The Incidence of Forced Migration and Access to COVID-19 Services in West Africa

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Research Article

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Abstract

Background

The paper focuses on the accessibility of COVID-19 services to forced migrants in selected countries in West Africa. The selected countries are Burkina Faso, Mali, Niger and Nigeria. The work is also focused on the risk of forced migrants to the contraction of the COVID-19; and the integration of forced migrants into COVID-19 national response programmes in West Africa.

Methods

The study was by desk research based on secondary sources of data from the United Nations, government and nongovernmental organizations, and other relevant publications.

Results

Findings revealed that forced migrants in conflict-stricken areas have no or little access to COVID-19 services. It was also discovered that forced migrants are not adequately included in COVID-19 national response plans.

Conclusion

COVID-19 response strategies at both sub-regional and national levels are not targeted at forced migrants or hard-to-reach populations. Poor living conditions are one of the many factors that make forced migrants vulnerable to the contraction of COVID-19 and other communicable diseases in IDP and refugee camps.

Background

The complicated nature of humanitarian crises occasioned by forced migration has become a global concern. Migration is an inevitable phenomenon on the human planet because of the interrelationship, interdependence, and interconnectivity between people and among nations. It rather calls for great concern when people are compelled by unpleasant circumstances to move out of their homes or settlements against their will. Reports show that as of the end of 2021, there were 89.3 million forcibly displaced people worldwide (of which 36.5 million, or 41% of the total, were children under the age of 18), 53.2 million internally displaced people, 27.1 million refugees, and 4.6 million asylum seekers [1]. It is a matter of concern that all facets of society are impacted by the COVID-19 pandemic, but people who have been forcibly displaced are undoubtedly among those who are more vulnerable to the hygienic and financial repercussions of deadly virus-related issues [2]. Certain humanitarian settings at higher risk for COVID-19 should benefit from early vaccination during the time of limited vaccine supply in order to reduce the disease and death burdens of COVID-19 [3]. Inclusive vaccine plans and strategies are crucial, especially when it comes to ensuring equitable access to vaccines [3]. The likelihood of continued transmission in communities, including spillovers into the local population, increases when refugees, other displaced individuals, or foreigners are not included in vaccination regimens [4].

In West Africa, the incidence of violent conflicts such as the Boko Haram insurgency, farmers-herders conflict, and armed banditry in Nigeria and Niger Republic, the armed conflicts by the Tuareg Militant Group in Mali, and other neighbouring countries such as Cameroon and Chad, has rendered many people homeless and forced them to flee to other countries as refugees or as IDPs in their own countries [5]. It is alarming that there are over 5 million refugees and IDPs in West Africa (United Nations High Commissioner for Refugees [6]. It is a matter of concern that these displaced populations are faced with very difficult challenges, including the high risk of having all kinds of health challenges due to overcrowding, inadequate access to clean water, and the greater exposure to the COVID-19 pandemic [3].

The complex nature of these movements, the rights and privileges of forced migrants to have access to COVID-19 testing, vaccination, and treatment, and the vulnerability of these group of people to the contraction of the COVID-19 virus as an issue of concern. A report from selected West African countries’ refugee camps shows that only 10% of refugees were tested for COVID-19 in the Niger Republic, 5% in Burkina Faso, and as low as 2% in Mali [7]. In Nigeria, there are 3.2 million displaced persons, with over 1800 refugees, mostly from Cameroon, who have received one shot in Benue, Cross River, and Taraba States, and 700 refugees who have received two doses [8]. The concern of managing the COVID-19 pandemic in refugee camps was voiced by the World Health Organization (WHO), which noted that the large number of displaced populations has made the COVID-19 response difficult in Nigeria [9]. Similar reports show that internally displaced persons (IDPs) are particularly vulnerable to the global coronavirus pandemic (COVID-19), as millions of IDPs worldwide live in densely populated regions, are unable to isolate themselves, and lack access to water, sanitary facilities, and basic healthcare, whether they were compelled to leave their homes due to conflict, violence, or natural disasters [10].

