# Women's Experiences of Disease Outbreaks in Conflict

## Reflections on lessons from the Democratic Republic of the Congo and Yemen


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Breaking the cycle of violence · ORG

This briefing has been written by staff at Oxford Research Group (ORG), with contributions from local experts, as part of the **'Reshaping The Process in Yemen: Exploring alternative methodologies for the peace process in Yemen'** project. Implemented by ORG and the Sana'a Center for Strategic Studies (Sana'a Center), the 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 towards the country's future political transition.

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Cover image: *A Trip to the Front Lines of the Fight Against Ebola, DRC. Credit World Bank / Vincent Tremeau.*

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This is the second briefing in a series released by the Oxford Research Group's (ORG) Strategic Peacebuilding Programme. These briefings examine 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 Background Information, Community, and Security – can be found here. For readers new to this topic, we suggest reading the 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.

Women, men and minorities experience different traumas during both conflicts and large-scale disease outbreaks. When these events occur at the same time, it is more necessary than ever to maintain a strong understanding of the complicated, distinct and often mutually reinforcing gendered challenges in each context. This is especially true as women – and the challenges they face – continue to be systemically excluded from decision making in international responses to crises.

However, in spite of rhetorical commitments[1] to an inclusive approach from the majority of international organisations, our research for this report clearly shows a gap between aspirations and reality on the ground, as the gendered aspect of disease outbreaks remain neglected. As this briefing shows, this was the case in both Yemen and the Democratic Republic of the Congo (DRC). This led to programmes which failed to respond to the actual needs of populations on the ground – in some cases even exacerbating these needs.

This briefing will explore the challenges facing women and girls in each of these contexts. It will first examine the response of the international community in the DRC, and identify key challenges to Congolese women in three different contexts: 1) their direct suffering from the Ebola Virus Disease (EVD); 2) the increased gender-based violence (GBV) during the outbreak; and 3) the neglect of other women's health concerns during the epidemic. It will then explore the challenges facing women and girls in Yemen, from a local expert's perspective. After this, the briefing examines how the response to COVID-19 has already – and will continue to – exacerbate the challenges facing this demographic group. Finally, the briefing lays out the findings that apply to both countries.

This briefing will not delve into the gendered challenges facing men and boys in the DRC and Yemen. These are plenty and require thorough assessment in future research, yet they are outside the limited scope of this briefing, which simply aims to examine the main challenges facing women and girls.

# Democratic Republic of the Congo (DRC)

## Women's experience of Ebola in the Democratic Republic of the Congo

In our research for this report, it became clear that there were three major areas of concern for women and girls' experiences during the 10th Ebola Virus Disease (EVD) outbreak (2018-2020) in the DRC, . Each of these will be analysed in turn:

1. **Gendered challenges as a direct consequence of EVD**
   56% of the EVD fatalities in North Kivu and Ituri provinces were women, compared to the 11% who were men.[2] No difference have been found in the biological susceptibility to EVD between women and men; rather, the differences appear in the level of exposure during the outbreak, and the response once infected.[3]

2. **Increased GBV against women and girls**
   This has been attributed to indirect impacts of the EVD outbreak, in addition to the design and implementation of the EVD response.

3. **Women's health neglected during the EVD response**
   The sexual and reproductive health (SRH) of women and girls was neglected and undermined during the response to EVD.

The disparity between men and women in their experiences of the EVD outbreak were fundamentally related to deep-rooted, pre-existing inequality throughout the DRC; at the start of the outbreak in 2018, the DRC ranked near the bottom of the Gender Inequality Index (GII), at 156 out of 162 countries.[4] This gender inequality remains evident across all aspects of life in the DRC. For instance, when examining the proportion of people living under the poverty threshold of $1.90 per day, it is notable that 61.2% of women live underneath the threshold, compared to 51.3% of men doing so.[5] Furthermore, while characterising the Kivu conflict as a "war against women"[6] is an oversimplification of the complex crisis[7], gender-based atrocities have been systematically employed by some belligerent groups as a weapon of war and women are disproportionately at risk from certain forms of violence.

The disparity between men and women, already deeply engrained in Congolese society, was exacerbated in eastern DRC, in the North Kivu and Ituri provinces. The normalisation of violence in these provinces, which have been embroiled in decades of conflict, extended to gender-based violence. At the same time, women in North Kivu are politically dis-empowered; the electoral districts of Goma town, Butembo town, Beni town and Masisi territory did not delegate a female parliamentarian at either national or provincial level in any of the past three elections.[8] Absence in such spheres of influence directly affects women's ability to dictate, influence and determine decisions which affect them.

