

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

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Abstract

Forced migration crises in West Africa are intensified by humanitarian challenges, notably the severe effects of the COVID-19 pandemic in Burkina Faso, Mali, Nigeria, and the Niger Republic. Factors affecting forced migrants' access to COVID-19 services include inadequate institutional capacity, invisible health systems, control by non-state actors over key regions, and inequitable distribution of resources, which exacerbate the pandemic's duration. Public perception, such as beliefs and lack of public trust in COVID-19 policies, affected people's attitudes to the pandemic in West Africa. Lack of inclusion of forced migrants in national response plans affects equitable access and management of the COVID-19 pandemic in the focus countries. This article discusses forced migration and access to COVID-19 services in Burkina Faso, Mali, Nigeria, and the Niger Republic, using reports from secondary sources to inform policy for effective management of the COVID-19 pandemic in West Africa. The paper dwells on the social determinant of health theory, explaining the impact of social and economic status and social cycles on access to COVID-19 services in West Africa. The paper proposes the establishment of funding plans aimed at addressing the needs of forced migrants within National Deployment and Vaccination Plans in West Africa.

Keywords: Forced migration, access, COVID-19, testing, vaccination, treatment, West Africa.

1. Introduction

The complicated nature of humanitarian crises occasioned by forced migration has become a global concern. Migration is an inevitable phenomenon on the human planet because of the interrelationship, interdependence, and interconnectivity between people and among nations. It rather calls for great concern when people are compelled by unpleasant circumstances to move out of their homes or settlements against their will. The global number of refugees has increased from 14 million people to 25.9 million people from 2000 to 2020. Similarly, the number of internally displaced persons (IDPs) has increased from 21 million to 41.3 million people (2000-2020), largely due to violent conflicts (World Migration Report, 2020). Concerning to forced migrants was the Declaration of COVID-19 by the World Health Organization (WHO) as a global

pandemic on March 1, 2020, after confirming over 118,000 infections and 4,291 deaths in more than 110 countries, leading to widespread fear regarding the containment of the virus (WHO, 2020).

However, all facets of the society are impacted by the COVID-19 pandemic, but people who have been forcibly displaced (FDPs) are undoubtedly among those who are more vulnerable to the hygienic and financial repercussions of deadly virus-related issues (Joint Data Center on Forced Displacement [JDC], 2020). Certain humanitarian settings at higher risk for COVID-19 should benefit from early vaccination during the time of limited vaccine supply in order to reduce the disease and death burdens of COVID-19 (WHO, 2021a). Inclusive vaccine plans and strategies are crucial, especially when it comes to ensuring equitable access to vaccines (WHO, 2021a). The distribution of vaccines must include refugees in order to stop the pandemic. The likelihood of continued transmission in communities, including spillovers into the local population, increases when refugees, other displaced individuals, or foreigners are not included in vaccination regimens (Gaynor, 2021).

In West Africa, the incidence of violent conflicts such as the Boko Haram insurgency, farmers-herders conflict, and armed banditry in Nigeria and Niger Republic, the armed conflicts by the Tuareg Militant Group in Mali, and other neighbouring countries such as Cameroon and Chad, has rendered many people homeless and forced them to flee to other countries as refugees or as IDPs in their own countries (International Organization for Migration, Displacement Tracking Matrix [IOM DTM], 2021). It is alarming that there are over 5 million refugees and IDPs in West Africa (United Nations High Commissioner for Refugees [UNHCR] 2021). It is a matter of concern that these displaced populations are faced with very difficult challenges, including the high risk of having all kinds of health challenges due to overcrowding, inadequate access to clean water, and the greater exposure to the COVID-19 pandemic (WHO, 2021a).

The complex nature of forced movements, the rights and privileges of forced migrants to have access to COVID-19 testing, vaccination, and treatment, and the vulnerability of these groups of people to the contraction of the COVID-19 virus have been called into question. A report from selected West African countries' refugee camps shows that only 10% of refugees were tested for COVID-19 in the Niger Republic, 5% in Burkina Faso and as low as 2% in Mali (Mixed Migration Center [MMC] 2020). In Nigeria, there are 3.2 million displaced persons, with

over 1800 refugees, mostly from Cameroon, who have received one shot in Benue, Cross River, and Taraba States, and 700 refugees who have received two doses (UNHCR, 2022). The concern of managing the COVID-19 pandemic in refugee camps was affirmed by the World Health Organization (WHO), which noted that the large number of displaced populations has made the COVID-19 response difficult in Nigeria (WHO 2020). Similar reports show that internally displaced persons (IDPs) are particularly vulnerable to the global coronavirus pandemic (COVID-19), as millions of IDPs worldwide live in densely populated regions, are unable to isolate themselves, and lack access to water, sanitary facilities, and basic healthcare, whether they were compelled to leave their homes due to conflict, violence, or natural disasters (Internal Displacement Monitoring Center [IDMC, 2022).

