COVID-19 and the Displaced

How does the COVID-19 pandemic impact the displaced population?

WORLD REFUGEE & MIGRATION COUNCIL LITERATURE REVIEW

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Introduction

This literature review examines how the COVID-19 pandemic impacts the displaced population, both from a health perspective and the wider socio-economic aspect.

The novel COVID-19 disease, caused by the virus SARS-CoV2, has swept across the world in a matter of few months. This global pandemic has been unprecedent in our lifetime. The virus has spread at an exponential rate from 118,000 reported in early-March, when World Health Organization (WHO) declared the outbreak a global pandemic, (Branswell & Joseph, 2020) to over 7 million as of mid-June (*WHO Coronavirus Disease (COVID-19) Dashboard*, n.d.).

The COVID-19 virus causes mild to moderate respiratory infection with a small number falling severely ill and needing critical care, especially the elderly and those with underlying conditions, such as cardiovascular, diabetes and chronic respiratory disease. (*Coronavirus*, n.d.) The virus is primarily transmitted through droplets of saliva or discharge of nose when an infected person coughs or sneezes. As a result, the public health recommendations include frequent hand washing and maintaining at least one metre distance from other people, among other measures. The reproductive ratio — how many additional infections will result from a given case of a communicable disease — is based on $R = c \times p \times d$; where 'c' is the average number of susceptible people an infectious person comes into contact with, 'p' is the average probability that transmission will take place with the contact, and 'd' is the average duration of infectious period (Checchi et al., 2007). The 'c' of 'R' is dependent on the context, such as population density, and transmission route, which can lead to large variabilities of 'R'. Public health measure of social distancing is aimed at reducing the 'c'. The 'p' of 'R' is mostly dependent on the pathogen's biology but also behaviour. The basic hygiene protocol helps to reduce the 'p'. The 'd' also determines the opportunities for transmission as a window of opportunity based on the period of infectiousness. In the case of COVID-19, the challenge is that asymptomatic infectious person can unknowingly spread the virus during this period. Challenges of the pandemic have extended beyond the transmission and threat to people's health; almost all countries' healthcare systems have been distressed in their capacity to manage the cases, shortages of PPE, testing kits and other medical essentials are being reported across the global, and the socio-economic fallout has not spared anyone.

As the outbreak starts to take hold in low-resourced regions, there is a new set of vulnerable groups that we must turn our attention to: the displaced population. Globally, there are estimated to be 41.3 million internally displaced people (IDPs), 25.9 million refugees and 3.5 million asylum-seekers (Refugees, n.d.). About 131 countries affected by the pandemic are hosting some refugee population. Eighty percent of refugees live in low- and middle-income host countries with already weak healthcare systems that are ill-equipped for the treatment capacity needed, and where the fourth wave of COVID-19 is expected to take place (Plan

International, 2020; The Lancet, 2020). Displaced people, refugees and low-paid migrant workers are particularly vulnerable to the virus and the policies resulting from the pandemic. As a result of their precarious conditions, they live in overcrowded conditions that can increase the 'R' of the disease and make following public health protocols challenging. They are also already facing chronic economic, health and social vulnerabilities as well as multiple forms of marginalization (Orcutt et al., 2020). The principles of human rights, solidarity and humanitarian require us to ensure no one is left behind. Thus, we must consider the particular vulnerabilities of the displaced population. As the pandemic has pulled the curtains on various societal disparities, the pre-existing gender and intersectional inequalities is another important consideration. This is especially important as evidence shows that emergencies disproportionately affect women and girls, yet there is lack of research on implications of public health emergencies on them (Fuhrman et al., 2020). Considering the mainstream discourse on the higher mortality rate among men due to COVID-19 infection, there is a case to also understand these biological and normative differences among displaced populations. As a result, this literature review looks at what discourse is available on the particular vulnerabilities of displaced populations based on these factors.

The review finds that there is a massive gap in literature as there has not been any in-depth study of refugees, IDPs and other asylum-seekers in the context of COVID-19. Most of the literature mentions them briefly by grouping them as part of other vulnerable groups and pulls evidence from past crises to gauge their vulnerability under this health emergency. This is despite the unique challenges and marginalization of displaced populations, compared to other vulnerable groups who may have full citizenship rights, as well as the unprecedent nature of this pandemic. The search criteria were expanded to include opinion pieces from peer-reviewed journal due to lack of academic literature. The search criteria also included grey literature, which had comparatively more analyses focusing on particular vulnerabilities of this group. However, most of the analyses seemed to also pull evidence from previous health emergencies, so the novelty of the disease could have other vulnerabilities and risk factors not considered in the literature. Details on search strategy can be found in Annexes 1 and 2.

The literature review found the following themes mentioned as particular challenges of COVID-19 on the displaced population: the living conditions; healthcare access and vulnerabilities; challenges of disseminating public health information; the socio-economic impact; prolonged displacement; disruption to humanitarian assistance operations; and gender implications.

