

# Categorising the Gendered Harms to Caregivers During Humanitarian Emergencies: An Analysis of Law and Practice During Ebola Crises

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## Abstract

Recent global health emergencies have highlighted the critical role of health care workers in stemming the spread of pandemics. Healthcare workers provide an essential service to local communities impacted by epidemics such as Ebola. Global health scholars suggest that carers may suffer harm while performing this essential work. Building on feminist theories of ‘harm’ and ‘social reproduction’, this article uses as case studies the early 21st century Ebola epidemics that broke out in West Africa and the DRC to ask how do women carers in humanitarian crises experience harm? The article illustrates the hierarchical and gendered nature of harm, and how those at the bottom of social hierarchies face intersectional harms stemming from their race, class and economic status. The article highlights an urgent need to rethink how law at both the domestic and international levels has contributed to the reproduction of inequalities faced by these carers.

## Keywords

COVID-19, Ebola, front-line workers, gender, human rights, humanitarian crisis, international law, private law, social reproduction

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## Introduction

Emergency situations caused by the outbreak of infectious diseases often leave developing states without the capacity to respond effectively to these crises, forcing them to seek medical humanitarian assistance from the international community (Gostin and Friedman, 2015; Harman and Wenham, 2018). For instance, some of the world's worst recent infectious disease outbreaks, such as Cholera and MERS in Yemen (2019), Ebola in West Africa (2014–2016) and the ongoing epidemic in DRC (2018–2020) and Lassa Fever in Sierra Leone, Guinea, Nigeria and Liberia (2016–2019) occurred in recently war-ravaged states, and/or during existing humanitarian crises triggered by armed conflict (Gostin et al., 2019). Many of these crises occur in states with weak health systems characterised by poor infrastructure, inadequate medical facilities, a scarcity of health professionals, and inadequate access to essential treatment and diagnostics (Anderson and Beresford, 2016; Kieny and Dovlo, 2015; Piot et al., 2014).

International bodies such as the World Health Organization (WHO) and the United Nations (UN) increasingly highlight the impact of violence on health workers during humanitarian health crises (WHA Assembly, 65/20 2012; UN Doc S/2013/689 Resolution 2286). This article argues that, in framing international discussions on the relationship between the risk of violence faced by frontline health workers in the field, and the scarcity of professionally trained health workers, the international community fails to recognise that caring during complex emergencies must often be provided by non-professionals. The patriarchal culture of many of these societies means that care work is gendered, and it falls on women to provide care work, and so it is women who most often perform this labour. I specifically investigate how caring is organised during humanitarian health crises by asking: how does caring during crises reproduce gendered and other hierarchies of power among different categories of women care workers?

Using as case studies the Ebola crises of West Africa (2014–2016) and the ongoing crisis in the DRC, this article contributes to the body of scholarship on the gendered nature of caring during global health crises (Davies and Bennett, 2016; Harman, 2016; Menendez et al., 2015). The role of carers in emergencies remains an underexamined area of research, and further analytic attention would provide a useful lens to examine how paid and unpaid social reproductive work generates different forms of harm during health crises. This article contributes to both law and political science by illustrating the uneven legal coverage of care work during national health emergencies, and how law – specifically human rights law and private domestic law – can provide understanding of how gender inequalities may be reproduced during humanitarian health emergencies.

Some of the lessons that we can take from this resonate powerfully with concerns over how caring is organised in the current COVID-19 crisis. Again, we see that, even in the most developed countries, caring is stratified along race and class. Many carers, such as cleaners, nursery workers and care workers, who are largely women, primarily with low economic status and from black Asian and other ethnic minority backgrounds, have struggled to gain access to Personal Protective Equipment to keep them safe. Many cleaners and healthcare workers are no longer paid directly by states, as this labour has shifted to private, extractive industries. As such, they enjoy weaker employment rights, are not unionised, and often cannot demand health and safety measures that many other

workers take for granted. Many are migrants, on precarious contracts, and consequently in a weak position to articulate their rights when they are violated.

Internationally, COVID-19 also illustrates the global deficit of care, with multiple crises in developing countries, such as Iran and South Africa, with weak health infrastructure, where the burden is yet again borne largely by poor, vulnerable women. Thus, understanding previous health crises, such as the Ebola crises, can help us to highlight how state responses which do not focus on how inequality is structured by race and gender only serve to reproduce it.

I begin by outlining theories on Harm Depletion and Social Reproduction in the context of humanitarian emergencies, and feminist engagements with these concepts. This enables understanding of harms suffered by care workers during crises, and the critical role of law in mitigating these harms. I briefly outline the research methods employed for data collection, before discussing how caregiving is gendered along a hierarchy based on race and economic background. Finally, I examine the limitations of private and international law responses to these harms and argue that legal remedies may in fact reproduce harms to carers.

## **Theorising Care in Humanitarian Crises: Law and Hierarchies Resulting from Depletion, Harm and Social Reproduction**

Social reproduction is generally defined as the unpaid production of goods and services in the home; social provisioning (voluntary work to meet community needs); the reproduction of culture and ideology; and as the provision of sexual, emotional and affective services (as are required to maintain family and intimate relationships) (Hoskyns and Rai, 2007: 300). Crucially, social reproduction is not defined as productive labour, and consequently carries no labour value, and hence, is unwaged. However, states rely on social reproduction, especially in times of crisis, to help families and communities withstand periods of adversity (Bedford and Rai, 2010; Doyal, 1995; Elson, 2010). In order to avoid the recognition of social reproductive labour as productive labour, and therefore as deserving of a wage, states often exploit gendered societal norms that define women as care-givers, exploiting and taking their unwaged care work for granted, and thereby rendering it invisible (Harman, 2016; Robinson, 2011, 2016).

