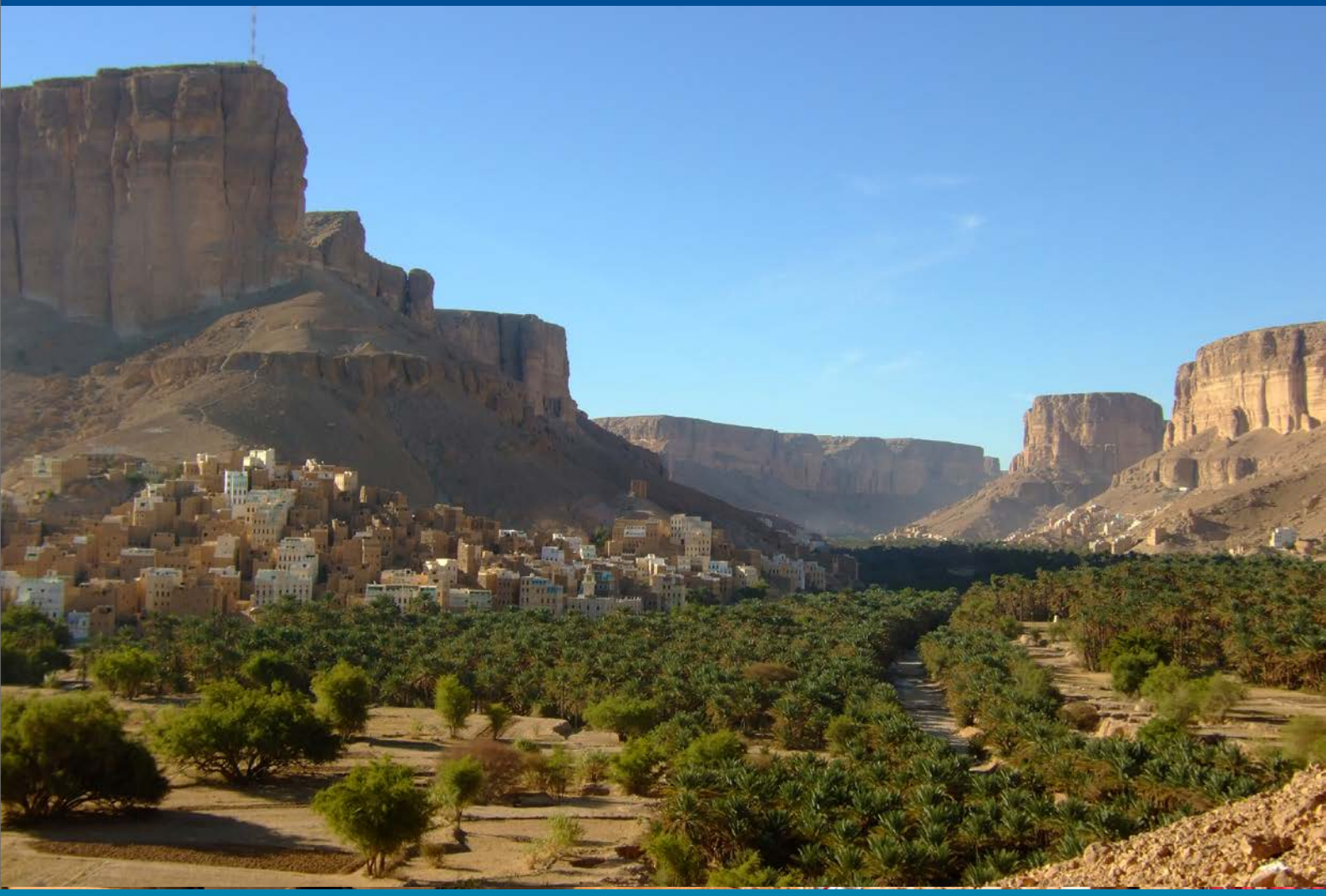
Background Briefing

Military Conflict, Disease Outbreak and Containment: A Comparative Study of Yemen and DRC



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Breaking the cycle of violence · ORG

This briefing and the following series has been written by staff at Oxford Research Group (ORG), as part of the **'Reshaping The Process in Yemen: Exploring alternative methodologies for the peace process in Yemen'** project.

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None of the experts who have helped us with our research bear responsibility for any of the opinions (or errors) in this report, which are the authors' own.

Implemented by Oxford Research Group (ORG) and the Sana'a Center for Strategic Studies (Sana'a Center), the *'Reshaping The Process in Yemen- Exploring alternative methodologies for the peace process in Yemen'* project seeks to strengthen local capacity for more inclusive and strategic dialogue in four key Yemeni Governorates- Hadhramaut, Marib, Shabwah and Al-Mahrah and lay the foundations for more effective peacebuilding efforts and contribute to the country's future political transition.

Oxford Research Group (ORG) is an independent organization that has been influential for nearly four decades in pioneering new, more strategic approaches to security and peacebuilding. Founded in 1982, ORG continues to pursue cutting-edge research and advocacy in the United Kingdom and abroad while managing innovative peacebuilding projects in several Middle Eastern countries.

The Sana'a Center for Strategic Studies (Sana'a Center) is an independent think-tank that seeks to foster change through knowledge production with a focus on Yemen and the surrounding region. The Center's publications and programs, offered in both Arabic and English, cover political, social, economic and security related developments, aiming to impact policy locally, regionally, and internationally.

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Breaking the cycle of violence

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This is the first briefing in a series released by the Oxford Research Group's (ORG) Strategic Peacebuilding Programme. These briefings examine the lessons that can be drawn from the response to Ebola in the Democratic Republic of the Congo, and how they can be applied in the response to COVID-19 in Yemen.

The other briefings – focused on respectively Community, Women's Experience and Security – can be found here. For readers new to this topic, we suggest reading this background briefing before the others, as this will provide background information on the disease outbreaks and conflicts in both the DRC and Yemen, as well as the international responses in both countries.

