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**Building the Evidence on Forced Displacement**

# **Preventing and Mitigating Indirect Health Impacts of COVID-19 on Displaced Populations in Humanitarian Settings**

# Preventing and Mitigating Indirect Health Impacts of COVID-19 on Displaced Populations in Humanitarian Settings

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## SUMMARY

The COVID-19 pandemic, declared on March 11, 2020, presents unprecedented challenges for health systems around the world, particularly in humanitarian settings. According to the United Nations High Commissioner for Refugees (UNHCR), 134 refugee-hosting countries are reporting local transmission of COVID-19 (the disease caused by the novel coronavirus, SARS-CoV-2) as of June 3, 2020. In low- and middle-income countries (LMICs), which host more than 80% of the world's refugees and nearly all internally displaced persons, health systems are often weak, overburdened by endemic health problems (including HIV, tuberculosis (TB), malaria, measles, malnutrition and non-communicable diseases (NCDs)) and easily overwhelmed. Indirect health impacts, resulting from health system failures and the pandemic response, are frequently under-addressed, yet we know that the mortality, morbidity and suffering they produce often exceeds the direct effects of a pandemic. Displaced populations (primarily referring to refugees, asylum seekers and internally displaced persons in this brief) are often disproportionately affected during a pandemic, by both the disease and indirect health effects. This knowledge brief highlights lessons learned from past epidemics, novel approaches, and helpful resources to prevent and mitigate indirect health impacts of COVID-19 on displaced populations.

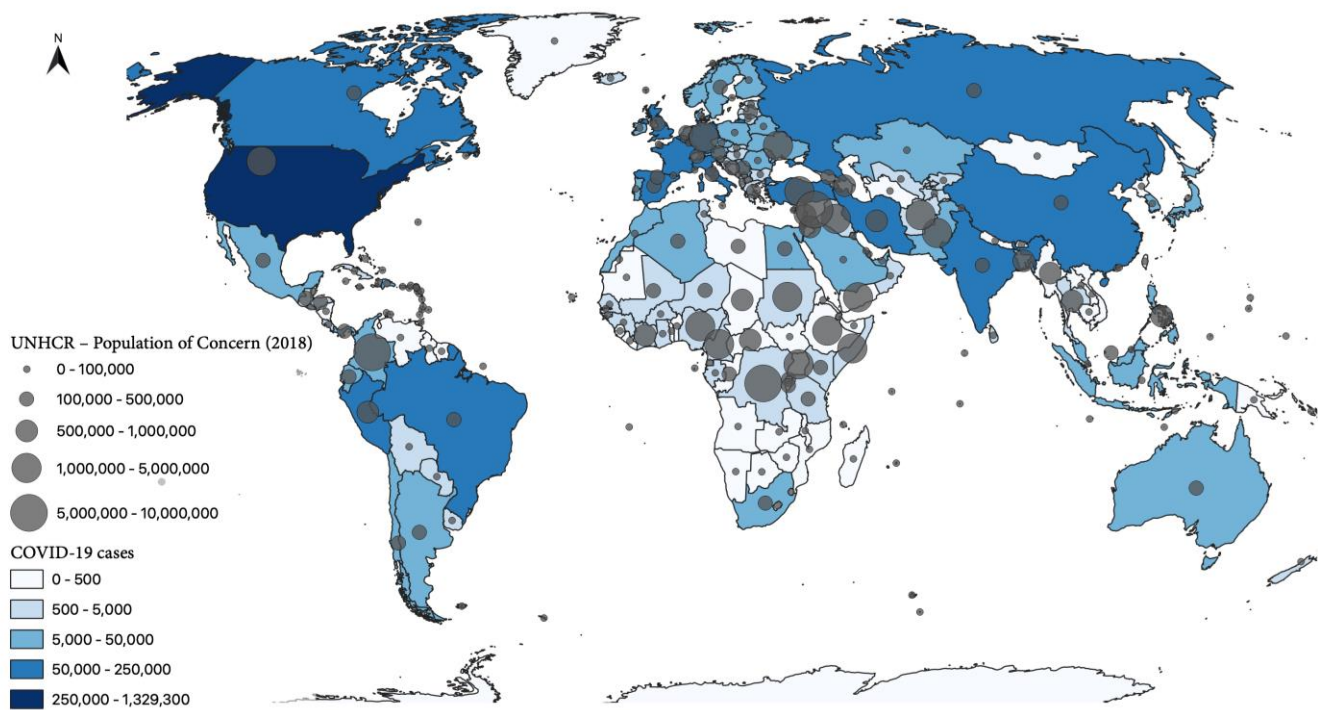
### KEY MESSAGES

1. Maintaining essential health services is vital to reduce additional indirect deaths, illness and suffering during the COVID-19 pandemic.
2. The COVID-19 response must integrate the voices, needs and priorities of displaced populations, with particular attention to marginalized and at-risk populations.
3. A “do no harm approach” should guide all interventions, with specific attention to contextual needs, challenges and possible unintended consequences, including those unique to contexts of displacement.

# WHY ARE INDIRECT HEALTH IMPACTS IMPORTANT?

Previous epidemics, including Ebola and H1N1 influenza, have demonstrated that indirect health effects often exceed the morbidity and mortality caused directly by the disease. Accounting for the “true toll” of COVID-19 is important to inform an effective, inclusive and equitable response. Knowledge of indirect health impacts will help to guide resource allocation and prioritization; and prevent and mitigate the most harmful impacts of the pandemic, including excess mortality. It is also important to identify vulnerable populations that require special attention, and to plan and prepare for current and future outbreaks. Early in the COVID-19 pandemic, actors working with displaced populations, including the UNHCR and public health experts, urged action to include displaced communities in pandemic preparedness and response efforts, and to maintain essential health services to prevent additional death and illness from non-COVID-19 related causes. While data are preliminary and the COVID-19 pandemic is rapidly evolving, evidence and models of indirect mortality and morbidity are already emerging in some of the most fragile and conflict-affected settings in the world.

**Figure 1:** Global map of populations of concern and confirmed COVID-19 cases as of May 11, 2020



Sources: Guidotti and Ardia, 2020 for confirmed COVID-19 cases; UNHCR, 2018 for populations of concern.

