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Health Systems & Reform

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/khsr20

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To cite this article: John A. Mushomi, George Palattiyil, Paul Bukuluki, Dina Sidhva, Nellie D. Myburgh, Harish Nair, Francis Mulekya-Bwambale, Jacques L. Tamuzi & Peter S. Nyasulu (2022) Impact of Coronavirus Disease (COVID-19) Crisis on Migrants on the Move in Southern Africa: Implications for Policy and Practice, Health Systems & Reform, 8:1, e2019571, DOI: 10.1080/23288604.2021.2019571

To link to this article: https://doi.org/10.1080/23288604.2021.2019571

Published online: 21 Jan 2022.

HEALTH SYSTEMS & REFORM
2022, VOL. 8, NO. 1, e2019571 (9 pages)
https://doi.org/10.1080/23288604.2021.2019571

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COMMENTARY

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Impact of Coronavirus Disease (COVID-19) Crisis on Migrants on the Move in Southern Africa: Implications for Policy and Practice

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ABSTRACT

Coronavirus disease 2019 (COVID-19) knows no borders and no single approach may produce a successful impact in controlling the pandemic in any country. In Southern Africa, where migration between countries is high mainly from countries within the Southern African Development Community (SADC) countries to South Africa, there is limited understanding of how the COVID-19 crisis is affecting the social and economic life of migrants and migrant communities. In this article, we share reflections on the impact of COVID-19 on people on the move within Southern Africa land border communities, examine policy, practice, and challenges affecting both the cross-border migrants and host communities. This calls for the need to assess whether the current response has been inclusive enough and does not perpetuate discriminatory responses. The lock-down and travel restrictions imposed during the various waves of the COVID-19 pandemic in SADC countries, more so in South Africa where the migrant population is high, denote that most migrants living with other comorbidities especially HIV/TB and who were enrolled in chronic care in their countries of origin were exposed to challenges of access to continued care. Further, migrants as vulnerable groups have low access to COVID-19 vaccines. This made them more vulnerable to deterioration of preexisting comorbidities and increased the risk of migrants becoming infected with COVID-19. It is unfortunate that certain disease outbreaks have been racialized, creating potential xenophobic environments and fear among migrant populations as well as gender inequalities in access to health care and livelihood. Therefore, a successful COVID-19 response and any future pandemics require a "whole system" approach as well as a regional coordinated humanitarian response approach if the devastating impacts on people on the move are to be lessened and effective control of the pandemic ensured.

ARTICLE HISTORY
Received 6 May 2021
Revised 30 November 2021
Accepted 14 December 2021

KEYWORDS
COVID-19; lockdown; travel restrictions; migrants; Southern Africa; whole system approach

Introduction

Africans account for 14.5 million international migrants, with 10 million moving within the Sub-Saharan African region, including Southern Africa.[1] The Southern African Development Community (SADC) is an organization founded and maintained by southern African countries with the goal of advancing socioeconomic, political, and security cooperation among its Member States and fostering regional integration to achieve peace, stability, and wealth. Angola, Botswana, the Union of Comoros, the Democratic Republic of the Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, the United Republic of Tanzania, Zambia, and Zimbabwe are the members.[2] SADC member states account for only 5% of the world's population.[3] The SADC region is known for its high levels of population mobility and the Southern Africa is home to nearly 20% of the continent's international migrant population, including migration from other regions, and just under 300,000 refugees.[4] Due to job opportunities in the mining, manufacturing, and agricultural industries, Southern Africa sees a high volume of migration.[5] Cross-border movements are common within the