A brief note on methodology: the sections focused on the DRC were written by the ORG team based on desk-based research which was conducted in the Summer and Autumn 2020. This was supplemented with a closed-door roundtable with international experts in August and interviews with experts and practitioners with experience of working in the DRC, including Congolese nationals, throughout Autumn 2020. The sections focused on Yemen have been written by local experts; each has a different methodology. These are meant to offer a local perspective on the early impact of COVID-19 in the country, and how lessons from the DRC can best be applied. These briefings are of limited scope; their purpose is to inspire future research more than to present final conclusions.

Introduction

COVID-19 has brought disease outbreak and responses into the global spotlight. Since the first cases of the virus were reported in late 2019, the virus has spread quickly across the globe. At the time of publication, there have been nearly 50 million cases worldwide, with more than 1.2 million deaths.[1] While the long-term implications remain hard to predict, the disease has already had severe medical, economic, cultural, political, and social consequences.[2]

Learning lessons from previous large-scale disease outbreaks is therefore more crucial than ever. For these lessons to be valuable, they must reflect the impact of large-scale diseases on all aspects of society, including – but not limited to – the impact on **local communities** and **women's experiences**. When disease outbreaks occur in countries scarred by conflict, the impact on **security** and aid **delivery** must also be considered. It is these four topics that this series of briefings will cover.

These briefing papers outline and analyse the outbreak and containment programmes in military conflicts, focusing on the tenth Ebola outbreak in the Democratic Republic of the Congo (DRC), which started on 1st August 2018 and ended on 25th June 2020, and the current COVID-19 pandemic in Yemen.[3] Each briefing examines one of the four thematic areas outlined above. They aim to draw lessons from the Ebola response to explore how these could be applied to the Yemen context, as well as other future disease outbreak responses.

Yemen has long been a focus area for the Strategic Peacebuilding Programme (SPP), which carries out peacebuilding processes in the country. It is vital to our work to understand the impact of Coronavirus in the country to date, and its likely future impact, so that we can adapt our programme accordingly. The Ebola outbreak in the DRC was chosen as a case study because there are clear

lessons to be drawn from the response to this outbreak. At the same time, while the countries are different in many ways, there are also strong parallels between the conflicts which ravage both countries. This complicates responses to disease outbreaks immensely.

This background briefing has three main purposes:

1. To provide a background to our research project and to provide an overview of the four briefings.

2. To provide a brief background to the history[4] and conflicts of both DRC and Yemen, as well as the disease outbreaks.

3. To outline conditions in the DRC and Yemen which will have particular impact on the response to disease outbreaks. In the case of the DRC, the general and health infrastructure shall be analysed, whilst for Yemen the focus will be on the macro-economic activities and developments.

Methodology

The briefings are based on a wide variety of primary and secondary resources. The SPP team conducted desk-based research and a comprehensive literature review for the DRC section of the briefing papers. This was supplemented by a series of detailed interviews with world-leading experts and practitioners with extensive in-country field experience. We held these between August 2020 and October 2020. In September 2020, Oxford Research Group hosted a virtual closed-door roundtable on the response to Ebola in the DRC with a range of international stakeholders. These included aid professionals working in the DRC, public health and aid workers who worked closely with the Ebola response, as well as researchers and donors. Finally, each briefing has undergone peer review.

As the Yemen section of each briefing is written by a local expert, the methodology differs for these and is described in the separate briefings. Common for these is that they have been reviewed extensively by the SPP team and have undergone peer review along with the DRC sections.

Due to funding issues exacerbated by COVID-19, Oxford Research Group will unfortunately close at the end of 2020. This created significant time pressure for our team, limiting both our research and writing capacity; as such, our briefings are not meant to act as conclusions on the impact of Ebola in the DRC or COVID-19 in Yemen. Instead, it is our sincere hope that these papers may guide future extensive research process that will delve far deeper into the topics outlined and analysed.

It is worth noting that given our tight timeline and the ongoing COVID-19 pandemic, we were unable to build an extensive network of Congolese experts and civil society, as we were otherwise keen to do. While we had some conversations with local experts, this briefing primarily reflects the findings of those international workers who were deployed to the DRC to respond to Ebola.

Brief historical overview of DRC and Yemen

Before proceeding, it is vital to briefly explore the history of the DRC and Yemen. Both countries have long, detailed and complex histories. The aim is not to cover these in depth, but simply to contextualise the chapters and topics covered in the briefings. Further reading and references on the historical backgrounds are provided in the bibliography.

Democratic Republic of the Congo (DRC)[5]

Established in 1885, the 'Congo Free State' was run personally by King Leopold II, the monarch of Belgium, and then the Belgian state. Under Belgian rule, which has often been characterised as genocidal, mass atrocities were common; it is estimated that 10-15 million Congolese children, men and women were killed or perished from disease.[6] With the rise of decolonisation movements across the African continent in the 1950s and 1960s, calls for independence in the DRC also became louder and more effective. In June 1960, Congo finally gained independence from Belgium.

After Congo's first election in the same year, Patrice Lumumba was sworn in as Prime Minister. Not long afterwards, the eastern Katanga province declared independence, with conflict erupting between the two sides. Lumumba was killed in February 1961, and power was then seized by Joseph Mobutu during a coup in 1965. In 1971 the country was renamed Zaire. What followed was an era characterised by political and civil strife, severe economic challenges, corruption, diversion, nepotism, systematic mismanagement, and numerous conflicts.

The DRC's colonial history has left deep scars in the country, which continue to mark it today. One interviewee, a Congolese expert based in Kinshasa, emphasised that the colonial history also brings a strong sense of pride for many Congolese, as everything they now have was built up by themselves from nothing.

The DRC, and its east in particular, has experienced decades of recurrent conflict, with a complex and ever-evolving number of actors, including armed non-state actors, regional interventions, UN Peacekeeping Missions and DRC security forces. Two of these conflicts are of particular note on account of their continued and explicit effect on Congolese society, which impacted the Ebola response as well as all other aspects of life in the DRC.

The First and Second Congo Wars

In the aftermath of the Rwandan civil war and genocide in the 1990s, violence and conflict spilled over into the DRC, heavily impacting the country as a whole.[7] Numerous African states and groups backed different Congolese leaders throughout the First Congo War (1996-1997), with Laurent-Desire Kabila eventually installed as president in May 1997, renaming the country the Democratic Republic of the Congo (DRC). Not long afterwards, the Second Congo War (1998-2003) broke out.