There is a thin line to tread for international responders, as they attempt to balance enabling women while also adapting to – and respecting – divisions of labour in a culturally sensitive manner. If this balance is not struck, and a one-size-fits-all approach is instead taken, the divide and mistrust between communities and response teams will increase. However, as many of the experts and practitioners interviewed for this report emphasised - despite rhetorical commitments to these

principles - the international EVD response was guilty of perpetuating the systematic exclusion and underrepresentation of women and girls' priorities, voice and agency. The national response, led by the Ministry of Health (MoH), did the same and had a very low level of female representation.

## Gendered challenges as a consequence of EVD

### Division of labour

The gendered division of household chores in the DRC, and the traditional roles in society, put women at a disproportionate risk of catching EVD in several ways. First, gendered mobility patterns put women at high risk, with women and girls' daily tasks demanding higher environmental ranges when fetching water, cultivating fields and going to the market.[9] The increased exposure to more people heightens the risk of contracting EVD. The needs for these tasks grew in response to the EVD outbreak, with infection prevention and control (IPC) measures prescribing regular hand washing, increasing the consumption of water at home, as well as in offices, health care facilities and other public areas.[10]

Secondly, within the home, women are largely tasked with cleaning and caring for the sick. At times, this includes accompanying patients to hospital, as well as taking leading roles in preparing bodies for funerals.[11] With a high viral load of EVD in dead bodies, women are at risk as they bathe, dress, shave, and handle dead bodies as part of the traditional rites performed during such ceremonies. The increased risk of EVD transmission associated with all of these tasks are compounded by inadequate WASH facilities such as limited supplies of water and soap.[12] At the same time, women were often stigmatised and accused of not performing their chores correctly when a member of their household died of EVD, adding to the emotional and psychological impact of the disease on their lives.

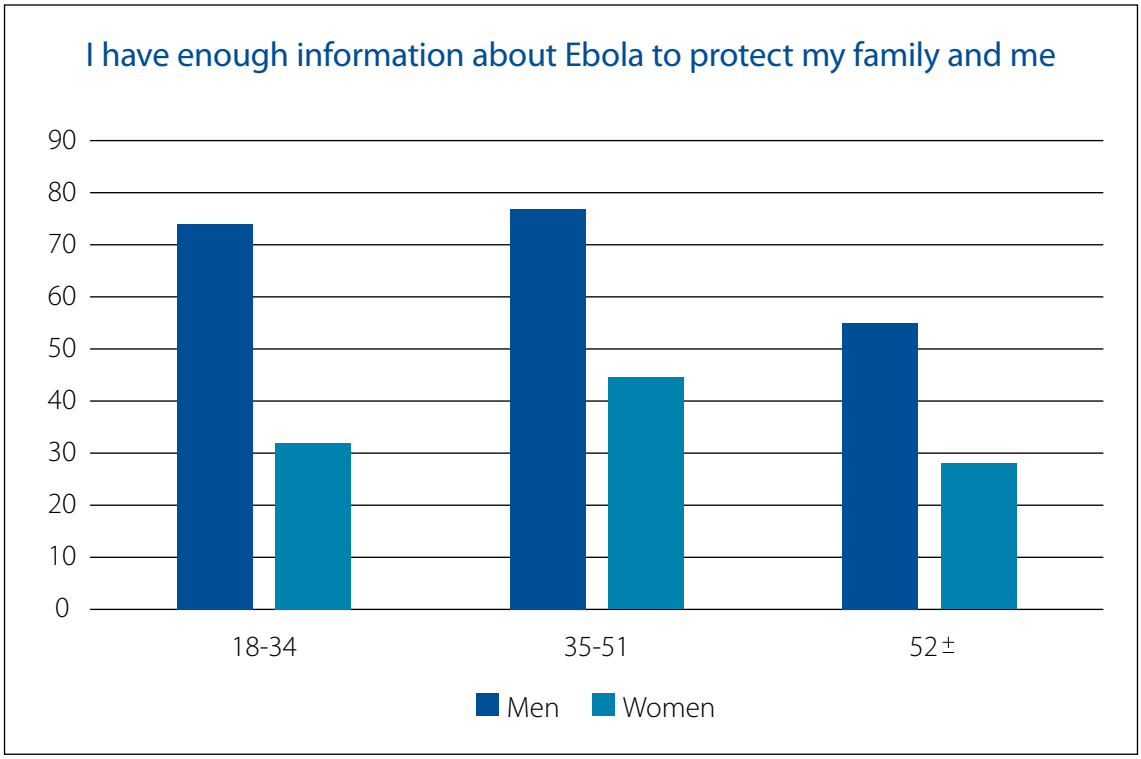
Employing women in the EVD response was vital in raising awareness and indirectly reducing the risk of transmission. For instance, an international gender consultant emphasised the change that had occurred in community relations once coordination mechanisms were established; these ensured that the funeral rites of specific ethnic groups were included in safe and dignified burials (SDBs) and women were allowed to take on their traditional roles in these ceremonies (while wearing appropriate personal protective equipment (PPE)).[13]

