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BACKGROUND PAPER:

COVID-19 AND FORCED DISPLACEMENT IN THE MIDDLE EAST AND EAST AFRICA

This background paper presents considerations on how the COVID-19 pandemic is accentuating existing vulnerabilities of populations forcibly displaced by war (refugees, asylum-seekers, internally-displaced and stateless persons), in settings across East Africa and the Middle East. In addition to the devastating health threat the pandemic poses, lockdown measures imposed by governments to reduce transmission are having outsized effects on forcibly displaced populations, further entrenching poverty, xenophobia and creating new humanitarian protection issues. With the exceptional physical distancing requirements of this pandemic adding impetus to a global drive towards the localisation of humanitarian responses, we also describe some of the local responses to COVID-19 mounted by forcibly displaced communities and humanitarian actors early in the epidemic. We end by offering suggestions for how greater inclusion could help address vulnerabilities of displaced people to COVID-19.

This background paper is based on a rapid review of existing published and grey literature and personal communication with humanitarian actors, social scientists and representatives of local organisations working in diverse settings of displacement in the Middle East and East Africa. It was developed for the Social Science in Humanitarian Action Platform (SSHAP) by the RECAP project at the London School of Hygiene & Tropical Medicine (led by Diane Duclos and Jennifer Palmer).

Summary considerations on the ways humanitarian actors, civil society organisations and government departments with specific responsibilities towards displaced people can lessen vulnerabilities in this pandemic are available in a summary paper: Operational considerations: COVID-19 and forced displacement in the Middle East & East Africa

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BACKGROUND AND SCOPE

According to the most recent estimates of displacement, there are 79.5 million people forcibly displaced by conflict in the world, including 45.7 internally displaced persons (IDPs), 26 million refugees and 4.2 million asylum seekers. 73% of people displaced across borders live in countries neighbouring their countries of origin,[1] meaning that conflict tends to affect health and social care systems in wide geographic regions. Despite international calls for a unilateral ceasefire in ongoing conflicts to enable COVID-19 disease control,[2] most wars in the Middle East and Africa have not ceased.[3] While the adoption of travel restrictions and border closures to reduce the spread of COVID-19 has slowed much migration globally, forced displacement continues within conflict-affected states and across borders, as does the need to provide humanitarian protection and assistance to refugees, IDPs, asylum-seekers and stateless persons.[4]

Entrenched conflicts in Palestine, Lebanon, Iraq and Syria, as well as South Sudan, Somalia and eastern Democratic Republic of Congo profoundly shape patterns of mobility in the Middle East and East Africa over generations, affecting coping strategies of people who decide to leave and those who stay, of people who are internally displaced and those who cross international borders. Responses to COVID-19 should consider the specific and varied types of settings occupied by displaced people in their migrations, as well as the diverse ways people migrate.

This background paper has five sections outlining 1) the diversity of forced migration contexts, 2) an overview of COVID-19 epidemics in humanitarian settings, 3) how COVID-19 is accentuating vulnerabilities of forcibly displaced populations across East Africa and the Middle East, 4) opportunities and challenges in the localisation of COVID-19 responses and 5) recommendations on how to address COVID-19 vulnerabilities in displaced populations.

DIVERSE FORMS OF DISPLACEMENT

During war time, the ability to move is key for populations' quest for survival and security. Forced displacement also triggers new vulnerabilities, and therefore new migration flows. Below are some key considerations about the types of spaces displaced people occupy on their journeys, reasons and ways people decide to move between them, as well as how people create a new sense of home in temporary and long-term sites of displacement.

Types of accommodation: Camps and settlements with their orderly rows of tents or huts are iconic of refugee and IDP spaces.[5] However, accommodation types where forcibly displaced people live are highly diverse, ranging from tented and highly-fortified camps, temporary transit and detention centres, unsheltered temporary arrangements, self-settled villages or neighbourhoods, rented private

accommodations or in temporary structures on unused land in towns and cities among 'host' populations who have not been displaced by fighting.

Settlement locations: Refugee and IDP spaces can be located near borders, at the outskirts of cities, or in urban neighbourhoods including slums. In Uganda, for example, which hosts the largest population of refugees in Africa, most of the 1.35 million registered refugees from South Sudan, Democratic Republic of Congo (DRC), Burundi, Somalia and other countries are in village-like open settlements managed by UNHCR near borders. Tens of thousands also forgo official assistance, choosing to move to towns and cities where they often have uncertain legal status but may find more opportunities to eke out a living.[6-7]

Evolutions of settlements: In Lebanon, which hosts the largest proportion of refugees globally compared to the size of its own population, collections of tented accommodation structures built for long-term refugees from Palestine have slowly transformed into semi-permanent homes and neighbourhoods, bringing profound spatial changes to camps as emergency responses have turned into protracted situations.[8] Following the largescale conflict in Syria, many Syrian refugees and Palestinian refugees who had been living there have chosen to settle in the Palestinian refugee camps of Lebanon, for affordability of rent as well as available social networks.[9-10]

Circular migrations: Migration routes may also be circular with the same journeys happening multiple times, following the ebb and flow of conflict and the evolution of other stresses, bureaucratic changes in access to residency and work permits, as well as opportunities to access aid. During these movements, people often enter new categories of displacement such as 'IDP', 'asylum-seeker', 'refugee', 'returnee' and 'labour migrant' with different accompanying rights. For example, while labour migration between Lebanon and Syria has historically been quite fluid, the influx of refugees fleeing the war in Syria has led to restrictions to access the Lebanese territory, and since 2015, renewing residency has become more difficult. This has forced Syrians in Lebanon to either stay in place and grapple with work and service restrictions as undocumented migrants and refugees or to keep moving: back to conflict-affected regions or on to new destinations.

Migrating with (and without) others: The forced or unplanned nature of much migration in wartime means that many communities move *en masse*, navigating migration and resettlement decisions together. Nevertheless, families may 'break-up' for many reasons during war-time, both through involuntary separation because of attacks but also as a result of rational assessments of the different needs members have for protection and their capacities to pursue opportunities and access resources on behalf of the family or community. Those in privileged positions (for example, those with links to military elite, faith-based or humanitarian organisations, or with more money for private transportation) often have greater access to more secure places.[11] Migrants may also use social media information from trusted individuals to plan their journey.[12] Men and boys are generally more mobile so might be better able to travel long distances to safe spaces, to pursue livelihood opportunities in cities or be expected to travel with armies to fight. Since camps usually offer free education, they may be seen as good places for children. Older people less fit to travel may

be left behind or extended families may see advantages in organising some households to protect existing land, houses or businesses. Those sent away often join existing communities of displaced people with shared languages, cultures or histories who, in turn, may help more migrants navigate their ways there.[11]

Hybrid authorities and plural cultures of displacement: Through processes of place- and home-making, displaced people create new cultures and systems which enable communal healing, coping and resocialisation.[11,13] Very often, the places where forcibly displaced people settle become sites of plural or hybrid authorities. Humanitarian programmes, religious organisations, elders' committees and customary courts, political and civil society organisations and local financing cooperatives operate alongside each other, offering various opportunities for leadership and participation, including in collaborating with public health interventions.

COVID-19 IN DISPLACEMENT SETTINGS

In the first quarter of 2020, as the epidemic looked set to affect all regions of the globe, crisis-affected populations, particularly those living in refugee and IDP camps were among the first groups international public health responses prioritised for preparedness efforts. In the second quarter, public health preparedness activities across humanitarian settings in the Middle East and East Africa have consisted of:

- Community engagement and COVID-19 education;
- Reinforcement and expansion of water, sanitation and hygiene (WASH) infrastructure by constructing hand-washing points in communal areas (in markets, at health facilities, at settlement gates) and increasing supplies of water and soap in camps and settlements;
- Organising community groups to sew washable face masks;
- Adapting essential humanitarian services normally delivered using mass gatherings, including food distributions, to suit physical distancing requirements of COVID-19 control;
- Adopting remote and community-based models of delivery for some health services;
- Training of staff and equipping health facilities to improve infection control and COVID-19 case management capabilities; and
- Construction, renovation or conversion of existing structures into COVID-19 quarantine or isolation units;

As of June 2020, there has been no large-scale outbreak amongst IDP and refugee populations in countries considered for this brief in either region, though local transmission is ongoing in all countries of the Middle East and North Africa, the East and Horn of Africa and the Great Lakes Region.[14-15] Moreover, most

humanitarian responses have struggled to address both the medical needs associated with what are predicted to be very large epidemics of COVID-19 and the vulnerabilities associated with government response measures adopted in areas where humanitarian programmes operate. Government control measures were adopted swiftly across the Middle East and East Africa at a relatively early stage in the epidemic, causing so much hardship and disruption to daily life that in some places they have even eased up before the epidemics have really gotten underway.[16]

Given this context of low COVID-19 caseload but high preventive measure intensity, the main vulnerabilities being experienced to date have been due to border closures, travel restrictions, interruptions to businesses and schools, prohibitions on large gatherings, curfews and mandatory stay-at-home orders - a collection of measures which constrain mobility and are referred to collectively as 'lockdowns'.

