Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

World Development 139 (2021) 105311

Contents lists available at ScienceDirect

World Development

journal homepage: www.elsevier.com/locate/worlddev

Research Notes

Localising Public Health: Refugee-led organisations as first and last responders in COVID-19

Alexander Betts [a], Evan Easton-Calabria [a,*], Kate Pincock [a,b]

[a] University of Oxford, UK
[b] Overseas Development Institute, UK

ARTICLE INFO

Article history:
Available online 24 November 2020

Keywords:
Refugee Studies
Localisation
Refugee-led organisations
Participatory assistance
COVID-19
East Africa

ABSTRACT

The COVID-19 pandemic and ensuing socioeconomic impact on already marginalised refugee communities demonstrate both the need for, and lack of, localisation in humanitarian and development responses. Our research with organisations founded and led by refugees, termed here refugee-led organisations (RLOs), in camps and cities in Kenya and Uganda shows their potential to be an asset in the response to COVID-19 and in contributing to more effective and participatory forms of humanitarian assistance. In this research note we draw on pre-pandemic research with around 80 RLOs and follow-up research with 15 in Uganda and Kenya who are actively responding to the pandemic and its effects. We identify five key areas in which refugees are or could be involved as responders to COVID-19 and other pandemics: providing public information, supplementing capacity gaps, healthcare delivery, shaping social norms, and virus tracking and contact tracing. Our research during COVID-19 shows how RLOs have pivoted their existing service provision to fill assistance gaps, including in areas directly related to public health. As the humanitarian system searches for ways to implement remote and participatory approaches to refugee assistance, RLOs offer great potential, if mechanisms can be found to identify those that are effective, provide them with funding, and build their capacities.

1. Introduction

Many of the most devastating consequences of COVID-19 are likely to unfold in the Global South. In areas with densely populated slums, weak public health systems, and poor sanitation, the type of preventive measures adopted by wealthier countries are proving extremely challenging to implement. There have also been claims that many crisis-affected countries are 'fighting the epidemic in the dark', due to a lack of testing and limited access to data on the pandemic (IRC, 2020). While Uganda and Kenya, the sites of our fieldwork, have both recorded very low cases and death rates – 101 and 902 deaths respectively at the time of writing (WHO, 2020a, WHO, 2020b) – there are concerns that many cases go unrecorded. At the same time, the swift actions taken by both the Government of Uganda and the Government of Kenya, including a strict lockdown in March 2020, effectively slowed the rate of transmission. However, as with many other countries, lockdown had adverse economic consequences, which have disproportionately affected the most vulnerable.

Reports suggest that in the face of these compounding factors among those most seriously affected are refugees (CGD, 2020), 85% of whom live in low- and middle-income countries (Furhman et al., 2020). In refugee camps, self-isolation and social distancing are nearly impossible, misinformation is endemic, and humanitarian presence has been reduced due to the suspension of international non-governmental organisation (NGO) missions (NRC, 2020). In cities, amid food shortages created by lockdown, refugees have often been excluded from government food distributions.

In ordinary circumstances, organisations created and led by refugees themselves (termed here refugee-led organisations, or RLOs) play an important role in meeting community needs (Pincock et al., 2020a).[1] Our existing research has shown that refugee-led social protection – defined as activities designed to reduce populations' poverty, vulnerability, or risk that are provided

* Corresponding author at: Refugee Studies Centre, University of Oxford, 3 Mansfield Road, OX3 1TB Oxford, UK.
E-mail addresses: alexander.betts@qeh.ox.ac.uk (A. Betts), evan.easton-calabria@qeh.ox.ac.uk (E. Easton-Calabria).

[1] Due to the scope of fieldwork, this paper focuses on refugee-led organisations rather than on those led by internally displaced people or other forcibly displaced people. While isolated research exists on informal social mechanisms of IDPs (e.g. Abadi 2020), to our knowledge there has not been comprehensive mapping of organisations led by forcibly displaced people more broadly.

https://doi.org/10.1016/j.worlddev.2020.105311
0305-750X/

by organisations or networks created by refugees – are frequently perceived to be among the most important sources of assistance by refugee communities (ibid.). Such activities are a key part of the social security apparatus of refugee camps and urban refugee communities, providing crucial services, from informal education to savings mechanisms, and even health services. In some contexts, United Nations (UN) agencies and NGOs use RLOs as a 'bridge' to work with communities, but this engagement is sporadic, and there are no clear international policy guidelines on how to do this equitably, systematically, and effectively.

