Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic

1 Introduction to the evaluation

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 cooperation, and the combined response of host states, agencies and non-government and civil society organizations, in ensuring the protection of the rights of refugees during the pandemic.

The evaluation focuses on specific rights: the right to seek and enjoy asylum; the right to health; protection against sexual and gender-based violence (GBV); child protection and family reunification; the rights of persons with specific needs; and access to information.

The Management Group for this evaluation includes the Evaluation Units of UNHCR, Ministry of Foreign Affairs of Finland, 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.

The evaluation involved five streams of research:

- **Targeted document review,** including documents with a global perspective, and documents focusing on country sample, for a total of around 500 documents. The documents were systematically analyzed using a coding software, MaxQDA.

- **Key Informant Interviews,** 40 interviews were conducted across global and thematic levels, including interviews with UN system agencies, Non-Governmental Organizations (NGOs), civil society organizations, donors and funders.

- **Analysis of key data sets**, those available globally and a more in-depth look at data in a selection of 27 countries.[1] The review of data across 27 countries offers a more systematic

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[1] Criteria for country selection included top refugee host countries with asylum seeker and refugee populations above a minimum threshold. 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 6 OECD member countries of which 3 are also traditional OECD DAC donors); exclusion of several conflict affected countries with high IDP caseloads to ensure a greater focus on refugees; exclusion of one country based on lack of data and a lower refugee per capita ratio

and comprehensive analysis of refugee needs and cooperation in the COVID-19 response. This approach was designed to combine indicators and facilitate analysis, provide information on trends and patterns and help compensate for data gaps.

- **Analysis of available financial data.**
- **Thematic snapshots (ongoing),** deeper dives into key emerging themes (but not country specific).

This paper provides only a short, high-level summary of the emerging themes from the data collection period (August-October 2021). Some of the triangulation and analysis of data is still ongoing, and this paper outlines only emerging findings to date. The draft and final evaluation reports will be fully referenced, in keeping with evaluation norms. Given that the emerging themes presented herein are a high-level summary of analysis derived from hundreds of individual sources, this summary is presented without citations at this point. The paper does not offer full answers to the evaluation questions, but is structured around their key themes:

- **Section 1** introduces the evaluation and outlines the limitations and constraints.
- **Section 2 covers the key themes in EQ1:** some of the global and overarching themes of this evaluation, including the overall impact of the pandemic on refugees; the Global Compact on Refugees (GCR); global level advocacy; and coverage.
- **Section 3 covers the key themes in EQ2:** emerging findings on effectiveness, including adaptation and innovations, organized by thematic area.
- **Section 4 covers the key themes in EQ3:** coherence and coordination.

Evaluation questions

The full report will seek to answer the prescribed evaluation questions:

Evaluation Question 1. Global level (relevance (promotion, inclusion, adaptation) and coverage). To what extent has the protection of refugees and their rights been recognized and addressed in the response of international cooperation 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?

Sub-questions under EQ1 require reflection on a range of topics: the extent to which the protection of the rights of refugees was considered within the totality of the COVID-19 response, and how the protection of rights was translated into the provision of essential services; the coverage/sufficiency of these services; effective practices within advocacy and diplomacy; and the extent to which the GCR has been utilized as a framework in response to the needs of refugees during COVID-19.

Evaluation Question 2. Effectiveness. How effective has been the combined response of international and national actors (states, agencies and civil society organizations) toward enabling refugees to realize their rights in the following areas: a) the right to seek and enjoy asylum; b) the right to health; c) protection from GBV; d) child protection, education; e) addressing the protection rights of persons with specific needs; f) Access to information. This question also considers good practices, innovation and community-based approaches, and key factors behind these.

Evaluation Question 3. Coherence. To what extent have national government, 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?

Sub-questions under EQ3 require reflection on the extent to which the response has been collaborative and cohesive, and inclusive of all local response options.

Limitations/constraints

The research team has completed the majority of the research tasks. Thematic snapshots, always slated to be undertaken last, are ongoing and will be completed by the end of December. A small number of interviews remain to be undertaken, and a small number of documents to be reviewed. The role of the World Bank in particular is under-represented in this briefing paper and will be strengthened in future iterations.

The COVID-19 pandemic is ongoing and continues to have wide ranging and dramatic impacts on the ability of refugees to exercise their rights. The global scale and the ongoing and evolving nature of the pandemic presents specific challenges for evaluators. This evaluation was tasked with looking at a range of contexts and scenarios, recognizing that refugees are hosted in high and low to middle income countries (LMIC), including those which are conflict-affected with a pre-existing humanitarian response. As such, this implies a wide variance of situations for refugees (e.g. camp-non-camp, urban settings). In addition, COVID-19 affectation rates, the timing of high affectation rates and the quality of data on affectation varies very significantly from country to country. The public health approaches, including management of borders and internal restrictions on movement, also differ greatly and defy broad generalization.

This evaluation focuses on a limited number of rights. We acknowledge that the economic impacts of the pandemic, beyond the direct scope of this evaluation, had devastating effects on the livelihoods of refugees. The lockdowns led to the restriction of informal economies where most refugees are employed, leaving them less able to house or sustain themselves and their families. As noted throughout in our data, refugees' ability to access services, either because of the costs of the services themselves or transport and other indirect costs and lack of information, was severely curtailed.