Living Conditions

The concern most consistently and widely highlighted across the academic literature is the substandard conditions of the camps and camp-like settings with overcrowding, lack of access to water and sanitation, as well as poor health and nutrition provisions (Armitage & Nellums, 2020; Brandenberger et al., 2020; Caruso & Freeman, 2020; Connolly et al., 2020; Corburn et al., 2020; Júnior et al., 2020; Kassem, 2020; Kluge et al., 2020; Lau et al., 2020; Meyer et al., 2020; Newland, 2020; Raju & Ayeb-Karlsson, 2020; Singh et al., 2020; Thakur et al., 2020; The Lancet, 2020). This is consistent with grey literature that also made this issue as a key priority in various impact analyses (ICMHD, 2020; IFRC & ICRC, 2020; MapAction & ACAPS, 2020; Norwegian Refugee Council, 2020; Plan International, n.d.; Refugees International, 2020a, 2020b; UNDRR et al., 2020). Considering the 'c' determinant of 'R', it makes sense that this is the biggest concern evident in the literature. The overcrowding and density of these settings increase the opportunity of transmitting the virus as people come into contact more frequently and social distancing becomes difficult to practice. The lack of access to water and sanitation also affects the 'R' through increase in 'p' rate as people who have come in contact with the virus may not be able to practice proper hygiene protocol to prevent the transmission. All of this is complicated further by the asymptotic nature of most of the COVID-19 infections, which means the opportunity window, 'd', of COVID-19 is unknown to the infected person in order for them to isolate, which is already difficult in an overcrowded condition. All of these create serious vulnerabilities for this group from an epidemiological standpoint in preventing and controlling the disease once it takes hold in the setting. Despite this epidemiology case, there is a knowledge gap in literature that applies an epidemiological lens for further examination of risk factors as well as unique prevention and control mechanisms for camp-like settings.

The poor, low-resourced and overcrowded conditions of refugee camps have been well-documented source for other infectious disease outbreaks, making threat of COVID-19 that much more real. However, the complication in following public health measures mentioned above makes COVID-19 particularly concerning. The extreme overcrowding makes self-isolation and physical distancing impossible both within the household and the wider community. These settings are densely packed with multiple families sharing cooking and WASH facilities. An example is Cox's Bazar in Bangladesh, which has the population density three times that of New York City (Júnior et al., 2020; Newland, 2020). In Moria refugee camp, there are 22,000 people in a setting suitable for only 3,000 people (Newland, 2020; Raju & Ayeb-Karlsson, 2020). Adding to the density challenges, humanitarian provisions, such as food distribution, require beneficiaries to assemble in crowds (Lau et al., 2020). The conditions are potentially even worse for detention centres where the immigrants are incarcerated in tight confinements with poor ventilation, communal settings, frequent population turnover and regular interaction with people from external community (Meyer et

al., 2020). Previous influenza outbreaks in detention centres have underscored the poor decontamination and control provision in federal detention centers (Page et al., 2020). The US ICE detention centres exemplify weak regulations as the Performance-Based National Detention Standards do not apply to most of their facilities that are operated through private or NGO agreements. Reports of asylum courts closing, or postponing hearings, is another cause for concern in further overcrowding at these centres.

Poor air quality and ventilation and prevalence of respiratory tract infections in these camps challenge the immunological capacity to fight COVID-19 (ICMHD, 2020). Here, Thakur et al. (2020) examination of slums, with similar camp-like conditions, can highlight plight of irregular migrants, IDPs and refugees. It highlights a unique vulnerability to COVID-19 that lacks attention in other literature. The authors link exposure to indoor smoke in these settings, from the commonly used biomass for cooking, to potentially facilitating an outbreak in slums. Similar to slums, displaced populations often use solid fuels for cooking and heating in shelters that are poorly ventilated. This routinely puts women and young infants at greater risk, but with the lockdowns the entire family is at risk of greater exposure. This is critical because exposure to smoke and air pollution has been linked with higher susceptibility to COVID-19 infection. However, because this hypothesis has not been readily studied for supporting evidence, this may not be prioritized in policymaking and mainstream discourse on variability of the disease's mortality and morbidity.

A study of informal communities termed 'peri-urbanisation' (Connolly et al., 2020) describes just how these camp-like settings increase risk for refugees and IDPs living in formal camps as well as for those settled in urban settings. These self-built structures, as a peripheral pattern of urbanization, have created conditions that increase spread of microbes, as evident in tripling of disease outbreaks every decade since the 1980s. The density of these informal communities, quality of transport and lack water and sanitation infrastructure were major factors in the outbreak of 2014–2015 Ebola in the dense urban slums of Liberia and Sierra Leone. Despite this major vulnerability, it likely will be overlooked as government policies for healthy cities generally have not focused on these peri-urban areas.