VULNERABILITY TO COVID-19 IN DISPLACEMENT

The COVID-19 pandemic has compounded insecurity and vulnerability for forcibly displaced populations on multiple inter-connected fronts, including by harming survival strategies.

THREATS FROM COVID-19 TRANSMISSION

Large-scale outbreaks of disease in refugee and IDP camps in the past prompted the introduction of minimum standards for the provision of housing, water and sanitation infrastructure and essential hygiene items to slow and control disease transmission in humanitarian responses since the 1990s.[17] In many humanitarian settings, however, access to land constrains the space that is available to meet such minimum standards. Even when space is more plentiful, outbreaks still occur.[18] For a disease as infectious as COVID-19, following the recommended basic protective measures, including frequent handwashing, maintaining physical distances, and isolating at home when sick is likely to be very difficult in camps and settlements. Some humanitarian actors are facilitating discussions with camp residents to reimagine living spaces to shield vulnerable people from transmission, though the constraints they face shouldn't be under-estimated.

Population and housing density in IDP and refugee settlements is often higher than in surrounding host communities. Population and housing density in IDP and refugee settlements is often higher than in surrounding host communities. In North-West Syria,[a] between 6 and 11 people who have been repeatedly displaced may share a small tent, caravan or one-room-shelter within larger formal or informal settlements. Most families share latrines with other households, sometimes having to queue for 30 minutes. Obtaining

[a] Study conducted by LSHTM and NUS School of Public Health Syria Research Group on the perceptions and experience of displaced people living in settlements in Syria.

soap can be a challenge. In this region, disease modellers have adopted an assumption that the COVID-19 attack rate will double every 2.3 days, compared to every 4 days for the surrounding population, and infect 20% of the IDP population within the first 6 weeks (causing 240,000 cases and 14,328 deaths) compared to 0.4% of the surrounding host population (16,384 cases, 978 deaths) within the first 8 weeks.[19] In South Sudan Protection of Civilian (POC) camps set-up in UN peace-keeping compounds, for example, space is so scarce that some people have been temporarily housed in stifling warehouses.[20] Residents have also often been told that they must accommodate eight people in one tent, meaning that some people are asked to share with strangers or relatives that it is culturally inappropriate to live with.

In urban areas where many refugees self-settle such as Kampala, Uganda, more than 70% of households sleep in a single room.[21] Just over half of Africa's urban population of 500 million has access to piped water.[21] Shelter is one of the highest burdens on displaced people, hosts and aid providers' financial resources, and affects security and health.[22] Loss of income due to COVID-19 may expose displaced people living in rented accommodation to a heightened risk of eviction and the possibility that people would have to travel or move in with other people, further increasing transmission risks.

THREATS FROM COVID-19 MEDICAL COMPLICATIONS AND DISRUPTIONS TO HEALTH SERVICES

The health of people who migrate depends greatly on structural and political factors that determine the impetus for migration, the conditions of their journey, and their destination.[23] Displaced people of all ages are more likely to suffer from poor health than non-displaced people, particularly when they have been uprooted for a long time and live in severe conditions. While it is not yet clear what the medical effects of COVID-19 will be in low income and humanitarian settings, forcibly displaced people are expected to be at higher risk of developing severe disease. Globally, older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness from COVID-19 and die from the disease. Most forcibly displaced populations have the benefit of younger age distributions,[24] however, they face additional risks of severe disease because of COVID-19's interaction with highly prevalent co-morbidities. These include non-communicable diseases such as hypertension and diabetes which are often more prevalent in low- than high-income settings, with a far lower treatment coverage, as well as undernutrition, tuberculosis and HIV.[25] Mal- and under-nutrition, which is particularly prevalent among young and older IDPs, is a major contributor to higher mortality rates among IDPs than the general population in most humanitarian crises.[22]

While most cases of COVID-19 among displaced populations detected to date appear to have been managed in dedicated hospital quarantine and isolation facilities,[26] such facilities are expected to become shortly overwhelmed. Forcibly displaced peoples' abilities to manage co-morbidities, diagnose COVID-19 infections, monitor need for higher level interventions and receive intensive care for severe complications will be affected by their overall access to healthcare. Displaced peoples' access to services outside of settlements is typically beset by difficulties navigating, reaching and paying for healthcare services and communicating with

healthcare providers amidst fragmented landscapes of care.[23] In such circumstances, displaced populations in both the Middle East and East Africa may be expected to rely heavily on local and transnational cultural and linguistic social networks which share practical information about how best to access health services[27] and help fund healthcare-seeking.[28] [29] The greater interventional capabilities of delivering outreach and home-based services to populations in camps and settlements may enable implementation of decentralised case management services for COVID-19,[30] if such an approach is eventually adopted. Challenges in coordinating activities across government and humanitarian programmes, however, should be anticipated.[31]

Moreover, evidence from previous epidemics, including Ebola outbreaks in West Africa and the DRC, has highlighted the excess mortality and morbidity caused by the suspension of routine essential health services when a system is overwhelmed by epidemic response. Indirect deaths can exceed those attributed to the infectious disease.[32, 33, 34] In Lebanon, where most hospital care is privatised, refugees tend to use the main, public hospital in Beirut for their services. However, according to some local observers, its allocation and reputation as a facility to quarantine and treat COVID-19 patients led to a decrease in health services utilisation, with unknown effects on refugee health and health-seeking. Elsewhere in East Africa, isolation units built to contain recent epidemics of cholera and Ebola have been repurposed for COVID-19 control.

INDIRECT HEALTH EFFECTS OF COVID-19 LOCKDOWNS

Difficulty of reaching and closure of health facilities: In Jordan and Uganda, temporary movement restrictions severely hampered refugee and host populations' access to key health services, including for chronic diseases.[35]

Gender-based violence: During pandemics, as in other types of crises, women may be exposed to greater violence, including in their roles as healthcare workers.[36] South Sudanese refugees and humanitarian actors in Uganda worry that COVID-19 measures are risking gender-based violence and early marriages, both because of the ways programmes are being interrupted and because of the inevitability that lockdown measures will push women and families into further poverty, with early marriage historically used as a coping measure in moments of crisis and poverty.

Mental health: The psychological impact of being unable to work, attend school or access care because of COVID-19, feeling disconnected from others, movement restrictions as well as the stigma and violence associated with their enforcement (discussed below) is likely to increase anxiety, depression and other forms of distress that displaced people are already at higher risk of.[37] Anxiety about COVID-19 may be further compounded by the challenges displaced people face accessing public health information because of a lack of internet connectivity in some camps or settlements or when information is not available in the languages displaced people speak.[38] In Iraq, 49% of IDPs surveyed in sites across the country reported psychological trauma, stress and anxiety since the beginning of the COVID-19 pandemic.[39] Since lockdown measures began,

UNHCR has noted higher reports of gender-based violence and attempted and completed suicides in Ugandan settlements compared to this time last year.[40]

THREATS TO SECURITY AND HUMANITARIAN ACCESS

With armed conflict set to continue, inter-related conflict-epidemic dynamics may further impede access for internally displaced people to reach care. Providing humanitarian assistance to populations is dependent on political will to maintain safe humanitarian corridors. Despite the UN Secretary General's call for a global ceasefire to help control COVID-19, the UN Security Council has failed to agree on a resolution to implement it, nor a way to ensure cross-border access for humanitarian assistance to populations trapped in conflict settings. Security Council members have, for example, in January 2020, failed to extend the cross-border authorisation to move aid supplies from Iraq to North-East Syria through the Yaroubiya crossing point,[41] a decision which increases the fragility of a health system decimated by nine years of conflict, at a point when local authorities need to prepare for a potential COVID-19 epidemic. During active conflicts, certain health facilities may also be attacked, or be off-limits to some men, especially soldiers, highlighting the risks to accessibility of limiting COVID-19 services (such as quarantine) to only some health facilities.

STIGMATISATION OF OUTSIDERS AND THE INCREASED MARGINALISATION OF VULNERABLE GROUPS

As has been the case around the world, COVID-19 has created acute fears of contagion and created stigma around human movement. Globally, migrant populations have been stigmatized, scapegoated and neglected in the emergency response to COVID-19.[42] In Lebanon, there are some reports of Syrian refugees coming from border-spaces being refused secondary healthcare at hospitals, because they are believed to carry the virus. Hygiene-related arguments are also a common tactic used by warring parties to exacerbate existing tensions with enemy groups,[43] which COVID-19 could contribute to.

Myths about migrants as disease carriers are not supported by the available evidence and ignore the critical contributions that migration makes to global economies.[23] Nevertheless, when forcibly displaced people are imagined as carriers of disease it creates short-term protection issues for their safety if host populations distrust them. Previous epidemics have shown that stigmatising disease transmission only further places stigmatised populations at risk and reduces their access to care.[44] Inciting stigma aimed at foreigners or minority groups undermines trust in community engagement efforts which are needed for an effective, whole-of-society epidemic response.[45] Such sentiments can also negatively impact the longer term goal of social inclusion as outlined in the Global Compact on Refugees. Stigma is hard to undo.[46] It is therefore important that all actors working on WASH and other interventions with displaced populations during COVID-19 are aware of disease discourses being used to 'other' migrant or enemy groups to avoid unintentionally exaggerating these stereotypes.

