REPORT ON THE STUDY ON

GENDER ASPECTS IN RISK COMMUNICATION WITH A FOCUS ON COVID19

BURKINA FASO, CAPE VERDE, GHANA, GUINEA, GUINEA BISSAU, LIBERIA, NIGER, NIGERIA AND SENEGAL

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Researchers: Aminata Talla-Diop, Stella Odiase

Under the supervision of: WAHO/RCSDC, GIZ

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1. Executive Summary

Risk communication (RC) is an integral part of public health risk assessment and management within the International Health Regulations (IHR 2005). Its success depends on the timely, accurate and relevant transmission and exchange of information, taking into account differences in perceptions, respect, trust and the specific needs and circumstances of target groups.

As we know from the experiences of previous epidemics and the current COVID19 pandemic, communication actions and messages can influence social beliefs and norms, either by reinforcing them or by establishing new ones. Thus, effective mainstreaming of gender in health risk communication in the context of an epidemic or pandemic can make messages more accessible to diverse target populations and contribute to social inclusion, equity and equality in gender roles.

The above approach is consistent with the '*leave no one behind'* principle, which underpins the African Union's Agenda 2063 and ECOWAS' Vision 2020. It also aligns with the European Union (EU) Gender Action Plan GAP III, which identifies, the social and economic wellbeing of women and girls, (including in healthcare, and information, communication technology) as an entry point for transformative change. This perspective is also presented in the (German Development Ministry) BMZ Policy Action Plan on Gender Equality (2016 – 2020), which promotes gender mainstreaming, policy dialogue and empowerment as a results-based intervention troika for transformative change

This study by the West African Health Organisation (WAHO) and the Regional Centre for Surveillance and Disease Control (RCSDC) with the support of GIZ-RPPP, took stock of how gender is integrated into the COVID19 risk communication plans and tools of nine ECOWAS countries: Burkina Faso, Cape Verde, Ghana, Guinea, Guinea Bissau, Niger, Nigeria, Senegal, and Sierra Leone through an extensive desk review, a set of semi-structured interviews with the stakeholders in charge of the development and implementation of these documents.

All of the 15 countries in the West African region were contacted for this study out of which nine of them responded and participated. Data analysis shows that gender is not prioritized or recognized as a crucial pillar in COVID19 risk communication in the nine countries. This is due to a number of reasons but mainly a misconception of the term 'gender' and what it means within the context of developing and implementing these communication plans and tools. The lack of practical guidelines on gender-responsive programming at policy level also compounds this situation.

There were several similarities across countries in terms of their respective RC approaches, but these were also matched by a few contextual differences. Some of the similarities include the reliance on community-based platforms and the establishment of multi sector RC coordinating mechanisms, which include the respective Gender Ministries. From a gender gap perspective, 2 similarities stood out. These were the absence of gender as a key pillar with clear action points and resourcing allocated in the RC strategies/plans as well as the '*everyone is at risk in the same way'* notion which appears to drive a gender disaggregation gap in proposed RC messaging.

Another gender gap, which cut across all the countries was the absence of 'gender-themed partnerships' as a key part of RC messaging. While some countries adopted generic partnership slogans like '*we are in this together'*, gender specific messaging which could perhaps mitigate the incidence of Gender Based Violence (GBV) and other secondary impacts of the COVID19 pandemic were missing. For instance, based on the available materials, there was no imagery and content which promotes couples working together or taking joint decisions to prevent infection or showing how being home together can provide opportunities for parents to engage with their children. Also missing

appears to be RC materials which address aspects of traditional masculinities that may prevent men and boys from seeking or accessing healthcare.

The disparate position of women and girls across sectors in different countries is well documented. For instance, the Global Gender Gap index (GGGI), which is cited for each country in this regional gender study, provides a benchmark of progress towards gender parity and compares gender gaps in 156 countries across the world in four priority areas: economic opportunities, education, health, and political leadership. A comparison of the GGGI data from 2006, when the World Economic Forum produced the first edition, to 2021, shows that West African countries have generally moved downward on the index with many of them (apart from Liberia and Cape Verde) dropping from a position above 90 in 2006, to below 100 by 2021.

Closing the gender gaps and ensuring a steady progression on platforms like the GGGI requires a combination of 'little' as well as 'large' steps in the key sectors at play for women's social and economic wellbeing, including the health sector. This is where the recommendations in this report have the potential to make a difference and ensure that there is a 'trickle down' of well-intentioned policy benefits in health sectors across the region.

We, therefore, strongly recommend that WAHO/RCSDC provide support to countries for gender-specific capacity building of institutions in charge of health risk communication as well as individuals involved in the development and implementation of risk communication documents. The recommendations include a set of immediate and more medium-term actions that can help improve national and therefore regional performance in health risks communication on infectious diseases outbreaks.

Highlights of recommendations

The recommendations contained in this report are split into those for country level consideration and those which are put forward for consideration at regional level.

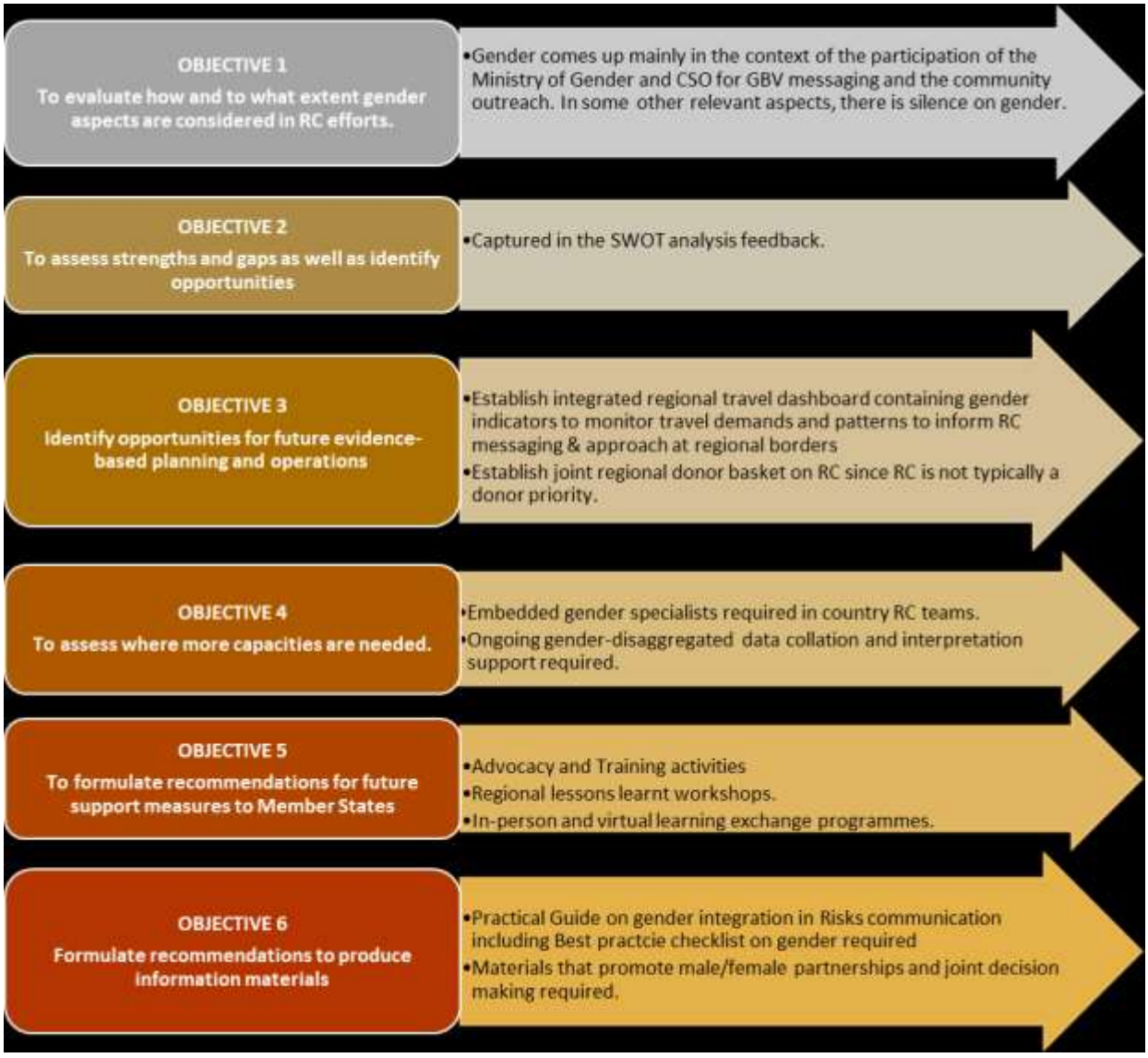
At country level, recommendations include: integrate gender specialists as part of core RC country teams; Generate short, catchy RC messages that promote male/female partnerships e.g., issues like partnering in the home to combat COVID19 also as a way of mitigating the incidence of gender based violence during lockdown periods; Produce materials that address how perceptions of masculinity can increase the vulnerability of men, by stopping them from seeking adequate care; Include in RC materials, graphics that do not reinforce gender stereotypical social norms; Document and disseminate gender case stories and observations about the pandemic from different parts of the respective countries to provide multi-ethnic country updates; Conduct ongoing rapid vulnerability assessments which include gender-focused questions e.g., by using weekly polling or regular periodic perception surveys; and establish community radio programmes.

Recommendations for consideration at regional level include: Advocacy with decision-makers in organizations conducting risk communication planning and implementation; Training in 'Gender and Health Risks Communication' for staffs who design and implement risk communication plans and tools; Provision of a reference document on the practical integration of gender in the process of developing and implementing health risk communication plans for epidemics. Generate gender indicators for monitoring and evaluation in RC for public health emergencies; Establish integrated regional travel dashboard containing gender indicators to monitor travel demands and patterns to inform RC messaging and approaches at borders; Organise virtual and 'in-person' gender learning sessions and exchange visits; Establish multi-donor funding basket and grant system for coordinating

regional donor collaboration; Support ongoing gender training in the risk communication space; And support ongoing mapping of and training for key actors in the RC space.

Snapshot of assessment against study objectives

Figure 1 below provides a quick snapshot of the feedback from this gender study against the study objectives. These and other key issues are discussed in more detail in section 5.4. of this report.



2. Context

Risk communication is one of the key capacities required for the implementation of the International Health Regulations (IHR 2005) which is the international legal instrument to help protect states from the international spread of disease. It is an interactive process of exchange of information and opinions on risks and advice between the different stakeholders including disease control experts and affected populations.

The quality of the response to the 2014-2016 Ebola epidemic and more recently to the COVID19 pandemic and various infectious diseases in West Africa (such as Lassa Fever, Yellow Fever) has demonstrated the need to strengthen the health systems of the members of the Economic Community of West African States (ECOWAS) in a number of technical areas, including health risks communication.

The focus on gender in Risk Communication (RC), is based on the critical need to ensure that life-saving information gets to everyone, but especially to specific groups who might be at higher risk of contracting diseases than others. A gender sensitive risk communication approach, therefore, is one which adopts measures to navigate the barriers which make it harder for such groups to access and use the information that they need to mitigate their risk of contracting diseases. This involves identifying and integrating such measures when the RC processes and measures are being planned and designed, while also adopting these measures during implementation, monitoring and evaluation. This approach falls within pillar 2 of the African Union strategy for gender equality and women empowerment 2018-2028 (Outcome 2.1 "Women and girls achieve higher chances of survival, improved nutrition and wellness and their rights are protected") and within Article 34 (Equality of Rights Between Women and Men in Media Content) of the ECOWAS supplementary Act on Gender Equality.

