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COVID-19 and its Impact on Persons Living in Poverty: The Case of Refugees and Internally Displaced Persons in Africa

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Abstract

In response to the current global health crisis, state-sponsored repressive measures are more damaging to people who, in normal times, are already facing survival difficulties, such as poor people. This article places particular concern on the protection of the rights of refugees and internally displaced populations in some African host countries during this period of COVID-19. This analysis shows that the role played by governments and some humanitarian agencies in ensuring their survival which has become difficult due to the existence of the liberticidal mechanisms, helps to minimise the harmful impact that the implementation of the measures places on the exercise of rights and freedoms by these vulnerable people. It further addresses the challenges that compromise the effectiveness and the efficacy of their guarantee.

Keywords: Global health crisis; refugees; internally displaced persons; human rights and freedoms; liberticidal mechanisms

INTRODUCTION

As African states face a flow of internally displaced persons (IDPs); refugees and migrants [1], they are confronting simultaneously a global health crisis that decimates thousands of people regardless of status. In order to contain the evolution of COVID-19, governments are adopting measures that are imposed not only on their nationals but on any foreign person on their territory, and that restrict the exercise of their fundamental rights and freedoms. These further prejudice the enjoyment of the human rights and freedoms of refugees and the IDPs- which will be the subject-matter of this article-, because of their vulnerability which can be exacerbated in this time of cross-border health emergency, by the stigma and discrimination they are and may be victims of. The fragility of their living conditions creates specific needs that host governments have an obligation to meet in accordance with the requirements of international law which some human rights legal instruments provide for the protection of these vulnerable groups in general [2], while other texts, universally [3] and in terms of African regional human rights law [4], are specifically devoted to securing the rights of refugees and internally displaced persons, both in normal and exceptional times. The management of COVID-19 has revealed a certain relaxation on the part of the public authorities in the realization and protection of the fundamental rights and freedoms of refugees and the IDPs, which can be explained by the fact that this pandemics has exposed not only the mediocrity of most public health systems of host countries characterized by inadequately humane and logistically equipped health infrastructures [5], but also the inability of most of these host governments to provide basic services to individuals subject to their authority. African states, despite the scale of the pandemic, have to

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draw again on their already limited and insufficient financial resources to provide quality health care to these vulnerable people, making it even more difficult for them to fulfil their obligations to protect the right to health of those people, whose marginalization increases the risk of the spread of coronavirus. In addition to the right to health, restrictions on the mobility of persons in order to reduce the progress of COVID-19, contribute to undermine the exercise of other fundamental socio-economic rights as well as that of individual freedoms enshrined in international human rights law, which are essential for the survival of refugees and internally displaced populations. This article aims to take a look - drawing on examples from African countries - on the impact of this global health crisis on the protection of the rights and freedoms of refugees and internally displaced populations. With a particular focus on the right to health whose guarantee is threatened by the existence of the pandemic, a critical analysis of the mechanisms provided by host states to reconcile the fight against the coronavirus crisis with their obligation to safeguard these vulnerable people's rights, will be conducted. Moreover, the choice of this fundamental right is justified by the fact that the enjoyment of other human rights depends on its effectiveness.

METHODOLOGY

The methodology relied upon is a human rights-based approach analysis, which pays attention to the relevant regional and global legal instruments dealing with specific aspects of the protection of internally displaced persons and refugees' rights to which host States are signatories. The analysis is thus based on documentary research and casuistic (certain countries will be considered as case studies for the purpose of analysing the nature of the support brought to these categories of individuals) that reveal the heterogeneous nature of the mechanisms for guaranteeing the right to health in particular and the human rights in general of these vulnerable people implemented in the host countries. This has the direct consequence of not granting them the same level of protection with the local populations, and of being in a way at odds with the requirements of international law.

The comparative approach makes it possible to assess the level of compliance of African governments' initiatives aiming at guaranteeing the effective enjoyment of these vulnerable persons' rights, with their human rights treaties' obligations. This methodological approach also enables to highlight the need for improvement in the protection of the rights of refugees and internally displaced persons in times of the global COVID-19 pandemic, as required by international law.

RESULTS

Protection of Rights and Public Freedoms of Internally Displaced Persons and Refugees Compromised for Public Health Imperatives

The meteoric rise of the COVID-19 has compelled most states as from March 2020 to adopt measures that represent legal and legitimate intrusions into the exercise of human rights and freedoms, but which unfortunately can have the consequences of widening the gap in social inequalities. These are particularly felt among the poor, including refugees and internally displaced persons. Inequalities in the enjoyment of human rights and freedoms for these vulnerable people during this pandemic derive from the existence of an institutional framework that is insufficiently guarantor of their right to health firstly, and come as a result of a certain exclusion of the specific needs of refugees and internally displaced persons in the policies to tackle COVID-19, secondly.