In contrast, in many parts of East Africa, rural populations including displaced people have tended to fear foreigners including aid workers and people in capital cities including politicians as carriers of COVID-19.[47] With these individuals coming from elite classes and even positions of authority in COVID-19 responses, they are less vulnerable to discrimination and social exclusion. Rather, fear of people perceived to carry disease in this context is more likely to take the form of resistance to public health measures and political messages, building on long-standing centre-periphery grievances, wealth inequalities and lack of engagement in national processes. Such resistance, however, also puts displaced people at further risk of enforcement-related violence. Particularly in conflict-affected places, therefore, discussions about lack of trust in political and healthcare systems and community engagement initiatives should be carefully considered in light of countries' histories of using the public health system to exercise power, including through quarantine practices and lockdowns.[48]

LIVELIHOODS AND ACCESS TO AID UNDER LOCKDOWN

What is sometimes referred to as 'resilience' in the development and humanitarian sectors encompasses a wide range of strategies developed over time to build and rebuild one's life in adverse situations. To cope with the economic insecurity of war and forced displacement, people tend to create livelihood 'systems'[49] exploiting a diverse repertoire of coping strategies and transnational income streams accessed through social networks including savings and capital, mutual assistance, aid, education and work opportunities. The multiple avenues used by migrants to cope with displacement means that they cannot be considered as exclusively 'aid-dependent' or 'self-reliant'. While no single strategy or income stream may be robust in times of crisis, a diversified approach is potentially more resilient and reflective of the realities of a globalised economy.[50]

Quarantines and travel lockdowns are negatively impacting nearly all livelihood strategies, immobilizing the structures that displaced people use to cope with crisis and compounding vulnerabilities associated with displacement. Restrictions on people's ability to secure income from informal employment and lack of access to 'safety nets' in host countries could put more pressure on humanitarian aid and remittances, which are also threatened by the financial implications of the pandemic. Moreover, disruptions to education due to schools and university closure under lockdown have both immediate consequences on well-being (such as lack of access to services provided through schools) and longer-term implications amplifying inequalities in peoples' abilities to build careers.

Jobs: IDPs and refugees are more often dependent on insecure and informal employment than non-displaced people,[22] depending on daily wages for subsistence, so have fewer savings, employment benefits and support from workers' unions to sustain these financial shocks.[51] COVID-19 lockdowns have worsened restrictions on displaced peoples' movements to pursue work outside of camps in Kenya, Jordan and the Occupied Palestinians Territories. Monitoring from UNHCR has reported that amongst IDPs surveyed in Iraq, 89% reported loss of employment since the COVID-19 pandemic began, and in Lebanon, the share of

respondents reporting 'not to have any household member currently working' increased drastically from 44 per cent to 70 per cent between March and May 2020.[52] With lockdowns in Lebanon implemented in the midst of a financial crisis, where there was already a dearth of job opportunities and increased numbers of people have accumulated debts, everyone is affected by the crisis, but for Syrian refugees, this is yet another crisis within the crisis. Daily wages have been devalued by the collapse of the Lebanese Lira and prices of basic goods have spiralled, while there have been reports of refugees facing difficulties withdrawing cash assistance due to bank restrictions.[53] Inside some of the Palestinian camps, lockdown measures have largely reinforced pre-existing movement restrictions implemented for security reasons and the economic hardship induced by recent employment restrictions rules for foreigners (including Palestinian refugees) dating from June 2019. Post-lockdown, forcibly displaced populations may face discrimination in accessing the same livelihood opportunities as before the epidemic and a heightened risk of labour exploitation.[54]

Food: Food prices have also increased exponentially in East Africa at the same time as stay-at-home orders have harmed peoples' capacity to provide for themselves. In already economically-depressed and food insecure South Sudan, hungry people without access to land or other productive resources may be forced to reorganize their livelihoods dramatically or migrate in search of food, work or aid.[54] Recent reports indicate that refugees and IDPs in Lebanon and Iraq cope with recent financial difficulties by reducing food purchases and changing their food consumption.[52]

International aid: Restrictions on access to nearby markets have damaging consequences for people living in camps who are reliant on petty trade for income. While camps and settlements serve as a useful way to organise populations to deliver humanitarian aid, the chronic underfunding of the global humanitarian response system means that people living in camps rarely receive enough food or cash to meet their daily needs. Financing COVID-19 responses and maintaining commitments for ongoing humanitarian crises, including emergency relief for vulnerable people, has challenged most humanitarian actors and governments. Aid to South Sudanese refugee settlements in Uganda, for example, was reduced by 30% in April.[55] Here, business women who can no longer sell goods in the market have been advised to 'go back' to agriculture. Uganda has a long history of constraining the repertoire of refugee survival strategies and expecting refugees to be self-reliant through farming, despite not providing refugees with enough land of sufficient quality to do so. Not only does this feel like a return to old ways of discussing refugee well-being, such advice is quite impractical given how swiftly both livelihoods and rations have been impacted.

Government relief: The African Union has pointed out that most states have not considered the needs of migrants in their national COVID-19 responses.[56] In Kenya, Uganda, Tanzania and Ethiopia, refugees, asylum-seekers and migrants have been left out of host governments' vulnerability criteria for government-led food distributions.[57] While UNHCR has concentrated their efforts on camps and settlements, emergency initiatives to distribute cash to urban refugees have been much slower and have achieved incomplete coverage, leaving many refugees stranded without food or drinkable water.

Remittances and neighbourhood savings: Loss of remittances from relatives abroad, also unable to work, is expected to further exacerbate vulnerabilities in forcibly displaced populations.[58] Some local communal financing mechanisms have become dormant.[59]

Enrichment of police and security forces: Lockdown measures are not only harming displaced peoples' ability to earn incomes by restricting markets and movements. In some areas, security and police forces are using COVID-19 public health measures as an opportunity to profit from rule-breakers. These activities are exposing poor people to violence. In Rumbek, South Sudan, the military have fined and beaten people for violating travel restrictions as well as business people which do not have wash basins outside their stalls.[b] In Kenya around Dadaab refugee camp, police have been arresting people who don't have the 'right' facemasks for travel, and refugees in Nairobi have been caught up in police harassment, extortion and violence associated with enforcing curfews.[60]

SURVEILLANCE AND THREATS TO MOBILITY AND SAFE PLACES

Displaced peoples' relative lack of long-distance mobility has been highlighted as a protective factor against COVID-19 transmission in low-income settings.[61] Movements are nevertheless dynamic within settlements, across borders and between border entry points, camps or settlements and towns. Given the ways families decide to settle and move to deal with crisis, mobility itself can be seen as a coping measure threatened by COVID-19 lockdowns and surveillance measures. Moreover, as highly visible sites inhabited by displaced people, camps and borders typically attract political attention which is adding to the complexity of understanding COVID-19-related protection needs, exacerbating racism and xenophobia,[62] and contributing to unequal imposition of lockdown measures.

Surveillance effects in camps: Camps have been described as a "privileged space for feeding, protecting, and controlling"[63] refugees and IDPs because of a combination of state poverty and security concerns, underpinned by foreign aid opportunities. These qualities make surveillance of camp residents for a range of purposes easier, which can generate new vulnerabilities.[64] South Sudanese people outside of UN PoCs have noted with dismay that COVID-19 tests are absent from the usual places they would seek healthcare. Tests have been largely only available to Juba-based government epidemic response teams.[65] Humanitarian actors were, however, able to organise testing for a suspected cluster of cases that emerged in a UN POC in May. Greater ability to test encamped people meant cases became visible here more quickly than in neighbouring communities, though community transmission was suspected. This bolstered an earlier decision by national security forces to close the gates to prevent transmission from the POCs to the wider population. Closure of

[b] Interviews

the gates, however, created new protection challenges as people living in these sites are dependent for their survival on UN staff and humanitarians trucking in food and water.

Surveillance effects at borders: Use of security surveillance resources to enable the crossing of borders have also affected vulnerabilities. The border between North-West Syria and Turkey has been closed to Syrians seeking refuge in Turkey since 2016. However, exceptions have typically been made for patients with critical conditions like cancer to seek medical care.[66] In March 2020, lockdown measures implemented by the Turkish government mean that crossing the border is no longer an option for Syrian patients, which threatens transnational health seeking practices that have developed over time.[67] This measure is particularly affecting people recently displaced by the military campaign on Idlib by Russia and the Syrian government. Here, health facilities have been bombed, but the violence and politics of the conflict means that Damascus is also not available as a safe space, leaving most patients in North-West Syria stranded without access to specialised healthcare.

