POLICY BRIEF

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EXPLORING THE RELATIONSHIP BETWEEN EPIDEMICS, NARRATIVES, HEALTH POLICY AND THE EXACERBATION OF GENDER INEQUALITY

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THE PROBLEM AND THE CONTEXT

While epidemics effect both men and women, women suffer the adverse impacts of communicable disease differently and disproportionately to men, socially, biologically and economically. As primary caregivers, women experience increased care workloads in the home and community as they care for the sick; they are also more likely to experience income losses due to poor work conditions, sexual and gender-based violence (SGBV), reduced and/or a total loss of sexual and reproductive health (SRH) services, and stigma (Akande, 2010; Harman, 2011; Harman, 2016; Smith, 2019; Wenham et al., 2020). Though epidemics do not create gender inequalities, they do exacerbate them. First, through poorly conceived policies and programmes which fail to adequality consider the different and disproportionate ways women experience disease. Second, through the heavy reliance in global health discourse of women being central in the prevention, management and containment of disease.

Using qualitative desk-top research this study has sought to understand the relationship between the premier global health organisation the WHO and INGO CARE International. The focus was on how health policy and programmes have contributed to the exacerbation of gender inequality for marginalised women of the Global South within the context of three biologically and socially complex epidemics, Zika, Ebola and HIV/AIDS.

KEY FINDNGS

- Women's social, biological and economic experience of Ebola, Zika and HIV/AIDS is significantly worsened by global health organisations and actors such as the WHO and CARE, because they deal with these diseases as solely **a women's problem.**
- Global health discourse sustained a **persistent assumption** that women and their gendered role in caregiving are valuable 'resources' which once 'empowered', through policies and programmes, can be used in the prevention, management and containment of disease.
- Global health discourse has **uncritically adopted 'women's empowerment'** as a way to justify and legitimise particular policies and programmes which rely on the care practices of women to deal with disease.

FINDINGS

Research shows that global health has made dealing with some diseases a women's problem. Women are targeted by global health policies and programmes as a way to deal with or plug holes in deficient health systems which are struggling to cope with the demands of complex epidemics such as Ebola, Zika and HIV/AIDS (Anderson and Beresford, 2016; Harman, 2011; Leach and Dry, 2010; McInnes, 2016). This research suggests that women are targeted by global health because of a persistent assumption about women which posits that as caregivers they are the 'best resource' to deal with diseases which typically require an immense amount of care labour both in the home and community. Further this research has also shown that this assumption about women is underpinned by global health's discourse that it is not just women, but 'empowered' women who are the best 'resource' to deal with diseases. This has seen an uncritical adoption of 'women's empowerment' by global health and the explicit linking of 'women's empowerment' with particular policies and programmes. This is highly problematic and causes women harm because it suggests that women are not empowered in the first place. Empowerment which is externally orientated and linked to large and powerful organisations and actors such as the WHO and CARE dismisses, devalues and ignores indigenous understandings of empowerment and expressions of it. Consequently, making disease a women's problem to deal with through her gendered role of caregiver under the guise of 'women's empowerment', has seen already heavy care workloads increase. This exacerbates pre-existing gender inequalities.

IMPLICATIONS FOR POLICY MAKERS AND DEVELOPMENT ORGANISATIONS

While this research focused on global health actors the WHO and CARE in relation to three complex diseases, it is timely and relevant in the current COVID-19 context. It has immediate implications for policy makers and development organisations involved in responding to the current pandemic and future health crises.

RECOMMENDATIONS

- Ensure women are not overburdened in their caregiving roles through addressing pre-existing gender inequalities in both in the home and community care economy.
- Challenge the uncritical adoption of 'women's empowerment' as a way to deal with disease. Acknowledge that true empowerment is defined by women themselves within their unique social and cultural contexts and not dependent upon, or linked to organisations, policies and programmes.
- Targeted responses should help women deal with the social, economic and biological impacts of epidemics rather than targeting women as a way to deal with diseases in so making disease a women's problem.

- Collect sex-disaggregated data to allow for a fuller understanding around the implications of complex health crises on marginalised and disease affected women and use this analysis to develop nuanced policies and programmes.
- Support and strengthen weak in-country health systems which increasingly rely on women's care labour as a way to deal with disease.
- Address the drivers of pre-existing gender inequalities which are made worse during epidemics, such as poor infrastructure, lack of sexual and reproductive health rights, tenuous work conditions and a lack of access to health care.

METHODOLOGY AND LIMITATIONS

The findings of this research are the result of desktop policy-based qualitative research. Based on a robust literature review and critical engagement with relevant scholarly literature, it became clear that there are often-explicit ways by which women are used in the prevention, management and containment of Ebola, Zika and HIV/AIDS. This led to adverse outcomes for women. The next step involved undertaking a critical analysis of the policy documents. To manage the scope of the research, policy documents were collected systematically within the period 2010-2018. Policy documents were analysed using reflective thematic analysis (RTA) to develop themes in the data for interpretation and analysis.

While there are advantages to using secondary data including time, cost and quality, it is also challenging (Bryman, 2016). Challenges included, a lack of familiarity with the data and time constraints around the size of the data set and analysis (Bryman, 2016). Time constraints around using secondary data saw me reduce the number of organisations from an initial five to two as there was too much data to manage in a master's time frame. This narrowed my focus to two organisations which may have affected my findings.

A further limitation was the complexity and length of policy documents and the use of medical terminology of which I am unfamiliar. Notwithstanding these challenges, this study has identified several key areas for further research to better and more fully understand the relationship between development organisations, actors, policy, programmes and the exacerbation of gender inequality within the context of complex health crises.

FURTHER RESEARCH

COVID-19 research has shown us that little has changed for marginalised women in the global south when complex health crises occur. Research is again raising the issue of gender inequality and how policies and responses are failing women who are suffering the adverse impacts of disease (CARE, 2020; Gausman and Langer, 2020; International Labour Organization, 2020; Wenham, Smith and Morgan, 2020; WHO, 2020). COVID-19 is going to be with us for a long time to come and it will not be the last heath crises to impact the world so development organisations and policy makers need to be better equipped and prepared to deal with the adverse impacts of disease on women.

- Nuanced research is needed to better understand the specific impacts western orientated policies and programmes have on marginalised women in the global south and how these contribute towards increasing gender inequality. Specifically, those policies and programmes which simply see the need to 'empower' women in their role of caregiving.
- Evaluation is needed to better understand how policies and programmes can produce better outcomes for women while not causing harm through over burdening women's already heavy workloads.
- Longitudinal research is also needed to help understand why some marginalised and disease affected women in the global south seemingly embrace western orientated and conceptualised 'empowerment' (as reflected in the data).
- Ongoing commitments are needed to understand how women themselves understand and live out empowerment within their unique contexts, how epidemics might impact this and how policies and programmes might be better aimed at supporting this kind of contextually developed and understood empowerment.

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