JOINT EVALUATION OF THE PROTECTION OF THE RIGHTS OF REFUGEES DURING THE COVID-19 PANDEMIC

Final report | July 2022

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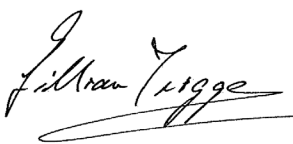
Foreword

We are pleased to present the first major joint evaluation conducted under the auspices of the COVID-19 Global Evaluation Coalition. This evaluation examines the role of international co-operation and national responses in protecting the rights of refugees during the COVID-19 pandemic. COVID-19 has profoundly challenged the capacity and willingness of states to live up to their international responsibilities and obligations. It is likely to continue to have a disproportionate effect on the most vulnerable, especially those forcibly displaced from their homes.

When we began this study a year ago, 25% of all states were denying access to their territory to all persons, including those seeking asylum. Pushbacks and refoulement continued with increasing incidents at land frontiers and at sea including refusal of disembarkation, contrary to the centuries-old maritime tradition of rescue at sea. One year on, at least 33 countries across the world still deny access to asylum for people fleeing conflict, violence and persecution based on public health or other measures enacted since the start of the COVID-19 pandemic.

This study assesses a number of key rights – access to healthcare and inclusion in health systems, access to vaccinations, sexual and reproductive health, protection from gender-based violence, asylum, child protection, and access to adequate information – to determine whether the international community, in support of national actors, upheld international legal obligations and safeguarded the rights of refugees during the response to the pandemic. Encouragingly, the evaluation finds many positives within the overall response, including strong co-ordination among international actors and governments and a capacity for responsiveness and adaptation of refugees themselves as well as organisations with a responsibility to provide protection. The pandemic also showed the importance of the principles on which the Global Compact on Refugees is based, notably international co-operation and responsibility sharing.

Overall, however, these collective interventions did not fully or consistently ensure the protection of the rights of refugees. The evidence shows that the response was imbalanced across rights and failed to anticipate the extent of the protection needs of children, women and girls and the specific needs of others, especially elderly people and people with disabilities. It also highlights the challenges of providing adequate and consistent information to refugees and countering the misinformation which has fuelled a rise in xenophobia and negative perceptions of people on the move. The report has six strong recommendations to governments, international protection actors and United Nations organisations about how to strengthen our preparedness. As the co-chairs of the Reference Group of this evaluation, we strongly endorse the report's findings and encourage you to read and follow through on its recommendations.

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Susanna Moorehead
Chair of the OECD's Development Assistance Committee (DAC)

Acknowledgements

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List of Acronyms and Abbreviations

DAC	Development Assistance Committee
GBV	Gender-based violence
GCR	Global Compact on Refugees
GHRP	Global Humanitarian Response Plan
HDP	Humanitarian-development-peace
IDP	Internally displaced person
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
RLO	Refugee-led organisation
RSD	Refugee status determination
SRH	Sexual and reproductive health
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN	United Nations
WHO	World Health Organization

Executive summary

This Joint Evaluation of the Protection of the Fundamental Rights of Refugees during the COVID-19 Pandemic was commissioned under the auspices of the COVID-19 Global Evaluation Coalition.[1] The evaluation examines the effectiveness of international co-operation and the combined response of host states, United Nations (UN) system agencies, and non-governmental and civil society organisations including refugee-led organisations[2] (RLOs) in ensuring the protection of the rights of refugees during the global pandemic.

The evaluation was carried out from May 2021 to January 2022 as the pandemic continued to evolve and present a constantly changing set of consequences for legal systems, social norms and the functioning of aid systems that are designed to offer support to the upholding of refugee rights. The evaluation was undertaken completely remotely and with layered evaluations methods (data analysis, document review, funding analysis and key informant interviews) to gather a balanced set of evidence.

The COVID-19 pandemic has challenged the protection of the rights of refugees in a way that is profound and with possible lasting consequences. Border closures and other movement restrictions related to the pandemic had significant and ongoing repercussions for refugee rights and for protection actors. There is clear evidence that some states used the pandemic as a purported justification to introduce restrictive measures detrimental to the rights of refugees. In some cases, restrictive practices adopted at the height of the pandemic for public health reasons have been retained or reinforced as security measures.

A complex pattern of access challenges remained across the spectrum of refugees' rights and needs throughout the pandemic. Gender-based violence (GBV) against women and girls has increased, which has also exacerbated protection risks to refugee children. Rising xenophobia and discrimination increased the challenges for people on the move to access a large range of protection services. The findings of this evaluation demonstrate the extraordinary efforts of protection actors in support of refugee rights in the face of an unprecedented global challenge. Many positives can be taken from the overall response: effective co-ordination among international actors and governments, responsiveness and adaptation on the part of refugees themselves and protection actors, and generosity and flexibility on the part of donors in the first phases of the response. Overall, however, these collective interventions did not fully ensure the protection of the rights of refugees in a comprehensive and consistent manner across countries and across the range of rights which are this evaluation's focus. The evidence shows that the response was imbalanced across rights and failed to anticipate the extent of the protection needs of children, women and girls and the specific needs of some refugees, such as elderly people and people with disabilities.

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1. The Management Group of this evaluation included the evaluation units of UNHCR, the Ministry of Foreign Affairs of Finland, the governments of Colombia and Uganda, and the humanitarian system network ALNAP. This project was funded by UNHCR, the government of Finland and the OECD
2. These are referred to collectively hereinafter as all protection actors.

Coverage and relevance of the collective response to COVID-19 in respect of the protection of the rights of refugees

Measures adopted to combat the spread of COVID-19 were, in many countries, not consistent with international law: The principle of non-re-foulement, the prohibition of collective expulsion and the right to seek asylum were not upheld in many instances. There is also compelling evidence of expulsions and pushbacks, at sea and on land, as well as indirect refoulement. Border closures and lockdowns also reduced the ability of governments and protection actors to resettle refugees to third countries and increased the number of those resorting to irregular border crossings.

UNHCR interventions at the beginning of the COVID-19 pandemic reminding states of their international obligations had some positive effects, but compliance was still not universal. Measures adopted at the height of the pandemic that narrowed access to international protection and tightened asylum policies were temporary in some countries but yet have deepened in others, and barriers persist into 2022.

Recommendation 1: To improve protection and assistance for all refugees, states should uphold international refugee law and international human rights law standards, particularly during times of crisis and emergencies.

Proposed actions:

✓ All states should automatically renew documentation for refugees and asylum seekers whenever government services have to shut down in any emergency (Action: governments with support of protection actors).

✓ With due regard to data protection and applicable international human rights law standards, UNHCR should work with governments to build systems that allow for secure digital registration and documentation that can be renewed remotely (Action: UNHCR and governments).

✓ Governments should ensure that all police, law enforcement and relevant national authorities are trained on non-refoulement, including the need for open borders for those fleeing conflict, violence and persecution in line with international refugee law and international human rights law (Action: governments).

✓ UNHCR should reaffirm once more the international obligation to ensure an exception for refugees and asylum seekers where borders are closed in future pandemics or large-scale emergencies, including through the Executive Committee[3] and liaison with UN system human rights actors (Action: UNHCR and other UN system human rights actors).

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3. This is the Executive Committee of the High Commissioner's Programme.

Within the totality of humanitarian financing for the COVID-19 response, funding for refugee programming remained strong through 2020. Preliminary figures, however, do suggest falling support from humanitarian donors in 2021. There were significant imbalances in the response over time and between sectors. There was no significant and proportionate increase in funding to non-governmental organisations (national or international), and funding levels to GBV and child protection sectors were low in relative terms throughout 2020.

The first phase of the pandemic (three to six months) had an immediate freezing effect on the provision of essential services in health, protection, child protection and GBV. Lockdowns and other movement restrictions also delayed, and in some cases, suspended, registration and documentation , refugee status determination (RSD) processes, resettlement, and family reunification during the pandemic.

Staff and programmes providing protection services other than health were rarely designated as essential, and staff were subject to movement restrictions. Beyond the first phase of the pandemic, child protection and GBV services remained severely curtailed in many settings. Protection staff were not able to have face-to-face meetings with refugees and asylum seekers and could not directly access quarantine facilities in which they were detained. Often, these facilities were densely populated and did not allow for social distancing and other pandemic-related safety measures.

The obvious priority placed on health, and the recognition of refugees as a vulnerable group, placed refugees' right to healthcare in a prefer-ential position in terms of funding and advocacy. The priority given to sexual and reproductive health is also clear in country-level documentation and shows that it was possible to advocate for the continuation of face-to-face service provision if this was deemed important. However, this focus on health services related to COVID-19 was to the detriment of other health service provision such as routine vaccination programmes, treatment for non-communicable diseases and emergency responses to other disease outbreaks.

Protection services were also badly affected by the focus on health, particularly GBV and child protection. Protection activities were not prioritised or seen as essential, which had serious negative impacts on GBV and child protection; by the end of 2020, both were described as crises in their own right. Not all lessons from other disease outbreaks, such as Ebola, were directly relevant, but the secondary crises faced by women and children as the pandemic response evolved were predictable, and more could and should have been done.

Prior to the pandemic, disaggregated service-level administrative data have not consistently been available for certain at-risk populations including refugees, and even less so for refugees with specific needs such as elderly people and those with disabilities. The pandemic magnified these data weaknesses, meaning some vulnerable groups were largely invisible to responders.

Recommendation 2:

In preparation for future pandemics and public health crises, advocate and plan for the maintenance of essential in-person protection services to the fullest extent possible, including the provision of adequate human and financial resources.

Proposed actions for international protection actors and governments:

✓ Ensure access by protection staff to all refugees and asylum seekers within and at the borders of countries during crises, in line with the underlying principles of the 1950 Statute and the 1951 Convention (Action: governments and UNHCR).

✓ Plan for the provision of adequate, safe quarantine facilities that respect the human rights of refugees and asylum seekers, placing the minimum additional financial burden on hosting states (Action: governments, UN system agencies and international finance institutions).

✓ Strengthen advocacy efforts to ensure that protection activities, including child protection and GBV, are fully recognised as essential and life saving and to advocate against the suspension of these services in future crises. Ensure that protection actors are provided with the necessary personal protective equipment, integration support and resources needed to sustain and deliver services in the face of a public health crisis (Action: governments, international protection actors and donors).

Adaptation and its contribution to the effectiveness of the COVID-19 response for refugee rights

The Global Humanitarian Response Plan (GHRP), the global framework for additional humanitarian needs arising as a result of COVID-19, is a product of collaboration between UN system agencies and humanitarian and human rights partners. The GHRP allowed for a co-ordinated effort to support humanitarian needs by ensuring complementarity between agencies as well as preparedness, flexibility and speed of responses. However, the first iteration of the GHRP was pulled together very quickly and with limited evidence of broader collaboration with or funding for organisations outside the UN system.

Global-level actors worked well together to reinforce pre-pandemic policy work on inclusion, consistent with the Global Compact on Refugees (GCR), the humanitarian-development-peace nexus and the Sustainable Development Goals. The recognition of refugees as a particularly vulnerable group provided a locus for collaboration between agencies, international humanitarian and development actors, and governments and contributed to significant steps towards the inclusion of refugees in national programmes, including national COVID-19 vaccination plans.

The evaluation also found a wealth of evidence on the extent of global-level co-ordination and its influence on the coherence of approaches at the country level. For example, anecdotal evidence shows that inter-agency co-ordination and advocacy in numerous countries created leverage with governments for inclusion of refugees in national health system responses to COVID-19. For health and child protection in particular, advocacy around the application of a package of pre-existing minimum standards was key to ensuring that these areas received increased priority. In GBV, health and child protection, national co-ordinating bodies and protection partners adapted a variety of global guidance to national contexts.

Collaboration and joint advocacy among international actors were key factors in the reprioritisation and rescaling of GBV and child protection services as the pandemic unfolded, although these efforts did not lead to significant complementary increases in funding.

While the decision to focus primarily on the health emergency early in the pandemic appears to have impacted the implementation of the Global Compact in terms of its practical roll-out in countries, it has shown the importance of the principles the Global Compact is based on, notably international co-operation and responsibility sharing. The evaluation found that the GCR had the most direct traction in countries that were part of the Comprehensive Refugee Response Framework or Comprehensive Regional Protection and Solutions Framework in Latin America processes prior to 2018 – that is, those where its tenets have been embedded since the New York Declaration of 2016.

Where the GCR intersects with other global policy priorities, notably the humanitarian-development-peace (HDP) nexus,[4] pre-pandemic priorities such as inclusion were bolstered during the pandemic. The evaluation found evidence that highlights the influence of the GCR directly in reference to leveraging greater inclusion of refugees in health systems, providing a clear framework for action and responsibility sharing.

Overall, however, more could have been done to amplify the GCR through reinforcing its direct relevance to successes in the response. The clearer that links are made between the GCR and enhanced protection and assistance for refugees as well as fairer and more predictable burden and responsibility sharing, the more the influence of the GCR is likely to grow with governments, UN system agencies, and other humanitarian, protection and human rights actors.

Recommendation 3: To enhance protection and assistance for all refugees, states and protection actors should strengthen the promotion of the Global Compact on Refugees.

Proposed actions:
The Global Compact on Refugees is a relatively new instrument and needs to be utilised more fully by governments and international, national and local protection actors; this includes using the compact during global crises and humanitarian emergencies:

- Governments and other members of the international community should consolidate the reporting they have already undertaken with respect to meeting their 2019 Global Refugee Forum Pledges during the pandemic, and which has generated persuasive evidence demonstrating how the GCR strengthened the international response to enhance protection and assistance to refugees and fairer and more predictable burden sharing and responsibility sharing by states, in preparation for the next Global Refugee Forum in 2023 (Action: governments and other relevant stakeholders).

All protection actors including UNHCR should:

- Improve awareness of the GCR and its specific remit with the goal of making the GCR central to the promotion of protection and assistance to refugees and to fairer and more predictable burden sharing and responsibility sharing

- With key partners including national and local governments, undertake awareness raising, training and capacity building on the GCR

- Undertake, for dissemination to governments and partners, a global review of all pandemic-related activities to see how those activities could have been and were rolled out as part of the GCR's frameworks so as to provide a comprehensive lessons-learned platform for using the GCR in emergency responses in the future.

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4. The nexus is clearly defined in the OECD DAC Recommendation on the Humanitarian-Development-Peace Nexus.

Overall, over the trajectory of the response, local actors including RLOs, refugees themselves and municipalities were increasingly involved in the response. Particularly in the health response, community-based organisations and RLOs played key roles in efforts to share information on COVID-19. In gender-based violence, efforts were made in a number of settings from the onset of the pandemic to engage local women's organisations and promote their participation in the response, including through service delivery. In child protection, a marked increase in engagement with local actors was reported, including the involvement of community workers in the identification of and support to children at risk and their caregivers.

The evaluation found many positive examples of contributions from national and local actors in their COVID-19 responses, though these are difficult to quantify at the global level. The value of existing partnerships and investments in national systems and structures was demonstrated in the early days of the response. However, an analysis of financial data, testimonies from local actors and interviews with international protection actors clearly show that partnerships and decision making remained largely top down and that additional funding for local actors was not forthcoming, even as their responsibilities increased in the context of lockdowns. Adaptation to new ways of working also put significant pressure on national actors, who were also scaling up operations. Increasing workloads and challenges in providing protection in the usual manner, on top of other stresses related to COVID-19, also placed additional burdens on international staff, often affecting their well-being.

There is little evidence of the inclusion of GBV and child protection issues in COVID-19 preparedness plans and policies. Local actors, including local women's refugee groups, were not sufficiently supported to carry out the work delegated to them during the COVID-19 response.

Irrespective of the extent to which the COVID-19 response has accelerated or deepened localisation in refugee responses, it is imperative to continue to work on strengthening partnerships in preparation for future emergencies. Likewise, it is critical to aim to further empower and improve funding for local and national actors, including RLOs and local women's organisations, as first responders.

Recommendation 4: Invest in planning responses to future crises that protect the rights of refugees through continuous strengthening of preparedness efforts, with an emphasis on strengthening partnerships with national and local actors.

Proposed actions for international protection actors and governments:

- In support of the localisation of specialised response services for GBV survivors and in line with efforts already underway, scale up systemic support and leadership of women-led organisations, especially those led by refugees.

- Ensure that GBV and child protection mainstreaming activities in refugee contexts are integrated into preparedness planning and prioritised during public health crises and other emergencies.

- Continue to invest in and reinforce long-term strategic partnerships with key protection partners, particularly with national child protection actors and national GBV actors ((Action: UNHCR, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the Alliance for Child Protection and donors)).

- Assess the viability of simplified procedures and practices based on the changes made during the COVID-19 pandemic with a view to strengthening localised responses going forward (Action: UNHCR).

The increase seen through the pandemic in the inclusion of refugees in national health and other services is positive. Evidence from this evaluation indicates that the COVID-19 response created positive, and potentially lasting, momentum around inclusion of refugees in national health plans, despite country-level differences in how this was applied in practice. However, while refugees were almost universally included in national vaccination plans, vaccination nationalism and various practical, technical and legal issues have kept the numbers of vaccinated refugees relatively low.

The COVID-19 response was characterised by the gradual and uneven reinstatement of services and their adaptation to the new context. However, pre-existing weaknesses in coverage in rural, remote or underserved urban areas persisted. There is evidence of heightened negative perceptions and stigmatisation of people on the move during the pandemic that clearly flowed in part from pandemic-related risks. There were cases of discrimination and xenophobic attacks against refugees in many countries. This affected the willingness of refugees to seek access to services (particularly health and asylum) due to fear of repercussions, especially deportation. The evidence demonstrates the key role of local actors, often supported by UNHCR and other protection actors, in successfully countering disinformation at the root of xenophobia as well as the challenges of doing so in the context of an explosive proliferation of negative messages on social media in some places.

There were challenges in the provision of adequate information on the availability of services for refugees. Messaging frequently failed to cater to the most vulnerable and marginalised and/or lacked sensitivity to local social, cultural or gender norms. Many refugees were unable to benefit from the rapid increase of online tools and platforms designed to connect, inform and support them during lockdown and isolation. With-

out concerted efforts to reach them, children, elderly persons and persons with disabilities were left behind, as were homeless asylum seekers and refugees and those staying in informal settlements or in reception centres that were not technically equipped.

Lessons from the Ebola response and other epidemics have not been consistently applied: To be effective, information must be tailored to and informed by affected people's information needs, including being sensitive to culture and gender, based on rumour tracking, and targeted at dispelling myths. Better co-ordination among aid agencies is required to reduce competition for leadership roles and the associated funding and improve information and communication efforts.

Recommendation 5: Strengthen the provision of information and messaging for refugees, ensuring that it is two way and needs based; sensitive to local social, cultural and gender norms; and effectively targeted to also reach those most vulnerable and marginalised, including those with limited access to online communication channels.

Proposed actions:

- Build on lessons from the Ebola and COVID-19 responses to identify the issues that have prevented the preparation of appropriately layered and targeted messages, including resource constraints (Action: international protection actors).

- Consult with specialist partners to ensure that information products can be better targeted to refugees with a range of disabilities and specific information requirements (Action: international protection actors).

Coherence of international approaches to the protection of refugees during COVID-19

The rapid change to remote programming early in the pandemic had positives. Such innovation allowed the maintenance of many services that previously relied on face-to-face contact. It also created new modalities that could strengthen the resilience and efficiency of protection programming in future emergencies (e.g. child protection and GBV case management, mental health and psychosocial support, registration and documentation and RSD for asylum, and telehealth for health responses).

Remote methods, however, are not always as effective, and there is a clear necessity for in-person case management in some instances. It is clear from the evidence of this evaluation that the adaptations did not overcome all the barriers to access and created new barriers for a minority of refugees.

Recommendation 6: Recognise that some in-person protection services are essential. While adaptation and innovation to support refugees' ongoing access to services during periods of restricted movement are important, it is equally important to recognise the limitations of remote delivery, especially for survivors of GBV, children at risk and their caregivers, and others with specific protection needs.

Proposed actions:

✓ Develop guidance that not only recognises that programme adaptations, including remote management, can be effective in future emergencies with movement and access constraints but also that a total shift to remote services should only be undertaken after careful consideration of the risk of harm versus the benefits. Incorporate recommendations on how to support advocacy for the continuation of necessary in-person protection services as part of the GBV response in pandemic or other emergency situations that are characterised by movement restrictions and/or access constraints (Action: international protection actors).

✓ Continue developing the capacity of the child protection and GBV workforces in refugee contexts. Ensure appropriate levels of dedicated child protection and GBV staffing, with the required level of expertise and skills and adequate funding (Action: UNHCR and partners).

✓ Improve tracking of unearmarked funds allocated to GBV programming and improve transparency to allow donors and the wider humanitarian community to better understand how money is being spent and where investments are lacking or needed (Action: international protection actors and co-ordination bodies).

1. Introduction to the evaluation

Jordan. Refugee health volunteer boosts vaccine uptake (01 June, 2021)
© UNHCR/Yousef Alhariri

The Joint Evaluation of the Protection of the Fundamental Rights of Refugees during the COVID-19 Pandemic was commissioned under the auspices of the COVID-19 Global Evaluation Coalition to examine the effectiveness of international co-operation and the combined response of host states, agencies, and non-governmental and civil society organisations in ensuring the protection of the rights of refugees during the pandemic globally. As outlined in the Terms of Reference (Annex 1), this evaluation is directed towards the rights of refugees and does not include internally displaced persons and stateless persons under UNHCR's expanded mandate.[5] Nevertheless, the findings of this evaluation often are equally appropriate to other forcibly displaced persons. Moreover, given that over 60% of refugees reside in urban settings, distinguishing the treatment they experienced with respect to rights protection from that of the general population was not always possible.

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5. On the basis that refugee status under the 1951 Convention is declaratory and not constitutive, asylum seekers are refugees within the Convention until it is determined otherwise. Refugees also include returnees until they have a durable and sustainable solution or cessation is declared.

However, it is worth noting that when the informal economies collapsed in countries where many refugees obtained employment, refugees returned to camp settings where they could access accommodation and health services.

The evaluation was carried out from May 2021 to January 2022, when the pandemic was still ongoing. This and every evaluation undertaken during the pandemic has had to grapple with the extraordinary nature and magnitude of the events.

In consequence, there was the need to take into consideration primary and secondary consequences of the virus on refugee populations and to consider how the measures taken to reduce the transmission of the virus, including border closures and lockdowns, have had universal consequences beyond refugee rights. The pandemic impacted legal systems, social norms, governments and the functioning of the aid systems that are designed to offer long-term or temporary support to the upholding of refugee rights.

The timeline taken into consideration for this evaluation starts at the onset of the collective response to the pandemic in late March 2020. Data collected covered the period from this date until the end of Q4 2021, as close to completion of the final report as possible.

The three objectives for the evaluation set out in the Terms of Reference (Annex 1) remain unchanged:

1. ascertain the coherence and coverage of refugee rights promotion and incorpora tion into international co-operation in the context of national COVID-19 responses

2. determine the effectiveness of the international response in support of states and with civil society organisations and refugees themselves towards enabling refugees to realise their rights in the con text of COVID-19

3. identify good practices and lessons that can be shared for preparedness and application in future emergencies, including a focus on innovation and scalable, adaptive solutions. In line with the Terms of Reference, the evaluation focuses on specific rights of refugees: the right to health; the right to seek and enjoy asylum; child protection, including family reunification; protection against sexual and gender-based violence (GBV); and access to information.

The Management Group for this evaluation includes the evaluation units of the United Nations High Commissioner for Refugees (UNHCR), the Ministry for Foreign Affairs of Finland, the governments of Colombia and Uganda, and the humanitarian system network ALNAP. The evaluation team is headed by Itad in partnership with Valid Evaluations and is a collaborative effort including a network of evaluators and academic institutions.

Evaluation questions and report structure

The evaluation set out to answer the following evaluation questions (see the full evaluation matrix, Annex 2):

Evaluation Question 1. Global level (relevance – promotion, inclusion, adaptation – and coverage). To what extent has the protection of refugees and their rights been recognised and addressed in the response of international co-operation to COVID-19? How widespread, profound and lasting are the impacts of the COVID-19 pandemic on the protection of the fundamental rights of refugees?

Evaluation Question 2. Coherence. To what extent have national governments, development partners and global responses aligned to ensure coherent approaches for the international protection of refugees during COVID-19 at the global, regional and country levels? To what extent was there synergy and coherence across the humanitarian-development-peace nexus? What were the drivers and barriers to alignment?

Evaluation Question 3. Effectiveness. How effective has been the combined response of international and national actors (states, agencies and civil society organisations) towards enabling refugees to realise their rights in the following areas: the right to seek and enjoy asylum; the right to health; protection from GBV; child protection and education; addressing the protection rights of persons with specific needs; access to information. To allow an easier narrative flow, the report is not structured strictly around the evaluation questions but around the global response and the selected rights of refugees, with thematic snapshots presented throughout:

Sections 1 and 2 introduce the evaluation, methodology and approach.