Over 5 million people have died during these two wars, through a combination of direct violence, starvation, or disease, making them some of the deadliest conflicts since the Second World War.[8] At the same time, 'serious violations of human rights and international humanitarian law'[9] were reported, including the extensive use of sexual violence as a weapon of war. Through various agreements with African nations and, more specifically, the Global and Inclusive Agreement on Transition in the Democratic Republic of Congo (Pretoria Agreement), hostilities officially ended in mid-2003. In spite of this, violence and fighting has persisted in some areas of the DRC. In 2019 alone, 1.7 million people were displaced, resulting in one of the highest numbers of internally displaced persons (IDPs) in the world.[10] The UN High Commissioner for Refugees (UNHCR) estimates that between October 2017 and September 2019 over 5 million people have been displaced inside the DRC.[11]

This violence is perpetuated both by a number of groups who participated in the Second Congo War and new ones that have since arisen. This is likely to continue in the near future, with no clear signs of the violence abating. In interviews, and during our roundtable, experts consistently emphasised the difficulty of working in the DRC because of such insecurity.[12]

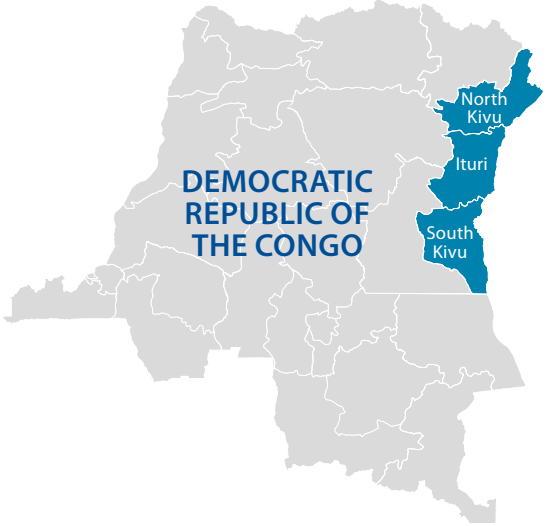
Current situation

The DRC is facing very difficult, complex and, in numerous cases, entrenched issues. Of particular interest for these briefing papers are the multitude of concurrent disease outbreaks. The DRC has seen repeated outbreaks of Ebola in recent years; most recently, the 11th Ebola outbreak in the country was announced on 1 June 2020. This was declared over on 18 November 2020, '42 days after the last case tested negative twice.'[13] This outbreak occurred at the same time as the world's largest measles outbreak, from which at least 6,000 people have died.[14] These come in addition to outbreaks of cholera, malaria and, recently, COVID-19.[15] According to the John Hopkins Universities' Coronavirus Resource Center, as of November 2020, there are 5,632 confirmed cases and 93 deaths from COVID-19 in the DRC.[16] As is the case in a number of other countries, these are believed to be underestimations.[17] Overall, these many outbreaks demonstrate the recurrent nature and the need to build long-term capacity to tackle them.

Overview of 10th Ebola outbreak (August 2018 to June 2020)

There has been a total of eleven outbreaks of Ebola across the DRC, encompassing different geographical areas and provinces. Known officially as the Ebola Virus Disease (EVD), the first recognised outbreak was declared in the DRC in 1976.[18] The 2018-2020 Ebola response in DRC was uniquely complicated as it took place in an area with significant conflict and insecurity.[19] None of the previously recorded Ebola outbreaks occurred directly in an area where fighting was ongoing, despite the multitude of large-scale conflicts throughout the DRC. This additional, and extremely complex, factor impacted the design and implementation of a disease containment response. Compounding the aforementioned are a multitude of influences and local dynamics in the North Kivu and Ituri provinces, the primary areas of the outbreak.

Figure 1: The 10th Ebola Outbreak in the DRC (2018-2020)



3,470 Ebola cases reported

2,287 deaths recorded

1,171 survivors

Of the total cases with recorded based on sex, age and professsion

57% Women

29% Children (under 18)

6% Health care workers

Source: Ministry of Health, Democratic Republic of the Congo

An outbreak of EVD was declared on the 1 August 2018, by the DRC Ministry of Health (MoH) in North Kivu and Ituri provinces. It spread rapidly within these provinces and subsequently into the South Kivu province. Led by the DRC MoH, and supported by the World Health Organization (WHO) and other organisations, a large response was organised to stop the transmission and spread of EVD among the local populations and communities, as well as across borders to neighbouring countries and regionally/internationally.

The EVD outbreak in North Kivu, South Kivu and Ituri provinces was declared over on 25 June 2020 by the MoH. Between the 1 August 2018 and 25 June 2020, 3,470 EVD cases were reported. Of the total cases, 57% were female, 29% were children aged less than 18 years and 5% were health care workers. 2,287 deaths were recorded (representing a case fatality rate of 66%), 33% of which were outside of Ebola transmission centres (ETCs).[20] 1,171 people recovered from EVD.[21] More than 16,000 local frontline responders and thousands of individuals were trained as part of the response.[22]

As these briefings will show, the international response to COVID presented both positive lessons to be learned, but also examples of worst practice to be avoided. This doesn't undermine the extreme capacities at which frontline staff, workers and practitioners were operating and the bravery of the individuals involved. Instead, it seeks to explore possibilities, effectively capture key learnings and ensure these are readily available so that they can help improve future disease outbreak and containment responses in conflict zones.

