

Responding to Covid-19 in conflicts: difficult but necessary*Michiel Hofman • Médecins Sans Frontières*

In this article, Michiel Hofman reflects on the difficulty of implementing a health response in war zones especially in a context where States are mistrusted, where non-state armed groups call on increasing hostilities and where humanitarian actors must deal with travel restrictions, supply shortages and fundraising gaps.

Covid-19 and conflicts do not mix well. In these, health care systems are weak, public health measures are difficult to implement and populations are vulnerable, conditions that can act as an amplifier for the pandemic. Hostilities, despite attempts from the United Nations to establish a global ceasefire, have not reduced since the outbreak started and, in some cases, have even increased. Publications from Islamic State (IS) and Al Qaeda (AQ) have called on their followers to “seize the opportunity” of a weakened enemy to increase attacks. From their perspective the pandemic is a factor for intensifying the conflict. States, at the forefront of the public health response to the pandemic, are mistrusted or sometimes completely absent in conflict zones. Humanitarian organisations can replace some of these State functions, yet these same organisations are feeling the impact of travel restrictions, supply shortages and fundraising gaps in these times of increased demand. Yet, it is crucial that the deployment of these limited resources continues in conflict zones. This is necessary to contain the disease, since controlling a pandemic requires it to be controlled everywhere, including in war zones, but that should not be the only reason. Ultimately, a society is defined by how it protects the most vulnerable and people trapped in conflicts are some of the most vulnerable in the world.

Many conflicts take place in resource poor environments, with weak health systems already overwhelmed by existing health needs. These health systems are understaffed, rarely free of charge, undersupplied and sometimes damaged or destroyed. Many people living in conflict zones live in unsafe, overcrowded conditions, especially those in makeshift displaced persons and refugee settlements, where any notion of social distancing or regular handwashing is impossible. Low vaccination coverage means outbreaks of other diseases are common, such as measles in Central Africa, Chad and the Democratic Republic of the Congo (DRC). Due to such insecurities, populations in conflict areas suffer more than usual from underlying health issues such as malnutrition, infections or unmanaged non-communicable diseases. When an epidemic strikes, and Covid-19 is no exception, this typically diverts already sparse health resources to outbreak response and leads to people avoiding health facilities for fear of infection. This ripple effect typically generates higher death rates from other health issues than

from the epidemic itself¹.

A State in which population lacks confidence or which is completely absent

Implementing a health response in a war zone is dangerous and expensive at the best of times, but epidemics introduce additional complexities that make this even harder. Controlling outbreaks firmly puts the State and its public health authorities (Health Ministries) at the forefront of the response. Many of the crucial aspects for the Covid-19 response such as testing, supply of critical items and treatment centres are controlled by one central authority, but health ministries do not operate in a political vacuum. They are part of a government, representing a State that, in all modern-day wars, is just one belligerent in what are effectively civil wars. As a result, the State is often not trusted, or far removed and completely absent in areas it does not control. In the best-case scenarios this causes practical inconveniences. For instance, a suspected case in the Kurdish areas in Syria can only be tested by sending a sample across frontlines to Damascus, causing a two-week delay. Crucially, this also means that populations living outside government control have no access to treatment at all. For example, a Covid-19 treatment centre in Maiduguri, the government-controlled capital of Borno State, is unlikely to receive any patients from “Boko Haram” controlled areas and a treatment centre in Mogadishu, Somalia, is unlikely to get patients from Al Shebab controlled territory. This State monopoly on tests and protective equipment is especially problematic in conflicts where the opposition forces run a civilian administration including a parallel Ministry of Health such as Afghanistan and North-West Syria. Since these health authorities are not recognised, opposed by the State in which they operate, in many cases, Covid-19 supplies do not reach these areas at all, or in limited numbers through humanitarian supply lines.

