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# Fighting Novel Diseases amidst Humanitarian Crises

by Lawrence O. Gostin, Neil R. Sircar, and Eric A. Friedman

The Democratic Republic of the Congo is facing two crises: a potentially explosive Ebola epidemic and a major insurgency. But they are not wholly distinct from each other: the first is intertwined with the second, and public mistrust and political violence add a dangerous dimension to the Ebola epidemic. The World Health Organization and other health emergency responders will increasingly find themselves fighting outbreaks in insecure, misgoverned or ungoverned zones, possibly experiencing active conflict. Yet the WHO has neither the mission nor the capabilities to navigate these security threats. We cannot expect that the usual public health strategy will succeed when health workers' lives are directly imperiled and community resistance runs deep. Tackling health emergencies amidst complex humanitarian crises requires fresh thinking.

## Ebola in the DRC

The Democratic Republic of the Congo is bitterly accustomed to novel diseases and political violence. The North Kivu Ebola epidemic is the DRC's tenth Ebola outbreak and now the second largest globally, after that in the West African countries of Guinea, Liberia, and Sierra Leone in 2014.<sup>1</sup> Making matters worse, combatants vie for dominance in the region, displacing millions of residents fleeing violence and disease—which

could accelerate and spread within and beyond the DRC.<sup>2</sup> Guerrilla and rebel groups, notably the Allied Democratic Forces, fight with government forces and international peacekeepers. Yet the long-running United Nations Stabilization Mission (MONUSCO) in DRC has been ineffectual, with UN troops themselves targeted as hostile forces.<sup>3</sup> More than two decades of conflict has destroyed any sense of order and structure. Systematic rape, murder, and kidnapping have eroded security and instilled fear.<sup>4</sup> Within this quagmire, Ebola has now spread to Butembo (a city of about one million people), while Uganda has vaccinated health workers in preparation for cross-border cases.

The WHO has adopted a “ring” strategy, vaccinating health workers and individuals at heightened risk of exposure. The investigational vaccine is highly effective, yet many infected and exposed people are lost to follow-up, often hidden by distrustful family members. In an atmosphere of violence and mistrust, vaccination and contact tracing are seriously disrupted. Each concussive rebel attack has coincided with a major spike in cases.

The U.S. State Department has banned all U.S. personnel from the hot zone, including from the Centers for Disease Control and Prevention and the U.S. Agency for International Development (USAID).<sup>5</sup> In the run-up to the DRC elections, the State Department also announced an “ordered

departure” of U.S. personnel even from Kinshasa, where the CDC was working with the DRC Ministry of Health to track cases in North Kivu.<sup>6</sup> The Kinshasa Ebola operations center may be left with as little as one CDC expert. Other countries, such as France and the United Kingdom, have followed the U.S. lead and have also withdrawn from North Kivu. The Trump administration apparently has adopted a policy of zero risk tolerance, fearing a “Benghazi-style” attack. In a vicious cycle, the few brave health workers remaining are under threat, and their inability to contain the epidemic has sadly become yet another cause of community frustration and anger.

A recent expert consensus statement urged the Trump administration to deploy all key assets while managing the security risk with “smart” peacekeeping, diplomacy, and community engagement.<sup>7</sup> The CDC personnel ban will certainly result in more disease and death in local populations. Deploying needed assistance is not just the right thing to do; it is also in our national interests. Fighting outbreaks at their source can halt an epidemic before it spreads regionally, even globally. Global health leadership enhances American “soft power.”

In mid-October 2018, acting under the International Health Regulations, the WHO director-general Tedros Ghebreyesus convened an emergency committee, which recognized the potential for cross-border transmission but did not recommend declaring the North Kivu outbreak a public health emergency of international concern. This was a mistake. A PHEIC declaration would have underscored the urgency and raised the political profile of the health crisis amidst the protracted violence and humanitarian crisis.<sup>8</sup>

Still, for the first time ever, the WHO director-general requested UN

Security Council action on behalf of global health security.<sup>9</sup> On October 30, the Security Council condemned political attacks, demanding “full, safe, immediate and unhindered access for the humanitarian personnel.”<sup>10</sup> Incredibly, though, it called on warring parties to “respect” international humanitarian law—a plea sure to fall on empty ears in a conflict where violations are the norm, while doing little to enhance peacekeeping operations or mobilize funding. The Security Council urged the DRC to take responsibility for security, despite the Congolese military’s own record of repression and weak capacities.

