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COVID-19 Pandemic: Syria's Response and Healthcare Capacity

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About the Conflict Research Programme at LSE

The Conflict Research Programme aims to understand why contemporary violence is so difficult to end and to analyse the underlying political economy of violence with a view to informing policy. Our research sites are Iraq, Syria, South Sudan, Somalia and the Democratic Republic of Congo.

The Syria conflict research programme focuses on five interrelated research topics. The function and legitimacy of public authority, identity politics, economic drivers of the conflict, civicness and reconstruction. The programme uses a mixed methodology using primary and secondary sources.

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Executive Summary

According to available data and research, our team has estimated that **the maximum number of COVID-19 cases that could be adequately treated in Syria is currently 6,500**. This is based on the number of available Intensive Care Unit beds with ventilators across Syria, which we estimate to be 325, and the calculation based on international COVID-19 research that an approximate 5% of the total COVID-19 cases would require critical care.

Once the number of cases passes this estimated threshold of 6,500, also known as the maximum capacity threshold, the healthcare system is likely to collapse, with rationing decisions needing to be made, and the overall mortality rate likely to increase by at least an additional 5 percentage points among infected people.

The COVID-19 maximum capacity threshold also varies considerably between different provinces in Syria, with capacity per province ranging from 1920 (Damascus) to 0 (Deir ez-Zor).

Only five cases of COVID-19 have so far been confirmed in Syria, despite significant indications that a wider outbreak has already begun. The response by the World Health Organization (WHO) has been deemed by many to be too slow, and while WHO tests have been delivered to the central government, none has been provided to northern Syria, which is outside government control.

Northwest Syria (NWS) and Northeast Syria (NES) have a particular vulnerability owing to the large internally-displaced populations and lack of adequate healthcare facilities. However, civil society organisations (CSOs) and local initiatives are better placed in these areas to implement community-based response plans, since, unlike in government-held areas, they are not subject to interference by non-state armed actors so far.

There is an overall lack of sufficient public awareness, a significant lack of resources, and a continued deterioration of humanitarian and socio-economic conditions across Syria, making the country acutely at risk of an uncontrollable COVID-19 outbreak.

Although only five cases have been officially confirmed so far, several factors make Syria highly vulnerable to a severe outbreak. As well as an exhausted health system, protracted violence and an extremely high poverty rate, there is also a high average number of individuals per household, including cross-generational households. There is also a large internally-displaced population in Syria, living either in high-density residential areas, or in IDP camps with little access to water and an inability to isolate.

Detainees are also extremely at risk, given their living conditions in crowded prisons and detention centres. The wide dependency on cash for daily transactions is another risk factor, while the unwillingness of the government to provide economic support to the most disadvantaged means that self-isolation and social distancing will prove unfeasible for many. Alongside this are unpredictable socio-economic, cultural and environmental factors. However, recent studies report that infection rate is slowing down in hot countries.¹ This could be a factor which could help slow down transmission in Syria as the weather gradually starts warming up. Syria's relatively young population could also contribute to a mortality rate which is lower than the global average.

While governments will be focused on responding to the outbreak within their own borders, we suggest that it is still vital that attention is paid by the international community to the spread of the virus in conflict-affected countries. An uncontrolled, unmonitored outbreak in these countries could cause the COVID-19 outbreak to persist globally for a longer period and risk new outbreaks.

¹ Bloomberg. 17 March 2020. Coronavirus Could Very Well Slow By Summer. <https://www.bloomberg.com/opinion/articles/2020-03-17/coronavirus-may-slow-by-summer-with-warmer-temperature-humidity>

The patterns of the COVID-19 outbreak could also be different in conflict-affected countries where governance is weak and healthcare systems are dysfunctional and have extremely limited capacity. This calls for more involvement from the international community in monitoring, planning and implementing response plans for such areas. New special response plans and protective measures need to be drawn up for these countries, where many do not have a home in which to self-isolate, and no access to clean running water with which to wash their hands. It is vital that aid plans target the most vulnerable, particularly those who would be left to starve without assistance, and that WASH and medical aid is scaled up significantly. Civil society also needs to be supported to play key role in the response.