Section 3 focuses on the overarching response, particularly on understanding the role and actions of global-level actors and structures. These include global bodies and instruments, policies, guidance, appeals, and advocacy platforms and positions derived from or influenced by the actions of global bodies, including the Global Compact on Refugees, the Global Humanitarian Response Plan, and other centrally organised instruments, appeals, guidance and policy. Section 3 also looks at some of the local responses headed by refugees, refugee-led organisations and municipalities.

Section 4 contains the bulk of the findings from all evaluation streams. It is organised around the evaluation's key themes and rights. Within each of these themes, the section considers coverage, relevance and access; co-ordination or coherence; and effectiveness.

Section 5 presents overarching findings and recommendations, bringing together the evidence from the individual themes. It is structured around the evaluation questions.

2. Methodology

Trinidad and Tobago. First group of refugees and migrants receive COVID-19 vaccine (01 August, 2021). © UNHCR/Carla Bridgla

This section outlines the evaluation principles, approach and data collection for the evaluation as well as the evaluation's limitations.

2.1 Evaluation principles and approach

Evaluation principles

The evaluation was carried out based on the following principles:

Participatory – Seeking the engagement of key stakeholders and audiences was critical to the evaluation's success. Throughout the evaluation, the team engaged the Management Group and its networks on a regular basis to seek their guidance and advice. The evaluation team also engaged with the Reference Group at specific points throughout the project to ensure that different perspectives and specialist inputs were included. This approach provided the added benefit of facilitating early communication with relevant stakeholders around existing evidence. Preliminary findings were presented at the High-Level Officials Meeting in December 2021 and have already had a relatively wide readership among interested parties.

Utilisation focused – All reporting and communication products[6] have been tailored to maximise accessibility and uptake of evaluation results by target audiences. The evaluation team aimed to produce outputs that can be used for future advocacy, collective learning and exchange on good practice areas for improvement.[7] The team engaged closely with the Management Group to identify priority audiences and products to facilitate this engagement. At the time of writing of this report, a series of dissemination activities were being planned in collaboration with the Management Group.

Independence, impartiality and credibility – The evaluation followed standards and principles for evaluation practice established in the OECD Development Assistance Committee (DAC) and UN systems, including the DAC and UN Ethical Guidelines for evaluations and ALNAP's guidance on evaluating protection. In practice, these imply protecting sources and data, systematically seeking informed consent, respecting dignity and diversity, and minimising risk, harm and burden upon those who are the subject of or participating in the evaluation while at the same time not compromising the integrity of the data.

Evaluation approach

Given the scope of the evaluation and the need to look at the international response globally, rather than focusing on specific country case studies, the team revised the approach envisaged in the Terms of Reference during inception. The approach included three levels of analysis:

1. Global level and/or overarching analysis This level provides a view on the action of global bodies and frameworks. This level of analysis was drawn from the document review, interviews at the global and regional level, and a light-touch review of global financing data.

2. Country level – This level informed the answers to all evaluation questions. Analysis was drawn from the document review, interviews at regional level, and a small number of interviews at the country level for the thematic snapshots. It also relied heavily on the analysis of data and indicators.

3. Thematic snapshots – This analysis covered specific rights and issue areas, focusing on the specific set of refugee rights analysed in this evaluation. For the thematic snapshots, the team analysed global and country-level data to identify specific issues, areas of good practice, innovation and challenges particularly relevant for the evaluation.

2.2 Data collection and analysis methods

The evaluation involved a mixed methods approach[8] for data collection and analysis:

Targeted document review including of documents with a global perspective and documents focusing on the country sample, for a total of 388 documents – The review included UNHCR documents and reports; other UN system agency reports; evaluation and research reports; and academic literature such as journals, guidance documents and grey literature of organisations relevant to the evaluation. The review also included data collected by Ground Truth Solutions[9] on refugee perceptions of the coronavirus in select countries. The guiding principle throughout was to ensure that the documents reflected verified

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6. At the time of writing, the communication products are being discussed with the Management Group.
7. See Covid-19 Global Evaluation Coalition (n.d.), Joint Evaluation of the Protection of Rights of Refugees during the COVID-19 pandemic, www.covid19-evaluation-coalition.org/evaluating-the-response/rights-of-refugees-and-covid.htm
8. A survey gathering opinions and perceptions was planned, but the evaluation team deemed it would be more useful to focus on gathering opinions through key informant interviews.
9. Ground Truth Solutions is a non-governmental organisation that works with people affected by humanitarian crises to understand their experiences of aid provision through research.

data from those dealing directly with the consequences of the pandemic. The academic literature was taken from peer-reviewed journals.

Key informant interviews sampled through purposive and snowball strategies. A total of 40 remote interviews were conducted across global and thematic levels, including interviews with UN system agencies, non-governmental organisations, civil society organisations, donors and funders. The key informant interviews covered global and thematic-level analyses to focus on specific issue areas identified through the document review. The full list of key informants is presented in Annex 4. Data collection did not involve refugees due to the constraints around meaningfully involving this group remotely as well as time and budget constraints to deploying consultants in-country to conduct interviews. Secondary sources about refugees' experiences, including Ground Truth Solutions' data, were used as a proxy. Given all these factors, the ethics and safeguarding risks predicted during inception were minimised. Nevertheless, all interviewees were asked for consent before starting the interviews and data protection standards were applied throughout.

Analysis of key data sets, including those available globally and a more in-depth look at data in a selection of 27 countries.[10] Data sets were accessed through portals of agencies that were gathering data and reporting on indicators, some of which covered multiple countries and issue areas, such as the Global Humanitarian Response Plan monitoring framework, Global Compact on Refugees indicators, and UNHCR's protection, health and education dashboards.

Analysis of available financial data. The team reviewed and analysed funding data to assess the evolution of funding flows during the evaluation and identified patterns and any

evidence of adaptation. The main financial data sets analysed included the United Nations Financial Tracking Service data; UNHCR financial reporting; OECD DAC data on official development assistance (ODA) in support of refugees or OECD DAC data on ODA contributions to top refugee-hosting aid recipient nations in the Creditor Reporting System, including preliminary 2020 data; the World Bank; the Global Humanitarian Response Plan (appeal documents); regional refugee response plans; reporting against Global Compact on Refugees indicators; UNHCR internal reporting and data; COVID-19 response plans in top refugee-hosting countries; and the UN COVID-19 Response and Recovery Multi-Partner Trust Fund.

All documents and interview notes were systematically reviewed and coded to generate evidence against the evaluation questions and sub-evaluation questions. The team used a coding software, MAXQDA, for this process. A coding tree was developed mirroring the structure of the Evaluation Matrix, in addition to sub-codes to enable better categorisation of data. Findings from the document review were triangulated with data from key informant interviews, indicators and data sets, and financial data and then assessed and validated against strength of evidence from all these data sets. These findings were tested at multiple points throughout the analysis phase with the Management Group and the Reference Group.

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10. Criteria for country selection included top refugee host countries with asylum seeker and refugee populations above a minimum threshold across all continents. Three additional adjustments were made to better adapt the list of countries to the needs of the review: Greater representation of developing states was favoured in the selection (with only six OECD member countries, of which three are also traditional OECD DAC donors); several conflict-affected countries with high IDP caseloads were excluded to ensure a greater focus on refugees; and one country was excluded based on lack of data and a lower refugee-per capita ratio.

2.3 Limitations

The evaluation was subject to a number of limitations:

All data collection was undertaken remotely due to COVID-19 travel restrictions still in place during the evaluation. All interviews were conducted remotely, reducing the breadth and depth of data. Despite persistent approaches from the evaluation team, certain groups of stakeholders were unable to find the time to engage. In particular, the team was able to engage with only a very limited number of representatives from donors, international financial institutions, global bodies, NGOs, refugee-led organisations and governments.

They typically cited overload, in part related to the ongoing COVID-19 response, and capacity limitations as a result of the pandemic itself. Ultimately, the number of interviews was lower than projected during the inception phase. Nevertheless, and exactly because of the remote nature of data collection, the evaluation has been able to reach a variety of actors worldwide that would not have been possible to contact if the evaluation had been conducted face to face.

There are limitations to the availability of comprehensive data on the impact of COVID-19 on forcibly displaced persons as a whole. In general, data on humanitarian assistance are rarely disaggregated by migratory status, and reliable data are not always available among certain at-risk populations. Even for UNHCR, the single largest source for such disaggregated data, the picture is nuanced. Many internal indicators consider "persons of concern" as the basic metric – that is, other displaced and sometimes vulnerable host populations are included as well as refugees. Other organisations use alternative classifications – for example, "forcibly displaced people", bringing together refugees and internally displaced persons. This demonstrates significant challenges of being able to paint an accurate picture specifically for refugees through the data available.

Given the unknown and volatile nature of the pandemic, another part of the challenge for organisations has been understanding what information would be most relevant to collect and to prioritise. Due to the acuteness of the crisis, data often were not systematically collected, leaving some gaps. This has led to challenges in the interpretation of the data. However, the evaluation team triangulated various sources of data to ensure rigour of the analysis.

3. The overarching response to the COVID-19 pandemic

Elderly Syrian among first refugees in Greece to receive COVID-19 vaccine (04 February, 2021) © UNHCR/Socrates Baltagiannis

This section presents a high-level summary of the role of global-level actors and global structures and of their efforts to support and strengthen the response of governments, humanitarian bodies and development assistance in the evolving response to COVID-19.

The localised response is an important dimension globally, but it is challenging to quantify with precision the contributions of local organisations, including refugee-led organisations (RLOs). Nevertheless, given the critical importance of local actors, this section provides some examples of the local-level responses to the pandemic.

Global-level responses to the pandemic

There was a distinct global component to the COVID-19 response, centred initially around the construction of the Global Humanitarian Response Plan[11] (GHRP)and also including the Global Compact on Refugees and other centrally organised instruments, appeals, guidance and policy issued or influenced by the COVID-19 Global Response and Recovery Framework, Inter-Agency Standing Committee, global clusters, and the OECD. For this global component, the evaluation team also conducted a light-touch analysis of funding data and data sets that were collected, collated and analysed at the global level. The full results of this analysis are available in Annex 5.

3.1 The Global Humanitarian Response Plan and global-level co-ordination

The GHRP[12] represented a co-ordinated effort by members and affiliates of the Inter-Agency Standing Committee to address the additional humanitarian needs arising from the COVID-19 pandemic, building on existing humanitarian co-ordination structures, plans and operations.[13] The GHRP aimed to complement the standalone plans developed by the International Red Cross and Red Crescent movement and brought together COVID-19 appeals and activities of UN system agencies[14] and non-governmental organisations (NGOs). The plan emphasised complementarity between agencies and responses, preparedness, early action, and flexibility to adjust responses and targets in the context of rapidly changing needs.[15] The maintenance of funding to ongoing humanitarian operations was emphasised in the GHRP, which specifically targeted those operations projected to be most affected, directly and indirectly, by the pandemic. The first iteration of the GHRP (March-April 2020) included 54 countries.[16] In May 2020, the GHRP was expanded to include 63 countries.[17]

The focus of the third strategic priority of the GHRP was indicative of the recognition that refugees, internally displaced persons (IDPs) and migrants, especially those in large camps and in concentrated living conditions, were initially seen as extremely vulnerable priority groups. The GHRP was based on three strategic priorities: "contain the spread of the COVID-19 pandemic and decrease morbidity and mortality"; "decrease the deterioration of human assets and rights, social cohesion and livelihoods", "protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic".[18]

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11. Many of the larger traditional donors to the humanitarian system still have predominantly global decision-making capacity. Humanitarian funding disbursed through central channels creates flows of reporting at the global level, which can be accessed via central systems.

12. An inter-agency evaluation of the GHRP response is currently in its very early stages, as is the Systemwide Evaluation of the United Nations Development System response to COVID-19. See the Progress Report: Global Humanitarian Response Plan COVID-19 Fourth Edition, 17 November, 2020, p. 2 at https://covid19.alnap.org/help-library/global-humanitarian-response-plan-covid-19-progress-report-fourth-edition-november-2020.

13. These include Humanitarian Response Plans, regional refugee response plans, the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, the Regional Refugee and Migrant Response Plan for the Venezuela crisis, and the Joint Response Plan for the Rohingya Humanitarian Crisis as well as a limited number of other priority countries.

14. The agencies are the World Health Organization, the International Organization for Migration, the United Nations Development Programme, the World Food Programme, the United Nations Population Fund, UN-Habitat, UNHCR, and the UN Children's Fund.

15. See OCHA (2020), Global Humanitarian Response Plan: COVID-19 (April – December 2020), p.20.

16. These countries included those that had an ongoing humanitarian response; those subject to a Humanitarian Response Plan, Regional Refugee Response Plan, the Refugee and Migrant Response Plan, countries covered by the 3RP for the Syria crisis, and the Joint Response Plan for the Rohingya crisis. Bangladesh, Democratic People's
Republic of Korea and Islamic Republic of Iran are also included as "other" priority countries because of the severity of the pandemic and/or appeals for international assistance.

17. The additional nine countries included were Benin, Djibouti (under the Horn of Africa and Yemen Refugee and Migrant Response Plan), Lebanon (classified as "country" in addition to being included under the Syrian 3RP), Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Togo, and Zimbabwe.

18. See OCHA (2020), Global Humanitarian Response Plan: COVID-19 (April – December 2020), https://www.unocha.org/sites/unocha/files/GHRP-COVID19_July_update.pdf

The recognition of refugees as a vulnerable group and a priority for the health response created a locus for co-ordination, facilitating the inclusion of refugees in national plans and encouraging co-ordinated efforts along the spectrum of international humanitarian and development actors. UN agencies and international finance institutions co-ordinated around the continuation of pre-pandemic policy work on inclusion, consistent with both the Global Compact on Refugees and the humanitarian-development-peace nexus.

Across the thematic areas for this evaluation, there were examples of pre-COVID policy work being continued into the pandemic response. Interviews conducted by the evaluation team revealed a clear consensus that the initial global level co-ordination and regional prioritisation were strong, as shown in the collaboration between the World Health Organization and UNHCR.

Before the pandemic, there had been a visible policy drive towards the inclusion of refugees into national services.[19] During the pandemic, both UNHCR and the World Health Organization purposefully pursued an integrated inclusion approach, successfully advocating for the inclusion of refugees into COVID-19 testing, treatment plans, preventative programmes and, more generally, national health systems and reducing reliance on parallel services to the extent possible. In addition, the World Bank developed stronger partnerships with UN system agencies and responded to humanitarian needs in countries where it and the UN already had a strong working relationship.

Specific World Bank efforts also sought to strengthen co-ordination mechanisms at the national and subnational level to address the needs of refugees and reduce their vulnerabilities in certain countries.

In the initial stages of the response, however, the focus on health led to the de-prioritisation, in relative terms, of protection services. Gender-based violence (GBV) and child protection were not included as essential services in the first phase of the response (see Thematic Snapshot 3). Recognition of this imbalance grew over time, as the UN Secretary-General stated in April 2020: "What began as a health crisis risks evolving into a broader child-rights crisis". After the initial stages of the pandemic, there were efforts to address this imbalance that included global-level advocacy, adaptation and innovations and containment measures to restore coverage, especially in non-health sectors (see Section 4).

The closure of the GHRP at the end of 2020 signalled a shift of emphasis from the central co-ordination of the global humanitarian bodies to country-level co-ordination and whole-of-government approaches, where possible. Increasing the centrality of local organisations to the response has been a key tenet in each iteration of humanitarian reform for at least the last two decades. The OECD DAC Recommendation on the Humanitarian-Development-Peace Nexus[20] and the Global Compact on Refugees both focus on reducing reliance on external assistance. The Global Compact, more specifically, focuses on the inclusion of refugee communities and RLOs at all levels of response.

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19. UNHCR's last inclusion survey was run prior to the pandemic; the results of the next survey will appear after this evaluation report is published.

20. The DAC Recommendation is to "ensure that, wherever possible, local actors are an integral part of their response with the ultimate goal to gradually end dependence on humanitarian assistance by fostering self-reliance and resilience". See OECD (2022), DAC Recommendation on the Humanitarian-Development-¬Peace Nexus, https://legalinstruments.oecd.org/public/doc/643/643. en.pdf.

3.2 Global-level financing for refugees in the COVID-19 response

The evaluation team opted for a light review of financing, factoring in the resources available and an understanding that the allocation of additional resources would have diminishing returns. The analysis is based on the levels of funding for Refugee Response Plans, contributions to key humanitarian organisations and preliminary data on development assistance to refugees in donor countries, using a series of proxies to estimate the effect of the COVID-19 pandemic on international assistance to refugees.

Any estimate of the impact that the COVID-19 pandemic has had on the global levels of financing for refugees needs to be read with several caveats in mind. First, except for reporting on requirements and contributions to the Refugee Response Plans, financing for refugees can be both humanitarian and development assistance and is not reported in a disaggregated fashion or specifically tagged, making it very difficult to trace and analyse.

Moreover, there is no specific database that offers a comprehensive overview of refugee financing. Some critical data sources, such as OECD DAC statistics, do not offer real-time data, further limiting the possibility to estimate current trends. This is also true of national level data, which is significant in that refugees' inclusion in health and social services is increasing. Any analysis, then, requires the combination of different data sources, each with its own methodology and reporting criteria.

With these caveats in mind, and taking a high-level view of coverage, it is still possible to establish that funding to the refugee response during the pandemic remained proportionally strong overall. Donors increased their level of humanitarian funding until the end of 2020, although appeals grew at an even faster rate. In keeping with the approach of the GHRP, funding to multilateral agencies was relatively strong, flexible and timely.

Funding to UNHCR was up in absolute terms through 2020. Preliminary data on official development assistance indicated that funding levels rose to an all-time high in 2020. However, funding was uneven across different sectors. For example, funding levels to GBV and child protection were low throughout the response and ultimately below the levels required to maintain adequate coverage at minimum standards.

In addition, there was no significant, proportionate increase in funding to either national or international non-governmental organisations. UNHCR's own data show a steady increase in the transfer of funding to national organisations over time (pre-pandemic) and no marked increase during the pandemic response in 2020. GHRP data show an insignificant increase in 2020.

For a more in-depth analysis of funding, see Annex 5 and Thematic Snapshot 3 in Section 4.

3.3 The Global Compact on Refugees as part of a framework for the COVID-19 response

On balance, the need to focus on the health emergency during the pandemic appears to have hindered the implementation of the Global Compact on Refugees (GCR) but has shown the importance of the principles on which the GCR is based – notably international co-operation and responsibility sharing.

In December 2018, the vast majority of states in the UN General Assembly affirmed the GCR after two years of consultations, demonstrating a commitment to international refugee protection and international co-operation in refugee responses. The 2018 launch of the GCR was followed in December 2019 with the first Global Refugee Forum, which brought the international community together in support of better protection and assistance for refugees and responsibility sharing, with states making pledges to support implementation of the GCR.

The pandemic was declared a few months after the first Global Refugee Forum, and the response dominated global attention. Among the restrictions, the closure of borders had a significant impact on refugee populations, contrary to the right to seek asylum and to the cardinal principle of non-refoulement, set out in paragraph 5 of the GCR and grounded in international refugee law, international human rights law, international humanitarian law, and international and national rule of law (paragraphs 8 and 9). During the pandemic, low- and middle-income countries continued to host 85% of the over 30 million refugees and asylum seekers and, more than ever, needed a fairer and more predictable burden and responsibility sharing.[21]

A range of interviewees with global and regional overviews cited the influence of the GCR directly in reference to leveraging greater inclusion of refugees in health systems. One senior UN staff member stated that the GCR provided a clear framework for action and cited examples of responsibility sharing during the pandemic. Interviewees also cited concerns, however, around the behaviour of some high-income states in which COVID-19 had "exacerbated stresses and frustrations that have been manipulated into extreme nationalism".

Despite the potential of the GCR as a framework and advocacy tool for protection and responsibility sharing during COVID-19, interviews with UN staff identified challenges to its implementation at the local and country levels, partly because of the urgent need to deal with the health emergency posed by the pandemic and prioritisation of short-term emergency assistance. Emerging evidence from key informant interviews suggests that in general, the GCR had most direct traction in countries that were part of the Comprehensive Refugee Response Framework or Comprehensive Regional Protection and Solutions Framework processes – that is, those where its tenets have been embedded since the New York Declaration of 2016.

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21. See UNHCR Figures at a Glance at www.unhcr.org/uk/figures-at-a-glance.html and the UNHCR Global Trends 2020 report on forced displacement at www.unhcr.org/flagship-reports/globaltrends/.

3.4 Local-level responses

Refugees and RLOs have played an important role in the response to the pandemic. The significant contribution of refugees and RLOs was cited in interviews and is captured in multiple country-level examples. The lack of data collated at the global level, however, means that it is impossible in any genuine sense to quantify the collective contributions of local actors, including refugees and RLOs. Agencies and bodies with a global remit such as UNHCR, the Global Refugee Youth Network[22] and the Women's Refugee Commission[23] are global co-ordinating bodies that produced a significant amount of reporting on local initiatives.

Particularly in the health response, community-based organisations and RLOs played key roles in efforts to share information on COVID-19.[24] For example, in Uganda, leaders of RLOs were among the first to speak out about the needs of urban refugees who did not receive humanitarian assistance, thus playing a key role in sensitisation on health issues.[25]

Other RLOs such as IRCA Casabierta in Costa Rica provided livelihood support and information on COVID-19 to LGBTQI+ refugees and asylum seekers through an online training programme.

In Bangladesh, Omar's Film School identified the scarcity of information about COVID-19 in the Rohingya language as a major challenge for the illiterate in Cox's Bazar and created a song and videos raising awareness about the pandemic.[26] In the West Nile region, the Community Empowerment for Creative Innovation, which runs community sensitisation programmes through video clips using languages spoken by refugees, produced videos to increase COVID-19 awareness.[27]

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22. Global Refugee Youth Network (2021), Refugee Self-Reliance and the Global Compact on Refugees. Unpacking Barriers and Opportunities for Success.

23. Women's Refugee Commission (2022), Research and Resources, www.womensrefugeecommission.org/research-resources/.

24. Segadlo, N. et al. (2021), Effects of the COVID-19 pandemic on refugees and their protection in Kenya, Uganda, Ghana, Nigeria, South Africa and Zimbabwe. Working Paper No. 18, https://www.arnold-bergstraesser.de/sites/default/files/field/pub-download/working_paper_18_effects_of_the_covid-19_pandemic_on_refugees_and_their_protection.pdf.

25 Pinock, K., et al. (2021). Localising Public Health: Refugee led-organisations as first and last responders in COVID-19, University of Oxford.

26. UNHCR (2021), Refugee-led innovations during COVID-19, https://reliefweb.int/sites/reliefweb.int/files/resources/61b312f24.pdf.

27. Betts, A., Easton-Calabria, E. and Pincock, K. (2021). "Localising Public Health: Refugee-led organisations as first and last responders in COVID-19". World Development, 139, 105311, https://doi.org/10.1016/j.worlddev.2020.105311.

Municipal responses were also key in the response to the pandemic. For example, the Mayors Migration Council supported a number of cities globally through the Global Cities Fund for Inclusive Pandemic Response, an initiative set up to respond to the unmet needs of cities as they supported migrants, refugees and IDPs during the pandemic.[28] The Global Cities Fund provides direct financial and technical support over one year to cities in low- and middle-income countries to implement projects related to public health, livelihoods and inclusive social services.

In Lebanon, Beirut's winning proposal[29] was awarded USD 176 000 for a mobile medical clinic.[30] The clinic provides free and non-discriminatory COVID-19 testing, vaccinations and other basic medical services and focuses on areas with a high concentration of refugees.[31] Beirut also directly engaged migrants, refugees, and marginalised Lebanese communities to identify the best use cases and locations for its mobile health clinic.[32]

There are also positive examples of engaging local women's organisations from the start of the pandemic to promote their participation in contributing to the response.[33]

For example, in May 2020, more than 200 women civil society organisations were mobilised by UN Women to provide critical insights on the impact of COVID-19 on violence against women and girls. The result was a publication documenting threats to women and girls, particularly those most marginalised, including both refugee and migrant women, and women with disabilities.[34] The International Rescue Committee also conducted a comprehensive GBV safety audit across multiple settings to access women's and girls' voices that similarly engaged women and women's organisations.[35]

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28. Mayors Migration Council (n.d.), Joint Statement Inclusive COVID-19 Response and Recovery, www.mayorsmigrationcouncil.org/mmc-covid19.

29. Beirut Mayor Jamal Itani put forward the proposal with the support of UN-Habitat.

30. Mayors Migration Council (2021), Pandemic Relief: Beirut Test-Drives Mobile Medicine for Migrants, www.mayorsmigrationcouncil.org/news/gcf-pandemic-relief-beirut.

31. Mayors Migration Council (2021), Beirut, Lebanon, www.mayorsmigrationcouncil.org/gcf-res/beirut-lebanon.

32. Mayors Migration Council (2021), The Global Cities Fund for Inclusive Pandemic Response, Progress Report, file:///C:/Users/Betsie.Lewis/Downloads/MMC%20GCF%20Progress%20report%20-%20Final.%20High%20Res%20(1).pdf.