## Why do we see harmful indirect health impacts during a pandemic?

The diversion of resources to the pandemic response, surges in healthcare demand, disruptions to medical supply chains and impacts on healthcare workers (including infection, deaths, redeployment, absenteeism, restrictions on movement) can overwhelm health systems, particularly in humanitarian settings. These shocks to the health system, combined with outbreak control measures and socio-economic shocks, can reduce access to and utilization of life-saving health services and prevention programs. Travel bans and other restrictions can prevent the movement of health personnel, essential medications and supplies. Fear of contagion, safety and security concerns (due to ongoing conflict, civil unrest or the enforcement of control measures) and movement restrictions may constrain service delivery and decrease the ability or willingness of individuals to access care. In addition, containment measures implemented to “flatten the curve” (suppress disease transmission), including lockdowns and social distancing measures, can cause social, political and economic upheaval. Socio-economic consequences can negatively impact health, contributing to mental illness, exposure to gender-based violence (GBV) and food insecurity. At a macro-level, economic contraction threatens the longer-term resilience of national health systems.

## What evidence is there of indirect health impacts in the current pandemic?

Globally, there have been numerous reports of disruptions to life-saving health services and prevention programs due to COVID-19, including immunization campaigns, maternal and newborn care, HIV and TB services, cancer treatment and dialysis. A rapid survey of 36 nations supported by the Global Financing Facility (GFF) found that nearly half of the countries were reporting life-threatening service disruptions due to COVID-19. The pandemic has disrupted global supply chains and logistics networks for health care, reducing the availability of essential medicines and supplies. Experts have warned that COVID-19-related health care disruptions will cause significant increases in preventable illnesses and death and will likely reverse important progress in maternal and child health and the prevention and care of diseases, including HIV, TB and malaria, NCDs and vaccine-preventable diseases. A preliminary analysis by the United States Centers for Disease Control and Prevention (CDC) has found substantial excess mortality during the COVID-19 outbreak in New York City, one of the world’s worst affected cities, while data tracking efforts have found increases in mortality in multiple countries around the world. Excess mortality is a non-specific measure of the severity and impact of a pandemic, which includes indirect deaths. Present modeling estimates predict that secondary indirect deaths will be more numerous in the poorest settings. Humanitarian workers in humanitarian settings have reported that addressing COVID-19 has reduced their ability to respond to urgent community needs, including food crises and locust plagues. Box 1 highlights some key health areas of concern, based on emerging evidence during the COVID-19 pandemic and experience during previous epidemics.

**It is important to note two points at the outset of this Knowledge Brief:**

First, the impact of the COVID-19 pandemic on health systems and health outcomes will vary in different contexts. Indirect health consequences are determined by many factors, including the baseline health system capacity and burden; the duration, intensity and timing of health system disruptions; the local burden of disease; the COVID-19 transmission context; the demographic profile of the population; community attitudes, beliefs and behaviors related to health-seeking, health services and COVID-19; and the effectiveness of the COVID-19 response and mitigation measures. While this knowledge brief aims to highlight general principles and to offer some context-specific examples, we emphasize that interventions must be adapted to local needs, priorities and contextual challenges. There is no “one size fits all” solution.

Second, the COVID-19 pandemic is rapidly evolving. New evidence, knowledge and guidance is emerging constantly; much of the available existing guidance and data are preliminary, and government policies and control measures are subject to change with little notice. This knowledge brief aims to provide a broad overview and recommendations that are current at the time of publication, but it is not an exhaustive analysis.

“The world is only as strong as the weakest health system.”

António Guterres, Secretary-General of the United Nations

## Box 1: Highlighted health areas of concern, based on emerging evidence and indirect health impacts in past epidemics<sup>1</sup>

### Non-communicable Diseases (NCDs)

People with NCDs, including cardiovascular disease, chronic respiratory disease, diabetes and cancer, are at increased risk of severe or fatal COVID-19 infection. They also face increased risks of death or complications due to disruptions to routine health services and supply chains. Restrictive measures, including lockdowns and social distancing, may worsen control of NCDs by limiting individuals' ability to exercise and access healthy foods. Increased healthcare burdens during the 2009 H1N1 influenza pandemic were associated with increased deaths from cardiovascular disease in the United States (U.S.). Diabetes-related hospital admissions decreased during the SARS outbreak in Taiwan, then surged after the epidemic waned.

### HIV, TB and Malaria

During the 2014-2016 Ebola outbreak in West Africa, indirect deaths from diseases including HIV/AIDS, TB and malaria exceeded those due to Ebola. Disruptions to malaria programs during Ebola and other health emergencies have been linked to over 75 major resurgences globally. During the current lockdown in India, approximately 80% fewer daily TB notifications were made compared to baseline. In high burden settings, additional HIV, TB and malaria-related deaths may increase by up to 10%, 20% and 36%, respectively, over 5 years, compared to the absence of the COVID-19 epidemic. The World Health Organization (WHO) projects a two-fold increase in malaria deaths in sub-Saharan Africa, to 769,000 deaths in 2020, if access to antimalarial medicines and prevention campaigns is severely reduced. A modeling study predicts that if people living with HIV in Sub-Saharan Africa experience a six-month interruption to antiretroviral supplies, there will be a two-fold increase in HIV-related deaths and mother to child transmission of HIV over a 12 month period, compared to a scenario without disruptions.

### Sexual and Reproductive Health (SRH)

Reduced access to life-saving care associated with the pandemic could substantially increase maternal mortality (by up to 38.6%) and child mortality (by up to 44.7%) over 6 months in LMICs that account for almost 98% of under-five deaths worldwide. The Guttmacher Institute estimates that more than 48 million additional women may experience an unmet need for modern contraceptives and that over 15 million additional unintended pregnancies and 3 million additional unsafe abortions could result from COVID-19 service reductions. Even before reporting a single COVID-19 fatality, at least 11 preventable maternal deaths were reported in Uganda due to a coronavirus-related transportation ban. Lockdowns increase women's risk of experiencing GBV, while reducing access to support.

