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

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Cover photo Migrant workers, wearing face masks or scarves, rest below the eastern freeway. Migrant workers have become stuck in Mumbai, without work or often shelter, as the borders of all the districts in India have been sealed against movement in an attempt to slow the spread of the coronavirus.

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Humanitarianism and Covid-19: Structural Dilemmas, Fault Lines, and New Perspectives

Issue Editors: **Jeremy Allouche and Dolf J.H. te Lintelo**

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Editorial: Covid-19 Responses: Insights into Contemporary Humanitarianism*

Jeremy Allouche[1] and Dolf J.H. te Lintelo[2]

Abstract The multifaceted nature of the Covid-19 pandemic has presented a crisis for the international humanitarian system, not only in terms of health impacts, but of socioeconomic challenges and increased inequalities. At a time when the number of people in need of assistance has drastically expanded, humanitarian funding has been cut as countries focus on their domestic economies. Moreover, pandemic responses have accelerated existing trends of eroding global refugee protection norms and regimes. International travel bans and lockdowns have impeded humanitarian access, thereby constraining conventional humanitarian response mechanisms and processes. Yet, the pandemic has given unanticipated impetus to the localisation agenda of the international humanitarian community. In the (partial) absence of state or international humanitarian responses, everyday forms of humanitarianism practised by and within local communities have been brought into sharp relief. These showcase a rich tapestry of actors, efforts, and solidarity practices that offer relief, typically at the micro level.

Keywords Covid-19, humanitarianism, vulnerability, protection, localisation, resilience.

1 Introduction

Much has been written about Covid-19. The pandemic is exceptional in its global scope, its unpredictability, the adaptive capacities of the virus, its devastation of human health, including millions of fatalities, its potential to destabilise economies and polities, and the unknown impacts on human health well into the future. As a major global crisis, Covid-19 has severely tested the humanitarian system in its ability to provide care and protection in crisis conditions. However, every crisis presents an opportunity to rethink policy, practice, and research, and commentators have proposed that the pandemic could be an opportunity for the

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humanitarian system to move forward on commitments to enable local humanitarian action and innovations in service delivery and programming. Accordingly, our call for this *IDS Bulletin* spurred contributors on to investigate in what ways the pandemic has exposed failings and generated new opportunities and challenges in the humanitarian system.

This *IDS Bulletin* presents original research articles from contributors located in academia and humanitarian practice. Synthesising across contributions, four themes emerge. The first concerns the multifaceted nature of the pandemic and its cascading impacts. The Covid-19 pandemic has triggered not merely a public health as much as a socioeconomic crisis, to deepen structural inequalities and highlight population-specific vulnerabilities. Moreover, we are increasingly witnessing Covid-19 as triggering political crises, as social division grows, and (violent) political protests challenge the democratic legitimacy of state responses to the pandemic, such as vaccine passporting.

The second major theme emerging in this *IDS Bulletin* concerns how responses to the pandemic have intertwined with a weakening of protection regimes for displaced people, including asylum seekers and refugees. Asylum seekers are increasingly prevented from accessing the protection to which they are legally entitled by international law, and responses to the pandemic have increased exclusion and exceptionalism.

The third major theme concerns the ways in which the pandemic has shone light on the functioning of the humanitarian system. The contributors to this *IDS Bulletin* have exposed not only the various responses, procedures, and practices by humanitarian actors to the pandemic, but also the geographical boundaries of the humanitarian system, both in relation to a global North–global South dichotomy and other forms of everyday humanitarianism. They show how the pandemic has presented both an ordinary and an extraordinary crisis for the international humanitarian system, and inevitably highlight the failures of states and international humanitarian actors to provide needed assistance.

Finally, the contributions note how the pandemic has given unanticipated impetus to the localisation agenda of the international humanitarian community. The term 'localisation', as used in the humanitarian sector, refers to the process of better engaging local and national actors in all phases of humanitarian action, including greater support for locally led action.

2 Socioeconomic challenges, vulnerability, and intersectionality

Although the focus on understanding the health impacts of Covid-19 has been paramount from the start of the pandemic, it soon became clear that the associated socioeconomic challenges could well be of equal, if not greater, societal

consequence. Economic contractions worldwide have brought about the first increase in extreme poverty since 1998. In January 2021, it was estimated that between 119 million and 124 million people could have fallen back into extreme poverty in 2020 due to the Covid-19 pandemic, with an additional increase of between 24 million and 39 million people in 2021, potentially bringing the number of new people living in extreme poverty to between 143 million and 163 million (Lakner *et al.* 2021).

Disruptions to supply chains, movement restrictions through border closures and lockdowns, and market volatility drastically increased food insecurity, pushing over 270 million people worldwide to suffer from acute food insecurity by the end of 2020. Health service disruptions also led to a 30 per cent reduction in the global coverage of essential nutrition services, leaving nearly seven million additional children at risk of suffering from acute malnutrition. The closure of schools led to the loss of important early intervention opportunities for protection, mental health and psychosocial support, and nutrition programmes (Cerna, Rutigliano and Mezzanotte 2020).

All these facts and figures not only point to a further deepening and spreading of socioeconomic inequalities, but also to the amplified need for humanitarian assistance globally. An estimated 274 million people will need humanitarian assistance in 2022, an increase of 39 million people from 2021 (OCHA 2021). Even before the Covid-19 pandemic, 2020 was going to be a year marked by humanitarian need. Conflict in Yemen, Syria, the Democratic Republic of the Congo (DRC), Mali, and elsewhere was driving food shortages and displacement of people. There were 79.5 million forcibly displaced persons by the end of 2019.

Moreover, these broad-stroke global figures belie the differential impacts that the pandemic has had on particular population groups. Hunt and Banks (this *IDS Bulletin*) highlight that while primary data are scarce, existing evidence suggests that within humanitarian settings, people with disabilities faced growing discrimination and amplification of pre-existing barriers to access health services during the pandemic.

The impacts of the pandemic are racialised. In the UK, black, Asian, and minority ethnic communities are disproportionately represented on the frontline of the very same health-care services. They are more likely to work in frontline jobs that do not allow for working from home (e.g. bus drivers), living with multiple generations in crowded urban housing, in low-paying jobs, to be undocumented, unemployed, food insecure, addicted, or imprisoned than their white counterparts, all factors that reduce an individual's ability to resist the virus (Public Health England 2020).

The impacts are also gendered: women disproportionately face the burden of increased homeworking and caring for others

(children, family members, sick people), even while the loss of referral pathways, access to information, the closures of schools and safe spaces, and the day-to-day isolation of women and girls during lockdowns and other measures have led to what the United Nations has described as a 'shadow pandemic' of rising gender-based violence (UN Women 2020). Consequently, migration status, disability, race, and gender have been overlapping factors involved in the production of differentiated impacts on sub-populations within countries.

On the socioeconomic challenges and the vulnerability of refugees, asylum seekers, and internally displaced persons (IDPs), the debate has been quick at distinguishing the health from the socioeconomic consequences. Initially, the focus was on health as it was believed that the conditions of refugees, asylum seekers, and IDPs, many of whom live in overcrowded conditions with little access to sanitation, health care, and reliable information, were such that an outbreak of Covid-19 could spread rapidly (Lang 2020; Akkerman 2020; Meer and Villegas 2020). However, for the first six months of the pandemic, case rates among refugees were far lower than expected. This was partly because of low testing rates in those urban settings where a majority of displaced people are located nowadays, but also because of the isolation of many refugee camps from host communities and strict lockdown measures which curbed the spread of the virus, as well as the relative youth of most refugees worldwide, which made them less susceptible to the virus (Godin 2020).

The economic and social impact of the pandemic on forcibly displaced persons has been severe. Covid-19 was less the pathogen that fundamentally altered everyday lives, but rather an additional stress that re-enforced pre-existing forms of precarity. Forcibly displaced persons' livelihoods and ability to survive have also been greatly affected as their legal status often means that opportunities in the formal economy are severely constrained by public policy. Consequently, dependence on informal jobs and self-employment is high, yet these kinds of livelihood opportunities have been heavily disrupted by Covid-19 and public health measures responding to it (such as lockdowns), while at the same time humanitarian support dried up (Godin 2020; UN 2020: 8, 10; Hoagland 2020: 31).

3 Weakening protection regimes

The threat to people on the move comes not only from material (in)security but, as is clear from several contributions to this *IDS Bulletin*, from increasing exclusion and exceptionalism associated with an eroding politics of protection. While experts on the global pandemic have mostly emphasised health and socioeconomic crises, a humanitarian perspective further underlines the gradual degradation of protection and human rights for refugees, migrants, and IDPs, with stricter border and migration policies across the world (Akkerman 2020: 2–3).

Asylum seekers are increasingly prevented from accessing the protection to which they are legally entitled by international law.

Efforts dealing with the Covid-19 pandemic have in some instances reinforced discriminatory discourses that frame refugees as a burden to the state and scapegoat people on the move as spreading the virus (Goodfellow 2020). Fear of Covid-19 and the increasing human and financial toll of the pandemic has resulted in increasing tensions between displaced populations and host communities (Lang 2020; UN 2020: 3).

Prior to the outbreak of the pandemic, refugee and asylum seekers' rights were already at risk and xenophobic attitudes and policies were gaining significant ground, despite states being unable under international law to legally prevent people from seeking asylum from persecution (Hoagland 2020: 6; Charney 2020: 1). Covid-19 policies of closing borders have *de facto* enabled governments to violate refugee rights and protections, as well as turn back on promises made with respect to refugee resettlement. Such border controls and policies come not only from authoritarian regimes. The European Union has increasingly securitised its borders and externalised them to third countries such as Turkey and other North African countries to prevent people, whatever the reason for their displacement, from ever reaching their borders (Akkerman 2020: 2). Despite a small number of governments taking temporary measures to release detained migrants, postpone deportations, and ensure access to health care, in general, the pandemic has led to 'an even greater erosion of the rights of those on the move, including the right to seek asylum and the principle of *non-refoulement*' (Meer and Villegas 2020: 3; Akkerman 2020: 2).

Moreover, as several articles note (Proudfoot and Rohwerder, this *IDS Bulletin*; Korobkova, Nepesova and Valette, this *IDS Bulletin*), not only have refugee mobilities and rights been rolled back under the pandemic, but their access to health care has been compromised too. 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, Nepesova and Korobkova 2021: 5). Proudfoot and Rohwerder (this *IDS Bulletin*) identify three key areas with respect to vaccination of migrants and refugees; namely, barriers to supply, barriers to mobility, and limited trust in broader politics. For instance, they show that the extent to which migrants and refugees are included in national vaccination programmes appears to be dependent on a range of factors: supply issues; the degree to which governments have actively sought to include these populations; how many obstacles were created 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.

Korobkova *et al*. (this *IDS Bulletin*) discuss a multi-country survey of refugee populations in Colombia, Peru, Brazil, Uganda, DRC, Jordan, and Turkey, and IDPs in Venezuela to highlight the impact of vaccine distribution inequity on the most at risk, and to better understand the barriers to vaccination and the impacts of the Covid-19 pandemic on displaced populations. The primary data findings were supplemented with secondary data to arrive at stark conclusions. Only one person out of 339 household interviews, representing 1,914 forcibly displaced persons, reported receiving a Covid-19 vaccine. Sixty-eight per cent of respondents had not heard of plans for vaccinations in their communities. Nearly half of the respondents either thought they were not eligible or did not know if they were eligible for a vaccination.

This points out overall how global humanitarian and refugee norms are increasingly contested (Easton-Calabria, this *IDS Bulletin* provides a counternarrative to this point in relation to the Global Compact on Refugees). In this context, the Covid-19 pandemic appears to have accelerated current trends relating to the undermining of global refugee protection regimes.

4 The pandemic as a driver towards a new form of humanitarianism?

The international humanitarian system's **orientation** of efforts towards mitigating the health and socioeconomic impacts of the pandemic has been quite conventional. Nevertheless, the **scale** and the nature of the multiple related health and economic crises incurred by the pandemic have been anything but. Humanitarian action is typically oriented towards more regional or local geographies in low- and middle-income countries, so the outbreak of Covid-19 at the global scale is unusual. This, and the pandemic's endurance and cyclical shifts over time, raise questions about humanitarianism and its nexus with development (Allouche and Lind 2014); namely, through its geographical boundaries, as well as its functioning.

The pandemic has had disproportionate impacts on the most vulnerable and poor communities, whether in low-, middle-, or high-income countries. Parallels can be drawn in shared trajectories of deepening income and wealth inequalities within society, but also in having common drivers of vulnerability; for instance, through the casualisation of labour in gig economies, racism, and the structural unavailability of affordable housing in major urban centres. For historical reasons, yet increasingly artificially, humanitarian efforts rarely seem to extend to addressing crisis events in high-income countries, even though these have significant populations that are severely deprived.

Perhaps lessons could be learned from the international development industry, which is slowly (and in some quarters reluctantly) adapting its focus towards a more universal understanding of development, in line with the Sustainable

Development Goals. The responses to the pandemic have accelerated this shift (Leach *et al*. 2021), enabling a more critical engagement with development processes in high-income countries and scope for drawing significant comparisons with and lessons from low- and medium-income countries.

In some ways, the pandemic has been quite unlike those crisis events that constitute the humanitarian system's *raison d'être*. Whereas humanitarian assistance tends to mobilise when earthquakes, flooding and other disasters, famine, and conflict-based displacement strike, responses to the pandemic are in significant ways characterised by immobilisation (not paralysis) of conventional responding mechanisms and processes. While the number of people in need of assistance rapidly elevated, international travel bans and local lockdowns impeded humanitarian access to crisis settings, and humanitarian funding was cut simultaneously as rich countries' resources were directed inwardly (Godin 2020; Hazard 2020: 18; UN 2020: 8, 10; Hoagland 2020: 31).

In this context, several contributors to this *IDS Bulletin* highlight the importance of local forms of solidarity and mutual assistance (Müller, this *IDS Bulletin*; Easton-Calabria, this *IDS Bulletin*; Beaujouan, this *IDS Bulletin*). These contributors observe the numerous everyday ways of humanitarianism practised by and within local communities in Covid-19-affected settings. They note a rich tapestry of actors, efforts, and practices that offer relief, typically at the micro level, in the (partial) absence of state or international humanitarian responses. Interesting examples concern migrant networks and transnational diasporas. In Addis Ababa, Khartoum, Nairobi, and Cape Town, their solidarity initiatives strengthened migrants' agency in the face of deepening economic insecurity, reduced remittances, job losses, and constraints on business activity, albeit in different ways. The articles highlight that the remit of such local responses uniquely covers not only material aspects (for instance through food aid provision) but critically extends to and relieves the immaterial and emotional ill-being effects that the pandemic has had on many people, including the loneliness felt by those affected by lockdown policies.

The pandemic has not only revealed such efforts at local self-reliance but may also have altered pre-existing configurations. In the rebel-held governorate of Idlib, Syria, Beaujouan (this *IDS Bulletin*) finds that responses to the pandemic created an impulse for collaboration among civil society and other grass-roots initiatives otherwise fractured along confessional and party-political lines. This translated into a strengthening of civic activism and voluntarism, and a more coordinated and proactive local civil society. Yet, as much as these local solidarities are praised, they also speak to the failures of states and international humanitarian actors to provide needed assistance.

5 Beyond the localisation agenda

The Covid-19 pandemic has prompted a revisioning and alternative filling in of the international community's localisation agenda. Advocated by the World Humanitarian Summit 2016, which considered that 'crisis-affected people' are often crucial first responders, localisation efforts have often sought to shift the focus of international humanitarian efforts from national governments to subnational authorities. Yet, it is clear that localisation will need to go beyond a statist orientation (Allouche and Maubert 2021). Contributors have noted the decentral everyday humanitarian work done by local communities and groupings, such as refugee-led organisations (as discussed by Easton-Calabria, this *IDS Bulletin* and Müller, this *IDS Bulletin*), both in their own right, and as crucial emerging intermediaries in the humanitarian system. Arguably, the renewed focus on the role of local actors offers an opportunity to turn the rhetoric of localisation agendas into action and provide more funding, support, and recognition for national and local humanitarian responders.

As Easton-Calabria (this *IDS Bulletin*) shows, a few organisations and foundations such as Open Society Foundations or the Lam Larsen award have adjusted their operational practices to provide more flexible funding mechanisms and faster bureaucratic procedures, recognising the importance of transferring ownership and resources to refugee-led organisations. Similarly, in the field of sexual health and reproductive rights, humanitarian providers have shifted towards telemedicine, task-shifting and sharing, and community-based service delivery (Jacobi and Rich, this *IDS Bulletin*). Yet, it is also clear that Covid-19 responses may have deprioritised particular services (Jacobi and Rich, this *IDS Bulletin*) or populations (Hunt and Banks, this *IDS Bulletin*). Consequently, both the adjustments within the humanitarian system as well as the turn towards localised responses demand a continued critical scholarly engagement, as these may express particular forms of 'resilience', and may not necessarily be inclusive in their remit, to understand their implications for a future humanitarianism.

6 Conclusion

Our editorial has highlighted previously underlit solidarities, and noted people's agency and the capacity of refugees, migrants, and IDPs to ingenuously cope with the Covid-19 crisis. It has also focused on the ways the pandemic has highlighted multiple forms of crisis and revealed more visibly the slow structural cracks in a global humanitarian system with the fading of protection rights and localisation slowly becoming an alternative to global solidarity. Are these two trends reflective of a bigger moment?

It seems that we are witnessing a moment of withdrawal, with more and more remote ways of working, from the international humanitarian bureaucracy to a larger withdrawal of the global North, reducing aid, closing the borders, not sharing the vaccines, and not worrying about the secondary economic impacts.

Is the pandemic offering a foreboding of how future climate emergencies will be dealt with? A form of detachment, a low level of concern, of weakening international solidarities, and a growing orientation to nearby troubles – which all point to a worrying future for humanitarianism.

Notes

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Covid-19 and Urban Migrants in the Horn of Africa: Lived Citizenship and Everyday Humanitarianism*

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Abstract This article focuses on the everyday humanitarianism of migrant communities in three cities in the Horn of Africa: Nairobi, Addis Ababa, and Khartoum. It is framed around the concept of lived citizenship, defined as a means to secure wellbeing through everyday acts and practices. Based on an analysis of comparative interview data among Eritrean and Ethiopian migrant communities in each city, the article argues that the Covid-19 pandemic has impacted lived citizenship practices to different degrees, linked to previous forms of precarity, and the means and networks of coping with those. Disruptions of transnational support networks resulted in a turn towards local networks and everyday practices of solidarity. These forms of everyday humanitarianism range from spontaneous to more organised forms, united by a perceived lack of involvement by international humanitarian actors and the local state. The article raises important questions in relation to transnational humanitarian action in a global crisis.

Keywords Covid-19, urban migrants, lived citizenship, everyday humanitarianism, Horn of Africa.

1 Introduction

In the globalised world we live in, any pandemic profoundly affects migration and mobility. At the same time, the wellbeing of migrant population groups is rarely at the forefront of government policies, and much less so during times of crises. This state of affairs is visible in global measures to contain the spread of Covid-19 that centred on lockdowns and (border) closures (Mueller *et al.* 2020; Zimmermann *et al.* 2020). Such measures were also key features of the 'quick and decisive response' to the pandemic in many African countries (Dzinamarira, Dzobo and Chitungo 2020: 2466) and have disproportionally impacted the

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lives of migrants and those dependent on transnational networks (Mobarak 2020; UN 2020).

In this article, I consider how migrants from Ethiopia and Eritrea who reside in Nairobi, Khartoum, and Addis Ababa (Eritreans only) have responded to the challenges that the Covid-19 pandemic created for their everyday lives. The concept of lived citizenship is used to analyse coping strategies and the forms of everyday humanitarianism that have emerged. Some policy-relevant conclusions are then drawn on how to better consider mobile lives in responses to global crises.

Lived citizenship conceives of citizenship as relational and affective practices grounded in multiple forms of interconnectedness (Isin and Nielsen 2008; Wood and Black 2018). In focusing on citizenship as practised in everyday encounters, it allows analysis of the lives of mobile populations regardless of official status or papers, but with respect to acts aimed at securing rights and wellbeing (for examples, see McNevin 2006; Nyers and Rygiel 2012; Müller 2016; Ticktin 2006).

Everyday humanitarianism is used here in its most basic sense, as aiming to alleviate suffering in everyday lives with the objective of making a difference outside the traditional structures or boundaries of humanitarian action (see Richey 2018). It is a form of affective engagement that, based directly or indirectly on a moral imperative to intervene when suffering occurs or help is needed, is always also a form of political action and governance (Ticktin 2014) – even if only in demonstrating a lack of other, more traditional, humanitarian responses.