33. It should be noted that strategies to enhance inclusion of women-led refugee organisations are also being developed within UNHCR at the global level, although these are not specific to COVID-19 nor have they been fully institutionalised. UNHCR created an advisory board that is made up of organisations led by refugees and other forcibly displaced people, with proportional representation of women-led organisations led by refugee and IDP women to advise on institutional reforms. UNHCR recently launched a small grant scheme in which regional funding has been allocated to provide operations with opportunities to fund (or co-fund) key initiatives. Projects focused on increasing the institutional capacity of women-led organisations. These processes and actions are foundational steps to allow for the implementation and operationalisation of policies that prioritise refugee-led and women-led organisations at an institutional level.

34. Pullen, K. (2021), UN Women Response to Covid-19 in the Arab States. March – December 2020, p. 14.

35. Abwola, N. and Michelis, I. (2020), What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls. International Rescue Committee, p. 13.

However, one study found that RLOs are still considered a high-risk investment and therefore often largely excluded from the formal humanitarian response.[36] Of the small proportion of humanitarian funding (approximately 2%) that goes to national organisations, less than 0.2% goes through local grassroots organisations.[37][38] Often, these organisations are also overlooked for funding when there are opportunities for partnership in project implementation.[39]

It appears that there are challenges with the systematic and meaningful engagement of local women and women's organisations in the GBV response during COVID-19, particularly utilising an intersectional approach.[40] As part of the planning approach, UNHCR operations engaged in consultations with the community of concern, among them women and girls, at least once annually, including on preparedness and consultations on the modes of service delivery.

However, given the shift to remote communications, in many contexts only women and girls with access to mobile phones could be reached and included in consultations about services (see Thematic Snapshot 4).

There were also challenges with supporting and enhancing the existing capacity of local women's organisations and networks, particularly when these were expected to provide services (see Thematic Snapshot 4). Moreover, the inclusion of diverse women and girls, including those facing intersecting forms of marginalisation, was not systematic and varied widely across contexts depending on which groups had previously been engaged by humanitarian actors.[41]

36. Refugee Law Initiative (2020), Refugee-led Organisations: The Time is Now, https://rli.blogs.sas.ac.uk/2020/08/05/refugee-led-organisations-the-time-is-now/.

37. Pinock, K. et al. (2021), Localising Public Health: Refugee led-organisations as first and last responders in COVID-19. University of Oxford.

38. Amnesty International (2020), Refugee-led organisations need support to continue their vital work, www.amnesty.org/en/latest/news/2020/08/refugee-led-organisations-osf-asylum-access/.

39. Pinock, K., Betts, A. and Easton-Calabria, E. (2021), "The Rhetoric and Reality of Localisation: Refugee-Led Organisations in Humanitarian Governance", The Journal of Development Studies, 57:5, pp. 719-734, https://doi.org/10.1080/00220388.2020.1802010.

40. Key informant interview.

41. Key informant interview.

4. Refugee rights in the COVID-19 pandemic

Bangladesh. Vaccination campaign for Rohingya refugees launched in Cox's Bazar (16 August 2021) © UNHCR/Amos Halder

This section looks at evidence collected from country-level reporting, data, documentation and interviews including thematic snapshots. It is organised around the key themes of this evaluation: the right to health, the right to seek asylum, child protection, protection from gender-based violence (GBV) and access to information. Where appropriate and possible, these themes are mapped against relevant evaluation criteria.

4.1 Refugees' access to health in the COVID-19 pandemic

This subsection looks at refugee rights to health, with a particular focus on policy and guidance of health responses (coherence); refugees' access to healthcare and inclusion of refugees in national health systems, including sexual and reproductive health (SRH) and vaccines (effectiveness); and adaptation of health services, with a focus on local partners (relevance).

4.1.1 Global level co-ordination: Policy and guidance (coherence)

From the onset of the pandemic, there was positive collaboration at the global level around guidance to support adaptation of health responses. Interviewees noted the importance of collegiality and co-ordination in the rapid production and distribution of guidance. A study[42] conducted in 2021 cited the publication of 131 separate guidance notes, 24% of which were published by the World Health Organization (WHO). Among these were guidance on case management, personal protective equipment (PPE), case definitions, risk communications and community engagement, infection prevention and control, screening, and mental health and psychosocial support.[43] All of this guidance is relevant to the refugee response, and some specific guidance was also produced in inter-agency fora.[44]

Global guidance to health clusters and sectors and all humanitarian and development actors (including donors) included advice to work with governments to prioritise the application of the Minimum Essential Service Package 4,

particularly where primary healthcare resources are diverted. Guidance specifically included the maintenance of life-saving SRH services, recognising the need to ensure that the unique SRH needs of diverse adolescent girls and youth are met.

4.1.2 Access to healthcare and inclusion of refugees in national health systems

Overall, the majority of countries offer refugees some degree of inclusion in national health systems, most often in primary healthcare services. UNHCR data from 2019[45] indicate that 62% of countries have inclusion plans for refugees that include health and that 60% of countries include refugees in the national health policy and/or regulatory framework. (The inclusion survey involved 48 countries.) More recent figures from the UNHCR[46] show that 95% of refugees are able to access primary healthcare facilities. Interviewees reported anecdotal evidence that COVID-19 created leverage with governments around inclusion of refugees in national health systems and linked this to inter-agency co-ordination and advocacy in numerous countries. However no data are yet available to quantify this.[47]

42. Odlum, A., James, R., Mahieu, A. et al. (2021), "Use of COVID-19 evidence in humanitarian settings: the need for dynamic guidance adapted to changing humanitarian crisis contexts". Confl Health, 15, 83, https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-021-00418-w.

43. Odlum, A., James, R., Mahieu, A. et al. (2021), "Use of COVID-19 evidence in humanitarian settings: the need for dynamic guidance adapted to changing humanitarian crisis contexts". Confl Health, 15, 83, https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-021-00418-w.

44. For example, the Inter-Agency Standing Committee published interim guidance on scaling up COVID-19 outbreak readiness and response operations in humanitarian situations, including in camp and camp-like settings. It contains an emphasis on readiness and response operations for the COVID-19 outbreak through effective multisectoral partnerships and was developed in alignment with the World Health Organization's COVID-19 Strategic Preparedness and Response Plan. See, IASC (2020), Interim Guidance Scaling-Up Covid-19 Outbreak Readiness and Response Operations In Humanitarian Situations, www.unhcr.org/uk/publications/brochures/5ec808c84/iasc-guidance-scaling-up-covid-19-outbreak-readiness-response-operations.html?query=-Covid-19%20Health%20guidance.

45. UNHCR's inclusion survey is conducted every two years and therefore the most up-to-date figures are pre-pandemic.

46. Based on UNHCR internal reporting.

47. It is important to highlight that the services designated as essential and accessible in principle to refugees vary significantly from country to country and along the trajectory of the pandemic response. Inclusion indicators were built into the Global Humanitarian Response Plan indicator set, but these were not fully aligned to UNHCR surveys, and the data showed disparities in terms of the way the indicators were interpreted from country to country. Part of the disparity with UNHCR data is around the language of the indicators – whether refugees were included in "essential health services" (with no consistent definition), included in primary health services or included in a broader range of services. Data on refugee access to healthcare during the pandemic vary according to context.

There are numerous examples of countries offering universal access to healthcare for refugees during the pandemic.[48] In numerous countries, treatment related to COVID-19 testing was available without charge. The governments of Albania, Chile, Colombia, Nepal and Peru[49] affiliated both refugees and migrants to the health systems for testing and treatment.

The pivoting of funds to the COVID-19 prevention and response efforts resulted in strain on the provision of regular, essential health services in refugee camps. Interviewees frequently cited significant challenges to access non-camp settings, most notably in rural areas where health infrastructure was already weak.[50] While the rates of consultations, clinical access, laboratories and tests were also reduced for host communities, interviews suggest that refugees were disproportionality affected.

UNHCR reporting confirms that globally, the pandemic had an impact on access to and utilisation of health services. At the onset, there was generally a reduction in outpatient consultations due to lockdowns, fear and diversion of the health workforce to provide COVID-19 care. However, adaptations were made to ensure the continuity of safe access to essential services and as lockdowns and restrictions were lifted, utilisation of services increased. Overall, the health facility utilisation rate remained within acceptable ranges over 2020 in comparison to 2019, despite periodic decreases in utilisation.[51]

As illustrated in Thematic Snapshot 1, fear of repercussions, especially deportation, negatively affected refugees' health-seeking behaviour, including for testing or care related to COVID-19. A global survey conducted by the WHO found that 22% of refugees and migrants with suspected cases of COVID-19 reported not seeking medical help due to fear of deportation

(see Thematic Snapshot 1).[52] A small number of countries were noted as having introduced a firewall between health and immigration services to overcome this problem. For example, Colombia was reported as confirming that no data would be shared with immigration services, and Korea suspended the obligation of medical facilities to report people to immigration authorities. Additional major barriers to accessing services include, but are not limited to, linguistic challenges, lack of information on the location of healthcare services, and lack of clear advice about COVID-19 treatment and testing.[53]

Older refugees faced increased difficulty in accessing primary healthcare services. A recent study into the difficulties faced by older Rohingya refugees in camps during the pandemic indicates that 30% of this population experienced difficulties in accessing routine medical care. Contributing factors that impacted their health-seeking behaviour include poor literacy, language barriers, and long walking distances to clinics.[54]

In addition, while aid agencies perceived positives from the increase in public health messaging through community partners, refugees were often more concerned about the long-term effects of lockdown measures.[55] Interviews revealed very commonly expressed tensions between risk-mitigating behaviour and economic concerns.[56]

There are numerous examples of limited access to critical care that was previously available for serious illnesses other than COVID-19. In Brazil, Costa Rica, Ecuador, Peru and South Africa,[57] for instance, primary healthcare for the treatment of COVID-19 was available to all, irrespective of migratory status, but refugees were found to be "neglected" in terms of secondary

or tertiary care for other diseases.[58 59] This was regularly cited in interviews as problematic for Venezuelan refugees who previously had access to medical diagnostic services and treatments for cancer and other non-communicable diseases but found themselves unable to access such care as a result of COVID-19-related restrictions.[60 61]

Overall, significant barriers remained for refugees seeking healthcare assistance during the pandemic. For a more in-depth look at access to primary care, the evaluation team designed a thematic snapshot focusing on two examples of efforts being made to increase refugee access to healthcare during the pandemic.

48. Examples include Belgium, France and Turkey.

49. World Health Organization (2021), Refugees and Migrants in Times of COVID-19: Mapping Trends of Public Health and Migration Policies and Practices.

50. Documentation cited a particularly stark example in Sudan, where 90% of refugees residing in camps in the country have access to primary health services compared to only 25-50% of refugees living outside camps.

51. UNHCR (2020), 2020 Annual Public Health Global Review.

52. UNICEF (2021), Child Protection Learning Brief #5.

53. MMC (2020), MMC East Africa and Yemen 4Mi Snapshot- July 2020: The impact of COVID-19 on Ethiopian refugees and migrants in Somaliland, https://reliefweb.int/report/somalia/mmc-east-africa-and-yemen-4mi-snapshot-july-2020-impact-covid-19-ethiopian-refugees

54. Mistry, S. (2021), Difficulties faced by older Rohingya (forcibly displaced Myanmar nationals) adults in accessing medical services amid the COVID-19 pandemic in Bangladesh, https://gh.bmj.com/content/bmjgh/6/12/e007051.full.pdf.

55. Comments from the WHO's Apart Together survey (p. 24) included the following: "Local NGOs used to provide us reminders about physical distancing and national health guidelines provided by Bangladeshi government agencies, but now-a-days, the rate of publicity and awareness has decreased", then "Lifestyle got changed. It's getting impossible for us to sustain in this environment"..

56. World Health Organization. (2020). Apart Together survey, p. 24

57. Mutambara, V. et al. (2020), Assessing the Impacts of Covid-19 on Women Refugees in South Africa.

58. In a World Vision survey that referred to COVID-19 testing and treatment only, fairly high numbers of refugee respondents in Brazil (51%), Jordan (38%) and Peru (32%) reported that the host country government temporarily regularised their status, and some reported having the same access to services as citizens as part of the national Covid-19 responses.

59. According to a key informant interview.

60. Gallo Marin, B. et al. (2021), "A Scoping Review of Non-Communicable Diseases and Maternal and Child Health Needs of Venezuelan Migrants in South America", Journal of Global Health Reports, 5, p. e2021045. https://doi.org/10.29392/001c.23621.

61. Key informant interview.

Thematic Snapshot 1 - Access to primary healthcare in Bangladesh and Lebanon

The snapshot illustrates some of the types of challenges that refugees faced in accessing primary healthcare across Bangladesh and Lebanon but without intending to compare these settings.

There are good examples of efforts to increase access to healthcare for refugees in camps during the pandemic. As the government of Bangladesh scaled up COVID-19 testing capacity, Cox's Bazar was one of the first districts outside of Dhaka city where laboratory diagnosis of COVID-19 was initiated.[62] International aid agencies built two field hospitals with 148 beds specifically for the treatment of Rohingya refugees with COVID-19. Additionally, "go and see" visits to health facilities were organised for refugee and host community members as part of ongoing efforts to increase testing in camps, improve understanding and trust between refugees and humanitarian actors, and address misinformation and rumours about COVID-19.[63]

Nevertheless, lockdown was levied in Cox's Bazar, restricting entry into or exit from the district except for deliveries of emergency food and medical supplies,[64] and menstrual hygiene and SRH services.[65] Relief operations and humanitarian access in the camps were significantly reduced – by 80% – although thousands of community volunteers stepped in to fill the gap.[66]

While health activities were prioritised during lockdowns in Cox's Bazar, the health-seeking behaviour of refugees was negatively impacted. An interviewee noted that movement restrictions within the camp were implemented, reducing health-seeking behaviour among refugees.[67] Refugees faced both direct and indirect issues with access to health, including the disruption of ordinary camp supply chains, the restructuring of humanitarian staffing and the redirection of resources.[68]

62. Homaira, N. et al. (2020), COVID-19 in the Rohingya refugee camps of Bangladesh: challenges and mitigation strategies. https://jglobal-biosecurity.com/article/10.31646/gbio.84/

63. Inter Sector Coordination Group (2020), Situation Report Rohingya Refugee Crisis, https://reliefweb.int/sites/reliefweb.int/files/resources/ISCG%20Situation%20Report%20-%20Rohingya%20Refugee%20Crisis%2C%20Cox%E2%80%99s%20Bazar%2C%20June%202020.pdf.

64. Barua A. and R. H. Karia (2020), Challenges faced by Rohingya refugees in the COVID-19 pandemic https://annalsofglobalhealth.org/articles/10.5334/aogh.3052/.

65. Guglielmi, S. et al. (2020), "Exploring the impacts of COVID-19 on Rohingya adolescents in Cox's Bazar: A mixed-methods study", Journal of Migration and Health, https://reader.elsevier.com/reader/sd/pii/S2666623520300313?token=F1D95D8C140B841548016324F4E365C38E3F34579905D00A6B96970DBCDF72005D50EC27C757866411D6EE1BD7C5E10F&originRegion=eu-west-1&originCreation=20220106135956.

66. Oxfam (2021), Four things to know about Covid in the world's largest refugee camp, www.oxfam.org/en/blogs/four-things-know-about-covid-worlds-largest-refugee-camp
67. According to a key informant interview.

68. Guglielmi, S. et al. (2020). "Exploring the impacts of COVID-19 on Rohingya adolescents in Cox's Bazar: A mixed-methods study", Journal of Migration and Health
https://reader.elsevier.com/reader/sd/pii/S2666623520300313?token=F1D95D8C140B841548016324F4E365C38E3F34579905D00A6B96970DBCDF72005D50EC27C757866411D6EE1BD7C5E10F&originRegion=eu-west-1&originCreation=20220106135956.

69. Guglielmi S. and al. (2020), "Exploring the impacts of COVID-19 on Rohingya adolescents in Cox's Bazar: A mixed-methods study", Journal of Migration and Health, https://reader.elsevier.com/reader/sd/pii/S2666623520300313?token=F1D95D8C140B841548016324F4E-365C38E3F34579905D00A6B96970DBCDF72005D50EC27C757866411D6EE1BD7C5E10F&originRegion=eu-west-1&originCreation=20220106135956.

70. Key informant interview.

71. Chandra, J. (n.d.), Building back better together for everyone: refugees, asylum seekers and the stateless amidst the COVID-19 pandemic, www.unhcr.org/en-in/5f5346e64.pdf.

The containment measures also altered, and at times further restricted, information flow within the camps.[69] Delayed communication about the virus contributed to the breakdown of trust between Rohingya refugees and humanitarian workers and is likely to result in refugees avoiding COVID-19 testing or waiting longer to come forward for healthcare.[70][71]

In other camp settings, lockdowns contributed to refugees' reduced access to health services.[72] In Lebanon, for example, aid groups reported difficulties in accessing the camps to provide non-COVID-19 medical supplies,[73] with multiple non-governmental organisations (NGOs) facing significant challenges linked to access to camps.[74] While organisations such as Médecins Sans Frontières and Amel Association International still reached patients in more remote parts of Lebanon, smaller NGOs that previously provided mobile medical services were blocked from entering the camps.[75]

There is emerging evidence that healthcare centres and hospitals requested refugees to present proof of identity for themselves and their children to access health services.[76] Stigma and fear of arrest, deportation and loss of legal status exacerbate a lack of healthcare-seeking behaviour among refugees in Lebanon.[77] Since the nationwide lockdown, health actors based in Lebanon reported a 30% decline in consultations at health centres. This was confirmed by a survey conducted by Norwegian Refugee Council with 130 Palestinian and Syrian households where 84% of the respondents stated that primary health centres require identification documents to proceed with the provision of the health service. The UNHCR registration certificate was mentioned by 92% of the respondents as the main document requested by the health centres, followed by identity documents (56%). Of the total of primary healthcare clinics and hospitals surveyed, 25 medical facilities reported to deny admission due to lack of documents, while only 11 reported that they could provide required healthcare without any documentation, allowing refugees to share only general information such as name, age and date of birth.[78]

72. Norwegian Refugee Council (2021), Documentation and access to healthcare for refugees in Lebanon, www.nrc.no/globalassets/pdf/briefing-notes/documentation-and-access-to-healthcare-for-refugees-in-lebanon/icla_briefing-note_documentation-and-access-to-healthcare_may2020.pdf.

73. Mhaissen, R. (2020), Covid-19 and Syrian Refugees in Lebanon, http://library.fes.de/pdf-files/bueros/beirut/16356.pdf

74. Lebanon Humanitarian INGO Forum (2021), Slipping Through the Cracks https://reliefweb.int/sites/reliefweb.int/files/resources/FINAL-Slipping%20Through%20The%20Cracks-LHIF%20Briefing%20Paper-June%202021.pdf.

75. Chehayeb K. and Sewell, A. (2020), "How Covid-19 is limiting healthcare access for refugees in Lebanon", The New Humanitarian, www.thenewhumanitarian.org/feature/2020/04/21/Lebanon-coronavirus-refugee-healthcare

76. Norwegian Refugee Council (2020), Documentation and access to healthcare for refugees in Lebanon, www.nrc.no/globalassets/pdf/briefing-notes/documentation-and-access-to-healthcare-for-refugees-in-lebanon/icla_briefing-note_documentation-and-access-to-healthcare_may2020.pdf.

77. Mhaissen, R. (2020), Covid-19 and Syrian Refugees in Lebanon, http://library.fes.de/pdf-files/bueros/beirut/16356.pdf.

78. Norwegian Refugee Council (2020), Documentation and access to healthcare for refugees in Lebanon, www.nrc.no/globalassets/pdf/briefing-notes/documentation-and-access-to-healthcare-for-refugees-in-lebanon/icla_briefing-note_documentation-and-access-to-healthcare_may2020.pdf.

4.1.3 Refugees' access to vaccinations

Overall, the emerging picture is one of increasing inclusion of refugees in national deployment and vaccination plans. Formal inclusion of refugees in national vaccine plans has been a focus of global advocacy and co-ordination, as pointed out by interviewees of this evaluation. Interviewees cited a positive pattern overall of country-level co-ordination between WHO and UNHCR to advance the inclusion of refugees in such plans (as well as in COVID-19 testing and treatment plans and in preventative programming). However, a review conducted by WHO in February 2021 found that just over half (53%) of national deployment and vaccination plans explicitly included refugees and asylum seekers. This finding is supported by UNHCR's internal inclusion data from April 2021, which show that formal inclusion of refugees is high among the 27 countries sampled by the evaluation.[79] According to a report published in 2021 by UNHCR, 162 countries included refugees in their national COVID-19 vaccine plans.[80] Additionally, UNHCR helped refugees enrol in Lebanon's national COVID-19 vaccination plan by supporting nearly 400 health workers and outreach volunteers and providing approximately 3 370 vaccinations to refugees through its mobile vaccination campaign between July and August 2021.[81]

However, formal inclusion in national vaccination plans does not equate directly to high coverage rates. Globally, and not specific to the refugee response, there are well-documented issues around vaccine nationalism, which has significantly impacted the procurement and distribution of vaccinations for low and middle-income countries. Most of these countries have relied on the COVID-19 Vaccines Global Access (COVAX) facility, which aims to vacci-

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

nate 20% of the population of each country, to obtain vaccines. Only 1% of the population in low-income countries had access to their first dose in July 2021.[82] By the end of 2021, 4.79 million vaccine doses were distributed to 3.25 million refugees and other forcibly displaced people across 66 countries. An additional 72 countries confirmed that they had begun vaccinating refugees, but these data were not publicly available. It is important also to emphasise that many of the countries hosting refugees have made only very slow progress towards the global goal of vaccinating 70% of the global population by mid-2022. Vaccine inequity has led to major delays in vaccine rollout in low and middle-income countries, but refugees face additional barriers due to lack of documentation, language barriers and complex vaccine registration systems.[83]

Humanitarian agencies have faced major barriers in procuring and distributing COVID-19 vaccines through the humanitarian buffer. Liability is a risk that pharmaceutical companies usually take; this is not the case for COVID-19 vaccines. Due to the accelerated development of these vaccines, manufacturers have required others to cover liability costs instead. The burden of covering a manufacturer's liability costs therefore falls on either the national authorities procuring vaccines or on NGOs seeking to pro-

cure vaccines. When humanitarian agencies apply for doses allocated through the COVAX Humanitarian Buffer, manufacturers are likely to request that liability be addressed directly by the humanitarian agencies. The buffer aims to cover unavoidable gaps in national vaccination plan coverage for high-risk and vulnerable populations in humanitarian settings. As the Inter-Agency Standing Committee highlights,[84] unless these problems with indemnity requirements are resolved, manufacturers are unlikely to be willing to accept purchase orders and deliver doses for which humanitarian agencies are the recipient and end-user. Humanitarian agencies cannot accept this condition, and therefore doses procured through the humanitarian buffer become inaccessible to them,[85] jeopardising vaccination coverage of all populations of concern.

4.1.4 Refugees' access to sexual and reproductive health

Evidence from the country-level analysis demonstrates that reproductive health was prioritised in policy and practice. The Minimum Package, prioritised in global guidance, included the maintenance of life-saving SRH services, noting the need to ensure that the SRH needs of adolescent

Kenya. Refugees and host community access maternal health during COVID-19 (26 October 2020) © UNHCR/Samuel-Otieno

girls and youth were met. Comparable data between 2019 and 2020 in the UNHCR health information systems of 15 countries showed that SRH services not only were maintained, but that there was a 5% increase in the number of deliveries attended by skilled staff in 2020, demonstrating that women continued accessing skilled birth attendance.[86]

In Tanzania, UNHCR is co-ordinating with partners, the Ministry of Home Affairs, and the Ministry of Health to reinforce information on physical distancing, community-level follow-up to reduce non-essential antenatal care visits, and provision of multi-month supplies of prophylactic treatment for anaemia and malaria.[87]

79. UNHCR internal data.

80. UNHCR (2021), UNHCR Covid-19 Vaccine Access Report 2021.

81. USAID (2021), Lebanon Complex Emergency Fact Sheet 5, https://reliefweb.int/sites/reliefweb.int/files/resources/2021_09_30%20USG%20Lebanon%20Complex%20Emergency%20Fact%20Sheet%20%235.pdf.

82. Tagoe, E. et al. (2021), Covid-19 Vaccination in Lower-Middle Income Countries: National Stakeholder Views on Challenges, Barriers and Potential solutions, www.frontiersin.org/articles/10.3389/fpubh.2021.709127/full.

83. UNHCR (2021), UNHCR Covid-19 Vaccine Access Report 2021.

84. Inter-Agency Standing Committee (2021), Frequently Asked Questions: The COVAX Humanitarian Buffer.

85. Médecins Sans Frontières (2021), Access to Covid-19 vaccines and manufacturer liability: time for Big Pharma to accept legal responsibility for its products.

86. UNHCR (2021), Emerging Practices Sexual and Reproductive Health & HIV Services in Refugee Operations During the COVID-19 Pandemic.
87. Ibid.

4.1.5 Adaptation of health services (relevance)

Border closures, lockdowns and other COVID-19-related constraints meant that significant adaptations to health service delivery were required. There are multiple examples of telehealth (consultations by telephone or internet-based platforms), hotlines, and/or telephone or internet-based booking systems. In Colombia, for example, telephone support lines were established for both refugees and migrants who requested HIV prevention and diagnostic services and other essential SRH services.[88] In the Kakuma refugee camp in Kenya, Resilience Action International collaborated with Ipas Africa Alliance, an NGO that focuses on women's health, to organise intensive online programmes through WhatsApp and short message service, or SMS.