Health crises may provoke what Harman and Wenham (2018: 363) term a ‘medical humanitarian’ response, often characterised by military involvement in health delivery, increased international assistance in capacity building, and the imposition of quarantine to contain the spread of disease. Military involvement may further transmit gendered ideas of appropriate masculine and feminine roles in the context of war into medical humanitarianism. Paying attention to gender relations illuminates the prioritisation of the frontline of conflict, specifically combat, which is invariably ‘masculinised’, while the ‘home front’ is scripted as the appropriate space for women, (along with children and male youth too young for the battlefield, the weak and the sick, the elderly, and of course, injured soldiers). In this domestic space, women are expected to perform the feminine work of caring. Consequently, gender hierarchies are reproduced within the context of humanitarian crises. The focus on the humanitarian response is largely on health workers as opposed to broader definitions of caregivers. These descriptions of health workers as

frontline workers replicate the language of armed combat, traditionally a male arena from which women are largely excluded, even though they may perform much of the informal caring during crises (Harman, 2016).

The WHO has focused on increasing the number of health workers as frontline workers, who are critical to infectious disease response in low-resource settings (WHA64.6; WHA69.19). However, in poor communities many different understandings of the frontline exist; it may include traditional healers and birth attendants, family members and other informal healthcare providers. Women represent a majority of those providing essential community frontline support at the local level (Davies and Bennett, 2016; Harman, 2016). During crises, this informal gendered caring structure is critical, compensating for acute shortages of health professionals and resources (e.g. diagnostics and labs). Moreover, when quarantine restrictions mean huge proportions of the population can no longer be in employment, it can represent a vast and critical labour resource. Humanitarian healthcare, therefore, involves delivering medical care in areas with weak health infrastructure, coupled with widespread human suffering, requiring urgent responses in areas where the state is either weak or incapable of responding (Lakoff, 2010: 64). Gendered care structure masks the structural inadequacies of national healthcare systems, which are a result of much deeper global socioeconomic inequalities due to structural adjustment policies, protracted civil war due to resource exploitation, and the migration of health professionals to developed countries (Leach, 2015). As carers, women may be at disproportionate risk of harm.

Besides contagion, carers often face physical, emotional and psychological distress when caring for victims of diseases with extremely high rates of mortality. Quarantine forces separation from families, and many endure economic hardship and stigmatisation when the crisis ends (Kollie et al., 2017; Kpanake et al., 2019; Masumbuko et al., 2018; Minor, 2017; Southall et al., 2017). These harms *deplete* them as individuals, while also negatively impacting on their communities and families (Rai et al., 2014). Rai et al. use the term *depletion*, which is associated with environmental accounting, to illustrate the 'reduction of quantity in a non-renewable resource or something that cannot be replaced' (2014: 88). They define depletion as 'the gap between the outflows – domestic, affective and reproductive – and the inflows that sustain health and well-being' (Rai et al., 2014: 86). Harm through depletion is experienced not only through worse physical and mental health outcomes on individuals engaged in caring; harm may also affect family and community. When individuals are harmed, there are repercussions on families' joint resources, and, ultimately, on communities (Rai et al., 2014). During crises, harms to women are intensified (Elias and Rai, 2015).

Becker-Schmidt (2002) links gender and care to *hierarchies* through the way in which power reproduces itself within caring relationships, thereby resulting in intersectional harms. Crenshaw (1989) coined the concept of intersectionality to describe how race, class, gender, and other axes of oppression overlap. Intersectionality can help us to see why carers who are lower down the hierarchy, in that they are poorly paid or unwaged, have less power and recognition and may be further disadvantaged. This results in differential harms grounded in race, class and educational background (Anderson, 2000; Liveng, 2008; Neysmith and Aronson, 1997). For instance, in her work on caring for the elderly, Liveng (2008) described the characteristics of care work with the dying,

which is useful for thinking about caring for patients with Ebola, which has a high mortality rate. This labour is often considered ‘dirty work’ – both a literal and a figurative descriptor, as it involves taking care of another individual’s personal hygiene, is often physically hard, unpleasant and repetitive, and involves providing affective services (eg comfort, emotional support) usually provided by intimate others (Liveng, 2008). Societal ideologies about the relationship between ‘gender, bodies, regulations around proper ways to care– and dirt’ mean that women (especially those from lower social classes) are more often the providers of intimate body care (Isaksen, 2002).

Restructuring of gender relations and the recognition and valuing of the labour of social reproduction are necessary for transformation (Rai et al., 2014: 99). Several scholars have proposed ways in which law can recognise and mitigate caring harms (Conaghan, 2014; Harding et al., 2017; Stewart, 2011).

However, law’s transformative potential is constrained. While law ‘can generate rules and customs and symbols internally, it . . . is also vulnerable to rules and decisions and other forces emanating from the larger world by which it is surrounded. . . . [It] has rule-making capacities, and the means to induce or coerce compliance; but it is simultaneously set in a larger social matrix which can, and does, affect and invade it . . .’ (Santos, 1987: 720). In order to use the law effectively to provide redress, we must think about the harms suffered by carers. Rai et al. (2014) define harm as loss that occurs to individuals in relation to legally protected interests over their own bodies or material possessions. In determining harm for care work, however, the law has often ignored the ways in which women engage in non-waged work (Conaghan, 2014; Elias, 2007; Stewart, 2010). Conaghan (2002) argues that ‘Social location has a role in determining the incidence and distribution of particular harms’ (2002: 322).