As COVID-19 spread, humanitarian organisations have struggled to respond effectively to the needs of refugees, and RLOs have frequently found themselves as default providers of assistance and mutual aid, but usually without additional or effective support from international organisations and NGOs. These developments underscore the urgency of situating RLOs within ongoing and longstanding debates on 'localisation' (i.e. the transfer of humanitarian and development funds, as well as agency and responsibility, to national and local actors). However, a criticism of RLOs is that they lack capacity to deliver at scale. In many cases, this is a fair criticism. They face a chicken-and-egg dilemma, unable to secure the resources to enable them to build capacity through growing in both scope and size. A main constraint is that donor governments are reluctant to engage in direct funding given, for example, many RLOs' inability to meet fiduciary and auditing requirements. And RLOs are only one of many segments of civil society cut off from funding opportunities: despite the humanitarian Grand Bargain's commitment to 'localise' 25% of humanitarian funding, less than 2% currently goes through national organisations, and less than 0.2% goes through local grassroots organisations (Singh & Mollett, 2019).

Yet despite these barriers in accessing available funding and overall funding shortages, RLOs serve members of their communities in significant ways. However, little discussion of the COVID-19 pandemic has explored locally-led responses, and the work of affected communities themselves has been largely off the radar. The COVID-19 pandemic and the mobilisation of RLOs to address its impact on refugees highlights the powerful role RLOs can play in public health response, as well as complementary areas such as food distribution and basic service provision.

This research note draws upon a combination of completed pre-pandemic research and ongoing in-pandemic research. During 2018 and 2019, we undertook qualitative research covering around 80 RLOs in cities and camps in Uganda (Nakivale and Kampala) and Kenya (Kakuma and Nairobi), using a mixture of semi-structured interviews, focus groups, and participant observation undertaken with RLO staff and beneficiaries, and covering a range of social protection and other activities. This research has been published in a variety of peer-reviewed outputs (e.g. Pincock et al., 2020a,b; Betts et al. 2020). Recognising the growing relevance of RLOs during COVID-19, we have embarked on a series of follow-up studies, with a particular focus on RLO-led public health and livelihoods activities in the context of the pandemic. This research has now taken on a longitudinal dimension, using qualitative and quantitative methods to follow a series of RLOs and their beneficiary populations over time, initially within East Africa. We will publish interim results in report form in 2021.

So far, we have completed initial remote qualitative research as the basis for this longitudinal study, undertaking interviews and focus groups with key staff at 15 RLOs involved in our original study that are actively involved in providing COVID-19-related support services. Even though the in-pandemic research is ongoing and we have yet to implement survey-based data collection, the research offers provisional insights of immediate practical relevance for COVID-19 related public health delivery in refugee-hosting contexts. As of yet, we have been unable to reach many RLOs' beneficiaries remotely, which would allow us to better understand the impact of their work during the pandemic; we have therefore focused this paper on RLOs' roles and potential impacts, which are strengthened through secondary sources that indicate their significance as first responders during crises. Table 1 below presents an overview of these organisations and their activities both prior to and during the COVID-19 pandemic.

Our data inductively reveals the type and scale of public health-related activities undertaken by RLOs in the context of COVID-19 and provides a sense of their impact on beneficiary populations. One of the key preliminary findings is a notable and growing focus on public health-related activities. We suggest that even this preliminary qualitative research demonstrates the significant and neglected potential of RLOs to complement international public health and wider humanitarian responses to the pandemic. We observe five important public health functions that RLOs are playing, and have the potential to play at increased scale. However, we further suggest that maximizing the potential contribution of RLOs will depend upon creating new mechanisms to rapidly identify, fund, and build capacity among RLOs.

2. Research background

Existing research underscores the gap and the necessity of increasing refugees' access to public health information (Fuhrman et al., 2020). Refugee and IDP populations are particularly vulnerable to transmission due to limited cross-cultural communication, language barriers, inaccessible and under-funded health services, and the inexperience of organisations working with refugees in responding to epidemics (Truman et al., 2009). This is reflected in work on the challenges facing refugees in accessing healthcare more generally, which highlights culturally insensitive care, and inadequate provision of interpreters, as serious practical barriers (Langlois et al., 2016). Whilst this literature focuses on refugees in the global north, an IOM-commissioned report (Ahmed & Dibb 2008) on Sudanese migrants' needs and preparation for a pandemic in Cairo, Egypt, also found that limited access to information on an influenza pandemic increased the risk of transmission.

