The deleterious effects of war and conflict on the provision of health care for vulnerable populations and the potential effects of COVID-19 on vulnerable populations in conflict zones

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Abstract
Conflict as opposed to just war, has devastating effects on the host population in a variety of ways. The plight of the internally displaced population (internal refugees) and the increased urbanization of this latter phenomenon, pose stark challenges on an already broken and beleaguered administration that may or may not be sympathetic to the needs of its people. We discuss the effects of conflict on the provision of health care, hygiene, sanitation, mental health as well as maternal and child health. Finally, we discuss the added complication and implications of the current COVID-19 pandemic ravaging health infrastructures worldwide.

Keywords: Conflict, Health care, War, COVID-19

Following the Cold War, the world has seen an overall reduction in the number of major conflicts[1]. However, conflicts and their long lasting effects, even those on a smaller scale, are still rife in many countries across the world and are likely to never be eradicated in their entirety[1,2].

Conflict today is notably of a more urban phenomenon[2] and is a process carried out by force of arms within the state, between parties within a nation or involving nonstate/international actors. As a term, conflict threatens the actual or implied use of violence and can, but does not necessarily include, warfare by land, sea or air. A war generally involves the use of weapons, one or more military organizations and soldiers/civilians fighting on behalf of military organizations. It is important to understand that the term conflict is not necessarily synonymous with the term war. The average conflict lasts ~17 years and leads to protracted crises[2].

Conflict today are increasingly complex and protracted[2]. The effects of these apply to both military, armed combatants as well as the civilian population and are summarized in Table 1[2]. Within the civilian population, these effects are often described as “collateral damage.” Mortality and morbidity associated with

Discussion
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The landscape of displacement, however, is changing. Gone are the days when the majority of displaced people live in sprawling refugee camps. Most refugees and IDPs now live in urban areas[6] often in overcrowded and unsanitary conditions and blending in with the urban poor[1,2]. Costs and language problems can be barriers to healthcare access whilst the anonymity of cities makes it difficult for local authorities and NGOs to target displaced people for health interventions[5].

Population movement and crowding in temporary shelters increase the risk of waterborne and respiratory disease outbreaks[7,3]. In refugee and internally displaced persons’ camps during (and after) previous wars in Iraq, diarrheal diseases accounted for between 25% and 40% of deaths in the acute phase of the emergency. 80% of these deaths occurred in children under 2 years of age[3].

**Water, sanitation, and food supply**

The availability and access to safe water and sanitation services will affect the rate and type of communicable disease spread within that population[1,2,7]. It also affects the quality of health care provision. Damage to water supplies, impaired sanitation, and reduced food supplies/limited food security all contribute to sickness and disease and an inevitable rise in mortality rates[2,7]. These, in addition to damaged, displaced and crowded living conditions, all create environments in which waterborne diseases such as cholera, can thrive[1,2,7].

Cholera is an example of a severe and common diarrheal disease within these settings that can kill within hours if left untreated[8]. It spreads particularly rapidly during conflict and its aftermath and its treatment depends enormously on access to clean water and rigorous sanitation[9].

If these risks are to be minimized, those involved in conflict must give priority to ensuring that civilians can access these basic commodities. If access is impaired, it must be restored as rapidly as possible. The 1951 Convention on the Status of Refugees states that ‘refugees are entitled to health services equivalent to that of the host population and that everyone has the right to the highest attainable standard of physical and mental health[2,4]’. However, if these services are already inadequate for the host population, meeting this requirement is less straightforward and politically challenging for refugees[2,4].

**Mental health**

Conflict has been shown to adversely affect mental health in both the armed and civilian populations and is an important standard according to the 1951 convention of refugees[2,4]. Armed conflict results in the uprooting of individuals, families and entire communities, exacerbating mental health issues, and destroying the very social networks that are protective[9].

The development or deterioration of existing mental health problems may be attributable to the loss of life, loss of property/possessions, personal danger or experiences, separation from family, socioeconomic peril, and poverty health[1,2,9].

**Women’s well-being**

Conflict creates new burdens of disease but also poses a challenge to ongoing health care needs such as access to family planning.
and emergency obstetric care. Between 1980 and 2008, 50% of all maternal deaths occurred in just 6 countries (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of Congo (DRC)—all of which had ongoing or recent armed conflict, as per a review of maternal mortality in 180 countries[10]. The conflict situation in Sarajevo resulted in severe destruction of existing health care infrastructure including women’s health services, the killing and fleeing of health personnel and the population were cut-off from basic amenities[11]. It is therefore understandable that 1/3 of maternal deaths and 1/2 of all child deaths occur in areas where health systems have been disrupted due to violence[12].

