Key considerations: COVID-19 in the context of conflict and displacement - Myanmar

This brief focuses on COVID-19 in Myanmar and how the interplay between conflict, displacement and inter-communal tensions may influence disease control. All health emergencies have social and political challenges, but sensitive consideration and effective management of these is especially important where there is past or ongoing conflict, and where trust in authorities imposing disease control may be low. Myanmar faces COVID-19 alongside serious humanitarian and health system vulnerabilities. The country has a range of conflicts and non-state actors who must be factored into a public health response. This brief highlights key considerations for COVID-19 against this complex governance backdrop. It can be read in conjunction with the SSHAP briefing on COVID-19 in South East Asia which outlines emerging evidence on COVID-19 control measures in the region, with a particular focus on marginal populations including transnational migrants, stateless populations, those working in the informal economy and the urban poor.[1]

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Summary considerations

Conflict

- The long history of conflict in Myanmar means that the COVID-19 response must be considered through a combination of social, conflict and governance lenses in addition to public health. There is ongoing conflict with a range of armed groups and significant areas of the country, including along international borders, are outside of government control.
- There are deeply rooted political economies based on conflict and control of territories and the political interests involved in these will intersect with the COVID-19 response. The response is particularly liable to politicisation and co-option to (re)assert control. The Government and other key actors may refuse to work with rival groups if such action could be deemed to undermine their own power or further the power of their opposition. It is essential that public health and humanitarian actors assess these interests when planning with whom to work and how.

Governance

- The political situation is varied across the country, with different degrees of peace, security, government or non-government control and inter-group conflicts. As such, a centralised command and control approach to COVID-19 is unlikely to work. There will be a need for a tailored approach for each area; cooperation by government and humanitarian agencies with a range of non-state actors and armed groups and, a range of formal and informal brokerage tactics and diplomacy channels.
- In areas outside of government control some armed groups have well established health and humanitarian sectors, as well as (to different degrees) the trust of local populations. This provides legitimacy for mounting COVID-19 responses and it will be important for the government or humanitarian agencies to establish effective partnerships with these groups.
- The military is an influential player and is in control of key ministries implementing the COVID-19 response. There have been reports of contradictory and sporadic implementation of control measures due to poor coordination between military and public health authorities, and at times, competition with local elected government officials. The relationship between military and civilian government institutions require consideration as they may not be aligned but are responsible for enforcing control measures.
- Trust is important but may not be neutral. Some groups will be trusted and legitimate because of their opposition to the government. It is important, where possible, for response partners to focus on grounded legitimacy (e.g. community based mutual obligations and social relationships) and to build on, and work with, customary beliefs and alliances.

Basic services and information

- Coverage of health and basic services and communication networks are uneven in Myanmar. This means that large numbers of people may not be reached by public health messages, protective measures or relief and could mean disease transmission goes undetected. Concerted efforts are needed across government and the humanitarian sector to identify and address these gaps and disparities.
- The government and agencies involved in delivering the COVID-19 response should prioritise the creation of clear, consistent and factual information in all regions and its delivery through trusted channels, including through social media, checking for accuracy of translations. Two-way information flows should be established as a priority.
- Some conflict affected areas of the country have had the internet cut off by the government. This will limit the flow of essential messages and information.

Inter-communal tension

- Myanmar is ethnically heterogeneous and the state uses a hierarchical system of racial categories to denote belonging, citizenship and moral superiority. As the current options for COVID-19 control rely on forms of social and physical separation, the potential for stigma and discrimination are high. Narratives which combine morality with biomedical risks, especially when they are ascribed to certain marginal groups, must be avoided.
- People's concerns about economic security may limit their adherence to control measures and may cause tension, especially where there is limited trust between social and ethnic groups, and with authorities. Interventions to strengthen the economy and support local livelihoods can reduce the impacts of COVID-19 and foster cohesion within the response.

Civil Society

- There is a great spectrum of civil society organisation in Myanmar. There are many grassroots groups and networks, some of which are village specific while some are semi-formalised and linked to larger township or regional networks. Many are based on religious and ethnic solidarities. Given these group-based affiliations it is important to recognise the potential limitations to their coverage, and to the differences in their overall capacities.
- Locally organised COVID-19 mitigation efforts (e.g. market hygiene, local surveillance, provision of water and sanitation measures) are emerging. There is an important role for local government and authorities to support, work with and connect these.
- Sustainability of civil society responses are linked to the wider livelihood, economic and social systems which these groups are part of, and from which they draw their strength. If these are hit by COVID-19 then it will weaken the resilience of civil society.

