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FORCED MIGRATION review

Public health and WASH

Plus special feature on:
Non-signatory States and the international refugee regime

REFUGEE STUDIES CENTRE

FORCED MIGRATION review

Forced Migration Review (FMR) provides a forum for the regular exchange of practical experience, information and ideas between researchers, refugees and internally displaced people, and those who work with them. It is published in English, Arabic, Spanish and French by the Refugee Studies Centre of the Oxford Department of International Development, University of Oxford.

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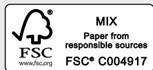

From the editors

Public health and WASH (water, sanitation and hygiene) have rarely been as much in the spotlight as they have been since the global COVID-19 pandemic began in late 2019, making our main feature particularly timely. Although a number of articles focus on the pandemic, this feature covers a broader range of topics, from practical improvements to WASH services in camp settings to community engagement around health issues in displacement crises.

The second feature focuses on non-signatory States and the international refugee regime, with authors examining the implications for protection when States are not signatories to the 1951 Convention Relating to the Status of Refugees (and/or its 1967 Protocol). In particular, authors explore the role of UNHCR, civil society and legal actors in facilitating access to protection in States such as Bangladesh, Hong Kong, Thailand, Turkey, Jordan and Lebanon.

We would like to thank Michelle Farrington and Ryan Schweitzer for their assistance on the public health and WASH feature, and Maja Janmyr for her partnership on the non-signatory States feature. We would also like to thank all those who have provided funding support (listed opposite).

This magazine and the accompanying Editors' briefing are available online at **www.fmreview.org/issue67**. The issue will also be available in Arabic, French and Spanish. Print copies will be available in English and Arabic but not in French or Spanish; we hope readers will take advantage of the online versions on this occasion.

Forthcoming themes:
In October we will publish an issue with a major feature on 'Externalisation', plus a short feature (in partnership with the TRAFIG research project) on the role of mobility and networks in situations of protracted displacement. We are currently welcoming expressions of interest for the March 2022 feature on 'Climate change: from commitment to action'. In September we will launch a call for articles for the July 2022 feature on 'Localisation of knowledge production', looking how and where research, insights and experiences, particularly those developed in regions most affected by displacement, are communicated, heard and valued. Details at **www.fmreview.org/forthcoming**.

With best wishes

Marion Couldrey and Alice Philip
Editors, Forced Migration Review

Front cover image: On the day this photo was taken in January 2020, in Western Uganda, water was supposed to have been running from 9am to midday and then from 3pm to 6pm. As usual, community members had left their water containers in a queue in anticipation of water being available. However, on this particular day, the water did not start flowing till way past noon by which time the community had been waiting for over three hours. And this was not uncommon. The community said that they have no concerns about the quality of the water but that the supply is neither reliable nor adequate for all their needs. At times the water point operator has to limit each family to two or three jerrycans so that everyone gets water for the day. Credit: Caroline Muturi.
Why are the faces pixellated? See FMR photo policy at www.fmreview.org/photo-policy

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Thank you!

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Breaking down silos: integrating WASH into displacement crisis response

Claudio Deola, Syed Yasir Ahmad Khan, Antonio Torres, Emmett Kearney and Ryan Schweitzer

Water, sanitation and hygiene (WASH) interventions are key to good public health outcomes for forcibly displaced people. A collaborative 'roadmap' for better integration of WASH services in crisis response has recently been launched.

Forcibly displaced populations are repeatedly exposed to public health risks and threats when they leave behind their social networks, livelihoods, service providers, and infrastructures. Displaced people often see their health weakened during their displacement journey because they lack food and adequate nutrition, safe water and sanitation services, and often do not have the resources to maintain basic hygiene.

There may be public health risk factors unique to a displaced population that make forced migrants specifically vulnerable compared with the host population. These additional risk factors are linked to a lack of access to health records, unknown immunisation histories, and limited knowledge of, and access to, health-care services. These public health risks are exacerbated by other challenges facing displaced people, including lack of the right to work, limited freedom of movement, lack of documentation, and poor access to financial services, housing, land, and property rights.

All these risk factors create vulnerabilities which often result in increased morbidities and mortality, caused by infectious diseases (for example, respiratory infections, diarrhoeal diseases, typhoid, measles and hepatitis) and vector-borne diseases (such as malaria, dengue, zika and leishmaniasis).[1] Lack of access to safely managed water, sanitation and hygiene (WASH) services accounts for approximately 829,000 preventable deaths per year worldwide, 297,000 of which are of children under five years old.[2] Unsafe drinking water, inadequate availability of water for hygiene, and lack of access to sanitation together contribute to about 88% of deaths from diarrhoeal diseases,[3] with diarrhoea being the second leading cause of death and a leading cause of malnutrition in children under five.[4]

The protracted nature of many displacement situations demands a change in how traditional emergency public health is delivered, with a strong need for prioritisation of sustainable solutions, including those that strengthen local and national systems. These solutions require a synergy of various components – such as the provision of WASH services – that contribute to sustained health outcomes.

Challenges for the WASH sector

Over the last decade, the humanitarian community's public health responses to displacement emergencies have struggled to provide life-saving relief at the same time as addressing the underlying causes of infectious disease. The WASH sector has often failed to assume a critical and proactive role in contributing to improved health outcomes and instead has frequently assumed a reactive role as coordinator of service provision.

The reasons for these shortcomings are many, including: growing complexity and duration of displacement situations; considerable gaps in the coordination between sectors of assistance; inadequate funding for public health response; and a plethora of humanitarian agencies responding to crises, resulting in competition for funding. These agencies have a range of mandates, which sometimes overlap and can pose considerable challenges to coordination and collaboration. In addition, there are instances where the collective areas of expertise of these organisations do not match the needs on the ground. Finally, these factors are compounded by the lack of clear frameworks that promote

collaboration, which can undermine individual actors' considerable efforts.

Environmental degradation and climate change are key challenges to reducing the spread of infectious diseases. The WASH sector needs to develop an in-depth understanding of the relationship between public health and the environment – including aspects such as water resource management and water safety, air and soil pollution control, vector control, treatment and disposal of chemical weapons, hazardous waste management, and human waste treatment and management.

Another key challenge is the lack of funding. In the past decade, WASH has been chronically underfunded, lagging considerably behind other sectors.[5] For example, Yemen faces one of the most complex humanitarian emergencies in modern times, with simultaneous cholera and COVID-19 outbreaks which require WASH services as a key part of the response. Despite this obvious need, resources for WASH in Yemen are dramatically declining: in 2020, funding for WASH was only 1.2% of the overall funding allocated to the response. The link between investments in basic WASH services and impacts on environmental and public health outcomes has been clearly demonstrated, yet WASH remains underfunded.

In addition to funding shortfalls, humanitarian organisations face the growing complexity of emergencies hampering their ability to deliver. For example, between 2017 and 2020 in the Democratic Republic of Congo more than five million people were forcibly displaced in an unstable environment with the threat of armed conflict coupled with numerous public health risks, including outbreaks of yellow fever, measles, plague, cholera, Ebola and, most recently, COVID-19. These dangers add to pre-existing burdens facing the population such as high acute malnutrition rates and high morbidity due to malaria. Ensuring the safety and well-being of displaced people within this complex environment is highly challenging, made worse by direct attacks against humanitarian actors, which have seen some agencies withdraw staff and cease operations.

Unlike the health sector, the humanitarian WASH sector is not yet equipped with coherent or effective systems to measure or evaluate the causal effects, outcomes or impacts of its activities. Agencies and coordinating bodies lack the resources to develop and scale up a robust monitoring system. This, in turn, makes it difficult to advocate effectively for increased WASH expenditure in a competitive funding environment.

Creating a roadmap

A process to integrate WASH, health and nutrition interventions into an effective and comprehensive public health response during humanitarian crises began in late 2017. This process was designed to address all relevant areas, from health-care facilities to social behaviour change programmes. It culminated with the launch of a dedicated five-year initiative called 'Integration and Coordination of WASH into Public Health Issues' within the WASH Roadmap 2020–2025, which will incorporate the global, regional and national contributions of WASH actors.

In June 2017, Médecins Sans Frontières published a report highlighting the main limitations of the humanitarian WASH sector, covering technical competency within the sector, operational capacity to respond rapidly, and the culture of complacency. The report challenged the sector to remove WASH 'silos' within humanitarian responses, to look beyond the emergency phase, and to make clearer the links between WASH and health outcomes.[6] The report found that sub-optimal emergency responses in public health crises (such as the cholera outbreaks in Haiti, Somalia and Nigeria, and the Ebola crisis in West Africa and DRC) cast doubt on the humanitarian WASH sector's competence and ability to deliver a timely, efficient and adequate humanitarian WASH response to a public health emergency. For example, when one of the worst cholera outbreaks on record was occurring in Yemen, very few WASH actors were able to intervene during the acute emergency phase (partly because of lack of access but also because of lack of

operational, logistical capacities), despite a growth in the number of actors worldwide.

In October 2017, the Inter-Agency WASH Group (IAWG) – an informal group, formed in the 1990s, of the largest WASH organisations – and the Global WASH Cluster (GWC) invited the major WASH stakeholders and agencies for a two-day workshop to identify challenges and opportunities for the sector. The recommendations emerging from this workshop[7] informally shaped the foundation of the WASH Roadmap. A comprehensive analysis was then commissioned by the GWC and presented to partners in 2019. Linked to the GWC annual meeting, UNICEF, the IAWG and the GWC organised a meeting with the emergency directors of the 15 largest international agencies involved in the WASH sector in order to formally launch the WASH Roadmap process.

Endorsement and rollout

By early 2020, the WASH Roadmap document had been completed. It includes three functional pillars – capacity, coordination and finance – and three operational axes. The first of these axes is the need (and capacity) of the WASH sector to deliver an effective humanitarian response that addresses the life-saving needs of affected populations at scale and with impact – also referred to as 'survival WASH'. One of the WASH Roadmap's main objectives is to ensure that by 2025 humanitarian WASH responses are systematically embedded and integrated into public health operational frameworks and programming, and driven by public health outcomes.

Seventeen strategic initiatives, each headed by one or more lead agencies, will deliver the WASH Roadmap, sharing the implementation work across agencies. In January 2021, all 15 Emergency Directors officially endorsed the WASH Roadmap, confirming their commitment to contribute and support the implementation plan. A number of initiatives have been prioritised for rollout, including 'Initiative 3.3: Integration and coordination of WASH into public health issues'. This five-year initiative on public health within the WASH Roadmap aims to identify existing gaps and further analyse the challenges for effective coordination among these sectors. Building on this analysis and lessons learned through other relevant programmes (for example, national coordination mechanisms), the leading agencies for this initiative will develop inter-sectoral guidance, tools and standard operating procedures for creating an enabling environment for a well-coordinated approach to public health emergency responses. The final phases of the plan will look at a list of pathways and opportunities to roll out the tools, pilot them in relevant platforms, and coordinate with local authorities. At the same time, a body of evidence will be built to sustain advocacy and secure funding.

Specific areas that will be explored under this initiative include how to:

- document the systematic use of data relating to epidemiology and the environment, to improve targeting within emergency WASH responses
- create a protocol for the systematic design and documentation of humanitarian WASH responses based on health outcomes, including the impact on lives saved and the reduction of the burden of disease
- expand the sector's capacity to tackle environmental health risks and impact
- strengthen the community management of WASH infrastructures linked to health-care facilities and nutrition-focused centres to ensure that they adhere to minimum WASH standards, expand use of services, and improve WASH provision overall
- strengthen engagement and participation with the UN health cluster system
- leverage and strengthen partnerships that support and advance cross-cutting approaches
- create linkages with advocacy efforts and bring interventions to scale.

Although there have been significant efforts made by some key agencies to ensure the systematic inclusion of WASH interventions within public health response strategies, there remains considerable work to be done. Successful implementation of the activities emerging from this initiative

will require an inclusive approach with active engagement from field practitioners, academics, government authorities, donors, displaced persons and affected communities. By promoting an integrated public health response, the humanitarian community can reduce public health risks and adverse environmental consequences for millions of forcibly displaced people across the world.

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Collaboration in times of crisis: a case-study from Mexico

Gabrielle Low

The COVID-19 pandemic has generated new thinking as those working with forced migrants try to secure safe accommodation and access to basic services for asylum seekers and refugees despite the challenging context.

Before the emergence of COVID-19, UNHCR had been working for several years in the southern Mexican city of Tapachula on ways to engage with local health authorities to improve access to health services for asylum seekers and refugees. The onset of the pandemic in Tapachula in March 2020 compelled both sides to step up that collaboration.

Located approximately 30km from the border with Guatemala, Tapachula is the main gateway into Mexico for migrants, asylum seekers and refugees travelling overland from Central and South America, making it a strategic point for the delivery of assistance to persons in need of international protection. Of the 41,223 asylum applications received by the Mexican Commission for Refugee Assistance (COMAR) in 2020, over 60% were registered in the state of Chiapas, the majority in Tapachula.[1] However, Chiapas is also one of the states that ranks lowest in socioeconomic indexes, with over 76% of the population living in poverty.[2] Economic opportunities and public services are limited, which means that efforts to assist asylum seekers and refugees must be combined with providing support to public institutions.

Accommodation

When COVID-19 struck, one of the first ways UNHCR was able to work with local health authorities centred on a local budget hotel in Tapachula. Since 2016, UNHCR has rented rooms at an 80-room private hotel as an alternative shelter option for asylum seekers and refugees, for use when the main shelters in the city reach capacity or to accommodate families with children and people with specific protection or security needs. Many of

the individuals housed at the hotel are asylum seekers released from immigration detention.[3]

When the pandemic began, most shelters in Tapachula and throughout the south of Mexico either suspended operations or stopped receiving new arrivals. In this context, it became increasingly important for UNHCR to ensure that asylum seekers and refugees had access to a safe space in order to follow the government's 'stay at home' recommendation. UNHCR increased the number of rooms it rented at the hotel, and made them available to all asylum seekers and refugees in need of temporary accommodation.

For local health authorities, this was useful in several ways. Tasked with addressing the situation of homeless people in Tapachula, health authorities were able to refer homeless asylum seekers and refugees for shelter at the hotel. Fewer people on the streets lowered the risk of infection among the general population.

Very soon the referrals expanded to include asylum seekers and refugees who had either been exposed to COVID-19 or had tested positive but did not have serious symptoms requiring hospitalisation. The hotel provided a place where they could quarantine or self-isolate, something that local health authorities were not able to provide. Patients were monitored every day by a doctor hired by UNHCR specifically for the COVID-19 response, while doctors from the public health system also conducted periodic checks either in person or by phone. All those with COVID-19 who had been referred to the hotel spent their period of quarantine and isolation without significant issues and without any known onward transmission of the virus.

In June and July 2020, as the number of COVID-19 cases rose, free room and board were offered in a separate wing of the hotel to frontline health personnel serving at the city's main COVID-19 facility. This helped health workers avoid any potential contagion in their households. Indirectly, the daily contact with frontline health personnel gave UNHCR a unique vantage point to observe how the response to the pandemic was unfolding.

For the hotel to provide these services safely, UNHCR developed COVID-19 Standard Operating Procedures (SOPs) specifically for its work at the hotel. These covered aspects such as separate zones for different profiles and needs, and the provision of items ranging from cleaning materials to mobile phones and emergency numbers. Asylum seekers and refugees were kept informed of the latest COVID-19 developments, including what services had been affected. All personnel were trained in COVID-19 prevention measures. In addition, local health authorities provided support with the chlorination of the hotel's water supply.

Primary health-care services

In Tapachula, UNHCR's engagement with local health authorities has helped ensure that asylum seekers and refugees are able to access basic public health services free of charge as long as they present identification documentation issued by either COMAR or the immigration authorities, a Unique Population Registry Code (CURP)[4] and proof of their place of residence. This is significant given that in some other cities, asylum seekers and refugees still face challenges in receiving treatment at public health facilities.

However, as the pandemic hit its first peak in Mexico between April and September 2020, public health services were overstretched. As the authorities diverted resources to prioritise emergency care, most primary care services provided at local health centres were suspended. This had a significant impact on many asylum seekers and refugees, whose limited social support networks and economic resources made it difficult for them to afford private health care. Crucially, prenatal health services were put on hold and pregnant women could only access medical attention shortly before childbirth or if there was an emergency.

As a result, the role of UNHCR's doctor had to evolve quickly to include running a clinic at the hotel to offer free primary health care to asylum seekers and refugees, including those who were not being housed at the hotel. Up to 45 individuals a week received medical attention, with priority

UNHCR/Gabo Morales

This hotel in Tapachula became a shelter for asylum seekers and refugees during the global pandemic.

given to prenatal care for pregnant women. The clinic also received a significant number of children suffering from skin disorders and urinary tract infections, and people with chronic conditions.

Local health authorities supported this initiative by including it in the local health surveillance system and providing some medical supplies and medicines while UNHCR waited for its procurement to come through. Importantly, the strong relationship that UNHCR had built with local health authorities meant that UNHCR had a direct line for referring cases that required specialised medical care at a public health facility, with immigration authorities providing emergency transportation.

The health services provided by UNHCR and local health authorities were complemented by UNHCR's cash assistance programme which supported asylum seekers and refugees with payments for medication and medical tests that were not available at the hotel clinic or at a public health facility.[5] UNHCR also increased donations of medical equipment to local health facilities, ensuring that assistance also benefited the local population.

Lessons learned

The hotel started off as a shelter but was adapted for different uses during the pandemic, reflecting some of the different ways that non-health spaces can be used for short-term public health interventions in times of crisis. Such adaptations could potentially be applicable in other epidemic or pandemic situations, or in other public health crises such as during a natural disaster. The cost of renting the space, however, can be high. Although the hotel used by UNHCR in Tapachula cost only US$9 per room per night,[6] the cumulative cost over time makes it viable only for a limited time. For longer-term needs, UNHCR now has a purpose-built shelter for asylum seekers and refugees on the outskirts of Tapachula.

While it is appropriate, perhaps even necessary, to provide primary health-care services as a stopgap measure in an emergency, this should not be allowed to transform into a parallel service. In providing medical consultations at the hotel, UNHCR aimed to provide the highest possible quality of care under the circumstances. Yet, with limited public health services under additional strain due to the pandemic, this inevitably created a disparity between the services available at public facilities and the services provided by UNHCR. This contrast became apparent as medical consultations offered at the hotel ended. Some of the asylum seekers and refugees expressed disappointment, stating that they would prefer to continue receiving treatment at the hotel's clinic rather than in the local

health facilities. However, local authorities would have little impetus to include asylum seekers and refugees in public health services if there was an expectation that UNHCR would cover these needs. In any event, it is not an efficient use of resources for UNHCR to continue providing health services where the services already exist. What the experience at the Tapachula hotel highlighted was that providing auxiliary health-care services should be kept within a circumscribed time and in specific contexts when public health needs warrant the intervention. It is crucial to know when to scale down operations and to ensure that an exit strategy is in place from the outset.

For asylum seekers and refugees in Tapachula, access to health services is now more predictable and consistent, reflecting a significant advance in the general protection of the population. The close collaboration established during the COVID-19 pandemic is likely to continue in the post-pandemic period. In non-crisis times, efforts should focus on strengthening health services through capacity building and technical support and through investments in infrastructure, equipment and supplies. For as long as UNHCR continues to have access to funding, it can provide material support to the local health system, while drawing on the local authorities for technical input and assistance. Both parties will continue to benefit from regular coordination and exchange of information.

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1. COMAR www.gob.mx/comar/articulos/la-comar-en-numeros-271284?idiom=es

2. The most recent data is from 2018, National Council for the Evaluation of Social Development bit.ly/CONEVAL-data-2018

3. Tapachula is home to Siglo XXI, a detention centre run by the National Institute for Migration. It is one of the largest in Latin America with the capacity to hold 960 people.

4. Clave Única de Registro de Población, a government-issued ID number.

5. Cash assistance for health needs is part of a broader cash assistance programme implemented by UNHCR in Mexico which helps to cover living expenses for people with specific needs.

6. Rooms can accommodate between two and 10 individuals, all for the same rate.

Equity and community engagement in the transfer of water supply management

John Allen and Caroline Muturi

Efforts are under way in Uganda's refugee settlements to transfer responsibility for water services from NGOs to the country's utilities. The transition needs to be carefully managed if it is to succeed.

Uganda hosts an estimated 1.4 million refugees mainly from South Sudan and the Democratic Republic of Congo. To improve long-term sustainability, Uganda's Ministry of Water and Environment (MWE) and UNHCR have begun transferring management of water supply schemes to the country's water utilities. Currently, humanitarian agencies (mostly NGOs) are responsible for the provision of water services to both refugees in Uganda and neighbouring host communities. As part of this, it has been agreed to begin charging water tariffs in refugee settlements.

Current efforts by actors in the water, sanitation and hygiene (WASH) sector have focused on a range of aspects, including upgrading water supply systems in advance of their handover, identifying tariffs that refugee users can afford to pay, and building the capacity of the regional water utilities (known as Umbrella Authorities, UA). However, there are fears that the transition in its current form could increase inequality, and result in water services being inaccessible – in terms of their physical location and people's ability to pay – for an already vulnerable population.