Gender mainstreaming in the health sector has been a part of global, regional, and national policy conversations even before the COVID19 pandemic began. Historical data suggests that communities with higher social vulnerabilities, including poverty and crowded housing units tend to have more adverse outcomes following a public health event[1]. Within this context, emerging research indicates that in many low and lower middle-income countries, women and girls are at most risk of suffering negative primary and secondary effects of the COVID-19 pandemic[2]. This is primarily because they were already at the bottom of the economic and social pyramid before the pandemic. It is also a consequence of their reproductive health roles relative to constraints in accessing timely and high-quality healthcare.

On behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) and the European Union (EU) in collaboration with the Economic Community of West African States (ECOWAS), GIZ is implementing the "Regional Programme Support to Pandemic Prevention in the ECOWAS Region (RPPP)" from 2016-2021. It includes additionally the EU-funded project "Support to the RCSDC in the ECOWAS Zone" from 2019-2021. The programme aims to support efforts towards a better protected population of the ECOWAS Region against epidemics by strengthening ECOWAS with its mandated entities to better support Member States in disease control as well as strengthen the National Coordinating Institutions in focus countries.[3] To this end, the programme focuses on several key aspects, including the support to gender-sensitive risk communication. The study in particular is funded by the EU Action of the RPPP programme.

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[1] Dasgupta.S.et al (2020) Association Between Social Vulnerability and a County's Risk for Becoming a COVID-19 Hotspot. Centre for Disease Control Morbidity and Mortality Weekly Report. Available at DOI: http://dx.doi.org/10.15585/mmwr.mm6942a3esternal *icon.*

[2] https://www.cgdev.org/blog/where-are-women-and-girls-especially-vulnerable-covid-19-pandemic

[3] Concept Paper for a Study on Gender Aspects in Risk Communication in the ECOWAS Region Draft II – August 2020

In 2018, a situational analysis on risk communication capacities in the ECOWAS Region was carried out as an upstream exercise within the framework of the development of the "Regional Strategic Plan for Risk Communication on Disease Outbreaks and Epidemics in the ECOWAS Region 2019-2023" by WAHO/RCSDC. It identified needs for the inclusion of socio-cultural and gender dimensions in communication strategies and tools as well as for capacity building in these areas. The Regional Study on Gender aspects in Risk Communication was commissioned by GIZ in December 2020 as part of the coordinated programme with WAHO/RCSDC in the support towards pandemic prevention in the ECOWAS region.

3. Study Objectives

The overall objective of this study is to assess and analyze the level of integration of gender aspects, in the frame of human rights-based approaches, in current risk communication systems, i.e., frameworks, plans, and activities in ECOWAS Member States and to which extent they reflect the relevant circumstances of the target populations. The specific objectives of the study are to:

i. Evaluate how and to what extent gender aspects are taken into account in operational risk communication efforts - including framework plans, strategies, actions, and tools produced,
ii. Assess strengths and gaps,
iii. Identify opportunities for future evidence-based planning and operations with regard to gender approaches in risk communication for epidemic prevention and control,
iv. Assess areas where additional capacity is needed at national and regional levels with regard to gender dynamics in epidemic prevention and control
v. Formulate recommendations for future support measures to Member States by the regional level, and
vi. Formulate recommendations for the production of information material on gender approaches in risk communication for Member States and ECOWAS institutions and agencies.

4. Methodology and its limitations

The methodological approach adopted was developed and validated by WAHO/RCSDC and GIZ/RPPP. It involves a qualitative approach that was carried out in three main stages: data collection, data analysis and report writing. The study was entirely conducted remotely as the current COVID19 situation still restricted travelling during the data collection period of March – May 2021.

The findings which are presented in this report were drawn from data which was collated through several means. This includes an extensive literature review of both grey and published material from global, country, and national levels, respectively. This was complemented by a series of semi structured interviews with RC experts who are involved in the COVID-19 national response efforts in 3 Anglophone, 2 Lusophone and 4 Francophone countries. The countries are: Burkina Faso, Cape Verde, Ghana, Guinea, Guinea Bissau, Liberia, Niger, Nigeria and Senegal. A gender-focused SWOT analysis was also carried out for each country based on an interview framework which was administered during the country level interviews. For this, 2 recognized tools were used and adopted: 1) the WHO Gender Assessment Tool (GAT) and 2) the USAID's Technical Brief for Integrating Gender into the COVID 19 Risk Communication and Community Engagement. The WHO Gender Assessment Tool (GAT) is a rapid assessment tool which comprises a set of 23 critical questions that help determine the gender-responsiveness of health programmes, policies and documents, from a high-level

perspective.[4] For this study, 10 of the more contextually relevant questions from the WHO GAT tool were adopted. The GAT tool was adopted and adjusted to conduct a preliminary high-level appraisal of the available risk communication materials and processes. In order to then further unpick the issues raised by the GAT at a more granular level, USAID's 'Technical Brief for Integrating Gender into the COVID 19 Risk Communication and Community Engagement' was used. The USAID technical brief provides a guide for integrating gender considerations into each of the six pillars of comprehensive risk communication and communication engagement as they apply specifically to the COVID-19 pandemic. For a more detailed methodology presentation see Annex 1.

The full study time frame took place between February – May 2021. The data collection period between March – May 2021, proved to be challenging in some cases due to the limited availability of the actors, mainly because of their understandably high workload in managing the different, current health crises (awareness and vaccination campaigns for multiple outbreaks simultaneously, training, etc.). Also, some documents in most cases were submitted at a later stage only and some individual interviews had to be conducted in two stages. In addition, in some countries the quality of the telephone/internet network was poor (Burkina, Niger, Guinea) and challenged a timely exchange. We appreciate each expert who made him/herself available for the interviews and exchanges during this challenging time.

Another factor was that some Country Risk Communications Focal Points were no longer in charge of COVID-19 risk communication. Many of the targeted interviewees were engaged in implementing the national responses to the COVID-19 pandemic and some countries did not respond to the request for interviews and relevant documentation. One country submitted documents after the closure of the data collection period. Nevertheless, out of the 15 West African countries targeted by the study, 3 anglophone (Ghana, Liberia, Nigeria), 4 francophones (Burkina Faso, Guinea, Niger, Senegal), and 2 Lusophone (Guinea Bissau, Cape Verde) countries participated. In some countries, documents were submitted, interviews conducted and the mini focus groups for the SWOT analysis held. In others, the SWOT analysis was integrated during the interview sessions.

Table 1: Number of actors interviewed per country

Profiles	**Total**	Number of women
Country Focal Points (National Coordinating Institute (INC) Communication Officer) - Director of Health Promotion Directorates/Divisions of Ministries of Health Other relevant staff (Gender Expert, Assistants)	**19**	**8**
Staff of bilateral or multilateral projects/programmes	**3**	**1**
Media representatives	**1**	**0**
Representatives of NGOs/associations including women's rights or women's development	**8**	**4**
Community leaders including women leaders	**3**	**2**
Relevant women CBO leaders and CBO members	**1**	**1**
Total	**35**	**16**

[4] https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentTool.pdf

The data collected during the online semi-directive interviews and SWOT analysis exercises were analyzed according to the specific results from the study and according to the five domains of the WHO integrated risk communication model: Communication Systems, Internal and Partner Communication and Coordination, Mass Communication, Engagement of Affected Communities and Dynamic Listening and Rumor Management.

5. Country Assessments

5.1. Country Profile

5.1.1. Anglophone countries

Ghana: The 2021 World Economic Forum's Global Gender Gap (GGG) report positions Ghana at 117 out of 156 countries. This is a nearly double drop from 58 out of 153 countries in 2006 when the first GGG was produced.[5] The country has provided a robust policy basis for mainstreaming gender into all aspects of national life. Ghana has ratified and implemented important international instruments and frameworks in support of gender mainstreaming and women's empowerment, including the Sustainable Development Goals (SDGs); provisions of the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Economic Social and Cultural Rights, the 1995 Beijing Declaration and Platforms for Action, and the new Protocol to the African Charter on Women's Rights, which entered into effect in 2005.[6]

Also, Ghana approved a National Gender Policy in 2015. This policy is anchored within the country's national gender machinery, which is the Ministry of Gender, Children and Social Protection. It aims to mainstream gender equality and women's empowerment concerns into the national development process and promote commitment throughout the government to empowering women.

Health information seeking behaviour in Ghana relies on both formal and informal means, with contextual factors like the burden of household care, leading more women to being passive recipients of information while more men engage in active information seeking[7]. Also, women with disabilities face reinforced barriers to healthcare information access[8]. Available evidence suggests that health issues in Ghana are multi-faceted requiring socio-cultural, health and economic policy interventions[9]. In a recent study, women's level of education was positively related to physical but not to psychological access to health care, while ageing has increasing relationship with poor physical health status[10].

[5] World Economic Forum. The Global Gender Gap Report 2020, 2019.
[6] OECD. Social Institutions and Gender Index Report, 2019.
[7] Lalazaryan A, Zare-Farashbandi F. A review of models and theories of health information seeking behaviour. International Journal of Health System Disaster Management. 2014;2(4):193
[8] Trani J-F, et al. Access to Health care, Reproductive Health and Disability: A Large-scale Survey in Sierra Leone. Soc Sci Med. 2011;73(10):1477–89
9 Africa Centres for Disease Control and Prevention *Interim guidance on the use of rapid antigen tests for COVID-19 response*. Addis Ababa: Africa Centres for Disease Control and Prevention, 2020; Welle. D. Healthcare workers in Ghana lack equipment in pandemic, 2020. Available: https://www.dw.com/en/healthcare-workers-in-ghana-lack-equipment-in-pandemic/av-54901513 [Accessed 3 February 2021]
[10] Boateng.J., Flanagna.C., *Women's Access to Health Care in Ghana: Effects of Education, Residence, Lineage and Self-Determination* Available at DOI: 10.1080/19485565.2008.9989132

Liberia: Liberia is placed at number 94 out of 156 countries on the 2021 Global Gender Gap report, which is a slight improvement from 97th position in 2020, and the 112th position in 2014 when Liberia was first included in this index. Liberia's National Gender Policy (2009) is domiciled in the country's Ministry of Gender, Children and Social Protection (MGSCP). The Policy aims to 'guide the country towards achieving gender equity and equality, building, and utilizing the potential of women and men, boys and girls in pursuing and benefiting from national development goals[11]. The National Gender Policy is being implemented, and the Ministry's Strategic Plan for 2016– 2021 is on track[12]. The Liberia National Action Plan (LNAP) for the Implementation of UN Resolution 1325 on Women, Peace, and Security (2009–2013) highlights specific actions needed to promote and advance the inclusion of women in all processes that affect their peace and security, including health, education, sexual and gender-based violence prevention, governance, and policies that support improved empowerment for women and children.