Religion

- Buddhism is the dominant religion and monks have considerable authority. This can veer into nationalism and exceptionalism. However, the Buddhist clergy, or sangha, is diverse including a range of Buddhist practices, ethnic identities, vernacular languages, generational divisions, and political affiliations. It would be better to amplify the roles and voices of monks who avoid partisan or exclusionary discourses.
- As with many epidemics, religious activities can present transmission risks e.g. communal worship, ablutions, funeral rites etc. Rather than being immutable these traditions are often easily adapted by working with religious leaders to maintain principles if not the practices. Religious and spiritual beliefs can be maintained in parallel to biomedically safe practices and the two do not, and should not, be presented as in opposition.

Key issues

A range of issues arise where there are disease outbreaks in contexts of conflict or displacement: large numbers of people living in conditions with poor and uneven coverage of health and basic services; limited access to camps and conflict-affected areas; a proliferation of competing state and non-state groups, often with disincentives to coordinate and cooperate; lack of trust and legitimacy between vulnerable populations and those in power; the potential for excessive use of force as part of disease control; opportunistic use of control strategies and resources to extend power or claims; the potential for stigma and exacerbation of communal divisions; and weaponisation of disease response and relief. The most recent outbreak of Ebola in the Democratic Republic of Congo (2018-ongoing) occurred in a conflict-affected region and the resulting dynamics have severely hindered the response and prolonged the epidemic.[2] Ebola is ostensibly an easier disease to control than COVID-19, and there is now a vaccine for Ebola, so this lack of progress serves as a warning.

Figures on displaced populations are notoriously poor. In 2018, an estimated 400,000 people were internally displaced as a result of fighting between the military and ethnic armed organisations in Kachin, Shan, Karen, Chin and Rakhine states. Over 700,000 stateless Rohingya refugees from Rakhine state live in crowded camps in Bangladesh. These numbers conceal may conceal many more who have been displaced in the past and for whom durable solutions have not been found. In Myanmar up to a third of the country is affected by internal and violent conflicts, and it is central to national politics.[3]

Political authority and the state in Myanmar

For nearly 50 years from 1962-2011, the government of Myanmar was ruled by two successive military dictatorships, both of which ran a centralised authoritarian state.[4] [5] Constitutional reforms contained in the 2008 constitution shifted some power from the military to a quasi-civilian government that began in 2011, while reserving 25% of the seats in parliament for military representatives, giving the military power to veto any constitutional amendments and also mandating that three key ministries, Defence, Home Affairs and Border Affairs, would remain under military control. The ministers of these three ministries are appointed by the head of the military.[6] Despite the economic and political transition from 2011, an initial wave of reform stalled and widely heralded gains, for example in the fields of free speech and political openness, have been in decline in recent years.[7] The government has been accused of committing genocide against the Rohingya, charges denied by the de facto head of state Aung San Suu Kyi.[8] This current political structure, combined with the historical dominance of the military in Myanmar's politics, continues to give the military great influence over the nation's politics.

Political authority in Myanmar is distributed between: (1) a central power perceived to be predominantly Burman (Bamar) and Buddhist, either under the control of the military (e.g. during the dictatorship), or under the influence of it (e.g. currently, as enshrined in the constitution); (2) the organisation of Buddhist clergy and lay donors; and (3) minority groups, mainly ethnic and religious. Although much of the country is stable, there exists a patchwork of conflict, ceasefires and peace processes, with varying levels of intensity, all fueled by longstanding tensions between ethnic nationalist movements. These distinct sources of authority are often in tension with one another and at other times form politically-convenient alliances. Some ethnic armed organisations (EAOs) run their own autonomous state institutions (see below). There are also local village or neighbourhood level forms of political authority rooted in the social fabric of each context.

