

The impacts of the COVID-19 outbreak response on women and girls in the Democratic Republic of the Congo

■ Introduction

Lessons learned from past public health crises shed light on the potential consequences of epidemics, not only on the health of women and girls, but on all aspects of their lives. Today, faced with COVID-19, [only 52% of countries](#) provide sex-disaggregated data on morbidity and mortality related to COVID-19. Analyses of the [broader impacts of the pandemic](#) and the public health measures put in place to control its spread on women and girls are still too scarce.

[Evidence worldwide indicates](#) that **women are disproportionately affected by the health and socio-economic impacts of intervention measures applied for the control of COVID-19**. Women make up the majority of the informal labour sector and are [more likely to suffer job losses](#) or reduced income as a result of closed borders, markets and shops, and restricted movement. **Sexual and reproductive health services are often the first to face restrictions** in terms of availability and access. **School closures place an additional burden on women, who take on childcare responsibilities, including ensuring adequate nutrition**. Girls who cannot go to school are at [increased risk of sexual violence, pregnancy, and early marriage](#) - a trend that was [widely observed](#) in areas affected by Ebola during the 2014-2016 epidemic in West Africa. Risks are exacerbated for women and girls [living in the poorest households](#) in remote rural areas.

Since the beginning of the COVID-19 outbreak in the Democratic Republic of Congo (DRC) in March 2020, mixed methods data produced by the [Social Sciences Analytics Cell \(CASS\) and its partners](#) presents a dynamic where **pre-existing disparities between men and women in terms of health, social protection and economic status are being exacerbated by the outbreak and its response**. This report presents an integrated multidisciplinary analysis of the impact of COVID-19 and its response on women and girls in the DRC, highlighting changes that have occurred since the beginning of the outbreak. **The objective of this report is to provide evidence to support decision-making for strategies to respond to the outbreak to ensure that the health, protection and economic security of women and girls is prioritised.**

■ Methodology: Integrated Multidisciplinary Outbreak Analytics (IMOA)

This analysis uses the IMOA ([Integrated Multidisciplinary Outbreak Analytics](#)) approach, which consists of combining data of different types and sources to establish a **complete picture of the health dynamics and secondary impacts of the COVID-19 outbreak** in the DRC. Since April 2020, the CASS has been conducting qualitative interviews with key informants each month in Goma and Kinshasa, in order to explain the trends observed in DHIS2 (reports on the use of health services) and other health services data. CASS data is analysed each month and integrated with research and programme results of partners working with and around the response to COVID-19 in the DRC; triangulating and verifying changing trends, their causes, and impacts. The IMOA approach **informs evidence-based decision-making by providing solid and comprehensive evidence to those involved in the response, facilitating the development of actions to establish new programmes and reinforce existing ones**.

■ Sex and gender data gaps

Although the CASS and many partners do collect data on the impact of COVID-19 on girls and women, much of the data on the impacts of the outbreak both in the DRC and globally, continue to be [analysed and presented without sex disaggregation](#). For example, data on food security is [rarely disaggregated by gender](#), making it difficult to fully understand the extent of the problem and how the growing food insecurity cultivated by the response to COVID-19 could affect women and girls. **This critical sex and gender data gap means that impact cannot be measured, and specific interventions to mitigate and address impacts cannot be developed and implemented.**

Key results of integrated analyses of the impacts of COVID-19 and its response on women and girls in the DRC

Socio-economic situation

- Most women work in the informal sector, which is heavily affected by border and market closures and restrictions on movement.
- High food prices, declining incomes, and the increase of the exchange rate limit women's ability to meet basic household needs, including food for children.



Women's general health and nutrition

- Increased delay in use of health services: women fear COVID-19 infection and the risk of being quarantined (and separated from their children).
- Women are typically the first in the household to adopt coping strategies, including reducing personal food consumption to ensure sufficient quantity and quality of food for children.



Maternal, sexual, and reproductive health

- Increase in the use of family planning services by women (since June): fear of becoming pregnant due to the cost of raising a child; increase in sexual activity among adolescents.
- Reduced antenatal care (ANC) visits: these are not always considered urgent, especially by women who have already given birth.
- Increase in the number of pregnancies and the number of women and adolescents who, without another option, are forced to seek clandestine abortions.