There is evidence to suggest that in a number of settings, organisations quickly adapted services for refugees with pre-existing medical conditions to mitigate against the closure of services due to lockdowns. For example, as Jordan went into lockdown in March 2020, health providers rapidly put in place measures to ensure continuity of treatment for refugees with pre-existing medical conditions who lived in urban areas and in camps.[89] Their health was already stable and managed via treatment received by telephonic guidance as well as a three-month supply of individually packaged medicines.[90] Interviews suggested that the use of this strategy was dependent on the burden of disease within the context but also the setting in which refugees resided.

There are also some examples of refugee health professionals being integrated into state health systems. In 2020, the government of Spain started a process to integrate 2 000 Venezuelan doctors into the national health system.[91] In Germany, the region of North Rhine-Westphalia asked foreign doctors, who are still undergoing the skill recognition process, to practise under the supervision of German-licensed physicians.[92] In Jordan, UNHCR facilitated the selection of medically qualified refugees to support the national health responses. In June 2021, the first three refugee doctors – two Iraqis and one Yemeni – completed the recruitment process and were onboarded into facilities in Irbid and Amman through UN volunteer contracts.[93] One interviewee reported that Venezuelan medics were being integrated into health systems in Argentina, Ecuador and Peru.

Evidence demonstrates some successes with the increased engagement of local organisations, particularly in improving medical and diagnostic services for HIV. An agreement with

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88. Ibid.

89. UNHCR arranged special government approval for a transportation company to make household deliveries of medicines. Home delivery of medications will continue to avoid increased visits at the health centres. After lockdown, patients were contacted for a physician review and adjustment of medication if needed. A challenge and lesson learned was the lack of glucometers and testing strips for diabetic patients to improve self-monitoring at home.

90. UNRWA (2020), Rapid Socio-Economic Study of the Effects of Covid-19 on Palestinian Refugees in Jordan.

91. Sturner, J. and Bekyol, Y. (2020), Going the (Social) Distance, www.icmpd.org/file/download/50556/file/GOING0THE06SOCIAL60D-ISTANCE0How0migrant0and0refugee-sensitive0urban0COVID-190responses0contribute0to0the0realization0of0the0Global0Compacts0for0Migration0and0Refugees.0EN.pdf.
92. Ibid.

93. UNHCR (2021), Jordan: UNHCR Operational Update, June 2021, https://reliefweb.int/report/jordan/jordan-unhcr-operational-update-june-2021

the Colombian League for the Fight against AIDS and the National Network of Women with HIV was established to link with UNHCR's partner to provide both medical and diagnostic services for HIV. Simultaneously, civil society invested in prevention work at the community level, and two NGOs now provide HIV treatment for both refugees and migrants who are not covered under the national health system. Other examples were cited in Afghanistan, Bangladesh, Jordan[94] and Turkey.

Limitations of adaptive measures

Adaptation of healthcare to remote services where possible was recognised as a positive. However, it is clear that the adaptations did not overcome all the barriers to access and created new barriers for a minority of refugees. Country-level examples show challenges with accessing online services that relate to access to and familiarity with technology and, significantly in some contexts, language barriers. Especially vulnerable refugees with less ready access to technology were less likely to receive critical information about access to health and COVID-19 services and, more broadly, social services. Although the total impact is impossible to quantify, barriers for older refugees and those with disabilities were especially great in this respect.[95]

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94. Weekly visits for up to 83% of refugees, according to the 2020 Annual Public Health Global Review Jordan

95. Inclusive Futures (2021). Consequences of Exclusion: A Situation Report on Organisations of People With Disabilities and COVID-19 in Bangladesh, Nigeria, and Zimbabwe; UNHCR (2021) Accessing Services During Covid-19: Persons with Disabilities and Older Persons in Azraq Camp.

4.2 Refugees and the right to asylum

This subsection focuses on the fundamental right of seeking asylum and describes the extent to which refugees were able to seek protection across an international border. It also outlines the consequences of border closures for the right to asylum and the extent to which protection actors were able to effectively adapt services during the pandemic and to allow and improve access to protection services (relevance, effectiveness, coherence).

4.2.1 Border closures and consequences for the right to asylum

One of the first reactions of states to the pandemic was the closure of borders to contain the spread of COVID-19, in line with their international obligations regarding the right to life and the right to the highest attainable standard of health.

States' duty to uphold the right to seek asylum under Article 14 of the Universal Declaration of Human Rights and not to return (refouler) "in any manner whatsoever" refugees and asylum seekers under Article 33 of the 1951 Convention Relating to the Status of Refugees was not suspended.[96] This is because the closure

Afghanistan. Border crossing (12 December 2021)
© UNHCR/Andrew McConnell

of borders should never prevent anyone from fleeing conflict or persecution. Health concerns can be met through safe quarantine measures and the provision of healthcare to those arriving who need it, as international human rights law applies to everyone in the territory or in the jurisdiction of the state.

Nevertheless, 195 states closed their borders fully or partially at some point between the start of the pandemic in March 2020 and November 2021 to contain the spread of the virus.As of December 2021, there were 48 border closures that prevented refugees from seeking asylum, contrary to Article 14 of the Universal Declaration of Human Rights.[97] As a result, across all regions of the world in 2020, there were approximately 1.5 million fewer arrivals of refugees and asylum seekers than would have been expected based on historical trends in forced displacement.[98]

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96. See UNHCR (2020), "Safeguarding fundamental rights", in UNHCR Global Report 2020, p.173, Error! Hyperlink reference not valid. https://reporting.unhcr.org/sites/default/files/gr2020/pdf/Chapter_Safeguarding.pdf.

97. During the writing of this report, UNHCR's COVID-19 platform was regularly accessed and figures were recorded. As of 6 April 2022, 46 countries still denied access to refugees and asylum seekers.

98. UNHCR (2021), Global Trends in Forced Displacement 2020, p.5.

At the same time, 76 countries preserved access to territory for people seeking international protection throughout the pandemic, and there are examples where states have maintained public health while upholding the rights of refugees by protecting them from refoulement. For example, Uganda, after initially closing its borders, accepted thousands of refugees from the Democratic Republic of the Congo (DRC) while implementing quarantine and other necessary measures to safeguard public health.[99] In response to the continuing movement of Venezuelans into Colombia during the pandemic, Colombian authorities provided ten-year temporary protection in the country that granted them access to the national health system, COVID-19 vaccines and other basic services.[100] In East Africa and the Horn of Africa generally, UNHCR ensured basic assistance and minimum standards during quarantine for new asylum seekers and for refugees who travelled internally within host countries.[101]

With many borders closed, asylum seekers had to resort to irregular border crossings, which in many cases are extremely dangerous and life threatening and where the provision of information is not available.[102]

Border closures led to other protection issues such as increased trafficking in persons and human smuggling. Evidence of irregular and secondary movements in South and Central America, Europe, Africa and Asia suggests that border closures did not stop forcibly displaced persons from seeking international protection.[103] For example, according to figures from UN Office on Drugs and Crime, more than 23 000 people attempted to travel from West Africa across the Atlantic to the Canary Islands to seek asylum in 2020,[104] a dangerous journey often facilitated by smugglers.[105] It is likely that other known smuggling routes will also have seen increased movements to avoid border closures and those movements will have included refugees and asylum seekers.[106] Nonetheless, many persons seeking international protection could not access services because they could not be officially registered with government authorities or UNHCR due to national lockdowns.[107] Lack of access to refugees and asylum seekers for protection staff also left refugees vulnerable to attacks from armed groups in conflict areas.[108]

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99. Ibid, p.6.

100. UNHCR (2021), "UNHCR and IOM welcome Colombia's decision to regularize Venezuelan refugees and migrants," UNHCR–IOM Joint Press Release, www.unhcr.org/news/press/2021/2/60214cf74/unhcr-iom-welcome-colombias-decision-regularize-venezuelan-refugees-migrants.html. Nevertheless, other circumstances in Colombia meant that on occasion, Venezuelans still crossed back, despite conflict and violence in Venezuela.

101. UNHCR (2021), Covid-19 External Update #31, East and Horn of Africa, and the Great Lakes Region, p.1.

102. UNHCR (2021), Covid-19 External Update #31, East and Horn of Africa, and the Great Lakes Region, p. 2. See also, IOM (2021), World Migration Report 2020, https://publications.iom.int/system/files/pdf/wmr_2020.pdf which claims that there was use of smugglers and traffickers throughout Africa, in Asia and in the Americas.

103. Ibid.

104. Klitgaard, Amalie (2021), "How better migration management is reducing xenophobia in the Canary Islands", The New Humanitarian, www.thenewhumanitarian.org/news-feature/2021/11/4/migrant-management-reducing-xenophobia-racism-Canary-Islands-Spain-camp-conditions.

105. UNODC (2011), The role of organised crime in the smuggling of migrants from West Africa to the European Union, p. 23.

106. See IOM (2021), World Migration Report 2020, https://publications.iom.int/system/files/pdf/wmr_2020.pdf.

107. See UNHCR (2020), "Thematic Chapter on Safeguarding Fundamental Rights", Global Report 2020, https://reporting.unhcr.org/sites/default/files/gr2020/pdf/Chapter_Safeguarding.pdf ; UNHCR (2022), Asylum Capacity Development (ACD) Evaluation – An Independent Evaluation of UNHCR's Support for Strengthening National Asylum Systems (draft, 2022), the Philippines.

108. See Regional Update on the Americas at the 71st Session of the Executive Committee, 5-9 October 2020, p. 3, regarding confinement by FARC-EP of Venezuelans.

There is also compelling evidence of deportations, pushbacks at sea and on land, and expulsions, and in 39 countries there was refoulement to persecution and violence. According to UNHCR's 2020 Global Trends in Forced Displacement, the erosion of protection through denial of the right to seek asylum and refoulement may have affected about 200 000 people.[109] While interventions by UNHCR with governments have removed some of these barriers, such barriers still persist into 2022. One very well-documented example among several others is the United States and its pushbacks under Title 42.[110] Where high-income countries with high-quality healthcare used COVID-19 as justification for limiting access, the case for burden and responsibility sharing, in line with the Global Compact on Refugees, was undermined.[111]

Border closures and lockdowns reduced the ability of governments and protection actors to resettle refugees to a third country. Resettlement is also seen as a significant contributor to burden and responsibility sharing under the Global Compact on Refugees. In the best of times, resettlement accounts for very few refugees compared to global refugee numbers and in 2020, the resettlement number slipped to a mere 22 800 people globally (from 63 726 in 2019 and 126 291 in 2016).[112] The pandemic had a dramatic effect on resettlement because transborder movements were restricted, refugees could not travel to countries of resettlement and decision makers from resettling countries could not travel to the hosting state to carry out face-to-face interviews to confirm resettlement eligibility. Given that resettlement targets the most vulnerable, refugees with specific needs may have been disproportionately affected by the limited resettlement, although there are no data available yet to show this.

Border closures and lockdowns posed serious health risks due to poor conditions in detention centres.[113] Measures to safeguard public health that prevented the entry of both migrants and asylum seekers led to inhumane detention conditions, with minors and families housed in cramped and dangerous conditions in some cases. According to UNHCR, reception conditions at European borders in Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Ireland, Latvia, and Malta, among others, created some of the greatest risks of COVID-19 infection due to frequent outbreaks.[114]

Evidence shows that the poor conditions of some facilities deterred asylum seekers from crossing borders or led them to return to persecution rather than remain in the country of asylum.[115] In some cases, COVID-19 resulted in the release of many persons of concern from detention facilities because the authorities could not guarantee safe conditions in the pandemic. [116]

While states' measures to protect public health may not specifically target persons seeking international protection, these may have significant implications nonetheless for refugees and asylum seekers.

Article 31 of the 1951 Convention rejects penalties for asylum seekers who arrive irregularly but who present themselves to the authorities without delay; restrictions on movement should also be for as short a time as is necessary to regularise the asylum seekers' situation. States can quarantine persons on arrival under international human rights law if there are concerns about health issues. Thus, during the pandemic, it was legitimate for states to protect their own populations but only if the conditions for detention respected the rights of refugees: Detention facilities needed to up hold social distancing and provide an adequate standard of living during detention (per Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights. During the pandemic, states across the globe often failed to meet these standards since taking precautionary measures to protect against the transmission of COVID-19 in detention facilities – such as social distancing – were extremely difficult to implement.[117] This failure to ensure the health and safety of people in search of international protection may well have dissuaded those who would otherwise have fled and may have induced return movements, even if these were back to situations of persecution.[118]

Additionally, the pandemic brought a dramatic increase in xenophobia, stigmatisation and misinformation that is linked to perceptions of refugees as carriers of disease and that has led on occasions to indirect refoulement.[119] Many refugees and asylum seekers work in the informal economy that was the first to be hit by lockdowns, resulting in a loss of income and in some cases loss of permits.[120] According to interviewees, where refugees could not return to camps to receive resources and services,[121] they moved on to seek protection in third countries or returned to their country of nationality even though they feared persecution.[122]

Given the weight of evidence emerging on stigma and xenophobia, the evaluation team agreed to look at the issue in more detail through a thematic snapshot. See Thematic Snapshot 2.

109. UNHCR (2021), Global Trends in Forced Displacement 2020, www.unhcr.org/60b638e37/unhcr-global-trends-2020. In 2019, 952,800 were granted international protection, whereas in 2020 it was only 765,200, when the figure had been rising every year for close to a decade until then.

110. Isacson, Adam, "Weekly U.S.-Mexico Border Update: Mexico Pushes Back Asylum Seekers Attempting to Leave, Remain in Mexico's 'awkward' restart", WOLA, www.wola.org/2021/09/weekly-border-update-mexico-pushes-back-asylum-seekers-attempting-leave-remain-mexicos-awkward-restart/; In May 2022, the US has at last said it will end using Title 42 to expel migrants because of COVID-19. BBC (2022), "US to end policy expelling migrants over Covid", www.bbc.com/news/world-us-canada-60961420.

111. See also Jefferies, R., J. McAdam and S. Pillai (2021), Can we still call Australia home? The right to return and the legality of Australia's COVID-19 travel restrictions, Australian Journal of Human Rights, 27:2, 211-231, DOI: 10.1080/1323238X.2021.1996529.

112. Available at UNHCR (n.d.), Resettlement Data Finder (RDF), https://rsq.unhcr.org/en/#P6kg

113. Global Detention Project (2020), Annual Report 2020. See also, OHCRA (2020), Report of the Working Group on Arbitrary Detention to the Human Rights Council, paragraph 25, A/HRC/45/16.

114. UNHCR (2021), p.2, Global Trends in Forced Displacement 2020, www.unhcr.org/60b638e37/unhcr-global-trends-2020; See, more generally, UNHCR (2020), "Practical Recommendations and Good Practice to Address Protection Concerns in the Context of the COVID-19 Pandemic", https://reliefweb.int/sites/reliefweb.int/files/resources/75453.pdf.

115. See UNHCR (2021), 80th Meeting of the Standing Committee of the Executive Committee, Update on UNHCR's Operation in the Americas, p.1.

116. Bureau, Brigitte, (2020), "Immigration detention centres emptied over fear of possible Covid-19 outbreaks", CBC, www.cbc.ca/news/canada/montreal/immigration-detainees-released-covid-1.5795659.

117. See, Chew, V., Phillips, M. & Yamada Park, M. (2020), COVID-19 Impacts on Immigration Detention: Global Responses, International Detention Coalition and HADRI/Western Sydney University, https://doi.org/10.26183/swc5-fv98, https://idcoalition.org/wp-content/uploads/2020/10/COVID-19-Impacts-on-Immigration-Detention-Global-Responses-2020.pdf. See also, for example, UNHCR (2020), UNHCR Europe's Regional Update to the Executive Committee, 71st Session, p.3.

118. See 80th Meeting of the Standing Committee of the Executive Committee (2021), Update on UNHCR's Operation in the Americas, p. 1 regarding inadequate quarantine measures in Italy. See also UNHCR (2021), COVID-19 Emergency Response, Regional Bureau for Europe, Update #33, p. 2. On a more positive note, the same update reports that the Austrian Constitutional Court had ruled that a local degree limiting movement in the Traiskirchen reception centre "lacked legal basis and proportionality"; UNHCR partnered with the local asylum lawyers.

119. Key informant interviews with protection specialists in Bogotá. See also, UNHCR (2020), Report on UNHCR's Response to Covid-19, p.23, https://reporting.unhcr.org/document/706 – "UNHCR Colombia launched the online campaign Somos Panas to combat xenophobia and discrimination against refugees".

120. See, for example, Kebede, T.A., S.E. Stave and M. Kattaa (2020), "Facing Double Crises Rapid assessment of the impact of COVID-19 on vulnerable workers in Jordan: Assessing the impact of COVID-19 on labour markets in Arab States", ILO www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_743391.pdf

121. See also UNHCR (2021), Covid-19 External Update #31, East and Horn of Africa, and the Great Lakes Region, p.2, regarding how reopening of registration for new asylum seekers in Kenya allowed access to services in camps. Equally, urban refugees in Kenya could also access services in camps again. Without that and with no employment, they would have been forced to return to their country of nationality.

122. See UN General Assembly (2021), "Report of the Special Rapporteur on the human rights of migrants, Felipe González Morales, Report on means to address the human rights impact of pushbacks of migrants on land and at sea", paragraph 98, A/HRC/47/30, https://reliefweb.int/sites/reliefweb.int/files/resources/A_HRC_47_30_E.pdf.

Thematic Snapshot 2: Stigma, xenophobia, refoulement and access to information in the response to COVID-19

The COVID-19 pandemic has exacerbated negative perceptions about refugees and heightened discrimination towards people on the move. Refugees and other persons of concern have been stigmatised as carriers of the virus, leading to a rise in xenophobia in border areas and host communities.[123] According to the Global Protection Cluster, in Chad, DRC, Nigeria, South Sudan and Zimbabwe, suspected carriers of the virus face stigmatisation, xenophobia and socioeconomic vulnerability. UNHCR field monitoring indicates that since the start of the pandemic, there has been a rise in reports of xenophobic attacks in Egypt on refugees from the rest of Africa. In Uganda, the pandemic reduced livelihood opportunities and increased pressure on competition over already limited resources, which exacerbated tensions between refugees and host communities. In Iraq, there are reports of stigmatisation of families who may have COVID-19 in camps. At its outset, the Omicron variant caused more border closures for South Africans, and refugees and asylum seekers were singled out for both direct stigmatisation by states and indirect targeting by host communities. According to reports, police forces did little to prevent this targeting and UNHCR and its partners had limited access to intervene because they, too, were locked down.[124]

Refoulement occurs regardless of whether there is a pandemic, but governments have utilised health concerns to justify border closures and pushbacks. Equally, the inability to access government services because of lockdowns has meant that on occasions when documentation expired, persons of concern to UNHCR were detained and deported. Breach of lockdown regulations by persons of concern looking for the means to support themselves as socioeconomic conditions worsened also led to deportation.[125] Lockdowns meant that it was more difficult for UNHCR and its partners to intervene and when they did, they were sometimes ignored.

There is some evidence that xenophobia, stigmatisation and misinformation about refugees as carriers of disease obstructed access to humanitarian protection, intensified negative coping mechanisms among displaced populations and forced vulnerable people in irregular situations to undertake dangerous journeys.[126] Additionally, discrimination, xenophobia and increased risk of violence "are likely to further reduce [the willingness of persons of concern] to come forward for screening, testing and health care".[127] This limits global efforts to manage the

122. See UN General Assembly (2021), "Report of the Special Rapporteur on the human rights of migrants, Felipe González Morales, Report on means to address the human rights impact of pushbacks of migrants on land and at sea", paragraph 98, A/HRC/47/30, https://reliefweb.int/sites/reliefweb.int/files/resources/A_HRC_47_30_E.pdf.

123. Ibid. ; Regional Update on Asia and the Pacific at the 71st Session of the Executive Committee (2020), p. 1; Regional Update on the Americas at the 80th Session of the Standing Committee of the Executive Committee (2021), p. 5.

124. See Pugliese, Michela (2021), "the Omicron variant's concerning impacts on asylum seekers and migrants in Europe" EuroMed's Human Rights Monitor, https://euromedmonitor.org/en/article/4812/The-Omicron-Variant%E2%80%99s-Concerning-Impacts-on-Asylum-Seekers-and-Migrants-in-Europe.

125. See 80th Meeting of the Standing Committee of the Executive Committee (2021) , Update on UNHCR's Operation in the Americas, p. 1.

126. See IFRC (2020), Least Protected, Most Affected: Migrants and refugees facing extraordinary risks during the COVID-19 pandemic, p.3, https://reliefweb.int/sites/reliefweb.int/files/resources/IFRC-report-COVID19-migrants-least-protected-most-affected.pdf; See also, GPC (2020), COVID-19 Protection Risks & Responses, Situation Report No.7 as of 24 August 2020, www.globalprotectioncluster.org/2020/08/24/covid-19-protection-risks-responses-situation-report-no-7-as-of-24-august-2020/; see alsoError! Hyperlink reference not valid.: This 2020 UN Migration Report 2020 asserts that there was use of smugglers and traffickers throughout Africa, in Asia and in the Americas.

127. Guadagno, L., (2020), "Migrants and the COVID-19 pandemic: An initial analysis", IOM, https://publications.iom.int/system/files/pdf/mrs-60.pdf.

pandemic while safeguarding the rights of refugees (see Thematic Snapshot 1).

The use of social media to channel and amplify xenophobia towards refugees and disinformation about COVID-19 has been a global phenomenon.[128] In Colombia, the Barometro de Xenofobia (Xenophobia Barometer), a platform that systematises and disseminates analysis of conversations on social media about the Venezuelan population in Colombia, found that there was a 600% increase in xenophobic comments in August 2021 regarding security incidents that involved Venezuelans.[129] In other regions, misinformation was spread among host communities about refugees and asylum seekers that falsely accused them of spreading the virus.[130]

Tracking and combatting misinformation and rumours, as well as building trust among affected populations, has been an ongoing challenge during the pandemic. In the current complex communication environment, with multiple platforms (including social media, WhatsApp and others), communicating risk in a controlled and co-ordinated manner has proven to be difficult. Because of an increase in misinformation on social media and the rise of xenophobia against Venezuelans, UNHCR launched a WhatsApp information line for mass communication called Help Alto Commisariado de las Naciones Unidas para los Refugiados (ACNUR), or Help UNHCR, that provides information on a daily basis to registered users. The service offers information to refugees about the process to request refugee status in Ecuador, alternatives for regularisation, rights and obligations in the country, and access to services. The system works through a combination of automated responses constantly updated by UNHCR. Help ACNUR also refers users to specialised UNHCR staff when they need specific support –, for example, to report an incident of violence or abuse. In addition, in the framework of the regional response for Venezuelans (R4V) co-ordination platform, UNHCR and partners countered misinformation through an inter-agency social media package on COVID-19 vaccinations.

In Italy, Signpost, an information and engagement project by the International Rescue Committee and partners such as Google and Microsoft use Facebook to reach asylum seekers with information about essential services, answer questions from users, and dispel misinformation about COVID-19. In Cameroon, to ensure 24/7 access to information, a WhatsApp group was established as the main communication tool to share key messages on COVID-19-related issues. All community focal points, including from the host community, are members of this group and disseminate key messages to the communities.

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128. Debora, M. Covid-19 (2020), "The Pandemic that Never Should Have Happened, and How to Stop the Next One", The Bridge Street Press; Ittefaq, M., M. Abwao, A. Baines, G. Belmas, S. A. Kamboh, E.J. Figueroa, (2022), "A pandemic of hate: Social representations of COVID-19 in the media", Analyses of Social Issues and Public Policy, https://spssi.onlinelibrary.wiley.com/doi/10.1111/asap.12300.

129. See Barametro de Xenofobia (2021), Boletín mensual barómetro de xenofobia en Colombia, http://barometrodexenofobia.org/wp-content/uploads/2021/09/Boleti%CC%81n-12-Colombia-BX.pdf.

130. See OECD (2020), "How best to communicate on migration and integration in the context of COVID 19", OECD Policy Responses to Coronavirus (COVID-19), www.oecd.org/coronavirus/policy-responses/how-best-to-communicate-on-migration-and-integration-in-the-context-of-covid-19-813bddfb/; See also, Howard, S., and G. Krishna (2022), "The world's refugees remain last in line for covid-19 vaccines", BMJ, 376:703, http://dx.doi.org/10.1136/bmj.o703

Social media and other communication platforms have also been harnessed to combat xenophobia against persons of concern. The Xenophobia Barometer (Barometro de Xenofobia) aims to influence social media and counter negative messaging and xenophobia towards both refugees and migrants, using an anti-xenophobia kit and a methodology called Tu Bandera es Mi Bandera (Your Flag is my Flag).[131] Similarly, UNHCR's Somos Panas (We are Buddies) Colombia campaign encouraged solidarity towards Venezuelans. With UNHCR support, Migración Colombia, the country's border control agency, designed a programme in September 2020 of workshops aimed at preventing and reducing xenophobia among immigration officials and local authorities and workshops on international protection.