This mistrust of State authority in conflicts becomes even more problematic when the police and army are involved in the actual health response. The containment component of disease control typically includes restrictive measures (quarantine and isolation) as well as measures that invade personal privacy (contact tracing and testing). The default response of most governments is to use their security assets to impose lockdowns, border closures and the quarantine of suspected cases or groups, where it is considered necessary from a public health perspective. The use of the armed forces to enforce such measures – healthcare at gunpoint – is always a sensitive matter. For this reason, there is an internationally-agreed ethical guideline for the use of force during epidemics, “The Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights²”. This was drafted in 1984 and became an official document of the forty-first session of the United Nations Commission on Human Rights, as

¹ Mit Philips, “Dying of the Mundane in the Time of Ebola: The Effect of the Epidemic on Health and Disease in West Africa”, in Michiel Hofman and Sokhieng Au (eds.), *The Politics of Fear*, Oxford University Press, 2017, p.101-119.

² UN Commission on Human Rights, “The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights”, 28 September 1984, E/CN.4/1985/4, <https://www.refworld.org/docid/4672bc122.html>

the guiding framework for the justification of limitations during a public emergency. This document describes in detail how any restrictions imposed need to be legal, in the general interest, necessary, proportional and non-discriminatory.

However, in civil war situations, State security forces are also combatants, considered as a legitimate target by the armed opposition and in many places, perceived as the enemy by the population. So, even if the State adheres to the Siracusa principles when deploying the army or police for public health reasons, public mistrust and targeting by armed opposition can lead to worsening of the health situation. This problem was clearly revealed during the Ebola outbreak in the eastern DRC in 2018/2019. The epicentre of the outbreak was in a region where the population was traditionally aligned with the political opposition to the government in Kinshasa and a region with a multitude of armed opposition groups that have been fighting against the State security forces for decades. Yet the response, coordinated by the central Ministry of Health, called upon the police, army and intelligence service to enforce public health measures, such as safe burials, contact tracing, forced admissions and vaccination campaigns. From a public health perspective this was counterproductive, as people would hide symptoms, avoid detection and refuse to participate in contact tracing and safe burial practices, thus prolonging the outbreak rather than curtailing it. The mistrust created by this coercive approach also contributed to a general hostility towards health care providers leading to the burning down of numerous health facilities, including two MSF run treatment centres and the death of several health professionals³. Mosul in Iraq is an example where such tensions have surfaced during the Covid-19 pandemic. The Ministry of Health was keen to use armed police to guard suspected cases, which led to violence by patients in some places.

In order to avoid such instances, it is crucial to establish that public health measures do not suspend obligations under International Humanitarian Law. This includes the obligation of warring parties to allow independent health actors to provide neutral and impartial medical care. Neutrality in conflict zones means that warring parties, including the State, cannot be deployed alongside neutral health providers, as this will make these health facilities a target⁴. In short, the “no guns” policy in hospitals still applies, even during a pandemic.

The impact of the pandemic on conflict dynamics

Antonio Guterres, the United Nations Secretary General, is acutely aware of the difficulty of responding to a pandemic in war zones. Consequently, he made a public call for a global ceasefire on the 23rd of March because “Our world faces a common enemy: Covid-19”, asking all warring parties to “Silence the guns; stop the artillery; end the airstrikes” in order

³ Karline Kleijer, “How the Ebola response failed the people of DRC”, MSF, 24 March 2020, <https://www.msf.org/how-ebola-response-failed-people-drc> ; Heather Pagano and Emmanuel Lampaert, “Ebola Healthcare at Gunpoint – the New Normal?”, MSF-Analysis, 26 December 2020, <http://msf-analysis.org/ebola-healthcare-gunpoint-new-normal>

⁴ ICRC, “COVID-19: How IHL provides crucial safeguards during pandemics”, 30 March 2020, <https://www.icrc.org/en/document/covid-19-how-ihl-provides-crucial-safeguards-during-pandemics>

“To help create corridors for life-saving aid⁵”.