In this article, the argument is made that the Covid-19 pandemic is exacerbating the inequalities and precariousness of lived citizenship practices among migrant communities to different degrees. At the same time, even where transnational support networks were disrupted, renewed attention to local support networks and everyday practices of solidarity enhanced migrants' agency in the face of adversity. These emerging forms of everyday humanitarianism range from spontaneous to more organised forms, but what unites them is their independence from international humanitarian actors and/or the local state. The Covid-19 pandemic can therefore serve as an interesting example to rethink the call for localisation of humanitarian responses from the perspective of migrant networks and transnational diasporas.

Methodologically, the article is based on the analysis of interviews conducted with 16 Eritrean and Ethiopian migrants in Nairobi, five migrants in Khartoum, and eight Eritrean migrants in Addis Ababa. The majority were long-term residents of their respective cities with relevant papers such as work permits; some were recognised refugees, others were non-status refugees. However, most regarded the city they lived in, often for a prolonged period of

time, as a transit destination and were planning for resettlement usually in the global North where in some cases family members already resided.[2]

The interviews were conducted for a broader comparative study on transnational lived citizenship and belonging among regional diasporas in urban centres of the Horn of Africa (with the cities Nairobi, Addis Ababa, and Khartoum as the key sites). Face-to-face fieldwork was to commence in Nairobi in March 2020, but due to the Covid-19 pandemic had to be postponed indefinitely. Instead of sampling based on participant observation of diaspora community activities on the ground, snowball sampling starting from informal personal networks was used to conduct virtual interviews via Zoom or WhatsApp.

The use of virtual interviews excluded potential participants without access to mobile technologies and/or the means to pay for data bundles. This was navigated through offering to use the internet facilities of local project partners, and through arrangements to pay for data bundles. Nevertheless, non-virtual fieldwork might have included other migrant groups; thus, the data and findings presented here need to be read with this bias in mind, and some of the coping mechanisms discussed later may not be available to all migrant groups.

The interviews were conducted by the former postdoctoral researcher of the project, Mesghina Abraha. Covid-19 was raised by most participants without probing, leading to more specific questions on the effects of the Covid-19 pandemic on their lives. Answers to those questions form the empirical basis of this article.

Participants have been anonymised and any markers that could help identify them have been removed from the article. The project received all required ethical approvals. All participants agreed to the use of anonymised content and quotations from their interviews in publications.

The remainder of the article is structured as follows. Section 2 discusses the specific repercussions of Covid-19 for migrants; Section 3 then focuses on how lived citizenship has taken a local turn in response. Section 4 analyses the forms of everyday humanitarianism and solidarity that have emerged from that response, and the article concludes with an emphasis of the importance of transnational diasporas in response to shock and crises.

2 The Covid-19 pandemic and repercussions for migrant wellbeing

Broadly speaking, Covid-19, combined with the policies pursued to combat its spread, had multiple repercussions for migrant communities and the way they exercised their lived citizenship, in both material and non-material terms.[3] These repercussions were intimately linked with migrants' legal or aspired legal status

in their respective city, as well as previous forms of insecurity.[4] In that sense, Covid-19 was less the pathogen that fundamentally altered everyday lives, but rather an additional stress that re-enforced pre-existing forms of precarity.

In terms of material or economic wellbeing, repercussions centred on changes in remittances combined with local changes in employment. Only in Khartoum, where no real lockdown took place and where most people who settle in the city for longer have work and are less dependent on remittances, was the economic impact negligible. Respondent 'V' said: 'I have my secure job so my income was not reduced, but a [weak Sudanese pound] has forced prices to surge'[5] leading to some difficulties at times. And respondent 'U' adds: 'As there was no lockdown, the virus did not bring any change in itself [for the] social and economic life of the migrant community',[6] adding that the main issue was the political situation in Sudan and the tensions between the civil and military arms of government during the ongoing transition period, thus not Covid-19. In particular, respondent 'U' enforced the argument that Covid-19 might not necessarily be the main cause of concern in a volatile political and economic environment.

In Nairobi and Addis Ababa, a majority of migrants from both communities depend on remittances solely or partly, Eritreans usually more so than Ethiopians. How the cycle of the Covid-19 pandemic has disrupted remittances that secure everyday material wellbeing is described in exemplary fashion by respondent 'D' from Nairobi: her partner and the father of their two children works in the construction sector in the UK. Since his departure, 'D' lives off the remittances he sends that also pay for tuition fees for the eldest school-aged child – the only way to secure a good education in Kenya's school system and to learn proper English. The Covid-19 pandemic and the lockdown measures in the UK left her partner without work for many months. She had just enough savings to allow the continuation of her child's schooling and started to give some home-schooling lessons to others, as she is housebound with her youngest child. When the UK lockdown eased, her partner started work again, but her example demonstrates the fragility of this transnational arrangement.[7]

Like 'D', those who rely on remittances usually do so from countries in the global North, and as those remittances for many have decreased in Covid-19 times, they struggle to make ends meet.[8] Even those who have work in 'customer service, as barista, in hairdressing [in this line of work] one does not earn a lot' so even with a job they rely on remittances for their regular expenses.[9]

In addition, many Ethiopians and Eritreans in Nairobi and Addis Ababa especially work in sectors particularly affected by the pandemic; namely, the hospitality industry or as drivers. These jobs are usually done on an informal or semi-formal basis, which

makes it easy for employers to reduce working hours and wages. In this respect, respondent 'N' says that for Eritrean-run business owners, it is good 'to have cheap labour', often meaning qualified Eritrean employees to whom they pay meagre wages as they lack official papers. In contrast, 'for us [Eritrean employees] it is an earning, we have to chase those jobs and if we are lucky, we get one'.[10]

Taken together, economic hardship was partly a result of the Covid-19 pandemic, in combination with the precarity already present in pre-Covid-19 migrant lives. While such economic hardship was difficult enough for those who experienced it, non-material aspects of wellbeing were of equal or even greater importance for many in those cities where social contacts were severely restricted or forbidden. Two social activities are of prime importance within both communities to similar degrees: gathering for daily coffee ceremonies to exchange news but also to develop mutual support networks and strategies; and attendance at religious gatherings, mainly in Christian churches (e.g. Orthodox, Catholic, Pentecostal) and Muslim places of worship. With lockdown measures, both social activities were restricted, albeit to different degrees.

Many places of worship were closed during periods of lockdown or had visiting numbers severely curtailed. Particularly for those who live on their own, church or mosque gatherings are the most important means to meet others, in terms of social connections as well as in relation to asking for actual help with any emerging problems. Especially for those residing in neighbourhoods without a substantial diaspora community and/or those living on their own, without family or relatives, isolation in such circumstances was a constant struggle. Eritreans and Ethiopians are social beings: 'People cannot handle the loneliness', as one participant summed up.[11]

Apart from or in addition to church/mosque gatherings, the coffee ceremony is often the only social outlet for many: it is a key feature of everyday life in their home country, and is even more important in a migrant setting. It is the glue that holds society together. But in some areas coffee ceremonies have ceased almost completely because of lockdown policies, according to some informants:

> *People* [referring to Kenyans] *started to monitor neighbourhoods for Covid-19 symptoms, and if they see somebody breaking the rules, they pass it on to the authorities to safeguard the neighbourhood health… people are very active in that respect to ensure government guidelines are followed*.[12]

This has resulted in a state of affairs where 'we refrain from going into other people's houses and have coffee as we

used to; this has created pressures on our lives'.[13] This pressure is more devastating for single men, who not only often lack the equipment necessary for a proper coffee ceremony but who in the past would have been invited by women living in their neighbourhood or by connections further away. Travel and visiting have been constrained while coffee houses they would otherwise have visited have also remained closed.

In Addis Ababa, many of the young Eritrean migrants who depend almost entirely on remittances and find jobs hard to come by, spend their time in *shisha* bars, restaurants, and night clubs – which were all closed due to the pandemic. Participant 'Q', a student who is also involved in setting up an informal association to help advance the education of members of the Eritrean migrant community, says in this respect: 'For young Eritreans who were regular visitors of such venues [such as bars] it was challenging… staying at home was hard for them'. He thus started to give them counselling with the hope that engaging them in the future in education would 'drive them away from their… habits of drinking and being lazy'.[14]

Taken together, many of the challenges raised by members of both migrant communities in relation to employment and economic security, but also in relation to social connections and community, are similar to those of migrant workers more generally, whether they are internal or external migrants. However, both migrant communities created new networks locally or strengthened pre-existing ones related to their country of origin as a coping mechanism. Before the Covid-19 pandemic, the orientation of many was towards transnational networks away from the city where they resided, with the ultimate aim of leaving that city. The pandemic resulted in or enforced what is described in Section 3 as a 'local turn' in lived citizenship.

3 Migrant responses: lived citizenship takes a local turn

In all three cities, migrants, even those with urban residence permits, have not only fewer legal rights than citizens, but they usually also lack access to social services, including health services, unless they pay for them privately. With economic insecurity accelerating throughout the pandemic and reduced remittances, those with more wealth who ran their own businesses were also partly affected.

The combination of these dynamics triggered a turn to localised networks and relations as the key means to respond to the material repercussions of the Covid-19 pandemic but also the non-material and emotional aspects, including the loneliness felt by those affected by lockdown policies. In relation to this, some notable differences have been reported between Eritrean and Ethiopian communities.

In the case of the Eritrean community, no support was provided by their embassy or other semi-formal networks. This has resulted in *ad hoc* support measures in their neighbourhoods or through friends gaining new importance, while the transnational dimension of lived citizenship has moved into the background. In addition, connections through faith-based groups have gained in significance, also in relation to the provision of material support.

Some churches, for example, organised prayer sessions via Zoom, as respondent 'O' elaborates:

> *One good thing was the church had organised daily prayer time using Zoom. That felt like we were together because we can see each other's faces on the screen. That was great… for people to comfort one another. We were spending more than one hour chatting after the prayer time to talk about how people were doing during lockdown… Some people did not have the opportunity to join and were suffering psychologically* [as a result]. *Some Eritreans were meeting up with their Eritrean neighbours in small numbers, to overcome that.*[15]

While one may imagine that these virtual encounters through faith-based groups within and beyond the neighbourhood and connecting to the transnational diaspora community might have a similar effect, these encounters could not disperse the feeling of being isolated for some migrants. Rather, of prime importance was the possibility of connecting directly to those within the city or the local community. This was partly the case as many concrete initiatives to provide support, not only psychologically but also in material ways, started from local churches or mosques, as this business owner from Nairobi explains:

> *I now support two families regularly with their rent payments… the assistance is organised by the church, they communicate with us which people need help… I don't know the people personally who I support, as it is better to do this anonymously.*[16]

Among parts of the Ethiopian community in Nairobi, support networks were more structured and drew upon connections already in place before the Covid-19 pandemic. Among the Ethiopian Oromo migrant community, for example, a strong semi-formal network of support does exist: 'We Oromos have a social welfare organisation where we support each other… this is our culture as Oromos; though I come from Ethiopia I am first an Oromo… we Oromo are helping each other as much as we can', interviewee 'B' says.[17] These social welfare organisations are in fact structured entities in the different communities, he continues to explain; in effect, 'it's like a social welfare system by the Oromo community in different parts of the city'. 'B' is a member of his local organisation made up of 75–100 people. They collect money on a regular basis from their members and then support either

activities for the common good of all Oromo or, in times of crises like Covid-19, those in urgent and unexpected need. They are also loosely interlinked across closed social media groups globally and thus can draw on wider support if needed.

Among both migrant communities, research participants felt the need to be reassured in their daily struggles by engagement within their locality. Some were simply lucky in relation to their personal living conditions. One example here is 'J' from Nairobi who says:

> *If I see it from my building's perspective, I can say we are lucky. I personally did not go out for two months at the beginning of the pandemic, I used my time to finalise some project. But in this neighbourhood in general and my building in particular, I always hear people laughing. People were trying to forget their problems by congregating in small groups inside their houses and chat, having fun and laughter while having traditional coffee, eating what they had together, doing most of the things together with their neighbours. That encouraged me to be optimistic that this problem will go away and the community will overcome it together*.[18]

Others tried to live in the same compound with people they knew or at least from the same original locality, and by doing this could draw on each other's support during periods of Covid-19 restrictions, while those living on their own or far away from areas where many migrants settle were often left lonely and isolated. 'R' elaborates in this respect on how her roommates in Addis Ababa 'are also my best friends, one from my childhood days and one who I met in the refugee camp… for me this is emotionally getting back to life in Asmara [the Eritrean capital]'.[19] And 'D' explains that she lives close to her friends who 'are mostly Ethiopian Oromo… there are also Kenyan Oromo in Nairobi but I do not socialise with them… I mostly socialise with Oromo from my province'.[20]

In a similar way, 'E' emphasises the increased importance of local connections: she shares a flat with a member from the same diaspora community whom she first met in a refugee camp in Kenya. When they decided to live together, it was partly as an extra layer of security and confidence, as for unmarried women to live on their own always carries risks. In Covid-19 times, it became a life saver, as she explains:

> *We were able to survive the lockdown because I shared my expenses and my life with my friend* [her flatmate]. *We were and are still supporting one another in all aspects, financially, emotionally and socially. That is a blessing for me*.[21]

While both participants see Nairobi as a transitional place, their future plans have moved into the background in favour of securing their joint life in the city.

Taken together, how well participants dealt with Covid-19 repercussions and, in particular, lockdown periods, depended strongly on local connections. Out of these connections forms of everyday humanitarianism emerged, in the absence of help from the host state or international organisations.

4 Everyday humanitarianism at different levels

Multiple expressions of everyday humanitarianism have emerged in both migrant communities, often with recourse to what people perceive as the solidarity borne out of the culture of their country of origin. Respondent 'R', who was made redundant from her job in a boutique due to the pandemic, describes it in this way:

> *'Til now, I could not get another job… and we receive less remittances because our family who send us money are struggling too… in this difficult time, I admire the social heritage of our people* [that is] *embedded in our culture, it helps us share what we have, helping family and friends and even others in our community. That is what is keeping us alive, I wish this culture could last forever… emotionally, the increasing life challenges are damaging,* [but] *the culture of support gives me hope*.[22]

Similar thoughts are expressed by respondent 'S' who says when looking back at the time with the most restrictions in Addis Ababa:

> *I admire the compassion of the Eritrean community during this difficult time. I am proud to be Eritrean, no one was left behind… people were looking after each other… we felt more connected during the pandemic… There was a real sense of community*.[23]

This sense of a new type of togetherness from which support could be drawn was widely reported, locally but also across closed international borders. This suggests that even as the economic situation of many migrants remained precarious, they could activate a range of relationships and networks.

'T' says, for example: 'Our family relatives were constantly calling us from abroad, we managed to get through [the pandemic at the time when restrictions were in place in Addis Ababa that prevented business activities] in a good emotional condition'.[24]

Taken together, for members of the Eritrean diaspora who participated in this research, everyday humanitarianism in the form of mutual support largely drew on informal networks of peer-to-peer support or local community groups, and also involved local faith-based organisations as outlined previously. The (re-)activation of such networks as *ad hoc* everyday humanitarianism in response to the Covid-19 crisis partly drew on narratives of past histories that define understandings of community, but are now lived in a migrant context that, ironically, was created as a repercussion of that history.

'J' says in this regard that those who still get remittances often share them with others, and then draws a comparison with wider Eritrean history: 'It reminds me of the time in 1990 when Massawa was liberated and people in Asmara were struggling to get some food, our mothers then shared what they had with their neighbours to get through that difficult time'.[25] 'J' here refers to some of the founding narratives of Eritrea as an independent state that centre on community and sacrifice, narratives that have ultimately resulted in the repressive politics in Eritrea from which the migrants in Nairobi, Addis Ababa, and Khartoum have actually fled. In this interesting referral back to this 'heroic' past, these narratives are now reinvigorated as a means to get through the difficult life of a migrant during a time of crisis (for a wider discussion of the role of memory in migratory lives, see Hirt 2021).

In the case of the Ethiopian participants, more coordinated forms of everyday humanitarianism emerged, often driven by business owners and/or other wealthy members of the Ethiopian migrant community. In Nairobi, reportedly partly coordinated through the Ethiopian embassy, immediate relief for the Covid-19 shock was provided in the form of necessities such as flour and sugar for those who lost their work. In addition, money was raised to provide monthly stipends to those affected by unemployment and the loss of other livelihoods.[26]

Also on an individual basis, Ethiopian employers often showed compassion to their employees. An example of this is provided by 'E' who works for an Ethiopian compatriot:

> *Our wages and jobs are not guaranteed by law, we are casual workers… I entirely depend on the mercy of the owner, if she wants, she can fire me anytime… I want to thank her for letting me work when possible. I owe her a lot for the help she gave me during that difficult time.*[27]

What was notable among all the respondents was the perceived lack of support they received, not only from host states but equally from international actors such as the UNHCR, including those registered with the agency and/or awaiting status outcomes or outcomes on potential resettlement, for which many had applied. Rather, in some cases in Nairobi, UNHCR augmented fears and anxiety instead of being helpful, according to some respondents:

> *UNHCR is sending text messages asking refugees to verify themselves. Nobody knows the purpose of this. The majority of people here wait for resettlement and people do not know if the text is good news or bad. Some have optimism that their process got a positive result and that the text is sent to such people. Others think it is for the purpose of checking up on them. This has a psychological impact or puts pressure on people who have received such text messages.*[28]

The issue here arguably is not so much a lack of response from organisations such as UNHCR, as the organisation did provide various forms of assistance to urban refugees in Nairobi and Addis Ababa, including outreach and awareness; needs assessments; donations of protective kits; and food and rent support. Rather, among respondents, a lack of trust in the agency or awareness of its role dominates, as much of this assistance was administered through local refugee organisations or jointly with local, international, or government partners (for further details, see UNHCR 2020a, 2020b).

In Khartoum, the government organisation dealing with refugees, the Commission for Refugees (COR), is the official authority to support those in need, but works with international organisations including UNHCR as it deems appropriate. For urban refugees, UNHCR through COR supports income grants as well as food and hygiene packages for vulnerable households (UNHCR 2020c). Respondents were, however, suspicious of this assistance, as they feared this would result in the cancellation of their urban permit and a return to refugee camps where UNHCR is then the main responsible body. This arrangement enforces the tendency to seek support predominantly in one's local community, not least as, in the words of an Ethiopian, migrants in Khartoum 'don't have rights and there is nobody to advocate for your rights'.[29]

5 Conclusion

In this article, I have analysed empirical data on the forms of everyday humanitarianism as a response to the Covid-19 pandemic within Eritrean and Ethiopian migrant communities in Nairobi, Addis Ababa, and Khartoum. These migrants lack formal citizenship and citizenship laws in all settings make it near impossible to ever attain full status. A majority see the city they live in as a transitory space, but at the same time secure their livelihoods and wellbeing through 'behaving like citizens' in the way they act out their everyday lives. While Covid-19 policies have been different in each setting, ranging from full lockdowns in Nairobi, partial restrictions in Addis Ababa, to more limited restriction in Khartoum, the pandemic added to pre-existing forms of precarity in everyday lives and impacted the material and non-material wellbeing of these migrant communities. At the same time, new forms of everyday humanitarianism emerged as a response to this additional crisis, ranging from informal and/or spontaneous responses to more structured approaches.

These different forms of humanitarian responses were strongly embedded in pre-existing networks of local or transnational support created and sustained by migrant agency and lived citizenship practices. As such, they served as an entry point to flesh out policy agendas in the localisation of humanitarian responses from the perspective of migrants.

The empirical analysis presented for these distinct migrant communities, even if based on a small sample, lends itself to the following policy recommendations in relation to the mitigation of the Covid-19 pandemic, similar future shocks, and the turn towards localisation in humanitarian debates.

Firstly, much has been said about the important role of civil society organisations in Covid-19 mitigation, and civil society in its organised form can play a vital role (a good summary on a global scale is provided in CIVICUS 2020). But when talking about civil society, the focus is predominantly on organised parts within the non-governmental organisation (NGO) sector, whereas migrant networks are often informal; all the more so in settings where migrants may not have the correct residency papers for their place of residence. Such networks are not part of civil society *per se* but, rather, are grounded in specific moral economies, as the empirical data for this article have demonstrated. That is, they partly make up for the (real and perceived) lack of response by states and/or international humanitarian actors. A better understanding and recognition of these informal networks and their functions in crises, and an effort to link those with state or international humanitarian actors, for example in including them in inter-agency coordination or consultation fora, would be useful.

Secondly, as the empirical data presented here has shown, migrant respondents, through the interconnectedness of their lives, were key actors in their own right in navigating the repercussions of the Covid-19 pandemic. Visions for a clearer focus on interconnectedness have been formulated as a tentative agenda for certain regions of the world in light of the pandemic (see, for example, Kabutaulaka 2020) – based largely on nation states as crucial actors; migrant networks could be a way to move beyond the state here or feed into state responses.