Additionally, there are limitations to the availability of data on the impact of COVID-19 on refugees. Results data for humanitarian action in general are rarely disaggregated by refugee status. 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, i.e. other displaced and sometimes vulnerable host populations are included other than refugees.

Indicators created for the Global Humanitarian Response Plan (GHRP) represented reasonable efforts to quantify the efforts included in the plan. Often, however, indicators were non-specific and/or required adjustment over time. For agencies, part of the challenge with COVID-19 has also been both understanding what information would be most relevant to collect and which areas to prioritize in this response given the unknowns at the start of the pandemic and the wide range of consequences, both direct and indirect.

Challenges with data demonstrate how the COVID-19 pandemic has exacerbated systemic data weaknesses (this mirrors findings in all of the evaluations themes). Prior to the pandemic response, clearly disaggregated data have not consistently been available for certain at-risk populations, including refugees, even less so for refugees with specific needs, including elderly refugees and those with disabilities. There were pre-existing data gaps, particularly on protection.[2] Quantifying the contributions of local organizations, including refugee-led organizations, continues to be challenging. Examples of the work of local actors are typically circulated on social media and defy collection through formal reporting. The significant contribution of refugees and refugee-led organizations (RLOs) was cited in interviews and is captured in multiple, country level examples. The final evaluation report will cite a number of examples. The lack of data which can be 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.

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[2] There are more significant gaps in child protection, in particular where violence against children has been less considered.

Finally, data collection and reporting were curtailed in precisely the same manner as other activities given movement restrictions. The switch to remote methods caused additional challenges for confidentiality and "do no harm" considerations.

The range of issues with data is complex and it would be over-simplistic to describe this combination of significant challenges as 'weak reporting'.

2   Inclusion, relevance, coverage and the GCR

2.1 Inclusion of refugees in the collective pandemic response (relevance and coverage)

Refugees are one specific group among those affected by the direct and indirect impacts of the pandemic. This and every evaluation undertaken during the pandemic has had to grapple with the extraordinary nature and magnitude of the events. This includes the need to take into consideration primary and secondary consequences of the virus on refugee populations, but also how the measures taken to reduce the transmission of the virus, including lockdowns and other restrictions, have impacted every society. Refugees, migrants and internally displaced populations were affected, as were governments and agencies charged with upholding and supporting refugee rights.

It is clear that pre-existing barriers to protection and assistance have, in many host countries, been compounded by the lockdowns. Pre-existing aid channels and refugees' access to services were severely curtailed in the first six months of the pandemic. As inequality widened, and extreme poverty increased overall, refugees were worse affected also facing lack of resources and additional stigmatization and discrimination during the pandemic.

The inclusion of refugees and migrants under one of the three pillars 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 an extremely vulnerable, priority group. The construction of the GHRP and the appeal was not without challenges but pulled together in a timely fashion. At the global level, the extraordinary nature of events helped to foster a collaborative environment. Donors provided additional flexible funding to their multilateral partners. The early response was based on predictions of a devastating impact for vulnerable population, not least in countries with large refugee populations.

Again, in broad terms, this spirit of collaboration was seen to have continued to country level, in that the recognition of refugees as a particularly vulnerable group provided a clear locus of coordination for WHO, UNHCR and other international actors. Ultimately, interviews conducted by the evaluation team stated that the overall strategy of inclusion of refugees in national healthcare systems was on a positive trajectory in the more recent stages of the pandemic. One facet of this was the successful advocacy in the inclusion of refugees in national vaccination plans, in COVID-19 testing and treatment plans and in preventative programs (including education and awareness raising efforts).

While refugees were adequately represented in the response overall, the initial focus on health meant the de-prioritization of Gender-Based Violence (GBV) and child protection assistance in the first phase of the response. EQs 2 and 3 below describe efforts to address this imbalance over the course of the response, and efforts to adapt and innovate to address some of the effects of the pandemic and containment measures to restore coverage, especially in non-health sectors.

Again, in very broad terms, patterns appear across the research streams. Advocacy at global and national levels restored emphasis on the GBV and child protection responses (EQ3). Adaptation, especially the use of remote service provision, allowed for the improved coverage (examples are cited across EQ2 below) – but from the global level, it is impossible to measure or estimate

coverage. In addition, it is clear that while the use of remote programming across the service delivery sections (Gender-Based Violence, Child Protection, Health and Refugee Status Determination) was a positive, it did not address the needs of the most vulnerable refugees. Multiple sources cite problems for refugees with disabilities, those without access to technology (including a gender divide in some contexts), challenges with language and for elderly refugees. Again, the full report will cite multiple examples and testimony, but quantification at the global level is impossible at this stage with the available data.

Adaptation and focus on balancing coverage notwithstanding, the pandemic response did not, overall, address chronic/systemic flaws. This includes adequate coverage of refugees with disabilities. Similarly, a lack of data undermines the ability of the evaluation to quantify the effects of COVID-19 on refugees with disability. Individual examples and testimony demonstrate the extraordinary challenges which resulted from lockdowns and other restrictions, as well as the shift to online/remote services delivery. Again, interviews, reports and testimony will be used in the full report, but the lack of data is does not allow to understand the subject with the adequate depth.