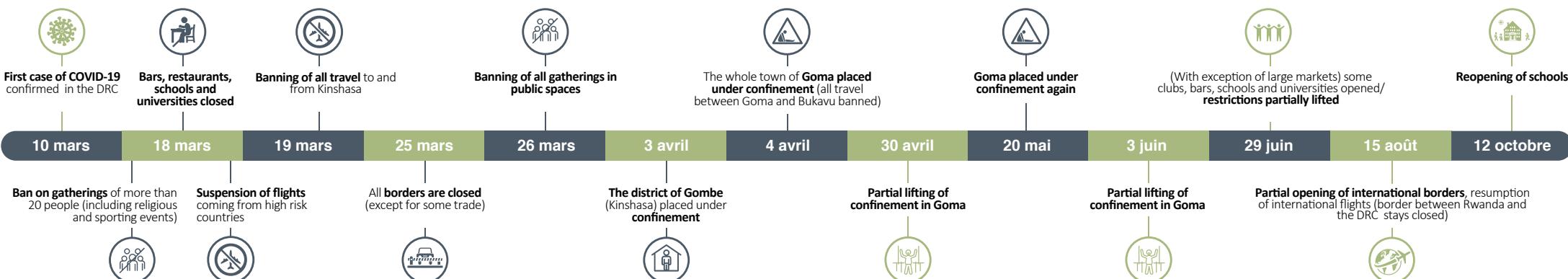


Protection of women and girls

- Increased incidence of sexual and gender-based violence (SGBV) nationally, particularly severe in North Kivu (and Goma)
- Increased unpaid care workload for women as primary caregivers and water collectors: increased exposure to COVID-19 and SGBV (when fewer people on the streets during confinement periods)
- School closures and financial difficulties push adolescent girls to engage in transactional sexual relationships.



COVID-19 outbreak response measures impacting women and girls



Changes in the health, social and economic situation of women and girls in the DRC from March 2020 - November 2020 under COVID-19

Impact	March 2020	November 2020	Data sources
Socio-economic situation 	Employment and business opportunities	Reported job losses and reduced access and availability of work	CASS (qualitative) ELAN (business surveys)
	Cost of living and exchange rates	Rising food prices (uncontrolled), high exchange rate	CASS ELAN (household surveys) REACH HHI-UNDP
	Challenges feeding children	Difficulties in providing food in sufficient quality and quantity (children at home result in additional demands on resources)	CASS Banque Mondiale / INS
	Accessibility and transport use	Reduced access to transport due to reduced availability and increased cost	CASS
Women's general health and nutrition 	Access to and use of health services	Reduced use of health services and delays in access to care	CASS CARE International DHIS2: - Ministry of Health - University of Hong Kong - Bluesquare
	Nutrition and coping strategies	Giving priority to children by reducing the frequency of meals and the amount of food consumed (coping strategies)	CASS REACH
Maternal, sexual, and reproductive health 	Use of contraception and family planning	Reduced use of services (not considered urgent)	CASS CARE International DHIS2 Marie Stopes
	Access to and use of antenatal care services (ANC)	Regular use of services (considered "urgent")	CASS DHIS2
	Access to and use of emergency contraception and post-abortion care	No reported or indication of change	CASS Marie Stopes
	Pregnancy	No reported or indication of change	CASS Marie Stopes
Protection of women and girls 	Teenage pregnancy	No reported or indication of change	CASS Marie Stopes
	Transactional sex	Incidents reported	CASS
	Sexual and gender-based violence	Increase in SGBV cases received in health centres	DHIS2 Médecins du Monde France UNICEF CARE International
	Children living on the street	No reports or indication of change	CASS CARE International AJVDC GHOVODI
	Unpaid work, mental load and household pressure	Increased difficulty in providing food, and keeping children and partners entertained at home	CASS ELAN (household surveys)

Economic and financial impacts of the COVID-19 outbreak and response on women and girls



Women's employment in the DRC is concentrated in agriculture and small businesses in the informal trade sector (where they occupy 64% of jobs), mainly in the sale of food and low-value perishable products. This sector is generally unregulated, heavily taxed and does not benefit from social security or other government benefits. The border and market closures implemented as part of the response to COVID-19 have limited business opportunities for women, many of whom have lost access to their workplaces, customers, and products for sale. The majority of women interviewed during CASS research in Goma and Kinshasa in October 2020 said they had not yet returned to work, although confinement restrictions were lifted in June. Most of the men interviewed as part of the same study in Kinshasa had at least partially returned to work.

