Security in the DRC and Yemen

Military Conflict, Disease Outbreak and Containment

Oxford Research Group

November 2020

Breaking the cycle of violence · ORG

This briefing has been written by staff at Oxford Research Group (ORG), with contributions from local experts, as part of the **'Reshaping The Process in Yemen: Exploring alternative methodologies for the peace process in Yemen'** project. Implemented by ORG and the Sana'a Center for Strategic Studies (Sana'a Center), the project seeks to strengthen local capacity for more inclusive and strategic dialogue in four key Yemeni Governorates - Hadhramaut, Marib, Shabwah and Al-Mahrah - and lay the foundations for more effective peacebuilding efforts towards the country's future political transition.

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We would like to extend our heartfelt thanks to the many people who gave up their time and shared their knowledge with us for this briefing. None of them bear responsibility for any of the opinions (or errors) in this report, which are the authors' own.

This project was funded with UK aid from the UK government.

Cover image: *A Trip to the Front Lines of the Fight Against Ebola, DRC. Credit World Bank / Vincent Tremeau.*

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Breaking the cycle of violence

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This is the final briefing in a series released by the Oxford Research Group's (ORG) Strategic Peacebuilding Programme. These briefings examine lessons that can be drawn from the response to Ebola in the Democratic Republic of the Congo, and how they can be applied in the response to COVID-19 in Yemen.

The other briefings – focused on respectively Background Information, Community and Women's Experience – can be found here. For readers new to this topic, we suggest reading the background briefing before the others, as this will provide background information on the disease outbreaks and conflicts in both the DRC and Yemen, as well as the international responses in both countries.

A brief note on methodology: the sections focused on the DRC were written by the ORG team based on desk-based research which was conducted in the Summer and Autumn 2020. This was supplemented with a closed-door roundtable with international experts in August and interviews with experts and practitioners with experience of working in the DRC, including Congolese nationals, throughout Autumn 2020. The sections focused on Yemen have been written by local experts; each has a different methodology. These are meant to offer a local perspective on the early impact of COVID-19 in the country, and how lessons from the DRC can best be applied. These briefings are of limited scope; their purpose is to inspire future research more than to present final conclusions.

Violent conflicts and instability present significant challenges for those responding to humanitarian emergencies and disease outbreaks.[1] In such environments, responders must navigate competing power dynamics of armed actors, in addition to the challenges of weak health infrastructure and fractured national institutions.

In such contexts, it is more vital than ever than those responding to disease outbreaks thoroughly coordinate with the state (where appropriate), conflict actors, local and international responders, and – importantly - local communities. This is essential to ensuring that vulnerable communities receive the required medical support and to ensure that health workers can operate without fearing for their lives.

This briefing examines the effect of military conflict on the response (and vice versa) to Ebola and COVID-19 in DRC and Yemen, respectively. First, it lays out the pre-Ebola security situation in eastern DRC, examining the security incidents and the key actors involved and the responses and the adaptation to those security challenges, including key lessons learnt. Similar trends shall then be explored within the Yemen context, where key security challenges pre-COVID-19 will be identified, conflict actors examined, and responses to the outbreak outlined. This section will also examine how COVID-19 affected the conflict dynamics and the security situation in the country.

Conflict and Ebola in the DRC

Conflict and instability severely compromise disease containment. These conditions create an environment in which diseases can – at times - spread uncontrolled.[2] Lack of access and protection, as well as displacement, all pose additional challenges in a conflict setting.[3]

Operating in this environment, decision-makers and responders were faced with daunting challenges upon the declaration of the 10th Ebola outbreak in the DRC. Throughout the response, severe, and sometimes deadly, challenges affected both communities and responders alike.

Security situation in eastern DRC (pre-Ebola outbreak 2018-2020)[4]

Intermittent and underlying conflict has been present in the east and north-east provinces in DRC for decades. The causes of insecurity, and conflicts themselves, are complex and multi-layered, with over a hundred armed groups present in the North Kivu and Ituri provinces alone.[5] Although these armed groups all fit under the umbrella of "non-state armed groups" there are many different entities, including an array of militias and Mai Mai[6] who are often deeply ingrained in local communities.[7] A primary armed group involved was the Allied Democratic Forces (ADF), alongside a number of other groups, some of which have alleged links with neighbouring countries, namely Uganda, Rwanda and Burundi.[8] These groups vary in capacity, size and objectives. At the same time, there have been ample accusations of atrocities and human rights violations by DRC state security forces.[9]