2.2 Funding

Overall funding data suggests that donors increased their level of humanitarian funding during the pandemic, although this rise in funding was not at pace with the increased level of appeal requirements. The international community initially responded to the foreseen increased humanitarian needs resulting from the pandemic through the COVID-19 GHRP. The GHRP covered countries and refugee host countries included in Refugee Response Plans (RRPs), and it was launched on March, 25th 2020 and updated in May 2020. The initial US$6.7 billion funding requirements needed in May 2020 to implement the response, were revised to **$10.26 billion in July 2020**. In 2020, according to the Financial Tracking Service data[3], funding for UN-led humanitarian appeals reached a record high with US$19bn, yet at the same time these appeals were seeing the lowest levels of coverage in its history. This was due to the sharp increase of appeal requirements, up by 39% from the pre-pandemic levels to US$39bn (US$37bn in 2021, a 36% increase from the 2019 levels).

Donors generally increased their levels of funding to multilaterals to help swiftly respond to the pandemic and provided additional flexibility. This approach was also in line with the COVID-19 GHRP that planned for almost all the allocation of the funding to be channeled through UN agencies. The trade-off was that resources were not always allocated as directly as possible to the partners best placed to respond. The revised GHRP added $300 million as a supplemental envelop for NGOs, on top of the over $8 billion in country-level requirements in an effort to enable NGOs to quickly act to the evolving needs on the ground to respond to the pandemic. A review of UNHCR funding data suggests that although the organization is steadily allocating a greater proportion of its funding to local actors over time, this trend was not accelerated during the pandemic. Initial overall data does not suggest that a greater proportion of funding was made available to local NGOs. Interviews suggest that the response revealed the need for greater work on needs-based funding amounts, effective partnerships and mechanisms through which funds reach local partners.

2.3 The Global Compact on Refugees

In December 2018, the United Nations General Assembly adopted the GCR after two years of consultations, demonstrating a commitment to international refugee protection and international cooperation in refugee responses. The launch of the GCR was followed up in December 2019 with the first Global Refugee Forum, which brought together the international community in support of

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[3] Based on data by UN OCHA Financial Tracking Services, last accessed on 17 November 2021.

better protection and assistance for refugees and fairer and more predictable burden- and responsibility-sharing.

The pandemic was declared a few months later in March 2020, lockdowns and other measures were implemented and the pandemic response dominated global attention. Among the restrictions, the closure of borders, contrary to the right to seek asylum and the cardinal principle of *non-refoulement*, set out in paragraph 5 of the GCR, had a significant impact on refugee populations. During the pandemic, developing countries continued to host 85% of the over 30 million refugees and asylum seekers and needed more than ever fairer and more predictable burden- and responsibility-sharing.

Emerging evidence suggests that the GCR had most traction in countries that were part of the CRRF or MIRPS processes, that is, those where its tenets have been embedded since the New York Declaration of 2016. 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 its influence is likely to grow.

The high-value pledges in areas such as health, protection, jobs and livelihoods, with UNHCR facilitating progress on these, were drawn upon during the pandemic. Despite the GCR's potential as a framework and advocacy tool for protection and burden- and responsibility-sharing during COVID-19, studies suggest that there have been challenges with 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 prioritization of short-term emergency assistance.[4] Interviewees drew parallels between the GCR and greater inclusion of refugees in health systems generally, but it is impossible to attribute this phenomenon to GCR implementation specifically. As the pandemic response continues, there is the need for greater effort with respect to third country solutions (resettlement and complementary pathways, both referred to in the GCR as a significant element of burden- and responsibility-sharing) and voluntary repatriation through the peace/ development nexus. On balance, the pandemic appears to have hampered the implementation of the GCR, but at the same time it has shown the importance of the principles it is based on, most of all international cooperation and burden- and responsibility-sharing.

3 Effectiveness

3.1 Seeking asylum in the pandemic

The COVID-19 pandemic led to the closure of borders and lockdowns. 195 states closed their borders since the start of the pandemic to November 2021, fully or partially, to contain the spread of the pandemic and protect their populations. In 64 cases, border closures were total and prevented refugees from seeking asylum, contrary to Article 14 Universal Declaration of Human Rights. As a result of border closures, restrictions on travel (direct and indirect) in 2020, across all regions, 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. As of November 7, 2021, 43 countries continue to deny access to territory based on COVID-19, down from 99 in May 2020, while in 76 countries, asylum seekers are exempt from restrictions on access to territory. The position is improving, in part due to UNHCR's advocacy, intervention and support.

The closure of borders obstructed access to asylum, heightened the risk of *refoulement* and led to other protection risks. 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 of *refoulement* and collective expulsion. Even after some travel restarted, a number of states still limited arrivals to nationals. The numbers able to seek asylum dropped – that does not mean the

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[4] DRC (2020) Exploring the impact of COVID-19 on the Global Compact on Refugees.

numbers needing asylum dropped. With many borders closed, many forcibly displaced persons had to resort to irregular border crossings and were exposed to heightened protection risks. Pushbacks and expulsions were witnessed across many countries. Other factors to do with states' failure to protect the rights of refugees in the pandemic also led to indirect *refoulement*. Through joint advocacy, many border closures were eventually relaxed in whole or in part by states with respect to refugees and asylum seekers. Overall, however, a negative picture of all outsiders in traditional and social media, exacerbated by images of walls and barbed wire, continues to be painted, leading to increased xenophobia, hate and stigmatization of refugees during the pandemic. There is also compelling evidence of pushbacks, at sea and on land, and expulsions, and in 39 countries there was *refoulement* to persecution and violence.