### Child Health and Vaccine-Preventable Diseases

A World Vision analysis of 24 of the world's most fragile countries estimated that 30 million children are at risk of preventable disease and death from the COVID-19 pandemic, threatening more children's lives than the virus itself. These secondary impacts were modeled using evidence of reduced health service utilization during the 2014-2016 Ebola outbreak. Gavi, the Vaccine Alliance, has reported the suspension of 14 national immunization campaigns in some of the world's most fragile countries due to COVID-19, depriving 13.5 million people of vaccines for preventable diseases. Measles vaccination campaigns have been disrupted in 37 countries (affecting 117 million children), while 21 LMICs are experiencing vaccine shortages due to border closures and travel restrictions. The benefits of sustaining routine childhood immunization programs in Africa are estimated to far exceed the risk of COVID-19 deaths associated with vaccination clinic visits (128 children's lives would be saved for every excess death attributed to COVID-19). The Democratic Republic of the Congo (DRC) is concurrently battling COVID-19, Ebola and the world's largest measles epidemic; measles vaccination programs that were disrupted by Ebola have been suspended again amidst the COVID-19 pandemic, leading to more than 6,000 measles-related deaths.

### Mental Health

The COVID-19 outbreak is expected to increase the prevalence of mental health problems among displaced populations, while simultaneously reducing access to and availability of services. A recent literature review concluded that mental health challenges experienced by refugees are exacerbated by the COVID-19 pandemic. Refugees in LMICs experience a range of adversity that puts them at risk for common mental disorders (depression, anxiety) and psychological distress, particularly in protracted emergencies. Although systematic reviews have found wide variations in prevalence among displaced persons, it is estimated that 22% of persons in conflict settings will have a mental disorder. A national survey in Sierra Leone conducted during the Ebola outbreak in 2015 found high prevalence estimates for anxiety, depression and post-traumatic stress disorder (PTSD) symptoms and a link between symptom severity and Ebola experiences.

### Nutrition

The World Food Programme (WFP) projects that, in the context of COVID-19, the number of people facing acute food insecurity is likely to double by the end of 2020, to 265 million people. Countries with the worst food crises include Yemen, the DRC, Venezuela, Ethiopia, South Sudan and Syria. Authors of a Lancet study estimate that acute malnutrition will account for up to 23% of additional child deaths indirectly attributable to the pandemic.

<sup>1</sup> This list is not exhaustive, and examples are illustrative.

# WHAT LESSONS CAN BE LEARNED FROM PAST EPIDEMICS?

## 1. Maintaining essential health services is vital to reduce additional deaths, illnesses and suffering due to the COVID-19 pandemic.

During the 2014-2016 Ebola outbreak in West Africa, deaths from diseases including measles, malaria, HIV/AIDS and TB attributable to health service disruptions exceeded the number of Ebola deaths. In Liberia, 57% of households surveyed nationally reported that it was very difficult or impossible to access health care during the outbreak. Multiple studies have found significant decreases in childhood immunization, routine visits for maternal and child health, reproductive health and care for common childhood illnesses in Ebola-affected countries. In addition, past discrete disruptions to health service delivery, such as the 1991 invasion of Iraq or Hurricane Maria in Puerto Rico in 2017, induced more indirect deaths in the months that followed than occurred during the initial event. Several modeling studies have projected indirect impacts of the COVID-19 pandemic, including a significant increase in maternal and child deaths due to service disruptions. However, some experts caution that these models are not intended to predict the trajectory of the response, but rather to illustrate the possible human toll if essential services are disrupted and to guide service prioritization and mitigation measures. Ensuring the continuity of essential health services and prevention programs is imperative to save lives during the COVID-19 pandemic.

## 2. The COVID-19 response must integrate the voices, needs and priorities of displaced populations, with particular attention to marginalized and at-risk populations.

Experience with Ebola and SARS shows that transparency, trust and community partnership are key to an effective response. In previous epidemics, engaging affected communities and trusted sources, including survivors and community leaders, was critical to the success of control efforts. This requires effective communication with and participation of population subgroups who are most vulnerable to COVID-19 and indirect impacts.

While displaced populations should be integrated into national pandemic preparedness and response plans, many countries are prioritizing the needs of citizens within their borders. Ensuring that displaced populations, as well as the healthcare workers who serve them, have access to infection prevention and control measures, testing and treatment is vital. Advocacy and incentives to promote the inclusion of displaced populations are important in the context of resource shortages. For example, the UNHCR has joined the COVID-19 Solidarity Response Fund aiming to support WHO activities and strengthen health services in LMICs hosting more than 20 million refugees and 40 million internally displaced people. In Uganda, the UNHCR facilitated the testing of more than 1,000 refugees by covering the cost of transporting samples to a laboratory.



### 3. A “do no harm approach” should guide all interventions, with specific attention to contextual needs, challenges and possible unintended consequences, including those unique to contexts of displacement.

Previous epidemics show us that implementing control measures without adequate community consultation and attention to contextual needs can produce harmful unintended consequences and undermine public health goals. For example, poor communication and a lack of cultural sensitivity during the Ebola response in West Africa fueled fear and mistrust of health providers and deterred individuals from seeking health care. Previous experience also shows that stigmatizing viral transmission places populations at risk and reduces access to care. During the current pandemic, returning Venezuelans and migrants in the U.S., Hungary and Yemen, have been stigmatized, unjustly blamed for the spread of COVID-19 and even subjected to violence. COVID-19 control measures – particularly when implemented without appropriate safeguards – have been implicated in migrant deaths in India, excessive use of force by police in Africa, global food insecurity and escalating GBV. Displaced populations are often disproportionately affected by restrictive measures, including lockdowns and restrictions on movement. Given the complexity of humanitarian and displacement settings, abiding by the principle of “do no harm” requires careful assessment of the risks and benefits of any intervention.