Maternal mortality and women's access to quality care remains a major issue in Liberia, especially for rural women who are far from health facilities. Slightly more than half of births take place in a healthcare facility, while the issue of sexual and gender-based violence (SGBV) is attracting growing attention both internationally and within Liberian society. Rape is one of the most frequently reported crimes in Liberia, and the rate of sexual violence against women in Liberia is among the highest in the world[13]. A mobile phone survey which was conducted during the Ebola outbreak 2014-16 indicates that health information seeking behaviour tends to rely heavily on information from outside formal health facilities due to some level of suspicion about formal health systems[14]. At the time, the first mass media messages provided by the government, stressed that "there is no cure for Ebola," caused greater fear among households as they did not understand what a treatment centre could do, because they had heard that there was no cure[15]. Generally, there is a tendency for people to seek information individually from among healthcare workers among their peers[16]. For women in particular, literacy and education rates, social exposure, and affective attachment (or the influence of a collective interest) are key drivers of health information seeking behaviour among women in Liberia[17].

Nigeria: Nigeria ranks 139th out of 156 on the 2021 Global Gender Gap Index, a drop from 128th position in 2020 and 94th position in 2006. The country has ratified 9 out of the 13 major global human rights frameworks in existence, which have implications for the situation of women and girls[18]. These include: The International Convention on the Elimination of All Forms of Racial Discrimination; the International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of all Forms of Discrimination against Women; and the Protocol to Prevent, Suppress and Punish Trafficking in Persons. In 2015, the country passed the Violence Against Persons Prohibition (VAPP) Law, an omnibus framework, that integrates the gender specific commitments in the international treaties to which the country is signatory, within an anti-violence context. Also, the 2006 National Gender Policy, which is domiciled in the Federal Ministry of

[11] The Liberia National Gender Policy at p.5
[12] https://pdf.usaid.gov/pdf_docs/PA00WB3Z.pdf
[13] https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20680&LangID=E
[14] United Nations Development Programme (2014*) Assessing the socio-economic impacts of Ebola Virus Disease in Guinea, Liberia, and Sierra Leone: The Road to Recovery.* New York: UNDP
[15] World Health Organization. (2015c). *Factors that contributed to undetected spread of the Ebola virus and impeded rapid containment: One year into the Ebola epidemic*. Available at http://www.who.int/csr/disease/ebola/one-year-report/factors/en/
[16] Kuehne A, Lynch E, Marshall E, Tiffany A, Alley I, Bawo L, et al. (2016) Mortality, Morbidity and Health-Seeking Behaviour during the Ebola Epidemic 2014–2015 in Monrovia Results from a Mobile Phone Survey. Available at: https://doi.org/10.1371/journal.pntd.0004899
[17] Simpsma.H. et al (2013) Healthcare Utilisation and Empowerment Among Women in Liberia. Available at doi: 10.1136/jech-2013-202647
[18] Federal Ministry of Women Affairs (2019) Beijing plus 25 country report. Abuja: FMWASD

Women Affairs is aligned with relevant regional and international protocols and instruments such as the Beijing Platform for Action (BPfA), New Partnership for African Development (NEPAD) AU Solemn Declaration for Gender Equality, African Protocol on People's Rights, and the Rights of Women (APPRRW) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The Gender Policy seeks to equip stakeholder with strategic skills for engineering the levels of social change required for achieving the desired empowerment of all citizens.[19]

Available evidence suggests that the internet is a major feature of healthcare information seeking behaviour in Nigeria generally and even among healthcare professionals[20]. Also, traditional, and orthodox sources of healthcare information appear to have coexisted over the years and this typically accessed through trained healthcare professional or patent medicine vendors.[21] Among women, health information seeking behaviour depends on whether the woman in question resides in the rural or urban areas[22]. In the former, health related information is mainly exchanged during peer interactions, which occur while household or economic activities are being carried out (e.g., going to the market, fetching water from the streams) For urban areas, women with formal education tend to rely on the internet and the media while women urban dwellers without formal education rely on the media to some extent but are also susceptible to rumours and informal sources.

5.1.2. Francophone Countries

Burkina Faso: Burkina Faso is 124th on the 2021 GGGI from 104th position in 2006, when the country was first featured. A national gender policy was developed in 2009. Also, the Ministry for Promotion of Women and Gender is the national gender machinery with the mandate of implementing and monitoring the Government's policies for the social and economic advancement of women. The Ministry also provides a framework for discussion and coordination of all the activities for women. Key gender challenges in Burkina Faso include maternal and reproductive health and hygiene, women's disparate access to credit and disparities at level of male/female enrolment in primary and secondary education.[23]

Evidence suggests that geographic access to care is one of the main determinants of healthcare seeking behaviour in Burkina Faso and that this affects rural women most with significant impacts on child mortality rates in parts of the country[24]. To some extent, social norms tend to shape resource negotiation for women seeking modern healthcare[25]

Guinea: Guinea ranks 118 on the GGI from 114 in 2018 when the country was first featured on the index. The government of Guinea has taken actions to boost gender equality[26]. These include the Law

[19] Nigeria National Gender Policy, 2006, at p.5
[20] https://core.ac.uk/download/pdf/84309419.pdf
[21] Olasehinde.N. (2018) *Healthcare Seeking Behaviour in Nigeria* Journal of Population and Social Studies 26. 207-218. Available at DOI:10.25133/JPSSv26n3.015
[22] https://www.unicef.org/nigeria/situation-women-and-children-nigeria
[23] Country Gender Profile: Burkina Faso published by the Japanese International Cooperation Agency
Available at https://www.jica.go.jp/english/our_work/thematic_issues/gender/background/c8h0vm0000anjqj6-att/burkinafaso_2013.pdf
[24] https://www.who.int/tobacco/research/economics/publications/oecd_dac_pov_health.pdf
[25] Nikièma, Béatrice & Haddad, Slim & Potvin, Louise, 2008. "*Women Bargaining to Seek Healthcare: Norms, Domestic Practices, and Implications in Rural Burkina Faso*," World Development, Elsevier, vol. 36(4), pages 608-624, April.
Available at https://www.jica.go.jp/english/our_work/thematic_issues/gender/background/c8h0vm0000anjqj6-att/burkinafaso_2013.pdf

[26] https://www.unwomen.org/en/news/stories/2019/5/news-guinea-adopts-law-on-parity

on Parity in Elective Positions and the National Policy for the Advancement of Women[27]. However, significant challenges persist.

Evidence suggests that health seeking information in Guinea is influenced by the reproductive roles which men and women play, with demographic groups like pregnant women in rural communities, for instance, refusing to seek maternal health support in hospitals that attend to both men and women[28]. The recurring challenge of the Ebola pandemic in Guinea has taken a toll on the country's health systems and processes. It also underscores the need for contextualized information sharing and risk communication approaches.

Niger: Niger ranks 138 out of 156 on the 2021 GGGI. This is the first time Niger is featured on the Global Gender Gap Index. Issues like violence against women, the gender pay gap, high infant mortality, low girl child enrolment and completion rates, and the prevalence of girl child marriage are some of the gender issues, which the country is trying to address[29]. In 2008, the country adopted a National *Gender* Policy (PNG) to promote women's human rights with the *Ministry* of Population, Women's Empowerment and Child Protection leading on the implementation of this policy.

Some of Niger's gender specific health sector challenges are concentrated in the areas of reproductive, maternal and neonatal healthcare access, as well as child and adolescent *health* and nutrition.[30] As in most of West Africa, health seeking behaviour in Niger is influenced by a household's social context, social structure, social networks, and support within the family. Intra household dynamics such as father's presence or absence and/or his disposition to the mother determine whether a sick child is taken to a health facility for treatment[31]. The World Bank estimates that 83% of Niger's population lives in rural areas and just 49% has access to a health facility within five kilometers of their home[32]. This has peculiar implications for how healthcare-related information is framed and disseminated.

Senegal: Senegal does not feature on the 2021 GGGI but is 99th (Out of 153) on the 2020 GGGI. This is a drop from 94 in 2018. The Government of Senegal (GOS) has ratified numerous international agreements related to gender equality and human rights, including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). The National Ministry of Gender developed the National Strategic Plan on Gender, known as la Stratégie Nationale d'Equité et d'Egalité de Genre (SNEEG 2005)[33]. The GOS also uses a system of Gender Focal Points located in each Ministry who are tasked to review gender integration in ministry programs.

Available research indicates that there are significant variations in health seeking behaviour and type of care dispensed across the country based on cultural, religious, and historical influences[34].

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[27] Ministry of social affairs and the advancement of women and children national office for the advancement of women reply to the united nations questionnaire on the major achievements and the challenges encountered in the implementation of the Beijing platform for action available at https://www.un.org/womenwatch/daw/review/responses/guinea-english.pdf

[28] Improving Human capital through maternal healthcare in Guinea: Local Solution for Local Problems
Available at https://www.worldbank.org/en/news/feature/2019/05/21/improving-human-capital-through-maternal-health-in-guinea-local-solutions-for-local-problems

[29] Niger Country Profile. Published by UN Women. Available at https://data.unwomen.org/country/niger
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[31] Richards E, Theobald S, George A, Kim JC, Rudert C, Jehan K, et al. Going beyond the surface: gendered intra-household bargaining as a social determinant of child health and nutrition in low- and middle-income countries. Soc Sci Med. 2013; 95:24–33 Epub 2012/07/20

[32] https://www.worldbank.org/en/news/feature/2020/06/25/rapid-results-initiatives-in-niger-advancing-womens-health-outcomes

[33] Country Gender Assessment for Senegal. Published by USAID
Available at https://www.k-state.edu/smil/docs/gender/Senegal_Gender_Assessment_Jun-2010.pdf

[34] Franckel. A. et al (2008) *Village context and health-seeking behaviour in the Fatick region of Senegal.* Population Volume 63, Issue 3, 2008, pages 469 to 490

5.1.3. Lusophone Countries

Cape Verde: Cape Verde is ranked at number 68 out 156 on the 2021 Global Gender Gap index. This was a drop from 52nd place in 2020. Generally, the country ranks very high among the best countries for gender equality on the Gender Gap Index: it is 5th among low-middle income countries and 6th in sub-Saharan Africa. This high position is primarily due to rankings in three of the four areas of the index: education, health, and political representation.

Cape Verde has integrated gender equality as a cross-cutting measure in the National Strategic Sustainable Development Plan 2017-2021[35]. Also, the country is a signatory to human rights as well as gender-related regional and international conventions and protocols, whose provisions are automatically incorporated into national law according to the Constitution[36]. These include the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Cairo Action Plan, and the Beijing Action Plan, along with the Sustainable Development Goals (SDGs).

It was not possible to access information relating to health information seeking behaviour during this study. However, Cape Verde's health system has successfully adopted innovative initiatives at national, regional and community levels, respectively. These include the introduction of telemedicine in 2015, the establishment of a milk bank and the focus on teen pregnancy prevention[37].

Guinea Bissau: Guinea Bissau does not feature on the 2021 Global Gender Gap or in prior editions of the GGG index because of the conflict situation which has spanned many years. This context has also resulted in the absence of a lot of gender disaggregated data from the country.