Other conditions that are extremely concerning for COVID-19 include shortage of water, toilets, sewers, drainage, water collections and secure housing (Corburn et al., 2020). The scarce availability of and widespread sharing of latrines and clean water supplies make frequent handwashing protocol difficult and increase risk of spread of the disease. For example, in Greece, Moria refugee camp has one water tap for every 1300 residents (Newland, 2020). Another report suggests that there is 160 people per one latrine in Greek islands and, in South Sudanese refugee camp of Uganda, just over half of the refugees have

access to latrine at all (Refugees International, 2020b). A study of overcrowded slums in Dhaka, Bangladesh, and Mumbai, India, underscores the risks in having only few shared water supplies and latrines (Raju & Ayeb-Karlsson, 2020). The shared sanitation facilities can become the source of airborne and contact exposure diseases, making SARS-CoV2 particularly dangerous since it lives for days on high-contact surfaces made of stainless steel and plastic, such as doors, toilets and latrines. Beyond this, the quality and availability of clean water is inadequate as well, including water shortage, intermittent access and contamination of water with fecal matter and drug-resistant pathogens (Kassem, 2020). All of these increase the 'R' rate of COVID-19 while also putting the population at risk of other infections as they try to follow public health measures.

There seems to be discrepancy in literature and technical guidance. Despite the wide use of shared sanitations, it is not mentioned in the WHO's technical briefing on WASH facilities (Caruso & Freeman, 2020). Moreover, despite evident efficacy of hand hygiene in reducing transmission of viral pathogen, the WASH standards for humanitarian settings are based on "prevention of illness transmitted by the faecal-oral route, with focus on hand hygiene proximate to latrines" (Poole et al., 2020). This is problematic for shared latrines due to its crowding and distance from residential area.

Adding to the challenge of poor sanitation are the soaring prices for disinfectants and soaps, making these essentials even more scarce. Moreover, in addition to chronic underfunding of water supplies, the pandemic comes at a time of increased water stress and shortage as a result of climate change (Armitage & Nellums, 2020). This is especially important to consider for IDPs and irregular migrants that are often affected by such climatic disruptions.

Healthcare Access and Vulnerabilities

Adding to vulnerabilities of camps is the lack of medical resources, facilities and personnel that can easily be overwhelmed with a major health challenge (Fegert et al., 2020; Newland, 2020; Singh et al., 2020; The Lancet, 2020; UNDRR et al., 2020). While the living conditions heighten risk of morbidity to COVID-19, the healthcare challenges can severely heighten mortality rates if there is a widespread outbreak among this population.

Healthcare Access Impact on COVID-19

Particularly for severe cases of COVID-19, the required resources for the type of intensive care are scarce or non-existent in camps (Refugees International, 2020a). Barriers to accessing healthcare has long been a major issue among this group. UNHCR reported that about 75 percent of refugees worldwide live in conditions with inadequate healthcare and sanitation, and the entire population of IDPs and 80 percent of refugees live in countries with weak health systems (MapAction & ACAPS, 2020). In refugee camps of Kenya, clinics have been operating with eight doctors for almost 200,000 people (Júnior et al., 2020). The shortage of personal protective equipment (PPE), lack of facility capacity and risk to healthcare workers will add further pressure on the system. Already in humanitarian settings, volunteers, UN agencies and NGOs managing healthcare provisions are reporting additional pressure in addressing needs of an already traumatized population. Testing is also challenging in refugee and IDP camps where sufficient supply of testing kits and access to laboratory are not readily available (ICMHD, 2020; Raju & Ayeb-Karlsson, 2020). For example, in Bangladesh, testing facilities are limited to Dhaka which is 400 km away from Cox's Bazaar refugee camp (Fuhrman et al., 2020).

There is also a growing trend of homelessness among refugees and migrants, which makes already scarce healthcare even less accessible to them. Immigration detention centres in the United States also have similar shortcomings, with low staffing and reduced capacity to screen, isolate, monitor and deliver medical care (Meyer et al., 2020).

Due to lack of accessible and affordable formal health clinics, as well as mistreatment by medical staff, informal and unregulated health care is common in informal settlements (Poole et al., 2020). While authors suggest mobile health clinics as a solution, it is important to note that testing and contact tracing become extremely challenging in complex humanitarian crises, where most IDPs are and where frequent displacement and access to affected populations is a major problem. These factors can worsen in conflict, political instability and humanitarian crisis where there is already limited resources, poor governance and weak health system grappling with other endemic communicable diseases (Lau et al., 2020; Wobi et al., 2020).

For example, in Syria, where there are 6 million IDPs, a major challenge is the deliberate attacks against health infrastructure and restriction of medical aid to besieged areas (Refugees International, 2020b). Additionally, the Syrian government has poor regional control and lacks transparency, creating problems of inadequate border monitoring to prevent disease spread, fragmented health system and response for disease detection and management, and frequent population displacement as a result of the conflict. All of these factors contribute to higher 'R' of the disease in context of protracted conflict (Abbara et al., 2020). Reports on other conflict-prone fragile countries are similar (Refugees International, 2020a). Afghanistan faces devasted and under-resourced health system as a result of decades of war, while ongoing violence continues to create persistent and growing humanitarian challenges. In Somalia, the IDP population is at severe risk and less accessible for humanitarian aid due to weak governance and militant group's control of large portion of the region, as well as a devasted health system with no testing kit that must send samples to South Africa. Venezuela, as a result of its economic crisis, faces a collapsed health system with the public lacking affordable sanitations, water and PPE, which is further forcing people to flee through risky routes despite border closures. All of these cases demonstrate the higher rate of 'R' as result of context and transmission route, and the challenges of testing, contact tracing and treatment for the disease.

