



“AS IF THE WAR WAS NOT ENOUGH”

STORIES OF HARDSHIP AND RESILIENCE
IN TIMES OF COVID-19

A REPORT ON THE PANDEMIC'S IMPACT ON THE PROTECTION
OF PEOPLE CAUGHT UP IN CONFLICT

Cover photo

Idlib, Syria. A child wears a mask during a disinfection campaign at a school, March 2020.

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ABOUT THIS REPORT

This report was commissioned by the Unit for the Protection of Civilians at the International Committee of the Red Cross (ICRC) headquarters and researched and written by Gregor Muller. It would not have been possible without the support and commitment of field teams at the ICRC's delegations in Iraq, the Philippines, Nigeria, Yemen, the Central African Republic, the Democratic Republic of the Congo, Colombia, Greece and Azerbaijan. They contributed the real-life stories which form the backbone of this report.

The stories reflect the experience of people met by ICRC teams as part of their humanitarian work over the course of the pandemic. The events they describe occurred between March and December 2020, documented through case files and in-depth interviews with the protagonists of the stories as well as with the ICRC staff who interacted with them. In some instances, the names of specific localities and people were changed to protect their privacy.

A special thank you goes to Jassim, Joaquin, Falmata, Abobakr, Augustin, Luisa, Jawed and Sara as well as their families for sharing their stories and agreeing to make them part of this report.

The report was reviewed by an ICRC editorial committee made up of Sarah Epprecht, Fiona Terry, Lindsey Cameron and Filipa Schmitz Guinote and chaired by Pilar Gimeno Sarciada, head of the Unit for the Protection of Civilians at the ICRC.

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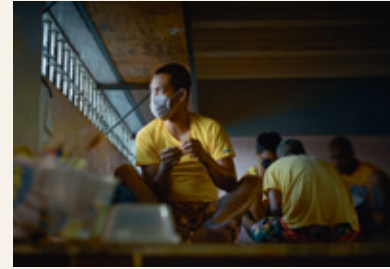
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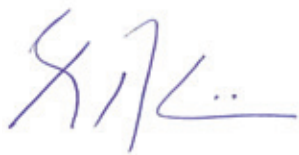
FOREWORD

Since it emerged at the end of 2019, coronavirus disease (COVID-19) has spread relentlessly around the planet. Everyone, everywhere, has been affected in one way or another – but not equally. People and communities affected by armed conflict – those displaced, in detention, separated from their families, deprived of their livelihoods and lacking access to basic services – have been among the hardest hit. In places with broken health systems, wracked with insecurity, the risk of serious illness and death is obvious. But the long-term effects of the pandemic there may be even more harmful than its immediate impact, setting back economic growth and development and entrenching hardship still further.

The International Committee of the Red Cross (ICRC) – together with our partners in the International Red Cross and Red Crescent Movement – has stepped up our COVID-19 response around the world from the outset, supporting vulnerable communities in areas affected by armed conflict and other violence, where the pandemic is just one more deadly threat among many. We have adapted our programmes to address additional needs and developed new hygiene protocols to ensure that we do not inadvertently endanger the health and safety of either our staff or the people we are working to protect and assist.

In the eight personal stories contained in this report, the narrators recount how their lives and the lives of their families have been affected by COVID-19 over the past year, sharing some of their insights and experiences. They bear witness to what the double burden of armed conflict and disease really means in places like Iraq, the Philippines, Nigeria, Yemen, the Central African Republic, Colombia, Greece and Azerbaijan. Through these stories, the report describes the unprecedented challenges facing people affected by both conflict and COVID-19, and how they have compounded ongoing humanitarian needs. It reflects on the policies and practices that, in the ICRC's view, have been effective in mitigating some of these challenges. And it considers possible lessons learned and future opportunities.

The pandemic has brought with it devastating risks – to lives and livelihoods, to economies and to humanity as a whole. Yet it has also brought a compelling imperative for change. We all know that the pandemic cannot be contained by a single country alone, and that no country is safe until we are all safe. To that end, ensuring equitable access to vaccines is vital. The need for increased global solidarity, for working together to look after the most vulnerable people in society and for protecting our planet has never been more important. Each of us has a role to play to make this happen; none of us can afford not to heed this call.



Robert Mardini
Director-General, ICRC

EXECUTIVE SUMMARY

More than a year has passed since COVID-19 began its seemingly unstoppable spread across the globe. This report examines the impact that the COVID-19 pandemic has had on people who live in parts of the world affected by armed conflict and other violence. It reviews some of the pandemic's complex consequences for communities already struggling with multiple crises and threats to their lives and livelihoods. It also highlights emerging good practice from governments, humanitarian organizations and other stakeholders for alleviating hardship, as well as lessons learned that can inform future efforts to limit the spread of disease, care for the sick and mitigate the social and economic impact of pandemics on vulnerable communities, now and in the future.

The insights presented in this report transpire from the stories of eight people whom delegates of the ICRC met over the course of last year in countries where the ICRC maintains major humanitarian operations. Their personal experiences of the pandemic are as diverse as their origins and current circumstances. Through their accounts of how the virus has affected them and their families, we learn about their lives and surroundings:

- A Yazidi family's plight in Sinjar, Iraq, reflects the interplay between COVID-19 and displacement, the effect of the pandemic on livelihoods and camps for displaced people, the power of cash-based aid to mitigate the impact of COVID-19 and why increasing access to social safety nets makes for good policy during a pandemic.
- A story on life behind bars in the Philippines demonstrates how the pandemic affects detention conditions, family life, the pace of the judicial process and prison reform, and why it proves the truth of the old adage that prison health is public health.
- Through a traditional birth attendant concerned about the health of her community in Borno state, Nigeria, we learn about managing water and resources, the nexus between humanitarian work and development, and the relation between international humanitarian law and pandemic preparedness.
- A physician on the front lines of the pandemic in Yemen tells us about resilience in the face of death, the stigma attached to working with COVID-19 patients, violence against health care and the importance of trust between health-care providers and the communities they serve.
- The story of a 12-year-old orphan returning home to the Central African Republic shows how COVID-19 has kept families apart, increased suspicion of foreigners, shuttered schools and put children at greater risk, but also how, with patience and perseverance, happy endings may prevail regardless.
- The violent deaths of two civilians in Colombia illustrate the pandemic's impact on communities living under the control of certain non-state armed groups, the need to protect civilians and respect international humanitarian law, and the importance of neutral, independent and impartial humanitarian action in hard-to-reach areas.
- An Afghan man's long wait for an asylum interview in Greece sheds light on the protection of migrants in camps and detention centres during the pandemic; access to state-run health-care and social protection systems; border closures, "push-backs" and the right to seek asylum under international law; and the need for solidarity in a global health crisis.
- The grief of an Azerbaijani family over the death of a relative speaks to the impact of the pandemic on traditional burial rites and practices, protecting the dignity of the dead during an emergency, the global mental health crisis triggered by COVID-19 and the silent suffering of the families of people gone missing owing to conflict.

Much of what these people tell us holds true beyond their specific situations and the places they find themselves in. Their experiences stand for countless individuals like them who, with courage and resilience, are shouldering the double burden of war and disease while trying to secure a life in safety and dignity for themselves and their families.

The COVID-19 pandemic has also been an unprecedented stress test for those providing services to conflict-affected populations. Over the course of the past year, both governments and humanitarian organizations have learned a lot about what works and what doesn't in terms of policies, practices and tools as they try to sustain programmes and services for communities in need and alleviate the worst effects of the pandemic. The testimonies in this report and what the ICRC has observed on the ground bring into focus five considerations that are relevant for governments, donors and the humanitarian, development and conflict-prevention communities, now and in future crises:

- 1. Invest in understanding the multiple dimensions of vulnerability and people's coping capacities in order to build an effective and holistic crisis response.** Each in its own way, the stories in this report highlight just how individual and varied the knock-on effects of this pandemic can be depending on what risks a person faces, including security risks, and how they have coped with previous shocks arising from conflict and other violence. Without a granular understanding of people's capacity for resilience, contingency plans and crisis-response measures aimed at countering the secondary effects of the pandemic may be ultimately ineffective or insufficiently responsive to socio-economic and mental health needs. Local expertise drawn from affected communities and those with direct access to them is needed to continuously enrich analysis carried out at the national and global levels. Ensuring rapid and unimpeded humanitarian access to vulnerable populations is also fundamental to avoiding gaps and blind spots in the response, particularly in places affected by armed conflict and other violence, where so many people are "off-grid" and hard for authorities to reach.
- 2. Prioritize community engagement and trust-building before, during and after a crisis.** The kaleidoscope of experiences presented in microcosm in this report would have been difficult to grasp without directly engaging with people affected by conflict. Community engagement is key not just to understanding vulnerabilities and coping capacities in all their complexity but also to ensuring trust during a crisis and preventing misinformation, rumours and violence against first responders. Community engagement cannot happen overnight, especially in conflict-affected areas, where relationships have been shaped by previous interactions and power dynamics between communities and weapon bearers, authorities, service providers and aid organizations. A sustained commitment by all stakeholders to community engagement and trust-building is what reaps rewards when a crisis hits.
- 3. Strengthen health, water and sanitation services, and protect them at all times.** Some of the stories in this report illustrate how the already poor state of health and water services in some places may have accelerated the trajectory of the COVID-19 pandemic, but they also show how previous efforts to rehabilitate essential health, water and sanitation infrastructure and to build local service-delivery capacities pay dividends in a major emergency. Ensuring that these essential services remain afloat in areas affected by protracted conflict involves short- and long-term interventions and a combination of humanitarian and development expertise. This can reduce the so-called "conflict debt" that these areas accumulate and help prepare for and respond to future crises. But strengthening essential services in conflict-affected areas is not only a technical matter – it is a political and legal one too. It requires parties to conflicts and all those with influence over them to ensure that civilian infrastructure and those providing essential services are protected from attack at all times, in line with their responsibilities under international humanitarian law.
- 4. Turn inclusive practices adopted during the pandemic into longer-lasting policies to address individual and systemic drivers of vulnerability.** In response to the pandemic, various governments have put in place or expanded more-inclusive policies and innovative practices regarding asylum seekers, refugees, other migrants and the internally displaced as well as other people in need, for instance through expanded access to social safety nets and social protection systems. The increased use of non-custodial measures to decongest prisons and the use of technology to facilitate contact with family and the outside world serve as just two of many examples of progressive measures that were taken because of COVID-19 but address broader, systemic challenges as well. The ICRC encourages all stakeholders to translate the inclusive and innovative approaches taken ad hoc during the pandemic into longer-lasting policies to strengthen vulnerable groups' resilience to health risks and social and economic hardship beyond this pandemic.

5. **Act locally, but think globally.** The personal stories recounted in this report illustrate how closely interconnected the concerns and experiences are of communities in different parts of the world. Risks and vulnerabilities as well as coping strategies in a given country are shaped by transnational and global economic, commercial, financial and political interdependencies, and this needs to be factored into any response. Nowhere is this issue clearer than around the ongoing roll-out of COVID-19 vaccines. This report advocates for working collectively towards equitable access to COVID-19 vaccines, not only to live up to ethical imperatives and to have a chance of overcoming the pandemic, but also to prevent further entrenchment of the systemic weaknesses that this crisis has laid bare around the world.

INTRODUCTION

Since its initial outbreak in China in December 2019, the COVID-19 pandemic has wreaked havoc around much of the world. This includes some of the most fragile countries beset by armed conflict, natural disasters, weak governance, poverty, and a lack of health care and other essential services. In war-torn communities where people were already struggling to keep their families safe from harm and secure the shelter, food, clean water and access to basic services that they need to live in dignity, COVID-19 has thrown up another formidable set of obstacles. Not only has the virus taken a severe toll on people's physical and mental health, but there are also the knock-on effects of government responses to contain it: The wide range of measures adopted to slow the pandemic, including movement restrictions, lockdowns and temporary closures of businesses and market activity, have undoubtedly saved lives, but they have come at a massive economic and social cost.

The pandemic has hit those living in conflict-affected countries particularly hard. This includes people fleeing violence who have sought temporary shelter in camps and in urban areas; people living in contested areas faced with old and new front lines; families separated by conflict and struggling to reunite; communities whose livelihoods have been destroyed by fighting; people held in prisons and detention centres, often in cramped conditions where maintaining physical distance is impossible; and families already bereaved by conflict who have had to endure further loss from this new disease. People who are already suffering from the roughly 100 armed conflicts that currently blight the world must now bear the double burden of war and COVID-19.¹

By January 2021, more than two million people had died of coronavirus disease.² A survey by the ICRC in 24 conflict-affected countries revealed that some 80% of the people we work for have seen their lives take a turn for the worse in recent months because of COVID-19.³ The World Bank projects that, owing to the pandemic, between 110 and 150 million people worldwide may be pushed into extreme poverty,⁴ and in mid-2020 it was predicted that the economic ramifications of COVID-19 would cause up to 132 million additional people to become undernourished by the end of the year.⁵ The equivalent of 255 million full-time jobs were lost worldwide, four times more than during the global financial crisis in 2009.⁶ More than 1.5 billion children dropped out of school because of restrictions linked to COVID-19, and many of them, in particular girls, may not return once the pandemic is over.⁷ Domestic, sexual and gender-based violence has surged worldwide amidst lockdowns, mass layoffs and a growing mental health crisis triggered by the pandemic.⁸

Behind these cold statistics, there are stories of immeasurable hardship, of lives altered in profound ways by the virus, of the silent suffering of men, women and children who battle every day with adversity and who are facing this new challenge with courage and resilience. This report presents eight such stories from people ICRC delegates met in 2020, in the course of our humanitarian work in Iraq, the Philippines, Nigeria, Yemen, the Central African Republic, Colombia, Greece and Azerbaijan, and lays out some of what we learned from listening to them.

Each of these narratives is at once both intensely personal and universal – eight individual experiences that embody what the combination of COVID-19 and armed conflict has meant for countless other people living amid or fleeing from violence. In each of the following chapters, after hearing from Jassim, Joaquin, Falmata, Abobakr, Augustin, Luisa, Jawed or Sara as they recount how the pandemic has affected them and their family over the course of last year, the report pivots to the more general issues that their story illustrates. As such, we hope to focus in on the challenges, but also the opportunities, that this crisis presents, both in the broad view and through the eyes of those on the sharpest end of the pandemic.

Iraq. Members of the Yazidi community flee violence
near Mount Sinjar, August 2014.



Rodi Said/REUTERS

1. IRAQ: REBUILDING A LIFE FROM RUINS

A Yazidi family's plight in Sinjar reflects the interplay between COVID-19 and displacement, the effect of the pandemic on livelihoods and camps for displaced people, the power of cash-based aid to mitigate the impact of COVID-19 and why increasing access to social safety nets makes for good policy during a pandemic.

"I'm mostly concerned about my children. I want them to have the kind of experience I had when I was young, go to school, get a decent education. We no longer have a school here. The nearest one still standing is in Sinjar town – too far, and the school is overcrowded. So much has been destroyed here: houses, roads, our orchards. They even rigged the wells with explosives and blew them up before departing, leaving us without clean water. Look at my house, look at what they did to it." Jassim pointed over his shoulder to the one-storey building behind him. "Half of it is gone and the other half needs repair. It will take me years to get it back to how it was before."

Jassim's house sits on the edge of Ain Ramoush, a hamlet on the southern flank of Mount Sinjar and a bumpy 20-kilometre trip down a dirt road from the town of Sinjar itself. A walk of five minutes separates it from the mukhtar's compound, where earlier that morning an ICRC team had held a meeting with residents to discuss the return of 18 families over previous weeks. There were now 26 families in all, half of the number who lived here in 2014 before they were forced to abandon their homes and flee north towards the mountains as fighters of the Islamic State group drew closer. In the tragic weeks that followed, thousands of Jassim's fellow Yazidis were killed, and Yazidi women and children were sold into servitude or sexual slavery.⁹ The unspeakable violence that the community has had to endure has left scars that are plain to see wherever one looks: in the ruined buildings, in the haunted look in the eyes of recent returnees, in the questions people ask about relatives who have been missing ever since.