Findings also show that displaced populations are more at risk of experiencing a higher burden of COVID-19 infections and inaccurate reporting in cases, hospitalizations, and deaths [11]. In addition, forced migrants, given the precarious situation they find themselves in, are likely to have a high rate of underlining health conditions that might increase their risk of being infected by COVID-19 [12]. It is worrisome that if due attention is not paid to forced migrants’ access to COVID-19 services, it may lead to an impending health disaster in the West African sub-region especially as it relates to national health planning and health insurance coverage [13]. It is against this backdrop that the paper examined if forced migrants have access to COVID-19 testing, vaccination, treatment, the risk of forced migrants contracting COVID-19, and the integration of forced migrants into COVID-19 national response programmes (NRP) in the selected West African countries.
Methods

The work is based desk review of secondary sources of information on the incidence of forced migration and access to COVID-19 services. Nigeria, Niger Republic, Mali and Burkina Faso were purposively selected as countries of focus due to the significant incidences of forced migration and incidences of COVID-19 recorded in the aforementioned countries. Data was derived from the publications of international organizations such MMC [7], IOM DTM [5], WHO [3, 9], UNHCR [1, 8], JDCFM [2], IDMC [10], ECDPC [11], and other relevant publications. Findings and discussions were based on the reports on forced migration and COVID-19 services on forced migrants in the above-mentioned sources.

Conceptual Clarification

Forced Migration

Forced migration is the involuntary movement of people from their homes based on unusual circumstances occasioned by natural disasters such as earthquakes, flooding, drought and/or human actions such as wars and conflicts. People might also be forced to move based on economic hardship, including hunger. Forced migration has to do with the movement of migrants, internally displaced persons (IDPs) and refugees within and across international borders [14]. It is important to note that there are technical differences between the above-mentioned terms, but they are generally referred to as forced migration. Forced migration may differ in magnitude and from place to place, but the major causes include wars and conflict, environmental change, and social and economic conditions. Given the above definitions, forced migration and population displacement are seen as one and the same since all the concepts involve the forced movement of people from their homes to other places.

COVID-19

The Corona Virus is another name for COVID-19, which was first discovered in the Chinese city of Wuhan on December 8 2019 [15]. On February 11, 2020, the International Committee on Taxonomy of Viruses (ICTV) declared that the new virus's name was "Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)" [15]. The virus's genetic similarity, though different from the coronavirus that caused the 2003 SARS outbreak, led to the choice of this name. Following criteria previously agreed upon with the World Organisation for Animal Health (OIE) and the Food and Agriculture Organisation of the United Nations (FAO), WHO announced the new disease's name as "COVID-19" on February 11, 2020 [15]. Since then, there have been many theories about its origin as many believe it's a disease that is rooted in animals, while others believe that it was created in a laboratory in China [16]. After the confirmation of over 118,000 cases of COVID-19 infections and 4,291 deaths in over 110 countries around the globe, there was widespread fear and concern all over the world with respect to the capacity to contain the spread of the pandemic [9]. It was based on this damaging effect that WHO on March 1, 2020, declared COVID-19 a global pandemic [9].

The Social Determinant of Health Perspective

The social determinant of health perspective has been adopted to explain how social, economic, and cultural factors play a key role in determining the health status of migrants. There have been several attempts to explain the relationship between migration and health from different perspectives over the years. However, the most notable contribution to the development and documentary contributions to migration and health issues was made in 1912 as a publication in the United States to address migration and health issues, but it was mostly linked to infectious disease [17].

Notably, there has been a wider acceptability among scholars of the social determinants of health perspective (SDH) based on the general propositions on social, psychological, cultural, and economic dimensions in explaining migration and health as opposed to the more focused and biological statements [18]. For example, for more than a decade, SDH has been featured permanently in many proposals associated with WHO. It is important to note that before this period, several proposals similar to SDH were featured in health discussions, especially in relation to traditional social medicine [18].