Infrastructure

Infrastructure networks across the DRC are poor and affect actors living, working and operating in the country. The geographic size, for one, presents a significant challenge; DRC is the second largest countries in Africa, with a territorial expanse close to 2.3 million square kilometres, sharing its borders with nine countries.[23] To put this into perspective, 'at over 1500km, the distance between the capital, Kinshasa, and Goma, the capital of North Kivu province, is greater than the distance between London and Algiers.'[24] The scale, combined with poor governance and corruption, has implications on the distribution, investment, construction, and maintenance of key infrastructure.[25]

Infrastructure weaknesses, although only part of a larger problem, are still exceptionally important when analysing disease outbreak and containment. In the DRC, for instance, the lack of reliable electricity, telecommunication networks, ad road systems significantly impacts on development and livelihoods.[26] Similarly, poor water, sanitation and hygiene (WASH) availability and coverage has been documented. According to data collated in 2017, only 20% of the population has access to safely managed and basic sanitation services, with drinking water available to 43% of rural environments.[27] All the above deficiencies have short- to long-term impacts on local communities, as well as operational consequences for healthcare services.

Health and general infrastructure capacity

The macro-structure of the DRC health system, according to The World Bank, is as follows:[28]

<table>
<tr><th>Public Medical Sector</th><th colspan="2">Private Medical Sector</th><th>Private Pharmaceutical Sector</th><th>Traditional For-profit Non-profit Medicine</th></tr>
<tr><td rowspan="2">Health centres, general reference hospitals, provincial and national hospitals, other state and parastate structures involved in service delivery</td><td>For-profit</td><td>Non-profit</td><td rowspan="2">Pharmaceutical companies and authorized wholesale, supply, and distribution structures</td><td rowspan="2">Traditional healers using plants and traditional practices to diagnose diseases and conditions and provide care for patients</td></tr>
<tr><td>Private medical and paramedical practices, clinics, polyclinics, and diagnostic centres</td><td>Health centres and hospitals managed by NGOs, including Faith Based Organisations (FBOs)</td></tr>
</table>

Access, services, quality of equipment and human resources vary considerably between and within these categories, yet each are vital and contribute to national healthcare provision.

Geographic distribution, similar to the above, differs greatly. Health facilities are largely based in and around urban areas, namely in the city-province of Kinshasa.[29] This inequitable coverage also pertains to the number of physicians, with most provinces having half the ratio of those in Kinshasa. Nevertheless, facilities based in the north-east played a key role in the containment of EVD.

However, health provision issues and difficulties were witnessed during the response including at such facilities. Ultimately, individuals actively sought to avoid these facilities for a multitude of reasons. One of these was access, which for some was cumbersome, dangerous, and expensive.[30] In light of this, some individuals were reluctant to travel to Ebola treatment centres (ETC) until their symptoms worsened, or sought other methods of treatment first, including self-medication and/or visiting traditional healers or pharmacies, who – in large part – lacked adequate Personal Protective Equipment (PPE).[31] Moreover, some poeple travelled far to health facilities, 'complicating the task of investigating transmission chains, increasing the risk of geographic spread, and increasing the risk of transmission within health centres.'[32] This complicated and compromised Ebola containment activities. Access, as stated above, was only one of the multitude of reasons why individuals avoided ETC facilities; others included not understanding the disease, misinformation and lack of trust of the responders.

Even if facilities were operational and accessible, they often lacked capacity, either in terms of human resources and/or equipment. In April 2019, a joint WHO and UNICEF report indicated that rural health centres had worse WASH service than those in urban areas, with the DRC witnessing the largest disparity out of the countries examined.[33] The WHO, among others, went further and stated that some local health facilities were, despite efforts to improve standards, worsening the situation 'where poor standards of infection prevention and control were amplifying transmission'.[34] Furthermore, transmission was also occurring in these facilities due to lack of policy adherence.[35] These assessments clearly demonstrate the crucial role that the appropriate equipment, WASH infrastructure and staffing play in effective containment programmes, as well as the cumulative consequences of these not being in place.

A key consequence of the above was the erosion of confidence in health facilities and services during the response.[36] In early 2019, The *New York Times* provided a focused insight into the situation in Butembo, North Kivu, and emphasised that resistance towards ETCs was often due to them being seen 'as a place to die rather than be cured.'[37] Given the need to ensure an infected individual seeks treatment quickly and isolates, such hesitation to seek medical assistance has serious and deadly implications.[38] When patients were unable or unwilling to take these precautions, on account of cost, mistrust, misinformation, or other factors, the response as a whole suffered.

The private sector, both for- and non-profit, filled some of the gaps in the public sector services in terms of capacity, location, and expertise, among others.[39] For instance, direct implementation by international and local NGOs enabled greater health outreach and increased availability, including building relations with local communities and establishing a degree of trust.[40]

A strategy deployed later in the response was to scale-up programming that integrated disease containment activities into other developmental and humanitarian needs. The World Bank, for example, invested in handwashing stations, whilst Médecins Sans Frontieres (MSF) built wells to stop the spread other deadly diseases, alongside Ebola.[41] Lastly, Mercy Corps, like MSF, drilled new wells and repaired 'existing water infrastructure' to support the response and to address 'a critical local need.'[42] If properly maintained, these will continue to benefit the community long after the response to EVD has ended.

Coordination and cooperation

Assistance was provided to the MoH, which was leading the response, on various levels and included direct delivery, training and technical expertise support, community campaigns, disease surveillance, coordination, logistical assistance and funding.[43] To manage this process, a multitude of operational and coordination systems, as well as funding structures, were established and utilised.

Provision of the aforementioned support, however, was not without its difficulties with working relationships between stakeholders often fraught or even fractured. With a large number of stakeholders on the ground, each with distinct priorities, the work of international actors became riddled with competition and territorialism. This was complicated further by the many management structures, different operations and categories of facilities, where there was a lack of coordination.[44] The Overseas Development Institute (ODI), for example, noted that a separate health system was established in 2018 for Ebola, but 'didn't cater for other health issues.'[45] These challenges regarding coordination have been 'cited as a major hindrance' to the Ebola outbreak response.[46]

As outlined above, 'the lack of coordination between responding actors can lead to the duplication of structures and activities.'[47] The situation was witnessed during the first many months of the Ebola response, to the detriment of the response as a whole, with one of our roundtable participants raising the issues of 'parallel systems' and 'coordination structures.'[48]

One of these detractions was the 'siloed' approach that was implemented at the outset of the intervention.[49] With the MoH as the primary lead and the WHO and others supporting the response, INGOs and NGOs found themselves excluded from strategic and operational discussions. Largely bypassed from the start, these organisations were only integrated later in the timeline, meaning that their collective knowledge, expertise and community networks were not fully utilised.[50] During our roundtable, this issue was raised by multiple attendees stating that NGOs were only involved in coordination meetings around April/May 2019.[51] As a result, an opportunity was missed to make the

response more inclusive from the planning phase, where their voices and experience could have been used more effectively and application of previous learning could be applied.