As part of a UNHCR initiative with the Volunteer Association for International Service (Brazil), Venezuelan refugees and migrants in the Brazilian city of Boa Vista are fighting misinformation with a community podcast. In a radio station set up in a refugee shelter, 11 volunteers record podcasts answering questions from the community about COVID-19, documents, access to rights and services, employment, and other topics.

Fighting misinformation can be challenging in places that lack digital infrastructure.[132] But refugees in Cox's Bazar in Bangladesh use rickshaws, bicycles and loudspeakers to deliver accurate information door to door.[133] In northwest Uganda, the Youth Social Advocacy Team, a refugee-led organisation, tackled misinformation and communicated measures to stop the spread of COVID-19 in Rhino Camp Refugee Settlement. Alight, formerly known as the American Refugee Committee, has supported refugee-led initiatives such as health messaging and combatting misinformation about COVID-19.[134]

Although it contributed to countering misinformation and disinformation, the provision of adequate information on protection and other services presented a distinct challenge. Surveys showed that while refugees progressively had better information on COVID-19, information on access to services was lacking. In some cases, agencies were not able to provide timely information on protection-related services because information was not available from governments. Providing accurate information in a rapidly changing environment was a challenge, and best practice included recognising the importance of timestamping information for accuracy.

In some instances, competition among agencies to lead on information and communication efforts has been problematic. Access to information has been more effective where co-ordination and solid, accountable live communication flows were in place. Innovation has also been positively leveraged in certain contexts, with WhatsApp and chat bots used

to better communicate with refugees and respond to their information needs. Overall, while the focus of the response to the pandemic is largely on health-related information and risk communication, protection-related information is also important for refugees and requires a strong, concerted inter-agency effort.

Official information has been in competition with misinformation and rumours, which often circulate knowledge of authorities and aid agencies. Reports cite a refugee preference for in-person or door-to-door communication in most camp contexts. Some countries have seen the extensive use of traditional mass media such as television and national radio, particularly as these are sources more commonly used by refugees in non-camp settings.

As is the case across all themes, the digital divide is a significant challenge. Most information is disseminated via internet-based media. Especially vulnerable people with less ready access to technology were less likely to receive critical information about access to protection, health and social services, and COVID-19 services. Alongside affordability barriers and lack of digital skills, cultural and social barriers further reveal a significant gender and disability gap in mobile phone ownership and usage in many low and middle-income countries.

131 See Barametro de Xenofobia (n.d.), Boletín mensual barómetro de xenofobia en Colombia, http://barometrodexenofobia.org/involucrate.

132. See The United Nations Department of Global Communications (DGC) (2020), "Battling COVID-19 misinformation hands-on", www.un.org/en/battling-covid-19-misinformation-hands.

133. IOM (2020), "Rohingya Cyclists Share Key COVID19 Information Door to Door in Cox's Bazar Refugee Camps", www.iom.int/news/rohingya-cyclists-share-key-covid19-information-door-door-coxs-bazar-refugee-camps

134. See ALIGHT (n.d.), Community-led coronavirus response in nakivale refugee settlement, https://wearealight.org/community-ty-led-coronavirus-response-in-nakivale-refugee-settlement/.

4.2.2 Adaptive measures for the asylum-related services of registration and documentation and refugee status determination

There are multiple examples of adaptation by protection actors and governments, particularly in response to lockdowns and border closures. In the absence of access to people seeking international protection, UNHCR and partners along with national authorities adopted remote management tools for community outreach, registration, status determination and resettlement processing. With support from UNHCR and other actors, community-based protection initiatives have supported refugees in their role as frontline responders.[135] Online awareness campaigns, hotlines for accessing services and remote monitoring, remote case management, and remote interviewing are other successful examples of adaptation during the COVID-19 pandemic. The use of digital technology also supported protection actors in countering access challenges. For example, UNHCR piloted contactless biometrics through an iris scanner to register refugees and verify beneficiaries' eligibility for cash assistance in South Asia and East Africa.[136]

Registration and documentation

Lockdowns and other movement restrictions (affecting most UNHCR staff) meant that refugees and asylum seekers could not readily acquire or renew their registration and documentation. In some countries, particularly in those states that have not ratified the 1951 Convention or 1967 Protocol, this placed them at greater risk of deportation and refoulement. The 1951 Convention provides no guidance to states on how to institute refugee status determination (RSD) within their domestic systems.[137] Access to all services, however, including RSD, depends on the initial step of registration and documentation by state authorities and UNHCR. Irregular entry to a country of asylum after the closure of borders implied the loss of opportunities to access registration and documentation.[138]

In those countries where there were lockdowns making renewal not possible, UNHCR advocated for extensions to the validity of expired documents.[139] This had some limited success in capital cities, although it is not possible to verify if this guidance filtered down to security forces in remote areas. With UNHCR staff under travel restrictions, it is likely that there were more expulsions during the pandemic.[140] Nevertheless, there have been some improvements more recently.[141] In Peru, for instance, a new method of access to the registration system enabled a greater number of asylum seekers to process the virtual work authorisation. The government of Peru continues to implement a regularisation procedure for those in an irregular situation, which is also available for asylum seekers, and a humanitarian residency permit for asylum seekers.[142]

135. UNHCR (2021) Executive Committee of the High Commissioner's Programme, Seventy-second session, Update on UNHCR's Operations in Asia and the Pacific, p. 1.

136. UN (2020), Global Humanitarian Response Plan Covid-19 Progress Report: Third Edition, p.6.

137. Paragraph 189 of the 1979 UNHCR Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees states that the determination of refugee status "is not specifically regulated. In particular, the Convention does not indicate what type of procedures are to be adopted for the determination of refugee status. It is therefore left to each Contracting State to establish the procedure that it considers most appropriate, having regard to its particular constitutional and administrative structure". UNHCR (1979), Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees, www.unhcr.org/4d93528a9.pdf.

138. Lack of registration and documentation also calls into question the validity and verifiability of the data on which analysis of the performance by the international community is based.

Adapted practices in registration and documentation made it possible for countries to mitigate the consequences of the COVID-19 pandemic for persons of concern in their territory.[143] Countries across all the regions extended the duration of visas and residence and work permits to prevent refugees and other persons of concern from falling into an irregular status. Some facilitated access to the labour market in essential services and regularised undocumented migrants, moves that helped refugees and asylum seekers as well; some released refugees and asylum seekers from detention or suspended forced returns.[144] In other countries, whether the extension was automatic or not was dependent upon the nature of the person's documentation and migratory status.[145] That said, given state obligations under Articles 32 and 33.1 of the 1951 Convention, no refugees should have been deported simply because their documentation was out of date.

Other than in Bangladesh, where nearly every refugee is a Rohingya, the refugee populations in the various countries in Asia are from diverse backgrounds. Hence, information needs to be translated to ensure access to services and protection in many forms.[146] UNHCR was able to share translations across the region. The challenge was to provide timely information while ensuring that announcements applied to refugees as much as they did to nationals, that these accurately reflected the situation of non-nationals and that official announcements were translated with a clear understanding of the law. As few states in the region have ratified the 1951 Convention and many may not have domestic legislation that distinguishes refugees from any other foreign migrant, refugee specific information was not common. Furthermore, because translations take time, there may well have been delays in ensuring that refugees were aware of the relevant rules. Access to internet services was an issue for some refugees,[147] and television and radio were equally inaccessible in some contexts. In some cases, the best way of informing refugees about access to protection was via refugee-led organisations that moved around refugee settlements with loudspeakers, to the extent that was possible.

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139. Adaptation to renewal via the internet was not possible where the paper documentation was watermarked to prove it was not a forgery.

140. For more on protection by presence, see GPC (2020), COVID-19 Protection Risks & Responses, Situation Report No.7 as of 24 August 2020, www.globalprotectioncluster.org/2020/08/24/covid-19-protection-risks-responses-situation-report-no-7-as-of-24-august-2020/; Mooney, E.D. (1995), "Presence, ergo protection? UNPROFOR, UNHCR and the ICRC in Croatia and Bosnia and Herzegovina", International Journal of Refugee Law, 407-35.

141. On 15 October 2021, UNHCR received a report from the government of Rwanda that about 10 893 refugee ID cards were produced. Distribution started from 1 November 2021. UNHCR (2021), Global Protection Brief, #31.

142. So far, 185 000 people have applied for regularisation and approximately 70 000 permits have been printed. In addition, 59 790 persons have been sent a resolution by the Ministry of Foreign Affairs confirming they have been issued a humanitarian residency permit. UNHCR (2021), Global Protection Brief, #31.

143. WHO (2021), Refugees and migrants in times of Covid-19: mapping trends of public health and migration policies and practices, p. 12.

144. WHO (2021), Refugees and migrants in times of Covid-19: mapping trends of public health and migration policies and practices, p. 13. In Portugal, in light of present difficulties to obtain or renew necessary documents, the government decided to extend the validity of all documents that expired after 24 February 2020 until at least 30 June 2020, including those related to the asylum status and residence permits. Similarly, in Ireland, permissions that are due to expire before 20 May are automatically renewed for a period of two months on the same conditions. In Italy, stay permits that expired between 31 January and 15 April, were valid until 15 June 2020. Poland has also taken exceptional measures to extend residence permits that were due to expire. See "Practical Recommendations and Good Practice to Address Protection Concerns in the Context of the COVID-19 Pandemic", https://reliefweb.int/sites/reliefweb.int/files/resources/75453.pdf.

145. WHO (2021), "Refugees and migrants in times of Covid-19: mapping trends of public health and migration policies and practices", p. 12.

146. See Howard, Sally and Geetanjali K. (2022), "The world's refugees remain last in line for covid-19 vaccines", http://dx.doi.org/10.1136/bmj.o703,

147. See also, UNHCR (2022), UNHCR Asylum Capacity Development (ACD) Evaluation – An Independent Evaluation of UNHCR's Support for Strengthening National Asylum Systems (draft, 2022).

Refugee status determination and backlogs

Across regions, access to RSD was obstructed by COVID-19 mitigation measures, which also had negative effects on the functioning of states' asylum systems and contributed to the creation of backlogs.

Remote interviews were also quickly adopted, especially remote RSD,[148] but these did not offer the same level of support as face-to-face contact. Given that movement was restricted during the pandemic, there were fewer people seeking refugee status. But even where they could do so, lockdowns meant that services were initially unavailable, even where UNHCR carried out RSD on behalf of a government. Adaptive measures were adopted for remote RSD that relied on refugee connectivity and the availability of an interpreter to join a three-way conversation. Pre-pandemic, interviews would have been in person and UNHCR staff could more clearly empathise and support the refugee. Nuances of conversations, even through an interpreter, are easier to recognise in person; remotely, with no guarantee that a connection could last, this is more challenging.

There are fears that compromised confidentiality put refugees, and especially those with specific needs, at greater risk. It was not certain that refugees could report their situation if they were speaking on a phone in front of other family or community members. Interviewees also cited additional risks such as the use of remote interpreters and the risks around their ability to ensure confidentiality.

UNHCR adapted in other ways, too, including using plexiglass screens for socially distanced, in-person interviews where movement was permitted. It took longer for governments to adopt such measures, but there is evidence that UNHCR's advocacy and financial support, especially in East Africa, facilitated access to RSD services. On the other hand, an interviewee stated that in several countries, even where in-person access had recommenced, governments had not prioritised RSD.

Finally, the pandemic added to the already-present backlog of RSD cases. One of the ongoing aspects that will continue to require monitoring is whether states retain the restrictive and/or remote processing even as the intensive lockdowns are phased out.

4.3 Child protection

This subsection looks at measures to protect children, particularly focusing on the consequences of the pandemic on refugee children, agency co-ordination and guidance for child protection (co-ordination, coherence), and adaptation of service delivery (relevance).

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

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148. See UNHCR (2020), Regional Bureau Europe Remote Interviewing: Practical Considerations for States in Europe during COVID-19 https://data2.unhcr.org/en/documents/details/77134.

4.3.1 Consequences of the COVID-19 pandemic

Lockdowns and emergency movement restrictions had severe consequences for refugee children, adolescent girls and their families.[149] **The pandemic has also had widespread psychosocial impacts on the lives and well-being of children** due to confinement measures and school closures. [150] Violence in the home against children has been rising globally since the start of the lockdowns, linked in part to confinement measures and school closures. [151]

The pandemic has affected the schooling of 1.5 billion students worldwide.[152] The closure of schools resulted in severe consequences for the protection, well-being and development of children, including refugee children and most notably girls. Prior to the pandemic, refugee children were often the most economically deprived and twice as likely to be out of school than other children.[153] As a result of the COVID-19 pandemic, access to education has been further affected by a lack of inclusion of refugee children in alternative schooling plans proposed by national authorities.[154] There are multiple obstacles to refugee children's access to remote learning solutions, including a general lack of access to technology such as mobile phones and/or computers and to internet connectivity as well as language barriers.

These challenges led to a widening of existing educational inequities and levels for all refugee children and especially girls and children with disabilities, who were at increased risk of being left behind as measures to support home-based learning fell short of their learning needs.[155]

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149. UNHCR (2020), Protecting Forcibly Displaced Children during the Covid-19 Pandemic, UNHCR Response and Field Practice, pp. 1-2; Child Protection Alliance (2020), Covid-19 SYNTHESIS #5: Children refugees, internally displaced persons (IDPs) and/or forced migrants, p. 4; OCHA (2020) Global Humanitarian Response Plan Covid-19, United Nations Coordinated Appeal, April-December 2020, p. 13.

150. In a 2020 global survey commissioned by Save the Children, 83% of children and young people and 89% of caregivers reported an increase in negative feelings, which increased as schools remained closed for periods of 17 to 19 weeks. Nearly half of parents surveyed (46%) reported seeing signs of psychological distress in their children, including changes in sleep and appetite and in how they handled their emotions, as well as more frequent aggressive behaviour, all of which increased in the weeks following the school closures. See Save the Children (2020), The Hidden Impact of Covid-19 on child protection and wellbeing, https://resourcecentre.savethechildren.net/pdf/the_hidden_impact_of_covid-19_on_child_protection_and_wellbeing.pdf/; INEE and The Alliance (2021), Evidence Paper, No Education, No Protection. What school closures under COVID-19 mean for children and young people in crisis-affected contexts, The Alliance for Child Protection in Humanitarian Action, p. 17.

151. While these are not exclusively focused on refugees, the findings are applicable. Data from a global survey provide evidence of an increase in harmful or violent parenting methods, as reported by 22% of the caregivers surveyed; a further 32% of all participants reported that physical and/or verbal abuse had occurred within the home, and that children and young people who were out of school reported experiencing higher rates of abuse. Save the Children (2020), The Hidden Impact of Covid-19 on child protection and wellbeing, https://resourcecentre.savethechildren.net/pdf/the_hidden_impact_of_covid-19_on_child_protection_and_wellbeing.pdf/

152. Although education is not a direct focus of this evaluation, the impact of COVID-19 and the closure of schools highlight the importance of and close links between education and the protection of children; INEE and The Alliance (2021), Evidence Paper, No Education, No Protection. What school closures under COVID-19 mean for children and young people in crisis-affected contexts, The Alliance for Child Protection in Humanitarian Action, p. 11.

153. UHNCR (2020), Coming Together for Refugee Education, p. 5.
154. Child Protection Alliance (2020), COVID-19 SYNTHESIS #5: Children refugees, internally displaced persons (IDPs) and/or forced migrants, p. 1; INEE and The Alliance (2021), Evidence Paper, No Education, No Protection. What school closures under COVID-19 mean for children and young people in crisis-affected contexts, The Alliance for Child Protection in Humanitarian Action, p. 9.

155. Executive Committee of the High Commissioner's Programme (2021), Note on International Protection.

Separation of refugee children from their families has increased and has prolonged due to disrupted family tracing and reunification services following restrictions on movements and border closures. Children, including unaccompanied and separated children, have been returned to their home countries without any individual assessment. There are cases of children having been stranded in border areas unable to return home, at risk of refoulement or serious harm.[156] In addition, children were often separated from primary caregivers due to quarantine or confinement measures and facing increased risk of neglect and abuse and suffering mental health and psychosocial impacts. [157]

Child labour, already a widespread problem for refugee children prior to the pandemic, has likely increased significantly. No comprehensive data exist to provide a complete and accurate picture of child labour in 2020, and specifically data on child labour among refugee children. But the International Labour Organization estimates that an additional 66 million children will be engaged in work during the COVID-19 pandemic as their households try to survive. In addition to having limited access to formal education and fewer opportunities for remote learning, refugee children face a higher risk of abandoning their education to enter into child labour.

Child marriage also emerged as a global concern as a result of closure of schools during lockdowns.[159] In March 2021, UNICEF concluded that the pandemic may result in 10 million more girls being put at risk of child marriage globally. Examples cited include countries in the Sahel and Jordan. [160] [161]

156 UNICEF (2021), Child Protection Learning Brief #5, p. 4; Child Protection Alliance (2020), COVID-19 SYNTHESIS #5: Children refugees, internally displaced persons (IDPs) and/or forced migrants, pp.8-9; UNHCR (2020), Protecting children during the COVID-19 pandemic: prevention and response Child Protection Unit.

157 The Alliance for Child Protection (2020), Children, Isolation and Quarantine: Preventing Family Separation and Other Child Protection Considerations during the COVID-19 Pandemic.

158. INEE and the Alliance (2021), Evidence Paper, No Education, No Protection. What school closures under COVID-19 mean for children and young people in crisis-affected contexts, The Alliance for Child Protection in Humanitarian Action, p. 9, pp. 26-27 and, p. 30; COVID-19 and child labour in Lebanon, Plan International Lebanon, 2020.

159 Abwola, N. and I. Michelis. (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls" International Rescue Committee, p. 4; Child Protection Alliance (2020), COVID-19 SYNTHESIS #5: Children refugees, internally displaced persons (IDPs) and/or forced migrants, p.3; UNHCR (2021), Note on International Protection. EC/72/SC/CRP.10, pp. 6-7; Nyamweya, N. (2020), "Displacement, Girl's Education and Covid-19", GPE; UNHCR (n.d.), Staying the Course, The Challenges Facing Refugee Education, www.globalpartnership.org/blog/displacement-girls-education-and-covid-19; UNHCR (2020), Impact of COVID-19 on the Protection of Displaced and Stateless Populations, West and Central Africa.

160. UNICEF (2021), 10 million additional girls at risk of child marriage due to COVID-19, www.unicef.org/press-releases/10-million-additional-girls-risk-child-marriage-due-covid-19; Protection 21 (P21), a harmonised regional protection monitoring system for the central Sahel countries, showed that child marriage is one of the most significant GBV concerns reported among populations on the move, affecting 21 % of those being monitored; UNHCR (2021), Update on UNHCR's Operations in West and Central Africa, p.5; Protection 21 (P21), a harmonised regional protection monitoring system for the central Sahel countries, showed that child marriage is one of the most significant GBV concerns reported among populations on the move, affecting 21 % of those being monitored; UNHCR (2021), Update on UNHCR's Operations in West and Central Africa, p.5; The Jordanian Humanitarian Fund annual report for 2020 noted concerns related to increases in child marriage among refugee girls. OCHA (2020), Jordan Humanitarian Fund 2020 Annual Report, p. 8.

161.In the Azraq camp in Jordan, 2 out of 13 marriages were child marriages (15%) in June 2019. In June 2020, 8 out 14 marriages there were deemed as child marriages (57%). In July 2020, out of a total of 17 marriages registered in Sharia court, 13 were child marriages (76%). See UNICEF (2021), Child Marriage In The Context of Covid-19: Analysis of trends, programming and alternative approaches in the Middle East and North Africa, p. 15. www.unicef.org/mena/reports/child-marriage-context-covid-19. Notably, however, in research undertaken in the West Bank and Gaza Strip, only a small minority of adolescent respondents (2.9%) reported that they were concerned about being pressured to marry earlier because of the pandemic, with some (7.7%) feeling that pressure to marry as children had decreased. See Jones, N. et al., (2021) 'Some got married, others don't want to attend school as they are involved in income-generation': Adolescent experiences following covid-19 lockdowns in low- and middle-income countries. Gender and Adolescence: Global Evidence, p. 27. Similar findings in research with Rohingya refugee girls found that only 19% of older adolescent girls (and 11% of boys) worried about marrying earlier, with these girls noting that pressure to marry has decreased since the COVID-19 pandemic. See Guglielmi et al. (2020), "Exploring the impacts of Covid-19 on Rohingya adolescents: A mixed-methods study" Journal of Migration and Health vol. 1-2, p. 5 https://doi.org/10.1016/j.jmh.2020.100031. This underscores the importance of contextual analysis in understanding the level of risk for child marriage related to the impact of the pandemic.

4.3.2 Agency co-ordination and guidance notes

A key example of agencies co-ordinating on child protection focused on the inclusion of refugee children into national child protection systems, social services, education and birth registrations. The Blueprint for Joint Action for Refugee Children, led by UNICEF and UNHCR,[162] aimed to improve the capacity of national actors to better plan, finance, co-ordinate and ultimately deliver quality services for all children, regardless of their status. Despite these efforts, concerns remain around the access of children on the move to national child protection systems, including education, healthcare and social protection.[163]

Collaboration and joint advocacy among international actors were a key factor in the reprioritisation of child protection services. Advocacy efforts focused on resuming child protection interventions and considered these as essential services. For example, the Alliance for Child Protection and the Child Protection Area of Responsibility together with the Inter-Agency Network for Education in Emergencies developed a joint advocacy strategy for the reopening of schools. In June 2020, a group of international civil society organisations and child-focused agencies issued an open letter highlighting the importance of holistic COVID-19 response plans to ensure the protection and well-being of children. The letter also placed specific emphasis on particularly vulnerable groups of children, including refugee children, who were facing increased risks as a result of the pandemic. [164]

Technical notes were produced to ensure that minimum standards of child protection were upheld during the pandemic. UNICEF, UNHCR and members of the Alliance for Child Protection were involved in the development of technical guidance notes, including the use of Minimum Standards for Child Protection in Humanitarian Action during COVID-19 and other infectious disease outbreaks.[165] At the global level, a guidance note for identification, family tracing and reunification of unaccompanied and separated children in the context of COVID-19 was developed and endorsed to provide technical support for staff at field level.[166] In many cases, guidance came in the form of practical guidance notes to be adapted and contextualised at field level and issued to support staff in the field.

In addition, a series of global webinars were organised by the Alliance, including three webinars co-hosted by UNHCR. [167] UNHCR also developed an online course on adapting child protection case management in the context of the pandemic that aimed to provide practical guidance and peer exchange on key approaches to respond to the protection needs of individual children at risk.

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162. The Blueprint was launched shortly before the start of the pandemic, aligning with the Global Compact on Refugees. See UNHCR-UNICEF (2021), Blueprint Indicator Overview.

163. UNICEF (2021), Child Protection Learning Brief, #5, Protecting children on the move during infectious disease outbreaks: Lessons from UNICEF's Covid-19 response, pp. 5-6.

164. Open Letter from International Civil Society Organisations and Child-Focused Agencies, June 2020. The Alliance for Child Protection in Humanitarian Action (2019), Unprotected, Crisis in humanitarian funding for child protection, Child Protection Area of Responsibility, Save the Children International.

165. See The Alliance for Child Protection in Humanitarian Action (2020), 2019 CPMS and COVID-19, www.alliancecpha.org/en/system/tdf/library/attachments/2019_cpms_and_covid_19_v3.pdf?file=1&type=node&id=38091. And, UNHCR (2020), Protecting Children During the Covid-19 Pandemic, Prevention and Response, Child Protection Unit.

166. See The Alliance for Child Protection in Humanitarian Action (n.d.), Protection of Children During The Covid-19 Pandemic, www.alliancecpha.org/en/series-of-child-protection-materials/protection-children-during-covid-19-pandemic.

167. Webinars on child protection and COVID-19; considerations for refugee settings, the adaptation of case management, and alternative care, reaching high levels of participation.

4.3.3 Decline in coverage for child protection

By the end of 2020, child protection actors were reporting a serious decline in coverage. In a survey in December 2020, out of 159 UNICEF country offices, 50% reported that refugees and asylum seekers were not covered under COVID-19-related government social protection measures and 36% of country offices reported reduced protection services for migrant and displaced children.[168]

Exacerbated by the impact of COVID-19, funding per beneficiary falls short of what is needed to achieve the Minimum Standards for Child Protection in Humanitarian Action. In 2020, UNHCR and the Alliance for Child Protection in Humanitarian Action published a report highlighting the systematic underfunding of child protection in humanitarian settings that had been made worse by COVID-19.[169] As humanitarian response plans were revised to address the impact of COVID-19 and measures put in place to limit the spread of the disease, the number of children identified as in need of protective interventions has increased significantly.

