COVID-19:
INTERACTIONS BETWEEN THE PANDEMIC AND CONFLICT
COVID-19 AND CONFLICTS

PREAMBLE

As it has done regularly in the past, in connection with complex, multi-factor and potentially long-lasting crises, the Groupe URD has begun to:

- Establish a ‘real-time evaluation observatory’ in order to produce synthesis reports, analysis and recommendations about the crisis.

In this framework, the team of the COVID-19 Observatory has produced a series of briefing notes on specific subjects:

- Health;
- Food, agricultural and economic security;
- Social cohesion and social tensions;
- Migration and mobility;
- Education;
- Conflicts;
- The Emergency-Development Nexus.

This briefing note is the eighth output by the COVID-19 Observatory. It presents our analysis on the implications of the management of the current COVID-19 crisis in contexts of conflict.
SUMMARY

Conflicts and their impacts vary greatly depending on the context (countries that are more or less rich, more or less organized, with a more or less competent administration), the nature of the conflagration (international war, civil wars, externalized internal conflicts, other types of high mortality violence such as organized crime in Latin America), the kinetics of the conflict (a flash war or long-lasting guerrilla warfare) and the desires of the bearers of arms. It is in these contexts that a “pandemic diplomacy” is trying to develop, but also a strong instrumentalization of the latter by certain armed groups, which seek national and international recognition through the implementation of a real response: this is the case of the Islamic State and the Taliban, who have issued fatwas and measures to try to manage the crisis. In other cases, armed groups are trying, with varying degrees of success, to gain ground by exploiting the economic and social disorder and the disengagement of the armed forces induced by the pandemic and by appropriating the responses provided. The socio-economic effects of the measures taken by the authorities create dissatisfactions and difficulties in daily life that are easily recovered in the anti-government campaigns of non-state armed groups.

A few countries have followed the UN Secretary-General’s call for ceasefires to enable better management of the pandemic. But governments are unlikely to sign peace agreements in the midst of a health crisis, as they may see this as an opportunity to weaken the enemy. An external shock such as the coronavirus suspends the conflict but does not change the underlying structures, such as control of territories, access to arms and sources of funding, and support from diasporas.

Working in conflict zones has always been difficult. Setting up humanitarian programmes in such contexts is dangerous, requires complex logistics, strong negotiation skills and a genuine ability to respect key humanitarian principles and to demonstrate the reality of that respect. Populations in affected areas, as well as those fleeing them, are often in situations of dramatic distress, and live in precarious and crowded conditions that are highly conducive to the transmission of contagious diseases, such as COVID-19. Responding to the needs of populations following the effects of the conflict while having to deal with the medical and non-medical consequences of a health crisis such as COVID-19 will require specific approaches, as operations in Yemen, Somalia, DRC, etc. have shown.
1. INTRODUCTION

The impacts of COVID-19 on conflicts and its impact on populations in war zones and on humanitarian action are two variables at the heart of many debates; being able to observe and understand what is happening is becoming increasingly essential.

The call for a global ceasefire issued on March 23rd, 2020 by UN Secretary-General António Guterres in the middle of the coronavirus pandemic (COVID-19) has received broad international support, revealing that just as there is “disaster diplomacy”, there could also be “pandemic diplomacy”. However, will the parties involved in various conflicts in the many countries facing civil wars heed this call and silence their guns for the time it takes to manage the crisis, or even potentially longer?

- What are the strategies of armed state actors and non-state armed groups in the face of the pandemic?
- Can a “pandemic diplomacy” exist in the short term? Would it help to advance peace in the long term?

In addition, the mobilization of NGOs, the European Commission (notably DG ECHO) and some of its Member States (France, Germany, the Netherlands, Italy), with the release of significant funds and the setting up of an “aerial bridge” to countries in conflict (CAR, Sudan, Afghanistan, etc.) show the extent to which the humanitarian sector is concerned about the feared impact of this pandemic on populations already heavily affected by conflicts.

Beyond the well-known difficulties surrounding aid in war zones, the COVID-19 crisis adds new difficulties in responding to the suffering of populations, made all the worse by the superposition of the sanitary, economic and food-security impacts of the pandemic on those of the conflict itself.