Concerning national government support, displaced populations are not often part of the national public health system and interventions, have limited knowledge of the national health provisions, and lack basic rights and financial means to access (Emmanouil et al., 2020; IFRC & ICRC, 2020; Plan International, 2020; Refugees International, 2020; UNDRR et al., 2020). When faced with weak and overwhelmed health systems, host governments will have to make difficult decisions in allocating scarce resources that prioritize the host population (Hargreaves et al., 2020; Singh et al., 2020). Based on available literature, and considering the barriers to accessing healthcare in "normal" times, the further scarcity of resources does not look promising for this vulnerable group in being equitably included in the pandemic national strategies. This is evident in reports that most governments have not prioritized testing, surveillance, treatment and data collection among displaced communities, while those with outdated legal papers may avoid testing for fear of being deported (Refugees International, 2020b). Proof of asylum application requirement for testing and treatment is early evidence of barriers faced by those without legal status.

There is evidence in literature suggesting refugees may not report infections due to lack of reliable information about the disease and its symptoms, as well as the fear of stigma, sanctions and further crackdown as a result of unwarranted curfews and deportations of unregistered refugees even before the pandemic (Brandenberger et al., 2020; ICMHD, 2020;

Kassem, 2020). In the United States, for example, with a history of raids, restrictions, detentions and threats by authorities, immigrants reasonably cannot be expected to trust the government (Page et al., 2020).

Healthcare Access Impact on Other Diseases

The general difficulties in accessing health services can be worsened by the pandemic as a result of restriction of movement and resources, closure of certain health facilities and shortage of medical supplies and workers. This has direct impact on receiving timely and adequate treatment for COVID-19, but also affects other pre-existing health vulnerabilities as it becomes difficult to receive treatment for noncommunicable diseases prevalent in the population.

This population has dealt with traumatic experiences, appalling living conditions and inaccessibility to adequate medical care, clean water and nutritious food. As a result, they have high rates of chronic stress, malnutrition, comorbidities and overall poor physical and psychological health, all factors that can heighten susceptibility to COVID-19 infection (Hargreaves et al., 2020; Hopman et al., 2020; ICMHD, 2020; Kassem, 2020; Refugees International, 2020a). In fact, literature points to evidence that refugees and migrants generally pose low risk of transmitting communicable diseases to the host population but are at increased risk of having diseases transmitted to them (Kluge et al., 2020). Past disease outbreaks in humanitarian crises also show that such outbreaks can exacerbate other existing health issues (International Rescue Committee, 2020). For example, during the Ebola outbreak in DRC, almost three times more people died of measles than Ebola. Although not discussed in the literature, recent news on suspension of vaccination campaigns point to likelihood of major increase in other communicable disease as result of the pandemic. Additionally, some of the risk factors of COVID-19 are more prevalent in certain racialized groups that are overrepresented among displaced populations (Page et al., 2020). For example, diabetes, a risk factor for severe COVID-19 infection, is most prevalent among Latinos in the United States, who are also overrepresented among the country's undocumented migrants. In addition to COVID-19's physical risks, there is also concern of worsening mental health (Júnior et al., 2020). Due to various factors, from forced displacement to the precarious conditions, this population is already at heightened risk of developing mental health disorder with a prevalence rate estimated to vary from 20 to 80 percent. The uncertainty and fear surrounding COVID-19 creates an environment that can further exacerbate their psychological illnesses.

These increased health risks come at a time when resources are being diverted toward the COVID-19 pandemic, which could make primary health and psychosocial support even less

available. During Jordan's lockdown, Syrian refugees not only faced higher risk of COVID-19 due to existing noncommunicable and chronic diseases but also had critical care and medicine for their pre-existing conditions impacted by the pandemic-induced lockdown, including temporary closure of humanitarian and NGO clinics (Fawad et al., 2020). Thus, it is reasonable to assume that refugees could be at double the risk for multi-morbidities as a result of the pandemic. Similar healthcare impacts of government shutdowns were reported in other regions, with decrease of volunteers in camps across Germany, France, Greece and Brazil, and many parts of Africa and Asia (Júnior et al., 2020).

Challenges of Disseminating Public Health Information

The distrust and fear, cultivated from experiencing many atrocities, mistreatment and forced displacement, create other issues (Refugees International, 2020a). A key prevention and control strategy in a pandemic is effective communication, which is hampered by distrust. In Cox's Bazaar, Rohingya refugees have fled violent state-sponsored persecution in Myanmar. The fear among the group is exacerbated due to the spread of misinformation regarding COVID-19, with some believing that authorities will kill those infected (Raju & Ayeb-Karlsson, 2020). This distrust of authorities as a result of past experience is made worse with travel bans, restrictions and rhetoric that stigmatize and scapegoat migrant communities (Lau et al., 2020). The mistrust is reinforced by government blunders sharing mixed or inaccurate messages that weaken public trust and heighten risk of rumours. The consequences of this has been increased reports of harassment, threat and intimidation of aid workers related to COVID-19 (International Rescue Committee, 2020b). The issue of misinformation and limited information does not only undermine public health efforts but also the ability of displaced populations to protect themselves from the infection. This also increases the 'R' rate among this group.

