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HUMANITARIANISM AND COVID-19: STRUCTURAL DILEMMAS, FAULT LINES, AND NEW PERSPECTIVES

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Anti-Migrant Authoritarian Populism and the Global Vaccination Challenge*

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Abstract This article explores the ways in which anti-migrant and refugee discourses and policies have flourished throughout the Covid-19 pandemic despite dominant global public health concerns, especially around vaccines. Our argument is that pre-crisis authoritarian, populist, and nativist political tendencies have proven remarkably resilient, interacting readily with the pandemic to further justify a rolling back on refugee and migrant rights. These tendencies risk, in several contexts, undermining the comprehensive global vaccination effort needed to combat the pandemic.

Keywords refugees, migrants, authoritarianism, populism, Covid-19, vaccinations.

1 Introduction

This article explores the impact of anti-migrant/refugee 'authoritarian populism' on our ability to fight the Covid-19 pandemic. In the years preceding the pandemic, a range of political leaders – including Donald Trump, Jair Bolsonaro, Viktor Orbán, Boris Johnson, Recep Tayyip Erdoğan, Narendra Modi, as well as many others – won or maintained power on mandates that tolerated (or encouraged) the demonisation of socioeconomically marginalised populations. As refugee host countries in the global North entered the vaccination stage of the pandemic, we are beginning to see some of the potentially more long-term public health impacts of populist anti-refugee policy and rhetoric.

We know from earlier sociological work on coronavirus that the outbreak's negative socioeconomic impacts were not equally distributed (e.g. Ali, Asaria and Stranges 2020; Bowleg 2020). From the very beginning, the virus has generated disproportionate harms for **certain** categories of person, from ethnic minorities

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(e.g. Bhatia 2020), to impoverished communities (e.g. Patel *et al.* 2020) and all those living in already deprived regions (e.g. Iacobucci 2020). Not only has the pandemic exposed existing structural vulnerabilities, it is also, in turn, contributing towards a vast array of potentially long-lasting transformations in socioeconomic life (e.g. Lund *et al.* 2021; Shah *et al.* 2020). While some believe that immunisation programmes and vaccine passports will allow a 'return-to-normal', it remains unclear what the impact of Covid-19 transformations will be for migrants and displaced people (Mukumbang 2020). Even if in global North countries – where vaccination supply is high – will eroded confidence in state authorities harm uptake among displaced non-citizens? What efforts are being made to include displaced persons in vaccination strategies? How will the real or imagined threats of deportation impact displaced people's willingness to seek vaccination? And to what extent will new bureaucratic obstacles to movement – such as vaccine passports – heighten the further ostracisation of migrants and refugees?

The article is structured as follows. In Section 2, we first define what we mean by authoritarian populism. In Section 3, we then survey how this political formation has strengthened its grip thanks to the Covid-19 pandemic. To make this case, this article draws on an analysis of emerging evidence and reports on vaccine access among displaced persons up to July 2021, and ten key informant interviews with academics and practitioners working to enhance access. Section 4 concludes.

2 Authoritarian populism and the pandemic

As an analytic category, authoritarian populism combines two hotly debated concepts. For the purposes of this article, our understanding of that latter term, 'populism', draws from the work of the political philosopher Ernesto Laclau. 'Populism', it should be acknowledged, is an analytic category often stretched in many directions at once, with scholars variously seeking to delineate lists of policies that make parties or movements fall within the term's boundaries. Yet classification does little to advance our understanding of how populism **operates**. On this point, Laclau (2005) offers us an escape from the definitional trap. Populism, he argues, is not a coherent ideological project, but a **style** of political claim-making (*ibid.*).

As a style, populism has no set 'objectives' – it is not inherently 'left wing' or 'right wing', nor is it necessarily nativist or anti-migrant. Rather, the core of populism is, first, the high-degree of importance awarded to rhetorical-symbolic construction of 'the people' – the political base on whose behalf populists claim to speak – and second, centrality of what he calls 'empty-signifiers'. Empty-signifiers are exemplified singular big political demands such as, for example, to 'Get Brexit Done' (Boris Johnson) or 'Build the Wall' (Donald Trump). Crucially, for Laclau these demands are not 'transactional', meaning

they do not operate as **actual** singular issues, but as symbolic vessels into which movement supporters can fill a vast array of socioeconomic hopes and fears – from feeling 'left behind' by systematic deindustrialisation to ever-rising economic inequality. Populism is thus a rhetorical **style** that can appear inherent to democracy itself – it is a manner of campaigning that all leaders draw upon, though to differing degrees.

