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COVID-19 IN THE TROPICS: IMPACT AND SOLUTIONS (M. BOTTAZZI, SECTION EDITOR))

Refugee Health During COVID-19 and Future Pandemics

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Abstract

Purpose of Review This commentary summarizes recent literature pertaining to healthcare challenges and needs during the current pandemic among refugees and asylum seekers residing in a host country. We conducted a literature review to identify barriers to shielding these structurally marginalized populations from the impact of the COVID-19 pandemic.

Recent Findings Many populations, including refugees, migrants, and asylum seekers, endure structural vulnerabilities in refugee camps and during their resettlement. These structural vulnerabilities include fear of contacting the healthcare system, cultural differences, housing insecurity, food insecurity, discrimination, lack of health insurance, health illiteracy and lack of readily available, and culturally appropriate educational materials. During pandemics, displaced persons suffer disproportionately from poorly managed chronic diseases, economic hardships isolation, and mental illnesses, in addition to the threats posed by the infectious agent.

Summary Underserved groups, including refugee populations, shoulder a disproportionate burden of disease during pandemics. In order to mitigate the impact of preventable chronic illnesses and also reduce the spread of COVID-19 and other easily-transmissible and deadly viruses during pandemics, governments and public health authorities need to implement policies that allow refugees, asylum seekers, and displaced persons to be fully incorporated into their respective healthcare systems, so that they can be supported and protected and to reduce the amplifying networks of transmission.

Keywords COVID-19 · Refugee health · Immigrants · Asylum seekers · Infectious diseases · COVID-19 management · Pandemics · Displaced persons

Introduction

On March 11, 2020, the World Health Organization (WHO) declared the outbreak of the novel coronavirus SARS-CoV-2, the causative agent of COVID-19, a global pandemic [1]. Ever since, countries around the world have struggled to implement measures to protect their citizens. Countries responded to the COVID-19 pandemic by halting immigration into their countries, restricting international and domestic travel, issuing stay-at-home and social distancing orders, ordering the use of personal protective equipment (PPE), and expanding COVID-19 testing [2]. Yet, with the pandemic severely affecting the health of their citizens, governments lacked adequate preparedness plans to implement proper responses to protect those who often fell out of their sight, including minorities and displaced populations—refugees, asylum seekers, and migrants, particularly those residing with required documentation [3•].

Globally, COVID-19 has disproportionately affected racial and ethnic minorities with higher number of deaths in this subset of the population [4]. In addition, many suspect that COVID-19 cases in the refugee and immigrant populations have been underreported in the U.S., Western European countries, and other high-income countries because of this population's fear of repercussions, including deportation and discrimination. [5]. Indeed, most of the benefits to prevent or ameliorate the impact of the present pandemic have been allocated to predominantly protect privileged groups [6], as it has occurred during previous influenza pandemics [7].

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The health status of displaced populations, whether in refugee camps, within their home country, or during resettlement into a host country, remains a major public health concern. During a pandemic, this concern grows exponentially due to the frequent inability of displaced persons to escape the present pandemic's impact. Indeed, history proves that failing to include displaced persons in pandemic response plans has left them vulnerable to the reemergence of infectious diseases, as was the case for cholera and now during the COVID-19 pandemic [8–10]. There is now increasing evidence that racial and ethnic minority groups, including many displaced populations, have been disproportionately affected by COVID-19 [10].

Displaced Populations Residing in Refugee Camps During Pandemics

The United Nations High Commission for Refugees (UNHCR) estimated that, at the end of 2019, there were 79.5 million people worldwide who were "forcibly displaced," fleeing from persecution, socioeconomic instability, or climate change. [11••, 12•]. These numbers represent a significant increase since the end of World War II. In models assuming even low transmission rates in refugee camps, the COVID-19 pandemic could have a potentially devasting impact on refugees due to their poor living conditions. [13]. During pandemics, displaced persons are often scapegoated and blamed for the spread of pandemics, despite a lack of evidence showing that they are spreading the virus to local host communities [14].

Worldwide, minimal attention has been paid to refugees located in camps during the COVID-19 pandemic [15]. WHO's recommendations (social distancing and hand washing) are almost impossible to implement or enforce in refugee camps. Indeed, humanitarian organizations have posed this simple question: How do you implement hand hygiene, social distancing, and self-isolation in refugee camps? [15]

Refugee camps cannot practically implement social distancing, especially in middle and low-income countries. For example, Bangladesh is currently home to millions of Rohingya refugees, many of whom reside in packed living conditions without access to sanitation centers or toilets. [16]. COVID-19 isolation centers have been established within Cox's Bazar, one of Bangladesh's largest refugee camps, but this still does not address this camp's high population density. [17]. Tragically, the lockdown imposed in Bangladesh left this population even more vulnerable, since most people living there live in poverty; they need to work daily, often outside the refugee camps, in order to survive. Models suggested that spatial subdivision of refugee camps and the use of face masks reduced transmission rates [18]; implementation of this model could help lower COVID-19 cases among refugees residing in camps.

In an effort to increase sanitation centers in refugee camps, international medical aid organizations, such as Doctors Without Borders, have increased water and sanitation facilities in refugee camps in Greece. In April, the European Union (EU) pledged $377 million to help displaced persons (although the use of these funds has not been reported) [19]. Importantly, the EU response effort does not include evacuation of camps or the incorporation of refugees into the national healthcare plan [20].