From the interview data presented, the tentative efforts by wealthy members of the Ethiopian business community to provide monthly stipends to those in need is a case in point. It is on the one hand, a charitable response to an immediate crisis. But in its rationale, it is an inherent acknowledgement that a form of income security (rather than, for example, donations of food or other necessities) is a vital component of wellbeing, not dissimilar in approach to that propagated by supporters of a Universal Basic Income.

Activism on the part of migrant networks could be one way to lobby state and/or international organisations to provide forms of such an income for mobile populations. But even on a smaller scale, simply strengthening local migrant networks with transnational links could have many positive externalities for migrant wellbeing, as also demonstrated in a recent paper on translocal connections and displacement outside Covid-19 concerns (Tufa *et al.* 2021).

Taken together, migrant populations, through the interconnectedness of their lives between their country of origin, their country of residence, and the wider transnational social field, should be better recognised as key actors in imagining different ways to ensure people's wellbeing, beyond material resources, when a shock such as the Covid-19 pandemic hits. To do so effectively, and potentially via claim-making from below in the cities they reside, support by key international humanitarian and other actors (such as UNHCR in this case) is important (see also Olliff 2018).

Local as well as transnational migrant networks are too often neglected when considering the localisation of humanitarian action. As demonstrated in this article, local support networks and everyday practices of solidarity strengthened migrants' agency in the face of adversity exacerbated by the Covid-19 pandemic. This happened in different ways in the three cities of Nairobi, Addis Ababa, and Khartoum. These findings highlight the importance of migrant networks and transnational diasporas to the call for localisation of humanitarian responses.

Notes

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2 From the 16 interviewees in Nairobi, three had lived there for three years, six between five and nine years, and seven for ten years or more. In Addis Ababa, three participants had lived there for two to three years, the rest for between four and eight years. In Khartoum, two participants had resided there for two years, two between 16 and 19 years, and one for more than 20 years.

3 Policy measures in response to the Covid-19 pandemic in each city were different. While Nairobi had two extended periods of lockdown that not only included public closures but also forbade private gatherings to different degrees, in Addis Ababa mainly the hospitality sectors were closed, while other services remained open with hygiene rules in place such as mask-wearing and social distancing. In Khartoum, there was no real lockdown, but various hygiene/social distancing rules were in place.

4 In terms of legal status, migrants in Nairobi were predominantly UNHCR-registered refugees hoping for resettlement (even if this wait could take years or never end); students; or those who

had residence papers for the city. The process of getting any of these papers is not without challenges but was reasonably straightforward in Nairobi before the Covid-19 pandemic (when many services, including access to asylum procedures, were temporarily halted). Similarly, Eritreans in Addis Ababa usually held urban residence permits, or were registered as refugees and covered by the Out-of-Camp policy (in January 2020, Ethiopia changed its general policy of granting all arriving Eritrean asylum seekers refugee status, but this change in policy did not affect any of the migrants interviewed for this study). The legal situation of migrants in Khartoum was often less secure: longer-term residents usually held residence permits, more recent arrivals often lived below the radar and were exposed to harassment by police or security forces. To discuss status issues in more detail goes beyond the objectives of this article (for more details, see for example, Betts *et al*. 2019; Kibreab 1996; MMC 2020; Treiber 2014).

5 Virtual interview with 'V', 13 April 2021.
6 Virtual interview with 'U', 24 March 2021.
7 Virtual interview with 'D', 31 October 2020.
8 Virtual interview with 'J', 28 September 2020.
9 Virtual interview with 'A', 8 September 2020.
10 Virtual interview with 'N', 6 October 2020.
11 Virtual interview with 'I', 9 September 2020.
12 Virtual interview with 'A', 8 September 2020.
13 Virtual interview with 'A', 8 September 2020.
14 Virtual interview with 'Q', 15 December 2020.
15 Virtual interview with 'O', 8 October 2020.
16 Virtual interview with 'G', 13 January 2021.
17 Virtual interview with 'B', 6 October 2020.
18 Virtual interview with 'J', 28 September 2020.
19 Virtual interview with 'R', 22 December 2020.
20 Virtual interview with 'D', 31 October 2020.
21 Virtual interview with 'E', 31 October 2020.
22 Virtual interview with 'R', 22 December 2020.
23 Virtual interview with 'S', 20 March 2021.
24 Virtual interview with 'T', 26 March 2021.
25 Virtual interview with 'J', 28 September 2020.
26 Virtual interview with 'A', 8 September 2020.
27 Virtual interview with 'E', 31 October 2020.
28 Virtual interview with 'G', 29 September 2020.
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Localising Refugee Assistance: Examining Refugee-Led Organisations and the Localisation Agenda During the Covid-19 Pandemic*

Evan Easton-Calabria[1]

Abstract Drawing on 70 interviews with humanitarians, members of governments, and civil society organisations, including refugee-led organisations, from major refugee-hosting countries in 2020 and 2021, this article explores the impact of the Covid-19 pandemic on humanitarian localisation and international refugee commitments, notably the Global Compact on Refugees (GCR). It highlights the work and widening recognition of refugee-led organisations during the pandemic, examining how they could be more prominent within the broader localisation agenda and ways in which the GCR and accompanying Global Refugee Forum may have contributed to some of their greater recognition today. Informant perspectives are shared on challenges to localisation wrought by the pandemic, including limited time, lack of communication with beneficiaries, and constrained budgets, and recommendations are presented on how to further refugee leadership and localisation in the ongoing context of Covid-19.

Keywords localisation, Covid-19, refugee-led organisations, Global Compact on Refugees, GCR, Grand Bargain.

1 Introduction

The Covid-19 pandemic has significantly impacted refugee responses around the world. The pandemic has led to the closing of borders and the slowing or halting of refugee resettlement, and short-term interventions that neglect many tenets of inclusive responses. At the same time, the pandemic has put the importance of local communities as both providers of assistance and partners of humanitarian organisations at the fore. There is, for example, a rising interest in the work of refugee-led organisations as humanitarian responders and development actors. Drawing on 70 interviews with humanitarians, members

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of governments, and civil society organisations, including refugee-led organisations, from major refugee-hosting countries in 2020 and 2021, this article examines the interplay between policy, humanitarian, and refugee responses to the Covid-19 pandemic and their resulting impacts. It explores important areas where the Covid-19 pandemic has illustrated the 'bridging' work that remains to be done between the localisation agenda and international refugee commitments, as evidenced by the Global Compact on Refugees (GCR), and the recognition of refugee-led organisations as important yet often overlooked local actors within localisation efforts around the world.

The article is structured as follows. Section 2 presents the methodology. Section 3 provides a literature review on localisation, refugee-led organisations, and the GCR. Section 4 follows with research findings focused on the impact of the Covid-19 pandemic on refugee-led organisations, the role of the GCR on acknowledging refugees' involvement in refugee assistance, and challenges to localisation wrought by the pandemic. Section 5 concludes with next steps and recommendations.

2 Methodology

This article draws on research conducted by the author through two separate research projects in 2020, one a study on the impacts of the Covid-19 pandemic on the GCR (DRC 2020) and the other on the role of refugee-led organisations in humanitarian assistance during the pandemic (Betts, Easton-Calabria and Pincock 2020). Follow-up interviews on these topics for this article were conducted in autumn 2021. Altogether, this article draws on 70 qualitative semi-structured remote interviews conducted with humanitarians (21), development actors (12), members of governments (7), and civil society organisations (30), including local non-refugee organisations (5) as well as refugee-led organisations (25), from major refugee-hosting countries in 2020 and 2021, with an emphasis on refugee-led organisations in Uganda and Kenya. Interview informants were selected based on their knowledge and/or relevance to the research topics, with both selective targeting as well as snowballing methodology employed. All necessary ethical review and approval were obtained.

3 Literature review

3.1 Localisation and refugee-led organisations

In recent years, the topic of localisation in the humanitarian and development sector has gained considerable attention, spurred on by the 2016 World Humanitarian Summit, which recognised 'crisis-affected people' as crucial first responders and localisation as an important way to increase the effectiveness and legitimacy of humanitarian aid. The so-called 'Grand Bargain' that emerged out of the summit proposed a commitment for 25 per cent of all humanitarian funding to be provided to 'national and local actors'. The recent five-year review of the Grand Bargain demonstrated mixed results; despite increasing numbers of

signatories committing to channelling 25 per cent of their humanitarian funding to local partners, progress does not come close to reaching the original goal (Metcalfe-Hough *et al.* 2021).

While the localisation agenda seeks to bring important but under-acknowledged actors into the humanitarian ecosystem, a key population has largely been missing from it: refugees. Around the world, refugees formally and informally organise to create their own groups, organisations, and networks to offer both emergency and development support to fellow refugees. This includes but is not limited to emergency shelter, language and literacy training, and livelihoods skills. These organisations are often – but not always – small-scale, working directly with communities in particular geographic areas of cities, settlements, or camps (Pincock, Betts and Easton-Calabria 2020).

Despite the significant work of so-called refugee-led organisations in refugee-hosting countries, the conversation on localisation has mainly stayed at the national level or with local host organisations, leaving refugees as a population **to whom** rather than **by whom** assistance is provided. Indeed, in many instances, the process of increasing the recognition of and transferring resources and responsibilities to these organisations remains parallel to wider localisation efforts despite clear points of connection with wider refugee policy processes.

3.2 The localisation agenda and the GCR

The pandemic has highlighted both the opportunity and the need for merging the localisation agenda with refugee policy commitments such as the GCR, which calls for a coordinated and equitable global response to refugee crises. The GCR's aim to promote 'predictable and equitable burden- and responsibility-sharing' (UN 2018: 41) provides a framework for addressing crises which induce forced displacement or within which refugees are involved. Through its approaches and core elements, it also presents a global recommitment to uphold and ensure the implementation of the international refugee protection regime – and has arguably been very challenged by global responses to the pandemic, including the temporary halting of resettlement, ongoing border restrictions, and increasing shortfalls in funding for humanitarian responses.

While the GCR is an international policy commitment made by states, affirmed by the United Nations General Assembly in 2018, it seeks to involve a variety of actors. Discussed in the Compact as promoting a 'multi-stakeholder and partnership approach' (*ibid*.: 14), it upholds whole-of-society and whole-of-government approaches in line with the broader localisation agenda. The Compact counts not just United Nations (UN) member states, international organisations, and financial institutions as stakeholders but local authorities; civil society actors, including faith-based organisations; host community members, and

refugees themselves (UN 2018: para 3). While the Compact does not use the term 'localisation' explicitly, the concept is embedded into its approach and the Compact has been called one of the main 'policy-based sources of localisation' (Erdilmen and Ayesiga Sosthenes 2020: 17). Given this, it presents an opportunity to build on wider localisation efforts.

A white paper on refugee-led organisations ahead of the GCR identified ways to include refugees in it, with many recommendations also relevant for refugees' larger presence within the localisation agenda. Alongside funding and supporting the capacity of refugee-led organisations, the paper advocated for the inclusion of these organisations within the humanitarian architecture through inviting them into working groups, clusters, and other structures and mechanisms (Urban Refugees n.d.). This need for formal decision-making power within both refugee policy and practice is strongly echoed by initiatives such as the Global Refugee-Led Network and in research on refugee-led organisations (Betts, Pincock and Easton-Calabria 2018).

On the localisation end, research and practice seeking to advance the role of local actors should more clearly include refugee-led organisations as relevant members of civil society. One positive example of this can be seen in a recent Oxfam report focusing on local humanitarian leadership in Ethiopia's Gambella region (Gidron, Carver and Deng 2021). The report explores the plethora of civil society actors involved in refugee responses, notably refugee self-help groups, refugee-led organisations, and church and faith-based initiatives, with recommendations to build on the government's national commitments to localisation, which include refugee participation, and arise through Ethiopia's role as a pilot country for the Comprehensive Refugee Response Framework (CRRF), itself envisioned to be a manifestation of the GCR (*ibid.*). Through this focus on refugee-led organisations as one civil society actor among many with the power to contribute to effective humanitarian assistance, the report exemplifies how commitments to expanding refugees' roles as key stakeholders as per the GCR and actors in refugee assistance can meaningfully converge with the localisation agenda.

The Global Compact on Refugees Indicator Framework (2019), created to monitor progress on the GCR's four objectives,[2] seeks, for example, to measure the 'proportion of official development assistance (ODA) provided to, or for the benefit of refugees and host communities, channelled to national actors in the refugee-hosting country' (UNHCR 2019: 17). On one hand, this indicator is promising, as is what is covered in its rationale:

> The Global Compact on Refugees emphasizes the importance of national ownership and leadership. Local authorities and other actors, in both urban and rural settings, are often first

> responders to large-scale refugee situations and among the actors that experience the most significant impact over the medium term.
> (*ibid*.)

At the same time, the 'national actors' referenced in the indicator include central governments, local governments, national non-governmental organisations (NGOs) as well as civil society organisations – in short, many non-refugee actors as well as refugee-led organisations. While this indicator is important regardless, the wide range of actors covered within 'national' (similar to what often happens under the banner of 'local') illustrates the need for a corresponding focus on refugee-led organisations within localisation work in particular.

4 Findings

4.1 The Covid-19 pandemic and refugee-led organisations

Somewhat paradoxically, although the Covid-19 pandemic has created enormous challenges for refugees relating to protection, health, livelihoods, and more, it has also raised more awareness of how they help each other. Since the pandemic began, refugee-led organisations have mobilised to provide food, cash grants, and soap to community members; sew and hand out masks; and offer Covid-19 education through videos, posters, and talks in refugees' native languages (Betts *et al*. 2020). Recent research has identified key ways that refugees are and could be assets as local actors in health-care responses, including in providing public information and countering misinformation; supplementing the capacity gaps of international organisations; delivering health care themselves; and being part of virus tracking and tracing efforts (*ibid*.).

Notably, this work by refugee-led organisations has occurred in the face of humanitarians' restricted access to camps and refugee populations as well as troubling situations where refugees have been denied government food aid (as was initially the case for urban refugees in Uganda) or health care, which often necessitated reliance on fellow refugees. In interviews, some humanitarians also discussed how the extreme impacts of lockdowns and travel bans to their operations highlighted the crucial intermediary role that local organisations play in their work. As one member of a major international humanitarian organisation explained in the summer of 2020,

> *In many ways we've gone dark due to Covid-19 lockdowns and not being able to directly access beneficiaries. It really shows the shallow roots of a lot of programming. But these issues aren't novel – they are exacerbations of existing issues*.[3]

This stance was echoed by the leader of a Rohingya refugee organisation in Bangladesh, who explained in 2020 that some prominent NGOs did not have the phone numbers of any

refugees within Cox's Bazar, which made it impossible for them to reach their beneficiaries during lockdowns. In contrast, as she worked directly with both refugees and refugee volunteers, she was able to stay in touch and relay information and ultimately provide needed supplies to fellow refugees in the camp.[4]

4.2 A rise in funding for refugee-led organisations

Despite the important role many refugee-led organisations play in communities, they are often small and work under the radar of international organisations (Pincock *et al*. 2020). They are often mainly or fully volunteer-run due to a lack of funding, and have limited opportunities to apply for existing grants or other funding sources due to challenges ranging from language barriers to not being considered 'auditable' by many funders (*ibid*.) At the same time, many refugee-led organisations are legally registered community-based organisations or NGOs in their host country and therefore could be formally embedded into the humanitarian system as implementing or operational partners.

The Covid-19 pandemic has led to both an increase in funding for refugee-led organisations and in some instances to helpful changes in donor requirements and procedures. Recognising that many refugee-led organisations sometimes provide the only assistance refugees receive, particularly during lockdowns, some organisations and foundations such as Open Society Foundations responded to the needs of refugee-led organisations by providing flexible funding with less rigid and thus faster bureaucratic procedures.[5] Reflecting on internal changes made to grant monitoring and evaluation due to grantee's limited time during the pandemic, another significant foundation donor in refugee assistance explained,

> *I have seen how* [the] *Covid-19* [pandemic] *has also sped up donor processes to be better administrative partners to grantees. We realised we could do away with a lot of reporting requirements which weren't actually necessary. This in turn could allow us to work with more local organisations and make it easier to do so*.[6]

Longer in the making but all the more pressing due to the pandemic have been new financing mechanisms for refugee-led organisations worth over US$50m. The Canadian government created, for example, the first-ever dedicated fund to support refugee-led organisations, committing a total of US$40m (Government of Canada 2021). In 2021, the prestigious Lam Larsen award gave US$10m to a coalition of six refugee-led organisations to support them in their ongoing work, which is 'rooted in the importance of transferring ownership and resources to refugee-led organisations' (Asylum Access 2021).

4.3 Refugee participation and the GCR

All of these efforts point towards a clear interest in elevating the role of refugee-led organisations. While impossible to ascertain, it is interesting to reflect on the role that policy processes such as the GCR, and other efforts towards localisation started prior to the pandemic, may have played in this shift. In interviews, informants often highlighted the importance of the theme of refugee participation present within the GCR and the 2019 Global Refugee Forum, which gathered stakeholders to make pledges to implement the GCR. This was often optimistically linked to widening opportunities for localisation. Reflecting on the GCR and the Covid-19 pandemic, an employee of a refugee-serving international non-governmental organisation (INGO) described the paradigm shift to remote working in 2020 as a positive opportunity for wider inclusion:

> *Because of budget cuts and because the ways of working have shifted, the whole issue of working through whole-of-society is being lifted up more. We can't move so freely, but we can work through NGOs easily. So some elements of the GCR are coming more to the fore because of* [the] *Covid-19* [pandemic]*. The whole issue of inclusion has been elevated and I think has improved in many contexts*.[7]

An emphasis on refugees and refugee-led organisations as key stakeholders in refugee assistance has also been maintained by the United Nations High Commissioner for Refugees (UNHCR) even after the Global Refugee Forum. In 2020, for example, winners of UNHCR's NGO Innovation Awards included two refugee-led organisations for their work during the pandemic. Filippo Grandi, UN High Commissioner for Refugees, stated during the virtual ceremony,

> *Through this award, we want to give a signal that – more than any other type of organization – refugee-led organisations have proven to be the most important and effective at finding innovative and local solutions to the challenges faced in their own communities during these difficult times.*
> (UNHCR 2021)

Notably, the UN has now created a new partnership status for refugee-led organisations. UNHCR-NGO monthly consultations now explicitly include refugee-led organisations (UNHCR 2020) and a session of UNHCR 2021 Regional Consultations with NGOs specifically focused on how NGOs and UNHCR can 'support organizations led by forcibly displaced and stateless persons to enhance inclusion in Europe' (UNHCR, ECRE and ICVA 2021: 1).

4.4 Constrained time and impacts on localisation

However, one of the tensions highlighted around localisation and the pandemic was the incredible amount of time that

many humanitarian and development actors had to spend making adjustments or changing programming entirely due to the Covid-19 pandemic, as well as the emotional drain of the pandemic itself. This lack of time and, in cases, of energy was described by some as a barrier to the very work of localisation – even as more and more programming was devolved from headquarters to national organisations and other local actors. As one member of an international agency explained,

> *Localisation is not all about funding although often that's what actors want. Parts of it are about greater participation and involvement in the whole funding cycle. I don't know how this has gone with* [the] *Covid-19* [pandemic] *as everyone has been so busy rushing around… the space for consultation is not always happening.*[8]

Similarly, in the summer of 2020, an international organisation policy officer shared that,

> *At the start of* [the] *Covid-19* [pandemic]*, I thought it would be a way for localisation and refugee participation to progress – in other words, what's described in the Compact – and that it would be obvious given so many international restrictions. But I can't really say that it's changed. In terms of funding, there is quite good progress for Covid money going to national governments and local authorities. But the figures of those receiving funds are tiny for local and national NGOs; refugee organisations that I know personally in different countries are struggling to get much-needed funding. This is key, it's the big issue we need to push forward on.*[9]

4.5 Wider recognition, remaining gaps in collaboration

This perspective was shared by many refugee-led organisations interviewed, which rarely had directly received some of the increased funding mentioned in the first part of this article. Instead, many felt that their work was disregarded by international and national humanitarian and development organisations prior to the pandemic, and some even as they tried to address the increased needs wrought by the Covid-19 pandemic, such as many refugees' desperate need for income generation. As one leader of a refugee-led organisation in Kampala explained in the autumn of 2021,

> *Personally, since* [the] *Covid-19* [pandemic]*, I think that many things have been disorganised, people from NGOs were mostly focused on activities relating to* [the] *Covid-19* [pandemic]*. It's only in these last two to three months that organisations like JRS* [Jesuit Refugee Service] *and CARITAS are trying to see how to assist refugees in livelihoods… we have the youth programme, which we want to target livelihoods, but which is having some difficulties due to lack of funding. I tried to reach out to those organisations*

> [INGOs] *but sometimes they have a sort of bureaucracy which can take long – but when they are the ones coming with a programme, then it can go fast. They come wanting to target particular groups with a programme that is already set. But when we are trying to ask them if they can assist in one area or another that we propose, they can say, 'Yes' but then they say, 'Wait, we will call you back'. Then one or two years pass.*[10]

Despite the inclusion and participation of refugees encouraged in the GCR, and then necessitated by the pandemic, many refugee-led organisations continue to feel resigned to being 'on the ground' while policy processes directly impacting them happen, again and again, at headquarters far away.