However, conceptualising populism as a style does not mean it lacks material effect. Indeed, what distinguishes **authoritarian** populism (from other manifestations) are the ways in which populist figureheads, in claiming to speak **for** the 'people', use their voice to enact and justify policies that breach civil liberties and break constitutional limits on political power. In other words, they use a populist style to undermine democratic institutions more broadly. Thus, 'authoritarian populists' harness and generate the hopes and fears of 'ordinary people' to generate division and differentiation from 'others', and in so doing they advance a vision of the political that blends anti-democratic measures with majoritarian aspirations and uncertainties.

Cooper and Aitchison (2020) rightly pinpoint that, prior to the outbreak of Covid-19, there was already a global trend towards authoritarianism, with far-right populists coalescing into a governing force in many countries. Across the world, authoritarian populism sought to generate a political platform based on insider/outsider divisions, often by deploying rhetoric that centralised apparent dangers, such as 'uncontrolled migration' and 'Islamic terrorism'. These populists thus pledged to 'control' borders and thereby protect the national population from external 'threats' (Campani 2018; Yuval-Davis 2018).

In the UK, for example, the insurgent anti-migrant populist right – in the form of then United Kingdom Independence Party (UKIP) leader Nigel Farage – has long fed into even more mainstream political discourse, with the former prime minister, David Cameron, once notably declaring that 'swarms' of migrants were making their way to British shores (Turner 2015: 22). Meanwhile, in the US, Donald Trump pledged repeatedly to stop the threat of illegal Mexican immigrants and lax border control (Saul 2017). Here we see how moments of crisis (real or constructed) strengthen authoritarian populists. Within these moments of emergency, political leaders reframe their actions not as some threat to democracy, international law, human rights, and so forth, but as a **contextually necessary** move to protect the people from various threats. This could mean the silencing of critics, permitting excessive violence by security forces, censoring and threatening independent media, harnessing disinformation, misusing digital surveillance, threatening minority rights and vulnerable groups, or weakening or shuttering important institutions by acting beyond what is reasonably necessary to protect public health (Repucci and Slipowitz 2020).

Across the world, we can observe various examples of such policy measures – now justified in relation to the Covid-19 pandemic. Put simply, the pandemic was a gift to the populists, providing another context to continue an assault on accountability, democratic institutions, civil liberties, and hard-won protections (see also Guterres 2021). Little surprise, then, that the Economist Intelligence Unit (2021) argues that democracy around the world is in its worst state since it began its index in 2006 (see also Stavrakakis and Katsampekis 2020). Indeed, the Economist Intelligence Unit (2021: 5) in 2021 found that almost 70 per cent of countries recorded a decline in their democracy score compared with their 2019 score. Typically, those nations already had weak(ened) safeguards against abuses of power.

Overall, it seems that already struggling democracies and highly repressive states were the most affected by the damage to democracy and accelerations of authoritarian agendas carried out under the cover of Covid-19, where 'government-imposed restrictions on individual freedoms and civil liberties occurred across the globe in response to the coronavirus pandemic' (*ibid.*: 4). Thomson and Ip (2020: 2) also note 'alarming regressions toward authoritarian governance', in both 'regimes already considered to be disciplinarian or tyrannical' **but also** in 'well-established liberal democracies' (*ibid.*: 4).[3]

In all cases, abuses of power during the pandemic have had a disproportionate impact on already marginalised communities, such as ethnic and religious minorities and migrants and refugees (Repucci and Slipowitz 2020: 5). Reflecting on these dynamics, Cooper and Aitchison (2020: 1) describe how, prior to the outbreak of Covid-19, there was a tendency within authoritarian governance, aided by political ethnic nationalism, to provide 'a vocabulary of fear and diversion, directing grievances towards "aliens" and other minorities within the polity and raising hostility towards imagined "foreign" enemies outside it'. Often these xenophobic narratives refer to immigrants or strangers as 'parasites or contagious agents' (Pericàs 2020: 1111).