There are regular clashes sparked by ethnic, intercommunal and political tensions, competing land ownership claims, state security operations against armed groups and subsequent counterattacks, clashes between armed groups, as well as criminality and opportunism.[10] At the same time there is great political uncertainty in the context of a disputed 2018 election, which led to the controversial curtailing of democratic elections in both Beni and Betumbo. allegedly because of security risks and concerns around EVD.[11] Ultimately, all of the above resulted in an extremely complex security climate.[12]

Tracking armed groups and identifying motivations behind security events themselves is a mammoth task. In fact, The Armed Conflict Location & Data Project (ACLED) has stated that, from January to July 2019, 'unidentified or anonymous armed groups are responsible for over half of all attacks on health and aid workers in North Kivu and Ituri.'[13]

Security during the Ebola response (2018-2020)

The focus of this briefing will be limited to the impact of insecurity on the Ebola response.[14] Since the start of the outbreak, in August 2018, there have been hundreds of attacks and threats not just against local communities, but also against frontline health workers and others working and associated with the response, individuals who have visited a facility and survived Ebola, as well as health facilities, UN compounds and bases.[15] Furthermore, kidnapping, robberies, and killings of humanitarian workers, associated staff and patients occurred across the North Kivu and Ituri provinces.[16] One of the most prominent and well documented deaths was of Dr Richard Valery Mouzoko Kiboung, a Cameroonian epidemiologist from the WHO, in an attack on Butembo

University Hospital, North Kivu in April 2019.[17] A well-known epidemiologist, his death shocked the international community and responders, highlighting the dangers faced by medical staff and other responders during the outbreak.[18] Such attacks have continued into 2020; for example, attacks on Ebola treatment centres (ETCs) in Beni and Lubero were recorded in April and another in Butembo in May 2020.[19]

Distrust of responders, conspiracy theories regarding Ebola and associated activities, as well as political pushback against election cancellations were identified as factors in some of these cases.[20] As a result of these attacks, some facilities were shut down, healthcare staff moved or evacuated, and activities reduced.[21] These moves were sometimes temporary, whilst others were more permanent.[22] Reduction in services, whatever the timeframe, can be disastrous to any disease containment programme. The interruption of surveillance and tracking activities, as well as the lack of adequate healthcare facilities and services that increase the vulnerability of the affected populations.[23] In addition to these detrimental effects, a number of studies have recently shown that areas with high rates of attacks witness an increased level of transmission soon afterwards.[24]

Additional studies and detailed investigations are required on the security environment, including the qualitative data, to map the drivers behind attacks, as well as the linkage between attacks and disease transmission. Such studies must be developed with community engagement at the core to truly reflect reality on the ground. Further quantitative studies are also required which, in combination with more qualitative studies, can form a broader picture to inform strategies and policies.

Working in such a complex and insecure environment creates challenging dilemmas for humanitarian decision makers who must abide by humanitarian principles, while pursuing security for their frontline workers. Ensuring that whatever strategy is employed does not increase insecurity in the operational areas for both responders and local communities is of vital importance. Such dilemmas and balances must be tackled during all humanitarian crises.

To try and learn lessons from the strategies chosen and utilized for the Ebola Response (2018-2020), the approaches taken will be outlined, analysed and considered.

Armed escorts

One of the key responses that was relied on to increase the safety and security of frontline staff, was to attach armed escorts to accompany healthcare workers during certain activities. This militarisation of humanitarianism has been the subject of much debate and criticism, accused of '"blurring the line between humanitarian assistance and political-military action", thus affecting their ability to operate in areas controlled by armed groups.'[25] In the response to EVD in the DRC, there were instances where armed convoys would enter communities without warning or adequate explanation, leading to fear among communities, distrust to the response as a whole, and perceived militarisation of the humanitarian aid. In addition to such armed convoys, there were other instances where military actors were relied upon; for instance, the DRC's National Intelligence Agency (Agence Nationale de Renseignement (ANR)), DRC's 'domestic intelligence service', were involved in 'tracing lost and displaced contact', alongside civil protection and United Nations Police (UNPOL).[26] The ANR itself, however, are alleged to have committed human rights violations and, as Human Rights Watch has stated, was an 'instrument of political repression.'[27] The inclusion of this agency, among others, contributed to the alienation between the response and local communities, and negatively impacted the community trust of the Ebola response and responders.

