COVID-19 GLOBAL Evaluation Coalition


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Refugee Rights & Protection During COVID-19: What Have We Learned?

Key Lessons from a Joint Evaluation on the Protection of the Rights of Refugees during the COVID-19 Pandemic

The COVID-19 pandemic has had profound and potentially lasting consequences for the rights of refugees. It has challenged the capacity and willingness of states to live up to their international responsibilities and obligations, and is likely to continue to disproportionately affect the most vulnerable, especially those forcibly displaced from their homes.

These findings come from The Joint Evaluation of the Protection of the Fundamental Rights of Refugees during the COVID-19 Pandemic, a study undertaken by UNHCR, Governments of Finland, Colombia and Uganda and the humanitarian network ALNAP, under the auspices of the COVID-19 Global Evaluation Coalition which examined the role of international co-operation and national responses in protecting the rights of refugees during the COVID-19 pandemic including their access to healthcare, vaccines, asylum child protection and gender based violence (GBV).

At the outset of the pandemic, states moved quickly to close borders to contain its spread. Many narrowed access to international protection, tightened asylum policies, with severe and ongoing repercussions for refugees and people on the move. **In 2020, across all regions of the world, there were approximately 1.5 million fewer arrivals of refugees and asylum seekers than expected.** In some places, the pandemic has been used as a purported justification to introduce restrictive measures detrimental to the rights of refugees.

Today, deportations, pushbacks, at sea and on land, and expulsions continue. **At least 33 countries still deny access to asylum for people fleeing conflict, violence and persecution, based on public health or other measures enacted since the start of the COVID-19 pandemic.** These measures were, in many cases, inconsistent with states' obligations and responsibilities under international law.

These actions have not stopped refugees from seeking international protection, but have forced them to resort to dangerous, sometimes life threatening irregular border crossings. Trafficking in persons and human smuggling has increased. Heightened xenophobia and stigmatisation of people on the move, stemming from disinformation, were clearly linked in part to pandemic-related risks. As a result, refugees feared repercussions, especially deportation, which negatively impacted their willingness to seek both health and asylum services.

Extraordinary efforts were exhibited by a range of protection actors - from the international community to refugee-led organisations - to support refugee rights in the face of this unprecedented global pandemic. When it came to the early planning of the pandemic response, refugees, internally displaced people and migrants, especially those in large camps were seen as extremely vulnerable, priority groups, spurring their inclusion in national plans and encouraging coordination between humanitarian and development actors.

International protection actors were responsive and made important adaptations including using remote management tools for community outreach, registration, status determination and resettlement processing. Donors were also generous and flexible in the first phases of the response.

States also exhibited flexibility, with some countries extending the duration of visas and residence and work permits to prevent refugees and other persons of concern from falling into an irregular status. Some states even facilitated access to the labour market in essential services and regularised undocumented migrants, while others released refugees and asylum seekers from detention or suspended forced returns.

Over the trajectory of the response, local actors were increasingly, if unevenly, involved, and played a range of critical roles. Particularly in the health response, community-based organisations and refugee-led organisations (RLOs) shared critical information on COVID-19. Many local women's organisations and community workers supported child protection efforts from the outset. Decision making, however, remained largely top-down, and RLOs were often largely excluded from formal humanitarian response.

Importantly, the Global Compact on Refugees (GCR), as a relatively new instrument that advocates for strengthened cooperation and solidarity with refugees and affected host countries, was a critical tool that directly influenced greater inclusion of refugees in health systems, enhanced protection and assistance for refugees and provided a framework for predictable burden sharing among states. Despite laudable efforts, the GCR could have been further amplified, and the protection of rights of refugees in the response to COVID-19 was often inconsistent and imbalanced.

Critically, in the initial COVID-19 response, protection activities and staff were deprioritized and seen as non-essential, with dire impacts on GBV and child protection, as well as other vulnerable groups such as the elderly and people with disabilities. Although lessons from the Ebola response foreshadowed these protection concerns and the potential 'secondary crises' faced by women and children, they were not sufficiently heeded. Funding levels for GBV and child protection activities were relatively low throughout 2020.

For refugee children and their families, lockdowns and emergency movement restrictions had punishing consequences, affecting the schooling of 1.5 billion students worldwide. Confinement and school closures were linked to increased violence in the home and psychosocial impacts. These were most severe for refugee children who were not included in alternative national schooling plans, and faced numerous barriers to remote learning solutions, resulting in a further widening of educational inequities for all refugee children. Some children


Lebanon. Syrian refugees and daily life in refugee camps (12 October 2021) © UNHCR/Haidar Darwish

faced prolonged and increased separation from their families due to disrupted family tracing and reunification services. Child labour and child marriage are expected to rise as a result of the economic impact of the pandemic and school closures.