3 Authoritarian populism and global vaccination efforts

Within various nation states there are often various legally binding human rights instruments that set out duties to provide equitable access to health care, regardless of nationality, migration status, or other prohibited grounds for discrimination, which applies to the provision of equitable access to Covid-19 vaccinations and treatments (Vallette, Nepesova and Korobkova 2021: 6). On the international level, various public health experts argue that '… exclusionary vaccine plans are ultimately self-defeating, leaving large pockets of the population unprotected and still able to contract and transmit the virus, including variants that may have the potential to evade the immunity granted by vaccines' (Safi 2021).

Nevertheless, despite these protocols and principles, the degree to which migrants and refugees are included in national vaccination programmes appears dependent on a range of factors, including supply issues; the degree to which governments have actively sought to include these populations; how many obstacles were erected that limited access to health care prior to the pandemic; and the degree to which anti-migrant and refugee rhetoric has eroded communal trust in the state or its medical infrastructure.

At the time of writing, several (wealthier) nations are making progress through their vaccination strategies. This is the point at which one might even expect to see some reversals in the above outlined authoritarian populist trends, insofar as vaccination and immunity ought to permit (if considered in isolation from actual political realities) a return to a certain degree of mobility, making it in theory harder to justify the continued shutting down of national borders. However, anti-migrant/refugee populist rhetoric often rests on some claim that non-citizens are gaining a privileged access to what would otherwise be limited resources, including housing and health care (Goodfellow 2020). These sentiments can easily feed into what is sometimes called 'vaccine nationalism' – that is, the hoarding of vaccines to facilitate the rapid immunisation of citizens (Bollyky and Bown 2020; Luck 2021). To unpick the nexus of challenges in vaccination access for migrants, we explore this next in terms of 'barriers'; that is, barriers to supply, in broader politics, and to mobility.

3.1 Supply barriers

When Covid-19 vaccination programmes began to roll out across the world, stark inequalities in stocks and supplies soon opened up between the global North and South. We know that most displaced people live in low-income countries. In addition, migrants and refugees, if they are moving using informal channels, often find themselves 'stuck' in transit, again typically in low-income countries. Such countries currently suffer from low supply of vaccines, with resulting low vaccination rates. This fact means it is difficult to judge the exact degree to which these populations will be included within national immunisation strategies – regardless of local political formations or stated positions on vaccine access.

At the time of writing, more than 84 per cent of all available vaccine doses are being administered in high- or upper middle-income countries (Reidy 2021b; *The New Humanitarian* 2021; Vallette *et al.* 2021: 2). In addition, a survey carried out by the United Nations International Organization for Migration (UN IOM) in May 2021 found that 40 per cent of 152 host countries' vaccination plans **did not** include, or were unclear about the inclusion of, refugees and asylum seekers (Vallette *et al.* 2021: vi). Potentially, this could mean that up to 46 million displaced people may struggle to get vaccinated, even if the global shortage of

vaccines eases (Safi 2021). Thus, with only 3 per cent of global vaccines available in low-income countries at present, even though several have pledged to include forcibly displaced persons in their national programmes, it remains difficult to judge how far refugees will be *de facto* included as the reality of low supply means vaccination rates still remain low (Vallette *et al.* 2021: vi). Indeed, in a range of interviews with key informants for this article, the majority cited lack of vaccination stock as the primary explanation for low levels of migrant and refugee immunisation; many experts suspected that these populations are unlikely to be prioritised if citizens cannot gain access either.

As of April 2021, only 20 countries had 'begun vaccinating refugees and asylum seekers on an equal footing to citizens' – this includes some low- and middle-income countries, such as Jordan, Nepal, Rwanda, and Serbia (*The New Humanitarian* 2021; Vallette *et al.* 2021: 5). By late June, at least 91 of 162 countries monitored by the United Nations High Commissioner for Refugees (UNHCR) had started vaccinating refugees or asylum seekers, although not necessarily on an equal footing with citizens (*The New Humanitarian* 2021). Unregistered refugees and undocumented migrants in particular risk being left out of national roll-out plans (Vallette *et al.* 2021: 5). For example, Pakistan will include the some 1.4 million Afghans who hold refugee cards in their vaccination plans, but it is unclear if unregistered Afghans, numbering in the hundreds of thousands, will also be included (*The New Humanitarian* 2021).