Sanitary and Medical Infrastructures Insufficiently Protective of the Right to Health

Despite the poor economic conditions faced by most countries that are home to IDPs and refugees which impede the optimal protection of the right to health of these vulnerable people, their governments have an obligation to address the public health threat posed by coronavirus [6], by adopting inclusive approaches to respond to the pandemic. They shall take into account not only the needs of their nationals, but also that of these specific categories of persons. However, the reality on the ground is quite different; indeed, cultural, linguistic and sometimes religious differences between these populations and host communities make their integration and acceptance by the latter difficult

[7]. This mistrust towards these foreign populations helps to reduce the access to preventive and curative care and services against COVID-19 [8]. These disparities also impede their access to information on pandemic prevention, which can lead to eroding government efforts to reduce the disease.

Moreover, the over-reliance of these populations on the informal economy, their lockdown in overcrowded and unsanitary environments where water points and local hospitals are almost non-existent, amplify their vulnerability to the pandemics [9]. Even where they exist, these health formations are already being stretched to the extreme by cases of people infected with coronavirus, in a context where there are very few specialized COVID-19 treatment units [10]. Again, the imposition of lockdown measures in most African countries restricts access to refugee camps, is an additional barrier to the health coverage available to refugees [11].

The Persistence of Inequitable Practices Threatening the Proper Administration of Health Services

Beyond the sociological barriers and the unequal distribution of health facilities in the territories of most host countries characterized by an infrastructure imbalance between regions and even between health districts where populations live more than 20kms from a hospital [12], the administration of health care and services has highlighted discriminatory practices encountered in hospitals , where priority is given to the financial aspect at the expense of social and humanitarian considerations [13]. This lack of equity in access to health care and services is the result of a system of direct payment of care by households, which is the main method of acquiring health services [14]. The latter constitutes a real dysfunction of most public health systems in African developing countries, and hinders the guarantee of the right to health of refugees and IPDs who do not have the means to afford basic and more quality health care and services, due to the financial precariousness in which they live.

Yet, equity is a principle that aims to eliminate health inequalities by improving the health of the most disadvantaged. However, the reality is quite different in most host countries: access to health care is different depending on income; public health spending benefits the rich more than the poor [15]. This discriminatory behaviour, contrary to the 1951 International Convention on the Status of Refugees; the African Union 2009 Convention on the Protection and Assistance of Internally Displaced Persons [16], and to the International Covenant on economic, social and cultural rights [17] undermines the right to health of these vulnerable people who are generally destitute because of their limited financial resources and opportunities to find an acceptable standard of living.

Liberticidal Mechanisms in Response to COVID-19 Disregarding the Special Condition of Refugees and Internally Displaced Persons

The fight against Covid19 has forced most, if not all African states to take measures that restrict the exercise of rights and freedoms, and that are imposed on anyone under their jurisdiction. Lockdown; social and physical distancing; curfews, the imposition of closing times on public places such as markets and places of relaxation; the closure of schools and universities [18] are all strategies aimed at reversing the curve of coronavirus evolution.

Beyond the necessity for these measures however, lies the impact of their implementation on the moral and economic development of refugees and internally displaced persons. The latter, because of restrictions on freedom of movement, face difficulties in obtaining decent employment; their survival depending largely on the informal economy. These repressive measures thus jeopardize their chances of achieving a decent standard of living and have as a results the impossibility of affording health care and services and meeting their educational needs or those in their care. As other consequences, they exacerbate food insecurity and make it tedious to get decent housing [19]. The response to the current pandemic also reduces opportunities to exercise their right to non-wage functions such as agriculture; trade or the creation of trade and industry associations, as enshrined in article 18 of the 1951 Convention on the Status of Refugees; OAU Convention being silent on this issue.

However, the management of COVID-19 does not exempt host states of their responsibility to protect and respect human rights and freedoms in general, and those of refugees and IDPs in particular [20]. It is also an expression of their sovereignty. The African Charter of Human and Peoples' Rights, on the exercise of rights and freedoms in the event of a threat to public order such as the current pandemic, allows States parties to the Charter only to restrict their enjoyment and not to derogate from their obligation to respect them [21]. This impossibility to derogate was later reaffirmed by the African Commission for Human and People's rights in the case of *Media Rights Agenda v Nigeria* [22]*;* hence the reconciliation of the protection of the rights of refugees and internally displaced persons with the management of the COVID-19.

DISCUSSION

The need to reconcile the Protection of the Rights and Freedoms of Refugees and IDPS and the Management of COVID-19

Given the evolving pandemic, some African countries are opting to maintain or toughen measures that are real intrusions into the realm of people's fundamental rights and freedoms. However, in an exceptional way, they can relax these restrictions, particularly with respect to refugees. Similarly, African governments, in order to meet their obligations under international law, are working with certain international entities to protect the fundamental rights of these vulnerable people and to minimize the impact of COVID-19 on the effectiveness of their rights and freedoms.