Displaced populations are more at risk of experiencing a higher burden of COVID-19 infections and inaccurate reporting in cases, hospitalizations, and deaths (European Centre for Disease Prevention and Control [ECDC] 2021). Forced migrants are likely to have a high rate of underlying health conditions, increasing their COVID-19 infection risk (Mukubang et al., 2020). Failure to ensure forced migrants' access to COVID-19 services may result in a significant health disaster in West Africa, impacting national health planning and insurance coverage (Molobe et al., 2020). It is against this backdrop that the paper examined if forced migrants have access to COVID-19 testing, vaccination, treatment, the risk of forced migrants contracting COVID-19, and the integration of forced migrants into COVID-19 national response programmes (NRP) in West Africa.

The paper examines forced migration and access to COVID-19 services through secondary sources, specifically focusing on Nigeria, Niger Republic, Mali, and Burkina Faso, which have notable incidences of both forced migration and COVID-19 cases. Data was derived from the Joint Data Center on Forced Displacement (2020), the World Health Organization (2021), the International Organization for Migration, the Displacement Tracking Matrix, the United Nations High Commissioner for Refugees (2021), the Mixed Migration Center (2020), the Internal Displacement Monitoring Center (2022), the European Centre for Disease Prevention and Control (2021), GAVI (2020) and other relevant publications. These sources were selected based on the availability of data and their role in humanitarian management and COVID-19 vaccine distribution and services.

2. Literature Review

Conceptual Definition of Terms

Forced Migration: Forced migration is the involuntary movement of people from their homes based on unusual circumstances occasioned by natural disasters such as earthquakes, flooding, drought and/or human actions such as wars and conflicts. People might also be forced to move based on economic hardship, including hunger. According to Giovetti (2019), forced migration has to do with the movement of migrants, internally displaced persons (IDPs) and refugees within and across international borders. Forced migration may differ in magnitude and from place to place, but the major causes include wars and conflict, environmental change, and social and economic conditions.

COVID-19: COVID-19 is a disease caused by the novel coronavirus identified in Wuhan is named coronavirus disease 2019, the term 'CO' denotes corona, 'VI' indicates virus, and 'D' signifies disease. Previously, it was referred to as '2019 novel coronavirus' or '2019-nCoV'. COVID-19 is related to the same virus family as severe acute respiratory syndrome (SARS) and some common cold viruses (United Nations Children's Fund [UNICEF], 2020a). Coronavirus disease (COVID-19), caused by the SARS-CoV-2 virus, typically leads to mild to moderate respiratory illness in most individuals, who usually recover without special treatment. Nonetheless, a portion of those infected may develop severe symptoms necessitating medical intervention (WHO, 2025).

Theoretical Framework

The social determinant of health (SDoH) has been adopted to explain how social, economic, and cultural factors play a key role in determining the health status of migrants. There have been several attempts to explain the relationship between migration and health from different perspectives over the years. Though the most notable contribution to the development and documentary contributions to migration and health issues was made in 1912 as a publication in the United States to address migration and health issues, it was mostly linked to infectious disease (Chikanda, 2003).

Notably, there has been a wider acceptability among scholars of SDoH based on the general propositions on social, psychological, cultural, and economic dimensions in explaining migration and health as opposed to the more focused and biological statements (Pionones-Rivora, Concha, & Gomez, 2021). For

example, for more than a decade, SDH has been featured permanently in many proposals associated with WHO. It is important to note that before this period, several proposals similar to SDoH were featured in health discussions, especially in relation to traditional social medicine (Solar & Irvin, 2006).

SDoH is a process that defines situations in relation to the social cycle of an individual's life, from birth, growth, life, age, and work. These situations are largely controlled by the interplay of power, wealth, and sources from the local to the global level, in addition to how policy formulation affects these factors. Recently, the correlation between migration cycle (origin, transient, routes, destination, and return) and migration health has been explained in the context of social determinant factors with a specific focus on vulnerability and resilience issues (Pionones-Rivora, Concha, & Gomez, 2021). Similarly, a study by Gushulak and MacPherson (2004) also explained how social situations such as risk, violence, and crime, especially sexual violence and nutritional status, may have a bearing on the health of forced migrants.