Nevertheless, the key point at present remains that even when forcibly displaced persons are included in national plans, this does not necessarily mean they will receive the vaccine due to issues with vaccine roll-out in host countries and global supply (Reidy 2021b; Safi 2021; Vallette *et al.* 2021: 5). However, there are also some examples of refugee inclusion. Colombia vaccinates registered Venezuelan refugees; Uganda has identified refugees as a priority group and is targeting them as part of the national vaccine roll-out; Moldova and Serbia have brought vaccines directly to people in asylum centres; while Senegal and Cameroon let refugees register in nearby health centres (*The New Humanitarian* 2021; Vallette *et al.* 2021: 10). Jordan is also an important example of positive inclusion, where access for forcibly displaced persons to testing and/or treatment/vaccines for Covid-19 is the same for citizens and refugees, with refugees in Jordan being among the first to get vaccinated in the world (Luck 2021; Vallette *et al.* 2021: 10).

One of the primary means through which refugees are supposed to access vaccines, if they are not included in national plans, is through COVAX (Covid-19 Vaccines Global Access) – an initiative that aims to deliver two billion vaccine doses for at least 20 per cent of the world's most vulnerable and high-risk groups (including refugees). However, deliveries through COVAX

have been underfunded and delayed (Reidy 2021b; *The New Humanitarian* 2021). This underfunding itself could potentially be explained through populist nativist approaches to the pandemic (i.e. vaccine nationalism and hoarding). The consequences are that countries such as Uganda, Pakistan, Lebanon, and Colombia, which host some of the largest refugee populations in the world, and actively seek to include those populations, are nonetheless facing issues with undersupply of vaccine doses through COVAX (Reidy 2021b).

Vaccinations for Rohingya refugees in Bangladesh, for example, have been postponed citing shortages and they are the only group in the country who have not yet had access to the vaccine despite on paper being included in Bangladesh's national vaccination plans (*The New Humanitarian* 2021; Vallette *et al.* 2021: v). The government has indicated that with rising caseloads and vaccine shortages, vaccines for refugees would only begin once COVAX supplies arrived (*The New Humanitarian* 2021; Vallette *et al.* 2021: 4). Overall then, we can conclude that, at the time of writing, a great majority of the world's migrants and refugees remain excluded, in large part due to supply constraints in the global South. However, this problem is, itself, entangled within the broader global trend of authoritarian populism, as well as anti-migrant policies, further discussed next.

3.2 Political barriers

Even prior to the current pandemic, forcibly displaced persons faced 'socioeconomic, sociocultural, and educational barriers when accessing immunisation services in host countries' (Bartovic *et al.* 2021: 3). A study looking at refugee and migrants' access to vaccines in Europe, for example, found that alongside administrative issues, migrants were concerned that registering with medical authorities might lead to legal consequences (Mipatrini *et al.* 2017: 66). Moreover, in several wealthier countries, such as the UK and the USA, deportation regimes have become more draconian over many years.

It is not surprising, then, that refugees and migrants might have little trust in governments that – often even during the pandemic – continued the systematic deportations of people seeking asylum (e.g. Taylor 2021). Such legal measures represent the clear material ramifications of authoritarian populism, where by generating the spectre of 'outsiders', and by whipping up fear and resentment, various governments have sought to 'limit' migrant and refugee access to basic welfare services (in the UK, see, for example, Goodfellow 2020). Such measures have harmed our collective ability to fight a virus that does not, quite obviously, differentiate by citizenship.

Nevertheless, several wealthier countries have now made explicit attempts to target and include migrants and refugees. Germany, for example, has directly included asylum seekers

living in accommodation centres as part of the second priority group to receive the vaccine (Pisoni 2021). Others have provided forcibly displaced persons with access to Covid-19-related health care directly (see Vallette *et al.* 2021). However, across Europe, certain trends (which vary in degree, country-to-country) are emerging where access to vaccines for migrants and refugees looks constrained not due to a strict **lack** of inclusion but due to a lack of trust in the vaccinations themselves or in the authorities administering those vaccines (Balakrishnan 2021).