1. Introduction

The current COVID-19 outbreak has pushed even the most advanced healthcare systems beyond their capacity. It has overwhelmed the healthiest economies and seen democratic states struggling to secure the compliance of its population over their increasingly strict prevention measures. Syria, whose healthcare system has been devastated by nine years of war, is at particularly acute risk of a severe COVID-19 outbreak, and the economic and social collapse that this would engender.

The grim predictions of the likely impact of a COVID-19 outbreak on Syria worsen still further for areas outside Syrian government control. Not only is governance highly fragile and uncoordinated in these areas, but they also seem to be outside the radar of the World Health Organisation's (WHO) response. Underfunded and understaffed local health governance actors and medical NGOs are currently racing against time in their attempts to respond to the situation.

On March 22, Damascus announced the country's first confirmed case of COVID-19, reportedly coming from abroad,² and to date, only five have been confirmed across the country³. However, up until March 16, only 103 tests had been conducted in the country,⁴ and there are many indicators to suggest that Syria already had a considerable number of COVID-19 cases prior to this announcement. Alongside a lack of transparency over the number of cases, very little is publicly known about the healthcare system's capacity to handle the inevitable outbreak.

This memo presents a rapid assessment of the capacity of healthcare system in all parts of Syria to respond to and contain a COVID-19 outbreak. This assessment was carried out using primary and secondary data; this includes available data from UN agencies, international organisations, and the governmental Central Bureau of Statistics in Syria, Syrian medical organisations and local health directorates. We have also drawn on interviews carried out with local activists, medical professionals and NGOs in different areas across the country. Finally, this memo presents summaries of the recent developments and response plans to contain an COVID-19 outbreak in all areas of Syria.

2. Syria's Healthcare Capacity to Respond to a COVID-19 Outbreak

Nine years of conflict has left Syria's healthcare system at the brink of collapse. Data from WHO and Syria's Ministry of Health (MoH) shows that out of the total 111 public hospitals in Syria, only 58 are fully functioning, with the remainder either partially functioning (27) or fully destroyed (26).⁵ On March 6, 2020, a UN report stated that up to 70% of the health workers had left the country as migrants or refugees.⁶ Moreover, between the start of the conflict and February 2020, 595 attacks were conducted on at least 350 separate health facilities, and 923 medical personnel were killed.⁷ 536 of these 595 attacks were conducted by the Government of Syrian (GoS) and its allies.

² The Guardian. 2020. Syria confirms first Covid-19 case amid fears of catastrophic spread.

<https://www.theguardian.com/world/2020/mar/23/syria-confirms-first-covid-19-coronavirus-case-amid-fears-of-catastrophic-spread>

³ Syrian Arab News Agency (SANA). 25 March 25, 2020. <https://www.sana.sy/?p=1128340>

⁴ Syrian Arab News Agency (SANA). 16 March 2020. <https://www.sana.sy/?p=1124392>

⁵ World Health Organization. 2018. Public Hospitals in the Syrian Arab Republic, HeRAMS Annual Report January – December 2018

⁶ United Nations Office for the Coordination of Humanitarian Affairs (OCHA).2020. [Syria anniversary press release](#)

⁷ Physicians for Human Rights.2020. Physicians for Human Rights' Findings of Attacks on Health Care in Syria

Based on WHO's HeRAMS data,⁸ Syria (excluding the province of Idlib) has a total of 465 ICU hospital beds with ventilators in the public hospitals. Data from the Central Bureau of Statistics (CBS)⁹ shows that private hospital capacity is almost 40% of that of public hospitals, making the total number of ICU beds in all hospitals approximately 650. The occupancy rate, which is the total number of occupied ICU beds divided by the total number of available ICU beds, is estimated to be around 53%, based on CBS data on the total number of occupied hospital beds during the year.¹⁰ The total available number of ICU beds with ventilators is, therefore, estimated at 305 (47% of 650). The Idlib Health Directorate (IHD) estimates the available number of such beds in the province to be 20, meaning that **there are an estimated 325 available ICU beds with ventilators across Syria.**