Integrated analytics ongoing since the start of the COVID-19 epidemic in the DRC highlight rising market prices, declining incomes, reduced transport accessibility and the depreciation of the Congolese Franc against the US dollar as the main factors influencing and impacting socio-economic security. In August 2020, 70% of households included in a Partnership for Evidence-Based Response to COVID-19 (PERC) survey across the DRC reported lower incomes compared to the same period in 2019 (n=1351). ELAN household surveys across the DRC conducted between August and September 2020 found that 87% of women compared to 76% of men reported a decrease in their household income. In a follow up survey conducted in October 2020, 79% of households reported having experienced a significant increase in food prices and 59% of female respondents compared to 38% of male respondents reported that they were required to pick up food or household items from government or other organisations since COVID-19 (n=2200). A survey conducted through the UNDP and Harvard Humanitarian Initiative in November 2020 in Bunia, Bukavu and Goma found that 90% of women compared to 80% of men reported a worsening financial situation since COVID-19.

Socio-economic consequences impacting protection and health

Reduced household incomes coupled with school closures has had an additional impact on the protection and health of children and adolescent girls. Women interviewed during CASS research in Goma and Kinshasa reported difficulties in providing adequate food for their children. Further women suggested that an increasing number of girls are engaging in transactional sex, as families have a reduced capacity to support them financially, and they lack the structure and security provided by schools. Others reported observing an increased number of children, including girls, living on the streets.



Evidence-based considerations to address the economic and financial impacts of COVID-19 on women and girls

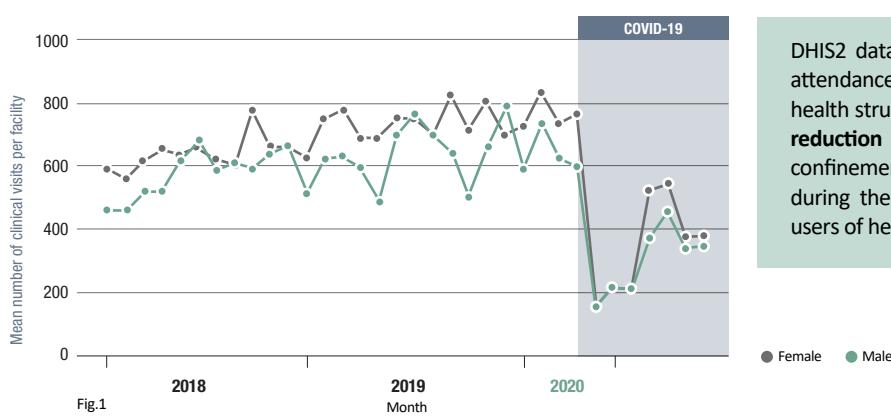
- Advocate for appropriate prioritisation of government subsidies to ensure that the primary needs of the most vulnerable women and girls are met (e.g., rent, food, utilities, health care). Work through existing women' organisations specialising in such support to reach those most in need.
- Promote and support the establishment of sustainable income-generating programmes for women and girls, especially those who have not been able to attend school on a continuous basis (or at all).
- Encourage women (traders, farmers) to form self-managed structures (cooperatives) with support (capital management, savings, business management) to develop their economic resilience.

General health and nutrition of women and girls

Delays and reductions in use of health service



All facilities - Gombe



DHIS2 data from April and May show a decrease in attendance of public and private health facilities. The health structures in Gombe, Kinshasa, recorded a 90% reduction in new visits by women during the confinement period (75% reduction in visits by men during the same period). NB: Women were greater users of healthcare facilities prior to COVID-19.