Even when forcibly displaced persons are explicitly included in vaccination plans, in practice, a long list of factors risks keeping refugees and migrants from getting vaccinated (Reidy 2021b; Safi 2021; *The New Humanitarian* 2021). These include incapacitated health systems, red tape, onerous registration systems, design oversights in national vaccine registration systems, long distances, and logistical challenges of reaching people in remote areas, language barriers, misinformation, vaccine hesitancy, pre-existing social marginalisation, lack of trust in authorities, and fear of arrest (Reidy 2021b; Safi 2021; *The New Humanitarian* 2021). Other potential problems include the simple cost of vaccination (if it is not being provided for free by host countries) and digital access and literacy needed to navigate online registration portals to coordinate vaccine appointments (Reidy 2021b). Indeed, a range of vaccine registration systems often also require forcibly displaced persons to have a certain type of identity card they may not have access to, effectively excluding them (*ibid.*).

In places where forcibly displaced persons are discriminated against for political gain, migrants and refugees show little trust in authorities and their willingness to accept the vaccine is lower (Pisoni 2021; Reidy 2021b). For example, while Syrian refugees in Lebanon theoretically have the same access to vaccines as citizens, their vaccination rates are lagging far behind (Human Rights Watch 2021; Safi 2021). The explanation for this includes years of 'policies making it difficult for Syrians in the country to maintain legal residency, access basic services, and earn a living' (Reidy 2021b), as well as forcible deportations and regular talk of sending them back to Syria, which means that 'many Syrians fear [that] registering on the government's vaccine platform could lead to arrest, detention, or even deportation' (*ibid.*) despite assurances that data will be firewalled from security services (Human Rights Watch 2021).

While Palestinian refugees in Lebanon do not face the same deportation fears, years of discrimination mean that there is little trust in the government and they fear that 'even if they were to register, they would not actually receive the vaccine and would have to pay a fee they could not afford' (*ibid.*). There are also concerns amongst Syrian refugees that they cannot afford to deal with any side effects of the vaccines as they do not have access to appropriate health care (Reidy 2021b). Lack of information and

misinformation were further challenges to vaccination, as many refugees were unaware of how to register to be vaccinated or that they were entitled to be vaccinated, while others heard that it was unsafe or that it was linked to a government plan to send them back to Syria (Human Rights Watch 2021).

Even where vaccines are available and governments have adopted a more open approach to vaccination, nations which exhibit strong authoritarian populist political movements, even where they explicitly include migrants and refugees, have to combat the impact of decades of hostile messaging against those populations. In the UK, for example, the remit to control the country's borders, in line with the so-called 'hostile environment policy', has increasingly fallen within diffuse areas of state and society, including the national health service, creating barriers to health care (Goodfellow 2020; Stone and Bulman 2021).

These recent histories have understandably eroded non-citizen trust in medical institutions and risk contributing towards vaccine hesitancy. Migrants and refugees in the UK with unofficial or uncertain status – up to 1.2 million people – were found to be unlikely to take up Covid-19 vaccinations despite government reassurances that there will be no checks on their right to live in the country (Stone and Bulman 2021; Walker 2021). Research by the Joint Council for the Welfare of Immigrants found that 56 per cent of people with refugee status were 'wary of accessing healthcare because of fears about data-sharing between the NHS and Home Office, rising to 81% for those with no official status' (Walker 2021).

In Colombia, undocumented Venezuelan migrants fear accessing health care due to concerns about what would be done to them if they sought care and treatment, as well as over the costs of treatment (Ebus 2021). Existing discrimination and growing xenophobia contribute to their uncertainty over vaccine access, despite a dramatic policy shift in February 2021, when the president declared that undocumented Venezuelans would be offered temporary protected status (*ibid.*). This is a significant shift from December 2020 when he made a much-criticised declaration that undocumented Venezuelan migrants would be excluded from the country's vaccination campaign (*ibid.*). Despite the policy shift there are concerns that many undocumented Venezuelans will still struggle to access vaccinations, especially as they will struggle to get the documentation to formalise their immigration status (*ibid.*). There are also concerns that issues around vaccination will increase xenophobia due to the fear of unvaccinated people (*ibid.*).