Oxfam undertook a study in 2020 focusing on a number of aspects of the utility transition: economics, community engagement, and governance and

accountability.[1] The study involved a literature review, key informant interviews and focus group discussions, held in Uganda in January and February 2020, focusing on four refugee settlements at different stages of the transition: Rwamwanja and Kyaka II in midwestern Uganda, and Rhino and Imvepi settlements in the West Nile sub-region. Several areas for improvement have emerged, which could lead to a more equitable, participatory and ultimately effective transition.

Context and risk

Generally, refugees in Rwamwanja and Kyaka II were knowledgeable about fees charged to water users; however, the concept was new in the West Nile sub-region. Most refugees (across both regions) said they would be willing to pay if services were high quality – that is, if safe water was available at all times at a nearby tapstand, with limited queueing time, and if they had livelihood opportunities to increase their incomes. However, refugee representatives in West Nile reported that livelihood opportunities were limited. The communities' preferences regarding receiving cash or vouchers for water (assuming funds were available for either) were split along age, gender and geographical lines. A key trend that emerged was a slight majority of men preferring cash, which they argued was better because of its multiple uses, while women largely preferred vouchers because of their negative experiences with cash given for food. Looking at these varied findings, stakeholders should not assume that one model for transitioning water services will fit all contexts.

Instead, approaches should be informed by in-depth contextual analyses to tailor utility transition to the local context. Stakeholders should identify formal and informal stakeholders, and trusted information sources and providers, at the community level. It is further recommended that the implementing WASH actor – alongside other relevant stakeholders – should analyse all possible risks of the proposed transition, drawing on qualitative data and ensuring that risk analysis is undertaken throughout the transition process rather than at just one point.

Financial monitoring

Utilities and sector stakeholders recognise that tariffs are needed in order to meet operational expenses and to contribute to the lifecycle costs of water service delivery. However, this study and others have identified that detailed expenses data are often lacking.

The construction in refugee settlements of communal pre-paid water dispensers, also known as 'water ATMs', is a nascent development in the sector. These dispensers allow service providers to adjust tariff rates, so that subsidies can be gradually phased out. There is uncertainty over the willingness and ability of end users in different refugee settings in Uganda to pay for water; the data produced by these pre-paid dispensers, however, offers an opportunity to determine rates based on usage and people's actual history of payments.

In advance of the formal tariffs to be charged by utilities, WASH agencies have introduced informal water user fees, typically at a rate of UGX 1,000 per household per month (equivalent of 28 US cents). These are not enough to cover monthly operating expenses but are seen to represent a valuable intermediate step before the introduction of formal tariffs. Asset management remains a major challenge in water supply management in refugee settlements, particularly the planning and budgeting of capital maintenance.

Effective financial monitoring in a successful utility transition requires key WASH agencies and stakeholders to:

- establish a monitoring and learning tool for pre-paid communal dispensers to document water usage and tariffs
- establish a sector-wide approach to testing and introducing tariffs and subsidies in systems without prepaid dispensers
- develop a common template and system for tracking operating expenses and improving transparency

Caroline Muturi

Women collect water at a protected water point in West Nile region.

- adopt a sector-wide asset management system for planning capital replacement schedules and budgets
- reach consensus across the sector on the intermediate introduction of informal water user tariffs in locations where the utility transition has not yet begun.

Improvement of financial models and planning

Upgrading existing piped water supply systems in advance of their handover to utilities is a major focus of WASH actors. The allocation of resources for capital expenditure on water supply systems contributes to both the sustainability of systems under their future management and to improved equity in access to safe water. Such expenditures include the extension of private connections to individuals seeking their own tapstands. However, these private connections are subsidised, and this raises the risk that the transition might benefit economically advantaged people at the expense of the most vulnerable populations who still lack access to public connections. Private connection costs should not be subsidised, unless targeting vulnerable populations. Nevertheless, users of private connections pay higher tariffs and so contribute to the revenue-generating potential of the water supply system, so may be beneficial – as long as complementary investments are made to ensure water supply access for all at public tapstands.

Uganda's National Water and Sewerage Corporation (NWSC), in agreement with UNHCR, has taken over operation of the water supply in the Rwamwanja and Bweyale refugee settlements where it charges refugees and host communities according to its 'pro-poor' rate of UGX 25 per 20 litres of water. However, the six Umbrella Authorities operate as limited companies and their water tariffs are determined on a system-by-system basis, based on the cost of operation and maintenance, and can vary from UGX 15 to 80 (from 0.4 to 2 US cents) for 20 litres. Water users must also pay a fee to operators of public standposts (PSPs). While much attention in the sector has been placed on utility tariffs, little progress has been made on determining what these PSP rates should be. A current risk is that PSP margins will be high and will price users out of water

access. However, refugee settlements offer an environment where the regulation of set rates is possible. The rates should be determined with the relevant stakeholders as part of the tariff consultation process that is carried out for UA tariff rates. Rates should be established that will provide enough financial incentive for PSP operators to take on responsibilities but that do not price out end users.

Inclusion, participation and accountability

None of the communities consulted during the Oxfam study was aware of the current or future role of the UAs or NWSC in managing water supply. Communities felt that they would be obliged to accept the transition to water supply management by utilities if that was UNHCR's policy. On the management aspects, refugee communities expressed higher levels of satisfaction with Refuge Welfare Councils (RWCs) – administrative structures for refugee representation – than with other bodies such as the Water User Committees (WUCs) which are often responsible for everyday running of tapstands. Refugees participated in the election of RWCs, whereas WUC members were sometimes selected by NGOs based on their proximity to water points. Refugees expressed concern about the WUCs' lack of proper record-keeping of user fee payments. Communities had no objections to WUCs collecting water user fees if WUC representatives were elected in a more transparent manner involving the RWCs and NGOs. This shows that participation of end users is paramount for behaviour change that will lead to a culture change towards paying for water.

A number of steps are needed to enable inclusion, participation and accountability:

- Implement a **communications strategy** targeting specific needs and local languages; this should allow for two-way communication with communities, including addressing complaints and acting on feedback to improve services and keep WASH actors accountable.
- Develop a tool for **measuring community participation**, ensuring that participation is inclusive and that all sections of the community are involved in decision making.
- Provide **key information to end users**; increased access to information enables communities to scrutinise the work of utilities and put pressure on the latter to be accountable, perform better and shun corruption. End users should have access to information on: water quality, pricing and tariff structures; the availability of subsidies; and systems for paying bills.
- Develop detailed **referral pathways** according to an agreed governance structure, with a clear link between the utilities and the communities through their trusted structures for representation. Water users should be able to give feedback and raise concerns through clear referral pathways that allow utilities to respond transparently.
- **Empower existing community structures** (such as WUCs and RWCs) to advocate for meeting their water needs including through raising awareness of issues of exclusion. NGOs could support existing community-based organisations through funding and/or capacity building to raise their own voices.

For this transition to truly benefit refugees it is critical that utilities and stakeholders have the capacity to improve equity, monitoring and inclusion. Relevant training and ongoing support by specialists in community engagement, economics and accountability would aid this process.

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1. For more information, see Allen J and Muturi C (2020) *Transition for All: Equity and community engagement in the transition of water supply management to utilities in refugee settlements in Uganda*, UNHCR and Oxfam bit.ly/uganda-water-transition

Thinking upstream: a critical examination of a cholera outbreak in Ethiopia

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A case-study from the Lower Omo Valley explores some of the challenges to water security for people who have been displaced within their own homelands.

According to one of the foundation stories of public health, in 1854 John Snow removed the handle from a pump in London – the water source used by local residents who were dying of a mysterious disease. At the time, the mode of transmission of this disease was contested, and there was no known cure. Since then, cholera has gained the status of a preventable and curable disease of bacterial origin that is known to be transmitted through networks of water supply. People who have fallen ill with cholera can be treated with rehydration and antibiotics. There are three oral vaccines available for mass administration. And knowledge of the means of transmission makes it possible to prevent outbreaks by protecting water supplies from contamination.

Despite advances in medical science and public health, however, cholera has not gone away; it continues to flourish in settings where people lack access to protected water supplies and basic sanitation.[1] Outbreaks of cholera in recent years have been particularly common in the wake of war and disaster, for example in Yemen in the context of armed conflict (2016–18), and in post-earthquake Haiti (2011). In such cases, emergency responses must focus on providing clinical treatment and vaccinating affected communities. After the crisis has passed, however, it is important to consider the conditions that make people vulnerable to the disease to begin with. The most immediate causes are inadequate water and sanitation services but more fundamentally these conditions are caused by social inequities. In the case we analyse here, an outbreak occurred not in the context of war or natural disaster but in connection with development projects – such as roads, hydro-electric dams, and plantations – that have displaced people within their own homelands.

Cholera and development in the Lower Omo

Cholera was reported in the Ethiopian highlands in April 2019, and in January 2020 it arrived in the Lower Omo Valley, where for several years we have carried out research. The focus of our research, and the backdrop to the outbreak, was the expansion of sugar plantations and road infrastructure in an ethnically diverse region that until recently was of little importance to the Ethiopian economy. In conjunction with the construction of the Gibe III dam upstream, development projects in the ten years to 2020 have brought large numbers of migrant workers and an increased military presence to the region.

The first cholera cases in the Lower Omo occurred in a village inhabited by the Kwegu, riverine fishers and farmers, who obtained their water from a tributary of the River Omo. Upstream, a camp of workers and a military detachment had, according to local reports, been releasing raw sewage directly into this tributary. In the following weeks at least 200 fell ill and 23 people died in the district where our contacts live. Eight of these deaths were among the Kwegu; a further seven people died among the Bodi and six among the Mursi.[2] These latter groups are agro-pastoralists; like the majority of the indigenous population of the Lower Omo, they make a living through a combination of herding and farming.

Why, in the context of development schemes in the region, were members of these groups newly vulnerable to cholera? In the previous ten years, the Kwegu, Bodi and Mursi had benefitted little from local development programmes. They had lost vital land to the State-run sugar plantations; and the Gibe III dam, by ending the annual

flood of the Omo, had eliminated a major component of their livelihood systems. Flood recession farming – a system that uses the water and silt provided by the annual rise of the river – was a mainstay of the local economy and a key source of the staple grain, sorghum. By 2020 they had gone four years without a harvest from the riverbanks. As a consequence, they were hungry, and when cholera arrived their immune systems were already weakened.

For a fuller explanation of the vulnerability of these people to cholera, however, we need to answer some more fundamental questions: Why did people in the Lower Omo not have access to protected water supplies? Why did basic water and sanitation services not feature as priorities in development plans for the region?

The villagisation model of development

The main focus of development planning for the Lower Omo's indigenous population was a villagisation programme. In 2012 the local government had declared that within the following year the majority of the population of South Omo Zone (some 45,000 people) should abandon their semi-nomadic lifestyles and settle permanently in newly established villages. In these new communities, residents would be provided with safe water, plus other basic services such as schooling and medical care. It was assumed that the population would comply, and that improvements in health and well-being would follow.

Unfortunately, this policy ignored important aspects of the economic and cultural reality. In particular, it overlooked the value of livestock as a form of wealth and – through dairy products – as an important contributor to local diets. The villagisation plan did not accommodate continued herding of cattle; the plan assumed the new residents would simply adopt the lifestyle of smallholder farmers. It also overlooked the pride they took in their roles as stewards of the land. By settling en masse in sites adjacent to the new sugar plantations, they would effectively be surrendering ownership of the bulk of their homelands.[3]

One advantage of the villagisation sites was the protected water supplies that were installed there, and residents of pre-existing communities nearby also enjoyed using them. But while it was possible to **live** in the new villages as long as the government was distributing food aid, those who attempted to **make a living** there found the farm plots too small and the provision of irrigation water insufficient. Conflict with other recently resettled groups led to a sense of insecurity. By 2018 the programme had unravelled. Primary health workers moved away, distribution of food aid ceased, and locals were left worse off than before.

An epidemic of prejudice?

As the number of people with cholera symptoms rose in the first weeks of 2020, it was a former school-teacher with friends in the affected communities who raised the alarm. Cholera – or its telltale symptom, acute watery diarrhoea – is a reportable condition in the Ethiopian public health system, but there were few medical professionals around to do the reporting. Through the initiative of the teacher, aid was mobilised, including sterilising agents and jerry-cans for treatment of water. Medical treatment was provided by a local NGO. These efforts successfully interrupted transmission, and within weeks the epidemic had passed. But questions remained: Why was there no provision of protected water supplies outside the villagisation sites? More generally, why had development in the region been planned with so little regard to local needs?

The short answer is prejudice. The global history of cholera has made clear that a major risk factor for the disease is membership of a group with a racialised or otherwise stigmatised identity. Pastoralists and people of the Ethiopian lowlands have long been viewed by highland Ethiopians as backward and uncivilised, and this prejudice was evident in the narratives that accompanied the outbreak. Some government employees blamed locals for drinking river water; others attributed the disease to the Kwegu practice of eating buffalo meat. These explanations ignored some important

facts. No other water sources were readily available to these communities; the river water was relatively safe to drink before the development projects; and the outbreak in the Lower Omo was preceded by an epidemic in Ethiopian highlands, where cholera had been circulating for months. It was outsiders who had brought the disease into the Lower Omo.

Looking upstream

This case-study demonstrates a narrowness in the way water security is imagined, which we suggest is representative of an unnecessarily narrow view of water, hygiene and sanitation (WASH) – and of responses to epidemics more generally. WASH is concerned primarily with individual hygiene and the provision of improved infrastructure such as taps and latrines, as opposed to environmental concerns such as the quality of water in rivers or the politics of resource distribution. This reflects a neglect in medicine and public health of the environmental and political conditions that affect human health. After John Snow removed the pump handle, where were people to get their water from?

The story of the pump handle is memorable because it draws attention to the source of the problem being the water supply. But it was not until London's water and sanitation systems were overhauled in the later 19th century that the spectre of cholera would disappear from the city. Similarly, people in the Lower Omo and elsewhere will remain at risk until improved sanitation and protected water supplies are accessible to them. Today, however, universal access to these basic amenities depends on the achievement of fairer political and economic arrangements. To protect the health and well-being of the world's most marginalised, we must think upstream.

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1. 'Protected water supplies' are those that, by virtue of their construction, reduce risks of contamination at the point of collection, e.g. having a concrete housing around the well-head. 'Basic sanitation' refers to facilities designed to safely separate faeces from human contact, e.g. by treating or isolating them in situ or transporting them for treatment off-site. See https://washdata.org/monitoring

2. The most recent census in 2007 suggests the Kwegu, Bodi and Mursi together number approximately 16,000 people. This figure does not, however, reflect the recent influx of people from elsewhere in Ethiopia, who are now likely to outnumber the indigenous population.

3. Stevenson E G J and Buffavand L (2018) '"Do our bodies know their ways?" Villagization, food insecurity, and ill-being in Ethiopia's Lower Omo valley', *African Studies Review* 61, 1: 109-133 https://core.ac.uk/download/pdf/188182104.pdf

Refugee women in Liberia: repairing handpumps, dispelling myths

Gibson Zulu

Two refugee women in Liberia are repairing handpumps in order to support others in their community.

The outbreak of COVID-19 has derailed employment and trade, and has jeopardised life in general. The adverse effects of the pandemic are innumerable but have been felt most by the most vulnerable members of the globe – refugees. In the most unlikely places, however, there are glimmers of hope. Even in the most uncomfortable places, such as refugee settlements, there are people who remain steadfast and committed to making a difference in their lives and that of their communities.

In the PTP refugee settlement in Grand Gedeh County, Liberia, Odell and Emma[1]

have been at the forefront of the COVID-19 response by repairing handpumps, a rare occupation for women. Not content with being mere spectators or recipients of aid, these two refugee women decided to act against the spread of COVID-19 and its consequences for public health and livelihoods. Emblems of determination, initiative and female empowerment, they are involved not only in repairing handpumps but also in livelihoods activities. They have planted and harvested maize, yams, pepper and rice, and are selling maize from this year's harvest.

UNHCR refugee WASH team

WASH team members gather at a handpump which they have repaired in the PTP refugee settlement.

Both women arrived in Liberia in 2011. They fled violence in Cote d'Ivoire in the aftermath of the disputed Ivorian presidential election. Odell and Emma did not want to depend on men for survival and this prompted them to participate in a one-week theoretical and practical training course on Afridev handpumps in June 2019. This training was organised jointly by UNHCR and the Government of Liberia to train 13 refugees and four host community members. Odell and Emma were among four refugee women who successfully completed their training and they have continued to use their skills since then.

Their role became particularly important in late 2020 during the COVID-19 pandemic, when they continued to work to ensure provision of clean water, despite risks to their own health. By early 2021 their team had repaired all the handpumps in the 33 blocks of the PTP refugee settlement, although the constant wear and tear means they still need to undertake occasional repairs. They hope also to travel to Maryland County to repair handpumps in Little Wlebo refugee settlement as a way of encouraging more refugee women to become handpump mechanics.

The two women have forged a strong bond through this work and earned the respect of their community. Residents of PTP refugee camp now not only have better access to clean water to wash their hands to prevent the spread of the COVID-19 but also use the water for their livestock and gardens. Since Odell, Emma and their team of 11 men repaired the handpumps, refugees no longer have to walk any further than 500 metres to access a water point. At a time when people are losing their livelihoods due to curfews and lockdowns, and facing a rise in transport and commodity costs and with grim economic prospects, here are two refugee women who work without remuneration to bring water to their fellow refugees in the settlement.

"Odell and Emma are courageous and hardworking. Society thinks this job is meant for men. Nonetheless, they have the passion for the job and have managed to excel at it and to dispel myths." Otis Zarzar, WASH County Coordinator, Ministry of Public Works, Grand Gedeh County

This is the story of two women who have vowed to use their skills to contribute to the well-being of their community, believing that every action counts and each one can make a difference. Their message to fellow women out there? "Believe in yourself. Don't be afraid to fail or try out something new and challenge the status quo. Refugees have so much to contribute to their host nations, and education and practical work are the key."

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1. Names have been changed.

The role of traditional medicine and community strategies in combating COVID-19

Angela Yesenia Olaya Requene

Displaced Afro-descendant communities in Colombia have experienced significant marginalisation during the pandemic but have drawn on ancestral knowledge to try to mitigate the impacts of COVID-19.

Colombia's Afro-descendant population represents approximately 12% of all internally displaced persons (IDPs) in the country. Thousands of Afro-descendant communities and families have been forced to leave their lands, moving to peripheral urban areas in cities such as Bogotá, Medellín and Cali. Other communities remain confined to territories controlled by illegal armed groups and drug cartels.

The displaced Afro-descendant population already faced difficulties in terms of living conditions, racism, marginalisation and exclusion, all of which affect their access to health services, work and education. Since the start of the COVID-19 pandemic, their food security, nutritional status and livelihoods have been drastically affected. Poor access to drinking water and sanitation facilities have made it impossible for them to comply with hygiene recommendations – washing hands regularly – to prevent COVID-19 infection.[1]

Their response has been two-fold: to develop community strategies to mitigate the risks of contagion, and to seek solutions in traditional medicine.

Strategies of protection

Some communities have established a monitoring system to control people's movements, seeking to contain the spread of the virus in communities whose access to health services is limited both by scarcity of services and by lack of transport options. In rural riverside areas, the displaced communities appoint a member of the community to buy food and water each month in neighbouring host communities. Designated cleaning areas have also been set up for disinfecting clothes and for handwashing, and they have banned people from entering their communities who are from elsewhere.

Beyond the immediate benefit of protecting the community, such systems have also helped trigger a re-evaluation of forms of community organisation and ancestral knowledge possessed by the Colombian Afro-descendant people.

Drawing on traditional medicine

Access to drinking water is a historical and structural problem for the Afro-descendant population, and this situation is compounded by the absence of comprehensive health systems and the overcrowded conditions in which displaced people live. For the displaced, overcrowding and the consequent difficulty in following social distancing advice represent a serious obstacle to the prevention of and response to COVID-19.

Afro-descendant leaders have put into practice some lessons from pandemics such as Ebola which affected African populations without access to drinking water, and have dug wells to access underground water. This knowledge about well digging has also been replicated in Afro-descendant populations in Ecuador and Honduras and in the Quilomba communities of Brazil.

At the same time, traditional medicine has emerged strongly in the communities' attempts to defeat the virus. Herbs and other plants are used for medicinal purposes and to make disinfectants to mitigate the symptoms of the virus and to prevent it spreading. The knowledge and application of traditional medicine that these people have applied during this pandemic has altered their own perception of the continuing value of traditional medicine.

In 2020, more than 28,500 Afro-descendant people had to leave their homes, fleeing from clashes between armed groups. As the displaced resettled in neighbouring lands, they shared their knowledge about the use of plants and trees for medicinal purposes, such as the *matarratón* (Gliricidia sepium), whose flowers are either boiled for consumption or used in baths and are believed to help stimulate the immune system. According to Tulia Martínez: "Our grandmothers taught us the healing properties of certain medicinal plants. This knowledge has helped us … to mitigate the effects of malaria, influenza, chikungunya and other diseases."