Related work has highlighted refugees' particular roles in the context of epidemics. In Tanzania, refugee health workers have played important roles in promoting HIV knowledge and safer practices (Tanaka et al., 2004; Tanaka et al., 2008). In Guinea, refugees trained as lay health workers in refugee camps were shown to be effective in promoting behavioural change relating to sexual and reproductive health and HIV treatment amongst displaced populations (Chen et al., 2008; Howard et al., 2008, 2011; Woodward et al., 2011). This literature largely treats refugees as a means through which international organisations can engage communities (Ehiri et al., 2014).

These positive effects of refugees' involvement in health service delivery are due to two main factors: community health workers share life experiences and backgrounds with service users, and this builds trust. Health workers who are themselves from affected communities also understand how to deliver health information and care in ways that are culturally appropriate (O'Brien & Gostin, 2011). This can avoid 'othering' of refugees within host country health services, which has been found in different settings to worsen refugee health outcomes but can be mitigated by integrating their experiences and narratives within healthcare approaches (Grove & Zwi, 2006). These findings align with broader work on refugees' reliance on social networks for social and economic support (Grabska, 2005; De Vriese, 2006; Palmgren, 2014; Omata, 2017; Betts, Omata, & et al, 2020). This mirrors our own research findings which show the importance of cultural proximity as a means through which RLOs build trust with the communities they assist (Pincock et al., 2020a).

Table 1
Overview of Refugee-led Organisations.

Organisation	General activities	Activities to address COVID-19 and secondary impacts
Kenya		
L'Afrikana	Vocational training in tailoring and crafts, youth groups, school feeding programme, community technology access in Nairobi.	Awareness-raising messages sent to the refugee community through the WhatsApp and Facebook platforms created for that purpose; making and distributing masks to members of the community; distributing food to a limited number of the most vulnerable people in the community.
YUSOM (Youth United for Social Mobilisation)	Skills development for youth in Kenya and Somalia.	Awareness-raising about the virus in Eastleigh, Nairobi; awareness-raising photo campaign on social media; writing blogs on a refugee platform to fight Covid-19.
Kintsugi	Membership organisation, operates on monthly contributions from members to help vulnerable in community with basic needs and scholarships for skills training in Nairobi.	Door to door food, face mask and sanitizer distribution to 6000 refugees and host community members with a focus on the most vulnerable households; sensitisation of community leaders about the virus and how/where they could get assistance.
African Youth Initiative for Development (AYID)	Provides capacity building on legal matters, economics, and gender empowerment to fellow refugees.	Providing vulnerable refugee community members with information, including translating materials into native languages; distributing PPE; assisting most vulnerable households with food, sanitizing materials, masks, soaps, and other essentials.
South Sudan United Refugee Association (SSURA)	SSURA seeks to represent the rights of South Sudanese refugees in Uganda. This includes teaching Sudanese refugees living in Arua Ugandan laws and code of conduct to try and prevent conflicts and violence from arising between refugees and host communities.	Awareness raising (especially for elderly and the sick); liaising with agencies over urban refugees' access to food rations in settlements in the West Nile region.
Kadana Refugee Network	Human rights monitoring; promotes social cohesion between refugees and hosts through activities including sport; offers law and human rights monitoring trainings with Kenya National Human Rights Commission	Awareness, sensitisation, advocacy with agencies and government for targeted support for refugees
Uganda		
Somali Community Association	Promoting community interests through advocacy, also organizes youth groups, women's groups in Kampala	Sensitization and awareness campaign concerning spread and prevention of COVID-19 via Whatsapp and online; encouraging social distancing in cases where personal support is needed; established an emergency team which reports urgent cases to the government task force for responses; lobbying the government's COVID-19 task force to include refugee communities in food distribution especially during Ramadan and to vulnerable households who lack access to food rations
Hope for Refugees in Action	Empowering refugees through leadership training, capacity development in Kampala	COVID-19 sensitisation
Hope for Women and Children Victims of Violence (HOCW)	Programs in healthcare, education and social entrepreneurship in Kampala	Food distribution
One Youth One Heart Initiative	Education and self-reliance promotion among young people in Kampala and rural refugee settlements.	Distributed food items (10 kg of maize flour) and hand soap to 120 refugee households; sanitizers are distributed with mobile money cash transfers.
YARID (Young Africa Refugees for Integral Development)	Supports urban refugees through sports, English classes, and vocational skills training to address social challenges like ethnic conflict, unemployment, public health, and lack of access to education.	Food distribution to over 800 refugees
Bondeko Refugee Livelihoods Centre	Emergency shelter and livelihoods organisation (mushroom-growing, English classes, business classes)	Distributed food and emergency cash to refugee household members of the centre
Global Society Initiative for Peace and Democracy (GLOSIPAD)	South Sudanese humanitarian group working in camps and urban areas on GBV, human rights, documentation, peace-building and advocacy	Awareness-raising to refugee communities to observe public preventive measures on hygiene and sanitation in camps
Wakati Foundation	Construction and other livelihoods training, sensitization about peace and non-discrimination to youth.	Sewing masks for refugees
Centre for Peace and Advocacy	South Sudanese group for peace and reconciliation, advocacy	Online survey to learn about refugees' household assets, support, and access to needed supplies
Community Empowerment for Creative Innovation (CECI)	Trains youth in conflict management and resolution, trauma healing, and entrepreneurial and vocational skills to encourage self-reliance and support peace and development at the grassroots level.	Raising local community awareness about COVID-19 prevention and safety guidelines among refugee communities, through both online and offline channels; translated information, education, and communication (IEC) materials into refugees' native languages; putting up 800 COVID-19 Prevention Posters in local languages in key areas; created and shared awareness-raising videos on Facebook, Twitter, and YouTube about COVID-19 and the situation faced by refugees (especially urban refugee women and girls) during the pandemic.