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SADC region, as well as to and from the region. There has been an increase in the number of major regional economies, including South Africa, Botswana, and Namibia, that have legally binding protocols governing free trade and cross-border movement of people.[6] Aside from legal migration, the region is witnessing both regular and irregular migration because of economic insecurity and political conflict in countries such as the Democratic Republic of the Congo and Zimbabwe.[6] By the mid-1980s, South African mines employed nearly a million people, nearly half of whom were migrants from within South Africa, with the other half coming from a dozen Southern African countries, including Lesotho, Swaziland, Botswana, and Zimbabwe.[6] By the early 1990s, migration to mines accounted for more than 16% of Swaziland's formal employment, and 36% of households had at least one member working in South Africa, the vast majority of whom worked in the mining industry.[6,7] All types of movements occur in the Southern African region, including mixed and irregular migration, labor migration, and displacement caused by conflict and natural disasters. According to a recent South African survey, half of lifetime migrants are from Zimbabwe (22.6%) and Europe (22.6%), with the remaining 10.4% born in the Democratic Republic of the Congo and other countries.[8] Despite the South African community's social, economic, and political challenges, it remained to be seen how African migrant women were coping and adapting in South Africa. As a result of the COVID-19 pandemic, overall labor demand for migrant workers is contracting in some sectors while increasing in others, such as health care.[9] Because many of the jobs in these sectors are temporary, informal, or unprotected, monitoring the social and economic impacts of COVID-19 on migrant workers become increasingly important in addressing their specific vulnerabilities and protecting their rights.[9]

The COVID-19 pandemic has demonstrated the consequences of vulnerability, with increased rates of infection and death among the poor and vulnerable, including refugees and migrants. Refugees and migrants are more vulnerable to infection and death due to a lack of financial protection, crowded living conditions, and informal and potentially dangerous labor settings; they also frequently have limited access to health-care related to the most common communicable diseases in Southern Africa.[10] Tuberculosis (TB), HIV, and malaria continue to be major public health concerns in Southern Africa.[11–14] The SADC region bears 36% of the global HIV/AIDS burden,[3] the highest malaria prevalence and morbidity rates in the world[3] and the most severely affected by tuberculosis.[15] These suggest that the prevention of TB, HIV and malaria may be compromised in refugees and migrants in Southern Africa. Studies sought to demonstrate how migrants were more likely to contract TB and HIV at their workplaces, and how their return to rural areas exposed their families and partners to diseases contracted in the mines.[6] Furthermore, cross-border migrants, particularly those traveling without documentation (irregular migrants), face conditions that increase their susceptibility to infection and limit their ability to access or adhere to treatment. Regardless of the dangers they face, as well as the dangers that communicable disease poses to the entire community,[16] many migrants are frequently excluded from national health promotion, disease prevention, treatment, and care programs, as well as financial assistance programs for health and social services.[17] Migrants continue to experience exclusion and it is more pronounced in the current COVID-19 response as they are excluded from testing, treatment, and other palliative measures which could affect the overall success of the response to combat the spread of the virus and undermine national efforts to stem its spread.[18] In addition, many irregular migrants are found in the informal markets and may be reluctant to seek health services for fear of being victimized by government officials.

In addition, evidence suggests that refugees and migrants faced high levels of xenophobia, racism, and stigma during the COVID-19 pandemic.[10] All these vulnerabilities have been exacerbated further by public health controls and border closures during COVID-19 pandemic.[10] Exclusion, barriers to access and discrimination are all visible in southern Africa, particularly in South Africa.[19] Refugees and migrants may be vulnerable due to the conditions of their migratory journeys, limited employment opportunities, overcrowded and poor living and working conditions, and insufficient access to food, water, sanitation, and other basic services.[17] Intra-African, migrant women are a particularly vulnerable group: intersecting and simultaneously occurring risk and vulnerability due to discrimination based on gender, ethnicity, or race and poverty can result in multiple disadvantages for migrant women in the host society, compounding preexisting hardships in the general population.[20] For undocumented/illegal migrants in South Africa, the consequences of being undocumented are severe. They are unable to obtain formal employment or bank accounts, and they face difficulties in obtaining basic health care and facing the constant threat of arrest, prosecution, and deportation.[19] Research conducted in 2004 by the Institute for Security Studies (ISS) reveal the level of fear prevalent among migrants in South Africa. The study reported that most migrants tend to remain invisible, and they lack an understanding of their health rights.[21]