So far, this call has had limited results. The only update published by the United Nations on the 2 April boasts that some 70 nations worldwide have signed up to this ceasefire, many of which are nations involved in conflict⁶. The report also mentions the agreement of non-state armed groups (NSAG) in Cameroon, the Central African Republic (CAR), Colombia, Libya, Myanmar, Philippines, South Sudan, Sudan, Syria, Ukraine and Yemen. However, closer scrutiny shows that in many of these countries only one or a few of the many different active groups have signed up (Cameroon, Iraq, Philippines), or have done so for just one month (Colombia), or it has since fallen apart (Libya, Ukraine, Yemen). Also, some of the 70 countries mentioned did not specifically endorse this coronavirus ceasefire. The UN simply expressed the hope that existing peace agreements or ceasefires would continue (CAR, South Sudan, Syria, Afghanistan, Gaza). The report states that only in Sudan did both the government and most of the armed groups sign up and fighting stopped. One of the most widely publicised responses to the pandemic from an armed group came from the “Taliban” in Afghanistan, promising free and safe passage for health workers to areas under their control⁷. However, they refused to endorse the ceasefire specifically, saying it would only apply in areas they control. This is effectively just a ceasefire with themselves!

Many humanitarian organisations have given strong public support to this UN ceasefire including Save the Children, Christian Aid, Concern, *Action Contre la Faim*, the International Rescue Committee (IRC) and the Danish Refugee Council. The International Committee of the Red Cross (ICRC) is reluctant to endorse the ceasefire explicitly, as they are concerned that a coronavirus ceasefire would fuel the wider debate on the concept of “health security”, using healthcare as a bargaining chip in peace negotiations. However, the ICRC President Peter Maurer came quite close to endorsement in a speech at the World Economic Forum: “There is a good reason the UN Secretary-General has called for a global ceasefire; humanitarian actors need all possible space to respond to the present pandemic”. Unfortunately, humanitarian ceasefires, corridors and safe zones are also prone to abuse. They risk legitimising violence and blocking humanitarian access to those areas that do not take part, or for one of the parties to appoint themselves as the arbiters of who, according to them, deserves aid and who does not.

The debate about the ceasefire shifted to the UN Security Council, with France and Tunisia proposing a resolution calling for a 90-day “humanitarian pause”, which quickly gained support from the UK and China. The United States and Russia initially refused to sign up to such a blanket arrangement, for fear this would curtail their counter-terrorism operations.

⁵ United Nations, “Secretary-General’s Appeal for Global Ceasefire”, 23 March 2020, <https://www.un.org/sg/en/content/sg/statement/2020-03-23/secretary-generals-appeal-for-global-ceasefire>

⁶ United Nations, “Update on the Secretary-General’s Appeal for a Global Ceasefire”, 2 April 2020, https://www.un.org/sites/un2.un.org/files/update_on_sg_appeal_for_ceasefire_april_2020.pdf

⁷ Al Jazeera, “Taliban launches campaign to help Afghanistan fight coronavirus”, 6 April 2020, <https://www.aljazeera.com/news/2020/04/taliban-launches-campaign-afghanistan-fight-coronavirus-200406055113086.html>

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Eventually, a watered-down version was tabled, but only in countries where the UN Security Council plays a role, and excluding counter-terrorism operations and all the armed groups designated as terrorists. Finally, more than 3 months after Guterres' original call – and bickering between the US and China how to both mention and not mention the WHO in the text –, the UNSC adopted resolution 2532 (2020) on the 1st of July. Most of the conflicts covered by the resolution involve one or more such prescribed "terrorist" groups, excluding them and operations against them does not amount to much of a pause in fighting at all.

Many designated groups did not need to be encouraged by a UN resolution to exclude themselves from any ceasefire. The two most well-known armed opposition franchises, Islamic State and Al Qaeda, published a position on the coronavirus pandemic. Islamic State took the most aggressive stance early on. On the 18 March, in their magazine *Al Naba*⁸, they urged their followers to seize the opportunity of "weakness of the enemy" to launch attacks and release Muslim prisoners "from the jails of the mushrikin and the camps of humiliation in which the disease threatens them". This is most likely a reference to the detention camps in north-east Syria holding ex-IS combatants and their families. Al Qaeda belatedly followed suit at the end of March⁹ stating that "Now is the time to spread the correct Aqeeda, call people to Jihad in the way of Allah and revolt against the oppression and oppressors". Al Qaeda however seems to promote a more passive approach, principally calling on everyone in the West to consider converting to Islam and telling the "crusaders" to "wait, we too are waiting". Both pamphlets also stress the Islamic credentials in support of public health messages, especially the need for hygiene practices.