There is no scientific evidence that using or consuming such plants can protect people against COVID-19. However, traditional Afro-descendant medicine is one of the few tools they have to try to alleviate the symptoms or prevent infections.

In the context of deepening racial inequalities due to the impact of COVID-19 and its intersection with other factors, displaced communities emphasise their need to use traditional medicine. They also stress that it is not possible to ensure comprehensive, equitable, quality and timely health-care services for them without recognition of their ancestral customs and cultural traditions, which are typically under-acknowledged by the national health system. The Colombian State needs to incorporate traditional medicine into its systems and to strengthen its intercultural competence through the incorporation of Afro-descendant health professionals.

Remaining challenges

The extreme vulnerabilities that affect displaced Afro-descendants have made them particularly vulnerable to both transmittable and non-transmittable diseases such as cancer, diabetes, heart disease and chronic respiratory diseases. This makes them even more at risk of serious consequences from COVID-19. Representatives of the Afro-descendant populations have stated that these risk factors have not been recognised by the State when preparing and implementing hygiene measures to confront the pandemic. This population is demanding that the State prepare protocols for special care for Afro-descendant people with COVID-19, protocols that take account of their underlying conditions.

Displaced people travelling by boat in the border region between Colombia and Ecuador.

Another important demand is the creation of a statistical information system with data disaggregated by race, gender and age. This would make it possible to measure the disproportionate effect of racial inequalities among displaced populations, which will in turn facilitate the design of appropriate strategies for the surveillance, prevention and control of the pandemic in this population.

For this purpose, it is essential that the State open up institutional spaces with the displaced populations for consultation and participation; this would allow intercultural dialogues with a view to incorporating traditional medicine in the response to COVID-19. A policy of affirmative action in intercultural health could be beneficial when facing future pandemics and could also contribute to redressing centuries of discrimination, marginalisation and exclusion.

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1. Economic Commission for Latin American and the Caribbean (2021) *People of African descent and COVID-19: unveiling structural inequalities in Latin America* bit.ly/ECLAC-African-descent-Jan2021

Work with the community or go home: local engagement in Mozambique

Gabriel Cardona-Fox, Giovanna De Meneghi, Edoardo Occa and Andrea Atzori

A health intervention in a complex crisis, such as in Cabo Delgado, Mozambique, can only succeed if the community is effectively engaged and actively participates in the response.

Providing basic health services in complex humanitarian situations during a pandemic presents significant challenges. Our experience working with internally displaced people (IDPs) in the Cabo Delgado province of Mozambique has taught us that a health intervention can only be successful with effective community engagement strategies. In other words, we either work with the community or we go home.

Engaging with the community is often the only way to guarantee acceptance of an intervention, allowing humanitarian workers to make the most efficient use of limited resources. Without community engagement, the deployment of effective communication strategies to influence perceptions and affect behaviours is almost impossible. In situations where a large inflow of forced migrants intensifies competition over limited resources and upsets the local equilibrium, community engagement is also essential in order to address conflict in a culturally sensitive manner.

The Cabo Delgado province of Mozambique is currently the site of one of the most urgent IDP crises in the world. Violent attacks by non-state armed groups in the north-east of the country and devastation by cyclone Kenneth in 2019 have displaced approximately 732,000 people. This population is now living in precarious conditions with limited access to basic health services. Approximately 36% of the health facilities in the hardest-hit districts have been destroyed and the northern section of the province is an effective 'no-go zone', outside the reach of humanitarian actors.[1] The economic effects of the COVID-19 pandemic and limitations on travel and gatherings have also greatly complicated the humanitarian response.

Doctors with Africa CUAMM, an Italian NGO, has been collaborating with local institutions in setting up systems for prevention, identification, referral and follow-up relating to COVID-19, cholera, acute watery diarrhoea, HIV-AIDS and other infectious diseases (as well as in reproductive, maternal and child health issues, and malnutrition). We have learned that providing medical expertise and support to the national health system alone are not enough. Cultural awareness and effective engagement of the local population and institutions are essential to success.

Community advocacy and monitoring

Community activists (CAs) are the core of CUAMM's work. These people are appointed by the local authorities but are supervised and paid by CUAMM, and can include IDPs. CAs understand the local context and the languages spoken by the forced migrants. They are part of the local health system and serve as a link with the local population. Their training includes early detection and reporting of outbreaks within the community as well as the promotion of preventive behaviours such as social distancing, handwashing and wearing masks. They also undertake advocacy to prevent marginalisation of people suffering from HIV-AIDS, cholera and COVID-19.

CUAMM also works closely with village health committees, community elders, traditional healers, midwives, and formal and informal health practitioners. Village health committees are particularly important; they are composed of medical and non-medical professionals, village elders, religious leaders and other individuals respected within the community, and derive their credibility from the collective authority of their members. With the active participation of the village

Doctors with Africa CUAMM/Nicola Berti

A CUAMM worker engages with a community member in Cabo Delgado.

health committees we have been setting up an epidemiological surveillance system to detect the outbreak of COVID-19 and other communicable diseases, using detection mechanisms (such as private screenings conducted during household visits) that would otherwise be considered too sensitive or intrusive. The engagement of CAs and local health committees is critical to ensuring that the system works, the community is kept informed, and those who abandon their treatment are found and brought back.

We have also learned how essential it is to enlist the participation of village elders, birth attendants, and traditional healers (*feticeiros*), who, although not formal health-care professionals, are respected in their communities and often accredited by government authorities. These local actors play an important role in raising health awareness and encouraging compliance with preventive measures. In the district of Montepuez, for example, traditional healers were instrumental in convincing reluctant families to adopt handwashing practices in their households and to forgo traditional burial ceremonies. Using more modest alternative rites, where a few selected representatives of the community performed the ceremony, minimised the risk of contagion. *Feticeiros* also play a key role in discouraging the stigmatisation of people who are infected with COVID-19, thus ensuring that they receive the proper treatment.

Mediating conflict between IDPs and host communities is an integral part of a larger strategy to contain the spread of communicable diseases, as conflict in the community promotes distrust, disrupting the necessary channels of communication for monitoring, referrals and medical attention. To this end, we have found it useful to work with community courts, providing them with medical training and supporting their work; we also complemented their functions by including in our work a) mediating in conflicts over water and other resources and b) advocating on behalf of victims of gender-based violence and accompanying them through the health and court systems.

Integration of displaced health-care practitioners

Among the people displaced by the conflict in northern Mozambique, we identified nearly 600 state-employed health-care workers. While obviously a loss to the populations that stayed behind, these workers presented an opportunity to reinforce the health response in areas where IDPs first arrive. In partnership with the national health authorities, we have begun negotiating

the reassignment of these professionals to the fragile state health facilities that have been stretched beyond capacity.

Displaced health-care workers are helping to set up Temporary Advanced Medical Posts in locations where many IDPs are registered and local health authorities are under stress. These posts are accessible to both the migrant and local populations and operate a basic triage system to screen patients and refer them when necessary to government health centres. We have noted that the inclusion of IDP health workers has greatly facilitated communication with the displaced communities and has encouraged trust. Integrating IDP professionals in the health response has also provided them with a source of livelihood and a sense of purpose.

Communication strategy

The engagement of community leaders, including village elders and religious leaders, has been crucial in our attempts to develop an effective communication strategy to disseminate culturally appropriate medical information to remote communities in compliance with the social distancing and travel restrictions imposed by the COVID pandemic. Because of the geographic isolation of many of the IDP resettlement sites and the constraints imposed by the pandemic, many of the methods and mobile technologies traditionally used to raise health awareness are not available. We were able to develop an innovative communication strategy, however, with the engagement of the community.

One approach that proved effective was to enlist a troupe of local actors to help broadcast a series of *radionovelas* – radio soap operas – in Portuguese and six local languages; these transmitted important COVID-19 mitigation information through storytelling. *Radionovelas* are very popular in Mozambique, particularly in areas with low literacy rates. In the districts of Montepuez, Balama and Chiure, our radio programmes reach approximately 380,000 people – just over half of the total population of 750,000.[2] CUAMM was also able to engage with religious authorities at the national and local level to help disseminate key public health announcements through religious communities.

One of the principle challenges we faced at the onset of the pandemic was how to convey epidemiological risks in a manner that the community would understand and take seriously. During the first months of the pandemic, we needed to dispel several myths about COVID-19 causes and cures that had been proliferating rapidly within the community. To do so, we engaged respected religious leaders to deliver correct information in a manner that was easily understood. The majority Muslim community of Cabo Delgado allowed their mosques' loudspeaker system to be used to disseminate accurate information, and CUAMM worked with these religious groups both to insert health information into religious services and to devise alternative religious ceremonies that were meaningful yet limited the risk of contagion.

As the migration crisis moves beyond the emergency phase, the community needs to own and be committed to the continuing success of the health programme, for the sake of sustainability. Ultimately, we are merely facilitators. We must either engage with the community or prepare to go home.

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1. *Humanitarian Response Plan, Mozambique* (Abridged Version), December 2020 bit.ly/Mozambique-HRP-2021

2. Source: Radio Comunitaria Mpharama de Balama; Radio Comunitaria Girimba de Montepuez; Radio e Televisao Comunitaria de Chiure; Instituto de Comunicação Social.

Tracking community perceptions in Venezuela during COVID-19

Raissa Azzalini and Oxfam team in Venezuela

A new tool to collect and track people's perceptions in the context of COVID-19 is providing valuable information to help support communities during the pandemic, while enabling greater community engagement.

In June 2020, Oxfam launched a project led by local partners to engage communities in preventing the spread of COVID-19. In a context where there was limited availability of official data, a Community Perception Tracker (CPT) was used to record communities' insights and concerns about the virus with the aim of giving voice to their views and supporting them to develop their own action plans to reduce disease transmission.[1]

During the first cholera epidemic in Haiti in 2010, and while responding to Ebola in West Africa in 2013–14, Oxfam learned valuable lessons about engaging with communities in disease outbreaks. The importance of collecting qualitative data was recognised to be key to putting crisis-affected people at the centre of the response,[2] and in 2018 Oxfam developed the CPT. This was piloted in the Democratic Republic of Congo during the 2018–19 Ebola outbreak. In 2020, Oxfam adapted the CPT for COVID-19 and implemented it in 13 countries, including in Venezuela where the pandemic had exacerbated an existing crisis in which an estimated seven million people were already in need of humanitarian assistance.

How does the CPT work?

A form loaded on a mobile device (whether phone, laptop or tablet) using Survey CTO software is used to record people's perceptions – their questions, concerns, beliefs and practices in connection with the spread of disease. Respondents are asked about their geographical location, age and gender, whether they are disabled, and if they (or a family member) have had COVID-19. They are also asked from where and whom they got the information which has influenced their perceptions. This is repeated regularly – daily or weekly – because of the dynamic nature of the disease outbreak and responses. Oxfam teams and partners enter data on the perceptions of individuals and groups they meet (in person and remotely) during the course of their daily activities. The information can be recorded directly in the form on the mobile device, or on paper and then transferred to computer later, depending on the sensitivity of the context.

Perceptions are grouped in relation to twelve pre-determined categories (including existence of the disease, treatment, vaccination and stigmatisation) to facilitate analysis and identify trends. Analysis of the qualitative data is then triangulated with epidemiological data. Weekly reports encapsulate the data analysis and recommendations for action, and rapid feedback can then be provided to communities and authorities. As people's priorities and perceptions change, staff are able to monitor and adapt responses. When more in-depth, supplementary information is needed, other data collection methods such as focus group discussions and semi-structured interviews are used. CPT is particularly useful in that it brings the voices of communities – through the evidence-based information gathered – into coordination and advocacy platforms.

Findings from Venezuela

From June to December 2020, Oxfam analysed people's perceptions in 16 communities across three states, providing valuable information about the situation of people on the move. Local communities shared their concerns about contagion risks in temporary shelters hosting migrant returnees. In addition, people spoke of their fear of infection from

returnees and expressed discriminatory beliefs and attitudes towards them. The lack of COVID-19 prevention measures at the unofficial border crossing points increased local communities' concerns and in some cases led them to restrict access to their communities for returning migrants.

"In the border area this affects us directly because returnees use the illegal roads on a daily basis and this means that the virus can be more widespread as many people pass through." (Male resident, Pedro María Ureña municipality)

As a result of better understanding people's perceptions, Oxfam's local partners promoted dialogue around inclusion in order to reduce discrimination; in addition, information on staying safe and preventing the spread of the virus while welcoming migrant returnees was included in community action plans. Community members disseminated social media and offline messages promoting inclusion.

One of the important features of the CPT in Venezuela has been its ability to provide systematic information where there has been a long-standing lack of official epidemiological data. Its ability to highlight trends has been vital in shaping and adapting Oxfam's humanitarian response. Between June and December 2020, the most commonly cited concerns relating to COVID-19 were about the perceived risk of contagion from migrant returnees, questions about prevention, doubts about the efficacy of using masks, poor acceptance of the importance of physical distancing, concerns about income-generating activities and access to food, concerns about children's education, and the psychological consequences of the pandemic. During the first months of data gathering, people even denied the existence of COVID-19. Six months later, people believed it existed. In December, the key concern expressed was about how to prevent COVID-19.

In Zulia state, data reflected information overload within communities, leading to misunderstanding of COVID-19 transmission and treatment. As a result, at the beginning of all their activities Oxfam and its partners organised question-and-answer sessions led by medical staff. For example, one boy said: "I would be afraid to go to the hospital if I felt any symptoms." Given that this fear was widely shared, more information was subsequently provided on self-isolation and shielding so that people could still help themselves even if they did not go to health facilities.

The analysis of data collected through the CPT process was fed back to communities who were encouraged to use the findings to develop community action plans to increase their capacity to prevent transmission of COVID-19. Examples of community action plans include plans for the dissemination of information, face-to-face and virtual workshops, training of community promoters, delivery of brochures with information on preventive measures to mitigate the risks of contagion, distribution of hygiene kits, and street art with prevention messages.

Challenges and successes

Given mobility restrictions, all CPT training, analysis and monitoring meetings were conducted remotely. This was challenging due to constant power cuts and poor internet connectivity and mobile networks, but with motivation, creativity and adaptability the local partners succeeded in engaging with communities.

Since 2015, Venezuela's health ministry has not published its epidemiological bulletin. The lack of regular dissemination of official data has led local organisations to question the reliability of the data which is actually available. Although the CPT cannot substitute for official epidemiological data, it does provide regular, relevant, useful and trusted data generated by community perspectives.

The CPT is not able to fully encapsulate the concerns of people on the move because it requires repeated contact with the same community members. Migrants and people moving frequently do not stay long enough to share perceptions regularly via the CPT or to build trust with the staff who want to record their perceptions. It is also more challenging to share CPT findings with migrants. Nonetheless, the communities

that participated in the CPT are greatly affected by migration and mobility. Many of their members have been displaced before or they have close relatives living in other locations, and their opinions are influenced by mobility trends in their communities.

Another limitation, which was also found in other countries where the CPT has been used, is that the CPT for COVID-19 does not necessarily allow capture of other concerns such as natural disasters or other diseases. Oxfam is exploring how a CPT for a broader range of issues could be developed and implemented.

In the evaluation conducted in Zulia among communities with Community Action Plans, people reported that they felt ownership of the action plans and described changes in their beliefs and attitudes about COVID-19 prevention. By 'taking the pulse' of communities and facilitating active community engagement, the CPT had contributed to creating an enabling environment for people to protect themselves despite the challenges they face. Over the course of several months, local organisations have developed their skills in listening and analysis, and the CPT has become part of their way of working. In Venezuela the CPT has also contributed to the Oxfam team's goal to provide valuable data and analysis to enable communities to design and implement their own action plans to prevent the spread of the virus.

Using a combination of participatory methods and tools to understand affected communities in humanitarian responses is not new, but it is more often done in relation to a specific sector of intervention (such as health promotion, protection or livelihoods) and not always well documented. What is new about the CPT is that it provides a single tool for all teams and partners, a more holistic approach when listening to communities, and a fast, systematic means of collecting and reporting. During the process, all sectors – plus managers and the monitoring, evaluation, accountability and learning teams – work together to get to the heart of community concerns in disease outbreaks. The CPT has shown great potential for adding value to improving community engagement in disease outbreak responses although its full potential has yet to be realised.

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1. www.oxfamwash.org/communities/community-perception-tracker

2. See UNICEF (2020) *Minimum Quality Standards and Indicators for Community Engagement*, pp18-19 bit.ly/UNICEF-MinStds-comm-engagement-2020

3. For security reasons individuals are not named.

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Assessing infection prevention and control during COVID-19 in 22 humanitarian contexts

Claire Eldred, James Kahia, Lilian Kiapi, Bibi Lamond, Stacey Mearns, Laura Miller and Liz Walker

Infection Prevention and Control (IPC) is important for building a resilient health system – and critical during a pandemic. A multi-country assessment undertaken in late 2020 has highlighted significant shortcomings which need to be addressed.

During the Ebola outbreaks in West Africa in 2014–15 and in the Democratic Republic of Congo in 2019, poor Infection Prevention and Control (IPC) infrastructure and practices led to high numbers of health-care worker infections, and reduced people's use of health services due to fear of transmission. Based on their experience with Ebola, the International Rescue Committee (IRC) developed a minimum package of IPC standards for COVID-19, aiming to enable rapid IPC improvements in health facilities serving populations affected by conflict and displacement. The core components of this minimum package for IPC focus on staff and accountability, skills and practice, and supplies and infrastructure.

Baseline assessment: highlighting the challenges to be addressed

The minimum package was used to develop an assessment tool to provide a baseline on the current state of IPC in IRC-supported health facilities across five regions. It did this by collecting information on the following categories: 1) triage, screening and isolation; 2) hygiene, environmental cleaning, disinfection and personal protective equipment (PPE); 3) water supply; 4) sanitation and health-care waste; and 5) management. The tool was adapted from the WHO/UNICEF WASH FIT tool to capture information at health facility level and uses a traffic light system to flag issues for action.[1] Each facility received a score on each category and an overall IPC score.

The IPC baseline assessment was completed in 1,106 facilities across 22 countries from August to December 2020. Each facility received a score in each category and an overall IPC score. Facilities that met 80% of more of the standards were categorised as 'meeting target' and labelled green; facilities that met 65–79% of standards were categorised as 'partially meeting target' and labelled amber; and facilities with a score of 64% or less were categorised as 'not meeting target' and labelled red. Of the 1,106 facilities assessed, 14% met overall IPC targets, 17% partially met the targets and 70% did not meet the targets. There was some regional variation in results but none of the regions had more than half the facilities meet the overall IPC target and all regions averaged below the 80% threshold for overall IPC score.

IRC health programmes have different implementation approaches depending on the context, with five approaches assessed in this case: facilities directly managed by IRC; facilities directly managed by the Ministry of Health, without IRC support; facilities directly managed by the Ministry of Health, with ongoing IRC support; partner-managed facilities, without IRC support; and partner-managed facilities, with ongoing IRC support.

Facilities managed directly by IRC performed better on average than facilities managed by the MOH and other partners, with 35% of assessed facilities meeting the target. Partner-managed facilities supported by IRC performed the next highest, while partner-managed facilities without IRC support had the lowest results. Based on facility type, hospitals scored best (62% met standards) and temporary/mobile clinics scored worse (3% met standards).

Facilities met standards for **cleaning and PPE** (71%) more than any other category, followed by water (64% met target), then sanitation (47%), management (43%) and screening (29%). While there were initial challenges to secure PPE, there was a global effort to ensure access to PPE for

all IRC-managed and -supported health facilities in the first six months of the pandemic, and it seems this effort had positive results.

Sixty-four percent of health facilities met the **water standard**. While this category was the second highest-ranking standard in the baseline assessment, it is also the most fundamental to achieving overall IPC standards and therefore the score is worrying. Within this category, the least practised activity was chlorination of water; this is problematic as non-chlorinated water may be highly contaminated with various pathogens which can easily invalidate cleaning and disinfection activities as well as lead to transmission of water-borne diseases.

Rachel Unkovic

An IRC staff member provides hygiene training in the context of an Ebola outbreak in Sierra Leone.

Fewer than 50% of facilities met the **sanitation standard**, with many not having gender- or staff-segregated toilets. Most of the facilities did have functional waste collection systems but more concerning was that fewer facilities had the correct mechanisms for final disposal of waste, thereby posing a risk not only to health facility staff and patients but also to neighbouring communities.

Fewer than 50% of facilities met the **management standard**, with many facilities not having IPC committees who hold regular meetings with clear terms of reference in place. Many of the components of this category require little or no financial resources and so are considered to be more easily achievable ways to improve IPC.

Screening and triage performed the worst, with an average of only three out of seven facilities meeting this standard. Most facilities did not have screening or triage at the entrance to the facility, and if they did it was often not functioning all the time or did not have the necessary materials to do it correctly. Challenges to meet this standard included lack of staffing.

Why are these standards hard to achieve?