The argument and debates surrounding the utilization of armed escorts and convoys are neither new nor confined to the Ebola response.[28] However, during the Ebola response, a strategic decision was made to use DRC state security forces, a number of which were paid by the response funds, reportedly 'procured at very high costs.'[29] One example of this is when the WHO paid per diems to some of these forces; some indications suggest the cost of this might be in the millions of dollars, the total figure has not been disclosed.[30] As one of the roundtable participants stated, though, '[o] nce you start paying armed people, it's very hard to stop.'[31]

Security actors and examples

The DRC state security forces, including the Armed Forces of the Democratic Republic of the Congo (FARDC)[32], have a very poor human rights record and have been 'implicated in widespread atrocities.'[33] The accusations against these security forces have included sexual assaults, rapes and mass rapes, as well as other breaches of human rights which have been well documented and evidenced.[34] FARDC have also been involved in other illegal activities, including illegal tax levies and mineral production, taking advantage of the instability in general and the response specifically.[35]

As the Strategy Peacebuilding Programme's sister project, the Remote Warfare Programme, has documented extensively in many former publications – albeit for different contexts - working "by, with, and through" local military actors who lack legitimacy and do not represent the values being pursued will not lead to successful outcomes in the long term.[36] Instead, it promotes the very insecurity that international actors wish to curb. It also often leads to the international actors suffering reputational damage as they lose legitimacy in the eyes of citizens on the ground.

MONUSCO[37], the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo, which was originally established in the late 1990s to monitor the Second Congo War and has since remained as a peacekeeping force to address various conflicts, was also involved in a number of the armed escorts and logistical support.[38] Despite this attempt to 'improve security and provide escorts', which fits into their broader mission[39], management of local communities' expectations proved difficult throughout.[40] The provision of this protection was made more difficult not only by the very challenging operational environment, but was undermined by the force itself as MONUSCO personnel were 'repeatedly being implicated in sexual abuse and exploitation.'[41]

Moreover, the peacekeeping force has been seen by Congolese citizens, in the context of the wider conflict, as a 'passive observer rather than an actor.'[42] Inactivity on behalf of MONUSCO has had profound consequences not only on the safety and security of the local populations, but also on the Ebola virus disease (EVD) response. An insightful example to cover here is the attack on a MONUSCO base in Beni, a city in the north east of the country. After attacks on civilians by the ADF in November 2019, civilians attacked a MONUSCO base in Beni on November 25 2019, citing the lack of protection as a main reason for their attack.[43] Despite this violence not necessarily being related to the response, the subsequent attack 'forced the evacuation of many EVD response actors and a near halt of response activities for several days.'[44] Given the fluid and rapid nature of disease transmissions, those several days and others were vital to EVD containment activities. The EVD response, in this situation, wasn't attacked directly, yet this demonstrates how insecurity can impact the operational environment indirectly and highlights the use of bases and how these could be exposed to attacks.

Wider strategic implications and impacts

A direct link was created between the security forces and the responders, with armed escorts playing a crucial part of the Ebola response. The relationship has, in a sense, 'facilitated the legitimacy of attacks on EVD response staff.'[45] The consequences of the perceived closeness of these actors went even further. As an expert stated in one of our interviews, the military is often associated with the Kinshasa-based regime/government; as they began accompanying frontline health workers and responders, outsiders became equated with the disease containment programme.[46] This perception of responders being non-local was exacerbated by the fact that many humanitarian responders were already seen as 'foreign' as they had come primarily from other countries, or Eastern Congo, following the 9th Ebola outbreak in the Equateur Region in 2018.

The debates surrounding the practice of using armed security, in this context, must take into consideration and account for humanitarian values, including neutrality and impartiality, and the "Do No Harm" imperative. During their Operational Review, Adam Smith International stated that 'the application of the "Do no harm" approach and conflict sensitivity is often rather illusory.'[47] This is rather damning in a conflict setting, but especially one that is deeply ingrained after decades of violence and war.

It is also particularly noteworthy that community engagement was undermined by the inclusion of armed individuals for response activities. The militarization of the response 'exacerbated tensions and further distanced the community from the response effort.'[48] Without communications with community leaders and providing adequate explanations to communities as to why these armed individuals were being used the distance between responders and affected communities grew.

One roundtable participant argued that, while it is vital to ensure staff are protected from violence, the use of military escorts was 'counterproductive' and that 'military accompaniment made responders an easy target.'[49] Whilst potentially providing some short-term benefits – the effectiveness of which can be questioned – the medium and long-term implications are severe for the entire response and related activities.

Fortification

In addition to relying on armed actors, the international EVD response was militarised through the 'fortification' of ETC facilities, bases and staff accommodation.[50] For instance, after an ETC in Katwa was attacked, it was only reopened once it was fortified to the extent that it resembled 'a military base.'[51] The fortification was pursued to protect the workers and patients. However, rather than fortifications acting as effective deterrence for future attacks, there are examples to the contrary. In March 2019, for example, an ETC based in Butembo was attacked again, only 10 days after the initial incident, 'despite being heavily guarded by the police and army.'[52] In the aftermath, the facility was fortified further.

