studies⁸ on the impact of EVD on women are yet to be pursued. Indeed, tailored interventions to address gender dimensions have been lacking, with only few of the recent interventions by the international community mainstreaming gender.

On the 28th August 2014, the AfDB Special Envoy on Gender, Geraldine Fraser-Moleketi, received requests from the MRU countries of Guinea, Liberia and Sierra Leone to advocate and champion the gender agenda during the many interventions planned in the countries. This preliminary report assesses the socio-economic impact of EVD on women providing empirical evidence to support the African Development Bank's establishment of an MRU Social Investment Fund for Women. Intended to restore and improve the socio-economic and political status and capacity of women in the three countries most affected

Figure 2.
EVD infections / fatalities, as of November 2014



⁶ www.foreignpolicy.com/articles/2014/08/20/why_are_so_many_women_dying_from_ebola?wp_login_redirect=0

⁷ www.eboladeeply.org/articles/2014/10/6411/ebola-women-julia-duncan-cassell-liberias-minister-gender

⁸ Although an example of ground breaking analysis, Martha Anker's 2007 WHO report entitled "Addressing Sex and Gender in Epidemic-Prone Infectious Diseases" does not focus solely on Ebola: www.who.int/csr/resources/publications/SexGenderInfectDis.pdf?ua=1

by EVD, this Fund will: i) strengthen the livelihoods of rural farmers, rural micro- and small-scale entrepreneurs and cross-border traders; ii) provide social protection for women and other vulnerable groups; (iii) establish an infectious disease protocol and handbook for maternal and child health care centres to minimise the risk of infection and provide psycho-social counselling to those most impacted; and (iv) support access to safe and sanitised facilities and infrastructure in border communities affected by EVD to recover agricultural, agri-business and small business activities.

The findings of this report suggest that without clearly defined, reliable and verifiable disaggregated data on the actual number of women EVD infections/fatalities in Guinea, Liberia and Sierra Leone; survey data collected from women heads of households, marketers, farmers, health-care practitioners, cross-border traders, etc.; and qualitative interviews with women based on snowball sampling, it is nearly impossible to provide a comprehensive analysis of the socio-economic implications of EVD on women in the three MRU epicentres. Nevertheless, previous EVD outbreaks in Uganda and the Democratic Republic of the Congo support some of the assumptions about how women may be disproportionately impacted by the current outbreak. For instance, in the Gulu district of Uganda during the 2000-2001 Ebola epidemic, the infection rate amongst women outpaced⁹ that of men.

EPIDEMIOLOGICAL OUTLOOK

Since October 2014 there have been major improvements in Ebola transmission rates in Guinea, Liberia, and Sierra Leone. These improvements have come from better awareness of correct sanitary procedures among populations, earlier case diagnosis, and increased availability of care within Ebola treatment units (ETUs). The expected spread of any potential outbreak of Ebola beyond Guinea, Liberia, and Sierra Leone is now lower and so, therefore, are the likely economic effects of such a spread.

As of 21 November 2014¹⁰, a total 15,351 confirmed, probable and suspected cases and 5,459 deaths have been reported across eight countries—namely Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Spain and the United States. Guinea, Liberia and Sierra Leone have had the most intense and widespread transmissions, with 2047, 7082, and 6190 respectively, as confirmed, probable and

suspected cases. Additionally, the three countries have also reported 1214 (Guinea), 2963 (Liberia), and 1267 (Sierra Leone) cumulative deaths. A total 588 health care workers (HCWs) have been infected with the virus—94 in Guinea; 341 in Liberia; 2 in Mali; 11 in Nigeria; 136 in Sierra Leone; 1 in Spain; and 3 in the United States (2 were infected in the US and 1 in Guinea). A total 337 HCWs have died. As of December 2014, the fatality rates in the three Ebola epicentres were 60 percent in both Guinea and Sierra Leone and 61 percent in Liberia.

Most troubling about data reported thus far is that confirmed, probable, and suspected infections and fatalities are not disaggregated. Also concerning is that reliable epidemiological statistics disaggregated by gender is difficult to access although Guinea has provided concrete data in this regard. According to the Ministry of Health, as of November 25 Guinean women accounted for 51 percent, 60 percent and 58 percent of the confirmed, probable and suspected cases of EVD, respectively. This means that out of the total 2047 cases, women have been particularly affected.

Apart from Guinea's preliminary statistics, it is very likely that gendered disaggregated data across all three MRU countries may not be forthcoming until EVD is fully contained. The need for reliable data cannot be overemphasised, as some figures on women have tended to contradict one another. At one point during the outbreak, the Liberian Ministry of Gender estimated that 75 percent of the confirmed, probable and suspected cases of Ebola were women, while Ministry of Health and Social Welfare figures appeared more conservative. Despite the paucity of gender-disaggregated data, however, anecdotal evidence suggests that there is a strong likelihood that women in all three countries having been disproportionately impacted by the virus.

In order to evaluate the extent to which women's socio-economic positions have been impacted by Ebola, it is first important to assess the status of women in Guinea, Liberia and Sierra Leone prior to the Ebola outbreak as a baseline. Although all three countries have explicitly ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), this initial framing will enable a discussion further, about how Ebola has reversed some of the gains made in improving the lives of women while also enhancing their socio-economic vulnerabilities.

⁹ www.ncbi.nlm.nih.gov/pubmed/12460399

¹⁰ WHO, "Ebola Response Roadmap Situation Report Update", November 21, 2014. Data is based on information reported by the ministries of health in Guinea and Sierra Leone up to November 18 and the Ministry of Health and Social Welfare in Liberia up to November 17.

Women before Ebola

All the three countries are in the last quintile of the Human Development Index, with scores that have been below the Sub-Saharan average since 2000. Their low rank on this index is also reflected at a more micro level in the very poor performance with respect to measures associated with gender inequality. For a bird's-eye view of the socio-economic status of women in Guinea, Liberia and Sierra Leone pre-Ebola, one only has to look at the latest Gender Inequality Index (GII) for the three countries in 2013¹¹, in which 152 countries were ranked. The GI is a measurement of gender-based inequalities in three categories: reproductive health, empowerment and economic activity. While reproductive health indicators measure maternal mortality and adolescent birth rates, empowerment is measured by the number of parliamentary seats held by women and the attainment of secondary and higher education. Economic activity is measured by women's and men's labour market participation.

Guinea's GI and rank were not recorded in 2013. Neither the percentage of adult men/women with at least a secondary education nor the percentage of women in parliament was recorded. Pre-Ebola women's participation in the labour force was 65 percent, compared to 78 percent for men. Guinea recorded lower maternal mortality rates than both Liberia and Sierra Leone. For every 100,000 live births, 610 women died from pregnancy related complications. Estimated female-headed households (FHH) are 17.3% in Guinea¹².

Liberia's GI in 2013 was 0.655, thereby ranking it below Sierra Leone at 145 out of 152 countries. This means that there was a 65.5 percent loss in human development because of entrenched inequalities between men and women in the country. While 11.7 percent of legislative seats were held by women pre-Ebola, 15.7 percent of adult women had obtained at least a secondary education compared to 39.2 percent men (slightly higher than Sierra Leone). Pre-Ebola women's

participation in the labour force was 58.2 percent, compared to 64.7 percent for men. For every 100,000 live births, 770 women died from pregnancy related complications, slightly better than Sierra Leone yet worse than Guinea. The number of FHHs are 30% in Liberia¹³.

Sierra Leone's GI in 2013 was 0.643, thereby ranking it 141 out of 152 countries. This means that there was a 64.3 percent loss in human development because of entrenched inequalities between men and women in the country. While 12.4 percent of parliamentary seats were held by women pre-Ebola epidemic, only 9.5 percent of adult women had obtained at least a secondary education, compared to 20.4 percent men. Pre-Ebola epidemic women's participation in the labour force was approximately 65.7 percent, compared to 68.9 percent for men. And for every 100,000 live births, 890 women died from pregnancy related complications. FHHs are recorded at 30%¹⁴ in Sierra Leone⁵.