The IPC baseline results highlight not only the areas of strength but also – more importantly – where improvements are needed if health facilities are to achieve minimum standards for IPC. However, the baseline results do not highlight **why** minimum IPC standards are so hard to achieve within humanitarian settings. Staff from the 22 countries provided input about the main challenges they experience to achieve IPC standards:

Safe water availability: In many humanitarian contexts, there is no easy access to safe water sources, or water is generally scarce. In locations with sufficient water, the water is often not treated with chlorine. If there is no or insufficient water, or the water is not properly treated, it is impossible to practise IPC adequately.

Supply chain: In more than half the countries, health-care staff reported one or more challenges in ensuring consistent supply of priority PPE items. The challenges included lack of local availability of suitable materials, international markets not being able to provide supplies due to limited supply and high demand, and delays in shipments of supplies due to travel or flight restrictions. These challenges were

compounded by the regular, non-pandemic challenges relating to supply chains.

Health facility infrastructure: Many health facilities are not designed to enable standard IPC precautions, let alone precautions against COVID-19 transmission. Many facilities are small, and are unable to accommodate social distancing, separate entrances and exits, isolation rooms, and dedicated screening and triage areas. While funding was a barrier to making many of the required changes, limited space and local restrictions also made it very difficult to make improvements.

Staffing: Many countries reported insufficient number of health-care workers and low IPC capacity – a not uncommon challenge in such settings but one that was exacerbated during COVID-19 by health-care worker sickness and fear. Among those staff who remained working in the health facilities, it was reported that some lacked motivation to practise IPC, perceiving it as adding to their normal workload and not part of their job description. Adherence to COVID-19 transmission-based precautions for health-care workers, such as mask use, was reported as extremely low, leading to a perception that COVID-19 was not being taken seriously.

Funding: Insufficient funding contributed towards poor IPC practices. While IRC health teams received small allocations of funding to support IPC improvements during the pandemic, there were very few donors who funded large IPC projects, as they have in other infectious disease outbreaks. Many donors were also quite slow to allow for budget realignments during the pandemic in order to improve IPC standards within health facilities. The increased costs of some items during the pandemic – such as PPE – put more pressure on existing small budgets.

Improving IPC: a priority

This baseline assessment has exposed the key vulnerabilities of health facilities during the pandemic and the importance of focusing on IPC improvements during the COVID-19 pandemic. In the long term, improvements in this area contribute to a better overall quality of health service delivery and patient outcomes. Protecting health workers and patients is central to building a resilient health system. As such, strengthened IPC systems and practices are fundamental to the ability of health systems both to respond to emergencies, and to deliver safe routine health care and manage future outbreaks.

It is important to note that IRC's managed facilities perform better overall than those managed by MOH and other partners. This difference is attributed to IRC being able to make changes more easily in facilities that it directly manages than in those facilities that it only supports. This should indicate that it is indeed possible to have good IPC measures in place even in the most difficult of contexts.

The World Health Assembly (WHA) passed four resolutions in 2019 where member states agreed to improve WASH services in health facilities.[2] Member states also urged countries to strengthen IPC, including in the WASH sector, in order to ensure the highest standards of universal health care. Despite these global commitments, IPC is still under prioritised.

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WASH responses to COVID-19 in Ethiopia, Somalia and South Sudan

Yasmine Zaki Abdelaziz, Gemma Arthurson, Haley West and Antonio Torres

In the face of COVID-19, adaptation, innovation and learning from experience have been key to responding adequately to the needs of displaced people.

The humanitarian community has had to learn about COVID-19 while responding to this new disease. From the start it was known that basic hygiene practices, such as proper handwashing, could help prevent its transmission. However, many displacement settings do not have the required facilities for implementing household and community-level Infection Prevention and Control (IPC) measures. They may also have weak governance systems for managing and maintaining water, sanitation and hygiene (WASH) services.

Some displacement settings, such as in Ethiopia, Somalia and South Sudan, host some of the hardest populations to reach, where communities are ill-equipped to protect themselves and respond to health threats. Overcrowding and limited access to adequate WASH facilities can increase vulnerability to diseases. Meanwhile, the fear around COVID-19 can lead to the spread of misinformation and increased xenophobia and stigma. IOM teams working in these settings had to adapt their Risk Communication and Community Engagement (RCCE) and IPC activities as new information emerged and as lessons were learned.

Adapting RCCE strategies

In typical WASH programming, surveys are conducted at the onset of an emergency to understand people's needs and enable effective and appropriate responses. In the case of COVID-19, localised lockdowns, access restrictions and the need to adhere to physical distancing guidelines impeded early data collection, and one-on-one interviews were prioritised over broad survey exercises. In Ethiopia, interviews were undertaken by people already implementing field activities in order to avoid additional personnel movements and increased health risks. Lack of funding is a common barrier faced in all emergency response; while more innovative communication methods would have been preferred, the method used in Ethiopia to collect data during COVID-19 managed both to keep activities going – in the face of potential complete closure – and to keep data collection costs low. Interviewees included vulnerable groups such as persons with disabilities to understand their perception of COVID-19.

In all three countries it was recognised there was insufficient time for baseline surveys, so the initial response was to increase water supply and handwashing facilities, and use existing strategies to deliver hygiene promotion messages, fit for any humanitarian and public health emergency. As time evolved and more information emerged, hygiene promotion messages were adapted to incorporate physical distancing, respiratory hygiene and the use of face masks.

In Somalia, insecurity further constrains access to certain populations and hard-to-reach locations. Hence, updates on COVID-19 were disseminated through mobile phones to hygiene promoters within the community, and trainings became virtual. In other cases, door-to-door engagement methods were adopted to target vulnerable populations such as people with disabilities; access to these communities actually improved, due to use of virtual communications. In South Sudan, movement restrictions did not apply to water truckers as they delivered an essential service; they were therefore trained by IOM to disseminate COVID-19 preventive messages. In Ethiopia, as restrictions eased, hygiene promoters, WASH committee members, community and religious leaders and government health

IOM/Alex McBride

IOM WASH teams monitor appropriate handwashing practices in Hai Referendum market, in Juba, South Sudan.

extension workers were provided with basic IPC materials (handwashing units and soap) in order to set up hand hygiene stations at water points, and were given appropriate training and encouraged to disseminate COVID-19 information. Child-friendly hygiene sessions were carried out in small groups outdoors, with tailored activities using puppets and colouring books. In general, COVID-19 information was paired with cholera prevention messaging, which proved effective as these communities were already accustomed to implementing cholera prevention practices.

In all countries, WASH teams used alternative communication strategies to reinforce COVID-19 messaging, such as radio broadcasts and broadcasting from vehicles with loudspeakers. In Ethiopia, culturally appropriate Information, Education and Communication (IEC) materials were printed in the early stages of the pandemic; later, to avoid unnecessary risks for staff distributing the flyers, these materials were re-designed as posters and banners, in collaboration with a local artist. Unfortunately, over-repetition of the same message resulted in decreased interest by the community in the messages; to address this, WASH teams mainstreamed specific COVID-19 messaging within a wider range of hygiene-related themes, and this was seen to engage communities more effectively. In Somalia, audio-visual and printed materials were developed for different literacy levels, and radio programmes were translated into a variety of languages used by the displaced populations. In South Sudan the existing communication strategy that had been developed in response to the Ebola outbreak in the neighbouring Democratic Republic of the Congo was revised to reflect COVID-19. Short, easy-to-remember messages were used in all cases.

At the beginning of the emergency, community stakeholder mapping was attempted in Ethiopia; however, as key staff were not able to travel to the field to train volunteers, the data collected was not sufficiently robust for use in planning. In addition, the WASH teams took into account the fact that in Ethiopia, where government presence is strong, communities often view government authorities as the main conduit for reaching communities, even at village level. Therefore, WASH teams used simple messaging in line with the widely accepted style of communication from government authorities, in particular the Ministry of Health.

Adapting IPC protocols

Given the access barriers imposed by travel restrictions, increased cooperation with other actors was essential for an effective response. In Ethiopia, the WASH team collaborated closely with Health Cluster partners and the government's health ministry to train the government-employed health extension workers. In South Sudan, WASH and Health Cluster partners developed joint standard operating procedures (SOPs)

and held weekly coordination meetings. SOPs were also developed by IOM teams in Somalia and Ethiopia, where IOM's Hygiene Promotion Training Manual was adapted to include COVID-19 guidelines.

Protocols released by WHO recommended handwashing after touching common surfaces, which led IOM teams to promote no-touch technologies for handwashing. Foot-operated 'Tippy taps' were manufactured in South Sudan with local materials; IOM promoted their use and provided instructions to communities on how to use them. It was observed, however, that the more traditional, hand-operated handwashing stations were preferred. This prompted IOM to prioritise community preferences over the introduction of an alternative technology which, despite its advantages in terms of preventing infection, would be used less.

The adoption of face masks – in terms of materials and usage – was one aspect that was particularly characterised by misinformation and shifting guidance at different stages of the pandemic. In Somalia, when there was a global shortage of masks at the beginning of the emergency, masks were recommended only for health-care workers, people with COVID-19 and their caregivers. This persisted even with increased mask availability, leading to a widespread perception of mask use being limited solely to persons with symptoms, which in turn encouraged low rates of acceptance. In Ethiopia, since the government mandated their widespread use in public from the onset, adoption of masks was easier but was still challenging in remote areas with a weaker government presence. This highlighted the importance of community engagement as key to building acceptance and ownership by the community, particularly in areas characterised by mistrust of the government.

Adapting logistics

Restrictions and lockdowns caused delays in delivering WASH emergency items, while the increased demand generated shortages in the markets and a sudden increase of prices, which in turn triggered a focus on local procurement. As a result of COVID-19, IOM missions in each country enhanced their stockpiling plans for emergency supplies in case of long-term closure of borders, while also prepositioning for other emergencies.

In South Sudan, donors supported the expansion of prepositioning to include Personal Protective Equipment (PPE) and additional WASH items; however, in Ethiopia – where prepositioning is not the norm – restricted donor funding only allowed for procurement of items for direct implementation, and therefore stockpiling remains a substantial challenge. To address the lack of standard items, household handwashing stations were establishing using plastic water containers and laundry soap, with masks produced by local suppliers. In Somalia, where there is also a lack of stock, new supply hubs are being planned, and prepositioning efforts dedicated to flood response are currently supporting COVID-19 preparedness.[1]

Responding to evidence

Knowledge, Attitude and Practices (KAP) surveys were conducted in late 2020 and early 2021, after the initial roll-out of IOM's response. Surveys indicated that people with disabilities had relatively heightened concerns about COVID-19, believing that they are a burden on their families due to the need for help in implementing basic measures, such as frequent handwashing.[2] The WASH team therefore increased the frequency of household visits to vulnerable people such as those with disabilities and prioritised them during distributions. Qualitative surveys also highlighted myths around COVID-19, such as being able to prevent COVID-19 by drinking hot beverages or killing the virus through sunlight exposure. In some locations, COVID-19 was considered to be a fictional story disseminated by the ruling government party in order to delay elections. Hygiene promoters were trained to identify these misconceptions and provide simple, easy-to-understand counterinformation.

Conclusions

Humanitarians are often faced with disease outbreaks in humanitarian contexts, and

lessons must be captured and applied to ensure future outbreaks are acted upon with maximum efficacy. While some of these recommendations are not new, COVID-19 reinforced the importance of certain approaches while triggering new approaches to overcome new barriers. Recommendations and lessons learned from our experience in Ethiopia, Somalia and South Sudan include the following:

- While emergencies often present the challenge of lack of community engagement because of information fatigue, COVID-19 presented a new challenge, and this sparked innovative messaging methods that can be used in future disease outbreaks and other emergencies. IOM used a mix of traditional methods such as radio shows, posters and household visits and new methods such as signs on water trucks to convey hygiene promotion guidance at critical points.
- While reaching the most vulnerable is always a priority, COVID-19 demonstrated that with some relatively minor additional funding it was possible to use remote communication methods for hard-to-reach locations and segments of the population, such as people with disabilities. A combination of localising hygiene promotion and using remote communication methods was proven to work, suggesting a reduced need for on-the-ground international staff; this approach should be prioritised and written into future project designs.
- Similarly, assessing vulnerable populations in the early stages of programming should be reinforced as standard practice in order to be able to plan targeted assistance. COVID-19 has proved that measures such as household-level distribution, which was previously an uncommon method of distributing emergency supplies, is possible and allows agencies to more accurately target those who are unable to leave their home.
- Acknowledging that epidemics are likely to present a threat in the future, pre-positioning of emergency supplies such as IPC materials for disease outbreaks (face masks, portable handwashing stations, etc) should be common practice in humanitarian response plans, in addition to the emergency supply items commonly prioritised; this requires vigorous advocacy by humanitarian actors for dedicated funding by donors.
- COVID-19 showed that rapid dissemination of IEC material is critical at the early stage of a disease outbreak. Preparing ready-made, context-appropriate IEC materials that can be quickly adapted in the event of any outbreak with similar IPC requirements (such as Ebola) would enable rapid roll-out whenever required.
- Pairing new disease information with well-known information and delivery methods is important to facilitate acceptance by the community, while engaging community members in all strategies for behaviour change is key to ensuring culturally appropriate and context-relevant delivery of messages, and to gain trust and acceptance of new information and technologies.
- While investing in capacity building for hygiene promotion to empower local responses has always been part of any emergency response, COVID-19 forced further localisation due to the lack of international travel. It highlighted strong local capacity and willingness in some communities, demonstrating how supporting local structures can help consolidate hygiene promotion capabilities while negating the need for a high level of international assistance in the event of future outbreaks.

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2. Nadia Kevlin, personal communication

Barriers to accessing services and assistance during COVID-19: learning from those directly affected

Vicki Mau and Nicole Hoagland

Recent research across a number of countries highlights significant disparities in access to basic public health services during the COVID-19 pandemic. States have a responsibility to learn from the current pandemic and address the barriers that exist.

In many ways, the COVID-19 pandemic had created solidarity across countries and within communities in efforts to address public health risks and minimise the socio-economic impacts of the virus. After significant advocacy and engagement with governments undertaken by a range of actors, some good practices have emerged; these include expanding free access to COVID-19 testing, treatment and vaccines for all migrants, regardless of status, and enabling stranded migrants and people without visas to access basic services. Yet, while these policy developments are to be welcomed, championed and replicated, we must also reflect on what this extraordinary situation and global public health emergency have meant for those facing continuing barriers to accessing basic services – including COVID-19 vaccines – and how this intersects with both individual and public health outcomes.

Research coordinated by the Red Cross Red Crescent Global Migration Lab on how COVID-19 policy has affected migrants' access to basic services demonstrates that despite policymakers frequently voicing that "we are all in this together", the voices of those a long way from home tell a different story.[1] While the research focused on all migrants, here we focus on people seeking asylum[2] and refugees: their heightened risk factors for COVID-19 infection and transmission, and the challenges they face in keeping safe and healthy.

Long-standing access barriers, as well as new challenges posed by movement restrictions and lockdowns, have the potential to compromise public health efforts. The research was conducted by National Red Cross and Red Crescent Societies in eight countries: Australia, Colombia, Egypt, Ethiopia, the Philippines, Sudan, Sweden and the UK (and insights from the Sahel region were also considered).[3] The findings conclude that inclusive approaches for reaching and supporting migrants and refugees must be embedded in national and local pandemic preparedness, response and recovery plans, both to end the pandemic and to ensure everyone has the opportunity to receive assistance in a dignified and supportive way. If inclusive policies are not complemented by operational guidance to address barriers in practice, public health risks will remain.

Legal exclusion

Exclusion based on legal status was identified as a key barrier to accessing basic services, including health care, during the pandemic. In Australia, for example, 67% of undocumented migrants interviewed explicitly cited ineligibility due to visa status as the main barrier to accessing support, while 100% faced some degree of difficulty

in accessing basic services including medical care, food, accommodation or financial assistance. And while most countries studied eventually offered free access to COVID-19 testing and treatment to everyone (though not necessarily to wider public health services), health and safety concerns and fear prevented many from accessing support. In the UK, for example, immigration checks are carried out (and fees applied) for people with insecure immigration status when they seek secondary health care; although this is not the case for COVID-19 testing and treatment, the fear of immigration enforcement remains real, hindering people's willingness to engage with health services. In Australia, a health service provider explained how "people will not present to hospital even though they are violently unwell because they are fearful of reporting and deportation or detention", despite free access to COVID-19 testing and treatment.

The research highlighted inconsistent application of relevant laws and policies; this reflects the need for policy changes to be paired with operational guidance for frontline staff. In Egypt, for example, the government extended the period for renewing residency permits for refugees and allowed expired permits to be used to access certain services, including health care. However, respondents explained that this national-level policy was not always mirrored at the local level in frontline service delivery and some were denied access to support. This was also evident in Australia, where one service provider explained: "[there is] confusion around free COVID-19 testing… among clients and service providers. One client went to a private clinic because he was directed by a public health [official] to go there. This affected access not just for him but also possibly his community. He had to pay for the test... this gave the impression the testing is not free.. This creates a barrier [and] future reluctance to get tested."

Information access

The lack of accessible information on COVID-19 in languages spoken and channels used by migrant and refugee communities relates directly to individual and community health. As one refugee in the UK described: "People are very confused… they are not getting the right information... They do not know what to do or even where to go to get information…" In Egypt, National Society staff and volunteers supported the government in translating official public health messaging from Arabic into languages spoken by migrant and refugee communities, recognising that key information was not reaching these communities. Without the availability of accessible information on COVID-19 prevention and on where and how to access testing and treatment, risks of increased prevalence or transmission are heightened.

Financial barriers

It is not just access to health care and information, however, which have the potential to either support or undermine public health efforts to control the virus. Access to health care overlaps with economic impacts. Financial barriers to health care existed prior to the pandemic and have increased during the pandemic due to loss of livelihoods and income. Economic hardship and financial insecurity were one of the main impacts highlighted in the research. As one respondent in Egypt explained, "the main determinant in getting services is money and you get money through work, which was affected by lockdown."

This loss of income was combined with a tendency for migrants without permanent residency status (including refugees and people seeking asylum) to be excluded from socio-economic support measures for nationals or permanent residents, as well as exclusion from mainstream welfare services and access to public housing. Such exclusion increases the likelihood of living in insecure housing, prevents access to medical treatment, and contributes to increased risks of infection and transmission as people are unable to follow public health recommendations (such as to physically distance or isolate). In Australia, 14% of respondents surveyed stated that they had to keep working despite facing risk of exposure to the virus as they

had no other means of financial support. In the UK and Egypt, because of increased costs and loss of livelihoods, respondents faced difficulties in purchasing soap, hand sanitiser and masks to keep themselves safe.

Recommendations

The evidence suggests that the exacerbation of pre-pandemic barriers to basic services is contributing to disproportionate impacts on the health, safety and well-being of people seeking asylum and refugees. On an individual level, barriers in accessing health support have led to worsening health outcomes, particularly those connected with mental health. As put bluntly by one refugee in Egypt, "[COVID-19] turned our lives upside down …we already have trauma." On a community level, barriers to basic services and exclusionary practices continue to place everyone at risk.

It is the primary responsibility of States to respect, protect and fulfil the human rights of all migrants, including their economic and social rights. The research report recommends that States work together with other stakeholders to ensure that all migrants, irrespective of legal status:

- are included in local and national COVID-19 responses that guarantee access to basic services, including health care, housing, food, WASH (water, sanitation and hygiene) services, psychosocial support, education, emergency support and protection services
- can access timely, accurate and reliable information on COVID-19 (and any future pandemics) in a language they understand and through accessible dissemination channels
- are included in, and have equal access to, COVID-19 testing, treatment and vaccination policies
- can access pandemic-related socio-economic support (now and in the future) if they need it.

States also need to continue to adapt existing laws and policies to ensure inclusive access to basic services, and provide operational guidelines and awareness training for frontline responders to ensure entitlements in law are realised in practice. Furthermore, people seeking asylum and refugees (and all other migrants) must have safe access to humanitarian assistance without fear of arrest, detention or deportation. In all circumstances, the primary consideration should be to treat people humanely, taking into account their specific vulnerabilities and protection needs, and to respect their rights under international law.

As the world looks with hope to vaccines to end the pandemic, it is critical that barriers to accessing basic services are addressed to ensure equal and equitable access for all. We need to collaborate with refugee and migrant communities for a more inclusive approach to pandemic preparedness, response and recovery – including in COVID-19 vaccination policies and rollout strategies. We need to ensure that policymakers understand the impacts of the pandemic on the lives of everyone in society, particularly the most vulnerable. We need to ensure that any recommendations for action are built upon sound evidence and advice from those directly affected. Public health efforts will only succeed if they are considered alongside access to other basic services and support and if they address both formal and informal barriers faced by people seeking asylum and refugees.

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1. Red Cross Red Crescent Global Migration Lab (2021) *Locked down and left out: Why access to basic services for migrants is critical to our COVID-19 response and recovery*
bit.ly/RCRC-2021-Locked-down

2. The authors' use of 'person seeking asylum' rather than 'asylum seeker' is intentional, in line with their approach to follow good practice in using person-first language, whereby terms are not used to define a person by their circumstances.