Border closures and lockdowns reduced the ability of governments and protection actors to resettle refugees to a third country. In some countries, protection of the rights of refugees cannot be assured and, there, resettlement to a third country is the only effective measure; a country may not accept refugees or may not have the capacity to provide a durable and sustainable solution either generally or to the specific refugee. Resettlement is also seen as a significant contributor to burden- and responsibility-sharing under the GCR. Nevertheless, resettlement, which at the best of times accounts for very few refugees, slipped to a mere 22,800 in 2020 globally from 63,726 in 2019 and 126,291 in 2016.[5] The pandemic had a dramatic effect on resettlement because trans-border movements were restricted and that meant that not only could refugees not travel to countries of resettlement, but 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 noted above.

Lockdowns suspended refugee status (RSD) determination during the pandemic for some periods of time. While the numbers seeking asylum dropped overall, in many cases, the backlog in RSD and processing times increased. This means that the effects of the pandemic continue even though lockdowns are easing. Adaptive measures were introduced during lockdowns, with remote interviews taking place. However, the support possible during face-to-face interviews was missing and there are fears that compromised confidentiality put refugees, and those with specific needs especially, at greater risk. Not only is it not certain that refugees could report their situation if they were speaking on a phone in front of other family/community members, but there was the additional risk, according to UNHCR staff interviewed, that the remote interpreter, was also unable to ensure confidentiality, as they interpreted what the refugee was saying. It should be noted, as mentioned elsewhere, that registration, resettlement and family reunification were also delayed by lockdowns.

Lockdowns limited refugees' access to services and humanitarian actors' ability to reach people in search of protection. As a consequence of the lockdowns, protection actors' staff (including UNHCR) had their movements severely restricted; typically, travel was restricted to individuals and services designated as critical, rarely including protection. Government services also shut down. Registration and documentation, the gateway to protection and rights within the country of asylum (and therefore central to accessing services), could no longer be carried out, so adaptive measures had to be implemented. These included remote technologies and eventually in socially distanced facilities using plexiglass shields. UNHCR facilitated the installation of such options for governments, but the return to face-to-face services by governments for refugees and asylum seekers has been slow. In many countries, UNHCR successfully advocated with governments for expired registration and documentation to remain valid so that refugees and asylum seekers could remain at liberty not fearing deportation.

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[5] Available at https://rsq.unhcr.org/en/#P6kg

Governments failed to protect refugees' right to health in detention and quarantine. States have the duty to protect the health of all on their territory and that can justify detention for quarantine. Nevertheless, the quarantine facilities must not put those detained at risk. The emerging findings show 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.

In sum, it will never be possible to ascertain how much closed borders, lockdowns, pushbacks and indirect *refoulement* led to a *global* failure to protect the most vulnerable fleeing persecution, armed conflict and generalized violence. However, advocacy and adaptation improved in part the protection of the rights of refugees during the pandemic.

3.2 Access to health

In the first phase of the pandemic (3-6 months), refugees' access to health services was severely curtailed. While services and access to services have been reinstated to varying degrees over time, multiple, complex challenges remain. All research streams reference multiple, country level examples of severe disruption in the early months, such as initial closure of routine services, severe shortages of staff due to travel restrictions, essential, life-saving medicines and equipment.

Travel restrictions and lockdowns severely curtailed the operations of emergency/humanitarian actors who were dealing with other major disease outbreaks.

Routine vaccination campaigns have been affected too - delayed or cancelled in some instances. For example, according to UNHCR data from 2020, the number of measles vaccinations administered to children under five decreased by 9.5%.

Health partners focused on the continued provision of the Minimum Package of Essential Health Services. While heavily affected by COVID-19 related restrictions in the first instance, essential health services were a stated priority throughout.[6] In general terms, there was success in maintaining the provision of pre- and postnatal care, delivery by skilled attendant, family planning, sexual and reproductive health. These were prioritized in both policy and practice. These additional measures notwithstanding, UNHCR's Health Information System confirms lower utilization of health services overall for refugees in 2020, down by 13% from 2019.

UN staff described a purposeful, pre-pandemic shift in strategy toward pushing for the inclusion of refugees in national health systems and structures - away from parallel services.[7] Interviews with UN staff (global and regional) consistently note that COVID-19 has created leverage with governments around inclusion; one consequence of inter-agency coordination and advocacy in numerous countries. Consensus suggests that COVID-19 may have created momentum for inclusion going forward, the significant disruptions to services noted above, leave a mixed picture with significant regional variations.

Formal inclusion of refugees in access to primary health care is high and, in many countries, theoretically on a par with nationals. In practice, however, refugees have experienced significant additional barriers to access during the pandemic. Data on refugee access to health care during the pandemic varies greatly according to context.

Reports contain numerous references from country level, significant challenges to access where health systems are already weak, most notably outside of camp settings. Those in camp settings, however, have also cited overcrowding as a barrier to access to healthcare.

Adaptation of healthcare to remote services where possible (notably telehealth), is recognized as a positive. It is clear, however, that it created new barriers for some refugees. Country level examples

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[6] An example of this prioritization is the repurposing of women and girls' safe spaces (WGSS) for health services in GBV guidance early in the response.

[7] UNHCR's last 'inclusion survey was run pre-COVID and the results of the next will appear after this report is published.

cite challenges with accessing online services, related to access to technology and, significantly in some contexts, language barriers. Although the total impact is impossible to quantify, barriers for refugees with disabilities were especially great in this respect.