Even though SADC has officially committed to harmonizing migration policy and facilitating intraregional migration at the state level, there is still widespread discrimination and violation of migrant rights.[16] Human Rights Watch (HRW) documented two broad categories of abuses affecting migrants' health in South Africa: abuses that lead to health vulnerability and barriers to health-care access.[16] The exclusion from health care makes early detection, testing, diagnosis, contact tracing, and seeking care for COVID-19 difficult for refugees and migrants, raising the risk of outbreaks in these populations, which may go unchecked or even actively concealed. These conditions pose a new risk to public health.[17] Furthermore, early research on migration and health in Southern Africa focused on migration as a vector for disease transmission.[6]

These challenges among others include social-economic as well as those relating to migrant health during the COVID-19 crisis.[18] We present policy implications and options available for governments to address the challenges in areas related to universal health coverage for migrant populations. The insights from this paper could help shape interventions to improve the health and socio-economic conditions of migrants in the context of the COVID-19 crisis and future pandemics of a similar nature.

Responding to a borderless pandemic calls for not only national but also regional and global solidarity as the pandemics come with major humanitarian, public health and socio-economic threats.[22] While countries need to reduce the spread of COVID-19 within borders, a regional outlook on the efforts is critical. In Southern Africa, there is limited understanding of how the COVID-19 crisis is affecting the social and economic life of migrants and migrant communities. This calls for the need to assess whether the current response has been inclusive enough and does not perpetuate discriminatory responses. Pandemics like COVID-19 place substantial strain on already scarce resources and overburdened public systems and in this situation, inequalities are most likely to thrive[23] or become exacerbated. Travel restrictions and lockdowns have already had a negative impact on many migrants in Africa: tens of thousands of migrants are trapped or stranded in their destination or transit countries, often abandoned by migrant smugglers.[24] As borders have become increasingly difficult to cross, stranded migrants have few to no options, and the temporary suspension of assisted voluntary return and voluntary humanitarian return assistance prevents them from returning. As a result, they end up in precarious situations and risk becoming stranded migrants or being trapped between countries.[24,25]

While questions of care appear with urgency amidst crises, attending to vulnerability as a collective response has long been central to literature on the ethics of care.[26] Outbreaks of certain diseases have been racialized, leading to xenophobia and fear.[23] In addition, many irregular migrants are found in the informal sectors and may be reluctant to seek health services for fear of being victimized by government officials.[27]

In this commentary, we share reflections on the impact of COVID-19 on people on the move in Southern Africa land border communities, and examine policy and practice challenges affecting both the cross-border migrants and host communities of Southern Africa.[18]

Current Measures

Following advice from the World Health Organization (WHO), most countries in the Southern African region have implemented various measures to break the chain of COVID-19 transmission through declaration of a state of emergency and lockdowns and behavioral interventions such as social distancing, ban on public gatherings, and school closures.[28,29] However, the lockdown conditions have not contextualized the effect of COVID-19 on living conditions especially of migrants. The WHO has classified three major national COVID-19 adaptation policies as border policies, migration policy responses to COVID-19 for foreigners within national borders, and public health policies on refugee and migrants' access to health care.[10] In fact, the United Nation High Commissioner for Refugees (UNHCR) found that allowing asylum seekers to enter and be registered lawfully at borders, followed by appropriate quarantine or movement restrictions, facilitated infection control more effectively than allowing irregular movement and entry at unofficial border points.[10,30]

Other adaptation policies implemented by governments include the extension of visas, residence, and work permits, the facilitation of access to the labor market in critical sectors, the regularization of undocumented migrants, the release of migrants and asylum seekers from detention centers, and the suspension of forced returns.[10] There is also a trend to relieve individual patients' financial burdens and cover COVID-19-related services,[10] and some countries have launched communication campaigns to improve access to health care for refugees and migrants.[10]

However, due to limited language skills, SADC refugee and migrant communities are among the most difficult to reach when it comes to disseminating critical information about HIV/AIDS, TB, malaria, and COVID-19 treatment and prevention measures.