The sharp decline in the number of visits by men and women correlates with the start of a three-month period of confinement in Gombe, suggesting that the main reason for delays and reduced healthcare demand and service use was the restriction of movement, preventing people from physically accessing services. Qualitative evidence highlighted that difficulties in accessing transport during the period of confinement, fear of being wrongly diagnosed as a case of COVID-19, fear of indefinite forced quarantine and lack of financial means were the main barriers for women to seeking care.

Despite a partial recovery in the number of visitors, which coincided with the end of the confinement period and the resumption of activities in Gombe, the monthly average recorded in October was still 50% lower than the figures reported before confinement. CASS analysis suggests that the reduction in clinical visits seen from August onwards is mainly due to increasing financial pressures and a reorientation of household priorities.

Qualitative research conducted to understand changes in DHIS2 data found that fear related to the COVID-19 response, including perceived forced quarantine, were more often cited by women in Goma who had recently been exposed to similar interventions during the 2018-20 Ebola outbreak response. Qualitative data from Goma found that women reported having a limited understanding of the measures that would be taken if a person tested positive for COVID-19. Most women believed that this would involve being transferred to a separate treatment centre and being detained for several weeks, and due to this fear, they would wait longer before seeking care if they perceived their symptoms similar to those of COVID-19, such as fever or cough. Since August 2020, mentions of COVID-19 and any associated risks have become less frequent each month in CASS data, suggesting that fear of the disease or associated factors is no longer an important consideration or the main barrier to accessing care.

Increasingly, the data identify money as the main factor limiting women's access to care and use of services, as the financial impact of the protracted outbreak and response forces women to change their priorities. The majority of women interviewed in Goma and Kinshasa said that food and the ability to feed their children were their main priority and that they had concerns for the coming months about the accessibility of food. None of the women said that they had set money aside for healthcare, preferring to deal with health problems and find a way to pay for them if and as they arise.

Food insecurity and adaptation strategies



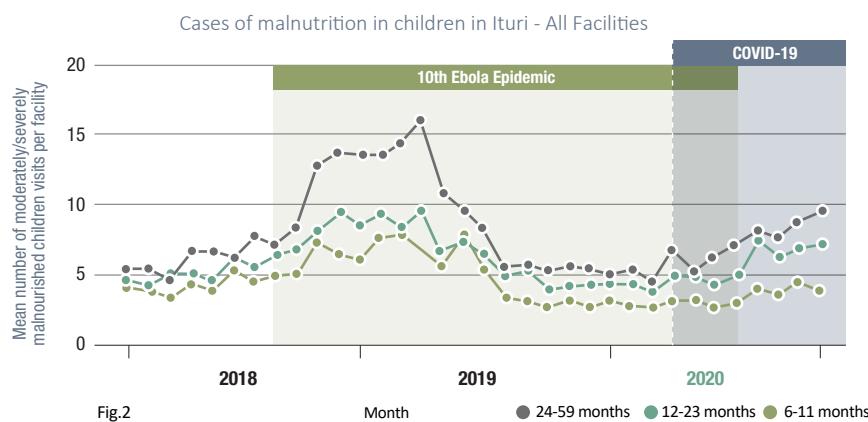
In August, the World Food Programme (WFP) estimated that more than 40 million people in DRC had insufficient food consumption - an increase of almost six million from May figures. This data is worrying, and crucial, but as it stands, fails to provide critical, gender and age specific analyses.

CASS data from October found women in Goma reporting being forced to reduce the size and frequency of the meals they eat each day to be able to adequately feed their children. 55% of women in the October ELAN household survey also reported decreasing household food and water consumption (n=2200). A study by the National Institute of Statistics (INS) and the World Bank from June and July 2020 in Kinshasa reported that 87.8% of households were worried about not having enough food and that 80.4% had reported reducing the number of meals per day (n=1596).



"...I go all day without eating when I have a baby to breastfeed...even the neighbours who could help didn't have any food...COVID-19 is a disease that has come to kill us in whilst we are alive. Instead of suffering like this, it is better that the corona kills us directly..."

