Humanitarian Health Responses in Urban Conflict Zones

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War has long tested the design, capacity, and protected status of health care personnel and systems. In recent years, however, urban conflict zones have come to exemplify many of the most intractable humanitarian dilemmas around the delivery of medical care. In this essay, I examine several recurring dilemmas concerning operational independence and physical safety, as encountered in Syria and Yemen. I argue that, as a generative force, war has the potential to make (and remake) social, economic, and political life in urban settings in ways that accentuate essential challenges facing the safe and principled delivery of health care. These far-reaching effects leave humanitarians and their supporters to adapt existing strategies, many developed in more rural contexts, to shifting urban environments. In such contexts, the establishment of "hospital" or "relief zones" may offer a pragmatic and principled strategy to mitigate many of the dilemmas surrounding the protection of medical facilities and personnel in urban conflict settings.

War has long tested the design, capacity, and protected status of health care personnel and systems. In recent years, however, urban conflicts have come to exemplify many of the most intractable humanitarian dilemmas facing the delivery of medical care. This is apparent across the Middle East, where shifting frontlines around Al-Hudaydah, East Aleppo, and Mosul have turned health providers into victims, their facilities into targets, and their patients into collateral damage.

What is the significance of these urban areas for the delivery of health care amid armed conflict? What explains their relative prominence in global debates? Prevailing accounts stress the degree of human suffering in Syria and Yemen.[1] Interdependent infrastructure and essential services have compounded the effects of direct or indirect targeting, and interrupted water, sanitation, and electricity services have placed greater pressure on already limited health assistance.[2] Scholars have cited the intensity of urban fighting.[3] Others point to wider changes in the character of war and the strategies and tactics of contemporary belligerents, many of which contravene international humanitarian law (IHL) and may constitute war crimes.[4]

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Beyond such explanations, these conflict zones also illustrate the potential for war to make (and remake) social, economic, and political life in ways that accentuate essential challenges facing the principled delivery of health care. War is more than just a destructive force: it can recast defining features of conflict areas where humanitarian health providers operate, altering population distributions, shifting legal frameworks, and replacing long-standing governance systems with rival authority claims.[5] These effects are pronounced in urban areas of the Middle East, where populations, geostrategic interests, and symbolic importance are concentrated.

Such effects have immediate consequences for strategies to ensure the operational independence and physical safety of humanitarian medical operations. Humanitarian health providers and their supporters are often left to adapt existing strategies, many developed in more rural contexts, often with mixed results. A global strategy to mitigate these dilemmas may prove difficult, especially given the local particularities of urban conflict zones. One option rooted in IHL may be to increase advocacy for the establishment of "hospital" or "relief zones." Consensual agreements among combatants and humanitarian actors about such areas may create a more predictable and permissive operating environment for the delivery of health assistance in urban conflict zones.

Armed conflicts in Syria and Yemen have challenged all facets of humanitarian medical operations. Few are more essential than operational independence. This challenge derives, at least in part, from regional legacies. As scholars note, health systems in the Middle East have never been characterized by independence.[6] On the contrary, health and health care have long been central to securing social and political legitimacy in the postcolonial state. The construction of hospitals, accreditation of physicians, and prerogative to deny or provide treatment have thus been essential to states' claims to and exercises of sovereign authority.

Amid recent armed conflicts, as sovereign authorities have faced new challenges, especially from emerging nonstate actors, many states have claimed even greater authority over the provision of health, including in areas outside their control. In Syria, in 2012, the parliament effectively criminalized the provision of medical assistance and other humanitarian activities outside government-approved structures.[7] In Yemen, health providers and other humanitarian actors are generally prohibited from working across the entire country; registration with either the internationally recognized government based in Aden or de facto authorities in Sana'a precludes recognition from its rival.