The consequences of the fortification process were similar to those which stemmed from the use of armed escorts. Coercion and violence was sometimes applied in extreme cases by security forces attached to facilities, including forcing 'suspected Ebola patients into quarantine centres before confirming whether they were infected' and opening 'fire on grieving family members who refused to turn over loved ones' bodies to safe burial teams.'[53] These were severe and unusual examples, yet significant in their impact on trust between communities and the response.

Lessons learned

Several lessons can be drawn from the above, the primary of which are attempts to reduce tensions from the planning and outset stages, as well as throughout a particular response. The authors recognise the absolutely vital importance of protecting all staff involved, the very difficult dilemma facing those responsible, and the pressures associated with timely humanitarian and public health interventions. Keeping this in mind, however, lessons can be learned from the EVD response in DRC to prevent the militarisation of future responses.

Firstly, it is vital to plan for what happens when armed attacks occur to avoid knee-jerk reactions. Strategies and standard operating procedures (SOPs) should be developed to identify these potential problems before they occur, and attempt to mitigate them where possible. Where this might not be possible, it will be necessary to carefully formulate pre-emptive responses to incidents such as attacks on facilities, among others. This is of course particularly important in a conflict zone. Security and management strategies should encompass macro aspects, as well as day-to-day procedures.[54] Included within this should be the full application of the UN Human Rights Due Diligence Policy on Support for Non-United Nations Security Forces (HRDDP) policy to prevent any support inadvertently contributing to human rights violations.[55] Whilst important in all contexts, it is vital in long-standing conflict zones and, particularly, in support of humanitarian and public health responses.[56]

Utilisation of strategic tools, such as security risk management methods, can aid in analysing certain contexts and situations 'to prevent security incidents from occurring in the first place.'[57] These should not be developed and implemented in isolation, but in coordination and consultation with other activities and strategies such as community engagement. They should also - importantly - coordinate with humanitarian approaches present in the country which pre-date the response to the disease outbreak and focus on other challenges.

Successful implementation of the response to the 10th Ebola outbreak in the DRC was increasingly difficult due to the prevalence of conflict and violence across the primarily affected areas, namely Ituri and North Kivu provinces. Two of the strategic decisions, armed escorts and fortification, resulted in a number of negative implications for both responders and local populations.

Conflict and COVID-19 in Yemen

Introduction

Yemen's war is multi-layered with regional, national, and local actors playing a role in fuelling the conflict. Now in its 6th year, the stability and human security of the population has been severely compromised. Since its eruption in September 2014, more than 3 million Yemenis have been internally displaced across the country.[58] Since March 2020 alone, the International Organization for Migration has tracked 100.000 displacements; while the majority of these are linked to 'fighting and insecurity', fears of COVID-19 have also emerged as a 'new cause of displacement.'[59]

Large-scale conflict between the internationally recognised government (IRG) and their allies, the Houthis, and the Southern Transitional Council (STC) have contributed to displacement and violence. This comes in addition to other clashes between armed groups and small-scale disputes over land ownership.[60] As in the DRC, conflict actors in Yemen are facing accusations of atrocities and human rights violations, with some cases amounting to war crimes, as reported by the UN Panel of experts' report on Yemen.[61] The extent and frequency of violence varies significantly between governorates. Some, such as Hadhramaut and Marib, have seen only isolated occurrences of violence, while others such Taiz, are experiencing continuous fighting.

Security incidents pre-COVID-19

Since the beginning of the conflict, Yemen has gone through several significant disease outbreaks.[62] Most notably, both local and international humanitarian responders continue to fight extensive Cholera outbreaks in several parts of the country.

Fortunately to date, unlike the DRC, while there have been attacks on health facilities, these have not specifically targeted the response to COVID-19, except isolated incidents whereby health workers were attacked inside facilities by patients' companions due to perceived inadequate care provision.[63] More widely, however, hospitals and health centres have been targeted by Saudi-led coalition airstrikes in the north and Houthi forces shelling during clashes in areas such as Taiz and Ad Dhale in the southwest. For example, in August 2016, Médecins Sans Frontieres (MSF) facilities in northwest Yemen were targeted for the fourth time that year, in an attack that killed 11 people, including one MSF staff member, and injured 19 others.[64] Consequently, MSF evacuated their staff from Sadaa and Hajja governorates, deeming them unsafe for both staff and patients.[65] Two years later, MSF held multiple negotiations with local stakeholders to address security threats and incidents, but were ultimately unsuccessful as an MSF staff house in Ad Dhale was attacked twice in a week. This resulted in the closure of their projects in the governorate to protect staff and patients.[66]