- How can we manage remote needs assessments, in contexts where it sometimes seems easier to collect false and crazy rumors than reliable information?
- How can aid be provided when, in addition to the traditional constraints of access to war zones, there are also constraints linked to the fight against the pandemic (border blockades, disruption of supply chains, confinement, etc.)?
2. IMPACT OF COVID-19 ON CONFLICTS

We have observed that a disaster can have surprising effects on conflict dynamics. In some cases, such as in Aceh, Indonesia, the 2004 tsunami opened the door to true “disaster diplomacy” leading to a peace agreement and elections that put former rebels in power. The same tsunami had a more limited, even opposing effect in Sri Lanka, where, after a few months of ceasefire to allow aid to be deployed (under heavy duress), accusations of ‘favouritism’ in the allocation of aid rekindled the conflict to its most devastating and deadly yet. In many cases, governments and armed groups have a predatory attitude towards this post-disaster aid, but in other contexts, the various parties embroiled in the conflict have mobilized to bring aid to the populations or have allowed aid to reach them (Tillabéri region in Niger), albeit obviously with many political ulterior motives.

How has the pandemic been used as a tool to advance peace in the various ongoing conflicts which affect many parts of the world? It may initially seem that the UN Secretary General’s March 2020 vibrant call for a ceasefire has so far had little impact. This does not mean that the various actors engaged in conflicts have not had very clear diplomatic strategies: some 60 states have signed a declaration at the initiative of the French government in favour of a global ceasefire and 70 states have expressed their support in one way or another for the call for a global ceasefire, as have several non-state armed groups. In practice, however, there is relatively little operational impact on the ground.

2.1. OBTAINING POLITICAL GAINS AND DEMONSTRATING ITS ABILITY TO HANDLE CITIZENS’ BASIC NEEDS

In contexts of conflict, bonds of trust are very often broken between populations and States. This makes it more difficult to implement health measures and provides options for significant political gains for armed groups to seize. Afghanistan offers a particularly instructive example: the global health crisis caused by the SARS-CoV-2 pandemic provided the Taliban with an opportunity to demonstrate to the international community and the Afghan population their credibility as an actor capable of managing the expected functions of the state. With very weak health infrastructure and very limited logistical and human resources in the health sector, the Taliban invested heavily in the “prevention” component of the response to COVID-19. The Taliban’s aim was to demonstrate that it was capable of managing a major health crisis. For many years now, maintaining and operating a minimum health infrastructure has been vital to the movement, particularly in the face of the need for this infrastructure in a conflict context. Negotiations with humanitarian actors, including the ICRC, were partly based on these needs.

Beyond the military dimension, the organization of medical care is a major means of marking control of the territory in the eyes of the population, even if it is often the Kabul administration or humanitarian associations that provide personnel and funding. As early as 2007, Mullah Omar, founder of the Taliban, called on international organizations to organize the care and vaccination of children. The major humanitarian and medical organizations and the competent UN structures, in particular the World Health Organization (WHO), tried to develop healthcare structures throughout the country “in the name of humanitarian principles”, while for the Taliban, it was a matter of seeking both legitimacy in the eyes of the population and political recognition and an improvement in their image vis-à-vis the international community. Faced with the current coronavirus crisis, it is clear that the lack of intensive care hospital beds, an effective quarantine zone and qualified personnel makes the capacity for purely medical management of the epidemic uncertain and raises the fear of a dramatic evolution of the COVID-19 if the preventive measures are not applied.

In a context of a lack of public confidence in the health care system, the Taliban, like other jihadist groups, including Daesh, launched a campaign on physical distancing, hygiene measures, etc., to prevent the spread of the disease. With no more resources than the government in Kabul, they are sticking to preventive measures and calls for compliance with health regulations. Generally speaking, gatherings have been banned in Taliban-controlled areas.
The mullahs, tribal leaders and commanders have been called upon to disseminate health instructions and ensure their implementation. In order to ensure the proper implementation of these measures, which involve restrictions on religious practice, shuras have been advised to obtain the endorsement of religious scholars whose message, based on a religious and traditional legitimacy far stronger than that of the Government, is listened to and generally respected.

But the great novelty is the explicit request to international humanitarian organizations, both in favour of the populations but also, in a very specific way, for prison contexts where many combatants are imprisoned in very precarious conditions. The Government of Kabul has released thousands of prisoners to avoid turning prisons into contamination bombs. Additionally, international organizations are once again being called upon to provide all the necessary medical and humanitarian equipment in the areas under Taliban control, where the movement is committed to ensuring their security. As of March 18th, the Taliban called on the population to follow the detailed health instructions issued by medical organizations in all the regions under their control. And they go one step further: they commit themselves to social protection; they order Afghan entrepreneurs and traders to refrain from trying to take advantage of the situation to speculate and provoke inflation (from March 22nd, coercive measures are announced by the movement to combat these economic practices). In fact, despite a large part of the resources and advice being sourced from organizations that do not recognize the legitimacy of the Taliban, or even come - such as the salaries of medical personnel - from the government in Kabul, they derive from the situation a certain political credit and an important international visibility. Beyond their concern for the health of their constituents, this crisis allows them to demonstrate to the world that they are capable of assuming the responsibilities to which they aspire.