As was the case with gender-based violence, a small proportion of funding requested through the Global Humanitarian Response Plan (GHRP) was for child protection and not all of this was funded. Child protection accounted for 2% of the overall requested funding, but only 0.8% of the funds was received. [170 .171] In 2020, child protection included in the GHRP received only 32.2% of the requested funding. In order to respond to the pandemic, some UNHCR operations reviewed their planned projects, reprioritising activities and, where possible, reallocating funds towards child protection responses during the pandemic.[172]

4.3.4 Adaptation of child protection services

Following the outbreak of COVID-19, global child protection actors rapidly shifted towards adapted service delivery. Quick and creative adaptations made it possible to maintain contact with children and families that otherwise would have been lost. [173] Remote case management was implemented mostly for children and families at low and medium risk, while face-to-face support and home visits for high-risk cases were continued where possible or were resumed shortly after the strictest lockdowns ended.

Country-specific guidanceto ensure that the most critical child protection cases are identified and monitored were revisited and updated by UNHCR and its partners.[174]

In various countries – among them, Egypt, Ethi-

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168. UNICEF (2020), Protecting Children from Violence in the Time of Covid-19: Disruptions in prevention and response services, pp 8-9.

169. This UNHCR report builds on analysis undertaken in 2019 and documented in the 2019 report, Unprotected: Crisis in Humanitarian Funding for Child Protection and incorporated 2019 and 2020 funding and additional funding streams related to refugee contexts. See UNHCR (2020), Still Unprotected: Humanitarian Funding for Child Protection, www.unhcr.org/en-us/protection/children/5fb3d1f54/still-unprotected-humanitarian-funding-child-protection-2020.html.

170. A total of USD 39 314 262 was requested and USD 12 790 676 has been raised. OCHA (2020), Global Humanitarian Response Plan Covid-19, United Nations Coordinated Appeal, (April- December 2020).

171. In the subchapter on response gaps and challenges in the GHRP (April-December 2020), child protection has not been covered. There is only a reference between brackets to unaccompanied and separated children.

172. UNHCR (2020), Protecting Forcibly Displaced Children during the Covid-19 Pandemic, UNHCR Response and Field Practices, p. 4.

173. The Alliance for Child Protection in Humanitarian Action (n.d.), Protection of Children during the Covid-19 Pandemic, www.alliancecpha.org/en/series-of-child-protection-materials/protection-children-during-covid-19-pandemic

174. UNHCR (2020), Protecting Children During the COVID-19 Pandemic: Prevention and Response, p. 11.

opia, Kenya, Lebanon, Pakistan, Tanzania and Uganda – UNHCR and partners worked to strengthen the role of community case workers through trainings on basic identification of child protection concerns, referrals and safety of interventions. In Bangladesh, UNICEF partners collaborated with community-based structures to provide information and raise awareness in refugee camps on child protection concerns. [175]

In some countries, remote support and monitoring of unaccompanied and separated children in alternative care arrangements (e.g. foster care or supported independent living arrangements) continued through phone calls and community volunteers. In Ethiopia and Ukraine, UNHCR scaled up community engagement and cash-based emergency assistance to unaccompanied children or their foster families to cover basic needs and also as a measure to prevent secondary separations. In Algeria and Egypt, UNHCR and partners distributed cash-based assistance and essential non-food items via mobile units to unaccompanied children living on their own.[176]

Some countries focused on increasing the number of social workers while adapting case management tools and reflecting new risks that children face due to the pandemic. For example, in Ethiopia, UNICEF supported the recruitment and training of 41 additional social service workers who were stationed at air and land ports to assist with the reunification and reintegration process of unaccompanied children being returned to the country. Between March and December 2020, UNICEF provided 141 refugee children with reunification and alternative care support in Ethiopia. [177]

In the context of widespread border closures, forced returns, and large movements of both migrants and refugees, UNHCR and UNICEF moved the best interests determination (BID) panel meetings online to ensure decision-making procedures continued, particularly for cases involving unaccompanied and separated children.[178] Online inter-agency BID panel meetings in Morocco and Turkey were supported by UNHCR to take critical and timely decisions for children and to provide them with case management support in accordance with their needs.

At the global level, UNHCR developed simple messages for children and caregivers on different protection issues in the context of COVID-19. Various actors developed and disseminated mental health and psychosocial support messages for children and their caregivers to help strengthen coping mechanisms and parental skills during the pandemic and lockdowns.[179] In Bangladesh, UNICEF and its partners delivered community messaging to children and caregivers when digital or phone options were not possible. The mental health and psychosocial support working group for Cox's Bazar developed audio-recorded awareness-raising material for children, delivered by bicycle through UNICEF's partners.

175. UNICEF (2021), Child Protection Learning Brief #4. Continuity through change: Adapting programmes and services to ensure protection of children during COVID-19, p. 15.

176. UNHCR (2020), Protecting Forcibly Displaced Children during the Covid-19 Pandemic: UNHCR Response and Field Practices, pp. 4-5.

177. UNICEF (2021), Child Protection Learning Brief #5. Protecting children on the move during infectious disease outbreaks: Lessons from UNICEF's COVID-19 Response, p. 3.

178. UNICEF (2021), Child Protection Learning Brief #5. Protecting children on the move during infectious disease outbreaks: Lessons from UNICEF's COVID-19 Response, p. 3.

179. UNHCR (2020), Protecting Forcibly Displaced Children during the Covid-19 Pandemic: UNHCR Response and Field Practices, p. 2. "My Hero is You: Storybook for Children on Covid-19" is an example of a storybook that aims to help children manage emotions and feelings and contains supplementary activities. The Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings the book through close involvement of children and caregivers and published it in 2020. Save the Children (2020), Key Messages and Considerations for Programming for Children Associated with Armed Forces or Armed Groups During the COVID-19 Pandemic.

Child protection helplines have reported a higher number of calls globally.[180] Research was undertaken to also inform and optimise the functioning of helplines for children and families, and laptops and other equipment were provided to expand communication via helplines.[181] In Jordan, Iraq, Morocco and Panama, among others, UNHCR and partners expanded helpline services by redeploying staff to call centres as a means of increasing staffing to provide advice and guidance to children and their families and to refer children to case management services when necessary. UNICEF and its partners also supported the set-up or expansion of helplines in various countries including Algeria, Bulgaria, Mauritania, Tunisia and several Gulf states.

Birth registration of new-born babies of refugee families was temporarily disrupted in a number of countries, leading to risks of statelessness.[182] Advocacy and collaborative efforts with the relevant authorities, supported by UNHCR, aimed to maintain birth registration procedures in refugee settings. In Lebanon and in the Dadaab camp in Kenya, adaptations included remote birth registration through information provision and phone calls. [183]

In countries where refugee children and youth were included in national response plans, there were efforts to ensure the continuation of learning during school closures through television and community radio broadcasting, digital platforms, small group tutoring sessions and self-study packs in low-resource contexts.[184]

Through the aforementioned Blueprint for Joint Action for Refugee Children, over half a million children were successfully enrolled in school. The partnership also reached more than 168 000 children and youth with individual education learning materials through nationally supported systems in Bangladesh, Cameroon, Ecuador and Iraq. In addition, UNHCR and UNICEF engaged jointly on advocating for the safe reopening of schools and expanding digital connectivity to schools in refugee-hosting areas. UNHCR assisted 934 000 students in 74 countries to follow distance and home-based learning. Continuity in education during school closures helped protect refugee children and youth and offered alternatives to negative coping mechanisms affecting their safety and well-being.[185]

Limitations of adaptations to service delivery

Although there have been huge efforts to provide remote child protection support, there remain significant limitations in the identification of children at risk as well as challenges regarding the safe delivery of specialised services by phone or other means. There are recognised limitations regarding the effective identification of children at risk as well as a lack of monitoring and direct

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180. Alliance for Child Protection in Humanitarian Action Inter-agency Network for Education in Emergencies. No Education, No Protection. What school closures under Covid-19 mean for children and young people in crisis-affected contexts. Evidence Paper, pp. 25-26.

181. Protecting Forcibly Displaced Children during the Covid-19 Pandemic, UNHCR Response and Field Practices, July 2020, p. 3.

182. UNHCR (2019), Protecting Children during the Covid-19 Pandemic: Prevention and Response.

183. Information provided through UNHCR dashboards in 2020-21.

184. It is important to stress that refugee children and youth have generally less access to technology and resources that would allow them to access remote learning.

185. Executive Committee of the High Commissioner's Programme (2021), Note on international protection; UNHCR and UNICEF (2021), Blueprint Indicator Overview.

support that impacts the safeguard measures for the delivery of services. In line with minimum standards for child protection, well-funded and well-supported in-person programming delivered by qualified, professional staff remains crucial.

While there are numerous examples of good practices regarding remote adaptation, access to technology including mobile phones, computers or internet connectivity and reliable electricity remained out of reach for many. All interviewees noted that one of the biggest challenges remains working remotely in low-tech areas, as it is nearly impossible to continue services and to reach children remotely. In a December 2020 survey, 58% of UNICEF country offices surveyed reported inadequate remote learning options for vulnerable child populations, including those living as refugees, migrants or internally displaced.[186] Language barriers sometimes prevent access to available remote learning solutions. Children with disabilities have been particularly at risk of not having their learning rights and needs fulfilled. [187]

4.4 Gender-based violence

This subsection looks at GBV, focusing on the increase of GBV during the pandemic; country-level co-ordination; advocacy to reinstate protection against GBV as essential (coverage, access), with a thematic snapshot on GBV

funding; and preparedness and adaptation measures (relevance).

4.4.1 Consequences of the COVID-19 pandemic

There has been significant attention to the problem of GBV, particularly intimate partner violence, escalating globally because of the social impacts of COVID-19. [188] This risk may be heightened among displaced women and girls. For example, a recent World Bank report found that displaced women and girls in Colombia and Liberia were 40-55% more likely than girls in host communities to experience intimate partner violence.[189] Research with Afghan, Palestinian and Syrian refugee women highlighted the gravity of intimate partner violence against women and adolescent girls in lockdown. [190]

Sexual violence such as harassment, exploitation and assault is another form of gender-based violence identified in regional and country-level research among refugee populations affected by COVID-19. In focus group discussions with refugee and internally displaced women and girls in 15 African countries, 51% of noted increased sexual violence as a concern linked to COVID-19. These women reported sexual harassment and assault by

186. UNICEF (2020), COVID-19 has led to dramatic reduction in essential services and protection for migrant and displaced children in countries around the world, www.unicef.org/press-releases/covid-19-has-led-dramatic-reduction-essential-services-and-protection-migrant-and

187. Grandi, F. (2022), Internet and Mobile Connectivity for Refugees – Leaving No One Behind - UNHCR Innovation, www.unhcr.org/innovation/internet-mobile-connectivity-refugees-leaving-no-one-behind/

188. According to a 2020 report for the International Rescue Committee, 73% of female refugees and internally displaced persons interviewed across 15 countries in Africa reported that lockdown measures and increased financial pressures contributed to increased intimate partner violence risk. See International Rescue Committee (2020), What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls, www.rescue.org/sites/default/files/document/5281/ircwpecovidreportv7.pdf; A 2021 Danish Refugee Council Lebanon report concluded that COVID-19 lockdown periods "have proved disastrous for GBV incidents" due to the combination of survivors being trapped in the home with the perpetrators, increased stress and loss of income. See Danish Refugee Council (2021), Global COVID–19 Response: Final Report May-December 2020, https://drc.ngo/media/y2wl33u0/drc-global-covid-19-appeal-2020-12-march-2021.pdf.

police at COVID-19 checkpoints and by men in the community when they were collecting water and/or food for the family past curfew, especially as social distancing prevented women from walking in groups. [191] In addition, COVID-19 quarantine centres heightened the risk of sexual harassment and violence for women and girls due to inadequate lighting and/or sex-segregated water, sanitation and hygiene facilities. [192]

Even as various forms of GBV have increased as a result of the pandemic, many women and girls struggled to report and receive assistance due to a variety of factors including proximity to the perpetrator and general lack of privacy as well as limited access to mobile devices.[193] COVID-19-related movement restrictions have also made it challenging for humanitarians to reach women and girls with needed services and supplies such as post-exposure prophylaxis for survivors of sexual violence.[194] The restrictions resulted in frequent changes in GBV referral pathways in the need for COVID-19 testing in order to access emergency services, particularly the police.[195]

189. Kelly, J. et al. (2021), "The Risk that Travels with You: Links between Forced Displacement, Conflict and Intimate Partner Violence in Colombia and Liberia", World Bank, p. 2.

190. Miller, H. (n.d.), "Women's Humanitarian Voices: Covid-19 through a Feminist Lens. A Global Report", The Feminist Humanitarian Network, https://static1.squarespace.com/static/6072068ad84bdb774791b965/t/609a20ad552ded2e7422dc95/1620713681053/FHN-Covid19-Global-Digital.pdf; Jones, N. et al. (2021) "Some got married, others don't want to attend school as they are involved in income-generation: Adolescent experiences following covid-19 lockdowns in low- and middle-income countries", Gender and Adolescence: Global Evidence, www.gage.odi.org/wp-content/uploads/2021/04/Adolescent-experiences-following-covid-19-lockdowns-in-low-and-middle-income-countries-1.pdf; and Osborn, C. (2021), "Magnifying Inequalities and Compounding Risks: The Impact of Covid-19 on the Health and Protection of Women and Girls on the Move", CARE, pp. 3-4.

191. Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 6; As a female respondent in the Liberia Safety Audit reported, "Those checkpoints are sometimes used to rape women who are caught in violation [of COVID-19 restrictions]. Most violence cases are being compromised at the community level due to the fear of being arrested and detained at the checkpoint". See International Rescue Committee (2020), What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls, https://reliefweb.int/sites/reliefweb.int/files/resources/ircwpecovidreportv6.pdf

192. CARE (2020), Gender-Based Violence (GBV) And Covid-19: The Complexities of Responding To 'The Shadow Pandemic', https://reliefweb.int/sites/reliefweb.int/files/resources/GBV_and_Covid_Policy_Brief_FINAL.pdf.

193. In Jordan, for example, reported cases of GBV decreased significantly in the immediate aftermath of the government instituting lockdown measures, with case management agencies reporting a 68% decrease in new cases. See the UNFPA response to Covid-19 – Report presented to OCHA as input for the Final Global Humanitarian Response Plan Covid-19 Progress Report, 22 February 2021.

194. Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 15. Notably, in research undertaken by UNHCR in Lebanon, lack of money was identified as the greatest contributor to accessing services since the COVID-19 outbreak—almost twice as many women reported this as a challenge as compared to fear of movement. See: UNHCR (2020), Impact of Covid-19 on the SGBV Situation in Lebanon, Inter-Agency SGBV Task Force Lebanon, p. 8.

195. Osborn, C. (2021), "Magnifying Inequalities and Compounding Risks: The Impact of Covid-19 on the Health and Protection of Women and Girls on the Move", CARE, p. 27; UNHCR (2021), Covid-19 Update June 2021, p. 4; OCHA (2021), Cameroon Humanitarian Needs Overview 2021(March 2021), p. 16; Danish Refugee Council (2021), Global Covid-19 Response: Final Report May-December 2020, p. 31.

4.4.2 Country-level co-ordination

There are examples from several regions[196] of GBV actors using GBV co-ordination mechanisms to facilitate rapid assessments in order to better understand how the pandemic affects women and girls and identify gaps in services.[197]

The assessments were used to conduct advocacy with national governments and donors to keep attention focused on the issue of GBV among both refugee and migrant populations.[198] In the Central African Republic, for example, safety audits among refugee and internally displaced populations identified GBV-related security risks in the context of COVID-19 that were subsequently shared with local authorities and communities for action. As a result, security patrols and other safety measures were introduced.[199] In Jordan, the Jordan Humanitarian Fund released USD 4.5 million in May 2020 that targeted GBV survivors (as well as elderly people and people with disabilities) in host communities and camps and in impoverished Jordanian households.[200] In Lebanon, a GBV risk analysis on needs and gaps related to COVID-19 led to inter-agency advocacy with donors for flexible funding.[201] The Kenya government also recognised the issue, but a continued lack of funding meant that GBV responders were not able to capitalise on these commitments.[202]

Co-ordination partners also used this information to inform the development of contextualised guidance. In Italy, a version of the GBV pocket guide for frontline workers and responders was launched in partnership with UNICEF, the International Organization for Migration and UNHCR to provide support to refugee and migrant GBV survivors and individuals at risk.[203] In Greece, UNICEF supported the General Secretariat for Demography and Family Policy and Gender Equality to develop operational guidance for safe shelters during the COVID-19 pandemic that could be accessed by both refugees and migrants. Critically, this support came at an early stage of the crisis when there were fears around keeping shelters open.[204] In Lebanon, a GBV Guidance Note on Remote Case Management was developed alongside web-accessible updates to the GBV referral pathway and online training modules for case managers on the delivery of remote services. In Mexico, standard operating procedures were updated to account for changes resulting from COVID-19.[205]

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196. The regions are Latin America, East Africa, and the Middle East and North Africa (MENA).

197. UNHCR (2020), Impact of Covid-19 on the SGBV Situation in Lebanon, Inter-Agency SGBV Task Force Lebanon - May 2020, p. 1; UNHCR (2021), Jordan - Inter-Sector Working Group. Refugee Response Coronavirus Update July 2021, p. 2.

198. UNHCR (2020), East and Horn of Africa, and the Great Lakes Region, SGBV Regional Overview, p. 2; Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela (2022), Regional Refugee and Migrant Response Plan ; Abwola, N. & Michelis, I. (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 7.

199. Regional Bureau in Q3 Safe from the Start 2021 report.

200. OCHA (2020), Jordan Humanitarian Fund 2020 Annual Report, p. 17.

201. UNHCR (2020), GBV Global workshops on field practices of GBV prevention, response, and risk mitigation, and Covid-19.

202. Abwola, N. and I. Michelis. (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 17.

203. UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response", UNICEF ECARDO, p. 8.

204 Ibid.

205. UNHCR (2020), GBV Global workshops on field practices of GBV prevention, response, and risk mitigation, and Covid-19.

4.4.3 Advocacy to reinstate protection against gender-based violence as essential (coverage, access)

Collaboration and joint advocacy among international actors were a key factor in the reprioritisation of GBV prevention as an essential service. One of the earliest collective efforts of GBV actors was to advocate for inclusion of a specific GBV objective in the GHRP, with over 200 GBV actors signing an advocacy letter and engaging in joint advocacy under the Call to Action. This initial advocacy was not successful in prioritising GBV in the GHRP and/or including a specific objective on GBV. When the GHRP was updated in July 2020, a GBV indicator was included and more emphasis was placed on GBV as it emerged that the rise in violence against women is "one of the most nefarious consequences of the pandemic".[206] However, this recognition of GBV in the second 2020 GHRP was not matched by attention to GBV in the GHRP direct response efforts and accountability measures[207] (see Thematic Snapshot 3).

Nevertheless, interviewees for this evaluation reported that they felt the initial advocacy was important to enhance donor awareness of the urgency of need.

From the onset of the pandemic, there was positive collaboration at the global level around guidance to support adaptation of GBV responses. Interviewees at the global level noted the importance of collegiality and co-ordination in the rapid production and distribution of guidance. For example, UNHCR co-ordinated with other actors (e.g. the UN Population Fund, UNICEF, International Medical Corps, International Rescue Committee, Trócaire and others) in the development of GBV information management systems guidelines and podcasts and guidance on remote case management. [208] This global guidance has been noted in key informant interviews as critical to supporting adaptation of services in the context of COVID-19.

At the country level in some refugee settings, GBV partners undertook successful advocacy to reopen women and girls' safe spaces and one-stop centres as essential services. The success of this advocacy often reflected a positive relationship with the government as well as strong GBV co-ordination capacity. [209] [210] [211] This advocacy frequently drew on previous learning from epidemics such as Ebola, including lessons about the problems associated with diverting resources away from GBV to other services as well as the limited uptake of case management services during the epidemic. [212]

Given the strength of concern in key informant interviews around funding for GBV within the overarching response and its effect on coverage, the evaluation team produced a snapshot on GBV financing (Thematic Snapshot 3).

206. OCHA (2020), Global Humanitarian Response Plan, COVID-19. GHRP July Update, https://reliefweb.int/sites/reliefweb.int/files/resources/GHRP-COVID19_July_update_0.pdf

207. In July 2020, the CARE International Secretary General issued a statement saying that the organisation was "pleased" to note " increased attention to GBV in the revised GHRP document", adding, "However, we are very disappointed that there is still no specific objective on GBV, which is critical if we are to unlock a proportionate level of funding and resources. This is despite a 700 percent increase in women and girls reporting to GBV hotlines in some countries, and nearly 600 actors from the GBV global community, including some of the major international donors, calling for a standalone objective on GBV. If we put our heads in the sand, we should expect massive gaps in the GBV response to persist and possibly widen. Worse still, if we don't properly track how the funds are being spent, we will remain largely in the dark about the extent to which needs on the ground are being met." See CARE (2020), CARE International expresses alarm over lack of funding for GBV in COVID-19 Global Humanitarian Response Plan,

208 https://reliefweb.int/report/world/care-international-expresses-alarm-over-lack-funding-gbv-covid-19-global-humanitarian.

209 This guidance is fully applicable to refugee contexts, if not exclusively so. Internally, UNHCR finalised a global mainstreaming GBV risk mitigation Learning Programme Facilitator's Guide in 2020 as well as guidance for inclusion of GBV in refugee response plan processes.

Thematic Snapshot 3 – Funding to gender-based violence in the COVID-19 response

Overall funding for GBV programming was and continues to be insufficient to meet the need and in refugee settings, the overall funding to GBV may be even lower.

The lack of attention to GBV in the first iteration of the Global Humanitarian Response Plan at the onset of COVID-19 was indicative of the lack of prioritisation of GBV as an issue in the initial stages of the pandemic. As Abwola and Michelis noted in a report for the International Rescue Committee, the GHRP "is not the only channel for humanitarian funding in response to COVID-19", but the absence of accountability to GBV in the GHRP represented an obstacle in advocating for "increased attention to GBV programming from Humanitarian Country Teams and other in-country coordination fora".[213]

A 2020 study on country-level funding for GBV, SRH and rights in five countries found that UN appeals for COVID-19 funding did not typically earmark GBV or prioritise funding for GBV programming.[214] The study also concluded that funds from international finance institutions similarly excluded attention to GBV in the early days of the pandemic. For example, of the USD 11.74 billion going to the five countries under review in the aforementioned study, only USD 235 000 was allocated to GBV programming. Recipient governments were similarly slow to call for greater investments in addressing the problem of GBV. By the end of June 2021, funding for GBV in 16 countries with humanitarian response plans (including COVID-19-related responses) amounted to USD 487 million, of which only USD 34 million (7%) was funded. [215]

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210 In Ecuador, UNHCR together with its partner provided PPE, which allowed the reopening of safe spaces for GBV survivors. UNHCR (2021), Emerging Practices Sexual and Reproductive Health and HIV Services In Refugee Operations during the Covid-19 Pandemic, p. 9.

211 In Jordan, the UN Population Fund's (UNFPA) enhanced collaboration and advocacy with government counterparts resulted in getting operational space and permits for service providers to address GBV cases. This was complemented by joint advocacy by the Gender-Based Violence sub working group (co-chaired by UNHCR and UNFPA) and its members to ensure GBV actors could continue providing services. UNFPA response to Covid-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan Covid-19 Progress Report 22 February 2021

212 In Kenya, many GBV actors and feminist organisations advocated to include GBV and SRH services as essential services. This advocacy got the attention of the president, who directed the National Crime Research Centre to conduct a study on violence against women during the pandemic. According to a national GBV expert, "This [advocacy] brought in a statement from chief justice of Kenya, David Maraga, who announced a pandemic level of GBV. As much as we are responding to COVID-19, now GBV has escalated to pandemic level. So the chief justice was able to publicly declare that GBV has now become a disaster to that level. So that now systems can now be resourced to respond to GBV".
See, for example, Phelps, C. (2020), "Rapid Gender Analysis Middle East and North Africa Region", CARE; Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee.

Notably, it is not possible to understand the full scope of GBV funding specifically to refugee contexts. According to several interviewees, agencies are reluctant to earmark GBV funds because doing so leaves them less flexibility in spending. In addition, coding and reporting on GBV at the global level are inconsistent or often non-existent.[216] Nevertheless, there is some information available from UNHCR that gives an indication of funding shortfalls in refugee contexts. In the period 2018-22, UNHCR's global budgetary needs for GBV grew by 65.5%. In 2022, UNHCR identified funding requirements totalling USD 276 million to address GBV, with additional needs pertaining to gender action under the Outcome Area for community engagement and women's empowerment. Despite a sharp increase in needs for GBV programming in the context of COVID-19, preliminary analysis by UNHCR indicates that 72% of UNHCR's identified operational needs for implementing GBV activities could not be funded in 2021.[217]

Within the Global Compact on Refugees and Global Refugee Forum pledges, 88% do not mention gender and only 3% refer to GBV. The only specialised GBV fund that benefits refugees directly (to an extent) is Safe from the Start, of which USD 5 million out of a total USD 17.7 million is allocated to UNHCR.[218] The largest global GBV fund is the Spotlight Initiative (USD 500 million) but with the exception of Uganda, this fund excludes refugee contexts because it is a demonstration fund for action on the Sustainable Development Goals and as such, focuses primarily on development contexts.

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213 Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls", International Rescue Committee, p. 10.

