

## The Pathology of Inequality: Gender and Ebola in West Africa

The international response to Ebola has been decried for being ‘too slow, too little, too late’. As well as racing to respond, we need to consider what has happened over the past decades to leave exposed fault lines that enabled Ebola to move so rapidly across boundaries of people’s bodies, villages, towns and countries. Gender is important to these fault lines in two related spheres. Women and men are differentially affected by Ebola, with women in the region taking on particular roles and responsibilities as they care for the ill and bury the dead, and as they navigate ever-diminishing livelihood options and increasingly limited health resources available to pregnant women. Furthermore, structural preconditions in ‘development’ itself have deepened these gendered fault lines. A currently powerful set of ideas in gender and development discourse locates certain patterns of ‘non-modern’ gender relationships as the root cause of poverty and underdevelopment. This has encouraged development actors to underplay the much deeper forms of structural violence that underpin the vulnerability of men as well as women, in some of the world’s poorest communities. By focusing on the current health crisis in Sierra Leone, Liberia and Guinea, the dangers of this form of ‘gender scapegoating’ are revealed to be tragically stark.

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### The gender dimensions of Ebola

Recent studies and reports on Ebola in West Africa speak to the importance of gauging the gender dynamics that both characterise and contribute to the spread of the disease. Principally, these dynamics relate to women’s provision of paid and unpaid care to those affected by Ebola, and to the role women play in giving life, and in burying the dead. The Liberian Ministry of Health reported that women made up as many as 75 per cent of the cases in the country, suggesting that women are more likely to come into contact with Ebola because of caring for infected people in health centres and at home, for example. Reports from health workers in Sierra Leone and Guinea, and by the United Nations Children’s Fund (UNICEF), similarly found that gender disparities exist across care providers and Ebola patients (Ravi and Gauldin 2014). In addition to coming into direct contact with Ebola through care work, women are affected by the implications of the measures taken to contain the epidemic (WHO and UNICEF 2014). In Sierra Leone and Liberia, for instance, women play a critical role in food production and are responsible for up to 70 per cent of cross-border trade. Trade restrictions and border closure have therefore diminished women’s earning power, and disproportionately affected female-led households in these countries.

In addition to navigating increasingly restrictive livelihood options and the risks related to providing paid and unpaid care to family members and patients, women are also disproportionately affected by Ebola on the edges of life, as they give birth and as they bury the dead. Burial practices and their implications are discussed in detail in Practice Paper in Brief 24 on Local Engagement. Here we consider the implications of Ebola for maternal health, and some of the lessons that might be learnt from development approaches to maternal health as the pre-Ebola era’s most pressing health emergency.

### Linked health emergencies: Ebola and maternal mortality

Prior to Ebola, maternal mortality was considered one of the most urgent health concerns in the region. Described by the Department for International Development (DFID) as ‘a clear and urgent crisis’, Sierra Leone’s maternal and infant

mortality rates are the highest in the world (2013). In 2013 in Sierra Leone, 1,100 women died per 100,000 live births (down from 2,000 ten years earlier), and in Liberia 770 per 100,000 died in 2010 (down from 1,100 in 2005) (WHO and UNICEF 2014). While still high, the improvements in maternal health in these countries were linked to the introduction of free health care to pregnant, birthing and lactating women in public health facilities. Now with Ebola, maternal mortality has escalated. When Ebola broke out in Sierra Leone, the number of women attending health centres dropped by 30 per cent. In Liberia, the number of births attended by a health professional dropped from 52 to 38 per cent after Ebola escalated (Black 2014; Kitching *et al.* 2015). The United Nations (UN) Population Fund estimates that of the 800,000 women expected to give birth in Liberia, Guinea and Sierra Leone in the next 12 months, 120,000 will face complications if the current strain on health services is sustained (UNFPA 2014).

The confluence of these two health emergencies – Ebola and maternal mortality – in West Africa is significant for two main reasons. First, it points to the importance of understanding the gendered dimensions of health emergencies, both in terms of women's compounded vulnerability to Ebola through their role as carers and as they give life, and in terms of the socioeconomic implications of Ebola on their own and their household's livelihoods. Second, as one of the most pressing health concerns in the pre-Ebola era, a consideration of attempts to address maternal mortality might, as a proxy, shed light on limits and successes of development responses to addressing health emergencies that are also strongly gendered.