A recent South African study discovered that health-related differences between immigrant and South African children seeking in-hospital care were less than expected.[31] Differences in parental educational level and socioeconomic factors were discovered, but they had no significant effect on HIV prevalence, or prevention of mother to child transmission (PMTCT) coverage.[31] Another study emphasizes the importance of revising South Africa's National Health Insurance (NHI) Bill to ensure an inclusive health-care system for all people, regardless of nationality.[32] However, legislative changes must be accompanied by investment in the South African health system, performance-improvement strategies, value-based health-system leadership and management, and a broad coalition to ensure the prevention and mitigation of medical xenophobia.[32] In the same line, Velcamp et al. demonstrated a significant divergence between the core idea of the South African Bill of Rights, which grants socioeconomic rights to everyone, and access to health care for asylum seekers, refugees, and immigrants in South Africa.[33]

According to the Internatoinal Organization on Migration, the SADC regional response to the COVID-19 pandemic showed that nearly all responding member states reported average disruptions in 50% of a set of 25 tracer services.[34] Disruptions were most prevalent in outreach services (70%) and facility-based services (61%).[34] These statistical percentages may be exaggerated in the case of SADC migrants as a vulnerable group, and a coordinated regional approach to migration management remains improbable. Even though a new migration policy framework for the SADC Region was drafted late in 2020 'to promote regular, safe, and orderly migration in the region,' it is still unclear how this type of renewed initiative will persuade powerful states such as South Africa, Botswana, and Namibia, which are already concerned about interregional migration, to open their borders further.[11] This demonstrates how a failure to adequately engage with migration and mobility at the regional and national levels within SADC member states is likely to stymie progress toward global health goals, including the 2030 target of Universal Health Coverage (UHC).[11,35–3738]

Despite significant challenges in developing and sustaining an effective HIV, TB, and malaria control program in the SADC Region, including the ongoing COVID-19 pandemic, human, equipment, and infrastructure constraints, and fluctuating economic and political climates, SADC policies on HIV, tuberculosis, and malaria found less success due to poor migration policy. Each member state has its own legislation governing cross-border migrants' access to health care, including HIV treatment.[39,40] Furthermore, the SADC member states represent diverse socioeconomic contexts and epidemiological profiles, posing a challenge to the development of regionally harmonized and coordinated responses to diverse population movements and communicable diseases.

Despite the adoption of the regional minimum standards for HIV, TB and Malaria Continuum of care and support across the region,[41] policy-practice gaps exist. In terms of existing policies, the cross-border intervention for HIV/AIDS is a Global Fund initiative that has established mobile clinics at border crossings to benefit vulnerable populations, migrants, and border communities.[42] This initiative is significant because it addresses the issue of migrant access to health care.[42] The Initiative's goal is to reduce HIV infections in the SADC region while also mitigating the effects of HIV/AIDS on mobile populations and affected communities in SADC Member States.[43] At the mobile clinics, each of these cross-border sites should provide the following clinical services to migrants: screening for HIV, TB, and malaria, voluntary HIV counseling and testing and medical referrals, screening and treatment for sexually transmitted infections (STIs), condom distribution, behavior change communication, HIV and TB information and education, and primary health-care service.[43]

In addition, all SADC member countries have established in-country HIV/AIDS coordinating authorities.[44] The national HIV/AIDS coordinating authorities have developed multisectoral strategic plans and associated with monitoring and evaluation frameworks that define the inclusion of non-health partners (private sector, civil society organizations, and government) in the single national HIV/AIDS action framework.[44]

Another cross-borders policy is the Lusaka Agreement, which focuses on TB control, delivery of health care to people living with HIV/AIDS, synchronized efforts to control malaria, ensuring access to quality primary health-care services as well as the sharing of best practices and expertise along cross border areas.[45] This initiative could certainly strengthen the existing cooperation between Angola and Namibia regarding the prevention and control of the main communicable diseases along the bordering areas, including the definition of therapeutic protocols to treat HIV/AIDS, TB and malaria, and epidemiological surveillance activities.[45]