Social determinants of health (SDH) is a process that defines situations in relation to the social cycle of an individual's life, from birth, growth, life, age, and work. These situations are largely controlled by the interplay of power, wealth, and resources from the local to the global level, in addition to how policy formulation affects these factors. Recently, the correlation between migration cycle (origin, transient, routes, destination, and return) and migration health has been explained in the context of social determinant factors with a specific focus on vulnerability and resilience issues [18]. A Similar study also explained how social situations such as risk, violence, and crime, especially sexual violence and nutritional status, may have a bearing on the health of forced migrants [19].

This mobile population, especially those who could not follow the formal routes, might create some psychological and mental health problems in their places of destination [19]. In most cases, these refugees and IDPs are denied access to basic necessities of life such as water, shelter, and health services [19]. In addition, these migrants might also import some diseases to their destinations that were earlier eliminated [20]. This implies that forced migrants are likely to re-introduce another cycle of health emergencies in their places of destination.

In reference to the postulations of the SDH perceptive, COVID-19 services can be made available to forced migrants in West Africa through appropriate policies since social and economic factors such as poverty, housing, and health problems depend largely on the decision of policy makers and political leaders. In addition, movement of refugees and asylum seekers involves border crossing which implies that there must be a synergy among national governments in the ECOWAS region to address the plight of forced migrants in respect to health services including COVID-19.

In addition, with very fragile health systems, policies should also be made along the lines of straightening the health systems at the places of destinations to avoid the outbreak of disease that were hitherto unknown to both the migrants and the host communities. This is on the basis that some of the disease may be contracted during the horrible journeys or transit points of these forced migrants before arriving at their destinations.
Results

After the establishment of COVID-19 Global Access (COVAX) to ensure equitable access to vaccines, much success has not been recorded due to paucity of vaccines [21]. The aim was to ensure that safe doses of COVID-19 are delivered to at least 2 billion people among committed countries and vaccination of a minimum of 20% of each of the vulnerable and high-risk populations of committed 92 low-income countries by the end of 2021 [21]. Records have shown that only 57.3% in high-income countries and 2.14% vaccination rates were achieved in low-income countries at the end of the third quarter of 2021, largely attributed to the lack of access to vaccines and the financial implication of having these vaccines [22, 6]. With just over 13% of people in low income countries receiving vaccinations, compared to nearly 70% of people in high income countries, Michelle Bachelet claimed that the failure to administer the vaccines in a fair and equitable manner was prolonging the [23]. This failure was incredibly unjust and immoral, as well as highly unacceptable [23].

Most African countries are struggling to have access to vaccines to administer their first does [11]. For example, a study carried out by the Organization for Economic Cooperation and Development (OECD) in several member states showed that the risk of infection in refugees was twice as high as native-born individuals [24]. Data collected from three West African countries on access to health care services in refugee camps, especially COVID-19 services, remains very discouraging. For instance, information gathered from 1,396 in selected refugee camps on COVID-19 testing in Niger Republic, Burkina Faso and Mali shows that 90% in Niger Republic, 98% in Mali and 95% in Burkina Faso were never tested for COVID-19 [7].

The Exposure of Forced Migrants to the COVID-19 Pandemic

COVID-19 worsens the already precarious condition of refugees according to the UN High Commissioner for Refugees, Filippo Grandi [25]. Children in this vulnerable population are especially at risk for lack of access to safe spaces, water, nourishment, and medical care, making them more susceptible to viral illnesses such as (COVID-19) water borne illnesses, and respiratory tract infections [26]. It was estimated by WHO (2020) that 52% of the global refugee population was under the age of 18. There are an estimated number of 31 million child migrants, 13 million child refugees, 936,000 asylum-seekers, and 17 million child IDPs [27]. In West and Central Africa, over 30,000 migrants remain stranded at the borders while over 2,000 are overcrowded at transit points waiting for assistance [27]. It was also reported that, since the outbreak of the COVID-19 pandemic, many people have been abandoned in the desert by smugglers and traffickers, exposing their lives to a variety of health risks, including the transmission of COVID-19 [27].