In the sections that follow, the socio-economic status of women in the three countries prior to the Ebola epidemic is presented in varying detail, largely dependent on data obtained during the writing of this report. The section on Guinea is the least comprehensive, largely due to the paucity of gender-disaggregated data available.

GUINEA

Women's labour force participation in Guinea was approximately 64 percent in 2005 and 65 percent in 2010 and 2012, respectively.¹⁶ According to the government's 2013 report on CEDAW, the vast majority of women work in the informal sector, particularly as market vendors, subsistence farmers, or agricultural workers. Women account for only 10 percent of formal sector work, and are primarily concentrated in agriculture, retail, catering, hospitality, and to a lesser extent the

Table 1.
Gender Inequality: Liberia, Guinea and Sierra-Leone

Country	Maternal mortality (deaths per 100k live births)	Share of women in parliament (%)	Female/Male population aged 25+ with at least some education	Female/Male labor participation rates (%)	Female Headed Households (%)
Liberia	770	11.7	15.7/39.2	58.2/64.7	30.0
Guinea	610	-	-	65.0/78.0	17.3
Sierra Leone	890	12.4	9.5/20.4	65.7/68.9	30.0
Sub-Saharan Africa	474	21.7	21.9/31.9	63.7/76.3	

Source: UNDP, Human Development Report, 2014.

¹¹ <http://hdr.undp.org/en/content/table-4-gender-inequality-index>

¹² World Bank 2011, <http://data.worldbank.org/indicator/SP.HOU.FEMA.ZS>

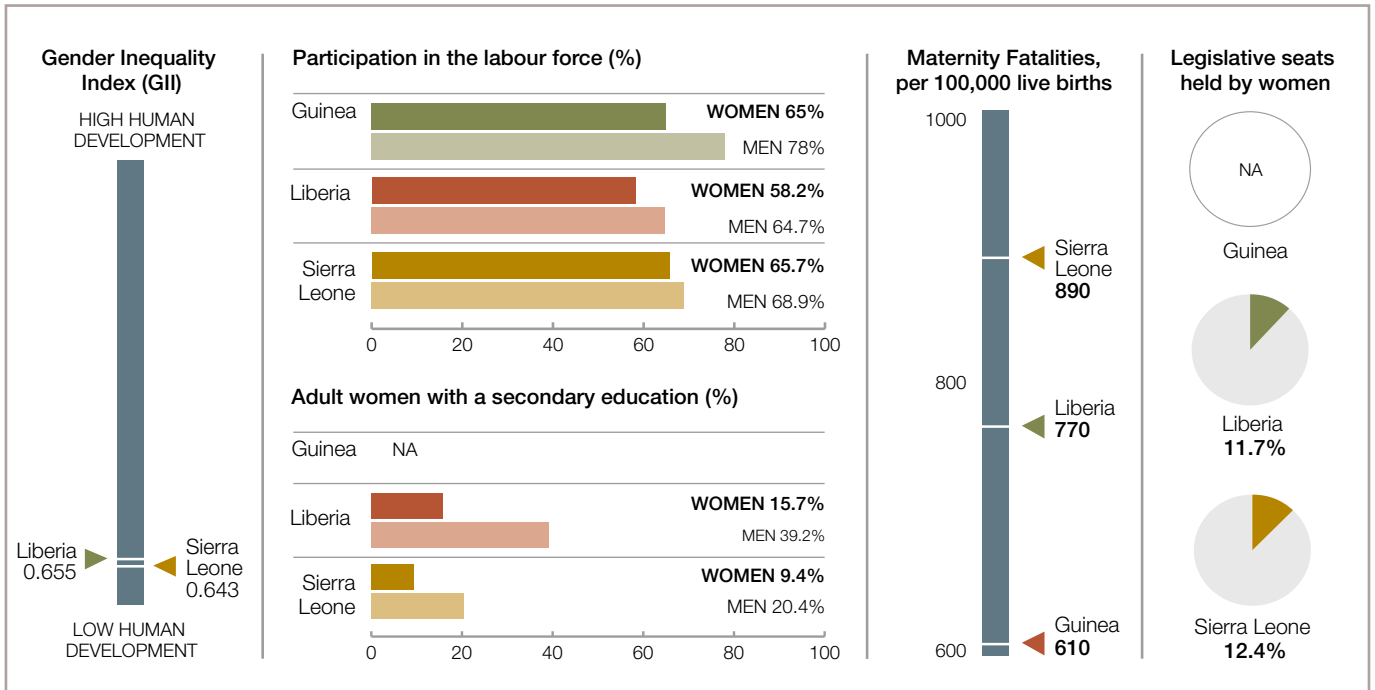
¹³ Indexmundi 2009 www.indexmundi.com/facts/liberia/female-headed-households

¹⁴ Indexmundi 2009 www.indexmundi.com/facts/liberia/female-headed-households

¹⁵ ICPD 2008 Country implementation profile

¹⁶ World Statistic Pocketbook Country Profile for Guinea: <https://data.un.org/CountryProfile.aspx?cname=Guinea>

Figure 3.
Pre-Ebola: Women in Guinea, Liberia and Sierra Leone



within the extractives industries. Seventy percent of Guinean women live in rural areas, where, based on customary law, they cannot inherit land. This severely limits their access to credit because collateral remains a pre-requisite for loans. Furthermore, women can be subjected to humiliating widowhood practices if accused of being the cause of death of a husband.

Guinea established a “Health for All Initiative” giving women wider access to pregnancy and post-natal services, revitalised women’s health cooperatives (called MURIGA), and embarked on an initiative to re-train women who practice female circumcision to provide them with alternative livelihoods. Yet, Guinea still has high maternal mortality rates, insufficient pre-natal care, and poor obstetric care where 75 percent of births occur without a trained professional. Contraception prevalence between 2006 and 2012 was only 9 percent, and the fertility rate between 2010-2015 (total live births per woman) has been 5 consistently.

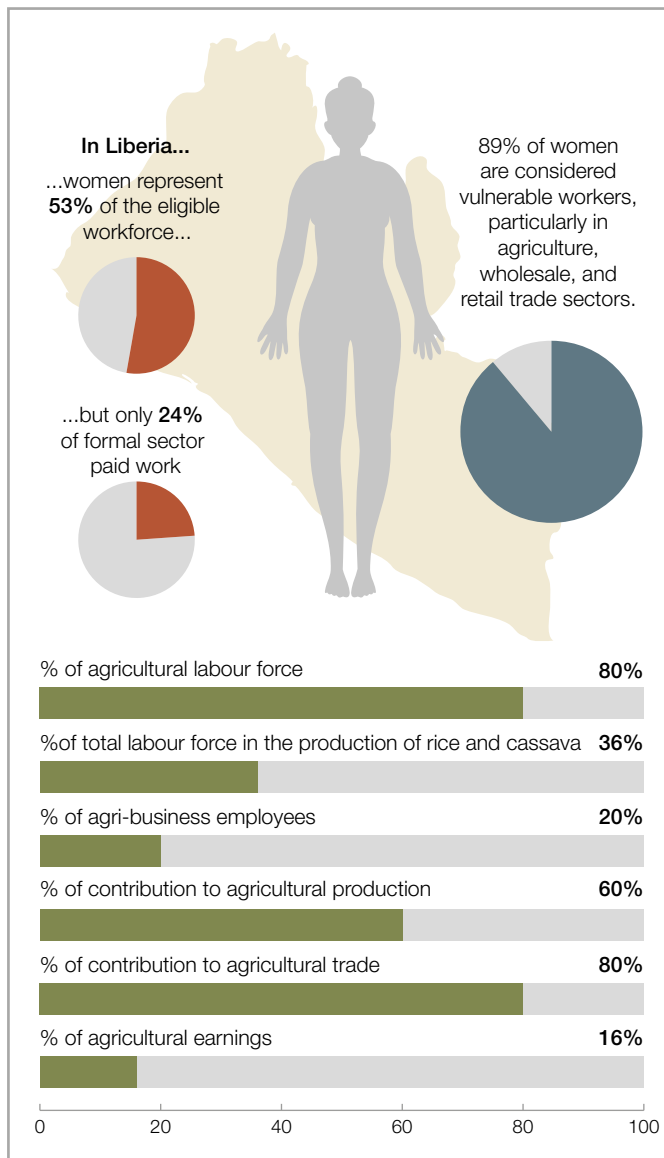
Guinea has a National Policy for the Advancement of Women that was revised in 2006, a National Policy on Gender 2011, and a National Strategy on Gender-based Violence, all of which have an expressed mandate to improve the socio-economic position of women. Guinea, like Liberia and Sierra Leone, ratified the Protocol on the Rights of Women in Africa in 2004.