Nascent governance structures further illustrate this legacy. Health provision was essential to the earliest attempts by the Islamic State of Iraq (ISI) to govern Iraqi territory before and during its self-declared caliphate that extended into much of Syria. In April 2007, for example, a minister of health was appointed to

ISI's first cabinet, along with ministers for war, public security, and martyrs and prisoners.[8] The ministry of health consolidated and expanded its authority in subsequent years, even as other administrative branches (such as "Al-Hesba" or the morality police) exercised considerable influence over hospitals and clinics, with grave consequences for the quality of care.[9]

Amid such sweeping exercises of political power, urban medical providers are often implicated in more localized contests over political authority. As seen in various contexts, including beyond the Middle East, war can turn cities into epicenters of competing authorities, particularly where emerging rivals struggle over potential revenues, strategic advantages, and political standing. The ensuing operating environment for medical providers can vary, ranging from lawlessness in urban battlegrounds to cities with nascent administrations, with both extremes posing serious dilemmas for health operations.

The challenges medical providers face amid competing authorities are apparent at Al-Thawra General Hospital in Taiz, Yemen. With support from international donors, most notably Médecins Sans Frontières (MSF), the hospital has operated for years in a violent urban environment. Located in a nominally pro-government area known as the "enclave," the hospital has been surrounded in recent years by a fractured collection of armed groups, all nominally united in a fight against pro-Ansarallah forces. In reality, however, these new and established groups are locked in their own contest over power, control, and territory with the support of various Yemeni and regional powers.[10]

This dynamic poses several chronic challenges for the medical operation. Fighting and indiscriminate shelling endanger the facility, assets, staff, and patients. Roadblocks restrict staff movements and essential supplies, especially from Ansarallah-controlled areas. Conditions do not permit medical assessments in the surrounding areas: patients that manage to reach the hospital are often the most reliable indication about the prevailing needs.[11] These conditions have deterred most other international nongovernmental organizations from operating in the urban warzone, leaving MSF as one – if not the only – international presence in the city center providing significant medical humanitarian support.[12]

Although related to this pervasive insecurity, a more intractable dilemma has been preserving medical providers' ability to operate without interference. The concentration of armed actors in a small, contested urban geography deeply constrains health care delivery. Staff warn about fighters' interference in hospital administration and decision-making.[13] More violent acts, however, are among the most flagrant challenges to the hospital's operational independence. Militias are often stationed in the hospital and the surrounding compound. Fighters have forced surgeons to operate at gunpoint.[14] Government-affiliated fighters have assaulted doctors and nurses over the treatment of enemy and allied soldiers. In 2020, in one of several press statements, an MSF manager in Taiz warned, "Our

humanitarian space is threatened by repeated violations committed by the different warring parties in Taiz."[15]

Recurring interference at Al-Thawra General Hospital illustrates urban medical providers' limited recourse to assert the principled nature of their operations. Management and staff have periodically reduced or suspended operations in protest, relying on national and international media coverage to highlight their difficult situation. Public attention complements private advocacy with commanders, armed groups, and other influential actors to increase acceptance of the hospital and MSF as a neutral and impartial medical humanitarian organization. But the contested urban enclave also serves to constrain such an advocacy strategy: the multiplicity of armed actors, changing leadership, and shifting alliances complicate MSF efforts to ensure these principles are respected.

Strong considerations may deter more severe responses. Closure of the facility, for example, would have outsized consequences for the surrounding population, which totals more than one million people, as Al-Thawra is the largest medical facility in the region. The remaining facilities in the area are insufficient to absorb the resulting unmet caseload. Relocation may only compound civilians' difficulties in accessing adequate medical treatments, particularly in the absence of other humanitarian medical workers.

In contrast to the lawlessness of Taiz, Yemen, select health workers in Northwest Syria navigate a more consolidated, albeit still emergent, political order. In 2017, Hayat Tahrir Al-Sham (HTS), an internationally designated terrorist entity, began to impose itself over rival factions across opposition-held areas of Idleb governorate. HTS used its growing military hegemony to force rival armed groups and a patchwork of courts, local councils, and independent authorities to submit to the new technocratic authority based in Idleb City, the Syrian Salvation Government (SSG).[16]

Under the SSG, humanitarian medical workers are an essential part of the provision of basic health services in Idleb. As with the wider humanitarian sector, the SSG does not have the personnel, financial resources, or technical expertise to support the millions of people in need of assistance across its territories. Instead, international humanitarian organizations and their local partners have largely taken over a deficient health sector, leaving a fragmented response with many basic and chronic needs going unmet.