214 The five countries reviewed were Colombia, Kenya, Nigeria, South Africa and Uganda. McGovern T. and Bencomo C. (n.d.). Missing in Action: COVID-10 Response Funding for Gender-based Violence and Sexual and Reproductive Health in Five Countries, Mailman School of Public Health, Colombia University.

215 See OCHA (2020), Global Humanitarian Response Plan: COVID-19 (April – December 2020) GHRP July Update, https://reliefweb.int/report/world/global-humanitarian-response-plan-covid-19-april-december-2020-ghrp-july-update-enar.

216 As captured in a recently published report, accessing funding data on GBV in humanitarian settings is a problem globally. Publicly available data present notable limitations since numerous partners do not systematically contribute to the Financial Tracking Service reporting process. The lack of consistent reporting across the humanitarian sector means the GBV funding figures are unreliable and the visibility of GBV activities within coding systems varies widely, creating challenges for comparability across contexts and over years. To combat this lack of reliable data, the Global Protection Cluster launched an initiative in 2022 to collect and represent the funding received by each Protection Cluster globally more accurately. It is hoped that through this new mechanism, GBV funding can be understood and analysed more reliably. See Hersh, M. (November 2021). "Why Not Local? Gender-based Violence, Women's Rights Organisations, and the Missed Opportunity of COVID-19," International Rescue Committee. pp. 8-10.

217 UNHCR (2022), Global Appeal.

218 See US Departement of State (n.d.), Statement of Work: Evaluation of the Safe from the Start Initiative - United States Department of State,
https://www.state.gov/statement-of-work-evaluation-of-the-safe-from-the-start-initiative/

This lack of funding links directly to the ability to respond, including ensuring availability of GBV specialists who can oversee implementation of programmes.

Some WGSS transitioned to health centres as funding was prioritised for health services. Resource allocations did not provide the additional funds (or reallocations) needed to adapt GBV programming to COVID-19 through procurement of PPE, for example, or for physical alterations to spaces to ensure distancing. [219]

Even when GBV actors were successful in advocating for women and girls' safe spaces to be designated as essential services and reopen, some GBV actors did not have sufficient funding for staff to meet the need.[220] Lack of funding also meant that central aspects of programming such as livelihoods activities or support for safe houses (a critical need given the reduction in legal response in some settings) were reduced or eliminated.[221]

In 2021, UNHCR noted that "additional funds are … required to deploy dedicated staff to reinforce prevention, response and mitigation of future risks related to GBV".[222] While UN-HCR has a small cadre of dedicated GBV specialists, much of the work is done by protection and community-based protection staff as well as by those working on risk mitigation across sectors.[223]

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219 UNICEF (2020), Child Protection Learning Brief #1, p. 13.

220 UNICEF (2020), Child Protection Learning Brief #1, p. 13; Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls", International Rescue Committee, p. 21

221 UNHCR (n.d.), Impact of COVID-19 on the Protection of Refugees, Particularly Women and Children in Uganda; Abwola, N. and I. Michelis. (2020), "What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls", International Rescue Committee; UNHCR (2021), Ethiopia Country Refugee Response Plan, January 2020-December 2021; Guglielmi, S. et al. (2020), Exploring the impacts of COVID-19 on Rohingya adolescents: A mixed-methods study, p. 3.

222 UNHCR (2021), Gender-based violence (GBV): Reinforcing Prevention, Risk Mitigation and Response Interventions.

223 In the words of one key informant interviewed in this evaluation, "We haven't started early enough to invest sufficiently in talent development, retention and recruitment of GBV specialised staff."

4.4.4 Preparedness and adaptation measures (effectiveness)

Preparedness measures have been an important contributor to a more effective rapid response in some settings, especially in countries which initially had low levels of COVID-19. [224] Efforts were made to learn from other refugee settings where GBV-related COVID-19 response had already been scaled up. According to UNHCR, across Africa, with the exception of countries such as Uganda that adopted strict and sudden lockdown measures, preparedness efforts were possible and were supported by lessons learned in Asia and Europe, where the pandemic hit earlier.

As with responses in child protection and right to asylum, creative solutions were introduced to ensure that responses to GBV survivors were maintained. Examples of such solutions include shifting to remote GBV case management through phones and WhatsApp, developing specific times to meet with survivors individually to reduce risk of exposure of staff and clients, introducing or expanding 24/7 hotlines, and strengthening community messaging on GBV and access to services (see Thematic Snapshot 4). In a June 2021 report, UNHCR reported that in more than 45 of the 63 countries in the GHRP, UNHCR operations had maintained or expanded GBV services in response to COVID-19. [225]

UNHCR and partners also sought to strengthen community messaging, including using Facebook, Instagram and WhatsApp. [226] [227] [228] [229] This included information directed towards populations that are often marginalised and/or hard to reach, such as people with disabilities, older women, women and girls who were uncomfortable using social media platforms, and illiterate women.[230] [231] [232]

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224 In one regional example, UNHCR operations in the Asia region took important preparedness measures to ensure as much continuity as possible in case management. Staff procured phones and laptops for caseworkers who did not already have them and issued phones to psychosocial counselling providers. As a result, the operation continued case intake through the UNHCR hotline and case assessment by UNHCR caseworkers over the phone. UNHCR (2020), Gender-Based Violence Prevention, Risk Mitigation, and Response during Covid-19. GBV Updates on Covid, p. 4.

225 See UNHCR (2021), Report on UNHCR's global strategic priorities, www.unhcr.org/60e4547f4.pdf.

226 In Mexico, Communication with Communities was expanded to include videos and online materials related to GBV prevention and response, resulting in a significant number of webpage hits and views on social media. UNHCR (2020), GBV Global workshops on field practices of GBV prevention, response, and risk mitigation, and Covid-19; See also UNHCR (2020), Global Report, Thematic Chapters: Responding with Lifesaving Support, p. 209.

227 In West Africa and MENA, partners used community methods such as rural radio to disseminate information about GBV services and GBV prevention, including information for men and boys on managing stress and angry behaviour under quarantine, with key messages on gender equality. UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the Covid-19 Pandemic: Examples of UNHCR gender responsive and gender-based violence (GBV) prevention, risk mitigation and response interventions, p. 3. Also see UNHCR (2021), Emerging Practices Sexual and Reproductive Health & HIV Services in Refugee Operations during the Covid-19 Pandemic, p. 9.

228 The Amaali application in Jordan provides timely updates and real-time mapping of available services during the pandemic and has been publicised by a campaign led by national NGOs. UNHCR (2021), Emerging Practices Sexual and Reproductive Health and HIV Services in Refugee Operations during the Covid-19 Pandemic, p. 9. Also see UNFPA (2021), Response to Covid-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan Covid-19 Progress Report.

229 In research undertaken in Azraq and Zaatari refugee camps in Jordan, 81% of women surveyed who were at risk of GBV reported that they had information and knowledge about how to access protection services during the crisis and confinement. UN Women (2020), Rapid Assessment of the Impacts of Covid-19, April 2020.

230 In Latin America, MENA and East Africa, UNHCR and partners sought to adapt communication materials to ensure information reached people with disabilities. UNHCR (2021), Note on International Protection. EC/72/SC/CRP.10, p. 12.

231 In Greece, UNICEF partners adapted their activities and services to better meet the needs of older women refugees and migrants who were not comfortable using Facebook (which was the original site of their safe spaces). A result was development of a specific application that accommodated older women's priorities and needs. UNICEF (2020), Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response: A Brief Review, UNICEF ECARO, p. 7.

232 In Serbia, UNICEF partners began sharing information on COVID-19 and GBV in audio as well as written form, following feedback from illiterate women about challenges accessing written information. UNICEF (2020), Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response: A Brief Review, UNICEF ECARO, p. 7.

Notably, while there have been many good examples of GBV programming adaptation, there may have been an overemphasis on the value of remote methods when in-person case management remains necessary. Much of the global GBV guidance produced early in the pandemic focused on remote care rather than advocating for keeping women and girls' safe spaces open. Several interviewees noted that while transitioning to remote care may be required and important in some settings, more emphasis should be placed on developing advocacy platforms and skills necessary to ensure that GBV response services are considered essential and that some basic level of response is maintained, including with allocations for PPE and other safety measures such as those instituted in health centres. An early report for the International Rescue Committee on GBV and COVID-19 impacts on refugee and displaced women and girls drew on the lessons from Ebola in recognising the need for ensuring continued face-to-face services, arguing that "the singular focus on health solutions appeared particularly short-sighted in the aftermath of multiple Ebola outbreaks, which proved time and again the need to prioritise protection programming to minimise the otherwise staggering risks faced by women and girls".[233]

Evidence also illustrates that the transition to phone, internet or SMS-based services is not workable for all GBV survivors, not least because of the digital divide in access to technology between rich and poor and, in many settings, between males and females. A heavy reliance on phones and remote interviews creates safety and supply challenges for survivors and providers alike, despite the investments in access to technology for women and girls in many settings.

Moreover, the shift to remote services has in many cases meant that limited staff with reduced working hours due to additional domestic responsibilities can only manage existing caseloads, not new clients. This shift has also left women and girls not knowing where to report if they had a problem.[234] Although the addition of hotlines may redress some challenges in meeting the needs of new clients, the extent to which these services are effective for ongoing case management is not clear.[235]

Although significant efforts have been made to address the problem of violence escalating in the home as a result of lockdown measures, arguably less attention has been afforded to some other types of GBV-related protection concerns that refugee women and girls have faced, such as those related to their caregiving responsibilities that require them to leave home in search of food, firewood and other goods. The availability of information about interventions to address these forms of violence is quite limited. This does not mean that no interventions were undertaken;[136] nevertheless, several interviewees noted that community-based risks for sexual violence and exploitation were likely under-recognised and under-addressed relative to risks for intimate partner violence or even child marriage.

233 Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 12.

234 This was citied in examples in Bangladesh, DRC, Ecuador and Turkey: Osborn, C. (2021), "Magnifying Inequalities and Compounding Risks: The Impact of Covid-19 on the Health and Protection of Women and Girls on the Move", CARE, p. 27; Mora, D.T. and Z. Yousuf (2021), "Doing Right by Women and Girls in Cox's Bazar: Gendering Perspectives on Social Cohesion", Saferworld, p. 15. Also see Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 16.

235. Service providers in Europe expressed concerns about trust and relationship building with both refugees and migrants through remote means, particularly when engaging with new clients and new arrivals. UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response.", UNICEF ECARO, p. 3.

236 For example, in the Central African Republic, safety audits were conducted with refugee and IDP populations that identified broad safety concerns and, in one positive outcome, resulted in local governments educating vendors about risks of sexual exploitation linked to the rising cost of goods associated with COVID-19 supply chains. Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee.

Moreover, interviewees repeatedly raised concerns about the relative lack of investment in addressing the needs of adolescent refugee girls during the pandemic and the implications for girls' long-term well-being. As noted, risks for early marriages and adolescent pregnancies have increased during the pandemic across refugee host countries and are linked to school closures, lack of access to SRH services and limited targeted protection programming for adolescent girls. Evidence from Lebanon suggests refugee girls are more likely than non-refugee peers to be out of school because of the pandemic. [237] Some settings (not exclusive to but including refugee contexts) have also reported an increase in domestic labour and a fear that girls will have a harder time returning to school and re-assimilating post-COVID-19. [238] A report by Plan International recalled the impact of Ebola and the importance of learning from that epidemic: During 2015 in parts of Sierra Leone, teenage pregnancy rose by 65%.[239]

While the welfare of adolescent girls has been recognised by UNHCR and partners and steps taken to transition GBV prevention activities online, programming investments have not matched awareness of risks or of need.[240] Documents reviewed by the evaluation team suggest that the plight of girls is of ongoing concern in multiple countries across regions, requiring targeted work to prevent long-term negative impacts.

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237 UNHCR (2020), Impact of Covid-19 on the SGBV Situation in Lebanon Inter-Agency SGBV Task Force Lebanon - May 2020, p. 9.

238 See Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to Covid-19 Failed to Protect Women and Girls", International Rescue Committee, p. 4; Osborn, C. (2021), "Magnifying Inequalities and Compounding Risks: The Impact of Covid-19 on the Health and Protection of Women and Girls on the Move", CARE, p. 25; Jones, N. et al. (2021), "Some got married, others don't want to attend school as they are involved in income-generation: Adolescent experiences following covid-19 lockdowns in low- and middle-income countries", Gender and Adolescence: Global Evidence, p. 26.. Also see UNHCR (2021), Note on International Protection. EC/72/SC/CRP.10, pp. 6-7.

239 Plan International UK (2020), The Impacts of Covid-19 On Girls in Crisis, p. 8.

240 UNICEF and UNFPA (2021), Child Marriage In the Context of Covid-19: Analysis of trends, programming and alternative approaches in the Middle East and North Africa, p. 23.

Thematic Snapshot 4 - Adaptation in GBV programming

The COVID-19 pandemic forced GBV service providers to find new and/or adapted ways to deliver life-saving aid to refugee women and girls. The most prominent adaptations to GBV case management services emerging in the context of COVID-19 – and some of the key lessons learned – are summarised below.

GBV hotlines

Existing to some extent in humanitarian settings before the pandemic, GBV hotlines were scaled up considerably as an alternative to in-person case management following lockdown restrictions. At least 18 UNHCR operations created or expanded emergency hotlines, including in South and Southeast Asia, Europe, Latin America, MENA and sub-Saharan Africa.[241] There is some evidence that these new and expanded GBV hotlines have improved access to GBV services during the pandemic: In 2020, UNHCR and partners assisted 2 million women and girls via 24/7 hotlines.[242]

However, hotlines present some challenges, including the ability to monitor quality of care and accessibility. To address these, strategies have been implemented in some settings for remote monitoring.[243] As mentioned above, despite investments in access to technology for women and girls, some at-risk groups may not have reliable access to a mobile phones and/or sufficient phone credit to place a call, especially adolescent girls and people with disabilities.[244] Even if survivors have access to a mobile phone, they may lack privacy in their home and be unable to contact the hotline while their perpetrator is present, leading to the decrease in call volumes as observed by some call centres at the start of the pandemic.[245] A promising good practice in response to these challenges is the inclusion of additional options to contact hotlines such as text messages.[246] [247]

Notably, while increased use of online platforms has allowed some GBV services to remain in place during the pandemic, UNHCR partners have raised concerns that increased reliance on technology increases the risks of fraud, cyberbullying and online sexual harassment for women and girls.[248] The GBV Helpdesk developed a series of guidance documents to improve the understanding of risks related to increased uptake of communications technology, and training on digital risks has been developed for affected populations.[249] [250]

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241 See UNHCR (2021), Note on International Protection EC/72/SC/CRP.10, p. 7; UNHCR (2020), Global Report. Thematic Chapters: Responding with Lifesaving Support, p. 209; UNHCR (2020), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic, pp. 2-4; UNFPA (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report; UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic: Examples of UNHCR gender responsive and gender-based violence (GBV) prevention, risk mitigation and response interventions, p. 5.; UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response. A Brief Review", UNICEF ECARO, pp. 8-9.

242 UNHCR (2021). Note on International Protection. EC/72/SC/CRP.10, p. 7. Note that hotlines were not only available to women and girls; in many cases they served other groups, such as lesbian, gay, bisexual and transgender populations and male survivors.

243 In Kakuma, Kenya, for example, calls are closely monitored by the UNHCR GBV Unit using a tracker-sharing tool. UNHCR (2020), East and Horn of Africa, and the Great Lakes Region (SGBV-Regional Overview), p. 5. UNFPA in Pakistan noted its remote monitoring increased operational efficiencies in its programming. UNFPA (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report.

244 Erskine, D. (n.d.), "Not Just Hotlines and Mobile Phones: GBV Service Provision during COVID-19", UNICEF, p. 2.

245 Erskine, D. (n.d.), "Not Just Hotlines and Mobile Phones: GBV Service Provision during COVID-19", UNICEF, p. 2.

246 One women's rights organisation working with Palestinian refugees noted that "we discovered that during confinement, during the closure, women were unable to call us because everybody was in the house. Calls from females went down for a certain time, but when we introduced our WhatsApp chat counselling, women began contacting us much more". Miller, H. (n.d.), "Women's Humanitarian Voices: Covid-19 through a Feminist Lens: A Global Report". The Feminist Humanitarian Network, p. 9.

Remote case management

Adaptations have been introduced in refugee settings across the world to facilitate individual case management through remote service delivery.[251] There is evidence that these adaptations have had a positive impact in maintaining access to case management services for low-risk and moderate-risk situations, particularly when these included appropriate training for case workers. [252] [253] [254]
While these remote modalities have supported ongoing care for existing clients, anecdotal evidence suggests that in some settings, new cases were less likely to access or receive remote case management services, in part due to challenges with new clients trusting remote services. [255] [256]

In other instances, shifts to remote case management have meant reduced opportunities for ongoing support to existing clients and new survivors, as the usual number of case management sessions were cut back to prioritise emergency response.[257] [258] In one strategy aimed at facilitating ongoing support, some operations used digital platforms to create online spaces for women and girls to connect with one another and share their experiences during periods of limited mobility. [259] [260]

In-person or hybrid adaptations

While many adaptations of GBV service provision during the pandemic have relied on remote modalities described above, the continuation of in-person services is essential to providing life-saving support to refugee women and girls.

247 Similar adaptations have been made in Jordan, Mexico and Panama using text, audio messages, email, WhatsApp and Facebook messages. In Bangladesh and Indonesia, an application called MyUNHCR allows refugees to remotely update information concerning their protection needs. See UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic: Examples of UNHCR gender responsive and gender-based violence (GBV) prevention, risk mitigation and response interventions, p. 4. See also, UNHCR MCO Panama (2021), Gender-Based Violence (GBV) Reinforcing Prevention, Risk Mitigation and Response Interventions. Thematic Notes, p. 1.

248 UNHCR (2022), Selection of Promising Field Practices by UNHCR and Partner Organisations on GBV Prevention and Response as well as Mainstreaming GBV Risk Mitigation in the Context of the COVID-19 Pandemic, p. 3.

249 The MENA region, for example, provided training on digital risks and digital literacy when distributing devices. (MENA outreach survey, and In Touch with Refugees)

250 See Social Development Direct (n.d.), Gender - Based Violence Area of Responsibility Helpdesk, www.sddirect.org.uk/our-work/gbv-in-emergencies-helpdesk/. In addition, UNHCR has partners in the development of guidance on remote services, drafted with support from the GBV Area of Responsibility Helpdesk. See "COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines" (2021), www.sddirect.org.uk/media/2140/covid-guidance-on-remote-gbv-services-04012021.pdf.

251 Italy, Jordan, Lebanon, Malaysia, Serbia, Syrian Arab Republic and Zambia are among such settings: UNICEF (June 2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response", UNICEF ECARO, p. 8-9. See also UNHCR (2020), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic, p. 2; UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic, p. 4; UNHCR (2022), Selection of Promising Field Practices by UNHCR and Partner Organisations on GBV Prevention and Response as well as Mainstreaming GBV Risk Mitigation in the Context of the COVID-19 Pandemic, p. 4; UNHCR (2021), Update on UNHCR's Operations in the Middle East and North Africa, p. 5.

252 For example, in Kenya, GBV colleagues participating in a regional assessment noted that the transition to remote case management was largely successful because GBV service providers were adequately trained on how to support survivors remotely and equipped with smartphones for continuous service provision. Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls", International Rescue Committee, p. 17.

253 In the Northwest and southwest regions of Cameroon, social workers received additional training on GBV case management and remote service delivery. UNHCR (2020), Gender-Based Violence Prevention, Risk Mitigation, and Response during COVID-19: GBV Updates on COVID, p. 3.

In some contexts, a hybrid model was introduced with remote case management services for most survivors but an option for in-person support for urgent high-risk cases.[261] Existing women and girls' safe spaces were adapted into GBV phone booth stations that survivors could visit to make confidential calls to case managers. [262] In one setting, GBV actors allowed three to four women and girls to access the safe spaces at one time to gain livelihoods skills such as sewing face masks and to practice language skills.[263]

Some GBV programmes found creative ways to work around COVID-19 restrictions using mobile clinics.[264] However, other types of multisectoral services for survivors, such as legal assistance, declined in many settings. [265]

A challenge to the continuation of in-person services was access to PPE, which was often difficult or impossible for GBV service providers to obtain, particularly at the start of the pandemic. In an example of efforts to overcome this challenge, UNHCR partners in Yemen employed refugee and internally displaced women in the production of cloth face masks to be distributed to persons of concern, host communities and staff.[266] PPE was also prioritised by national governments in Burundi and Kenya thanks to activism by the GBV community; however, in Kenya, the lack of funding for additional staff limited the ability of centres to provide critical GBV services.[267]

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254 In Lebanon, case workers were trained using a specialised GBV coaching programme adapted to remote case management. They reported that training and inter-agency guidance was important and beneficial to the transition online. UNHCR (2022), Selection of Promising Field Practices by UNHCR and Partner Organisations on GBV Prevention and Response as well as Mainstreaming GBV Risk Mitigation in the Context of the COVID-19 Pandemic, p. 2.

255 In research on the impact of COVID-19 on GBV service delivery, UNICEF partners in Bulgaria, Greece, Italy and Serbia highlighted both benefits and drawbacks to remote GBV service provision, expressing concerns about trust and relationship building through remote means, particularly when engaging with new clients and new arrivals. UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response." UNICEF ECARO, p. 3.

256 As an UNRWA caseworker explained, "Before the virus outbreak, we used to be in the field, conducting face-to-face case meetings [but] now, we work remotely with the cases, which makes it harder to communicate". UNRWA (2020), Safety at Home: Supporting Survivors under COVID-19 Lockdowns.

257 In Colombia, for example, comprehensive case management services transitioned to phone-based information kiosks that provided one-time phone-based crisis interventions and referrals to additional services to address immediate needs and safety concerns. UNHCR (2020), Global Report. Thematic Chapters: Responding with Lifesaving Support, p. 209.

258 In Venezuela, UNFPA developed a protocol that focused on rapid GBV case management during the COVID-19 pandemic to meet emergency needs of Venezuelan women and girls in transit. UNFPA (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report.

259 Within two weeks of the lockdown in Serbia, for example, UNHCR partners established online groups via Viber and other platforms in Arabic and Persian for both refugee and migrant women and girls. Members shared COVID-19 information and benefited from peer-to-peer interactions. UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response", UNICEF ECARO, p. 9.

260 UNHCR partners in Europe also created digital safe spaces for women and girls to socially interact during lockdowns. UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response." UNICEF ECARO, p. 8.

261 UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic, p. 4; UNFPA (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report; CARE (2020), Girl-Driven Change – Meeting the Needs of Adolescent Girls during Covid-19 and Beyond, p. 26.

262 See Erskine, D. (n.d.), "Not Just Hotlines and Mobile Phones: GBV Service Provision during COVID-19", UNICEF, p. 3; UNFPA. (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report; SGBV Working Group Jordan (2020), Guidance note on GBV Service provision during COVID-19 in Jordan and a forward look at a safe resume of service, p. 5.

263 UNFPA (2020), Gender-Based Violence: Donor Advocacy Brief on Critical Services during COVID-19 (Syria Crisis Region), p. 1.

Community volunteer networks

Given the challenges of accessing survivors during lockdown, many GBV service providers turned to community networks and focal points to reach GBV survivors. Across Asia and Africa, UNHCR worked with local partners and refugee women and girls to identify both community focal points and outreach volunteers to facilitate referrals and increase awareness of GBV and COVID-19 preventative measures. [268 269 270]

These include existing networks that were expanded as well as new networks of community volunteers mobilised during the pandemic. Early evidence suggests that the use of community volunteer networks has

Refugee pharmacist provides vital COVID-19 support to her community (26 April, 2020).
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264 In Serbia, the national curfew system allowed GBV mobile outreach service to operate in a number of communities to access vulnerable (including homeless) refugee and migrant women. Erskine, D. (2020), Double Jeopardy: The European Refugee and Migrant Crisis and COVID-19: Insights into the Emerging Impacts on Women and Girls, p. 6; In Jordan and Libya, UNFPA operated mobile health clinics to provide integrated SRH-GBV care to vulnerable women and girls in remote areas. Given the context of pandemic restrictions, these services achieved broad reach beyond the Libyan capital of Tripoli. UNFPA (2021), Response to COVID-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan COVID-19 Progress Report.

265 For example, in Chad, the number of GBV incidents for which survivors received legal support decreased from 3 911 in 2019 to 39 in 2020, according to reports from UNHCR. Similarly, in DRC, legal assistance significantly decreased from 59 reported cases to none. UNHCR dashboard data provided to the evaluation team, RR COVID 27 country data set.

266 UNHCR (2021), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic: Examples of UNHCR gender responsive and gender-based violence (GBV) prevention, risk mitigation and response interventions, p. 3.

267 Abwola, N. and I. Michelis (2020), "What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls" International Rescue Committee, pp. 12-21; UNICEF (2020), Child Protection Learning Brief #1, p. 13.

268 In Dadaab, Kenya, for example, community structures monitor hotspots and sensitise community members about GBV, and an emergency community-based monitoring committee has been set up to identify and flag cases and risks. UNHCR (2020), East and Horn of Africa and the Great Lakes Region (SGBV-Regional Overview), p. 5. Also see UNHCR (2020), Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic, p. 2; UNHCR (2020), Global Report. Thematic Chapters: Responding with Lifesaving Support, p. 209.

