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NGO Statement
International protection and durable solutions
in the context of a public health emergency

Dear Chair, Ladies and Gentlemen,

This statement was prepared in close consultation with a wide range of NGOs, and reflects their diverse views.

The COVID-19 pandemic revealed a massive vulnerability with impacts on public health, economies and social systems, as global, national and local preparedness and response capacities continue to be strained. While the slow vaccination campaign rollout offers hope of a gradual return to pre-pandemic life, the pandemic reminded that authorities everywhere must invest in human rights-based public health emergency preparedness and response capacities at all levels.

Restrictions of movement
In their legitimate right and responsibility to protect public health, States implemented a range of measures, including lockdowns and closing of international borders. Those impacted the legal right of people fleeing persecution to lodge international protection claims, or denied many stateless persons and those affected by discriminatory nationality laws access to their home countries for family reunification[1]. There are still 57 States denying access to their territories, and 26 countries where access is currently pending[2]. Experience from 81 countries shows that in health emergencies, States can protect public health through screenings and quarantine measures, while still upholding the 1951 and 1954 Conventions. Seeking international protection is a first step towards durable solutions for stateless persons and people fleeing persecution.

- *We urge all States to respect and uphold their obligations under IHL, refugee law, IHRL, and the principle of non-refoulment, and ensure access for those seeking international protection, while adhering to health protocols in their public health emergency response.*[3]
- *We urge States not to use public health emergencies and the vaccination status as measures to prevent refugees, migrants and stateless persons from moving between countries.*

Resettlement and complementary pathways to third countries are durable solutions for those facing protracted displacement, helping them to rebuild their lives, and achieve self-reliance. Yet, the number of resettled individuals during 2020 fell to almost a third, with nearly 23,000 resettled, compared to nearly 64,000 in 2019[4]. This is just over 6% of the total annual resettlement quota of 360,000, committed

[1] See Principle No. 4, *Human mobility and human rights in the COVID-19 pandemic: Principles of protection for migrants, refugees, and other displaced persons*: https://zolberginstitute.org/wp-content/uploads/2020/04/Human-mobility-and-human-rights-in-the-COVID_final-1.pdf; Institute on Statelessness and Inclusion, *Impact Report* (2020): https://files.institutesi.org/Covid19_Stateless_Impact_Report.pdf.
[2] https://data2.unhcr.org/en/dataviz/127?sv=44&geo=0
[3] See *Human mobility and human rights in the COVID-19 pandemic: Principles of protection for migrants, refugees, and other displaced persons*: https://zolberginstitute.org/wp-content/uploads/2020/04/Human-mobility-and-human-rights-in-the-COVID_final-1.pdf
[4] https://www.unhcr.org/resettlement-data.html

to by States in 2017. Compared to the current global number of refugees[5], this percentage is less than 0.1%.

Collectively we have to improve solidarity and sharing the responsibility of hosting millions of displaced persons. 67% of refugees recorded in 2019 came from just 5 States[6], with over 70% hosted in neighbouring States, mostly in low or middle income, and fragile States[7]. By comparison, only 0.6% of the total population of the European Union were refugees in 2019[8]. Thousands of women, men and children are desperately waiting for this life-saving, durable solution, which can be implemented with technology and continued travel during pandemic restrictions.

- *We urge all States to uphold their commitments and apply the experience of States that have continued their resettlement processing in the pandemic. In future public health emergencies, and wherever feasible, States should conduct in-person resettlement processing, interviewing and cultural orientation, or do so using technology and innovative methods.*
- *We urge States to scale up complementary pathways, with a particular focus on family reunification.*
- *We remind States that the Three-Year Strategy on Resettlement and Complementary Pathways sees 3 million refugees benefiting from its implementation by 2028. We urge States to work with UNHCR and other stakeholders to achieve this vision.*

Impact of health emergencies on humanitarian situations and durable solutions

The COVID-19 pandemic provided evidence that public health emergencies are compounding vulnerability of millions of asylum seekers, refugees, migrants and stateless persons living in protracted crises. They already suffer from **violence, stigma, mental and psychosocial illnesses, discrimination and unequal access to basic services and living conditions,** often due to lack of documentation. As States primarily adopt an inward, 'citizens first' approach, they face a **denial of rights and services, loss of livelihoods and income, deteriorating housing, less food, water and sanitation, and education. They also face increased risk of intimate partner violence**, resulting in a rise of negative coping strategies, including early marriages[9], child labour[10], and selling or exchange of sex.