4.6 Moving towards action

Despite the clear observation that much work remains to be done, multiple INGO and NGO informants described recognising a heightened need for refugee inclusion and leadership within organisations, and a need to reflect on their own processes and practices. Many attributed this in large part as a result of the pandemic, due to a widespread recognition of the limits of humanitarian capacities as the Covid-19 pandemic has disrupted programme implementation as well as supply chains. There was an overall consensus that while the pandemic has created an opportunity borne out of necessity for positive change, the effects and outcomes remain to be seen. As one NGO advocacy officer working in East Africa put it,

> *There are two givens with the pandemic: in the future we will see increased needs and increased gaps in funding. We as the NGO sector are faced with very few options. But there are some simple ones: how to become more efficient, how to find ways to be more impactful, and also to focus more on niche areas of impact – humanitarian agencies don't need to be trucking water or building schools or latrines. We really need to get off the things that can be done locally*.[11]

It is clear that the rhetoric of localisation and broader publicity about refugee-led organisations must be matched in practice. As one head of a major refugee donor portfolio explained,

> *This* [is] *a moment that will eventually go away, and maybe the humanitarian sector won't go back to the way it was. But the risk is that change won't happen unless we put real advocacy and energy in the nexus between* [the] *Covid-19* [pandemic]*, the GCR and the Global Refugee Forum, and refugees' own ability to respond*.[12]

5 Conclusion

These findings highlight an increasing recognition of the valuable role that refugee-led organisations play both for refugees as well as within the humanitarian system. While the Covid-19 pandemic appears to have spurred on some of the awareness of and funding for refugee-led organisations, policy processes such as the GCR, the Global Refugee Forum, and the wider localisation agenda have likely contributed, as well. Now two years into the pandemic, over three years since the signing of the GCR, and six years since the making of the Grand Bargain, there remains a need for more critical discussions of localisation, how refugee-led organisations can be more clearly represented within it, as well as how it can occur meaningfully through partnerships and sustainable funding.

Local relevant stakeholders, including refugee-led organisations, must be financially supported to continue their work. Broader remote programming must not become a means to place disproportionate risk on local actors while maintaining unequal power dynamics. The risk of ongoing restrictions on movement, wherein vaccinated humanitarian and development actors from the so-called 'global North' can yet again move freely between countries while their unvaccinated counterparts in the so-called 'global South' continue to face travel restrictions and remain at risk of the virus, must be called out and advocated against.

While increasing localisation and the ability of refugee-led organisations to do their work is undoubtedly important, it is also necessary to recognise the ways that the pandemic may have also more deeply entrenched the unequal status quo. Moving forward with this in mind, supporting refugee-led organisations and the localisation agenda is one piece of the bigger work of allocating the resources, responsibility, and power necessary to uphold rights and keep borders safe and open, as well as to enable local action where refugees remain.

Notes

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2 These four objectives are: (1) ease pressures on host countries; (2) enhance refugee self-reliance; (3) expand access to third country solutions; and (4) support conditions in countries of origin for return in safety and dignity (UN 2018).

3 Interview, August 2020.

4 Interview, Bangladesh, July 2020.

5 Interview, July 2020.
6 Remote interview with a US-based foundation, July 2020.
7 Interview, July 2020.
8 Remote interview, August 2020.
9 Remote interview, July 2020.
10 Interview, Kampala, Uganda, October 2021.
11 Remote interview, July 2020.
12 Remote interview, July 2020.

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The Covid-19 Pandemic and Alternative Governance Systems in Idlib*

Juline Beaujouan[1]

Abstract As Covid-19 hit Syria after a decade of protracted conflict, the fragmentation of the territory and governance system prevented the adoption of a national strategy to mitigate the impact of the pandemic. In Idlib Governorate, the Covid-19 pandemic highlighted the inability of the Syrian Salvation government to offer an effective alternative to the Syrian regime. While it failed to provide health care and social services and to corner the international aid market, international aid routes were blocked by al-Assad's regime in an attempt to squeeze the opposition further. In this context, local civil society in northwest Syria emerged as another non-state agent of governance.

Keywords Covid-19, Syria, civil society, rebel governance, Idlib, humanitarian access.

1 Introduction

Covid-19 officially hit Syria on 22 March 2020, 11 days after it was declared a pandemic by the World Health Organization (WHO). Observers feared the humanitarian emergency might reach a new level in view of the 13.4 million Syrian people in need of humanitarian assistance. For instance, the International Rescue Committee warned that Covid-19 in Syria could become one of the most severe outbreaks in the world as a result of the collapse of the country's health system (IRC 2020). In addition to the lack of capacity and resources of governmental actors, the fragmentation of the territory and governance system prevented the adoption of a unified national strategy to mitigate the impact of the pandemic.

Fears about the rapid spread of the virus particularly mounted in Idlib Governorate in northwest Syria, which is home to over four million civilians, including about 1.5 million internally displaced persons (IDPs) living in 871 self-settled and planned

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camps that do not provide a sanitation system and lack the minimum essentials of hygiene (CCCM Cluster Syria 2020). As for the residents of urban centres, concerns were no less. These 'opposition areas', that slipped away from the administrative and military control of al-Assad's government, suffered constant infighting between local armed groups and a series of military offensives from the Syrian regime forces and their Russian allies ever since April 2019, despite the efforts of international mediation to demilitarise the northwest of the country (SOHR 2019). The attacks greatly underscored the access of civilians to primary health care, leaving them dependent on 166 doctors, 133 primary health-care facilities, and 54 functioning hospitals operating with mostly minimum capacity infrastructures (WHO 2020).

Amid a volatile situation, the UN Secretary-General António Guterres issued an appeal for a global ceasefire on 23 March 2020, urging warring parties around the world to silence their guns to focus on the fight against the Covid-19 pandemic. But the powerful players on the Syrian chessboard did not wait for the global call to act upon hopes for peace. Al-Assad's pursuit for full military victory was (temporarily) halted on 5 March 2020 when Russian President Vladimir Putin and his Turkish counterpart Recep Tayyip Erdoğan struck a ceasefire deal for Idlib Governorate. While members of the Syrian Civil Defence (commonly known as the White Helmets) told the author that the Syrian and Russian forces violated the ceasefire more than 100 times in a year, the lull in the fighting gave opposition institutions in northwest Syria the space to try to mitigate the impact of the Covid-19 pandemic. Against all odds, the year 2020 offered Syrians some respite and the country witnessed its least violent year since March 2011. The relative stability was the opportunity for the author and Syrian colleagues to investigate the impact of the pandemic on non-state governance in Idlib Governorate, which is under the control of the Syrian Salvation government (SSG), unofficially affiliated with the Salafi-jihadi coalition Hayat Tahrir al-Sham (HTS).

This article demonstrates that, while Covid-19 showed the inability of SSG to provide an effective alternative to the Syrian regime, the pandemic set the stage for the emergence of local civil society as another non-state actor of governance – with a focus on providing health care and social services – in Idlib. While SSG is commonly branded as the 'opposition' or 'rebel' government, local civil society seems to provide a more legitimate inclusive and grounded system of governance. This article adopts Kawakibi and Sawah's (2013: 11) definition of Syrian civil society, which refers to 'the active and voluntary participation of citizens in organisations (outside their families, friends and workplace) where they support their interests, views and ideologies'. It includes community-based organisations as well as non-governmental organisations (NGOs), established locally but also by diaspora networks.

The findings presented in this article are based on 73 in-depth interviews conducted between June 2020 and August 2021 across Idlib Governorate with members of the local civil society, community leaders (tribal and religious representatives), representatives of governmental institutions at the central (i.e. ministry) and local level (local council) and grass-roots communities. Efforts were made to provide a representative sample of the Syrian population in Idlib Governorate; for instance, the research included 37 per cent of women and 70 per cent of IDPs. Interviews were conducted by the author and two local researchers, mostly over the 'phone to lessen the risk of Covid-19 transmission. More interviews were conducted face-to-face when health restrictions were eased in early 2021.

After introducing the fragmented governance system in Syria (Section 2), this article discusses how the efforts of SSG to mitigate the impact of the pandemic in Idlib Governorate (Section 3) were further impeded by the politicisation of Covid-19 and humanitarian access in the country (Section 4). These conditions provided an opportune environment for the emergence of local civil society as another actor of governance in Idlib Governorate (Section 5), a role that comes with opportunities (Section 6) but also many challenges (Section 7).

2 A fragmented governance system

In Syria, the shortcomings of the governance system in mitigating emergencies predate the Covid-19 pandemic. The country is effectively divided between political and military spheres of influence and corresponding institutions and affiliated health systems. While the Syrian regime has regained much territory, it has lost much legitimacy and popular support and is not the only source of authority across the country. For instance, the northwest has effectively been under the authority of two *de facto* governments since September 2013 – the Syrian Interim Government (SIG) and SSG – even though these areas fell under the military protectorate of Turkish forces following the Idlib ceasefire in March 2020.

The Turkish-affiliated SIG and the National Army – a coalition of the Free Syrian Army (FSA) and Salafi-jihadi factions – hold tight to the northern countryside of Aleppo Governorate and parts of Rojava at the Turkish border. SIG was established in September 2013 by the National Coalition for Syrian Revolutionary and Opposition Forces (SNC), sitting in Turkey, and aims at replacing the government of Bashar al-Assad. The rest of the opposition-held areas, namely Idlib Governorate and the western countryside of Aleppo, are controlled and administered by SSG, which is unofficially affiliated to HTS, including the former branch of al-Qaeda in Syria, Jabhat Fatah al-Sham (JFS).

SSG emerged as a second *de facto* alternative government in northwest Syria following the victory of a coalition of opposition

armed groups in Idlib Governorate in late 2015. The move enshrined the rejection of SIG's authority and the creation of a dual power in the northwest of the country. In an attempt to reinforce the power of SSG, HTS launched a campaign to disband several local councils cooperating with SIG, replacing them with appointed councils linked with SSG and transferring a number of roles and powers of local councils to the SSG's technical directorates, including health. The growing influence and control of HTS over Idlib Governorate resulted in a series of armed clashes throughout 2017 and fierce competition between the two *de facto* governments (Enab Baladi 2017).

In Syria, SSG is thus a typical example of rebel governance as 'the development of institutions and practices of rule to regulate the social and political life of civilians by an armed group' (Mampilly 2013: 45). Analyses of its establishment and attempts to perform the state have recently added to the scholarship on rebel governance (Al Dassouky 2017; Martínez and Eng 2018; Furlan 2020; Zelin 2020). Because of the fragmented nature of the Syrian opposition, SSG not only offers an alternative to the Syrian regime but also to SIG inside opposition-held territory. In this competition for legitimacy and grass-roots support, the Covid-19 pandemic provided SSG with 'an opportunity to project [itself a] more reliable [provider] of governance' to 'score additional points in the battle for credibility, support, and legitimacy against the [Syrian] government' (Furlan 2020: 16). As such, one could expect that SSG saw the Covid-19 situation as a 'single-actor play on stage' (Kövér 2021: 3). Yet, our research in northwest Syria suggests that, while SSG offered a more rapid and efficient response than the Syrian regime, it tried to corner the international aid market and relied mainly on local civic initiatives.

3 SSG's unprecedented mitigating efforts… doomed to failure

SSG showed remarkable seriousness in facing the health emergency and started taking preventive measures as soon as 14 March; that is, more than a week before the Syrian government officially recognised that Covid-19 had reached Syria (Zelin 2020) and three months before the virus hit Idlib. Our research shows that SSG's Health and Education ministries were the most active governmental institutions. Both issued preventive measures and conducted (online and face-to-face) awareness and sterilisation cleaning campaigns across Idlib. SSG also created an emergency response committee to coordinate the government action across its ministries and local councils.

More interestingly, SSG distanced itself from HTS and adopted pragmatic policies by closing Koranic schools and mosques and forbidding Friday prayers in early April 2021, which caused a rift between Salafis (al-Modon 2020). Doing so, in the early stages of the pandemic, SSG portrayed itself as the main player in charge, disseminating its actions through an intense use of social media and other online platforms (Jihadology n.d.). Moreover, a

series of comparative interviews conducted in areas controlled by the Syrian regime in Daraa Governorate during the research clearly establish that SSG provided relatively indiscriminate services across its territories. Conversely, the Syrian regime instrumentalised the pandemic and used it as an opportunity to further securitise areas that had previously escaped its control, such as Eastern Ghouta (al-Ra'i 2020).

Despite its will to provide a reliable and efficient answer to the pandemic, in the long term, SSG did not manage to endorse the role of a unified authority capable of issuing and enforcing decisions across Idlib Governorate. Its lack of monopoly, coupled with the mistrust of the Syrian people, and the influence of rival factions over various localities were strong barriers to a unified and efficient official response to the Covid-19 pandemic (COAR 2021: 22). Another impediment was the destruction of the health sector following intense bombing campaigns by the Syrian and Russian air forces that targeted health facilities across Idlib (Wille and Weir 2020). One final challenge to the action of SSG to confront the pandemic was its failure to corner international aid markets and Assad's instrumentalisation of international aid to further squeeze the opposition (Berti 2016).

4 The politics of humanitarian access during the Covid-19 pandemic

Beyond offering an alternative authority to that of Bashar al-Assad's government in Idlib, SSG was established as a channel to gain international recognition and circumvent the embargo on humanitarian aid in northwest Syria imposed by the Syrian regime (Kayyali 2019; Duclos *et al*. 2019). The weaponisation of humanitarian aid reached a new level with the arrival of Covid-19 in opposition-held areas on 9 July 2020. The Syrian regime demanded control over all border crossings for humanitarian aid between Syria and its neighbours. Doing so, it directly called into question the validity of Resolution 2165 adopted by the United Nations Security Council (UNSC) in July 2014, and which authorised UN agencies and their partners to use routes across conflict lines and four border crossings – two in Turkey, one in Iraq, and one in Jordan – to deliver humanitarian assistance to Syrian civilians living in areas beyond the control of the Syrian government.

In July 2020, just weeks after Covid-19 hit in Idlib Governorate, Russia, backed by China, wielded its veto to prevent the renewal of the two border crossings between Turkey and northwest Syria. The move was countered by the UK, France, and Germany, which managed to keep the Bab al-Hawa border crossing with Turkey open as the UN's last remaining entry point for transporting assistance into northwest Syria and to the four million Syrians depending on external aid (UNSC 2020). UNSC's decision resulted in enormous delays in the delivery of relief, especially to northern Aleppo that saw the arrival of aid convoys decreasing from one

every couple of weeks to one every two months according to local sources (Nashed 2021).

Faced with insurmountable obstacles to its action, SSG tried to convince the international community and funders that it should be given the tools and legitimacy to handle the pandemic (Beaujouan 2021). Its policies were quickly supplemented by the intervention of the WHO-led Health Cluster cross-border operation in cooperation with other UN agencies and international NGOs (INGOs), supported by local civil society. Yet, the WHO's action felt conspicuously weak and far from being politically neutral (Hammou 2020). The unofficial status of Idlib Governorate, which is not recognised as a country or an independent entity, justified a one-month delay in the distribution of aid and testing kits compared to regime-held areas. The impact of the lack of involvement of the international community and its biased policy towards northwest Syria were recorded by the author and her colleagues through a small-scale online survey. Among 50 participants randomly selected across Idlib Governorate, only 22 per cent put a lot of trust in the international community compared to 60 per cent in local civil society, while 13 per cent of them had little or no trust that support would come from across the borders.

5 Local civil society front of stage for Covid-19 mitigation

The limited ability of SSG to provide health care and social services predates the Covid-19 pandemic, and the health sector in Idlib Governorate has been partly managed by civic actors for years. Most notably, Idlib Health Directorate (IHD) emerged in May 2013 as a health governance system to fill in the governance gap in opposition-held areas. Unlike SSG, IHD gained nominal political independence and the trust of grass-roots communities and international donors alike. Moreover, relief organisations gained experience during the 2013 polio outbreaks (Ekzayez *et al*. 2020) and the seasonal spread of communicable diseases such as leishmaniasis.

This local network in northwest Syria is greatly supported by a Syrian diaspora network that established medical NGOs, such as the Syrian American Medical Society (SAMS) and the Syrian Expatriates Medical Association (SEMA) and collaborates with local civil actors directly rather than rebel governance institutions. As such, and despite the real efforts of SSG to step in as the key mitigating actor of the pandemic, when Covid-19 hit Idlib in June 2020, local civil society networks were 'both the first responders and the main interlocutors with international organi[z]ations' (al-Achi 2020).

Local civil society was not a mere *de facto* substitute to rebel governmental authorities' failure to deliver services and meet the needs of local populations. One could say that civil society 'inherited' the Covid-19 file, complementing the response of SSG

in Idlib Governorate. While al-Assad's government securitised its response to the pandemic and curtailed the role of NGOs and the private sector (COAR 2021: 3), local civil society in Idlib enjoyed the relative lack of political and military interference in its activities – which is nuanced later in this article. For instance, the Ministry of Development and Camp Management within SSG coordinated with military groups to facilitate the access of volunteer teams in IDP camps to control the process of food and services delivery. The cooperation of military groups in this regard was unanimously appreciated by the people we interviewed.

The unprecedented threat posed by the Covid-19 pandemic, coupled with the inefficiency of the action of rebel governance and the international community, uniquely mobilised local civil society and triggered the emergence of creative and coordinated grass-roots initiatives in northwest Syria. The most striking example is the launch of the 'Initiative of Volunteers Against Corona', on 19 April 2020 by IHD and the White Helmets. The initiative is an intersectoral operation room initially composed of around 50 local organisations and 600 volunteers (Enab Baladi 2020), and was the first of its kind despite the constant humanitarian emergency in opposition-held areas since they gained nominal independence from the Syrian regime in 2013. It aimed to institutionalise civil society to coordinate and facilitate the response to the Covid-19 pandemic and the protection of civilians. Under the leadership of the White Helmets, the initiative directly coordinated with SSG to: establish several confinement centres for patients infected with the virus; conduct campaigns of cleaning sterilisations of schools, mosques, and public spaces; provide hundreds of awareness sessions within weeks; and distribute brochures giving guidance and including information on mitigation measures.

6 Local civil society: a new governance actor?

In a series of reports on the public governance response to the Covid-19 pandemic around the world, the Organisation for Economic Co-operation and Development (OECD) emphasised the critical role of good governance in the mitigation and recovery of the health crisis. Based on its analysis, OECD developed evidence-based policy responses to help governments tackle the crisis and plan for a sustainable recovery (OECD n.d.). In Idlib, several of these public governance policy responses were developed and implemented by local civil society, action that exceeded mere crisis management through infrastructure resilience and service delivery.

Crisis communication: Local civil society put unprecedented efforts into raising awareness about the virus and mitigating measures but also the need to target the most vulnerable people in order to ease social tensions, notably between displaced and host communities. Public communication in northwest Syria was crucial given the lack of independent media, the existence of

several discourses by competing governmental institutions, and also the spread of rumours about Covid-19 (Beaujouan 2021). Local civil society became a key transmission channel to fight misinformation and raise public awareness, both in-person and via online campaigns. As well as this, social media became a crucial platform for in-need communities to ask for support, as the inhabitant of an IDP camp did on the Facebook page of the Initiative Against Corona on 16 September 2021: 'We are about 115 families in a camp near Idlib Governorate. We need a team to raise awareness and sterilise the camp mosque, anyone can contact me… there are [Covid-19] cases in the camp'.

Public trust: Medical (public) services are free for all in Idlib, but Syrians are often reluctant to visit hospitals and medical centres. Importantly, citizens must trust the institutions and people delivering medical services. Building knowledge and trust was a key mission of local civil society during the pandemic through awareness campaigns about the virus, while mobile campaigns (i.e. clinic and classroom buses) were also the occasion to break isolation and provide educational and psychological support to civilians. The mission of civil society was facilitated by the relation of trust and reliance built over years by key civil society organisations (CSOs) such as the White Helmets and IHD. For instance, the White Helmets posted several videos of its staff receiving the vaccine to push the grass-roots community to follow their example (White Helmets 2021).