The health impacts of violent conflict are often strongly gendered[10]. While men are more likely to be killed or maimed in battle, targeted for assassination or exploited through forced conscription, women and children often bear the brunt of the lasting consequences of war with some women, for example, in Afghanistan, denied access to medical care[8,13]. Rape and other forms of sexual violence are commonplace in armed conflict, often used as weapons of war, intended not only to harm women (and sometimes men too) but also to tear apart the very fabric of societies[8,13]. Aside from the social implications, sexual violence leads to intense psychological trauma, the spread of sexually transmitted diseases, unwanted pregnancies, and lasting physical damage[8,13].

The risk of death and violence during conflict is also applied to health professionals which in turn impacts the delivery of women and children’s services. A study looking at Médecins Sans Frontières health facilities concluded that the main barrier to accessing health care was insecurity but also included high costs, long distances, political affiliations[14].

In the Maoist insurgency in Nepal, the number of Antenatal Care (ANC) visits decreased by between 0.3 and 1.5 for women living in high-intensity conflict environments[15]. This was attributed to “an atmosphere of insecurity” stemming from political instability, regional violence leading to women having a reduced willingness to travel to ANCs as well as closure of health services[15]. Within the nondisplaced Syrian population, the percentage of women having at least one ANC visit declined from 87.7% to 62%. Similar trends were noted in births with a skilled attendant at delivery, dropping from 96.2% to 72%;[16].

**Education, health spending, and other factors**

Education facilities are often targeted, in addition to health care facilities, by armed groups aiming to destabilize a country[24]. In a number of countries, schooling ensures certain school based feeding programs as well as an environment of safety and lack of truancy and radicalization[26]. In a 12-month period of conflict in Afghanistan, there were 133 attacks targeted at schools[17]. The Mozambican National Resistance also targeted primary schools, resulting in 45% closing and over 50% of the child population losing access to their education[24].

Ongoing conflict causes economic instability resulting in a reduction in funding in critical sectors. In Sub-Saharan Africa, between 1993 and 2004, countries with a history of conflict reduced median spending on health from an average of 7% of computable general equilibrium to 3.5% (a 50% reduction in spending). Education saw a similar decrease from 20% to 10.5%[10]. If the health facilities are there, then access to them is often dangerous and arduous as illustrated by a study of 2228 people presenting to emergency departments of three hospitals within the Palestinian West Bank. 18% of people attending were delayed due to checkpoints or associated detours[27].

**COVID-19**

It is evident that complex conflict situations have deleterious effects on all components of health care provision and delivery. In light of the current COVID-19 pandemic, it is becoming rapidly evident that the effects of the virus, and equally as importantly, the official governmental responses to the pandemic[28,29] are having a damming affect on health care provision and delivery to those in conflict and war-torn areas; in particular, those in vulnerable groups as well foreign civilian humanitarian workers and peacekeepers[30,31]. Measures to control virus transmission across fragile humanitarian settings are resulting in the reduction,
adoption or in some instances, the complete postponement of services by national and international service providers\textsuperscript{28}. Examples of these include health care, water, sanitation and hygiene services, income and social protection, child protection and education services\textsuperscript{28}.

This, in part, is attributable to the need for redirection of funding away from perceived noncritical services to the critical response sectors\textsuperscript{28}. The resurgence of polio in Syria, cholera outbreaks in the conflict zones in Yemen and ongoing Ebola outbreaks within insecure regions of the Democratic Republic of Congo illustrates the worrying relationship between violent conflict and the propagation of infectious diseases\textsuperscript{29}. This brings to the forefront the inevitable question: is COVID-19 here to plague conflict zones indefinitely? If so, the effects will be catastrophic.

The following discussion highlights briefly, the impact of COVID-19, on various important factors within the context of the discussion earlier.

IDPs and refugees

COVID-19 is a threat wherever we reside geographically, but the risk that the virus poses is unbalanced, with much higher stakes for those living in war-torn and conflict zones where social and economic conditions are already unstable and compounded by weak governance, unequal access to resources and community mistrust of the government\textsuperscript{29,32,33}. Those who are very poor, belong to minority groups or are part of a marginalized or vulnerable populations are reported as being disproportionately affected\textsuperscript{29,31,33}.