Health emergencies and a decrease in livelihoods often **restrict access to food**, especially amongst stateless populations and those without nationality in their country of residence, including those affected by gender-discriminatory nationality laws. People are resorting to lower quality food or facing famine including in DR Congo, northeast Nigeria, South Sudan and Yemen[11]. Poor nutritional status of youngest children can severely impact their development and many lives could be lost to hunger.

Lack of access to health is common due to high costs, lack of documentation, administrative hurdles, restrictions of movement, stigma and discrimination. Women and girls often lack access to antenatal care, sexual reproductive and health services, and family planning. Many health facilities have closed or reduced services due to lack of sufficient PPEs, directly impacting access to treatment of non-

[5] 26.3 million: https://www.unhcr.org/refugee-statistics/#:~:text=Forcibly%20displaced%20people%20worldwide,80%20million%20at%20mid%2D2020

[6] Syria (6.6 million), Venezuela (3.7 million), Afghanistan (2.7 million), South Sudan (2.3 million), and Myanmar (1 million)

[7] https://www.infomigrants.net/en/post/29030/unhcr-numbers-of-displaced-people-in-world-passes-80-million#:~:text=UNHCR%3A%20Numbers%20of%20displaced%20people%20in%20world%20passes%2080%20million,-Published%20on%20%3A%202020&text=The%20year%202020%20is%20not,displacement%20released%20on%20December%209

[8] https://ec.europa.eu/info/strategy/priorities-2019-2024/promoting-our-european-way-life/statistics-migration-europe_en

[9] Percentage of children married before 18 varying, with 76% in Niger, 68% in CAR, 67% in Chad, 52% in Burkina Faso, Mali and South Sudan respectively, and over 40% in Ethiopia, Mozambique, Nigeria and Somalia) https://www.globalprotectioncluster.org/wp-content/uploads/Global-Protection-Update_191120-1.pdf

10 Especially in Afghanistan, Cameroon, CAR, Colombia, Iraq, Mali, Niger, Somalia, Syria and Yemen https://www.globalprotectioncluster.org/wp-content/uploads/Global-Protection-Update_191120-1.pdf

[11] https://www.washingtonpost.com/world/2021/01/06/coronavirus-starvation-poverty-inequality-hunger-un/

communicable diseases, exposing many to higher risks of illness and death from COVID-19. Stateless persons are acutely impacted, given their disproportionate lack of access to documentation[12].

Pandemic lockdowns, insecurity, forced confinement of refugees to camp settings, and other **restrictions of movement** have increased vulnerability of people, their sense of anxiety, while decreasing access to livelihoods, food, essential services, and protection. These restrictions are the main cause for a skyrocketing of **GBV against women and girls[13]**. They also result in inexistent or sporadic access to education for children, resulting in increased sexual and other forms of physical and emotional abuse[14], forced labour and sexual exploitation. Other groups such as **older people, persons with disabilities, LGBTQI+, stateless persons, and other marginalised groups**, face limited access to services and assistance due to **social exclusion, stigmatisation, discrimination, racism and xenophobia**, now further compounded by health emergencies.

Psychological trauma, stress and anxiety impacts fragile individual and collective psychological state, especially for millions of displaced, already traumatised by conflicts, loss of their loved ones, homes and livelihoods. The misinformation, fear and distrust in pandemic-related issues are dangerous trends that are weakening the status and well-being of refugees, especially older people, stateless persons, children and women.