Migrants, especially those who could not follow the formal routes, might create some psychological and mental health problems in their places of destination. In most cases, these refugees and IDPs are denied access to basic necessities of life such as water, shelter, and health services (Gushulak, & MacPherson, 2004). In addition, these migrants might also import some diseases to their destinations that were earlier eliminated (Castelli, Matteeli, Signorini et al, 1999). This implies that forced migrants are likely to re-introduce another cycle of health emergencies in their places of destination.

Scientific consensus indicates that SDoH indicators, such as housing availability, social distancing, hygiene practices, remote employment, food security, and health access, can reduce the prevalence and severity of COVID-19 outcomes (Palacio, 2020). COVID-19 has significantly strained health-care systems, underscoring the need to further investigate the complex and multi-layered impacts of SDoH on the pandemic and their reciprocal effects (Brakefield et al., 2022). Findings indicate that the Covid-19 pandemic has exposed significant structural factors that contribute to health inequities, notably poor working conditions, economic disparities, and undemocratic political systems. These determinants have intersected with social factors like class, ethnicity, gender, and education, worsening vulnerabilities in society during the pandemic (Paremoer, 2021). COVID-19 services for forced migrants in West Africa can be improved through

appropriate policies influenced by social determinants of health (SDoH), as poverty, housing, and health issues are significantly affected by the decisions of policymakers and political leaders.

Access to COVID-19 Services in West Africa

COVID-19 Global Access (COVAX) was established to ensure equitable access to vaccines; however, much success has not been recorded due to paucity of vaccines (GAVI, 2020). The aim was to ensure that safe doses of COVID-19 are delivered to at least 2 billion people among committed countries and vaccination of a minimum of 20% of each of the vulnerable and high-risk populations of committed 92 low-income countries by the end of 2021 (GAVI, 2020). Records have shown that only 57.3% in high-income countries and 2.14% vaccination rates were achieved in low-income countries at the end of the third quarter of 2021, largely attributed to the lack of access to vaccines and the financial implication of having these vaccines (Jison, deFrancisco & Gordillo-Tobar, 2021; UNCHR, 2021). With just over 13% of people in low-income countries receiving vaccinations, compared to nearly 70% of people in high income countries, Michelle Bachelet claimed that the failure to administer the vaccines in a fair and equitable manner was prolonging the pandemic (United Nations High Commissioner for Human Rights [OHCHR], 2022). This failure was incredibly unjust and immoral, as well as highly unacceptable (OHCHR, 2022).

Most African countries are struggling to have access to vaccines to administer their first doses (ECDPC, 2021). For example, a study carried out by the Organization for Economic Cooperation and Development (OECD) in several member states showed that the risk of infection in refugees was twice as high as native-born individuals (OECD, 2020). Data collected from three West African countries on access to health care services in refugee camps, especially COVID-19 services, remains very discouraging. For instance, information gathered from 1,396 in selected refugee camps on COVID-19 testing in Niger Republic, Burkina Faso and Mali shows that 90% in Niger Republic, 98% in Mali and 95% in Burkina Faso were never tested for COVID-19 (MMC, 2020).

As of 26 November 2023, approximately 46% of Nigeria's population has received at least one dose of a COVID-19 vaccine, and 39% have completed the primary vaccination series (WHO, 2024). In a cross-sectional study involving 1,537 unvaccinated internally displaced persons (IDPs) from 18 camps, 2022, Gidado et al (2022) found that of the IDPs surveyed, 63.5% intended to accept the

COVID-19 vaccine. Among those refusing, 42.8% gave no reason, while others cited misconceptions (35.3%), safety concerns (9.5%), and a perceived lack of necessity (7.4%). Those who recognized COVID-19 as a serious threat were more inclined to accept the vaccine.

The Exposure of Forced Migrants to the COVID-19 Pandemic

COVID-19 worsens the already precarious condition of refugees according to the UN High Commissioner for Refugees, Filippo Grandi (Gaynor 2020). Children in this vulnerable population are especially at risk for lack of access to safe spaces, water, nourishment, and medical care, making them more susceptible to viral illnesses such as (COVID-19) water borne illnesses, and respiratory tract infections (Niyi-Gafar & Adetakun, 2022). It was estimated by WHO (2020) that 52% of the global refugee population was under the age of 18. There are an estimated number of 31 million child migrants, 13 million child refugees, 936,000 asylum-seekers, and 17 million child IDPs (IOM, 2020). In West and Central Africa, over 30,000 migrants remain stranded at the borders while over 2,000 are overcrowded at transit points waiting for assistance (IOM, 2020). It was also reported that, since the outbreak of the COVID-19 pandemic, many people have been abandoned in the desert by smugglers and traffickers, exposing their lives to a variety of health risks, including the transmission of COVID-19 (IOM, 2020).