In Taiz, a city that has been under Houthi siege since 2015, people are unable to access health services unless they walk for several miles to find safe passage to a facility. The main hospital in the city, Al-Thawra General hospital, recorded more than 40 instances of violence (including 15 instances where the hospital was targeted by small arms and shelling) between 2018 and 2020.[67] These attacks have discouraged medical staff from working in the hospital and affected patients' decisions to seek medical support.[68] Alongside the above, there has also been obstruction of vital goods across the country. In 2016, for example, the Human Rights Watch and Amnesty International both reported instances of Houthi forces blocking key food and medical items from Taiz city, including oxygen canisters from Al-Thawra hospital.[69]

As demonstrated above, in both the Yemen and DRC contexts, it is necessary to ensure health facilities remain a safe zone for staff and patients, and that conflict actors adhere to international humanitarian principles and law. This could contribute to the reduction of anxiety and concerns of patients when seeking medical support and, in this case, COVID-19-related assistance.

Health Infrastructure, Conflict Actors, and COVID-19 Responses

To understand the security implications of COVID-19, it is necessary to study each of the conflict actors' response to the pandemic, focusing particularly on the IRG, Houthi rebels and the UAE-backed STC. The responses of these actors varied considerably, with actors taking different levels of responsibility, capacity, and care.[70]

In the relatively more stable and secure IRG-controlled governorates, namely Hadhramaut, Marib and al-Mahra, there were better responses than those seen from local authorities in Aden and Houthi-held areas; in both of these areas, the pandemic has been politicised and weaponised.

The Internationally Recognised Government of Yemen

The IRG, whose authority has gradually eroded since the *coup d'état* in September 2014, took several local and national measures to cushion the spread of COVID-19. This sub-section shall outline and analyse the strategies implemented at the national and local levels by the IRG.

Nationally, the IRG imposed travel restrictions, temporarily closing airports and border entry points with Saudi Arabia and Oman. However, in late May, the Supreme National Emergency Committee for Covid-19 announced the resumption of flights for stranded nationals, mainly from Jordan, India and Egypt.[71] Other national measures included: the establishment of the Supreme National Emergency Committee for COVID-19; the designation of Aden, the interim capital, as 'infested' city in early May; and the allocation of a sum of six billion Yemeni Riyal (YER) (approximately USD 9 million), to address the crisis.[72] The IRG, however, has faced numerous challenges. One of the key hurdles has been the Prime Minister and cabinet's inability to return to the de-factor capital of Aden, since the STC blocked their return from Riyadh in late April 2020. Lack of access to its temporary capital has limited the government's ability to centrally manage COVID-19 response from within the country.

On a local level, the authorities in so-called liberated areas – that is, outside Houthi control – implemented different strategies. In Hadhramaut and al-Mahra, the authorities sporadically imposed curfew measures and later restricted travel to and from other governorates, to reduce cross-governorate spread of COVID-19. Developments were continually monitored and both authorities adapted to changes in an agile manner, at very short notice. For example, the Hadhrami authority was the first to impose curfew when the first COVID-19 case was confirmed in the governorate.[73]

In Marib governorate, the local authority established the Local Emergency Committee to Confront COVID-19 in mid-April. This committee announced the temporary closure of Qat markets in a bid to reduce the spread in heavily populated areas, calling security forces and Aqils (chiefs of neighbourhoods) to promote local guidelines.[74] Governorate health and security departments would communicate guidelines to district-level officials and Aqils, with the latter providing updates on infections and compliance requirements. In addition to curfew measures, further precautions were also taken, including the closure of entry points for travellers arriving from Aden and Sana'a, increased isolation centres for confirmed and suspected cases, and the provision of testing kits in May.[75]

These measures contrasted heavily to the response of the Houthis in Sana'a, who instead relied on militarised measures, such as firing live bullets into the air to instil fear and anxiety in targeted neighbourhoods, and banning families of deceased relatives from sharing COVID-19 news about their deaths.

Due to the lack of a unified mandate, it is difficult to commend the IRG's COVID response. However, local authorities in the relatively stable areas provided some level of guidance to the public and took important measures which contributed – at least so some extent - to reducing the transmission of COVID-19 in Hadhramaut and Marib.