269 In Egypt, adolescent Syrian refugee girls and young women have disseminated awareness-raising messages about COVID-19 and the emotional impact of the curfew on their peers. In addition, young women are addressing the rising trend of GBV by offering peer-to-peer support to adolescent girls and women and alerting them to available services. Plan International (n.d.), Close to Contagion: The Impacts of Covid-19 on Displaced Refugee Girls and Young Women, p. 4.

270 In Cox's Bazar, refugee women reported that they appreciate opportunities to support their communities to prevent COVID-19, including being involved in door-to-door awareness raising as outreach volunteers and being involved in mask production. UN Women Rohingya Women Speak Up on Covid-19: Concerns, Demands, and Solutions, p. 20.

been critical to maintaining access to GBV services.[271] In a 2020 report, UNICEF notes that such adaptations "helped partners reach new refugee and migrant women and girls and spread the word about available services." [272]

However, adaptations did not always include the necessary technical support for local women's organisations and networks to provide adequate assistance. Reports from different regions indicate that UNHCR recognised limitations to these community approaches, suggesting the need for greater investment in community networks to empower them to provide services safely and ethically and to ensure that they have adequate PPE and other tools to support their own well-being.[273] [274]

This lack of support was also evident in funding. Research in 2020 found that globally, less than 0.1% of COVID-19 funding was going directly to national or local actors. According to a 2021 report, local organisations interviewed across three countries (two of which included refugee response) noted that "the only meaningful change they experienced during COVID-19 regarding localisation and the empowerment of [women's rights organisations] is that their international counterparts relied more heavily on them to lead field-based work and assume all the risk of COVID-19 transmission, while receiving no additional support or funding". [275]

In 2021, Filippo Grandi, Commissioner of UNHCR, hailed the localisation that the COVID-19 response was bringing about. But as the evidence discussed illustrates, there are many potential lessons learned about improving substantive support to local women's organisations and groups.[276]

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271 In Malaysia, refugee women leading community volunteer projects reported "a significant increase in feeling that they were being listened to and respected, and in Cox's Bazar, the majority of all GBV cases managed by the International Rescue Committee were first referred through community volunteers. UNHCR. (2022), Selection of Promising Field Practices by UNHCR and Partner Organisations on GBV Prevention and Response as well as Mainstreaming GBV Risk Mitigation in the Context of the COVID-19 Pandemic, p. 5; International Rescue Committee, (2021), Under-Reported and Under-Addressed: Gender-Based Violence Among Rohingya Refugees in Cox's Bazar, p. 3.

272 UNICEF (2020), "Impact of Covid-19 on Gender-based Violence Refugee and Migrant Response." UNICEF ECARO, p. 4.

273 "COVID-19 and related movements restrictions ... prevented humanitarian actors to implement necessary capacity-building efforts of GBV service providers and led to rely on precarious community-based response at times". OCHA (2021), Cameroon Humanitarian Needs Overview, p. 16.

274 A UNHCR report noted that "communities were not prepared and lacked training to deliver services at such scale and which at the same time could impact their own safety and health, during the crisis. While various efforts were made, the provision of remote training is difficult due to lack of access to technology. Some of the SGBV survivors reported that they did not feel confident to turn to refugee outreach workers". UNHCR (2020) East and Horn of Africa and the Great Lakes Region SGBV - Regional Overview.

275 Hersh, M. (2021), "Why Not Local? Gender-based Violence, Women's Rights Organisations, and the Missed Opportunity of COVID-19," International Rescue Committee. p 8.

276 Bahre, S. (2021), "How the aid sector marginalises women refugees", in The New Humanitarian, www.thenewhumanitarian.org/opinion/first-person/2021/3/15/How-the-aid-sector-marginalises-women-refugees; Cited in Hersh, M. (2021), "Why Not Local? Gender-based Violence, Women's Rights Organisations, and the Missed Opportunity of COVID-19," International Rescue Committee.

Gender-based violence risk mitigation efforts

In addition to the aforementioned GBV specialised programming examples, there are examples of GBV risk mitigation efforts that have helped facilitate greater protection for women and girls. At the global level, UNHCR contributed to the development of the Inter-Agency Standing Committee guidance note, Scaling Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Settings, that, while not specifically referencing the issue of GBV, highlights the importance of continuing to prioritise protection concerns and gender sensitivity. UNHCR also contributed to the inter-agency risk mitigation guidance for identifying and mitigating GBV risks within the COVID-19 response.[278] At the national level, guidance and tools have also been produced to improve GBV risk mitigation across several sectors in the context of the COVID-19 pandemic.

Food distribution has been an important entry point during the pandemic to provide information to GBV survivors and those at risk.[279] [280]   Shelter actors have similarly been engaged in a variety of ways in promoting protection, for example through safety audits and through distribution of relevant non-food items such as hygiene kits.[281] Health services have also been an important entry point to offer education and referral for GBV services. [282]

Access to water, sanitation and hygiene (WASH) services has been a significant problem for refugee women and girls, one that COVID-19 amplified.[283] In some settings, consultations were undertaken with women to redesign services to facilitate safe access to WASH facilities. [284]

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277 See Interagency Standing Committee (2021), https://interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response-0.

278 GBVIMS (n.d.), COVID-19: Resources to address gender-based violence risks, https://gbvguidelines.org/cctopic/covid-19/.

279 In Lebanon, for example, a guidance note was developed on food and non-food item distribution packages that included GBV risk mitigation. In Zimbabwe, food distribution sites have been used as venues to share information with refugees and asylum seekers on GBV services: UNHCR. (2021), Protecting Forcibly Displaced Women and Girls during the Covid-19 Pandemic: Examples of UNHCR gender responsive and gender-based violence (GBV) prevention, risk mitigation and response interventions, p. 4.

280 In collaboration with the World Food Programme, UNFPA-Congo set up a mechanism to refer victims of GBV to free holistic care. These were identified around food distribution activities during and after confinement in Brazzaville: UNFPA response to Covid-19 - Report presented to OCHA as input for the Final Global Humanitarian Response Plan Covid-19 Progress Report 22 February 2021.

281 In Lebanon, a safety audit was undertaken as part of the shelter planning linked to COVID-19 isolation strategies. Hygiene kits (personal hygiene and household cleaning materials) were distributed to the most vulnerable families, including poor Lebanese, Syrian and Palestinian refugees, and combined with materials on appropriate use of hygiene materials, protection from sexual exploitation and abuse, and GBV: OCHA, Covid-19 Emergency Appeal Lebanon, p. 20.

282 In Sudan, COVID-19 screening at points of entry was coupled with GBV risk mitigation efforts through messaging on GBV risks and referral points: UNHCR (2021), South Sudan Year-End Report 2020, p. 10. In Ethiopia, UNHCR and partners provided training for health professionals on prevention and protection methods of COVID-19, focusing on GBV-related risks. These included co-ordination with the government health units working in camps to disseminate information about GBV and COVID-19 prevention: UNHCR (2020), East and Horn of Africa, and the Great Lakes Region SGBV Regional Overview, p. 6. In Lebanon, training on GBV foundational standards, safe disclosure and referral was provided to frontline staff. Leaflets on prevention of GBV and referral pathways also were made available at all primary healthcare centres: OCHA (2020), Covid-19 Emergency Appeal Lebanon, p. 20. In Dadaab, Kenya, GBV partners have worked closely with health facilities on safe disclosure and referral of GBV cases. A GBV office is located in a health facility to facilitate referrals: UNHCR (2020), East and Horn of Africa, and the Great Lakes Region SGBV Regional Overview, p. 6.

283 Inter Sectoral Coordination Group (ISCG) Gender Hub (2020), Covid-19 Outbreak: Cox's Bazar Rapid Gender Analysis, p. 13.

284 Trimiño Mora, D. and Z. Yousuf (2021), "Doing Right by Women and Girls in Cox's Bazar: Gendering Perspectives on Social Cohesion", Saferworld, p. 15.

5. Conclusions and recommendations

Colombia. Venezuelan refugees seize chance to register for legal status (19 June, 2021).
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Relevance and coverage

To what extent has the protection of refugees and their rights been recognised and addressed in the response of international co-operation to COVID-19?

The COVID-19 pandemic and response were truly global in nature. This "global" tag, however, can mask the fact that there were well over 100 individual responses in which the combination of national and international effort was truly unique as well as a body of work by global actors. This evaluation was not able or designed to quantify and aggregate coverage in each and every country-level response. Rather, the team set out to identify patterns emerging in literature, available data and interviews and both in the work of global bodies and country-level findings as well as similarities across countries and regions. Taking a relatively high-level view of coverage in this way yielded interesting results.

The evaluation presents a wealth of evidence on the impacts of border closures and their profound consequences for refugee rights and for protection actors. Measures adopted to combat the spread of COVID-19 were, in many countries, not consistent with international law and did not conform to the prohibitions on refoulement and collective expulsion.

The principle of non-refoulement, the prohibition of collective expulsion, and the right to seek asylum were not upheld in many countries, and there is compelling evidence of expulsions and pushbacks, at sea and on land, as well as refoulement. Border closures and lockdowns reduced the ability of governments and protection actors to resettle refugees to a third country and increased the numbers resorting to irregular border crossings.

COVID-19-related restrictions also impacted the right to asylum, delaying and in some cases suspending registration and documentation, refugee status determination, resettlement, and family reunification during in the early phase of the pandemic. There is a direct correlation here with the experience in relation to gender-based violence (GBV) and child protection, in that the prioritisation of the public health response arguably served to relegate the realisation of other rights. It is clear that while measures that narrowed access to international protection and tightened asylum policies were temporary in some countries, they have deepened in others and that barriers persist into 2022.

It is possible to draw clear linkages between the priorities that were set early in the global-level response and their roll-out and ultimate effect on coverage across countries. There is a contrast across themes. As noted throughout, the obvious priority placed on health, and the rec-ognition of refugees as a vulnerable group, appear to have placed refugees in a preferential position in terms of funding and advocacy, albeit with significant variations under the broad umbrella of public health. The priority given to sexual and reproductive health (SRH) is clear in country-level documentation and seems to demonstrate that it was possible to advocate for the continuation of face-to-face service provision if deemed important. The prioritisation of the COVID-19 response acted to the detriment of other aspects of public health. The extent to which this is the case will be a long-running debate.

The lasting effects of the initial deprioritisation of addressing gender-based violence and child protection are also clear. Lessons drawn from the Ebola response certainly foreshadowed the rise in violence against women and children and other severe secondary consequences of movement restrictions, school closures and lost livelihoods. Not all lessons from Ebola were directly relevant, but the "secondary crises" faced by women and children as the pandemic response evolved were predictable and more could and should have been done.

In some themes, the relative success of global co-ordination and advocacy was undermined by challenges at the country level. Evidence of an increase in the inclusion of refugees in national health and other services is undoubtedly a positive. Interviewees at the regional level were confident that the COVID-19 response had created positive and potentially lasting momentum around inclusion. Country-level detail, however, demonstrated the variation and complexity across countries. The reinstatement of services and their adaptation for the new context are commonly referenced as characteristics of the COVID-19 response. There is little evidence that previous systemic weak-

nesses were addressed. For example, in the literature and interviews, there was a clear sense that pre-existing weaknesses in coverage in rural, remote or underserved urban areas persisted. Another clear-cut example is offered in the case of COVID-19 vaccinations. While refugees were almost universally included in national vaccination plans, vaccination nationalism and a number of practical, technical and legal issues have kept numbers of vaccinated refugees relatively low initially.

There is clear evidence of heightened negative perceptions and stigmatisation of people on the move. The snapshots also highlight examples of discrimination and xenophobic attacks against refugees across multiple regions. Especially across the themes of health and asylum, the snapshots also highlight numerous examples of reductions in refugees' willingness to exercise their rights to services. The evidence also clearly demonstrates the key role of local actors, often supported by UNHCR and other protection actors, in countering disinformation at the root of xenophobia as well as the challenges of doing so in the context of an explosive proliferation of social media in some contexts.

Aside from the need to counter misinformation, there was an overall challenge in the provision of adequate information on the availability of services. Protection-related information is important for refugees and requires a strong, concerted inter-agency effort. Messaging frequently fails to cater to the most vulnerable and marginalised and/or lacks sensitivity to local social, cultural or gender norms. Overall, there has been a lack of child-friendly messaging, which is especially a concern for unaccompanied children. Many refugees were unable to benefit from the rapid increase of online tools and platforms to connect, inform and support

them during lockdown and isolation. Without concerted efforts to reach them, children, elderly people and persons with disabilities were left behind, as were homeless asylum seekers and refugees and those staying in informal settlements or in reception centres that were not technically equipped. Access to information was extremely challenging for persons with disabilities who have specific communication needs according to the kind of disability they have, as information was not available in accessible formats.

Risk communication efforts have been ineffective when top down not two way or needs based. Lessons from the Ebola response and other epidemics have not been consistently applied: To be effective, information needs to be tailored to and informed by affected people's information needs, including sensitivity to culture and gender and also based on rumour tracking and targeted at dispelling myths. Better co-ordination among aid agencies is required to reduce competition to lead on information and communication efforts. Access to information is most effective where co-ordination and solid, accountable, live communications are in place.

Coherence

To what extent have national governments, development partners and global responses aligned to ensure coherent approaches for the international protection of refugees during COVID-19 at the global, regional and country levels?

At the very highest level, the Global Humanitarian Response Plan (GHRP), the global framework for additional humanitarian needs as a result of COVID-19, was a product of collaboration between UN agencies and partners. The evaluation undertook only a very small number of interviews specific to the GHRP process, and this is yet to be evaluated. UN agencies and donors were positive about the speed and the positive spirit of collaboration. It is clear, however, that the first iteration of the GHRP was pulled together very quickly, and there was limited evidence of broad collaboration with non-UN actors. The evaluation found a wealth of evidence on the extent of global level co-ordination and its influence on the coherence of approaches at the country level.

The Global Compact on Refugees as a framework in the COVID-19 response

Evidence suggests that the Global Compact on Refugees (GCR) had the most direct traction in countries that were part of the Comprehensive Refugee Response Framework or Comprehensive Regional Protection and Solutions Framework, or MIRPS, processes prior to 2018 – that is, those countries where the tenets of the GCR have been embedded since the New York Declaration of 2016. It is also clear that where the GCR intersects with other global policy priorities, notably the humanitarian-development-peace (HDP) nexus (clearly defined in the OECD DAC Recommendation on the Humanitarian-Development-Peace Nexus), pre-pandemic priorities

such as inclusion (above) were bolstered during the pandemic. Equally, while founded in international refugee law and international human rights law, the GCR is also expressly based on rule of law at the national and international levels (GCR, paragraphs 5 and 9) reflected in the inclusive approach that the HDP nexus fosters. International rule of law also promotes greater collaboration among all international and regional human rights actors, which UNHCR can leverage for enhanced refugee protection.

Overall, more could have been done to amplify the GCR through reinforcing its direct relevance to successes in the response. The more UNHCR creates clear links between the GCR and enhanced protection and assistance for refugees as well as fairer and more predictable burden and responsibility sharing, the more the GCR's influence is likely to grow. A precedent is set by the 1998 Guiding Principles on Internal Displacement, which was a similarly "soft" instrument at the outset. After repeated reference and use by UNHCR and the humanitarian sector as a whole and then in the General Assembly, the GCR now reflects, for the most part, customary international law. The pledges made at the Global Refugee Forum in late 2019 were leveraged during the pandemic, so it would have been possible for UNHCR to emphasise in all operations the core relevance of the GCR in achieving burden and responsibility sharing during 2020 and 2021; rolling out the GCR in all UNHCR training and messaging going forward will ensure its enhanced value in the future.

To what extent has the collaborative response in support of refugee rights been fully inclusive of local response options?

There are a huge number of country-level examples of partnership with national actors. The sheer number of countries and contexts, however, and the paucity of global-level data make it impossible to meaningfully quantify the total contribution of local actors in the COVID-19 response. Because it was a rapid- onset response, by nature, in its early phase, there was little likelihood that the response would have led to any immediate step change in the quality or quantity of partnerships with local partners. It does appear, however, that the early response was able to build on existing partnerships and previous investments in national systems and structures.

This evaluation does not attempt to make a judgement on whether, or the extent to which, the engagement of national partners constitutes an improvement in the localisation of the response. "Localisation" has a variety of nuanced meanings, although it is generally held that localised humanitarian action requires a genuine paradigm shift away from a top-down system towards a model that meaningfully engages with the people it intends to serve. Looking across the evidence from this evaluation, it appears that quantitative increases in partnerships fall into the category of adaptation by necessity as much as they constitute or support a paradigm shift on principled grounds. Funding data and testimonies from local actors appear to support the notion that partnerships and decision making remained largely top down. This remains a critical debate, but one that will require a retrospective analysis at some point in the future. Irrespective of the extent to which the COVID-19 response has accelerated

or deepened localisation in refugee responses, it is imperative to continue to work on the basis of partnership. Changes in partnership arrangements also have to be seen in the context of the bigger issues of coverage and capacity, particularly in GBV and child protection. Both seem to have been lacking in the COVID-19 refugee response. Despite an increase in partnerships with local actors in some contexts, the pressure on humanitarian actors who stayed and delivered does not appear to have been significantly relieved. The extra work imposed by adaptation measures combined with the inability to protect in the traditional manner placed significant additional burdens on staff, affecting their well-being in many instances.

For health and child protection in particular, advocacy around the application of a package of pre-existing minimum standards has been key and its influence at the country level is clear. In GBV, health and child protection, there is clear evidence of the country-level adaptation of global guidance by national co-ordinating bodies and in many settings, guidance was developed by co-ordination partners related to the provision of GBV services in the context of COVID-19. For GBV, there is evidence of quicker co-ordination between different country-level co-ordination bodies and active lesson learning from countries affected by COVID-19. Collaboration and joint advocacy among international actors were a key factor in the reprioritisation and rescaling of GBV and child protection services.

Global-level actors co-ordinated around the continuation of pre-pandemic policy work on inclusion, consistent with both the GCR and the HDP nexus. Interviews with UN staff

(global and regional) consistently noted that the pandemic response created leverage with governments around inclusion – specifically, that the recognition of refugees as a particularly vulnerable group provided a locus for collaboration between agencies and governments. Significant success in advocacy for the inclusion of refugees in national vaccine plans is a prime example.

It is also an example of the challenges of translating inclusion in practice to practical coverage.

Each of the thematic sections above details examples of the engagement of local actors in the COVID-19 response. Overall, the evidence is clear and relatively consistent: Over the trajectory of the response, local actors were increasingly, if unevenly, involved and played a range of critical roles. In GBV, efforts were made in a number to settings to engage local women's organisations from the start of the pandemic to promote their participation in contributing to the response, including through service delivery. Evidence suggests that in some instances where local women's organisations were recruited to provide services, this did not always include the support necessary to provide adequate assistance.

Efforts to engage local actors also included the use of workers from the community, often in communication roles and in GBV and child protection to identify and communicate with at-risk individuals. Women's organisations and networks were engaged for service delivery in the GBV response. In child protection especially, a marked increase in engagement with local actors was reported. While the important role of local partners is noted, however, in each of the themes, further evidence also recalls familiar commentary on the need for strengthening aspects of these partnerships.

Recommendations

Recommendation 1: To improve protection and assistance for all refugees, states should uphold international refugee law and international human rights law standards, particularly during times of crisis and emergencies.

Proposed actions:

- All states should automatically renew documentation for refugees and asylum seekers whenever government services have to shut down in any emergency (Action: governments with support of pro tection actors).

- With due regard to data protection and applicable international human rights law standards, UNHCR should work with govern ments to build systems that allow for secure digital registration and documentation that can be renewed remotely (Action: UN HCR and governments).

- Governments should ensure that all police, law enforcement and relevant national authorities are trained on non-refoulement, in cluding the need for open borders for those fleeing conflict, vio lence and persecution in line with international refugee law and international human rights law (Action: governments).

- UNHCR should reaffirm once more the international obligation to ensure an exception for refugees and asylum seekers where borders are closed in future pandemics or large-scale emergen cies, including through the Executive Committee of the High Commissioner's Programme, and liaison with UN system human rights actors (Action: UNHCR and other UN system human rights actors).

Recommendation 2: In preparation for future pandemics and public health crises, advocate and plan for the maintenance of essential in-person protection services to the fullest extent possible, including the provision of adequate human and financial resources.

Proposed actions for international protection actors and governments:

- Ensure access by protection staff to all refugees and asy lum seekers within and at the borders of countries during crises, in line with the underlying principles of the 1950 Statute and the 1951 Convention (Action: governments and UNHCR).

✓ Plan for the provision of adequate, safe quarantine facilities that re spect the human rights of refugees and asylum seekers, placing the minimum additional financial burden on hosting states (Ac tion: governments, UN system agencies and international finance institutions).

Strengthen advocacy efforts to ensure that protection activities, including child protection and gender-based violence, are fully recognised as essential and life saving and to advocate against the suspension of these services in future crises. Ensure that protection actors are provided with the necessary personal protective equipment, integration support, and resources needed to sustain and deliver services in the face of a public health crisis (Action: governments, international protection actors and donors).

Recommendation 3: To enhance protection and assistance for all refugees, states and protection actors should strengthen the promotion of the Global Compact on Refugees.

Proposed actions:

The Global Compact on Refugees (GCR) is a relatively new instrument and needs to be utilised more fully by governments and international, national and local protection actors including during global crises and humanitarian emergencies:

✓ Governments and other members of the international communi ty should consolidate the reporting they have already undertaken with respect to meeting their 2019 Global Refugee Forum pledges during the pandemic, generating persuasive evidence that demonstrates how the GCR strengthened the international response to enhance protection and assistance to refugees and fairer and more predictable burden- and responsibility sharing by states in preparation for the next Global Refugee Forum in 2023 (Action: governments and other relevant stakeholders).

All protection actors including UNHCR should:

✓ improve awareness of the GCR and its specific remit, with the goal of making the GCR central to the promotion of protection and as sistance to refugees and to fairer and more predictable burden and responsibility sharing.

✓ undertake awareness raising, training and capacity building on the GCR, particularly by UNHCR and key partners such as national and local governments

✓ undertake a global review for dissemination to governments and partners of all pandemic-related activities to see how those activi ties could have been or were rolled out as part of the GCR's frame works in order to provide a comprehensive lessons-learned plat form for using the GCR in emergency responses in the future.

Recommendation 4: Invest in planning responses to future crises that protect the rights of refugees through the ongoing strengthening of preparedness efforts, with an emphasis on the strengthening of partnerships with local and national and local actors.

Proposed actions for international protection actors and governments:

- In support of the localisation of specialised response services for GBV survivors and in line with efforts already underway, scale up systemic support and leadership of women-led organisations, especially those led by refugees.

- Ensure that GBV and child protection mainstreaming activities in refugee contexts are integrated into preparedness planning and prioritised during public health crises and other emergencies.

- Continue to invest in and reinforce long-term strategic partnerships with key protection partners, particularly national child protection actors and national GBV actors (Action: UNHCR, UNICEF, UNFPA, the Alliance for Child Protection and donors).

- Assess the viability of simplified procedures and practices based on the changes made during the COVID-19 pandemic with a view to strengthening localised responses going forward (Action: UNHCR).

Recommendation 5: Strengthen the provision of information and messaging for refugees, ensuring that it is two way and needs based; sensitive to local social, cultural and gender norms; and effectively targeted to also reach those most vulnerable and marginalised, including those with limited access to online communication channels.

Proposed actions:

- Build on lessons from the Ebola and COVID-19 responses to identify the issues that have prevented the preparation of appropriately layered and targeted messages, including resource constraints (Action: international protection actors).

- Consult with specialist partners to ensure that information products can be better targeted to refugees with a range of disabilities and specific information requirements (Action: international protection actors).

Recommendation 6: Recognise that some in-person protection services are essential. While adaptation and innovation to support refugees' ongoing access to services during restricted movement are important, it is equally important to recognise the limitations of remote delivery, especially for survivors of gender-based violence, for children at risk and their caregivers, and for others with specific protection needs.

Proposed actions:

- Develop guidance that recognises that programme adaptations, including remote management, can be effective in future emergencies with movement and access constraints but also that a total shift to remote services should only be undertaken after careful consideration of the risk of harm versus the benefits. Incorporate recommendations for how to support advocacy for the continuation of necessary in-person protection services as part of the GBV response in pandemic or other emergency situations characterised by movement restrictions and/or access constraints (Action: international protection actors).

- Continue developing the capacity of the child protection and GBV workforces in refugee contexts. Ensure appropriate levels of dedicated child protection and GBV staffing, with the required level of expertise and skills and adequate funding (Action: UNHCR and partners).

- Improve tracking of unearmarked funds allocated to GBV programming and improve transparency to allow donors and the wider humanitarian community to better understand how money is being spent and where investments are lacking or needed (Action: international protection actors and co-ordination bodies).

JOINT EVALUATION OF THE PROTECTION OF THE RIGHTS OF REFUGEES DURING THE COVID-19 PANDEMIC

COVID-19 GLOBAL
Evaluation Coalition