### Gender-gap in communication

A study by CARE International found that a significant proportion of women and girls in North Kivu perceived key messaging and content related to the EVD response as confusing.[14] In addition to possible targeting issues in information campaigns, this was likely exacerbated by the differing levels of education among men and women; 91.2% of males aged 15-24 are literate compared to just 73.6% of females aged 15-24.[15] All surveys examining the level of understanding of pamphlets and flyers showed reduced reach amongst women and girls.[16]

This confusion occurred in a climate of disproportionate distrust trust among women, in contrast to men, in the government in general; the government's role in the EVD response; and in EVD response teams.[17] Our interviews revealed this lack of trust is tied to several factors. The first is the lack of women involved in leading the response. Such involvement could have ensured that the response addressed women's concerns. The second is women's perception that the EVD response was

overshadowing other health concerns. This is not without good reason, with one practitioner describing; "[t]he response came to the detriment to everything else that's being done, it's like an absolute dump truck which takes over the entire discussion."[18] Other experts backed this up and argued that because the response to EVD was treated independently from the coordinating body of the Health Cluster, other health concerns, such as maternal health, were not integrated. The third reason concerns the general lack of understanding of the cultural distances within the DRC. Local staff in the Western Equateur province quickly shifted from dealing with a response there in early 2018 to supporting the response to EBV in North Kivu and Ituri. As a result, many of the "national staff" of this second Ebola response had different cultural traditions, spoke a different language (which women were less likely to speak than men), and were generally mistrusted by eastern Congolese. This increased the mistrust to the response by local populations, including women, who were often confronted with them in health facilities, when accompanying a sick relative. Finally, distrust in the response was severely exacerbated by stories circulating of sexual abuse by international actors, such as those revealed in Autumn 2020.[19]




*1: Source: Mahrukh Maya Hasan, 'Missing the mark? People in Eastern DRC Need Information on Ebola in a Language they understand. A Rapid Language Needs Assessment in Goma, DRC – March 2019', Translators Without Borders, 2019, accessed Sep 4, 2020, 9, https://reliefweb.int/report/democratic-republic-congo/missing-mark-people-eastern-drc-need-information-ebola-language*

The response to EVD in 2018-2020, echoes earlier international responses to crises that are perceived by international actors as primary and urgent, but as secondary (or even a lower rank) by Congolese people. Primarily, the strong focus on GBV, including sexual violence, during conflicts in the DRC has seen several recipients of aid rejecting programmes. In a country where 77% of people have lost property, and 58% of citizens have lost a close relative as a result of the conflicts, the Congolese often express disdain for programmes focused only on female victims of sexual violence.[20] Even these women themselves often long for programmes that help them to re-integrate into their communities, retain their land, and be reunited with their families.[21]

## Causes of exclusion

A key driver of the gender gap in communication is language. In North Kivu and Ituri provinces, it is vital to have staff with local language skills, given local women's, especially elderly women's, lack of comprehension of French and Swahili. However, local languages were rarely prioritised.[22]

A successful alternative means of messaging to women and girls during this outbreak was through pictorial communication. Focus groups conducted by the non-governmental organisation Translators without Borders revealed that this type of communication was valued by all participants regardless of their age or gender.[23] However, such materials must be carefully designed to be culturally sensitive. When they are not, it can lead to confusion; for instance, there were documented cases where the use of certain colours interacted with cultural attitudes – wherein yellow/gold symbolise wealth and red symbolises death – to cause the viewers to believe that responders were profiting from EVD.[24] Another example of this lack of cultural sensitivity saw pictures of women performing traditionally male roles, creating confusion and concern.[25] In addition to the gaps in cultural sensitivity, there were also gaps in contextual awareness; for example, community members in some provinces emphasised that information posters had been inefficient because they had not been laminated and were therefore not resilient to local weather conditions.[26]

Women's inclusion in the design of communication strategies from the outset of the response would have helped to enhance women and girls' exposure to correct EVD information. A key lesson from this EVD outbreak is therefore the need to strengthen women and girls' meaningful participation in decision-making processes during the response to disease outbreaks. Their inclusion and agency must be facilitated from the outbreak's outset.