The importance of bringing more varied actors to the table was clearly recognised in early- to mid-2019. The WHO, for instance, communicated in May 2019 that they, in partnership with DRC government and all partners, sought to 'increase support for humanitarian coordination' and that a 'strengthened coordination and support mechanism in the epicenter of the outbreak, Butembo' was established by the UN Secretary-General.[52]

To assist with the above, a number of coordinators were appointed to increase and facilitate dialogue between the various stakeholders. While many of these brought significant changes, two in particular were influential. The first was the appointment of a new position of UN Emergency Ebola Response Coordinator, a role which was taken up by David Gressly.[53] Gressly 'sought to strengthen financial tracking, humanitarian coordination, political engagement, and "preparedness and readiness planning.'[54] Second was the greater involvement and deployment, in March 2019, of Dr Ibrahima Soce Fall, then-UN WHO Assistant Director-General of Emergency Response to Butembo, North Kivu.[55] Although such efforts were designed to enhance cooperation, not only did these initiatives occur months into the response, but they also did not fix or mitigate coordination and communication issues present during the response.[56]

As we have previously noted, coordination was improved in May 2019 and was linked to the "system-wide scale-up", with NGOs 'given a voice in strategic coordination forums.'[57] While this process also had faults, and did not result in anything close to perfect coordination, it allowed decision-makers to more efficiently tap into expertise, alternative humanitarian perspectives and contextual experience that fed into strategic and procedural changes.

Developments were not just seen in the international response, but also nationally. In July 2019, Felix Tshisekedi, the President of DRC, stated he planned to oversee the national Ebola response through an expert committee that would report directly to him, in place of the MoH who had previously been the response lead.[58] The strategic shift was aimed at utilising multiple ministries and increase coordination between them and various partners.[59] Further pressure was exerted on the DRC government by international foreign officials and donors to implement more coordination and reforms.[60]

Yet despite each of the decisions and practical steps, it was estimated that even by September 2019, the 'coordination and communication fundamental to a unified and effective public health response were not yet in place.'[61] This demonstrates the challenges that were still faced over a year into the response.

Aid disruption and corruption

Given the nature of the response, quick release mechanisms – funds that can be accessed to rapidly implement a humanitarian or other crisis response – were activated to align with the emergency status of the situation and disease outbreaks more generally.[62] A multi-phased response was implemented by the DRC MoH, with support from the WHO, other UN agencies and a range of INGO/NGOs.[63] To achieve this, hundreds of millions of dollars were requested and spent on the disease containment programme, spanning entire provinces and geographical areas.

The WHO alones received and managed over $376 million, of which over $276 million was from a variety of government agencies, donors, trusts and other funding mechanisms, with just more than

$100 million received from the WHO Contingency Fund for Emergencies (CFE) contributions.[64] This does not include the fund requested for the response until September 2020 or the regional preparedness funds distributed between 2018 and 20. Total funds are estimated to be more than $700 million for the entire response, inclusive of the WHO figure above, but not the additional requested figures for 2020 or for the 11th outbreak.[65]

Within this operational environment, there were numerous daily obstacles and challenges. One of the most pertinent was predation[66], which has been described as existing in 'every sector in the DRC, including humanitarian aid.'[67] This predation was exacerbated by operating in a conflict zone. For the aid sector specifically, diversion and corruption were (and remain) ingrained across multiple levels; the response to EVD was no exception. The emergence of what has been termed as "Ebola Business" outlines the systematic and complex nature of these practices, which will be explored below.

Ebola Business

A cross-organisational method of aid diversion, corruption and embezzlement was unearthed by an investigation, funded by DFID.[68] Dubbed "Ebola Business" by the affected populations, the systematic and widespread nature of the procedures has shocked even hardened and experienced humanitarians and investigators.[69] Collusion and coordination were witnessed on an inter- and intra-departmental basis, between sectors such as the private sector and UN agencies, INGOs and NGOs, as well as with the local and national authorities. The scope and breadth of the scheme raises questions about funding, monitoring, accountability, and detection frameworks, as well as reporting and feedback mechanisms. Some estimates state that approximately $6 million was lost over the two year period by many aid organisations.[70] Loss of funds, however, are only part of the wider story.

These practices have been extensively listed in an Adam Smith International investigation and report, which was leaked to the news outlet The New Humanitarian (TNH).[71] Some of the prime examples pertain to the rental of vehicles, payments and per diems to DRC security forces, manipulation of beneficiary lists and monitoring reports and coercion by armed groups and/or prominent individuals. A number of these situations and practices have either been created or used for personal gain and advantaged. Alongside massive influx of capital, a surge of individuals devoted to the response caused levels of resentment against some organisations and agencies.

Conclusion

As we have demonstrated above, the DRC's weak general and health infrastructure severely impacted the 10th Ebola response, hindering key activities and compromising containment programme implementation. Moreover, the complicated systems negatively impacted coordination from the outset. Although these were somewhat mitigated later, the fact that certain stakeholders were not included during the process, including INGOs and NGOs, was largely to the detriment of the response. Increased investment in long-term needs of local communities and more inclusive programmatic development and design processes, more defined and clear management and coordination structures should occur at the very planning/outset of a disease containment programme.

Yemen

History

In southern Yemen, the British Empire established a protectorate in Aden in 1839. In the context of increased insecurity and a mounting insurgency, it eventually withdrew from the south entirely in 1967. Swiftly afterwards, in 1969, the south renamed itself the People's Democratic Republic of Yemen and adopted a communist ideology. Meanwhile, a kingdom declared independence from the Ottoman Empire 1918 in the northern part of the country.[72] In the 1960s, a civil war erupted, in north Yemen, then titled the Yemen Arab Republic, between Royalists (backed by Saudi Arabia) and Republicans (backed by Egypt), with the latter emerging victorious.

