Avoiding another failed outbreak response:
addressing areas outside State control and hard to reach populations

Health Security Roundtable, 2017 Munich Security Conference

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Introduction

Outbreaks of infectious diseases with the potential for uncontrolled spread are inevitable but they can be contained. The International Health Regulations (IHR), a binding international legal instrument of the World Health Organization (WHO), exists to ensure that such outbreaks are identified and controlled early. While the recent outbreaks of Ebola and Zika have stimulated strengthening of individual states’ capacities to respond to such threats, the threats posed by an outbreak in ‘conflict-affected and hard to reach’ populations are not being adequately addressed. Indeed, there is evidence that the overall resilience and ability to rapidly detect and respond to public health threats in conflict-affected areas is worsening owing to attacks on health facilities that are needed to manage outbreaks. These attacks are by both state and non-state actors alike: whether deliberately, by accident, through negligence or from a belief that the health facility has lost the protection to which it is entitled under International Humanitarian Law (IHL). Where non-state armed groups (NSAGs) allow or encourage external organizations (e.g. humanitarian actors) to work within areas that they control, some of these external organizations claim that counterterrorism legislation hinders their work, for example, by criminalizing some of their essential activities.

This meeting summary is a record of discussions held on 17 February 2017 at the Munich Security Conference. The meeting was held under the Chatham House Rule. ¹

Some major points of discussion included:

- Maintaining a health system in conflict-affected and hard to reach areas is the key to preventing the spread of outbreaks. However, increasingly health infrastructure appears to be the target of attacks, which undermines the health system.
- Both national and foreign militaries may have a role responding to an outbreak in an ungoverned area. Any military involvement must be assessed on a case by case basis.
- There was no consensus during discussions on the extent to which NSAGs should be involved in containing an outbreak. Nor was there consensus on which organizations should provide leadership in such circumstances.
- There were few practical proposals for how attacks on health resources should be minimized or prevented. In the meantime, restoring respect for, and compliance with, IHL must be a priority for both states and NSAGs.

Discussion Summary

How can health services for populations affected by conflict or in ‘ungoverned’ areas be protected and strengthened to create resilience?

First and foremost, the key to managing any infectious disease outbreak is an effective local health system. This view was expressed by many participants and echoes wider discussions about preparedness, where the first solution should always be investing in and strengthening national health systems. It was also noted that there are currently many ongoing outbreaks in ‘ungoverned’ and insecure places. For example, Médecins Sans Frontières (MSF) and others are currently responding to yellow fever in the Democratic Republic of the Congo (DRC) and cholera in South Sudan.

¹ When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.
Engagement with local community was emphasized, both in the context of impartiality of health facilities and infectious disease preventive measures. Involving women and young people, and providing education and/or training for them, is particularly important, recognizing that women are often the first responders and primary caregivers.

Foreign militaries may contribute to strengthening of health systems, particularly in low-income countries and especially where the military are sometimes major providers of healthcare to civilians. However, the military may not always be an appropriate health provider and evidence presented from Nigeria demonstrated how local militaries may disrupt health and/or humanitarian activities. Nevertheless, if considered appropriate, military to military training may facilitate the development of an appropriate role for the military in an integrated civilian-military response to an epidemic.

**How to respond in conflict-affected areas to an infectious disease outbreak with the potential to spread across international borders? How to respond in areas under control of non-state armed groups or in areas with large mobile populations?**

Conflict and ungoverned areas vary greatly and there is no ‘one size fits all’ approach for the challenge of preparing for and responding to infectious disease outbreaks. In addition, conflict is becoming ‘fuzzier’ and there is a need to contextualize approaches to deal with the different types of conflict we find today, for example, unceasing urban warfare. The boundary between civilians and combatants is ever more blurred, while the conduct of war is ever more brutal with the use of starvation, forced migration and arbitrary execution not uncommon. The question was thus raised: is it realistic to expect cooperation of belligerents just because there is an epidemic (which has pandemic potential)? Identifying and responding to an epidemic in a conflict area could take longer; for example, gaining access may be an issue. Supply chains may be interrupted by belligerents.