In order to estimate the overall capacity of the current healthcare system in Syria to deal with cases of COVID-19 we shall adopt the assumption that at least 5% of the total COVID-19 cases will require Intensive Care Unit (ICU) support. This is based on research carried out by China's Medical Treatment Expert Group on COVID-19 response.¹¹ With 325 ICU beds with ventilators available, **the maximum capacity threshold of Syria's healthcare system for COVID-19 cases is estimated at 6500** (325 / 5%). Since patients with severe COVID-19 symptoms require an average of 13 days of respiratory support,¹² the system's capacity to respond to new cases is expected to be very slow.

Furthermore, the maximum capacity threshold differs dramatically from province to province, given the huge disparity in the numbers of intensive care beds. The highest capacity is in Damascus, with a maximum threshold of up to 1925 cases; in areas outside the capital, the maximum capacity drops considerably: fewer than 100 COVID-19 cases in each of Homs, al-Raqqa and Daraa, and a capacity of zero in Deir ez-Zor (See Table 1).

Table 1: Maximum Capacity Threshold of Syria's Healthcare System in Containing COVID-19 Cases by Province

Province	Available ICU beds with ventilators (public & private)	Maximum capacity threshold for COVID-19 cases
Damascus	96	1920
Aleppo	5	100
Rural Damascus	11	220
Homs	5	100
Hama	29	580
Lattakia	77	1540
al-Hasakah	18	360
Deir ez-Zor	0	0
Idlib	20	400
Tartus	30	600
al-Raqqa	4	80
Deraa	3	60
al-Sweida	22	440
al-Quneitra	5	100
Whole of Syria	325	6500

Source: Authors' calculations based on WHO, CBS, and IHD data

When the number of COVID-19 cases crosses the maximum threshold, the healthcare system becomes exposed to a risk of collapse, and what is known as 'rationing' decisions will need to be made. The mortality rate, moreover, will likely increase by at least 5 percentage points among

⁸ World Health Organization. 2018. Public Hospitals in the Syrian Arab Republic, HeRAMS Annual Report January – December 2018

⁹ Statistical Abstract. 2019. Central Bureau of Statistics, Damascus-Syria

¹⁰ Ibid

¹¹ Guan WJ, Ni ZY, Hu Y, et al; China Medical Treatment Expert Group for Covid-19. Clinical characteristics of coronavirus disease 2019 in China. N Engl J Med. 2020. doi:[10.1056/NEJMoa2002032](https://doi.org/10.1056/NEJMoa2002032)

¹² Ibid

infected people, given the number of people who would require ICU beds with ventilators and who cannot access them. It should be noted that the maximum capacity estimation at the national level assumes that critical cases would be able to move easily between the Syrian provinces.

3. Response Measures in the Government-Controlled Areas

Although at time of publishing this memo, there has been only five confirmed cases of COVID-19 in Syria, several indicators suggest that the virus is already significantly more widely spread across the country. According to a situation report issued by WHO, all Syria's neighbouring countries are reporting an exponential increase in the number of COVID-19 cases: 266 in Iraq, 127 in Jordan, 267 in Lebanon and 1529 in Turkey¹³. Furthermore, Iran, which is facing a catastrophic surge in the numbers of COVID-19 cases, has thousands of its military forces in Syria, and, until very recently, hundreds of them were going back and forth between Syria and Iran via Damascus International Airport or through Iranian military bases in Syria in the eastern province of Deir ez-Zor, near the Iraqi borders. Additionally, Iranian pilgrims and religious tourists, which number over 22,000 people each year,¹⁴ continued to visit Damascus-based shrines up until the first week of March. The Pakistani government, meanwhile, announced on March 10 that seven people arriving from Syria had tested positive for the virus,¹⁵ and on March 24, the Iraqi government announced two confirmed cases arriving from Syria.¹⁶ On March 10, the UK-based Syrian Observatory for Human Rights reported that several cases of people with COVID-19 symptoms were detected in four different provinces in Syria: Latakia, Tartus, Homs and Damascus.¹⁷

We also have significant anecdotal evidence from government-controlled areas of people displaying severe COVID-19 symptoms, some of whom have already lost their lives. Khaled M., a surgeon from Tartus, and Salma S., a primary health practitioner from Damascus (we have used pseudonyms for security reasons) told us over Skype on March 20 that there has been a sharp rise in deaths caused by pulmonary infections and pneumonia in patients over 60, a phenomenon witnessed in different areas across the country. Salma reported, 'With only one functioning COVID-19 detection device in al-Mujtahed hospital in Damascus, and the lack of portable testing kits so far, it is hard to conclusively indicate COVID-19 in all of these cases.'