The Syrian Arab Red Crescent (SARC), the internationally recognized Red Cross/Red Crescent Movement national society, occupies a precarious place in the wider humanitarian medical response in Idleb. SARC-Idleb is one of the oldest medical providers in Northwest Syria: its operations date back decades, long before HTS and the SSG emerged. SARC personnel have remained active amid repeated kidnappings, attacks, and casualties during the ongoing armed conflict. Despite this established presence, SARC's activities in Idleb have decreased in re-

cent years, focusing mostly on first aid and primary health services. As of 2019, SARC only maintained two urban medical facilities in Idleb City and Ariha, providing some sixty-eight thousand people with medical assistance during the first half of the year.[17] This reduction made SARC a relatively small part of humanitarian medical response activities, especially compared with cross-border NGO actors operating from Türkiye.

More important, SARC-Idleb is the only Syrian health actor to operate in HTS-controlled territory with governance and financial structures headquartered in government-controlled areas. Historic ties between SARC and the Syrian government implicate the Idleb branch in wider debates, accusations, and conspiracies about the organization's operational independence.[18] In 2019, local councils, medical professional societies, and other stakeholders in Northwest Syria began to refuse to cooperate with SARC, with some calling them an extension of the government, not an independent humanitarian health provider.

This precarious status escalated in 2020. The SSG attorney general's office responded to growing accusations about SARC by closing its offices in Idleb City and Ariha and seizing assets, citing charges of corruption. Staff and volunteers were temporarily detained. Several SARC leaders later fled to other parts of Northwest Syria after the SSG opened criminal cases against them. SARC headquarters condemned the "assault and intrusion," questioning the legality of both the court order and the SSG.[19] The International Committee for the Red Cross raised concerns about the closure, citing the need to respect and protect the humanitarian relief personnel and objects for humanitarian relief.[20]

More than two years since the raid, SARC offices in Idleb are still closed and court cases are still pending, even as health needs in Northwest Syria continue to increase. The SSG's position on the situation remains unchanged, despite public and private calls for greater acceptance of SARC in Northwest Syria. Its relative absence from other health-related matters only affirms the SSG's nascent political-legal authority and the wider transformation of governance in HTS-controlled areas.

The Idleb case illustrates how this transformation is most pronounced in urban areas. The SSG's presence in Idleb City and, to a lesser extent, in Ariha enables it to exercise a degree of authority that would be untenable in wider, more rural parts of Idleb. The SSG lacks the means and will to fully regulate the social, economic, and political life in HTS-controlled territory, particularly outside urban areas. As an administrative and legal matter, SARC and its supporters must manage not only the highly politicized medical humanitarian response in HTS territory, but also the often arbitrary legal and procedural stipulations of the SSG order.

Beyond preserving operational independence, the protection of staff, patients, and medical facilities is a recognized challenge across conflict settings worldwide. As World Health Organization Director-General Dr.

Margaret Chan warned in 2014, violence is occurring "with growing frequency in all regions of the world, and in all contexts, during peacetime as well as armed conflict and other humanitarian crises."[21] The scope of such violence has not been reliably calculated.[22] Its cumulative effects are even less understood.

In Syria, the protracted war has transformed health care provision throughout the country.[23] As Dr. Aula Abbara and colleagues have argued, since the outbreak of the armed conflict, geopolitical, fiscal, and humanitarian factors have fragmented and politicized the Syrian health system, creating distinct systems across the country, including in the HTS-controlled Northwest.[24] Overt challenges to the protected status of wartime medical units have arguably been the most far-reaching factors in fragmenting and politicizing the Syrian health system. As many scholars have noted, parties to the conflict have recast patients, medical providers, and their facilities as strategic targets, intrinsic to the enemy war efforts and warranting attacks.[25] The resulting protection challenges extend throughout the country, particularly in opposition-held areas, even as researchers acknowledge systematic underreporting.