In most countries of East Africa, screening and quarantine measures were implemented early on in the epidemic to enable migration and control potential transmission from international travellers as well as large numbers of lorry drivers bringing in essential goods. The same sorts of provisions have not always been made available to forcibly displaced people. Partial or complete border closures affect asylum-seekers in all countries of the Horn of Africa and Great Lakes Region with refugee registration processes typically only available to asylum-seekers already in the country.[14] In Uganda, some refugee reception centres have instead been converted into COVID-19 quarantine facilities to serve refugee and host area populations.[40] Migration at informal border crossing points has nevertheless continued both by people who are already registered in camps and those who intend to. Elsewhere, border lockdowns have reinvigorated the smuggling of people and cash as a source of military-security income.[68] Without registration, asylum-seekers do not have access to services provided by UNHCR and its implementing partners including food and healthcare. They can also not register for telephone sim cards to communicate and receive mobile money transfers. Moreover, border closures prevent the sorts of 'self-reliant' transnational economic activities that people claiming refugee assistance are not supposed to engage in. While in early June, the Ugandan government lifted most lockdown restrictions on movement to enable commerce in the centre of the country, including the capital, they remain in place in rural border districts where most refugee settlements are located.[14]

Surveillance of strangers: In refugee settlements in Uganda, there is an understanding of why people who have crossed borders during the lockdown need to 'hide' in the community, but there is also fear that those migrants may facilitate the transmission of COVID-19. Groups of refugee youths are now patrolling informal crossing points at rivers and in forests in Adjumani at night when Ugandan border authorities are not active, and settlement residents are reportedly highly attuned to the entry of strangers into the settlements. Such an improvised 'surveillance' system, which primarily aims to identify (and punish) outsiders who pose a risk of disease transmission –rather than to identify symptomatic cases as in public health strategies– has emerged during many other epidemics on the continent, including during the West African Ebola crisis.[69]

Such behaviour can be seen as an understandable part of the communal place-making process displaced people engage in to defend their new homes which they have invested in. This type of surveillance strategy for COVID-19, however, may create additional vulnerabilities which should be monitored, such as the potential for incarceration of migrants in unsafe conditions or mob violence directed towards those seen as putting the safety of camps at risk.

RISKS OF INDUCING FURTHER INVOLUNTARY DISPLACEMENTS

As described above, in many ways, forcibly-displaced people's use of mobility as a coping measure has become more difficult amidst public health responses to COVID-19. These measures have also created conditions which may nevertheless prompt new forced and unsafe migrations.

Emptying camps: In South Sudan, newly displaced populations sheltering in churches in Wau and Yei areas have been asked by church authorities to move and live with relatives or seek refuge in nearby POC camps, partly because they don't want to encourage social gatherings that could spread COVID-19. Meanwhile, mechanisms for reducing the population in POCs across the country have been a preoccupation of the UN and government departments since they were created in 2013. As the COVID-19 crisis loomed in March 2020, UNMISS staff "very strongly encouraged people in the POCS to return home" to rural areas where people are assumed to have ancestral ties. The reduced connectivity and wider spacing between homes in villages were also presumed to make people safer from transmission.[70] But for most residents, the assertion that they should go home is nonsensical, impractical and could push them towards dangerously violent realities. No POC residents' 'home' has remained unchanged. Many residents have grown up in urban centres or moved there from sites of exile during the 1980s and 1990s. Emptying camps during a pandemic which has caused economic hardship for so many others across the country will add to the numbers of hungry people on the move and add to the demands on poor rural people's food supplies. It would also likely contribute to conflicts over land which have driven the war so far.

Reduction in peace-keeping efforts: As in many areas of the Middle East and East Africa, there is also a risk of new conflict-driven migrations if international peace-keeping efforts cannot be maintained through global travel restrictions for COVID-19. A likely consequence of retreating peacebuilding activities is that non-state armed groups will seize the opportunity to expand their frontiers, thus undermining ongoing peace processes. It also opens up the possibility of increased mortality in the context of violent conflicts. For displaced people wanting to return home, COVID-19-related delays to peace-keeping is yet another disappointing set-back, as poignantly captured by social media messages by images circulating on social media showing Syrians carrying signs reading "Stay at home, I wish I could!'.[71]

OPPORTUNITIES AND CHALLENGES IN THE LOCALISATION OF COVID-19 RESPONSES

Amidst insecurity, insufficient funding, mobility restrictions and uncertainty around how best to respond to this novel threat, displaced populations, humanitarian actors and governments are mounting responses to COVID-19 across sites of forced migration in the Middle East and East Africa. Importantly, many of these responses have built on existing local social and aid delivery structures particular to the displacement context (see Box 1).

These have included: drawing on communication channels that displaced people actively maintain to politicians and humanitarian agencies to obtain COVID-19 information; leveraging the legitimacy of and relationships between medical providers to coordinate responses across fragmented systems; and building on long-term relationships between providers and patients to maintain remote services for people with chronic conditions. Refugee-led organisations have also functioned as important actors in solidarity networks to address the gaps and limitations of existing international aid and host government support systems in providing food relief for self-settled groups.

Box 1. Examples of local initiatives to respond to COVID-19, highlighting the social relations that responses built on

Obtaining information for COVID-19 education & advocacy: In August 2018, violent clashes broke out in a UN POC for IDPs among ethnic Nuer people aligned to different vice-presidents in South Sudan, leading to one group leaving the camp en masse for Mangateen settlement, a government-managed site for IDPs on unused land outside of the city.[72] Among several popular explanations for the move was the idea that this minority group was supported financially through charity and patronage networks by one of the wealthiest politicians in the country, and so should not be receiving UN aid.[73] When rumours of the cluster of COVID-19 cases in the POC reached Mangateen, residents used different channels that they had developed during their move to find out more information on behalf of the settlement. One was a channel to the politicians linked to the earlier clash who had direct experience of the disease. So many of the country's leadership had become infected with the virus that the entire COVID-19 taskforce was self-isolating.[74] Another channel	**Coordinating responses across fragmented systems:** In both Syria and Lebanon, healthcare governance is highly fragmented but frontline medical workers have been key to ensuring responses to COVID-19 are coordinated. In Syria's opposition-held province of Idlib, the civil society-led health directorate has taken the lead in coordinating a COVID-19 task force through which NGOs, international agencies, volunteer rescue workers and opposition groups are implementing COVID-19 preparedness activities for its besieged population, half of whom are displaced.[77] In a context where so many actors are in dispute over territory, the local and international legitimacy of the medical doctors leading the directorate has been key to enabling coordination and fundraising.[77] Grounded coordination is also key within and around Ein-El-Helwe Palestinian refugee camp in Lebanon. Staff from the Ministry of Public Health, UN agencies, international and local NGOs and first aid responders have collaborated to reach communities with

involved women's groups and camp chairmen who had been seen as 'neutral' in the POC clashes and were good communicators with multiple constituencies in multiple languages. They had developed good relations with some NGOs who had agreed to provide outreach services to the new settlement. Through these interactions, Mangateen's leaders were able to disseminate information about the symptoms that some of the first cases of COVID-19 in the country were feeling --such as losing a sense of smell[75] and feeling a swelling in the chest[76]-- and they continue to advocate for services for the settlement.	educational material via social media, adapt the physical spaces of ambulances and hospital entryways to protect staff and patients from infections, and reinforce referral systems to transfer patients when the main hospital inside the camp becomes overwhelmed. Each of these issues have been recognised to affect people and systems inside and outside the camp and the innovations adopted are being translated as much as possible across systems.
Going remote with disease management and support: Health services addressing chronic conditions which involve long-term relationships between providers and patients have been particularly targeted for remote management during the COVID-19 pandemic. A key challenge encountered when 'going remote'[78] in insecure settings such as Somalia, South Sudan, Iraq and Syria has been the tendency to lose sight of realities on the ground including an awareness of the power relations affecting access to services, as well as the risk of overburdening in-country local partners who also bear high security risks.[79] Efforts by one international NGO to offer physical rehabilitation services via video link for Syrian refugees in Turkey have therefore focused on simplifying standard operating procedures and creating transparent patient selection approaches. Agencies are also building on community models of care to deliver drugs through peer or patient groups.[80] This approach relies on peer groups to identify and help solve ongoing social, medical and logistical challenges their members face. It has been presented as an option to enable individuals at high-risk of developing complications of COVID-	**Responding to hunger:** In both Uganda and Lebanon, refugee-led organisations have helped fill gaps in state and humanitarian social protection by identifying vulnerable households in need of emergency food relief, advocating to their networks to help fund relief and procuring and distributing food. In Uganda, three months into the lockdown, less than 10% of urban refugee households had been reached with emergency cash by UNHCR because of a lack of funding and means to reach refugees outside of settlements.[32] Refugee-led organisations have assisted UNHCR verification exercises in urban areas and used their visibility in the Global Refugee-Led Network to advocate for more rapid responses. Though modest in scale, RLOs have also mounted their own emergency food distributions using funds collected from individuals, INGOs and some donor support. In the Palestinian refugee spaces of Lebanon and Jordan, there is a sense that enduring hardship has created a sense of communal trust and preparedness for COVID-19.[9] To a certain extent, solidarity is being claimed as

19, such as refugees or IDPs living with a chronic disease, to continue their treatment under lockdowns or while being shielded from transmission.	an alternative to humanitarian assistance,[81] with food banks largely locally funded.