As of January 2013, women represented only 22 percent of positions in Guinea’s high-level decision-making bodies such as the National Transition Council, Supreme Court, Independent National Electoral Commission, Economic and Social Council, and National and Communication Council. Furthermore, only seven out of 36 government ministers and three out of 38 mayors were women.

LIBERIA

Although Liberia has adopted a number of key policies to enhance the status of women—namely, the Gender Equity in Politics Act—mandating that women occupy at least 30 percent of the leadership of political parties; the Sexual and Gender-Based Violence Action Plan; the National Gender Policy; the National Action Plan on the Implementation of United Nations Security Council Resolutions 1325 and 1820; and the amended Customary Marriage Law of 1998, which provides equal inheritance rights to women married under both customary and statutory laws—its 2013 Report on CEDAW states: “Liberian women are marginalised in all sectors and at all levels.” In 2014, women comprised only 11 percent of the national legislature, with nine representatives and five senators out of a total 108. Liberia also has two women out of five judges of the Supreme Court.

Figure 4.
Liberian women in the work force



The marginalisation of Liberian women is particularly stark in their economic positioning. In a country where 60 percent of the population relies on agriculture for their livelihoods, Liberian women are deeply entrenched in this sector. In 2010 alone, 68.8 percent of all economically active women were farmers, weeding, harvesting and processing most cash crops. They represent 80 percent of the agricultural labour force; 36 percent of the total labour force in the production of rice and cassava, Liberia's staple crops; and 20 percent of agri-business employees. Despite being the backbone of the Liberian economy—contributing to 60 percent and 80 percent of agricultural production and trade, respectively—women only generate 16 percent of agricultural earnings, which are primarily controlled by men.

Between 2005 and 2012, women's labour force participation was approximately 58 percent.¹⁷ According to Liberia's 2010 Labour Force Survey, women represent 53 percent of the eligible workforce, but only constitute 24 percent of formal sector paid work. With 68 percent of Liberia's population engaged in informal work and 79 percent in 'vulnerable employment', 89 percent of women are considered vulnerable workers, particularly in the agricultural, wholesale and retail trade sectors. Market women have become particularly visible during the two administrations of Liberian president Ellen Johnson Sirleaf. The Sirleaf Market Women's Fund, for instance, has actively provided rehabilitated market infrastructure, skills training, and financial assets to market women throughout the country through their fundraising efforts in Liberia and abroad. Yet, women's earning power is generally lower than men's, regardless of their educational attainment. Moreover, their low share of paid employment is not based on the lack of skills acquisition, but rather on deeply entrenched gender inequalities.

With respect to land ownership, Liberia's customary tenure practices are similar to most patrilineal societies where women have usage rights to nuclear family land and upon marriage the right to cultivate her husband's land. Upon the death of a husband, however, if a Liberian woman does not have children with the deceased and decides not to marry his male relation, she loses all claims to his land. The implementation of inheritance provisions within the Customary Marriage Law of 1998 has stalled because of resistance from men in certain communities. The 2003 Inheritance Law grants women married under customary law the same inheritance rights as those married under statutory law, but implementation remains a challenge. Although the land accessibility gap between female and male-headed households has decreased from 12 percent to 4 percent, women owned only 16 percent of land compared to 33 percent of men in 2006. Furthermore, 11 percent of women compared to 20 percent of men held title deeds to property. A 2008 study on women's pre- and post-war land ownership in four of Liberia's subdivisions (counties) showed a decrease in both communal and customary rights from 15.4 percent to 10 percent and 59.8 percent to 57.5 percent, respectively. Given that secure land tenure for women is the only means of enabling female farmers to move beyond subsistence agriculture, the administration of land requires a complete overhaul. The Land Commission was established in 2009 to do just that.

Liberia has instituted other measures, particularly in the health sector, to improve the condition of women. Access to skilled maternal care during delivery increased from 65 percent in 2010 to 80 percent in 2012, and, according to

¹⁷ World Statistic Pocketbook Country Profile for Liberia: <https://data.un.org/CountryProfile.aspx?crname=Liberia>

the Demographic Health Survey (DHS) of 2007, eight in 10 mothers reported receiving pre-natal care from a trained health professional. This is primarily why maternal mortality decreased drastically from 994 in 2000 to 770 in 2012 per every 100,000 live births. In 2012, 87 percent of the first antenatal clinic visits were reportedly attended by a skilled professional. Nevertheless, contraception prevalence between 2006 and 2012 was low at 11 percent and the fertility rate¹⁸ between 2010-2015 has been consistently high at 5 percent. According to Liberia's 2007 DHS, 58.2 percent of women—39 percent urban and 72 percent rural—underwent female circumcision, although the practice has been subsequently banned in the country.

SIERRA LEONE

Like Liberia, Sierra Leone has adopted a number of policy measures to improve the conditions of women, such as the National Policy on the Advancement of Women and the National Gender Mainstreaming Policy. In 2007, "Gender Justice Laws" were instituted in succession, namely, the Domestic Violence Act; the Registration of Customary Marriage and Divorce Act; the Devolution of Estates Act and the Sexual Offences Act of 2012. To anchor these laws in practice, the Government of Sierra Leone (GoSL) devised national action plans including the National Gender Strategic Plan (2010-2013); the new Ministry of Social Welfare, Gender and Children's Affairs Strategic Plan (2013-2018); the Sierra Leone National Action on UNSCR 1325 and 1820 (2010-2014); the National Action Plan on GBV (2012) and National Referral Protocol on GBV (2012).

Although women's rights are stipulated in policy pronouncements, the practice of women's empowerment is more tenuous. During the 2012 elections, for instance, only 16 out of 65 women vying for parliamentary seats were elected, falling below 13.7 percent in the 2007 parliament. At the district level, there has been some improvement in the number of female local council members elected, at 18 percent representation. At the executive level, nine women were appointed ministers although only two have cabinet ranking. Despite women comprising 53 percent of the population in Sierra Leone, their share of political power is negligible. Nonetheless, there are slight indicators of economic advancement. Between 2003 and 2011, female-headed households were doing relatively better than male-headed households. For instance, the percentage of female-headed households living below

the poverty line decreased, from 59.8 percent (compared to 61.3 percent male-headed households) to 43.8 percent (compared to 47.5 percent male-headed households).

Although Sierra Leone has a Draft Land and Devolution of Estate Bill, land tenure administration for women varies from region to region. In the North and Western areas, for instance, women can own land whereas in the South and Eastern areas women can only access the land of their male relatives. In the South and East, widows or divorcees are particularly vulnerable, as they cannot claim land owned by a deceased husband or former spouse. If they return to their nuclear family, they are only entitled to cultivate the land of a male relative. Similar to Guinea and Liberia, the patrilineal land tenure administration pre-dominates in Sierra Leone where customary law often supersedes statutory law.