3. Research in Australia, Egypt, Sweden and the UK specifically considered people seeking asylum and/or refugees.

The impact of COVID-19 on older refugees

Evelyn Avalos Cortez and Lorraine van Blerk

Older refugees are particularly at risk from COVID-19. WASH services are key to reducing disease transmission for this vulnerable group.

According to the World Health Organisation, older people are at highest risk from COVID-19. This is because those over the age of 60 are most vulnerable to developing co-morbidities and are among the most vulnerable in terms of direct virus impact and indirect impact from infection prevention and control measures.[1] Older people living in refugee settlements face particular difficulties accessing basic WASH services, limiting their ability to implement hygiene measures aimed at preventing the transmission of COVID-19. These contexts are also extremely challenging for the implementation of social distancing and self-isolation measures due to overcrowded and inadequate housing.

Kyangwali refugee settlement is located in Kikuube District, Western Uganda, and is home to more than 120,000 refugees. This article is based on repeat in-depth interviews conducted in Kyangwali settlement with 24 older refugees who had fled DRC within the previous five years. The 50 interviews were conducted in March and December 2020 before and during the COVID-19 pandemic and discussed older refugees' access to potable water, hygiene and sanitation. An additional 26 interviews were carried out with key stakeholders.[2]

Access to WASH services prior to COVID-19

From our research, it is apparent that even prior to COVID-19 access to WASH for older refugees was challenging, with access to water the most important and cross-cutting component.

Water, including potable water, is commonly available from wells, natural springs, taps and tanks. Other access to

Evelyn Avalos Cortez

Younger community members collect water for their grandparents from a well in Kyangwali refugee settlement in Uganda.

clean water, such as bottled water, is very limited due to cost. This makes access to water dependent on the efficiency of public distribution, availability of natural resources, and income to buy clean water or to pay someone to collect water. Although most of the settlement zones had water taps, frequent water shortages hindered effective access. Our research showed that it was common for older refugees to move to neighbouring zones within the settlement in search of water. This produces additional hardships as the older refugees have to walk longer distances and navigate steep terrain to reach natural springs. Fetching water in these conditions is a daily activity that puts stress on their already deteriorated physical condition.

The most disadvantaged were the oldest refugees, who suffered reduced mobility and those living without the support of younger relatives. Due to the disruption caused by displacement, it is very common to observe older refugees living alone or with others of a similar age or with much younger relatives, such as grandchildren.

"I fetch 30 litres of water per day… It is very difficult for me to carry the water. I rest twice before reaching the house." (71-year-old male refugee)

The location of older refugees' households matters in terms of quantity and quality of water services. For instance, those living in areas where public distribution of water is effective were satisfied with the quantity and, usually, the quality of water. However, those who lived in areas of water shortages or where water springs were far from their homes reported rationing their consumption of water due to access difficulties. Even though natural sources are available for everyone, in practice inequalities emerge in terms of consumption and use of water, affecting the most disadvantaged.

Water quality was also a problem reported by most older refugees that used wells.

"We drink that water because we think it is potable, but other people say it is not. We suffer typhoid when we drink that water." (60-year-old female refugee)

Access to soap is limited and most interviewees said that they had received soap only once or twice during the four to five years they had lived in the settlement.

Impact of COVID-19

Priority actions in the emergency humanitarian response to COVID-19 include increasing handwashing facilities, hygiene promotion and community awareness-raising on WASH practices to reduce transmission.[3] Like the pre-pandemic WASH interventions, these emergency responses affected older refugees in particular ways. Soap distribution increased in the settlement, with most respondents receiving bars of soap every two months. For some interviewees the procedure for receiving cash and soap was divided into two steps which occurred in different locations in order to slow down the queue and avoid mass gatherings; for older refugees, however, investing an entire day in queuing outdoors to access cash and soap meant they experienced physical fatigue and over-exposure to the sun.

Access to water remains a challenge for older refugees. Although older refugees have implemented strategies to try to meet their WASH needs, these strategies have wider impacts on their lives. For instance, rationing water for drinking and bathing may have consequences on their nutrition and health; it also impinges on their hygiene:

"Water availability is the same as before COVID-19. We have reduced the use of water to be able to wash our hands. We wash our clothes from the well, not from home. We have reduced the amount for drinking and bathing." (88-year-old male refugee)

Community engagement

Since the beginning of the COVID-19 pandemic, humanitarian operations across Uganda have been affected. Communicating COVID-19 health messages in refugee settlements like Kyangwali where several different languages are spoken, and when mass gatherings are banned, has been very challenging. Community leaders – who understand their community's needs and are used to engaging with community

members – were trained by humanitarian actors to disseminate information on WASH measures. This approach to disseminating health information appears to be effective for older refugees, who reported that they know and trust their community leaders. As a result of these strategies, understanding of good practice seems to be growing and is producing positive results.

Community engagement in public health services, such as the distribution of jerry cans and the dissemination of information, has been key to reaching more people and delivering services efficiently. Partnerships with community leaders to deliver humanitarian actors' services have resulted in good practice, particularly for those – mainly older refugees – who have mobility issues and chronic diseases. However, where leaders are also poor, some cash incentives may support engagement. Monitoring and accountability systems also need to be in place to ensure equal distribution of commodities and services for the most vulnerable.

Conclusions

Access to, and use of, WASH services for older refugees partially improved during the COVID-19 pandemic in Uganda, although some barriers remain. Sanitation and hygiene issues were addressed by increasing the distribution of soap and jerry cans to refugee households. While most older refugees reported receiving enough soap for their monthly sanitation and handwashing facilities, however, the continued shared use of latrines by two or more households was still an issue for some families. Implementation of stricter handwashing was impeded when access to clean water was not also increased. Some older refugees did not receive more or better access to water and continued to drink from natural springs and wells where the quality is unchecked. Although a strategy on the provision of handwashing facilities to the refugee community has been implemented, there are other factors such as distance and time for fetching water that impinge on older refugees' effective access to water.

Older refugees need access to good quantity and quality of water from an improved water source, available when needed and free of charge, along with increased access to soap and handwashing facilities. Building awareness of the particular WASH needs of older refugees will contribute to improving their access to essential services in times of pandemic and beyond.

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Non-signatory States and the international refugee regime

Maja Janmyr

Many of the world's top refugee-hosting countries have not acceded to the 1951 Refugee Convention and yet they engage with the international refugee regime in a number of ways. Not only are international refugee law norms being disseminated and adopted in these States but also non-signatory States often participate in the development of international refugee law by being present and active in global arenas for refugee protection.

The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol form the foundation of the international refugee regime, namely the legal norms and supporting institutions that focus on the protection of refugees. The great majority of the world's nations have signed or ratified the Convention and its Protocol yet many of the world's top refugee-hosting countries have not done so: 149 UN Member States are currently party to the Refugee Convention, its 1967 Protocol or both, while 44 UN Members are not.

We find these non-signatory States mostly in the Middle East and in South and Southeast Asia. In the Middle East region, only Iran, Israel, Egypt and Yemen are party to the Convention, while States such as Iraq, Lebanon and Jordan and most States in the Gulf region are non-signatories. Important non-signatory States in South and Southeast Asia include India, Bangladesh, Pakistan, Sri Lanka, Malaysia and Indonesia. In other regions of the world, non-signatory States include Eritrea, Libya, Mongolia and Cuba. Uzbekistan is the only Commonwealth of Independent States country that is not a party to the Convention, while Guyana is the only non-signatory State in South America.

New accessions to the Convention are rare. In the first ten years of the Convention, 27 states ratified or acceded to the Convention; since 2006, however, only two States – Nauru (2011) and South Sudan (2018) – have become States Parties. The reasons for not acceding to the Convention are varied but the fact of not being a party has long been taken to mean that these States are 'exceptions' to the international refugee regime.[1]

This perceived 'exceptionalism' – though more recently (and rightly) challenged as a concept, including by Barbour in this FMR special feature – has notable historical roots stemming from the Convention's drafting process between 1946 and 1951. Although many of today's non-signatory States were not yet independent at the time of the Convention's drafting, States like Lebanon, Saudi Arabia, Syria, Iraq, Pakistan and India participated at various stages. Indeed, during this process, many Global South States disagreed with the proposed Convention's lack of universal applicability, and scholarship focusing on this process has long highlighted the many ways in which the process, and the resulting Convention, failed to reflect a reality beyond Europe.

The research project BEYOND ('Protection without Ratification? International Refugee Law beyond States Parties to the 1951 Refugee Convention')[2] aims to reconsider the impact of international refugee law by analysing the various ways in which non-signatory States relate to the international refugee regime. By examining this interplay more closely, we may in fact discover that many non-signatory States engage with the international refugee regime in a number of ways, and that the Convention plays a substantial role in some of these States.

As an introduction to this thematic feature, this article highlights firstly how UNHCR functions in non-signatory States and how international refugee law norms are being spread and used in these States, and secondly how non-signatory States participate in the development of international refugee

law by being present and active in global arenas for refugee protection.

UNHCR and international refugee law

UNHCR has operated for decades in many non-signatory States, engaging in both international protection of and direct assistance to refugees and asylum seekers. Under UNHCR's Statute, its competence in refugee issues is universal in nature, without any geographical limitation.[3] As such, UNHCR's mandate permits it – with the host State's consent – to supervise refugees not only in signatory but also in non-signatory States. Indeed, in many of these States, UNHCR has a highly operational presence, often taking on responsibilities typically belonging to States, such as refugee status determination.[4] Central here is UNHCR's promotion and negotiation of 'protection space' for refugees, generally understood to be "…an environment sympathetic to international protection principles and enabling their implementation to the benefit of all those entitled to protection."[5]

One specific form of cooperation between UNHCR and non-signatory host States is the bilateral Memorandum of Understanding (MOU). By setting out the terms of cooperation and by reiterating core refugee protection principles, these MOUs can create an important link between non-signatory States and the Refugee Convention. However, there is no single approach to such agreements, and their content varies considerably.

One example is UNHCR's 1998 MOU with Jordan, discussed in the contribution by Clutterbuck and co-authors in this feature, which adopts a refugee definition similar to that of the Convention and declares Jordan's commitment to international standards of refugee protection, including the principle of *non-refoulement*. By comparison, in the case of Pakistan the substantive content of the agreement could bind the host State to observe norms and principles well beyond anything that could be derived from the Convention itself.[6] Sometimes, however, these agreements are far from benign and may even be a protection concern in themselves; UNHCR's 2003 agreement with Lebanon's Directorate of General Security, for example, has been criticised in some quarters for being negotiated only with the country's security agency and, as such, for adopting the perspective of refugees as security threats.

UNHCR is often key in the creation of national spaces where State actors are 'socialised' into the international refugee law regime – that is, where such actors are drawn into accepting certain international standards, which in turn influences State behaviour. UNHCR's support for training and higher education in international refugee law is a good example of this; in India, UNHCR recently formed a research and advocacy initiative with academics working on refugee issues, and in Saudi Arabia it has collaborated with an academic institution in the dissemination of international refugee law to law enforcement officials from the region. In the same vein, UNHCR regularly co-organises courses on international refugee law at the International Institute of Humanitarian Law in San Remo, Italy, sponsoring the attendance of judges, government officials and civil society actors.

But socialisation can also occur in other, different spaces. In some States, UNHCR – often in collaboration with local and regional civil society organisations – also mobilises support for, and participates actively in, domestic legal reform. In Pakistan, UNHCR has argued that such legislatory change "could be a first step toward getting Pakistan to sign the 1951 UN Convention on refugees".[7] In Indonesia, UNHCR has similarly supported the development of a national protection framework to assist the government in managing the presence of persons seeking asylum.

Finally, as the articles on Bangladesh and Hong Kong in this feature strongly indicate, domestic courts in non-signatory States also occasionally engage with international refugee law norms and principles. The Convention was directly referenced by the Bangladeshi Supreme Court in cases relating to unlawful expulsion orders against Rohingya refugees, while in Hong Kong a series of court cases led

the Hong Kong government to launch its mechanism for determining claims for protection against *non-refoulement* with reference to Article 33 of the Convention.

The development of international refugee law

Global forums on refugee protection are key spaces in which signatory and non-signatory States alike not only are socialised into the international refugee law regime but also where these same States reaffirm, and help develop, key concepts of international refugee law. UNHCR's Executive Committee (ExCom) was established in 1958 and today comprises 107 States, many of which have not acceded to the Refugee Convention. By participating in this forum, however, non-signatory States actively contribute to developing the substance of refugee law in drafting the annual ExCom conclusions. These conclusions, adopted in plenary by consensus, are formally non-binding but may nevertheless be highly relevant in their expression of an international consensus on legal issues concerning refugees.

In addition to the work in UNHCR's ExCom, non-signatory States also participate in other high-level meetings and forums. On the occasion of the 60th anniversary of the Convention in 2011, a Ministerial Communiqué was adopted in which representatives of signatory and non-signatory States alike reaffirmed:

…that the 1951 Convention relating to the Status of Refugees and its 1967 Protocol are the foundation of the international refugee protection regime and have enduring value and relevance in the twenty-first century. We recognize the importance of respecting and upholding the principles and values that underlie these instruments, including the core principle of non-refoulement, and where applicable, will consider acceding to these instruments and/or removing reservations.[8]

More recently, non-signatory States have participated in the negotiations leading to the adoption of the 2016 New York Declaration for Refugees and Migrants and the Global Compact on Refugees (GCR) in December 2018, and also participated in the first Global Refugee Forum in late 2019 where pledges were made to put the GCR into action. (The Forum was in fact co-convened by Pakistan.) In this FMR special feature, the article by Thanawattho and co-authors details the engagement of the Thai government in these processes, and how Thai civil society has followed up locally on the pledges made by the government at the international level.

Of these processes perhaps the most noteworthy is the GCR, which was adopted by 181 Member States, many of whom were non-signatory States. While it takes the Convention as its starting point and reaffirms many of the Convention's core principles, in many respects the GCR also goes beyond the legal commitments articulated in the 1951 Refugee Convention. One section of the GCR also explicitly acknowledges the contributions made by non-signatory States, with a call for these States to consider accession to the Convention.

What these examples arguably demonstrate is that the division between 'outsiders' and 'insiders' is often blurred when it comes to participation of non-signatory States in formal global arenas. By their participation at the international level, non-signatory States arguably help create soft law obligations that build on the hard law (the Convention) that these States have formally opted out of. An additional but complex and greatly overlooked aspect warranting further consideration is explored by Cole in her contribution in this feature: how non-signatory States engage in the international refugee regime by being important donor States, thereby potentially influencing the direction of UNHCR's operations and, through this, the provision of international protection and assistance.

Conclusion

While there is a widespread and entrenched assumption that refugee protection is superior in signatory States when compared with non-signatories, there are no systematic and comparative studies supporting an argument that accession to the 1951 Refugee Convention automatically means better

protection. Rather, in many signatory and non-signatory States alike, limiting refugees' access to asylum has arguably become an increasingly common political aim, and in some cases protection may even be better in non-signatory States than in signatory States. We need to challenge the current emphasis only on signatory States in discussions of the international refugee regime. International refugee law also 'happens' in non-signatory States, and non-signatory States also 'do' international refugee law.

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Beyond Asian exceptionalism: refugee protection in non-signatory States

Brian Barbour

Few Asian States have acceded to the Refugee Convention yet they may have laws, policies, practices or systems that can be of use in responding to refugees' protection needs.

The number of refugees in the Asia Pacific is consistently high, with nearly 4.2 million cited in UNHCR's most recent *Global Trends*.[1] Statistics show only part of the picture, however, because of large numbers of unregistered populations and because of unreliable reporting by States. Despite the numbers and magnitude of needs, Asia has few States Parties to the 1951 Refugee Convention and even fewer that have passed specific legislation on refugee protection. Where refugee law exists, it is often not implemented, or is characterised by unfettered discretion in how it is applied and by a lack of transparency.

This context is well documented by practitioners and academics alike. Much of the scholarly literature recognises a lack of Asian State participation in international refugee protection and human rights regimes – what some refer to as 'Asian exceptionalism'. Reasons cited for this include the Euro-centric origins of the Convention, political expediency, the non-interference principle of ASEAN (Association of Southeast Asian Nations), and economic and security-related factors.

There is also regional scholarship, however, that challenges the notion of Asian exceptionalism, attempting to find a different starting point for the analysis. Third World Approaches to International Law (TWAIL[2]) scholars highlight the impact that centuries of colonialism have had and continue to have for the countries of Asia. BS Chimni argues that Asian States should refuse to accede to the Refugee Convention as long as there is a "strategy of containment which seeks to shift the burden of caring for refugees to the poor world."[3] He suggests that the focus should first be on national systems before seeking a regional declaration, and calls for careful study of the needs and experiences of the countries in the region.

If we look more closely at any specific context in Asia, we can see that States have often committed to various legal obligations under international law, and often have human rights provisions in domestic law. In practice, they may have laws, policies,

practices or systems that can be used to respond to protection needs. States also recognise and permit international institutions like UNHCR – often through a Memorandum of Understanding – to register, assist and refer persons of mutual concern. Moreover, civil society actors in every jurisdiction have developed substantial infrastructure and capacity for providing protection, and refugees are coping and/or contributing to the provision of protection for themselves, their fellow refugees and/or for host communities in every context. Three broad trends among the jurisdictions of Asia are discussed below.

Policies and practices

Firstly, some States (such as Thailand, Indonesia and Bangladesh) are not party to the Refugee Convention but are developing policies or practices to address the needs of displaced persons.

In Thailand, where no specific legislation is in place, there is hope that a new regulation establishing a "screening mechanism" will regularise stay and provide rights for those in need of protection.[4] Although the regulation was due to come into force in June 2020, it has yet to be implemented. There are a number of concerns, however, including: the word refugee does not appear in the regulation, a 16-member Inter-Ministerial Committee will determine who becomes a "protected person" in accordance with criteria they establish, pre-screening will allow immigration officers to serve a gate-keeping function, and the first instance decision is final with no appeal. Meanwhile, civil society actors and lawyers are strengthening their own capacity to support the government screening mechanism, networking through a number of collaborative endeavours including the Coalition for the Rights of Refugees and Stateless Persons (CRSP) and a Refugee Rights Litigation Project.

In Indonesia, a Presidential Regulation on the Handling of Refugees was passed in 2016; this includes provisions for (among other matters) inter-agency coordination and responsibility for search and rescue of refugees found on boats in distress.[5] Although the Presidential Regulation had been in preparation for years, the Andaman Sea Crisis in 2015 and negotiations with the Acehnese leadership and communities provided the real impetus for change. It was the fishermen of Aceh who, in accordance with centuries-old customary law, pulled to safety stateless Rohingya refugees in distress at sea in 2015 and 2020 in defiance of the Indonesian military. With civil society calls for action growing stronger, there has been more strategising between national and local civil society actors in Aceh and Jakarta, with greater potential to influence policy-level discussions based on concrete information about the protection context and operational needs.

In Bangladesh, both the State and local civil society have developed substantial humanitarian capacity in response to the 2017 movements of stateless Rohingya refugees. Rohingya refugees are confined to large and overcrowded camps, while Bangladeshi and international NGOs are supporting the Government of Bangladesh and the UN in a massive humanitarian response. Access to justice in Bangladesh is not strong but the legal infrastructure does exist, with a Constitution with a strong rights base, a judiciary that provides judicial review, and lawyers and legal aid organisations with national-level coverage. There is precedent relating to refugees, perhaps most notably the case of *Refugee and Migratory Movements Research Unit (RMMRU) v Government of Bangladesh*.[6] The court found the continued detention of five Rohingya who had served their sentences to be a violation of article 31 of the Constitution which prohibits deprivation of liberty without the authority of law, and found that *non-refoulement* obligations under customary international law and the UN Convention against Torture both prevented expulsion. The engagement of the legal infrastructure in Bangladesh is important and is increasing within and outside formal litigation.

Alternative protection schemes

Secondly, among States that are not party to the Refugee Convention there are

Andrew Philip

Cox's Bazar in Bangladesh is home to nearly 900,000 displaced people, mostly from neighbouring Myanmar.

also jurisdictions that have developed a status determination procedure outside the Refugee Convention context. These include India, Hong Kong and Taiwan.

In India, refugee protection is divided between the government and UNHCR, with those arriving from neighbouring countries (with the exception of Myanmar) handled by the Ministry of Home Affairs. There is differential treatment between populations and a lack of clear, publicly accessible procedures and criteria. India has been praised for its long history of refugee protection but recent developments are concerning. Along with increasing xenophobia across the country, in 2017 an advisory was issued by the Ministry of Home Affairs ordering the "detection and deportation of … illegal immigrants from Rakhine State, also known as Rohingyas… expeditiously and without delay." In the case *Mohammad Salimullah v Union of India*, currently pending before the Supreme Court, two Rohingya claimants are challenging this advisory. They argue that deportation would violate fundamental rights provided in the Indian Constitution, that India has obligations under customary international law to respect the principle of *non-refoulement*, and that there is a de facto refugee protection regime in India which includes a long history of refugee protection and that India is therefore under an obligation to implement existing policy fairly.[7] On 8 April 2021, the court rejected an application for interim relief that was made on behalf of hundreds of Rohingya who were arrested and detained in Jammu and were under immediate threat of deportation while the case was pending.