In the same way, the Islamic State has promulgated a Fatwa and Sharia Guidelines promoting physical distancing and hygiene measures, recalling how compatible they were with ritual ablutions before the 5 prayers. In Somalia, the Shebbab who control much of the interior of the country have set up medical clinic systems while accusing Christians of spreading SARS-CoV-2.

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2.2. TAKING ADVANTAGE OF THE PANDEMIC TO EXACERBATE DISORDER

For many analysts\(^6\), there was a strong risk that the state of astonishment and paralysis resulting from the pandemic would be heavily instrumentalized by non-state armed groups to increase the intensity of their operations and maximize military gains. The reality proved to be much more complex.

A very active and highly ideological propaganda campaign has rapidly been rolled out by radical Islam movements' headquarters. It should be noted that the imposition by the Islamic state of a halt to attempts by fighters to infiltrate Europe, inviting "healthy people not to enter the lands affected by the pandemic and those who are infected to stay where they are" is accompanied by strong propaganda that the pandemic is "a painful punishment to the Crusader Nations of the West".\(^7\).

Al Qaeda insisted that "COVID is a punishment for the injustices and oppression carried out by Western governments against Muslims". Boko Haram stressed that this pandemic was a divine blessing and that only good believers would be spared.

In Yemen, the Houthi rebels attempted a political and ideological instrumentalization of the pandemic: portraying it occasionally as God's creation which "stems from the evil deeds of human beings who are not guided by God", occasionally an attempt by "Zionist lobbies and the United States" to carry out a bacteriological war in Yemen, even using humanitarian aid for the transmission of the virus\(^8\).

But at the tactical level, these movements seek to instrumentalize several elements related to the situation:

- General dissatisfaction with national health services among populations, which unfortunately were already weak in many contexts before the conflict and which the conflict has not improved;
- Dissatisfaction with the impact of the measures taken to manage the pandemic and attempt to reduce transmission: quarantine, containment, isolation and contact tracing (often perceived as a police operation), which sometimes proved to be very violent measures, also directly interfering with access to the means of daily survival;
- Dissatisfaction with the closure of borders for pastoral groups and the blocking of ports for all those who depend on international trade (from small cocoa farmers to large traders).

2.3. MANAGING THE PANDEMIC AND ITS RESPONSE AS A WEAPON OF WAR OR AS A TOOL FOR PEACE

In these war-torn countries where health infrastructures are often nearly completely destroyed, the arrival of the virus is particularly dangerous. The history of public health action against major infectious diseases has seen overwhelming successes when it has involved political negotiations and ceasefire agreements to allow mass immunization in conflict zones: UNICEF's immunization campaigns in Cambodia were negotiated with stakeholders despite the Cold War, ceasefires have been achieved in some contexts...

However, even where vaccines exist, diseases are often more difficult to eradicate in conflict areas. Indeed, the maps of the resurgence of polio, meningitis and even smallpox cases are in many ways modelled on the map of conflict, where routine immunization is usually virtually stopped in areas under the control of armed groups or in areas that are regularly on the front line.


The UN Secretary General’s call for a comprehensive ceasefire as a response to the pandemic has only been heeded in a very limited number of contexts where armed groups have finally given their consent (e.g. Yemen and Syria). But experience shows that ceasefires for health reasons are mostly very temporary and do not (with rare exceptions) lead to peace. The ongoing dynamic between the United Arab Emirates and Iran, the country most affected by the virus in the Middle East (more than 78,000 infections and more than 5,000 deaths) is being followed with great attention. In fact, despite the fact that Abu Dhabi maintains relations with Tehran that are conflictual to say the least, accusing Iran of ‘destabilizing’ the region, the United Arab Emirates have sent a significant amount of medical aid to the Iranian capital: on March 16th, 2020 two planes containing 32 tons of protective equipment (masks, gloves and suits) followed the earlier dispatch of five medical experts and 7.5 tons of medical aid as part of a WHO mission to the Islamic Republic.

Hostilities have also ceased in countries with better infrastructure and health prospects: at the end of March, the New People’s Army (NPA), the armed wing of the Communist Party in the Philippines, proposed a ceasefire in a 50-year war to give the entire population access to testing and treatment; in Colombia, the National Liberation Army (ELN), the oldest active guerrilla group in the country, agreed to a one-month ceasefire starting April 1st.