The failure to do this, in the DRC, was particularly disappointing because there was – and is, in fact, still – active capacity and willingness of local women's groups to independently mobilise to tackle EVD.[27] Women's groups with strong collective agency are said to have developed resiliency in influencing political decisions concerning the response. A prime example of women's groups positive inclusion was described by an INGO field-based responder:

> In May 2019 we started to work with women-led community organisations and NGOs. These were very small but had strong roots in communities. We trained them in Ebola prevention measures and in advocacy around what the response teams were doing… Not only was the community more engaged, but the response teams were more accepted and their bad image changed. This was the impact of these local organisations' type of roots.[28]

Many women's groups already had experience as service providers to other women in their fragmented and politically neglected localities.[29] Others mobilised during the epidemic, specifically in response to their exclusion and disproportionate suffering from EVD.[30] The capacities and willingness of all these groups to assist the EVD response was described by one Congolese responder as being ignored by response leadership 80% of the time throughout the outbreak.[31]

It is important to note that the DRC's socially prescribed gender norms, attitudes and practices cannot be captured by national generalisations. Indeed, socially prescribed roles and relations can vary significantly across geographical regions and within communities of differing religious, ethnic or linguistic heritages.[32] Such contexts demands that local women and girls are meaningfully included in the adjustment and customisation of programmes to local conditions.

# Health and Safety

## Bias against women in the treatment of EVD

Beyond the risks that come from these gender divisions in the DRC, our research suggests bias against women during treatment of EVD. While data remains poor and the true extent of the issue remains unknown, it is clear that this has been especially problematic in cases of pregnancy, with extremely high maternal and perinatal mortality rates reported for pregnant women during this and previous outbreaks.[33]

Qualitative data from UNICEF shows that the criteria for vaccine eligibility fuelled communities' mistrust toward the response, with messaging on the vaccine's importance seemingly contradicted by the refusal to administer it to some of the most vulnerable women and children.[34] Despite justified medical concern for the safety of pregnant women receiving the vaccine, an evaluation by CARE International found a gender bias in research and resourcing. The report attests a de-prioritisation in research on the safe use of EVD vaccines for pregnant and lactating women.[35] Such actions by response actors undermines their duty to protect the most vulnerable populations, as well as their responsibility to be accountable to the concerns of affected communities. As one interviewee pointed out, the decision to exclude them would not have been made had women been involved in decision-making processes.[36]

The World Health Organization (WHO) acknowledged the lack of women's involvement, claiming success in their belated shift to spreading risk communication messages through local female leaders.[37] Similarly, pregnant women were eventually made eligible for the vaccine. However, several interviewees for this report emphasised that this had come too late, at a time when the legitimacy of the response had already been lost among many women.

# Increased GBV against women and girls

The EVD response sought to prioritise and resource GBV-related services, including GBV case management, mental health services, and group-based or individual psychosocial support. However, focus groups with female community members revealed that their awareness of the availability of these services ranged from 0 to 50%.[38] Additionally, many women and girls' cited fears over the confidentiality of GBV and psychosocial services as a central impediment to their willingness to access them.[39]

This fear was tied to women and girls' lack of familiarity with and trust of many EVD response actors. As discussed in the Community Briefing, the EVD response did not engage many NGOs or INGOs with experience of operating in the affected communities over a year after the outbreak of EVD.

Women and girls' buy-in to the increased GBV services, as part of the EVD response, would have been enhanced if the services were implemented by trusted actors. A successful example of this was the humanitarian and ecumenical organisation Norwegian Church Aid, which had ongoing programmes targeting water/sanitation and gender-based violence which tackled issues including hygiene and community sensitisation. This programme was adapted to concurrently address EVD and activities that were not related to the epidemic; this integration of EVD and non-EVD activities enhanced the perceived legitimacy and trust in such services, leading to greater utilisation by female victims of GBV.[40]

## Women's health neglected during the EVD response

The DRC Government and international actors' predominant focus on stopping EVD transmissions was detrimental to other critical health services. This included SRH services, such as provision of safe birth facilities, family planning, or treatment for victims of sexual assault. A major impact of the outbreak and response on SRH came in the form of increased delays in seeking, accessing and receiving appropriate SRH care.