After decades of turmoil and intra- and inter-state (north-south) conflict, the two states united in May 1990 and was renamed the Republic of Yemen. The following years saw economic hardship, nepotism, corruption, and exclusion of Southern voices. Tensions continued between north-south political leadership and, in 1994, became violent as Leaders of the former southern Yemeni state and allies -who previously signed the Unification agreement- fought for separation. They lost the civil war and the two countries eventually united.

Throughout the early to mid-2000s, there were a series of conflicts between the Houthis, a Shia movement and insurgency based in the north, and the Yemeni national army and state.[73] In the South, there were a series of protests organised by the Southern Movement from 2007-2011 'demanding "southern independence" and secession.'[74]

Recent conflict

In the midst of the Arab Spring in 2011, protests broke out across Yemen against grievances related to the economy and corruption, among other things, demanding reforms to rectify these. President Saleh and pro-Saleh forces initially resisted, with numerous protesters killed.[75] However, as part of the Gulf Cooperation Council Initiative (GCC) agreement, Saleh resigned in exchange for immunity on November 2011 and his deputy, Vice President Abdurrabu Mansour al-Hadi, led a new government.[76] Another process soon followed titled the Yemeni National Dialogue Conference (NDC). However, clashes in the north compromised the NDC's implementation and culminated in an alliance of Houthis and security forces loyal to Saleh fighting for control of the capital of Sana'a in late 2014, seizing the city in January 2015. Hadi and his cabinet were forced to flee, exiled to Saudi Arabia. Saleh and the Houthis formalised an alliance against the Hadi-headed Internationally Recognised Government (IRG), with fighting and violence erupting between the two sides.

In response to these rapid escalations and the Houthi/Saleh force advances', a Saudi-led multi-national coalition militarily intervened in March 2015, with frontlines emerging after the Houthis were pushed further north. Numerous states involved in this coalition, and outside of it, backed a wide variety of factions, militias and groups.

In northern Yemen, the relationship between the Houthis and Saleh broke down in November 2017, eventually results in the assassination of Saleh. An escalation of clashes and an offensive on the critical and strategic Red Sea port of Hodeidah saw the signing of the UN-backed and brokered Stockholm Agreement by the Internationally Recognised Government (IRG) and Houthis in December 2018.

In the south, tensions mounted between the various factions within the Saudi-led coalition, namely the Southern Transitional Council (STC), a southern separatist movement, and its forces, against the IRG and its forces. STC-supported groups, backed by the United Arab Emirates (UAE), seized the southern city of Aden in early 2018. Clashes continued within the coalition allies in 2019 and a meeting was convened by the backers, Saudi Arabia (IRG) and UAE (STC), where the Riyadh Agreement was signed in November 2019 to end the power struggle over the Control of the South. Issues quickly arose and, in April 2020, the STC declared self-rule in Aden.

It should be noted that the implementation of both the Stockholm and Riyadh agreements have been fraught with violations and accusations of non-compliance by all sides, whilst fighting has continued unabated across multiple fronts.

Current situation

More than five years have passed since the start of the civil war in Yemen and, much like the DRC, Yemen is facing a multitude of severe problems. Widely considered to the 'world's worst humanitarian crisis'[77], an estimated 24 million people are in need of humanitarian assistance, out of a total population of just over 29 million.[78]

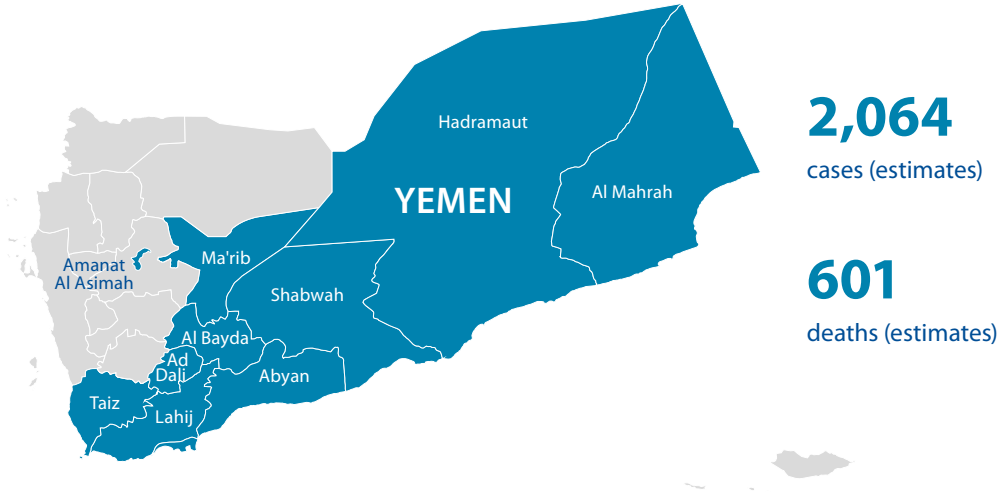
The conflict itself poses one of the most critical challenges, with agreements not holding and fighting continuing between a multitude of state and non-state actors. The anti-Houthi alliance is an uneasy one which has, on numerous occasions, turned deadly and further complicated the situation for their backers.[79] Moreover, the actors described in this section so far are only some of the many groups operating in the country; the extremist groups Al-Qaeda in the Arabian Peninsula (AQAP) and Islamic State of Iraq and the Levant (Yemen Province) are both active in the country, with regular attacks and counter-attacks.[80]

Concurrently, there are the infrastructural weaknesses and reductions of key services and facilities. The infrastructure pre-conflict was already poor, but the fighting has damaged, degraded and destroyed key infrastructure across the country.[81] Particularly important for this briefing are the poor WASH services and infrastructures, which are contributing factors behind a number of disease outbreaks, of which there are many in Yemen.[82] In fact, in recent years, Yemen has seen a cholera outbreak that began on April 2017.[83] By January 2020, the WHO estimated that there has been over 2.2 million cases and between January and October 2020, another 200,000 suspected cases were documented.[84] Outbreaks of measles, diphtheria and dengue fever have also occurred over the past few years.[85] Lastly, there is of course the current COVID-19 outbreak and spread, which shall be explored further below.[86]