The Southern Transitional Council (STC)

In contrast, the situation in Aden spiralled out of control. What contributed in part to this was the STC's announcement of self-administration on 25th April – during the COVID-19 crisis – and growing instability in the city since 2019.[76] On Wednesday 29th April, the Health Minister Nasser Baoum acknowledged the first COVID-19 deaths in Aden, ending rumours which had arisen as a result of sudden, undiagnosed deaths.[77] On the same day, the STC announced a three-day curfew in Aden and the closure of Qat markets and mosques; however, according to local residents, neither of these measures were fully implemented.[78] Additionally, as Ahmed Nagi, a nonresident scholar at Carnegie Middle East Center, notes, 'STC forces held [back] essential coronavirus-related equipment, sent by the WHO, in the port to prevent government medical staff from accessing it [. . .] to gain recognition for its ongoing de facto rule of Aden.'[79] Two weeks earlier, the STC wanted to ban qat trade in Aden to reduce overcrowding in the market, as well as men's qat gatherings, to curb the spread of COVID-19. To ensure qat trader adherence, STC-allied local security forces, known as the Security Belt Forces (SBF), were responsible for enforcing the new restrictions. Yet, a number of incidents occurred at the hand of these forces; one of these involved SBF militarily engaging other STC-aligned forces who were attempting to secure the Commander of the 2nd Giants Brigade's house in Northwest Aden.[80] SBF forces allegedly fired bullets towards the Commander's residency while chasing qat importers defying the ban. This might have initially discouraged the STC to push the execution of measures forward.

The dire situation worsened in early to mid-May as catastrophic floods, hot temperatures and annual seasonal epidemics, such as dengue fever, chikungunya, cholera and malaria, took hold of the city.[81] Confusion around COVID-19 also grew as a result of the outbreaks of several diseases with similar symptoms, making it increasingly difficult to diagnose causes of death.

Not only did fear and anxiety spread among the local populations, it was also present among health workers who were responding without access to Personal Protective Equipment (PPE) and operating in ill-equipped hospitals. This led, in some instances, to healthcare facilities closing their doors to certain patients in fear of COVID-19 transmission.[82] Although the STC attempted response measures, their feud with the IRG has hindered the response from the early stages. Tensions were increased when the STC called on civil society organizations, local authorities, and international community to support the self-administration model.

The poor response in Aden was weakened by the absence of a unified government approach, weak institutions and the declaration of self-administration by the STC. Nevertheless, it is important to note that although the number of cases is estimated to be underreported in Aden, the STC allowed WHO officials access to available data on COVID-19 and reported the daily death rate in the city. This sets them in direct contrast to the Houthis. This reporting and cooperation – however limited -, as well as transparency, are commended and must be maintained.

The Houthis

In the heavily populated swathes under Houthi control, the Houthi insurgents have pursued a deliberate policy of concealing COVID-19. The Houthis are dealing with the pandemic as a top-secret security matter to achieve political, security and military gains. Before even acknowledging the existence of COVID-19, the Houthis circulated conspiracy theories, pre-emptively blaming the Saudi-led coalition for the spread of the virus and accusing the United States of manufacturing it.[83] The Houthis only announced the first COVID-19 case on May 5th – and since then, they have reported a disproportionately small number of cases. This created suspicions of underreporting and concealment of the true extent of the pandemic.[84] For example, early on in the outbreak on COVID-19, on 13th May, a local news outlet revealed that al-Kuwait Hospital alone in Sana'a had over 50 COVID-19 infections and 20 deaths demonstrating such underreporting in Houthi controlled areas.[85]

To cover-up COVID-19 figures, the insurgents deepened biopolitics (the governance of bodies), tightened surveillance measures of COVID-19 patients and their families, and threatened health workers and hospitalised individuals.[86] Furthermore, the Houthis refused to share COVID-19 information with international health organisations. They have consistently kept WHO, other UN agencies, and local communities in the shadows, going as far as secretly burying the bodies of hundreds of people at night.[87] To isolate suspected cases, the Houthis deployed militants in targeted neighbourhoods in Sana'a, threatened citizens with AK-47s, fired bullets in the air, and detained civilians with COVID-19 symptoms as if they were war prisoners.[88] This reckless behaviour has instilled further societal fear, discouraged the public from visiting hospitals and, as a result, helped the virus spread undetected.

Detained individuals have been quarantined in a variety of ill-suited facilities. These ranged from unprepared isolation and treatment centres in Rada'a, al-Bayda, to poorly managed centres such as the Dar al-Salam Hotel in Hodeida and a few facilities more aptly managed by MSF, such as Sheikh Zayed Hospital in Sana'a.[89] Such factors, as well as the spread of misinformation and fear of stigma, serve to explain why many individuals have chosen to self-isolate rather than go to hospitals.[90]