Responding to the harms of carers, lawyers have recognised the spatial nature of law and noted the challenges of implementing legal obligations that straddle jurisdictions (Stewart, 2016). Stewart was specifically addressing multinational corporations, but this argument could be extended to other scenarios; for instance, between international aid agencies who may have international health staff and local health care workers at the national level. Legal scholars have in response promoted two avenues for legal redress for caring-related harms: private law, which may help individuals at the inter-personal level, and international law, which may offer structural resolutions at state level (Stewart, 2016).

Sloan (2013) describes the remedy of compensation under private law, which can include either reward or remuneration. Compensation focuses ‘on the loss or detriment suffered by the carer as a result of taking on caring responsibilities’ (Sloan, 2013: 24). In this context, the carer might be limited to compensation for loss which occurred in reliance on a promise. Stewart (2016: 149), on the other hand, argues that ‘maintenance’ ought to be recognised as an individual right, which would involve remuneration or reward. However, under private law, these measures are primarily advantageous only to the highly educated and economically secure, whose status as waged labourers in a workplace affords recognition of harm suffered (Harding et al., 2017). Moreover, specific circumstances exist in a humanitarian crisis. First, work is undertaken in a crisis situation rather than within a ‘normal’ labour market. Second, the humanitarian crisis may distort national employment law environments. Thus, it is important to analyse if

and how different care workers can make claims for harm under extraordinary conditions, and, if so, against whom. Focusing on carers allows us to build on the critique of the role of law within social reproduction, and to analyse also how different hierarchies of law reinforce harm to certain groups of carers, while also determining which carers are worthy of rescue in a crisis.

## **Ebola in West Africa and the DRC**

This article focuses on two Ebola crises: the first in West Africa (2014–2016), and the ongoing crisis in the DRC, because they represent excellent examples of caring within humanitarian emergencies. Both crises were declared by the WHO to be Public Health Emergencies of International Concern, defined as ‘an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response’ (IHR, 2005). Both crises have also been presented by the UN Security Council as threats to peace and security (SC 2177/2014; SC, 2439/2018). Security Council resolutions on health aim to increase international collaboration, particularly mobilising resources (Burci, 2014). This necessarily involves diverse agencies – the military, UN, NGOs, etc – working collaboratively to stem the crisis.

This is not a comparative project; the case studies are illustrative. The West African crisis took place much earlier and over a larger geographic region than the DRC crisis, which occurred within a single country. To investigate ways of organising caring during humanitarian health crises (with and without armed conflict), this article draws on academic scholarship and reports by international agencies (eg, the UN, WHO, and NGOs) to identify the hierarchy of carers and the harms faced by each hierarchy, in our efforts to identify effective strategies for mitigating those harms.

Since the law may also provide remedies to health workers as a specific group, the article also investigates whether there exist any national or international bodies of law which protect the rights of different kinds of carers. Focusing on the role of law enables us to assess the suitability of legal remedies in providing redress in the context of humanitarian conflicts.

## **The West African Ebola crisis**

Ebola killed an estimated 11,310 West Africans during the crisis, and is suspected to have infected another 28,616 people who survived. The WHO believes these figures substantially understate the magnitude of the outbreak, which remains the largest Ebola epidemic (WHO, 2014–2015). Recognising the severity of the crisis, the UN General Assembly established a UN peacekeeping mission – The United Nations Mission for Ebola Emergency Response (UNMEER) – to provide logistics for the West African response (UN, 2014, GA/RES/69/1).

## DRC Ebola Crisis

The Ebola crisis in the DRC began in August 2018–2020 in North Kivu, an area that has witnessed continuous armed conflict over the last 25 years. Over 2,000 people are estimated to have succumbed to the largest crisis the DRC has suffered since Ebola was discovered there in 1976. Unlike the West African crisis, the epidemic was caught early, the international community immediately released resources, and clinical trials of Ebola vaccinations began, in efforts to protect carers (Saranya et al., 2018). Unfortunately, attacks on health workers by armed groups caught up in the armed conflict made the response more complex (Belluz and Ward, 2018; Gostin et al., 2019). In October 2018, the Security Council unanimously adopted a resolution expressing ‘grave concern’ about the most recent outbreak of the Ebola virus in the DRC, and the fact that this epidemic was occurring in the context of a wider humanitarian crisis, armed conflict and violence (SC 2349/2018).

## Exploring Gendered Care and Social Reproduction Through the Hierarchies of Caring Within Humanitarian Health Crises

Health workers in this study are commonly defined as any persons at risk from *occupational* exposure to Ebola – nurses, doctors, lab technicians, midwives, community health professionals, traditional healers and herbalists – providing direct patient care in formal/informal settings. This definition of health workers is expansive and includes other individuals or workers whose regular occupational activities led to them being called on to perform exceptional duties in healthcare settings. These included community volunteers, cleaners, drivers, caretakers, morgue workers, burial team members and other unspecified volunteers in diverse roles. Some sources also referred to caring performed in homes.

Carers are placed in one of four categories: those most protected from harm, to those least protected, especially when using legal mechanisms: 1) international humanitarian workers 2) locally recruited medical professionals 3) community volunteers, such as Water, Sanitation, and Hygiene (WASH) staff, and 4) family members who assumed unpaid caring responsibilities during and after the crisis.