Overview of COVID-19 outbreak

On 23 March 2020, the UN Secretary-General António Guterres appealed for a global ceasefire in light of the emergence of COVID-19.[87] The Saudi-led coalition responded to this by announcing a two-week long ceasefire that started on 9 April 2020, a move welcomed by the UN Secretary-General, Special Envoy of the Secretary-General for Yemen, Martin Griffiths, aid agencies, and others.[88] Implementation and adherence to the call were, however, flawed with accusations of violations from both sides and the conflict has continued unabated throughout 2020.[89] Of particular focus was the intense fighting over the strategic provinces of Jawf and Marib that began in early- to mid-2020.[90]

Figure 2: Reported COVID-19 cases in Yemen (March 2020 - Present)



Source: UNOCHA

Regarding COVID-19, the first reported cases in Yemen were declared on 10 April 2020.[91] According to United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), as of 24 October 2020, there have been 2,064 cases and 601 deaths, with 1,361 individual recoveries, across 11 governorates in Yemen.[92] A number of organisations and institutions, however, have flagged these figures as significant underestimations.[93] Two models developed by the Imperial College London and London School of Hygiene and Tropical Medicine respectively estimate significantly higher figures, with the latter stating that there have been 1 million COVID-19 infections across the country and that, in their worst-case scenario, 'up to 10 million people' could be 'infected with between 62,000 to 85,000 deaths.'[94]

Impacts of COVID-19 are already being felt across the country, especially in the terms of access to food and water shortages.[95] Moreover, there have been dire forecasts that suggest the situation could deteriorate further, with Action Against Hunger warning of a 'worsening food crisis in Yemen.'[96] Activities to combat the spread of COVID-19 have been challenged by the ongoing conflict, alongside other outbreaks and crises, including flash floods and locust swarms.[97] Described by the World Food Programme (WFP) as the 'perfect storm', Yemen now faces a series of interrelated crises, compounding an already dire humanitarian situation.[98]

Macro-economic overview

This summary explores recent economic developments in Yemen in light of the COVID-19 outbreak. It does so through secondary analysis and a literature review, with a focus on data collected from the World Bank and International Monetary Fund (IMF).

To achieve this, we look to the broad consensus amongst institutional and political analysts for a general overview of Yemen's economy in early to mid-2020. From this, it is clear that:

- Yemen was a low-income country before the conflict escalated in 2015; since then, its GDP has decreased by 50%. It was – and remains – the poorest country in the Middle East and North Africa (MENA) region.[99]

- Before the recent conflict, Yemen already had a dire import-export balance, particularly concerning food. Oxfam has estimated that, 'even before the crisis, 90% of Yemen's food was imported, including 90% of wheat and 100% of rice, which are the country's staple foods.'[100] This has worsened due to the war.

- The national economy and infrastructure have been devastated by five years of civil war, external intervention and insurgency, made worse by further crises, including floods, locusts destroying agricultural output, and disease outbreaks.[101]

- Successive waves of currency depreciations in 2018 and 2019 have increased the fragility of basic service provisions.[102]

- As of late 2018, 40% of Yemeni households are estimated to have lost their primary source of income since the conflict began.[103]

Yemen's unfortunate designation as 'the worst humanitarian crisis in the world' is widely considered to have been made worse by exclusionary economic and political institutions.[104] Within this context, it must be acknowledged that Yemen's economic and social prospects depend crucially on the political and security situation.

Operational Environment in COVID-19 Yemen

Before proceeding, it is vital to first outline the quality of Yemen's institutions. This summary references two key indicators, chosen because of the strength of their data:

1. Transparency International's Corruption Perceptions Index (2019 results): 177th out of 190.[105] The absence of a national chapter on Yemen in the Index is indicative of the extremely poor institutional quality in Yemen, with its score suggesting that Yemen is highly corrupt.

2. The World Bank's Doing Business score (2020 results): 187th out of 190.[106] Yemen scores low across all ten sub-indicators, but particularly so in measurements of access to electricity and credit, trading across borders, and dealing with construction permits.

The ongoing conflict has significantly reduced the economic governance agency of the IRG. Significant areas of north and south Yemen fall under the de facto authorities, the Houthis and Southern Transitional Council, respectively.[107] Division among the three key actors extends to the Central Bank of Yemen which, whilst officially relocating to the IRG's seat of governance in Aden, is forced to compete with a Houthi-controlled branch in Sana'a which has better access to the country's largest consumer markets and financial centres.[108] Nevertheless, the IRG continues to benefit from international recognition and support from Development Finance Institutions, including the World Bank, and donors for the official Central Bank of Yemen. Consequently, the IRG is considered the primary actor responsible for drafting and implementing macroeconomic policies to tackle the economic consequences of civil war and COVID-19, with the eventual view to kick-start economic development. As a result of this, although the economic agency of the Houthis and STC does merit analysis, these are beyond the scope and focus of this paper. Other actors from the private sector and humanitarian aid are noted, but are not the focus here.[109]

The Yemeni Economy in light of COVID-19

Yemen's fiscal revenue is forecasted to shrink dramatically in 2020-21, causing the budget balance to fall deeper into deficit. Monetization of this deficit and ongoing hard-currency shortages will likely lead to a sharp depreciation of the official currency, the Yemeni Riyal, which has already lost 25% of its value since the COVID-19 outbreak, as of September 2020.[110] These have compounded the falling value since the war began, jumping from 215 Yemeni Riyal to the U.S. Dollar in 2015, to an estimated 820 Yemeni Riyal to the U.S. Dollar in September 2020.[111]

The public debt deficit and IRG's inability to pay regular and full salaries has also led to the depletion of foreign exchange reserves and poor foreign exchange-management. The Central Bank's other issues are a weak payment system, infrastructure and core banking system, poor monitory policy and inadequate measures to build confidence in the economy. As a consequence, poor banking supervision, combined with low capacity, has meant fragmented and incomplete implementation of Anti-Money laundering and Counter-Terrorism Financing (AML/CTF) procedures and systems.[112]