Lockdown restrictions led to **limited or no access to legal assistance**, with those lacking identity documentations, including stateless persons, becoming vulnerable to violence and abuse, fear of deportation, lack of access to services and humanitarian assistance, legal and immigration procedures, legal assistance in detention centres, and inability to register births, marriages and deaths. Barriers to civil registration in pandemic undermine efforts to prevent and reduce statelessness globally. It also impacts **access to Housing Land and Property security**, leading to risk and experience of evictions[15], and forcing many stateless and undocumented people into informal and often exploitative relationships with landlords.

Recommendations:

- *Using pandemic experience, multi-sectoral preparedness plans should be developed to address protection, health, social and humanitarian concerns of forcibly displaced populations in future public health emergencies.*
- *We call for strong coordination of all stakeholders to ensure that all needs of forcibly displaced populations, including stateless persons, are being addressed comprehensively, and that populations are being reached during public health emergencies, including in non-government-controlled areas.*
- *Refugee-hosting governments should enable refugees, asylum seekers, stateless persons, and migrants to contribute to the national health response, in line with their skills and experience.*
- *All protection or other assistance should be based on needs identified through community engagement, translated into relevant languages, to avoid fear and mistrust, and to ensure that the assistance considers their health behaviours and cultures.*
- *Durable solutions for forcibly displaced and stateless populations cannot be put on hold; States must uphold commitments and obligations in keeping with available guidance on COVID-19 and other public health emergencies. We wish to remind States of the commitments made during the first GRF towards strengthened protection capacity, protection of stateless persons as well as prevention and reduction of statelessness, refugee inclusion in national systems and increased access to jobs and livelihoods, thus supporting their self-reliance. National governments, bilateral donors, international finance institutions, humanitarian actors, and the private sector must work*

[12] https://www.refworld.org/docid/5eb2a72f4.html
[13] GPC reported in November a 120% increase in calls to domestic abuse hotlines in Colombia, Fiji and Zimbabwe.
[14]Reported in at least 89% of operations, Including in Afghanistan, Cameroon, CAR, Colombia, Ethiopia, Libya, Mali, Niger, Nigeria, Sudan, Ukraine, Venezuela and Zimbabwe
[15] Risks of evictions are significant in Cameroon, CAR, Ethiopia, Honduras, Libya, the Pacific, Sudan, Somalia and Yemen: https://www.globalprotectioncluster.org/wp-content/uploads/Global-Protection-Update_191120-1.pdf

together to build back more inclusive, resilient, and sustainable economies and provide flexible multi-year financing to help rebuild refugee livelihoods.

- *We also urge States to systematically include refugees, asylum seekers, migrants, stateless persons and host communities into national and local-level health response plans and social protection schemes.*
- *Protection assistance should be adapted to health emergencies constraints, ensuring continuity, while adhering to health protocols, staff safeguarding measures and social distancing. Technology should be used for remote services, including GBV case management, providing 24/7 services to enable survivors to call at opportune times; MHPSS to help individuals better cope with mental health issues, build resilience and process traumatic issues; and adapt protection monitoring to regularly collect data on humanitarian needs and changes in vulnerabilities, adapted coping mechanisms, and updates on access to services.*
- *Migrants, asylum seekers, stateless persons, and refugees should be included in National Vaccination Plans (NVP) to enable their access to employment, thus achieving and maintaining self-reliance.*

A projected availability of 2 billion doses of vaccines through COVAX for 92 GAVI-eligible countries in low and lower-middle-income countries gives hope of comprehensive vaccination of all people, regardless of their nationality, economic status, or cultural, religious, ethnic or other identity.

Vaccine (in)equality

However, although global allocation of COVID-19 vaccines should be based on needs and not on the ability to pay, and despite calls for global solidarity, we see a "vaccine nationalism" trend in Europe and North America, with governments rushing to secure enough vaccines for their own populations[16], negatively impacting access to vaccines for less wealthy countries. More than 319 million vaccine doses have been administered worldwide as of 10 March, the majority in North and South America, Europe and the Gulf, while only a few vaccines were administered in Africa[17].