Jassim had joined a movement of Yazidis returning to their homes from northern Iraq that started in the summer of 2020. He was born in Ain Ramoush; the village and its surroundings were all he had ever known. When asked why he had decided to return after spending six years in camps for internally displaced people (IDPs) together with his wife and

his three children, he said matter-of-factly, as if stating the obvious, "This is our village. We have to come back."

It started raining again. Jassim got up from his chair and beckoned his visitors to follow him into what remained of his home, a single room with walls made of mud and a flat roof. There was a stove and some basic furniture next to belongings brought back from the camp, some of it still packed in suitcases and boxes. Jassim pointed to a spot in the middle of the room and invited the visitors to sit down on the carpeted floor while his wife busied herself preparing tea. As he resumed the conversation, he pulled out a stack of photographs, including one of a young girl.

"This is Hanan, our youngest. We lost her when we ran towards the mountain. The whole village moved at once, and there was a lot of confusion, people everywhere. As we moved with others, suddenly, she was gone. We kept looking for her, but we couldn't stop or turn back or else we would have all been killed. Ever since, we've been asking everyone we meet whether they've seen her somewhere. Some have told us she's in Syria, others say that she died. We keep hoping that she is alive and will return to us. She's always in our thoughts – her disappearance has broken our hearts."

On Mount Sinjar, Jassim's family and their neighbours – along with thousands of Yazidis as well as some Christians, Shia Turkmen and Shabaks – were trapped without supplies and besieged from all sides for three months until finally they managed to escape north to safety. In December 2014, they were able to move to Sumel district in Dohuk and settle into their new existence as displaced people.

In the following years, Jassim lived off casual labour on farms near the camp, planting and harvesting crops. Sometimes he managed to get a short-term contract as a truck driver, work that was less back-breaking and better paid. Jassim did not mind either way. He had

worked in agriculture for as long as he could remember, and before leaving his village he had been tending the farm inherited from his parents. What he managed to earn supplemented what the government and non-governmental organizations (NGOs) running the camp were able to provide, which included basic shelter, monthly food rations, free medical care and schooling for his children. Farm work was seasonal, and there were stretches each year when finding work became more difficult. Yet never had times been as hard as those starting in March last year, after the first COVID-19 cases were identified in Iraq.

“There were simply no more jobs – none at all. From March to early May, we weren’t allowed to leave the camp anymore. And once the ban was lifted, the locals were no longer looking for farmhands. Farmers had received exemptions from the government – they were able to continue working the fields. But because of the restrictions no one came to buy. The trucks that usually come from far away, buy up the harvest

and then transport it to the big towns had all disappeared. Everything just stopped.”

Beyond Iraq, early data from surveys undertaken by the World Bank in 2020 show the drastic impact that the pandemic and related government measures have had on the income and employment situation of the world’s most vulnerable people.¹⁰ Surveys among people displaced within their countries and across borders have shown that loss of income forced many to spend their last savings, sell property, take on more debt or reduce spending, including in some instances by going hungry.¹¹

To measure pandemic-related vulnerability, 34,000 beneficiaries of ICRC projects in 24 key countries were interviewed in recent months. Of them, 79% reported that their livelihoods had been negatively affected by COVID-19 through job loss or reduced income. Only 7% reported that they had enough savings to absorb the initial shock and keep afloat for more than a month were they to lose their

“Because of the restrictions no one came to buy. The trucks that usually come from far away, buy up the harvest and then transport it to the big towns had all disappeared. Everything just stopped.”

income. The same data showed that day labourers like Jassim were at particular risk of losing their earnings owing to the economic fallout of COVID-19: 72% of those relying almost entirely on casual labour to pay their bills reported having lost such earnings since the pandemic began. In many cases, they were the breadwinners of already vulnerable households. A lack of government policies for supporting the informal labour market had forced many of the day labourers interviewed to choose between either putting their health at risk or else losing their income and subsequently resorting to harmful strategies to make up for the shortfall, such as selling off essential household assets or taking on unsustainable debt.¹²

Informed by these results, the ICRC recommended adjusting transfer values in its programmes using cash assistance, modified targeting criteria and expanded existing safety-net programmes to include the hardest-hit

households. Cash assistance proved particularly suited to the challenges created by COVID-19 as government restrictions have complicated the movement of in-kind assistance from central warehouses to the communities that need them. Globally, the ICRC provided cash grants for covering essential needs to about a quarter of a million households over the course of 2020 and more to small businesses to tide them over in the short-term. In all, ICRC teams transferred some 70 million US dollars in the form of small grants to more than 1.4 million people affected by conflict to help cover their essential needs and sustain their livelihoods – a significant amount and at the same time barely a drop in the ocean of what is needed given the lingering effects of war and the economic downturn linked to COVID-19.¹³

All this did not come as a surprise – many observers had warned in spring 2020 that governments in fragile countries would be



Mosul, Iraq.
Small-business owners in the Old Town register to receive cash grants, November 2020.

presented with an impossible choice of either forgoing heavy-handed containment measures and risking the virus running rampant, or enforcing strict measures to reduce the virus's spread and risking pushing those already struggling to make ends meet into greater misery. This has been particularly true in conflict-affected countries that suffer from underlying poverty and food insecurity, where people rely on casual labour, emergency coping strategies and humanitarian aid to survive.¹⁴

The effort by humanitarians and governments to square this circle has drawn renewed attention to the links between humanitarian action and social protection systems. Social protection instruments – such as cash transfers, food distributions, fee waivers for basic services, pensions or health insurance – have been central to both government and non-government responses to COVID-19. In a similar vein, humanitarians and governments have worked to sustain the businesses of farmers and livestock owners through cash transfers, better storage of produce and support to market chains, which has proven key to ensuring they come out the other end of a sudden economic downturn with their livelihoods intact. Going forward, the goal must be to better connect such small-scale community safety nets with broader government-run social protection systems. Providing access to social protection

systems big and small has proven an effective way of responding to the pandemic. Expanding access to these benefits to further vulnerable populations would be a promising way to bolster societies' and economies' resilience to future shocks.¹⁵

With rain falling softly on the roof, Jassim continued his story: "Once the government imposed the restrictions, the food parcels we got in the camp became less frequent. Previously, we had been given cash payments through local money transfer agents so we could purchase essential items, which was useful because you have more flexibility than if they give you goods, but then there were problems with this, too. We were told the banks had closed. Then there were issues with the power supply. The problems would not stop. We discussed it with our neighbours, and at some point, we decided that it was better to leave and return home with our families. If you have to live with nothing either way, it's easier to do so when you're home." Thousands of Yazidis living at the time in camps for internally displaced people in northern Iraq pondered their options in light of the new situation. Like Jassim, by June 2020 many had made up their minds that it was time to move.¹⁶

In fairness, local and central authorities together with the humanitarian sector in Iraq

Dohuk, Iraq. Yazidi women carry containers of water in the Bajed Kadal camp for displaced people, August 2014.



had worked hard throughout spring 2020 to maintain service delivery to internally displaced people in camps in the face of massive constraints created by lockdowns, business closures and restrictions on moving goods and staff across provincial boundaries. As Jassim had been told, banks had indeed closed for a time and subsequently curbed transactions in hard currency, affecting purchases of goods, cash transfers and salary payments for staff. Disruption to traditional supply chains forced many organizations to rely on goods available domestically or stored in their warehouses for longer than planned, while humanitarian logistics specialists trying to bring in more were faced with a dog-eat-dog competition for air cargo space created by the global run on masks and other protective gear from China. Some camps did see a temporary reduction in some services and delays in the distribution of relief items, but overall, conditions in camps in Iraq remained adequate even during the height of the pandemic. Simultaneously, services and

distributions came online specifically to address vulnerabilities created by COVID-19, including an additional cash grant of 200 US dollars for each family to purchase personal and household hygiene items.¹⁷ Despite this, the flow of displaced Yazidis moving south was not stemmed over the coming months. By the end of November, over a period of only six months, nearly 8,000 households had packed up their belongings, put them on trucks and moved back home, including places south of Mount Sinjar, which had been the theatre of some of the most brutal massacres prior to 2016 and had seen few returns up to that point.¹⁸

People's motivations for returning home were varied and included both factors driving them from the camps and factors drawing them home – known as “push” and “pull” factors. Most of the time, COVID-19 was not the sole trigger. At most, the economic downturn and fewer jobs owing to pandemic-related restrictions may have tipped the balance in favour

For the more than 50 million people who were internally displaced when the pandemic began, COVID-19 added yet another problem to be factored into decisions on whether, and where, to move in the wake of conflict or disaster.

of returning home – a bit like the proverbial straw that broke the camel's back. Another key consideration was pandemic-related movement restrictions that kept displaced Yazidis from commuting from the Kurdish north to areas around Sinjar for work, putting before them the difficult choice of forfeiting either their salary or the chance to continue seeing their families. On the “pull” side, there were the promise of improved security in Sinjar owing to recent political developments, cash grants from government and international organizations meant to incentivize returns, the impending start of the growing season and the hope of a more normal life outside of the camp setting.

Beyond Iraq, there is emerging evidence that the virus may have influenced displacement patterns in the Middle East, the Sahel and South America.¹⁹ For the more than 50 million people who were internally displaced when

the pandemic began, COVID-19 added yet another problem to be factored into decisions on whether, and where, to move in the wake of conflict or disaster.²⁰ Similarly, humanitarian organizations responding to displacement were faced with an additional challenge: providing displaced people inside and outside camps with shelter and essential services while maintaining physical distancing measures in settings which are often overcrowded and where the risk of contagion is high. As a result, what normally constituted an efficient and safe response now posed a potential health risk in the absence of precautions to prevent further spread of the disease. A large body of guidance and new operational practices bear testimony to humanitarian organizations' efforts to continue serving people like Jassim who were displaced or had returned home over the course of 2020 while keeping them, and the organizations' staff, safe from infection.²¹

“Recently, we cleared my land of mines and ammunition,” Jassim said. “We had some help from the army, and some of it we did ourselves with the help of our neighbours. There are tunnels between houses, which were dug as defensive positions – we still need to check if there are mines or booby traps there. In the meantime, if I manage to get some money, I’ll start working the land again, so I can pay for the repair of my house. I still have a few fig trees, and I know how to grow vegetables, tobacco, barley, wheat – like my father taught me. For the school and the water supply, we’re hoping for help from outside. They destroyed in a few days what took our parents years to build. Without help, it will take us even longer.”

Over recent weeks, the ICRC had given cash grants to returnees in 18 villages nearby Jassim’s home to help them settle in, and that day’s visit was meant to discuss with him and his neighbours whether it was the right time to include them in the next round of distributions. Eligible families would receive up to three payments spaced over several months of just under half a million Iraqi dinars each, in total the equivalent of a bit over 1,000 US dollars. Another organization had been supporting

them with food parcels, and a local charity had promised to donate water reservoirs to each household. There were plans to rebuild the school. For Jassim and his neighbours, after years of displacement a return to a steadier, more settled existence seemed achievable.

“We just want to live, you know. We’re not asking for much. A simple life, just enough to provide for our families. For now, I still rely on others to give me work. Sometimes I manage to secure a job, and there are days when there are none. Once this thing with the virus is over, I hope everything will go back to normal. God willing, I’ll be able to restart my own farm soon. I want life to be again as it was before we left – quiet, stable, giving me an opportunity to earn enough money to live in dignity. Not just for me, but for the sake of the children.”

He glanced at the corner of the room where his three children had been waiting patiently for the conversation to end. There was a moment of silence, followed by farewells and a promise to meet again. As the visitors stepped outside, the rain had stopped, and the sun was breaking through.

Sinjar, Iraq. A man stands in the ruins of his house, February 2019.



Manila City Jail, Philippines. Maintaining physical distance as a preventive measure against COVID-19 is a major challenge in detention, March 2020.



2. PHILIPPINES: WHEN YOU ARE DETAINED, FAMILY IS EVERYTHING

A story on life behind bars in the Philippines demonstrates how the pandemic affects detention conditions, family life, the pace of the judicial process and prison reform, and why it proves the truth of the old adage that prison health is public health.

Joaquin's speech had clearly improved, but now he had trouble hearing. Standing upright was a challenge, and so was keeping his balance when walking. His body was leaning to one side, and his limp right arm had thinned further from muscle wasting. When he tried to remember things from the past, his mind kept playing tricks on him. At night, he had trouble sleeping. Head injuries do strange things to people. The damage done by an explosion or a bullet ripping through the brain can affect a wide range of physical, sensory, cognitive and psychological skills, temporarily or forever. Joaquin was no exception.

The good news was that Joaquin's wounds were healing well. What remained were a few metal plates and screws in his left arm that the surgeon had placed there to hold his broken bones in place. One more trip to the hospital to remove these, and he would be in the clear. He had survived against the odds. That night in early summer when his armed opposition group had clashed with the Philippine Army, survival had seemed anything but certain.

"Show me the inside of the arm – can you zoom in on the scar tissue there – Joaquin, can you bend your elbow for me, please?" The surgeon's instructions in Tagalog came at a brisk pace. Over the speakers, his voice was tinny as he instructed the ICRC health officer to move the computer tablet's camera so that he could examine the patient's injuries on his screen. From his office at a hospital in the provincial capital, he saw that his patient, who was detained in a police station nearly 200 kilometres away, was making slow but steady progress.

Joaquin had been transferred to the station six months earlier, after being wounded in a remote area during a firefight with government forces. His injuries were such that without surgery there was little chance that he would make it. A medical evacuation to a government hospital meant certain arrest and detention,²² but there was not much of a choice. A couple of days after the incident, the people looking

after him informed the local ICRC office that one of their comrades needed urgent care. After coordinating with the authorities, an ICRC convoy picked him up in a secure location and transferred him to the nearest hospital that had the capacity to deal with his complex wounds and fractures. Then, while doctors continued to battle to save his life, the police took formal custody of him on charges related to the on-going armed conflict.

As Joaquin showed his scars to the doctor over the internet, his mother was watching the scene from the far end of the cell. For the last few months she had set up camp in the hallway of the police station, on a bench just opposite the cell. The station chief had allowed her to stay there to look after her son during the healing process since his hemiplegia – the weakness in his right side – required the presence of a caretaker to help him eat, do his laundry, dress his wounds and take care of other daily chores. The station had a small kitchen where she occasionally prepared fish and other food for her son and his cellmates to supplement the rations provided by the police station. For the first three months after Joaquin's arrest, she had lived off an ICRC stipend to pay for meals, transport and prescription drugs, but more recently she had taken to doing laundry for some of the station's staff to add to her income. She needed the money, she said.

The fact that Joaquin had remained in police custody since his arrest, rather than being transferred to a jail to await trial after a few days, was one of the many complex consequences that the COVID-19 pandemic has had for detainees in the Philippines. To prevent the spread of disease, the federal government was forced early on in the pandemic to suspend all commitment orders to transfer newly arrested people from police stations to jails. In parallel, in-person court appearances were stopped. New rules were introduced making future transfers contingent on a negative COVID-19 test before departure and a two- to three-week quarantine upon arrival at the new place of detention. In some locations, detainees up for



Calamba City Jail, Philippines. A visitor holds hands with an inmate at the infirmary, March 2020.

J. Aznar/IGRC

release needed to test negative for COVID-19 to be allowed to go home. Despite the authorities' best efforts to keep things running in the face of the challenges brought on by the virus, the complexity of these new rules and the limited availability of tests and quarantine space led initially to widespread gridlock across the judicial and penitentiary systems. For many detainees, this meant that they found themselves stuck wherever they had happened to be at the beginning of the year, with no clear outlook on how long they would have to stay. Joaquin, too, did not know if and when he would be transferred to one of the jails that customarily held detainees waiting for trial.