The SADC Protocol on Health Article 10, which commits Member States to deal effectively with HIV/AIDS, includes the following elements: harmonizing policies aimed at disease prevention and control, including co-operation and identification of mechanisms to reduce HIV infection; developing approaches for the prevention and management of HIV/AIDS to be implemented in a coherent, comparable, harmonized and

standardized manner; developing regional policies and plans that recognize the intersectoral impact of HIV/AIDS and the need for an intersectoral approach to HIV; and cooperating in the standardization of HIV surveillance systems, in regional advocacy efforts, and in the sharing of information.[46]

Even though national surveillance systems on HIV/AIDS, tuberculosis and malaria are developed in SADC and regional policy has been implemented, there are some significant gaps in the components of the surveillance systems among tracking more vulnerable populations for most Member States. The Southern Africa TB Control Initiative had some success establishing routines of information sharing and comparing of work plans and successes between national TB programmes in the different Member States.[15] However, poor working conditions, social exclusion, poverty, and barriers to health care are some of the key risk factors associated with migration, making mobile populations more vulnerable to risks of ill health and disease in general, and communicable diseases such as TB, including multidrug resistant TB (MDR-TB) and extensively drug resistant TB (XDR) in particular. Most migrants do not have access to anti-TB and anti-retroviral therapy.[47] The travel restrictions especially in South Africa denote that most migrants (especially undocumented migrants) living with HIV/TB and who are enrolled in chronic care in their countries of origin will suffer. South Africa has recognized the importance of access to health care for vulnerable and migrant populations in its laws and policy documents but continues to tolerate unlawful discrimination by health-care workers, undermining efforts to contain disease and improve treatment outcomes.[16]

While the SADC regional response to COVID-19 pandemic plan acknowledges the adoption of WHO guidelines on COVID-19, migration and migrants do not find a place in this plan.[48] This may make the response less inclusive of migrants, especially those in irregular situation who are among the most vulnerable. Amidst the pandemic, ethics of care demand that vulnerable populations should be collectively cared for.[26]

Gender inequalities are exacerbated by crises and the COVID-19 is no exception. Women and girls are experiencing its consequences including loss of livelihoods, worsening power imbalances, access to and control over resources and increasing their gender roles including the burden of care. In terms of gender roles in particular, women bear the responsibility of unpaid care work, and are likely to face increased levels of domestic and sexual violence. Measures taken to prevent and control COVID-19 also have implications for survivors of violence against women and girls including women and girls being trapped at home with their abusers as the states are placed under mandatory lockdown.[49]

Concerns have been raised that some of the unintended outcomes of the lockdown will be an increase in rape and other forms of sexual violence given that survivors tend to remain in proximity of perpetrators over a prolonged duration.[49] Concrete measures to support them would include mechanisms to ensure victims of domestic violence or intimate partner violence get access to justice; that they continue to access essential sexual and reproductive health services; and a commitment to promoting women's leadership and effective participation in task forces at the helm of response to COVID-19. Similarly, it is important and urgent to explore and fast-track strategies to expand services to address violence against women and girls, including increasied allocation and accountability of resources to ensure access to shelters, psychosocial support, women and girls' helplines to facilitate reporting of violence, as well as online counseling.[50]

Lastly, the obvious lack of migration-aware and mobility-competent policies in Southern Africa is likely to reduce the level of engagement of asylum seekers, refugees, and foreign migrants in the regional fight against the COVID-19 pandemic, and thus their consideration for a COVID-19 vaccine.[51] COVID-19 transmission knows no boundaries, and as long as there is active transmission anywhere, there is a risk of transmission everywhere.[52] As a result, equitable prioritization and access to health care and COVID-19 vaccines for all groups, including refugees and migrants, is critical.[52] Unfortunately, the overall limited supply of doses around the world, particularly in African countries, continues to make it difficult for many people, including nationals, to have access to vaccinations, but this affects particularly marginalized communities, such as migrants in irregular situations, refugees, and asylum seekers.[53]

