

COVID-19 and gender in the Democratic Republic of the Congo: Key findings on distrust, and health and security impacts



In a fragile state like the Democratic Republic of the Congo (DRC), the COVID-19 crisis highlights the structural inequalities that exist in all areas: from health and the economy to security and social protection. COVID-19 has created a number of upheavals in the daily life of the Congolese in general and in certain subgroups more than others. These upheavals have affected several aspects, such as on access to resources and work, norms and beliefs, laws and institutions

Presented here are the preliminary findings findings of a study that focused on analyzing and understanding the effects of COVID-19 on gender in the DRC. The aim of this Project is to mitigate the spread and negative consequences of the pandemic through the development of practical tools that help to raise awareness about inequalities between the sexes and to remedy these in real time. The preliminary findings show that interventions by institutions, and healthcare and religious structures (including the offices of liberal pastors – not attached to a church), but also certain norms and beliefs have had impacts on the risk of infection and vulnerability, management of the disease/illness and patients, healthcare and medical services structures, social life, the economy, and physical and emotional security in the DRC

Methodology

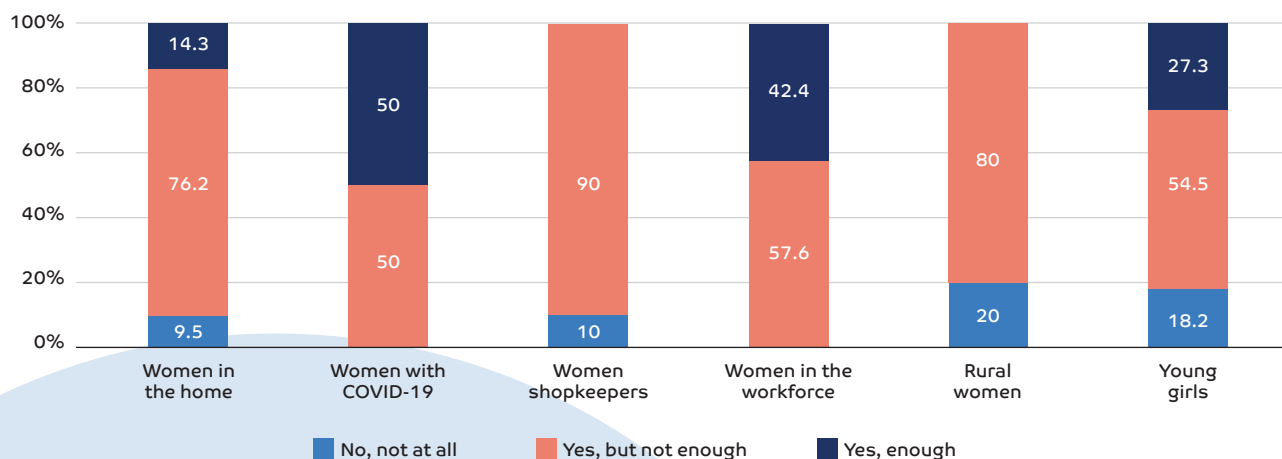
This research was conducted in the DRC in of Kinshasa and Bukavu in the Province of South-Kivu. Data were collected in three stages: ongoing documentation, a survey of women (119 women in total), and interviews with the organizations, media and women involved in the response against COVID-19 (eight resource people in total). The gender analysis matrix was used to identify the main gender-related considerations.

Findings

Misinformation, rumours and distrust in the health system

During the pandemic, in certain segments of society in the DRC, it was observed that adequate information about COVID-19 was delayed or lacking. For example, the study's surveys show that most of the women interviewed were knowledgeable about COVID-19, but there was a discrepancy between the quantity and the quality of information available in the different categories of women.