Uneven coverage of basic services

There are large disparities in income between Myanmar's small elite, its relatively small middle class and the economically challenged majority. People living in major cities like Yangon and Mandalay have better access to government services and have experienced a stronger public health response to COVID-19 than in the countryside, where a majority of the population still lives.[9] These differences are further pronounced between parts of the country that are home to the countries' ethnic minorities, like Kachin, Shan, Karen and Rakhine states where active conflicts are ongoing between EAOs and the central government, and the Bamar majority populated areas. The majority of Myanmar's internally displaced come from ethnic and religious minorities. Communication is also uneven, and therefore so is data coverage. In some states and townships the government has blocked the internet while in other areas communication lines between central government and local authorities and populations are limited due to long term neglect and/or ongoing conflicts. This will hinder flows of vital public health information (e.g. detection and reporting of cases, coordination around control strategies, knowledge sharing about successes and failures). The uneven coverage of services and communication means that large numbers of people may not be reached by messages, protective measures or relief, and it may conceal pockets of transmission and suffering. Concerted efforts are needed across government and the humanitarian sector to address these gaps and disparities.

Trust and cohesion

A continued legacy of Myanmar's long era of military rule is that levels of trust in the country are low, not only of government institutions but also of strangers, relatives, and acquaintances. People have more trust in civilian leaders than in the military.[10] They tend to rely on informal sources of information, especially from social media, rather than official sources.[11] The poor quality and inaccessibility of many government services likely explains the low trust in institutions but the low trust also indicates limited social cohesion. Both present challenges to COVID-19. Trust must and can be built through the provision of reliable services and information, and by identifying and working through institutions and people who already inspire some confidence. Disease outbreaks are stressful experiences which could further damage social cohesion between already untrusting groups. Attention to inter-communal relations is needed as well as to improvements in services. Widespread hardship and the potential for COVID-19 to exacerbate this due to loss of livelihoods may fuel unrest and sew further divisions. People's concerns about economic security may limit their willingness (and capacity) to adhere to control measures and cooperate with others. Interventions to strengthen the economy and support local livelihoods will be important to reduce the impacts of COVID-19 and to maintain and build cohesion within the response. There are early anecdotal reports that relief is being distributed unevenly in villages and that who qualifies for support and who does not (e.g. for those with or without farmland) is causing disagreements and is deemed by some to be unfair and not based on need.

Trust is likely to look very different from the point of view of the ethnic Bamar Buddhist majority than ethnic and religious minority groups and people living in areas impacted by military fighting. While mistrust of the central government is by no means a view universally held amongst Myanmar's non-Bamar ethnic people, longstanding ethnic grievances and the perceived failure of the current National League for Democracy (NLD) government to seriously address them, has resulted in a situation where many of the country's minority ethnic peoples do not appear to have confidence or trust in either the central government, tethered to military interests, or the NLD as the head of the civilian government, which is often seen as unsympathetic to ethnic minority issues. Further, COVID-19 efforts appear to be spurring a sense of nationalism among Buddhist Bamar majority residents in cities, who believe that the government is doing an excellent job with stringent public health measures.[12]

Socio-cultural identity and difference

Since colonial times the state has used a hierarchical system of racial categories to denote belonging and citizenship. Much of modern Myanmar's current conflict has been attributed to ethnicised state building processes[13,14] which have divided and reified ethnic identifies. The result is a state apparatus and sense of national identity dominated by a Bamar and Buddhist majority. While Myanmar is a very ethnically diverse country the various categories and labels used to describe people, remain a highly contested, issue.[15] The official list of 135 national races, has been described as a list whose "formulation remains something of a mystery" and was never actually formally announced.[16] Approximately 88 percent of citizens are Buddhist, 6 percent are Christian, less that 5 percent are Muslim, 0.5 percent Hindu. Although a religious minority, Muslim communities in Myanmar are ethnically diverse and comprise nearly 1.5 million people.[17]

Burmese nativist discourses identify Burmans are the original inhabitants of the region, who along with some other officially recognised indigenous ethnic minorities, have been joined by other more recent immigrants.[18] While earlier citizenship legislation was more liberal the reformulation of the Citizenship Law in 1982, explicitly defined citizenship as a product of indigeneity, a legislative decision that excludes groups perceived as foreign for example the Muslim Rohingya[19] who have been made stateless. This has set up a socio-political landscape of inclusion and exclusion, claims to identity, threat, and autonomy in which ethnicity is an ordering principle – and all of which could come to inform and define COVID-19 responses, and is evident already in the nationalism around the response.[20]

While much commentary and media on Myanmar emphasise these ethnically based identities and governing institutions, some point to a heterogeneity which is overlooked[21]. There is a paradox in which Myanmar is increasingly understood as divided down deeply rooted identity lines, drawing nationalist and exclusionary boundaries, all of which are fed by social media, but also as a place of great complexity, change and capacity to incorporate diversity which is concealed by these reductionist views.[22] Ethnic labels are used inconsistently on people's identity cards which means that close relatives may have different characterisations of their ethnic subgroups. This is of relevance to the potential ways COVID-19 will play out in Myanmar's society. In practice identity, social relationships and cooperation can be more fluid than sometimes supposed. It will be important to distinguish where there are categories and divisions which will almost certainly create, or worsen, vulnerabilities (e.g. exclusions from services and protection based on citizenship and ethnic identity) but also where there are potential for mutual aid, cooperation and brokerage. Given the diversity within sub-groups it should also not be assumed that they are monolithic blocs with similar allegiances, there are many inter-group disputes too.