Some countries are more explicit in their exclusion. Greece, for example, has declared that asylum seekers in camps are not a priority group, despite concerns that they are more likely to be susceptible to the Covid-19 virus due to their living conditions

(MacGregor 2021). Whether or not forcibly displaced persons will be prioritised when there are only a small number of available doses and countries push to inoculate their own citizens first is a significant concern (Reidy 2021a, 2021b).

Further, Mukumbang (2020) suggests that the focus on the protection of citizens and neglect of obligations to protect asylum seekers and refugees is the result of 'structural xenophobic tendencies' (*ibid.*: 2). Vallette *et al.* (2021: 9) suggest that 'xenophobia and fear of consequences may be key contributors to respondents' hesitancy in getting vaccinated' and seeking other forms of Covid-19-related treatment and testing. There is fear relating to the potential consequences of disclosing immigration status, especially for unregistered refugees and internally displaced persons (*ibid.*: 9).

3.3 Barriers to mobility

There are concerns amongst refugee advocates that 'the unequal distribution of vaccines will help cement policies that have restricted the mobility of vulnerable populations and access to protection during the pandemic as part of a "new normal" ' (Reidy 2021a). The systematic exclusion of undocumented migrants from accessing vaccines may be used as a 'pretext to limit people's movement' (*ibid.*). In addition, it could become 'another layer of documentation and paperwork, and things that people don't have access to in order to seek protection' (*ibid.*).

Official documentation, such as Covid passports, can be difficult to access for refugees and asylum seekers, who may have needed to destroy identifying documents when fleeing their homeland, or come from places with inadequate documentation of their identity (Loughnan and Dehm 2021). If they become a requirement for global mobility in the same way as state-issued passports, they could potentially limit mobility for refugees and asylum seekers (*ibid.*). For example, needing ' "Covid passports" for refugees outside Australia awaiting family reunification, sponsorship, or resettlement to Australia would… be an added hurdle to their access to asylum and safety' (*ibid.*). The UN's special rapporteur on racism, racial discrimination, xenophobia, and related intolerance also warned that COVI-Pass, an immunity passport being rolled out in West Africa, risks threatening freedom of movement for refugees and migrants (Achiume 2020). The increasing institutionalisation of vaccine passports means that several governments look likely to implement additional bureaucratic obstacles to movement and asylum, likely under the pretence of 'variant threats'.

4 Conclusions

As public health experts note, no one is safe anywhere from the Covid-19 pandemic until everyone is safe everywhere – yet across the world forcibly displaced persons remain unable to access vaccines. A rising tide of authoritarian populists, especially in

capitalist democracies, have responded to the crisis, not with the universalism a pandemic demands, but by instead deepening exclusionary policies and tightening their grip over various political orders. This has had a range of negative impacts for migrants and refugees. Most forcibly displaced people live in the global South, where vaccine nationalism and limited international assistance has left these populations exposed to endemic outbreaks. Such supply limitations now look set to continue with the addition of 'booster doses' (i.e. third doses) in global North countries. Even for refugees in the global North, those authoritarian, populist, and nativist political tendencies have generated a climate of fear, where forcibly displaced persons are likely discouraged from accessing vaccine services. It is vital that vaccines are made accessible to all across the world, that global South host countries receive enough vaccines, and that forcibly displaced persons' right to equitable access to health care is upheld in both practice and rhetoric.

Notes

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3 It is worthwhile mentioning here that these trends are not universal and unilinear – a range of alternative inclusive democratic and development trends, such as mutual aid organisations, housing the homeless, and re-thinking work, also emerged in response to the Covid-19 pandemic. Likewise, Youngs and Panchulidze (2020: 17–21) noted that there are some encouraging democratic trends through civil society efforts to protect democracy, the pushback against disinformation, political opposition gathering steam, new types of democratic processes, and new protest activity.

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