"I'm so tired," his mother sighed. "I worry about my son and his health, and at the same time I worry about my husband, who's now alone on our family farm. The authorities consider him a senior citizen, and as such he's not supposed to leave home under current rules because of the virus. He can still work the fields, but he had to stop going to market to sell the produce. For the next harvest season, I need to go back and help him, but who will look after my son while I'm gone? No one can tell me how much longer Joaquin will stay here. I've only been home three times in the last six months – I can't continue like this forever."

Despite her predicament, Joaquin's mother knew she was fortunate. Elsewhere in the Philippines, family visits to detainees had been

suspended in parallel with detainee transfers as a precaution against spreading COVID-19. Nationwide, jails for detainees on remand and prisons holding convicts had gone under lockdown – locking in detainees and staff and locking out those with loved ones inside. Anyone who has ever worked or done time in a prison will confirm that there are very few things more important to a detainee's well-being than regularly seeing family or close friends. In the Philippines as in other places, families provide detainees not only emotional comfort and a conduit for meaningful contact with the outside world but also food and other essential items that help keep up their health and spirits. Cut off from their families, detainees quickly lose morale, with gloom and anger taking its place. Mental health issues or unrest often follow. In 2020, Italy and Brazil, among others, saw prison riots that had been caused, at least in part, by the temporary suspension of family visits.²³

In addition, the global lockdown of prisons has kept hundreds of thousands of people detained around the world in conditions that are significantly harsher than what they should be. Partial or complete bans on movement within facilities have meant that prisons with single-cell-based infrastructure are obliged to keep detainees confined to their cells, enforcing a form of solitary confinement that has a notoriously pernicious impact on mental health. Elsewhere, detainees have been left without

access to communal areas, workshops or the leisure activities that usually structure a prison’s daily routine. The frequency and duration of access to recreation yards for exercise and sports have been reduced in many places, as have collective worship, religious study and educational activities. Key services that rely on providers coming from outside the prison walls have been cut on health grounds, including psychosocial support as well as rehabilitation programmes and other efforts to prepare detainees for release and reintegration into the community.²⁴

The cumulative damage of these measures to the health and well-being of the global prison population is difficult to overstate. Yet these measures were also mostly inevitable from a public health point of view. Prisons are often overcrowded, and the cramped conditions together with insufficient hygiene provide fertile ground for contagious disease. Once COVID-19 reached communities outside the prison walls, outbreaks inside prisons were all but guaranteed unless the movements of staff, detainees and visitors were tightly controlled. Prison health is public health and vice versa,

“Jails for detainees on remand and prisons holding convicts had gone under lockdown – locking in detainees and staff and locking out those with loved ones inside.”

they say. The coronavirus pandemic has only confirmed the fundamental truth of this old adage.²⁵

In the Philippines, where the ICRC has been supporting detainees for three decades, efforts to help jail and prison authorities develop a comprehensive approach to COVID-19 prevention and control began in early 2020. The ICRC

carried out multidisciplinary assessments in a range of places of detention to identify gaps in preparedness and help develop protocols in line with World Health Organization guidance to better tackle the multiple challenges posed by the virus. The protocols were then shared directly with guards and health staff working on the front line of the pandemic in detention facilities, and later with trainers from the



Quezon City Jail, Philippines. ICRC staff and guards practice preventive measures at a COVID-19 isolation centre, April 2020.

detaining authorities who in turn promoted good practices in other facilities. Information on how to protect oneself against COVID-19 behind bars, how to identify symptoms and when to seek care was shared with detainees through posters and leaflets or, in larger facilities, via recorded messages played over public address systems. Where required, the ICRC helped jails and prisons get personal protective equipment, including masks, gloves and gowns, and other critical items such as hygiene materials until their regular suppliers were able to catch up. Eight medical isolation facilities were set up on jail and prison grounds by the ICRC in cooperation with the penitentiary authorities, providing extra capacity to treat patients with mild and moderate symptoms. The Philippine Red Cross and ICRC joined forces to establish a ninth isolation facility.²⁶

Despite this, by early April the virus had found its way into a place of detention in Manila, and other facilities would follow. The first detainee deaths came shortly thereafter. Considering that the occupancy rate of Filipino jails habitually hovers around 500% of stated capacity, it was clear that staving off disaster would require an extraordinary effort by guards, medical staff and other frontline workers over coming months to try to prevent further spread of the disease.

Even though things could conceivably have turned out worse, COVID-19 took a terrible toll worldwide among people deprived of their liberty. By the end of 2020, more than 300,000 detainees had been infected, and at least 2,737 had died, according to available figures. Given limited testing capacity and the fact

The COVID-19 pandemic has revealed the cracks in the system, but it also created a space in which detaining authorities have come up with innovative ways to address related challenges.

that many countries underreport or choose not to release such figures, the true number is likely far higher.²⁷ By the end of 2020, an astonishing 1,738 detainees had died in the United States alone.²⁸ Correctional officers, categorized as essential workers in most countries and duty-bound to continue in their jobs regardless of the risks, were also heavily affected, with infections and death rates among officers rising alongside those of the prisoners in their charge.²⁹

While the havoc wreaked by the pandemic over past months on prisons and detention centres across the globe was certainly outside the norm, it brought to the fore issues that have beset criminal justice systems worldwide to differing degrees for years: an over-reliance on incarceration to combat crime; overloaded courts and slow judicial processes; detention facilities lacking the required capacity for the number of detainees they hold; an aging prison infrastructure and governments' chronic underinvestment in its upkeep; overcrowding and unsatisfactory sanitary conditions that help propagate contagious disease; a lack of trained correctional staff and anaemic services for detainees, particularly around health care;

and in some countries a lack of coordination between the ministries and other government bodies in charge of various components of the system, impeding its smooth functioning overall.

The COVID-19 pandemic has revealed the cracks in the system. On the other hand, it created a space in which many detaining authorities have come up with effective and innovative ways to address related challenges. The pandemic is thus an opportunity for governments to build on some of the lessons learned and good practices developed over past months and to continue investing in their judicial and penitentiary systems to prepare for future emergencies – in particular, by focusing on areas where the usual responses to known systemic problems were not robust enough to withstand the current crisis.

In the Philippines, for instance, opportunities for remote family visitation through Skype were put in place in many facilities, an initiative the ICRC supported by donating computer tablets. New hygiene protocols were developed that enabled the resumption of the so-called

pa-abot system, whereby families deliver medication and other essential items to their detained relatives or deposit money in detainees' digital wallets so they can continue purchasing goods in prison shops. In-person court appearances were replaced by e-hearings, during which prosecutors and judges meet online with defendants and their lawyers to move cases forward. According to government figures, some 80,000 detainees were released between March and October, more than half as a result of e-hearings.³⁰

Elsewhere than the Philippines, prison authorities also released detainees en masse to reduce overcrowding and put themselves in a better position to combat expected outbreaks. Starting in spring 2020, authorities across the Americas, the Middle East, Europe and Asia combed through their caseloads to identify vulnerable individuals and categories of detainees who could be safely released – either on parole or through pardons or because they were being held in pretrial detention or on minor offences. In places such as Iran, Turkey, India and Indonesia, oversized prison populations were reduced by several tens of thousands of inmates. In other countries, including much of Europe, the numbers were less impressive but still notable when measured against smaller populations.³¹ Simultaneously, authorities needed to ensure that detainees were let go under conditions that would keep them safe and enable them to reintegrate into society, a significant challenge given how rapidly the pace of releases accelerated in some places.

The pressure created by the pandemic also sharpened focus on old problems and related agendas for prison reform, including support for greater use of non-custodial alternatives to incarceration. And there is renewed appreciation of the value of contingency planning and practical exercises to prepare for emergencies. Finally, in a few noteworthy instances, authorities opened up previously closed facilities to the ICRC or other organizations and provided access to new categories of detainees for assistance with infection prevention and control – progress towards greater transparency. Fragile and reversible, yes, but progress nonetheless. In the midst of every crisis lies opportunity, as the saying goes. One can hope that some of these positive side effects of the pandemic will outlast what was otherwise a cataclysmic event for detainees and detention systems worldwide.

As for Joaquin, he hoped to be released on bail owing to COVID-19 and wait for his trial at his parents' home. Given the charges against him, the odds were not high. Still, he and his mother hoped that his fragile health would weigh in his favour since it put him at high risk for severe COVID-19 in case of an infection.

Unlike most other detainees, for Joaquin the coronavirus pandemic has had its advantages. Being stuck in a police station since his arrest meant that he was able to benefit from an environment that was more conducive to his physical recovery than the crowded conditions in a jail would have been. In addition, he had been lucky to find himself in the hands of pragmatically minded police officers who allowed his mother to remain at his side and look after his needs. He shared his cell with only three other detainees, and no one new had arrived in months, minimizing the risk of infection with COVID-19. In normal times, detainees should, for their own good, not remain in police stations longer than necessary since police stations do not have the mandate, the infrastructure, the personnel or the budget to accommodate people for prolonged periods of time. Joaquin's case was unusual in this sense. Because of his handicap, short of a conditional release staying at this station was as good as it could get.

At the same time, Joaquin was painfully aware of the burden that his prolonged detention in a police station had put on his family. When he overheard his mother saying that she did not know how to continue caring for him when she also needed to help her elderly husband with the harvest, he murmured, almost inaudibly, "Please come back for me." Watching Joaquin drag himself across the room after the end of his medical examination, the guilt weighing down his battered limbs and mind was palpable. Arriving at the far end of the cell, he turned around and collapsed on his bunk bed. He took another glance at the visitors and then added wearily, as if wanting to push back against anyone finding him selfish, "You have to understand: If you're in my situation, your family is all you've got."



Borno state, Nigeria. A woman sifts maize in a camp where people have sought refuge from fighting, September 2019.

3. NIGERIA: FALMATA'S WISH

Through a traditional birth attendant concerned about the health of her community in Borno state, we learn about managing water and resources, the nexus between humanitarian work and development, and the relation between international humanitarian law and pandemic preparedness.

“The announcements made via megaphones, they’re the most effective,” Falmata said as she readjusted her hijab and the flowing red fabric that covered her body from head to toe, revealing only her face and the tribal markings on her forehead and her cheeks that are typical for the Kanuri people. She spoke softly but with confidence, using her hands for emphasis. “Radio messages are good, too, and then there are the gatherings with community mobilizers. It took a while for everyone to fully understand the threat to our communities. But then people accepted that they had to keep a distance between each other, wear masks and wash their hands frequently.

“Before Ramadan, people were terrified. When a man was seen coughing or sneezing, everyone worried that he had the virus. There was a lot of mistrust and suspicion. At the time there were no large ceremonies, and most people no longer went to the mosque to pray – they prayed at home instead. But the weeks passed, and there were no confirmed cases in Dikwa, and the fear wore off. Today, people are more relaxed. Some people respect the rules, others don’t. Some people deny that the virus poses a threat and say that we have more pressing problems: insecurity, no access to our farms, high prices, not enough food. The virus is not the only thing we have to worry about.”

Falmata looked at the other women sitting in a semicircle beside her. They nodded in agreement. There were twelve of them, all traditional birth attendants who had gathered here to discuss their communities’ attitudes and practices in dealing with the coronavirus. They had met previously, but there was a sense of nervousness in the room, as there often is at the beginning of such events.

The meeting was one of 18 focus group discussions organized in Dikwa in October and November by the ICRC and the Nigerian Red Cross Society to get a clearer idea of how the popular understanding of COVID-19 had evolved since a similar survey that June. Dikwa, a town in the north-east of Nigeria, had been mostly spared by the pandemic so far. At the time, the official figures for Borno state showed just over 800 confirmed cases for the entire province, with 36 people having succumbed to the disease since the beginning of the year, far below the numbers in Lagos, Abuja, Ibadan and Kaduna, the major population hubs further south where hundreds of people had perished.

Since early December, however, a second wave had been building. By the end of the year, confirmed case numbers countrywide began again exceeding 1,000 per day and kept rising.³² There was talk of new, more infectious strains of

“Insecurity, no access to our farms, high prices, not enough food. The virus is not the only thing we have to worry about.”

COVID-19 in the United Kingdom and Brazil, and another, more aggressive variant of the virus had recently been detected in southern parts of Africa. Many observers predicted that the second wave would be stronger and more sustained than the comparably mild one

Nigeria had seen the previous summer. And there was reason to believe that its ripple effects would soon reach the country’s north-east, which was among the regions least prepared to deal with it.



Borno state, Nigeria. Falmata in February 2021.

“Also, advice alone is not enough,” Falmata continued. “People can be told to wash their hands often, but they need water and soap to do so. I remember we once had piped water here in Dikwa, and the government ran a big generator so we all could get clean water in our neighbourhoods. But then the attacks happened, and much of this infrastructure was destroyed. Me for example, I live in the community, and I now must buy my water from a vendor. I need four jerrycans of 20 litres per day for me and my children, and each jerrycan costs me 20 naira. That’s a lot of money if you have to pay for it day in, day out. I manage because I have a job as a traditional birth attendant, but because of the situation others may find this difficult.”

The assault on Dikwa that Falmata referred to had its origins in 2009, when an armed insurgency erupted in neighbouring Maiduguri, the capital of Borno state. During subsequent fighting, hundreds of thousands of civilians were killed or displaced across north-eastern Nigeria. In March 2015, fighters overran several townships in Borno state, including Dikwa, whose entire population fled to Maiduguri. Government forces supported by the Chadian army subsequently retook Dikwa and have since maintained a security perimeter on the outskirts of the town. In 2019, this situation was formalized, in Dikwa and elsewhere, when a finite number of garrison towns with a reinforced military presence were established in northeast Nigeria – so-called “super camps”, where civilians were meant to congregate for their own safety.³³

Today, more than 100,000 people are packed into Dikwa’s urban centre and several overcrowded camps set up along the periphery, with displaced farmers and livestock herders making up three out of every four inhabitants. Unable to access their lands and deprived of their livelihoods, they are almost entirely dependent on humanitarian aid for survival. Resources are scarce, including access to safe water and sanitary facilities. Food prices have soared, and malnutrition is on the rise.³⁴ People are selling the soap they have received from humanitarian organizations because they have no other means to earn money. Cholera is a permanent threat. This ongoing humanitarian tragedy is what Falmata subtly alluded to when she spoke of “the situation” standing in the way of her community fully respecting precautions against COVID-19.

Falmata was among the stream of people who fled Dikwa in 2014 and 2015. She managed to get her children to safety but lost her husband, who was killed during the violence. “We had been married for thirty years. He had a job working at the department of education in Dikwa. We had a good life,” she said quietly during a visit to the ICRC offices in Maiduguri a few weeks later. She had travelled from Dikwa earlier that day together with a colleague from an ICRC-supported primary health-care centre who had come to town on other business and agreed to stay for lunch.

“You know, the place where we had the group discussion last month, that was originally the general hospital,” Falmata explained, while sipping a cup of tea. “Before we left Dikwa because of the fighting, we had this general hospital where people could go for care in addition to the primary health-care clinic. After we went back, both were gone. The hospital had been looted and vandalized, the clinic burned down – all the staff had fled. For a while there was no care anymore. Later, aid organizations began to provide medical services again. Today, there are again trained doctors and nurses to take care of patients. But if someone is very sick and the local clinic can’t help, there is no solution in Dikwa presently. Patients need to be transferred to Maiduguri, but to go there you need a military escort. Otherwise it’s not safe.” Falmata took another sip of her tea.

Falmata’s point about the inadequacy of health care in Dikwa was understandable. Over recent years, international and local aid organizations have set up a network of clinics delivering primary health care to camp dwellers and the greater community, but there is little in terms of specialized care and no surgical services.³⁵

Other government services also continue to lag behind population growth. Teachers and functional schools are lacking, with only a fraction of children in Dikwa currently enrolled in school. Those who are enrolled have access to primary education, but, except for a single lower secondary school, no opportunities for learning exist above the sixth grade.