## Box 2: Refugee-led community outreach in the context of COVID-19

### Filling the gaps in health care, basic needs and community services

- In Kenya, Mozambique, and Uganda refugees have been hired as community health worker (CHWs) or worked with community service organizations to fill service gaps and maintain and enhance basic health and community services during the COVID-19 pandemic, including distributing food and non-food items, disseminating information and providing basic health services and youth-focused programs. In Latin America, refugees with relevant expertise and training have been hired as health providers to engage directly in the COVID-19 response.
- Refugee-led organizations in Beddawi Camp, Lebanon and Koboko District and Bidi Bidi refugee settlement in Uganda, have mobilized to meet the needs of their communities during the COVID-19 pandemic, by sourcing and distributing food supplies and other essentials to refugee families in lockdown and adapting and translating COVID-19 information and disseminating it through social media and offline modalities.

### Prevention of family and gender-based violence

- To address the increased risk of GBV and family violence during the COVID-19 pandemic, UNDP has developed programs in Somalia and for internally displaced persons in Sudan to strengthen community-led violence prevention and response programs. Strategies include developing ‘neighborhood watch’ systems led by nominated community members and community-based conflict resolution strategies.

### Mental health and psychosocial support

- In Lebanon, trained refugee outreach workers have delivered remote and in-person community-based psychosocial support services to over 4,000 people since the beginning of the COVID-19 outbreak, through June 2020. They have reached over 332,000 individuals with virtual information and awareness sessions, covering mental health and psychosocial support, parenting skills, and COVID-19 prevention.
- UNHCR has trained frontline workers, many of whom are refugees themselves, to integrate Psychological First Aid into their humanitarian and COVID-19 response activities, providing brief supportive and practical assistance to refugees.

### Ensuring continuity in education and child development

After COVID-related school closures, CIYOTA, a refugee-led organization in Kyangwali Refugee Settlement (Uganda) partnered with the Ministry of Education to increase access to education for refugee students, through online and offline strategies.

# WHAT ARE THE UNIQUE CHALLENGES IN CONTEXTS OF DISPLACEMENT?

Displaced populations often live in countries with weak capacity to respond during a pandemic, due to fragile health systems and public health infrastructure, conflict, political instability and weak governance. Displaced individuals may experience poorer baseline health and nutrition due to challenges accessing healthcare, substandard shelter, financial insecurity, food insecurity, and inadequate water and sanitation.

## **The COVID-19 response has disrupted health services that are disproportionately utilized by displaced populations.**

In the Central African Republic, where the Norwegian Refugee Council estimates that 70% of health services are provided by aid organizations, COVID-19-related service disruptions will have far-reaching health consequences. Travel restrictions have impacted the ability of non-governmental organizations (NGOs) to access areas with urgent medical needs in countries including Yemen and northeast Syria. The repatriation of international staff and lockdown measures that restrict entry of staff, including in Cox's Bazar, have left health services severely understaffed. An April 2020 ACAPS survey found that 28% of survey respondents worked for organizations that had repatriated international staff. Disruptions in international supply chains – exacerbated by restrictions on cargo flights, port closures, and quarantine periods – are likely to disproportionately impact humanitarian operations, which often rely on large-scale procurement and stockpiling of emergency supplies. Existing resources, including staff and supplies, have been diverted to the COVID-19 response. As multilateral organizations pivot to the COVID-19 response and bilateral donors focus on national priorities, funding gaps will increasingly impact essential health services. For example, the United Nations Population Fund (UNFPA) has announced dramatic shortfalls in its response in Yemen, jeopardizing SRH services. USAID has redirected supplies intended for international assistance to the U.S. domestic response and restricted the purchase of personal protective equipment (PPE) with USAID funding, threatening both effective COVID-19 mitigation and access to supplies for preventing and treating other infectious diseases, including Ebola.

## Displaced populations experience unique vulnerabilities and challenges in accessing health care, which are often compounded by the COVID-19 response.

Lockdowns and restrictions on movement disproportionately impact displaced populations, particularly in camp settings and informal settlements. In Lebanon, NGOs reported decreased utilization of health services as the country's lockdown limited movement out of informal settlements in the Bekaa Valley. SRH providers in Jordan reported delays in accessing camps due to requirements for additional government permissions. In Ecuador, although migrants are eligible for national health services, there is concern that health care workers may informally prioritize the treatment of Ecuadorians before Venezuelan migrants.

Displaced persons, particularly those who lack legal status, often rely on daily wages and precarious work in the informal sector, making them vulnerable to job losses resulting from pandemic response. At the same time, they are generally excluded from government COVID-19 income support schemes and housing programs. These socio-economic impacts may pose risks to health by promoting negative coping strategies and reducing the ability to pay for health care. Stigma and discrimination related to COVID-19, concerns about legal status and mistrust of authorities may also deter displaced populations from seeking health care.

**Figure 2:** Indirect health impacts on displaced populations associated with the COVID-19 pandemic

Availability & Quality	Accessibility	Utilization	Self-Management
<ul style="list-style-type: none"> <li>• Closure and repurposing of health facilities</li> <li>• Limited availability of healthcare workers for routine health services (diversion to COVID-19 response, illness, death, absenteeism, movement restrictions),</li> <li>• Limited essential medicine and supplies (disrupted supply chain and logistics, diversion to COVID-19 response)</li> <li>• Disrupted surveillance and prevention programs (e.g. immunization, malaria prevention)</li> <li>• Disrupted routine health services and treatment programs</li> </ul>	<ul style="list-style-type: none"> <li>• Decreased humanitarian access to communities</li> <li>• Restricted movement (e.g. lockdowns, travel bans)</li> <li>• Limited transportation options (transportation bans and service reduction)</li> <li>• Remote health services inaccessible to those who lack phone/internet connectivity</li> <li>• Deprioritization or exclusion of displaced populations in national health services and COVID-19 response</li> <li>• Decreased availability of affordable health services</li> <li>• Lack of culturally and linguistically appropriate services</li> </ul>	<ul style="list-style-type: none"> <li>• Stigma/Discrimination</li> <li>• Fear or mistrust of health facilities or providers</li> <li>• Fears of COVID-19 infection</li> <li>• Safety and security concerns</li> <li>• Legal status concerns (e.g. fears of arrest, deportation)</li> <li>• Limited awareness of health care options and service availability</li> <li>• Inability or reluctance to utilize remote health services (e.g. privacy concerns)</li> <li>• Inability to pay health care fees and associated costs (e.g. transport)</li> </ul>	<ul style="list-style-type: none"> <li>• Food insecurity (malnutrition)</li> <li>• Financial insecurity (loss of livelihoods, ineligibility for national social assistance)</li> <li>• Limited access to information and communication</li> <li>• Disrupted social support and caregiving networks (including quarantine of caregivers)</li> <li>• Mental health risks</li> </ul>

Adapted from [ACAPS, 2016](#) and [IOM, 2020](#).