Similarly entrenched inequalities confront women in the labour market. Women's labour force participation¹⁹ was approximately 65 percent in 2005 and 66 percent in 2010 and 2012, respectively. According to a 2008 economic survey, women represented 17 percent of the formal private sector labour force, with hospitality (hotels/restaurants), (34 percent), insurance (33 percent), air transport (28 percent), shipping (23 percent), and foreign exchange (22 percent) among the top five. The numbers are more pronounced in the informal sector, with 84 percent of rural women and 63 percent urban women, respectively, engaged in informal employment, most notably farming and petty trading. Because 70 percent of women are small-holder farmers they dominate the agricultural sector, which employs 70 percent of the total population and accounts for 40 percent of Sierra Leone's GDP. Women process, preserve, store and transport all food crops for marketing, and are most adversely impacted by poor road conditions and limited transportation facilities because of the lack of cold storage facilities to preserve highly perishable produce. With very little access to land, credit, extension services, post-harvest technologies and training, women farmers are barely surviving in the very sector that should enable them to thrive.

While men dominate the cash-earning economy, women are often relegated to the low-income earning categories of service and retail, as well as agriculture and fisheries, all of which lack social-protection benefits and occupational safety. According to the AfDB's 2011 Country Profile of Sierra Leone: "Women's predominance in low-skilled occupations reflects their low status in the society, low skills

¹⁸ Total live births per woman

¹⁹ <https://data.un.org/CountryProfile.aspx?cname=Sierra%20Leone>



Source: CERD, AfDB

training and educational levels, and poor career and promotion prospects” and “... leaves them open to exploitation and increases their vulnerability to poverty.” Unlike the informal sector, women’s participation in the formal sector is negligible at best. A 2009 enterprise survey of 150 firms by the International Finance Corporation (IFC) reported that women owned only 7.9 percent of the businesses surveyed.

Although Sierra Leonean women represent 80 percent of micro-finance clients, mostly between the ages of 18 and 60, many have opted not to use such facilities because of their high interest rates or collateral requirements. Regardless of whether or not they ‘opt-out’ of micro-finance, many female entrepreneurs supplement their incomes with alternative sources of financing, such as rotating and credit associations called ‘osusus’.

The health sector is another area of concern for women. In April 2010, Sierra Leone introduced the Free Healthcare Initiative (FHI) for pregnant women, lactating mothers, and children under five, thereby improving maternal and child health in the ensuing years. Despite these gains, however, Sierra Leone had 2436 health care workers for a population of 6.34 million, two doctors per 100,000 people, and only 35 percent of the population had access to health

care services—significantly lower than the sub-Saharan Africa rating of 65 percent. Furthermore, Sierra Leone’s 2013 GII shows a decline in maternal mortality, yet WHO figures for 2013 indicate an increase at 1100 per 100,000 births. Contraception prevalence between 2006 and 2012 was only 8 percent, primarily because of men’s perceived need to control fertility rates, which have been consistently 5 total live births per woman in the past five years. According to the 2008 DHS, 72 percent of women delivered at home while 25 percent delivered in health facilities. Only 42 percent of those deliveries were assisted by healthcare workers. Contrastingly, 87 percent of women received antenatal care (ANC) from health professionals. The 2008 DHS also reports that the prevalence of female circumcision was 95 to 96 percent among women aged 25 to 49. It is highest in the Northern (97 percent) and Western regions (80 percent), and higher in rural areas (95 percent), than in urban areas (85 percent).

The analysis included here-in shows that although gains have been made in attempting to improve the conditions of women in the three MRU countries, following protracted political and economic instability, their pre-Ebola socio-economic positions adversely exposed them to the shocks of the outbreak.

Women during Ebola

FARMING, AGRICULTURE AND FOOD SECURITY

Given that women dominate the agriculture sectors in Guinea, Liberia and Sierra Leone, it is vital to assess how their livelihoods have been impacted by EVD. In Sierra Leone alone, the Ebola virus disease continued to rise at critical junctures in the country's agricultural production calendar; when land preparation, planting, weeding, harvesting, and marketing are most actively pursued by women. The epicentres of the disease were the Eastern districts of Kailahun and Kenema, Sierra Leone's proverbial breadbaskets that produce the country's staple food (rice) and other important cash crops such as cocoa and palm oil. Kailahun and Kenema boast of a large number of women master farmers and heads of households whose livelihoods have been compromised by EVD.

Figure 5.
Sierra Leone's 13 districts

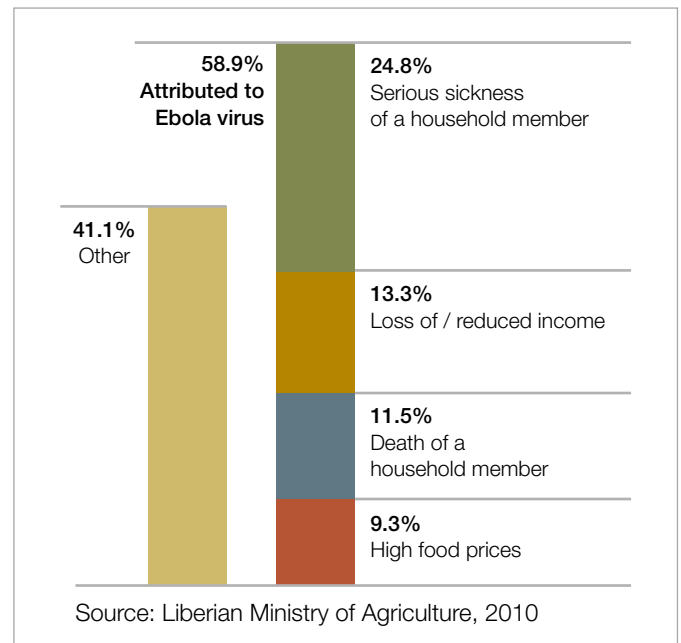


According to estimates, 65 percent of rice farms are cultivated and run by women in Sierra Leone, though they also consume imported rice. Agricultural production is largely subsistence, with cocoa, coffee, palm oil, cassava, local rice, livestock and fisheries produced on a small-scale by mostly female farmers. Based on a food security rapid assessment²⁰ conducted in September 2014 by the Ministry of Agriculture, Forestry, and Food Security in partnership with the Food and Agriculture Organisation (FAO) in Sierra Leone, findings that labour shortages in farming and

inflation in key commodities such as cassava (52 percent), fish (43 percent) and imported rice (13 percent) were commonplace during the Ebola virus, as families who owned farms reported migrating to areas with low numbers of Ebola cases.

Apart from the direct impact of EVD on agriculture, women's productivity in this sector has also been hurt by the abrupt halt in manufacturing activities. The Sierra Leone Brewery Company, for instance, uses raw material such as sorghum, which is produced by female farmers, primarily. With the drop in sales of local beer, women sorghum producers have been adversely impacted. Food insecurity is a significant problem in Sierra Leone, with more than two-thirds of households reporting having to undertake coping strategies in the week prior to the survey conducted jointly by the Government of Sierra Leone, Innovations for Poverty Action, and the World Bank, though quarantine restrictions do not seem to be a major contributing factor. Finally, there is important evidence in Freetown that the Ebola epidemic has reduced the use of non-Ebola related health services, with a sharp decline in post-natal clinic visits by women who have recently given birth.

Figure 6.
Top four reported contributors to shocks in food security attributed to the Ebola virus



²⁰ Ministry of Agriculture, Forestry and Food Security (MAFFS) Sierra Leone and United Nations Food and Agriculture Organisation (FAO), (2014). "The Food Security Situation in the Context of Ebola Outbreak in Sierra Leone: A Rapid Assessment Report." Freetown, Sierra Leone: MAFFS and FAO.

In a 2010 report by the Liberian Ministry of Agriculture, the top four reported contributors to shocks in food security then can all be attributed to the current Ebola virus, namely: i) serious sickness of a household member (24.8 percent); ii) loss of/reduced income (13.3 percent); iii) death of a household member (11.5 percent); and iv) high food prices (9.3 percent). The traditional kuu²¹ system, in which primarily female farmers work together in small groups to plant and harvest, has been disrupted because of EVD. Thus, food production has slowed down drastically in Bong, Bomi, Lofa, Margibi, and Nimba, Liberia's breadbaskets. The price of imported rice has increased by as much as 12 percent²² in July and August, while cassava prices remained stable.