Inclusivity

An estimated 80 million forcibly displaced people, older people, women and children, people living with disabilities, LGBTQI, stateless persons, and other socially excluded groups, with majority living in low- and middle-income countries that are behind in accessing the vaccines, risk further exclusion from accessing the COVID-vaccine, due to discrimination or lack of documentation.

We do however note that, according to UNHCR, out of 151 countries currently developing national vaccination plans, 106 countries have committed to include refugees, including in the current vaccination campaign conducted in Germany, Jordan and Rwanda. Undocumented migrants and stateless persons are also included in the plans by the Netherlands and Spain.

One of the key vaccination challenges in humanitarian contexts will be around **physical access to populations**, especially to people living in urban slums, remote areas, as well as to migrants, stateless persons, homeless and people affected by conflicts, violence, insecurity and disasters. Coordinated efforts between national governments, UN organisations, community-based organisations and others will be essential for access, particularly in conflict and hard to reach areas.

Without **trust from the community**, people may not accept or support immunisation activities. In extreme cases mistrust could lead to violence against vaccination teams or vaccinated people. Established community presence and links between NGOs, CSOs, community leaders, local authorities, and others will be essential for increasing trust and the vaccination success.

[16] Many wealthier nations have bought up enough doses to vaccinate their entire populations at least three times over by the end of 2021, despite that the rich nations represent just 14 per cent of the world's population.

[17] https://ig.ft.com/coronavirus-vaccine tracker/?areas=gbr&areas=isr&areas=usa&areas=eue&cumulative=1&populationAdjusted=1

Furthermore, in an era where information is spreading at lightning speed, **tackling pandemic disinformation and misinformation**, including the mistrust in vaccines, will be essential. Clear and coordinated information campaigns on vaccine effectiveness and safety needs to target all communities, especially those that are isolated from or wary of authorities.

The COVID-19 vaccination is one of the **greatest logistical challenges**, with millions of vaccines transported from manufacturers to all countries in the world, and from there distributed across the countries, including to conflict-affected places, with limited infrastructure for adequate and safe storage.

Challenges will include **overcoming other barriers**, such as the lack of legal documents, IDs, and other documents that are required by forcibly displaced and stateless persons to access services, including access to health facilities.

Strong coordination of all stakeholders in planning and implementation will be key to overcome logistical and security issues, especially in conflict-affected countries and in hard to reach areas. We trust that the MoU between UNHCR and GAVI on COVAX collaboration will strengthen the coordination and access to essential vaccines to asylum seekers, refugees, stateless persons, migrants and IDPs.

- *NGOs call on States to adhere to their political commitments and support the multilateral COVAX facility by honouring pledges to secure access to the vaccines in a proportionate manner for all countries and regions. We encourage nations to follow the example of Norway, which has made explicit commitment to donate vaccines to other nations, in parallel to its ongoing vaccination efforts at home.*
- *We call on States to ensure that NVPs are transparent and accountable to public health principles and include all individuals in all countries regardless of who they are, including refugees, asylum-seekers, stateless persons, migrants and IDPs.*
- *NGOs call on States to conduct their NVPs with multiple stakeholders, including health and other ministries, humanitarian and community-based organisations, to ensure that the mass vaccination rollout is done efficiently, and reach those that need it in line with prioritisation criteria and schedules, especially in fragile and conflict areas.*
- *NGOs call on States to recognise the role of NGOs and CSOs in mass vaccination campaigns, especially in urban and hard-to-reach/remote areas in some of the following areas: cold-chain management; managing and deploying vaccination, community mobilisation and awareness, identifying and facilitating access to communities and marginalised groups at risk of exclusion; and supporting communications campaign to tackle misinformation.*
- *With its well-established networks, capacities, proximity and access to communities in countries of operation, NGOs will play a decisive role in addressing distrust challenges and increasing the number of people that would be vaccinated in a neutral, impartial and transparent manner, especially in fragile and hard to reach contexts.*
- Finally, NGOs call on *Donor States to provide additional and sufficient funding for the COVID-19 vaccination campaign and ensure that this critical operation is fully funded without diverting funding needed to respond to increasing humanitarian needs.*

Thank you, Chair.