Chapter 1

Five Lessons from Past Ebola Epidemics for Today's COVID-19 Pandemic

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Introduction

Lessons learned from previous infectious disease outbreaks underscore the diversity of ways in which girls and young women can be disproportionately affected (Kapur 2020a). The experience of Ebola highlights the gendered dimensions that they will likely face as a result of the current COVID-19 pandemic. Drawing on qualitative data collected during the 2018–20 Ebola epidemic in the eastern Democratic Republic of Congo (DRC), in this chapter I examine critically five key lessons about the experiences of girls during large-scale infectious disease outbreaks.

First, understand the intersectionality and influence of age and gender.

Second, anticipate the exacerbation of preexisting gender disparities in the domestic space.

Third, navigate the economics of survival.

Fourth, acknowledge and address gender biases in scientific research and resourcing.

Fifth, pay attention to the persistent invisibility of girls.

Notes for this section can be found on page 29.

Both the immediate and secondary implications of these lessons underscore how key learning from the past can be used proactively to identify and redress the evolving gender-driven consequences of the novel coronavirus, COVID-19. Policymakers and practitioners from across the humanitarian–development nexus should use these lessons to inform the development of gender-responsive interventions at local, regional, and international levels, thus ensuring that girls remain at the center of pandemic prevention and response efforts.

The Methodological Framework

A by-product of the contagiousness of COVID-19, and the concurrent widespread mobility restrictions at the local and global level, has been a data-constrained environment for decision-makers. In the absence of conventional forms of face-to-face data collection to inform global efforts to develop responses to the pandemic, in this chapter I rely on a reflective analysis of evidence. I use primary data from consultations with Congolese girls and young women who survived the second largest Ebola epidemic in history, supplemented with publicly available statistics and information on the evolving trends of the COVID-19 pandemic. This contributes to an ever-growing body of literature that seeks to identify and draw lessons from the experiences of past pandemics, epidemics, and outbreaks around the world (Davies and Bennett 2016; Moore et al. 2020).

To better understand and address the gendered implications of Ebola, CARE International commissioned a groundbreaking gender analysis at the height of the 2018–20 crisis. Age- and gender-disaggregated focus group discussions were therefore held between October and November 2019 at the epicenter of the outbreak in the province of North Kivu, eastern DRC (Kapur 2020a). The research sample consisted of 1,008 individuals of varying ages, genders, and (dis)abilities, and included participatory consultations with 240 preadolescent girls, adolescent girls, and young women aged ten to nineteen. These were divided into two different age tranches (ten to fourteen years and fifteen to nineteen years) to allow for sufficient exploration of age-specific dynamics. To explore the impact of the Ebola crisis on the availability and accessibility of sexual, reproductive, and other health services, expectant and new mothers were also actively included, as were participants with different types of disabilities. Child-friendly, inclusive, and age-appropriate methodological tools and facilitation techniques were employed during the focus group discussions

to document participants' first-person perspectives on prevention and response measures in the Ebola epidemic.

In developing the methodology, we considered the ethical implications throughout to ensure that the research teams worked respectfully and reciprocally with both children and adults. Participation was voluntary for all. Depending on the age of the participant, informed assent or consent was obtained prior to data collection. Safeguarding, anonymity, and data protection protocols were developed, and training was cascaded to all members of the research team. Enhanced safety and security measures were put in place with due consideration of the confluence of armed conflict and infectious disease outbreak in the area. Given the complex operating environment and the potential for mistrust and retaliation against perceived outsiders, it was critical that qualified enumerators were recruited in and around the research sites. They worked under the technical supervision of CARE International staff members of Congolese origin who were also either local to the area or long-time residents with a solid understanding of prevailing dynamics. As a foreigner, I limited direct interaction with research participants to interviews with key informants in the provincial capital of Goma so as not to derail the efforts of the research team further afield. Both the initial development of the research framework and later interpretation of data nonetheless benefited from my personal and professional experience of living and working in the eastern DRC and in the wider region for more than a decade.

The strength of qualitative research of this kind is that it enables the examination of the *how* and *why* questions that underpin the differential ways in which girls and young women experience a public health crisis. It draws on the expertise and insight of individuals and groups who have intimate knowledge of the crisis. However, because people experience the same situation differently, personal perspectives can vary widely between and among individuals. While this diversity of viewpoints limits the extent to which findings can be generalized, they do nonetheless offer valuable insights that, with appropriate contextualization and in complementarity with emerging evidence, can be applied to the COVID-19 pandemic.