As the pandemic evolves, measures taken to avoid infection and mitigate the secondary effects of the virus could result in further conflict or cycles of repeated displacement internally or across borders\textsuperscript{28,29}. Competition over scarce resources will become even more fierce, exacerbating the potential for discrimination and violence\textsuperscript{28,29}.

Preventative measures

A recent article by the British Broadcasting Corporation described the unpredictability of the situation in Libya\textsuperscript{34}. In this single example, multiple political groups are seen to achieve political gain through manipulation of the population based on the desperate need for basic commodities such as food\textsuperscript{34}. “Sudden imposition of curfews were reported which changed arbitrarily with little thought for social distancing\textsuperscript{34,35}. The manipulation of the pandemic through exploitation of fear and vulnerability of the population threatens to counteract the measures required to contain the virus.

Where there is health care provision and infrastructure, it is basic, if present at all, and in many cases, peacekeepers are increasingly unable to reach vulnerable groups\textsuperscript{34}. More than ever, the lack of access to clean soap and water is proving detrimental\textsuperscript{32,33,34}. To quell the spread of the virus through basic hand hygiene, these resources are needed in abundance and their scarcity and allocation will be the point of contention when it comes to existing discrimination towards IDP and those with disabilities\textsuperscript{32,33,36}.

Refugees, IDPs, the communities that host them as well as nomadic and pastoral groups face densely populated camps or collective sites where a lack of adequate housing, structurally inadequate shelters or placement in shared homes has made physical distancing and mitigation of COVID-19 transmission an impossible task. This has also led to an increase in communicable diseases and the potential for a rise in health complications relating to living while exposed to the elements\textsuperscript{28,29,32,33,36}. For those who would be advised to shield to reduce risk of virus transmission and mortality (eg, those with existing premorbid health conditions or expectant mothers)\textsuperscript{30,36}, this is next to unachievable.

The surges in COVID-19 mortality and the resultant rising death toll brings another issue to the forefront: management of the deceased. Many countries are reported to be struggling with the logistics of managing and burying the dead with dignity\textsuperscript{32,33}. In cities, this is particularly concerning given the scarcity of suitable burial areas and an increasing number of COVID-related deaths\textsuperscript{32,33}. The conditions described all contribute to the development of fertile arenas for the virus to spread\textsuperscript{32,33}. It is therefore imperative that prevention and response measures addressing these complex health and social needs are developed following risk assessments within the affected population\textsuperscript{16}.

The physical replanning of camps may be required with consideration for health imperatives such as self-quarantines and to ensure that physical distancing requirements do not result in lack of support and access to commodities by the most vulnerable\textsuperscript{36}. The participation of IDPs and refugees in the planning and execution of these measures is essential in order to ensure that responses to challenges exacerbated by COVID-19 are tailored\textsuperscript{36}.

Women and children

The full impact of COVID-19 on children in fragile and displaced environments is still being determined by the World Health Organisation (WHO) and other leading health authorities but early observations emphasize that although children are at no higher risk of infection or mortality, the secondary impacts will be unprecedented and disastrous\textsuperscript{28}. Children are at extreme risk of having their most basic health needs unmet as well as increased risk of physical and sexual violence, exploitation and abuse, child marriage, child labor, gender-based violence, and limited or no access to basic services\textsuperscript{28,37}. COVID-19 also threatens to increase the number of separated and unaccompanied minors\textsuperscript{28}.

The provision of education since the pandemic began has been severely disrupted with schools and learning facilities providing services to millions of children in conflict areas closed as preventative measures\textsuperscript{28}. Schools represent dedicated safe spaces and sources of vital information and referral for services such as vaccination programs, feeding programs, and other public health initiatives\textsuperscript{28,37}. The disruption of schooling during the pandemic and protracted absence creates space for potential major child protection risks particularly for young girls\textsuperscript{28,37}.

