Migrant health is public health: a call for equitable access to COVID-19 vaccines

According to the International Organization for Migration (IOM) there are about 1 billion international and internal migrants worldwide, and the UN Refugee Agency (UNHCR) estimates that 80 million migrants are forcibly displaced. Inclusion of these populations in COVID-19 vaccination plans is essential. Migrants experience multiple risk factors for SARS-CoV-2 infection and adverse clinical outcomes, including poor or overcrowded living conditions, employment in informal or essential roles with inability to work from home, sparse access to adequate water, sanitation, and hygiene services, and complex health needs including cardiometabolic comorbidities.[1] These populations also experience multiple barriers to public and health services, including discrimination, insecure legal status, restrictive policies, limited knowledge of health systems, linguistic and cultural barriers, and mistrust of authorities.[1,2] However, migrants have not been meaningfully included in public health planning since the outset of the COVID-19 pandemic.

According to Our World in Data, more than 90 million SARS-CoV-2 vaccines have been administered globally. Concerns have been raised about inequitable delivery to migrants and across minority ethnic groups because of inadequate inclusion or engagement of these communities, poorly targeted information, and vaccine hesitancy.[3] It is imperative migrants are integrated into local, national, and transnational SARS-CoV-2 vaccine strategies to reduce morbidity and mortality and limit transmission.

WHO and the IOM have promoted equitable distribution of SARS-CoV-2 vaccines, supported by the Access to COVID-19 Tools Accelerator and the COVID-19 Vaccine Global Access Facility (COVAX Facility), with calls to explicitly include migrant populations. However, UNHCR estimates that only half of countries have integrated refugees in their national SARS-CoV-2 vaccination plans. This concerning exclusion is likely to exacerbate existing risk factors, increase morbidity and mortality, and inhibit infection prevention and control measures.[4]

Migrant and displaced communities—regardless of their legal status—urgently need to be explicitly and proactively included in vaccination plans. This action not only recognises the interdependence between migrant health and public health but also offers a crucial opportunity to strengthen the dissemination of vital public health information to this excluded group and engage them in health systems to address wider protracted disparities. A collaborative cross-sectoral strategy will be key, and a targeted community-centred approach will be needed that addresses social and systemic barriers and prioritises proactive outreach (eg, advocacy, deployment of mobile clinics, and collaboration with community organisations). This approach should be supported by research with involvement of migrant communities to inform, monitor, and evaluate evidence-based policies and practice,[5] alongside financial commitment and robust governance, allocation, and monitoring mechanisms.

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*Amani Al-Oraibi, Christopher A Martin, Osama Hassan, Kolitha Wickramage, *Laura B Nellums, Manish Pareek*
laura.nellums@nottingham.ac.uk

Division of Epidemiology and Public Health, School of Medicine, University of Nottingham, Nottingham NG5 1PB, UK (AA-O, OH, LBN); Department of Respiratory Sciences, University of Leicester, Leicester, UK (CAM, MP); Department of Infection and HIV Medicine, University Hospitals Leicester NHS Trust, Leicester, UK (CAM, MP); International Organization for Migration, Geneva, Switzerland (KW)

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For **Our World in Data** see https://ourworldindata.org/

For more on the **COVAX Facility** see https://www.gavi.org/covax-facility