To quench Dikwa’s thirst, some 200 boreholes, wells and taps have been repaired or newly built in town, and more continue to be added. Yet in a 2019 survey, three out of four households in camps and two out of five in the rest

of the community reported that they did not have enough water to meet their basic needs.³⁶ During the ICRC's survey late last year, participants in the focus group discussions said that, despite efforts to improve service delivery, the situation had not changed. Insecurity in rural areas and continuing displacement to Dikwa has led to extreme population pressure. At the same time, government authorities have not been able to expand the area where displaced people can settle since doing so would make it more difficult to protect the population against further attacks. Within the fortress that Dikwa has become, more and more boreholes are being drilled deeper and deeper into the ground to find enough water for the growing population – the latest one drilled by the ICRC reached a depth of 350 meters before it hit a viable aquifer carrying clean groundwater.

Corralling a growing number of people into a confined space without the infrastructure or the resources needed to sustain them over time can be a recipe for grave humanitarian concerns – in Gaza, Cox's Bazaar and Idlib just as in Dikwa and Maiduguri. Add climate change, environmental degradation and continued violence to the mix, and the crisis will only deepen. Round this out with a worldwide pandemic, and all the elements are in place for a full-blown humanitarian disaster.

Much of the destruction of the previous health and water supply facilities in and around Dikwa has to do with a lack of respect for international humanitarian law and for civilians, their property and the civilian infrastructure

that serves them. This trend is not new, nor is it limited to north-eastern Nigeria. The wars of the last decade – in Syria, Yemen, Libya and elsewhere – suggest that attacks against critical infrastructure have become an intentional tactic rather than simply incidental damage. Blown-out windows and walls riddled with bullet holes readily remind us of recent violence, but it is the destruction of the environment and essential infrastructure that has the most debilitating impact on the resumption of normal life – broken water and sewage pipes, damaged health clinics, ransacked schools, downed electrical lines, poisoned wells and – least visible but most destructive – the quiet departure of all those people who knew how to build, run and maintain those facilities.

International humanitarian law requires belligerents to take constant care in all military operations to spare civilians and civilian objects (for example, schools, homes and places of worship unless they are being used for a military purpose), including troop movements and manoeuvres carried out in preparation for combat, such as ground operations in urban areas.³⁷ Attacking, destroying, removing or rendering useless objects indispensable to the survival of the civilian population is prohibited under international humanitarian law.³⁸ Such objects include foodstuff, crops, livestock, irrigation works, and drinking water installations and supplies. In addition, parties to conflicts must take a range of precautions during attacks, and against the effects of such attacks, to protect these objects.³⁹

In Nigeria as elsewhere, the ability to respond to a sudden onset of a complex emergency such as COVID-19 hinges in large part on the resilience of the country's public service systems.

International humanitarian law also recognizes that such civilian infrastructure and resources are indispensable to people who must rebuild their lives in the wake of hostilities. It also contains a number of rules that can contribute to reducing the scale of displacement and strengthening the protection of those displaced. The same rules can also contribute to finding durable solutions to the plight of

displaced people, including by allowing and facilitating their eventual return home.⁴⁰

Attacks unlawfully directed at schools, water-works, health-care facilities, power grids or the natural environment, as well as indiscriminate or disproportionate attacks that cause harm to them, all inflict immediate suffering, but their most pernicious impact is long-term.



M. Abdulkamy/CRC

Borno state, Nigeria. Mothers attend an information session at Biu General Hospital on complementary feeding for malnourished children, November 2020.

Their deadly legacy has been called “slow violence” – devastating environmental and health after-effects that continue to haunt civilians long after the close of hostilities.⁴¹ Others speak of the “conflict debt” countries accumulate during each cycle of violence, which, even after conflict has ended, stymies economic recovery, increases the impact and cost of endemic disease, holds back the development of human capital and entrenches poverty and injustice in societies.⁴² Beyond the immediate emergencies, these long-term effects of war on people’s welfare and the protracted suffering they cause are what humanitarians and those who support them must worry about.

After a pause, Falmata picked up the conversation again: “For me and my work, nothing much has changed. Women still come to see me when they are pregnant, and I accompany them when they give birth as before. I ask them whether they have a cough or fever or any other signs of the virus, and if I’m not sure or if there are complications with the pregnancy, I refer them to the clinic. Months ago, when I first heard about the virus, I was very worried. I was afraid of what I would do if I got sick, if one of my children got sick. What gives me hope is the news that they found a vaccine. My wish is that we get this vaccine quickly here in Dikwa. In the meantime, we need to remain vigilant. If

the virus begins to spread in our community, I don’t know what will happen.”

To avoid the outcome that Falmata feared, since early 2020 Nigerian government agencies and NGOs with guidance from the Nigeria Centre for Disease Control have been promoting risk education and improved testing capacity and diagnostics. They have also scaled up the provision of clean water and sanitation services, set up quarantine facilities and prepared hospitals to take care of sick patients – building on what was already there to adjust to the new challenge. In Nigeria as elsewhere, the ability to respond to a sudden onset of a complex emergency such as COVID-19 hinges in large part on the resilience of the country’s public service systems – government agencies’ capacity to ensure service delivery, the strength and makeup of the country’s economy, the availability of a skilled workforce able to address and weather the emerging crisis.

In protracted conflict situations, systems are put under strain and progressively degraded. Water distribution, health care and waste management deteriorate under the combined pressure of wanton destruction and neglect.⁴³ Investment in future generations through education slows while governments focus on security. People leave, including the

skilled workers, public servants and entrepreneurs who are needed to tackle the crisis and eventually rebuild.⁴⁴ When another crisis hits, humanitarians can help ensure access to some essential services more easily than to others. Preserving public health during a pandemic is a particularly complex task, and, without pre-existing investment in strong systems, humanitarian aid, even if delivered at scale, will not be able to tackle the problem.⁴⁵

In Maiduguri, the ICRC thus combines traditional emergency interventions – such as promoting basic hygiene measures, distributing soap and personal protective equipment, repairing handpumps and trucking water – with long-term preventive investments in large-scale urban water supply systems in collaboration with the state’s ministry of water resources.⁴⁶ Among other projects, the ICRC has upgraded the local Alhamduri water treatment and distribution facility and considerably increased its production capacity to bring more water to Maiduguri, for the locals and the displaced alike. The ICRC has also set up an institutional capacity-building programme to enable the Borno state ministry to operate and maintain the infrastructure and provide more reliable service. Engaging in both short-term emergency interventions and longer-term investments in infrastructure is no contradiction – quite to the contrary. Building the resilience of essential service systems in places affected by protracted conflict and recurrent natural disasters can be achieved more easily if

humanitarian and development efforts go hand in hand, building on each other’s strengths and achievements. This is the often-cited “nexus” between short-term humanitarian assistance and long-term development goals that can improve the prospects of these communities for the long haul.⁴⁷

The ICRC has argued for some time that under the right circumstances partnerships between humanitarian organizations and development agencies, including multilateral financial institutions, have the potential to achieve better outcomes for people living in protracted conflicts and perpetual crisis. Combining expertise and different means of response capitalizes on the experience of each: Development agencies can make an impact in environments that are usually outside their comfort zone because of high levels of insecurity and political instability, and humanitarian organizations can draw on the technical expertise, long-term vision and financial firepower that development agencies bring to the table in order to enhance, expand and sustain their response.⁴⁸ There is still some way to go until such partnerships become second nature, but first steps are being made.⁴⁹ Doing so improves the lives of people living in conflict today, as Falmata and her group of traditional birth attendants have seen first-hand. Yet it is also about preparedness for future crises. COVID-19 is not the first pandemic the world has had to cope with. It is unlikely to be the last.⁵⁰

Maiduguri, Nigeria. Aerial view of the Alhamduri water plant, February 2019.





Sa'ada, Yemen. Children play football against a backdrop of destroyed houses, 2019.

4. YEMEN: THE HARDEST PART OF BEING A DOCTOR

A physician on the front lines in Yemen tells us about resilience in the face of death, the stigma attached to working with COVID-19 patients, violence against health care and the importance of trust between health-care providers and the communities they serve.

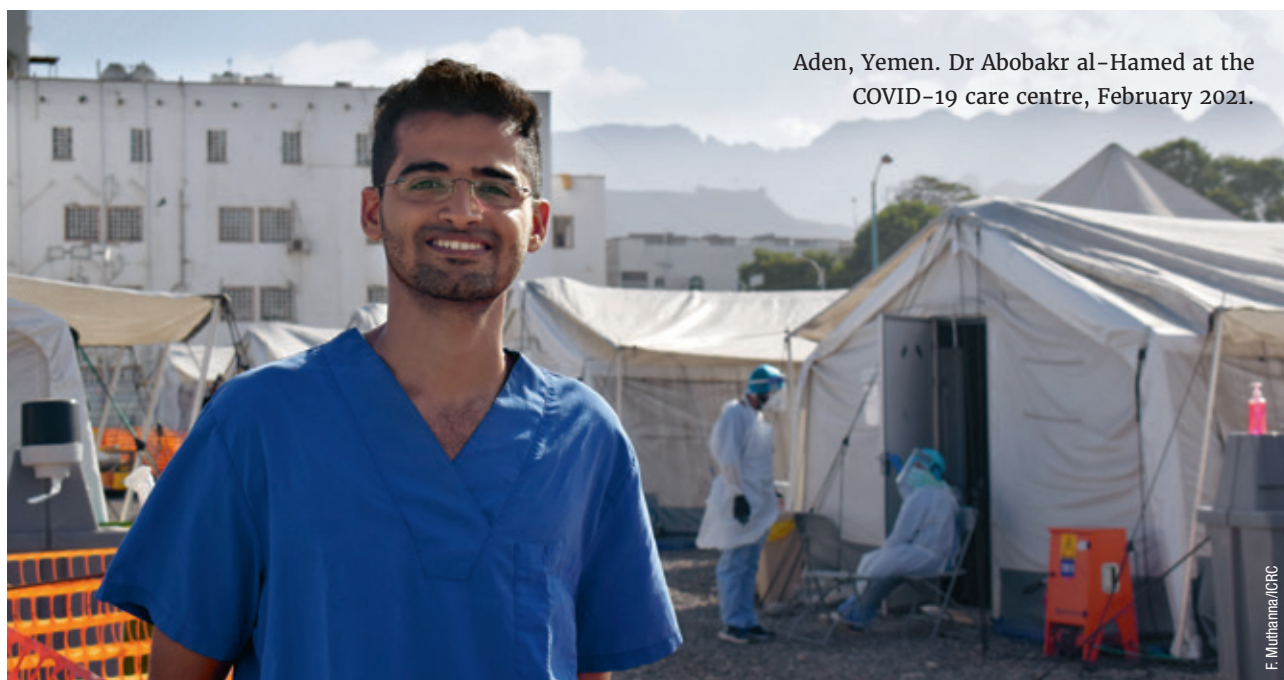
“You know, it’s tough sometimes. The hardest part is dealing with death. I see patients suffer and it makes me suffer, too, but as long as I believe I can help them, I feel all right. But when I have a desperate case, when I know there is nothing I can do, it’s hard to take. And then there is your own death as a possibility. I’m only 25 years old, but I saw a lot of people dying, and some of them were my age. It reminded me that I could catch the virus and die, too, despite all our protective equipment, despite the precautions we take. Many good doctors and nurses died because of this pandemic. And you worry about your family, the ones you love. Going back home, seeing my friends, knowing that they may get infected because of me – perhaps that was the hardest part of all. I volunteered to work with COVID-19 patients, but there were moments when the thought of quitting crossed my mind, particularly at the beginning. But I didn’t. I thought, if I can’t do anything to help people now, why did I become a doctor?”

At times Dr Abobakr hesitated as he recounted his experiences working on the front lines of the pandemic, during a break in his shift at the COVID-19 care centre in Aden. He was shading his eyes against the evening sun setting behind

the white tents of the 60-bed hospital, run jointly by the ICRC and the National Red Cross and Red Crescent Societies of Norway, Finland and Yemen. As he was weighing his words, one could sense that he still struggled with the answer to his rhetorical question.

One of the last countries in the world to announce its first case of COVID-19, Yemen did so on 10 April 2020, when a 60-year-old patient in the southern governorate of Hadhramaut was diagnosed with the disease. The arrival of the pandemic came at the worst possible time. Yemen’s health-care system had been broken by six years of unrelenting war. The fighting had destroyed much of the health infrastructure, disrupted medical supply chains and curbed the delivery of essential services. It had also led to an exodus of foreign medical staff, who had made up a significant proportion of the country’s health-care professionals prior to the war.

The destructive force of the conflict was also staggering beyond the health sector: Today, 80% of Yemenis are in need of humanitarian assistance. In addition to health care, those living in hard-hit areas lack much of what they need



Aden, Yemen. Dr Abobakr al-Hamed at the COVID-19 care centre, February 2021.

F. Muthanna/ICRC

to live in safety and dignity, let alone to withstand the additional impact of the pandemic: decent shelter, enough food to eat, clean drinking water, electricity or fuel – the very basics of survival. There was little testing capacity in Yemen at the outset of the pandemic, and the disruptions caused by the conflict made implementing complex public health measures, such as effective quarantine procedures or contact tracing, nearly impossible. By the end of July, the health authorities had recorded 1,726 confirmed cases and 487 deaths from COVID-19, one of the highest mortality rates in the world.⁵¹

“It shocked us all – people couldn’t believe what was happening,” Abobakr said of last spring. “In Aden, we have a hot climate, and we have many other infectious illnesses, such as malaria, dengue, cholera. COVID-19 added a massive challenge at a time when we had our hands full already. We were looking towards other countries with far more means, and we saw that they couldn’t manage to contain the virus, that people were dying in large numbers in Asia, in Europe. So, you can imagine how worried we were here in Yemen, which has a broken health system and a brutal war going on at the same time. It was all a bit overwhelming – as if living through war was not enough already.

“Throughout these months, we did what we could. In hospitals across the country, we fought hard, believe me. We had patients dying of COVID-19, and we had patients dying because they had to be turned away because intensive-care beds were filling up with COVID-19 patients.”

Many predicted the pernicious impact COVID-19 would have on the delivery of health care when the contours of the pandemic became apparent in early 2020. Public health experts and humanitarian organizations warned that the worldwide focus on fighting COVID-19 risked creating other public health challenges in fragile countries owing to the combined effect of overloaded health systems, reduced access to routine health care, suspended vaccination

campaigns for diseases such as measles, reluctance by patients with other health needs to seek timely care and an economic downturn that would make health care generally less affordable for the poor.

Such predictions were based on experiences with previous epidemics, such as Ebola. For instance, a meta-study covering research from Liberia, Guinea and Sierra Leone on the Ebola outbreaks of 2014 to 2016 found that outpatient consultations, inpatient care including deliveries, and malaria, HIV and tuberculosis services dropped by up to 28% in the hardest-hit areas, with an average decline of 18% across all surveyed health facilities.⁵² Maternal, sexual health and nutritional programmes were also heavily affected, leaving large numbers of women and children exposed.

Interestingly, studies showed that the decline was perhaps less caused by the supply side in the relationship between health-care providers and their patients – i.e. less availability of services – than by reduced demand for those services. Not only did available health care shrink following the onset of Ebola, but so did the use of health services by the population. Much of this was down to myths and misconceptions about the disease itself, how it spread, and how it could be cured.

Thinking back to summer 2020, Abobakr echoed these findings: “The other thing that worried me were the patients that we did not see. People got poorer because of the virus. The economy has suffered, inflation is high, and fewer people send money from abroad. Some decide not to get treated because they think they don’t have the money to pay for it. And then there is the fear of the virus, which at the beginning was so great, you cannot imagine. There were many rumours circulating at the time. There were those who believed that when you get COVID-19 and you go to hospital, it’s like a death sentence. That’s where the rumour of the lethal injections started. Essentially, the rumour held that when you have COVID-19 symptoms, doctors would inject you upon arrival with a deadly

“The stigma that comes with this job is one thing – I have got used to it. But being attacked for my work, this I cannot accept.”