COVID-19, Burmese and Buddhist exceptionalism and threats 'from outside'

The central government's initial response to COVID-19 was to downplay the risk and emphasise the unique protections from Myanmar's climate, geography and diet. To this, protection through sacred traditions and Buddhist faith were soon added so an idea of Buddhist and Burmese exceptionalism emerged.[23] Much early focus was on the potential for imported cases via air routes rather than across the porous land borders. These present a number of risks: that the real nature of COVID-19 risks were overlooked, leading to insufficient planning and a false sense of protection, but also it fosters existing racist and xenophobic attitudes where non-natives (e.g. non-Bamar) or non-Buddhists are blamed.[24] As the current options for COVID-19 control rely on forms of social and physical separation, the likelihood for stigma is high. Narratives which combine morality with biomedical risks, especially when they are ascribed to certain marginal groups, must be avoided. Faith in religious protection is not unique to Buddhism as a recent case where a Christian pastor had preached protection but was later identified as a source of a major COVID-19 cluster. The pastor was charged under the Prevention and Control of Communicable Diseases Law, and it is unclear how this may affect majority perceptions of non-Buddhist communities.[25]

Territories and governance

There are more than 20 ethnic armed organisations (EAOs) in Myanmar, and about half of these control significant stretches of territory where they serve as the de facto government in the areas they control. Organisations like the Kachin Independence Organisation (KIO), Karen National Union, United Wa State Army, Restoration Council Shan State/Shan State Army South (/SSA South), all have their own respective health departments[26] that have taken the lead in implementing COVID-19 responses in their territory. Some border areas (e.g. with China and Thailand) are relatively porous and the sphere of influence of neighbouring government's and institutions can be greater than Myanmar's central government. Movement is heavily restricted in many parts of Myanmar, including those areas controlled by EAOs and the government. These restrictions have been furthered with COVID-19 public health measures, which have further complicated the delivery of assistance.[27] The government has restricted INGO's and UN agencies from travel to certain regions and on the occasions

that access is possible it involves a lengthy bureaucratic process. Each state has its own particular territorial and governance complexity which will require tailored approaches to addressing COVID-19. The war in Rakhine and Chin areas between the government military and the Arakan Army had intensified in recent months, compounding the vulnerability of communities in those areas. Related to COVID-19, on April 21, a driver employed by the WHO was shot and killed while driving from the Rakhine State capital, Sittwe, to Yangon while passing through Rakhine State's Minbya Township. The driver had been transporting swabs for testing. Following the incident both the Myanmar army and the Arakan Army, the main armed group in Rakhine state, denied responsibility, with both parties blaming each other. Other similar but less violent disputes between the army and armed groups have been reported in Karen and Shan states over the past few weeks during the implementing of COVID-19 response.

Camps and displacement

There are a variety of arrangements and conditions in which displaced persons live. In 2018, Myanmar's national government began closing displaced persons camps, building more permanent homes next to the camps. In new sites movement is still severely restricted.[28] Many other IDPs remain in original settlements, as negotiations proceed between the national government and EAOs. IDP camp residents face increasingly difficult circumstances, as humanitarian aid was on the decline before COVID-19.[29] Displacement camps have been flagged as "COVID-19 tinderboxes" characterised by overcrowding, internet shutdowns, blockages on humanitarian aid, and movement restrictions, magnified by the challenges of poor healthcare infrastructure in the country.[30] Shelters and other infrastructure are in poor condition. Women and girls are vulnerable to forced sex due to economic circumstances[31]. The national government's COVID-19 response plan identifies the need for unconditional cash and in-kind transfers to individuals in IDP camps, although it remains to be seen how or whether this will be implemented and what kinds of coordination with EAOs will take place.