STRUCTURAL CHALLENGES TO LOCALISING HUMANITARIAN ASSISTANCE

Despite recent global commitments to localise humanitarian aid,[82] and WHO COVID-19 guidance which advises that displaced people should be "recognized as co-developers as well as providers of health and other essential services and prevention efforts",[83] however, refugees and IDPs have nevertheless often been marginalised from disease control decision-making at all levels of the response. Their exclusion stems from legal and normative practices of host community governments, professional societies and humanitarian partners with consequences for the overall effectiveness of the COVID-19 response. Examples include:

- **Limited participation of displaced people in COVID-19 task forces:** In Uganda, refugee organisations have been excluded from COVID-19 response task forces at both national and district levels, even in places where refugees outnumber the host population. In many countries, the lack of consultation of displaced populations about the imposition and lifting of lockdown measures along borders and in camps and how they could be adapted is particularly problematic, given how much vulnerability these measures have created specifically for these groups.
- **Legal barriers to registering refugee-led organisations:** In Lebanon and elsewhere, organisations led by refugees face substantial legal and administrative obstacles preventing them from receiving direct funding, particularly if their staff are undocumented refugees.[84] Even in settings where local organisations are not discouraged by national governments, they may be at a disadvantage in competing with international organisations and must survive on very small operating budgets.[85] These obstacles prevent refugee- and IDP-led organisations from taking a larger role in response efforts.
- **Exclusion of displaced healthcare workers from humanitarian responses:** Despite the need for greater health human resources in a pandemic, many IDP and refugee workers are excluded from humanitarian and government responses because of local hiring laws and norms. Such practices conceal uncomfortable structural political questions on the representation of refugees in health systems and society.[86] Whereas other regions of the world have addressed this issue through rapid credentialing schemes for migrant healthcare workers,[87] public health responses to COVID-19 in the Middle East and East Africa appear to be overlooking the capacities of displaced HCWs, especially to build culturally sensitive healthcare programmes for patients through trusting relationships.[88]

HOW TO ADDRESS VULNERABILITIES OF DISPLACED POPULATIONS THROUGH LOCALISED COVID-19 RESPONSES

Addressing vulnerability to epidemics in forcibly displaced populations who have witnessed violence, experienced extreme hardship and already had to rebuild their lives multiple times is a complex task. The coping systems which populations displaced by war have built up are fragile and humanitarian responses should take care not to harm the social relationships, networks and systems which populations turn to in times of crisis. Furthermore, international responders and actors from capital cities are having difficulties reaching displaced populations with public health interventions and peace-making initiatives. To address current and future vulnerabilities in such a context, social science research and the participation of local actors will be key to identifying emerging vulnerabilities, creating feasible and appropriate strategies to address them, and delivering assistance. The COVID-19 pandemic therefore provides a unique opportunity to support and further localise responses.

We offer the following recommendations on how humanitarian agencies and governments can support local actors during this pandemic to reduce vulnerabilities created by COVID-19:

Promote holistic public health responses which address multiple vulnerabilities related to COVID-19: COVID-19 is exposing the limitations of humanitarian protection systems to provide safety, protect livelihoods and deliver durable solutions for forcibly-displaced populations.[6] COVID-19 responses should acknowledge the multiple sources of trauma forcibly displaced populations have already experienced and ensure that displaced populations are not pushed into even more precarious situations by public health measures. A holistic approach enables solutions to public health problems without endangering existing coping strategies, for example, by:

- Avoiding imposing complete lockdowns for conflict-affected and displaced populations to minimise economic hardships and violence and finding ways to adapt agricultural production.[89] For example, less restrictive strategies such as adopting queuing systems and alternating days for individual vendors can help maintain safe physical distances in outdoor markets that enable some trade.[90] As few displaced people are exclusively 'aid-dependent' or 'self-reliant', global donors should also continue to give generously to humanitarian funding mechanisms to support displaced people in precarious economic circumstances. Humanitarian and local actors should invest in emergency financial protection systems which can reach self-settled refugees in exceptional circumstances.
- Protecting peoples' existing homes and safe spaces and work with them to become safer from COVID-19 transmission. Displaced people should not be asked to leave camps, settlements and other sites where they have sought sanctuary during an epidemic, especially if they cannot do so safely. Health facilities which serve large displaced populations should not be entirely given over to COVID-19 activities unless alternative service provision arrangements can be made and are communicated about clearly.

Likewise, alternative arrangements should be made to maintain asylum activities if reception centres are repurposed for the COVID-19 response.

- Ensuring border controls balance needs to control COVID-19 transmission and protect peoples' right to asylum so that entry is safe for everyone.[91] People fleeing war in an epidemic still need protection, regardless of real or perceived fears of COVID-19. For undocumented refugees, every effort should also be made to enable temporary amnesties to access health services without putting refugees at risk of being arrested or deported. These measures will require cross-sectoral and multi-level responses to protect the lives and futures of forcibly displaced persons.

Use research to tailor responses: COVID-19 responses should incorporate social science research and vulnerability assessments to adapt interventions and ensure they reflect the diverse realities and political contexts of displacement. Research in previous epidemics has highlighted the critical importance of understanding local social responses to the epidemic, consulting people affected by interventions to find the best ways of adapting them, identifying response priorities including non-medical needs, and engaging representatives who are trusted by communities in decision-making.[90,92-94] Research can also be used to identify local groups and individuals best placed to overcome political tensions driving armed conflict, liaise with international aid groups and provide local insight to the vulnerabilities that standard approaches are not addressing.[85] Special care should be taken in a remote programming approach to monitor power relations and intervention effects on frontline workers.[95-96]

Adopt a whole-of-society approach to COVID-19: The WHO emphasizes a whole of society approach to control COVID-19.[83] In settings of forced displacement, this means that:

- Multiple sectors and stakeholders should be involved in the response, including the various and legitimate forms of local authorities (such as elected representatives, hereditary chiefs, religious and civil society organisations) which govern displaced populations and enable coping and participation in social life. Bypassing or discrediting them could otherwise have damaging effects in post-pandemic times. Initiatives which value the skills and context-specific knowledge of displaced healthcare providers to engage with patients who are similarly displaced can potentially be powerful in an epidemic like COVID-19, where trust and localisation are key to successfully implementing any public health measure.
- Perspectives from different forms and waves of displacement should be welcomed. Partnerships encouraged with diaspora and local groups involved in humanitarian response in ways that the comparative advantages of these actors are complemented and built on for the benefit of all.[97] Involving diaspora and refugee-led groups may be especially important to improve support to displaced people not living in formal settlements, though care should be taken to understand who certain groups represent, whose voices may remain marginalised within these structures and how strategies can be adapted to reflect the diversity of forcibly displaced people within and across borders.[98-99]
- Coordination between different types of actors should be supported. While not always possible in conflict settings where IDPs flee government persecution, coordination between governments and civil

society actors should be prioritised so that forcibly displaced populations are not adversely affected by state-level decision-making.

Support organisations led by forcibly displaced people: There are several steps that can be taken now to support the work of and increase the capacities of local civil society organisations led by forcibly displaced people who are already participating in COVID-19 responses. These include:

- Funding, supporting and working with existing networks of organisations for displaced people such as the Global Refugee-Led Network;
- Building-in processes and funds for local organisations of displaced people to participate in meetings at local, national, regional and global level, including by helping procure communications technologies and licenses;[100]
- Increasing direct financial support to local organisations within displaced communities to properly compensate humanitarian work done by local actors and investing in long-term strategic partnerships. The acute need to localise activity in the COVID-19 crisis provides a window of opportunity to re-examine refugees' and undocumented migrants' right to work, particularly in humanitarian responses aimed to meet their needs;
- Granting local organisations exemptions from lockdown measures to provide essential services to their members;
- Adopting fair and accountable approaches to assessing gaps in capacity organisations may face to response to the COVID-19 crisis[101] and providing technical support when needed;
- Sharing existing and generate new evidence of good practices in capacity strengthening to encourage a collective approach to capacity strengthening.[101]

Support local peace-making and ceasefire efforts: Perspectives from war torn places highlight the need for COVID-19 responses to be conflict- and peace-sensitive (e.g., avoid exacerbating, and ideally contribute to reducing the risk of violence and conflict)[102] as well as the need for global actions to support ceasefires to ameliorate the conditions which lead to forced displacement. Existing vulnerabilities created by conflicts and displacement intersect with those created by epidemics, making it difficult for effective public health interventions to stop the spread of the disease.[3] Particularly while international travel restrictions are in place, it is important that stakeholders adopt mechanisms that will sustain peacebuilding efforts by supporting national and local capacities for peace.[103]