Safety risks have forced medical service providers in Syria and their supporters to devise elaborate responses. The "hardening" of medical facilities, particularly in underground sites, became one of the most notable strategies in areas outside government control across North, Northwest, and, to a lesser extent, South Syria.[26] Beginning in June 2011, hundreds of medical facilities were established, consolidated, and concealed behind and beneath reinforced structures.[27] Several specialized facilities were later built inside caves, perhaps most notably Al-Maghara (Dr. Hassan Al Araj) Central Hospital outside Kfar Zeita, Hama, which was constructed below meters of rock. In 2018, a survey of health workers in Syria commissioned by the UK Department for International Development found that, among various protection measures and strategies, underground facilities and fortified sites were the "most commonly used protection tool[s]."[28]

Space, structural, and cost constraints have prevented the construction of fully underground facilities in urban settings. Instead, two related approaches have become more commonplace, especially in North and Northwest Syria. First, beginning in 2011–2012, medical providers and their donors have established facilities in "unconventional places," including private homes, cellars, mosques, and churches.[29] Although the quality of care varies, these smaller medical points and "field hospitals" have helped extend service delivery, including to areas that lacked adequate facilities, materials, and professional staff. Moreover, hospitals have been divided into smaller sites across several locations, with networks of connecting tunnels, to lower the risk posed to health workers and assets. This footprint has decreased the potential for large queues of patients around facilities, with a view toward reducing the chance of detection by surveillance aircraft and civilian casualties during an attack.[30]

Second, existing buildings have been retrofitted and reinforced. Such an approach was common in hospital facilities, including Idleb National Hospital in Idleb City and Al-Sakhour Hospital in East Aleppo, which were too large and often too well-known to conceal. Emergency rooms, intensive care units, and other service areas were relocated to lower floors for protection. In addition, vacant buildings with basements were rehabilitated and turned into hospitals, using the existing structure as a base. Upper levels were abandoned given their exposure to shelling, missiles, and airstrikes. If budgets permitted, these areas were often reinforced with sandbags, concrete, and other construction materials to provide additional protection for the floors below.

Principle and pragmatism underpinned the rationale for constructing underground medical facilities. Health providers and their supporters continued to insist that IHL afforded a protected status to medical operations in all areas outside government control. This argument was apparent in May 2017, when a consortium of medical providers and advocates appealed for more international support to construct fortified and underground hospitals. As they explained, "We have called for the protection of hospitals and health workers from the beginning of the conflict."[31] Yet, after five years of conflict, appeals to IHL had proven insufficient. Amid increasing attacks, medical providers had taken it upon themselves to protect their staff, patients, and facilities in both urban and rural areas. "While the international community fails to protect Syrian medics from systematic aerial attacks on their hospitals," the consortium explained, "Syrians have developed an entire underground system to help protect patients and medical colleagues as best they can."[32] A strategy of self-protection was borne out of necessity; it was a practical recourse given the limits of principle-based protection. "We are forced," the consortium concluded, "to fortify our hospitals and rebuild them underground for our own safety. This is not development – this is protection."[33]

In subsequent years, efforts to disperse, conceal, and fortify urban medical sites helped save lives and enabled medical operations in opposition-controlled areas, even following attacks.[34] At the same time, as peace efforts stalled and frontlines encroached, urban conflict zones in East Ghouta, Idleb, and Aleppo revealed the limits of self-protection strategies: hidden and reinforced medical facilities could not evade intensifying attacks, safeguard staff and patients, or compel greater respect for IHL.

Medical providers' public resolve for self-protection strategies diminished amid the realities of escalating violence and bombardment. Concealment strategies in urban areas were relinquished in favor of other approaches, including greater public advocacy. By mid-2018, with escalating fighting outside Damascus and in Northwest Syria, many medical providers and supporters became more outspoken about the inherent risks of delivering medical services, especially in urban contexts. This was evident in the advocacy of two of the largest internation-

al medical providers, the Syrian American Medical Society (SAMS) and Union of Medical Care and Relief Organizations (USSOM): in 2019, the two networks published more than forty press releases in English about incidents affecting their urban operations.[35] Essential details about location names, years of international support, and status of operations were disclosed in repeated calls for fighting to stop and IHL to be respected. Graphic photos revealed the structural damage and loss of life.

After years of advocating for concealment and fortification strategies, SAMS began to acknowledge that such approaches could not overcome a lack of respect for the protected status of medical staff and facilities under IHL. "The symbolic Red Cross or Red Crescent markings," they explained, "have been removed from most hospitals in Syria as they are now a literal target."[36] Moreover, the physical limitations of self-protection strategies became evident. Repurposed and reinforced structures could not withstand repeated attacks, especially with the deployment of larger artillery and more sophisticated missiles. SAMS lamented the situation, warning, "Bunker buster bombs have been used to cut through concrete and decimate basements and underground hospitals."[37]

Humanitarian medical workers have been left with few options. In Idleb and North Aleppo, some medical providers relocated larger hospitals away from urban areas, opting to reopen closer to the Syrian-Turkish border, where hundreds of thousands of displaced families had settled. The remaining humanitarian health operators continue to deliver assistance in uncertain conditions.