Aden, Yemen. Health staff at the COVID-19 care centre check a patient's oxygen levels, November 2020.



B. al Saww/OIRC

substance so you would not have to suffer. This is how people explained to themselves why many people who were diagnosed with COVID-19 died shortly after admission. The real reason was that they often came to seek care much too late, in a very advanced stage of the disease, and even with extra oxygen, many patients didn't make it.

“Sometimes I sit with my friends, and we recall this hard period during the first wave. And they still tease me about the rumour. They say, ‘Oh doctor, please, please don't kill me, I don't want the *ibrat arrahmah* [“mercy drug”].’ I know they're joking, but it still affects me. Only two weeks ago, I had the family of a patient admitted to our centre tell me, ‘Thank you so much doctor for admitting our mother, but, please, if you can't save her, don't send her to a place where she will be killed. We want to let her die in our home, we don't want her to die because of the mercy drug.’ It leaves me speechless. This stupid rumour is so strong, it's not going away.”

Rumours and conspiracy theories around COVID-19 have flared not only in Yemen. Born out of fear and mistrust of official narratives about the virus's origins, spread and contagiousness, misinformation and disinformation keep pitting unverified, speculative and often plainly false claims against official communications by health authorities, and in this contest they often win outright.⁵³ They continue to

sow confusion among those looking for trustworthy sources in an overwhelming amount of information, something that is particularly true in conflict settings where authority is contested and the health system tends to be weak. Rumours also continue to drive violence against doctors and nurses, patients, hospitals and ambulances because they paint health-care professionals as being involved in schemes to profit off the virus at the expense of patients or as being responsible for spreading the virus because of their proximity to patients.⁵⁴

“Does it bother me that I am sometimes treated more like a COVID-19 case than a COVID-19 doctor? Yes, it does, but I understand where it comes from because people see me spend a lot of time in hospital with COVID-19 patients. The stigma that comes with this job is one thing – I have got used to it. But being attacked for my work, this I cannot accept. It happened to a friend of mine in another hospital. They had no more beds, and a new patient was deteriorating. She was elderly and needed ICU care, but the ICU was full. He explained to her son that his mother was very ill, that there was nothing more he could do, that she might die and he should prepare for this. Initially, the son seemed calm and understanding, but then he contacted his relatives upcountry, outside Aden. And soon after, they were at the centre, four of them, and they called my friend and said, ‘Our mother needs to be transferred to the ICU, and you said there are no more beds.

This isn't our problem, this is your problem, you either transfer her now, or we will make a problem.' My friend explained the situation again, pleaded with them that he was doing everything humanly possible given the constraints. And guess what they did, they pulled out their guns and pointed them at him. Imagine, you're trying to do your best, you are overwhelmed with patients, you're fighting to save as many lives as you can, and you're threatened with death for doing so. It's unbelievable."

From February through December 2020, ICRC delegations in 42 countries received 848 reports of violence against health care linked to COVID-19, spanning the globe from Europe to Africa, the Americas and Asia. Most attacks targeted health-care personnel and were generally perpetrated by state authorities, local communities or patients' relatives. The causes were varied and occurred all along the continuum of care: some objected to preventive measures promoted by health authorities, elsewhere people opposed the idea of testing. Communities in multiple locations violently objected to the creation of quarantine centres, and in others, tribes and families used violence

to express disagreement with relatives being transferred into quarantine. Some cases documented by ICRC field teams were caused by frustration at the quality of treatment COVID-19 patients received in hospitals, others by anger and despair among relatives when health-care staff were unable to save a loved one. Finally, where patients succumbed to the virus, restrictions imposed on funerals and traditional rites and customs owing to concern that they might contribute to spreading the disease also repeatedly provided a trigger for violent events.⁵⁵

Some of these situations were again reminiscent of previous challenges encountered in controlling Ebola.⁵⁶ A more recent outbreak of the disease, which began in 2018 in the Democratic Republic of the Congo, had just peaked when COVID-19 began to spread last year. Ebola raged across the eastern parts of the country and across the border into Uganda and ended up taking the lives of 2,287 people. Thankfully, unlike in previous outbreaks, there were now effective vaccines and treatment protocols available, and much more was known about Ebola that could inform policies to contain its spread. In addition, much was known about what had clearly not worked on earlier

Trust and mutual understanding between communities and those looking after their health are the most effective antidote, built through intense two-way dialogue on not just what to do about the virus but also communities' many other problems.

occasions, knowledge accumulated through trial and error over the course of nine previous outbreaks: overly aggressive, if well-intentioned, enforcement of quarantine and public health measures (known as "health care at gunpoint"); reliance on contact tracing among a highly mobile population fleeing violence; a lack of support to communities where people were falling ill; insufficient respect for cultural customs, taboos and local narratives explaining disease and healing; and inadequate cooperation between the different parties contributing to the health-care response. More generally, it had become clear that focusing narrowly on preventing and containing a virus without understanding and supporting the surrounding communities and responding to their other

needs was often ineffective and sometimes dangerous for both patients and frontline health workers.⁵⁷

In short, one key lesson learned was that trust and mutual understanding between communities and those looking after their health were the most effective antidote. Such trust must be built through intense two-way dialogue on not just what to do about the virus but also communities' many other problems – a premise that is all the harder to put into practice in conflict-affected countries where trust between communities and authorities is often already broken.⁵⁸ Even though COVID-19 behaved differently to Ebola in terms of symptoms, mortality and epidemiology, there was

good reason to think that many of the lessons from fighting Ebola were pertinent for this new illness. And, as the ICRC saw in the 40-odd conflict-affected countries in which it worked over the course of 2020, most of them did indeed hold true.

The ICRC continues to urge government authorities and other stakeholders to adopt good practices that have shown to prevent adverse reactions from the public during health emergencies: communicating effectively – through engagement with communities in person and on social media – to explain the disease as well as the rationale and protocols of preventive and curative measures and to dispel misinformation; protecting personal data and confidentiality to ensure that patients are not afraid to seek care or get tested; avoiding family separation at every step when restricting movements, imposing quarantines or suspending family visits in prisons and other institutions; and trying to square biosecurity measures with what is acceptable in the local culture – especially as regards funeral rites – through engagement with community and religious

leaders.⁵⁹ Only with such accompanying measures have health-care workers a chance to prevent and contain the spread of a new virus.⁶⁰

“Today, things are much calmer, there are fewer COVID cases in Aden,” Abobakr added as if wanting to wrap up the conversation. His shift was not over, and more COVID-19 patients suffering from shortness of breath and other symptoms were waiting for him. “It was a crazy few months, but we learned a lot. Today we are better prepared to confront the disease if the numbers rise again. I have my team here, the people I’m blessed to work with, and I have my family back home, who have always supported me in my choices – even though they were shocked initially when they heard that I would volunteer to work with COVID-19 patients. Every day I get up to go to work, and I feel that, as a doctor, I have the chance to make a difference in people’s lives. That is where I draw my strength from. Some people have a passion, and then they have a job. I am lucky because, for me, the two have become the same.” And with this, he was off to look after another patient.



Sana'a, Yemen. A health worker disinfects a market street amid concerns over the spread of COVID-19, April 2020.

Khaled Abdullahi/REUTERS



Central African Republic. A mother signs paperwork during a family reunification, February 2020.

5. CENTRAL AFRICAN REPUBLIC: AN ORPHAN'S HOMECOMING

The story of a 12-year-old orphan returning home from the Congo shows how COVID-19 has kept families apart, increased suspicion of foreigners, shuttered schools and put children at greater risk, but also how, with patience and perseverance, happy endings may prevail regardless.

As the small convoy of cars worked its way south along the main highway, Augustin looked out the window at the passing landscape. The closer they came to the destination, the more things seemed familiar. At a roundabout, the convoy turned left down a country lane, kicking up a cloud of red dust. Augustin grew more apprehensive with every minute that passed. They had been driving for nearly 100 kilometres since leaving the capital of the Central African Republic, but he felt neither hungry nor tired. At the end of this trip, he had been promised, he would be seeing his family again, after years of separation.

“Do you recognize the place?” he was asked. He wasn’t quite sure. He remembered his two older brothers, his friends with whom he used to play around the house. “I wonder whether they’ll recognize me,” he said timidly.

Augustin had last seen them in 2013 when an insurgency by a coalition of rebel groups against the government in Bangui led to months of widespread violence, including several brutal massacres of civilians. Augustin’s family had been caught up in one of these, and both his parents were murdered. Augustin was five years old at the time.

He had a lucky escape and joined a stream of refugees fleeing the chaos to seek shelter beyond the country’s borders. The group of villagers he travelled with went south along the western bank of the Ubangi River, towards the border with the Republic of the Congo. He tagged along with a stranger, a woman who had taken pity on him and made sure he did not fall behind. When they crossed the border post, everyone had to give their names, home towns and the details of their relatives. When it was Augustin’s turn, a Congolese official passed him a slip of paper. Next to the date and a round stamp, there was something scribbled in red ink in the bottom left corner: *ENA*, it said, the French abbreviation for “unaccompanied child”.

From the border, Augustin moved on to a refugee camp at Ikpengbélé, near Betou. At the

camp, he was taken in by a foster family who had arrived a little earlier. They were kind and caring and treated him as if he was their own child, but the memories of the family he had lost did not fade.

Several years went by until he learned from traders passing through Betou that they knew his grandfather Michel who, they said, had returned to live in a village not far from where Augustin had grown up. Augustin still had fond memories of his grandfather, memories of happier times. When a volunteer of the Congolese Red Cross working in the camp offered to put camp residents in touch with relatives, Augustin told him about his grandfather and other relatives across the border whom he hoped to see again. The volunteer encouraged him to write a Red Cross message to his grandfather. Augustin wrote to ask for news and added, “Life is difficult when you are separated from your family.” When Michel received the message later that year, he was relieved to learn his long-lost grandson was still alive and filed a request for family reunification with the ICRC delegation in Bangui.

A subsequent assessment of the family’s circumstances confirmed that it was in Augustin’s best interest to return to his grandfather’s home. In late February 2020, an ICRC team travelled north from Brazzaville to Ikpengbélé to meet once more with Augustin’s foster family, the village chief, representatives of the United Nations Refugee Agency and the national authorities. The ICRC team then took temporary custody of the boy in order to reunite him with his family back in the Central African Republic. Only a couple of weeks in Brazzaville to get clearances, temporary travel documents and a shot against yellow fever stood between Augustin and his trip to Bangui on 24th of March. From there he would continue his journey to his grandfather’s home.

But ten days before his departure, the first positive case of COVID-19 was confirmed in the Congo, resulting in lockdowns, border closures, limitations on travel and other restrictions



Republic of the Congo, Augustin at eight years old, three years after his arrival as an unaccompanied child, 2016.

by mid-March. In the neighbouring Central African Republic, a priest returning from Milan tested positive while national authorities began to implement similar measures, causing schools, bars and places of worship to close and travel from abroad to be suspended. The border between the Congo and the Central African Republic, which had once signified a refuge, was now an obstacle keeping Augustin from returning home.

Meanwhile, Augustin's family also worried about the upcoming family reunion. In the Central African Republic, as elsewhere in sub-Saharan Africa, the first patients to fall sick from COVID-19 did so after returning from Europe (to most of western and southern Africa), the Middle East (to Uganda and Sudan), Asia (to Somalia and Ethiopia) or the United States (to Kenya). As a result, foreigners and locals returning from abroad were looked upon

“The border between the Congo and the Central African Republic, which had once signified a refuge, was now an obstacle keeping Augustin from returning home.”

with increasing suspicion. The community where Augustin's family lived was no exception, and this was exacerbated by the fact that the Italian priest identified as the first COVID-19 case had previously lived in the same region and many knew him personally. Augustin's return home after years as a refugee in the Congo would not go unnoticed. While a source of joy for Augustin and his family, his return might signify something very different to their neighbours, who were already on edge owing to fear of the mysterious disease. More work was needed to ensure that the family would not be stigmatized and seen as a potential vector of the disease.

Across the border, in the Congo, Augustin had been staying in downtown Brazzaville in an orphanage that partners with the ICRC. He realized that something was amiss when his roommates stopped going to class.

“One morning, the lady from the Red Cross came to see me and told me that my return home would have to be postponed because there was a new disease and the government no longer allowed people to travel. I cried a lot that day, and then I locked myself in my room. The sister in charge of the orphanage tried to comfort me, but I was just very sad. I refused to speak to anyone or even come out to eat. This lasted a day and a night. By the following morning, I felt better.” After that, days of waiting turned into weeks, and then months.

Augustin's case was anything but unique. Work by child protection agencies to reconnect and reunite families separated by war and violence was hampered everywhere by closed borders, cancelled flights, shuttered government offices, staff drawdowns in embassies and increasing movement restrictions within and between countries. Between January and March 2020, ICRC teams and their partners in the greater International Red Cross and Red Crescent Movement reunited 133 unaccompanied girls and boys with their families in other countries across the African continent. With the onset of the lockdowns, cross-border family reunifications came to a near-standstill. Despite intense efforts by Movement teams across Africa to comply with evolving restrictions, hygiene protocols and other rules, the number of cross-border family reunifications of unaccompanied children decreased over the following six months by more than two thirds compared to the previous year, before recovering during the fourth quarter. For scores of children separated from their families by war and aching to go home, this meant months of further uncertainty and anguish, compounding the trauma of the initial separation and the violence they had lived through.

The process of reunifying families – the painstaking effort to trace and locate people, restore contact with relatives and verify whether reunification was possible – was similarly hobbled by COVID-19. Movement



Bangui, Central African Republic. National Society volunteers promote COVID-19 preventive measures with community mobilizers, April 2020.

restrictions kept people from visiting the offices of child protection agencies. Reduced access to camps holding displaced people frustrated efforts to trace missing family members. The best-interest assessments carried out prior to reuniting children with their families were delayed since they require on-site assessments and interviews, and travel had become impossible. While the ICRC and its partners in the Movement in Africa, the Middle East and the Americas know of 2,233 missing people who were located during the first quarter of 2020, that number decreased during the second quarter to 1,160 – a drop of nearly 50% attributable in large part to the new constraints on movement and tracing activities.

There is little dispute that COVID-19 has taken a massive toll on the future of children worldwide – extending far beyond the issue of separated families. Like Augustin, more than 1.5 billion children in 195 countries stopped going to school and were cut off from a vital source of learning.⁶¹ Remote education, promoted as an alternative for the duration of the pandemic, remains a distant dream for the overwhelming majority of children in countries affected by armed conflict, children who have neither smartphones nor computers nor the internet access needed for online learning.⁶² Closing schools has also put children in conflict zones at greater risk. Schools and teachers can keep a child from being recruited into an armed group, and a daily school meal can stop them

going hungry. To make matters worse, many children who were forced to quit school during the pandemic will likely not return when the pandemic ends, particularly girls.

As well, being confined at home has exposed children to a greater risk of domestic violence because of the prolonged physical proximity to potential abusers and the heightened levels of stress and frustration among the adults around them.⁶³ And with children out of school and economic pressure weighing down on parents, there is a risk that some girls will be pushed into child marriage sooner and that both boys and girls will be forced to supplement their household income through child labour. COVID-19 also led to the suspension of vaccination campaigns, thus putting the youngest children at a higher risk of falling ill with preventable diseases such as measles, diphtheria or polio, diseases against which they would otherwise be protected.⁶⁴

Augustin had been lucky in most of these respects. He had lived through the pandemic in the protected environment of an orphanage and was looked after by trained staff committed to his well-being. He was fed and clothed through an ICRC stipend and had access to adequate health care. Instead, a different kind of tragedy eventually found him: a letter from his uncle brought the news that his grandfather Michel, the driving force behind Augustin's return, had died after falling sick

“COVID-19 has taken a massive toll on the future of children worldwide.”

from a disease unrelated to the pandemic. Once again, Augustin had to face terrible misfortune, adding to his experiences over the previous years he spent as an orphaned refugee. But he remained determined. He would go home, no matter the obstacles.