In Nigeria, IOM situational study of COVID-19 in the North-East found that there were no operational hand-washing stations with soap and water on-site in 76% of the locations analysed [28]. Only 34% of the places surveyed had hand-washing stations with soap and water, according to a subsequent examination into the availability of soap and water in IDP camps, camp settings, and host communities [28]. The advent of COVID-19 has created a double emergence for forced migrants as the struggle to contain the virus and at the same time try to have access to basic needs [29]. In Africa for instance, displaced populations are more vulnerable to COVID-19 transmission because they are not in formally organized refugee camps and are more vulnerable as most of them are found in urban slums with no official support [30]. It was also reported that 54% of refugees in Burkina Faso, 42% in Niger, and 39% in Mali do not have access to COVID-19 protective gear. Many people reported that they do not have adequate information or they lack where to have testing and treatment (47% in Niger, 42% in Burkina Faso and 37% in Mali) [7].

Public perception about COVID-19 has greatly affected the attitude of the public towards COVID-19 control in Nigeria and other West African countries [31]. These perceptions are influenced by many factors, including cultural belief systems, religion, and a lack of public trust in the policies and those saddled with the responsibility to handle the pandemic [32]. It is unfortunate that many people out there (in West Africa and others) still believe that the Corona Virus is not real in Africa [32]. These categories of people may not adhere to any guidelines or protocols set by the WHO or their national regulatory agencies, thereby endangering themselves and others. Based on religious beliefs, some people think that the COVID-19 pandemic is a disease for unbelievers, and that those who trust and believe in God will not be infected [32]. These different perceptions and beliefs are inimical to the fight against the pandemic. Also, face masks are misused, even by highly placed government officials, by wearing them on their chin or neck without necessarily paying attention to covering their mouths when talking [33]. It is unfortunate that most people who wear face masks do so only when they are involved in public activities where it is required.

COVID-19 National Response Strategies in West Africa

The global strategies for COVID-19 Preparedness and Response stress the necessity to ensure that considerable attention is given to vulnerable populations and hard-to-reach populations [34]. Any effective public health and recovery response to COVID-19 must take into account everyone, along with all migrants irrespective of their nationality or migration status [23]. Following the establishment of National Deployment Vaccination Plans (NDVP) by many countries, the performance of such plans has been called into question on the progress in the NDVPs, but there is still a huge challenge of accommodating the undocumented displaced persons across many countries [28]. Most countries have included refugees in their national vaccination plans, more is needed to ensure that these services get to the vulnerable populations [8]. According to Professor Stanley Okolo, the Director General of the sub-regional body, the West African Health Organization (WAHO), a unit of ECOWAS, said that the organization had distributed over 100,000 medical materials and over one million personal protective equipment [35].

West African governments have taken a variety of measures to combat the pandemic since its inception, including the formation of task forces and other action committees to prevent and contain the disease. It is a matter of concern how well these committees are working in their countries. However, it was warned that COVID-19 nationalist measures that could further put vulnerable people at risk or worsen the spread of the virus should be avoided by governments in Africa [30].

National COVID-19 Response Strategy in Mali
Mali recorded its first two confirmed cases of COVID-19 on March 25th, 2020. These cases rose to 56 by April 7th of the same year, with at least six confirmed deaths cutting across the regions of Bamako, Kayes, Koulkoro, and Mopti. The Mali government quickly formed the Central Coordination Cell and Crisis Committee for Epidemic Management COVID-19, coordinated by the National Institute of Public Health, to handle the national response, among other things. Afterwards, thousands of cases were confirmed after that period. As a response to the pandemic, the country has put in place a plan of action to ensure the prevention, communication, capacity building, prevention and case management, and other related issues of the pandemic. The sum of $57 million was set aside to achieve these objectives [36]. As it was common practice globally, the government of Mali on March 25th declared a state of emergency in the health sector to tackle the disease. Among the notable measures were the prohibition on all public gatherings, the suspension of all commercial flights, and the closure of schools. Interestingly, a gathering of more than 50 people was restricted, but it is unfortunate that at that very time there were more than one million IDPs in Mali interacting freely in these camps—a place and condition that made any physical distancing very difficult to maintain. It is quite disturbing that the efforts of all these response frameworks could not address the needs of forced migrants, which is evident in the [7].