The first category comprises *international aid workers*, primarily employed by humanitarian aid agencies (eg Oxfam, Mercy Corps, Doctors without Borders (MSF), International Committee of the Red Cross, and foreign public health agencies such as Public Health England and the Centre for Disease Control). During the West African crisis, 40 organisations deployed 1,300 foreign medical personnel (WHO, 2014–2015) contracted by international employers and who retained a high level of autonomy about their work in that they had clear contractual terms about the kind of work that they could reasonably be expected to do, and always had the option of leaving the country.

The second category, *medical professionals at the domestic level*, consists of doctors, nurses and other highly trained domestic health workers, such as nurse aides, nurse assistants and midwives, referred to here as *domestic nurses*. In both West Africa and the DRC, a severe shortage of domestic health workers, especially in the public health system, created an overreliance on nurses (Buseh et al., 2015; WHO, 2015). In global

health crises, domestic nurses are often the first responders, due to a shortage of local doctors. The nurses often worked in very poor conditions, lacked sufficient knowledge of haemorrhagic fevers, and in the early days of the epidemic often worked without personal protective equipment (PPE) (Erhuvwukorotu and Kollie, 2017: 77). Their vulnerability to infection was borne out by a systematic review of research on health workers in West Africa, which found that nurses and midwives – predominantly women – were particularly vulnerable to Ebola because of the intimate care they provided (Selvarej et al., 2018). In the West African crisis, nurses accounted for more than 50 percent of infected health workers (Senga et al., 2016; WHO, 2015). As employees of the state, the nurses had low bargaining power, though some managed to negotiate more lucrative employment with humanitarian aid agencies. Others had no choice but to remain at their stations in low-paid government hospitals, thereby suffering differential and disadvantageous economic reward compared to the higher remuneration packages paid to foreign humanitarian workers and nurses who worked for humanitarian agencies.

The third category is that of *Community volunteers*, such as Water and Sanitation (WASH) staff, who performed the highest-risk jobs: cleaning and disposing of blood, vomit, waste, burying bodies, and educating local communities about the epidemiology of the disease. Many worked as cleaners in hospitals and treatment units, some washed clothing, while others (primarily traditional healers) helped wash and bury bodies (Richards and Mokuwa, 2014). In the West African Ebola crisis, many of these staff were volunteers, and, although they received training, their lack of experience, and their poor working conditions, placed them at greater risk of contagion. As non-medical professionals, these community health workers fell between the category of professional workers and citizens. Due to their legal status as volunteers, their pay and working conditions were less favourable, making them particularly vulnerable (Desclaux et al., 2017; Kpanake et al., 2019; Masumbuko et al., 2018).

The fourth category consists of *individual carers* in homes – predominantly women – who looked after families during and after the crisis (Davies and Bennett, 2016; Walsh and Johnson, 2018: 276). In a patriarchal culture, women's primary designation as carers meant they were more likely to have responsibility of nursing and caring for extended families (Tanyag, 2018: 659). They performed various care roles in homes, and sometimes, as a result of quarantine, had to leave their own home to reside near Treatment Units to care for loved ones in isolation – and then had to manage the precarity posed by living in temporary accommodation in a male-dominated environment (Walsh and Johnson, 2018: 151–152).

Survivors face a host of psychosocial symptoms: eye defects, muscle and joint pain, extreme fatigue, memory loss, and inflammation around the tissue of the heart (Esptein et al., 2015; Nanyonga et al., 2015; Qureshi et al., 2015). Ebola also leads to gastrointestinal symptoms, including diarrhoea and vomiting, which makes it very nursing-intensive (Senga et al., 2016; Walsh and Johnson, 2018: 113).

Carers faced stigma from their communities after the crisis, yet some were expected to care for children orphaned by the epidemic. Over 10,000 West African children are believed to have lost their parents to Ebola (Evans and Popova, 2015). UNICEF estimated that over 200 children in the DRC were orphaned by Ebola (Willemot, 2019).



These forms of personal caring go unremunerated, and there is little support from either government or the international community in the wake of the crises.

Although these harms may seem gender-neutral, they are in fact highly gendered, disproportionately affecting women. For instance, in recent years, problems encountered by women aid workers have been highlighted in reports highlighting endemic sexism, pay inequality, increased rates of sexual violence, and increased policing of their bodies while in the field (Curling and Simmons, 2010; Stoddard, 2019; Mazurana and Donnelly, 2017). Therefore, the harms women face while responding to humanitarian crises are invariably worsened.

In West Africa and the DRC, the number of domestic health workers has been decimated by long periods of civil war and structural adjustment programmes that have impacted on human health resources. Migration of male health professionals to developing countries creates shortages, placing greater reliance on women nurses and informal health workers.

At both the community and the individual level, the patriarchal culture of the societies affected by Ebola is highly gendered, with women primarily defined as caregivers. In West Africa, women spent six times more hours on unpaid care than men do (Bouchama et al., 2018). In West Africa, women also have lower literacy rates and higher rates of unemployment, making them particularly vulnerable to long-term infectious diseases. Women also experience high rates of domestic violence in all three West African countries (Demographic and Health Surveys: Liberia, 2013; Guinea 2018; Sierra Leone, 2014). In 2015, the UN Office of the Special Representative on Sexual Violence in Conflict recognised structural gender inequalities which translate into discriminatory social norms and values that permeate all aspects of women's lives in the DRC (UNSC, 2015).