Fear has also played a significant role in impeding refugee access to primary health care services, in particular fear of detention and possible deportation as a result of disclosure of immigration status. In addition, there are widespread reports that xenophobia and prejudice against refugees were heightened as a result of the pandemic. A small number of countries[8] constructed clear firewalls between the bodies responsible for health and those for immigration, promoting the fact that refugees and asylum seekers could access health systems when necessary, without fear of attention from immigration officials.

Formal inclusion in national vaccine plans is high, but low rates are reflective of the national vaccination rates of host communities. A survey conducted by WHO in February 2021 found that just over half of National Deployment and Vaccination Plans (NDVPs) explicitly included refugees and asylum seekers. Numerous sources published after this date and key informant interviews, referenced strengthened global efforts for the inclusion of refugees in vaccination plans. This is supported by UNHCR's internal inclusion data from April 2021 which notes that formal inclusion of refugees is high.[9] Overall, therefore, while gaps in data remain, the emerging picture is one of increasing inclusion of refugees in NDVPs. This does not equate, however, to high rates of vaccination of refugees. Most LMICs have relied on the COVAX facility to obtain vaccines, which aims to vaccinate 20% of the population. Only 1% of the population in Low Income Countries had access to their first dose in July 2021. It is not yet clear from the data available if refugees are facing relative inequity within these low numbers. It is likely, however, that low vaccination rates among refugees in LMICs is reflective of the extremely low vaccination rates among host populations.

Major barriers have impeded humanitarian agencies from 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 its accelerated development manufacturers have required others to cover these costs instead. The burden of covering manufacturer's liability costs therefore falls on either national authorities procuring vaccines or on NGOs seeking to procure 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 IASC[10] highlights 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, therefore doses procured through the humanitarian buffer become inaccessible to them, thus jeopardizing vaccination coverage of all populations of concern.

These challenges notwithstanding, reporting cited numerous examples of good practice beyond those listed above, including multiple instances of the use of Community Health Workers recruited from refugee populations. In some instances, this extended to the use of refugee health professionals. Another good practice reported by several countries is the provision/delivery of multiple months of medication for refugees previously diagnosed with chronic conditions (HIV/TB).

3.3 Child protection

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[8] This action was not recorded in global data i.e. it does not appear to recorded in global data. Interviews and document review report these actions by a handful of governments but reporting was not systematic.

[9] Out of the 26-country sample this evaluation has reviewed, 21 were covered in UNHCR data on inclusion. Of these 21 countries, 100% formally included refugees in their national plans.

[10] IASC. (2021). Frequently Asked Questions: The Covax Humanitarian Buffer.

The COVID-19 pandemic has exacerbated protection risks of refugee children and their families, worsening drivers of violence in settings where the stresses of daily life are already severe and child protection services less consistent/concentrated. Over 13 million children are refugees and asylum seekers. Children are over-represented among the world's refugees accounting for less than one third of the global population, but almost half among the world's refugees in 2020. Confinement measures, school closures, household economic breakdown, separation from caregivers, and disruption of services have worsened pre-existing inequalities and exposed children to heightened risks of violence at home, sexual violence, social exclusion, psychosocial distress, child labor, including child recruitment, and child marriage.

Violence in the home (or family violence) against children has been rising globally since the start of the COVID-19 lockdowns. 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.[11]

Separation of refugee children and their families has increased and prolonged due to disrupted family tracing and reunification services; one consequence of the imposed restrictions of movements and border closures. Other children, including unaccompanied and separated children, have been returned to their home countries without any individual assessment, as countries of return are often ill-equipped to receive children in safety. There are reports of children having been stranded in border areas unable to return home, putting them at risk of *refoulement* or serious harm. In addition, children losing or being separated from primary caregivers due to quarantine or confinement measures face increased risk of neglect and abuse and suffer mental health and psychosocial impacts.

Child labor, already a widespread problem for refugee children prior to the pandemic, has likely seen a significant increase. There are cases of children who had been working before the pandemic often continued to work despite the government-enforced curfew for children. Furthermore, the evidence shows that some employers required children to sleep at the workplaces overnight. No comprehensive data exist to provide a complete and accurate picture of child labor in 2020, and specifically of data on child labor among refugee children, but the International Labor Organization estimates that an additional 66 million children will be engaged in work during the COVID-19 crisis as their households try to survive.

The pandemic had widespread psychosocial impacts on the lives of refugee children. In one global survey, 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. [12] 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, and more frequent aggressive behavior, all of which increased in the weeks following the school closures[13]

In response to some of these child protection concerns and containment measures, there are many examples of adjustments to remote service delivery, including the set up or scale up of helplines, remote child protection case management, adapted referral pathways and case prioritization criteria, the development of additional case management protocols, online activities for mental health and psychological support, as well as audio recorded guidance for children and parents, which resulted in opportunities to remain in touch with children and families at-risk in areas with phone/internet access. Where possible, face-to-face support by case workers for particularly high-risk cases continued or resumed over time. Research was done in terms of the functioning of

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[11] The Hidden Impact of COVID-19 on Child Protection and Well-Being, A Global Rsearch Series, Save the Children, 2020

[12] The Hidden Impact of COVID-19 on Child Protection and Wellbeing, a Global Series of Research, Save the Children, 2020

[13] N.B. These surveys are not specific to refugee children but it reasonable to conclude that these effects are universal. As we continue the evaluation, the research team will seek to determine whether and to what extent these trends have affected refugee children specifically.

helplines in order to improve and optimize its use and laptops and other communication resources were provided to expand the operationalization of helplines.