The climate of fear brought about by the EVD outbreak, compounded by the response's failure, led to changes in women and girls' health-seeking behaviour. Practitioners interviewed for this report noted a widespread perception amongst communities that Ebola treatment centres (ETCs) were 'death camps' where 'people go to die.'[41] As discussed in the Security Briefing, such beliefs were intertwined with a general mistrust of institutions and decades of violent conflict and suffering at the hands of government forces. As the ETCs came to represent the Ebola response, and many did not believe that EVD was real, the centres themselves faced significant opposition. To compound this, the ETCs were manned by outsiders and linked with the Ministry of Health and Government This increased the traction of misinformation, casting doubt on the intentions and duty of care of EVD health responders. Combined with the lack of other healthcare provisions in EBV treatments centres, such as obstetric care, culminated in an overabundance of caution from women and girls, who were afraid that declaring their SRH needs would lead to them being diagnosed with EVD symptoms and subsequently sent to the feared ETCs.[42]

These dynamics were concurrently driven by fear concerning EVD's broad case definition. A cornerstone of ending an EVD epidemic is to break the chain of transmission. This relies, in part, on the early identification of anyone exhibiting signs suggestive of EVD.[43] For example, the case definition includes 'unexplained bleeding' as criteria for isolation and testing; this is both broad and non-specific. Physiologically, women and girls bleed due to menstruation, the side-effects of family planning and during abortions or obstetric emergencies. Health care workers (HCWs) in non-EVD facilities are reported to have been reluctant to take the initiative when faced with a bleeding patient, wary of allowing an EVD-positive individual who could transmit to staff and other patients into the facility.[44] At the same time, protocol did not allow for the HCWs to provide emergency obstetric care in isolation.

Moreover, attacks on ETCs and even non-EVD health clinics – caused by numerous factors such as accusations of local HCWs 'collaborating' with the EVD response – led to closures. This increased women and girls' distance from appropriate SRH care. Delays to or even abandonment of women and girls' journeys to seek urgent SRH care proved fatal, particularly when it came to medical conditions that require urgent medical attention, such as spontaneous abortions or haemorrhages. A related consequence was the decision of patients and/or their families to pre-empt travel delays, with a documented case of a pregnant woman arriving at a maternity waiting home a whole month prior to her due date.[45] Such prolonged presence in a medical facility significantly increases the risk of exposure to EVD.

Several lessons concerning SRH can be taken from this EVD outbreak. Evaluations of SRH during the epidemic called for pregnant women to be prioritised for the receipt of rapid EVD testing.[46] Regarding the triaging of pregnant women suspected of EVD infection, SRH specialists have called for improved systems which streamline the process of providing initial life-saving care within isolation.[47] ALIMA (the Alliance for International Medical Action) trailblazed this method, establishing ETCs within existing health facilities such as the general hospitals in Beni and Mambasa, North Kivu.

Several pregnant women admitted as suspected Ebola cases at the ETCs were given a safe emergency caesarean section, before being referred to the maternity ward for post-operative monitoring and neonatal care.[48]

Regarding the reduction of delays in accessing SRH care, one method to help this situation is to bring health care closer to communities. As discussed in the briefing on women's experience, Médecins Sans Frontières and ALIMA created decentralised transit centres that address both EVD and non-EVD health conditions, leading to increased community buy-in and ownership. This also led to communities actively encouraging women to give birth at the centre.[49]

As the epidemic progressed, there was a documented return of pregnant women to SRH clinics following the earlier wave of home deliveries at the outbreak's outset. An International Rescue Committee report found this to be attributable to sensitisation efforts, especially a change in response staffing. The utilisation of local HCWs reduced fear of treatment by 'outsiders', whose inability to speak local women's and girls' language served to heighten communities' anxieties of being mistakenly sent to an ETC. Through the employment of local staff, the response was seen to have strengthened the local SRH system in some ways. This included the use of new IPC procedures, the wearing of PPE and more formal training in triage systems.[50] However, as seen in the West African EVD outbreak, without extensive ongoing support with materials and mentorship, the gains made (especially those related to IPC) during the outbreak are not guaranteed to be maintained post-outbreak.

At a broader level, the coordination of the EVD response took place parallel to the health cluster, with the response leadership failing to facilitate sufficient interaction between the two, resulting in the neglect of SRH and women's suffering. A public health advisor for an international donor claimed that there was:

> … not enough emphasis on protecting the public. They weren't talking about continuity of care, maternal and child care. We as a donor were part of the problem, we chose to fund the response as a medical response, not a public health response.[51]

There is a need for disease responders and SRH actors to be sensitised to one another from the outset of disease containment. An evaluation of the EVD response in North Kivu and Ituri provinces recommended that the lead SRH coordinating actor should have a seat at the table in the EVD response coordination. In future disease outbreaks, this will ensure that SRH needs assessments take place, that needs identified are considered and planned for in strategic decision making, there is adequate gender disaggregation to understand how women and girls are differently affected, and advocacy for funding to reduce the negative impacts of the response on SRH occurs.