In some contexts, this "weakening of the enemy" is quite literal as top officials as well as military bases have not been immune to the virus. In Mali, both the French anti-terror forces involved in Operation Barkhane and the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) have been hit by the virus, leading to lockdowns in barracks and a reduced capacity. In Nigeria the President's Chief of Staff, seen as one of the country's main powers, died of Covid-19. There have been no public endorsements by individual groups linked to Islamic State or Al Qaeda of this call to arms – one statement from the Al Qaeda affiliated Al Shebab in Somalia on coronavirus predates the Al Qaeda publication – but fighting has increased in many places. The number of attacks claimed by Islamic State in Iraq has doubled since the pandemic, the conflict in northern Mozambique has accelerated in the last two months including many attacks on district capitals, Boko Haram has stepped up attacks in Nigeria, including incursions on the Borno State capital, Maiduguri, and the conflict between Al Qaeda and Islamic State has intensified in the Sahel. In all cases, these intensifications can be explained by local dynamics, but generally the trend is for more, not less war since Covid-19.

⁸ "The Worst Nightmare of the Crusaders", *Al Naba Newsletter*, issue 226, accessed through: Aymenn Jawad Al-Tamimi, "Islamic State Editorial on the Coronavirus Pandemic", 19 March 2020, www.aymennjawad.org/2020/03/islamic-state-editorial-on-the-coronavirus

⁹ "The Way Forward, A Word of Advice on the Coronavirus Pandemic", accessed through: <https://twitter.com/thomasjoscelyn/status/1245311851325423616>

Help those that fall through the cracks of the “greater good”

The pandemic has made providing health care in conflict situations even more expensive and dangerous than usual, whilst humanitarian organisations will struggle to maintain, much less expand operations as the pandemic blocks staff and supplies. Most of these blockages are imposed by States, which necessitates an uncomfortable collaboration with these States to overcome. In conflict areas this needs to be explained to the non-state armed groups. The urgency of the needs may be an opportunity to open channels with armed groups that have previously been difficult to access, with others it may be an additional barrier. Whether Covid-19 is a challenge or an opportunity, will depend, as always, on each context.

With all these constraints, choices need to be made and priorities set. An unfortunate temptation would be to use the limited resources available only in places that are easy to reach, where larger populations can be helped and where the largest number of lives can be saved. Conflict zones are not such places. However, humanitarians are supposed to look after the most vulnerable, those that fall through the cracks of the “greater good”. That includes migrants, the homeless and the elderly in Europe and North America, people living with HIV/AIDS and tuberculosis in Africa, and people living in conflict everywhere. First and foremost, to maintain life-saving medical care, mostly unrelated to Covid-19, and where possible, respond to the pandemic as well.

Biography • Michiel Hofman

He worked for *Médecins Sans Frontières* (MSF) in field missions between 1993 and 1998 as emergency coordinator and head of mission for MSF in Liberia, DRC, Bosnia, Burundi, Sri Lanka, Brazil, South Sudan and Kosovo, returning to his former career as freelance journalist between missions. Between 1999 and 2001, Michiel co-founded the Antares Foundation, a Dutch non-profit organisation which supports local NGOs in providing psychosocial support for staff working in high-stress environments. Michiel returned to MSF in 2001 working as country director in Russia, director of operations at MSF Amsterdam HQ and as country representative for Afghanistan. Since 2011, Michiel Hofman has been working as a senior humanitarian specialist for MSF based in Belfast, concentrating on research, training and operational support, as well as publications in the humanitarian field.

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