## **Beyond sociocultural explanations of death and disease: gender, health and structural violence**

Rather than considering the value of engaging with local gendered institutions, or of addressing the deeper structural violence – specifically drivers of impoverishment – that is captured in the stark rates of maternal mortality, there has been a tendency over the past five years to emphasise sociocultural, rather than structural, causes of the region's reproductive health emergency (Lori and Boyle 2011). A 2009 report by Amnesty International, for example, placed the weight of blame for these figures squarely at the feet of a local culture and a national government, both of which were represented as discriminatory in their 'indifference' to the survival of poor young women (Amnesty International 2009). Such 'culturalist' explanations are dangerous precisely because they enable observers in wealthier parts of the world to avoid facing uncomfortable questions about the global economic processes that have impoverished certain regions of the world to the extent that governments are unable to take the most basic measures to safeguard the lives of their citizens. This is evident in certain discourses around gender and Ebola, for instance, that focus mainly on household-level gender dynamics that contribute to women's greater likelihood of caring for a sick family member (Ravi and Gauldin 2014), but that do not also consider that many local health centres are under-resourced, unable to provide essential care or medicines: thus, implicitly relying on women's roles as carers to take on the burden of care that the state and bilateral and multilateral agencies cannot provide (Folbre 2014).

These approaches may also lead well-intentioned development agencies to overlook the most appropriate solution to a public health crisis. So, although DFID has invested tens of millions of pounds (DFID 2013) in trying to improve Sierra Leone's poor reproductive health outcomes, the focus was not on reconstructing the health system at large but rather on subsidising women – as a population of individuals – to have their health care provided free of charge. Within some development discourse, such claims to 'empower' young women through health subsidies, for instance, have been cleaved from any broader interest in a politicised struggle for social justice (Cornwall 2014). Critics argue, instead, that the language of female empowerment is mobilised to promote strategies with a far narrower neoliberal agenda, aimed at transforming individual young women into successful entrepreneurial subjects (Hickel 2014).

Given the utterly shattered state of Sierra Leone's post-war health care system, we might question how logical it was to view poor reproductive health as evidence of gender discrimination; or how possible it could ever be to address Ebola or maternal mortality as standalone problems, in isolation from each other or more comprehensive structural investment, building the basic capacity of health-care systems. Although the Amnesty report is more polemic than most, its message reflects a recurring trend in development discourse over the past 15 years, in which the suffering endured by women in the world's poorest communities is blamed on local patriarchal values, rather than fully acknowledging the extent to which women's vulnerabilities (like those of men) are driven by broader global structures of impoverishment and inequality (Cornwall and Brock 2005). From the merciless resource extraction of mining companies, to the illegal trawlers that decimate West African fisheries to feed European Union appetites, wealthy countries are implicated in eroding the ability of impoverished states – as well as impoverished households – to meet the most basic health needs of their members.

## Implications for development policy: towards a more open conception of ‘empowerment’?

The difficulty of making simple claims about ways to address health concerns that affect women and men differently and, correspondingly, what ‘gender empowerment’ ought to look like, is revealed particularly vividly in the region of West Africa currently hit by the Ebola crisis. The UN places Guinea, Liberia and Sierra Leone 179th, 175th and 183rd respectively, in a ‘Gender Inequality Index’ that ranks 187 countries (UNDP 2014). Yet, for many of us who have lived and worked in the Mano River region, these dismal figures are difficult to correlate with our experience of communities in which members of both sexes have held positions of religious and political authority, and have been active participants in public economic life, for as long as anyone can remember (Bledsoe 1984; Leach 1994; MacCormack 2000).

A reason for this striking mismatch may lie in the reluctance of mainstream development institutions to engage with certain kinds of ‘traditional’ institutions. One of the most distinctive characteristics of social life for most language groups across the region currently affected by Ebola, is the central role played by gendered initiation societies. Across most of Sierra Leone, Liberia and parts of Guinea, all adolescent girls and young women are initiated into the Bundu society as part of their transition to adulthood. To many international development actors, these so-called ‘secret’ institutions are narrowly depicted as deeply problematic (cf. DFID 2013). In the case of the Ebola outbreak, the reluctance of development actors to engage with these gendered institutions has come at a cost. As institutional structures widely respected as holding and transmitting information about the most deeply felt matters of life, health and death, these actors might have been very useful allies in the fight against the outbreak (cf. Jambai and MacCormack 1996; Richards *et al.* forthcoming).

This reluctance to engage constructively with longstanding gendered institutions is consistent with an approach to ‘gender empowerment’ that targets interventions to individual women and girls, while making sense of health emergencies like Ebola and maternal mortality by pathologising ‘traditional’ cultures. In so doing, interventions both fail to engage the constructive dimensions of sociality so thoroughly woven into people’s lives, and overlook the wider structural drivers that erode the very systems needed to sustain life.

If the Ebola crisis will teach us anything, it is that we cannot afford to focus solely on the visible manifestations of ill-being without unpicking the heart of violent structures that underpin them. This will require development actors and agencies to consider, too, their role in perpetuating historic and extractive economic and political relationships. Far more crucially, it will require a paradigm shift: if we are going to build resilient health systems and resilient societies we cannot focus on women and girls as atomised individuals. Rather, we need to take into account existing hierarchies and the contextually specific institutional fabric into which men and women’s lives are woven. Effective development responses to the gendered dimensions of health emergencies would require agencies to work more creatively with existing social models for regulating society, and more sustainably to reconfigure the institutions that bear the legacy of historic and entrenched structural violence.

### Further reading

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