However, the African Development Bank notes that the country does have a National Gender policy and framework for action, called the National Policy for Gender Equality and Equity, Política Nacional para a Promoção da Igualdade e Equidade de Género (PNIEG)[38]. The PNIEG finds that women and girls have been especially disadvantaged by the years of crisis since they are allocated by gender to a secondary status in all spheres of household, community, and national life (p.12). They face gender-based restrictions on their access to scarce resources and to education, and the double burden of household work to care for and feed their families along with market work to contribute to family income. Additionally, girls and women in Guinea-Bissau face the gender-specific risk of maternal mortality, and gender-specific abuses such as domestic violence, female genital mutilation (FGM), and early/forced marriage (PNIEG, p. 57).

5.2. The State of Play with Risk Communication Frameworks, Plans, Strategies and Tools

Table 2 below presents a list of the materials reviewed during this study. These include respective risk communication plans or strategies that were generated because of the COVID-19 pandemic. For Liberia and Sierra Leone, the risk communication materials which were shared for review also included those which were developed during the Ebola pandemic.

[35] https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24824&LangID=E
[36] https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/180320-PGP_EN_F_final_version.pdf
[37] https://www.afro.who.int/news/cabo-verde-shows-us-health-care-progress-we-want-see-across-africa
[38] https://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/Guinea-Bissau_-_Country_gender_profile.pdf

Table 2: Risk Communication materials reviewed during study

Document Source	Document title
Global	• Communicating Risk in Public Health Emergencies: A WHO Guideline for Emergency Risk Communication • EU Gender Action Plan • BMZ Gender Action Plan • WHO gender mainstreaming Guide for Health Managers • UN Report on socioeconomic impacts of Ebola
Regional - ECOWAS	• WAHO/RCSDC Risk Communication Strategy 2019 – 2023 • WAHO/RCSDC Twitter Messages (selected) • WAHO Bulletin on Outbreaks and Other Emergencies (selected) • WAHO/RCSDC factsheet on pandemic prevention in the ECOWAS region
Burkina Faso	• Risk Communication and Community Engagement Plan (Crec) New Corona Virus (Covid-19) TV spots • 7 ways to protect yourself against the coronavirus • TV spot to protect yourself from COVID 19 (INSP) • TV spot "Practical tips to protect yourself from Covid 19 • Covid19 poster - Toll-free number
Cape Verde	• Risk Communication and Community Involvement Plan for prevention and response to the COVID 19 epidemic
Ghana	• Official Twitter Messages and Video clips from the Ghana Health Service on the COVID-19 Vaccine • COVID-19 stakeholder Engagement Plan
Guinea	• Annual plan for communication, social mobilisation and community engagement against COVID 19 in Guinea - Ministry of Health - ANSS - April 2020 • -Strategic plan for community response STOP COVID-19 IN 60 DAYS • "Be a hero in the fight against the corona virus" • "12.41 million reasons to keep wearing the mask • "Help make your school safe • Poster on distancing
Guinea Bissau	• Plano Nacional Anual da Comunicação de Riscos e Engajamento Comunitário para a luta contra Covid 19 na Guiné-Bissau (National Annual Plan for Risk Communication and Community Engagement to Fight Against Covid 19 in Guinea Bissau)
Liberia	• National Public Health Institute of Liberia Communications Policy • National Risk Communication Plan (2017 – 2019)
Niger	• - Risk Communication Plan and Community Engagement in Response to COVID-19; • - Video Clip " Nazi Covid Haoussa" " Dear Defense and Security Forces, let's respect the barrier gestures" • - Flyers "Coronavirus general information; " Coronavirus, what you should know about the disease ". • - Audio message "validated isolation"
Nigeria	• Twitter messages from the Nigeria Centre for Disease Control (NCDC) • Risk Communication and Community Engagement Strategy for COVID 19 Prevention and Control in Nigeria
Senegal	• ‘’Community Engagement for a Response to the Coronavirus Epidemic COVID19 - Orientation Guide" • National policy document for multisectoral risk communication interventions on COVID 19 - MSAS-SNEIPS - April 2020 • Different Posters : "hand washing with the president of the republic; Wearing a mask on public transport; Wearing a mask at the market; Posters workers/mechanics; Home visit
Sierra Leone[39]	• Message Guide for Zoonotic Diseases in Sierra Leone (2019)

[39] Even though the document from Sierra Leone were provided by GiZ at the start of the study they were unable to participate in the interviews or the rest of the process which is why they do not feature in this report

5.3. Gender Gaps in COVID-19 Risk Communication: Anglophone and Lusophone Countries

This section presents feedback from an assessment of the country risk communication documents against 3 frameworks: the WHO Gender Assessment Tool (GAT); the ECOWAS Risk Communication in the Event of Disease Outbreaks and Epidemics in the ECOWAS Region Strategic Plan 2019 – 2023, which aligns also with the Integrated Model for Risk Communication outlined in the USAID Technical Brief on Integrating Gender into COVID 19 Risk Communication.

5.3.1. Assessment against the WHO Gender Assessment Tool

The feedback from this assessment is summarised in Table 3, but also discussed in some further detail further below.

Table 3: Overview of the analysis of risks communications strategies, plans and tools with WHO-GAT

No	Themes/Questions	Cabo Verde	Ghana	Guinea Bissau	Liberia	Nigeria
1	Do the vision and goals of the Risk Communication (RC) frameworks/strategies/documents include a gender-specific rational and/or gender policy objectives?					
2	Does the RC strategy/plan include sex as a selection criterion for targeted messaging population					
3	Does the target population include both women and men?					
4	Did both women and men participate in the design of the RC framework/strategy/document					
5	Does the RC framework/strategy/document consider the life conditions and opportunities to access healthcare and health related information for men and women?					
6	Has the RC approach been piloted with both men and women?					
7	Did the RC frameworks/ strategies/ document development process include consultations with a range of stakeholders including gender expertise?					
8	Do the RC frameworks/strategies/documents indicate a consideration of different health needs of women and men?					
9	Do the RC frameworks/strategies/documents consider gender-based divisions of labour?					
10	Do the images, graphics and language on the RC documents respond to or address gender norms, roles, and relations?					

Yes: No: Partly:

Table 4: summary of feedback from WHO GAT assessment

ISSUE AREA OUTLINED IN WHO GAT	FEEDBACK FROM COUNTRY LEVEL ASSESSMENT
1. Do the vision and goals of the Risk Communication (RC) frameworks/strategies/documents include a gender-specific rational and/or gender policy objectives?	None of the country strategies and plans reviewed mentions gender in their broad goals or objectives.
2. Does the RC strategy/plan include sex as a selection criterion for targeted messaging population?	Not in all cases For example, the Cape Verde plan talks of educating '*different target audiences'*; Also, the Ghana strategy refers to '*faith-based organisations and community leaders'* but does not delineate targeted populations with a gender lens. This is also the case with the Nigerian strategy, which refers to *'individuals, families, peer networks, community leaders, structures, health workers, policy makers'*. The strategic relevance of delineating these target populations by gender is discussed in the narrative section beneath this table.
3. Does the target population include both women and men?	Some of the country documents do. For instance, the Plans for Guinea Bissau and Liberia specifically mention women as part of the target population. So does Liberia's Ebola RC plan.
4. Did both women and men participate in the design of the RC framework/strategy/document?	Yes, but only in countries where there are men and women in the teams of the National Coordinating Institutions, for instance in Ghana and Guinea Bissau. Also, yes for a country like Nigeria where NGOs were part of the drafting process for the RC strategy.
5. Does the RC framework/strategy/document consider the life conditions and opportunities to access healthcare and health related information for men and women?	All the documents were based on the respective country healthcare contexts. However, it was not clear that the gender issues in these contexts influenced the RC strategy content.
6. Has the RC approach been piloted with both men and women?	Yes, especially at community level. In actual implementation all 9 countries indicated during the interviews, that they had targeted women in their community outreach.
7. Did the RC frameworks/ strategies/ document development process include consultations with a range of stakeholders including gender expertise?	All the countries adopted a multi sector approach that involved consultations with their respective Ministries of Gender. However, none of the RC country teams has an embedded gender adviser.
8. Do the RC frameworks/strategies/documents indicate a consideration of different health needs of women and men?	This is not reflected in the country documents reviewed.
9. Do the RC frameworks/strategies/documents consider gender-based divisions of labour?	No.

10. Do the images, graphics and language on the RC documents respond to or address gender norms, roles, and relations?	It was only the twitter and YouTube messaging from Nigeria that featured a mix of male/female imagery and graphics in a way that tried to break away from stereotypical gender roles. E.g., pictures of women as doctors and men as nurses.

5.3.1.a. Do the vision and goals of the Risk Communication framework/strategy/document include a gender-specific rationale or gender policy objectives?

All the country strategies contain well-articulated medium- to long-term vision statements. However, none of them appears to integrate gender as one of the core pillars, at 'vision' or 'mission' levels. Feedback obtained during the interview sessions, indicates that this is based on the perception that infectious disease outbreaks affect everyone in mostly the same way. This suggests that since entire societies are at risk during outbreaks and epidemics, it might be appropriate to present information relating to these infectious diseases outbreaks as if such information is tailored to target societies as singular homogenous demographic groups.

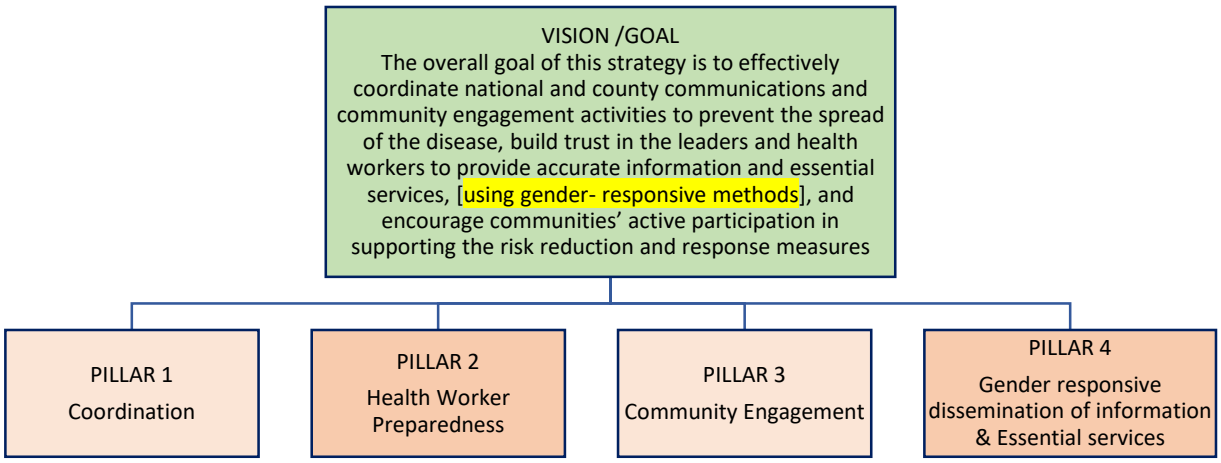
The '*everyone is affected by pandemics'* perception overlooks two critical points. Firstly, societies are not made up of homogenous demographic groups and these different groups play different roles, have different health needs and are at risk in different ways. Therefore, while everyone is affected by the pandemic, they are affected differently or in different ways because of the roles they play. Also, different demographic groups and different socio-economic groups tend to access information in different ways. For instance, anecdotal evidence indicates that a woman in rural West Africa is likely to obtain information through the peer-to-peer conversations which occur at micro level, in places like the farm or the market or cooperative association meetings. She is less likely than a woman who lives in an urban area, to access or read an infographic or a tweet. Also, a man in rural West Africa is likely to access information through formal media and communication channels such as a transistor radio, or a mobile phone.