The Experience of Ebola: Five Lessons about Girls

Endemic to the DRC, the deadly Zaire Ebola strain responsible for the 2018–20 outbreak in the eastern part of the country is known to have the highest fatality rates of all Ebola virus disease (EVD) strains (World

Health Organization 2021). The disease spread from its epicenter in a highly enabling environment characterized by armed conflict, population mobility, and community resistance. Despite aggressive efforts to stamp it out, the virus claimed 2,287 lives over twenty-two months (World Health Organization 2020b). However, these top-line casualty numbers obscure the underlying nature of the Ebola crisis. In fact, according to the World Health Organization (2020a), most of those who died were women (57 percent) and children (29 percent). Adult men constituted just 9 percent of Ebola-related deaths (ibid.).[1]

While the feminization of fatalities was a clear trend with Ebola, initial numbers in relation to COVID-19 deaths show that men appear to be more likely to succumb to the disease (The Sex, Gender and COVID-19 Project 2020). This contrast, however, does not preclude the many and varied ways in which girls and young women continue to bear the brunt, not necessarily of the coronavirus itself, but of its implications. In fact, the Ebola outbreak in the DRC had a staggeringly high case fatality rate of 66 percent (World Health Organization 2020b), while that of COVID-19 at the time of writing arguably ranges between 3 and 4 percent (Our World in Data 2020).[2] This indicates that fatalities alone do not fully demonstrate the differential ways in which individuals are exposed to, or experience, the immediate risks and longer-term consequences of an infectious disease outbreak, underscoring the necessity of looking beyond the statistics to capture the full array of secondary harms stemming from this latest coronavirus. Socially prescribed cultural norms, attitudes, and practices in relation to gender and age influence the needs, capacities, and coping strategies of individuals, ultimately dictating how they may be affected. Although these norms can and do vary across communities and countries, as well as over time, the five key lessons learned from Ebola point to the need to better understand the socio-behavioral underpinnings of disease etiology to identify the diversity of ways in which girls may be affected (Kapur 2020a).

Lesson #1: Understand the Intersectionality and Influence of Age and Gender

The experience of Ebola exemplified the extent to which the short- and long-term impacts of an infectious disease outbreak are not felt equally across all segments of the population. The ways in which girls and young

women experienced the crisis were directly tied to their standing in society and their typically subordinate position within the patriarchy. Age was also an important determinant. Indeed, it was the very intersection between their age and gender that rendered preadolescent girls, adolescent girls, and young women particularly vulnerable. Accorded less social agency and decision-making power, they were also more likely to be economically reliant on male counterparts. This not only increased their vulnerability to risk, it also directly affected their help-seeking behaviors (Kapur 2020a), a trend that is becoming increasingly clear during the current pandemic as well (Pereira et al. 2020).

The risks faced by girls and young women during an infectious disease outbreak correlate, overlap, and intersect with each other. While the exact nature and prevalence of these risks will change from one context to another and will continue to evolve over the life cycle of an epidemic, the experience of Ebola is indicative of how gender and age can dictate both the immediate experience of the crisis and secondary harms well into the future (International Rescue Committee 2020), as explored in greater detail below.

Unfortunately, in both policy and practice there is a detrimental tendency toward homogeneity when it comes to questions of age and gender. At times, social discourse can misleadingly conflate girls (especially adolescent girls) and women, treating them as one homogeneous group with uniform risks, needs, and rights, as Caroline Harper and colleagues (2012) remind us. As minors, both younger and older girls face specific risks and therefore have unique needs relative to adult women. Precisely because of their status as children, girls are entitled to (but do not always benefit from) specific legislative and normative protections and provisions.

Lesson #2: Anticipate the Exacerbation of Preexisting Gender Disparities in the Domestic Space

Research shows that troubled times can exacerbate and further entrench preexisting gender inequalities, while traditional gender norms can become increasingly regressive or restrictive (Kapur 2020b). Discriminatory norms, attitudes, and expectations that are rooted in gendered beliefs and practices can amplify during crises, disproportionately affecting girls and women. One of the spaces in which this is most apparent is within the home. Socioculturally prescribed disparities in the division of domestic responsibilities and resources can be significant.