Diversity and inclusion: Through its action, local civil society tried to foster social cohesion and solidarity between grass-roots communities. Most importantly, the activities it implemented did not discriminate between ethnic and religious groups, gender, or age – even though vulnerable people such as IDPs inside camps were often prioritised for aid delivery. Specific activities targeted frontline workers such as medical staff but also poor students who could not afford distance learning, and street cleaners. Because grass-roots initiatives greatly relied on volunteers, they did not require previous experience or an intense recruitment process. As a result, local civil society initiatives during the pandemic proved to be more inclusive than external humanitarian programmes and governmental actors in terms of gender, ethno-sectarian identity, age, and political views.

Policy coherence and coordination: The pandemic created an impulse for collaboration and coordination among civil society and other grass-roots initiatives, a practice that was absent before the arrival of the virus. From the admission of several humanitarian workers and activists in Idlib, before the Covid-19 crisis, CSOs were 'forced' by donors to cooperate through information exchange or common activities. The practice became natural during the pandemic. Besides, the health crisis showed the relevance of local civil society as a bridge between decision makers and officials on the one side and grass-roots communities on the other.

7 Challenges to the emergence of an independent bottom-up governance system

In Idlib Governorate, the Covid-19 situation translated into a strengthening of civic activism and voluntarism and a more coordinated and proactive local civil society. Yet, the new role of civil society as a non-state service provider comes with great challenges that might hinder the sustainability of grass-roots responses and the transformation of the local humanitarian space into a key driver of bottom-up governance in the future.

First, the question of the relationship between civil society and SSG must be clarified. During our research, 96 per cent of grass-roots respondents considered the action of civil society and that of the opposition government as complementary, suggesting the absence of competition between the two governance actors in Idlib Governorate. Similarly, representatives of governmental institutions insisted on cooperation with civil society under the umbrella of SSG and local councils. According to them, SSG's action to mitigate the impact of the pandemic was rooted in a clear collaborative action that included, and indeed mostly relied on, local civil society.

Yet, civil society and local activists recorded different dynamics. While SSG did not enact restrictive policies against CSOs or directly attempt to thwart their efforts since Covid-19 reached Syria, it endeavoured to become the only channel for international funding and to limit the autonomous aspirations of civil society. The extent of the cooperation between the two governance actors is also subject to debate. Several members of local civil society expressed that cooperation with governmental central and local institutions was limited in scope and time, and that the action of local initiatives was confined to providing awareness sessions and advising on emergency plans. They regretted the absence of civil society members in decision-making: 'The government takes [the] decision and we provide [the] services'.[2]

Moreover, for several CSOs operating in Idlib Governorate, the branding of SSG as a rebel government indirectly but infamously affiliated with HTS means that independence and cooperation with governmental institutions are mutually exclusive. For instance, several CSOs refused to sign a Memorandum of Understanding (MoU) with SSG in a bid to retain their independence and attract more international funding. Data collected in Idlib show that when an MoU is in place, a common practice of governmental institutions is to determine the location and the type of response to an emergency, and in rarer cases, suggest names of beneficiaries. In the absence of a law to regulate the roles and relations between CSOs and SSG, the absence of an MoU is often an insurmountable obstacle to the development of CSOs' activities. In the near future, this situation might lead to increased competition between SSG and local civil society to attract

funding and provide reliable services to grass-roots communities. More research is needed to elucidate the interactions between the two non-state agents of governance in northwest Syria. The main question to be answered is whether they will compete over the provision of services or, conversely, cooperate and complement their actions to offer a more representative and effective hybrid governance system in Idlib.

Second, local civil society remains largely dependent on international donors. When asked about the lessons learned from the Covid-19 pandemic in Idlib, several research participants emphasised the importance of gaining self-reliance. During the pandemic, in addition to adapting their working environment and the practicality of the programmes, local NGOs and other CSOs saw the scope of their development-oriented projects redirected to emergency plans that they were not equipped or trained to implement. Besides, funding targeted at fighting the pandemic only started flooding in when the virus effectively reached Idlib in June 2020, jeopardising the efficiency of preventive policies.

As a result, between March and September 2020, when the number of cases increased in northwest Syria, local civil society was left working from a reactive paradigm, or what the inhabitants of the Levant commonly call *Nidam al-faza'*, literally 'the dreadful system'. The expression describes the work done in 'happening' environments where programmes fail to rely on an informed assessment of the local situation and needs, strategic planning, capacity, and training. In this regard, one of the greatest challenges of local civil society in Idlib is to move from the position of mere 'implementer' of the policies and priorities of the international community, and for that matter, SSG.

The challenge is even greater since local civil society in Idlib has not been spared by the Syrian conflict and its situation is punctuated by a rapidly changing landscape where corruption allegations and reports of links with armed groups are used as tools to discredit competing NGOs/CSOs and blacklist them in donors' networks. A striking example of such practices is the campaign of delegitimisation launched by the Russian media against the White Helmets several years ago, which accuses the volunteering force of links with terrorist groups in Syria (Solon 2017).

8 Conclusion

In Idlib, the Covid-19 pandemic has exposed the Syrian opposition's (SSG) lack of capability to provide a reliable governance alternative to the Syrian regime, and the challenges of the international community to stand up as a key relief actor in northwest Syria. On the other hand, grass-roots communities that have lived through a decade of violence, displacement, and trauma were, understandably, reluctant to assess the full impact of the health crisis on their lives. While the virus constituted yet another fundamental shock to the system of governance across

the country, in Idlib, it led to the emergence of a new form of a more legitimate, inclusive, and grounded system of governance: local civil society. As such, Idlib is a textbook example of how the Covid-19 pandemic exposed the tensions in the humanitarian space between restrictions – in the case of the international community – and transformation – namely, that of local civil society.

While the pandemic strengthened civic activism and voluntarism, local civil society remains dependent on support from the international community to foster locally owned governance. In addition, more efforts will be needed to study the response of SSG to the rise of a new non-state governance actor in Idlib Governorate. Finally, a resurgence of the national conflict may be witnessed in the near future that will jeopardise the efforts of local civil society to reinforce its role as a service provider. As a result, non-state governance in northwest Syria is likely to experience more challenges and transformations; thereby testing the adaptability and sustainability of local civil society as a driving force for the future of Syrian opposition-held areas.

Notes

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2 Pers. comm., July 2021.

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Left Behind: The Multiple Impacts of Covid-19 on Forcibly Displaced People*†‡◊

Natalia Korobkova,[1] Nina Nepesova[2] and Delphine Valette[3]

Abstract To better understand vaccination barriers and the impacts of Covid-19 on forcibly displaced persons (FDPs, i.e. refugees, and internally displaced persons (IDPs)), World Vision International carried out a multi-country survey of refugee populations in Colombia, Peru, Brazil, Uganda, the Democratic Republic of the Congo (DRC), Jordan, and Turkey, and IDPs in Venezuela. The survey found that a combination of barriers led to FDPs falling through the gaps of national Covid-19 vaccination campaigns, despite their heightened vulnerability to Covid-19 infection and transmission. Only one person out of the 1,914 FDPs surveyed reported receiving a Covid-19 vaccine. The survey also highlighted the significant indirect impacts of the pandemic on forcibly displaced families, and children specifically, with the socioeconomic aftershocks of the Covid-19 pandemic worsening displaced children's deprivations across health and nutrition, protection support, and education.

Keywords Covid-19, forcibly displaced, internally displaced, refugees, vaccine equity, vaccine access, pandemic response, humanitarian response, children, vulnerabilities.

1 Introduction

The Covid-19 pandemic has changed the world. It has tested our resilience and capacity to adapt; disrupted health systems; and plunged the global economy into deep contraction. Most of all, the pandemic has tested our collective sense of unity and humanity. We have witnessed countless examples of solidarity, compassion, and altruism. We have also witnessed an increase in inequality and a worsening of nationalism and discrimination, particularly in relation to Covid-19 vaccine access.

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1.1 The forcibly displaced are the worst off

The pandemic has affected everyone, but what we do not always see is how it has not affected everyone equally. People who are forcibly displaced face myriad challenges that others do not. They must protect themselves from contracting Covid-19, access (often limited) health-care services when family members fall ill, and cope with the pandemic's indirect impacts. They must do all of this while also living in precarious situations resulting from crises, persecution, conflict, and violence.

Despite early warnings by humanitarian agencies and public health experts (IRC 2020), the disparate impacts of the Covid-19 pandemic on forcibly displaced persons (FDPs)[4] have been largely overlooked (Poe *et al*. 2020). Over the past months, Covid-19 cases in humanitarian settings, including amongst FDPs, have reached alarming levels (IRC 2021). In April 2021, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) reported that over one third of countries covered by Humanitarian Response Plans recorded more cases in the first four months of 2021 than in the whole of 2020 (OCHA 2021). This is why equitable distribution of the Covid-19 vaccine to these particularly vulnerable groups is a critical and substantial challenge that must be addressed.

The vaccine deployment strategies of a large number of many low- and middle-income countries (LMICs) (based on data available) are lacking in equity and clarity about eligibility and prioritisation. This is despite the critical frameworks in place to support equitable vaccine distribution to FDPs (OHCHR 2020) and the World Health Organization's (WHO) comprehensive guidance on vaccine allocation and prioritisation. The United Nations High Commissioner for Refugees (UNHCR) reported that in April 2021 (UNHCR 2021b), only 20 countries were known to have begun vaccinating refugees and asylum seekers on an equal footing to citizens, including Jordan and Uganda (Kasujja 2021). World Vision's survey found that FDPs, in particular unregistered refugees and undocumented migrants in the DRC and Turkey, were being left out of national plans or were included in the plans in theory, but in practice were not receiving or were very unlikely to receive the vaccine.[5]

In May 2021, the International Organization for Migration (IOM) published the most comprehensive analysis on the inclusion of migrants in National Vaccination Deployment Plans available at the time. This analysis was based on a review of 152 of these plans, as well as a review of the practices of 168 countries (IOM 2021).[6] It showed that 61 countries did not include refugees or asylum seekers in their plan (34) or were unclear (27) if they were included, and about 30 per cent of plans reviewed did not include IDPs (29) or were unclear (17).

During this time, high-income countries (HICs) sat on millions of surplus Covid-19 vaccine doses (UNICEF 2021), while many LMICs

struggled to access doses to vaccinate their populations (Our World in Data 2021). The situation was further intensified by the second wave of Covid-19 in India in April 2021, which led the government to suspend vaccine exports. This led to shortfalls globally and disrupted vaccination campaigns (GAVI 2021), including in countries that were due to start vaccinating refugees, such as Bangladesh (WHO Bangladesh 2021).

LMICs, which host the majority of the world's FDPs, also often deal with overwhelmed health systems and a host of other issues that contribute to their vaccine shortages. These issues include poor financial resources, lack of capacity (e.g. cold chain equipment and reliable electricity), and weak infrastructure to implement vaccination programmes and reach people living in rural and remote areas. A lack of strong and efficient distribution systems, shortage of sufficient health workers, and inadequate facilities, combined with high rates of vaccine hesitancy,[7] are leading some of the poorest countries, such as the DRC and South Sudan, to send doses to other countries (Jerving 2021) or throw away expired doses (Aizenman 2021). These countries are facing a double burden to cope with the effects of the Covid-19 pandemic on their own populations and those they host, all with less resources than HICs.

A solution is available to ensure vaccine delivery to FDPs: COVAX. As of July 2021, COVAX (Covid-19 Vaccines Global Access) aimed to deliver 2 billion doses to vaccinate countries' high-risk populations by the end of 2021, with agreements or commitments in place from over 190 countries. A further 1.8 billion doses were planned to be made available by early 2022 for 92 LMICs (CEPI *et al*. 2021). This included Uganda, host to one of the world's largest refugee populations. While COVAX has established a 'humanitarian buffer' to save 5 per cent of vaccine doses for emergency purposes, such as vaccinating refugees who may not otherwise have access to vaccines, the buffer is considered a mechanism of last resort. In addition to this, the actual cost of delivering vaccines in emergency hotspots and responsibility for paying for delivery and distribution is not always clear, with global humanitarian appeals not appearing to cover vaccine roll-outs (IASC 2021).

As we know, global mechanisms do not always reach the most vulnerable individuals. Thus, ahead of World Refugee Day 2021, World Vision spoke directly with FDPs in several settings to hear their perspectives and the issues most affecting their families. This was done through a survey, which focused on two key areas: Covid-19 vaccine access, including information, eligibility, and availability; and Covid-19's indirect impact on livelihoods and subsequent effect on children's living conditions, education, health, nutrition, and wellbeing.

The survey, which was conducted in eight countries between 25 April and 9 May 2021, used a mix of sampling methodologies

(random, purposive, and convenience sampling). A total of 339 households in Brazil (39), Peru (50), Colombia (43), Venezuela (39), Turkey (49), Jordan (39), Uganda (34), and the DRC (46), with an average number of six people represented per household, were interviewed over the phone or face-to-face.[8] Consideration was given to the sex, age, legal status, and living situations of the respondents. Respondents lived in many contexts, including urban, rural, semi-urban, slums, refugee/IDP camps, and low-income housing settings, and over 62 per cent were women, reflecting the high number of female-led households amongst displaced families, particularly in Colombia, Peru, and Venezuela. The survey was supplemented with desk-based research.

2 Key findings

Survey data and desk-based research show that several of the host governments made efforts to include FDPs in national Covid-19 vaccination, prevention, and treatment plans. A number of refugees in Brazil (51 per cent), Jordan (38 per cent), and Peru (32 per cent) reported that their host countries provided them with temporary legal status so that they could access any services available to FDPs. In Jordan, the government adapted the vaccinations and health-care measures it already provided to asylum seekers and refugees (OECD 2020), to respond to Covid-19-related needs. Colombia vaccinates registered Venezuelan refugees and provides them with access to Covid-19 health care (Treisman 2021). Peru approved temporary health coverage for migrants suspected of or testing positive for Covid-19 (IISD SDG Knowledge Hub 2020). Turkey provided registered refugees with free protective equipment, Covid-19 tests, and treatment, irrespective of whether they were entitled to these social security benefits. In addition to Covid-19 tests and comprehensive health care (d'Orsi 2020), Uganda has identified refugees as a priority group and is targeting them in their vaccine roll-out (UNHCR 2021a).

The first key finding indicates that **FDPs face multiple barriers to accessing Covid-19 vaccines**, even when they are available to them. This is largely due to a lack of reliable information, xenophobia and mistrust, and/or migration status. Out of 339 household interviews (representing 1,914 FDPs), only one refugee in Uganda reported receiving a Covid-19 vaccine.

Lack of reliable information is a critical barrier that prevented or deterred FDPs from accessing the Covid-19 vaccine. Almost half (45 per cent) of respondents reported not receiving any Covid-19 information, affecting their knowledge and awareness about vaccine eligibility, safety, and costs. Even if FDPs wished to get vaccinated, the majority (68 per cent) had not heard of any vaccine roll-out plans in their communities, and many (47 per cent) did not know if they were even eligible to receive a vaccine or thought they were ineligible.

In the absence of adequate governmental communication strategies providing fact-based information about Covid-19 vaccines to FDPs, FDPs have no choice but to resort to less reliable sources such as social media. Further complicating matters, the pandemic has led to what the WHO has called an 'infodemic' (Fleming 2020). An 'infodemic' can be explained as an over-abundance of information from many sources (some accurate and some not) that quickly spreads. The majority of respondents said that they used 'informal' or unverified information to find out about the Covid-19 pandemic. The top three sources reported were social media (40 per cent), television (25 per cent), and friends and relatives (24 per cent). This suggested that even FDPs that said they had access to Covid-19 information did not necessarily have accurate information, which may compound inaccurate beliefs about Covid-19 and vaccines.

Even when national communication campaigns are in place, unless they are tailored to specifically include messages to reach FDPs, information may still not reach the most marginalised and vulnerable. This is because information may be communicated via inaccessible channels (IFRC 2020) or in a way that does not make sense to these communities. For example, language and cultural differences can lead to misinterpretation of messages and present barriers to accessing health information (Kluge *et al*. 2020).

Information channels also vary greatly depending on context, as some may not have access to electronic or online resources. For example, in Uganda, 76 per cent of respondents said that they rely primarily on the radio to access Covid-19 information. In the DRC, however, the majority of refugees surveyed reported that they do not own electronics, so presumably they have more limited access to information that is not provided using offline tools such as posters and pamphlets, or in-person communication. This is especially relevant as when FDPs were asked about which sources they trusted to inform them about the effectiveness and safety of vaccines, respondents said that health providers (52 per cent) had their highest level of trust, followed by religious leaders. Depending on local Covid-19 prevention measures, access to in-person meetings with these individuals may be limited, which could cause further challenges to IDPs seeking trusted advice.

For those who could access information, additional barriers such as **xenophobia** may prevent FDPs from accessing vaccines and contribute to hesitancy. The survey found that all FDPs had experienced increased xenophobia, including hate speech and physical attacks, over the past 12 months. FDPs in Peru (46 per cent), Colombia (28 per cent), Brazil (15 per cent), and Turkey (10 per cent) reported the highest numbers. Respondents also said that they were being blamed for the virus, with Central African refugees in the DRC (32 per cent) most likely to report this, followed by South Sudanese refugees in Uganda (17 per cent).

Increased economic and financial pressures on host populations due to the indirect impact of the Covid-19 pandemic have also aggravated existing xenophobic attitudes and contributed to lessening support for FDPs by host governments.

These findings support existing evidence that xenophobia (UN 2020) has been fuelled by the pandemic. This is largely due to the 'othering' of displaced people within political discourse and media as well as discriminatory restrictions towards these populations who are often seen by host communities and governments as a threat to public health (Rohwerder 2021; ESCWA 2020).

FDPs face greater risk of contracting Covid-19 and have fewer resources to fight it. When populations live in overcrowded, unsanitary living conditions with inadequate access to water, sanitation, and hygiene services (Vince 2020) – such as large camps or informal settlements – their risk of disease significantly increases, including their vulnerability to Covid-19. Respondents in Turkey (61 per cent) and the DRC (60 per cent) told us that lockdown rules and movement restrictions were more stringent for them than for host communities, which affected their access to health care. Beyond this, even when restrictions are equal, they can still disproportionately affect FDPs. For example, in Uganda, the government banned public and private transportation, which prevents FDPs in refugee settlements from accessing essential health services as homes can be located several kilometres from service points (Persons with Specific Needs Sub-Working Group, Uganda 2020).

A third barrier to accessing vaccines that arose from the survey findings was **migration status**. Fear of the consequences related to potentially needing to disclose immigration status (Zard *et al*. 2021) to access vaccines (and a broader range of Covid-19 health services) acted as a deterrent for unregistered refugees and IDPs (Kluge *et al*. 2020). Some respondents said that they would be 'very unlikely' or 'somewhat unlikely' to get the vaccine because of documentation concerns. Other respondents reported that shutdowns due to the pandemic led to their asylum and/or refugee claim or resettlement process being delayed or halted, particularly in Uganda, potentially excluding them from vaccination campaigns.

While these three intersectional barriers (lack of reliable information, xenophobia, and migration status) were the primary drivers of vaccine hesitancy, more than one third of respondents (36 per cent) reported being hesitant to get the Covid-19 vaccine even if it was available and accessible. Hesitancy rates were especially high amongst respondents in Turkey (71 per cent), Peru (46 per cent), the DRC (43 per cent), and Brazil (41 per cent). Reasons were varied and dependent on context. Out of the 36 per cent who said they were unlikely to get the vaccine, some felt the vaccine was not safe (22 per cent) or ineffective

(22 per cent), or they did not want to share their personal information to register (13 per cent).

The second key finding was that the **indirect impact of Covid-19 on livelihoods has significantly affected FDPs' living conditions, education, health, nutrition, and overall wellbeing**.

The pandemic had a significant impact on FDPs' income, with the majority of respondents reporting an income drop (73 per cent) or job loss (40 per cent) in the last 12 months. This is primarily due to the types of jobs they do, which are often casual and thus lacking in regulation when a lockdown takes place or they themselves fall sick. Due to *de facto* barriers to economic inclusion, including restrictions on employment rights and options (legally or in practice) and/or lack of access to bank accounts, refugees are 60 per cent more likely than host communities to work in industries highly affected by the Covid-19 pandemic (Dempster *et al*. 2020).

The survey also found that women, who represent a large proportion of survey respondents and heads of households in Venezuela, Peru, and Colombia, have been more affected by livelihood disruptions (Cone 2020) and income losses (64 per cent) than men (36 per cent) (Dempster *et al*. 2020). Determining the full impact of economic shocks on FDPs' livelihoods is difficult, but evidence does show a difference between FDPs and host communities. In Jordan, 35 per cent of Syrian refugees lost their employment as a result of the pandemic versus 17 per cent of Jordanian citizens (Kebede, Stave and Kattaa 2020). In Lebanon, 60 per cent of Syrians lost their jobs permanently compared to 39 per cent of Lebanese (ILO 2020).