Ultimately, it is important to know whether the coronavirus can change the dynamics of conflict so that peace can be achieved. In Yemen, international bodies and the Arab coalition, led by Saudi Arabia, have been trying since April to negotiate a ceasefire with the Houthi rebels; but on the front line, east of Sana’a, the Houthis have made major military inroads; expanding eastwards, they are posed to increase pressure on Saudi Arabia in the run-up to a future peace treaty; they have no interest in letting the COVID-19 pandemic cut off their advances. Consequently, this context is likely why Saudi Arabia has advocated for a “COVID ceasefire”.
3. HUMANITARIAN RESPONSE TO COVID-19 IN CONFLICT ZONES

In contexts of ongoing political instability and internal or cross-border conflict, several major constraints to the pandemic response need to be taken into account:

**Constraints related to the precariousness of health infrastructures in conflict zones and adjacent regions.**

The areas where conflicts start and continue are de facto areas often left behind, where health structures are very weak or almost non-existent. Detecting a major infectious event and understanding the potential impact is secondary to the conflict dynamics. It is therefore difficult to know what the real kinetics of the pandemic are in areas such as the Sahel or Nigeria. However, there is evidence that health facilities are regularly targeted by some of the parties to the conflict - for example in Yemen or Afghanistan - making them unable to provide not only basic health services but obviously also a coordinated response to an epidemic. In Syria, where the health system used to be one of the best in the Middle East, in many areas there is virtually nothing left, apart from the ruins of bombed-out hospitals and war surgery departments operating in disastrous conditions. Under such conditions, surveillance, notification of infected persons and patient care are entirely compromised.

**Constraints related to the high mobility of populations, with streams of refugees and displaced persons.** Conflicts and mass movements of refugees and displaced persons encourage epidemics: in July 1994 in the Rwandan refugee camps in Goma (in the Democratic Republic of Congo), it was estimated that cholera had killed 23,800 people in a few weeks (with a lethality rate close to 30%); today, Rohingyas fleeing by boat to escape the conflict in their country are being prevented from disembarking for fear of spreading the virus.

**Constraints on restricting movement and access to areas where the epidemic is present:** it is therefore a question of implementing approaches that enable access to stricken areas, working with the authorities and establishing mechanisms that facilitate acceptance by the populations. In contexts such as Yemen, obtaining permission to go to areas close to the front lines and affected by cholera is sometimes very difficult. In countries such as Burkina Faso, the constraints on movement due to the pandemic are compounded by those resulting from the conflict, making it very difficult for people to survive.

**Constraints related to the precariousness of populations and the high volatility of commodity prices:** in Southern Sudan, as in many other countries where landlockedness and climatic hazards which predate COVID-19 have made speculation phenomena very frequent, the increase in food prices further weakens households, making them more vulnerable to the disease and especially to the socio-economic consequences of the measures taken.

**Constraints related to the possibility of politicization of the crisis and consequent weakening of humanitarian actors:** In these very sensitive contexts, the fear of the epidemic, the stakes of political positioning, the need to find scapegoats can easily turn against humanitarians. They must anticipate these risks very early on and plan the necessary mitigation measures, particularly in terms of communication.

**Constraints related to militarization and issues of respect for humanitarian principles:** In conflict contexts, humanitarian action, including health infrastructure, is said to succeed in finding its place in the midst of military operations or militarized control of areas held by the various parties to the conflict. The response to a pandemic, including both primarily medical and non-medical actions to address the non-medical needs arising from the pandemic and measures to control it, must be based on respect for humanitarian principles. Militarized approaches, whether for the control of territory, compliance with containment measures or securing the areas where the response is to be deployed, must imperatively be consistent with International Humanitarian Law.
4. POTENTIAL AVENUES AND QUESTIONS FOR ACTION

4.1 COVID-19, WAR AND PEACE

In the face of the horrors and suffering generated by conflict, no opportunity should be missed to try to move towards peace. The gesture of the United Nations Secretary-General, calling on the parties to conflicts to agree to ceasefires so that the pandemic could be better managed, was courageous. Whatever the effect, this appeal was necessary at a time of multilateralism endangered by the decisions and positions of a number of major actors, including members of the UN Security Council. The countries that effectively support it, the parties to conflicts that respect it and the actors on the ground that use it to best manage the pandemic, will be lauded.