In West Africa, the UN recognised that although women were more likely to be caregivers, both at the community level as traditional healers and in the home, female community volunteers and individuals were often neglected in official responses, thereby reinforcing the harms they faced (Wilkinson et al., 2017). Domestic and international Ebola responses attempted to harness local gendered cultural differences to create effective response strategies through replicating social hierarchies; for instance, giving men public leadership roles while reaffirming women's domestic caring roles (Abramowitz et al., 2015). Men's duties reinforce their social power (eg surveillance, membership on community task force teams), whereas women are expected to monitor and care for family members (eg washing clothing, caring for young and elderly sick), especially during quarantine. This puts individual women at particular risk of contagion within their home, and, moreover, affords them less bargaining power with external agencies who control the distribution of resources (eg food or protective equipment). Despite active roles as healers and domestic caregivers, they were often overlooked in the official response (Harman, 2016; Kpanake et al., 2019; UN Women, 2014). While men may have experienced other dangers, women were particularly prone to the harms posed by their caring responsibilities.

These categories of carers are determined not only by their gender, but also by geographic location, race, education level, and socioeconomic status (Dhamoon, 2011). For instance, humanitarian carers often reside within specially protected

compounds, which mitigates their risks. Highly educated and/or wealthier carers often exercise greater agency; even under quarantine, they can better negotiate with government agencies for access to food and basic treatments. Being literate provides greater access to crisis information, often first released in official languages, such as French and English.

Carers face different types of harm in humanitarian health crises: contagion, violence, stigma and economic harms. Caring during humanitarian crises leads to serious risks of contracting potentially fatal bodily harm through contagion, which, even if survived, can significantly increase chances of reinfection, and many struggle with ongoing debilitating symptoms (Kuzmina et al., 2018). Long-term studies on Ebola survivors show that the virus can persist within the body. Some harms are particular to women because they disrupt biological reproduction. The Ebola virus has been seen in amniotic fluid, the placenta and breast milk (Deen et al., 2017; WHO, 2016).

Depletion can lead to physical harms, experienced through worse health outcomes (Rai et al., 2014). We do not have full data on the DRC, crisis due to its ongoing nature, but data from West Africa reveals that different carers were affected to different degrees, possibly because employers of international aid workers legally owed their employees higher standards of care, so they often enjoyed greater protections than local carers. Even when deployed in the affected country, some international aid workers were not permitted in the most contagious areas (Walsh and Johnson 2018: 245). International aid workers who worked directly with patients were generally on shorter rotations of just 3-6 weeks, thereby decreasing their vulnerability to contagion (Du Bois et al., 2015). All were provided with personal protective equipment, had insurance policies that covered physical and psychological treatments, and medical evacuation for specialised infection treatment unavailable in West Africa. Those who contracted Ebola were highly visible in media reports, unlike their local counterparts, and, moreover, were always evacuated for treatment, enabling their higher survival rates (Carell et al., 2014; James, 2015). They were treated with antibodies from other Ebola survivors using ZMAPP, an experimental drug which had not yet received approval for human trials (Gulland, 2015). There are accounts that when Ebola Treatment Units were constructed, some were reserved for international aid workers; eg initially the UK military reserved the treatment unit at Kerry Town for UK nationals (Walsh and Johnson, 2018: 286).

In contrast, in the opening days of the West African Ebola crisis, many local domestic nurses and community volunteers were reduced to using plastic bags for protection, as governments and international agencies struggled to provide adequate protective clothing for them. By 2016, most domestic nurses had protective equipment, but it was always a struggle catering for community volunteers stationed in the communities (Pallister-Wilkins, 2016; Perry et al., 2016). Home-based carers were even more vulnerable, often lacking any protective equipment (Farmer, 2014). As a result of the inequity in protection among carers, domestic nurses, community volunteers and individual carers faced a disproportionate amount of 'dirty work'/intimate work (Becker-Schmidt, 2002).

The DRC has improved treatment options, better infrastructure through the expansion of Ebola Treatment Units, increased financing, and extensive national and international efforts to curb transmission. Personal Protective Equipment has also been distributed much more speedily to all health workers. However, carers at home still lack recognition

as health workers, and were not issued with protective equipment, a neglect that places them at continued risk. The breakthrough in the DRC arises from the availability of a vaccine, but the response has been hampered by insecurity, weak community engagement, limited coordination with the humanitarian sector, and poor infection prevention and control (WHO 2019a). As of May 2019, 102 health workers had contracted Ebola, which is approximately 5 percent of the prevalence in the general population (WHO Situation Report, 2019b). The total number of carers is likely much higher than official estimates, as carers at home are not included in official data as health workers.

Violence has also impacted on carers. In August 2014, riots broke out in the Guinean city of Nzerekore following rumours that health workers had deliberately infected people with the Ebola virus (BBC, 2014). A month later, in one of the worst incidents, eight members of a community outreach team were attacked and killed in a remote area of Guinea (BBC, 2014). Anthropologists' accounts of the crisis show that many community volunteers were also at high risk of sexual violence as they were vulnerable when moving about within regions under quarantine (Minor, 2017). The hierarchies among health workers left local carers more vulnerable than international aid workers. Several health centres were set on fire due to local mistrust of professionals fighting Ebola (Nguyen, 2019). In the DRC, for instance, MSF withdrew staff from Butembo and Katwa amid increasing security threats, and the operation of these treatment centres was transferred to the Ministry of Health. In November 2019, two attacks in eastern DRC led to the deaths of four workers and injuries to five others. All WHO and UNICEF staff from Beni were subsequently evacuated (Gostin et al., 2019; Nguyen, 2019; WHO, 2019).