A vision statement usually provides the thematic signposts which shape the content for the rest of a document, which is why it is important that the overarching vision or goal acknowledges in some way, that these gender disparities exist. Where there is no reference at all to gender in the overarching vision or goal, the rest of the document is likely to be silent on gender as well or at best, mention it briefly at some point without any concrete actions, steps, or resource allocation (financial and human) linked to it. Eventually, such a document may lead to some impressive results in other areas, but the results that promote gender justice, are likely to be minimal.

Figure 2 below presents an example of a gender responsive vision statement or goal and how that trickles down to specific work pillars, actions, and budgets within a document[40].

[40] Adopted from the Kenya National Communication and Community Engagement Strategy for Coronavirus

Figure 2: Example of gender responsive vision statement/goal and how it trickles down into the body of the document
Source: Adopted from the Kenya National Communication and Community Engagement Strategy for Coronavirus



5.3.1.b. Does the RC Strategy include sex as a selection criterion for targeted messaging population?

All the Risk Communication strategies contain clear provisions around targeted messaging even though they do not delineate these targeted audiences along gender lines. The messaging population is described using terms such as 'external target audiences'[41] and 'stakeholder categories.'[42]. So far, just one of them[43] specifically mentions 'women's groups' as a distinct cluster within the 'community engagement' participants list. Interestingly, one of the strategies[44] identifies adolescents (15 – 19 years of age) as the key audience even though this is also not disaggregated along gender lines.

Women and girls suffer disproportionately from the consequences of disasters and emergencies[45]. The reasons for this are varied and complex, but they include limited access to information and resources that can help people to act during an emergency, culture and language barriers, and frequent reliance on informal sources of information. Also, men's higher tolerance of risk calls for male-focused communication and awareness strategies[46].

It has been argued that at the centre of the above factors is the phenomenon of communication inequalities, which refers to the differences among individuals/ social groups in accessing and using health information and the resultant impact on knowledge and behaviours[47]. These communication inequalities suggest the need for sex as a selection criterion for delineating those who are targeted to receive the risk communication messaging.

5.3.1.c. Does the target population include both women and men?

All the documents mention women as part of the target audience, especially at community level.

[41]Sierra Leone Draft Public Health National Emergency Risk Communication Strategic Plan 2017
[42]National Public Health Institution of Liberia Communications Policy
[43] Liberia National Risk Communication Plan 2017 –2019.
[44] Sierra Leone Health Promotion Strategy (2017 – 2019)
[45] https://www.who.int/risk-communication/guidance/download/en/
[46] https://www.gdnonline.org/resources/GDN_GenderNote5_RiskCommunication.pdf
[47] Savoia E., Lin.L, Viswanath.K (2013) available at: doi: 10.1089/bsp.2013.0038

5.3.1.d. Did both women and men participate in the design of the RC framework/ strategy/ document?

All 5 countries (anglophones and lusophones) adopted a multisector collaborative approach to developing and implementing their strategies. As a result, the respective Ministries of Gender have been involved in the RC processes. Countries like Nigeria relied on input from some non-governmental organisations during the consultations that led to the design of the country strategy.

It is important to note that the involvement of respective Gender Ministries appeared to be more visible in the design of secondary impact risk communication messaging. For instance, the Ministry of Gender was typically cited in relation to producing information materials around two of the secondary consequences of the pandemic, which are gender-based violence (Cape Verde) and livelihood support (Ghana). Other secondary impacts such as the risks to education and psychosocial health which have equally significant gendered implications and require specific mitigation and preventive measures were not mentioned as part of the contribution from the different Ministries of Gender.

5.3.1.e. Does the RC framework/strategy/document consider the life conditions and opportunities to access healthcare and health related information for men and women?

The country Risk Communication strategies do not highlight gender related disparities in healthcare access per country. While the RC documents are not expected to go very deeply into an assessment of country health contexts, they do need to briefly refer to the gender differences in healthcare challenges, opportunities, and access per country. This is an acknowledgement that disparities exist and that these disparities could possibly act as drivers of vulnerability for different groups. Highlighting these differences briefly, also indicates an awareness that these disparities will require targeted RC messaging and action plus the funding to implement them.

If the response to disease outbreaks such as COVID-19 is to be effective and not reproduce or perpetuate gender and health inequities, it is important that gender norms, roles, and relations that influence women's and men's differential vulnerability to infection, exposure to pathogens, and treatment received, as well as how these may differ among different groups of women and men, are considered, and addressed.

5.3.1.f. Has the RC approach been piloted with both men and women?

Each of the countries have developed and administered risk communication messaging across the country generally and particularly among women in the communities.

5.3.1.g. Did the RC frameworks/strategies/document development process include consultations with a range of stakeholders including gender expertise?

The respective Ministries of Gender were involved in the document development process and implementation arrangements. Nigeria and Cabo Verde included civil society groups who work on gender issues, as part of the consultation processes leading up to the development of the documents.

5.3.1.h. Do the RC frameworks/ strategies/ documents consider gender-based divisions of labour?

The gender-based division of labour refers to the allocation of different jobs or types of work to women and men as well as the institutional rules, norms and practices that influence this allocation of tasks[48]. It positions women and men, boys, and girls, differently in the production process where

[48] https://www.oecd.org/gender/resources/

they have (and need) different information to protect themselves. Where a Risk Communication strategy does not reference the gender division of labour in a particular context, there is the danger of gender stereotyping when it comes to deciding what types of messages are best suited for which members of the public. E.g., targeting men as earners with warnings and forecasts, while targeting women about home preparedness.

None of the country documents reviewed contain any reference to the gender division of labour.

5.3.1.i. Do the images, graphics and language on the RC documents respond to or address gender norms, roles, and relations?

The images, graphics and language in the documents reviewed do not appear to address gender norms, roles, or relations. The only exception was with the images which were adapted in the Nigerian social media risk communication materials where women and men were depicted in non-stereotypical roles.

Gender norms have to do with the informal rules and shared social expectations that distinguish expected behavior based on gender. The images and languages used in RC materials could, unintentionally reinforce existing gender myths. For instance, consistent use of images depicting women as home managers or cooks or assistants or specifically in the health sector, as nurses. This also applies to images that always depict men as doctors or as people who are engaged in the formal economy. Both men and women play these roles across West Africa, which has implications for their respective risk vulnerabilities and the measures they need to take to mitigate them.

5.3.2. Assessment against the WHO Integrated Model for Risk Communication and the USAID Technical Brief on Integrating Gender into the COVID 19 Risk Communication and Community Engagement Response

Table 5: Summary of feedback from the WHO Integrated Model and USAID Technical Brief

ISSUE AREA	ASSESSMENT FEEDBACK
Risk Communication system	None of the country RC team has an embedded gender specialist. Women form significant numbers of those trained and deployed for the community outreach aspect in Liberia and make up at least half of staff strength in the coordinating structures for Ghana and Guinea Bissau. No indication that RC plans have undergone periodic reviews to upgrade them with gender feedback/data. No gender checklists or question guides for periodic review of RC materials. Nigeria and Cape Verde have GBV hotlines. However, it was not possible to confirm whether those who work at the call centres are trained on gender.
Internal and Partner Communication/Coordination	No evidence of internal partner mapping, which also includes groups working with women or marginalised populations. Target audiences are delineated in some plans to include women and youth, for instance in the Liberia and Guinea Bissau documents. Cape Verde, Ghana, and Nigeria indicate clear linkage between COVID-19 health facilities and GBV referral systems.
Mass/ Public Communication	Apart from Nigeria, reviewed imagery in RC materials reflect gender stereotypes in the depiction of the roles which men and women play.

	Messaging does not promote joint decision making by men and women. Messaging does not include support to access sexual and reproductive health information and services, bearing in mind women's unique reproductive roles during the COVID19 pandemic. Messaging does not address how traditional perceptions of masculinity among men and boys could increase their vulnerability to infection by preventing them from adopting preventive measures or seeking adequate care. Generally, messaging does not appear to consider approaches, which highlight how being home together can provide opportunities for parents to engage with their children, particularly how mothers and fathers can model shared responsibility in caretaking and use the time to discuss what it means to be a man with their sons and get to know their daughters' aspirations. The link to RC here has to do with the potential for this kind of messaging to minimise the incidence of gender-based violence which generally spiked during the compulsory lockdown periods RC material does not appear to focus on equal use of voices and images of women and men from different socio-economic and ethnic groups to talk about COVID-19. Not all the countries position both women and men as authoritative, trusted sources of information in the RC materials E.g., by using them in YouTube video messaging or in twitter messages
Community engagement	Liberia has been very deliberate about including women in the community engagement teams. Guinea Bissau, Liberia, and Nigeria have also been very deliberate about working with traditional rulers in the communities. What appears to be missing from the community level engagement is an integration of some of the gender perspectives in the messaging. For instance, gender perspectives that promote equitable decision-making among couples and sharing of household responsibilities including caretaking of those who are ill, as well as prevention of GBV and support to survivors. No community radio stations established or being supported to report on women's and men's experience of the disease or to encourage a gender balance on call-in programs with time set aside specific time slots to hear from women, youth, and other groups that may be marginalized.
Dynamic Listening and Rumour Management	In Cape Verde, Nigeria both female and male influencers were co-opted to amplify correct information in their communities or social circles. No indication that any of the countries have been analysing rumours to assess whether they are fuelling gender-based inequalities, stigma, and discrimination in order to design responsive messaging. No indication of institutionalised rumour tracking systems, which tap into communication channels used by both women and men, including younger populations Only exception to this is the Nigerian weekly polling mechanism.
Capacity Building	No gender specialists embedded in national RC teams No gender awareness training integrated for in-house Risk Communication teams in all 5 countries. No ongoing training for hotline counsellors /all agents on gender and COVID-19 related issues. No gender training for journalists to ensure that they are equipped to report ethically on how women and men differ in how they experience and cope with the pandemic and include a diversity of voices in their reporting. No evidence of ongoing training for COVID-19 health care workers and other frontline responders to probe for— and respond to—reports of GBV and provide information on available GBV support services.

5.3.3. Feedback from SWOT Analysis

The gender-specific Strengths, Weaknesses, Opportunities and Threats (SWOT) per country were discussed during the interviews and are presented in table 5 below.