In the DRC, where girls and women already routinely take on the bulk of daily chores, their physical, mental, and logistical burden only increased at the onset of the Ebola crisis. In the context of COVID-19, this is even more pronounced. Adolescent girls especially are often expected to help their mothers or other female caregivers with household tasks, including the additional domestic demands stemming from widespread travel restrictions and school closures during the pandemic (International Rescue Committee 2020). Older girls may be required to care for younger siblings, affecting their own ability to continue their education via available distance-learning portals. Relative to boys, girls are at greater risk of dropping out of school, either temporarily or permanently (Interagency Network for Education in Emergencies and the Alliance for Child Protection in Humanitarian Action 2020).

While early fatality statistics imply, generally, that girls may be spared the virulence of COVID-19, sociocultural determinants and drivers of gender norms remain a critical factor. As was also seen during the Ebola crisis, adolescent girls and women already undertake most of the unpaid care work in the home and are therefore more likely to assume the role of caregiver to any infected family members. This makes it impossible for them to adhere to the physical distancing guidelines that protect against infection, leaving them, at least potentially, more predisposed to viral infection. This aspect cannot be underestimated in the context of COVID-19, where many authorities, in an attempt to prevent overwhelming available health services, are advising infected people to remain at home unless they require emergency care. The social isolation resulting from quarantine measures can also be significant for those with primary care responsibilities, limiting the practical and psychosocial support they are likely to receive from peers or members of their extended family (Interagency Network for Education in Emergencies and the Alliance for Child Protection in Humanitarian Action 2020).

Moreover, discriminatory gender norms often privilege the health, nutrition, and welfare of men and boys (World Food Programme 2020). In the face of increasing economic hardships and food shortages, women and girls are likely to be the last to eat. Past crises have shown that women and older girls are often the first to adopt coping strategies such as reducing the quantity or quality of food intake relative to men and younger children in the family setting (ibid.).

As with Ebola, clean water is a crucial resource in the fight against COVID-19 infection. In many contexts, gender determines the allocation

of domestic tasks such as the fetching of water. During past Ebola crises, the increased need for water in the household pushed girls and women to leave their homes at odd hours of the late evening or early morning, exposing them to heightened risk of sexual violence or kidnapping as a result (UN Trust Fund to End Violence against Women 2020). One adolescent girl interviewed during the Ebola crisis in the DRC explained, "Because we need more water, we're obliged to leave our homes early in the morning or even after dark in search of water. That's when we can be raped" (Kapur 2020a: 17). The militarization of efforts to enforce infection prevention and control measures worldwide is a hallmark of the COVID-19 pandemic that cannot be overlooked in terms of its possible repercussions on the safety of girls and women as they interface between public and private spaces to carry out their domestic obligations (UN Trust Fund to End Violence against Women 2020).

Lesson #3: Navigate the Economics of Survival

The correlation between economic uncertainty and the neglect, violence, abuse, and exploitation of women and girls is well established (International Rescue Committee 2020). Past Ebola crises have provided ample evidence of the exploitative practices employed by those in positions of power, including front-line responders (Kapur 2020a). Girls and young women were reportedly extorted for financial kickbacks by those who were responsible for securing their employment. There were also indications that men in decision-making roles forced women and girls to perform sexual favors as a prerequisite to being employed or prior to receiving their salary. According to one young woman, "You must always have sexual relations with agents working on the Ebola-response, even if you have a diploma. It's very remarkable amongst women" (Kapur 2020a: 22). Healthcare providers and local authorities disclosed details of confirmed cases of pregnancies resulting from the sexual exploitation perpetrated during the Ebola crisis. One healthcare worker reported, "I've had a patient come to me to ask for an assisted abortion. She was pregnant as a result of being forced to have sex with an Ebola responder in order to get her job" (ibid.). This is indicative of more cases that were likely not reported or formally documented, as Robert Flummerfelt and Nellie Peyton (2020) point out. Collectively, this led some girls and women to abandon their posts or to avoid seeking such roles altogether, thus denying them

the possibility of supplementing their income during a time of economic hardship.

The current COVID-19 crisis carries similar risks. An unexpected death in the family can pressurize children, particularly adolescents, to find ways to contribute (Interagency Network for Education in Emergencies and the Alliance for Child Protection in Humanitarian Action 2020). Girls in families already made fragile by the death of a critical breadwinner may be obliged to seek recourse in harmful coping mechanisms and survival strategies to provide for their families in impossible circumstances. Such economic insecurity can, for example, put girls at risk of being groomed for the purposes of commercial sexual exploitation, trafficking, or sale (International Rescue Committee 2020). Adolescent girls are especially at risk of resorting to transactional sex as a means of survival. During the Ebola crisis in the DRC, the sexual exploitation of girls could "be observed in local bars, and it . . . increased since the beginning of Ebola activities." Among Francophone Congolese, these girls were viewed as something of a snack to be ordered alongside drinks and were commonly called "poireaux accompagnateur de la boisson" ("leeks accompanying the drink") according to one research respondent (Kapur 2020a: 22).