Commissions established in the aftermath of the 2014 Ebola outbreak in West Africa urged decisive UN action when a health emergency rises beyond the WHO’s mandate and capacity.<sup>11</sup> Now is that time, both because of the urgency of the DRC epidemic and to set a precedent, leading the way for future complex health emergencies. Fighting disease in conflict zones and disaster settings is rapidly becoming the new normal. We need to plan accordingly. Consider just a few recent examples in which epidemics have coincided with political violence. In December 2018, the WHO was forced to extend a PHEIC for wild polio, which is stubbornly persisting in war-torn Afghanistan and Pakistan. Taliban fighters have killed dozens of polio vaccine workers, threatening countless others.<sup>12</sup>

In Yemen, cholera has killed several thousand people, as the country’s health system unravels due to civil strife and foreign aggression. Beyond disease, the people of Yemen are dying from starvation.<sup>13</sup> Haiti, another country with weak governance, has unsuccessfully fought a cholera epidemic ever since UN personnel inadvertently introduced the disease following a devastating earthquake in 2010.

In unstable countries and regions, health workers are at major risk. In 2018, Boko Haram killed and abducted International Committee of the Red Cross personnel in Nigeria. The ICRC’s plea for mercy did not save the health workers’ lives.<sup>14</sup> In Syria, rebels and government forces have killed hundreds of

health workers, including through intentional targeting.<sup>15</sup> All this violence has occurred despite Security Council resolutions condemning attacks on health workers and facilities.<sup>16</sup> International humanitarian law proscribes attacks on health workers, but it does not apply to humanitarian workers. The UN, mindful of this gap in legal protection, has nonetheless refused to extend the Geneva Conventions to include humanitarian personnel.<sup>17</sup>

### A Blueprint for Fighting Disease in Conflict Zones

Given these trends, it makes little sense to use the same public health playbook that has worked in the past. Health workers must be able to operate freely and safely to bring infectious diseases under control. Political violence undermines public health’s ability to reach contagious, exposed, or at-risk individuals to conduct vaccination campaigns and contact investigations or to separate the sick from the healthy through isolation or quarantine. Health workers and patients must have secure access to clinics and hospitals for diagnosis and medical treatment. At the same time, first responders must gain the public’s trust. If local communities fail to cooperate, if they hide sick family members, if they follow unsafe burial rituals, or if they go underground or flee the conflict, an outbreak can rapidly spin out of control. Further, misinformation can endanger health workers. In 2015, Guinean villagers slaughtered health workers under the belief that they were spreading Ebola.<sup>18</sup>

Here, we offer a blueprint for fighting diseases in complex humanitarian emergencies. The building blocks of security and trust include high-level political support, street-level diplomacy, community engagement, enhanced funding, and protection of health professionals working in conflict or disaster zones. When epidemics rage in hostile environments, high-income countries should not stand idly by but, rather, join the WHO and local health workers on the ground, where assistance is badly needed. This is all far from simple, but

the alternative is to allow dangerous diseases to go unchecked, threatening countries, regions, and the globe.

**Peacekeeping.** Peacekeepers are supposed to act as a neutral force, separating warring factions and providing “space” for diplomacy to end hostilities. Yet where communities feel alienated from decades of violence—including rape, torture, and possibly genocide<sup>19</sup>—peacekeepers can become engulfed in the conflict. Humanitarian organizations have also resisted armed protection because they want to serve as mediators, health advocates, and healers.<sup>20</sup> Consequently, the United Nations must fundamentally reform peacekeeping conducted in a health emergency.