## The pandemic response disrupts prevention and self-management of disease among displaced populations.

Traditional caregiving structures may be disrupted by displacement and control measures impacting caregivers. It is difficult to maintain continuity of care for NCDs and other chronic diseases, including HIV and TB, in contexts of displacement; this may be exacerbated during the pandemic response. Food shortages, which disproportionately impact humanitarian settings, increase the risk of acute malnutrition and limit displaced individuals' ability to self-manage NCDs. The COVID-19 response and supply chain disruptions will increase food insecurity. There have been reports of food shortages in Cox's Bazar camps and delays in food distributions in northeast Nigeria. Movement restrictions jeopardize access to markets and displaced families may lack sufficient food stores to feed their families during lockdowns. Food insecurity is exacerbated by disruptions to livelihoods and decreased purchasing power.

## WHICH POPULATIONS REQUIRE SPECIFIC ATTENTION TO THEIR HEALTH NEEDS?

Persons with specific needs, including older persons, people with disabilities, people living with chronic diseases, lesbian, gay, bisexual, transgender, and intersex (LGBTI) people, and survivors of gender-based violence, face unique challenges in the context of COVID-19 that can exacerbate health risks. WHO estimates that 15% of the world's population has a disability. Displaced persons living with disabilities, including mobility restrictions, frequently rely on public transport to access essential services, including health care and food distribution points. In Uganda, a government ban on public and private transportation has prevented displaced populations from accessing essential services, particularly in refugee settlements. Restrictions to mitigate COVID-19 can also reduce access to health care, social services, basic medical and sanitary goods, and livelihood resources for individuals with disabilities.

According to UNHCR, older refugees comprise 8.5% of the overall population of concern. Older persons have an increased risk of death or severe COVID-19 disease, due to their age. They also frequently have mobility restrictions and other health conditions that place them at additional risk of health complications if their treatment is interrupted. Many older displaced people who rely on social support networks to meet their basic needs are finding that assistance has been reduced or withdrawn during the pandemic. Social isolation resulting from social distancing and lockdown measures may also place older people at risk of psychosocial distress and mental, physical and cognitive decline.

Displaced LGBTI people may be uniquely vulnerable during the COVID-19 pandemic, in part due to increased stigma and discrimination when accessing health services, disruptions to health services, including hormone replacement therapy, and increased household social tensions resulting from lockdowns. Movement restrictions and lockdowns have exacerbated the difficulty that many trans individuals face in accessing hormone therapy.

The COVID-19 crisis has contributed to an “exponential increase” in GBV and family violence<sup>1</sup> globally, attributed to an increase in socio-economic stressors associated with the pandemic, social isolation measures and mobility restrictions that may increase exposure to abusers, and reduced access to support services. Services to prevent and respond to GBV and family violence should be considered essential services, and efforts made to adapt them in accordance with COVID-19 prevention measures. In displacement settings, a range of strategies should be considered, including low-tech solutions.

## HOW CAN WE PREVENT AND MITIGATE INDIRECT IMPACTS OF COVID-19 AND THE PANDEMIC RESPONSE IN DISPLACEMENT CONTEXTS?

### **Implement interventions with a “do no harm approach”.**

All interventions, including strategies to prevent and mitigate indirect health impacts of COVID-19 must account for culture and context to mitigate unintended harmful consequences. Interventions should:

#### **1. Consider context and avoid a “one size fits all” approach.**

Lockdowns are often implemented with the assumption that people have access to safe drinking water, electricity, adequate sanitation, social support, communication and sufficient food and income. In humanitarian contexts, these requirements are often not met. It is vital to ensure that individuals can continue to meet their basic needs, through the provision of food, financial assistance and other support. This may require flexibility in funding, policies, and programming. For example, advocacy by a refugee-led organization, the South Sudanese United Refugees Association (SSURA) in Uganda, led the WFP to adapt its policies to allow family members and friends to collect monthly food rations on behalf of urban refugees affected by COVID-related movement restrictions. Restrictive measures must only be implemented when necessary and proportionate to the COVID-19 risk, and with a view towards harm mitigation. Lockdowns and transportation bans must include exceptions for medical emergencies, to avoid preventable deaths, as reported in Uganda

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<sup>1</sup> A forthcoming knowledge brief will explore family violence, including intimate partner violence and violence against children in the context of COVID-19 in displacement settings.

(Box 1). COVID-19 control measures must not discriminate against displaced populations or violate the principle of non-refoulement.

## **2. Reinforce localization of the response in a way that prioritizes “do no harm.”**

As restrictions on movement force international actors to scale back operations, local communities will play an increasingly important role in the COVID-19 response and addressing community health needs. The [Global Humanitarian Response Plan](#) notes that this requires “increased partnership and support to national and local staff and organizations that are equally impacted but retain a greater capacity to operate locally than international agencies, provided they receive the necessary resources and are able to act.” Community-based organizations cannot be expected to do more without concomitant increases in funding. [Local and national staff](#) should receive the same access to protection (including medical evacuations) and support that is afforded to international colleagues to ensure that they are not exposed to additional risk.

## **Ensure essential health services for displaced populations are maintained.**

Displaced persons must have continued access to essential health services, as emphasized in the [WHO COVID-19 Operational guidance for maintaining essential health services during an outbreak](#) and the [UN Office for the Coordination of Humanitarian Affairs \(OCHA\) Global Humanitarian Response Plan Strategic Priority 3](#). Priority health services may include prevention of communicable diseases (including vaccine-preventable diseases), SRH services, management of NCDs including mental health conditions, and access to emergency care. While some services, such as SRH services, will likely be essential across the board, the designation of which health services are considered essential will vary by context. In the Central African Republic, MSF has conducted assessments to identify the major causes of medically preventable deaths, to inform programmatic triage. The Institute for Health Metrics and Evaluation at the University of Washington has developed a global template for organizations that lack sufficient information to make these assessments locally. Needs assessments and decisions about prioritizing essential health services must include displaced communities. Moreover, strategies to maintain essential services must consider the specific challenges faced by displaced populations.