Displacement conditions include:

- IDP camps, including those controlled by the government and those controlled by EAOs.
- Host families may provide shelter to displaced persons, with conditions wide-ranging.
- Residence (temporary or longer-term) in townships. Authorities have restricted humanitarian access in half of Rakhine's townships, and so supplies cannot be delivered there.[32]
- Makeshift displacement sites in villages and monasteries, characterised by poor access to clean water, temporary shelters, growing malnutrition.[33]

Public health system and coordination for non-state actors

The health system in Myanmar lacks resources and capacity. It is pluralistic, meaning it is a mix of public and private providers with varying degrees of quality and accessibility. The government health system (which operates in areas under government control) has limited reach, especially in rural areas, with traditional and informal providers filling the gaps. In non-government-controlled areas, some of the ethnic governing bodies (e.g. the Karen National Union (KNU) and the Restoration Council Shan State (RCSS) have longstanding relationships with NGOs and CSOs that operate on the Thai/Myanmar border who have helped implement a range of basic health services in their territory that in some ways are equivalent to or better than what communities would receive across the front-line in government-controlled territory. Some of these armed groups have publicly stated e.g. in open letters and public statements, a willingness to work with the Myanmar government to respond COVID-19, but the lack of initial formal response indicate that the government does not appear enthusiastic at the present time. This has changed more recently, as there is better formal and informal collaboration between the government and EAOs on issues related to COVID-19.

While there has been some level of cooperation between the central government's Ministry of Health Department and the respective EAO health departments in the past, particularly those from groups that are in ceasefires with the central government, the cooperation has for the most part remained at the early stages. A lack of trust on both sides and a tendency on the part of the central government to view ethnic armed organisations as threats or illegitimate, even for groups that haven't clashed or fought with the central government in many years, does not help.

Governance and the military

The military continues to play a central role in much of the country's affairs, with control especially over three key ministries, Defence, Home Affairs and Border Affairs. Given their remit, the latter two ministries can be expected to play a significant role in implementing Myanmar's COVID-19 response. In terms of implementation the General Administration Department (GAD), which used to be under the Ministry of Home Affairs until it became a separate ministry at the end of 2018[34], plays a central role in much of the day-to-day running of Myanmar. As a recent report from the Asia Foundation noted the GAD is the "primary actor for public administration in Myanmar. No other civilian government organisation has such a wide presence, and even the Tatmadaw (army) is not spread among the general population to the same degree.[35]" While now at least officially under civilian control the GAD is playing a significant role in the government's COVID-19 response plan. For example, it is the GAD and their counterparts from the health department that are involved in implementing quarantines and lock-downs in neighbourhoods across Myanmar but media reports suggest the GAD's handling of the COVID-19 pandemic has not been without significant challenges. Historically cooperation between ministries is limited and on the ground there have been reports that chains of command within GAD are slow and meanwhile there is limited coordination between GAD and public health authorities, and at times, competition with local elected government officials. This has led to contradictory instructions and sporadic implementation of control measures.[36]

Information

Further complicating matters is the information ecosystem in Myanmar. Social media is a dominant source of information which has the potential to spread unreliable and damaging information. False, biased or hateful information should be addressed and countered with clear, consistent and factual messages (see SSHAP brief on online information and misinformation[37]). Accurate translation of public health information into the various languages and dialects is required and understanding should not be assumed. Many non-Bamar ethnic people living in Myanmar's rural borderlands, particularly those who are in territory held by EAOs, do not speak Burmese fluently and translations may not be good quality. The deliberate shutdown of internet in parts of Rakhine and Chin states will clearly limit the supply of information about COVID-19 and prevents any attempt at the trust and two-way dialogue which is needed between vulnerable communities and authorities.

Civil society

There is a great spectrum of civil society organisation in Myanmar, in terms of strength, formalisation and diversity. There are many grassroots groups and networks, some of which are village specific while some are semi-formalised and linked to larger township or regional networks. Many are based on religious and ethnic solidarities. Activities include ad hoc response to disasters as well as development project. Some groups – often the more formal networks - are well resourced and have good connections to donors. Smaller groups may be more reliant on community donations or remittances. These groups will be central to mitigating the harm of COVID-19. Given their religious affiliations it is important to recognise the potential limitations to their coverage, and to the differences in their overall capacities. Buddhist and Christian networks are more likely to be strong and formalised, whereas Hindu and Muslim networks may be more informal and limited. There will be significant differences in the make-up of civil society across different parts of the country. Myanmar's diverse ethnic and religious makeup means that the country is complex at both the national as well as local level. Careful consideration is needed when formatting relief and pandemic contingency plans, taking into consideration the local context as well as the capacity and coverage of civil society groups, both of their links upwards to formal structures and resources, and also downwards to the populations they are likely to serve (or not).