Table 6: Feedback from (gender-specific) SWOT analysis

COUNTRY	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS	GENDER COMMENTARY
Cape Verde	Collaboration across different sectors and national agencies. (National Coordination Unit). Collaboration with the media/journalists. Strong community outreach + public figures with influence Weekly epidemiological news- letters produced and shared at ports. Strong messaging around COVID-19 related Gender Based Violence (GBV)	Funding constraints Personnel capacity + institutional arrangements not enough to effectively respond to rise in cases Cultural barriers to effective Risk Communication RC does not appear to be driven, across board by gender perception surveys or gender disaggregated data	Unique tourism economy made it possible to engage with Ambassadors from different countries for messaging in different languages of tourists.	Cost of travel makes it difficult to implement risk communication across the islands.	Collaboration across sectors made it possible for the National Gender Machinery to have a seat at the RC table. One important point that cuts across all countries, not just Cabo Verde, is that it is not clear in some countries the extent to which the participation of the Ministry for Gender influenced the RC approach or if it did at all. This is an important point as not all staff within these Ministries are gender specialists Training of community level officers was a plus from a gender perspective as it enabled the inclusion of more women in the RC process. Outstanding training needs to also include gender awareness training as there are perception gaps around gender Unique tourism context highlights need for some additional gender context in the RC messaging. This should be driven by gender disaggregated data. i.e., Based on ongoing tracking of travel demand with some focus on variations between male and female travellers. One way to do this is by setting up a regional travel dashboard with

					travel demand indicators.
Ghana	Multi sector coordination approach including the Gender and Social Protection Ministry Emphasis on data driven RC including gender-focused perception surveys Gender balance in RC staff teams e.g., in Health Promotion Division there are 2 female directors + 2 male directors. Focused on GBV messaging and response in partnership with relevant Ministry	Funding constraints. Training and personnel gaps Messaging focuses on the public in a homogenous fashion (without emphasising gender). This is because everyone is at risk of contracting the virus.	Visibility of RC has improved and increased. Ongoing partnerships present opportunity to build systems +structures	Outreach and coordination from regional level (AU, ECOWAS, WAHO) was not as strong as expected. International donors prefer to focus on surveillance and treatment, not RC.	Where funding for core Agency activities is lacking, gender mainstreaming becomes even more challenging. Training gaps include gaps in gender awareness training. Perceptions around gender appear to be limited to some areas only (e.g., GBV) Attention to RC presents opportunity to also strengthen gender systems and structures for instance through gender training and the production of quick access materials like gender checklists, for institutional use.
Guinea Bissau	Strong multi sector coordination with gender balance in coordinating committee (7 out of 15 are women). Strong community outreach Risk Communication approach has been very Intentional about women focal persons at community level	Some weaknesses in the strategy for combating rumours. Gender dimensions of behavioural barriers to effective risk communication not quite identified & addressed	Opportunity to collaborate more deliberately with traditional rulers and existing community platforms	International collaboration a challenge due to some aspects of country political context	For the rural outreach (e.g., the network of community health workers) many focal persons are women. There were country consultations with women leaders which tried to link RC with education (supported by UNICEF). However, there is need for ongoing gender awareness training as the issue of gender is constrained to certain areas rather than considered across the entire process. Opportunity to collaborate with community leaders creates room for collaboration with women leaders also

Liberia	Strong institutional RC preparedness and response because of prior experience with Ebola. Multi sector approach also brought the Ministry of Gender to the table as part of national response efforts.	Generally, RC messaging focuses on the public in a homogenous fashion (without emphasising gender). This is because, everyone is at risk of contracting the disease. Not enough funding to undertake ongoing data capture of emerging gendered perceptions and risks. Institutional arrangements for tracking and monitoring generally but also for gender specific tracking are not strong enough. Lack of sufficient work equipment (e.g., means of transportation to communities) could discourage more women from participating in community outreach	Enhanced collaboration among international partners including partners with gender focused mandates.	Sometimes there were tensions in the respective approaches of the designated national RC professionals and the messaging from the non-professional cadre (e.g., political office holders).	The strong institutional preparedness was a plus from gender perspective because it led to targeted and timely community outreach, which was delineated across demographic groups including women + youth. Also, significant numbers of women engaged as part of community health outreach teams. However, there is need to update current approaches with 'new' gender disaggregated data, covering the post-Ebola period.
Nigeria	Successful multi-sector collaboration at federal level. Used weekly opinion polls to inform RC messaging Engaged both male and female influencers (E.g., actors + actresses) in public messaging Some focus on targeted messaging for vulnerable populations even though gender was not the key driver within this context.	Multi sector collaboration was less successful at state level due to institutional capacity deficits. More challenging to integrate gender issues Male/female disparities in sample size for weekly polling not focused on gender, in a very deliberate manner	Very useful engagement, and collaboration with the regional RC structures (WAHO + the Africa CDC) & with International Partners	Tensions when politicians get in the way of the messaging and coordination by professional health sector experts. International donors prefer to focus on surveillance and treatment, not RC	The integration of gender lens within feedback from weekly opinion polls and the gender-specific perception feedback resulting from this is a win for gender mainstreaming. However, the coordinating mechanisms at federal and state levels require gender awareness training and also support to continually collate, interpret, and integrate gender data in general RC approach. The fact that there are weaker institutional arrangements on gender and also less awareness on gender in

	Some focus on GBV messaging during the lockdown				the federating units (states) affects the country's general performance ranking from a gender perspective. As such, gender awareness training at state level is key.

5.4. Gender Gaps in COVID 19 Risk Communication: Francophone Countries

5.4.1. Assessment against the WHO Gender Assessment Tool

Following the analysis of the COVID19 risk communication documents and the interviews a limited use of the gender concept by actors, including managers/decision-makers, women managers, leaders of community and women's organisations can be seen.

- Little use is made of existing gender-specific data in the field of risk communication, health and general information to understand the context, justify strategies and better specify the actions to be developed. Indeed, none of the documents refer to contextualised statistics on the situation of men, women, children and young people, nor on the use of information media and channels, except for the document by Niger, which devoted a paragraph to the use of the media with gender and geographical rates.
- Despite the presence of women and organisations committed to women in the validation and design commissions of COVID19 risk communication documents, questions relating to gender norms and roles, the specific needs of men and women, and the dynamics of decision-making are not asked and analysed upstream. However, the framework documents on COVID19 risk communication in Senegal in particular and in Burkina Faso take into account the specific needs of vulnerable groups to a certain extent.

  Indeed, Senegal was one of the first countries in the sub-region to institutionalise gender (2008). This is evidenced, among other things, by the presence in each ministry of a Gender Unit with resources (even if limited) and a clear mandate to integrate gender into policies and programmes. Also, the participation of the Ministry of Women's Affairs and the Gender Unit of the Ministry of Health in the design and review of the national policy on multisectoral interventions on COVID19 risks and community involvement has enabled:

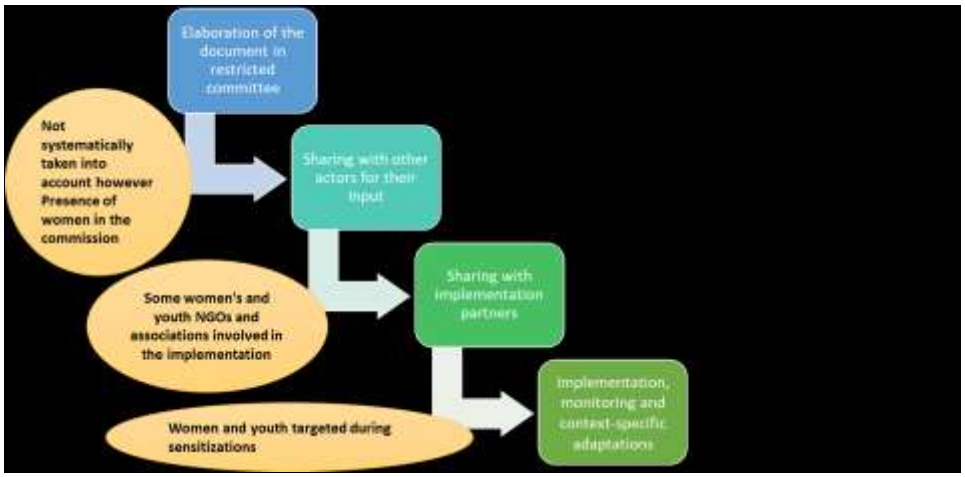
  - The consideration of the specific needs of women and vulnerable populations (pregnant women, individuals with immuno depressed-related conditions, street children, disabled people, etc.), and
  - The planification of activities towards health and youth facilities and GBV management when needed to explain protection measures and reassure people about the continuation of health services and GBV management.

- Gender-specific data is considered for the target groups (Women are listed as a target group and in some cases with some gender-specific data). Issues related to gender norms and roles,

the specific needs of men and women and the dynamics of decision-making are not discussed and analyzed, except in Senegal

- The process of developing and implementing COVID19 risk communication is essentially "top down". There is, therefore, no involvement of the targets in the design and development of tools. Their involvement begins in the best-case scenario at the stage of testing and validating the communication tools and of reporting on the use of the tools during the follow-up activities carried out by the committee in charge of COVID19 risk communication implementation. Their presence in the validation committee is very limited (generally 1 representative) and sometimes non-existent.

Figure 3: Risk Communication process and Gender



- Some communication tools (for example in figure 4 below) do not cater for gender transforming stereotypes and inclusive language as shown in the images below. Women, young people and men are represented in the communication materials and messages seem to be formulated without prior reflection on their impact in terms of maintaining, deconstructing or constructing gender stereotypes.

Figure 4: Images contributing to maintaining gender stereotypes

- Risk communication was designed with the participation of civil society, but without specific gender expertise. Involvement of the target groups in the design and development of the tools was evidenced by sharing the tools within the implementation and receiving feedback on their use.
- Involvement of selected women's organisations for awareness raising. These women's organisations act as resource structures for community mobilization.

The table below, which presents the results of the analysis of COVID19 risk communication strategies, plans and tools with the adapted WHO Gender Analysis Tool, provides an overview of gender consideration in the process of designing and implementing COVID19 risk communication materials and tools.

Table 7: Overview of the analysis of risks communications strategies, plans and tools with WHO-GAT

No.	Themes/Questions	Guinea	Senegal	Niger	Burkin
1	Do the vision and objectives of the risk communication (RC) framework/strategy/document include a gender justification? (i.e. gender strategic objectives)				
2	Does the RC include gender as a criterion for selecting the target population for messages?				
3	Does the target population include both women and men?				
4	Did women and men participate in the design of the RC strategy/action plan/materials?				
5	Do the RC strategy/action plan/materials take into account men's and women's living conditions and opportunities for access to health care and health information for men and women?				
6	Has the RC approach been piloted with men and women?				
7	Did the process of developing the RC strategies/action plans/materials include consultations with a range of stakeholders and gender expertise				
8	Do the RC strategies/action plans/materials indicate a consideration of the different health needs of women and men?				
9	Do RC strategies/action plans and materials take into account gender divisions of labour?				
10	Do the images, graphics and language in RC documents address or deal with gender norms, roles and relations?				

Yes No partially

5.4.2. Assessment against WHO Integrated Model for Risk Communication and the USAID Technical Brief on Integrating Gender into the COVID 19 Risk Communication and Community Engagement Response

Analysis of the data collected according to the five domains of the WHO Integrated Risk communication model made it possible to assess the extent to which gender is taken into account in the COVID19 risk communication of the countries.

In general, gender is not systematically taken into account in the **risk communication systems** of the French-speaking countries that participated in the study, with the exception of Senegal, which has been in the process of institutionalising gender since 2016. Despite the presence of women among the members of the committees which develop and validate communication plans and tools, the participation of the Ministry of Women's Affairs and the existence of gender units or gender focal points in the Ministries of Health, the issue of gender is not addressed upstream. In addition, the concept of gender mainstreaming in policies and programmes is little used by decision-makers, including country communication focal points, who have generally never received specific training or reference material on gender mainstreaming in risk communication. Some rare gender-specific data are contained in the documents (target groups, media statistics, and activity indicators) but an in-depth analysis of the specific needs of men, women, girls and boys does not yet exist.