Also, momentum was created to seize opportunities to advance addressing certain child protection issues, such as the release of children in migration detention and support of family based alternative care arrangements following the outbreak of the pandemic and joint advocacy by UN system agencies.

Furthermore, locally driven and community-based interventions have been accelerated and scaled up, following the outbreak of COVID-19 and the restrictive measures. There has been a massive shift toward supporting local platforms, local actors and community volunteers were considered pivotal to deliver services for child protection.

Furthermore, online open training courses on the protection of refugee children, practical guidance and peer to peer exchange, reached a wide range of frontline workers, including local and community-based actors, aiming to adapt child protection case management and other child protection program modalities during the pandemic.

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 specialized services for children at-risk, by phone or other types of remote service provision.

The pandemic has affected the schooling of 1.5 billion students[14] worldwide and is likely to exacerbate the vulnerabilities of the millions of refugee learners around the world. The closure of schools has had huge negative ramifications for the protection of children, including refugee children, particularly in areas that were already vulnerable and under-resourced. Prior to the pandemic, refugee children, particularly girls, were often those most educationally and economically deprived, as they were twice as likely to be out of school than other children. As a result of the outbreak of the pandemic, access of refugee children to education has been further affected by a lack of consideration for or inclusion of refugee children in alternative schooling plans proposed by national authorities.

In response to the closure of schools, there are numerous examples of good practices regarding distant learning support, including online modalities, as well as through local and community radio broad cast targeting refugee children.

However, access to technology for remote learning, including access to mobile phones, computers or internet connectivity and reliable electricity, remained out of reach for many, especially for children in remote areas, including refugee camps or informal settings, while language barriers sometimes prevent access to available remote learning solutions. It has also been noted that girls were more often have less access to technology than boys. Children with disabilities were at increased risk of being left behind as measures to support home-based learning fell short of their learning needs.

3.4 Gender-Based Violence

There has been significant attention to the problem of GBV –particularly intimate partner violence (IPV) – escalating globally as a result of lockdown measures associated with COVID-19. IPV may have had an even greater impact in refugee settings where GBV services were shut down precipitously and women were confined within camp settings.

To address these risks, there are multiple examples of adaptation to rescale services as quickly as possible in refugee contexts. In some settings, GBV partners undertook successful advocacy to reopen women and girls' safe spaces and/or One-stops as essential services. The success of this

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[14] Strictly speaking, education is beyond the scope of this evaluation. However, given the intersection of the curtailment of education and child protection during the pandemic, high level findings on education were included for context.

advocacy often reflected a positive relationship with government as well as strong GBV coordination capacity. In more than three quarters of the 63 countries in the GHRP, UNHCR operations reported that they had maintained or expanded GBV services in response to COVID-19. There was adaptation of physical safe spaces for women and girls into GBV phone booth stations where phone-based case management support could be given. However, despite success in ensuring One-stops stayed open, many did not have funding for staff to meet the need.

Another contributor to rapid response in some settings was linked to positive preparedness actions in countries which initially had low levels of COVID-19, including efforts to learn from other refugee settings where GBV-related COVID-19 response had already been scaled up. Specifically, there is evidence that some responses took measures to support continuity of services before lockdowns were imposed. New programming was introduced such as digital platforms for local community networks, remote individual case management and emergency cash assistance. Cash was provided through mobile wallets to those who could not access the ATMs due to movement restrictions. Many UNHCR operations created or expanded communication channels for survivors such as 24/7 emergency hotlines. Additionally, an application called "myUNHCR" that allows refugees to remotely update information concerning their protection needs is in a pilot phase. There were also targeted campaigns on Instagram, Facebook, and rural radios to support dissemination of information on remote GBV services.

However, 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, even from the start of a pandemic. There are numerous reports of transitions to phone, internet or SMS-based services, slimmed-down services, referrals to health providers for emergency care. These solutions are not workable for all survivors: a heavy reliance on phones and remote interviews create safety and supply challenges for survivors and providers alike. There is evidence from multiple countries that the shift to remote services has only been able to manage existing caseloads, not new clients, and left women not knowing where to report if they had problem.

In addition, although significant program investments have been made to address the problem of violence escalating in the home as a result of lockdown measures related to COVID-19, arguably less attention has been afforded to some other types of GBV-related protection concerns that refugee women and girls have faced as a result of COVID-19, such as those related to their caregiving responsibilities. In a multi-country safety audit, women reported sexual harassment and assault by police at COVID-19 checkpoints and by men in the community when out past curfew collecting water and/or food for the family, especially as social distancing prevented women from walking in groups. In addition, in some contexts, quarantine centers established to curtail spread of COVID-19 have had inadequate lighting and/or sex-segregated water, sanitation and hygiene facilities, increasing the risk of violence for women and girls. Refugee women and girls who experience multiple and intersecting forms of discrimination are likely to have been disproportionately affected.

Moreover, preliminary interviews have raised concerns about the relative lack of attention to the needs of adolescent refugee girls during the pandemic and the implications for girls' long-term well-being. Early marriages and adolescent pregnancies have increased during the pandemic across a number of refugee host countries, linked to school closures, lack of access to sexual and reproductive health services, and limited targeted protection programming for adolescent girls. Evidence suggest refugee girls were more likely than non-refugee peers to be out of school as a result of the pandemic. Some settings have also reported an increase in domestic labor and a fear that girls will have a harder time returning to school and reassimilating post-COVID-19. While the issue of child marriage was recognized by UNHCR and partners even in the early stages of the epidemic, it is not clear that programming investments matched awareness of risks.