3. Localisation in the context of COVID-19

As the significance of the COVID-19 pandemic became clearer, some refugee organisations in Uganda and Kenya quickly mobilised. Amid COVID-19 lockdown and related food shortages in Uganda, the RLO Hope of Children and Women (HOCW) has been distributing food and soap to refugees and Ugandans in the Ndejje area of Kampala. South Sudanese refugees in the West Nile Region have called upon refugee organisations to develop a coordinated COVID-19 response (Interview, CECI, 12 April 2020). In Nairobi,

the organisation Youth United for Social Mobilisation (YUSOM) are running information campaigns to raise COVID-19 awareness among refugees. The following sections highlight the key roles of RLOs in the face of COVID-19, including other areas in which RLOs could be key 'first responders'.

4. Public information

Illustrating the broader global 'infodemic' of false information regarding COVID-19 (WHO et al., 2020), one of the biggest issues in refugee camps is countering misinformation. Myths about COVID-19 abound, and the effectiveness of mass communication campaigns is likely to be affected by how socio-culturally embedded they are (WHO, 2008; Scott et al., 2018). In some camps rumours have spread that Westerners including aid workers have brought the virus to Sub-Saharan Africa (Personal communication, 2020), echoing findings that the threat of disease can increase levels of ethnocentrism and intolerance towards so-called 'out-groups' (Van Bavel et al., 2020). Community-level intermediaries thus have a crucial role to play in ensuring that accurate knowledge reaches communities. In Uganda, there are established networks within many refugee camps that can be deployed by international organisations, including refugee welfare committees and community outreach workers (Vancluysen & Ingelaere, 2020). Where gaps exist in these networks, RLOs can play a crucial role in ensuring the most marginalized refugees are included in health messaging.

10 out of the 15 organisations we contacted are spreading awareness about COVID-19 and how to prevent infection through messages on Whatsapp group, mass texts, posters, and even Youtube videos shared on social media. The Community Development Centre, a refugee-led organisation operating in camps in the West Nile, Northern Uganda, has adapted an existing information campaign called Hagiga Wahid (meaning 'One Truth' in Arabic) to dispel rumours about COVID-19 and provide official health information via text messaging. As the project already had hundreds of subscribers across several camps, it was able to quickly and effectively provide information in ways that formal humanitarian institutions have struggled to do.

Another RLO in the Koboko settlement in the West Nile region is the Community Empowerment for Creative Innovation (CECI), which focuses on peacebuilding and education. As COVID-19 entered Sub-Saharan Africa, CECI quickly shifted focus to increase awareness. The founder explained,

At the moment, CECI is running on and offline COVID-19 prevention community sensitization programs through video clips and COVID-19 materials translated into local languages spoken by refugees. So far, we've reached over 1000 refugees communities both online and offline within 2 months. We're also soliciting resources from donors and NGOs to provide food supplies to most vulnerable refugee families in Koboko to enable[e] them to cope during these trying moments since refugees can no longer go to collect food rations from refugee camps due to public and private transport bans. Additionally, starting next week our teams will be distributing and pinning on walls, entrance and exit points of markets, hospitals, clinics and water points 300 COVID-19 prevention posters translated into Bari to improve refugees access to reliable information about the coronavirus disease. (Interview, 24 June 2020)

The organisation's founders feel that CECI has had success in spreading awareness about COVID-19 due to the strong community links it had already forged through its normal work. In addition to the work it has done in person, it shares regular information on its Facebook page, which has over 2000 followers, and twitter, where it has nearly 400. Through clips of members speaking about how to properly wash hands and socially distance, the organisation is able to share messages with members as trusted voices.