Mother, Goma, October 2020



DHIS2 from Ituri province show an increase in the number of moderately and severely malnourished children under five years of age presenting in health facilities since the beginning of the COVID-19 outbreak. This increase is particularly marked among infants aged 2 to 5 years.

CASS research suggests that women put the health and nutritional needs of their children ahead of their own. Given the proven intrinsic links between a mother and child's nutritional status, these trends may mean that women themselves are not able to access food in sufficient quantity or nutritional quality.



Evidence-based considerations to address the food insecurity impacts of COVID-19 on women and girls

- Advocate for comprehensive reporting of sex-disaggregated food security data to improve understanding of the extent of the problem, and the differential impacts facing women and girls.
- Support free or subsidised facility-based healthcare for general health services for women and children (towards universal health coverage).
- Strengthen the provision of community-based services, including vaccination and vitamin A campaigns, mosquito net distribution, deworming treatment, etc.
- Support the provision of subsidised food to the poorest families, including free school meals.
- Ensure clear and context-specific communication about COVID-19 care processes, and the process followed when a person tests positive

Maternal, sexual, and reproductive health

Pregnancy



During qualitative interviews conducted in Goma and Kinshasa in September and October, healthcare workers and community members said that they had observed more pregnant women and girls in their neighbourhoods, churches, and health facilities since the previous month. This finding was echoed in interviews with healthcare providers at Marie Stopes-supported mobile clinics in Kinshasa and in Tshopo district, where staff reported both an increase in the number of pregnant women and girls coming to their clinics for consultations and observed in the surrounding neighbourhood.

Confinement measures, job losses and restrictions on movement were cited as the main explanations for the increase in pregnancies, as men and women spent more time together at home, leading to an increase in sexual activity. In addition, school closures removed the structured environment that generally ensured the safety of girls, as well as regular supervision by teachers, which many parents were not able to replicate. This increased the risk of teenage pregnancy and removed opportunities to provide sexual health education that could normally be provided in schools.

Contraception and family planning



DHIS2 data from March to May show a reduction in the use of family planning services in Kinshasa. Qualitative data suggest that many women did not consider obtaining contraception as an urgent need during a period when there were concerns about visiting healthcare facilities, relating to risk of COVID-19 infection and enforced quarantine.

DHIS2 data from May onwards show an increase in the use of family planning services. Qualitative data suggest that the main factor motivating married women's demand for contraception was a growing concern about the long-term financial implications of having an additional child, at a time when finances are strained.

Healthcare workers reported an increase in the number of adolescent girls seeking access to contraceptives, and generally believed that this reflected increased sexual activity - a consequence of school closures. Data from CARE International in North Kivu also show a 74% increase in the number of adolescent girls (<19 years) visiting their supported health facilities for family planning services between March and October 2020 (new users).

Healthcare workers from Marie Stopes clinics in Kinshasa highlighted the difficulties in engaging adolescent girls with their services since the beginning of the COVID-19 outbreak. Staff reported observing older women criticising young women and adolescent girls for needing to use family planning and reproductive health services and for not abstaining from premarital sex. Other staff consulted with girls who feared that other women they knew might report to their parents that they were visiting the clinic:



"...young girls are sometimes frustrated when they meet women who know them, or who are the same age as their mothers and who talk badly to them because they already use the planning service..."

Healthcare worker, Kinshasa, October 2020

Some healthcare providers considered the pandemic to be responsible for increased stigmatisation of adolescent girls by older women, since a greater demand for and use of sexual and reproductive health services heightened the risk that women and girls would meet people whom they know.

Money influences maternal, sexual, and reproductive health decision making

Marie Stopes International (MSI) provides free sexual and reproductive health services in Kinshasa and Tshopo province through mobile clinics, targeting women in remote and disadvantaged areas selected by the Ministry of Health (areas where most people live on less than a dollar a day). These clinics provide women and girls with easy access to services that would otherwise only be available in fixed structures requiring transport to reach them. In addition, while some public health centres offer contraceptives free of charge, there is usually a cost involved.