Financial difficulties can also expose girls to early or forced marriage; there is growing evidence that existing drivers of child marriage are further exacerbated during times of crisis (Girls Not Brides 2020). Prior to the pandemic, one in five girls was already married before the age of eighteen (Girls Not Brides 2018). Without appropriate mitigation measures, it is reasonable to expect a surge in child marriages during both the acute and recovery phases of the pandemic (Save the Children 2020). While more research is needed, it is already clear that parents in duress will sometimes broker marital arrangements for their daughters as a perceived protective measure. In societies where a bride price is commanded, families may also view the marriage of their children as a means of generating income (International Rescue Committee 2020).

Lesson #4: Acknowledge and Address Gender Biases in Scientific Research and Resourcing

As was the case with Ebola, the future course of the current COVID-19 outbreak hinges on an effective medical response. In fact, vaccinations were developed and deployed to successfully control an Ebola epidemic

for the first time during the 2019–20 outbreak in the DRC. However, the conditions necessary to receive the vaccination were unfavorable to women and children. Lactating and pregnant women were classed as ineligible, as were children under five years of age. Because of a lack of urgency in research, these population subsets were left without vaccinal protection at the peak of the crisis (Kapur 2020a).

Unequal access to vaccines is inextricably tied to gender biases evident in the ways in which empirically driven scientific research is both conceptualized and financed. Another key example of this pertains to viral transmission trends, particularly those that disproportionately affect women and young children. With Ebola, the continued presence of viral load in seminal and maternal fluids in male and female survivors was identified. Yet little was done to invest in further research to better understand the persistence of the virus after an Ebola patient had been declared recovered, despite the fact that women and babies were the most likely to be affected by secondary infections, as Sam Mednick (2019) notes.

Women and girls constitute approximately half the global population and should therefore command a proportionate investment in scientific research and resourcing. Moreover, the Director-General of the World Health Organization, Dr. Tedros Adhanom Ghebreyesus, claims that "[i]n everything we do, we are driven by science" (World Health Organization 2019). Yet the scientific underpinnings of COVID-related policy decisions risk being subject to the same partiality. It is vital to avoid a similar de-prioritization of issues directly affecting the health of women and children.

Lesson #5: Pay Attention to the Persistent Invisibility of Girls

Appropriately tailored responses that target the divergent needs of different segments of the population are possible only when there is empirical evidence to allow for this. Consistent and sufficiently detailed data disaggregation is therefore an essential first step. Yet key institutional actors, governmental agencies, and media outlets repeatedly release reports with statistics that eclipse the full picture. During the Ebola outbreak, for instance, the World Health Organization issued weekly bulletins that were widely read but lacked age disaggregation beyond adult and child, as well as sex disaggregation of children or health workers who had died of Ebola.[3] The presentation of statistics in this way can contribute to dangerous

misperceptions about the homogeneity of children and increase the invisibility of girls and women.

School Closures, Home Confinement, and other Containment Measures: The Secondary Consequences for Girls

Beyond the five key lessons from past Ebola epidemics, emergent evidence from the COVID-19 pandemic demonstrates the extent to which infectious disease outbreaks transcend questions of public health alone. Attempts to contain and control virus transmission can trigger a host of secondary consequences for girls, many of which will have far-reaching implications long after the outbreak is brought under control. School closures and home confinements, in particular, can result in social isolation, removing the protective factor of schools, teachers, and peers while simultaneously increasing the likelihood of sexual and gender-based violence. Out-of-school girls may have more unstructured or unsupervised time, including that spent with men and boys. This can result in a higher probability of risky sexual behavior, as well as exposure to sexual exploitation and abuse, the impact of which can be significantly compounded by limited availability of and access to contraception and other sexual and reproductive health services during large-scale infectious disease outbreaks (World Vision 2020).

Ebola showed that the scale of the problem can be immense. Spikes in teenage pregnancies of up to 65 percent were recorded in some areas with prolonged school closures because of the outbreak of Ebola in West Africa (United Nations Population Fund 2018). Of the fourteen thousand girls who became pregnant in Sierra Leone during the 2014–15 Ebola epidemic, eleven thousand were previously attending school (ibid.). In the context of COVID-19, the issue is likely to be even more amplified. At its peak, early childhood, school, and university closures affected 90 percent of the world's student population, an estimated 1.5 billion children and young people (UNESCO 2020). Policies vary, but in many places pregnant girls or young mothers have been expelled from school, barred from sitting examinations, or face long wait times for reentry and, in addition to childcare burdens, will often face social stigmatization (World Vision 2020).