In Nigeria, IOM situational study of COVID-19 in the North-East found that there were no operational hand-washing stations with soap and water on-site in 76% of the locations analysed (IOM DTM, 2021). Only 34% of the places surveyed had hand-washing stations with soap and water, according to a subsequent examination into the availability of soap and water in IDP camps, camp settings, and host communities (IOM DTM, 2021). The advent of COVID-19 has created a double emergence for forced migrants as the struggle to contain the virus and at the same time try to have access to basic needs (Kirisici & Yavcan, 2020). In Africa for instance, displaced populations are more vulnerable to COVID-19 transmission because they are not in formally organized refugee camps and are more vulnerable as most of them are found in urban slums with no official support (Mbiyozo, 2020). MMC (2020) reported that 54% of refugees in Burkina Faso, 42% in Niger, and 39% in Mali do not have access to COVID-19 protective gear. Many people reported that they do not have adequate information or they lack where to have testing and treatment (47% in Niger, 42% in Burkina Faso and 37% in Mali).

Public perception about COVID-19 has greatly affected the attitude of the public towards COVID-19 control in Nigeria and other West African countries (Oleribe et al, 2020). These perceptions are influenced by many factors, including cultural belief systems, religion, and a lack of public trust in the policies and those saddled with the responsibility to handle the pandemic (Ossai, 2021). In West Africa and other parts of Africa, there is believe that the Corona Virus is not real in Africa (Ossai, 2021). These affects people's adherence to guidelines or protocols set by the WHO or national regulatory agencies. Based on religious beliefs, some people think that the COVID-19 pandemic is a disease for unbelievers, and that those who trust and believe in God will not be infected (Ossai, 2021). These different perceptions and beliefs are inimical to the fight against the pandemic. Also, face masks are misused, even by highly placed government officials, by wearing them on their chin or neck without necessarily paying attention to covering their mouths when talking (Ogoina, 2020). It is unfortunate that most people who wear face masks do so only when they are involved in public activities where it is required.

COVID-19 National Response Strategies in West Africa

The global strategies for COVID-19 Preparedness and Response stress the necessity to ensure that considerable attention is given to vulnerable populations and hard-to-reach populations (WHO, 2021). The OHCHR emphasized that effective public health and recovery responses to COVID-19 must be inclusive, considering everyone including all migrants, regardless of nationality or migration status (OHCHR, 2021). National Deployment Vaccination Plans (NDVP) implemented by various countries have faced scrutiny regarding their effectiveness. Despite noted progress, the International Organization for Migration (IOM) (2021) emphasizes significant challenges remain, particularly in addressing the needs of undocumented displaced persons in many nations. Most countries have incorporated refugees into their national vaccination plans, but further efforts are necessary to deliver these services to vulnerable populations (UNHCR, 2022). The West African Health Organization (WAHO), a unit of ECOWAS, reported the distribution of over 100,000 medical materials and more than one million personal protective equipment (Erunke, 2021). West African governments have implemented various measures to address the pandemic, including the establishment of task forces and action committees aimed at preventing and containing the disease (Erunke, 2021). A report by Mbiyozo (2020) warned that COVID-19 nationalist measures that could further put

vulnerable people at risk or worsen the spread of the virus should be avoided by governments in Africa.

Mali's first confirmed COVID-19 cases emerged on March 25, 2020, increasing to 56 by April 7, accompanied by at least six deaths across several regions. In response, the government established the Central Coordination Cell for Epidemic Management. A study conducted by Doumbia *et al.* (2020) in Mali shows that centralised approach has improved COVID-19 control activities, resource allocation, public health practices, and decision-making. Despite challenges, Mali's use of clinical research for its COVID-19 response offers valuable lessons for future global health research and demonstrates the importance of enhancing research capacities in resource-limited areas through international collaboration. About \$57 million was needed for prevention, communication, and management strategies in Mali (UNICEF, 2020b). A state of emergency was declared, enforcing bans on public gatherings, commercial flights, and school closures, although over a million IDPs faced challenges in maintaining physical distance in camps. Despite these measures, MMC (2020) reported that the needs of forced migrants remained unaddressed. A study by Ly *et al.* (2022) involving 68 IDP participants in Mali highlighted several challenges in managing COVID-19. These included difficulty in reaching positive cases, a lack of adequate quarantine and isolation facilities, insufficient physical space for new facilities, and limited financial resources. Additional issues included changes in social behavior, fear of stigma, low literacy levels, and language barriers.