Khaled and Salma also told us that they received 'verbal orders' from multiple Syrian intelligence officers to 'bury the stories of these deaths' and 'not to raise any alarms' in the media. 'Given the total collapse of the economy and growing popular anger, the government doesn't want to give the people an additional reason to revolt against them' said Khaled.

Zaid T., whose name has also been changed for security reasons, is a civil society activist from the province of al-Sweida, who told us over a Skype interview that there had been five pneumonia-related deaths in the province over the past three weeks, and that the bodies were handed over to the military intelligence agency. Their relatives, he told us, were not allowed to see them or give them a burial, and they ended up being buried in secret by intelligence officers.

Furthermore, despite the delivery of several testing kits by WHO to the public hospitals in the government-controlled areas, several sources confirmed to us that some public hospitals, such as al-Mujtahid hospital in Damascus, are asking patients to pay up to 50,000 SYP (approx. 50 USD) per test; this is greater than many people's monthly salary. In some cases, patients have to rely on *wasta* (informal personal connections) to get tested or even to be admitted to hospitals. Some private hospitals are also offering the test for a 300,000 SYP fee (approx. 300 USD) for the few able to afford this sum.

Unworkable Measures

The Government of Syria (GoS) began taking gradual precautionary measures at the beginning of March, three weeks before it announced the first case. These measures included the partial closure of borders; the suspension of the majority of unessential economic activities; the reduction of the

¹³ World Health Organization. 2020. Coronavirus disease 2019 (COVID-19), Situation Report - 64

¹⁴ Statistical Abstracts. 2019. Central Bureau of Statistics, Damascus, Syria

¹⁵ Gulf News article accessed in 10 March: <https://gulfnews.com/world/asia/pakistan/pakistan-records-11-new-coronavirus-cases-bringing-the-total-tally-to-18-1.70279643>

¹⁶ Al Sumaria TV, 24 March 2020. Available at: <https://bit.ly/2UwBg4I>

¹⁷ SOHR. 2020. <http://www.syriaahr.com/?p=368173>

public sector to 40% of its capacity through the introduction of a two-shift part-time system; and the closure of schools, universities, restaurants and other nonessential public facilities.¹⁸ The government also postponed the parliamentary elections that were scheduled to take place on April 13, with a new date scheduled for May 20.

The government's lack of transparency and prevarication in their management of the COVID-19 outbreak is compounded by the lack of public trust in the authorities, severely hindering their ability to effectively respond to the crisis. 'Since people do not trust government reports, and given the deliberate delay to announce cases of coronavirus in Syria, people are continuing their daily lives in a regular manner, which raises the risk of infection and outbreak,' said Mais S., a journalist from Damascus in a Skype interview on Sunday, whose name was also changed. She continued, 'Until the announcement of the first confirmed case on Sunday [March 22], markets and public transportation were still crowded, and mosques and churches were still full of worshippers without any enforcement mechanisms in place.'

The country's economic collapse, all-time high inflation rates, and the prevalence of corruption, clientelism and patronage are likewise jeopardising the emergency response in the GoS-controlled areas. With almost 83% of the population below the poverty line¹⁹, self-isolation will prove unworkable for a huge number of Syrians, especially those who rely on informal daily work. It is, moreover, highly unlikely that GoS will introduce policies to reduce the financial burden of self-isolation. 'Only rich people can afford to self-isolate in Syria' said Mais. 'Daily workers, taxi drivers, small shop owners cannot work from home and cannot afford to protect themselves against the virus.'