## **Service Delivery Strategies**

Alternative mechanisms of service delivery may need to be implemented as health systems resources are diverted and access to care is limited. Any changes to service delivery should be communicated clearly to displaced communities, including those traditionally underrepresented in community leadership, including women and girls, adolescents, persons with disabilities, older persons, and persons with diverse gender expressions, gender identities, sexual orientation and sex characteristics. Adapted service delivery strategies may:

- 1. Ensure continued access to medicines and family planning supplies** through multi-month dispensing (for example, prescribing a three month supply, such as the [International Rescue Committee’s \(IRC\) new protocol in camps in Jordan](#)), utilizing CHWs to deliver

medicines to patients' homes, or establishing alternate pick-up points for medicines, accompanied by remote follow up. When possible, policy changes to allow medicines, including contraceptives, to be obtained without a prescription can increase the availability of essential medicines if access to health facilities is limited.

- 2. Leverage digital health technologies, including telemedicine and mobile health (m-Health) strategies** to maintain access to health services and to reduce congestion at health facilities that remain open. Telemedicine approaches have been suggested for the provision of services for mental health, SRH and TB, through platforms including web-based services, SMS, and WhatsApp (see Box 4 for examples). Studies in LMICs have found that m-Health technology is generally cost-effective, with positive impacts on clinical outcomes and management of chronic diseases, NCDs, obstetric and cardiology conditions. Telemedicine strategies have been implemented in displacement settings, including remote mental health and psychosocial support for Venezuelan refugees. While some refugee-hosting countries, including Bangladesh, have a history of innovating in telehealth, others have only recently begun exploring its potential and may lack the infrastructure, human resources, or an enabling policy environment to allow them to quickly transition. It is also important to recognize the potential risks and limitations of digital health technologies, including privacy and connectivity challenges specific to contexts of displacement. For example, Rohingya refugees and host communities living in Cox's Bazar, Bangladesh, have been subjected to sustained internet blackouts. Digital technologies have the potential to increase health disparities for marginalized populations and are not always an appropriate solution. For example, survivors of gender-based and family violence may have their digital access restricted by their abusers. Digital technology must be implemented with appropriate safeguards and attention to issues of quality, equity, safety and security.
- 3. Promote strategies to reduce crowding and time spent in health facilities.** Suggested approaches include utilizing outreach workers to collect patients at designated times, scheduling appointments, and separating individuals with suspected or confirmed COVID-19 from individuals presenting for other health reasons. Implementation of these strategies must consider additional barriers to access among displaced populations, restrictions on access to camps or settlements by outreach workers, differential access to communication technology, and issues around stigma and discrimination if suspected COVID-19 patients are separated from other patients.
- 4. Build and utilize partnerships and networks**, including approaches that integrate care for displaced and host communities, to support system resiliency. Inclusive healthcare services expand the entry points through which displaced and host communities can access health services, which is essential if facilities become overwhelmed or otherwise find themselves without sufficient resources to provide certain services. WHO guidance specifies that "refugees and migrants should be progressively integrated into the existing local and national health structures." Coordinated action between and among humanitarian and national actors can ensure that patients receive timely, quality care even when existing health services are disrupted by the pandemic response.

## Health Workforce Strategies:

Strategies to support the health workforce are essential to maintaining essential health services, particularly in humanitarian contexts where there are often pre-existing shortages of trained health staff and the presence of international staff may be limited by movement restrictions.

1. Utilize **task-sharing** and capacity building of CHWs, lay providers, and informal caregivers to increase the provision of care outside the health facility. When utilizing task-sharing, cadres including CHWs must be “appropriately trained, remunerated, and supplied.” In Chad, UNHCR trained teams of Chadian psychosocial assistants and Sudanese refugee community mobilizers to provide community-based mental health and psychosocial support including awareness sessions, counseling, home visits, and follow-up for refugees with mental health conditions supported by remote supervision. Services were adapted to comply with social distancing recommendations with home visits only occurring for refugees with severe mental disorders and/or at high risk of family violence. Another model of community-based health service provision by lay refugees or teams of refugee and host community members in Uganda was found to be feasible and effective for improving mental health and psychosocial outcomes in emergencies.
2. Supportive supervision should be modified to limit in-person encounters. Remote supervision of CHWs, including through WhatsApp and other mobile platforms, has been used widely, including in Zambia and Kenya. During the COVID-19 pandemic, groups such as Save the Children are using WhatsApp for remote supervision, monitoring and information sharing. In Mozambique, the upSCALE app, which has been used to monitor CHW performance, track stock levels of drugs and supplies, and transmit data directly to the District Health Information System, is now being adapted for the COVID-19 response. Guidance on remote supervision from groups such as the Malaria Consortium include setting times for remote follow-up, providing communication allowances, and instituting flexible reporting periods to accommodate delays due to connectivity.
3. Promote pathways to expand the **inclusion of health workers from the displaced community**, including through rapid credentialing or waiving local accreditation requirements. Similar strategies have been introduced in the United Kingdom (UK), Germany, and Colombia.
4. Facilitate the **movement of humanitarian staff** in settings where movement restrictions have limited the entry of personnel. The Inter-Agency Standing Committee (IASC) urges governments to classify humanitarian workers as essential and facilitate rapid movement of personnel into and within countries.
5. **Support CHWs and lay providers**, as part of broader support to all health workers. In their interim guidance on the rights, roles and responsibilities of health workers during COVID-19, WHO specifies that health workers must be provided with adequate PPE and appropriate safety measures. WHO guidance also outlines the right of health workers to mental health and counseling resources, which are essential in settings in which health workers may be stigmatized as potential disease carriers and where tensions between displaced and host communities may exacerbate this stigmatization. Health workers should



be supported in implementing adapted service delivery mechanisms through the provision of, for example, phones, phone credit, and flexible working hours.