With the high levels of unemployment and increases in the prices of basic commodities, anecdotal evidence indicates that food security is becoming a cause for concern in Guinea, Liberia and Sierra Leone, with families severely limiting their food intake. According to Sierra Leone's food security rapid assessment, 70 percent of respondents reported having only one meal per day. This represents a recipe for disaster, particularly for women across the three countries who are responsible for both food cultivation and preparation. These challenges have also impacted inter-regional trade amongst women in Guinea, Liberia and Sierra Leone as well as daily, and periodic market activities.

Agriculture has been particularly hard hit in Guinea as the epidemic began in one of the country's main agricultural regions. Rice production is estimated to have fallen by 20 percent in 2014, coffee by half, cocoa by a third, and corn by a quarter. World Food Program (WFP) telephone surveys have found some households substituting foodstuffs and reducing the quality and frequency of meals to cope with shortages. The most recent WFP estimates project 1.2 million Guineans suffering severe food insecurity in March 2015, of whom it estimates about 470 000 as the additional effect of the Ebola epidemic²³. Falling commodity prices also play a role in this downward revision of economic growth.

CROSS-BORDER TRADE AND MARKET RESTRICTIONS

It has been argued that well-functioning cross-border trade increases food security in regions where it is most prevalent. According to MRU Secretary General, Dr Saran Daraba Kaba, there were at least 22 weekly markets functioning between Sierra Leone where nationals of at least 9 countries would meet to trade and exchange goods (including Mauritania, Burkina Faso, Ghana amongst MRU countries).

Because women comprise 70 percent of all cross-border traders in the MRU sub-region, they have been severely constrained by EVD. According to the Sierra Leone Chamber of Commerce, Industry and Agriculture (SLCCIA) women account for 60 percent of all cross-border traders and 70 percent of owners of small and medium sized enterprises. Informal cross-border trade represents 70 percent of the income for Sierra Leonean women who are engaged in this form of employment. Sierra Leonean cross-border traders supply processed cassava products such as gari exports to markets in Liberia²⁴. According to an AfDB brief in October 2014, Sierra Leone has increasingly supplied gari, palm oil and local rice to the Guinean market.

While Guinea imports nearly 25 percent of its rice, imports from Sierra Leone cover 1.4 percent of the country's domestic rice production gap. With the closure of borders between the two countries, women traders in Guinea have been unable to access this market lifeline and Sierra Leonean women traders have not been able to access this important source of income.

Women in Liberia have not escaped these limitations. In an interview²⁵ with Ebola Deeply²⁶, Minister of gender Julia Duncan-Cassell lamented the negative impact EVD has had on women, cross-border traders in her country:

In Lofa in northern Liberia, known as the breadbasket of the country, a lot of the agricultural workforce [are] women. They are traders, too; they are the ones normally going across the border to buy goods at the markets in Guinea. Now they can't do that very easily. Either way, they are stranded—by the death of a loved one or by the loss of business.

²¹ Mercy Corps, 2014

²² AfDB brief, October 2014

²³ FAO and WFP 2015

²⁴ Government of Liberia, 2010

²⁵ www.eboladeeply.org/articles/2014/10/6411/ebola-women-julia-duncan-cassell-liberias-minister-gender

²⁶ www.eboladeeply.org

In August 2014 when the Liberian government declared a state of emergency, it promptly closed borders with Guinea, Ivory Coast and Sierra Leone, and advocated for the closure of weekly markets throughout the country. The livelihoods of many women in Lofa and Nimba were particularly compromised because they relied on cross-border trade to purchase and sell goods before the Ebola outbreak—such as beans, peanuts, peppers and agricultural inputs including fertilisers and seeds from Guinea—and have had to shift their focus to Monrovia for imports. The reduction in flights and shipping lines to Liberia also increased the prices of imported goods.

Just as cross-border trade has been severely hampered, internal domestic market activities have slowed down in Guinea, Liberia and Sierra Leone as a result of EVD. This has adversely impacted the livelihoods of women vendors. In a report published by Mercy Corps in October 2014, based on an assessment of the economic impact of Ebola on markets and households in Monrovia, Nimba and Lofa counties, one female pepper vendor in Monrovia complained:

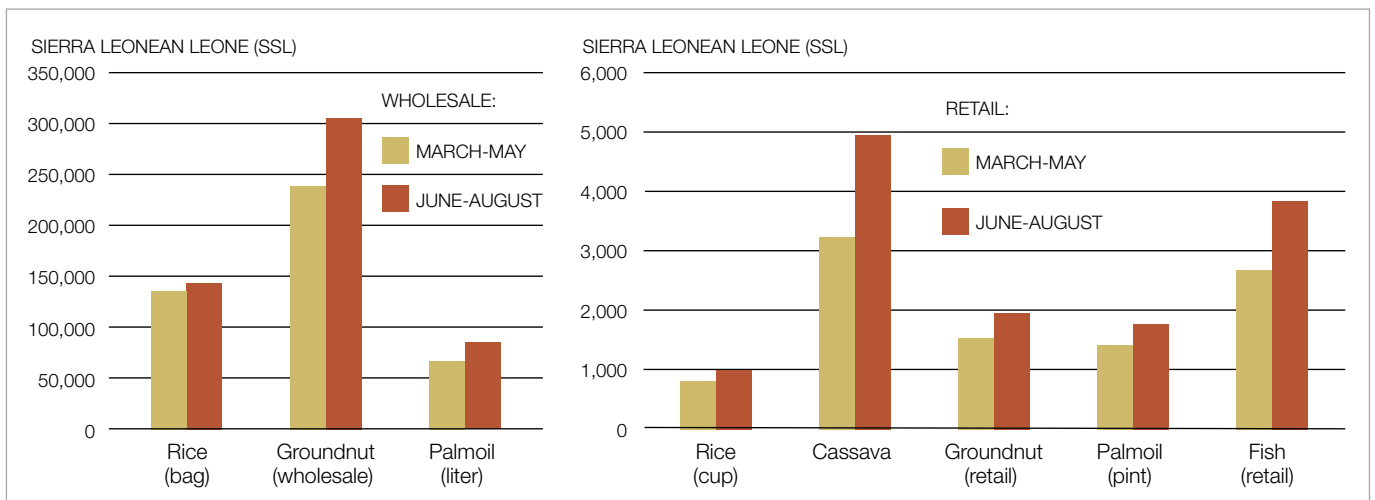
Before Ebola, I sold maybe 10-15 bags of pepper per day. Now, I sell maybe two-three bags. I have eight children, but we've had to reduce the amount of rice we eat from 10 cups per day to eight.

The Mercy Corps report findings show that household income during the outbreak declined drastically in the surveyed counties and borrowing increased to stave off hunger. Purchasing power of households particularly has decreased. Monrovia vegetable vendors also complained

that perishable goods from the counties were getting spoilt due to long transportation times. For instance, the transport union in Sanniquellie, Nimba, reported that due to bad road conditions and checkpoints erected throughout Liberia to prevent the spread of Ebola, their usual four to five commercial trucks travelling to Monrovia per day in the rainy season were reduced to only two. Transportation costs have also increased for women vendors because the state of emergency required fewer passengers on motorbikes and taxis. Because Liberia's state of emergency was officially lifted in early November, a few weeks before the writing of this report, a more detailed analysis will have to be conducted to determine if this has mitigated the vulnerability of women marketers.

The state of emergency in neighboring Sierra Leone, however, has been maintained, largely because of an unanticipated spike in EVD cases during the latter part of November. Quarantines, restricted movement and curfews during the state of emergency halted market activities in Sierra Leone's thirteen districts, particularly the sale of agricultural goods and other food items such as cassava, groundnuts and palm oil. As argued by Haja Fatmata Marah, a female marketer from the Kabala Women Vegetable Cooperatives Society, "... even when we take our produce to the market, we can stay there for the whole day and still not sell everything, so I'll rather stay home." In August 2014, traders like Marah in the Society reported losing revenues of approximately 200 million Leones, primarily because limited incomes have constrained consumer spending. Figure 7 captures the average prices of staple food commodities in Sierra Leone's 13 districts from March to August 2014.