The language and cultural barriers also challenge information dissemination about COVID-19 that is accessible (Kluge et al., 2020; Refugees International, 2020a; UN Women et al., 2020; UNDRR et al., 2020). The linguistic barrier goes beyond just understanding the language the information is communicated in. Socio-cultural differences between refugees and the host countries may create discrepancies in how information is understood and received if the cultural or religious beliefs do not align with public health recommendations (Júnior et al., 2020). In this regard, Bal et al. (2020) considers how terms and metaphors are used in framing public health information appropriately. Certain words to initiate a 'war-talk' surrounding the disease may be helpful for certain populations but can be problematic for traumatized groups. At the same time, the mistrust and past traumas may lead many to perceive the message on the virus as a low priority compared to other existential threats, which highlights the importance of conceptualization (ICMHD, 2020).

IDPs face further obstacles and exclusions in accessing information, including access to current news (ICMHD, 2020; Refugees International, 2020b). Other important considerations are trusted authoritative information and access to technology. For example, in Rohingya refugee camps, government restrictions on communication networks have impeded reliable information and facilitated the spread of rumours (MapAction & ACAPS, 2020; Newland, 2020; Refugees International, 2020a). Mobile phones are also not widely available to the Venezuelan refugees in Ecuador (Torres & Sacoto, 2020).

Socio-economic Impact

The legal status of displaced populations that excludes them from the national system also reduces social support and increases risk of poverty, given their limited ability to earn income (FSIN, 2020; IFRC & ICRC, 2020; MapAction & ACAPS, 2020; UN SG, 2020). The socio-economic impact of the pandemic's lockdown measures has been widely felt across the globe. However, the crisis is particularly discerning to the precarious conditions of displaced and migrant populations who often work in the informal economy with little to no regulation, casual work and limited access to social protection, if any at all. This is partly the result of host governments barring refugees from working in formal sector (Refugees International, 2020b). Pandemic-induced lockdowns not only result in loss of income but also increase vulnerability to exploitation and abuse. For those receiving humanitarian aid, the support is generally not sufficient to meet the needs of an entire family; those living in urban and informal settings may not receive any assistance at all (Refugees International, 2020b). Displaced populations also face discrimination and legal barriers to accessing financial and other social relief (International Rescue Committee, 2020; Norwegian Refugee Council, 2020). The lockdown measures that have resulted in suspension of asylum systems have further challenged exercising their right to legal status, healthcare, livelihood and protection (MapAction & ACAPS, 2020).

The loss of income also creates food insecurity. Globally, of the estimated 79 million displaced population, more than half are hosted in countries with a "high number of acutely food-insecure people" (FSIN, 2020). With limited employment and social rights, refugees and IDPs rely on humanitarian assistance but this dependency is also threatened with funding constraints affecting food assistance. Exacerbating food insecurity, the lockdown measures of stockpiling food may not be possible for displaced populations who lack the resources to do so, and with soaring food prices, many are resorting to reduced meals (MapAction & ACAPS, 2020). Certain country-specific situation makes these socioeconomic implications even worse. For example, Lebanon, which is hosting 1.5 million Syrian refugees, is facing a severe economic crisis and soaring food and medicine prices as it relies heavily on imports (Kassem, 2020). The impact on children missing out on nutritious meals, as a result of school closures, is especially concerning among migrant children who are at greater risk of food insecurity and malnutrition. In the United States, the recent public charge rule that immigrants are inadmissible if they are unable to care for themselves has led many undocumented migrants to disenroll their children from the Supplemental Nutrition Assistance Program (SNAP) out of fear of being denied legal status or deportation (Dunn et al., 2020; Page et al., 2020).

Adding to their socio-economic plight, refugee and migrant populations also are disproportionately vulnerable to scapegoating, discrimination and stigmatization due to

misconceptions of them carrying diseases. This could increase incitement of hatred, blame and violence due to the panic and fear surrounding COVID-19 (CARE & IRC, 2020; Fegert et al., 2020; FSIN, 2020; IFRC & ICRC, 2020; Ishiwatari et al., 2020; Lau et al., 2020; UN SG, 2020; UN Women et al., 2020; UNDRR et al., 2020). Additionally, COVID-19 could be used as an excuse to target displaced populations through arbitrary restrictions. This is already reported in South Africa. Despite most infections coming from those arriving from Europe, government priority has been to stop undocumented migrants by building a fence (Zanker & Moyo, 2020). This "COVID-justified fence" reflects the securitization approach to migration that many countries have taken (Zanker & Moyo, 2020). Adding to this xenophobic political action, government rules have excluded immigrant-owned shops from orders that allow certain shops to stay open (Zanker & Moyo, 2020). This is despite the irony of the shutdowns increasing movements as customers travel further to buy necessities, hence the spread of disease.