A recent review of fifteen Southern African countries reported on the WHO/COVID-19 Vaccines Global Access (COVAX) National Deployment and Vaccination Plan (NDVP) among refugees and asylum seekers, regular migrants, irregular migrants, and internally displaced persons (IDPS).[53] In terms of inclusion practice, this study found that only three Southern African countries included refugees and asylum seekers in NDVP, two did not, and nine others were deemed unclear.[53] In the same line, six countries included migrants in regular situations in NDVP, four countries did not, and data in five countries were unclear.[53] Only four countries included irregular migrants, they were

excluded in four countries, and data were unclear in eight countries.[53] Finally, IDPS were included in the NDVP in three Southern African countries; three other countries excluded them, seven countries had unclear data, and two countries did not report data.[53]

In sum, due to preexisting barriers and challenges related to Southern Africa, refugees and migrants, including irregular migrants, may face multiple barriers to vaccination and health system access relevant to the implementation of COVID-19 vaccine programs, despite increased policy inclusion of these populations. These barriers include: limited vaccine supply; lack of trust in vaccine benefits and safety; social influence and norms; lack of trust and practical information about how to obtain vaccines; outreach and language barriers; lack of documentation and complex registration processes, such as via the Internet; and fear of arrest, detention, or deportation.[52,54,55] The SADC region has shown high variability in NDVP between countries, demonstrating a lack of cooperation and coordination in relation to COVID-19 vaccine policy. This is predictable of very low COVID-19 vaccine coverage among migrants and increased vulnerability to COVID-19 risk among asylum seekers, refugees and migrants in the camps in case of future COVID-19 waves in Southern Africa.

Implications for Policy and Practice

Despite initially lower numbers of COVID-19 cases and fatalities in Africa compared to other parts of the world, the pandemic is considered capable of causing economic, health, and social emergencies. Priority is given to health-related responses.[24] The COVID-19 crisis has far reaching negative implications on the health and survival of both migrants and members of the families left behind—reduced employment and loss of income as most of them depend on mobility as the survival mechanism, reduction in remittances to home countries and exacerbated poor health outcomes especially among irregular migrants due to restricted access to health care due to lack of proper documentation. COVID-19 knows no borders and no single approach can work for any country. Therefore, a successful COVID-19 response will require a regional coordinated humanitarian response approach if the devastating impacts on the people on the move are to be lessened.

Within the humanitarian regulatory framework tools, Southern Africa needs to adopt regional solidarity and a tangible geopolitical humanitarian approach to dealing with migrants on the move and border communities. We recommend that migrants, refugees and internally displaced populations (IDPs) should be treated free of cost, irrespective of birth registration and then referred for birth registration. Cross-border health systems strengthening and surveillance are needed more than ever before, with meaningful involvement of the migrants or migrant associations in risk communication and community engagement responses. The existing cross-border coordination mechanisms need to be activated—multisectoral and multidimensional—involving government, civil society and the multilateral organizations, to address migration flows and health impacts of the pandemic.

Most Southern African countries have announced specific support for their own citizens without considering migrant populations. There is a need to consider humanity first and citizenship next. Also, we note that as countries put in place policies, actions and programs for citizens, they should be migrant sensitive, considering that different migrant populations find themselves in context-specific challenges during the crisis. Countries need to take a closer look and improve their migration policies and responses.[14]

Within South Africa, "online extension" refers to a process where a holder of an asylum seeker (section 22) or a refugee permit (section 24) makes a request to Home Affairs, via e-mail, to have the validity of his/her visa extended.[56] This online service makes it possible for current holders of asylum seekers and refugee visas to request an extension of their visas without having to physically go into a Refugee Reception Office. However, there are some significant gaps in the components of the surveillance systems. Nevertheless, the adopted measures still lack universal or even regional cohesion,[10] as the policy does not consider border migrants, restrictive immigration, and undocumented people. Most importantly, immigrants' and asylum seekers' health care, gender inequalities, job security, and accommodations are not considered. None of the above have been implemented in other SADC countries.