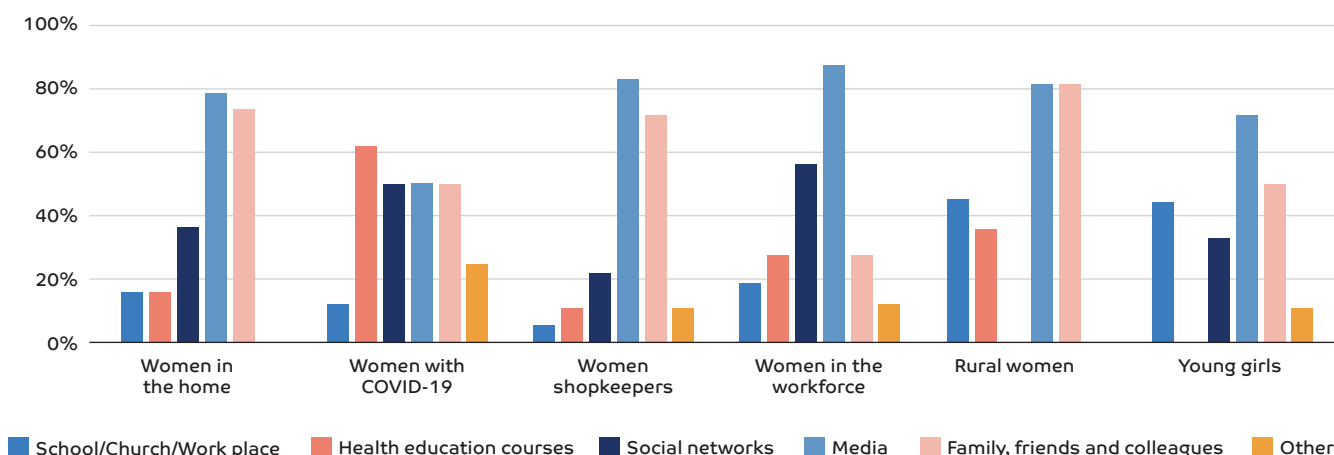
Figure 1 : Access to COVID-19 information by women



It should also be underscored that COVID-19 information has frequently circulated through unofficial channels, in particular social networks and family, friends and colleagues.

Figure 2 shows COVID-19 information sources identified by women who were surveyed for the study.

Figure 2 : COVID-19 information sources



Negative impacts

This has led to a number of consequences, including misinformation. Widespread suspicion, following disinformation claiming that health facilities were complicit in spreading COVID-19, created fear and a crisis of confidence among the population towards these facilities. The population believed that the hospitals were hastening people's deaths and recording these as positive COVID-19 cases. Furthermore, in the eyes of the people, the hospitals were passing each death off as a COVID-19 case. And later during the pandemic, the vaccine fed certain conspiracy theories.

Overwhelming of some healthcare systems:

This disconnect from reality among the people resulted in many avoiding hospitals that were assigned to caring for COVID-19 patients, and they overloaded the hospitals that were not involved in this care. This was confirmed by women who had been infected and those working in healthcare facilities, who noticed a decrease in patients being admitted to hospitals dedicated to COVID-19 patients. In fact, hospitals not involved in COVID-19 care had an influx of patients with other pathologies. This situation caused illnesses to spread more quickly and overwhelmed medical staff.

Decrease in the demand for care:

As result of the "delusional" notion that had been circulating to the effect that, at the hospital, people were being killed in order to swell the number of positive cases of COVID-19, some women were no longer taking their children to the Preschool Consultation (CPS) and no longer attended Prenatal Consultations (CPN). Women also avoided healthcare facilities out of fear of being infected by COVID-19 and the risk of being quarantined (and separated from their children) or because they were afraid of being vaccinated.



"I could no longer take the child to the CPS because I started to be suspicious of the different vaccines that were being given to the children. Why were other types of vaccines added for our children only during this time? There are strange things going on now."

Use of traditional and non-standard treatments:

In addition to the crisis of confidence between the healthcare staff and the population, the lack of a standard and popularized model for patient care made COVID-19 medications expensive and inaccessible at all social strata. This also contributed to a crisis of confidence between healthcare services and the population. During the first wave, screening and care were guaranteed to be provided for suspected infections. When the borders reopened, screening became a for-pay service (for travellers) and care was no longer provided through isolation at the different COVID-19 Treatment Centres; instead, the treatment was to have people quarantine for a couple of weeks at home. This meant that the treatment protocol was no longer standard, and accessing COVID-19 medications became very difficult for certain social strata, in particular because of the ever-increasing price. This situation was observed in all categories of women, and more particularly with women at home and women who had been infected.

