War in Nagorno-Karabakh highlights the vulnerability of displaced populations to COVID-19

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Conflict, war and the resultant displacement of populations increase risk for infectious disease transmission. Forced migration, loss of safe shelter, loss of livelihood and interrupted access to clean water, electricity and healthcare all lead to increases in epidemic risk. Refugees and displaced people are uniquely vulnerable to COVID-19. The chaos of war and its aftermath override the population health education messages to wear a mask, socially distance and wash hands frequently.

Risk of COVID-19 transmission is heightened for people living in densely populated community spaces and overcrowded shelters, particularly for those with inadequate access to clean running water, soap and appropriate sanitation and hygiene facilities. Such circumstances make it challenging to physically distance and maintain proper hand hygiene. Overwhelmed healthcare systems and fragile capacities for social services further contribute to group-specific vulnerabilities of refugees and displaced people. World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) have recognised the disproportionate impact of the pandemic on these communities and the need to protect them.1 2 We, the Public Health Working Group for Armenia, echo the call previously made by Kluge et al4 for an inclusive approach in guiding the global response to the COVID-19 pandemic, emphasising the principle of leaving no one behind. We are particularly concerned about the postconflict setting in the Nagorno-Karabakh Region and the recently displaced Armenian population who have relocated to the Republic of Armenia.

In November 2020, the governments of Azerbaijan, Russia and Armenia signed a ceasefire agreement which brought an end to a 6-week long war between Azerbaijan and Armenia over the disputed Nagorno-Karabakh region, an enclave historically populated by indigenous ethnic Armenians (online supplemental file 1). A recent re-escalation of the decades-long conflict, despite the United Nations Secretary General’s call for a global ceasefire during the pandemic resulted in thousands of deaths and injuries among military personnel and civilians, and forced nearly the entire population of Nagorno-Karabakh (more than 75 000 people) to relocate to Armenia.3 The compounded impacts of the pandemic, war and immediate relocation of an entire population have overwhelmed the healthcare system in Armenia as competing priorities have exhausted hospital and healthcare capacity. During the war, numerous families were sheltered in overcrowded basement bunkers, which significantly increased the transmission of COVID-19, causing a surge of new cases in Nagorno-Karabakh.6 Many healthcare providers in Stepanakert, Nagorno-Karabakh’s capital, continued to treat patients despite being infected with COVID-19 due to staff shortages caused by the pandemic and service to the military,6 further increasing the transmission. Continuous shelling of civilian areas, including healthcare facilities7 (a war crime under the Geneva Convention)8 hampered access and receipt of timely care from healthcare providers and efforts to contact-trace and contain the virus’s spread. Targeting civilian structures and healthcare facilities has been practised in other conflicts to terrorise the population and force capitulation.9 Examples of this tactic include the non-military bombings in Great Britain by German Zeppelins during World War 19 and Japan’s capitulation after the USA dropped atomic bombs in Hiroshima and Nagasaki without discretion to where civilian structures including health facilities were located during World War II destroying these cities and killing thousands of civilians.10 11

The war also profoundly impacted individual behaviours and attitudes toward the spread of COVID-19 in Armenia, as people mobilised to provide military support and aid to Nagorno-Karabakh. With the people’s attention redirected toward the more proximal and severe threat to national security, vigilance towards following safety guidelines, like mask-wearing and physical distancing decreased, contributing to a seven-fold increase in Armenian’s 7-day average of daily new COVID-19 cases since the start of the war on 27 September (figure 1). By mid-November, Armenia’s hospital bed capacity and oxygen supplies for COVID-19 patients was surpassed.14 While it is clear that war and conflict contributed to the spike in cases in Armenia, it is challenging to tease out the direct impact of the war at the same time as cases were increasing in the region. Contributing to the exponentially growing rate of cases and deaths are the combination of inadequate disease control programmes and surveillance systems, severely strained capacity of healthcare workers, and shortages in necessary medical equipment and supplies—a circumstance observed in other conflict and postconflict settings.15 Additionally, the healthcare system in Armenia, already overburdened by the provision of COVID-19 care, has also absorbed the healthcare needs of those wounded during the war. Currently, thousands of injured need ongoing hospital and rehabilitation care.16 Although Armenia’s government has encouraged Nagorno-Karabakh residents to return to their homes, many are reluctant due to fear of re-escalation of violence. Additionally, residents from areas such as Hadrut and Shushi/a have permanently lost their homes and livelihoods as these cities are currently under Azerbaijan’s control, where it is unsafe for them to return. They
remain in overcrowded housing conditions that heighten the risk of COVID-19 transmission. The winter months further decrease opportunities for physical distancing in outdoor settings to minimise risk of COVID-19 transmission. Additionally, as critical energy infrastructure has been destroyed in major towns and cities in Nagorno-Karabakh, those who are able to return to their homes must rely on solid fuel burning stoves and heaters, affecting indoor air quality which is associated with respiratory and other illnesses.

Displaced populations are often more likely to be in positions of disproportionate vulnerability to the COVID-19 pandemic. In light of these challenges, we believe that displaced populations residing in overcrowded spaces should be given priority in receipt of the upcoming COVID-19 vaccine. Equitable, efficient and timely access to the vaccine among refugees and migrants has been endorsed by the International Organisation for Migration and the Director of Migration and Health at WHO. Equitable, efficient and timely access to the vaccine among refugees and migrants has been endorsed by the International Organisation for Migration and the Director of Migration and Health at WHO. In light of these challenges, we believe that displaced populations residing in overcrowded spaces should be given priority in receipt of the upcoming COVID-19 vaccine. Equitable, efficient and timely access to the vaccine among refugees and migrants has been endorsed by the International Organisation for Migration and the Director of Migration and Health at WHO. In light of these challenges, we believe that displaced populations residing in overcrowded spaces should be given priority in receipt of the upcoming COVID-19 vaccine.

As the world grapples with the possibility of new, more infectious variants of SARS COV-2, those countries who have yet to start vaccine programmes like Armenia, need to amplify effective policies, risk communication campaigns and enforcement measures. In populations facing instability and threats to security, every effort should be made to improve adherence to preventative behaviours and new guidelines such as the Centers for Disease Control and Prevention recommendations on double masking while waiting for vaccines. This includes not only the vulnerable populations such as displaced and refugees but also the host communities in which they reside and those working for organisations who provide humanitarian assistance.

Correction notice This article has been corrected since it first published. Tsoline Kojaoghlianian is now included in the list of collaborators of the 'Public Health Working Group for Armenia.'

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