## Concluding remarks

Women were disproportionately at risk during the Ebola outbreak in the DRC. They were at increased risk of catching and dying from the disease itself, increased risk of GBV and their other health concerns were brushed aside as the focus of many organisations shifted exclusively to Ebola.

These risks would likely have been addressed more efficiently, and from an earlier point, had women been effectively included in the planning and delivery of programmes. However, rhetorical commitments from the UN, INGOs and NGOs to ensure their inclusion, did not translate to inclusion on the ground. This happened in spite of capacity from women-led groups to get involved.

# Yemen

## Gendered challenges as a consequence of COVID-19

### Women Bearing the Brunt of Conflict and Pandemic in Yemen

Similar to Ebola outbreak in the Democratic Republic of the Congo, the juxtaposition of an ingrained conflict and the outbreak of a pandemic has had dire consequences for women, men, girls, and boys in Yemen. Yet each of these groups are likely to suffer different, distinct consequences. Differences in socio-economic conditions exacerbate this and mean that the long-term impact will differ for each group.

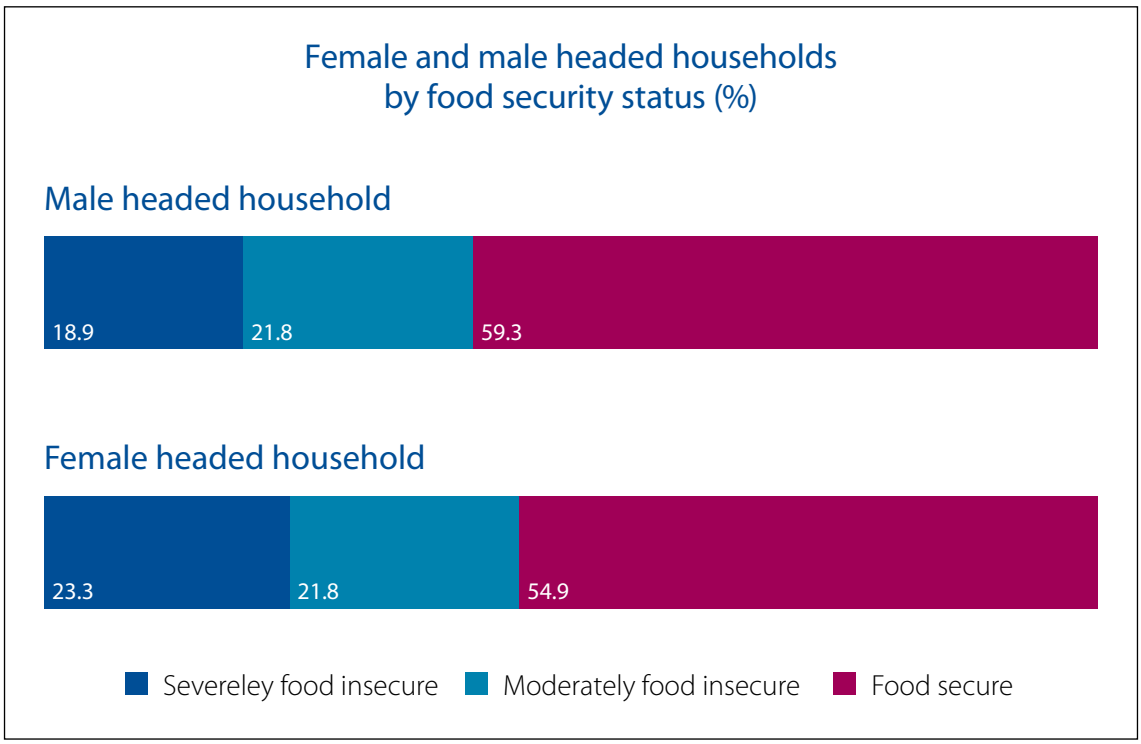
While men are disproportionately at risk of being drafted into the conflict in Yemen (often resulting in their deaths), and exposed to certain forms of violence, women and girls also face distinct challenges, including systemic discrimination in Yemen. This section explores the consequences of both the conflict and the pandemic for women and girls in Yemen. It does this based on desk research, as well as informal conversations with members of the Women Solidarity Network (WSN). These conversations were conducted by a senior member of the WSN. WSN's members include female leaders in Yemen from various geographical, political and professional backgrounds. It has more than 270 female members making it the largest gender-based network in the country.