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REFERENCES

1. Global Trends—Forced Displacement in 2019—UNHCR. UNHCR. Retrieved 30 June 2020, from https://www.unhcr.org/uk/statistics/unhcrstats/5ee200e37/unhcr-global-trends-2019.html
2. Secretary-General Calls for Global Ceasefire, Citing War-Ravaged Health Systems, Populations Most Vulnerable to Novel Coronavirus | Meetings Coverage and Press Releases. (n.d.). Retrieved 15 June 2020, from https://www.un.org/press/en/2020/sgsm20018.doc.htm
3. Marclint Ebiede, T. (2020, May 15). Local Ownership of Peace Processes in African Countries in Times of Covid-19. African Arguments. https://africanarguments.org/2020/05/15/local-ownership-of-peace-processes-in-african-countries-in-times-of-covid-19/
4. Dorai, K. (2015, February 27). Palestinian #refugees and the current Syrian conflict: From settled refugees to stateless asylum seekers? Allegra. https://allegralaboratory.net/palestinian-refugees-and-the-current-syrian-conflict-from-settled-refugees-to-stateless-asylum-seekers/
5. Earle, L. (2020, April 6). A world without refugee camps? IIED launches research on urban refugees. International Institute for Environment and Development. https://www.iied.org/world-without-refugee-camps-iied-launches-research-urban-refugees
6. Hovil, L., & Capici, V. (2020, May 12). Neglected refugees find themselves even more neglected during COVID-19. African Arguments. https://africanarguments.org/2020/05/12/neglected-refugees-find-themselves-even-more-neglected-during-covid-19/
7. Sabates-Wheeler, R. (2019). Mapping differential vulnerabilities and rights: 'Opening' access to social protection for forcibly displaced populations. Comparative Migration Studies, 7(1), 38. https://doi.org/10.1186/s40878-019-0142-6
8. Sanyal, R. (2017). A no-camp policy: Interrogating informal settlements in Lebanon. Geoforum, 84, 117–125. https://doi.org/10.1016/j.geoforum.2017.06.011
9. Maqusi, S. (2020, May 12). 'The displacement virus is much stronger than the coronavirus': Reflections from Burj el-Barajneh and Baqa'a Camps in Lebanon and Jordan. Refugee Hosts. https://refugeehosts.org/2020/05/12/the-displacement-virus-is-much-stronger-than-the-coronavirus-reflections-from-burj-el-barajneh-and-baqaa-camps-in-lebanon-and-jordan/
10. Meier, D. (2016). The blind spot: Palestinian refugees from Syria in Lebanon. In M. Felsch & M. Wahlish (Eds.), Lebanon and the Arab Uprisings: In the Eye of the Hurricane (p. 15). Routledge.
11. Chatelard, G. (2007). Emigrating from Iraq in the period 1991-2007: Social networks as alternatives for international protection. 8.
12. Dekker, R., Engbersen, G., Klaver, J., & Vonk, H. (2018). Smart Refugees: How Syrian Asylum Migrants Use Social Media Information in Migration Decision-Making. Social Media + Society, 4(1), 2056305118764439. https://doi.org/10.1177/2056305118764439
13. Grabska, K. (2014). Gender, Home & Identity: Nuer Repatriation to Southern Sudan. Boydell and Boydell. https://www.prio.org/Publications/Publication/?x=12312
14. UNHCR East and Horn of Africa, and the Great Lakes Region COVID-19 External Update (20-28 May 2020)—Sudan. (n.d.). ReliefWeb. Retrieved 16 June 2020, from https://reliefweb.int/report/sudan/unhcr-east-and-horn-africa-and-great-lakes-region-covid-19-external-update-20-28-may
15. UNHCR. (2020). UNHCR Regional Bureau for Middle East and North Africa COVID-19 Emergency Response Update #7. UNHCR. UNHCR Regional Bureau for Middle East and North Africa COVID-19 Emergency Response Update #7
16. Roser, M., Ritchie, H., Ortiz-Ospina, E., & Hasell, J. (2020, March 4). Coronavirus Pandemic (COVID-19). Our World in Data. https://ourworldindata.org/coronavirus
17. What are humanitarian standards? | Sphere Standards. (n.d.). Sphere. Retrieved 18 June 2020, from https://www.spherestandards.org/humanitarian-standards/
18. Altare, C., Kahi, V., Ngwa, M., Goldsmith, A., Hering, H., Burton, A., & Spiegel, P. (2019). Infectious disease epidemics in refugee camps: A retrospective analysis of UNHCR data (2009-2017). Journal of Global Health Reports, 3, e2019064. https://doi.org/10.29392/joghr.3.e2019064
19. Hariri, M., Rihawi, H., Safadi, S., McGlasson, M. A., & Obaid, W. (2020). THE COVID-19 FORECAST IN NORTHWEST SYRIA The Imperative of Global Action to Avoid Catastrophe. MedRxiv, 2020.05.07.20085365. https://doi.org/10.1101/2020.05.07.20085365
20. South Sudanese Fear Leaving UN Protected Camps Despite Peace | Voice of America—English. (n.d.). Retrieved 16 June 2020, from https://www.voanews.com/africa/south-sudanese-fear-leaving-un-protected-camps-despite-peace
21. Wine, B., & Mills, G. (2020, April 16). Aid has failed. COVID-19 both exposes this and offers the chance for a reset. African Arguments. https://africanarguments.org/2020/04/16/aid-has-failed-coronavirus-covid-19-both-exposes-this-and-offers-the-chance-for-a-reset/
22. The ripple effect: Economic impacts of internal displacement. (n.d.). [Data set]. Koninklijke Brill NV. https://doi.org/10.1163/2210-7975_HRD-9806-20180010

23. Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., Dhavan, P., Fouad, F. M., Groce, N., Guo, Y., Hargreaves, S., Knipper, M., Miranda, J. J., Madise, N., Kumar, B., Mosca, D., McGovern, T., Rubenstein, L., Sammonds, P., … Zhou, S. (2018). The UCL–Lancet Commission on Migration and Health: The health of a world on the move. The Lancet, 392(10164), 2606–2654. https://doi.org/10.1016/S0140-6736(18)32114-7
24. Davies, N. G., Klepac, P., Liu, Y., Prem, K., Jit, M., & Eggo, R. M. (2020). Age-dependent effects in the transmission and control of COVID-19 epidemics. MedRxiv, 2020.03.24.20043018. https://doi.org/10.1101/2020.03.24.20043018
25. Dahab, M., van Zandvoort, K., Flasche, S., Warsame, A., Spiegel, Paul. B., Waldman, R. J., & Checchi, F. (n.d.). COVID-19 control in low-income settings and displaced populations: What can realistically be done? LSHTM. Retrieved 15 June 2020, from https://www.lshtm.ac.uk/research/centres/health-humanitarian-crises-centre/news/102976
26. South Sudan in Focus | Voice of America—English. (n.d.). Retrieved 18 June 2020, from https://www.voanews.com/episode/south-sudan-focus-4288606
27. Samerski, S. (2019). Health literacy as a social practice: Social and empirical dimensions of knowledge on health and healthcare. Social Science & Medicine, 226, 1–8. https://doi.org/10.1016/j.socscimed.2019.02.024
28. Dewachi, O., Rizk, A., & Singh, N. V. (2018). (Dis)connectivities in wartime: The therapeutic geographies of Iraqi healthcare–seeking in Lebanon. Global Public Health, 13(3), 288–297. https://doi.org/10.1080/17441692.2017.1395469
29. Parkinson, S. E., & Behrouzan, O. (2015). Negotiating health and life: Syrian refugees and the politics of access in Lebanon. Social Science & Medicine, 146, 324–331. https://doi.org/10.1016/j.socscimed.2015.10.008
30. Garry, S., Abdelmagid, N., Baxter, L., Roberts, N., Ratnayake, R., Favas, C., Lewis, E., & Checchi, F. (n.d.). Considerations for planning COVID-19 case management services in humanitarian responses. 15.
31. Palmer, J. J., Robert, O., & Kansiime, F. (2017). Including refugees in disease elimination: Challenges observed from a sleeping sickness programme in Uganda. Conflict and Health, 11(1), 22. https://doi.org/10.1186/s13031-017-0125-x
32. CMMID nCov working group. (2020, April 7). Benefit-risk analysis of health benefits of routine childhood immunisation against the excess risk of SARS-CoV-2 infections during the Covid-19 pandemic in Africa. CMMID Repository. https://cmmid.github.io/topics/covid19/EPI-suspension.html
33. Parpia, A. S., Ndeffo-Mbah, M. L., Wenzel, N. S., & Galvani, A. P. (n.d.). Effects of Response to 2014–2015 Ebola Outbreak on Deaths from Malaria, HIV/AIDS, and Tuberculosis, West Africa—Volume 22, Number 3—March 2016—Emerging Infectious Diseases journal—CDC. https://doi.org/10.3201/eid2203.150977
34. Sochas, L., Channon, A. A., & Nam, S. (2017). Counting indirect crisis-related deaths in the context of a low-resilience health system: The case of maternal and neonatal health during the Ebola epidemic in Sierra Leone. Health Policy and Planning, 32(suppl_3), iii32–iii39. https://doi.org/10.1093/heapol/czx108
35. Fawad, M., Rawashdeh, F., Parmar, P. K., & Ratnayake, R. (2020). Simple ideas to mitigate the impacts of the COVID-19 epidemic on refugees with chronic diseases. Conflict and Health, 14(1), 23. https://doi.org/10.1186/s13031-020-00277-x
36. Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., & Van Gelder, N. (n.d.). Pandemics and Violence Against Women and Children. Retrieved 15 June 2020, from https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children
37. Cazabat, C. (n.d.). Durable solutions to displacement must include mental health. IDMC. Retrieved 15 June 2020, from https://www.internal-displacement.org/expert-opinion/durable-solutions-to-displacement-must-include-mental-health
38. Network, C. (2019). How to Guide on Collective Communication and Community Engagement. CDAC network. http://www.cdacnetwork.org/i/20190205111959-9qxsl
39. UNHCR MENA COVID-19 Emergency Response Update #7 (4 June 2020)—Syrian Arab Republic. (n.d.). ReliefWeb. Retrieved 16 June 2020, from https://reliefweb.int/report/syrian-arab-republic/unhcr-mena-covid-19-emergency-response-update-7-4-june-2020
40. Document—UNHCR Uganda COVID-19 response bi-monthly update, 8 June 2020. (n.d.). Retrieved 16 June 2020, from https://data2.unhcr.org/en/documents/details/76946
41. Security Council beats midnight deadline, renews Syria cross-border aid in contentious vote. (2020, January 10). UN News. https://news.un.org/en/story/2020/01/1055181
42. Lau, L. S., Samari, G., Moresky, R. T., Casey, S. E., Kachur, S. P., Roberts, L. F., & Zard, M. (2020). COVID-19 in humanitarian settings and lessons learned from past epidemics. Nature Medicine, 26(5), 647–648. https://doi.org/10.1038/s41591-020-0851-2
43. Livingstone Smith, D. (n.d.). Less Than Human | David Livingstone Smith | Macmillan. Macmillan. Retrieved 18 June 2020, from https://us.macmillan.com/lessthanhuman/davidlivingstonesmith/9781250003836
44. Person, B., Sy, F., Holton, K., Govert, B., Liang, A., Garza, B., Gould, D., Hickson, M., McDonald, M., Meijer, C., Smith, J., Veto, L., Williams, W., & Zauderer, L. (2004). Fear and Stigma: The Epidemic within the SARS Outbreak. Emerging Infectious Diseases, 10(2), 358–363. https://doi.org/10.3201/eid1002.030750
45. Yardley, L., Amlôt, R., Rice, C., Robin, C., & Michie, S. (2020, March 17). How can we involve communities in managing the covid-19 pandemic? The BMJ. https://blogs.bmj.com/bmj/2020/03/17/how-can-we-involve-communities-in-managing-the-covid-19-pandemic/