With regard to **internal coordination and coordination with partners**, there is intersectoral collaboration in all countries with mixed and interdisciplinary commissions. The Directorates of Ministries deemed relevant are designated members of the development and monitoring and evaluation commissions, as are representatives of civil society and the media. Multilateral cooperation organisations such as UNICEF, WHO and bilateral partners (USAID - Breakthrough Action Programme) as well as international NGOs (Red Cross) closely support these commissions.

However, there does not seem to be a clear referral mechanism between COVID-19 health services and other necessary health and social services for women, men and children, including maternal care, sexual and reproductive health, child health and support for gender-based violence, even though there is intense advocacy and support actions by women's organisations on issues of domestic violence.

In regard to **mass communication**, although all francophone countries have generally statistics on needed information, only Niger seems to explicitly rely on gender-specific data on media use by the population for the choice of communication tools. The mass communication strategy implemented is usually top-down. The target groups are not involved in the design and development of the upstream tools and their content. The messages developed target the general population and are made accessible through radio, television (video spots) and posters in public places. Slogans, songs, dialogues and similar are also used. The information contained in these materials is not differentiated according to the various groups in society and remains essentially focused on prevention (barrier measures and personal hygiene).

Most of the posters analyzed that contain characters made from drawings show mainly men. This is the case for the posters below which could be perceived as discriminatory as they present only men as models to show the right behavior to adopt in the context of the pandemic.

Figure 5: Posters on protection measures

In addition, posters that present only men or women in specific situations (Figure 4 shows only men in vehicles, only women at the market although men are also present) unintentionally reinforce gender stereotypes and inequalities. This allows the assumption that these risk communication materials were not designed to avoid gender stereotypes and inequalities.

The example of an imagine from Guinea (Figure 6) shows that there are possibilities to solve this issue by representing both men and women.

Figure 6: Distancing with mask

The involvement of affected communities is ensured during the implementation. Community leaders including women and youth leaders are involved as intermediaries to access the populations. They essentially ensure the mobilisation and transmission of messages (awareness raising) to the populations. It is at this pillar that gender segmentation is used in order to reach all segments of the population (men, women, youth, elderly) and make messages more understandable during oral transmission.

Dynamic listening and rumour management has been observed generally limited to collecting feedback and reporting this information without putting in place mechanisms to ensure that it is

processed according to gender criteria. In some cases (e.g. in Guinea) women are targeted and involved to support the reporting of information (especially rumours).

5.4.3. Feedback from the SWOT Analyses

In general, the internal factors that could promote the mainstreaming of gender in risk communication plans are the interest of managers in capacity building in the field and the involvement of partners working to achieve the Sustainable Development Goal 5 on Gender Equality in the risk communication plan validation committee. These include Ministries responsible for women's and children's issues (women and social action), civil society umbrella organisations (including community associations) and international development cooperation organisations (international NGO representations, bilateral and multilateral cooperation).

However, the limited use of the gender concept by male and female decision-makers, but also by community representatives and some NGOs, partly explains the absence of gender analyses in the risk communication processes, particularly at the planning level. Furthermore, the design of risk communication tools without prior studies or analysis of existing studies or detailed segmentation of target groups can be detrimental to risk communication. Developing communication tools without the participation of target groups also limits the effectiveness of implementation.

The existence of several technical and financial partners and civil society organisations is an important level at which the structures in charge of health risk communication could rely to meet the challenges of integrating gender in the field. In addition, the presence of a Ministry mandated with gender issues could include the thematic area in its action plan and so contribute to the mobilisation of human resources. In most countries, statistical data on specific information, particularly the use of information and awareness-raising channels, is available. The presence of community radios and proximity actors in the health system are hence an undeniable asset in terms of opportunities.

In terms of threats, some socio-cultural contexts that are not very conducive to gender equality issues can constitute real risks. In some cases, the concept of gender seems to be perceived as a "foreign" concept that does not take into account local cultural realities, as laid out by the following quotes: "*It's a European and American thing*" and "*It is as if our women are mistreated*".

Table 7: Results from the SWOT Analysis by country

COUNTRY	STRENGHT	WEAKNESSES	OPPORTUNITIES	THREATS
Guinea	Willingness to integrate gender and an interest in acquiring skills in the field	Lack of guidelines, limited expertise in the field (the ministry in charge of women is represented in the commission), no representation of women in decision making (women in the unit are assistants)	Existence of partners who can provide support (GIZ RPPP project), organisations and associations for the promotion of women, communication agencies run by women, statistics in the field of communication, anthropological studies on epidemics etc.	Impact of social constraints on the mobilisation of women (participation in the development /implementation), Limited understanding of gender mainstreaming by communities; Women's level of education
Niger	A readiness to effectively mainstream gender in risk communication	Insufficient knowledge of the gender concept	TFPs available to provide support	Mistrust of the gender concept (Representing Western values)

COUNTRY	STRENGHT	WEAKNESSES	OPPORTUNITIES	THREATS
	An interest in acquiring skills in the field Women's civil society organisations as partners in the implementation	Lack of gender expertise within the committee	Several NGOs and Associations on which to rely for implementation, including some women's associations A well-organised network of community radio stations	Women's rights organisations perceived as 'feminist' and not credible in the eyes of society
Senegal	A Gender Unit within the Ministry of Health Existence of a passport for gender institutionalisation at the MSAS Interest of communication officers in acquiring skills in the specific area of gender mainstreaming for more effective risk communication Strong presence of women in decision-making positions	Lack of awareness of the gender issues in risk communication and the added value it can bring to communication by decision makers Limited participation of vulnerable populations and women, especially women health workers, in the development and design of communication plans and tools A gender unit that is not systematically involved No gender expertise within the SNEIPS	The gender institutionalisation process is being implemented with a strong political commitment from the state. Civil society organisations structured and represented at all levels of the health sector Very active and organised community actors A women's association active and present at all levels on issues of "Women and Health" "Badiénou Gox" (means "*The Aunt*")	The urgency of risk management and communication in the event of epidemics
Burkina Faso	Research and communication skills and experience Disbanding at regional level Awareness of the importance of the topic in the field and willingness to engage effectively	Limited skills and knowledge on gender mainstreaming Lack of resources including financial	Developed media, radio and television Community relays (1 man-1 woman) in each village of Burkina Faso to support communication and awareness-raising A Ministry in charge of Gender Issue	Few technical and financial partners to support the actions

6. Recommendations for mainstreaming gender in planning and implementation of Risk Communication

Based on the findings from the anglophone, lusophone and francophone countries, this section presents recommendations for consideration by each of the countries, in section 6.1 and for WAHO/RCSDC in section 6.2.

6.1. Recommendations for Respective Countries

One of the factors that behind the lack of consideration of gender in the analysed risk communication documents is the fact that the concept 'gender', and its contextual implications are not clearly understood and therefore not considered both from a perspective of limitations but also from a value-

add perspective. This suggests the need to build and strengthen the capacity of relevant RC practitioners in the region, on gender, highlighting why it's important to the work they do, and clarifying how to address it.
The respective countries may wish to consider the following recommendations in this regard:

- The design of country-level advocacy strategies which target decision-makers and which can be implemented within the framework of WAHO/RCSDC's regular activities.
- Identification of one Gender Focal Point per country RC team who can participate in capacity building activities organized by WAHO/RCSDC.
- Training of Country RC Focal Points on gender mainstreaming in risk communication planning so that the responsibility of mainstreaming gender is not left solely with the Gender Focal Person but rather is a shared responsibility.

Other country level recommendations include:

- Review RC strategies to integrate gender responsiveness as a core issue from the planning phase to the implementation and monitoring phase
- Collect and analyse gender-disaggregated statistics and studies (especially statistics that relate to public communication, media, socio-anthropology, and behavioural change)
- Ensure the participation of target groups representatives in the design and implementation of the risk communication materials and tools
- Identify women leaders at community level as well as female social influencers to partner with as part of message dissemination partners
- Generate short, catchy RC messages that promote male/female partnerships e.g., issues like partnering in the home to combat COVID-19
- Develop simple, easy to access checklists on best practices on gender in RC
- Produce materials that address how perceptions of masculinity can increase the vulnerability of men and boys to the disease by stopping them from seeking adequate care
- Document and disseminate gender case stories and observations about the pandemic from different parts of the country to provide multi-ethnic country updates
- Conduct ongoing rapid vulnerability assessments including gender-focused questions e.g., by using weekly polling or regular periodic perception surveys
- Organise gender training for journalists and forge partnerships with them for gender responsive COVID-19 reporting
- Promote design and implementation of community radio programmes which include gender focused programming as part of the RC approach
- Organise training on gender-based violence for frontline health workers
- Develop gender-specific indicators for monitoring RC in health pandemics

6.2. Information material needs for "gendered" risk communication for Member States and ECOWAS institutions and agencies

At the level of ECOWAS and WAHO/RCSDC, the following recommendations are proposed for consideration:

- ☞ Produce a **Regional Advocacy Brief**. This can be adopted for use by those in charge of the structures in charge of health risks communication, including those in charge of general communication and members of the committees developing risk communication plans.

- ☞ Generate a **Gender Integration Guide** for emergency health risks communication. This guide will help to
  - Clarify the gender concept with regard to the communication on health risks,
  - Show how to integrate gender into the 5 pillars of the communication on health risks with a listing of existing resource documents,
  - Identify and demonstrate from lived experiences the added value that its application could bring to the achievement of risk communication objectives and above all be very practical.

- ☞ Produce simple, easy to access **Checklist(s) on Best Practices** on gender in RC. WAHO/RCSDC may wish to consider producing this as part of the gender mainstreaming guide, or for purposes of brevity and user-friendliness, as a stand-alone piece. The checklist(s) will contribute to the update of existing training modules in risk communication with elements on gender mainstreaming.

The production of the above suggested materials can be done during workshops. The participants in these workshops should include the institutions in charge of health risks communication for epidemics. This will not only ensure that the product conforms to the real needs identified, but also builds on lived experiences. The involvement of the NCI Focal Points is an opportunity to facilitate the appropriation of this tool by the latter as well as its sustainability.

- ☞ Support ongoing mapping and gender needs assessment of different levels of actors in the risk communication space as a basis for the design of relevant regional training and capacity building packages.
- ☞ Convene periodic regional 'lessons learnt workshops' on gender and RC.

We further recommend that these actions be carried out as part of the next phase of the GIZ-RPPP project, to ensure a certain continuity of the current programme and a sustainability of programme results so far. It is also critical to retain the flow and consistency of the approach adopted in this study.

7. Conclusion

This study on gender aspects in risk communication in the ECOWAS Region with a focus on COVID19, has been conducted to assess the integration and use of the gender concepts along established tools and formulate recommendations from the findings for the regional level (ECOWAS) and national level (ECOWAS Member States). Out of the 15 invited ECOWAS Member States, nine countries responded and participated. These include Burkina Faso, Cape Verde, Ghana, Guinea, Guinea Bissau, Liberia, Niger, Nigeria and Senegal. Data collection took place between March-May 2021.