Another phenomenon was noted: self-medicating (purchase of medications in side rooms or from street vendors without a medical prescription). The situation caused people to resort to traditional treatments, such as practising traditional self-remedy commonly called “Muvuke,” which consists of inhaling hot water- and herb-based vapour, etc. Indeed, during this period, people and especially women were relying on rumours, and therefore they might allocate the largest portion of their budget to purchase a supply of traditional preventative products recommended on the rumour mill.

Non-compliance with preventative measures

The administrative authorities prescribed a set of COVID-19 preventative measures with penalties for non-compliance. Of these measures, physical distancing created antipathy and a lack of understanding between some members of the family and society. In certain zones, the application of such barrier measures was simply made a mockery of. According to the study, this situation was at the root of the following events:

- People no longer trusted the media
- It was no longer possible for people to help others
- Staying at home was at the root of some misunderstandings between spouses and between parents and children
- Weakening of fellowship



In some cases, membership of certain ideological movements or affiliations with a church to which members owed allegiance contributed to a set of rumours and beliefs circulating, which affected the community's perception of COVID-19. For example, COVID-19 was considered to be satanic and it was believed that a child of God could not become infected.

Some examples of these beliefs based on the study data:

- Blaming atheists for causing COVID-19
- Saying that COVID-19 cannot affect the children of God
- Believing in a wonder drug
- Believing that COVID-19 is one of the signs of the Antichrist's arrival with the requirement to be vaccinated (as the stamp of 666) allowing people to be mobile and that condemns people to hell
- Believing in several biblical teachings whereby the only medication to take is the name of “Jesus.”

Security Impacts

In addition to having a negative impact on people's health and contributing to non-compliance with preventative behaviours, COVID-19 affected physical and emotional security. In some churches, violent acts were observed (sexual, physical and emotional) perpetrated by religious leaders who claimed that the Lord had given them the power to put an end to COVID-19 in the life of believers. Some women had sex with them, while other religious leaders demanded a particular sum of money or even forced labour from their followers.

Measures to stop the spread of COVID-19 – such as wearing masks, regular hand washing, methods of greeting, wearing hand sanitizer, banning meetings and other get-togethers among



friends – caused annoyance and regular assaults by police officers who were taking advantage of the situation. An incident of police harassment was observed following non-compliance with barrier measures and a false interpretation of these measures by law and order officers. Women in particular regularly experienced the fear of being imprisoned and being given fines.

The dissemination of COVID-19 information was seen to be skewed against certain categories of women, especially rural women who waited until barrier measures were proclaimed before seeking to become informed about COVID-19, and then were faced with a lack of information. Women shopkeepers and rural women were arrested and fined for violating barrier measures, thus leading to fear and psychological overload. Women shopkeepers, especially those who were selling goods by the roadside, were more often the victims of assaults by the police. Indeed, police officers were going around with their own masks and were selling them for 5,000 Congolese francs each to any woman who was not wearing one. If women defied these measures, they could be arrested or brutalized.

“Police officers were going around with their own masks and, if they found someone without a mask, those people were forced to buy one at 5,000 Congolese francs per mask.”

Stigmatization and impacts on the health system

Another effect of the pandemic in the DRC was the stigmatization experienced by certain groups, in particular those infected by COVID-19 and their families or loved ones. This led to consequences such as rejection by the community, distrust of the healthcare system, and profiling.

Negative impacts

Rejection at the community and household level

Women who were infected were often avoided and rejected by the community, thus weakening the social fabric in households and within the community.

“COVID-19 helped me to understand many things about life and society. I will never forget how, even in my own house, people avoided me. From the time that I returned from the Bwindi COVID-19 Treatment Centre, I was locked up in my bedroom like a prisoner. I could not get close to my children, and I was forced to wear a mask and gloves when I wanted to breastfeed my daughter.”

Some infected women were subjected to discrimination in the community because they were considered to bring bad luck.