In order to maximize access to healthcare for populations in ungoverned areas and protect against infectious disease risks, there is a need to talk to belligerents and other non-health stakeholders. This may include NSAGs. Indeed, participants expressed the view that, from their experience, non-state actors are interested in cooperation (although noted there is a need for training), and are willing to cooperate (indeed they want to be involved, and even take ownership). However, they need additional capacities and resources to be effective public health players. It was also noted that there are many barriers for actors ‘outside’ the international system; for example, counterterrorism legislation can impede mobilizing such actors to contribute to health systems for conflict-affected populations. A contrary view was that it was inappropriate to involve NSAGs in any response. In seeking to resolve these two opposing views, it was suggested that there was a need to differentiate between those armed groups which might contribute and those which are ‘part of the problem’. The debate was taken ‘offline’ to be discussed in more depth.

Involving the private sector could be one way to secure resources for a response in an ungoverned area that is out of state control but well known to companies operating there. It was noted that little work had been undertaken on the contribution of the private sector during the Ebola outbreak, and that some companies invested significantly in the health of their workers and the community from which they came in order to sustain their commercial operations. Mobilization of these resources to respond to outbreaks could make a significant contribution to the management of outbreaks in hard to reach areas.
What would be the role of WHO and the UN Security Council in an Ebola-like outbreak in a conflict-affected area? What is the role of regional organizations such as the African Union?

Participants suggested that it should be a government and/or locally led response, with WHO in support and with financing from WHO member states; this support should be guaranteed, regardless of who and where is affected. WHO should lead in developing regional response mechanisms, although there was disagreement whether this should be the responsibility of regional or sub-regional organizations. The need to share data between all parties (civilian and military, at the local, national and international levels) was emphasized, and should be facilitated by WHO. There was agreement that WHO needed strengthening, but without any in-depth discussion as to how.

How should the propensity for attacks on health resources be reversed?

Increasingly, health services that are present in conflict-affected areas are being undermined by attacks on healthcare workers and health resources in violation of IHL. To stop attacks, trust must be established in those organizations providing health and humanitarian services. However, we must recognize that there may be a widespread lack of trust in conflict-affected contexts, and health services may be seen as a tool of one or more of the belligerents. Although there were many comments on the issue, solutions for how to stop attacks were not clearly articulated. One suggestion was the potential to engage international health professional associations on how to protect themselves; this may not be feasible as these organizations are not used to or do not understand operating in conflict. Another possible solution is to develop ‘safe zones’ around hospitals (and schools and other public buildings), but the lack of trust within combat areas may require some form of independent verification to ensure that they are complying with IHL as it applies to health facilities. There is also a need to consider the impact of urban warfare: to what extent is protection of any facility in unrestricted urban warfare feasible? Restoring respect for IHL, especially respect for rules around the protection of healthcare workers in conflict, is a necessity. It was pointed out that while new solutions need exploring, humanitarians must continue to engage in negotiations with NSAGs controlling the territory where humanitarians are working but that such negotiations add to the ‘fuzziness’ of contemporary conflict.

Areas not fully addressed during the discussions

A major omission was discussion on who would provide leadership in the event of a major epidemic with pandemic potential in a conflict-affected area. This is a complex question that will require a more concerted effort from all stakeholders. Although specific issues around leadership will depend on context, the question is sufficiently important to warrant further discussion (for example, at regional health security roundtables) but would also benefit from a generic simulation exercise where participants would be challenged to overcome potential points of conflict or controversy.

The role of the UN was not fully addressed and there is a need to have broader discussion around the ‘Responsibility to Protect’ as it applies to health security.

The issue of how to engage with NSAGs, especially when they are in control of territory, was raised several times but there was no consensus and more effort is required to bring stakeholders together.

Protecting collective global health security means involving all parts of the world – governed, ungoverned, places in peace and places at war. The message from this roundtable was clear: the world is not ready for the next outbreak. If it originates in an ungoverned area, the challenges of access, prevention and control
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are likely to increase. As are the potential security impacts of the outbreak. Health security actors must therefore engage proactively with humanitarian and security actors that are already working in ungoverned areas; these actors should be involved in preparedness as, inevitably, they will be involved in any response.