5. Supplementing capacity gaps

With many senior humanitarian staff absent from refugee camps and aid budgets under threat, social services in camps may become stretched across a range of sectors (e.g. education, food distribution, and water and sanitation). Finding ways to deliver these essential services, while trying to observe social distancing, will require local staff and volunteers to play an important role. RLOs and informal groups can be effective actors for this type of work – in part because they are already undertaking it themselves.

Between 2017 and 2019, we integrated a series of questions on refugees' sources of social protection into a broader survey on refugees' economic lives, with a sample size of over 5000 refugees for Uganda and Kenya. We asked, 'Who would you ask if you are looking for money for an emergency, for example to purchase medicine?' 90% said that they would first turn to community-level support, including community-based organisations, rather than larger international organisations or financial lenders. We found similar response levels relating to community sources of other forms of social protection such as the need for money or employment (Pincock et al., 2020a). This points to RLOs playing a significant role in 'bridging' gaps in healthcare and assistance, as well as the relative capacity some already have compared to individual refugees.

Equally crucial is conducting advocacy to alert agencies of needs and gaps in capacity and other responses. Leaders of RLOs were among the first to speak out about the needs of urban refugees when Uganda went into lockdown on March 31st. In contrast to refugees in camps, most urban refugees do not receive humanitarian assistance, meaning most survive on petty trade as informal street hawkers – livelihoods which lockdown immediately restricted. Given this, some refugees report being less afraid of the virus than of its secondary consequences: restricted access to food, medicine, and basic services. In Kampala, for example, many refugees face severe food shortages because of the lockdown. The government initially announced on national television that 'refugees should be in the camps' and that 'non-nationals will not get food aid' except in refugee camps (Betts, Easton-Calabria, & et al., 2020). While this was ultimately rescinded, RLOs immediately began organising to raise money and deliver food to their members. The RLO Hope for Children and Women Victims of Violence ordinarily supports around 1300 refugees a year through vocational training, psychosocial support and English lessons. In the current crisis, it has been distributing food and soap to refugees and Ugandans in the Ndejje area of Kampala, with over 400 beneficiaries. Meanwhile, Young African Refugees for Integral Development (YARID), an award-winning organisation for refugee assistance,[2] has distributed baskets of flour, soap, beans, sugar, and cooking oil to the most vulnerable in the community. It has identified recipients through community networks, and delivered food on bodaboda (motorcycle taxi) where needed. So far it has provided this support to more than 200 households.

6. Healthcare delivery

In recent years, community health workers (CHWs) have been recognised as key actors in health delivery in developing countries

[2] In 2016 YARID won the Ockenden International Prize for excellence in self-reliant refugee projects.

(WHO, 2008). As noted earlier, they have been increasingly used in refugee settings, providing important local level support to public healthcare systems. CHWs can be rapidly trained, affordably equipped, and play a range of roles from public information to tracking, as well as providing basic preventive, promotional, and rehabilitative support. Some refugees are also formally trained doctors, nurses, and other medical professionals, though many face restrictions on their ability to practice in their host countries. In our previous research, we found medically trained refugees working with communities who were unable to access treatment elsewhere due to barriers including discrimination and lack of transportation. However, many were unable to legally practice due to barriers such as document translation and licensing, and thus worked in an informal capacity (Pincock et al., 2020a).

Health services for refugees in Uganda are provided through integrated humanitarian and development funding, meaning that refugees are in theory able to use the same public and private health facilities as local people. However, refugee access to healthcare is restricted by practical barriers including under-resourced services, which makes it difficult to handle the high disease burden in rural areas (Komakech et al., 2019). In cities, other challenges include inadequate information and awareness about the availability of services, and an inability to pay for treatment or transport (Langlois et al., 2016).