Race and citizenship may disproportionately harm particular groups of carers, especially with regard to treatment. Reviewing MSF's activities in West Africa, McClean (2017) reflected on the difficulty of securing agreement on evacuation for non-European and American citizens. All efforts to evacuate domestic health workers failed, and all cases of attempted evacuation of locals solely involved doctors, such as in the case of Olivet Buck (discussed below) and Sheik Umar Khan. This neatly illustrates socio-economic differences; doctors are more likely to be male, highly educated and well paid, and to have others to advocate on their behalf, in attempts to mitigate the harms of contagion and violence.

Stigma affects carers' future social and economic interactions within their communities. During the West Africa Ebola crisis, societal beliefs of women's supposed inherent caring abilities meant that women could be blamed for not caring well enough when either they or their loved ones fell ill (Minor, 2017: 28). This had serious consequences, ranging from being shunned to being subjected to violence and suffering economic marginalisation (Nuriddin et al., 2018). For instance, Salome Karwah, celebrated as one of the nurses who was critical in the fight against Ebola, contracted the virus in 2014, but fortunately recovered. She later returned to the international NGO Médecins Sans Frontières (MSF) centre where she had been treated, to help other patients. Tragically though, in 2017, Karwa died in childbirth, having been refused treatment by her health centre, due to the stigma of being an Ebola survivor (Baker, 2017).

Although often performing the same roles, international and local caregivers were not equally remunerated. Foreign workers retained the more generous salaries paid by their home countries, and, in some instances, received additional compensation for putting

themselves at extra risk. Draper (2015) highlighted an instance in which some international aid workers earned up to US \$1,600 dollars per month on top of their salaries. Contrastingly, domestic workers in both West Africa and the DRC were forced to take strike action after their salaries were delayed (Gostin et al., 2019; Walsh and Johnson, 2018). At various points in the crisis, foreign aid workers also enjoyed greater autonomy in deciding whether to remain and treat patients or leave for home. Conversely, some domestic nurses were coerced into treating Ebola patients, even though they lacked expertise in treating haemorrhagic fevers. Kollie et al.'s study (2017) highlighted an instance of a nurse threatened with dismissal for refusal to 'volunteer' to work with Ebola patients. The low pay of nurses – around US \$130 per month – was a disincentive for them, given the highly risky nature of treating Ebola until, in 2014, the UN realised that a lack of nursing care could hinder adequate treatment for all those affected. Subsequently, frontline workers became eligible for hazard pay (Ovadiyah et al., 2015; UNDP, 2015); domestic nurses treating Ebola patients were entitled to US \$115 per week on top of their very low salaries (Draper, 2015; Walsh and Johnson, 2018: 111). Some domestic health workers were also promised permanent roles if they volunteered in Sierra Leone. However, to this day these promises remain unfulfilled (Lahai, 2017; Lahai and Carrick, 2017; vignette 2; Walsh and Johnson 2018).

Community careworkers were officially perceived as volunteers, which in some way seeks to further undermine the extent of their contribution. (Maes, 2015) While some had left jobs in order to help in West Africa, others in regions with high unemployment viewed the crisis as an opportunity to gain lucrative employment. West African governments promised incentive packages to volunteers of US \$250 per month and, after the outbreak, a take-home salary of US \$2,500 per month. In the event they died, their families were entitled to receive US \$5,000 (Kingori and McGowan, 2016). However, many volunteers never received payment from their respective governments (Walsh and Johnson, 2018).

Moreover, many carers at home went unremunerated. Women's responsibility for caring for their family was so imbued within the social fabric that they held no expectation of payment, and many home carers went uncompensated for hard and dangerous work (Farmer, 2014; Harman, 2016). This lack of compensation reproduces a global political economy of humanitarian health crises that rely on gendered caring without adequate recognition or mitigation of the harms caused.

## **Limitations of the Law in Addressing Harms to Carers**

This section explores ways in which legal mechanisms can support healthcare workers. The legal remedies discussed are private and public remedies. While private law governs relationships between individuals, public law generally governs relationships between individuals and state bodies.

Under private law, it is important to establish contractual relationships between carers and their employees. In most jurisdictions, employers owe their employees a legally recognised duty of care. While this duty cannot be construed as the duty to provide *absolute* safety in a humanitarian health crisis, courts have interpreted the law as placing a duty on employers to provide the highest possible standard of care in cases of infection

(McClellan, 2017). International NGOs interpreted this as a duty to evacuate infected foreign staff. Under MSF guidance, for instance, the directive was to airlift individuals to high-level hospitals within 24 hours of infection. MSF's attempts to evacuate its employees from West Africa illustrates the complexities of racialized nationalities; initially North American and European governments prioritised evacuation of their citizens, leaving other nationalities vulnerable. Finally, the European Parliament passed a resolution calling on member states 'to coordinate flights and establish dedicated air bridges to move health personnel and equipment to the affected countries and to provide medical evacuation if necessary'. This applied to international aid workers regardless of nationality (EU Parliament, 2014, EU Res 2814/2842). In the Security Council's Resolution 2177, the UNSC also specifically mentioned, 'medical evacuation capacities and treatment'. However, the SC did not deal with the practicalities of citizenship within medical evacuations.

The EU was involved in 16 medical evacuations, including four people who tested positive for Ebola, all of whom survived. This contrasts starkly with the experience of local staff such as Olivet Buck, former medical superintendent of Lumley Government Hospital in Sierra Leone. Buck contracted Ebola due to the lack of protective equipment in public hospitals. The Sierra Leonean government tried to evacuate her to Germany for treatment, but WHO officials insisted they could help only those careworkers they had deployed to Sierra Leone. Buck's death illustrates how inequitable evacuation protocols can cause racialized and often intersectional harms to domestic workers (Green, 2014; McClellan, 2017).