## Access to Essential Medicines and Supplies Strategies

1. **Ensure sufficient supplies for essential health services**, including personal PPE. Health workers providing essential services must have consistent access to PPE, even if no or limited PPE was the standard of practice prior to the pandemic. Diversion of production capacity, reallocation of supplies, and general supply chain disruptions are likely to limit access to commodities required for essential health services. WHO operational guidance on maintaining essential health services during an outbreak encourages actors to develop resource lists that can be used to guide coordinated procurement for the pandemic response and essential health services. Humanitarian actors should be included in these coordination mechanisms.
2. Develop **flexibility in procurement** by pooling the procurement of key supplies, procuring from private sector suppliers, or engaging in local procurement. For example, in Nigeria, UNFPA is working with the private sector to support procurement.
3. Facilitate **expedited movement of medicines and supplies**, including across borders. IASC has encouraged the fast-tracking of customs clearance procedures, which are critical given the large-scale international procurement often utilized in humanitarian operations.

## Health Information Systems Strategies

1. Utilize health information systems to **monitor access, availability, and coverage of essential health services**. PATH's guidance for monitoring essential health services during COVID-19 recommends identifying priority indicators, implementing simple analyses to detect disruptions, and exploring the root causes of identified disruptions. These indicators should be disaggregated, when possible, in order to identify differences in service provision and utilization by displaced and host communities, as well as among marginalized populations.
2. Promote **data sharing of supply availability** among actors to better coordinate procurement and distribution of medicines and supplies for essential health services. WHO recommends including public and private suppliers and pharmacies in information sharing to “allow dynamic inventory assessment and coordinated re-distribution.” The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) has promoted this approach for PPE and SRH supplies in humanitarian settings.

## Health Financing Strategies

1. Prioritize **funding to fight COVID-19 in displaced populations**, to strengthen health systems capacity to support the pandemic response, while maintaining essential health services. This may include providing supplemental funding to LMICs, where most displaced persons reside, to bolster countries' efforts to respond to COVID-19.
2. Ensure **continuous funding for existing health programs** in humanitarian settings, even as additional funds are mobilized to respond to COVID-19. As outlined by the IASC guidance document on flexible funding during COVID-19, the redirection of funding in humanitarian settings from existing programming to fight COVID-19 could exacerbate existing humanitarian crises.
3. **Remove financial barriers for seeking care** to ensure that members of marginalized groups are able to access health services. This may include providing free testing and treatment for COVID-19. WHO recommends suspending user fees for healthcare during the COVID-19 crisis, in recognition that many people are experiencing economic hardship due to epidemic containment measures and that user fees may become prohibitive barriers to care seeking.
4. **Engage the private sector**, especially where the public sector is ill-equipped to respond adequately to the crisis. This might include actions such as contracting private sector health providers when public resources are constrained. WHO recommends combining available capacity from the public and private sector, as well as community resources, in order to implement the strongest response to COVID-19.

## Leadership and Governance Strategies

1. **Include displaced persons** in planning to maintain essential health services. WHO interim guidance specifies that refugees and migrants' "health care must be included in the COVID-19 programmes, national health systems, policies and planning to ensure essential services." The meaningful participation of displaced communities in decision-making processes is essential to ensure that their needs are addressed in the response. In Greece, refugees have organized a community psychosocial workforce that performs community outreach, liaises with local governmental and non-governmental stakeholders, and strengthens linkages between these community members and national social and health services. Further select examples are provided in Box 4.
2. **Promote coordination and cooperation** between national health actors and humanitarian actors. These actors should work to coordinate services and referral pathways to ensure that essential services remain available as the health system is strained. Planning should anticipate human resource and infrastructure needs during the COVID-19 peak. Displaced populations must be able to access these services without discrimination.

3. **Include local and community-based actors** in coordination mechanisms. As humanitarian operations are scaled back due to restrictions on movement, local actors are increasingly relied upon. These actors must be included in planning to maintain essential health services.
4. **Strengthen global coordination and collaboration and joint advocacy to ensure sustained inclusion of displaced populations in COVID-19 preparedness and response plans and allocation of resources.**

## **Displaced populations must be included in the pandemic response, including efforts to prevent and mitigate indirect health impacts.**

As described in the WHO interim guidance on preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings, meaningful participation of displaced persons throughout the decision-making and implementation process is essential to ensure that interventions target needs identified by the community, do not present disproportionate barriers to displaced communities' inclusion, and minimize the risk of unintended consequences. While refugees in many contexts are playing a leading role in responding to community needs during COVID-19 (Box 2), their efforts are often hampered by a lack of flexible and sustainable funding, technical support, social capital, political commitment or meaningful participation in policy and decision-making.

## Box 3: Toolkit of helpful guidelines and resources

### Resources Relevant to Displaced Populations and Humanitarian Settings

- [Preparedness, prevention and control of coronavirus disease \(COVID-19\) for refugees and migrants in non-camp settings – Interim guidance](#) (WHO)
- [IASC COVID-19 Outbreak Readiness and Response Resource Hub](#) (IASC)
- [Global Humanitarian Response Plan COVID-19](#) (OCHA)
- [COVID-19 Guidance Note Protecting Residents of Informal Settlements](#) (UN Special Rapporteur on the Right to Housing)

### Health System Strengthening

- [Guidance for monitoring essential health services during COVID-19 using data from routine health information systems](#) (PATH)
- [Operational Guidance for Continuity of Essential Services Impacted by COVID-19](#) (Jhpiego)
- [Maintaining essential health services: operational guidance for the COVID-19 context](#) (WHO)
- [Priorities for the Global COVID-19 Response](#) (Community Health Impact Coalition)
- [WHO recommendations on health financing during COVID-19](#)
- [Coronavirus disease \(COVID-19\) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health](#) (WHO)

### Sexual, Reproductive/Maternal, Neonatal, Child and Adolescent Health (SR/MNCAH)

- [PMNCH compendium of COVID-19 related partner resources on women's, children's, and adolescents' health](#) (WHO)
- [IAWG Covid-19 Resource Hub](#) (IAWG)
- [GBV Area of Responsibility COVID-19 Thematic Resources](#)
- [Guiding principles for immunization activities during the COVID-19 pandemic](#) (WHO)