After announcing the first case, the Houthis declared a 24-hour closure of mosques and put 10 neighbourhoods under experimental lockdown.[91] Subsequent measures, in comparison to Hadhramaut, Marib and al-Mahra, were largely tokenistic and extended to the temporary closure of malls and restaurants.[92] At the same time, the Houthis have used the COVID-19 pandemic to pursue controversial policies, such as the increased closure of cafes, which are common gateways for youth and further restrictions of public freedom, including the mobility of women.[93] Radhya al-Mutwakel, a well-known activist, decried the increasingly sexist Houthi restriction on freedom, saying 'we were asked to leave by a security official, just because we are women. That happened for the second time in a month. Since when did the sidewalks of this city [Sana'a] become for men only?"[94]

Financial concerns also fed into specific measures, for instance, the Houthi Zakat Authority wanted to ensure the smooth collection of annual Zakat[95] payments, even during a pandemic, to finance the war effort, thus collecting over YER 43 billion (approximately USD 66 million) by late May.[96]

Tellingly, in June 2020, Mohammed Ali al-Houthi, a senior Houthi figure, told the BBC that 'announcing or concealing COVID-19 cases doesn't slow down the pandemic's spread'.[97] As revealed in this statement and above examples, COVID-19 containment measures in Houthi-controlled areas are

driven more by security, military and economic factors, rather than medical ones. COVID-19 has been used as a tool for the insurgency to restrict freedom and tighten control. On the other hand, these measures have served to highlight the key differences between local authorities and each of their response models, which, in some ways, characterises key aspirations for Yemen and its people.

COVID-19's impact on insecurity across Yemen

The security landscape in Yemen has continually deteriorated, with this downward trend persisting after the first COVID-19 cases were recorded in early April 2020. With the IRG largely on the defensive since at least the Stockholm Agreement in December 2018, the Iranian-backed Houthis and UAE-sponsored STC have escalated their political and military activities.

In Yemen's south, the STC announced self-administration in late April and established shadow administration committees similar to those of the Houthis, looted resources from state institutions, and seized the Central Bank of Yemen's cash containers in Aden. A few weeks later, fighting erupted between the Yemeni army and STC-aligned forces in Abyan province, with tacit Saudi approval, and then extended to the Socotra archipelago. STC fighters were dispatched from mainland Yemen to Socotra, eventually forcing Saudi-backed forces to retreat and handover Hadiboh city.[98] These recent escalations disregarded two important things; the first is the possible risk of COVID-19 transmissions from the mainland to an island with poor health infrastructure. The second is that it distracted attention from pursuing more effective COVID-19 responses.

Additionally, demonstrations occurred in many governorates, risking the further spread of COVID-19. On 24th April, hundreds of protesters took to the streets in Aden, chanting 'No STC, no legitimacy, our revolution is popular' and expressing frustration about the lack of basic services and worsening conditions.[99] In mid-July, the STC attempted to stage a protest in Al-Mahra, but failed to gather more than a dozen people after the Security Committee of Al-Mahra declared a temporary ban of public gatherings.[100] Lastly, the Southern National Coalition called for a mass demonstration in Abyan to reject the STC's monopoly over the Southern cause while reiterating support for the IRG.[101]

Demonstrations and military tensions are also present across the west coast of Yemen. In Khawkha, south to the port city of Hodeida, hundreds of locals from the Tehama area orchestrated a demonstration, to reject the *de facto* chief of the Joint Forces' and demanding greater local involvement in security provision.[102] Between demonstrations and counter-demonstrations, and enduring conflict dynamics, the virus likely spreads undetected as grievances continue to surface.

Central Yemen has also witnessed fighting and conflict. In Radman al-Awad, Bayda governorate, the Houthis launched a 24-hour surprise attack defeating Shiekh Yasser al-Awadhi, who reportedly vowed to foment tribal resistance against the Houthi murder of a woman, considered as 'a grave violation of tribal customary law'.[103] Fighting intensified in Ganya, Bayda, the Southern gateway to Marib, where the Houthis continue to send reinforcements in a bid to encircle Marib and capture oil and gas facilities. Further to this, there have been indiscriminate Houthi ballistic missile attacks targeting residential neighbourhoods in Marib city.[104]

In addition to military escalation, the Houthis have instrumentalised the COVID-19 pandemic for public mobilisation and recruitment. A Houthi activist publicly advocated that 'it is better to die a martyr in heroic battles than dying at home from the coronavirus' and 'being in a battlefront is safer than being at risk in crowded towns.'[105]

Given the multitude of examples presented above, it is clear that the COVID-19 pandemic has been exploited by various actors and stakeholders. While numbers are not forthcoming, it is clear that the disease continues to spread in spite of limited containment programmes.