The results of the interviews and desk studies show that the COVID19 risk communication strategies and plans were developed and implemented in a participative way. However, they did not sufficiently take into account the specific needs of men and women due to a limited knowledge by the actors on gender mainstreaming issues by the actors and the notion that everyone is affected by the pandemic in the same way. The direct effect of this situation is the lack of demographic delineation and disaggregated data in the COVID19 risks communication approaches in the ECOWAS region.

Integrating gender into health risk communication is not a challenge but rather a logical, if not natural, process. Indeed, one of the fundamental principles of any communication process is the definition of the target, that is to say the people for whom the messages are intended. It is critical that this heterogeneous target group is being analyzed, and the constraints as well as needs per demographic group, identified. Tailoring risk communication messages is critical for a successful communication campaign, not only in the context of infectious diseases outbreaks. Ideally, it should come after the objectives have been defined and helps to determine the media and communication support required for conveying the messages. The tone, the choice of words, the choice of communication channels, places and times of transmission of messages, etc. are also affected by the characteristics of the target group.

Thus, carrying out capacity building activities in the integration of gender in communication on health risks, (i.e. taking into account the specific needs of men, women, young and elderly people, children, vulnerable people in general in contexts of epidemics or a pandemic is essential to ensure proper management of these emergencies), can be seen more of a necessity than a choice. Therefore, WAHO/RCSDC and the national risk communication units may wish to adopt the recommendations contained in this report as these will aim to ensure:

- Fair, relevant and timely transmission of information and
- That the differences in specific needs and circumstances of various target groups are taken into account, here the realities of men and women during the ongoing pandemic.

An effective consideration of gender as a social determinant of health in risk communications in the context of a health emergency will make the messages more accessible to the target populations in their diversity, but also contribute to social inclusion, equity and a more prosperous West African region.

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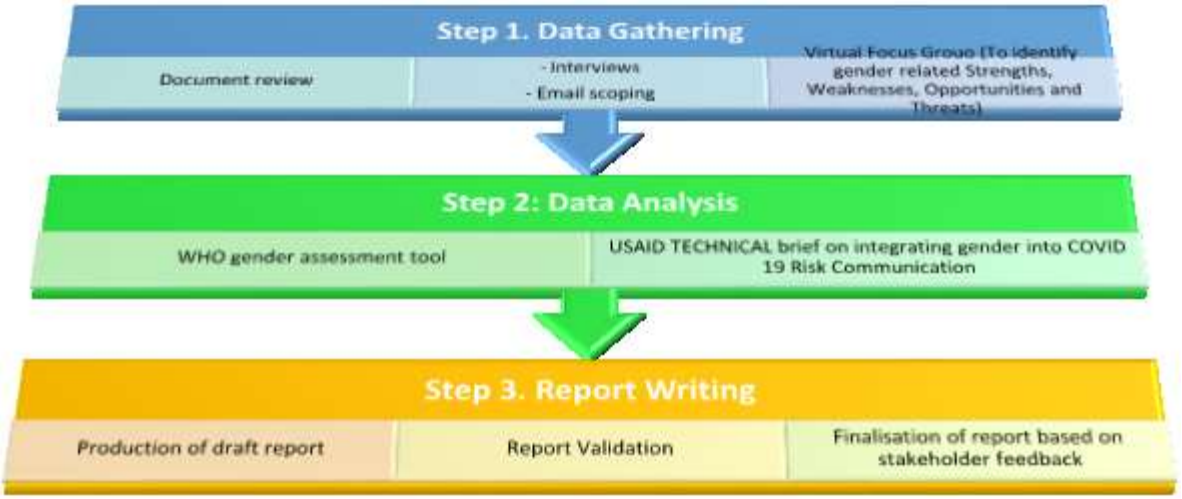
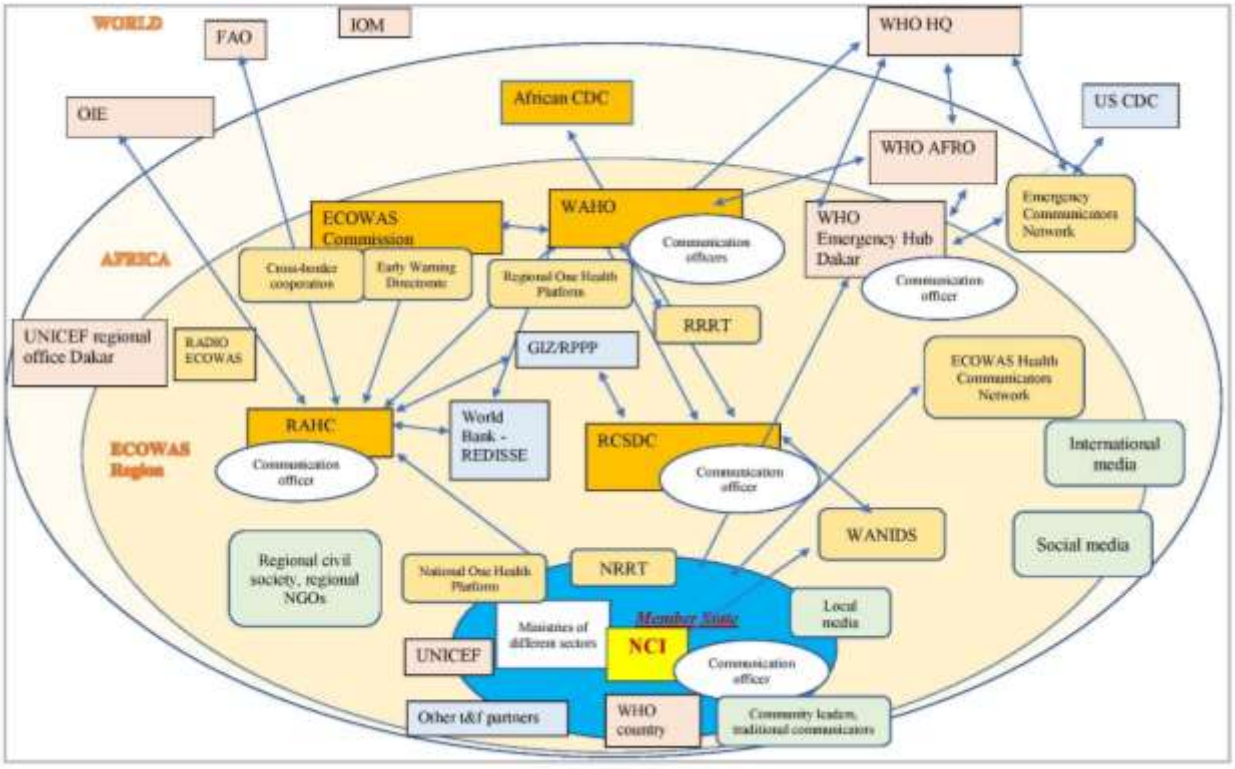
Annex 1 Methodology

The methodology note explains the approach used The approach is a qualitative mixed method study, using multiple methods.



The target group of the study is identified based on the stakeholders mapping in ECOWAS Risk Communication Regional Strategic Plan 2020-2023.

Ecowas risk communication stakeholders' mapping



Methods and tools

An approach with a mix of participatory methods has been used and tailored to suit the objectives of the study. The proposed approach is structured around the following points:

- Understanding of the respective regional and national contexts and emerging issues around risk communication and Gender
- Assessing the gender degree of gender responsiveness in risks communication strategies, action plans and produced materials of ECOWAS Member States implemented during the COVID-19 pandemic and the current Ebola outbreak in Guinea
- Analysing the gender considerations, which informed the process of developing COVID-19 risk communication materials in each country
- Assessing the gender capacity, gaps and needs for an effective mainstreaming of gender in risk communication
- Suggesting strong operational-oriented recommendations for a better consideration of gender in risk communication strategies, action plans and materials.

Understanding the respective national context and issues related to risk communication and Gender in the ECOWAS region

Through a document review, email scoping and semi-structured interviews with staff at regional and national levels, this aspect of the methodology enabled a stock taking of the Gender and human rights-based standards that are required in risk communication systems. It also allowed to gather information around the state of art across the ECOWAS region in terms of the gender situation update as well as an overview of the COVID-19 prevention and control mechanisms.

Measuring the levels of gender-responsiveness in current risk communication efforts using the WHO and USAID gender assessment tools

For this study, portions of the WHO GAT were adopted and adjusted to conduct a preliminary high-level appraisal of the available risk communication materials and processes. In addition, 'USAID's Technical Brief for Integrating Gender into the COVID 19 Risk Communication and Community Engagement' was used. The USAID technical brief provides a guide for integrating gender considerations into each of the six pillars of comprehensive risk communication and communication engagement as they apply specifically to the COVID-19 pandemic. On the one hand, the WHO GAT helped answer the questions '*Are the risk communication materials and processes gender responsive*'? On the other hand, the USAID technical Brief will help answer the question '*What specifically is missing in these materials and processes from a gender perspective*?'.

The two analytical tools are complementary and relevant given the context, which surrounds this study. While the GAT tool enables a general rapid assessment of all interventions, policies and programmes in the health sector, the USAID technical brief was generated in 2020, and responds very specifically to the COVID-19 pandemic with a focus on community level engagement. The use of both tools for analysis purposes will enable the team to consider a range of issues as they apply not just to COVID-19, but also to other outbreaks.

Gender Assessment Tool[49]

Country: Document: Disease/Year:					
Topic/Questions	Yes	No	Partly	N/A	Comments
Do the vision and goals of the Risk Communication (RC) framework/strategy/document include a gender-specific rationale (i.e. gender policy objectives?)					
Does the RC include sex as a selection criterion for targeted messaging population?					
Does the target population include both women and men?					
Did both women and men participate in the design of the RC framework/strategy/document?					
Does the RC framework/strategy/document consider the life conditions and opportunities to access healthcare and health related information for men and women?					
Has the RC approach been piloted with both men and women?					
Did the RC frameworks/strategies/document development process include consultations with a range of stakeholders including gender expertise?					
Do the RC frameworks/strategies/documents indicate a consideration of different health needs of women and men?					
Do the RC frameworks/strategies/documents consider gender-based divisions of labour?					
Do the images, graphics and language on the RC documents respond to or address gender norms, roles and relations?					

Assessing gender consideration in COVID-19 risk communication processes in each country

A reconstruction of the development and implementation processes of COVID-19 risk communication strategies / action plans and materials were carried out. The consideration of gender were oriented along the five areas of the WHO Integrated Model for Risk Communication[50]:

- Risk communication systems,
- Internal and partner communication and coordination
- Mass communication,
- Engagement of affected communities,

[49] Adopted from the WHO GENDER Assessment Tool

[50] Source: Risk Communication in the Event of Disease Outbreaks and Epidemics in the ECOWAS Region Strategic Plan 2019 – 2023

- Dynamic listening and rumour management.

Strengths and gaps were then analysed and opportunities identified for future evidence-based planning using a SWOT-G matrix. The SWOT-G matrix is used to identify strengths, weaknesses, opportunities and threats from a gender perspective. It is usually conducted in a participatory manner with the institutions or parties responsible for designing and implementing a particular policy or programme indicating their perceived SWOTs.

Extrapolating targeted recommendations

Recommendations are based on the issues, gaps and underlying factors identified through the literature review, the GAT, the SWOT-G and the gender gap analysis. They are along quality measures ***specific, measurable, achievable, and relevant and time bound (SMART).***