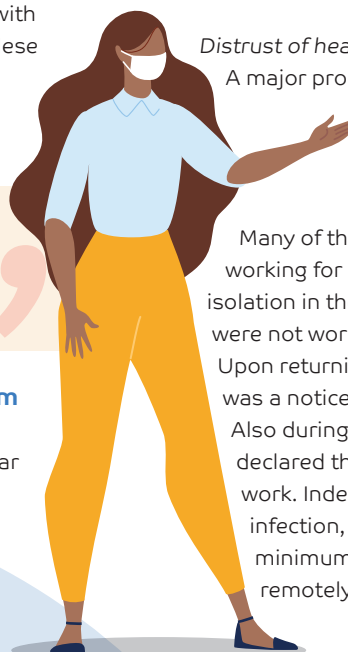
“My husband avoided me, he told me that I brought misfortune. It really hurt me. If I didn’t love him, truly I was on the verge of abandoning him.”

Women who had become infected stated that the level of intimacy between them and their husbands had decreased considerably. In addition, misunderstandings and marital conflicts could follow isolation or a lack of intimacy. This rejection pushed them to reduce how much they went out after recovering. Even when they contracted other illnesses, they could not easily go to the hospital for fear of once again being suspected of having COVID-19.

Distrust of healthcare systems and services

A major problem observed among women who became infected during this period was post-traumatic stress and the loss of work.

Many of the women who became infected were working for healthcare services. Already during isolation in the COVID-19 Treatment Centre, they were not working and were not receiving a salary. Upon returning to healthcare service work, there was a noticeable decrease in inpatient admission. Also during this period, women in the workforce declared that they had lost motivation in the work. Indeed, to reduce the risk of COVID-19 infection, the latter could also provide a minimum service level of work or could work remotely, unfortunately without equipment.



Medical staff felt stigmatized by members of the community. Women employed in health facilities were avoided because they were suspected of being in regular contact with COVID-19. Medical workers were also considered by some people as a tool used by the response team to make the population believe that COVID-19 is present in the DRC.

In some cases, health institutions and their partners intervened in an indecent and discriminatory manner against women who had been infected. For example, infected women were not allowed in some health facilities out of fear of losing clients.

Profiling was also seen to occur in some health facilities. Indeed, healthcare staff considered women to have had the highest exposure levels, especially nursing mothers, pregnant women and elderly women. Under some circumstances, this apparent vulnerability worked in favour of women as they were prioritized by the medical staff. Some institutions responded more favourably; they reportedly organized an educational course and awareness training for women who had been infected on family planning, and counselling on barrier measures and individual protection. The healthcare systems and the media tried to remind women that, because they were more vulnerable, they should follow barrier measures strictly. In other situations, this vulnerability could work against them. The women might have to go through too many protocols in order to access healthcare services, especially in COVID-19 care facilities. It was also difficult for some people to access health education courses located far from households.

Conclusion

The findings of this study illustrate how beliefs and actions that undermine a community's trust during a pandemic can increase both vulnerability and the risk of illness. Disinformation and lack of information during a pandemic contribute to spreading rumours that can affect people's preventative behaviours and whether they seek care, and can impact the performance of the healthcare system. It is important to note that any communication campaign must consider not only how to overcome the community's distrust, but also how to reduce stigmatization around the illness, which can have disastrous consequences, notably social isolation and obstacles to accessing health care. In order to organize a strong pandemic response, multisectoral co-operation also needs to be in place to fight against the corruption of authorities and community leaders seeking to take advantage of the vulnerability of people who lack important information about the nature of the pandemic.

Mechanisms should be considered to ensure the promotion and dignity of vulnerable sub-groups, including women, healthcare workers and people living in rural areas, whether this is during or after the COVID-19 period, and to invite them to participate in designing and implementing strategies for addressing the pandemic so that their points of view and their needs are duly taken into account.

References

Cecilia Agino, Dédé Aliango Marachto, Germaine Furaha Mirindi, and Erica N. Rosser (2022) COVID-19 and gender in the Democratic Republic of the Congo: Key findings on distrust, and health and security impacts, Gender and COVID-19 Project.