The impact of COVID-19 on the peace process

On March 23rd, 2020, the United Nations Secretary-General (UNSG) António Guterres called for a global ceasefire to confront the unprecedented COVID-19 pandemic, most notably in conflict zones and fragile states.[106] Although the conflict actors in Yemen, including non-state armed actors, initially responded positively to gain international applause, this failed to materialize into actual changes on the ground as the previous sections have shown.[107]

The Saudi-led coalition announced an extendable, two-week unilateral ceasefire in early April, which was extended throughout the month of Ramadan. The Houthis, however, rejected this and intensified their offensive in Sirwah, Marib, while repeating their hard-line demands for a ceasefire: firstly, the withdrawal of the coalition, and secondly, lifting the naval, ground and air blockade in Yemen. In reference to cumulative behaviour since 2004, Julia Palik, a researcher at the Peace Research Institute Oslo (PRIO), wrote that '[p]rospects for implementing the ceasefire are bleak. This is not the first ceasefire to be used by the Houthis to regroup and expand territorial control.'[108]

Since then, the UNSG Special Envoy for Yemen, Martin Griffiths, has attempted to bring about a ceasefire proposal, known as the Joint Declaration (JD). The IRG officially rejected the JD proposal in mid-July, with several commentators stating that the proposed version discussed with President Hadi and the IRG was largely different from the original version.[109] Over 40 Yemeni figures issued a 5-point statement refuting the JD, arguing that its "quick fixes" and superficial solutions would "puts Yemen further from an equitable, sustainable peace and could potentially sow seeds for new cycles of endless conflicts."[110] The main dilemmas of this proposals are that all issues are tied together, including the urgently required COVID-19 measures and looming spill and/or potential explosion of FSO Safer Oil Tanker in the Red Sea. As such, the JD offers an 'all or nothing' approach, which appears counter-productive due to the urgent nature of these crises.

Most recently, Riyadh re-convened talks between the Saudi-backed IRG and the UAE-backed STC to broker a subsidiary agreement known as 'The Mechanism to Accelerate the implementation of the Riyadh Agreement.' Since it was signed in November 2019, however, it has largely stalled.[111]

Broader implications on peace and conflict trajectories

The ramifications of the COVID-19 crisis in Yemen are alarming. This is unlikely to change as conflict will likely endure in the near future, at a continuously rising humanitarian cost. Yemen's inadequate health system will continue to face rising pressure. If the government and international actors fail to invest in the healthcare sector in a timely manner, full collapse could occur, which would significantly deepen the humanitarian crisis. If this was to happen, the pandemic would spread with even less control than it currently faces and deaths will increase. It would become more difficult to rapidly mobilise resources, implement an effective response, and build trust; all of which are required to respond to a potential second wave of COVID-19 in Yemen.

Further displacement as a result of the fighting and the COVID-19 outbreak will compound pre-existing overcrowding and inadequate WASH and other services in IDP camps.[112] Such conditions make it increasingly difficult to 'follow social distancing guidelines or "self-isolate" when sick.'[113] This exacerbates pre-existing challenges.[114]

Finally, it is worth mentioning that the pandemic will almost certainly not lead to a successful ceasefire or change in the behaviour of armed groups and the IRG. Instead, it will continue the patterns of political and military opportunism observed since the outbreak of COVID-19.

Findings and Conclusion

Although the security dynamics in Yemen did not significantly change as a direct result of COVID-19, the Houthis and STC took advantage of the situation and employed tactics to further their interests in their areas of de facto control. The use of security tactics, for instance, within neighbourhoods has been a tool to control the COVID-19 narratives in their respective areas. Both actors' politicization and militarization of the pandemic undermined the disease containment programme. This should be wholly and fully condemned. Moreover, both parties should be encouraged to increase cooperation with the IRG and WHO to improve the response.

Despite some successes, the IRG should, with support from the World Health Organization (WHO), provide more assistance and guidance to local authorities and avoid delayed access to tests. The measures taken by the local authorities in Hadhramaut should be a model for others, especially due to the high level of responsibility exercised. Although the governorate currently has the highest rate of cases, experts attribute this to the high number of tests performed across the governorate.[115]

Similar to the DRC, health facilities, medical staff and patients continue to be attacked, undermining the capacity and ability to provide a secure environment for staff and patients seeking medical assistance. Conflict actors in both countries should adhere to international law, conventions and human rights laws, and refrain from attacking health workers and patients and allow safe passages for humanitarian activities.

The IRG should negotiate with the other conflict actors to develop a unified national response strategy to manage the second wave of COVID-19. This should include taking lessons learned from the first wave, mitigating and addressing, as best possible, the challenges faced by responders and capitalising on opportunities.

In a politically polarised conflict environment, it is crucial for humanitarian responders to ensure they take a conflict-sensitive approach that doesn't jeopardise the physical and human security of their staff and local communities.

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