Months later, in the Central African Republic, Augustin's convoy of cars was entering the final stretch of road leading to his relatives' house. Neighbours lined the street, waving at the passengers. The convoy had stopped a few kilometres earlier in the main village to pay their respects to local elders and inform them of Augustin's return. Word spread quickly. By the time the cars arrived at their destination, a small welcome committee had formed in front of the house, jumping with joy and chanting Augustin's name.

There was a moment of hesitation. Then Augustin clambered out of the car and was greeted enthusiastically by his entire family. He seemed unsure about what to make of it at first, but then his mood brightened, and he broke into a smile. His two older brothers were there – he recognized them, and they recognized him. They asked questions, and he answered as well as he could, but haltingly. In exile, Augustin had become fluent in Lingala, the lingua franca of the Congo, but he had rarely used Sango, the language he had spoken with his parents. But as the minutes passed, his conversation with the other children became more animated and cheerful. When the time came for the Red Cross staff to say goodbye, it was difficult to find Augustin again amid the throng of children who had gathered around him. They checked one last time and asked him whether he felt okay. “I'm home,” he said, in Sango.



Central African Republic. Family members surround Augustin on the day of his return home, December 2020.



Bogotá, Colombia. An empty street during the nationwide COVID-19 lockdown, April 2020.

S. Barros Salamanca/Latin America News Agency

6. COLOMBIA: I PRAY MY MOTHER WILL GET BETTER

The violent deaths of two civilians in Colombia illustrate the pandemic's impact on communities living under the control of certain non-state armed groups, the need to protect civilians and respect international humanitarian law, and the importance of neutral, independent and impartial humanitarian action in hard-to-reach areas.

They arrived in the provincial capital with nothing but their clothes on their backs. There were seventeen of them: an elderly woman and her daughter, a young man and fourteen children, the youngest a one-year-old girl. Together they made up what was left of the Ramirez and Alvarez households after a bloody attack against their homes three days earlier. The heads of both families had been murdered in cold blood, with two more family members suffering grievous injuries and the remainder traumatized by the violence they had been forced to witness.

The two families had fled to this town from a village in an isolated area in the far south of Colombia, where armed opposition groups and criminal gangs engaging in the coca trade have been active for decades. Repeated government offensives against armed opposition and criminal groups had caused violent clashes in the past but had failed to dislodge the armed groups or keep them from holding sway over remote areas. When the COVID-19 pandemic reached Colombia in March 2020, working its way upriver from the Pacific coast to these hard-to-reach inland settlements, the Ramirez and Alvarez families had to depend on the dominant armed groups to give them guidance on how to protect themselves and their loved ones from the virus.

A few days earlier, on a Saturday after dark, Santiago Ramirez sat on the front porch of the Alvarez family home, immersed in an animated conversation with his neighbour over a couple of drinks. Around 9pm, two gunmen arrived on a motorcycle and began shooting at the house. The two neighbours were killed instantly by multiple gunshots to the head and body, while a third member of the Alvarez family was injured by a stray bullet when trying to escape through the roof. The gunmen then shot Santiago's wife, who was having dinner inside with her two daughters, three times in the stomach and left her for dead. Her girls, Luisa and Maria, had their lives spared but were forced to witness the carnage. After the gunmen had ridden

off on their motorcycle, the girls cried out for help. Eventually, an ambulance arrived, and emergency medical staff checked on the survivors and rushed the girls' mother to a hospital in the nearest town.

Like others before and after them, the Ramirez and Alvarez families had fallen victim to the aggressive curfew-enforcement tactics employed by some armed groups across Colombia trying to hold off the new illness that was spreading rapidly in the capital, Bogotá, and other urban centres. In response to growing fear, these groups had begun imposing their own containment measures, which ranged from bans on traveling in boats and vehicles to shop closures, night-time curfews and complete lockdowns of entire communities. Threats, heavy fines and violence were deployed to enforce the new rules.⁶⁵ In the area where the Ramirez and Alvarez families lived, armed groups had declared anyone breaching the curfew to be "military targets". In order to preserve the life of others, the argument ran, it might be necessary to kill those who disobeyed.⁶⁶

"We had heard that you weren't allowed to sit outside at night anymore because of the virus. Leaflets had been handed out that said that much, but my father thought that as long as he stayed on the porch and didn't go any further it would be ok," Luisa said haltingly while sitting on a chair at a psychological care centre supported by the ICRC. Her gaze was fixed on the floor in front of her. She and her little sister had been referred to the centre to recover from the horror of that night last spring, while the Ramirez family were temporarily housed in another shelter that partners with the ICRC in the provincial capital. Their mother was still in hospital after undergoing multiple operations. "I pray every day that my mother will get better," Luisa added, still staring at the floor. "She's in a lot of pain." After another pause she continued: "It's not fair. My father and my mother had done nothing wrong. Why did they do this to us? We weren't sick from the virus, we were no risk to anyone. Why kill us?"

As if losing loved ones were not enough, on Tuesday of the week following the massacre, more armed men appeared at the doorsteps of the Alvarez and Ramirez families' homes and told the surviving members that they had 24 hours to leave the village. In the eyes of the armed group that controlled the area, the two families and their neighbours had shown insufficient discipline by not respecting the COVID-19 curfew. Their fate was meant to serve as an example for the rest of the community.

Both in Colombia and beyond, not all non-state armed groups have taken the law into their hands so brutally. Some armed groups fighting governments have responded to the pandemic by issuing health advice and guidance while at the same time distributing food and other essential items to low-income families. By promoting public health messages, looking after their communities' welfare and enforcing containment measures of their own making, they took on roles that would usually be reserved for the authorities.

For armed groups wanting to control territory and govern populations, COVID-19 presented an opportunity to appear as responsible parties capable of replacing the governments they compete with. For instance, in Afghanistan and Syria's Idlib province, the Taliban movement and the militant group Hayat Tahrir al-Sham, respectively, announced early on that they would launch COVID-19 awareness and prevention campaigns in line with World Health Organization guidance. In other places, the approaching pandemic was interpreted by armed groups according to their worldviews and framed, in religious or ideological terms, as a tactical opportunity to attack adversaries weakened by disease or as divine punishment that would primarily affect non-believers.

Governments, for their part, mobilized military units to help police forces control borders, restrict movements, man checkpoints and enforce curfews and lockdowns. When popular protests erupted against the hardship these measures inflicted on communities, the military was at times called in to assist in controlling or dispersing crowds.⁶⁷ In parallel, across the Americas, Africa and Asia the ICRC registered a significant uptick in violence against people who were seen as non-compliant with movement restrictions, lockdowns or business closures. In February 2020, the ICRC recorded ten major

incidents of violence around the world affecting civilians, events that were motivated in one way or another by COVID-19. That figure rose to 75 in March before peaking at 180 in April, a curve that echoes the first wave of infections.⁶⁸

For a short period in spring 2020 it seemed that the prevalence of violence was not one of the things the pandemic would make worse. Several armed groups and some states initially called for a pause to fighting, an initiative amplified by a call from the United Nations for a universal humanitarian cease-fire in March. Later that same month, the National Liberation Army, an armed group in Colombia, declared a unilateral one-month ceasefire as a humanitarian gesture. Another armed group, the New People's Army in the Philippines, followed suit, as did three armed groups of the Northern Alliance in Myanmar. The Saudi Arabian-led coalition fighting in Yemen announced in early April that it would stop its military campaign for two weeks, and Syria saw a marked reduction in violence, although the relative calm was due to other factors.

Sadly, the hope that these early developments inspired was short-lived. By early summer, violence in most of the countries where the ICRC works had largely gone back to previous levels and, in some cases, intensified. Fighting in the east of the Democratic Republic of the Congo, for instance, continued unabated. In Libya, the battle for Tripoli between the forces of General Khalifa Haftar and the Government of National Accord was far from over. In Nagorno-Karabakh, Azerbaijani and Armenian forces rekindled a decades-old conflict in late September. Two months later, Ethiopian government troops and regional forces clashed in Tigray province, killing scores and displacing tens of thousands. And by the beginning of 2021 chronic insecurity in the Central African Republic threatened to spiral out of control in the wake of a national election.

Elsewhere, the COVID-19 pandemic may have aggravated existing patterns of violence. In Colombia, in areas such as the one where the Ramirez and Alvarez families lived, after the initial lockdowns were lifted targeted killings of social activists and of former armed opposition fighters increased significantly compared to the previous year. One possible explanation for the trend is that the reduced presence of humanitarian organizations and

Quibdo, Colombia. Hygiene materials are distributed as part of a COVID-19 prevention campaign, July 2020.



the distraction of the pandemic might have created a more permissive environment and a sense of impunity.⁶⁹ In Colombia, 242 cases of violence against health care were recorded between January and September 2020, a surge of 150% compared to the same period in 2019. Two out of five incidents were likely linked to the pandemic, and half were caused by community members.⁷⁰ It also appears that the pandemic has led to an increase in domestic violence, exacerbated by families' prolonged confinement at home and the frustration experienced by those whose livelihoods are threatened by prolonged lockdowns and business closures.⁷¹ Some estimate that, for every three months of lockdown worldwide over the course of last year, 15 million additional cases of domestic violence occurred.⁷² And the same circumstances have put up additional obstacles between victims of violence and outside support and services.⁷³

What conclusions can be drawn from this? First, belligerents will not stop fighting wars even in the face of a deadly pandemic. Second, pandemics may increase violence as fear of illness and containment measures add another layer of complexity to existing tensions and fracture societies along old and new fault lines. And third, pandemics can and will spread into active conflict zones and territories that are contested or controlled by non-state armed groups. There, the spread of disease only adds to the burden of those who already have to deal with the consequences of chronic violence, reduced access to health-care services and a lack of reliable information on how to protect themselves and others.

Today, between 60 and 80 million people live in areas that are controlled by non-state authorities. Ten ICRC delegations operate in places where armed groups govern more than

one million inhabitants. The ICRC is in contact with 465 armed groups worldwide, some of which have replaced state authorities and provide services akin to those of established governments. Almost 100 armed groups capture people or otherwise engage in detention of some kind.⁷⁴

During armed conflict, states as well as non-state armed groups are bound under international humanitarian law to allow and facilitate impartial humanitarian assistance when they are unable to cater for the essential needs – shelter, food, water and health care – of the populations under their control.⁷⁵

Governments, including donors to the humanitarian cause, can make this effort easier or harder. In order to do their work effectively

and impartially, humanitarian organizations need to be given rapid and unimpeded access to territories and populations under the control of belligerents. The principle of impartiality calls on humanitarians to prioritize the needs of the most vulnerable, regardless of which side of the front line they are on. The government concerned must accept that doing so does not mean the humanitarian organization in question is taking sides nor does its action provide any kind of legitimacy to the opposing party. Helping these communities is not about being biased – it is about being neutral and impartial in response to urgent needs.

With the rise of nationalism, authoritarianism and the tendency of governments to treat non-international armed conflicts on their territory as an internal matter, respect

During armed conflict, states as well as non-state armed groups are bound under international humanitarian law to allow and facilitate impartial humanitarian assistance when they are unable to cater for the essential needs – shelter, food, water and health care – of the populations under their control.

for these fundamental humanitarian principles is eroding. Yet consent to humanitarian operations in such circumstances is not meant to be discretionary. The question of whether a party to armed conflict can lawfully turn down an offer of humanitarian services is intrinsically linked to its obligations vis-à-vis the communities under its control, notably whether it is able to fulfil its primary obligation: meeting their basic needs. In the view of the ICRC, if a belligerent is not in a position to fulfil this obligation towards the population it claims to control, it must consent to the humanitarian activities of impartial humanitarian organizations, including in the field of health.

Governments that support humanitarian work as donors can help by keeping political agendas and humanitarian work separate, even where the two appear to conflict. For one, pandemics do not stop at borders simply because governments on

the other side have been declared rogue actors or happen to be on someone's sanctions list. Early on, COVID-19 hit several countries particularly hard whose capacity to tackle a pandemic had been compromised by years of sanctions.

Similarly, when humanitarian organizations develop activities that support vulnerable communities under the control of armed groups categorized as terrorist or criminal, criminalizing those humanitarian activities sits uncomfortably with international humanitarian law and its underlying principles. Taken together, increased challenges related to accessing vulnerable communities, sanctions regimes and the threat of criminal prosecution discourage smaller NGOs from developing projects in contested areas, skewing the humanitarian response in favour of programmes that may not reach those in greatest need.



Colombia. With the ICRC's facilitation, a civilian is released after being held by an armed group, June 2020.

COVID-19 should reinforce the notion that, even when living under the control of armed groups and governments categorized by other states as terrorist, criminal or rogue, civilians remain simply that: civilians. Under international humanitarian law, the enemy's sick and wounded are entitled to the same level of

protection as the sick and wounded on this side of the front line. As such, humanitarian organizations owe them the same level of attention and care, and governments and donors should encourage and enable humanitarians to act accordingly. This is true in normal times, and truer still during a worldwide pandemic.

“COVID-19 should reinforce the notion that, even when living under the control of armed groups and governments categorized by other states as terrorist, criminal or rogue, civilians remain simply that: civilians.”



Lesbos, Greece. A rescue team from the Hellenic Red Cross assists migrants who have crossed from Turkey.

7. GREECE: WE WERE ALL SUSPENDED IN TIME

An Afghan man's long wait for an asylum interview in Greece sheds light on the protection of migrants in camps and detention centres during the pandemic; access to state-run health-care and social protection systems; border closures, "push-backs" and the right to seek asylum under international law; and the need for solidarity in a global health crisis.

A light breeze was blowing one morning in November 2020 as a small group of men, women and children gathered in the waiting area, sandwiched between a yellow one-storey building and a grey office container. Some sat alone on plastic chairs while others huddled together in groups of two or three, talking quietly, waiting for their turn. Every now and then, names were called out and someone stood up and disappeared through a gate. One could feel the tension in the air. This was the moment when their future would be decided.

Jawed sat with his back to the container wall. His future, too, would be decided that morning. Hours earlier he had been bussed here together with other migrants to be interviewed by the asylum authorities.⁷⁶ Some of the people among the attendees were familiar to him from previous occasions. There were people from Afghanistan, Syria, the Democratic Republic of the Congo, Somalia and places further afield. All of them had come to the Greek island of Lesbos following a perilous journey across the Aegean Sea from Turkey.

While he waited for his name to be called, Jawed mentally went once more through what he planned to tell his interviewers. He had grown up in Afghanistan, in the province of Baghlan, a vast expanse of rugged mountains and green valleys on the southern slopes of the Hindu Kush, situated at the crossroads between the three major Afghan towns of Kabul, Mazar-i-Sharif and Kunduz. He remembered it as a place of great natural beauty and agricultural wealth, where generations of Afghan farmers had transformed the fertile river plains into a lush landscape of rice and wheat fields interspersed with villages and orchards full of grapes, pomegranates and pistachio trees. With its mixed population of Tajiks, Hazara, Pashtuns and Uzbeks, it has also over past decades become a place where armed conflict had firmly taken root and where violent clashes between the government and opposition forces have become a near-daily occurrence.

After finishing school, Jawed had moved north to Mazar-i-Sharif to study engineering before returning home again. Meanwhile, the war that had initially been fought primarily in the southern and eastern parts of the country was drawing closer. In 2015, the Taliban overran the nearby town of Kunduz and held it for several days until government and coalition troops eventually pushed them back. In other places, air strikes, night raids, kidnappings and bomb blasts had made life for civilians increasingly unsafe. Political and tribal tensions between communities added further threats. Jawed and his family followed the Ismaili tradition of Islam and were ethnic Hazara, a minority community in Afghanistan that had often been at odds with Sunni armed groups in the past. As the fighting intensified, deadly attacks targeting the Hazara became ever more frequent. At the end of 2018, which had been an exceptionally violent year, Jawed, his younger sister and his aunt felt that it was time to leave. They gathered whatever savings they had and in January 2019 set off on a long journey across the border to Iran and from there onwards to Turkey, where they arrived two months later.