The findings from this research illustrate the scale of challenges facing women and girls in contemporary Yemen. These challenges include GBV which is increasing in the context of the ongoing conflict[52]; and a severe lack of access to water, sanitation, and hygiene assistance in Yemen, with a disproportionate impact on the lives of women and girls[53] At the same time, there is little protection found in a justice system which is biased and discriminatory towards women; for instance, a lack of legal protection leaves women exposed to both domestic- and sexual violence.[54]

## Health and Safety

The challenges facing women and girls have increased and been exacerbated by COVID-19, as well as the measures taken by authorities to curb its spread.

Most notably, many women face the challenge of taking on leadership roles in their households for the first time – often as as a consequence of their fathers or husbands having been killed in the war – in a society not accustomed to women holding this role. They must take on these new roles while continuing to maintain their unpaid domestic work and care duties. The challenges this presents have been exacerbated by the extreme socio-economic hardship brought on by the pandemic. For instance, their new roles as heads of households come at a time when food is becoming less affordable, forcing families to ration food and key sanitation products. This threatens welfare across the country.[55] The Norwegian Refugee Council survey of families in Yemen found that since April, half of the respondents had lost at least half of their income, while 25% of vulnerable families reported losing their entire income. These families stated that obtaining adequate amounts of food was their top priority. At the same time, the World Bank estimates that women are disproportionatley affected by worsening poverty rates and deprivation in the country.[56]




*Source: 'Comprehensive Food Security Survey (CFSS) Yemen – November 2014', World Food Programme (WFP), 2014, accessed Sep 4, 2020, 35, https://documents.wfp.org/stellent/groups/public/documents/ena/wfp269771.pdf*

Women's heightened vulnerability is likely to exacerbate a trend that has deepened since the beginning of the conflict in 2015, in which women must rely on negative coping mechanisms for survival, including early marriages and child labour.[57] In 2017, 9% of girls were married before the age of 15. By 2018, the rate has increased threefold.[58]

At the same time, accessing health care facilities, especially ones specialising in women's health, has become more difficult. One woman spoken to for this report said that the journey from Sanaa to Aden took twice as long as the normal time due to the closure of roads and inspection and examination procedures. At every security point authorities check the temperature of travelers.

To ensure that the international community, regional responders, and local actors respond to COVID-19 as effectively as possible, these actors must take the gendered aspect of these challenges into account.

In addition to the challenges outlined above, women's traditional roles domestically and, notably, as caretakers of the ill raises similar challenges to those experienced by women in the DRC as they are more exposed to people afflicted with both Cholera and COVID-19. In a further echo to women's experience in the DRC, Yemeni women are also expected to fetch water for daily use, a role that has become more strenuous as health recommendations focus on increased hand-washing. It has also become more costly as the price of water increases, forcing women and children to travel longer distances to obtain affordable water from collection points. Just as in the DRC, the increased travel time and distance to water does not just leave women exposed more frequently to COVID-19, but also to GBV.

## Women's roles in the response

Amidst the shadows of the conflict and pandemic, female Yemeni responders – volunteers, activists, leaders, women-led groups, organisations and networks – are taking actions to mitigate and respond to risks. Women's networks, such as the aforementioned WSN, started preparing early into this crisis by supporting clinics and hospitals with supplies, advocating for response measures to be taken by the state and local authorities, and raising awareness in their communities of the danger posed by COVID-19.

Yemeni women were also the first to warn of an impending crisis and called for a ceasefire so that efforts could be focused on combating the COVID-19 pandemic. These efforts included attempts to address basic needs, such as disbursing salaries and providing of clean water and electricity.[59]

Unfortunately, this draws another parallel with our findings in the DRC, where this existing capacity was overlooked – and at times overwritten – by international programming. This is of course not just discriminatory against local actors, it is a significant and damning waste of previous capacity. Women in Yemen are the ones facing the protection risks. As such, they need to be part of the solution so that they are not relegated to the role of simply being passive 'beneficiaries' of assistance.

Nevertheless, the work by women-led organisations is done with limited resources and funding as they face difficulties in accessing the UN pool of humanitarian funding, which is too restrictive. This is reflective of wider funding challenges facing local civil society organisations. Additionally, women-led organisations have reported that humanitarian aid has made its way into the black market or is being used by armed groups, instead of going to the intended communities. These organisations have also noted that there is a significant imbalance and inequality in aid distribution which affects the health and immunity of Yemeni women, making them more vulnerable to COVID-19 and other diseases.