On March 9, 2020, Burkina Faso reported its first COVID-19 case, which quickly spread across nine regions country (Doctors without Borders, 2020a). As of March 14, 2022, WHO (2022) reported 20,813 cases and 379 deaths, with 2,554,907 vaccines administered. The Ministry of Health established an emergency response team to support pandemic control efforts. However, findings show that the lack of accurate epidemiological data limited effectiveness and concerns regarding the government's commitment to addressing COVID-19 (Tarnagda et al, 2021). Furthermore, reports indicate that insufficient engagement with religious leaders and traditional authorities, contributing to anti-lockdown protests (World Politics Review, 2020).

The Niger Republic reported its first COVID-19 case on March 19th, 2020, involving a 36-year-old who had travelled to neighbouring countries (Shaban, 2020). As of 2022, Niger recorded 8,799 confirmed cases and 308 deaths, and

2,674,381 were vaccinated, representing only 6.61% of the population (John Hopkins University, Coronavirus Resource Center, 2022). The World Bank established a \$13.95 million Rapid Emergency Response Project to support the government in procuring COVID-19 medications and equipment. However, challenges in delivering protective gear, especially to IDPs and refugees, were exacerbated by armed conflicts in regions like Diffa and Tillabery, rendering vulnerable groups a significant threat in the context of COVID-19 in an already weak health system (World Bank, 2020).

In Nigeria, the first COVID-19 case was recorded on March 23, 2020, traced to an Italian in Lagos, prompting widespread panic. The Federal Government established a Presidential Taskforce on March 17, 2020, leading to a nationwide lockdown. Furthermore, In Nigeria, a study by REACH (2021) in Borno and Adamawa States, heavily affected by Boko Haram terrorism, found that vulnerable populations are in perilous situations, complicating humanitarian efforts. Data from 400 settlements indicated that only 62% of newly arrived refugees in camps were instructed to wash their hands, and 89% of sick individuals were mixed with other members of the community.

3. Discussion

The forced migration situation is affected by humanitarian resources, education, and healthcare in displacement camps, which are strained in Nigeria, with government and international agencies involved in relief efforts amidst ongoing security challenges. In Mali, the situation complicates peacebuilding and development efforts, as insecurity hinders access for UN peacekeeping (MINUSMA) and humanitarian actors. Burkina Faso faces an escalating humanitarian crisis, prompting the government to declare a state of emergency and enhance military operations. Niger balances its role as both a host country and a source of displacement, receiving international support aimed at refugee protection and addressing underlying causes (United Nations Office for the Coordination of Humanitarian Affairs [OCHA], 2024).

Access to COVID-19 vaccines remains a significant challenge in the four countries of focus, where many developing countries continue to struggle. Despite having a population exceeding one billion, Africa has reported roughly 1.5 million COVID-19 cases, markedly lower than the more severe situations seen in Asia, North and South America, and Europe, which feature more robust public health systems (Soy, 2020). These numbers are far lower than those in Europe,

Asia, or the Americas, as approximately 37,000 deaths have been reported in Africa, compared to approximately 580,000 in the Americas, 230,000 in Europe, and 205,000 in Asia (Soy 2020). The impact and burden of COVID-19 is not equally shared by countries and regions but there are concerns on the global deployment, roll-out and plans for vaccines (WHO, 2021b).

The UN Security Council Resolution 2565 of 2021 strongly advocated for ensuring availability and equitable access to COVID-19 vaccines in situations of instability and humanitarian emergencies (UN Security Council, 2021). Based on the above reports, there is rare evidence that the plight of people living in IDPs, refugees, and hard to reach populations in terms of COVID-19 testing, vaccination, and treatment has been prioritized. According to the first-ever WHO World Report on the Health of Refugees and Migrants, many forced migrants are invisible to health systems because they lack access to basic health services as well as decent work, housing, and food essential to good health (Fletcher, 2022). There was also concern about the commitment of the governments of West Africa, especially Nigeria, to equitably fight COVID-19. For instance, in the global campaign to combat inequality during the COVID-19 pandemic, the 2021 Commitment to Reducing Inequality Index (CRII) places Nigeria bottom among the 16 members of ECOWAS and second-to-last in Africa (45th out of 46 countries) (Ogundipe, 2021).