The limits in programming have been linked to funding shortfalls. There is evidence of advocacy at the country level for increased funding. For example, the sexual and gender-based violence (SGBV) working group chaired by UNFPA and UNHCR in Ethiopia designated an OCHA allocation to 3 GBV projects to address urgent gaps and adapt to the COVID-19 situation. The Jordan Humanitarian Fund released $4.5 million in May 2020, targeting the needs of elderly, people with disabilities, SGBV survivors and Syrian Refugees in host communities and camps, as well as impoverished Jordanian households.

There also appear to be challenges with systematic and meaningful engagement of local women and women's organizations in the GBV response during COVID-19, particularly utilizing an intersectional approach. There are some positive examples of engaging local women's organizations to promote their participation in contributing to the response. For example, in May 2020, more than 200 women civil society organizations were mobilized to provide critical insights on the impact of COVID-19 on violence against women and girls (VAWG) by UN Women. International Red Cross (IRC) also conducted a comprehensive GBV safety audit across multiple settings to access women and girls' voices that similarly engaged women and women's organizations. However, in many contexts, only women and girls with access to mobile phones could be reached and included in consultations about services, as was the case with the IRC safety audit exercise. Moreover, the inclusion of diverse women and girls, including those facing intersecting forms of marginalization, was not systematic, according to GBV experts, and varied widely across contexts depending on which groups had previously been engaged by humanitarian actors.

In instances where local women's organizations were recruited to provide services, this did not always include support necessary to build capacity. There have been some good examples of engaging with local Community-Based Organizations and women-led groups to maintain services. There are also many examples of positive engagement with local women's groups for community outreach around GBV prevention. However, COVID-19 and related movement restrictions have presented challenges to international humanitarian actors in providing sufficient support and capacity-building to women's organizations and groups to ensure they have technical skills necessary to undertake case management interventions. Particularly in terms of response, this has at times resulted in the provision of GBV services through relatively precarious community-based responses.

In addition to GBV specialized programming examples noted above, there are a number of examples of GBV risk mitigation, especially at health entry points and through WASH programming, which have helped to facilitate greater protections for women and girls. Examples of these will be detailed further in the report.

3.5 Access to information

Understanding the importance of access to information and effective risk communication has been key in the response. Within the pandemic response, efforts to ensure access to information to refugees and to maintain two-way communication have been critical to the broader public health response and to addressing the protection concerns of refugees. Effective risk communication strategies need to be customized to meet the specific interests, concerns, and habits of the target audiences. This means that refugees and those with specific needs, in particular, require different types of messaging, as well as different distribution channels. Examples suggest that early in the response, while information may have been available, in the absence of translation, it remained inaccessible to refugees due to language barriers. Reporting included numerous examples of refugees listening to messaging from their countries of origin, or countries hosting refugees from their communities, rather than countries of asylum. Varying messaging and positions on non-pharmaceutical interventions to COVID across countries presented an additional challenge for refugees. Reporting, interviews and the broader literature review cite numerous detrimental effects of failures to engage with and communicate effectively with communities and find means for them

to participate actively in the response and the gendered, age and diversity dynamics of communication being overlooked.

Early studies suggested that information needs and strategies related to the pandemic may have been better understood and rolled out in country contexts with pre-existing aid structures. Even in such contexts, however, it has been hard to provide consistent messaging and misinformation has been difficult to tackle. Evidence suggests that there has been some learning in certain cases from responses to other outbreaks (e.g. Ebola) on the need to rapidly address misinformation and rumors in culturally appropriate ways to avoid the further rapid spread of the disease and further loss. Rumor tracking efforts and COVID-19 awareness surveys were rolled out in many countries and that this enabled actors to better understand information needs and dispel myths. Experience from work in Ebola-affected countries showing that faith leaders can play a key role in response to health emergencies was also leveraged in communication efforts with refugees during the pandemic. Positively, there are also examples of refugee-led efforts to spread accurate information on relevant platforms and through diverse channels.

Surveys efforts showed that while refugees progressively had better information on COVID, information on access to services was lacking. In some cases, agencies were not providing information on the lack of protection related services being provided at the time, either because information was not available from governments or in an effort to avoid communicating negative news. The result is that refugees could be left in an information vacuum. Providing accurate information in a rapidly changing environment was a challenge and best practice included recognizing the importance of timestamping information for accuracy. In certain refugee contexts, agencies were also able to provide more tailored information to refugees where these have the right to legally own a SIM card and an enabling communications ecosystem was in place that allowed them to leverage pre-pandemic ways of working. Overall, there is evidence that while most of the focus of the response is health related information and risk communication, protection related information is important for refugees and requires a strong concerted inter-agency effort.

Official information has been in competition with misinformation and rumors, often circulating without the knowledge of authorities and aid agencies. Tracking and combating misinformation and rumors and building trust among affected populations has been an ongoing challenge, there has been a persistent tendency for affected groups to rely on informal or unverified sources of information (social media, friends and family). The obvious counterpoint is that social and other internet-based media are significant sources of misinformation and disinformation. In the current complex communication environment with multiple platforms, communicating risk in a controlled and coordinated manner is difficult and even more challenging refugee contexts as refugees can rely on sources outside their country of asylum. Competing with positive messages and contributing to confusion and information overload. The use of social media to channel and amplify xenophobia toward refugees and disinformation about COVID-19 and vaccines has been a global phenomenon. 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, TV and national radio, particularly as sources more commonly used by refugees in non-camp settings.