The secondary effects of these income losses have led to significant psychological impacts and strains at home for FDPs, with 77 per cent of families reporting increased levels of stress and tension. Additionally, respondents reported being unable to meet their food (77 per cent), accommodation (71 per cent), education (69 per cent), and health-care (68 per cent) needs. A staggering 77 per cent of respondents also reported the dramatic impact of the Covid-19 pandemic on their psychological wellbeing as a result of social and daily stressors (Spiritus-Beerden *et al*. 2021), such as xenophobia, living conditions, migration status, and financial hardship.

2.1 Safer but still not secure: the impact of Covid-19 on children is far-reaching and devastating

Although less susceptible to the physical effects of Covid-19, respondents reported a number of indirect impacts they were worried about when asked what their top Covid-19 concerns were for their children. Community safety (40 per cent), lack of shelters for children (40 per cent), limited food or poor diet (37 per cent), lack of psychosocial support (28 per cent), dropping out of school (22 per cent), and exposure to violence, neglect, abuse, and exploitation (14 per cent) were the top concerns mentioned.

Communities are perceived to be less safe for children than before the Covid-19 pandemic. Eighty per cent of respondents in Colombia reported worrying more about children's safety. Safe shelter was critically missing before the pandemic, but is even more reduced now, with respondents in Peru (71 per cent), Venezuela (69 per cent), the DRC (68 per cent), Colombia (67 per cent), and Uganda (29 per cent) reporting no access to safe shelter for large proportions of forcibly displaced children.

Children's lack of access to food or poor diet was reported as the top concern for most FDPs in Colombia (67 per cent), Venezuela (56 per cent), and Peru (50 per cent). This response parallels the main coping strategy that respondents reported adopting – reducing the quantity and quality of food (61 per cent) – and echoes existing reports on increases in hunger and malnutrition (UNHCR 2021b). A World Vision survey conducted in Latin America in 2020 found that families were unable to provide decent food for their children, and as many as one third of children were going to bed hungry (Korobkova 2020). An assessment between June and September 2020 found that 74 per cent of respondents in Syria and 65 per cent of respondents in Lebanon worried that they would not have enough to eat in the coming months (Breidy 2020).

Although reported as largely available in Turkey and Jordan, the survey found that mental health and psychosocial support services were significantly affected by the Covid-19 pandemic. In particular, respondents in Colombia (52 per cent), Peru (48 per cent), Venezuela (56 per cent), and Brazil (31 per cent) reported concerns about impeded access to psychosocial support services.

Children's education across the world has been deeply affected by the pandemic. In April 2021, the United Nations Educational, Scientific and Cultural Organization warned of a 'generational catastrophe' (UNESCO 2021). Forcibly displaced children are particularly disadvantaged due to existing barriers to education. Before the pandemic, a refugee child was twice as likely to be out of school as a non-refugee child (Grandi 2020). Children dropping out of school was a top concern for respondents, particularly in Turkey, Jordan, and Uganda. This may be explained by a number of reasons, such as the inability to afford school fees and supplies due to income losses, ongoing school closures, and/or limited or complete lack of accessibility of remote learning.[9]

Across all countries, gaps in accessibility to remote education were reported (i.e. no countries said they had complete remote access with all necessary tools available), although children in Turkey and Jordan had greater access. FDPs surveyed in Turkey said that 100 per cent of schools had remote learning arrangements in place; however, 31 per cent said they had no resources to access the arrangements. In Jordan, 100 per cent of schools had some arrangements in place for students to continue

learning (89 per cent remote learning); with only 8 per cent of students stating they had no tools available to access. In the DRC, despite one third of schools still being temporarily closed (and no remote learning services or tools available or school arrangements in place), half of respondents said their children were not in school because they did not have the resources to send them.

Education disruptions also affected children's nutrition and protection. These were two of the other top concerns for children, and are due to school meals not being available and children not having a protective environment to go to either when stress and tensions are high at home.

The survey found that a combination of factors, including stay-at-home orders, movement restrictions, school closures, and increased stress linked to livelihood losses, have led to heightened exposure to violence, neglect, abuse, and exploitation for children. Respondents in the DRC (41 per cent) were particularly concerned about this: families reported resorting to negative coping strategies at the cost of the social wellbeing of family members, especially children. Early marriage was reported – in Uganda (17 per cent), the DRC (8 per cent), and Jordan (5 per cent) – as one way that some respondents dealt with the effects of income or job loss. Respondents from three quarters of the countries surveyed said that they had sent their children to work to compensate, with especially high levels reported in the DRC (43 per cent) and Uganda (18 per cent). As children face increased protection risks, the survey found that a range of protection services have been severely disrupted, particularly in Colombia, Peru, Venezuela, the DRC, and Uganda.

3 Conclusion and key recommendations

Millions of the most vulnerable are being left behind in the race to access vaccines. Barriers in policy and practice are affecting FDPs' ability to protect themselves from the direct and indirect impacts of the Covid-19 pandemic or to access vaccines. Yet the world will only emerge from the pandemic if vaccine distribution is inclusive and equitable.

While the survey results are only indicative of the situations faced by the respondents in eight countries, the overarching experiences are likely to apply to many FDPs. Thus, decision makers must consider how to adjust their recovery plans to better address their specific needs.

Donor governments must ensure equitable access to vaccines between countries by:

- Fully funding COVAX and plugging the US$18.1 billion funding shortfall for the Access to COVID-19 Tools (ACT) Accelerator;[10]
- Providing increased financial, technical, and logistical support to LMICs to ensure efficient vaccine distribution; and

- Accelerating financing for community engagement, vaccine hesitancy interventions, and distribution in alignment with WHO's '10 Steps to Community Readiness'.[11]

Host governments must ensure equitable access to vaccines within countries by:

- Explicitly including all FDPs, regardless of legal status, in immunisation roll-outs equal to their own citizens;
- Increasing access to vaccine information in relevant languages and formats;
- Ensuring that personal information is stored securely and information about a person's legal status or residence is not shared with other government departments; and
- Providing vaccine registration through a variety of accessible channels.

There are tangible risks associated with excluding FDPs from vaccination campaigns as leaving large groups unvaccinated opens the door for further mutations and puts everyone at risk. While the implications of this for the world as a whole should not be underestimated, we must acknowledge that it is FDPs specifically who will suffer the most due to lack of access to vaccines and the arrival of further mutations. FDPs do not have access to adequate health care in illness, nor the socioeconomic safety nets required to protect them from the aftershocks of Covid-19.

Governments have a role to play in ensuring greater support for FDPs as they face Covid-19 and the challenges that come in its wake.

Donor governments should:

- Urgently fund ongoing humanitarian responses and ensure essential health care, protection, food, and social protection for FDPs;
- Prioritise strengthening of health and water, sanitation, and hygiene (WASH) systems to better respond to Covid-19 health-related challenges, address FDPs' complex health needs, and ensure poor countries are better prepared for future shocks; and
- Adopt policies and fund Covid-19 recovery plans that holistically address the indirect impacts on FDPs, especially children.

Host governments should:

- Explicitly include all FDPs, including children, regardless of legal status, in response plans and national health systems, providing equitable access to Covid-19 testing, vaccines, and treatment;

- Expand social protection schemes to minimise the pandemic's economic impacts on all families and children living in their country; and

- Implement inclusive and quality formal and non-formal education strategies for continued learning for all children where schools are still closed, and enable children to return to school by providing suitable equipment, learning materials, and financial support to pay for school fees.

Notes

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‡ World Vision is a Christian relief, development, and advocacy organisation dedicated to working with children, families, and communities to overcome poverty and injustice. Inspired by our Christian values, we are dedicated to working with the world's most vulnerable people. We serve all people regardless of religion, race, ethnicity, or gender.

◊ This article is based on the *High Risk – Low Priority: Why Unlocking COVID-19 Vaccine Access for Refugees and Internally Displaced Communities is Critical for Children* report released by World Vision in June 2021 to bring urgent attention to the pandemic's impact on forcibly displaced persons (FDPs) and their challenges accessing Covid-19 vaccines. It uses primary data collected from a multi-country survey and was supplemented by desk-based research to further elaborate on those findings and provide contextual background. Other data presented is as of July 2021.

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4 Forcibly displaced persons (FDPs) have been defined by this study as refugees (registered or unregistered) and IDPs.

5 The results of World Vision's survey are not representative of the whole refugee and/or IDP populations in respective countries

and are indicative of the situations faced by surveyed respondents at the time of assessment.

6 The list of the 168 countries included in the review by IOM referenced by this article was not made public.

7 Although it did not come up strongly in the survey, vaccine hesitancy has been reported to have affected the vaccination process amongst refugees and asylum seekers (Athumani 2021).

8 All of World Vision's in-person interviews were conducted in compliance with Covid-19 safety regulations and local mandates.

9 World Vision's survey findings reflect a broader learning gap for displaced children, which has been accentuated by the Covid-19 pandemic, including the 'digital divide' and lack of learning resources. In five of the 10 countries hosting the largest numbers of refugees, less than 20 per cent of households have a computer at home, with only two countries passing the 20 per cent mark.

10 See **Access to Covid-19 Tools (ACT) Accelerator**.

11 See **10 Steps to Community Readiness**.

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Anti-Migrant Authoritarian Populism and the Global Vaccination Challenge*

Philip Proudfoot[1] and Brigitte Rohwerder[2]

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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The Health of People with Disabilities in Humanitarian Settings During the Covid-19 Pandemic*

Xanthe Hunt[1] and Lena Morgon Banks[2]

Abstract People with disabilities are at a higher risk of poor health outcomes and face barriers to accessing health services, which may be exacerbated in humanitarian settings and during the Covid-19 pandemic. This scoping review explores how best to protect the health of people with disabilities in humanitarian contexts during the Covid-19 response. Forty-eight articles across the peer-reviewed and grey literature were identified. Key challenges include a lack of accessibility of mainstream Covid-19 prevention and response measures, disruptions to routine care pathways for people with disabilities, and double discrimination based on disability and displaced status. Specific priority areas include continuity of basic and specialised services, prioritisation of women and children with disabilities, the need to adapt mainstream recommendations for the Covid-19 response to be disability- and humanitarian-setting inclusive, and strengthening data systems.

Keywords disability, Covid-19, pandemic, humanitarian setting, emergencies, inclusive health.

1 Background

An estimated 15 per cent of the global population has a disability. This percentage may be even higher amongst the world's 82.4 million forcibly displaced people (Women's Commission for Refugee Women and Children 2008; WHO and World Bank 2011; UNHCR 2021). People with disabilities include 'those with long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (UN 2006). Globally, people with disabilities and their families are at significant risk of discrimination, stigma, and violence, and face barriers to accessing health and social services, all of which may be exacerbated in humanitarian settings and during the ongoing Covid-19 pandemic.

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The rights of people with disabilities to health is enshrined in Articles 25 and 26 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which has been ratified by 182 states (*ibid*.). The right to health comprises equitable access to the same health services as the rest of the population, and, in the context of the current pandemic, includes health services for preventing and treating Covid-19, including vaccines, sanitation and hygiene measures, and access to personal protective equipment (PPE) (UN 2020; Kuper *et al.* 2020). People with disabilities may have additional health needs related to their disability, and so require access to specialist health services (Kuper and Heydt 2019; Shakespeare, Ndagire and Seketi 2021).

However, even before the pandemic, people with disabilities in humanitarian and non-humanitarian settings faced physical, informational, financial, and attitudinal barriers to accessing required health care, which often led to poorer levels of health, decreased functioning, and a reduction in social participation (Kuper and Heydt 2019; UN 2019). Specialised health and rehabilitation services are almost entirely absent in many humanitarian settings, including camps, and as such, treatable medical conditions can progress into significant impairments due to lack of proper medical attention (Mirza 2015). Disability is also not routinely considered when planning health services in humanitarian settings, leading to limited accessibility and appropriateness (*ibid*.; Hunt 2020).

Little is known about the health and health-care access of people with disabilities in humanitarian settings during the Covid-19 pandemic. Yet, existing evidence has highlighted that the health of people with disabilities in non-humanitarian settings has been disproportionately affected by the pandemic (Shakespeare, Ndagire and Seketi 2021; Shakespeare *et al.* 2021; Williamson *et al.* 2021). The health inequalities faced by people with disabilities may be further exacerbated when response planning and service delivery in the context of the pandemic are not inclusive or fail to consider the impact that decisions will have for people with disabilities (Perry *et al.* 2020; ACAPS-NPM Analysis Hub 2021).

The pandemic, and measures necessary for its containment, pose a particular threat and challenge in humanitarian settings. For example, containment measures such as mass 'stay-at-home' orders, social distancing, and quarantine are often difficult to implement in humanitarian settings such as camps (Hunt 2020). Displaced people living outside of camps may not be able to access health services for Covid-19 prevention and treatment if they do not have recognised legal status, or they may lack access to information on Covid-19 if it is not available in their own language.

People in humanitarian settings and people with disabilities, then, need special consideration within the Covid-19 response.

However, there is a lack of evidence exploring the intersection between the two groups. This article therefore seeks to review the available evidence and guidance on how to support the health of people with disabilities in humanitarian settings[3] during the Covid-19 pandemic.

Section 2 describes the methods used in this evidence synthesis and Section 3, the results of our search. Section 4 discusses the key themes emerging from the review, with a focus on key challenges and lessons learned. We conclude, in Section 5, by noting the implications of our findings for research and practice.

2 Methods

We conducted a scoping review of the literature with a narrative synthesis. Non-systematic reviews of this kind are appropriate where there is a variety of evidence from different disciplines, and on a topic for which there have been few prior evidence syntheses (Greenhalgh, Thorne and Malterud 2019).

2.1 Search strategy

There are six types of information which are relevant to synthesising learning about how to support the health of people with disabilities in humanitarian settings during the Covid-19 pandemic. These include information about what works to improve health among the following groups:

1 All people in humanitarian settings;

2 All people in the Covid-19 pandemic;

3 People with disabilities generally;

4 People with disabilities in humanitarian settings generally;

5 People with disabilities in the Covid-19 pandemic; and

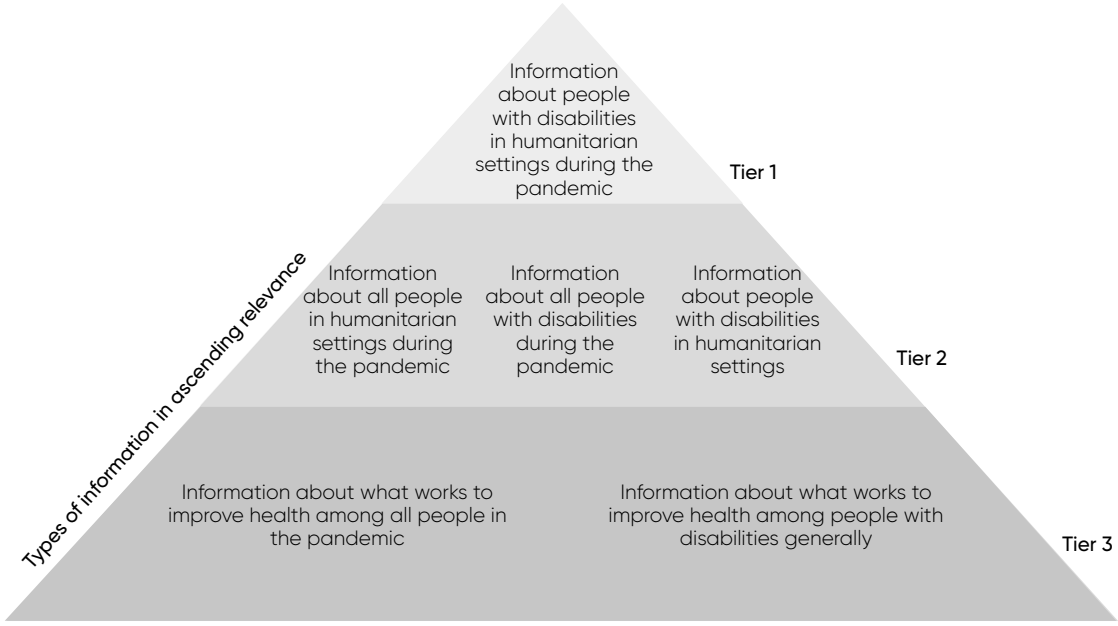
6 People with disabilities in humanitarian settings in the context of the Covid-19 pandemic.

These different types of information, summarised in Figure 1, also exist across both grey literature and peer-reviewed publications.

To provide a broad overview of the literature, but not lose the specificity of the research question, our review focuses on the top two tiers of the pyramid in Figure 1 (the four types of information most relevant to our question).

The search was structured as follows. First, new evidence specific to the situation of people with disabilities in humanitarian settings during the Covid-19 pandemic (Tier 1 of Figure 1) was gathered through systematic searching of key academic databases (Africa-Wide Information, MEDLINE, Embase Classic+Embase, PsycINFO, CINAHL, ERIC, CENTRAL, Scopus). Preprint databases

Figure 1 Hierarchy of information relevant to the research question 'How to support the health of people with disabilities in humanitarian settings during the Covid-19 pandemic?'



Source: Authors' own.

medRxiv and OSF preprints were also searched, as was Google Scholar. Grey literature was searched using ReliefWeb, a database managed by the United Nations Office for the Coordination of Humanitarian Affairs. Terms related to 'disability', 'Covid-19', and 'humanitarian settings' were used. The search was restricted to 2020 to July 2021, given that the World Health Organization (WHO) declared the Covid-19 outbreak a global pandemic on 11 March 2020. Findings from this search were exported, abstracts screened, and included full texts reviewed for relevant content (see Section 2.2).

Second, given the expected lack of evidence from the first search, we sought to identify additional literature relevant, but not necessarily specific, to the health of people with disabilities in humanitarian settings during the Covid-19 pandemic – literature covering topics in the second tier in Figure 1. To do so, we drew on Disability Evidence Portal Briefs, which are rapid reviews (that were written or reviewed by Xanthe Hunt) that provide recommendations on supporting the health of people with disabilities during the Covid-19 pandemic and/or in humanitarian settings (Hunt 2020; Wilbur and Hunt 2020; Qureshi and Scherer 2020), and relevant grey literature and academic publications identified from the reference lists of studies included in the first search. These sources carried important information about supporting the health of people with disabilities in humanitarian settings and/or during past times of crisis. Drawing on these

sources is particularly important given the timescales for research and publication, and the need for urgent responses in the initial stages of the pandemic which would not have been possible based on current evidence alone.

No restrictions were placed on publication type, and editorials, grey literature, impact studies, and descriptive research were all eligible for inclusion.

2.2 Publication management and extraction

Included publications from both search strategies were critically reviewed, relevant information entered into an Excel spreadsheet, and the information organised according to its relevance to the specific research question (i.e. along the tiers in Figure 1). Extracted information included the following:

- Publication type (e.g. editorial, observational study, review);
- Type of health care covered (e.g. sexual and reproductive health, primary health care);
- Key challenges and barriers to health for people with disabilities in humanitarian settings and/or during the pandemic; and
- Strategies and guidance for supporting access to health for people with disabilities in humanitarian settings and/or during the pandemic.

In the findings discussed next, primacy is always given to information gathered from publications with the greatest specificity (Tier 1), and from peer-reviewed reviews.

3 Results and narrative synthesis

3.1 Results

Twelve publications were retrieved that were specific to the experience of people with disabilities in humanitarian settings during the Covid-19 pandemic (Tier 1 of Figure 1). All 12 publications were grey literature. A further 36 publications were identified covering topics in Tier 2 of the Figure 1 pyramid: 18 concerning the health of people with disabilities during the Covid-19 pandemic (outside of humanitarian settings), nine on the health of people with disabilities in humanitarian settings (not in the Covid-19 pandemic), and nine concerning the health of all people in humanitarian settings during the Covid-19 pandemic (not specifically people with disabilities). Included publications are listed in Annexe 1.