This argument about a 'de facto refugee protection regime' was in fact the winning argument in a case in Hong Kong that resulted in the establishment of a Unified Screening Mechanism (USM). In *C & Ors v the Director of Immigration and Another*,[8] the Court of Final Appeal noted that although not bound by the Convention, the Hong Kong government nonetheless voluntarily complies with its requirements, and held that therefore "the Director must observe high standards of fairness". The USM considers torture claims under the Convention Against Torture, *non-*

refoulement under the Hong Kong Bill of Rights, and considers the risk of persecution with reference to the principle of *non-refoulement* as a matter of government policy.

Taiwan is not a member of the UN. This prevents Taiwan from officially acceding to international conventions, and yet Taiwan has already acceded to international human rights conventions through domestic legislation. The country's Executive has ordered the National Immigration Agency to develop regulations to implement human rights obligations, including *non-refoulement* obligations under Article 7 of the International Covenant on Civil and Political Rights. Taiwan also has a draft refugee law, and civil society actors and lawyers have progressively taken on refugee cases, drawing on external partners for technical support.

States Parties

Finally, there are some States in Asia that are party to the Refugee Convention. The Philippines was the first State to sign the Refugee Convention and Protocol in Asia and is one of the few countries in the world with a joint refugee and stateless status determination procedure.[9] The system is now operational. It was established through a Department of Justice Regulation and, while no legislation is yet in place, there are a few draft bills currently before the House and Senate to formalise it. Civil society actors and UNHCR collaborate with the State and with each other and are well networked. Korea is the only country in Asia to have developed a comprehensive refugee law independent of its immigration law; Korea has also built an open immigration reception centre with programmes for reception, residence, and cultural introduction and integration. Japan and Korea both offer small resettlement schemes alongside their asylum systems. Civil society is well networked and collaborative in both countries, and the legal community is heavily involved in legal support to refugee cases. In Japan, the Ministry of Justice, the Forum for Refugees Japan and the Japan Federation of Bar Associations have signed a tripartite Memorandum of Understanding. One initiative under the MOU is a pilot project for airport arrivals to establish a support mechanism involving local NGOs and UNHCR in order to assist newly arriving refugees.

Beyond Asian exceptionalism

The above policies and practices should not be interpreted as implying that the trajectory is always a progressive one. There are a number of negative trends, from encampment and border closures to growing xenophobia. Protection is hard work, and its success is measured by its ability to resolve situations for people in need. Scholarly research has made important contributions to our understanding of the Asian context but it is time now to go beyond Asian exceptionalism. Research and practice should investigate and support the development and sustainability of laws, policies and practices that can contribute to refugee protection in Asia, whether through treaty ratification, domestic legislation or ground-level practices that improve protection outcomes for the many refugees in the region.

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Turkey: party or non-party State?

Özlem Gürakar Skribeland

Somewhere between party and non-party to the Refugee Convention, Turkey is a rather unique case from the perspective of refugee law and practice, with its protection regime fundamentally shaped by the Refugee Convention and the optional geographical limitation allowed under it.

Turkey has ratified the 1951 Refugee Convention and its 1967 Protocol but with the optional geographical limitation offered in 1951. This means that Turkey applies the Refugee Convention only to refugees originating from Europe or, to put it more accurately, to those persons who seek protection in Turkey as a result of "events occurring in Europe".

Located in a region with unstable regimes, Turkey has long considered itself vulnerable to refugee influxes, fearing not only the more general challenges of mass immigration but also its national security implications. The geographical limitation has thus been seen as a protection against these.[1] The European Union (EU), on the other hand, wants Turkey to qualify as a 'first country of asylum' or a 'safe third country' so that refugees and asylum seekers who travel through Turkey to Europe can be sent back to Turkey. The EU has long demanded the lifting of the geographical limitation, and Turkey was amenable to this if it was part of possible EU accession.

Turkey's EU membership prospects have – to put it mildly – weakened over the years and, perhaps unsurprisingly, the EU no longer insists on the lifting of the geographical limitation. Instead, it takes the view that Turkey's new legal framework for migration and asylum (gradually established since 2013) provides appropriate protection despite it.[2] At the same time, as part of the ongoing reform of the Common European Asylum System, the definitions of safe country rules seem to be moving towards more flexible criteria where they will not be interpreted as demanding that a State has both ratified the Refugee Convention and does not impose a geographical limitation in order to be considered safe.

For the past seven years, Turkey has been hosting more refugees and asylum seekers than any other country. The four million people who have sought protection in Turkey (3.6 million Syrians and about 330,000 persons of other non-European origin) do not, however, do so as a result of events occurring in Europe. It is estimated in fact that there are fewer than 100 persons in the country with actual refugee status as per the Refugee Convention. From this perspective, Turkey can for all practical purposes be regarded as a non-signatory State. At the same time, Turkey has a rather unique position in the international refugee regime. It was among the 26 drafters of the 1951 Convention and, moreover, Turkey has been a member of ExCom, UNHCR's governing body, since its establishment in 1958. As such, it has been part of the drafting of ExCom conclusions, and has had the chance to substantively affect the interpretation of the Refugee Convention.

Turkey's fragmented protection regime

The Refugee Convention has had a major influence on Turkey's protection regime. Those who fulfil the definition of refugee and originate from Europe can get refugee status in Turkey as per the Refugee Convention and the rights that attach to that status. By contrast, those who fulfil that definition but do not originate from Europe can get 'conditional refugee' status under Turkish law. The latter allows its holders to remain in Turkey with a very limited set of rights while they wait for UNHCR to resettle them in a third country. Considering the low resettlement quotas, it is clear that only a tiny number of Turkey's conditional refugees will ever get resettled. Thus, in theory the conditional refugee status is only a temporary status but in practice it is not. In other words,

the Refugee Convention and the geographical limitation allowed under it have resulted in the creation of an unusual protection status in Turkey with very limited rights attached to it.

The second major shaping influence on Turkey's protection regime has been EU law. In 2013, Turkey enacted the Law on Foreigners and International Protection (LFIP), which contains, alongside refugee and conditional refugee statuses, a 'subsidiary protection beneficiary' status, taken from EU law. That said, the latter status is estimated to have been given to few people, so for all practical purposes Turkey's main international protection status is the conditional refugee status. The country also passed its own Temporary Protection Regulation in 2014, which has since applied to Syrian refugees in Turkey. Turkey's temporary protection regime is inspired by and based on its EU counterpart, the EU Temporary Protection Directive (which, to date, has not been activated). There are, however, fundamental differences between the two, especially when it comes to their 'temporariness'. Firstly, the Turkish temporary protection regime has already been in place for many years, and there is no upper limit on how long it can last. Secondly, it is unclear what will happen to Syrians under temporary protection when that protection is terminated. All in all, Turkey's refugees have limited rights and no long-term prospects in the country.

The ever-changing role of UNHCR

Under the Refugee Convention, States Parties undertake to cooperate with UNHCR in the exercise of its functions, and in particular to facilitate UNHCR's duty of supervising the application of the Convention (Art. 35(1)). Given that Turkey is a State Party but has undertaken to apply the Convention only to European refugees, the exact scope of Turkey's international obligations under this provision is an interesting legal question. In more practical terms, UNHCR's role in Turkey has evolved since it first established a presence in Turkey in 1960 (with a formal agreement only signed in September 2016), and has lately been going through another period of major change. Until recently, asylum seekers in Turkey registered both with UNHCR and with the Turkish authorities (so-called parallel procedure), and the Turkish authorities largely relied on UNHCR's assessment of applications. Legal research shows that the European Court of Human Rights (ECtHR) judgments against Turkey have been influential in the gradual development of the country's protection regime; the creation of this parallel procedure was one such development and has led to increased cooperation with, and reliance on, UNHCR in the decision-making process.[3]

With the adoption of its new legal framework, however, Turkey also established the Directorate General of Migration Management as the agency in charge of migration and asylum matters. Following a transitional period, UNHCR announced in September 2018 that it would no longer register applicants or carry out mandate refugee status determination procedures. Since then, the new Turkish agency has been fully in charge. The full impact of this change is yet to be seen but it is worth noting that there have since been multiple reports of problems with access to registration/asylum procedures.

Currently, UNHCR has an important role in Turkey with respect to resettlement. When the Turkish authorities identify cases of particular vulnerability, they refer them to UNHCR, which assesses those cases for resettlement and coordinates with possible resettlement countries. More generally, UNHCR supports the Turkish authorities with capacity building and technical advice.[4] As a matter of Turkish law, UNHCR is to be given access to international protection applicants in Turkey (including those under administrative detention), as well as to foreigners in removal centres (LFIP Articles 92, 59 and 68); lack of transparency, however, is a major problem with Turkey's protection system, and the question of whether this access is given in practice should be assessed.

The refugee population in Turkey is particularly young (including when compared with the rest of Turkey's population).[5] As such, access to both education and legal employment is key. In the past few years,

UNHCR has been particularly active in the latter, providing (in cooperation with Turkish partners) counselling, training and entrepreneurship support in different Turkish cities, as well as carrying out a service mapping exercise to achieve better coordination between needs and services.[6] Most recently, in January 2021, UNHCR announced the completion of a three-and-a-half-year project on the 'Reinforcement of Turkey's National Asylum System', intended to support Turkey's capacity-building efforts.[7]

In recent years, UNHCR's role in Turkey seems to be moving to a more secondary and supporting role. This appears to be mainly due to the establishment of Turkey's specialised agency – the Directorate General of Migration Management – which is in itself a positive development. At the same time, this development should be viewed against the backdrop of the political climate in Turkey, which makes it generally more challenging to operate in the country for organisations such as UNHCR and international and local NGOs. The full impact of this transition is yet to be seen and should be followed.

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Hong Kong's Unified Screening Mechanism: form over substance

Rachel Li, Isaac Shaffer and Lynette Nam

Hong Kong is often cited as a positive example of a non-signatory territory that has established a government-led refugee status determination mechanism. However, in the absence of a broader public or executive-led commitment, this mechanism falls far below international standards.

In the 20th century, Hong Kong has been a safe harbour for refugees and migrants from mainland China and Vietnam. Although China acceded to both the Convention and its Protocol in 1982, the Refugee Convention has never been extended to Hong Kong, whose government maintains that it has no intention to ratify it. The official explanation is that Hong Kong's dense population, long coastlines, liberal visa regime and status as a regional transportation hub makes it vulnerable to the "ill-effects of illegal immigration".[1]

However, Hong Kong is party to other human rights treaties including the Convention against Torture (CAT) and the International Covenant on Civil and Political Rights (ICCPR), both of which impose *non-refoulement* obligations. Since 2004, a series of judicial review decisions led to the government being compelled to establish *non-refoulement* screening, addressing commitments under the CAT and then ICCPR.

Initially, the government's screening ran parallel to a separate refugee status determination (RSD) process operated by UNHCR's Hong Kong sub-office. However, a further judicial review challenge culminated in the case of *C and Others v Director of Immigration and Another*,[2] in which the Court of Final Appeal ruled that, in exercising the power to remove a person from Hong

Kong, the Director of Immigration must independently determine whether that person meets the refugee definition as contained in the 1951 Refugee Convention.

Hong Kong's Courts have repeatedly urged that high standards of fairness must be observed in the exercise of immigration powers where "life and limb are at stake"[3] and where removal could lead to a risk of torture or violation of other absolute and non-derogable rights. The applicants in *C and Others v Director of Immigration and Another* (who had all been rejected by UNHCR after appeal) successfully argued that the Director was required to independently determine whether a claim is well-founded. By recognising this obligation, the Court of Final Appeal thus introduced into Hong Kong law a limited form of *non-refoulement* protection based on Article 33 of the Refugee Convention.

In compliance with the Court's ruling, the Unified Screening Mechanism (USM) was launched in March 2014, unifying the consideration of all *non-refoulement* obligations into one screening process. This was perhaps the first of its kind: a government-led refugee status determination system based on the Refugee Convention but operating in a non-signatory territory. Following this shift to increased state responsibility, UNHCR rolled back its operations in Hong Kong, limiting their role to that of assisting claimants who are successfully identified within the USM as being at risk of persecution with resettlement to a safe third country.

Given the considerable political challenges of persuading States to ratify the Refugee Convention, the development of Hong Kong's USM is often considered an example of an alternative means by which refugee protection might be effectively derived. Indeed, on paper, the USM gives every appearance of an effective system replete with an array of in-built procedural protections. Claimants are provided with free legal representation from a panel of duty lawyers and receive access to interpretation and translation assistance. They are provided with an opportunity to articulate their claims in writing before attending one or more interviews with civil servant decision-makers, who are specifically designated to evaluate and determine such claims. Claimants are provided with written decisions that explain the reasoning behind them. In the case of negative decisions, claimants have a right to appeal to an appellate board composed of independent Adjudicators.

However, since it began operation in 2014, the recognition rate within the USM remains alarmingly low at below 1%, almost the lowest in the industrialised world. It is particularly telling that this rate reflects a significant and almost overnight precipitous drop upon transition from the previous UNHCR-led process. While the Hong Kong government maintains that this rate is a result of claimants abusing the system, modest scrutiny unearths a more likely cause.

Despite apparent procedural protections, in all operative aspects the USM is qualitatively deficient. Implemented with almost no civil society consultation, the system bestows upon decision-makers broad discretion and wide case-management powers that are not counterbalanced by effective or adequate mechanisms for transparency or accountability. The requirements of fairness, while widely accepted in principle, are significantly undercut by the very low standard of decision-making in both procedural and substantive matters.

A flawed protection system

The central flaw of this so-called protection system is that the USM operates solely as an expression of a limited, negative legal obligation. The imposition of this *non-refoulement* obligation remains defined and constrained by the absence of public engagement or support, executive intention, or any other form of broader moral commitment or source of legitimacy. Both the development and the operation of the USM are marked by an absence of any driving humanitarian impulse, which has contributed significantly to a backlash and to an environment in which negative perceptions and hostile attitudes at all levels of society towards asylum seekers go unchecked.

A refugee looks out over the harbour in Hong Kong.

The Hong Kong government's open hostility to people seeking protection is evident from its frequent insistence that refugees are "illegal immigrants", "overstayers" or "foreigners who have smuggled themselves into Hong Kong", who must be removed from Hong Kong as soon as practicable.[4] This language, which permeates all official communications, has fuelled a broader xenophobic narrative that portrays people in need of international protection as abusers of the system, "fake refugees"[5] and criminals.

Decision-makers within the USM are clearly not immune from these prevailing cultural attitudes. For, although substantive decisions to grant or deny protection appear to be based on legal analysis, there are numerous instances where the Courts have found that accuracy and procedural fairness have (inevitably) been undermined when decision-makers carry hostile attitudes, bias or flawed assumptions into that process.

What we observe in the USM is that in this way, despite giving the appearance of ensuring fairness, each individual mechanism for procedural protection within the system falls short in practice. For example, as the complexity of legal proceedings increases, the likelihood and ease of obtaining legal representation swiftly decreases; although legal representation is initially obligatory it becomes discretionary from the appellate stage onwards. Where an independent appeal process is provided by right, its hearings are held in private, with decisions unpublished; and relevant lawyers (after minimal training) are given unsupervised discretion as to whether to continue to provide representation (and so the result is that 92–95% of appellants are unrepresented). Similarly, although there is a right to apply for Legal Aid to seek legal representation for judicial review of negative decisions, over 90% of such applications are refused. And while only a few succeed in their asylum claims, those who do succeed are not then granted legal status; their removal orders remain in place for an indefinite period until they are resettled to a safe third country or leave Hong Kong for other reasons.

Despite these clear structural failings, the government continues to evade improvement. This is despite repeated concerns raised by civil society and the Courts, and repeated recommendations of relevant Treaty Bodies. Rather than addressing such shortfalls, in April 2021, the government passed the Immigration (Amendment) Ordinance

2021 seeking to introduce amendments to the USM that are widely considered to be regressive.[6] The amendments include allowing the government to increase the use of immigration detention, restricting the submission of new evidence on appeal, shortening the timeframe for notice of hearings, and mandating the language of asylum proceedings. The stated purpose of the Bill is ostensibly to expedite the screening process but civil society has repeatedly articulated concerns not only that these proposals risk eroding procedural fairness and human rights safeguards even further but also that there is no real evidence-based policy requirement or need for increased expediency in a system where the main delays are actually delays in government and Courts' decision-making.

In the absence of political will, holistic reform to the USM is unlikely in the foreseeable future. To address the high rate of refusal and lack of durable solutions, some civil society organisations are assisting refugees in Hong Kong to pursue complementary pathways (such as private community sponsorship programmes) to migrate to safe third countries. In collaboration with civil society coalition Refugee Concern Network, Justice Centre Hong Kong engages in constructive dialogue with policymakers, while collecting and publishing relevant data, advocating for reform through print and social media, and training and working with legal practitioners to identify and litigate strategic cases.

If anything, the Immigration (Amendment) Ordinance 2021 embodies the precariousness of Hong Kong's *non-refoulement* protection regime: a system where court-imposed legal responsibilities continue to flounder unsupported by any apparent moral commitment, and without the Refugee Convention's normative foundations. This is therefore a cautionary tale for those advocating for a shift to government-led RSD systems in other jurisdictions, and one that emphasises the need for political buy-in and a whole-of-society approach.

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6. See bit.ly/HKFP-20210428-immigration-law

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Alternative protection in Jordan and Lebanon: the role of legal aid

Martin Clutterbuck, Yara Hussein, Mazen Mansour and Monica Rispo

In the absence of a codified refugee rights framework in Jordan and Lebanon, legal actors must be creative in the development of strategies and approaches to ensure the protection of refugee rights in practice.

Jordan and Lebanon share common challenges in relation to refugee protection but are poles apart in practice. Neither has signed the 1951 Refugee Convention. Both host a disproportionate number of refugees. Both share the collective trauma of large-scale protracted refugee displacement, namely the influx of Palestinian refugees from 1948 onwards and of Syrian refugees since 2011. While protection gaps exist for refugees in both contexts, the chasm is considerably wider in Lebanon. However, legal aid actors, courts and national and local institutions can all play a constructive role.

A national legal framework for refugees

Although neither Jordan nor Lebanon has signed the Refugee Convention, both have signed Memoranda of Understanding (MOU) with UNHCR which set out basic points of agreement and cooperation. Jordan's MOU, signed in 1998, notes Jordan's commitment to treating asylum seekers and refugees in accordance with international standards and confirms their rights to education, health, religious practice and freedom of movement, plus access to courts and the right to legal assistance. The MOU between the Lebanese Directorate of General Security (GSO) and UNHCR, signed in 2003, authorises UNHCR to determine asylum claims and confirms that temporary residence permits are to be issued to asylum seekers and refugees. While the MOUs act as a statement of commitment by both States to certain levels of refugee protection, they are unenforceable and have little legal weight.

More significantly, neither country has a national legal framework setting out the rights owed to refugees. The treatment of refugees is covered by legislation governing the entry and residence of foreign nationals. In Jordan, Law No 24 of 1973 on Residence and Foreigners' Affairs applies to all foreigners equally. The only references to refugees are for the recognition and issuance of travel documentation. Refugees in Lebanon are bound by the 1962 Law Regulating the Entry and Stay of Foreigners in Lebanon and their Exit from the Country. The law contains a limited number of provisions on the right to seek asylum and the issuance of identity cards but remains barely implemented. Due to Lebanon's fears and concerns surrounding the issue of permanent settlement (*tawteen)* generated by the Palestinian issue, Lebanon labels refugees as displaced persons and asserts that it is neither a country of asylum, nor a final destination for refugees, let alone a country of resettlement.

The lack of a comprehensive domestic legal framework covering refugees with dedicated implementation mechanisms has resulted in a plethora of directives, policies and rules which change frequently and do not always address the protection concerns faced by refugees. An entire system built on directives rather than anchored within a solid legal framework is weak and arbitrary and can erode basic rights. While legal aid actors have on occasion used human rights arguments in litigation, more often they are forced to resort to arguments of fairness, humanitarian consideration and consistency as 'alternative protection mechanisms' rather than relying on the law. Furthermore, different rules apply to refugees from different contexts, such as Palestinian Refugees from Lebanon (PRL) or from Syria (PRS) in Lebanon, and non-Syrian refugees in Jordan, including Iraqi, Sudanese, Yemeni, PRS and Somalis, thereby

creating parallel systems that offer greater protection to Syrian than non-Syrian refugees.

The right to residence

The Refugee Convention obliges States to regularise the status of asylum seekers within their borders, including those entering illegally. Yet legal aid actors, both in Lebanon and Jordan, spend an inordinate amount of time advocating for the right to legal stay. Both countries generously opened their borders to Syrian refugees until they felt they had exceeded their capacity to support the growing numbers of refugees and given that the crisis was clearly becoming yet another protracted refugee situation. Lebanon effectively closed its border to Syrian refugees in 2014 and Jordan in 2015.