The response to Cyclone Nargis in 2008 is considered to have been a breakthrough of sorts, with the then military regime allowing civil society to take part in relief efforts, many of the groups operating today have their origins in the Nargis relief but coverage was not even and coordination with the government fraught with difficulties. More than a decade later it should not be assumed that efforts to provide COVID-19 will automatically target the most vulnerable groups, indeed the most vulnerable groups are those for whom by definition, these networks fail.[38] Sustainability of civil society responses are linked to the wider livelihood, economic and social systems which these groups are part of, and from which they draw their strength. If these are hit by COVID-19, as the surely will be, then it will weaken the resilience of civil society. The more prolonged the crisis the more they are put under strain. It will be important to continually assess vulnerability.

Local organisation

There are already examples of local communities disinfecting market places, allocating buildings to be used for their own quarantine procedures. Disease control measures such as these are more likely to be effective when they are developed with local involvement. The level of organisation varies, and can be quite extensive: a township in Mandalay Region, has established a “collaborative working team involving township departments, local CSOs, and volunteers; a centralised surveillance and communication structure throughout all its wards/villages; 14-day quarantine facilities for overseas returnees; wash facilities in wet markets; and an information campaign engaging local community leaders including monks.”[39] There is an important role for local government and authorities to support, work with and connect these community based initiatives.

Harnessing religion

The Buddhist clergy, or sangha, possess considerable influence in Myanmar and will likely be important channels of information, spiritual guidance, resilience and the provision of aid. Some monks in the country have opened up monasteries for use as quarantine facilities.[40] However, Buddhist nationalism and above-mentioned exceptionalism, mean this also poses a potential barrier to inclusive and cohesive response. Monks and Buddhist leaders must be engaged sensitively and encouraged to adopt inclusive actions and messages. The sangha is diverse including a range of Buddhist practices, ethnic identities, vernacular languages, generational divisions, and political affiliations. It would be better to amplify the roles and voices of monks who avoid partisan or exclusionary discourses.

Religion will also be important for COVID-19 protection and response among minority ethnic groups. A range of religious and traditional leaders are relevant for Muslims communities,[41] e.g. Mullahs, Imams and Mulvis are simultaneously able to command/motivate resources from the community (financial resources or labour, although scope for this decreases when resources are low. Since women do not attend the mosque, contact with women could be through women Háfes and midwives (see below); Sodor: are the enactors of community solidarity and redistribution (Zakat and other forms of charity) and would be good vehicles for awareness and key messages and protection issues; traditional and spiritual healers: alternative practitioners who work with herbal remedies, shopkeepers who sell drugs and give advice, doctors who heal jinn possession and use prayer; female Háfes – women who have memorised the Quran and who educate other women on religious matters and on issues to do with marriage and proper behaviour. Háfes would be good interlocutors to engage for communication and to spread messages.

As with many epidemics, religious activities can present transmission risks e.g. communal worship, ablutions, funeral rites etc. But rather than being immutable these traditions are often easily adapted by working with religious leaders to maintain principles if not the practices. Religious and spiritual beliefs can be maintained in parallel to biomedically safe practices and the two do not, and should not, be presented as in opposition.

Conflict Settings and Lessons Learned from Ebola

Previous epidemics in conflict settings demonstrate lessons for COVID-19 and Myanmar. The complexity of linkages between conflict and infectious disease transmission and management requires contextually tailored approaches, which may need to be iteratively developed. During the recent Ebola epidemic in the Democratic Republic of Congo, existing socio-political complexities had implications for who trusted government-disseminated information about the epidemic. Mistrust in the Ebola response was a factor in low uptake of Ebola control measures.[42] Also commonplace were reports of ad hoc agreements with non-government military groups to negotiate temporary access to rebel-held territories to identify and control Ebola cases. During COVID-19, conducting rapid assessments (e.g. governance and power mapping) can provide a snapshot of which social actors are most trusted. Public health information can be disseminated through those trusted individuals, sometimes called “ethical brokers.” Brokers can be engaged to build trust in epidemic response in areas with experiences of conflict.[43]

Contact

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviatulloch@anthrologica.com). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).

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