To achieve the goals mentioned above, SADC should allocate specific budget to migrants and asylum seekers. Knowing resources are limited related to the COVID-19 pandemic, SADC countries should build stronger multisectoral partnerships between service providers, TB and HIV programs, civil society, nongovernmental organizations (NGOs), and other stakeholders to improve the welfare of migrants and asylum seekers. All strategic approaches in responding to the pandemic should include migrants and asylum seekers with attention to health care, gender inequalities, work security and accommodations. In the past, emphasis has been placed on vertical responses to HIV/AIDS, TB, and malaria among asylum seekers and migrants in the SADC region. Vertical, horizontal, and integrated health-care approaches should all be considered in Southern Africa.

However, horizontal health care refers to more established methods of prevention and care provided by publicly funded health-care systems also known as comprehensive primary care.[42] This is the health systems that the SADC region should explore in each country member context to improve cross-border initiatives and internal migrant health care.

Finally, Southern African countries should work together to develop a regional policy to ensure that COVID-19 vaccines reach migrants. The International Organization for Migration (IOM) recommends that governments implement the following interventions to increase COVID-19 vaccine uptake among migrants: advocating for inclusion and removing barriers; partner capacity-building; providing data on migrant stocks and vulnerabilities; social mobilization and outreach to combat vaccine hesitancy; operational support (transport, storage, etc.); assistance in establishing monitoring mechanisms; vaccine administration to migrant communities; vaccine administration via the humanitarian buffer; and vaccine administration to UN personnel.[53] This means that health systems must be culturally and linguistically sensitive to the needs of refugees and migrants, as well as to the circumstances that may raise their health risks and create barriers to treatment and care.[57] The experience of Cameroon and Senegal, where refugees are permitted to register in designated centers near their communities,[58] could be used to improve COVID-19 vaccine access in Southern African migrants. In the days to come, Southern Africa will require a flexible socio-economic strategy as well as coordination response that is coherent with various levels and spheres that are open to scale up. Within the context of COVID-19, attention needs to be given to the analysis of how existing gender and social norms are affecting particularly the risk and vulnerability of women and girls in border and other migration affected communities. The SADC region will also be an entry point to intensify interventions aimed at ensuring access to primary health care by communities living in the cross borders' areas, refugees and asylum seekers, regular migrants, irregular migrants, and Internally Displaced Persons (IDPS)

Conclusion

In early 2022, COVID-19 is still with us, and COVID-19 mutations as well as other pandemics are likely to occur and reoccur in the Southern Africa region. The region and its countries will need to be better prepared to respond to pandemics while leaving no one behind. This should be reflected in policies, institutional and operational capacities, and enhanced collaboration among institutions and countries. The positive role migration plays for poor households should be at the center of the response for the benefit of both internal and cross-border migrants. During the COVID-19 pandemic, a 'whole systems' approach should be implemented to address health-related issues faced by asylum seekers and migrants in Southern Africa. Other vulnerabilities, such as gender equity, migrant work, and accommodation, should be addressed in Southern Africa migration policies. Furthermore, existing migration policies must be strengthened to be effective. A multisectoral and multidimensional approach is required among Southern African countries. Qualitative and quantitative studies on health-related issues, gender equity, migrant labor, and the economy among migrants and asylum seekers are important because SADC countries differ greatly in terms of politics, social, and economic development.

Paper Context

COVID-19 lockdown regulations greatly affected the livelihood of migrants living within the Southern African region mostly in South Africa due to reduced economic activity and lack of access to external support. This disproportionately affected women and children. The breadth of challenges faced by these migrants is a cause for concern. Therefore, there is need to conduct in-depth interviews with migrants as findings would reinforce future response to pandemics where migrant livelihood will be prioritized collectively.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Funding

The authors reported there is no funding associated with the work featured in this article.

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