However, since that time, the vast number of the estimated 663,000 Syrian refugees in Jordan have obtained lawful residency permits while 80% of the estimated 865,000 Syrian refugees in Lebanon are without lawful residency permits. On the other hand, non-Syrian refugees continue to face challenges with entry and residence into Jordan. Following Jordan's 2013 policy of non-admission of PRS, many live irregularly in Jordan and are at risk of deportation. Non-Syrian refugees are required to apply for Jordanian visas before arrival and are often refused. Those who do enter struggle to obtain annual residency and are subject to fees for overstaying once their entry visa and/or residency permit expires.

In Lebanon, obtaining and maintaining legal residency remains extremely difficult for Syrian refugees, as is also the case for non-Syrian refugees in Jordan. In December 2014 Lebanon's GSO established new entry policies and restrictive residency regulations to curb the massive flow of Syrian refugees into the country, requiring Syrians to provide a complex and prohibitive set of documents and to pay an annual fee of US$200 for residency permits. Moreover, in May 2015 the Lebanese Ministry of Social Affairs asked UNHCR to stop registering refugees arriving in Lebanon, which resulted in a continuous reduction in the rates of legal residency among Syrian refugees. An administrative circular issued in 2017 to allow some refugees to renew residence permits without charge does not apply to the majority of refugees. Without lawful residence in Lebanon it is hard to move freely, work and access essential services such as health and schooling. Refugees face the risk of detention and the issuance of deportation notices. Even if such notices are typically not implemented, they create fear among refugees and are incompatible with Lebanon's international obligations.

Legal aid actors are limited in their strategies for ensuring legal residency. Advocacy efforts, often led by the UN and NGOs, have resulted in some concessions, such as time-limited amnesties on regularising legal status, and in some cases lawyers have been able to successfully challenge decisions to detain persons without legal residency. However, protection risks for family members without legal residence in the community and other adverse consequences for detainees (such as deportation) must be weighed up when considering legal action. In an important case in Lebanon, the court ordered the immediate release of an Iraqi refugee who had been convicted for illegally entering the country and issued with a deportation order. The court highlighted both the right to individual liberty under the Lebanese Constitution as well as the prohibition on arbitrary arrest, detention and exile under the Universal Declaration of Human Rights (UDHR).[1] Such cases remain the exception, however, and have not yet resulted in a change in administrative practice. Often lawyers can do no more than scrutinise eligibility requirements, advise refugees of any changes that may benefit them and advocate for the release of refugees who are detained on account of a lack of legal residency.

Legal protection against *refoulement*

Nevertheless, in recent years there have been increasing references by Lebanese courts to international human rights law obligations, including the principle of *non-refoulement*. While the majority of courts have penalised the unauthorised entry of Syrian refugees into Lebanon, other judges

have granted mitigating circumstances given the situations of *force majeure* and the de facto legal impossibility of Syrian refugees entering through lawful means when fleeing persecution. In one decision the court cancelled a deportation order of an Iraqi refugee with reference to the right (in the UDHR) to seek asylum as well as the prohibition against *refoulement* in the Refugee Convention and the Convention Against Torture.[2] In an important case in 2018 initiated by two legal aid NGOs, Lebanon's State Council – its highest administrative court – found that the 2015 regulations issued by the GSO which limited the entry and residence of Syrians to Lebanon were invalid because only the Council of Ministers could issue such regulations. The court held that the role of the GSO is limited to implementing regulations and confirmed that even the processes of security agencies are subject to judicial oversight.[3] Despite the significance of this decision, and its use by lawyers in arguments, the regulations continue to be applied and in May 2019 Lebanon's GSO and Higher Defence Council declared that all Syrians coming into Lebanon illegally after 24 April 2019 should be deported.

Within Jordan, deportation decisions can be challenged in the Administrative Court although decision-makers enjoy wide discretion with no obligation to provide reasons for deportation. The role of the Court is limited to ensuring that procedural requirements have been met. However, in cases where decision-makers do in fact provide reasons, the courts may review the legality and adequacy of the reasons to ensure that decisions are legally and factually grounded and do not exceed the authority of the decision maker. In some instances, local legal aid providers have been successful in persuading courts to rescind deportation orders based on breaches of the Residency and Foreigners' Affairs Law. Another innovative approach involves hotlines staffed by lawyers who can provide an urgent round-the-clock response to potential deportations. A future litigation strategy may involve invoking the right to a fair trial or due process in cases of potential deportation as well as strengthening legal arguments around international obligations on *non-refoulement*.

Courts and remedies

At the heart of rights protection lies the ability to claim an effective and enforceable remedy for rights owed under national or international law. Countries that have not signed the Refugee Convention are nevertheless bound to respect the human rights of refugees as stated by other international human rights treaties that States have ratified, as well as by those provisions of the Refugee Convention that have become part of customary international law, such as the prohibition on *refoulement*. This provides a powerful 'alternative protection mechanism'

NRC staff offer information, counselling and legal assistance to refugees and asylum seekers in Beka'a, Lebanon.

in which domestic and international law arguments can be promoted by legal aid actors.

Jordanian law prioritises international treaty and human rights obligations in the interpretation of domestic law and courts have recognised this principle in various decisions such as the duty to investigate allegations of torture, the right to a nationality, the right to work, the prohibition on arbitrary detention and the presumption of innocence. Such judgements can help promote a normative framework for rights protection and influence legislators. Nevertheless, consultations conducted by the Norwegian Refugee Council with lawyers and legal aid providers in Jordan in February 2021 indicate that while lawyers sometimes use human rights arguments in court proceedings, judges only occasionally make references to international human rights principles in decisions, preferring to rely upon national legislation.[4] Within Lebanon, judges are trained in the application of international conventions in the Lebanese legal system but the impact of such training is limited and inconsistent, particularly in relation to sensitive issues of refuge rights, and there is a general but notable lack of guidance on how to operationalise human rights law in jurisprudence and in practice.

A legal aid approach

Significantly, legal aid services are available to refugees in both countries to help them protect their rights within existing frameworks. Regulations governing legal representation in both countries authorise the provision of legal aid services for persons in financial hardship, typically at the request of the court or through the relevant Bar Associations. In practice, the majority of legal aid services for refugees is provided by non-governmental legal aid providers generally funded by the international community. Accessible and effective administrative remedies and informal dispute resolution mechanisms, such as mediation, are the clear preference of beneficiaries.

Within this restricted space, legal aid providers operate at a practical level by liaising with government officials, accompanying refugees to obtain documents, negotiating disputes and providing legal awareness services. Lawyers can serve a critical intermediary role for refugees who are fearful of approaching authorities, going to court or doing anything that might attract attention to their situation. This allows births to be registered, disputes to be resolved, detention to be minimised and deportations to be challenged. Such efforts have previously resulted in time-limited amnesties by authorities in both Lebanon and Jordan which have allowed refugees to regularise their stay, register marriages and apply for the late registration of births of children (although such amnesties have sometimes required refugees to give up other rights and entitlements).[5] However, legal aid providers are increasingly facing legal and administrative barriers which compel them to fight on two fronts: firstly to protect the legal rights of beneficiaries and secondly to maintain their own freedom to provide services.

Practical measures towards protection

It may be politically unrealistic for either Jordan or Lebanon to sign the Refugee Convention at this stage. Nevertheless, in both countries practical measures can be taken to strengthen protective frameworks under national law. Jordan has established the administrative and regulatory machinery to protect many refugee rights, despite having no national legal framework and despite the differential treatment it demonstrates towards Syrian and non-Syrian refugees which leads to inconsistent levels of protection. Lebanon, struggling with a fragmented political landscape and fearful of continuing refugee influxes and changing demographics, lags behind.

In the absence of a national refugee framework, courts, legal aid providers and national and local institutions can help fill the protection gap by interpreting national legislation through a human rights lens. This is entirely consistent with human rights treaties ratified by both Jordan and Lebanon. While no substitute for a formal legal framework, such an approach would

allow existing laws and regulations to be interpreted in the most protection-focused way possible through the use of greater judicial and administrative flexibility and discretion. This in turn should lead to regulatory changes to codify practice. Legal aid actors can play an instrumental role by raising human rights arguments, presenting compelling humanitarian considerations, negotiating outcomes and raising awareness of legal rights and options. In this way, alternative approaches to protection can maximise benefits for refugees living in the shadow of the law.

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Non-signatory donor States and UNHCR: questions of funding and influence

Georgia Cole

Non-signatory States are increasingly important as donors, and UNHCR has been targeting some of these new funding sources. With funding, however, come influence and challenges.

As UNHCR has sought to plug an increasingly large gap between operating costs and donations, the agency has targeted new 'growth markets' for philanthropic and State-based funding, many of which are in wealthy non-signatory States. This has implications for how UNHCR operates within these countries, as fundraising strategies need to be considered alongside the organisation's other goals, such as encouraging accession to the 1951 Refugee Convention. The nature of these donations also affects UNHCR's operations wherever those funds are spent, thereby shaping refugee protection on a more global scale. To fully understand the ways that non-signatory States influence both the implementation of UNHCR's mandate and the provision of refugee protection more generally, we must therefore 'follow the money'. In this brief case-study, and with the intention of raising, rather than answering, questions about this evolving area of donorship, that 'money' will be the Refugee Zakat Fund.

The Refugee Zakat Fund

In September 2016, UNHCR launched the first iteration of its Zakat Initiative. It did so in partnership with the Tabah Foundation, a non-profit organisation based in the United Arab Emirates that provides support to organisations seeking to build their services "in alignment with Islamic, and faith-based values".[1] The Initiative was designed to encourage Muslims to give their Zakat contributions (monetary donations indexed to individual wealth that form one of the Five Pillars of Islam) for distribution to refugees and other persons of concern through UNHCR's extensive humanitarian networks. In the Initiative's first year, all the funds raised were distributed through

cash assistance programmes to Syrian refugees in Jordan to help them cover essential living costs and repay their debts.

In April 2019, UNHCR completed a rebrand of this initiative and unveiled the new Refugee Zakat Fund, intended to "help individuals and Islamic financial institutions to realise their social responsibility with global impact"[2] and targeting the approximately $76 billion in Zakat contributions donated by Muslims each year. The Fund's publications and marketing material emphasise the enormous and unmet needs among displaced Muslims, and that the private sector – including private philanthropists – has a key role, if not responsibility, to play in assisting them. The rebranded Fund indeed aims to support predominantly displaced Muslims in a series of non-signatory States (Jordan, Lebanon, Bangladesh, Malaysia and Iraq) and signatory States (Egypt, Yemen and Mauritania). For the research firm hired to assist UNHCR with the Fund's conception and launch, the initiative presents a promising "solution to address UNHCR's funding gap".[3]

Islamic finance and non-signatory States

While in theory UNHCR's embrace of Zakat as a potential solution is aimed at all Muslims globally, in practice the Fund has prioritised building support and partnerships with wealthy non-signatory States, particularly those in the Gulf and Indonesia and Turkey. Zakat, Islamic finance and Middle Eastern wealth are regularly spoken of together in UNHCR's statements, showing the organisation's inclination to target them collectively. UNHCR has stated that the potential value of Zakat "is modest in the context of $1.7 trillion in wealth held by high net worth individuals in the Middle East, and separately, $2.5 trillion in assets held globally by the Islamic Finance Industry".[4] The Zakat Initiative was consciously relaunched in Dubai as "the capital of Islamic economy", and UNHCR's Head of Private Sector Partnerships in the Middle East and North Africa region made it clear that the fund had been remodelled in order to "evolve into a structure that better appeals to the global Islamic finance industry".[5]

This targeted fundraising strategy is beginning to yield results. In its first year, the Fund raised $38.1 million, although $35 million of this came from just one donor: His Excellency Sheikh Thani Bin Abdullah Al Thani of Qatar, who was appointed UNHCR's Eminent Advocate just a few months after donating. UNHCR has also been trying to harness individual donations, particularly from "tech-centric Muslim millennials" in the Gulf States.[6] In 2019 nearly 60% of all digital donations to the Refugee Zakat Fund came from individuals based in the UAE and Saudi Arabia.

These funds have enabled UNHCR to support programmes and populations that have been historically neglected. Donations of Zakat have bolstered UNHCR's cash assistance funds and provided the organisation with funds to address chronic underfunding of humanitarian programmes for Muslim-majority refugee populations, such as Afghan refugees, Yemenis and Rohingya in Bangladesh. When donating, donors are able to select which population group they would like their money to go to from a drop-down list which includes 'Where it's most needed' alongside specific nationality groups in specific countries. In the year the fund launched, UNHCR's response to Rohingya refugees in Bangladesh was augmented by almost $22 million of Zakat donations. Donations from individuals and governments within non-signatory States have thus benefited protection-oriented activities across the organisation's programmes, while enabling citizens in these States to contribute towards humanitarian efforts even if overarching legal reforms around refugee protection remain off the agenda among their governments.

Further implications

Both types of donations targeted from these Muslim-majority non-signatory States – namely smaller, individual donations based on Zakat and other Islamic principles, and large private or government contributions –

nonetheless may have broader implications for refugee protection that are worth considering.

In terms of collecting and distributing Zakat, UNHCR has to uphold three key principles as laid out in a series of *fatwas*,[7] all of which have an impact on the organisation's operations. First, the recipients of the Zakat donations must fall within one of the eight categories that are considered eligible in verse 9:60 of the Qur'an – including the poor, needy, in debt and 'stranded travellers' – and most *fatwas* specify that these recipients should be Muslims. As 60% of displaced people worldwide are currently eligible to receive Zakat, however, this is unlikely to require any change in UNHCR's activities for the foreseeable future.

Second, 100% of the funds received through Zakat donations must be channelled to eligible families without the deduction of any wages or fees for administering these programmes, which must be covered from other funding sources. Only in locations where the population's need for in-kind distributions exceeds the demand for cash, or when the distribution of hard currency is not feasible, can UNHCR distribute goods instead of cash and cover the charges for their storage and transport through Zakat donations. The organisation must therefore make up its standard 7% overhead operating costs from other sources of finance, with potential budgetary implications for projects elsewhere.

Third, in order to guarantee that UNHCR donates every penny of Zakat directly to beneficiary populations, the organisation is largely expected to distribute these donations through cash assistance programmes. While UNHCR has therefore marketed these programmes as a key way to ensure 'dignified support' for refugees, the need to accurately report that Zakat funds have only reached eligible populations has reinforced the organisation's move towards more controversial monitoring strategies, such as iris scanning. The distribution and accountability mechanisms that accompany Zakat funds thus, like most donations to the organisation, have specific and tangible impacts on the recipients and types of UNHCR's activities.

The receipt of large-scale humanitarian funding from non-signatory States raises a separate series of questions. His Excellency Sheikh Thani Bin Abdullah Al Thani of Qatar provided UNHCR with the largest contribution it has ever received from an individual donor, and yet Qatar has ratified neither the 1951 Convention nor its 1967 Protocol. What are the implications for UNHCR's advocacy work in Qatar when members of its ruling Al Thani family have donated such significant sums to the organisation? Similarly, UNHCR has voiced its intention to target Saudi Arabia, Indonesia and Turkey as three countries which it considers offer the greatest potential for Zakat donations in the Islamic world. With Saudi Arabia and Indonesia not signatories to the 1951 Convention, how might UNHCR's financial courtship of prominent businesspeople and politicians in these States translate into less leverage for conversations about enhancing refugee protection *in situ*?

As with any donor funding, donations from non-signatory States are also connected with those States' political and economic priorities. To give one example, through first the Dubai International Humanitarian City, and then under the umbrella of the Mohammed Bin Rashid Al Maktoum Global Initiative, Dubai is now the largest humanitarian hub in the world. The country has supported huge humanitarian efforts in Yemen – a country that it has also blockaded – including through reconstructing the country's port infrastructure. Dubai's rulers have been clear, however, that part of this support is to enable market opportunities for the Emiratis as part of a market-led humanitarianism that openly seeks to ensure return on investment. While non-signatory States are thus being lauded by agencies such as UNHCR, UNICEF and UN OCHA for filling funding shortfalls (particularly for protracted relief operations in Muslim-majority countries), partnerships on the ground risk entangling these multilateral actors in the particular processes of social and political engineering that Gulf States are attempting to achieve through their targeting of humanitarian aid.

Non-signatory States may remain reluctant to insert themselves into the international refugee regime through legal ratification of the 1951 Convention but they are increasingly important as donors and 'investors' and their citizens are increasingly being called upon to uphold their philanthropic responsibilities. With funding, however, comes influence. This is nothing new in the history of development and humanitarian aid, and continues through countless current agendas for refugee protection, such as European Union-funded initiatives across Africa that are largely oriented towards addressing the bloc's priorities on migration management. Alongside exploring how signatory and non-signatory States exert influence over each other and over UNHCR through laws, norms and actions, these financial connections and interdependencies may also warrant further investigation.

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Bangladesh's judicial encounter with the 1951 Refugee Convention

M Sanjeeb Hossain

Despite Bangladesh not having ratified the 1951 Refugee Convention, a number of recent court judgements indicate respect for elements of the Convention's rulings.

When it comes to the 1951 Refugee Convention and its application in Bangladesh in the context of the Rohingya refugee situation, most accounts will state something along the following lines: "Bangladesh has not ratified the Refugee Convention of 1951 or its Protocol […]." While this statement is factually accurate, it does not mean that Bangladesh is devoid of a framework geared towards supporting and protecting refugees. As will be explored here, the Supreme Court of Bangladesh has emerged as an entity potentially capable of upholding the rights of refugees such as the Rohingya.

In May 2017 a bench of the High Court Division of the Supreme Court of Bangladesh handed down a judgement of particular significance. In considering the relevance of the principle of *non-refoulement* in relation to Md Rafique, a Rohingya refugee being held in detention long after completing a formal prison sentence, the Supreme Court held that the 1951 Refugee Convention had "become a part of customary international law which is binding upon all the countries of the world, irrespective of whether a particular country has formally signed, acceded to or ratified the Convention or not."[1]

In 2007 Rafique had admitted to illegally entering Bangladesh; he was detained, and proceedings were initiated against him. Rafique pleaded guilty and was sentenced to five years of imprisonment under Section 14 of the Foreigners Act, 1946. The Magistrate further directed the jail authorities to return him to Myanmar after serving his sentence. In 2016, in response to a Writ Petition filed by the Refugee and Migratory Movements Research Unit (RMMRU), the State was required to explain why Rafique, who had completed his five-year sentence in May 2012, was still languishing in prison. On 31 May 2017, after three full hearings, the Supreme Court held that Rafique had been imprisoned without lawful authority since the expiry of his prison term. It further

directed the State to immediately release him from prison and hand him over to RMMRU, which would arrange with UNHCR for Rafique's accommodation in a refugee camp in Cox's Bazar.

Similar judgements were handed down in 2013 and 2015. In 2015, the Court directed the release of five Rohingya refugees (who possessed UNHCR-issued refugee cards) to be returned to the Kutupalong refugee camp where they had previously been living. The judgement handed down in 2015 makes no reference to the principle of *non-refoulement* although that is essentially the principle that the Supreme Court was upholding through its judgment.

It is worth contrasting the judgement handed in 2015 with the one from 2017 concerning Rafique. Unlike the five Rohingya refugees from 2015, Rafique was not returned to Myanmar after his release despite not being in possession of a refugee card. The Supreme Court acknowledged that Rafique would be likely to "suffer persecution or torture" and that his life might be at stake if he were to be returned to Myanmar. It rationalised its decision further by referring to the fact that Bangladesh is a signatory to the 1987 Convention Against Torture which provides that States Parties shall not "expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture."[2]

International and domestic law

The Constitution of the People's Republic of Bangladesh refers to international law on two occasions. In the first instance Article 25 (as part of the judicially unenforceable Fundamental Principles of State Policy of the Constitution) states:

The State shall base its international relations on the principles of respect for national sovereignty and equality, non interference in the internal affairs of other countries, peaceful settlement of international disputes, and respect for international law and the principles enunciated in the United Nations Charter […].

This is followed by Article 145A which governs the adoption and codification of international treaties in domestic law and provides that a treaty shall be laid down by the President for discussion in the Parliament. Article 7(2), however, sets out clearly that the Constitution is the "supreme law of the Republic" and therefore overrides both national and international law; as time has progressed, case law has strengthened the understanding that in case of conflict, national law prevails over international law.[3] International treaties need to be incorporated into Bangladesh's domestic legislation before they can become legally enforceable. This interpretation has been reflected in a number of judgements including *Hussain Muhammad Ershad v Bangladesh* where the Appellate Division of the Supreme Court held that: "it is [true] that Universal Human Rights norms, whether given in the Universal Declaration or in the Covenants, are not directly enforceable in national Courts. But if their provisions are incorporated into the domestic law, they are enforceable in national Courts."[4]

In the absence of any constitutional provision clearly depicting the status of 'customary international law' in the legal order of Bangladesh, it remains a generally accepted principle that customary international law is binding as long as it does not contradict domestic law. Therefore, in situations where courts are left with the option of enforcing either a municipal law or customary international law on a given subject, the tendency in Bangladesh is to adhere to the municipal law.

