

# The Impact of COVID-19 on Humanitarian Crises

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The increasing spread of COVID-19 has dominated global attention. Governments and media are focusing attention on the domestic impacts of the virus and the medical and political responses. With over 126 million people in need of humanitarian assistance globally, including 70 million forcibly displaced, this critical questions looks at the potential impacts of the pandemic on existing humanitarian crises and the immediate impacts on vulnerable populations in conflict affected settings.

## **Q1: Are there any known cases of COVID-19 within displaced communities?**

**A1:** The confirmed number of COVID-19 cases in displaced communities is small; however, this is more likely a result of a lack of testing and awareness than the absence of the virus. Iraq reported its first case in a displaced persons camp in Nineveh. Known cases are being documented in multiple countries with existing humanitarian emergencies. Somalia has reported its first case, with cases also reported in Afghanistan, Nigeria, Sudan, and Venezuela. Others are sure to follow shortly. Syria is particularly high risk given its proximity and close ties with Iran and the complete decimation of its health facilities. Doctors warn of a “potential catastrophe.”

The report of cases in Burkina Faso is particularly illustrative of the challenge of responding in a context where health care is limited. Malian refugees once displaced into Burkina Faso are being forced back into Mali, and ongoing violence inhibits humanitarian and medical access to affected populations.

## **Q2: What are the implications of COVID-19 for displacement and humanitarian contexts?**

**A2:** Many countries in the midst of armed conflict have seen substantial damage to critical health infrastructure. Dr. Mike Ryan, head of the World Health Organization’s (WHO) Medical Emergencies Programme, noted most conflict-affected states have the weakest health infrastructure, and displaced populations are especially vulnerable due to the physical environments they live in as a result of armed violence. The Assad regime’s targeting of health facilities in Syria, for example, is well-documented as the prevailing impact of displacement on their overall health. Consequently, Dr. Esperanza Martinez, the head of the International Committee of the Red Cross’s (ICRC) health unit, said that the virus reaching Syria or Yemen would be “impossible to manage,” and it could bring down entire medical systems in countries like South Sudan and the Democratic Republic of the Congo.

Many refugee camps suffer from insufficient hygiene and sanitation facilities, creating conditions conducive to the spread of disease. Official response plans in the United States, South Korea, China, and Europe require social distancing, which is physically impossible in many displacement camps and in the crowded urban contexts in which many forcibly displaced people live. Deteriorated health conditions due to malnutrition, poor sanitation, lack of access to clean water, and basic medical care means displaced populations are acutely vulnerable. Jan Egeland, director general of the Norwegian Refugee Council, has warned that COVID-19 could “decimate refugee communities.” Though far from the only areas of concern, the density of the Rohingya camps in Cox’s Bazaar, Bangladesh and the restrictions on movement and limited health capacity within the Gaza Strip portend a very dire outcome if COVID-19 spreads into those places. As attention also focuses on the potential impact to health care workers domestically, humanitarian organizations are grappling with the responsibility of duty of care to their staff working in humanitarian contexts while striving to maintain the provision of essential services.

National policies of isolation in reaction to the spread of COVID-19 also have negative consequences for persons facing humanitarian emergencies. For example, Colombia closed its border, which effectively cut off “a vital supply and healthcare lifeline for thousands of Venezuelans needing assistance.” The UN High Commissioner for Refugees (UNHCR) and International Organization for Migration have announced a halt to refugee resettlement programs as some host governments have stopped the intake of refugees and imposed travel restrictions as part of their official response.

Compounding these challenges is the reality that humanitarian funding—already barely able to keep up with global demand—may become impacted. Donor states are considering reprogramming funding already allocated toward humanitarian crises for the COVID-19 response, or restricting funding altogether as calls for stimulus packages and domestic spending on internal health responses increase. The U.S. Congress is considering a stimulus proposal potentially exceeding \$1 trillion to combat the economic impact of the virus; it begs the question of how voluntary contributions for humanitarian bodies like UNHCR, UNICEF, and the World Food Programme, may be impacted.

In a somewhat ironic twist, the coronavirus could also present opportunities for reductions in conflict. The European Union has called for the cessation of hostilities and a stop to military transfers in Libya to allow authorities to focus on responding to the health emergency. The Islamic State has put out repeated messages in its Al-Naba newsletter calling for fighters not to travel to Europe and to reduce attacks while focusing on staying free from the virus. It is too early to say if the threat of the virus has impacted combatant behavior in any major conflict zones. The potential for a humanitarian pause to respond to the health implications of the virus is worth watching and encouraging.

### **Q3: What lessons can be learned from existing humanitarian responses for the United States?**

**A3:** As hospitals in Italy and the United States grapple with potential shortages of equipment and personnel and the need for triage, lessons can be learned from how humanitarian organizations provide medical care and other essential services in situations of armed conflict. Humanitarian responses are universally underfunded, forcing organizations to make difficult choices about allocation of resources to achieve the greatest humanitarian outcomes. The fundamental humanitarian principle of impartiality is predicated on the notion that humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress. Policymakers in the United States should consult humanitarian organizations for guidance on ethically managing challenging operations with scarce resources.

Many doctors are comparing the health care response to managing field hospitals in situations of armed conflict. For those that have been in conflict zones, watching the Chinese government erect a hospital in Wuhan in mere days was eerily familiar. While there is not a universally agreed approach on how to make determinations of need in triage scenarios, in 2017, the WHO and ICRC convened an expert meeting on triage, with a special emphasis on having a system in place to seamlessly transition from regular operations to surge. A key takeaway from that exercise is of critical relevance for COVID-19: having agreed upon standards in place for how decisions are to be made, and how to transition from routine to surge capacity, is essential to ensuring the best outcome for patients.

Finally, this is an opportunity to reflect on the nature of humanitarian work overseas and ensure it is not overlooked even as Americans consider the challenge faced domestically. The potential economic impact of this pandemic are massive. As a means to stop the spread of COVID-19 in humanitarian and displacement contexts, some economists are pointing to donations to reliable humanitarian organizations responding to the pandemic overseas while injecting critical cash into the economy.

As the United States grapples with the prospect of real medical vulnerability, there is an opportunity to foster greater understanding of the needs of conflict-affected and forcibly displaced communities overseas. Médecins Sans Frontières (MSF) has now opened up facilities in four locations in Italy, portending the possibility that humanitarian organizations might similarly open up operations within the United States. The International Rescue Committee has already begun work in Seattle, the Bay Area, and Boise in coordination with the Centers for Disease Control. The United States would be smart to consider expanding such cooperation as the health situation deteriorates. Cooperating with reliable humanitarian organizations domestically will be critically important to both respond to the needs of the population while building greater understanding of the vital work they do in humanitarian settings abroad.

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