46. Vertovec, S. (n.d.). Covid-19 and enduring stigma. Retrieved 15 June 2020, from https://www.mpg.de/14741776/covid-19-and-enduring-stigma
47. Pendle, N. (2020, May 17). COVID-19 in South Sudan's UN PoC sites. Africa at LSE. https://blogs.lse.ac.uk/africaatlse/2020/05/17/covid-19-south-sudans-un-protection-of-civilian-sites-poc-trust-unmiss/
48. Dewachi, O. (n.d.). Webinar: How is the MENA Region Dealing with the COVID-19 Outbreak? Chatham House. Retrieved 15 June 2020, from https://www.chathamhouse.org/event/webinar-how-mena-region-dealing-covid-19-outbreak
49. Thorleifsson, C. (2016). The limits of hospitality: Coping strategies among displaced Syrians in Lebanon. Third World Quarterly, 37(6), 1071–1082. https://doi.org/10.1080/01436597.2016.1138843
50. Zetter, R. (2007). More Labels, Fewer Refugees: Remaking the Refugee Label in an Era of Globalization. Journal of Refugee Studies, 20(2), 172–192. https://doi.org/10.1093/jrs/fem011
51. Landau, L. B., Misago, J.-P., Majidi, N., Marden, A., Sarkar, A., Mathebula, J., Murahwa, B., Freemantle, I., & Okoth, F. (2018). Free and Safe Movement in East Africa Research to promote people's safe and unencumbered movement across international borders. Open Society Foundation, African Centre for Migration & Society, University of the Witwatersrand and Samuel Hall.
52. UNHCR Regional Bureau for Middle East and North Africa. (2020). COVID-19 Emergency Response Update #7. http://reporting.unhcr.org/sites/default/files/UNHCR%20MENA%20COVID-19%20Regional%20Update%20-%204JUN20.pdf
53. Sewell, A. (2020, January 9). Lebanon's financial crisis hits Syrian refugees hard. The New Humanitarian. https://www.thenewhumanitarian.org/news-feature/2020/1/9/Lebanon-financial-crisis-Syrian-refugees
54. Thomas, E. (2020). South Sudan's food imports in the time of COVID-19. Rift Valley Institute. http://riftvalley.net/publication/south-sudans-food-imports-time-covid-19
55. Nnabugwu, T. (2020, April 15). "Food rations to more than 1.4 million vulnerable refugees in Uganda have been cut"-WFP. Ventures Africa. http://venturesafrica.com/food-rations-to-more-than-1-4-million-vulnerable-refugees-in-uganda-have-been-cut-wfp/
56. Statement of the African Union (AU) Labour Migration Advisory Committee (LMAC) on the novel Coronavirus Disease COVID-19 and the condition of African Migrant Workers | African Union. (n.d.). Retrieved 15 June 2020, from https://au.int/en/pressreleases/20200414/statement-lmac-condition-african-migrant-workers-covid-19
57. Refugee Leadership & COVID-19 in East Africa – Advocacy, Policy & Information Working Group. (2020). [Summary note]. Open Society Foundation.
58. Garcia Mora, A., & Rutkowski, M. (n.d.). Remittances in times of the coronavirus – keep them flowing. Retrieved 15 June 2020, from https://blogs.worldbank.org/psd/remittances-times-coronavirus-keep-them-flowing
59. Omata, N. (n.d.). Many refugees living in Nairobi struggle to survive because of COVID-19. The Conversation. Retrieved 15 June 2020, from http://theconversation.com/many-refugees-living-in-nairobi-struggle-to-survive-because-of-covid-19-138455
60. Ratcliffe, R. (2020, April 1). Teargas, beatings and bleach: The most extreme Covid-19 lockdown controls around the world. The Guardian. https://www.theguardian.com/global-development/2020/apr/01/extreme-coronavirus-lockdown-controls-raise-fears-for-worlds-poorest
61. INFORM COVID-19 Risk Index Version 0.1.2—Humanitarian Data Exchange. (n.d.). Retrieved 18 June 2020, from https://data.humdata.org/dataset/inform-covid-19-risk-index-version-0-1-2
62. Document—UN Policy Brief: COVID-19 and People on the Move. (n.d.). Retrieved 16 June 2020, from https://data2.unhcr.org/en/documents/details/76793
63. Janmyr, M., & Knudsen, A. J. (2016). Introduction: Hybrid Spaces. Humanity: An International Journal of Human Rights, Humanitarianism, and Development, 7(3), 391–395. https://doi.org/10.1353/hum.2016.0021
64. Palmer, J. J., & Storeng, K. T. (2016). Building the nation's body: The contested role of abortion and family planning in post-war South Sudan. Social Science & Medicine, 168, 84–92. https://doi.org/10.1016/j.socscimed.2016.09.011
65. South Sudan: COVID-19 Update, 21 May – 05 June 2020 - South Sudan. (n.d.). ReliefWeb. Retrieved 15 June 2020, from https://reliefweb.int/report/south-sudan/south-sudan-covid-19-update-21-may-05-june-2020
66. Al Hosse, M., & Edwards, M. (2020, May 20). COVID-19 border closure cuts off Idlib cancer patients from treatment. The New Humanitarian. https://www.thenewhumanitarian.org/feature/2020/05/20/Turkey-Syria-Idlib-medical-treatment-coronavirus
67. Dewachi, O., Skelton, M., Nguyen, V.-K., Fouad, F. M., Sitta, G. A., Maasri, Z., & Giacaman, R. (2014). Changing therapeutic geographies of the Iraqi and Syrian wars. The Lancet, 383(9915), 449–457. https://doi.org/10.1016/S0140-6736(13)62299-0
68. Diing Majok, J., & Kindersley, N. (2020). COVID-19 in South Sudan's Borderlands: A view from Northern Bahr el-Ghazal |. Rift Valley Institute. http://riftvalley.net/publication/covid-19-south-sudans-borderlands-view-northern-bahr-el-ghazal
69. Fairhead, J. (2016). Understanding Social Resistance to the Ebola Response in the Forest Region of the Republic of Guinea : An Anthropological Perspective. African Studies Review, 59(3), 7–31. https://doi.org/10.1017/asr.2016.87
70. Transcript of SRSG and Head of UNMISS Press Conference on COVID-19. (2020, May 7). UNMISS. https://unmiss.unmissions.org/transcript-srsg-and-head-unmiss-press-conference-covid-19