Overview of national and international economic responses during COVID-19

The IRG's economic response to COVID-19 have been somewhat minimal, reflecting its limited capacity. Beyond the establishment of a COVID-19 commission, there have been no fiscal measures nor any monetary or macro-financial policy responses, including none to address the exchange rate depreciation and balance of payment issues.[113]

In several instances, international aid organisations have attempted to address the COVID-19-related investment gap. For instance, recent months have seen the following;[114]

- Marginal debt relief of USD 19.76 million from the IMF in April 2020 and tranche of USD 15.45 million in October 2020.[115]
- Yemen COVID-19 Response Project of USD 26.9 million from the World Bank in April 2020, as well as an additional USD 25 million in June 2020 to combat locust swarms, focus on food security/livelihoods and enhance early warning systems.[116]
- Partnership agreement between United Nations Development Programme in Yemen (UNDP), and the European Union was signed in August 2020 to the value of USD 82.4 million to strengthen local authorities' fight against poverty and foster long-term development.[117]

Challenges associated to response

As has been the case internationally, measures taken by the IRG, and de-facto authorities elsewhere in Yemen, to tackle COVID-19 have struggled to mitigate the virus' direct negative impact on economic growth, employment, and poverty. The International Rescue Committee (IRC) found that, as of August 2020, respondents to a survey 'noted a decrease in income since the start of the pandemic.'[118] Across Yemen, many businesses and commercial activities ceased as a direct result of social distancing measures introduced. Furthermore, the impact on the global economy saw a decline in oil production and prices, a reduction in the movement of commodities in the ports, and lockdowns which prevented Yemeni expatriates from sending remittances back home.[119]

We shall now focus on three sectoral challenges that are associated to Yemen's response to COVID-19. The first is expatriate remittances, vital for livelihoods and key source of foreign currency. The second is fisheries, which form a key livelihood for many communities. Finally, the provision and distribution of medicine and medical supplies is to be outlined, including the difficulty of coordinating with multiple authorities and armed groups.

Expatriate remittances

Decline in expatriate remittances has largely occurred due to quarantine measures in host countries, particularly in the Kingdom of Saudi Arabia, which hosts the most Yemeni expats. Such remittances are vital not just to individual Yemenis, but to the Yemeni economy as a whole; Oxfam International estimated that total remittances transferred to Yemen in 2019 was USD 3.8 billion, equating to 13% of Yemen's GDP.[120] Other institutions, however, have valued this higher, with the Sana'a Center for Strategic Studies stating it could instead be USD 8 billion.[121]

Fisheries

Due to COVID-19 restrictions, there has been a total halt of exports of fish from Yemen due to declining import among countries in the European Union (EU), most notably Italy and Spain.[122] As a result, there was an accumulation of fish products in the companies' stores, raising operational costs.[123] Fishing companies were forced to sell these products at lower prices to ensure liquidity, cover these increased costs of electricity and oil, and to buy new products to avoid collapse, with associated risks set to worsen.

Medicine and medical supplies

The medicine and medical supplies sector faced difficult challenges, even before the pandemic. The duplication of authorities in Aden and Sana'a, for example, has led to increased costs and delayed arrival of goods. This was a consequence of different exchange rates, negative impact of fiscal policies, supply chain complications, export delays, and reduced employment capacity, especially in Aden, due to the numerous epidemics of cholera and typhoid.[124]

As a consequence of the above, alongside other factors, it is estimated that prices of medicine and medical equipment increased by 30% and supply shortages were associated with COVID-19, including of face masks, gloves, important vitamins and antibiotics.[125]

Conclusion

The brief overview and three sectoral examples clearly demonstrate the wide and deep impacts these economic complications and challenges have had on Yemen, which are only likely to deepen in the future. As has been shown in the DRC sections, these have far reaching consequences and require short- and long-term efforts to address.

While this briefing has only scratched the very surface, having a fuller understanding of contexts in the DRC and Yemen are key. Without conflict sensitivity and some understanding of the origins of conflicts, tension, and insecurity, responses to diseases cannot hope to be effective.

Overview of the briefing papers

Each briefing covers one of the following topics: background, community, gender, and security. Within each of these topics, lessons from the DRC are first outlined before the likely impact of COVID-19 in Yemen is examined. The overall findings from both will then be laid out.

Community Engagement and Misinformation

Meaningfully engaging the local community during disease responses is critical to effectively implement activities. Such dialogue can prevent the manifestation and spread of misinformation, which can negatively impact how the response is seen, raise the resistance to certain activities, undermine the legitimacy of certain actors/stakeholders and increase both the spread of a disease, as well as the incorrect information and conspiracy theories stoking that spread.

The paper demonstrates that community engagement was introduced far too late into the DRC Ebola response; this had profound consequences on the response as a whole, responders themselves, local communities and those afflicted with the disease. Many failures of the Ebola response have their root in this lack of early engagement. Future responses to large outbreaks must factor such community engagement into the planning and conceptualisation phases, throughout delivery, and as part of post-delivery assessments.

Women's Experiences

While there have been ample rhetorical commitments to ensuring the inclusion of women and girls in international responses to conflict, insecurity, and disasters (including pandemics), this has not translated into consistent progress on the ground. Instead, women were insufficiently included in the planning of the response to Ebola in the DRC, and their needs were insufficiently addressed. For future disease outbreaks to be effectively combatted, there must be a genuinely inclusive approach. This is especially important as women-led groups stand ready to guide and assist the international responses.

Security

Stopping the spread of diseases is a difficult enough challenge. It is made worse in a conflict or highly insecure environment. Understanding these contexts and risks are vital to designing strategies to effectively navigate them. In this paper, the conflicts in the DRC and Yemen are outlined, with particular focus on the actors, affected areas and conflict dynamics. The impact of these on the outbreak and response, and vice versa, are then analysed. Then, measures and strategies deployed by the various response actors are outlined, including consequences.

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