The COVID-19 response for vulnerable people in places affected by conflict and humanitarian crises

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Next year I will have worked full time in the UK's National Health Service (NHS) for 40 years. I seem to be a survivor not only from the political rollercoaster that various governments have enacted on the NHS, but also from volunteering my surgical skills in places affected by conflict and natural disasters for the past 25 years. The experiences of the patients I have served whose lives have been impacted by war, injustice, and inhumanity during this time have given me insight into what life is really about. Every person on this planet has a right to live and survive by whatever means possible. Having seen the adverse health impacts of conflict and humanitarian disaster on patients, I understand the mass movement of unprotected people from war to places of relative calm.

Many of the estimated 70·8 million forcibly displaced people worldwide live in insanitary and inhospitable conditions,[1] sometimes up to six families living in one tent in a 3 m^2 area.[2] At a time when so many people are living under lockdown because of the coronavirus disease 2019 (COVID-19) pandemic, it is important to highlight the dreadful conditions that displaced people endure, which I have personally witnessed in refugee camps throughout the world. Apart from difficult living conditions in these camps, many people share one latrine and washing facilities and hundreds queue for food every day.[3] People tolerate such conditions because they want to live. They have been forced to live this way by inhumane acts in conflict and authoritarianism.

Many people in high-income countries might think that these humanitarian problems happen to other people far away and have little to do with them. At the start of this year with the first reports of a new virus in China, some people watched with casual nonchalance. Even when Joseph Wu and colleagues[4] reported in late January that COVID-19 was going to become a global pandemic requiring substantial preparation, this warning received insufficient attention. Too many of us were lulled into a false sense of security by shrugging politicians. Looking back now, it is hard to understand from a scientific and epidemiological standpoint that there seemed to be no one with sufficient leverage to wave that red flag very early on.

Since then, I have seen the impact of this disease on patients in the NHS: patients with COVID-19 on routine wards with face masks that provide oxygen, others on continuous positive airway pressure (CPAP), and those requiring ventilation in the intensive-care unit. I have watched my critical care colleagues work ventilators and change the settings to provide the best volume and pressure that COVID-19 patients require. I have been in awe of nurses in their full personal protective equipment (PPE) who stay with their patients for many hours at a time, doing all they possibly can to get their patient through. I have been part of the proning team that needs six to eight people to turn a patient carefully and safely onto their front to allow the previously compressed alveoli to open up. I have watched how this disease causes damage to other systems and how many patients require inotropic and renal support. There have been many patients who need extracorporeal membrane oxygenation when their lungs stop functioning. I have seen the effects of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) on the arterial and venous circulation, causing micro and macro thrombosis, which in some patients have necessitated amputation. Despite the dedicated efforts of well trained NHS staff working in good hospitals with appropriate equipment, mortality is high among patients on ventilators and CPAP. Data from the UK on April 24, 2020, show that of 2677 patients with COVID-19 who died in critical care, 1744 (65·4%) were on

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ventilators and of the 870 patients who required renal support in addition to ventilator support 679 (78·0%) died.[5] A case series in New York showed 282 (88·1%) of 320 COVID-19 patients on ventilators died.[6] In my opinion, alongside the efforts of health professionals, the main positive influences on reducing the number of deaths from COVID-19 have been handwashing, social distancing, and the lockdown to stop the transmission and contain SARS-CoV-2.

But for the most vulnerable people on this planet, such strategies are not an option. People who live in conflict zones or in refugee camps cannot physically distance, they cannot self-isolate, they have inadequate facilities for washing, and are often without access to health care. Why don't they have access to health care? Conflict is one reason. In some parts of the world, such as northern Syria, where there has been conflict since 2011, hospitals have been targeted and destroyed.[7] Indeed, in this age of impunity, health care has been used as a weapon of war—you take out one doctor or hospital, you take out the lifeline for thousands of people who then leave and become refugees. And in other parts of the world where some refugee camps hold close to a million displaced people such as the Rohingya in Bangladesh, there is little time to ramp up constrained health services to respond to COVID-19.[8] In fragile settings, there is no massive infrastructure like the NHS. There are few ventilators—eg, South Sudan has four ventilators per 11 million people, Chad has three per 5 million people, and in northern Syria there is one ventilator for every 36 000 people.[9] Even if there were ventilators, there are insufficient numbers of trained staff to work them and there are no adjuvant treatments such as haemofiltration and cardiovascular support for the consequences of multiple organ failure that can occur with COVID-19. In such settings, there is no piped oxygen, electrical power cuts are common, and the health workforce capacity is unlikely to be enough to deal with even a small number of COVID-19 cases, never mind the potential of thousands of deaths from this disease.[10]

There is now an urgent need to strengthen the COVID-19 response for the most vulnerable populations in places affected by conflict and humanitarian crises, where there is limited infrastructure for the response to COVID-19. But there is an opportunity at this present time to tackle the spread of the disease and contain it at its source. Political and humanitarian pressure must be put on warring parties in places like Syria and Yemen to end restrictions on access to health care to ensure humanitarian assistance. And I do not mean sending in vast amounts of PPE and ventilators; I mean ramping up the public health support with a goal to provide conditions that do not allow the virus to spread. Substantial financial support from the wealthiest nations is needed to overhaul the present conditions.

Governments and humanitarian organisations need to do what WHO advised early on in this pandemic,[11] which is to test every suspected case of COVID-19, then isolate, quarantine, and trace contacts, and this must be done immediately. The security and safety of health-care workers, engineers, and water consultants must be paramount and all parties made aware of the Geneva Conventions. The COVID-19 pandemic requires a global response for the most vulnerable populations. Pressure must be put on every country where there are refugees and displaced people to allow testing and subsequent isolation, keeping families together if necessary. The time has come for world leaders to stop putting their countries first and to unite and fight this disease on a global footing.

I declare no competing interests.

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