### Chronic Diseases

- [COVID-19 technical guidance](#) (Global Fund to Fight HIV, TB and Malaria)
- [Tailoring malaria interventions in the COVID-19 response](#) (WHO)
- [Addressing noncommunicable diseases in the COVID-19 response: Interim guidance](#) (WHO)

### Mental Health and Psychosocial Support

- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#) (IASC Reference Group on Mental Health and Psychosocial Support)
- [Operational considerations for multisectoral mental health and psychosocial support programmes during the COVID-19 pandemic](#) (IASC)
- [Basic Psychosocial Skills- A Guide for COVID-19 Responders](#) (IASC)
- [Toolkit of mental health and psychosocial technical resources for COVID-19](#) (MHPSS.net)

### Community Engagement and Risk Communication

- [COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement](#) (Regional Risk Communication and Community Engagement Working Group)
- [Risk Communication and Community Engagement \(RCCE\) Action Plan Guidance COVID-19 Preparedness and Response](#) (WHO)
- [Meaningful Refugee Participation as Transformative Leadership: Guidelines for Concrete Action](#) (Global Refugee-led Network)

### Populations with Specific Needs

- [Interim Guidance: Gender Alert for COVID-19 Outbreak](#) (IASC)
- [Policy Brief: A Disability-Inclusive Response to COVID-19](#) (UN)
- [COVID-19 and the rights of persons with disabilities: Guidance](#) (OHCHR)
- [Policy Brief: The Impact of COVID-19 on older persons](#) (UN)
- [ASPIRE Guidelines on COVID-19 response and recovery free from violence and discrimination based on sexual orientation and gender identity](#) (UN)

## Box 4: Highlighted approaches to prevent and/or mitigate indirect effects in humanitarian and displacement settings during the current COVID-19 pandemic

### Innovative service delivery mechanisms

**Primary care and chronic diseases:** The IRC has modified its health service delivery in refugee camps in Jordan to maintain access to essential primary care services in the context of COVID-19. Strategies include remote consultations and referrals, online renewal of NCD medications and multi-month dispensing of essential medications, drawing from previous HIV care models. The Stop TB partnership has compiled a directory of digital health technologies, community-based monitoring tools and virtual care solutions to support continuation of life-saving TB programs during the COVID-19 pandemic. Resources include a publicly accessible Digital Adherence Technology (DAT) implementation toolkit. A mobile clinic in Palestine has served thousands of individuals affected by COVID-related health facility closures, providing medical and community-based services, including breast cancer screening, SRH services and distribution of food items and hygiene kits.

**SRH:** In Colombia, Fundacion Oriéntame, provides SRH care to women through telemedicine, including legal, safe abortion services, an approach that a U.S. study found was “noninferior to in-person provision with regard to clinically significant adverse events.” The International Planned Parenthood Federation (IPPF) has reported home or doorstep delivery of SRH products, including contraceptives and pregnancy tests, by 12 member associations in countries including Burundi, Central African Republic, Sierra Leone and Bangladesh. A further 24 member associations offer comprehensive sexual education through platforms including WhatsApp, Skype and hotlines.

**Vaccine-preventable diseases:** Countries in the Middle East and North Africa have maintained routine childhood immunization programs by applying strict precautionary measures, including PPE and social distancing in clinics.

**Gender-based violence:** UNICEF has provided guidance on GBV service provision during COVID-19, including low-tech solutions. Strategies include GBV phone booth stations, low-tech alert systems and phone and non-phone panic button systems. A remote GBV case management service in Uganda incorporates “verbal passwords” for GBV survivors to signal to their case manager when it is a safe time to talk.

**Mental health:** Telemedicine and hotlines staffed by multilingual professionals and paraprofessionals have increased access to information, psychosocial support, psychotherapy and triaging and safety assessments for refugees. Trained refugee community workers provided vital mental health services to fellow refugees in locked-down camps in Northern Iraq, while Venezuelan refugee psychologists have provided psychological first aid services remotely to Venezuelan refugees in Peru.

### Expanded access to health and other essential services for displaced populations

Portugal announced that all non-citizens, including asylum seekers, will be treated as permanent residents and receive full access to public services during the COVID-19 crisis. This includes access to national health services, the right to work, financial assistance and housing contracts. Other governments, including those of Jordan and Qatar, have announced that they will include migrants in their COVID-19 response, including access to free testing and treatment. Other countries, including Colombia and Ecuador, continue to provide access to healthcare for displaced populations. However, discrimination at health facilities or fears of legal consequences may prevent displaced populations from receiving care.

### Health workforce

Italy, Germany and the UK have responded to workforce challenges during COVID-19 by lifting restrictions on foreign-trained and foreign-born health workers, including refugee health workers (Italy) and expediting medical credentialing (Germany and UK). IRC is piloting an out-of-clinic care model where Syrian Community Health Volunteers (CHVs) provide support to Syrians and uninsured Jordanians with NCDs. UNHCR has trained frontline (non-health) workers to provide Psychological First Aid to identify refugees in need of specialized care and provide basic support outside of clinical settings in Egypt, Lebanon, Niger and Peru. During COVID-19, this model enables CHVs to identify people living with NCDs, ensure continuity of medication supplies and provide remote follow-up. CHVs have adapted to address important health care gaps during previous Ebola and Zika epidemics.

### Health Education and Information

The Bangladesh NGOs Network for Radio and Communication (BNNRC) has engaged health providers, civil society organizations, government actors and community members and mobilized community radio to keep rural and hard-to-reach populations informed during the COVID-19 pandemic. All community radio stations have been harnessed to convey important health information, including how to access health care providers and prevent COVID-19.

An IRC multi-platform Health Information Hub in El Salvador and Honduras (soon to be launched in Guatemala) integrates two-way messaging, “CuentaNos,” where users can obtain information about essential services, including health, education, gender-based violence support and COVID-19 health information.

In Ecuador, a UNHCR WhatsApp information line, HELP ACNUR, provides information to displaced persons regarding food, shelter, cash assistance and regularization issues. Between March and early June, the program sent 460,000 messages and served 30,500 people, including Venezuelans and Colombians, through its protection lines.

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