Prolonged Displacement

Discrimination, stigmatization and arbitrary restrictions have other direct impact on the precarious conditions of refugees, IDPs and undocumented migrants. Concern across the literature has been on protracted displacement as plans for resettlement or voluntary return are put on hold and blanket border closures are implemented in violation of the *non-refoulement* principle — which requires countries to ensure refugees are not returned if they face risk (IFRC & ICRC, 2020; Kluge et al., 2020; MapAction & ACAPS, 2020; UN SG, 2020; UN Women et al., 2020). COVID-19 could be used as an excuse for camp closures or relocations without consideration for dignity and safety of the group. The border closures are particularly concerning for displaced populations fleeing violence and other insecurities, especially with reports of conflict-induced new displacement and concerns of the pandemic and food insecurity triggering large-scale displacement (FSIN, 2020; IFRC & ICRC, 2020; International Rescue Committee, 2020; Norwegian Refugee Council, 2020). Suspension of visa processing and asylum courts creates dilemmas for migrants that are detained or otherwise waiting to be granted legal status but left out of basic support services (MapAction & ACAPS, 2020; UN Women et al., 2020). Moving services online creates further barriers due to challenges related to technology and language, as mentioned previously. This impact will extend beyond the pandemic in the system's capacity to process backlogged claims. Capacity challenge in processing backlogged cases is already reported in South Africa (Zanker & Moyo, 2020). Few countries have taken steps to ensure this does not impact the ability to seek assistance.

Already, there have been reports of these concerns taking shape in reality. UNHCR and IOM responded to the travel restrictions by temporarily suspending refugee resettlement (Kluge et al., 2020; MapAction & ACAPS, 2020; The Lancet, 2020). UNHCR also reported that as of 31 March, at least 30 countries have barred asylum seekers' entries; this includes repatriation and resettlement programs for Afghan refugees in Pakistan, voluntary return programs for migrants in Niger, and banning of all refugees by Uganda's government (MapAction & ACAPS, 2020). Barriers created for the displaced population to flee means that they will resort to informal and riskier routes, which are often controlled by armed groups (CARE & IRC, 2020; MapAction & ACAPS, 2020). This has already been reported following the Colombian-Venezuelan border closure.

Disruption of Humanitarian Assistance Operations

The restrictions on movement and tightening of borders also worsen the already precarious conditions, as there are other disruptions to humanitarian assistance operations. Some countries' restrictive actions have affected humanitarian corridors around the world, thereby disrupting vaccination campaigns, cash programmes, deployment of staff and supply chain for food, medicine and other lifesaving services (FSIN, 2020; IFRC & ICRC, 2020; International Rescue Committee, 2020; Kluge et al., 2020; Norwegian Refugee Council, 2020; Refugees International, 2020a, 2020b; Sharma et al., 2020; The Lancet, 2020). Locally imposed measures are impacting normal humanitarian operations and volunteer community's services (International Rescue Committee, 2020; Kluge et al., 2020). For example, Bangladesh's government is only allowing essential services to be delivered to Cox's Bazaar, which is undermining efforts to address growing food insecurity and cyclone preparedness (Refugees International, 2020a). In addition to service disruption, there is concern for decrease or withdrawal of foreign aid for humanitarian assistance to fragile settings (Kassem, 2020; Refugees International, 2020a, 2020b; UNDRR et al., 2020), which is a reasonable fear given the already significant WHO funding cuts in Yemen. This is especially problematic since at the same time of funding cuts, there are reports of soaring costs of transportation of humanitarian supplies and prices of PPE and other necessary supplies (International Rescue Committee, 2020). Under COVID-19, the supply chain affects how humanitarian actors can effectively meet the growing need for sanitation, health, food and other assistance as a result of the pandemic.

Other disruptions have occurred in the Mediterranean Sea, where 16,000 migrants have died since 2015. Search and rescue operations have been suspended due to logistical difficulties caused by COVID-19 and the Italian government's decision to stop landing of rescue ships at their port during the pandemic (Kluge et al., 2020; MapAction & ACAPS, 2020). Considering the outlined challenges discussed thus far, which all add to creating conditions that can trigger further displacement, this disruption to humanitarian assistance should be a major concern.

Gender Implications

The challenges discussed thus far have wide gender implications. However, academic literature lacks gendered focus analysis of COVID-19 on displaced populations. For example, a study in Turkey to understand pregnant women's attitude towards COVID-19 and healthcare-seeking (Yassa et al., 2020) missed an important opportunity to understand particular vulnerabilities of refugee women. The study's 213 sample comprised 27 Syrian refugees who had difficulties in translation. Yet, the study did not disaggregate the results to understand their unique factors or language barriers in influencing their attitudes, beliefs and care-seeking behaviour. Other academic literature generally mentions women and girls as part of vulnerable groups, rather than an in-depth analysis. Grey literature's analysis draws evidence from previous crises to understand the impact of COVID-19 on women and girls. However, given the unique circumstances of this pandemic in relation to other health emergencies, there is a knowledge gap on how COVID-19 impacts this population's gendered vulnerabilities. Furthermore, despite the mainstream discourse on biological sex difference in COVID-19's mortality rate, neither the academic nor grey literature mention vulnerabilities of displaced men and boys. Given the above-mentioned comorbidities and living conditions of this group, this knowledge gap is concerning. Lastly, although gender norms are discussed in relation to disproportionate effects of a health emergency on women and girls, the problematic gender norms often extend to men in their general and specific care-seeking behaviours that can play a significant factor on their morbidity and mortality. Yet, there is no mention of particular gendered vulnerabilities of men to COVID-19.