Olivet Buck's death also highlights the limitation of employment law in this area; it cannot be enjoyed by carers without proper contractual relationships. Local health staff, for instance, were never included in negotiations for evacuation, despite being at equal or sometimes greater risks, as evacuation was not a right specified in their contracts. Reliance on contractual relationships has always made it harder for informal workers to establish favourable employment relationships (Stewart, 2016). Moreover, the uncertain nature of humanitarian crises leads to precarity, characterised by short-term, unstable and sometimes unclear/no contractual rights. The reliance on voluntarism is often abused, for many domestic nurses and community carers volunteer expecting that it will result in long-term work. Indeed, West Africans were encouraged to become volunteer carers on those promises. Risks that lead to high levels of harm are transferred to workers through precarious employment relations (Stewart, 2011, 2013).

Tort law provides another mode of recourse for carers, for it allows claims of damages for monetary loss caused by wrongful injuries to a person. Further claims can also be made for wrongful injuries leading to pain and suffering. The aim of damages in tort law is to return the individual to the state they enjoyed before the harm occurred. In *Dennis V Norwegian Refugee Council*, (Oslo District Court, Deputy Judge Lena Skjold Rafoss, 25 November 2015) a claim was brought by an international aid worker for compensation and non-economic losses arising from the kidnapping and injury of Steven Patrick Dennis, a Canadian citizen. Dennis, an employee of the NRC, was kidnapped and held hostage in Kenya in 2012. Following his release in 2015, Dennis brought a claim in Oslo, arguing that his employer had been grossly negligent in not foreseeing the extra risk of kidnap he faced as a foreign national, and that the NRC therefore owed him damages

under the Norway Compensation Act. Using tort law, used across most common law jurisdictions (Liberia and Sierra Leone are both common-law countries), the court upheld Dennis's claim that the NRC had been grossly negligent in its duty of care to him. The NRC should have foreseen the risk of injury, taken reasonable and necessary measures to prevent the risk and so, in the absence of such measures, were held responsible for causing the injury. Dennis was awarded compensation of EUR 623,900 for losses, pain and suffering and contributions towards his legal costs.

This ruling is significant to all healthcare aid workers, as it confirms that, even in situations of humanitarian crises, aid agencies owe employees a duty of care to try to mitigate possible physical and mental harms arising in the course of their duties. However, although the principle is established, humanitarian health workers who may contemplate suing their employer face several hurdles. It is expensive (Dennis's legal costs were approximately EUR 127,000), health workers would need to know their rights, and the legal test for what amounts to harm while treating a highly contagious virus like Ebola may be much higher than the test for establishing harm in ordinary cases where there is a duty of care. In this case, the judges were careful to establish that employers could not eliminate all risks, but rather stipulated that the risk must be unforeseeable. Private law solutions necessitate a high threshold burden when applied to many carers in humanitarian health crisis situations; for instance, individual carers are not employed and community volunteers may be ineligible to make claims. This makes it nearly impossible for poorer, less-educated women, who may not know the law, and may have few resources or legal contacts to bring claims for harm.

Furthermore, feminist lawyers have critiqued tort law and claims of gender neutrality (Conaghan, 2002, 2003; Finley, 1999). They argue that tort law often focuses on duties of care owed by individuals to each other, while ignoring the relationships that underpin the legal duty (Steele, 2012). This means that even when cases are decided in favour of female carers, courts are likely to underestimate the degree of harm faced by women.

## Health Rights

International Human Rights law exists independently of crises. Medical professionals are protected under the right to health in the International Covenant on Economic Social and Cultural Rights (ICESCR). The right to medical care is also enshrined in Article 25 of the Universal Declaration of Human Rights. The International Committee of the Red Cross (ICRC) also urges states to maintain functioning healthcare systems, and to allow humanitarian health relief where the state is unable to provide treatment, as may happen during the spread of an infectious disease.

It is clear from this and other guidance that health workers retain their rights under the ICESCR. These rights are not only negative rights protecting them from violence but can also confer a right to treatment. Article 25 of the Universal Declaration of Human Rights states, '[e]veryone has the right to a standard of living adequate for the health and wellbeing of himself [sic] and of his family, including food, clothing, housing and medical care and necessary social services'; while Article 12 of the ICESCR states that parties should recognise 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. This right was further articulated by General

Comment No 14 (CESR Gen Comment 14, 2000), which provides an authoritative interpretation of Article 12 in terms of States' obligations – that is, what constitutes violations of the right to health and what implementation requires (UN, 2014). More determinants of health have been taken into consideration, such as resource distribution and gender inequalities. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict (General Comment No 14). General Comment No 14 (para 11, 18, 20) is very alive to intersectional issues that may determine whether people can access the right to health, such as gender, conflict and even social economic status.

However, it is unlikely that Article 14 of the ICESCR gives carers the right to experimental treatment, even though there may be intersecting and potentially discriminatory sites of differences, such as race and socioeconomic status, that mean that some groups, such as international aid workers, will benefit from treatment at the expense of domestic carers. If evidence begins to suggest that a treatment works, however, this may make a difference, as we saw for the case of ZMAPP for Ebola. Here, the history of AIDS may be instructive. In looking at the right to health and access to antiretroviral treatment (ARVs), there is an emerging norm for essential medicines as part of the realisation to the right to health when they are necessary to save lives (Sekalala, 2017). This norm falls both on the state party and on the international community to provide financing to poor countries incapable of affording essential medicines for their populations. Given that people without access to experimental Ebola drugs will die, there is a compelling case for using this logic to argue that their treatment for highly infectious diseases should be part of the realisation of the right to health. To avert the spread of Ebola in the DRC, the WHO is now using an experimental vaccine, being given to health workers and all known contacts of those with Ebola. In a departure from previous practice, the international community is now financing a vaccine that is given to pregnant and lactating women, and children under the age of 1.