The Ministry of Health, its directorates, public hospitals and first responders seem to have a very little information about the current status of COVID-19 in the country, as well as having very limited resources to conduct tests on a large scale. Further to this, many indicators suggest that the intelligence agencies have been interfering in healthcare policies, attempting to control the media narrative about the pandemic, threatening private doctors and health facilities, and restricting the ability of civil society organisations and NGOs to implement social response plans. Laith T., a civil society activist from the province of al-Sweida, speaking under a pseudonym, told us over a Skype interview that a public awareness campaign on COVID-19 had been started by a local initiative, but that their attempts were hindered early on. 'Intelligence officers are preventing us from distributing leaflets and posters about the possible effects and preventative measures,' Laith said. 'The government wants us to pretend that everything is fine. Our major concern is that when things get more serious, and they are bound to, people won't know what to do or where to go.'

A further complicating factor relates to the country's territorial divisions, with the government's response strategy only limited to the areas it controls. While this unprecedented health crisis could be an opportunity for coordination between government- and opposition-controlled areas, there are no signs that the government will be liaising with health directorates in opposition-controlled areas. On the contrary, some officials, such as Health Minister Dr. Nizar Yaziji, have given politicised statements about the crisis in apparent attempts to attack the opposition. In a televised interview, Yaziji answered a question on the Ministry's strategy in confronting this pandemic by saying, 'I want to assure all Syrians amid this coronavirus outbreak that the Syrian Arab Army has cleansed all germs that exist on Syrian soil.' This was an unmistakable echo of a speech from the early years of the Syrian popular movement, where opponents of the regime were referred to as 'germs', while the reference to the army is another clear politicisation technique. While a coordinated response to the COVID-19 outbreak would be in the interests of actors across the territorial divides, there does not seem to be the political will to initiate such a response.

¹⁸ The New Arab Newspaper. 2020. <https://english.alaraby.co.uk/english/news/2020/3/13/syria-bans-shisha-closes-schools-while-denying-coronavirus-presence>

¹⁹ UNICEF. March 2019. Syria Crisis Report



Syrians gathering in front of a Syrian trading cooperative to receive government-subsidised food, Damascus, March 23, 2020

4. Emergency Response in Northwest Syria

The humanitarian situation in opposition-controlled northwest Syria (NWS), made up of the province of Idlib and northern Aleppo, has deteriorated drastically since the military escalation of the Syrian army and its Russian allies in the southern parts of Idlib. This makes the area acutely vulnerable to a severe outbreak of COVID-19. In January alone, almost 1.5 million people fled their homes, and the large majority of those displaced ended up in already-overcrowded urban centres in northern Idlib and Aleppo.²⁰ Recent data indicates that, since January 2020, around 60,000 newly-displaced Syrians have been living in open fields, schools and mosques.²¹ In terms of healthcare infrastructure, 62 health facilities were closed over the last two months due to severe damages and security constraints, and many health professionals lost their lives or were forced to flee. As a result, the entire NWS currently only has 166 doctors and 64 health facilities, mostly operating with minimum-capacity infrastructure.²²

Health emergency response plans in NWS are usually implemented by Syrian medical NGOs and the Idlib Health Directorate (IHD), a quasi-state local governance structure established by local doctors and NGOs. Both the medical NGOs and the IHD are chronically under-staffed and under-funded. In a letter issued by IHD on March 19, Dr. Munzer Khalil, the head of IHD, said that the probability of a current COVID-19 outbreak in NWS was very high; however, given the current absence of any testing kits in the area, it is difficult to be conclusive.

The IHD, in collaboration with several medical NGOs, has launched a COVID-19 Task Force and Emergency Plan, which consists of: 1) allocating three medical facilities, equipped with all the remaining 20 ICU beds with their ventilators, to treat confirmed COVID-19 patients; 2) setting up 28 community isolation centres for suspected cases; and 3) launching a public awareness campaign about protecting oneself against the virus. Schools, mosques and markets have been closed, and people have been instructed to self-isolate. However, Khalil warned that it would be difficult for this response plan to be completely effective without the full support of international donor agencies. This is because of the deteriorating capacity of health facilities; a lack of well-trained nurses and

²⁰ WHO. Jan, 2020: Health Cluster Turkey Hub Bulletin. <https://www.who.int/health-cluster/countries/turkey/Turkey-Health-Cluster-Bulletin-Jan-2020.pdf?ua=1>

²¹ REACH. Jan, 2020. Northwest Syria – Situation Overview.