It took another six months until they found a way to cross the straits between Turkey and Greece in an inflatable rubber dinghy, together with a group of Afghans and Syrians. Their craft was barely seaworthy, and it almost capsized en route. When they arrived onshore, Jawed was elated to have made it alive and hopeful that they would quickly be allowed to travel on to Austria, where his aunt had family able to help them start a new life. They filed a request for family reunification with the authorities and were brought to the Moria camp in the north of Lesbos, Europe's largest reception centre for asylum seekers. Four months went by without much progress on their case. By the time they received their appointment for an interview in March 2020, the first cases of COVID-19 had been identified in Greece. Soon after, the entire country went into a strict, six-week lockdown and all interviews and other activities linked to asylum claims were abruptly stopped.



Lesbos, Greece. Jawed in December 2019.

“The cancellation of our interview came as a shock because first they said that it was unlikely we would be called again before the end of the year,” Jawed told an ICRC delegate in November 2020. “The uncertainty throughout the summer months was very stressful. We felt stuck, suspended in time, without the right to go anywhere, without an idea of what the future would hold. We tried to tell each other that things would work out all right, but as months went by without change or progress on our case, my sister and aunt grew increasingly sad. Meanwhile, for me the uncertainty about my own future was not the worst part. I mostly worried about my mother and my other sister, who stayed behind in Afghanistan together with five little nephews and nieces. During the first lockdown, I lost contact with my family for several weeks. The virus had spread in Afghanistan as well, more so than in Greece even. I knew that if anyone of my family got sick, getting good health care would be almost impossible. There are hardly any doctors in Baghlan, and health centres are not equipped to deal with this virus. My mother is elderly and frail. I was terrified of what would happen if she got the virus.”

Jawed had reason to be worried. Years of conflict and instability have held back the development of Afghanistan’s health system, which today faces a serious shortage of health-care professionals. There are only five hospital beds and three physicians for every 10,000 people, and most of them are concentrated in urban areas.⁷⁷ When the virus began to spread across

Afghanistan in April, a survey by the ministry of health revealed that there were only 300 ventilators for a population of just under 40 million.⁷⁸ The health sector is fragmented between public health facilities that are chronically under-equipped, NGO-run centres that remain vulnerable to funding cuts and deteriorating security, and private health facilities that provide services that are unaffordable to the vast majority of Afghans. COVID-19 risked exacerbating the unequal health outcomes that underdevelopment and structural inequality had already produced for Afghans depending on whether they were rich or poor.

“Eventually, I received news that while the number of cases in Afghanistan was soaring, my family had been spared,” Jawed said. “I was so relieved, you cannot imagine. And then there was more good news because I was given a new interview date. But then I was unlucky again. Shortly before I was supposed to go to the interview, Moria had its first COVID-19 case, an asylum-seeker from Somalia who tested positive. As a result, the camp got locked down completely. Before this, 120 residents or so were able to leave the camp each day, for things like urgent medical needs or asylum interviews. At the time, there were more than 12,000 of us living in the camp. The chance that you would be able to leave the camp for a day was one in a hundred, which wasn’t great but at least it remained possible. But after the first case in early September, even this got cancelled, with no one allowed to go in or out.



Lesbos, Greece. An informal migrant camp at Olive Grove, next to Moria, December 2019.

S. Papardias/ICRC

“Moria had become a bit like a prison, with the virus locked inside together with its residents, in a place where everyone is living in cramped conditions, with few means of keeping a safe distance from one another. The virus spread very quickly. After a few days, we had 30 cases. There was panic inside the camp. Then a large fire broke out, and over the course of one night in September, the camp completely burned to the ground. Thousands of us were left without shelter, and some were trying to get to Mytilene, the nearest town. Police used tear gas to keep them from moving further, and over the coming days they were chasing down camp dwellers who had had positive COVID-19 tests in the days before. It was complete mayhem. To top it off, my interview was cancelled again.”

To put things into perspective, the Greek authorities had made a serious effort to move vulnerable camp residents from Lesbos to the mainland in the wake of the lockdown. Migrants who were elderly or had other medical conditions were able to leave the Moria camp, and, after some back and forth, unaccompanied minors were also moved to more protective settings outside the camp. For the rest, Greece responded to the threat with a combination of severe movement restrictions, quarantine periods for newcomers and a reduction of staff movements to block the virus from getting in. Their approach resembled that adopted by most other countries hosting large refugee and migrant camps. On the face of it, the strategies appeared to work. In most countries, infection rates in camps initially remained lower than in the general population, with some camps still declared free of COVID-19 in August.

Authorities used a similar combination of quarantine for newcomers and access restrictions for staff and outside visitors in order to stave off the virus in immigration detention facilities. As in the case of camps and prisons, attempts to postpone the first positive cases of COVID-19 among detained migrants by isolating them from the outside world deprived them of services available only outside the facilities’ walls, including legal advice, social services, and support in administrative matters and court cases. This, in combination with the partial suspension of judicial and asylum proceedings as well as a drop-off in global air travel, often led to prolonged detention. And it added to migrants’ sense of isolation.

Whatever health benefits there may have been initially in shutting off camps and detention facilities in this way, they were not to last. Around the same time community transmission started in the camp at Moria, Syria’s al-Hol camp confirmed its first local COVID-19 infection, a few weeks after cases were detected in the country’s rebel-held north-west. In Bangladesh, numbers in Cox’s Bazar started to slowly creep up in August despite limited testing capacity, as did case figures in Kenya’s largest camps of Dadaab and Kakuma. From mid-year, camps and immigration detention facilities across continents began following the general upward trend in infections.

An alternative to lockdowns at camps would have been to try to alleviate some of the factors that made migrants vulnerable to COVID-19 in the first place. This would have required decongesting camps and moving vulnerable

“In immigration detention facilities, putting a premium on reduced vulnerability in lieu of increased restrictions would have meant decongesting those facilities, rather than locking them down.”

individuals away from the crowded conditions to more appropriate care arrangements, to a much greater degree than what was attempted in Moria. Migrants in non-camp settings should then have been given access to the same level of government-run preventive and curative health care available to everyone else and, in parallel, they would have become subject to the

government-ordered COVID-19 containment measures applicable to the general population. Similarly, in immigration detention facilities, putting a premium on reduced vulnerability in lieu of increased restrictions would have meant decongesting those facilities, rather than locking them down.⁷⁹

Lesbos, Greece. Migrants at Moria do their laundry, December 2019.



To do so would have been in line with authoritative guidance such as that issued by the European Centre for Disease Prevention and Control, which has found no evidence that lockdowns of migrant camps would necessarily be the most effective means to prevent contagious disease from spreading inside or, for that matter, to make the general population outside any safer.⁸⁰ It would also have been in line with the Global Compact for Migration, which 152 countries signed in 2018, committing “to prioritize non-custodial alternatives to detention that are in line with international law, and to take a human rights-based approach to any detention of migrants, using detention

as a measure of last resort only.”⁸¹ Several countries experimented with such progressive approaches over the course of 2020 and suspended arrests of people without valid status, released significant numbers of migrants from detention or tacitly extended residence permits beyond their nominal expiry date for the duration of the pandemic.⁸² This is, by and large, what experts on migration had recommended at the outset of the pandemic.⁸³

As a matter of law and policy, the ICRC, too, recommends that immigration detention should be only used as a measure of last resort: liberty should be the norm, and when there

“Moving across borders is often the only available option for people to avoid violations of fundamental rights, notably in situations of armed conflict and other situations of violence.”

are individual grounds that warrant detention, alternatives to detention should be considered first. The ICRC was encouraged to note that government authorities in many countries, from prison directors to ministerial-level officials, showed increased interest in reconsidering how to use immigration detention in light of the challenges posed by COVID-19. Many governments also took another look at starting to mainstream welfare arrangements for migrants in health-care and social protection systems meant for the general public.⁸⁴

While some governments thus developed innovative and solidarity-based solutions to confront these exceptional times, the closure of an estimated 167 countries' borders – with at least 57 making no exceptions for asylum seekers – created additional concerns around ensuring the protection of migrants.⁸⁵ Reports of so-called “push-backs” came in throughout the pandemic, the practice of migrants, including refugees and asylum-seekers, being returned at or across borders without consideration for their individual circumstances or the possibility to apply for asylum. Such reports reached the ICRC from South and Central America, Central and South-East Europe, the Middle East and South-East Asia.

When protection is not available in-country, moving across borders is often the only available option for people to avoid violations of fundamental rights, notably in situations of armed conflict and other situations of violence. As such, avenues for asylum seekers to access international protection must be safeguarded. The systematic rejection of all foreigners at the border in a manner that precludes the admission of individuals in need of international protection, without measures to protect them against *refoulement* (the act of transferring a person to an authority when doing so would put the person at a substantial risk of suffering violations of certain fundamental rights), is incompatible with the obligations of states under international refugee law and international human rights law. And because the principle of *non-refoulement* protects absolute and non-derogable rights – rights that cannot be compromised under any circumstances – the ICRC believes that denial of access to territory without safeguards cannot be justified on grounds of public health risks. If there are identified risks for an individual or a group of people, other measures should be implemented, such as testing and/or quarantine, so as to enable authorities to limit health risks while respecting their international legal obligations.⁸⁶

COVID-19 has underlined that, during a pandemic, “no one is safe until everyone is safe” – a phrase that has become so ubiquitous that a Google search for it in combination with “COVID-19” produces more than 100,000 links to articles and reports stating the same. At the same time, migrants remain among the most vulnerable populations there are, regardless of whether they live in camps, are held in detention centres or remain isolated in urban areas. Whatever their reasons for leaving home – be they armed conflict, other situations of violence, persecution, human rights violations or poverty – in the absence of a legal status migrants often lack shelter and access to health care and other government services while making their way. They fear arrest and expulsion, have few sources of income and often face economic and sexual exploitation. In addition, as foreigners they are easy targets for others’ prejudice and xenophobia, a fact that COVID-19 has only exacerbated, with migrants being accused of spreading the virus.⁸⁷

Governments must take the full measure of these often-desperate situations when deciding on ways to protect public health. Dealing with all categories of migrants, including asylum seekers and refugees, with empathy and inclusivity rather than through the lens of security alone is the right thing to do. It also happens to be good and effective government policy for

achieving other aims, such as protecting public health, and not only during a pandemic. COVID-19 has presented us with an opportunity to strike a better balance between the right of states to ensure border control and security and their obligations under international law, which must always be respected: to uphold the rights of, and respond to the needs of, those who cross their borders in search of a better life.

As for Jawed, he finally had his interview. “It went well, I think,” he said after a pause. “They confirmed my identity and asked things like whether I had served in the military, about my family back home, the threats we faced, why I had left Afghanistan, why I don’t want to go back. I replied to all their questions truthfully, and they took notes. They didn’t tell me whether my case was likely to succeed or not however. Waiting for the result is very stressful. The thought of being rejected keeps me up at night. At the same time, I try to keep up hope and support my sister and aunt. We survived years of war in our home country, a near shipwreck when crossing over from Turkey, and now a worldwide pandemic while locked into a refugee camp, so I guess life can only get better, wouldn’t you agree?”



Lesbos, Greece. Migrants flee with their belongings from a fire burning at Moria, 9 September 2020.

A. Konstantinidis/REUTERS

Terter, Azerbaijan. A woman in the ruins of her home, which was exposed to shelling during recent fighting, September 2020.



B. Kilic/AFP

8. AZERBAIJAN: WHAT BAHRUZ WOULD HAVE WANTED

The grief of an Azerbaijani family over the death of a relative speaks to the impact of the pandemic on traditional burial rites and practices, protecting the dignity of the dead during an emergency, the global mental health crisis triggered by COVID-19 and the silent suffering of the families of people gone missing owing to conflict.

To Sara, nothing was quite as it should be. There was the photograph of the deceased affixed to the wall, the black ribbon around it, the muffled voices of women weeping. In the neighbouring room where the men were, one could hear the soft clicking sound of prayer beads turning between fingers, murmured reminiscences of events long past and short bouts of activity whenever a new set of well-wishers showed up at the door to convey condolences. The outer trappings of a proper funeral. Yet Sara knew that she and her mother would not get to see the body of her uncle when it finally was delivered from the airport, and this to her felt profoundly wrong. According to the Muslim faith and Azerbaijani tradition, the body was supposed to be ritually washed and then wrapped in white cloth at the local mosque, at which point relatives and other mourners were to be given an opportunity to be in the presence of the deceased. Instead, she had been told that her uncle's remains were going to be transferred in a sealed metal coffin from the airport directly to the local cemetery to be interred there. Sara was overwhelmed by sadness but also a sense of guilt – towards her uncle, who would be deprived of the proper last rites of Islam, and towards her mother, who would have no opportunity to bid her brother a last farewell.

The flight from Moscow that carried Uncle Bahruz in its cargo compartment had been delayed. Every now and then, Sara left the living room to place a call to her brother, who was waiting at the airport for news about the coffin. As the hours ticked away slowly, Sara busied herself preparing tea, serving treats and fiddling with the heating to make the guests comfortable. It was April and well past the winter season, but the day had been unusually chilly.

When her brother finally called to say that the plane had landed, Sara felt relief. She wanted this to be over with. Her mind was filled with the images and videos that her nephew in Moscow had sent to her smartphone in the days before her uncle died, showing him on a hospital bed next to medical staff in full

protective gear, his face swollen and almost unrecognizable, his eyes closed, a plastic tube coming out of his mouth connecting him to a mechanical ventilator that pumped oxygen into his lungs at regular intervals to keep him from suffocating. She did not want these cold, cruel photographs to be the last that her mother knew of her brother. “Why do they want to bury him wrapped in metal?” her mother had asked her earlier that morning, and it had left a sting in Sara's heart. “Everything will be as it should be. They will bathe him and shroud him in a white *kefen* before he is lowered into the ground,” she had tried to reassure her mother. Sara knew this to be untrue but could not get herself to say otherwise.

For Sara's mother, this was the second time she was losing a brother without being able to properly say goodbye. Twenty-six years before almost to the day, her brother Iskander, who as an 18-year-old had enlisted with the Azerbaijani army to fight in Nagorno-Karabakh, went missing in action only days before a temporary ceasefire put a halt to the fighting. She had seen him last when he had come home the previous New Year for a few days of leave before vanishing forever. Ever since, Sara's mother had been waiting – for news of him being found alive somewhere, or for a confirmation that he had died, together with a name of the place where his body had been buried – but neither was forthcoming. As a result, she had never truly managed to come to terms with her brother's disappearance and move beyond her grief. Whenever she convinced herself that she needed to turn the page and declare him dead, the next day she would feel crushed with remorse and blame herself for abandoning hope when hope was the only thing that could keep her brother alive. Sara worried that losing a second brother without being able to find closure would take a further toll on her mother's health.