It is essential to keep the above context in mind when critiquing Bangladesh's judicial encounter with the 1951 Refugee Convention. On the one hand, Bangladesh has not ratified the Refugee Convention of 1951 or its Protocol and does not have any national laws addressing refugee matters. On the other hand, Bangladesh is constitutionally mandated to respect international law and the principles of the UN Charter. In light of the compelling argument that the principle of *non-refoulement* is now a rule of customary international law, it is unsurprising that the Supreme

Court of Bangladesh adhered to it, given the absence of a municipal law contradicting it.

Did the Supreme Court go too far when it referred to the entire 1951 Refugee Convention as customary international law? It is unlikely that this position adopted by the Supreme Court was an inadvertent error given that the judgement handed down in 2017 clearly states: "Though Bangladesh has not formally ratified the Convention relation to the Status of Refugees, yet all the refugees and asylum-seekers from scores of countries of the world to other countries have been regulated by and under this Convention for more than 60 (sixty) years. This Convention by now has become a part of customary international law […]."[5]

Bangladesh's judicial encounter with the 1951 Refugee Convention in the case concerning Md Rafique is worthy of note because it situates the Supreme Court as an entity that clearly has the potential to assist and protect refugees. At the same time, however, the Supreme Court's stark classification of the 1951 Refugee Convention as "customary international law" should perhaps be treated with some caution, especially in light of Bangladesh having refrained from ratifying the Refugee Convention despite being a major refugee-hosting nation.

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Advancing refugee rights in non-signatory States: the role of civil society in Thailand

Naiyana Thanawattho, Waritsara Rungthong and Emily Arnold-Fernández

A coalition of civil society actors has developed effective strategies for working alongside the Thai government to facilitate better policies for refugees.

Despite hosting refugees for decades, Thailand has never clearly granted refugees a legal right to reside in the country. Refugees arriving in Thailand in large numbers from neighbouring countries – such as Vietnamese and Cambodian refugees in the 1970s, or Burmese or Myanmarese refugees since the late 1970s and 80s – have been permitted to stay on a de facto basis, provided they remain in closed camps near the borders of the country they fled. However, they have enjoyed none of the other human rights granted them under myriad other conventions (such as the International Covenant on Economic, Social and Cultural Rights and its sister covenant on Civil and Political Rights, to which Thailand acceded in the 1990s). Refugees of dozens of other nationalities have historically had no way to regularise their status or remain in Thailand lawfully, even on such a limited de facto basis. Many obtained a short-term tourist visa upon arrival but had no further options to stay legally after the visa expired.

The government of Thailand has long resisted becoming a party to the 1951 Refugee Convention, and at times has entered reservations excluding refugees from the rights granted under other human rights instruments. Instead, the government historically responded to the presence of refugees by conducting intermittent enforcement actions to detain

Forced migrants are 'people with rights… not just needs'.

those caught residing in the country without a visa, with such efforts justified by references to national security despite little evidence to support this link.

Five years ago, however, at the September 2016 Leaders' Summit adjacent to the UN Summit for Refugees and Migrants, Thailand's Prime Minister pledged to establish a mechanism that would identify refugees and strengthen implementation of *non-refoulement* – in other words, creating an avenue to allow refugees to remain lawfully in the country on at least a temporary basis. The government also pledged to end detention of refugee children and indeed in November 2016 the Chiang Rai Juvenile and Family Court refused to punish a Somali refugee boy for illegal presence in the country, ruling – in a first for Thai courts – that refugee children have rights to protection and to judicial determinations that prioritise their best interests.

Two years later, Thailand voted to affirm the Global Compact on Refugees, and in early 2019 the Cabinet gave final approval to a new mechanism, the National Screening Mechanism (NSM), that would allow those recognised as a "person under protection" – effectively, a refugee – to remain in the country.

Status determinations under the NSM, however, have been repeatedly delayed, partly as a result of the COVID-19 pandemic. Additionally, NSM criteria for determining who qualifies for this status does not explicitly align with internationally accepted criteria for refugee status, and includes vague language that some advocates worry may be used to evade Thailand's *non-refoulement* obligations. While this has led to some criticism, Thailand has also received approbation from Thai refugee rights organisations for inviting civil society participation in training government officials charged with carrying out status determinations under the NSM. There is no timeline for starting status determinations under the NSM but advocates hope the proceedings will begin in early 2022.

Thai civil society

Prior to 2015, most civil society organisations working with and for refugees in Thailand, particularly those in urban areas, were international NGOs staffed by foreigners. These organisations had limited direct communication with the Thai government and were ill-equipped to lead the charge for refugee rights in Thailand. In 2015, a recently expanded coalition of mostly Thai refugee-focused organisations started discussing new approaches to advancing refugees' rights and safety in Thailand. Recognising that a broader coalition would be more likely to achieve success, the group invited other organisations and individuals that did not directly work with refugees to join the coalition, now called the Coalition for the Rights of Refugees and Stateless Persons (CRSP).

CRSP focuses on engaging directly with the Thai government to achieve refugee

protection at the policy level. As a network comprising mostly Thai NGOs, CRSP is able to engage government officials in their own language, with a nuanced understanding of context, and at times utilising social or collegial relationships unrelated to refugee issues. Alice Nah observed in 2015 that Asia Pacific Refugee Rights Network (APRRN) member organisations "appeal to [Asia Pacific] states as concerned (and outraged) citizens and residents who witness the suffering of refugees and believe that this should not happen in their own countries";[1] CRSP – some of whose members are also members of APRRN – uses similar strategies. CRSP thus acts as what Nah and others describe as "norm entrepreneurs," socialising shared international norms into the Thai context.

CRSP prioritises advocacy for changes that will be effective at reshaping Thailand's treatment of refugees, in particular changes to national laws and policies. Because the Refugee Convention (unlike the core human rights conventions) lacks an enforcement mechanism, CRSP does not believe accession to the Refugee Convention alone would have sufficient impact on the Thai government's treatment of refugees; accession also has virtually no support within the Thai government.

Unlike other networks that primarily share updates and information between members, or focus on critiquing government policies or actions, CRSP aims to work alongside the government to achieve solutions for refugees and their Thai hosts. The coalition does communicate concerns directly to the government but it also provides suggestions for solutions and offers support to design and implement those solutions. The shifts in Thai government policy from 2016 to present are in part – in addition to the role of UNHCR and foreign governments – a product of CRSP's multifaceted strategy to engage, support and ultimately influence the Thai government.

Elements of CRSP's success

CRSP's success is a result of several factors. First, CRSP is led by local Thai civil society. This gives it credibility with the Thai government and legitimacy in its policy proposals. Second, the coalition includes a broad base of actors. This demonstrates to the Thai government that a broad spectrum of actors endorse CRSP's advocacy positions and consider policies that advance refugees' rights and well-being as a priority; it also equips CRSP to offer expertise and technical support to the Thai government to build effective solutions to the problems that the coalition brings to government attention. Third, CRSP makes use of a multifaceted advocacy strategy such that each advocacy approach leverages and reinforces the others.

CRSP engaged directly with Thai authorities at all levels as well as with other powerful actors such as donor governments and multilateral institutions. The most important initial strategy was to build a relationship with the Thai Immigration Bureau in order to follow up on and ensure the implementation of the commitments that Thai government made on refugee protection at the regional and global level, such as the pledges at the Leaders' Summit on Refugees, the Global Refugee Forum and the Global Compact for Migration. CRSP regularly organised closed-door meetings with the Immigration Bureau to ask about progress in developing the refugee screening mechanism, provide suggestions on certain human rights principles that should be included, and submit an NGO version of the screening mechanism.

This development of relationships has borne some fruit. The new Immigration Bureau subdivision responsible for implementing the NSM has shown willingness to work with CRSP, for example by asking CRSP to provide training on refugee law, human rights principles and case management, and to provide nominations for non-governmental members of the National Mechanism Committee and the Sub Committee tasked to review the Standard Operating Procedures for the NSM. However, regular government reshuffles makes it challenging to maintain smooth relationships, and CRSP still has no access to the decision-making officials of the Immigration Bureau and the Royal Thai Police. In addition, the comments and recommendations that

CRSP provides often get lost before they reach higher levels of government.

CRSP has found it helpful to link refugee issues with existing domestic laws and policies that can immediately apply to refugees, without the need to amend existing policies or adopt new ones. While advocacy for the rights of refugees alone has often proven unsuccessful, where issues (such as detention of children, universal education or health care access) have an impact on a broader population, the government is less reluctant to discuss solutions that include refugees. With both of these strategies, CRSP has found that presenting their desired changes as linked to Thai identity — that is, presenting the desire for change as stemming directly from their understanding of Thai local norms and values — can increase government officials' willingness to consider or agree to CRSP's proposals.

In addition to engaging directly with the Thai government, CRSP also leverages the power of peer governments, in particular those governments that also provide significant aid and/or trade benefits to Thailand. With these actors, CRSP uses the language of international human rights, rather than emphasising their proposals' links to Thai identity and values. Diplomatic missions participate actively in CRSP's quarterly diplomatic briefings, and some were also able to provide financial support for the coalition. This coordination and mutual support between civil society and influential peer governments has improved the ability of both sets of stakeholders to effectively encourage Thailand's progress on the NSM to date.

Another important strategy has been to keep urban refugee rights on the policy agenda at national, regional and international levels, so all stakeholders are constantly reminded of the situation and encouraged to collaborate more to ensure that NSM is in line with international mechanisms. For example, CRSP regularly organises open forums bringing together all stakeholders from government, diplomatic missions, international organisations, UN agencies, academia and local civil society.

Lastly, CRSP also uses international human rights mechanisms such as the Universal Periodic Review and the review by the Committee on the Elimination of Racial Discrimination to report on progress and concerns related to refugees' rights and well-being in Thailand. This keeps Thailand in the international spotlight and requires the government to respond, including by taking concrete remedial action to provide legal protection for refugees. Even though it can sometimes be difficult to see immediate results from the pressure such international mechanisms exert on Thailand, CRSP can use the reports issued through these mechanisms as an advocacy tool.

Lessons from CRSP's experience

Chief among the lessons emerging from CRSP's success is the importance of national civil society organisations and the essential skills and capacity they can provide. Thai government officials have emphasised that in some cases they take CRSP's input into account where they would not, or do not, take into account the input of non-Thai actors, particularly non-Thai NGOs. In this way, CRSP's experience differs somewhat from theories that transnational networks are central to "empower and legitimate the claims of" domestic NGOs opposing or seeking to transform government behaviour;[2] rather, refugee rights advocacy in Thailand has been more effective when transnational networks are not visibly urging a new policy or practice. Relatedly, CRSP's success relies in part on the coalition's ability to 'code switch' between the language of Thai values and that of international human rights, depending on which actor is addressed.

Furthermore, CRSP's strategy of both raising problems and suggesting solutions, including its offers of expertise and implementation support, have had an important impact on the Thai government's progress on the NSM. For example, in addition to providing training for government officials, CRSP also provided case management for refugee mothers and children released from detention; this support has made the Thai government more willing

to discuss refugee-related problems with CRSP, and to embrace CRSP suggestions for policy changes to address those problems.

CRSP's myriad contributions toward advancing the shared agenda of lawful stay for refugees in Thailand were possible because the coalition and its members had access to funding resources from within and beyond Thailand. Funding national civil society organisations and coalitions should be a priority; such funding is all too often an afterthought for international donors, even though national policy reform is the centrepiece of sustainable solutions for refugees and other displaced persons.

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The challenges we face in a non-signatory country

JN Joniad

Refugee journalist JN Joniad has been living in Indonesia since 2013, unable to move on and yet unable to access his basic rights.

After fleeing genocide in Myanmar in 2013, I became trapped in Indonesia. I had hoped to seek refuge in Australia but was confined to a hotel room for three months and then transferred to a detention centre where I was detained for nearly two years. I still consider myself to be luckier than most refugees who are often detained for more than five years. For the last eight years, I have been living in Indonesia without access to basic rights.

Indonesia has not acceded to the 1951 Refugee Convention. In the absence of effective domestic protection mechanisms, asylum seekers and refugees are considered illegal. There is no law to protect refugees from indefinite detention, mistreatment by officials, and corruption. Even if asylum seekers are recognised as refugees by UNHCR, there is no guarantee of freedom or safety. If they are lucky enough to leave the detention centres, they are then moved into IOM-supported community housing. In 2015, I was released into community housing where I thought I would be free, but what I found was continued suffering with no basic rights nor any certainty about my future.

In the IOM accommodation, posters on the wall outline the rules and restrictions refugees must obey. A strict curfew is implemented between 10pm and 6am, and we can neither visit friends nor receive guests. Our movement is restricted and we are not allowed to travel more than 20km from our accommodation. We must report all our movements to security and are barred from vehicle ownership. We are even barred from love! We are banned from marrying outside our community or entering a relationship with a local Indonesian. A few refugees marry locals but are refused marriage certificates; they are not allowed to stay with their wife, nor are they allowed to bring their wife into their own accommodation.

"Why is it a problem to live with my family? Am I not human? They said we are safe and free here, but why am I prevented from working to feed my children?" asks Nur Islam, a Rohingya refugee with four children who is married to a local woman and has been living in Indonesia for eight years.

We are not allowed to work. We cannot even pursue an education. In 2016, I tried to enrol at Hasanuddin University (in Makassar, South Sulawesi) but was refused even though I have all the required qualifications. The

dean told me that the immigration authority does not accept my refugee status.

We have no property rights. Our refugee cards are not accepted in agencies such as banks so we cannot open a bank account. We are also denied national health-care services. Those living in community housing receive only limited medical assistance, and many have died due to delayed medication and treatment. Insomnia is very common, as are anxiety and depression.

Indonesian citizens are widely known as tolerant people but they have hardly ever raised their voices in support of refugees. When we protested in front of the UNHCR office against cruel treatment by immigration officers in Makassar in 2019, local people complained to the police that we were disturbing them. Twenty-eight of my friends were imprisoned in solitary confinement and many were beaten. I was threatened with detention and my life was made so hard – due to my journalism which I use to advocate for refugee rights – that I had to flee from Makassar to Jakarta in 2020.

What we are asking

Many of Indonesia's refugees – like me – originally intended to seek asylum in Australia but Australia has shut its door to refugees (though it provides funding to IOM to offer us free airfares and $2,000 if we agree to repatriate). We are pressured from all sides to accept so-called voluntary repatriation despite the war and persecution that are still ongoing in the countries that we fled. In the IOM accommodation, a poster hanging on the wall says that the resettlement quota is very limited, and that IOM will help those willing to return to their country. UNHCR also tells us to go home as we will probably never be resettled.[1]

The government does not consider refugees to be a priority. Denying us the possibility of local integration, yet too concerned about the responsibilities and costs that it would incur if it were to sign the Refugee Convention, Indonesia simply hands refugees over to the care of international agencies such as UNHCR and IOM.

One of the reasons given for Indonesia's reluctance to sign the Refugee Convention is its lack of resources to implement refugee protection. If citizens do not enjoy full access to health and education, 'non-citizens' should certainly not receive any privileges.[2] However, in an amendment to its 1999 law No 39, Indonesia has recognised the right to seek asylum and is party to core international human rights Conventions and has adopted human rights standards into its domestic legislation. It is therefore bound by international and domestic legal obligations to uphold these rights. The most important provision relevant to asylum-seeker and refugee protection is the recognition that everyone has equal rights to the enjoyment of the rights outlined in these Conventions, without discrimination. Although Indonesia honours the principle of *non-refoulement*, it is alleged to have – on many occasions – towed a stranded Rohingya migrant boat back to sea.[3]

The first thing that Indonesia's government could do to reduce our suffering is to lift all restrictions. A good policy initiative would be to issue Refugee Temporary Stay Permit Cards to refugees in transit to resettlement, thus allowing us to work legally. Such a policy would not only improve refugees' health and dignity but would also enable us to pay taxes to the Indonesian government. More importantly, we would be able to contribute to the local economy through our labour, talents and allegiance, building communities and working with all Indonesians towards a brighter future. We also ask Indonesia to use its influence with Australia to ask for an increase in Australia's annual refugee intake from Indonesia.

We, as refugees stuck in Indonesia, seek the intervention of the international community to bring about a solution and a safe future.

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Rohingya journalist

1. https://jakartaglobe.id/context/refugees-go-home-or-wait-years-for-resettlement
2. Missbach A (2016) *Troubled Transit: Asylum Seekers Stuck in Indonesia*
3. www.bbc.co.uk/news/world-asia-32701199

The Refugee Studies Centre (RSC) was founded in 1982 and is part of the Oxford Department of International Development at the University of Oxford. Find out about the RSC's research and teaching at www.rsc.org.uk and sign up for notifications at www.rsc.ox.ac.uk/forms/general/connect. Forced Migration Review is an RSC publication.

New! Online School

This year, for the first time ever, the RSC's renowned Summer School in Forced Migration is taking place online, once in July and once in September.

The online format takes some of the best features of the in-person Summer School and offers them in a new, shorter (one-week) and more financially accessible format. As ever, it offers a programme of study that is theoretically rigorous, empirically informed, and participatory. Those attending have early access to pre-recorded lectures and readings which are followed by live online seminars and discussions, and complemented by a range of social and networking opportunities.

Participants in July were enthusiastic about the new format:

"The course was efficiently run and user friendly, the faculty and invited experts accessible, and the other participants knowledgeable. I could not have asked for a more intense or fulfilling week. Thank you!"

"Really happy to count myself among the graduates of the first online school."

www.rsc.ox.ac.uk/study/international-summer-school

Refugee Economies Programme: Activities and Impact 2016-2021 report

This new report provides an overview of the work of the RSC's Refugee Economies Programme during the last five years, with summaries of publications and activities. It highlights the ways in which the Programme has collaborated with other organisations in order to ensure its research has impact, and it thanks the many contributors to this research, including 290 research assistants in Ethiopia, Kenya and Uganda.
www.refugee-economies.org/publications/activities-and-impact-2016-2021

Shelter Without Shelter: award-winning film

The Architecture Film Festival London 2021 featured as its closing film the world premiere of *Shelter Without Shelter*, a film by RSC researchers Mark E Breeze and Tom Scott-Smith. Filmed as part of the Architectures of Displacement project at the RSC (funded by the ESRC and AHRC), *Shelter Without Shelter* explores the complex dilemmas involved in attempts to house refugees in emergency conditions. In November 2020, the film won the AHRC's Best Research Film award. For more information, visit www.shelterwithoutshelter.com.

Rethinking Refuge

The RSC's Rethinking Refuge platform offers short, accessible, research-based articles aimed at rethinking refugee issues from various angles, including politics, international relations, law, history and anthropology. Read the latest articles at www.rethinkingrefuge.org

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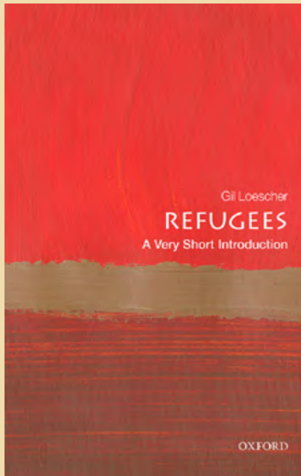
Refugees: A Very Short Introduction

by Gil Loescher



This is a special book.

Gil Loescher died on 28 April 2020. He was in the final stages of preparing the manuscript for this book, which he considered to be one of his most important.

Gil was a gentle giant of refugee studies. His writings on refugees and world politics were pioneering and endure as a cornerstone for the discipline. He was humble, empathetic, thoughtful, curious and kind. But Gil was deeply troubled by world events in recent years, especially how the rise of populist and exclusionary politics and misinformation contributed to a breakdown in international cooperation and collective action.

Gil's hope was that this book would be read by people wanting to understand the complexities of refugee movements and to take informed positions on the issue for themselves.

James Milner, colleague and friend, Ottawa, Canada

On 27 May 2021, viewers from 27 countries attended the virtual launch for *Refugees: A Very Short Introduction*. The book offers a concise and compelling introduction to the causes and impact of contemporary refugee responses. By drawing on Gil Loescher's 40-year legacy as an authority on UNHCR and global refugee issues, the book offers a critical insight into the impact of today's responses to refugee movements for States, global order and refugees themselves. The book also draws on more recent developments to call for a new approach that engages with the root causes of displacement and the politicisation of refugee responses, and for an enhanced role for civil society actors and refugee-led responses.

Gil in Thailand, 2006.

The launch event began with reflections from Gil's family before turning to a discussion of the themes of the book and their significance, including from the perspective of global policy discussions, national responses in the Global South, and refugee leadership. The event concluded with a discussion of how the book can act as a catalyst for new approaches to addressing the source of refugee displacement as well as ensuring that responses to refugee movements are more inclusive, comprehensive and rights-based.

Watch the launch event here: **https://carleton.ca/lerrn/2021/gil-loescher-book-launch/**

For more details, and to buy the book (also available as an Ebook), visit bit.ly/OUP-Refugees-VSI. Note: 20% discount available to FMR readers - details at **www.fmreview.org/issue67/refugees-VSI**.

Proceeds from the sale of the book will support the Gil Loescher Memorial Fund **www.rsc.ox.ac.uk/gil-loescher-memorial-fund**