4.2. COVID, CONFLICTS AND HEALTH EMERGENCIES: THE RISKS OF AUTHORITARIAN MANAGEMENT

Conflict contexts generally lead to the implementation of measures to control populations. The measures taken in some states to counter COVID (exceptional measures/state of emergency) may strongly echo those wartime measures to control citizens. Seeking to reinforce the centrality of states and the power of governments, they can generate significant protest and protest movements. While these measures are legitimate in a public health approach, they are likely to be used disproportionately to crush protest movements. In conflict contexts, their impact is either to induce great passivity (the superimposed conflict and pandemic leading to such difficulties in daily life that there is no energy to react) or, on the contrary, to generate, under pressure, a strong sense of anger, which reinforces the violence of confrontational dynamics.

In these contexts, the space needed for international aid intervention to alleviate the suffering of populations tends to shrink, due to the political and security agendas of States. The capacity for negotiation is therefore at the heart of the management of the pandemic. The financial means, human capacities, appropriate tools and legitimacy will thus still be needed.

4.3. PLACING THE CHALLENGES OF INCLUSIVE GOVERNANCE AT THE HEART OF CRISIS EXIT STRATEGIES (TOWARDS PEACE?)

While the challenge of changing societies is not at the heart of the practice of humanitarian actors, it is important that the response to the COVID-19 crisis and the consequences of the measures taken anticipates the risks of social upheaval, tensions and renewed conflict. Humanitarian NGOs and development actors must seize every opportunity to strengthen both civil society actors as well as eventual emanations that bring about social change. Indeed, in many cases, the dynamism of civil societies in responding to the COVID-19 crisis, and the consequences of the measures taken has been an essential leverage to change the situation. Responding to the pandemic, in a context of conflict or of high tension, requires support, beyond the purely medical aspects, for bold programmes and activities combining public health, social cohesion and the strengthening of social/societal mechanisms. The great challenge will be to include them - and to accompany them - in a long-term approach to peace.

This will require clear efforts dedicated to strengthening institutions and public services.

Often mishandled in the context of conflict, and additionally at risk in a major epidemic dynamic, efforts to restore trust between the various stakeholders - belligerents as well as civilian populations - are an essential element of a successful response to the pandemic. Confidence must be built through the proper care and consideration of the needs of all. Perhaps, in the end, this will lead to increased justice, efforts towards inclusive governance, and even an appeasement foreshadowing peace?
4.4. CONFLICTS, DETENTION OF PRISONERS AND EPIDEMIC RISK MANAGEMENT

Conflicts tend to significantly increase the number of detainees living in conditions even more deplorable than before they start. These prisons can very quickly become time bombs where epidemics can be transmitted rapidly, affecting prisoners, staff (who themselves become a contaminant for their families and neighbors) and all visitors. Enhanced containment efforts - to combat the pandemic - quickly become sources of high tension that can lead, if preventive measures are not taken, to major security incidents.

4.5. MANAGING POSSIBLE CIVIL-MILITARY ISSUES

To respond to disasters characterized by their powerful impact, their rapid speed and their cross-border dynamics, states often base their response on their armed forces9, trained, disciplined bodies with multiple tools at their disposal to best respond to any crisis. This is also often the case in responses to large-scale health crises. The Ebola crisis in the Gulf of Guinea revealed three scenarios. The first is based on the mobilization of the Army Medical Corps and/or specialized civil service military brigades (as was the case for France). In the second, it is the logistical and military engineering capacities (US Army in Liberia) or the capacity to reinforce coordination (British Army in Sierra Leone) that are mobilized. In the third, as in Eastern DRC, it is directly the National Armed Forces (in DRC the FARDC), or even militias of certain armed groups that have been mobilized, this time to ensure the security of WHO vaccination campaigns. As demonstrated by the escort practices used during the Ebola response in the Kivus, abuses in these mechanisms can be numerous and have a strong potential to affect the overall integrity of aid in the area and respect for humanitarian principles in conflict zones. In order to address these risks, it was necessary to ensure in every instance that the OCHA offices were equipped with sufficient CIM-Cord capacity.

The COVID crisis may result in the mobilization of the armed forces. While the medical or logistical functions of these forces can be useful if done in time,10 concerns arise surrounding potential abuses: notably the use of force in countries that are already authoritarian in dealing with the social tensions that erupt11 during economic and food crises, and especially when isolation and containment measures are put in place and applied. Moreover, non-authoritarian countries may also use their armed forces, for example to control their borders12. In these contexts, there is a major risk of subverting the humanitarian goals of these missions. It is important to be very vigilant, both at the national level with civil society networks and with parliaments but also at the international level, with its networks of technical and financial partners, and its watch on human rights abuses.

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