A Response Strategy in Burkina Faso

In Burkina Faso, the first case of the Corona Virus was discovered on March 9, 2020, with the virus immediately spreading in nine regions of the country [37]. It was confirmed that there were 20,813 confirmed cases of Corona Virus and 379 deaths, with a total vaccination of 2,554,907 vaccines administered as at March 14th, 2022 [38]. In a swift response, an emergency response team was set up by the Ministry of Health to support the National Influenza Reference Laboratory and the activities of the US Center for Disease Control and Prevention (CDC) to curtail the disease. It is unfortunate that a lack of accurate epidemiological data hindered the effectiveness of this intervention in Burkina Faso at that time [39]. There was also concern by the commitment of the Government of Burkina Faso to actually handle and respond to COVID-19 as a public health disaster [39]. According to Moumni Niaone, a 38-year-old doctor in Burkina Faso, the government at the inception had done little or nothing to reach out to religious leaders and local traditional authorities which eventually lead to anti-lock-down protests in the country [40].

COVID-19 Response Strategy in Niger

In Niger Republic, the first case of the Corona Virus was recorded on Thursday, March 19th, 2020. This was announced by the Nigerien President through his Twitter handle that the patient was a 36-year-old Nigérian who had traveled to Togo, Ivory Coast, and Burkina Faso [41]. A report by John Hopkins University, Corona Virus Resource Center shows that Niger recorded 8,799 confirmed cases, 308 deaths, and 2,674,381 doses administered [42]. The report also shows that in total, only 6.61% of the total population is vaccinated. The Rapid Emergency Response Project was set up with the assistance of the World Bank to support the government of Niger in making procurements for medications and equipment to tackle COVID-19. Notably, $133.95 million was set aside to take care of this project [43]. It was primarily focused on preparedness, response, and straightening of an already weak health system [43].

These interventions were very difficult to get to, especially for IDPs and refugees. For instance, delivering COVID-19 protective equipment to remote areas was more difficult, owing to armed conflict and violence, particularly in the Diffa and Tillabery regions [44]. It is unfortunate that Doctors without Borders stated categorically that IDPs and refugees living in camps where safety is not guaranteed are vulnerable, exposed, and are a threat to COVID-19 given the precarious nature of their living conditions [44].

COVID-19 Response in Nigeria

In Nigeria, the index case of COVID-19 was recorded on March 23rd, 2020, which was traced to an Italian in Lagos. This was followed by many other cases on a daily basis, as reported by the Nigeria's Center for Disease Control (NCDC). The news brought a lot of apprehension and panic to the general public, as I 11f to say the worst has come. The Federal Government of Nigeria, in a swift reaction, constituted a Presidential Taskforce headed by Boss Mustapha on March 17, 2020, to handle the pandemic [45]. This later led to the declaration of a total lock down of the whole nation by the then President-Muhamadu Buhari as a way to control the spread of the pandemic.

The common measure among countries in the region and elsewhere was the closure of international borders for migrants, among others. Unfortunately, most of these measures could not work in a region where there are very porous borders between neighbouring countries. For instance, the Nigeria Immigration Service (NIS) stated that Nigeria's borders share a 7,73 km and 87 km long border with Benin and Chad respectively, as well as 1,497 km and 1,690 km long with Niger and Cameroon, respectively. Only 853 km of Nigeria's borders are coastal, mostly in the Atlantic Ocean with Sao Tome and Principe, Ghana, and Equatorial Guinea [46]. It is a matter of concern that the NIS admitted that the nation had only 84 official borders, but there are more than 1,490 illegal routes into Nigeria, which are mostly unmanned and serve as illegal entry points for people (who may otherwise become stateless) into Nigeria [47].