For women and girls, starting with conditions of camps, the shared sanitation facilities are particularly problematic since WASH standards in humanitarian settings place water supplies close to latrines. There is well-documented evidence that women and girls are often exposed to gender-based violence (GBV) while travelling to and from these shared facilities and during latrine use, and moving in groups to ensure safety is made difficult with distancing practices under COVID-19 (Poole et al., 2020; Refugees International, 2020b; UN Women et al., 2020). It is reasonable to assume that the protocol of frequent handwashing puts women and girls at higher risk as they face the dilemma of following hygiene protocol and increasing their risk to GBV.

Increases in GBV and intimate partner violence (IPV) within households have been widely discussed as a major concern under lockdown measures. This again disproportionately affects refugee women and girls as they are often in fragile environment with pre-existing problematic gender norms and violence, made more pervasive by the conditions of displacement (Fuhrman et al., 2020; International Rescue Committee, 2020; Lokot & Avakyan, 2020; MapAction & ACAPS, 2020; Plan International, n.d.; Refugees International, 2020b; Tran et al., 2020; UN SG, 2020; UN Women et al., 2020; WHO et al., 2020). Additionally, studies in

Uganda, Lebanon and West Africa have found an increased risk of their sexual exploitation and abuse during public health crises, especially in the way it is manifested in distribution of food, water, shelter and other assistance (UN Women et al., 2020). Considering the supply shortage resulting from the pandemic, this should be a serious cause for concern. Higher rates of GBV, IPV and child marriage are already being reported among Syrian and Rohingya refugees. This increased risk coincides with the reduced safe space, referral paths, social protection and other support services as a result of the pandemic-induced lockdown and restrictions. Displaced women are disproportionately disconnected as they lack equal access to technology, leadership role in the community, language skills and literacy, which further excludes them from accessing important public health information, support and reporting channels (CARE & IRC, 2020; Refugees International, 2020b; WHO et al., 2020). As an example, Nyarugusu refugee camp in Tanzania has a 42 percent gender gap in mobile phone ownership (CARE & IRC, 2020). The border restrictions and asylum court delays further endanger women and girls fleeing violence, while quarantine and detention measures put them at further risk of abuse (UN Women et al., 2020). GBV also increases the risk to women and girls of other chronic health issues, disabilities, pregnancy complications and sexually transmitted diseases (Lokot & Avakyan, 2020).

Women face major health vulnerabilities as a result of the pandemic's disruption. As resources are diverted to COVID-19 prevention and response, it is creating further limitations in services that are vital for the unique health care needs of women and girls (Refugees International, 2020b). Moreover, prevailing social norms in these types of fragile settings dictate women and girls to receive care last if they become ill (Fuhrman et al., 2020). There is obvious implication on access to test and treatment for COVID-19, but this also has wider implications that include critical sexual and reproductive health (SRH) services, which are already insufficient in these settings. This is an important consideration for displaced populations as about 61 percent of global maternal deaths are occurring in fragile settings where many refugees and IDPs are located (Refugees International, 2020b; Tran et al., 2020). In the 2014–2015 Ebola pandemic in West Africa, there was a significant increase in maternal and neonatal deaths as a result of decreased SRH services and fear of contracting the disease (Fuhrman et al., 2020; Lokot & Avakyan, 2020). Additionally, the loss of income and soaring prices create resource competition that will make menstrual hygiene and sanitary materials unavailable or unaffordable. The above-mentioned connectivity isolation further adds to their health vulnerabilities and makes data collection to understand their unique challenges more difficult. All of these health implications have even further disproportionate effect on displaced women with disability.

Women's caregiving role that increases their risk of infection during health crisis also extends to displaced women. Moreover, the economic fallout of the pandemic seriously undermines their caregiving role and informal, low-wage work, especially since 25 percent of refugee women are heads of households (Plan International, 2020; Refugees International, 2020b). There is also increased risk of malnourishment as a result of expected food insecurity and social norms that expect women and girls to eat last and least. Compounding GBV risks, the loss of economic opportunities and heightened food insecurity are also linked to increases in negative coping mechanisms of families that result in displaced women and girls being exploited, such as transactional sex, forced and early marriage, sexual abuse and human trafficking (Fuhrman et al., 2020; Refugees International, 2020b).

Education suspension disproportionately impacts vulnerable children, which includes displaced girls in fragile settings. Refugee and IDP girls are already disadvantaged in their access to education, so school closures disproportionately undermine their education as they have little or no opportunity for alternative forms of learning, their psychosocial support and nutritious school meals are disrupted, their likelihood of re-enrollment is reduced, while also putting them at increased risk of sexual exploitation and child marriage (Fuhrman et al., 2020; International Rescue Committee, 2020; MapAction & ACAPS, 2020; Plan International, 2020; Refugees International, 2020b; WHO et al., 2020; World Vision, 2020). Even when schools reopen, the economic hardship faced by migrant and displaced families will significantly impede girls' access to education as families weigh their opportunity cost against problematic gender norms that often lead to loss of education for girls.