²² WHO. Jan, 2020: Health Cluster Turkey Hub Bulletin.

ICU technicians; decreasing donor funding; disruptions to water and electricity networks; the continuous movement of IDPs; and the inability of many people to cope with the economic pressure resulting from self-isolation and the suspension of economic activities.



A hospital in northern Idlib destroyed by an airstrike, September 2017. (Ahmed Khatib/Anadolu Agency/Getty Images).

The IHD informed the people in NWS, via a video message on March 22, that there were five suspected cases of COVID-19 in Atmeh Hospital, near the Turkish border. All of these patients, along with their families, are currently quarantined. Samples have been sent to Ankara to be tested, and results are expected to be received within the next three days.

The WHO response in NWS appears noticeably absent. At time of writing, no COVID-19 testing kits have been sent to this region, despite the delivery of such kits to the central government almost a month ago. WHO's official clarification of this delay was that it only delivers to governments, and that 'northwest Syria is not a government'.²³ Many Syrian CSOs and medical NGOs consider this position to be politically biased, and that it indicates a lack of consideration and understanding of the underlying political reality of the Syrian conflict. 'They will leave us at the mercy of the Syrian regime,' said Bahjat Hajjar, the executive director of the Local Administration Councils Unit (LACU). 'Syrian CSOs are considering buying commercial testing kits from the Turkish market, because there is no trust that the regime will be responsive to the north.'

Several local CSOs are launching awareness campaigns and are developing several response strategies that could complement IHD and other medical NGOs responses towards the pandemic, such as sharing some of their available financial and human resources, launching video conferences to spread awareness about COVID-19, and increasing the accessibility to health facilities and the community isolation centres. Owing to the lack of security interference which exists in government-controlled areas, CSOs in the north-west have a greater capacity to carry out such initiatives.

5. Challenges and Obstacles in Northeast Syria

Over 4 million people are currently living in northeast Syria (NES), consisting of the provinces of al-Raqqa, Deir ez-Zor and al-Hasakah. The region, which is governed by the Democratic Self-Administration (DSA), has 11 public hospitals, only two of which fully functioning, with the rest

²³ New York Times. 'Wash Our Hands? Some People Can't Wash Their Kids for a Week.' <https://www.nytimes.com/2020/03/19/world/middleeast/syria-coronavirus-idlib-tents.html>

partially functioning due to conflict-related damages.²⁴ According to our in-country sources and HeRAMS reports, only 22 ICU beds are available, including those in both public and private hospitals. 18 of these ICU beds are located in the province of al-Hasakah (including the city of al-Qamishli) and 4 are in al-Raqqa, with none available in Deir ez-Zor.²⁵

There are also more than 600,000 internally-displaced people (IDPs) in NES, 200,000 of whom were displaced since October 2019 as a result of the Turkish military operations in northern Syria.²⁶ Around 100,000 of the internally displaced population are being housed in IDP camps; there are 14 such camps in total, the largest being al-Hol camp in the province of al-Hasakah near the Iraqi borders. Al-Hol was originally designed to host a maximum number of 10,000 people, but the number has increased to over 69,000 during the past year.²⁷ This has caused extreme levels of overcrowding, with the camp facing catastrophic humanitarian and health conditions long before the current pandemic. The camp has only three field hospitals and 12 static medical points, none of which is equipped with ICU units or ventilators.²⁸

