# Global Displacement, COVID-19 and the Risk of a False-positive Flattened Curve

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Forcible displacement includes individuals who were internally displaced within their own countries, asylum seeks in foreign countries and stateless people. While the media has been consumed by COVID-19 and urban population health, barely anyone seems to be discussing the threat of COVID-19 on displaced communities across the world. The global population of forcibly displaced people increased from 43.3 million in 2009 to 70.8 million at the start of 2019(UNOCHA, 2020). To put the number into perspective, forcibly displaced individuals increased by 2.3 million in 2018 alone –that means that 28 people were forced to flee their community every minute and approximately 37,000 people were forced to abandon their homes and livelihoods per day (UNHCR, 2019). Most of these individuals end up in IDP/Refugee camps with restricted access (if any) to the internet, WiFi, TV or phone service. Meaning they do not receive essential updates or news on COVID-19.

Today, out of the 100 countries reporting on local COVID-19 transmission, 34 have refugee populations exceeding 20,000 people (NRC, 2020). In addition to an abundant array of other health risks that jeopardize the overall health of displaced individuals – such as malnutrition, disability, physical abuse and psychological distress – most of these individuals are frequently housed in shelters where over crowdedness is common and public health professionals are lacking. This conundrum further impedes reliable data collection and fully eliminates the effectiveness of using self isolation or “Social Distancing” as a protection measure. Let alone accessing clean water, electricity, or even reliable means of communication. While individuals around the world have been busy hoarding supplies, food, water, and medical supplies… displaced population cannot afford these privileges. In fact, in some areas of the world, displaced individuals often share a tent with 5-8 people at a time and can barely manage to find enough water to bathe their own children (Hill, 2020), let alone access clean water to wash their hands on a daily basis.

To name a few alarming global health issues that threaten displaced populations to this day: outbreaks of cholera impact nearly 5 million people a year; cases of measles have once again spiked around the world due to gaps in vaccination coverage; across Africa, reported cases in the first three months of 2019 were astonishingly 300 per cent higher than for the same period in 2018 (who, 2019). There was a substantial increase in reports of dengue infections in 2019 compared with 2018 (ECDPC, 2020) with half of the world’s population – approximately 3.7 billion people – now at risk. Progress in combating malaria has stalled worldwide, with no significant gains made in reducing cases in the past three years (UNOCHA, 2020).

Despite social media attention, precautionary measures, lockdowns and the partial halt in international travel, Coronavirus has now put the lives of over 200,000 individuals at risk in a matter of a couple of months and threatens the lives of many more people worldwide – but for the better part of the past few decades, the aforementioned diseases had been doing the same on a global level. In light of this, it is difficult to see how this novel emerging global threat would raise universal awareness of the health risks facing displaced populations everywhere.

Conflicts and natural disasters trigger displacement; geographic mobility is taking place all over the world, regardless of how many airports shut down. So far, most countries have implemented border lockdowns, but they have only done so at official border crossings, seaports and airports while many refugees cannot afford to use any of them to migrate to begin with. Instead, forcibly displaced individuals often rely on informal travelling routes that allow them to

avoid detection by warring factions or authoritarian parties who may pose a significant threat to their lives. Consequently, this creates a reporting void both at the border crossing and within the recipient country's healthcare system.

Upon arrival to their destinations, displaced populations and refugees are often hesitant to access the healthcare system out of a fear of being detected, imprisoned or even deported back to the same conflict zone they attempted to escape in the first place. In turn, many refugees who may be infected with COVID-19 are then unaccounted for and further lost in the system, increasing their vulnerability to Coronavirus and other diseases. Moreover, border crossing lockdowns may be curtailing the rights of displaced populations, especially asylum seekers who are trying to access safe territory and safe passage. Perhaps now more than ever, a closer collaboration between governments and nongovernmental organizations involved in refugee protection issues is needed.

Humanitarian actors rely on reporting data to better plan for and conduct their aid missions. When refugee populations are left stranded or unaccounted for, the process of collecting crucial data and even reaching these marginalized individuals becomes extremely challenging (if not impossible altogether). Even before the emergence of COVID-19, more than 80% of displaced population deaths were not a result of violence, but the main causes of mortality among them were preventable diseases such as cholera, malaria and diarrhea (Snyder, 2018). With the threat of COVID-19 looming, along with the absence of reliable data on Coronavirus virulence or mortality rates among displaced populations, a new dimension to the virus may yet emerge – a false positive flattened curve.

Internally displaced people are currently cohabitating in confined shelter clusters within camps that are usually cordoned off from surrounding areas. Many of these communities rely on the delivery of aid, medicine, food, water and other necessities to sustain their lives. In the event that Coronavirus begins to spread among IDPs, setting up field clinics that isolate those who test positive would be extremely challenging. Moreover, numerous other infectious diseases are becoming more prevalent and harder to control in most IDP camps, because of conflict, weak health systems, poor water and sanitation, and chronic lack of access to critical vaccinations. The latter raises a serious concern about the viability of any future attempt to deliver COVID-19 vaccines to conflict ridden areas.

In order for global testing to be effective it ought to be rationally structured. Any effort to start testing citizens at random, or if and when they present themselves at a health facility would barely yield any reliable data – minding the long onset of the symptomatic clinical presentation. In conflict and post-conflict settings, communities struggle to access safe roads and adequate health facilities. IDPs for instance rely on mobile health clinics, an internationally orchestrated effort to equip these remote health facilities with critical means of protection and testing is vital. Indeed some experts have suggested that the relatively young average age of displaced populations will help keep the death rate among them low, citing that IDP camps are already isolated from urban communities (Hendrix. 2020). However, given that most camps with displaced populations heavily rely upon aid deliveries from urban centers by way of charitable groups, civil society organizations, humanitarian aid agencies and various individuals, the risk of viral transmission in either direction seems highly probable.

Infectious diseases, including COVID-19 are a clear and present threat to displaced populations everywhere. Any meaningful global health strategy to combat Coronavirus must take the potential risk to IDPs, refugees and other vulnerable groups into consideration.

**All opinions expressed in this feature are the author's own and do not necessarily reflect the opinions of his current or former employers.*

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