As across all themes, the digital divide is a significant challenge. Most information is disseminated via internet-based media. Especially vulnerable refugees with less ready access to technology are less likely to receive critical information about access to protection, health and social services and COVID-19. 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 LMICs.

Messaging frequently fails to cater to the most vulnerable and marginalized, and/or lacks sensitivity to local social, cultural or gender norms. Overall, there has been a lack of child-friendly messaging, 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, the elderly and persons with disabilities were left behind as were homeless asylum seekers and refugees, those staying in informal settlements or in reception centers 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 rumor tracking and targeted at dispelling myths. Aid agencies have not always been trusted as sources of information. In some instances, competition among agencies to lead on information and communication efforts without the necessary capacity has been problematic. Access to information has been more effective where coordination and solid accountable live communication flows were in place. Innovation has also been positively leveraged in certain contexts with examples of the use of WhatsApp and chat bots used to better communicate with and respond to the information needs of refugees.

4 Coordination and coherence

4.1 Coordination and joint advocacy

As noted in section 2, interviews revealed a general sense of positivity around the initial global level coordination and across countries and regions. This was largely attributed to the exceptional circumstances presented by the pandemic. As in all areas, however, it is unlikely that this effect was sufficient to overcome any severe, pre-exiting tensions and fragilities.

Interviewees cited the recognition of refugees as a vulnerable group and a priority for the health response as having created a locus for coordination. In general terms, this is seen as having served to facilitate the inclusion of refugees in national plans, and to have leveraged coordinated efforts along the spectrum of international humanitarian and development actors. For example, the World Bank developed stronger partnerships with UN system agencies and responded to humanitarian needs in countries where the Bank and the UN already had a strong working relationship. Specific Bank efforts have also sought to strengthen coordination mechanisms at the national and subnational level to address the needs of refugees and reduce their vulnerabilities in certain countries. The closure of the GHRP at the end of 2020 signaled a shift of emphasis from the central coordination of the international humanitarian structures to country level coordination and whole-of-government approaches where possible.

As discussed in section 2, inter-agency advocacy to include refugees in national vaccination plans, in COVID-19 testing and treatment plans and in preventative programs, was seen as a relative success story. As noted throughout, barriers to inclusion remained.

Given the specific health focus of the early response, GBV and child protection appear to have been under prioritized in particular during the initial phase of the response. There was a consensus that collaboration and joint advocacy among international actors was a key factor in the development of guidance and the re-prioritization of these sectors as the response progressed.

For child protection, at the global level, core inter-agency technical guidance was developed during the initial phases of the pandemic with active engagement of local actors. Joint advocacy efforts highlighted the importance of holistic COVID-19 response plans that ensure protection and well-being of children, with a specific emphasis on particularly vulnerable groups of children, including refugee children, facing increased risks as a result of the pandemic. In 2020, UNICEF and UNHCR developed the "Blueprint for Joint Action for Refugee Children" initiative in line with the GCR and the commitment has been extended till the end of 2022. The initial phase of the initiative coincided

with the outbreak of COVID-19 and focused on inclusion of refugee children into national child protection systems, social services and birth registration across 11 countries.

5   Concluding remarks

As suggested by the evaluation's terms of reference, the COVID-19 pandemic appears to have challenged the protection of the fundamental rights of refugees in a way that is profound and with possible lasting impacts. Although the pandemic is global in nature there are important gaps in data in major refugee host countries on the level of needs and effectiveness of the response. The overall picture suggests that trends that were in place before the pandemic – both positive and negative- have been accelerated. The emerging findings suggest that principle of *non-refoulement*, the prohibition of collective expulsion, and the right to seek asylum were not preserved in many countries. The trend of narrowing access to international protection and tightening of asylum policies have deepened during the pandemic. Even when easing over time, new waves of the pandemic have often led to restrictive measures being implemented again.

The emerging findings of this evaluation indicate that international cooperation and the response of key actors have struggled to meet the protection needs of refugees and to keep up with the pace and the level of required adaptation. Evidence suggests that refugees who face specific needs have been disproportionately affected by the pandemic and its various challenges. Border closures and increased xenophobia against refugees in many contexts have also triggered greater use of coercive engineered migration policies that have presented new challenges.

Nevertheless, there have been some silver linings during the response related to increased collaboration, advocacy, promotion of rights and the streamlining of essential services. There is an increasing realization of the importance of whole of society approaches with greater support for localized responses, prioritizing protection.

Understanding how profound and widespread the pandemic's impact has been on refugees' rights will still depend on the effectiveness of the collective international response over time, increased accountability, adaptation and learning. As the spread of COVID-19 remains a concern in the foreseeable future, many of the adapted working methods and measures in service provision will continue to be relevant, thus justifying the continued investment in them and additional optimization and improvement to increase the adaptability the response and address similar challenges in the future. Improved tracking of inclusion efforts has also become more relevant. Lastly, as we attempt to understand the impact of the pandemic on refugees and the relevance, effectiveness and coherence, we acknowledge that refugees play critical roles in society can and must be an integral part of efforts to recover better from the COVID-19 crisis.

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