Private organizations and international donor agencies, international governments and other well-meaning Nigerians donated large sums of money, PPES, isolation centres, vehicles, among others, to both states and the federal government in Nigeria to fight the outbreak. Many Nigerians, including the business mogul, Aliko Dangote, donated the sum of two billion naira (N2,000,000,000) to the Nigerian government. The Lagos State Government, which was the epicentre of the pandemic, also received various donations from both individuals and cooperating organizations. Reports indicate that these donations amounted to over 25 billion as at May 31st, 2020 [48].

In addition, there are no adequate measures and policies put in place to address the needs of the hard-to-reach population with COVID-19 services in West Africa. In Nigeria, for example, a study conducted by REACH in 2021 in Borno and Adamawa States (two of the worst hit states by terrorism caused by Boko Haram in North East Nigeria) revealed that hard-to-reach and vulnerable populations were living in extremely dangerous and disturbing circumstances, posing a significant challenge to humanitarian actors [49]. According to data collected from 400 settlements in Borno and Adamawa States, only 62% of newly arrived refugees in refugee camps were asked to wash their hands; 89% of sick people were mixed with other members of the community [49]. With these records, the vulnerability of the population in hard-to-reach areas is still hanging in the balance as far as the fight against COVID-19 is concerned.
Discussion

Based on the findings of the study, Access to COVID-19 vaccines has been a major challenge in the fight against the pandemic with most developing countries in Africa still struggling to get these vaccines. The number of cases and deaths that have occurred in Asia, North and South America and Europe is worst compare to the situation in Africa, a continent with very fragile public health systems [50]. According to data gathered by the John Hopkins University, the African continent, which is home to more than one billion people, has experienced roughly 1.5 million cases [50]. Given the ongoing drop in reported cases, these numbers are far lower than those in Europe, Asia, or the Americas, as approximately 37,000 deaths have been reported in Africa, compared to approximately 580,000 in the Americas, 230,000 in Europe, and 205,000 in Asia [50]. The impact and burden of COVID-19 is not equally shared by countries and regions but there are concerns on the global deployment, roll-out and plans for vaccines [34]. It is commendable that the UN Security Council Resolution 2565 of 2021 strongly advocated for ensuring availability and equitable access to COVID-19 vaccines in situations of instability and humanitarian emergencies [51]. Based on the above reports, it is rather unfortunate that there is rare evidence that the plight of people living in IDPs, refugees, and hard to reach populations in terms of testing, vaccination, and treatment has been prioritized. Many forced migrants are invisible to health systems because they lack access to basic health services as well as decent work, housing, and food essential to good health, according to the first-ever WHO World Report on the Health of Refugees and Migrants [52]. There was also concern about the commitment of the governments of West Africa, especially Nigeria, to equitably fight COVID-19. For instance, in the global campaign to combat inequality during the COVID-19 pandemic, the 2021 Commitment to Reducing Inequality Index (CRII) places Nigeria bottom among the 16 members of ECOWAS and second-to-last in Africa (45th out of 46 countries) [53].

A report on the impact of COVID-19 on the most vulnerable children in a few IDP camps in Adamawa, Borno, Benue, and Federal Capital Territory (FCT), Nigeria found that 80% of all IDPs in Nigeria are women and children, with roughly 23% of them being children under the age of six [54]. According to research, IDP camps are haphazardly constructed with few to no basic amenities, especially adequate access to clean water for sanitary purposes, especially during pandemics like the COVID-19 when washing hands with soap and water as a preventive measure is imperative [54].