Several documents published by organisations working in humanitarian contexts (e.g. UN agencies, non-governmental organisations (NGOs)) recognised the increased risk faced by people with disabilities during the Covid-19 pandemic, including the potential for exclusion from needed routine health care

Table 1 Key findings and priorities for action

Domain	Challenges for people with disabilities in humanitarian settings	Priority actions
Covid-19-related health care		
Following preventative measures	• Increased need for sanitation supplies (e.g. due to incontinence, reliance on others/surfaces to move around) • Lower capacity to pay for increased need for sanitation supplies • WASH[4] facilities in humanitarian camps may be dangerous and inaccessible	• WASH infrastructure must be accessible and in safe locations • Allocate hygiene products in line with specific needs • Provide information in accessible formats and to carers
	• Mask-wearing may be difficult for some (e.g. people using lip reading, people with cognitive impairments) • Masks may not be available or affordable	• Allow exemptions on mask-wearing for people with certain disabilities • Provide free masks or materials for home-made masks
	• Social distancing may be impossible for people who require caregiving support for daily life activities • Social distancing in densely populated humanitarian settings may be difficult	• Allow exemptions on social distancing for people who require caregiving support • Provide caregivers with guidance on how to interact safely • Alternatives to social distancing may be required (e.g. enhanced surveillance and testing) in camps
Information about Covid-19	• Covid-19 information is not always in accessible formats • Humanitarian camps or long-term care facilities may not be included in public health information campaigns	• Provide information in accessible formats, in the language(s) of the displaced population, in a range of different settings
	• Public health information campaigns can be ableist and lead to discrimination against people with disabilities	• Include information about adaptations that people with disabilities can use to follow guidance • Publicise and explain exemptions to following guidance • Avoid stigmatising people for whom Covid-19 prevention behaviours are challenging
Access to health care for Covid-19	• Greater risk of infection or severe disease from Covid-19 • Financial, accessibility, attitudinal, and legal barriers accessing health care • Stigma and discrimination can lead to the deprioritisation of care	• Barriers to health care must be addressed (e.g. improve accessibility of facilities, staff training) • People with disabilities in humanitarian settings should not be excluded from treatment prioritisation based on their disability and/or refugee/displaced person status
Access to vaccines	• Limited provision of vaccines in humanitarian settings • Financial, legal, accessibility, and attitudinal barriers may limit uptake	• Ensure equitable prioritisation in the delivery of vaccines based on risk • Vaccination registration and administration sites must be easy to access, in accessible and safe locations • Staff should be trained and monitored to prevent discrimination • Vaccinations should be provided at no or low cost to all, regardless of insurance/ legal status

Other health needs and access to health care		
Violence prevention and intervention	• High pre-existing risk of violence due to disability and displaced status. Social distancing and isolation can increase risk of violence and limit options for escaping it • Poor access to support services if non-inclusive or disrupted due to Covid-19	• Address drivers of violence (e.g. discrimination, social exclusion) • Integrate intimate partner violence screening into routine services offered in humanitarian settings • Promote the continuation of accessible services and supports for addressing and preventing violence during the pandemic
	• Children with disabilities may be at elevated risk of exposure to violence, neglect, and exploitation (e.g. due to financial distress, loss of support networks) • Children protection services not disability-inclusive and disrupted due to the pandemic	• Provide guidance and support to caregivers to keep their children safe • Prioritise inclusive child protection efforts
	• Beliefs that people with disabilities and displaced persons are carriers of the virus can lead to stigma, discrimination, and violence	• Conduct awareness campaigns dispelling misconceptions
Access to needed health care	• Key health services have been disrupted • People with higher health needs are more affected by disruptions • Accessing health facilities and support services interrupted by restrictions • Remote approaches may not be accessible or available	• Existing barriers (e.g. legal, financial, accessibility) to health care must be addressed • Efforts to ensure the continuity of care (e.g. telemedicine) must be accessible and available in humanitarian settings • Social protection should be available to people in need to offset the economic impacts of the pandemic
Early identification and intervention with children with disabilities	• Pandemic-related restrictions reduce opportunities for disability detection	• Low-risk opportunities for engagement with caregivers of young children for detection and referral (e.g. assessments over phone/video; home-based visits with precautions)
Mental health	• Social distancing, movement restrictions and lockdowns, as well as the negative social, health, and economic impacts of the pandemic, can lead to isolation and increased depression and anxiety	• Drivers of stress and isolation should be addressed • Ensure programmes are inclusive of people with disabilities in humanitarian settings • People with disabilities in humanitarian settings must be prioritised for psychosocial support programming
	• Traditional mental health intervention modalities for humanitarian settings may not be possible under the restrictions of the pandemic	• Interventions must be adapted to the current situation by drawing on existing evidence and evaluating innovative approaches such as accessible videoconferencing

Source Authors' own.

(general and disability-specific) and health-care and preventative measures linked to Covid-19 (UN 2020; IASC 2020a, 2020b; Hall and Damon 2021; Live and Learn Environmental Education and CARE 2021; Syria Protection Cluster (Turkey) – Inclusion Technical Working Group 2021; United Nations Sustainable Development Group 2020; Humanity and Inclusion 2020). Still, little data were available – outside of a few small-scale, non-representative surveys conducted early in the pandemic by NGOs – documenting the experience of people with disabilities in humanitarian settings during the Covid-19 pandemic. Table 1 describes the available evidence and guidance on the health of people with disabilities in humanitarian contexts, and what is known from the broader evidence base on access to health care of people with disabilities in humanitarian settings or during the pandemic.

3.2 Key challenges affecting the health and health-care access of people with disabilities in humanitarian contexts during the Covid-19 pandemic

Table 1 summarises key challenges to supporting the health of people with disabilities in humanitarian settings during the pandemic, as well as priorities for action. Several cross-cutting issues were identified across challenges. First, people with disabilities in humanitarian settings face double discrimination on account of their disability and being a displaced person (Mirza 2015; Hossain *et al.* 2020). This discrimination may be heightened by the pandemic (UN 2020; Lokot and Avakyan 2020). For example, Turkish media have reported that refugees and asylum seekers are falsely blamed for spreading coronavirus and, as a consequence, face stigma and discrimination (Sevencan 2020). Similarly, people with disabilities can face discrimination if they are unable to follow certain guidelines (e.g. mask-wearing for people who lip read, or with intellectual impairments) (Humanity and Inclusion 2020; Qi and Hu 2020). Discrimination and violence not only have negative physical and mental health consequences but can prevent access to key health services (United Nations Sustainable Development Group 2020).

Second, people with disabilities in humanitarian settings faced systemic barriers to accessing essential services even before the pandemic (Schiariti 2020). For example, health and social services are often not disability-inclusive (e.g. lack of accessible communication, physically inaccessible and hard-to-reach facilities) (Kuper and Heydt 2019; Shakespeare, Bright and Kuper 2018). Within camp settings, needed services may be in limited supply, while displaced people living in communities may not be able to access available services due to their lack of legal status or the lack of communication/information in their preferred language (Hunt 2020). The pandemic has brought further challenges, as many health services were disrupted due to the strain on many health systems (Shakespeare, Ndagire and Seketi 2021; Shakespeare *et al.* 2021). Evidence from several settings indicates disruptions were particularly difficult for people with disabilities,

given their increased need for health services and products (e.g. rehabilitation, assistive devices, medication) for functioning and participation (UNRWA 2020; Human Rights Watch 2020).

Third, the pandemic is disrupting key referral pathways into much-needed care for people with disabilities in humanitarian settings (United Nations Sustainable Development Group 2020). For instance, routine sexual and reproductive health services are a critical entry point for women affected by violence, and when disrupted, opportunities for gender-based violence screening are missed (Lokot and Avakyan 2020). Similarly, closure of schools and other programmes for children may reduce opportunities for early identification of disability and disability-related services, as well as child protection mechanisms (Shakespeare *et al.* 2021; United Nations Sustainable Development Group 2020; Leonard Cheshire Working Group on Inclusive Education 2020).

Fourth, the pandemic is likely deepening pre-existing inequalities, which can drive negative health consequences. For example, the Covid-19 pandemic has caused financial strain for many people, but people with disabilities and in humanitarian settings already were more likely to be in poverty before the pandemic (Banks *et al.* 2020; Banks, Kuper and Polack 2017). Worsening economic status can then prevent people with disabilities in humanitarian settings from following preventative measures (e.g. affording sanitisation products) and accessing needed services for both Covid-19 and other health care.

Finally, recommendations for pandemic responses, including in humanitarian settings, may be unsuitable for people with disabilities (Humanity and Inclusion 2020; Qi and Hu 2020). For example, guidance may not consider specific challenges that people with disabilities in humanitarian settings may face in following prevention guidelines or accessing Covid-19 health care. Similarly, adaptations are not made to account for the varying needs of people with disabilities in humanitarian settings (e.g. some people with disabilities have the additional need for safe water/hygiene supplies due to both their impairment and Covid-19, but allocation of these supplies in humanitarian settings tends to be set at a standard amount for all).

4 Ways forward

Table 1 highlights strategies to support the health of people with disabilities in humanitarian settings during the Covid-19 pandemic. Specific priority areas include continuity of basic and specialised services, the prioritisation of women and children with disabilities, the need to adapt mainstream recommendations for Covid-19 responses to be disability- and humanitarian-setting inclusive, and strengthening data systems.

Continuity of basic and specialised services for people with disabilities in humanitarian settings is essential, as disruptions can

lead to worsening health and functioning (San Lau *et al*. 2020; Tran *et al.* for the Inter-Agency Working Group on Reproductive Health in Crises 2020). Continuity of mental health-care services is particularly important given the associations between the pandemic and increased stress (Qureshi and Scherer 2020; Nankervis and Chan 2021). Remote provision (e.g. through phone, video appointments) is increasingly used as a strategy to access key services during the pandemic (UN 2020; Hunt 2020; IASC 2020a). These strategies may improve access to health care for people with disabilities in humanitarian settings both during and beyond the pandemic, particularly for disability-related health care, which is often urban-based and in limited supply. Still, these remote alternatives must be available in accessible formats (e.g. sign language interpretation available, screen-reader compatible platforms) (UN 2020; IASC 2020a; United Nations Sustainable Development Group 2020). Further, complementary efforts are needed to promote access to needed technology for people with disabilities in humanitarian settings, as this group is likely to have poorer access due to higher levels of poverty (Banks *et al*. 2017).

Women and children with disabilities need specific consideration during the Covid-19 response in humanitarian settings, as isolation, reliance on distant WASH services, and isolation in the home with abusive family members can elevate vulnerability to gender-based violence and child abuse (Wilbur and Hunt 2020). WASH stations need to be close enough to where people live so as not to place women and children at risk of violence (*ibid.*). They must also be accessible to people with disabilities so that they can be used independently and hygienically (Kuper *et al.* 2020; Wilbur and Hunt 2020). Efforts must be made to ensure continuity in sexual and reproductive health services for women with disabilities and early identification and intervention for children with disabilities so that existing vulnerabilities are not exacerbated during the pandemic (Tran *et al.* for the Inter-Agency Working Group on Reproductive Health in Crises 2020; Tanabe *et al.* 2015). Further, as intimate partner violence rates may spike during lockdown, continuity of routine services for women (such as antenatal care) must be ensured to allow for ongoing intimate partner violence screening (Lokot and Avakyan 2020).

Mainstream recommendations for the containment of Covid-19 need to be adapted to be both disability-inclusive and appropriate for different humanitarian settings (including camps) (Hunt 2020; United Nations Sustainable Development Group 2020; Qi and Hu 2020). People with disabilities and their carers in humanitarian settings need to be supported to implement disease control measures such as social distancing and hygiene, through specific and accessible guidelines and material support (e.g. provision of additional soap, water, and other hygiene products based on need rather than on universal standards) (Shakespeare, Ndagire and Seketi 2021; Hall and Damon 2021;

Syria Protection Cluster (Turkey) – Inclusion Technical Working Group 2021). Given the challenges of social distancing, both due to the crowded nature of many humanitarian settings and the need for caregiving support for some people with disabilities, alternatives such as priority testing and access to PPE and vaccination for people with disabilities and their caregivers may be necessary and of benefit in humanitarian settings (IASC 2020a).

Additionally, organisations of persons with disabilities (OPDs) and people with disabilities from humanitarian settings must be consulted during all stages of planning and implementation to ensure that the resulting policies and programmes reflect the priorities and needs of people with disabilities in humanitarian settings during the pandemic (Hall and Damon 2021; Live and Learn Environmental Education and CARE 2021; Humanity and Inclusion 2020; Rotas and Cahapay 2021). OPDs and other networks can be leveraged to identify opportunities and resources to make the Covid-19 response more inclusive (Hunt *et al.* 2021).

Finally, to inform planning and programming, data systems in humanitarian settings must be strengthened to collect sex, age, and disability disaggregated data, including on differing rates of infection, access to key services (e.g. vaccination uptake), impacts on families, and violence exposure (ACAPS-NPM Analysis Hub 2021; Hall and Damon 2021; Humanity and Inclusion 2020). This review revealed the lack of primary data on the experience of people with disabilities in humanitarian settings, indicating a pressing need for further research. While the lack of data should not delay action, rigorous research can help to identify further priorities and strategies for tailoring responses.

5 Conclusion

People with disabilities in humanitarian settings face compounded challenges to protecting their health and accessing needed care during the Covid-19 pandemic due to the interaction of disability and living in a humanitarian setting. Most of the evidence from this scoping review was not specific to the experience of people with disabilities in humanitarian settings during the Covid-19 pandemic and was based on guidelines produced by NGOs and international NGOs (INGOs) rather than primary data. While helpful, further primary research is needed to better understand the experiences of people with disabilities in humanitarian settings during the Covid-19 pandemic, and their inclusion in response actions. Rights- and evidence-based approaches are needed to ensure that people with disabilities in humanitarian settings are not left behind in the pandemic response (Schiariti 2020; Battle 2015; Kluge *et al.* 2020). Dignity and respect for the rights of people with disabilities need to be the starting point from which all response actions must develop. Strategies for containing Covid-19 must not worsen inequalities and reinforce ableist assumptions (Rotarou *et al.* 2021).

Notes

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3 It is worth briefly noting that humanitarian emergencies are very diverse phenomena, and differences between them will influence the types of provisions which are needed to support the health of people with disabilities. However, the purpose of our review is to identify general guidance which can be applied to supporting inclusive responses to the pandemic.

4 WASH = water, sanitation, and hygiene.

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Annexe 1 Included literature

	Types of information				Categories of publication			
Reference	**Health + People with disabilities + humanitarian settings + Covid-19 pandemic**	**Health + people with disabilities + Covid-19 pandemic**	**Health + people with disabilities + humanitarian settings**	**All people in humanitarian settings + Covid-19 pandemic**	**Impact evaluation**	**Descriptive study**	**Evidence synthesis**	**Editorial/commentary/guidance document/grey literature**
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Covid-19's Effects on Contraceptive Services Across the Humanitarian–Development Nexus*†

Lily Jacobi[1] and Sarah Rich[2]

Abstract Sexual and reproductive health (SRH) services, including contraception, save lives in humanitarian emergencies. To document practitioners' perceptions of the effects of the Covid-19 pandemic on contraceptive programming in humanitarian settings and across the humanitarian–development nexus, the Women's Refugee Commission conducted 29 key informant interviews with respondents from non-governmental organisations, the United Nations, and government ministries. Disruptions to contraceptive services included closures or repurposing of health facilities, limited availability of health providers, supply chain interruptions, restricted service delivery modalities, and lower demand for services. Adaptations to sustain services included telemedicine, task-shifting and sharing, community-based service delivery, and other innovations. Underlying factors affecting the types and extent of disruptions and adaptations included emergency preparedness for SRH, decision makers' prioritisation of SRH services, funding, and coordination. Findings reinforce the need to build awareness that SRH services, including contraception, are lifesaving and essential in humanitarian settings, and to improve preparedness, including bridging gaps between humanitarian and development actors.

Keywords sexual and reproductive health, contraception, family planning, humanitarian settings, Covid-19, humanitarian–development nexus, emergency preparedness.

1 Introduction

Access to basic, primary health care is a critical component of humanitarian response. Sexual and reproductive health (SRH) services – including maternal and newborn care, family planning, prevention and treatment of sexually transmitted infections, and gender-based violence prevention and response – are lifesaving and critical to meeting basic health needs. The 2018 Minimum

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Initial Services Package (MISP) for SRH, the global standard for SRH response in acute emergencies, outlines the priority activities to be implemented at the outset of all crises to save lives and mitigate impacts – including the prevention of unintended pregnancies (IAWG 2018). Contraception must be made available with other essential SRH services at the outset of every emergency response, including epidemics and pandemics, and should be expanded after the acute stage of an emergency (*ibid.*).

Investing in contraceptive services reduces maternal mortality and morbidity (Ahmed *et al*. 2012) and is essential to respect, protect, and fulfil the human rights of women and girls, as established by multiple human rights treaty bodies (UNFPA and CRR 2011). Moreover, investing in contraception fosters resilience, promotes participation in livelihoods and education initiatives, and empowers women and girls – amplifying humanitarian investments across the board (Singh, Darroch and Ashford 2014).

Numerous studies document robust demand for contraception across diverse humanitarian settings, and evidence shows that more women and girls will find a contraceptive method that works for them when services are of good quality and a range of methods are available (Jacobi and Rich 2021; Hancock *et al*. 2016). For example, studies in conflict-affected areas of Sudan, Uganda, and the Democratic Republic of the Congo (DRC) found that 43–71 per cent of women wanted to delay pregnancy or did not want additional children (McGinn *et al*. 2011), and a survey of Syrian refugee women in Lebanon found that nearly three quarters of them wished to prevent future pregnancies (Kabakian-Khasholian *et al*. 2017). Yet gaps in the availability, accessibility, and quality of contraceptive services persist across diverse humanitarian settings, including stockouts of supplies and equipment, poor quality of care, and barriers for women and girls such as stigma, partner opposition, low knowledge of contraception, and prohibitive costs (McGinn *et al*. 2011; Casey *et al*. 2015; Chynoweth 2015; Tanabe *et al*. 2017; Jacobi and Rich 2021; Ackerson and Zielinski 2017; Ivanova, Rai and Kemigisha 2018).

The Covid-19 pandemic has amplified the need for humanitarian assistance, yet emerging evidence suggests that the pandemic and related response measures have severely impacted the availability and accessibility of SRH services around the world. A World Health Organization (WHO) survey in mid-2020 found that contraceptive services were one of the most frequently disrupted health services, with 68 per cent of respondents from 105 countries reporting disruptions (WHO 2020b). A second WHO survey, in early 2021, found that 40 per cent of 135 reporting countries were experiencing disruptions in contraceptive services (WHO 2021b). Studies from Nigeria, Bangladesh, and Ethiopia all found reductions in the use of contraceptive services (Adelekan *et al*. 2021; Roy *et al*. 2021; Ahmed *et al*. 2021; Belay *et al*. 2020). Estimates suggest that a 10 per cent decline in the

use of short-acting and long-acting reversible contraceptive (LARC) methods across 132 low- and middle-income countries due to Covid-19-related disruptions could result in 48.5 million additional women with unmet need for modern contraceptives and 15.4 million additional unintended pregnancies over a 12-month period (Riley *et al*. 2020).

However, there is still limited evidence available that is specific to the impact of Covid-19-related disruptions to contraceptive services in humanitarian settings and the health and rights of crisis-affected women and girls. This is a critical gap: in 2022, an estimated 274 million people will be in need of humanitarian assistance – the highest number in decades and an increase of 39 million people from 2021 (OCHA 2021). The Women's Refugee Commission undertook a series of key informant interviews (KIIs) with global stakeholders working across humanitarian and development settings to document their perceptions of the effects of the pandemic on contraceptive programming in humanitarian settings and across the humanitarian–development nexus. For the purposes of this assessment, the humanitarian–development nexus was defined as the continuum and intersection of settings and stakeholders spanning stable development settings, fragility, humanitarian response, and recovery.

This qualitative assessment was part of a broader, mixed-methods landscaping assessment funded by a private foundation to evaluate and build the evidence base on barriers, opportunities, and effective strategies to ensure access to contraceptive services among women and girls affected by crises. The assessment also included a literature review, a global contraceptive programming survey, KIIs, and three case studies, all conducted prior to the Covid-19 pandemic (see other assessment findings in Rich and Jacobi 2021). This article presents findings from the KIIs focused on the impact of the Covid-19 pandemic.

Section 2 lays out methods and limitations. Section 3 discusses findings from the research, including disruptions to contraceptive services and programmes; service delivery and programming adaptations; and underlying factors affecting contraceptive access and availability during the pandemic. Section 4 provides concluding remarks.

2 Methods and limitations

Between August and October 2020, the Women's Refugee Commission conducted 29 KIIs to collect qualitative data from stakeholders supporting contraceptive service delivery on (1) their experiences of the effects of the Covid-19 pandemic on contraceptive service delivery; (2) innovations and adaptations to ensure contraceptive services remained available and accessible; and (3) facilitators and barriers to contraceptive service delivery during the pandemic across the humanitarian–development nexus.