The pandemic has also exacerbated issues of violence and sexual health issues faced by women in countries that were already struggling\textsuperscript{37}. Lockdown measures have increased tensions within the home, resulting in profound consequences such as, increased rates of gender-based violence secondary, but not exclusively to, changes in household income and requirements for families to stay confined to overcrowded and inadequate housing.
where abusive relatives cannot be avoided\cite{28,37}. The restrictions on the freedom of movement have prevented women from escaping abuse and accessing health services such as sexual, reproductive and maternal health services, if these are still available and of good quality\cite{28,37}. Increased rates of early forced marriage and domestic responsibility including caring for sick family members has also reported\cite{38}, which significantly affects the ability for young girls to attend school\cite{38}. Previous crises, such as the Ebola outbreak in DRC\cite{37}, suggests that girls may be less likely to return to school but instead forces to look for work or take on additional duties within the home which exposes them to sexual exploitation and violence\cite{28,37}.

**Geopolitical context**

Following the confirmation of pandemic status\cite{34}, United Nations (UN) Secretary-General António Guterres called for a global ceasefire to allow humanitarian and medical workers to access areas and vulnerable populations in an effort to fight back against the effects of the virus\cite{31,35}. Some of these areas in pre-COVID times would normally be considered too dangerous to access due to active conflict\cite{31,33}.

In addition to this, it was hoped that a global ceasefire could facilitate a platform for peacebuilding negotiations between conflicting sides to enable tentative initial progress to transform into a long-term state\cite{31,33,35}. Without work toward resolving the root issues, maintaining the peace and laying solid foundations in this respect, any progress could quickly erode away\cite{31,32}. Unfortunately, a report by the Armed Conflict Location and Event Data Project\cite{35} saw only 10 of 43 countries take action in response to the call for a global ceasefire by declaring a universal ceasefire or establishing a mutual ceasefire agreement\cite{31,32}. Thirty-one of 43 countries failed to take steps to meet the call but alarmingly, in some of these countries, the opposite effect was seen and increased rates of organized violence were reported\cite{31,33,38}. This has naturally affected peacekeeping missions and as of April 2020, there were only 13 active UN peacekeeping missions with activities confined to critical functions only (82,000 peacekeepers assembled from 117 different countries)\cite{35}. The number of COVID-19 cases was reported to have increased in both peacekeeper contributing and receiving countries\cite{35}.

Struggles with fragmented authority, political violence, low state capacity, high levels of civilian displacement and low citizen trust in leadership will work against any efforts to introduce measures to help control and mitigate virus spread\cite{38}.

**Health care and infrastructure**

The bombing and shelling of health care systems creates huge disruption in the provision of medical assistance and, during a time when quelling the spread of the virus is vital, ongoing violence and warfare has a crippling effect on access to commodities making measures such as handwashing, social distancing or access to internet-based public health resources difficult\cite{37}. Reports suggest that heaving medical facilities continue to be the target of artillery fire or other explosive devices in some countries\cite{34,39}. Explosive weapons used in urban warfare today were originally designed for use in open battlefields\cite{37}. Their “wide area effects,” when used in the urban or populated setting, inflicts “massive and indiscriminate destruction”\cite{37}.

As a result, hospitals are overwhelmed with complex, poly-trauma casualties that quickly inundate the emergency services\cite{34,37}. Essential infrastructure is damaged either intentionally or within the crossfire, which includes medical facilities, health or humanitarian workers, power and water supply lines and sanitation systems. The ability to provide care for casualties, those affected by COVID-19 and other communicable diseases or illnesses is severely limited\cite{36–38}.

Damage to other infrastructure leaves people homeless and forced to seek shelter with relatives or in overcrowded camps\cite{37} where we already know, are fertile ground for spread of the virus\cite{36}. “For victims of this kind of warfare, who are already reeling from injury, disability, displacement and insecurity, the threat of COVID-19 pandemic is too much to bear”\cite{37}.

Furthermore, if arms continue to fire then civilian targeting is still a high risk and this may cause some reluctance of those on peacekeeping missions or working for humanitarian organizations to deploy\cite{35,39}.

**Conclusions**

The coronavirus pandemic has taken a drastic toll on the health and economic well-being of many countries but its effects on developing or fragile states will likely leave long lasting and profound geopolitical and health effects\cite{38,39}. Although the risk profile for each country will differ with unique challenges it is imperative that the immediate response and longer term investments of countries affected by conflict\cite{29} address the issues highlighted in order to prevent their exacerbation and promote resilience. A publication by the Carnegie Endowment for International Peace\cite{38} has compiled and published the potential implications of the pandemic for 12 conflicts across multiple regions. This document serves to highlight just how much of an impact the COVID-19 pandemic will have on areas of conflict.

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All 3 authors have contributed equally.

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