Conclusion

This literature review examined how the COVID-19 health emergency impacts the unique vulnerabilities of displaced populations. The review found the majority of discourse focused on the poor, overcrowded living conditions of refugees, IDPs and migrants, with lack of sanitation and clean water access, all of which make public health protocols impossible. Barriers to healthcare access are another major challenge within the low-resourced refugee camps, the fragile settings of IDPs and the legally and financially inaccessible national health systems. The underlying health conditions not only make the displaced more vulnerable to the virus, but the resource diversion and lockdown measures affect the ability to receive critical health care provisions that potentially worsen other health outcomes. Legal status and marginalization add unique challenges for this population that depends on informal work and is ineligible for most socio-economic support offered by national governments. As a result, they face dire economic hardships, food insecurity and other related vulnerabilities. The lockdown measures and border closures are prolonging their displacement and precarious conditions as countries are banning entry, in violation of international norms, and closing down asylum processes. Disruption of humanitarian operations are largely driven by the disruption to supply chains and cuts to foreign aid, making their growing needs that much more difficult to address. All of these vulnerabilities have disproportionate precarity and double burden on women and girls. This includes increased risk of GBV as result of shared WASH facilities, the lockdown measures and reduced support services; risk of exploitation and forced marriage as a result of the economic hardship and school closures; risk to their sexual and maternal health as a result of reduced or diverted services; disproportionate access to technology and other information channels; and other health vulnerabilities linked to problematic gender norms putting them last for provisions of food and health in a low-resourced context.

Overall, there is a large knowledge gap in the literature to better understand the novelty of the disease and its subsequent unique challenges for the displaced population. Moreover, gender norms challenge the dynamics of both gender and sex vulnerabilities to COVID-19, which lacks proper examination. Lastly, all the challenges point to a need for more-robust data collection and disaggregation in order to fill the knowledge gap, yet these same factors also create challenging barriers to collecting timely, accurate and disaggregated data for this fast-evolving, novel disease.

Annex 1 – Inclusion and Exclusion Criteria

	Included	Excluded
Article Type	• Peer reviewed • From international organizations with review process • Opinion pieces	• Web page data • Books
Methodology	• Qualitative studies • Quantitative studies	
Geographic Scope	• Developing countries • Developed countries	
Time Frame	• After 2020	• Before 2020

Annex 2 – Search Strategy

Date of Search	Database	Search Terms	Total # of Articles	Reviewed Articles
21-May	Jstor	refugee AND covid-19 OR coronavirus	7	0
21-May	Jstor	refugees AND covid-19	4	0
21-May	Jstor	refugees AND covid-19 AND Gender	1	0
21-May	Jstor	idp OR internals displaced AND covid-19 OR coronavirus	24	0
21-May	Jstor	internally displaced AND covid19	3	0
21-May	Jstor	idp AND covid-19	1	0
21-May	Omni	refugees AND covid-19	1,397 total (94 peer-reviewed articles)	9
21-May	Omni	gender AND refugees AND covid-19	137	0
21-May	Omni	IDPs AND gender AND covid19	7	0
21-May	Omni	IDPs AND covid-19	108	0
21-May	Omni	internally displaced AND covid19	275	0
21-May	Mendeley	refugee AND covid-19	4	1
21-May	Mendeley	refugees AND covid-19	5	0
21-May	Mendeley	refugees AND covid-19 AND gender	0	0
21-May	Mendeley	IDP AND covid-19	0	0
21-May	Sage Journals	refugees AND covid-19	6	3
21-May	Sage Journals	refugees AND covid-19 AND Gender	3	0
21-May	Sage Journals	idp AND covid-19	0	0
21-May	Sage Journals	internally displaced AND covid19	2	0
21-May	BMC	refugees AND covid-19	3	2
21-May	BMC	refugees AND covid-19 AND Gender	2	0
21-May	BMC	idp OR internally displaced AND covid-19	0	0
21-May	Pubmed	refugees AND covid-19	20	4
21-May	Pubmed	internally displaced AND covid19	2	1
21-May	Pubmed	humanitarian AND covid-19 AND health	26	5
21-May	Pubmed	humanitarian AND covid-19 AND gender	3	0
21-May	ScienceDirect	refugees AND covid-19	63	9

21-May	ScienceDirect	refugees AND covid-19 AND Gender	12	1
21-May	ScienceDirect	internally displaced AND Covid19	16	0
21-May	ScienceDirect	humanitarian AND covid-19 AND health	99	0
21-May	ScienceDirect	humanitarian AND covid-19 AND gender	16	0
21-May	Scopus	refugees AND covid-19	19	1
21-May	Scopus	internally displaced AND covid19	1	0
21-May	Scopus	humanitarian AND covid-19 AND gender	2	0
21-May	Scopus	humanitarian AND covid-19 AND health	13	1
21-May	Omni	Humanitarian AND covid-19 AND health	2854	0
10-Jun	WHO COVID-19 Global Literature on coronavirus	Refugees	20	2
10-Jun	New English Journal of Medicine	Immigrants AND covid	6	4
10-Jun	Reliefweb (Global Analysis & Manuals/ Guidelines)	COVID AND refugees OR migrants OR internally displaced	59	18

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