Lack of basic infrastructure also impacted natively on access to COVID-19 services in West Africa. A report on the impact of COVID-19 on the most vulnerable children in a few IDP camps in Adamawa, Borno, Benue, and Federal Capital Territory (FCT), Nigeria found that 80% of all IDPs in Nigeria are women and children, with roughly 23% of them being children under the age of six (IOM DTM, 2019). According to research, IDP camps are haphazardly constructed with few to no basic amenities, especially adequate access to clean water for sanitary purposes, especially during pandemics like the COVID-19 when washing hands with soap and water as a preventive measure is imperative (IOM DTM, 2019). In a report on the conditions in Gubio camp, which houses over 30,000 individuals, only one borehole with 24 taps is available, leading to long water lines and inadequate access for vulnerable groups like children and the disabled. Daudu camp, with more than 4,000 residents, has just one health center, creating a disparity between healthcare needs and capacity, necessitating continuous medical support (IOM DTM, 2019).

Local, regional, and global health insecurity in the Sahel region including Burkina Faso, Mali and Niger, is exacerbated the mobility of unvaccinated populations such as refugees. Vaccination efforts are hindered by the control of non-state armies over significant areas. To address this, Ministries of Health require support through diplomatic channels, multilateral frameworks, and enhanced funding for community infrastructure. Furthermore, the lack of real-time data on vaccine-preventable diseases complicates the understanding of health conditions, highlighting the urgent need for better data collection and innovation to improve vaccination strategies (Sabahelzain, 2025).

In all the four countries of focus, the COVID-19 pandemic worsened the vulnerabilities of forced migrants, creating challenges in repatriation and increasing exploitation risks while straining humanitarian resources. Despite international efforts for assistance, the situation underscored the need for effective strategies to manage forced migration amid public health crises. In the Sahel region, particularly Burkina Faso, rising extremist violence further complicated the COVID-19 response (UNHCR, 2025). To enhance vaccination acceptance among individuals in unofficial camps, it is essential to intensify health education and risk communication to combat misinformation, bolster vaccine confidence, and influence perceptions of COVID-19 severity (Gidado et al., 2022). Accessing COVID-19 vaccines in the Sahel necessitates strong coordination, overcoming logistical challenges, and building community trust, with international collaboration being crucial for enhancing vaccine coverage in the region (UNHCR, 2025).

4. Conclusion and Recommendations

West Africa is affected by forced migration due to conflict and climate issues. Nigeria and Mali are experiencing intense insurgencies, while Burkina Faso's crisis is newer but escalating quickly. Niger serves as both a source and host for displaced people. Responses to these challenges often face security and resource limitations. Response strategies at both sub-regional and national levels are not really targeted at forced migrants or hard-to-reach populations, which further paves the way for an impending health disaster in the ECOWAS sub-region. Also, other COVID-19 preventive strategies such as border closures put trapped migrants at the borders at risk of more infections and other harmful activities. Institutional capacity and infrastructure affected COVID-19 response strategies for forced migrants in West Africa. Based on the foregoing, the following recommendations are made:

1. More efforts should be made at both subregional, regional and global levels to ensure the equitable distribution of vaccines especially to low-income countries where the burden of refugees and IDPs are more pronounced. The existing intervention programmes have not yielded the desired result, hence the need to strengthen the existing ones or creating new programmes which ever appropriate.
2. Governments of the selected West African States and other key stakeholders should make efforts to ensure that there is proper provision of water, hygiene, sanitation and other COVID-19 kits such as face masks in refugee and IDP camps to reduce the spread of the virus and other health problems.
3. National Disease Control Centers in Nigeria and other similar agencies West Africa should create funded sub-plans targeting IDP and refugee populations within their National Deployment and Vaccination Plans, ensuring clear coverage targets and dedicated budget lines.
4. ECOWAS, through WAHO, should mandate the inclusion of non-citizens in member states' health emergency preparedness reports and establish a regional mechanism for sharing health data on mobile populations.
5. There should be a strong campaign by all the stakeholders to enlighten not just the refugees and IDPs but the general public to dissuade people from the cultural myths associated with COVID-19 vaccines in West Africa. If this is not done, vaccine hesitancy will continue and most IDPs and refugees will not be willing to be vaccinated even if the vaccines are made available to them.

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