Women who use mobile clinics cite the importance of free care:



"If this service cost money, I couldn't be here... it's difficult for me given the burden I have raising my existing children..."

Female visitor, mobile clinic, Kinshasa, October 2020

MSI data shows a **350% increase in the number of visits to mobile clinics between April and July** (during the national state of emergency) (from 1643 to 5819). Between March and October, CARE International also reported a **44% increase in the number of women and girls visiting the health facilities they support for family planning services.**

Qualitative data suggest that the decision to seek contraceptives during COVID-19 could be a **trade-off between the short-term costs, and the longer-term costs of raising a child**. Interviews with MSI health staff highlighted an **increase in the number of women consulting for contraceptive methods accompanied by their husbands**, and some also cited a general shift in women's preference from short-term (3 months) to longer-term methods of contraception (lasting 3-10 years) (IUDs; implants).

Antenatal care (ANC)

Data from the CASS in Kinshasa and Goma from April to August 2020 suggest that in addition to maternity and childbirth, antenatal consultations (ANC) are considered an essential service to ensure the health of the mother and unborn child, which must and will never be compromised. DHIS2 data confirm that the use of services has remained constant.

However, qualitative analyses from October 2020 increasingly suggest that **fewer women are attending ANC sessions in Kinshasa or Goma**. Several women who had never given birth indicated that they would **prefer to receive support from experienced relatives or other women in their community**, while others who had already given birth felt that they **could not learn anything new during ANC sessions**. The data highlights that, although women view ANC sessions as an essential service, **with limited financial resources, they feel compelled to adjust their priorities**, and for ANC, many see a more accessible option within the family or neighbourhood to receive what they consider sufficient support. Interviews with healthcare workers and women highlighted that the restructuring of ANC sessions to reduce group sizes (in accordance with COVID-19 response measures), and the suspension of group health promotion components have also impacted women's participation. In addition to offering specific information and promoting best practices in pre- and post-natal care for mothers, **data suggest** that compared to individual sessions, group ANC sessions lead to higher rates of institutional delivery - an important factor in **reducing maternal and neonatal mortality**. The reported impacts of COVID-19 on these sessions must therefore be closely monitored, not only for attendance but also for the quality of services provided during the sessions.

Emergency contraception, abortion, and post-abortion care

CASS interviews with healthcare workers and communities in Kinshasa and Goma indicate a **perceived increase in the number of pregnant women and girls who, without other option, seek clandestine abortions** or drugs from pharmacies to perform abortions themselves. Some respondents hypothesised that **health personnel perform clandestine abortions to supplement their income**, which has decreased significantly since the start of the COVID-19 outbreak, reflecting a decline in the number of patients.

It is difficult to quantify the impact that COVID-19 response measures may have had so far on the frequency of abortions in a context where this act is illegal under most circumstances, and therefore poorly documented. Pharmacy inventory reports showing changes in the sale of drugs known to induce foetal abortion could be used as an indicator, as could attendance at health facilities by women seeking post-abortion care. For example, staff at **Marie Stopes mobile clinics in Kinshasa reported in October that more women and adolescents were using emergency contraception and post-abortion care services than in April and May**. However, these indicators alone are insufficient data.



Evidence-based considerations to address the maternal, sexual, and reproductive health impacts of COVID-19 on women and girls

- Promote and support a community-centred approach to the provision of maternal health services - e.g., ANC (channelled through the Ministry of Health and organisations providing maternal, sexual, and reproductive health services).
- Provide maternal, sexual, and reproductive health services through mobile clinics, giving access to the hardest-to-reach, most financially deprived areas; provide services free of charge (especially for vulnerable groups, for the services most in demand).
- Engage men in health promotion programmes around contraceptive use, explaining the health and financial benefits of family planning and birth spacing.
- Consider the development of community-based mutual health insurance (contribution system) for women and child access to health care (in connection with Universal Health Coverage projects).
- Provide separate timetables for older women and adolescents for access to sexual and reproductive health services.
- Use a sensitive method to inform women about emergency contraception, abortion, and post-abortion services (depending on the context) - e.g., word of mouth through women's community networks.
- Identify and work with informal practitioners performing non-medical abortions to ensure that procedures are carried out safely, to minimise the risks to the woman/girl.