A refugee working at an RLO called the Bondeko Center Refugee Livelihoods Centre in the outskirts of Kampala was a trained nurse in the Democratic Republic of Congo yet is prevented from practising as a nurse in Uganda due to the cost of becoming re-certified. He emphasised, however, that he and his fellow refugee nurses could be tremendous assets to the refugees at Bondeko Center, as well as to Ugandans in the area, if they were to receive support to treat instead of just educate refugees. Describing a health training offered by InterAid, the main implementing partner in Uganda of UNHCR (the UN Refugee Agency) prior to the outbreak of COVID-19, he said,

InterAid gathered all the refugee nurses for a meeting but trained us only to sensitise refugees in malaria.... refugees must go all the way to InterAid just to get paracetamol. Or they go and wait two days to go to Mulago [Uganda's national referral hospital] for malaria. But there are many nurses here. We can diagnose and treat from right here at the Center!

Although sensitisation on health issues is a valuable contribution to communities, the main health challenge cited by refugees is obtaining medicine and treatment at hospitals and clinics.

Given the known gaps in numbers of medical personnel and resources on the front line of the COVID-19 pandemic in the global South, specifically equipping refugee community health workers with the knowledge and skills to raise awareness about preventing transmission of COVID-19 and its symptomology may be an opportunity to limit the spread of the virus. Indeed, there is a precedent for this, with Mexico recently starting to work with UNHCR to accelerate the licensing of foreign-trained medical practitioners, including approximately 100 refugees. There are also calls in Western countries of asylum to allow refugees to enter the medical workforce (UNHCR, 2020). In instances where this is not formally possible, there is value in raising further awareness of – and legalizing – the support that refugee health workers deliver to their own community, such as in Turkey where Syrian physicians can assist fellow Syrians (Özdemir et al., 2017).

7. Shaping social norms

RLOs may also play a role in shaping social norms that limit transmission of COVID-19. In wealthier countries, governments are using behavioural economics to design interventions that shape social compliance with public health policies. States in the global North have access to big data and top social scientists to design responses adapted to cultural context. This approach is not readily available in many humanitarian settings. In refugee camps, shaping social norms relies upon building trust. We already know from previous research that refugees consistently say that they rely on community-level support as much, if not more so, than international aid. Refugee-led organisations and initiatives are aware of community needs and appropriate responses because they are *part of* these communities; the trust they foster is generally borne from close, regular contact rather than one-off interventions, suggesting that guidance provided from them on COVID-19 may be more effectively received and adhered to. More research is needed on how community-level trust, legitimacy and authority are affected in the context of pandemics (Vaughan & Tinker, 2009).

8. Virus tracking and contact tracing

In contexts in which social distancing is inhibited by dense and open housing, epidemiological tracking of the virus' spread becomes even more important. Many humanitarian organisations have equipped displaced populations with mobile technology and apps capable of community-level reporting, on issues from the functioning of boreholes to school attendance and birth registration. Communities have a role to play in supporting virus tracking. Many RLOs have contact details of hundreds of their refugee members, which they are already using to spread awareness and, in at least one instance, send funds for food via mobile money. Some refugees live clandestinely in cities, meaning they risk being overlooked in formal monitoring programmes.

RLOs have the potential to serve tracking functions, capable of interfacing with both communities and formal authorities to share information anonymously while retaining trust. However, this role has risks that must be carefully mediated. These include the concern that if outbreaks were identified within refugee communities, this could be used to justify stigmatizing public health controls which further restrict refugees' mobility and work. Long-term relationships which treat RLOs as equal partners with agency in the design and trajectory of data-gathering processes, and in the development of strategies to control outbreaks, must be built to sustain such trust. More research – and better transparency – will be needed to address ethical questions relating to the storage, use and long-term consequences of sharing data if RLOs are to promote contact tracing.

9. Conclusion

COVID-19 highlights the vulnerability and marginality of refugees in low and middle-income countries. As the virus and its legacy continue to affect refugees, the challenge will remain how to respond to humanitarian needs, whether pre-existing or exacerbated by the pandemic, at a time when international capacity is stretched to its limits. Assistance may need to be more remote and participatory, and one of the humanitarian community's greatest assets is likely to be the affected communities themselves. In refugee settings – whether urban or camp-based – refugees have long mobilised to provide various forms of protection and assistance to both refugees and host communities.