In a response to the COVID-19 pandemic, the DSA issued a statement on 19th of March, announcing the closure of its border crossings with Iraq, as well as the closure of restaurants, cafes, malls, public places and small private clinics, with a mandatory curfew for all citizens except medical personnel, grocery store workers and food delivery truck drivers. Kamal F. a doctor working in the city of al-Raqqa who provided a pseudonym, told us on March 21 over Skype that NES has not yet received any testing kits from WHO. 'The risk of coronavirus in the northeast is very high due to the continuous movement of civilians from and to the Kurdistan region of Iraq,' said Kamal. 'We don't have kits yet and we cannot rely on Damascus to deliver these kits.' The DSA's Health Commission has designated Amuda Public Hospital to deal with suspected cases of COVID-19 and has established several quarantine centres across the region. Mohammad W. (also a pseudonym) from the Damascus-based Syria Arab Red Crescent (SARC) said that SARC are sending testing kits and other necessary medical supplies to their health facilities in NES. However, our sources in the local authorities in the region told us that they have not received any formal confirmation about the delivery of such kits or supplies.

Several local NGOs in NES have launched public awareness campaigns to encourage self-isolation and social distancing. 'Fear is the main motivation for people. People's response to DSA instructions are different from one city to another,' said Sasha B., a civil society activist in al-Qamishli, also using a pseudonym. 'We are seeing more and more people responding to these crucial measures. But we cannot expect total compliance. When people's livelihood is at stake, they will risk everything.'

Considering the growing conflict with Turkey in the north, the closure of the Iraqi borders from the east, and isolation from NWS, which is controlled by Turkish-backed armed groups, health actors in NES are left with few choices. They can either wait for a seemingly nonresponsive WHO, or rely on the Syrian government, which insists on exploiting the few available resources for its own political gains.

6. Syrian Detainees: The Forgotten Victims

Several Syrian civil society activists and international human rights organizations have raised the issue of the tens of thousands of political prisoners in Syria's formal and informal prisons amid the current pandemic.²⁹ They have warned of an inevitable outbreak of COVID-19 amongst these prisons and detention centres, the majority of which place 50 detainees in a cell measuring 3 metres by 3 metres.³⁰

In a statement issued on March 18, several members of the Civil Society Bloc in the Syrian Constitution Committee demanded the immediate release of all detainees from political prisons and the establishment of a UN mission to monitor the health conditions in all remaining prisons.

²⁴ WHO. June, 2019. Summary of Key Indicators in North-East Syria.

²⁵ HeRAMS Annual Report: January – December 2018.

²⁶ UNHCR. October, 2019. Northeast Syria Response.

²⁷ REACH. October, 2019. Camp and Informal Site Profiles – Overview.

²⁸ HeRAMS Annual Report.

²⁹ Human Rights Watch. 2012. Torture Archipelago

³⁰ Amnesty International. 2016. It Breaks the Human: Torture, Disease and Death in Syria's Prisons

Human Rights Watch likewise released a plea urging the UN to seek access to the detention facilities 'to provide detainees with life-saving assistance. The Syrian government certainly won't.' The statement went on to warn the international community of a growing catastrophe: 'Torture and executions account for many of the thousands of deaths among Syrian government detainees, but prisoners also die because of horrific conditions in prisons.'³¹

On March 22, a general amnesty was issued to all prisoners, with one crucial exception: it would not be applicable for crimes committed under Law 19/2012, which is the country's anti-terrorism law.³² It is this law under which almost all political prisoners are charged, meaning that the amnesty will have almost no effect for the tens of thousands of political prisoners across the country.

7. Discussion and Recommendations

None of the countries where COVID-19 is currently widely spread has a context similar to Syria. So far, all the data available about the spread of the virus comes from non-conflict-affected countries. This makes it difficult to make solid projections about the pattern and extent of a widespread outbreak in Syria.

There are two factors which point to a potential slowing of the spread of the virus, and a decline in its mortality rate in Syria. Firstly, recent studies suggest that the infection rate is slowing down in hot countries; this could potentially help to slow down transmission in Syria as the weather gradually starts warming up. A second factor is the relatively young population in Syria, which could lead to a mortality rate which is lower than the current global average.