Humanitarian medical professionals face near intractable dilemmas in urban conflict zones in the Middle East. These settings illustrate more than just the depraved nature of contemporary warfare; they also demonstrate the potential for war to recast essential features of conflict zones, often in ways that undermine the safe and principled delivery of health assistance. These effects can be especially pronounced in urban environments, where social, political, and economic life are concentrated. Humanitarian medical workers are liable to be directly implicated in violent contests, including among emerging nonstate entities, over authority, legitimacy, and service provision. Nascent political orders may encroach on humanitarian health operations, exercising a level of authority otherwise limited beyond their de facto capitals. Escalating targeting can outstrip concerted efforts to conceal medical operations, fortify structures, and compel great respect for their protected status under IHL.

Immediate solutions to such challenges may prove difficult. The violent, shifting, and often very particular urban environments likely preclude a global approach. It may be opportune, however, to increase advocacy for the establishment of designated localities for the provision of humanitarian health assistance. As outlined in the Geneva Conventions, "hospital zones" or "relief zones" can be or-

ganized on the territory of a party to the conflict or occupied territories to protect the sick, wounded, and assigned medical personnel from the effects of war.[38] Such zones can include, but are not limited to, established medical facilities; temporary and unconventional medical sites can also be accommodated. More notable, these distinct zones are founded on a consensual agreement among relevant parties about their protected status, physical delineation, and duration. This agreement distinguishes such zones from other kinds of protected areas (such as "safe havens") that may be organized on a unilateral basis and lack a grounding in IHL.[39]

Hospital zones have supported various medical and humanitarian operations. Nonetheless, several operational realities may limit their viability in urban conflict zones, including in Syria and Yemen. A consensual agreement, for instance, may prove difficult to achieve in settings like Taiz City, where the number of belligerents is high, overall levels of trust are low, and strategic interests are entrenched following years of conflict. Moreover, in such contested settings, any agreement is liable to be tested: a single spoiler can jeopardize a negotiated arrangement, particularly in the absence of monitoring or enforcement mechanisms. Perhaps most important, hospital zones have the potential to attract large numbers of civilians, as physical safety and humanitarian assistance are strong pull factors.[40] Other kinds of protected areas are also likely to be combined, potentially complicating the agreed purpose of the designated areas.[41] Such possibilities pose serious protection risks for affected populations, but also for patients and humanitarian medical personnel.

With these realities in mind, greater advocacy for the establishment of hospital zones may help humanitarian medical providers and their supporters navigate several of the challenges identified in urban conflict zones: First, hospital zones can support humanitarian medical providers in establishing – and possibly preserving – their operational independence in urban conflict settings. From the outset, minimum operating requirements can be part of the consensual agreement to create a hospital zone. Such an understanding could afford humanitarian medical providers and their supporters greater leverage with parties to the conflict, particularly if these agreements encourage compliance (such as reliable medical treatment for war-wounded) and raise the potential costs (that is, reduced or suspended medical operations) of their interference.

Second, hospital zones could reduce the security risk humanitarian medical providers face in urban conflict environments. In principle, the consensual agreement would further deter direct attacks against humanitarian medical operations, since the potential political, strategic, and legal consequences of such an act would be greater. In practice, their effects may be more varied. Parties to the conflict, for instance, may only agree for zones to be created in safer areas, away from current or prospective fighting. Furthermore, humanitarian actors electing to work within the zone may reorganize their individual medical operations (such as consol-

idated facilities, standard demarcations, and collective civil-military liaison) to reduce their collective security exposure. In any case, the creation of consensual humanitarian zones may help medical operators better manage the inherent and shifting physical dangers of urban warzones. Such possibilities warrant further consideration given the inherent challenges facing humanitarian health responses in urban conflict zones.

AUTHOR'S NOTE

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ENDNOTES

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