Respondents were identified using purposive and snowballing sampling and included representatives of one UN agency, 11 international non-governmental organisations (INGOs), five national non-governmental organisations (NGOs) across various regions, and three government health authorities from three countries (all of which were in sub-Saharan Africa). Among the UN agency and INGO respondents, 12 were based at headquarters, and eight were working at the regional or country level. For the purposes of anonymisation, data from UN agency respondents are reported as INGO respondents. Six interviews were conducted and transcribed in French, then translated into English for coding and analysis. All other interviews were conducted and transcribed in English. All interviews were conducted virtually.

Data were analysed using thematic analysis: the primary data collector first developed a small number of deductive codes, then read and annotated the transcripts to identify trends and emergent themes, which were used to develop the codebook. All transcripts were coded in NVivo 12 Plus by either the primary data collector or a second coder who was trained on the codebook prior to coding. Both coders analysed a selected transcript to assess and establish intercoder agreement and the primary data collector reviewed coding for all transcripts to identify any excerpts needing further discussion to ensure intercoder agreement.

Researchers obtained verbal informed consent prior to all interviews, and all data and materials were stored on secure, password-protected devices. No identifying information about respondents or their organisations is included in this article or any product of the assessment. Research was conducted in accordance with the Women's Refugee Commission's *Ethical Guidelines for Working with Displaced Populations*, which establishes ethical standards for data collection (Women's Refugee Commission 2016). Researchers did not submit the research for approval from an Institutional Review Board because personal information was not collected, the interviews aimed to understand organisational perceptions and experiences, and there was minimal risk to participants.

Researchers did not attempt to reach saturation, and findings are not representative of all practitioners' and organisations' experiences providing or supporting contraceptive service delivery in settings across the humanitarian–development nexus following the onset of the pandemic. Many respondents worked at the global or regional level and were reporting on numerous countries comprising both humanitarian and development settings, or supporting humanitarian and development programming; other respondents were representing one country with both humanitarian and development settings. Thus, the authors are not able to describe each respondent as representing humanitarian or development organisations and/or settings. Similarly, the authors are not able to systematically identify

respondents' country contexts, either to preserve confidentiality or because many respondents were reporting on multiple countries. Data presented in this article are key informants' perceptions and self-described experiences, and may not be representative of all humanitarian or development contexts. The study did not examine additional programming or quantitative data.

3 Findings

3.1 Disruptions to contraceptive services and programmes

Respondents were essentially unanimous in reporting that the Covid-19 pandemic had disrupted contraceptive programming and service delivery. Disruptions included closure or repurposing of health facilities, limited availability of providers, supply chain disruptions, restricted service delivery modalities, and limited access to services due to movement restrictions and other factors.

3.1.1 Health facility and provider availability and capacity

Many respondents reported that health facilities delivering contraceptive services were closed, at least temporarily, as a result of lockdowns and movement restrictions. Respondents working in both humanitarian and development settings described disruptions due to providers being redirected to and/or facilities being converted for Covid-19 response. One respondent lamented,

> *Some of the staff have been moved to emergency response for Covid-19. So, this already creates a big gap, and definitely some clients visit the facility, and they might not get the services they need. And once a client* [has visited the facility] *for family planning, that means they really need it – they probably needed it yesterday*.

Some respondents also noted that movement restrictions prevented providers from reaching health facilities. Multiple respondents also reported health workers falling ill, and in some cases dying, from the Covid-19 virus.

3.1.2 Contraceptive and PPE supply availability

Many respondents across organisations and settings described challenges with the availability of contraceptive and SRH supplies, and personal protective equipment (PPE). Respondents described supply chain disruptions at the international, national, and subnational levels caused by movement restrictions, including international production and availability of supplies, increased shipping and transportation costs, the ability to import supplies, and staff ability to reach warehouses. Two respondents working in humanitarian settings noted that Inter-agency Reproductive Health (IARH) kits were not available when respondents tried to order them.

Respondents also emphasised that PPE was extremely expensive given global demand. Multiple respondents reported that lack of PPE disrupted services at the outset of the pandemic, even

when all other elements required for contraceptive services were in place. Several respondents noted that providers went on strike due to lack of PPE; one respondent reported that providers decided to 'strike, saying that they are not protected and no one cared about them.' Another respondent explained that they had to shift funding intended to purchase contraceptive supplies to purchase PPE.

3.1.3 Range of services and service delivery modalities offered

Several respondents working across a range of settings described greater challenges to the provision of LARCs compared to short-acting methods, particularly early in the pandemic. This was reportedly due to the required provider presence for insertion and removal, limited availability of PPE, and reduced client flows through static facilities. Additionally, a few respondents reported that their organisations were following government guidelines on service delivery during the Covid-19 pandemic, emphasising the provision of short-acting methods over LARCs. However, some respondents across organisations and settings said that they were able to continue providing a diverse method mix, suggesting the pandemic's impact was strongly influenced by context, including the parameters of government guidelines on health service provision during the pandemic.

Many respondents across contexts stated that community sensitisation activities were severely disrupted, particularly by movement restrictions and lockdowns, but explained that demand generation activities gradually resumed as restrictions eased.

3.1.4 Clients' ability to reach and obtain services

Respondents representing diverse settings reported that people were unable to leave their homes due to movement restrictions or were stopped by authorities when attempting to reach facilities. Most respondents also explained that communities were afraid to seek services due to the risk of catching Covid-19 or were deterred by messaging about the importance of staying at home. Several respondents also reported decreases in client flow due to mistrust of health authorities and systems, including in settings with a history of Ebola, and myths and misinformation about Covid-19.

Respondents were particularly concerned about reaching isolated and marginalised communities, including adolescents. Multiple respondents across settings described increased transportation costs for clients, while facility closures exacerbated existing barriers posed by distance to health facilities. One national NGO respondent explained that many refugees in their country had lost their jobs due to the pandemic and could not afford services. Several respondents noted that clients were not able to seek services, or were turned away, because they did not have their own masks.

3.2 Service delivery and programming adaptations

Organisations implemented innovations and adaptations to sustain or resume contraceptive service delivery, including using telemedicine or other technology; task-shifting and sharing, including community-based service delivery; and implementing new service delivery, training, and supply chain mechanisms.

3.2.1 Technology and telemedicine

Nearly all respondents described using technology to maintain operations and, depending on the organisation, some elements of service delivery. Respondents described developing protocols and training and supplying providers to connect with clients via telephone and WhatsApp to schedule appointments, provide counselling, direct clients to obtain contraceptive methods, and conduct follow-up. Some respondents described establishing helplines or call centres to field inquiries on SRH services. One respondent working in a humanitarian setting said,

> *In two-and-a-half weeks, we seamlessly shifted from having crowds in our clinics to actually saying, 'Call the centre and you go through your symptoms, tell us what your location is, and we'll tell you what's the easiest way to get* [your method].'

Another respondent, working on humanitarian programming at the headquarters level of an INGO, remarked, 'There's such an opportunity there. We'll just make certain people's lives a lot easier, and decrease travel for women and providers, and everyone involved… We've discussed [this] for a long time… This is just the kickstart.' However, some respondents' organisations in both development and humanitarian settings could not implement telemedicine because they did not have the necessary electricity, internet connectivity, time, or resources.

3.2.2 Task-shifting and sharing, including community-based distribution of services and information

Some respondents reported task-shifting and/or sharing, including authorising community health workers to provide contraceptive methods and shifting provision of certain methods to pharmacies or dispensaries. One INGO respondent said that the pandemic has 'primed' stakeholders for task-sharing and shifting, as they recognised that 'We can't be doing this at our district hospitals because all [the] beds are taken by Covid-19. Therefore, it's okay for it to be happening at the [primary health-care] level.' He continued, 'It's also showed that change is possible… we need to really recognise that, as we say, necessity is the mother of invention.'

Several respondents across organisations and settings cited community-based distribution as an effective tool to reach communities and deliver contraceptive services and commodities. One respondent from a national NGO in a humanitarian setting said,

> *If people are not coming to the clinics, we have to reach them in their home. Believe me – when we were… reaching them in their homes, they were saying that* [they were] *out of contraceptives. We were thinking we had to get them these services*.

An INGO respondent, based at the headquarters level and working on a project in several development settings, felt shifting to community-based service delivery even had added benefits of reaching new populations, including 'married adolescents that may normally not be able to go outside that have perhaps been getting access to information'.

Conversely, some respondents reported that community-based distribution was suspended or reduced due to concerns that community health workers could spread the Covid-19 virus. Others explained that community-based distribution resumed or continued with PPE provision and social distancing. These variations reflect the extent to which disruptions and adaptations were highly context dependent.

In addition, respondents across organisations and settings described adopting new mechanisms to share information about contraceptive services, including radio, television, social media, community leaders, and socially distanced community-based mechanisms. For example, one INGO respondent working at the country level in humanitarian settings described using 'town criers' who 'had an individual megaphone… [and they] remind [communities] that all the services are open, and that anyone who needs family planning services can go there.'

3.2.3 Alternate service delivery modalities

Many respondents across settings reported increasing the amount of short-acting contraceptives dispensed to clients at one time to reduce facility visits. Respondents representing a range of settings noted that Covid-19 guidelines issued by global health authorities and many governments promoted multi-month distribution of these methods.

Respondents across settings expressed their perceptions that the pandemic had increased interest in self-injection of subcutaneous injectable contraceptives. Two respondents cited the DRC as an example of a crisis-affected country that accelerated approval of self-injection in response to Covid-19. Multiple respondents representing both humanitarian and development settings where self-administration was already authorised noted that greater emphasis was placed on self-administration as part of the Covid-19 response.

3.2.4 Adaptive training and provider support mechanisms

Respondents described adaptations to continue provider trainings, including social distancing, consolidated trainings,

smaller groups, and online trainings – although they noted negative implications for quality of training, cost, and the number of providers trained. Respondents across settings explained that providing PPE, training providers on infection prevention and control, openly communicating about risks, and providing psychosocial support was essential for addressing providers' concerns and resuming service delivery.

3.2.5 Coordinated supply chain actions

Respondents also discussed a range of solutions to address supply chain challenges, including redistributing supplies between districts and facilities according to demand and availability, and coordinating with partners to address stockouts. Several respondents working with INGOs in humanitarian and, in some cases, development settings described exploring or using local procurement options, given difficulties with sourcing and importing supplies from international suppliers.

3.3 Underlying factors affecting contraceptive access and availability during the Covid-19 pandemic

The types and extent of disruptions and adaptations differed across countries and settings. Respondents cited several factors affecting contraceptive service availability and accessibility during the pandemic, including emergency preparedness; the extent to which decision makers prioritised contraception; funding levels and flexibility; the crisis context preceding the pandemic; and coordination.

3.3.1 Emergency preparedness

Diverse respondents reported that contraceptive service delivery was negatively impacted by a lack of emergency preparedness, or that preparedness measures were ineffective. Respondents working in humanitarian and development settings largely explained that governments did not have emergency preparedness plans for health in place. Some reported that where government preparedness plans existed prior to the pandemic, they did not include or sufficiently prioritise SRH, or anticipate a global pandemic. However, several respondents in contexts impacted by Ebola outbreaks indicated that this experience primed stakeholders to respond to the Covid-19 pandemic. Respondents in humanitarian and development settings also noted that in some cases, strict lockdowns or movement restrictions instituted to prepare for the arrival of Covid-19 cases in-country severely disrupted essential health services and did not address the continuity of SRH services.

Diverse respondents across settings also reported organisational emergency preparedness to be a significant gap. Several development INGO respondents expressed the perception that many donors and implementing organisations operating in development settings largely do not consider preparedness to be part of their remit. However, several respondents – primarily

in humanitarian settings – did report that their organisation had preparedness plans in place and/or cited preparedness activities that supported Covid-19 response, such as training staff on the MISP for SRH and strengthening supply chains to ensure stock availability during emergencies.

3.3.2 Prioritisation of SRH services

Respondents' perceptions of the extent to which governments and other decision makers prioritised SRH services, including contraception, varied. Some respondents were adamant that governments failed to prioritise SRH and contraception during the pandemic. Others said that although authorities did not consider contraceptive and SRH services when instituting initial restrictions, many governments did include these services in the development of longer-term Covid-19 response guidelines and plans. However, a number of respondents clarified that even where governments recognised the importance of SRH, contraception specifically was not adequately prioritised.

Respondents shared that some governments were receptive to advocacy to prioritise contraceptive and SRH services. Advocacy emphasised the long-term risks of lack of contraceptive access, including increases in unintended pregnancies, unsafe abortion, and maternal mortality and morbidity. Several respondents also explained that high levels of attention to gender-based violence (GBV) during the pandemic provided an opportunity to advocate for increased prioritisation of SRH services. As one respondent stated, '[Y]ou cannot talk about GBV without talking about SRH… I think it's the opportunity to say, "Okay, this is a package, and you cannot do one without doing the other." ' Some respondents also noted that lessons learned from the impact of Ebola outbreaks on maternal and child mortality and morbidity were leveraged to ensure that SRH services remained available amid the Covid-19 pandemic. Two INGO respondents cited the WHO operational guidance for maintaining essential services (WHO 2020a), which include contraceptive services, as being an effective advocacy tool.

Respondents also acknowledged that the inclusion of SRH services in guidelines and plans did not guarantee available and accessible services. One respondent said that his organisation had worked with the national health ministry's emergency preparedness and response department in 2018 to include the MISP for SRH in preparedness and response plans, but reported that 'during Covid-19, it was not effective. It was of no use.' Respondents also described cases of governments in both humanitarian and development settings failing to allocate funding to or shifting funding away from contraception and SRH activities due to the pandemic.

3.3.3 Funding

Respondents across settings largely spoke positively about their donors' responses to the Covid-19 pandemic, including allowing flexibility to pivot and adapt programming. Respondents said that the pandemic significantly increased operating costs, but most did not report having to reallocate funding away from SRH to Covid-19 activities. Multiple respondents across organisations and settings also described seeking, and in some cases receiving, new funding to support PPE procurement and/or SRH service continuity.

However, a small number of respondents – representing both national NGOs and INGOs – reported that donors were not able to follow through on committed funding, either because funding was shifted to Covid-19 activities, or due to donors' financial challenges. Moreover, as previously mentioned, some respondents reported that governments had reallocated funding away from SRH, although others noted that their efforts to ensure that governments maintained funding for SRH were successful.

When asked about the longer-term impacts they anticipated in the funding environments, respondents described heightened uncertainty, with many noting that the economic impacts of the pandemic will also affect donors, which could in turn impact their long-term funding prospects.

3.3.4 Crisis context preceding the Covid-19 pandemic

Respondents expressed varying beliefs as to whether humanitarian or development settings and actors were better able to respond to the pandemic. Multiple respondents – working in both humanitarian and development settings – perceived development settings to be better resourced and thus able to absorb the shock of the pandemic, and that it was more challenging to maintain services in humanitarian settings due to weaker health systems, poor access to water and sanitation facilities, fewer resources, and limited technology. Several respondents from humanitarian settings expressed that insecurity compounded the effects of the pandemic, exacerbating challenges to reach affected populations and further deterring people from seeking services.

Conversely, a significant number of respondents – also working in both humanitarian and development settings – felt that humanitarian actors, and/or programmes in humanitarian settings, were more agile in responding to the pandemic and adapting service delivery. Some respondents felt that these settings were better prepared, with relevant policies and procedures in place for emergencies, including prior knowledge of the MISP for SRH and stronger coordination mechanisms.

3.3.5 Coordination

Respondents explained that stakeholder coordination affected the availability of contraception amid the pandemic, with coordination

being more effective in settings where stakeholders had existing relationships, and where robust coordination mechanisms were operating prior to the pandemic. One national NGO respondent from a humanitarian context said that the SRH coordination mechanism in her setting was effective because 'we've been working together and coordinating together for a long time. It's not just suddenly [that] it was created for Covid.'

Respondents from humanitarian and development settings specifically cited the need to strengthen coordination across the nexus as an important lesson learned. One development INGO respondent reflected, '[I]t seems so apparent that yes, of course, we should be reaching out to humanitarian actors… But I think those relationships don't necessarily exist across the nexus at the country level.' Respondents reflected that as the number of countries at risk of or experiencing crisis grows, distinctions between humanitarian and development settings are fading – rendering humanitarian and development silos outdated and inefficient. One respondent called for 'moving away from a discourse that talks about humanitarian versus development', and instead focusing on building resilient, adaptative health systems capable of absorbing and managing shocks, including epidemics and pandemics.

4 Conclusion

The Covid-19 pandemic affected the availability and accessibility of contraceptive services across humanitarian and development settings. Many respondents reported their perceptions that SRH services, including contraception, were particularly impacted because government authorities and other decision makers did not perceive them to be lifesaving or essential. The findings point to the critical need to continue building awareness among donors, governments, and partners across the humanitarian and development sectors that contraception is lifesaving, essential, and a human right in all emergencies, including the pandemic.

Stakeholders should also leverage the currently heightened awareness of the risk of crises to engage governments and development and humanitarian actors in emergency preparedness and resilience-building activities. SRH and contraception must be integrated into these plans and policies to address barriers to contraceptive service delivery, such as movement restrictions, that emerged during the pandemic (WHO 2021a).

Finally, stakeholders should institutionalise mechanisms implemented during the pandemic that improve contraceptive availability and access, including telemedicine and digital protocols, multi-month provision of short-acting methods, task-shifting and sharing, community-based provision of methods, and self-care methods. As well as improving access during the pandemic, these shifts will ensure preparedness for future crises, and boost access to contraceptives across stable and crisis times alike.

Notes

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Glossary

AHRC Arts and Humanities Research Council [UK]
BICC Bonn International Center for Conversion [Germany]
CCCM camp coordination and camp management
CENTRAL Cochrane Central Register of Controlled Trials
CEPI Coalition for Epidemic Preparedness Innovations [Norway]
COR Commission for Refugees [Sudan]
COVAX Covid-19 Vaccines Global Access
CRR Center for Reproductive Rights [USA]
CRRF Comprehensive Refugee Response Framework
CSO civil society organisation
DGC Department of Global Communications [USA]
DRC Democratic Republic of the Congo
ERIC Education Resources Information Center [USA]
ESCWA United Nations Economic and Social Commission for Western Asia [Lebanon]
ESRC Economic and Social Research Council [UK]
FCDO Foreign, Commonwealth & Development Office [UK]
FDPs forcibly displaced persons
FSA Free Syrian Army
GBV gender-based violence
GCR Global Compact on Refugees
GDI Global Development Institute [UK]
HICs high-income countries
HTS Hayat Tahrir al-Sham [Syria]
IARH Inter-Agency Reproductive Health
IASC Inter-Agency Standing Committee
IAWG Inter-Agency Working Group on Reproductive Health in Crises [USA]
IDPs internally displaced persons
IFRC International Federation of Red Cross and Red Crescent Societies [Switzerland]
IHD Idlib Health Directorate [Syria]
IISD International Institute for Sustainable Development [Canada]
INGO international non-governmental organisation
IOM International Organization for Migration [Switzerland]
IRC International Rescue Committee [UK]
JFS Jabhat Fatah al-Sham [Syria]
JRS Jesuit Refugee Service [UK]
KII key informant interview
LARC long-acting reversible contraceptive
LERRN Local Engagement Refugee Research Network [Canada]
LMICs low- and middle-income countries
MISP Minimum Initial Services Package
MMC Mixed Migration Centre
MoU memorandum of understanding
NGO non-governmental organisation
OCHA Office for the Coordination of Humanitarian Affairs [USA]

ODA official development assistance
OECD Organisation for Economic Co-operation and Development [France]
OHCHR Office of the United Nations High Commissioner for Human Rights [Switzerland]
OPDs organisations of persons with disabilities
PPE personal protective equipment
PSNs persons with specific needs
SAMS Syrian American Medical Society
SDG Sustainable Development Goal
SEMA Syrian Expatriates Medical Association
SIG Syrian Interim Government
SII Serum Institute of India
SNC National Coalition for Syrian Revolutionary and Opposition Forces [Syrian National Coalition]
SOHR Syrian Observatory for Human Rights
SRH sexual and reproductive health
SSG Syrian Salvation government
TC tropical cyclone
TRAFIG Transnational Figurations of Displacement
UK United Kingdom
UKIP United Kingdom Independence Party
UN United Nations
UNCRPD United Nations Convention on the Rights of Persons with Disabilities
UNFPA United Nations Population Fund [USA]
UNHCR United Nations High Commissioner for Refugees [Switzerland]
UNICEF United Nations Children's Fund [USA]
UNSC United Nations Security Council [USA]
US United States
WASH water, sanitation, and hygiene
WHO World Health Organization [Switzerland]
WRC Women's Refugee Commission [USA]

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Humanitarianism and Covid-19: Structural Dilemmas, Fault Lines, and New Perspectives

Editors **Jeremy Allouche and Dolf J.H. te Lintelo**

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