Escalating levels of gender based violence, mainly domestic violence, were described as "one of the most nefarious consequences of the pandemic." COVID-19 quarantine centres also heightened the risk of sexual harassment and violence for women and girls due to inadequate lighting and poorly designed sanitation facilities. Many women and girls struggled to report and receive assistance, and humanitarians also struggled to reach them with the necessary services and supplies.

Despite strong advocacy and inclusion of GBV in global COVID-19 plans, as well as creative solutions to maintain services for GBV survivors, including online awareness campaigns, hotlines for accessing services and remote monitoring, remote case management and interviewing, on the whole, direct response and accountability efforts were inadequate. Adolescent girls were particularly at risk - for example of increased domestic labor, early marriage and adolescent pregnancy - and received limited targeted protection programming.

Critical protection-related information was also lacking, especially child-friendly messaging. Many refugees were unable to benefit from the rapid increase in online tools and platforms to connect, inform and support them during lockdown and isolation. Without concerted efforts to reach them, children, elderly persons, and people with disabilities were left behind, as were homeless asylum seekers and refugees, those staying in informal settlements or in reception centres, that were not technically equipped. The sheer scale of providing information and advice in all relevant languages for refugees and asylum seekers added to the normal difficulties that were faced by host communities as well as refugees.

What is clear is that **protection services as well as regular non-COVID health service provisions, were badly affected by the focus on and pivoting of funds towards COVID-19 related health services in refugee camps**. Routine vaccination programmes, treatment for non-communicable diseases, emergency responses to other disease outbreaks - were detrimentally impacted. Host communities also experienced reduced rates of consultations, clinical access, laboratories, and tests, but refugees, especially those in non-camp settings were disproportionality affected.

That said, refugees were included in COVID-19 testing, treatment plans, preventative programmes, and more generally, national health systems. While this inclusion is a potentially lasting positive outcome, significant barriers remain for refugees seeking pandemic-related healthcare.
However, **refugees faced specific obstacles in accessing vaccines and other Covid-related services.** First, vaccine inequity has led to major delays in vaccine roll-out in middle


Pakistan. Afghan refugees receive COVID-19 vaccination (06 September 2021) © UNHCR/Saiyna Bashir

and low-income countries, but refugees face additional barriers due to lack of documentation, language barriers, and complex vaccine registration systems, leaving the numbers of vaccinated refugees relatively low. Refugees also feared repercussions, especially deportation, disincentivising them from seeking health services, including COVID-19- testing or care. Linguistic challenges and a lack of information - especially for those who could not access on-line tools and platforms to connect and seek advice - also hampered access.

The evaluation makes six recommendations directed at governments, UN agencies, protection actors and donors. More detailed recommendations as well as specific action points can be found in the report.

First, states should uphold international refugee law and international human rights law standards, especially during times of crisis and emergencies. This means, among other things, that governments should automatically renew documentation for refugees and asylum seekers whenever government services have to be shut down in any emergency. They should build systems that allow for secure digital registration and documentation that can be renewed remotely. In particular, states should reaffirm international obligations to ensure an exception for refugees and asylum seekers where borders are closed in future pandemics or large-scale emergencies.

Second, in preparation for future pandemics and public health crises, protection actors and others should advocate and plan for the maintenance of essential, in-person protection services to the fullest extent possible. This includes ensuring that protection staff have access to all refugees and asylum seekers within and at the borders of countries during crises, and that refugees and asylum seekers have adequate, safe quarantine facilities that respect their human rights. Protection activities - critically, child protection and GBV - must not be considered an add-on, but should be recognised as essential and life-saving, with necessary equipment and support provided to those delivering these services.

Third, the Global Compact on Refugees must be utilized across the board during global crises and humanitarian emergencies. This will require governments and other members of the international community to consolidate reporting on upholding their pledges during the pandemic to demonstrate evidence of its effectiveness for enhancing protection. It will also require awareness raising and promotion of the GCR and its principles.

Fourth, partnerships with and support to local and national actors, including women and refugee-led organisations is critical. GBV and child protection activities should be prioritized during public health crises and other emergencies, and require investment and long term-strategic partnerships with key national protection partners.

Fifth, Information and messaging for refugees must be two-way and needs-based, sensitive to local social, cultural and gender norms, and effectively targeted to also reach those most vulnerable and marginalised, including those with limited access to online communication channels.

Finally, in-person protection services are sometimes needed, especially for survivors of GBV, children at risk and others with protection needs. Guidance that recognises programme adaptations is important, but should also consider the risk of harm versus the benefits of a total shift to remote services. Protection actors should continue to ensure there are appropriate levels of dedicated and experienced child protection and GBV staffing in refugee settings.

This brief summarises findings and recommendations from the joint evaluation. For the full report and more information, please visit: www.covid19-evaluation-coalition.org.