71. Sahar Atrache. (n.d.). A Crisis on Top of a Crisis: COVID-19 Looms over War-Ravaged Idlib. Refugees International. Retrieved 15 June 2020, from https://www.refugeesinternational.org/reports/2020/4/27/a-crisis-on-top-of-a-crisis-covid-19-looms-over-war-ravaged-idlib
72. 3500 displaced people successfully relocated by UNMISS and humanitarian agencies. (2018, September 4). UNMISS. https://unmiss.unmissions.org/3500-displaced-people-successfully-relocated-unmiss-and-humanitarian-agencies
73. South Sudan: Vulnerability Verification and Return Intentions Mangateen IDP Collective Site Juba | April 2020 - South Sudan. (n.d.). ReliefWeb. Retrieved 15 June 2020, from https://reliefweb.int/report/south-sudan/south-sudan-vulnerability-verification-and-return-intentions-mangateen-idp
74. Manyang David Mayar. (n.d.). South Sudan Officials, COVID Task Force Test Positive for Virus | Voice of America—English. Retrieved 15 June 2020, from https://www.voanews.com/africa/south-sudan-focus/south-sudan-officials-covid-task-force-test-positive-virus
75. John Tanza. (n.d.). South Sudan's Senior Officials Test Positive for Coronavirus | Voice of America—English. Retrieved 15 June 2020, from https://www.voanews.com/africa/south-sudan-focus/south-sudans-senior-officials-test-positive-coronavirus
76. Editor, E. (2020, May 22). Reports: South Sudan President Kiir rushed to Cairo over COVID 19. East African Business Week. https://www.busiweek.com/reports-south-sudan-president-kiir-rushed-to-cairo-over-covid-19/
77. Ekzayez, A., al-Khalil, M., Jasiem, M., Al Saleh, R., Alzoubi, Z., Meagher, K., & Patel, P. (2020). COVID-19 response in northwest Syria: Innovation and community engagement in a complex conflict. Journal of Public Health, fdaa068. https://doi.org/10.1093/pubmed/fdaa068
78. Jaspars, S. (2020, May 4). Going Remote: Learning from Aid Practices in Somalia and Sudan for the Covid-19 Crisis. African Arguments. https://africanarguments.org/2020/05/04/going-remote-learning-from-aid-practices-in-somalia-and-sudan-for-the-covid-19-crisis/
79. Duclos, D., Ekzayez, A., Ghaddar, F., Checchi, F., & Blanchet, K. (2019). Localisation and cross-border assistance to deliver humanitarian health services in North-West Syria: A qualitative inquiry for The Lancet-AUB Commission on Syria. Conflict and Health, 13(1), 20. https://doi.org/10.1186/s13031-019-0207-z
80. HIV/AIDS: Community models of care explained | MSF. (n.d.). Médecins Sans Frontières (MSF) International. Retrieved 16 June 2020, from https://www.msf.org/hivaids-community-models-care-explained
81. Tabar, L. (2016). Disrupting Development, Reclaiming Solidarity: The Anti-Politics of Humanitarianism. Journal of Palestine Studies, 45(4), 16–31. https://doi.org/10.1525/jps.2016.45.4.16
82. Change, C. for. (n.d.). Charter for Change. Charter for Change. Retrieved 16 June 2020, from https://charter4change.org/
83. World Health Organization. (2020). Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings: Interim guidance, 17 April 2020. World Health Organization; WHO IRIS. https://apps.who.int/iris/handle/10665/331777
84. By refugees, for refugees: Refugee leadership during COVID-19, and beyond | Kaldor Centre. (n.d.). Retrieved 15 June 2020, from https://www.kaldorcentre.unsw.edu.au/publication/refugees-refugees-refugee-leadership-during-covid-19-and-beyond
85. Moro, L., Pendle, N., Robinson, A., & Tanner, L. (n.d.). Localising humanitarian aid during armed conflict Learning from the histories and creativity of South Sudanese NGOs. LSE.
86. Antara, L., & El-Helou, Z. (2018). Political Participation of Refugees: The Case of Syrian Refugees in Lebanon. International Institute for Democracy and Electoral Assistance (International IDEA). https://doi.org/10.31752/idea.2018.11
87. Taylor, D. (2020, March 25). Covid-19: Call for fast-track registration of refugee doctors in UK. The Guardian. https://www.theguardian.com/world/2020/mar/25/covid-19-call-for-fast-track-registration-of-refugee-doctors-in-uk
88. Honein-AbouHaidar, G., Noubani, A., El Arnaout, N., Ismail, S., Nimer, H., Menassa, M., Coutts, A. P., Rayes, D., Jomaa, L., Saleh, S., & Fouad, F. M. (2019). Informal healthcare provision in Lebanon: An adaptive mechanism among displaced Syrian health professionals in a protracted crisis. Conflict and Health, 13(1), 40. https://doi.org/10.1186/s13031-019-0224-y
89. Kindersley, N. (n.d.). Responding to COVID-19 in South Sudan: Making local knowledge count | Rift Valley Institute. Retrieved 16 June 2020, from http://riftvalley.net/publication/responding-covid-19-south-sudan-making-local-knowledge-count
90. Richards. (n.d.). Preparing for Covid-19 in Africa—African Arguments. Retrieved 16 June 2020, from https://africanarguments.org/2020/03/30/preparing-for-Covid-19-in-africa/
91. Reidy, E. (2020, April 17). How COVID-19 is being exploited to harden migration policies. The New Humanitarian. https://www.thenewhumanitarian.org/analysis/2020/04/17/coronavirus-global-migration-policies-exploited
92. Parker, M., Hanson, T. M., Vandi, A., Babawo, L. S., & Allen, T. (2019). Ebola, community engagement, and saving loved ones. The Lancet, 393(10191), 2585. https://doi.org/10.1016/S0140-6736(19)31364-9
93. MacGregor, H., Leach, M., Wilkinson, A., & Parker, M. (n.d.). COVID-19 – a social phenomenon requiring diverse expertise. Retrieved 16 June 2020, from https://www.ids.ac.uk/opinions/covid-19-a-social-phenomenon-requiring-diverse-expertise/
94. Veran, J.-F., Burtscher, D., & Stringer, B. (n.d.). Médecins Sans Frontières and Humanitarian Situations: An Anthropological Exploration. Taylor & Francis Ltd. Retrieved 22 June 2020, from https://www.routledge.com/Medecins-Sans-Frontieres-and-Humanitarian-Situations-An-Anthropological/Veran-Burtscher-Stringer/p/book/9780367419998

95. Palmer, J. (2020). Summary report on doing community engagement at a distance. Hygiene Hub. http://resources.hygienehub.info/en/articles/4028628-summary-report-on-doing-community-engagement-at-a-distance
96. Anthrologica. (n.d.). Compliance with Physical Distancing Measures for COVID-19 and Implications for RCCE in Eastern and Southern Africa. SSHAP. Retrieved 30 June 2020, from http://www.socialscienceinaction.org/resources/compliance-physical-distancing-measures-covid-19-implications-rcce-eastern-southern-africa-april-2020/
97. Bashair, A., & Asquith, P. (2020, May 22). Love (from Afar) in the Time of Covid-19: Diaspora Humanitarianism and Pandemic Response. African Arguments. https://africanarguments.org/2020/05/22/love-from-afar-in-the-time-of-covid-19-diaspora-humanitarianism-and-pandemic-response/
98. URBAN REFUGEES | Raising the voice of the invisible. (n.d.). Retrieved 15 June 2020, from http://www.urban-refugees.org/
99. Global Refugee-led Network – Take the refugee participation pledge now. (n.d.). Retrieved 16 June 2020, from https://www.globalrefugeelednetwork.org/
100. Global Refugee-led Network. (n.d.). Meaningful Refugee Participation Guidelines_Web. Retrieved 16 June 2020, from https://asylumaccess.org/wp-content/uploads/2019/12/Meaningful-Refugee-Participation-Guidelines_Web.pdf
101. Barbelet, V. (2019). Rethinking capacity and complementarity for a more local humanitarian action (HPG Report). ODI.
102. Commitments into Action: A holistic and coherent response to COVID-19 across the Humanitarian-Development-Peace Nexus | IASC. (n.d.). Retrieved 15 June 2020, from https://interagencystandingcommittee.org/humanitarian-development-collaboration/commitments-action-holistic-and-coherent-response-covid-19
103. UN Security Council Fails to Support Global Ceasefire, Shows No Response to COVID-19. (2020, May 19). International Rescue Committee (IRC). https://www.rescue.org/press-release/un-security-council-fails-support-global-ceasefire-shows-no-response-covid-19

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If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviatulloch@anthrologica.com). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).

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