Figure 7. National Retail and Wholesale Market Prices of Selected Commodities in Sierra Leone



Source: Primary Data from Rapid Market ASSESSMENT-PEMSD/FAO August 2014

Table 2.
Change of Vegetable prices in Kabala, March-September 2014

Item	Unit	Price range /unit before March in Leones	Price range /unit after March in Leones
Cabbage	50kg/bag	90, 000 -200,000	30,000-40,000
Pepper	50kg bag	250, 000-300,000	110,000
Lettuce	10 dozen	180,000 -200,000	10,000-20,000
Tomatoes	carton	120,000 -130,000	50,000
Spring onions	bundle	10,000 -20,000	1,000
Cucumber	1 dozen	10,000	7,000 -8,000
Egg plant	50kg bag	80,000 -100,000	60,000 -80,000
Carrot	50kg bag	150,000 -170,000	80,000 -100,000

Source: Primary Data from Rapid Market ASSESSMENT-PEMSD/FAO August 2014

While some basic commodity prices increased, other food items such as maize, sweet potatoes, and peppers nose-dived. If not sold, these food items were left to rot because of the ban on periodic markets, known as lumas, and limited transportation of goods between districts. During focus group interviews conducted for Sierra Leone’s food security rapid assessment, women vegetable traders in Koinadugu reported losing millions of Leones because they tend to sell perishable goods. As indicated in Table 2, prices of vegetables were nearly slashed in half to meet consumer demands.

Apart from losses in income from the sale of basic produce, female-headed households reported that restrictions on the sale of bushmeat adversely impacted their livelihoods. Concerned about fruit bats being the vectors of Ebola, governments within the MRU instituted drastic measures by banning the sale of all bushmeat without introducing

an alternative source of livelihood for bushmeat traders. Besides relying on it for a source of income, women also prepare bushmeat as an alternative source of animal protein and nutrition for their families. In its place, there is now widespread hunger and malnutrition.

TOURISM AND HOSPITALITY

Before the Ebola outbreak, Guinea, Liberia and Sierra Leone had over 10 commercial flights each. As of November 30, Sierra Leone and Liberia were only serviced by Brussels Airlines and Royal Air Maroc. Visitors and investors to the region have been particularly wary because of fear of contagion. According to data from the National Tourist Board in Sierra Leone, for instance, tourist arrivals at the Lungi International Airport declined by 30 percent from January to August 2014, compared to the same period in 2013. The number of business visitors (investors) decreased by 46.9 percent. As indicated earlier, women within the MRU tend to dominate the airline and hospitality industries. Because of declines in commercial airline traffic and hotel bed occupancy, they have either been laid off or are experiencing reduced salaries. Comprehensive quantitative and qualitative research will have to be conducted to assess the full extent of tourism/travel declines on women in the sector. While one could argue that restricted travel within and between the three MRU countries generally impacts women more adversely than foreign travel restrictions, the medium- to long-term difficulties women in this sector will face after EVD is fully contained, cannot be overemphasised .



Source: CERD, AfDB

ACCESS TO FINANCIAL SERVICES

The decline in banking hours and loan facilities has compromised women's ability to access financial services or pay off loans. For instance, BRAC, the largest provider of micro-loans amongst the micro-finance institutions in Liberia, closed its operations in August 2014. According to a combined report²⁷ published in September by the GoSL and its development partners, community banks and rural financial services have either closed completely or severely scaled down operations. For instance, normal banking hours in non-epicentre regions had been temporarily reduced from 8:30 a.m. to 1:30 p.m., while in the epicentres of Kenema and Kailahun banking hours were 8:30 a.m. to 12:30 p.m. Anecdotal evidence suggests that with the halt in agricultural activities, closure of some markets, and limited tourism and cross-border trade, women's borrowing through informal channels has increased and their ability to pay off micro-loans has decreased. Furthermore, savings groups such as osusus in Sierra Leone and susus in Liberia may either be buffers against loss of livelihoods, or the source of severe stress for women who cannot maintain their monthly payments. Given the current situation, a number of MFIs which have closed may either never return at all or come back only after a few years. This further makes the access to economic sustainability and empowerment much more difficult for women.

ACCESS TO LAND

Given that women's access to land in Guinea, Liberia, and Sierra Leone was already limited because of some discriminatory policies and practices, women who have experienced the loss of a husband from Ebola-related or non-Ebola related complications are likely to encounter obstacles of inheritance since customary land tenure systems in rural areas primarily favour men in practice, if not in formal policy.

ACCESS TO HEALTH SERVICES

With the closure of some medical facilities and funding diverted to Ebola-related relief, women's access to health services for non-Ebola related ailments has significantly decreased. Although contraceptive use was relatively low before Ebola, women in Guinea, Liberia and Sierra Leone



Source: CERD, AfDB

have experienced severely limited access to birth control and family planning services. In Sierra Leone, for instance, the Marie Stopes Obstetrics Clinic in Freetown reported that family planning methods declined by 90 percent between May and August 2014 alone. Similarly, pregnant women and lactating mothers attempting to access health facilities have been particularly challenged. In Sierra Leone, for instance, deliveries in primary health care centres dropped by 7 percent, and post-natal as well as ante-natal consultations declined by 8 percent and 15 percent, respectively²⁸. The gains made in reducing maternal and child mortality across the three countries have been compromised by EVD. In October, the United Nations Population Fund (UNFPA) substantiated these assumptions. They estimated²⁹ that of the more than 800,000 women giving birth within a year in Guinea, Liberia, and Sierra Leone, 120,000 would face severe complications during pregnancy and childbirth.

While the fatality rate of Ebola during the most recent outbreak in Guinea, Liberia and Sierra Leone hovers at 70 percent, pregnant women are at a higher risk of spontaneous abortions and/or miscarriages. One study³⁰ in the Democratic Republic of the Congo (DRC) found that for a small sample of pregnant women who contracted Ebola in 1995, the fatality rate was close to 95 percent. And while pregnant women are at risk, those who come in contact with them—primarily women midwives, nurses,

²⁷ UNFPA, October 2014

²⁸ UNFPA, October 2014

²⁹ www.unfpa.org/news/pregnant-shadow-ebola-deteriorating-health-systems-endanger-women

³⁰ http://jid.oxfordjournals.org/content/179/Supplement_1/S11.long

and doctors—the risks are also enormous. In a November 18 National Public Radio (NPR) post entitled “Dangerous Deliveries: Ebola Leaves Moms and Babies without Care”³¹, Liberian midwife Lucy Barh recalls how she came in contact with a pregnant woman who was later suspected to have died of Ebola:

I was on duty that day when the patient came in. We did the examination. She was not in labour. But to our utmost surprise, the very next day, that woman was rushed on our ward, bleeding profusely. Right after the fetus came out, that woman started bleeding from all over. We did everything we could, just to save her life. But even with a blood transfusion, she ended up dying.

The woman’s medical history was revealed only after her baby also died: she had been in contact with two relatives who eventually died of Ebola. Barh talked about how the instinctual drive to help without personal protective equipment (PPE) is what led to the high number of female health-care workers dying from Ebola, because the risk of coming into contact with bodily fluids is so high: “Sometimes it doesn’t even give you ample time to put on your gloves... That alone is so dangerous for the midwives.” Agreeing wholeheartedly, Esther Koleh, lead midwife at Eternal Love Winning Africa (ELWA) Hospital outside Monrovia, said³²: “Everybody is afraid of catching Ebola because most nurses who caught Ebola died. Last night we received three ladies. They had been in labour one week, two weeks. Nobody to help them... The babies died before they came.”