■ Protection of women and girls



Impacts of school closures on the protection of girls

A study conducted in October 2020 by REACH examined changes in school attendance through key informant interviews at the beginning of the new school year in South Kivu and Tanganyika provinces, after the seven-month closure imposed as part of the national COVID-19 response strategy. More than **two thirds (67%) of teachers interviewed in South Kivu reported a reduction in school attendance** ($n=99$), compared to 39% in Tanganyika ($n=76$). In South Kivu, among secondary school teachers, 35% said that the number of girls aged 12-17 attending school had decreased, compared to 13% who said that the number of boys aged 12-17 attending school was lower than it was before the closure of schools. **The main reason provided by teachers for adolescent girls leaving school was that they were married during the school closure period.**

Adolescents who do not have the structure and safe space provided by school are more likely to engage in sexual activities, including **transactional sex**, which **increases the risk of violence, pregnancy and transmission of sexually transmitted infections**. In the DRC, there is no law or policy specifically protecting the continued education of pregnant girls and teenage mothers. As a result, any girl who became pregnant during the period when schools were closed (who was unable to access emergency contraception or abortion services) risks being unable to return to school.

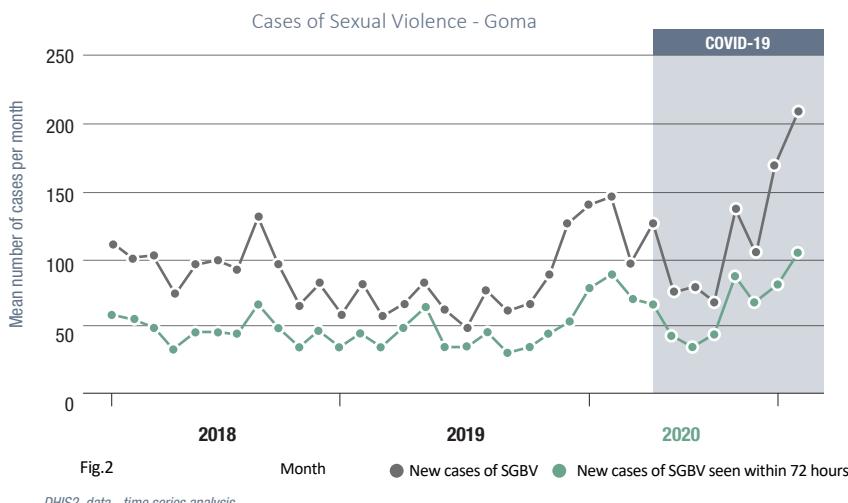


« ...for the last five months, the children have been at home doing nothing... I have personally seen three young girls in my neighbourhood become pregnant... they did not go back to school»

Young woman, Goma, October 2020

Sexual and gender-based violence

A helpline operated by the **Forum des Femmes Citoyennes et Engagées pour la Gouvernance la Démocratie et le Développement** in Kinshasa offering support to victims of domestic violence recorded **20 times more calls from women than men** between April and July (during the **national state of emergency**)¹. The humanitarian non-governmental organisation **Médecins du Monde** reported **double the number of cases of SGBV** received in its health centres in Kinshasa between April and June.



DHIS2 data from North Kivu province show a sharp increase in new cases of SGBV reported since July 2020, with a particularly large increase in Goma. Acknowledging that men can also be at risk of sexual and gender based violence, the vast majority of cases are perpetrated by men towards women.

The DHIS2 data highlights that **less than 50% of survivors of SGBV are presenting at health facilities within 72 hours of an incident occurring**. This can have considerable implications for female survivors who may have been exposed to HIV infection, as post-exposure prophylaxis (PEP) is rendered ineffective outside of a 72-hour timeframe (in addition to being the window during which unwanted pregnancy can be easily prevented).

Seeking to better understand the SGBV data: hypotheses

Why do we see a reduction in cases at the beginning of the COVID-19 outbreak?