Our research highlights how prior to COVID-19, RLOs in Kenya and Uganda were providing crucial sources of social protection in areas including health and livelihoods. From the perspective of the communities these were often regarded as more important than the assistance of international organisations and NGOs. Yet few RLOs received funding. Our follow-up research during COVID-19 shows how RLOs have pivoted their service provision

to fill assistance gaps, including in areas directly related to public health. As the humanitarian system searches for ways to implement remote and participatory approaches to refugee assistance, RLOs offer great potential, if mechanisms can be found to identify those that are effective, provide them with funding, and build their capacities.

CRediT authorship contribution statement

Alexander Betts: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Evan Easton-Calabria:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Kate Pincock:** Data curation, Formal analysis, Investigation, Methodology, Writing - review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors gratefully acknowledge the many refugee informants who took their time to speak with us, as well as the incredible work of refugee-led organisations who are assisting fellow refugees in myriad ways. The authors also thank the Economic and Social Research Council (ESRC) and the Arts and Humanities Research Council (AHRC) for the grant that funded the initial research this article's research built on.

References

Abadi, D. (2020) IDP-led Women's Assistance: New Roles for Traditional Groups. Rethinking Refuge Platform, Refugee Studies Centre, University of Oxford. Available at: https://www.rethinkingrefuge.org/articles/idp-led-womens-assistance-new-roles-for-traditional-groups (Accessed 1 October 2020).

Ahmed, Y., & Dibb, R. (2008). Pandemic preparedness among Sudanese migrants in greater Cairo. Centre for Migration and Refugee Studies & IOM Cairo.

Betts, A., Omata, N., & Sterck, O. (2020). Self-reliance and Social Networks: Explaining refugees' reluctance to relocate from Kakuma to Kalobeyei. *Journal of Refugee Studies, 33*(1), 62–85.

Betts, A., Easton-Calabria, E. & Pincock, K. (2020) Why refugees are an asset in the fight against coronavirus. The Conversation. 28th April 2020. Available at: https://theconversation.com/why-refugees-are-an-asset-in-the-fight-against-coronavirus-136099 (Accessed 31st May 2020).

CGD (Center for Global Development) (2020). Locked Down and Left Behind: The Impact of COVID-19 on Refugees' Economic Inclusion. Policy Paper 178, July. Available at: https://www.cgdev.org/publication/locked-down-and-left-behind-impact-covid-19-refugees-economic-inclusion (Accessed 1 September 2020).

Chen, M., von Roenne, A., Souare, Y., von Roenne, F., Ekirapa, A., Howard, N., et al. (2008). Reproductive health for refugees by refugees in Guinea II: Sexually transmitted infections. *Conflict and Health., 2*, 14.

De Vriese, M. (2006). *Refugee livelihoods: A review of the evidence*. Geneva: Evaluation and Policy Analysis Unit, UNHCR.

Ehiri, J., Gunn, J., Center, K., Li, Y., Rouhani, M., & Ezeanolue, E. E. (2014). Training and deployment of lay refugee/internally displaced persons to provide basic health services in camps: A systematic review. *Global Health Action, 7*(1), 23902.

Fuhrman, S., Kalyanpur, A., Friedman, S., & Tran, N. T. (2020). Gendered implications of the COVID-19 pandemic for policies and programmes in humanitarian settings. *BMJ Global Health, 5*(5) e002624.

IRC (2020). Press Release: As confirmed COVID cases more than double in July across African countries, a lack of testing in crisis-affected contexts keeps responders in the dark about the real spread of the disease, warns IRC Available at: Https://www.rescue-uk.org/press-release/confirmed-covid-cases-more-double-july-across-african-countries-lack-testing-crisis.

Grabska, K. (2005). Living on the Margins: The Analysis of the Livelihood Strategies of Sudanese Refugees with Closed Files in Egypt. Working Paper No. 6, Forced Migration and Refugee Studies. Cairo: American University in Cairo.

Grove, N. J., & Zwi, A. B. (2006). Our health and theirs: forced migration, othering, and public health. Social Science & Medicine (1982), 62(8), 1931–1942. https://doi.org/10.1016/j.socscimed.2005.08.061

Howard, N., Kollie, S., Souare, Y., von Roenne, A., Blankhart, D., Newey, C., et al. (2008). Reproductive health services for refugees by refugees in Guinea I: Family planning. *Conflict and Health., 2*, 12.

Howard, N., Woodward, A., Souare, Y., Kollie, S., Blankhart, D., von Roenne, A., et al. (2011). Reproductive health for refugees by refugees in Guinea III: Maternal health. *Conflict and Health., 5*, 5.