Displaced Populations During Resettlement: Chronic Illnesses and Primary Care

Displaced persons who have chronic diseases are at a higher risk of morbidity and mortality during pandemics. In fact, in past pandemics, more people have died from complications related to untreated chronic illnesses or discontinuation of care than from the infection itself [21]. There is a growing concern that displaced persons during the COVID-19 pandemic will have even more restricted access to routine but critical healthcare services, including visits for primary care-responsive conditions (for example, asthma, hypertension, heart failure, and diabetes), cancer screening, and maternal and childcare visits [21]. There is also a growing concern that displaced persons will forgo emergency care [22, 23].

Displaced persons also suffer from a greater burden of mental illnesses due to trauma and isolation, made worse by implementation of lockdowns and quarantines and interruption of government and volunteer services [7, 24]. In the context of the COVID-19 pandemic, factors rendering displaced persons more susceptible to mental illnesses include: a lack of access to information about COVID-19; sociocultural differences between refugees and host countries regarding healthcare practices; inadequate housing; lack of mental healthcare access; and lack of other resources (for example, childcare, social networks, and educational centers) due to shut downs [24]. The response to the growing need for mental healthcare for this population has been inadequate [20]. Telehealth visits have been popular during the pandemic, but they seldom incorporate language services for those who do not speak English or Spanish. Additionally, telehealth visits are not always accessible in countries hosting displaced persons.

Health Equity Approach to Reduce Disparities Among Displaced Populations

The plight of refugees and immigrant populations has grown direr due to COVID-19; making matters worse, this

vulnerable community is being relegated in planning and implementing the response effort. The socioeconomic and health consequences of COVID-19 have been severe. As the world continues to move forward in combatting the COVID-19 pandemic, it is vital for refugees, asylum seekers, and migrants be included in national and local response plans (Table 1). The healthcare and resource needs of displaced persons, as well as their dignity and rights, must be considered when addressing this crisis.

Steps must be taken to decongest refugee camps, provide more sanitation centers and hand hygiene supplies, and expand testing and vaccine access [21, 24]. Additionally, reporting of COVID-19 symptoms needs to be destigmatized; this can only happen with assurance from the host community that displaced persons will not face deportation or other repercussions if they report their symptoms. [25]. Vaccine-related educational materials must also be developed for refugees, migrants, and other displaced persons, in order to mitigate stigma and overcome doubts regarding vaccine safety. This is currently being done in the U.S. and in some other developed countries. Globally, refugees and displaced persons must be prioritized to receive vaccines [25].

Access to routine and urgent healthcare is critical. Humanitarian organizations have proposed that, during a pandemic, displaced persons must be incorporated into the national healthcare system of the host country, in order to ensure adequate protection for this population [26]. It is also critical to ensure that granting temporary access to needed healthcare services will not adversely affect them when they apply for citizenship. Displaced persons must be considered a priority in pandemic response efforts [27].

In helping displaced persons during COVID-19, it is not enough to implement measures to ensure protection from the contagion; it is also critical to ensure ongoing care for chronic health conditions. Additionally, sexual and reproductive health services are instrumental in response efforts, for it is estimated that almost a quarter of displaced persons are women and girls of reproductive age [28]. For displaced persons dealing with chronic health conditions, including diabetes, cardiovascular disease and mental health disorders, and for those requiring reproductive healthcare services, humanitarian organizations suggest utilizing community health workers [29]. These community health workers would be in direct contact with those with chronic illnesses and would work with local organizations to arrange the delivery of the care and medications that displaced persons need [28].

As part of all pandemic response plans, governments must pass legislation allowing displaced persons to access healthcare resources and not fear for their legal status. In past pandemics, this population has been afraid to come forward. [7]. The United States and other countries must ensure that legal barriers, real, and perceived, do not come between displaced persons and the care they need [30]. There is an immense fear associated with deportation in the United States that severely discourages patients from accessing healthcare.

Moving forward, a major concern is how to prioritize vulnerable, and often hidden, populations. Lessons were learned during the HIV pandemic, when meaningful involvement of the community helped bring about change and reduce the spread of the disease [31]. Community engagement included peer-led support groups and intensive HIV education programs designed specifically for vulnerable and high-risk communities [32]. Similarly, the COVID-19 response needs to include displaced persons in order to combat this pandemic. As the United Nations Secretary General has stated, "we are only as strong as the weakest health system in our interconnected world" [28, 33]. We must acknowledge that, during this pandemic, no one is safe until everyone is safe.

Table 1 Summary of existing challenges and recommendations

Existing challenges	Recommendations
'Social distancing' in refugee camps	• Decongest refugee camps by relocating refugees and providing safer housing options • Build more sanitation centers in refugee camps • Provide basic hygiene kits to allow refugees to follow WHO's guidelines regarding hand washing • Increase access to COVID-19 testing and face coverings
Treating chronic illnesses	• Utilize community health workers to help displaced persons access care for their chronic conditions • Incorporate refugees into the host countries' national healthcare systems
Mental health	• Incorporate language interpreters into telehealth phone calls with mental healthcare providers • Incorporate refugees into the host countries' national healthcare systems
Community engagement	• Survey this population utilizing text messaging and phone calls to better assess and prioritize needs • Provide training and support to frontline workers in refugee camps
Displaced persons' legal status	• Countries should implement policies that separate legal status from healthcare access • Displaced persons' legal status should not be negatively affected when they report COVID-19 symptoms • Although not citizens of the host country, this population needs to be incorporated into national response plans

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Declarations

Competing Interests The authors declare no competing interests.

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Papers of particular interest, published recently, have been highlighted as:
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•• Of major importance

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