- Figures are returning to "normal" average levels after a peak in early 2020.
- During the period of confinement, victims of domestic abuse may have difficulty leaving the house or their aggressors to report an incident or seek care.

Why do we see a sharp increase in cases from June/July onwards?

- Partial lifting of the Goma confinement in June, lifting of the national state of emergency in July: shops, bars, markets open, increased movement of people, alcohol, exposure of women and girls to an environment of increased risk of SGBV.
- Delays in seeking healthcare by survivors of abuse during the confinement period, unable to access health facilities at that time due to restrictions on movement (most cases present in health facilities after 72 hours).
- Female survivors of SGBV go to health facilities to report SGBV if/when they find out they are pregnant (several months after the incident, if abuse has occurred during confinement).

¹ 78% of the calls received by the helpline during the national emergency period concerned cases of physical and sexual violence against children under the age of 14

- Due to financial difficulties faced by households, women working in the informal sector potentially remain on the streets longer and venture further than usual in the hope of selling more - in doing so, they may be exposed to increased risks of SGBV. Women may also resort to transactional sex to increase their income, thereby increasing the risk of SGBV.



Evidence-based considerations to address the protection and safety impacts of COVID-19 on women and girls

School closures

- Establish and reinforce alternative **support structures for adolescent girls who do not have access to school** (either if schools are closed in future or if they have not returned to school) - for example, adolescent-friendly centres that provide access to sexual and reproductive health information, family planning services, etc.
- **Advocate for free or heavily subsidised secondary education**, ensuring that **teachers are paid, and schools are adequately funded to ensure that quality is maintained** (some degree of free education in certain primary schools was introduced in September 2019).
- **Incentivise poorer families to send their daughters back to school** (e.g. financial subsidies, provision of free school meals).
- Establish and support technical apprenticeship programmes (carpentry, tailoring, electrician, etc.) for young people, with a strong **focus on girls and young women**.

Sexual and gender-based violence

- Establish and reinforce community engagement strategies to **promote and facilitate early access to care for survivors** of sexual violence (<72 hrs).
- **Establish context-specific mechanisms for reporting SGBV cases**, being mindful of preferred and accessible communication methods for women, children, men, elderly etc.
- **Support local civil society programmes** that engage communities around the theme of SGBV to **establish and strengthen community monitoring mechanisms**.
- **Facilitate access to medical support for survivors of SGBV** by ensuring confidential care, provided by staff specially trained in the provision of SGBV care.
- **Strengthen the training of health personnel on the detection, management, and referral of SGBV cases**, and on their role in raising awareness among their patients (women, men, children).

Summary and reflection

There is a growing body of data and analysis concerning the **gendered impacts of outbreaks and the considerations that need to be taken into account to ensure that women's health, protection and socio-economic needs are met**.

This integrated analysis has shown that **intervention measures against COVID-19 have a disproportionate impact on the health, security and socio-economic stability of women and girls in the DRC and exacerbate existing inequalities**. Many of the broader health and financial impacts of the COVID-19 intervention measures on women will not be felt immediately, but when they are felt, they will be long-lasting.

By recognising that **COVID-19 is a syndemic**, rather than an isolated public health emergency, this **analysis and the existing body of evidence provide a compelling case for improved action to better understand and address the impacts and needs women and girls affected by COVID-19 in the DRC**.

While data play a critical role in understanding the impacts of COVID-19 on women and girls, we should not wait for more evidence before taking action. It is critical that programmes and strategies are developed to address current impacts and mitigate future risks. Programmes and the funds required to support them, must shift to reinforce, and scale up access and availability of services to women and girls, to identify opportunities for women to regain employment and girls to return to school.

Contributing partners



If you or your organisation would like to work with the CASS, the Information Management Commission, of the COVID-19 response, if you have relevant data that you would like to share, or if you need additional data that can be included in future analyses, please contact :

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This work is part of an ongoing study examining the impacts of COVID-19 on communities and community health in the DRC. The National Institute for Biomedical Research (INRB) has given the CASS, INRB and KSPH ethical approval for this project.