Another report carried out on 30,462 people living in Gubio camp, it was observed that there was only one borehole with 24 water taps. There were consistently long lines for water and no extra care is taken to ensure that the most vulnerable campers, such as children and those with disabilities, have access to drinking water [26]. Despite the fact that Daudu camp only has one health center to serve its more than 4,000 residents, local and international NGOs have made a number of interventions throughout the years to support the government's efforts. However, the quantity of children in need of healthcare outweighs the capacity of the infrastructure and staff. As a result, the camp requires ongoing medical assistance in terms of both human and material resources [26]. It is based on the above that the UN expressed concern for urgent help and funding for millions of people that have been hit by COVID-19 pandemic including conflict hit communities “on life-support” in Nigeria [55]. This has pointed to the dare need to make COVID-19 services available and accessible to displaced populations in Nigeria.

Conclusion

Based on the findings of the paper, conflicts in the West African region are largely responsible for forced migration within and across international borders. Also, the number of refugees and IDPs is alarming and it may continue to rise in the near future. Forced migrants have little or no access to COVID-19 services. There is also little or poor adherence to COVID-19 regulations in refugee and IDP camps due to overcrowding and poor sanitary conditions in these places. These poor living conditions are one of the many factors that make forced migrants vulnerable to the contraction of COVID-19 and other communicable diseases in IDP and refugee camps. Response strategies at both sub-regional and national levels are not really targeted at forced migrants or hard-to-reach populations, which further paves the way for an impending health disaster in the ECOWAS sub-region. Also, other COVID-19 preventive strategies such as border closures put trapped migrants at the borders at risk of more infections and other harmful activities.

Recommendations

Based on the foregoing, the following recommendations are made:

1. More efforts should be made at both subregional, regional and global levels to ensure the equitable distribution of vaccines especially to low-income countries where the burden of refugees and IDPs are more pronounced. The existing intervention programmes have not yielded the desired result, hence the need to strengthened the existing ones or creating new programmes which ever appropriate.
2. Governments of the selected West African States and other key stakeholders should ensure that there is proper provision of water, hygiene, sanitation and other COVID-19 kits such as face masks in refugee and IDP camps to reduce the spread of the virus and other health problems.
3. National COVID-19 response programmes or plans should be restructured to prominently include forced migrants which are considered as the more vulnerable populations given the conditions of housing and overcrowding in IDP and refugee camps. In places where these programmes are put in place, they should be properly implemented.
4. Since force migrants’ cross international borders, there is need for a strong synergy and the political will by the national governments in West Africa to develop a common strategy of approaching migration health issues in the region. This is based on the fact that the very nature of population displacement in West Africa is commonly linked to violent conflicts.
5. There should be a strong campaign by all the stakeholders to enlighten not just the refugees and IDPs but the general public to dissuade people from the cultural myths associated with COVID-19 vaccines in West Africa. If this is not done, vaccine hesitancy will continue and most IDPs and refugees will not be willing to be vaccinated even if the vaccines are made available to them.
6. Conflict is inevitable in human society, but efforts should be made to tackle the root causes of armed conflicts in West Africa through strong institutions and political will by the leaders in the region. By doing so, the burden associated with displaced populations (including COVID-19) in IDPs and refugees will be greatly minimized.
Declarations

Consent
The work does not require consent because it is based on secondary data which is publicly accessible. The link to every document or organization is provided in the reference section.

Conflict of Interest
There is no conflict of interest

Ethics
Ethics was not required in this work because it is based on desk review of already existing secondary information or published documents. The access or links to these materials are provided through the links in the reference section.

Availability of Data and Materials
Data and information used in the article is available in the organizations and publishers’ websites. They are available for public use and are cited in the work appropriately. Details of such is contained at https://mixedmigration.org/resource/refugees-and-migrants-access-to-health-services-in-west-africa-in-times-of-covid-19/. The links to all other sources are also provided in the references.

Authors Contribution
The work is desk research carried out by only one author through a review of published works from individuals and organizations.

References