Human rights frameworks would also empower carers to address employment issues. Under Articles 6 and 7, everyone has the right to work; forced labour is apparently precluded, even in crisis situations such as an Ebola epidemic. Article 7 of the ICESCR states 'Everyone . . . has the right to just and favourable working conditions'. General Comment No 18 expressly prohibits discrimination in the continuation of work, an important human right, for carers could then demand recognition of their work as waged labour. Moreover, it would ensure that neither states or international agencies can discriminate against workers – especially when providing different kinds of protective equipment on the basis of race, social background, education, etc. (CESC, General Comment 182006).

There is increasing awareness at the international level of the need to recognise unpaid care workers, which would help those at the bottom of the hierarchy. The United Nations Commission on the Status of Women stresses 'the need to recognise and redistribute the disproportionate share of unpaid care and domestic work . . .' (E/CN.6/2017/L/5 at para 30). The Special Rapporteur on extreme poverty and human rights argued that heavy and unequal caring responsibilities are a major barrier to gender equality, to women's equal enjoyment of human rights, and in many cases condemns women to poverty. However, the international human rights regime often struggles with negative

rights in which the violation is hard to identify (Roth, 2004: 68). Gender rights disproportionately fall under this category as, in order to succeed, an argument must be made about the impact of this discrimination on the woman and that it is the state and not a private employer or husband or community which is responsible for violating the right.

Even when an argument can be made that the State did nothing to enable women to achieve their gender rights, human rights also often remain difficult for individuals to pursue because the legal regime relies on the state to enforce it. This becomes problematic if the state itself obstructs that right. States can sign up to the Optional Protocol for Economic Social and Cultural Rights, which provides individuals with remedies, but many states have yet to become signatories. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) recognises women's rights to equality, dignity and equal worth with men. While it does not specifically mention caring, it forbids discrimination against women. Similar agreements exist at the regional level, such as the Maputo Protocol in Africa, and all the case countries discussed have ratified this Protocol. Moreover, in General Recommendations 25 and 27, the CEDAW Committee recognised intersectional discrimination on the grounds of race, ethnic or religious identity, disability, class, caste or other modalities (General Recommendation 25, S 12; 2004 General Recommendation 27: 2010). However, all these are recommendations, and states routinely ignore them. As feminist critics have argued, CEDAW is already one of the treaties with the most reservations, which indicates weak adherence to its normative principles (Cook, 1990). Human rights treaties do not have a persuasive record of responding to the concerns of individuals on the periphery (Charlesworth et al., 1991). In order to realise women's human rights, we will need to see huge structural reordering in order to address inequalities, which makes continued violations inevitable (Chinkin et al., 2005; 17, 26). As a result, many carers only have access to private law remedies, which has implications for how carers can use law to challenge the harms they face.

## **Conclusion**

This article has described a hierarchy of four categories of carers, and outlined the physical, mental and financial harms that flow from their specific caring responsibilities. In doing so, it has highlighted the lack of recognition of the gendered nature of caring in humanitarian health emergencies such as Ebola. Although Security Council Resolution 2177 (West Africa) and 2439 (DRC) both argued that responses to the Ebola outbreak should address the specific needs of women and the importance of their full engagement in such responses, in both health crises, engagement with the harms caused to carers has been minimal. Consequently, scant consideration has been given to implementing measures enabling carers to legally obtain redress to mitigate harm. The two case studies clearly reveal the inadequacy of legal obligations for addressing harms to carers in crises, and, as mentioned earlier, all of this resonates strongly with the situation of the current COVID-19 crisis. Even in developed countries, we continue to see caring stratified according to race and class. The fact that many vulnerable women, often from black, Asian and other ethnic minority backgrounds, cannot even obtain access to necessary



Personal Protective Equipment highlights the way in which racial and gender inequalities continue to be reproduced.

This article has argued that gender hierarchies are intersectional, and carers at home, regardless of gender (but more usually women), are likely to be disadvantaged. It has illustrated that the hierarchies and structure of international laws, including human rights, which are intended to protect individuals, may actually be failing to, due to the lack of remedies through private law at the national level.

I have illustrated the challenges of applying international humanitarian law, human rights or domestic law, such as tort law, to seek redress. Feminists have long favoured changes to domestic and international law and have attempted to use the Convention to Eliminate all Discrimination Against Women to highlight the gendered way in which we think about law; for instance, by ignoring violence in the home, as a space that is not constrained by law. CEDAW would therefore be an ideal treaty body to create a specific recommendation on the gendered nature of humanitarian health caring and the specific ways in which we can recognise the different aspects of caring that are necessary to respond sufficiently to these crises in order to avoid reinforcing harms to women. Additionally, the WHO could provide guidance on how public health and human rights could serve to protect different categories of healthcare workers. Just as it has done in previous cases on corruption and the anti-retroviral treatment, the WHO could do this through asking the Special Rapporteur on the right to health to issue normative guidance on the gendered nature of caring on humanitarian crises, and use this to coalesce support for a WHA amendment which provides state legitimacy.

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