In relevant literature, the confusion of feelings that tormented Sara's mother are known as “ambiguous loss”. Coined initially in the 1970s

by Pauline Boss, an American researcher studying the families of missing U.S. soldiers who fought in Vietnam and civilians forcibly disappeared by military regimes in South America, the term refers to the prolonged and traumatic mourning period that ensues when a loved one goes missing without further news.⁸⁸ Family members experiencing ambiguous loss face feelings of confusion, helplessness, depression and anxiety. Those feelings are a normal human reaction to an abnormal situation – unresolved loss resulting in unresolved grief. Yet ambiguous loss tends to be draining and destructive over time, not only for those in grief but also for their relationships with the people around them.⁸⁹

Today, over 4,500 families in the region remain without news of a relative who went missing during hostilities over Nagorno-Karabakh in the 1990s. The ICRC has for some years run programmes for these families that provide psychosocial and other forms of support. In Azerbaijan, this is done through a volunteer network of women with missing loved ones who are taught how to provide peer support to others. After establishing a baseline of these families' circumstances and their emotional and material needs, the programme has since 2012 run several cycles of interventions meant to help them work towards some sort of closure, find a way to accept a situation marked by uncertainty and reduce their emotional

All I wanted that day was to make sure that my mother did not have to live through the same experience again – losing a brother without a chance to mourn over his body and to accept that he had passed and would not come back.

distress. The programme also helped them with legal and administrative issues, such as sorting out land or inheritance issues or filing petitions for government benefits that they were entitled to. And some families were destitute and needed support in cash and in kind to recover a decent quality of life.

Sara decided to volunteer and received training to help others. She had witnessed herself what Iskander's disappearance had done to her own family. The lack of clarity about the fate of a loved one removes the customary markers of life and death – there are no witnesses, no places, no documents, none of the rituals that usually accompany these events. As a result, relatives' distress over a disappearance is never validated by their community or society at large. After initial sympathy, communities tend to lose patience with the lack of closure, and the families of the missing can become isolated. Similarly, ambiguous loss can estrange family members from one another. At times, parents may remain stuck in their grief, while their children find it easier to move on with their lives despite the lack of answers. Parents who realize that their grief is no longer shared then retreat and stop talking about their feelings,

isolating themselves even further. It was partly to keep this from happening that Sara decided to sign up for the ICRC programme and later to become a peer supporter.

"All I wanted that day," she said of her uncle's funeral, "was to make sure that my mother did not have to live through the same experience again – losing a brother without being able to understand what happened, without a chance to mourn over his body, to accept that he had passed and would not come back. That's what mattered to me. When I got the call that the plane had arrived, I told my mother and our other relatives who were in the house. A small group of men planned to go to the cemetery to meet up with the hearse that brought the coffin from the airport to our district in Sabirabad. Officially, Uncle Bahruz had died of a weak heart – that's what some of the paperwork said, and, to be honest, to me it was just as well. I had seen pictures in the media of COVID-19 victims being buried in other countries. They showed workers dressed like astronauts digging row after row of anonymous graves, without the families of the dead anywhere near. I did not want this to be the way my uncle was buried."

At the time, Azerbaijan was in the middle of a three-week lockdown to control the rapid spread of COVID-19. The movement restrictions put in place allowed funerals to continue as long as the person laid to rest had died for unrelated reasons. COVID-19 victims, on the other hand, were to be handled only by municipal workers who had been specifically assigned and equipped for this purpose.

As in Azerbaijan, authorities elsewhere began issuing new instructions in early 2020 on how to handle those who had succumbed to COVID-19. With little known initially about the new virus, many people across the globe turned to common misconceptions about the risk that the dead pose of spreading disease, at times fuelled by media reports that, for lack of recent relevant photographs, used images from earlier, unrelated campaigns against Ebola which poses a significantly higher risk of transmission through the handling of dead bodies. Fear of infection spreading through the dead also led some communities to object to having people buried where the dead were usually laid to rest. Cemetery staff, death-care workers and families trying to bury their deceased found themselves the target of stigma and at times violence.

Over the coming weeks and months in many parts of the world, pandemic-related restrictions became the cause of much additional hardship for bereaved families who were kept from recovering, and sometimes even viewing, the body of their loved ones before burial, kept from caring for them in line with their beliefs and kept from burying their dead in a place and in the company of the people of their choice. Some of this initial bias was due to a lack of conclusive scientific data on the infectiousness of COVID-19 and thus justifiable. In other cases, in Europe and East and South Asia, some government restrictions clearly went overboard, such as blanket orders to cremate the bodies of COVID-19 victims across communities regardless of their creed, a practice that is prohibited or discouraged among followers of many faiths.

Since that early period, more scientific data has become available which suggests that infection risks linked to handling intact bodies of COVID-19 patients are low. Many, but regrettably not all, government regulations that remain in effect today reflect this growing body of forensic knowledge as well as the relevant WHO and ICRC guidelines.⁹⁰ In addition, the ICRC over the first half of 2020 published



Sabirabad, Azerbaijan. Sara in front of the grave of her uncle Bahruz, March 2021.

a set of specific guidance notes for burials that are both safe and in line with religious precepts of different faiths, developed through forensic specialists' engagement with senior figures of various faiths and dialogue with communities.⁹¹ More recent guidance thus tries to find a better compromise between how to best ensure the protection and dignity of the dead and their surviving relatives, the need to investigate the cause of death, and the risks of exposure to infection, and in this way to avoid some of the pitfalls of practices enforced during the early phase of the pandemic.⁹²

“When my brother and other male relatives came back from the cemetery, they brought with them photographs and videos taken with their mobile phones,” Sara continued. “Later that evening, my brother showed them to me. In the photographs, one can see how they lowered the casket into the ground, how the mullah was leading the assembly in prayer, how family members were able to stand around the grave in remembrance of Uncle Bahruz. In one video, one can hear a relative of mine say to the others how thankful he was that they were able to fulfil his last wish and lay him to rest in the country of his birth, next to where his parents lie – may God have mercy on their

souls. It was strangely soothing to watch these videos. It looked like a real funeral – sad surely, but also gracious and caring. The videos were meant for Uncle Bahruz's son and wife who were unable to travel from Moscow because of the restrictions. But I knew that these images would also help my mother once I showed them to her.”

In the shadow of the exponential growth in infections and fatalities, the distress caused to those who lost loved ones to COVID-19 keeps contributing to what public health experts warn is a massive mental health crisis in the making which will outlive the pandemic. The causes of this crisis are multiple and relate to both the pandemic's primary and secondary impacts. Beyond the immediate loss in human life, there is the anxiety triggered by social isolation due to quarantines, lockdowns and furloughs, the existential fear that comes with losing jobs and livelihoods and facing an uncertain future. There are the burn-outs and other mental health issues among exhausted medical staff and other frontline workers, the psychological trauma caused to women and children who are at increased risk of domestic violence as a result of the pandemic. There are the patients who received mechanical

There is a massive mental health crisis in the making which will outlive the pandemic. Among those suffering mental health consequences, people living in conflict settings will be hit particularly hard.

ventilation, a significant proportion of whom develop post-traumatic stress disorder. And there is the mounting concern about patients with “long COVID” – people who have recovered but suffer from long-term conditions as a result of the disease.⁹³ As the list keeps getting longer, one begins to grasp the magnitude of the lasting psychological impact that COVID-19 will end up having on communities worldwide.

Among those suffering mental health consequences, people living in conflict settings will be hit particularly hard. Even without the additional impact of COVID-19, an estimated 22% of communities living through violence and upheaval suffer from mental health problems as a result, including depression,

anxiety and post-traumatic stress disorder.⁹⁴ The displaced, refugees and detainees as well as women, children, the elderly and people living with disabilities in conflict-affected areas are often exposed to particularly stressful or traumatic experiences. Given this pre-existing fragility, COVID-19 is likely to exacerbate existing mental health conditions in conflict settings, inflict new hardship and limit access to already scarce mental health services.⁹⁵

Today, in conflict settings and elsewhere, the vast majority of mental health needs continue to go unaddressed. Yet good mental health is critical to the functioning of society, and it should therefore be central in every country's response to and recovery from the COVID-19



Baku, Azerbaijan. Families lay flowers in front of photographs of their missing relatives during a commemoration event, 2015.

pandemic. Without additional investment in mental health promotion, prevention and care, we will not only fail to mitigate the massive psychological impact and related social and economic cost of this emergency but be again insufficiently prepared for tackling the next one. To change this, national health systems and humanitarian organizations need to continue investing in mental health services and build communities' resilience while ensuring that mental health considerations are fully integrated into systems and future response plans. If they do, COVID-19 could become a springboard, putting us on a better footing for the future.⁹⁶

When asked if she felt that the pandemic had increased the psychological burden on the families of the missing, Sara replied, "Early last year when the virus started spreading, people became very afraid. It added pressure to families who were already not doing well. Among our network of women, we felt we had to do something, and we started doing outreach by phone to all the families who were still part of the programme. Nothing elaborate, just a simple call to ask them how they were doing and give them advice on how to protect themselves from the virus. Most of the time what we got in reply was a grateful "Thank you for remembering us because no one else does."

They say this because they're used to their pain being invisible. I hope there will be a law on the missing from the war one day. Without one, you either go to court and declare your missing relative a martyr or you don't exist. But many families do not want to declare their relative dead because they still have hope, so they are used to suffering in silence.

"The rest of our volunteer work pretty much stalled. Before the coronavirus, we had our routine of making home visits to families of missing people or gathering them every now and then for small commemoration events we do together in honour of our missing. There's also a companion programme where the ICRC works with the government to collect samples from the families of the missing and build a DNA database for identifying exhumed remains in the future. Me and the other peer supporters used to go with the families to the hospital to support them when they provided the samples. The programme was on track to reach all families countrywide by the end of 2020, but it had to be suspended. The deadline has now been pushed back – who knows for how long."

Escalating hostilities in Nagorno-Karabakh starting in September last year have added to the caseload of people gone missing in association with the long-running conflict, on both

sides of the front lines. But it also rekindled families' hopes that, after years of waiting, certainty about the fate of their missing relatives might finally be within reach. Since the events of last fall, there is renewed hope that relevant authorities will be able to make progress in marking, preserving and eventually searching areas known to contain cemeteries and other sites where people missing since the 1990s may be buried. The information and DNA evidence gathered from these sites will then need to be matched against where and when people went missing and, eventually, against the biological reference samples collected from families of the missing. The process will take years, but the prospect of more waiting leaves Sara and her mother unperturbed.

"These past years, I've been drawing strength from supporting other families of missing people, and I would like to continue doing this

for as long as there's a need," she said as the conversation drew slowly to a close. "They have a right to know what happened to their relatives, and now there may be a chance to actually find answers for them and perhaps give a few among them a body to grieve over. I pray that, one day, I will be able to come home and tell my mother that Uncle Iskander has been found. It would come as a terrible shock to her, and we would both cry, but I know in the long run it will be better and help us find closure. We will have a proper funeral, with all that this includes, and bury him next to his parents and Uncle Bahruz, without the current restrictions because of the virus. Like this, the family will at last be together again. I know that this is what he would have wanted."

EPILOGUE: NONE OF US IS SAFE UNTIL ALL OF US ARE SAFE

By early 2021, the world recorded more than 100 million confirmed infections and more than two million deaths caused by the coronavirus pandemic.⁹⁷ Over the course of the preceding 12 months, governments across the globe have taken unprecedented steps to combat the spread of the virus and cushion some of the devastation that the disease and measures to contain it have inflicted on societies and economies worldwide. After a year of trying to limit its impact, the start of vaccination campaigns in many countries has now opened the prospect of the world eventually overcoming this pandemic. The key to achieving this aim is fulfilling Falmata's wish – to bring the vaccine to places like her home town of Dikwa, in Nigeria's conflict-affected north-east.

The case for making safe and effective COVID-19 vaccines available to all humankind equitably and fairly is patent and plain. If there is one lesson to be retained from how this pandemic developed over past months, it is that only a coordinated global effort that leaves no one out has a chance of beating it. By leaving behind even a single community we will collectively ensure that the virus continues to spread and mutate, eventually coming back stronger and more resistant to previous vaccines to bite those who previously jumped the queue. None of us is safe until all of us are safe – regardless of whether you live in countries at peace or in conflict regions, under government authority or the control of armed groups, in migrant camps or urban slums, in prisons or detention centres, among those fleeing violence, among the displaced and the dispossessed. We are, for better or worse, truly all in this together. The pandemic has brought this simple message home in the most convincing of manners.⁹⁸

The eradication of smallpox at the height of the Cold War in the 1970s showed that the world was capable of coordinated action in the face of a global threat to public health. Much of the global effort in response to COVID-19 has so far fallen short of this standard. Countries have turned inward, locked down their borders and for the most part focused exclusively on looking after their own citizens. Ruthless competition for personal protective equipment took the space that global solidarity was meant to occupy. In the main, countries with the material means to tackle the pandemic showed little inclination to share these with others in need. A year later, affluent northern countries hoarding limited supplies of vaccines at the expense of the global south appear set to continue this course of action, which is as ethically questionable as it is ultimately self-defeating.

The future trajectory of the pandemic remains uncertain. While efforts to defeat the virus through universal vaccination are maturing, there must be no let-up in our collective determination to prevent its spread, care for the sick and mitigate its social and economic knock-on effects on vulnerable communities. Some of these effects will far outlive this pandemic and likely stay with us for years.

Meanwhile, none of the other crises have gone away: the millions of people worldwide enduring hardship because wars and other forms of violence have deprived them of essential services and sometimes humanitarian aid; the millions of people forced to trade in their homes for a life in displacement in the face of insecurity and persecution; the families separated or without news from loved ones owing to conflict or disaster; people returning to their homes in the wake of hostilities and struggling to reconstruct their lives amidst destruction; detainees battling to survive inadequate detention conditions; migrants who have bet their lives on the hope of a better future elsewhere stuck somewhere midway, falling prey to human trafficking and exploitation. The countless people like Jassim, Joaquin, Falmata, Abobakr, Augustin, Luisa, Jawed and Sara who have stories to tell about how these protracted crises disrupted their lives and livelihoods prior to the pandemic, all these people are still there, facing the challenges thrown their way with courage

and resilience. Given its massive impact, COVID-19 may seem to momentarily supersede all these other crises. Yet for those on the receiving end, crises do not succeed one another – they simply accumulate. We owe it to them and to ourselves to not only carry on the collective pre-pandemic effort to alleviate human suffering caused by conflict and violence but to enhance and expand this effort to account for the additional strain that COVID-19 has inflicted on communities that were already struggling to cope.

But not all is bad about this pandemic and how it interfaces with other protracted humanitarian crises. These last months have made many stakeholders – governments, the private sector, civil society and humanitarian organizations, including the ICRC – experiment with progressive ideas and strategies, accelerate reforms and adopt new policies and technologies, some of which bear promise for the future of global crisis management.

We have learned much: about tail risks and black swans, rare events with massive consequences; about global public goods and the moral and practical imperative of ensuring equal access to them; about the value of preparedness and what can happen in its absence. We have witnessed the force of human creativity and ingenuity in solving problems when we put our minds to it and pool our resources, as when developing a vaccine faster than anyone thought possible; and we have seen what works and what doesn't in terms of policies, practices and tools for mitigating the social and economic impact of the pandemic.

What we take away from this crisis will decide how effective we are in dealing with present and future challenges: wars, natural disasters, environmental destruction, climate change and the next global pandemic, which epidemiologists predict will occur sooner or later. Among many other lessons, this includes the importance of contingency planning and of early and determined action; the recognition that investment in systems is like front-loaded emergency aid and that the sum of emergency and development aid together equals more than its parts; that social safety nets and national welfare systems, particularly when using cash-based approaches, have proven uniquely effective in mitigating the impact of such a sudden-onset crisis; that preserving the physical and mental health of communities during a pandemic is about access to food, clean water, dignified living conditions, jobs, education, hope and family as much as it is about combating a virus; that any government policy or humanitarian action can only go as far as the trust that affected communities have in those who deliver them; that there is not only moral virtue but practical value in global solidarity and inclusiveness; and that, in the absence of respect for international law and the protections it affords, almost every crisis regardless of its nature will, if it is not one to begin with, turn into a humanitarian crisis by the end, with COVID-19 being no exception.⁹⁹

For governments as well as humanitarians, it is worth taking these lessons to heart. It will put us in a stronger position to address the challenges still ahead and make sure that the hardship imposed on so many communities over the course of this pandemic will not have been in vain.

NOTES

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