However, there are several major risk factors for Syria. These are: the country's protracted violence, a shattered healthcare system with an enormously limited capacity; low public trust in the authorities; an extremely high poverty rate; a high number of individuals per household including cross-generational households; a large number of internally-displaced persons (IDPs) living in high-density residential areas; a large number of IDPs living in camps with little access to water and an inability to isolate; crowded prisons and detention centres; and a wide dependency on cash for daily transactions. These are among many other unpredictable socio-economic, cultural and environmental factors. Many people, moreover, cannot afford stay at home to self-isolate and practise social distancing, given the unwillingness of the government to provide economic support for those who rely on going out to work for their livelihood. The Syrian population is also exhausted from the war, and poor health and nutrition are commonplace; the national mood was already extremely low, given the lack of hope that a political solution will be found and that ordinary life will return any time soon.

While governments will be focused on responding to the outbreak within their own borders, it is still vital that attention is paid by the international community to the spread of the virus in conflict-affected countries. While most of these countries, such as South Sudan, Libya, Somalia, Syria and Yemen, have reported zero, or very few, cases so far, this should not be taken as an indicator that an outbreak in these countries is unlikely. Moreover, an uncontrolled, unmonitored outbreak in these countries could cause the COVID-19 outbreak to persist globally for a longer period. The risk is that, after other countries have seemingly countered their domestic outbreaks, new outbreaks could be triggered as restrictions on movement are lifted.

The UN Secretary General has called for a worldwide ceasefire³³ to help all nations to respond to the outbreak. The UN Special Envoy to Syria also called for a ceasefire in Syria to counter COVID-19.³⁴ All actors involved in the Syrian conflict, local and international, have a responsibility to build on these initiatives, and end the fighting and aerial bombardment. To limit the spread of the virus and defeat the pandemic, it is critical that all actors on the ground coordinate with one other; COVID-19 will cross easily from one security-controlled area to another – checkpoints will not stop the spread of the virus. The international community, especially UN agencies and the World Health

³¹ Human Rights Watch. 2020. Syria's Detainees Left Even More Vulnerable to Coronavirus.

<https://www.hrw.org/news/2020/03/16/syrias-detainees-left-even-more-vulnerable-coronavirus>

³² Syrian Arab News Agency. <https://www.sana.sy/?p=1126865>

³³ Al-Jazeera. 23 March 2020. UN chief calls for global ceasefire to help fight COVID-19.

<https://www.aljazeera.com/news/2020/03/chief-calls-global-ceasefire-fight-covid-19-200323190330845.html>

³⁴ UN News. 24 March 2020. Enable 'all out effort' to counter COVID-19 in war-ravaged Syria, urges top UN envoy <https://news.un.org/en/story/2020/03/1060112>

Organization, need to help Syria and all conflict-affected countries in responding to the outbreak. To start with, they should not limit their dealings and distribution of testing kits to the government-controlled areas only. Areas outside government control also need to be provided with testing kits, personal protective equipment, and other medical assistance.

The recent COVID-19 Global Humanitarian Response Plan³⁵ launched by the UN Secretary General to help the least-developed countries is a positive step. It needs to be expanded in particular to conflict-affected countries where state governance is weak and more involvement from the international community is needed.

New response plans and protective measures need to be drawn up for these countries, where many do not have a home in which to self-isolate, and no access to clean running water with which to wash their hands. It is vital that aid plans target the most vulnerable, particularly those who would be left to starve without assistance, and that WASH and medical aid is scaled up significantly.

Just as civil society across the world is playing a vital role in the response to COVID-19, organising community support groups and campaigns to raise awareness, Syrian civil society has the potential to play a vital role in responding to this crisis. This is particularly the case in the north-west of the country, where medical Syrian NGOs are leading the fight against the virus. Civil society and community organisations should be given full support, in particular local initiatives, which have a huge role to play in mitigating the impact of this crisis. This includes much-needed funding, but also an end to the clampdown on civil society by the authorities in charge of each area. Instead, they must treat civil society as an essential partner in rescuing the country from a potentially catastrophic situation.

³⁵ UNICEF. 25 March 2020. Remarks by UNICEF Executive Director. <https://www.unicef.org/press-releases/un-launches-global-humanitarian-response-plan-covid-19-pandemic>

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