To curb the spread of COVID-19, over ninety countries were put into some form of lockdown, with billions of people facing some variation of shelter-in-place orders (Interagency Network for Education in Emergen-

cies and the Alliance for Child Protection in Humanitarian Action 2020). While these restrictions on mobility were put into place as a protective measure against viral infection and transmission, they have also triggered an alarming spike in violence against girls and women. Homes should be safe for them, particularly during a pandemic of this nature. Yet homes, particularly those under confinement, can also be the sites of violence and abuse, often perpetrated by parents and other caregivers. It is here that children bear witness to intimate partner violence or experience physical, psychological, or sexual abuse themselves. School closures and other control measures can also mean that children are locked at home with their abusers. These risks are further exacerbated by the multiplicity of stress factors affecting parents during a pandemic of this nature, including economic uncertainty, resource scarcity, and health fears (ibid.).

The intersecting risks faced by girls and women have given rise to a "shadow pandemic" (UN Women 2020) of sexual and gender-based violence, yet widespread underreporting of abuses is commonplace because of stigma, family rejection, or lack of access to, or confidence in, the judicial process, among other factors. Community-based reporting and referral mechanisms that were available pre-pandemic may no longer be functional or accessible. Lockdowns and other movement restrictions may prevent girls from seeking support outside of the nuclear family, abruptly cutting access to teachers, neighbors, friends, and relatives, among others. This can severely restrict the safety net upon which they might normally rely. While helplines might be available in some contexts, it may be more difficult for girls under home-based quarantine to use them confidentially without fear of reprisal. Limited peer interaction can translate into delayed access to information, especially for adolescent girls who probably rely on these social networks even more (Pereira et al. 2020).

Acting in the knowledge of their impunity, many perpetrators are able to exploit the prevailing context of social isolation and limited mobility to exercise increased control over their victims, including restricting access to available services or basic necessities (Pereira et al. 2020). Research shows that stigmatization alone can prove deadly (Thompson 2015). Sociocultural norms that promote the notion that girls embody the purity of their family can add to the psychosocial trauma experienced by survivors of abuse, who are at higher risk of suicide and self-harm (Save the Children 2020).

Survivors can face a multitude of debilitating consequences, including untreated sexually transmitted infections, obstetric fistula, unwanted

pregnancy, and unsafe abortion. For very young girls, the effects of physical injuries consequent upon sexual intercourse can be even worse because their bodies are not yet biologically adapted to this (Thompson 2015). Sexual and gender-based violence can have long-term implications for the educational, economic, and health outcomes of survivors as well as any future children they may bear (Plan International 2016).

Girls who find themselves pregnant as a result of sexual violence, including the rape that is endemic to forced early marriage, face potentially life-threatening complications. These can include the elevated risk of eclampsia, hemorrhage, and premature, prolonged, or obstructed labor. In fact, complications from pregnancy and childbirth are the leading cause of death among girls aged fifteen to nineteen worldwide, while girls fifteen and under have a maternal mortality rate five times higher than young women in their twenties (Kapur 2020b). In previous Ebola crises, maternal mortality rates were even higher than usual (International Rescue Committee 2019). Similar spikes can be expected in the context of COVID-19 as limited human and financial resources are diverted away from sexual and reproductive health services, as the International Rescue Committee (2020) predicts.

In addition to the provision of essential services, a localized outbreak can lead to changes in health-seeking behaviors, as evidenced by experiences with Ebola (Kapur 2020a). This can have a particularly devastating impact on girls and young women of childbearing age. Fears of inadvertently contracting the virus in addition to the possibility of forced quarantine were among the reasons most cited by research respondents to explain their avoidance of medical centers and health services during the Ebola crisis in the DRC. Girls and young women commonly indicated that family separation, social isolation, and stigmatization as a result of infection prevention and control measures pushed them to avoid seeking medical attention for other health needs during the outbreak. Those who were either pregnant or lactating reported that they preferred to forego care altogether (ibid.).