Komakech, H., Atuyambe, L., & Orach, C. G. (2019). Integration of health services, access and utilization by refugees and host populations in West Nile districts, Uganda. *Conflict and Health, 13*, 1.

Langlois, E., Haines, A., Tomson, G., & Ghaffar, A. (2016). Refugees: Towards better access to health-care services. *The Lancet, 387*(10016), 319–321.

NRC (2020) Covid 19 restrictions preventing thousands from accessing livesaving aid. Norwegian Refugee Council. Available at: <https://www.nrc.no/news/2020/march/covid19-restrictions/> (Accessed 31st May 2020).

O'Brien, P., & Gostin, L. O. (2011). *Health worker shortages and global justice*. New York: Milbank Memorial Fund.

Omata, N. (2017). *The myth of self-reliance: Economic lives inside a liberian refugee camp*. Oxford: Berghan Books.

Özdemir, V., Kickbusch, I., & Coşkun, Y. (2017). Rethinking the right to work for refugee Syrian healthcare professionals: A call for innovation in global governance. *BMJ, 357*. https://doi.org/10.1136/bmj.j2710 j2710.

Palmgren, P. (2014). Irregular networks: Bangkok refugees in the city and region 1. *Journal of Refugee Studies, 27*(1), 21–41.

Personal communication, Refugee informants in Arua, Uganda, 2020.

Pincock, K., Betts, A., & Easton-Calabria, E. (2020a). *The Global Governed: Refugees as providers of social protection and assistance*. Cambridge UK: Cambridge University Press.

Pincock, K., Betts, A., & Easton-Calabria, E. (2020b). The Rhetoric and Reality of Localisation: Refugee-Led Organisations in Humanitarian Governance. *The Journal of Development Studies*, 1–16.

Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., et al. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human Resources for Health, 16*(1), 39.

Singh, S. & Mollett, H. (2019) Grand Bargain 3 years on: not enough progress on localisation. BOND Network. Available at: <https://www.bond.org.uk/news/2019/07/grand-bargain-3-years-on-not-enough-progress-on-localisation> (Accessed 31st May 2020).

Tanaka, Y., Kunii, O., Okumura, J., & Wakai, S. (2004). Refugee participation in health relief services during the post-emergency phase in Tanzania. *Public Health, 118*, 50–61.

Tanaka, Y., Kunii, O., Hatano, T., & Wakai, S. (2008). Knowledge, attitude, and practice (KAP) of HIV prevention and HIV infection risks among Congolese refugees in Tanzania. *Health and place, 14*(3), 434–452.

Truman, B. I., Tinker, T., Vaughan, E., Kapella, B. K., Brenden, M., Woznica, C. V., et al. (2009). Pandemic influenza preparedness and response among immigrants and refugees. *American Journal of Public Health, 99*, 278–286.

Van Bavel, J. J., Baicker, K., Boggio, P. S., Capraro, V., Cichocka, A., Cikara, M., et al. (2020). Using social and behavioural science to support COVID-19 pandemic response. *Nature Human Behaviour*, 1–12.

Vancluysen, S., & Ingelaere, B. (2020). Conflict resolution as cultural brokerage: How refugee leaders mediate disputes in Uganda's refugee settlements. *Journal of Refugee Studies*.

Vaughan, E., & Tinker, T. (2009). Effective health risk communication about pandemic influenza for vulnerable populations. *American Journal of Public Health, 99*, 324–332.

WHO (2008). The World Health Report 2008: Primary Health Care - now more than ever. Vol. 26. Geneva: World Health Organization. Available from: <http://www.who.int/whr/2008/whr08_en.pdf> (Accessed 20th May 2020).

WHO, UN, UNICEF, UNDP, UNESCO, UNAIDS, ITU, UN Global Pulse, and IFRC (2020). Managing the COVID-19 infodemic: Promoting healthy behaviours and mitigating the harm from misinformation and disinformation. Joint statement by WHO, UN, UNICEF, UNDP, UNESCO, UNAIDS, ITU, UN Global Pulse, and IFRC. Available at: https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation

WHO (2020a). Uganda Global Dashboard Available at: https://covid19.who.int/region/afro/country/ug.

WHO (2020b). Kenya Global Dashboard Available at: https://covid19.who.int/region/afro/country/ke.

Woodward, A., Howard, N., Souara, Y., Kollie, S., von Roenne, A., & Borchert, M. (2011). Reproductive health for refugees by refugees in Guinea IV: Peer education and HIV knowledge, attitudes, and reported practices. *Conflict and Health, 5*, 10.