Although data is currently unavailable on the number of female health workers who have been infected with Ebola, anecdotal evidence has shown that they represent a large share of the incidence rates. When Freetown-based medical superintendent Dr. Olivet Buck³³ was infected with Ebola in mid-September and subsequently denied a request to be airlifted to Germany for treatment, this dealt a huge blow to the country. Not only was Dr. Buck on the frontlines of containing the disease, but she was also among a handful of female doctors (and hospital administrators) that Sierra Leone could boast of. Having disappeared from the headlines not too long after her tragic death, Dr. Buck was a classic example of the gendered dimensions of Ebola: one of female sacrifice.



Source: CEFID, AFD

Another gendered storyline that has escaped media attention is the rate of women infected by partners who survived Ebola and engaged in sexual intercourse without a condom. Because semen may be infected with the Ebola virus for up to three months from the onset of symptoms, women are at an increasingly high risk of infection. In late November, Dr. Atai Omurutu, overall head of the Island Clinic ETU on the outskirts of Monrovia, expressed³⁴ alarm that male Ebola survivors were infecting their partners at an alarming rate. “Almost all the wives of male Ebola survivors are coming to the ETU as patients” he said, imploring the Ministry of Health to distribute free condoms to survivors and local communities. The medical doctor’s concerns raise other important questions about the ability of women to demand the use of condoms in sexual relations with partners who have survived Ebola.

ACCESS TO HEALTH AND INFRASTRUCTURE

The EVD epidemic revealed the serious challenges that lack of infrastructure (specifically that of roads and energy) posed for all three affected countries at the onset of the epidemic and even now in dealing with isolated hotspots in remote locations. The poor state of rather limited roads in the region made it very difficult to move medical teams and supplies into remote areas. It also spelt delays in determining EVD status from test results since it took several

³¹ www.npr.org/blogs/goatsandsoda/2014/11/18/364179795/dangerous-deliveries-ebola-devastates-womens-health-in-liberia

³² www.npr.org/blogs/goatsandsoda/2014/11/18/364179795/dangerous-deliveries-ebola-devastates-womens-health-in-liberia

³³ www.nbcnews.com/storyline/ebola-virus-outbreak/ebola-outbreak-dr-olivet-buck-dies-sierra-leone-after-who-n202991

³⁴ www.emansion.gov.lr/2press.php?news_id=3144&related=7&pg=sp#sthash.P4y1dVh5.dpuf

days to get necessary blood samples to laboratories. This then resulted in a delay in relaying this critical information to suspected patients—adding to anxiety and frustration of both medical staff and patients. The infrastructural challenges that hampered the EVD fight include lack of decent accommodation for the teams for healthcare workers and insufficient volunteers to reach the sick in remote areas, making it necessary and costlier to rotate the medical teams over shorter periods of time for rest and recuperation.

STIGMA, GBV AND BREAKDOWN IN FAMILY STRUCTURES

For Guinea, Liberia and Sierra Leone, the psycho-social trauma has been enormous, with some arguing that the toll from Ebola has been heavier than the toll of armed conflict.

According to a report filed by ActionAid Liberia, women who have lost their breadwinner husbands to Ebola have been scarred in multiple ways. A pregnant widow with four other children, Christina Scotland, 33, was stigmatised by her neighbours and lost her home. Now jobless, she lamented the tragic death in October of her husband, a medical doctor, as well as the psycho-social toll Ebola has had on her:

“It’s not easy at all. It hurts so much, especially in the evenings. That’s when I would usually expect him to get home from work. I still expect him home and when I remember that he isn’t coming home ever, it gets too painful to bear”.

For Guinea, Liberia and Sierra Leone, the psycho-social trauma has been enormous, with some arguing that the toll from Ebola has been heavier than the toll of armed conflict. There has been an erosion of social cohesion in communities that had stuck together. Women, particularly, have watched their children and husbands languish and die while still trying to revive them. In an interview³⁵ in August with BuzzFeed, Sayday Williams Taylor, a Liberian psychiatrist, talked about the dehumanising logic of Ebola:

DEFYING THE ODDS



Source: CERD, AIDB

While it is evident women have been disproportionately impacted by EVD, they have also defied odds. In September, CNN released a story³⁸ about a 22-year-old Liberian final year nursing student, Fatu Kekula, who single-handedly treated four family members at home when they fell sick with Ebola in Kakata, Margibi County. With most hospitals closed and no access to PPEs, Kekula relied on her wits, using trash bags, rubber gloves, boots and a face-mask to shield herself from contagion. Three of her four relatives survived and Kekula never got infected. Her ‘trash bag method’ was hailed as an example of local ingenuity. Her story is a testament of the resilience of women across the sub-region who have triumphed over the disease.

“We’re used to bathing our bodies. We’re used to burying. We’re used to hugging. When you’re told not to ... it’s like we’re being denied the chance to give a mother, a child, that last love... And it’s hard for the sick. You have to say, ‘I love you, but I can’t touch you.’ You have to do that for the people you are leaving behind”.

³⁵ www.buzzfeed.com/jjnamoore/ebola-is-killing-women-in-far-greater-numbers-than-men

³⁶ www.buzzfeed.com/jjnamoore/ebola-is-killing-women-in-far-greater-numbers-than-men

³⁷ www.wfp.org/stories/liberia-wfp-supports-ebola-survivors?utm_content=bufferff3b3&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

³⁸ <http://edition.cnn.com/2014/09/25/health/ebola-fatu-family>

In a similar fashion, Dr. Wvannie-Mae Scott McDonald, Chief Administrator at the John F. Kennedy Medical Centre in Monrovia, said: "To care is to comfort, to console. Ebola has taken away our comfort. It has taken away our humanity."³⁶ The attendant stigmatisation of families of the dead, Ebola survivors, burial teams, and healthcare workers, has left entire communities across the MRU sub-region psychologically wounded, particularly women who serve as both breadwinners and caregivers.

Besides stigma, another unintended consequence of Ebola is that the breakdown in law and order and policing may have exposed women to increased gender-based violence and sexual exploitation. The militarisation of Ebola, in which security forces have been deployed to quarantine entire

communities in Liberia and Sierra Leone, for instance, conjured up war-time experiences and may have exposed women to secondary trauma. Although there is no documented evidence of this, it is an area of policy research and intervention that should be pursued. The psycho-social impact of Ebola on communities of women across the three countries deserves critical attention, especially for women who experience loss on multiple levels. For instance, some young women have been left behind to fend for orphaned relatives. This was the case of 30-year-old Siatta Stewart and her 32-year-old sister, Famatta, who are now raising six children after losing their mother, father and five other members of their family to the disease.³⁷ Without steady incomes or social safety nets to anchor them, these two young women face enormous challenges in Kakata, Margibi County, Liberia.

Women after Ebola

While projections have been made about the short-, medium-, and long-term impacts of Ebola on the economies of Guinea, Liberia and Sierra Leone, it is clear that women in the three countries are likely to experience those impacts disproportionately. Yet, it is difficult to speculate with any certainty about the post-Ebola socio-economic implications for women given the limited empirical data available now. Data must be disaggregated by gender in all country reports to include statistical analysis on the number of women confirmed, probable, and suspected cases, as well as fatality rates.



Source: CERD, AfDB

Commissioned research should be undertaken to conduct cross-country quantitative and qualitative analyses on the socio-economic impact of EVD on women, in order to inform policy decisions about how to mitigate challenges post-the Ebola pandemic. It is important to sample across a broad range of ages, socio-economic status, regional locations (urban + rural), and professions. Data collected from the comprehensive study should include household surveys (equally distributed between female- and male-headed households) and semi-structured interviews with key women informants in the EVD epicentres across each country. Purposive sampling should include women whose professions have been particularly impacted by the virus, such as healthcare workers, farmers, cross-border traders, marketers, teachers, and tourism/hospitality sector employees. Such data should feed into an MRU Crisis Information Management System that will enable the three countries to collect, verify, analyse and report data in real time, as Ebola infection rates are constantly changing. This

should lend itself to developing an MRU infectious disease management system that can be used in future outbreaks, in the same way that Nigeria used its polio eradication programme to contain Ebola within three months.