For the response to COVID-19 in Yemen to improve and effectively take on lessons from the DRC, the international community must:

1. Ensure access to sufficient and affordable water, sanitation, and hygiene services for vulnerable groups of women, including those in informal settlements, rural areas and refugee camps.

2. Avoid politicising humanitarian access and funding to Yemen. At this time of a global pandemic, any suspension of life-saving aid, or withdrawal of support to health care programmes will heighten the risks for an already vulnerable population.

3. Take into account gender specific vulnerabilities, including those of women, girls and children, by getting their input and encouraging the creation of programmes that can support women's role in decision-making within their communities. This could be achieved through enhancing women and girl's knowledge of and skills in responding to GBV; greater inclusion in processes, improved feedback mechanisms and effective community monitoring and evaluation. Displaced people and refugees must also be included in national response plans to address COVID-19.

4. Support women in rural settings, specifically those working in vital economic sectors such as health, agriculture, livestock breeding and fisheries, through providing them with psychosocial support, strengthening their knowledge on GBV, enhancing social protection programmes, training, and encouraging them to access labour markets and/or to become micro entrepreneurs. This can improve their livelihoods by creating sustainable incomes that will encourage them to strengthen their household's access to food security, nutrition and access to basic services for themselves and their children.

5. Empower female entrepreneurs to be more resilient by building their capacities and strengthening their access to markets and financial services. This in turn empowers them because it allows women to be more independent and have an active role within their households and communities.

6. Catalyse community engagement on gender sensitive inclusion through involving communities, including men and boys, to help in creating a more gender sensitive environment.

7. Support the scaling up of preventative, mitigation and containment measures in internal displacement (IDP) camps and settlements which are particularly at risk.

8. Ensure that female-led organisations have access to flexible and core funding.

9. Ensure that female-led oranisations are engaged in the preparation, execution and post-delivery assessment of programmes.

10. Ensure that any financial aid allocated for COVID-19 response is in line with the humanitarian principles and is not exploited by armed groups and has a gendered perspective.

## Conclusion: COVID-19 in Yemen

Though COVID-19 and economic collapse have already disproportionately affected women in Yemen, it also presents opportunities. Historically, Yemeni women have educated others and protected them against the spread of disease. They have continued to do so since the start of the COVID-19 outbreak by sewing masks to protect individuals in their communities, supporting laboratories, encouraging the youth to abstain from fighting and contribute to peace and innovation. The mechanical ventilator project by Food4Humanity that has led a group of mechanical engineers to devote their talent to save lives in the city of Taiz is an example of this.

Additionally, it is notable that female-led initiatives stand ready to engage. As seen in the DRC, the main problem concerning female exclusion in Yemen is not a question of a lack of women leaders; rather; it is that these leaders are ignored. Though the situation seems grim, women are nonetheless an extremely valuable asset for improving the situation in Yemen and are essential for shaping a healthier, more peaceful future.

# Findings and conclusion

The challenges that come from conflict and disease outbreaks are different depending on gender, with men, boys, women and girls, emerging differently from such crises. When a disease breaks out on the scale of an epidemic or pandemic, in an active conflict zone, it is more important than ever to understand and address the different challenges for different genders. Women are disproportionately at risk of disease outbreaks and the impacts of outbreak responses, and certain conflict-related violence.

It is vital, then, to keep these differences in mind, when operating in societies where inequality is ingrained and systemic. This is the case for both the DRC and Yemen, where women and girls suffer great inequality.

To address these challenges, women must be actively included in the planning, implementation and assessment of responses to both disease outbreaks and conflicts. At the same time, it is essential to note that there is not one "female experience" of conflicts or disease outbreaks. Consequently, women's engagement must be varied and come from an intersection of society.

The international community has made significant rhetorical commitments to increasing women's engagement, and to addressing the challenges facing women and girls more efficiently. Nevertheless, in both the DRC and Yemen, women were prevented from having a meaningful say in the response. Their needs were therefore both under- and mis-addressed.

This was evident across the response in both countries, from the communication campaigns, which lacked non-literate signalling for illiterate people, the majority of whom are women, to vaccines not being granted to pregnant women.

Additionally, women's health suffered greatly in both cases as attention shifted almost exclusively to COVID-19 (in Yemen) and Ebola (in the DRC), leaving few resources and little attention for women's health. This also impacted children's health, as post-natal care was de-prioritised. As one interviewee emphasised, had women been involved in decision making throughout these responses, this would not have happened.[60]

This is particularly disappointing because women's groups, female leaders, and female-led youth groups stand ready in both countries to offer valuable contributions for the international response. It is vital that these are sufficiently enabled and collaborated within future outbreaks.

# Endnotes

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