It is clear that the sexual and reproductive health of girls and women will be particularly affected as a result of such realities. Menstrual hygiene is likely to be compromised because of self-isolation, movement restrictions, and supply shortages (International Rescue Committee 2020). Preexisting differences in the source, stability, or size of income, compounded by the adverse economic conditions provoked by the pandemic, may mean that women and girls have less purchasing power to acquire

items essential to their health and sanitation, such as menstrual hygiene products and soap (World Food Programme 2020). Avoidance because of the fear of infection can limit access to family-planning services, affecting utilization rates, while interruptions to contraception protocols that require routine follow up, such as intrauterine devices, can lead to unwanted pregnancies (Kapur 2020a). For girls, the movement restrictions themselves further exacerbate the preexisting dependency on adult or male peers or family members, some of whom may be reluctant to allow their daughters and wives to access services because of the fear of infection (Pereira et al. 2020).

Survivor-centered services adapted to minors, such as the provision of post-exposure prophylaxis kits designed for girls, may be even harder to source. The combination of fear and taboo, compounded with lockdown-related restrictions, can force pregnant girls to redirect themselves toward risky behaviors such as traditional medicines or underground abortions (UN Trust Fund to End Violence against Women 2020). Access to appropriate prenatal, postnatal, and safe post-abortion care are all hindered by both the physical barriers of lockdown restrictions and attitudinal shifts leading to changes in health-seeking behaviors.

Concluding Thoughts and Considerations for the Future

Lessons from the Ebola epidemic validate the need to apply a gender perspective to the analysis of public health crises. Gender analysis provides information about the relative needs, capacities, and coping strategies of girls, women, boys, and men. It reveals otherwise hidden biases among policymakers and practitioners across the humanitarian–development nexus, exposing the extent to which prevention and response efforts can be influenced by the norms of the overarching patriarchy. In this instance, gender analysis makes visible the distinct and multifaceted ways in which girls and young women are exposed to and affected by infectious disease outbreaks, creating an opportunity to close historical gender gaps in policy and practice.

Lessons from Ebola make clear that the gendered dimensions of the COVID-19 pandemic extend far beyond vulnerability to the virus itself, but must, instead, focus on the far-reaching secondary harms experienced by girls and young women. What is needed is a comprehensive consideration of the multiplicity of ways in which girls occupy spaces simultane-

ously related to both their age and gender. The duality of girls' experience and exposure to the short- and long-term implications of public health crises demands the judicious application of both child- and gender-sensitive approaches by actors of all stripes, including multisectoral service providers and other practitioners at local level, national policymakers, and UN agencies, international NGOs, and donors.

It is imperative, therefore, that actors engaged in prevention and response efforts identify and acknowledge the influence of socially prescribed roles and relations, including how they may have evolved over the course of a crisis. In the absence of systematized data disaggregation in data collection and reporting, it is difficult to undertake a more in-depth epidemiological and etiological analysis of infectious disease outbreaks. Actors on the ground must therefore ensure that data is "available, analyzed and actionable" (UNICEF 2020: 2).

Designing and delivering gender-responsive action in the context of COVID-19 and its aftermath is of paramount importance. It is crucial that local and international actors heed the lessons that have emerged from past practice to inform the way forward (Munnoli et al. 2020). To that end, they must anticipate and prepare for an uptick in gender-based violence in all its forms while also finding ways to mitigate the diversion of resources away from core protective services in health, education, and livelihoods (UNICEF 2020). Both child protection and the awareness of gendered norms and practices must be fully embedded in response plans, with corresponding resource allocations. While interventions must uphold the principle of *do no harm* by minimizing the risk of unintended negative consequences, they must also maximize their potential for positive impact by placing women and girls at the forefront of decision-making. Next steps must concentrate on the need to build back better in ways that substantively strengthen the ability of communities and countries to strive for greater gender equality.

Acknowledgments

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gratefully acknowledged. Although the COVID-19 pandemic had yet to become a reality at the time of this fieldwork, the research team and its participants were fully cognizant of the significance of gaining a better understanding of the potentially gendered implications of both present and future infectious disease outbreaks.

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Notes

1. The term *adult men* does not include those otherwise categorized as healthcare workers, who constituted 5 percent of Ebola fatalities and for whom no sex disaggregation is publicly available.
2. The case fatality rate (CFR) is the ratio between confirmed deaths and confirmed cases. During an outbreak of a pandemic such as COVID-19, the CFR is a poor measure of the mortality risk of the disease because of the likelihood of unconfirmed cases.
3. See, for example, how data is presented in the World Health Organization's External Situation Reports on Ebola virus disease in the Democratic Republic of Congo (World Health Organization 2020b).

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