The Security Council should provide peacekeepers with a mandate and modalities fit for the purpose of quelling a health emergency. Separate from other peacekeeping missions that may be operating, such a health peacekeeping mission’s mandate should specifically be to safeguard the public health response, deploying sufficient forces to enable health workers to operate safely. This requires peacekeeper training on health emergencies and working cooperatively with first responders. To build trust, forces should be trained on the values and strategies of “community policing”—engaging community members as partners, listening to their concerns, and respecting their rights and dignity. Peacekeepers must work with anthropologists and local leaders to value local culture, customs, and languages. Peacekeepers must build trust and security from the bottom up, rather than from the top down.

**Diplomacy.** A classic tool of statecraft, diplomacy needs to become a central piece of the global response to health emergencies during complex humanitarian crises. The clear aim of negotiations with belligerents and community members would be safe entry and a secure working environment for health and humanitarian workers. While overall conflict resolution is necessary, the immediate goal should be to create the respect and trust needed for impartial and independent health and humanitarian workers to function.

Much as diplomacy helped secure the Taliban's agreement to allow health workers in Afghanistan to carry out polio vaccination,<sup>20</sup> negotiations could result in an agreement that insurgents would avoid interfering with the public health response.

**Deployment of all needed assets.** A zero-risk policy for deployment of personnel from the United States and other high-income countries is a recipe for failure. The WHO and the DRC have requested U.S. deployment to the Ebola hot zone. The CDC could fill significant capacity gaps, such as surveillance, laboratory testing, and contact investigations. Other public agencies, such as USAID and the National Institutes of Health's Fogarty International Center, could provide peer-to-peer training in diagnostics, treatment, and the safe use of personal protective equipment.

Just as the CDC has expertise in emergency response, the State Department has diplomatic and intelligence capacities, and thus the responsibility to act. The diplomatic power of the United States extends beyond intelligence and mediation to political leverage. President Obama, for example, secured an unprecedented Security Council resolution, which was a milestone in ultimately bringing the West African Ebola epidemic under control. Bringing hostile parties to the negotiating table, as recently occurred in Yemen, requires high-level political attention. That level of political action has been sorely missing in the DRC.

The United States should urgently create a strategic plan for future deployment of expert personnel to conflict zones. Rather than having zero risk tolerance, the United States should *manage* the risk by shoring up security, engaging diplomats, and embedding U.S. personnel in ongoing international humanitarian operations through, for example, the United Nations.

**International assistance.** The International Health Regulations require every nation to create core health system capacities to detect, report, and respond to health emergencies, and they charge states with providing international assistance to build those capacities.<sup>21</sup> Yet

most countries have failed to meet IHR standards, including for laboratories, surveillance, risk communication, and human resources. And high-income countries have virtually ignored their responsibilities for international assistance. The U.S. launched the Global Health Security Agenda in 2014 to expand capacities, and it recently recommitted itself to the GHSA at the GHSA Ministerial in Indonesia. Yet Congress has not reauthorized GSHA funding. Investing in preparedness is much less costly than crisis response.

Developing national, inclusive health systems is a sure way to build public trust. Beyond health systems, international assistance should extend to meeting basic needs such as clean water and nutritious food. The public is much more likely to view foreign health workers as a force for good if their presence comes with tangible long-term, sustained improvement in health and social services—even as ensuring such needs should hardly depend on a health crisis that poses international risk.

### Toward a New Public Health Playbook

The standard public health playbook is still vital, combining therapeutic countermeasures such as vaccines and antiviral medications with public health measures such as surveillance, contact investigations, and hygiene. But in an era when health emergencies coincide with complex humanitarian crises, we cannot expect the old public health to succeed; we must adapt to the world we live in. Where distrust and insecurity run deep, politics, diplomacy, and peacekeeping become vital assets. With the United Nations Security Council, the Trump administration, and Western allies standing idle while international health actors struggle, the interconnected epidemics of violence and disease escalate.

The Ebola crisis in parts of West Africa spurred major reforms to the WHO's health emergency program. The ongoing Ebola and humanitarian crisis in North Kivu ought to similarly transform how we understand, prepare

for, and respond to future public health crises in hotbeds of violence and human suffering. Political actors will need to assume their responsibilities if humanitarians and health workers are to carry out theirs.

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