Whilst the Bank is implementing an MRU Initiative designed to help reduce the infrastructure gap in Cote d'Ivoire, Guinea, Sierra Leone and Liberia, the EVD epidemic has demonstrated the urgency of the road transport and energy programs of the MRU Initiative. The Bank needs to push for greater partnership among donors to contribute towards reducing the infrastructure gap, especially due to the cyclical nature of the outbreaks. As part of preparedness to deal with a second or even third round of the epidemic, transportation and accommodation can be facilitated if these urgent investments are made now.



Source: CERD, AfDB

For healthcare workers (male and female) who have lost their lives to EVD, their spouses and children should be compensated with life insurance packages that will offset the cost of economic difficulties. Healthcare workers currently on the frontlines should be paid daily rates and hazard pay comparable to that of their international counterparts to ensure equity. As a result, donors may have to top-up the salaries of these employees through Ebola relief aid. Salaries should, of course, be commensurate with rank and the level of risk involved in performing one's duties. On the AfDB's President, Dr. Donald Kaberuka, visit to the region in August 2014, this was an issue that was raised by the President Sirleaf as well as the Minister of Health, and subsequently AfDB's health interventions have accommodated for this. For more long-term interventions, post-Ebola governments should establish bilateral scholarships specifically tailored for women healthcare workers who want to specialise in epidemiology, public health, infectious diseases, or who want to be trained as medical doctors.

In the short-term and as a matter of national policy women should be prioritised for any planned programmes, as they have borne the brunt of EVD. Women farmers should also be provided with agricultural and livestock inputs (fertilisers, farm tools) for the production of high-yielding food crops (rice, cassava, vegetables) and livestock production. Donors, banks and Ministries of gender should consider providing social cash transfers to female-headed households, recognising and compensating them for the hours of unpaid care work that they do inside the home.

For women who agree to serve as the legal guardians of children orphaned by Ebola, a system could be devised similar to the foster care system where they are compensated for each child under their supervision and care. The Ministries of health in the three MRU countries can deploy social workers already in their employ to monitor this system for efficiency.

Policy makers should consider easing the burden on women cross-border traders by establishing three special Ebola economic zones, and deploying equal numbers of female and male police officers at the borders to monitor the movement of goods. Committed investments for infrastructure should proceed following a careful risk analysis, and renewed commitment by donors should be forthcoming in order to support economic opportunities in the region.

For women farmers selling perishable goods, governments and donors should partner with female farmers' cooperatives and women's savings and loans groups to rent cold storages at minimal fees. For women who have lost husbands to Ebola and are hampered by customary inheritance practices, governments should allocate plots of public land for them to purchase on a mortgage scheme. Inheritance laws must be revisited and validated by rural communities to ensure compliance.

BANK ENGAGEMENT IN THE MANO RIVER UNION

Guinea, Liberia and Sierra Leone will experience a reduction in their economic growth and related fiscal revenues, which makes the African Development Bank and other key financial institutions an important recourse of affected states to ensure the continuity of their operations and facilitate the resilience of their economies.

Conclusion: After the Emergency Building Resilience for Gender in MRU

Women are the main caregivers in the countries of the MRU, as elsewhere in Africa, as health workers and in their homes—they are literary on the front-line in the fight against the disease. Secondly, it is predictable that women traders in local markets and across borders have been affected by the quarantines and restrictions to the movement of people and goods. Their income generating activities are thus constrained when they are most needed. Thirdly, women are predominant in agriculture. The expected sharp decline in productivity in the sector will hit their incomes hard. There is thus a case for designing interventions to help women remain return on their feet during the crisis—and also to assist them to recoup their losses and those of their households ex post. In the aftermath of the current Ebola crisis, women in Liberia, Sierra Leone and Guinea will require substantial financial, material and technical assistance to return their economies back to its pre- Ebola state. **A good policy response by the AfDB will be the establishment of the Ebola Social Investment Fund.**

Indeed, the AfDB was among the first development partners to approve an emergency operation to respond to the epidemic in April 2014. The Bank responded swiftly to the Ebola emergency by providing a package of assistance of about US\$ 210 million towards efforts at containing the spread of the disease and to creating fiscal space for the affected countries to meet their budget deficits through Budget Support operations.

There is an urgent need to mitigate the economic losses of women during the pandemic and to position them for economic recovery and eventually, economic empowerment in the aftermath of the pandemic. The affected economies need to ensure that women are empowered to help them rebuild. The current nature of the on-going Ebola outbreak requires an increasingly multi-disciplinary approach to provide an integrated response. Therefore, we must look at how we can innovatively assist governments in responding to what will be one of their biggest

The AfDB is proposing a Social Investment Fund³⁹ to complement ongoing containment support of the Bank by providing livelihoods support and assistance to EVD survivors, orphans and health workers. It will also complement efforts of other development partners such as the Food & Agriculture Organization (FAO). The proposed Fund will be the Bank's holistic response to the gender dimensions of EVD. The Fund will operate on a Public Private Partnership (PPP) arrangement adopting a community demand-driven intervention strategy guided by a Standard Operations Manual to be developed. It will be an autonomous entity established at the regional level with country-level affiliates.

Globally, the project will foster economic and social inclusion, and gender equality. It is important to halt any further damage to financial and social institutions in order to ensure basic livelihoods in the affected countries. Specifically, it aims at mitigating socioeconomic effects of EVD and preparing women and girls to recover from economic and social losses. It will play a catalytic role in improving community response to outbreaks thereby contributing to inclusive growth and poverty reduction in the three affected countries of the MRU region.

Through this Investment Fund, the Bank will be able to help women to come out of the current disadvantaged situation and rebuild the financial foundation, particularly in rural areas. As indicated in this report, Ebola induced poverty due to the curtailment of economic activities, particularly handled by women (e.g. farming and cross-border trade). This Fund will support revival of agricultural and trade activities which will increase food security. The project activities are designed in such a way that those who come out of poverty will continue to stay above the poverty line as the project will link women with sustainable financial means. As a result, women will be permanently relieved from the dual economic and social burden in households where they are the main source of income and care givers.



Source: CERD, AfDB

The engagement of civil societies and community groups promoted by the project will be essential to empower, reach and mobilize women. In the three countries, NGOs and CBOs operating at the community level are playing an increasingly important role in supporting the Government in containing the disease and providing assistance to groups affected by EVD. The proposed design of the Fund will not only strengthen the institutional capacity of these organizations, but also help them to build linkages with the government agencies and the private sector so that they can maximize their impact at the community level. Overall, the project will strengthen the capacities of the MRU, Ministries of Gender, community groups, NGOs as well as individual women in Liberia, Sierra Leone and Guinea.

³⁹ The Bank has experience in financing Social Funds, such as the ECOWAS Peace and Development Project, the Gambia Social Development Fund Project and the Lake Chad Sustainable Development Program; the experience will be extensively tapped in during the project implementation.

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About AfDB

The African Development Bank is a multilateral development institution, established in 1963 by agreement by and among its member states, for the purpose of contributing to the sustainable economic development and social progress of its Regional Member Countries (RMCs) in Africa. The members of the Bank, currently seventy eight (78), comprise 54 RMCs, and 24 Non-RMCs. The Bank's principal functions include: (i) using its resources for the financing of investment projects and programs relating to the economic and social development of its RMCs; (ii) the provision of technical assistance for the preparation and execution of development projects and programs; and (iii) promoting investment in Africa of public and private capital for development purposes; and (iv) to respond to requests for assistance in coordinating development policies and plans of RMCs.

Contacts :
Immeuble du Centre de commerce International
d'Abidjan CCIA
Avenue Jean-Paul II
01 BP 1387
Abidjan 01, Côte d'Ivoire
Tel.: (+225) 20 26 10 20
Email: d.elhassan@afdb.org
Website: www.afdb.org



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