Exceptions to Restrictions Related to Mobility of Vulnerable Persons as one of the Mechanisms for Reconciling the Guarantee of their Rights with States' Treaty Obligations to Realize the Right to Health in Times of Health Crisis

In general, countries have opted in the context of the fight against the current pandemic, for a mechanism that seriously infringes on the enjoyment of the rights and freedoms relating to the mobility of persons, such as the right to come and go; freedom of movement or freedom of assembly, which are enshrined in broad human rights instruments, and those relating to the guarantee of refugees' rights such as the right to move freely; to be protected against expulsion- except in exceptional cases provided for by the host country's legislation- , the right not to be returned forcibly [23]; and that of not being discriminated against [24].

Thus, the exceptions to restrictions on the movement of individuals in this context are more concerning refugees than internally displaced persons (IDPs) who move within the borders of their country and whose relocation does not require the completion of entry formalities similar to those imposed on refugees. Given their obligations to respect and protect the rights of refugees, States cannot use as a pretext the threat posed by COVID-19 to deny access to their territory to a refugee or even an asylum seeker from another country, where his or her life is in danger for reasons listed in article 1(1) & (2) of the 1969 OAU Convention.

Therefore, in order to comply with international law, some governments do not impose any restrictions on the entry of refugees into their territory [25]; unlike others who keep their land borders closed to any individual, regardless of their status [26]. A few have introduced the partial closure of their land borders with a special exemption granted to refugees and asylum seekers [27].

It is equally important to reveal the adherence of African states to the principle of non-return and non-expulsion enshrined in human rights conventions, despite the potential public health risks posed by the massive reception of refugees, particularly at a period where the disease had reached a critical threshold in all the regions of the world.

Moreover, as a palliative solution to the formal ban on crossing their land and air borders, the care of refugees is provided in some states such as Côte d'Ivoire, by the establishment of "humanitarian corridors" and by the organization of "humanitarian flights" by CAR and Guinea. These corridors aim at providing support to individuals or communities in urgent need or assistance.

Internally displaced persons on the other hand do not really have constraints related to their movements within their country of origin, but also face difficulties as refugees in enjoying their basic rights whose effectiveness depends on access to basic social services, particularly access to local and quality health services. Moreover, the financial implications of the fight against COVID-19 do not allow most of the host countries that are in the process of developing to devote more resources to the care of refugees and IDPs, hence their collaboration with the UN humanitarian institutions under which these vulnerable people fall. Beyond the multiple benefits of these inter-institutional partnerships, particularly in the context of improving the living conditions of refugees and IDPs, this cooperation is a conventional obligation arising from Articles 35 of the 1951 Convention; article 8 of the OAU Convention of 1969 in relation to refugees, and article 5 (3), (5) and (6) of the Kampala Convention of 2009 related to IDPs issues.

The Implementation of Special Measures for the Protection of the Right to Health of Refugees and Internally Displaced Persons in Times of COVID-19

Notwithstanding host governments' struggles to grant refugees and IDPs a treatment similar to that enjoyed by nationals as far as the protection of fundamental rights and freedoms is concerned, and as required by international law [28], it is clear that the obstacles to the improvement by the State of the living conditions of these groups who depend totally or partially on its assistance, especially in this period of health crisis, are the result of their current poor economic situation.

As such, in order to enable refugees and IDPs to benefit from the international standard of treatment contained in international instruments through concrete actions, the United Nations High Commissioner for Refugees (UNHCR) assumed the task of providing these marginalized groups with basic needs and services, either solely-which is the case most of the time- or in collaboration with host governments, and this, according to international and African human rights law provisions [29]. It is worth noting that contrary to the Kampala Convention provisions relating to the protection of IDPs, the OAU Convention of 1969 relating to refugees' issues, makes it an obligation for States Parties to collaborate with the UNHCR [30]. This could explain why in most countries hosting a flow of refugees, their care and that of internally displaced persons now, has become the sole responsibility of this UN humanitarian agency. In order to minimize the impact of COVID-19 on the enjoyment of the rights and freedoms of these vulnerable people, UNHCR is opting in most countries for an inclusive approach that translates into logistical, financial and humane support to states, which aim at protecting their rights to health and to education.

As such, to mitigate the impact of the crisis on the enjoyment of the rights and freedoms of these stigmatized people, UNHCR is opting in most countries, for an inclusive approach that consists of logistical, financial and humane support to states, which helps to protect their right to health and education. Given the inequalities created by the implementation of prevention measures against COVID-19 [31]; the mediocrity of public health systems in the majority of host countries with very few means of treatment for COVID-19 patients, especially those living in communities far from urban areas; and above all by the challenges faced by Africans to get access to clean water and sanitation [32] on which the maintenance of a healthy and decent environment depends, the UN institution favours programmes aiming at preventing the spread of the disease and at the same time ensuring the continuity of the exercise of their fundamental rights by refugees and IDPs, with the main objective of reducing the gap of injustices and stigmas between refugees and host communities. Indeed, the fight against COVID-19 requires respect for basic hygiene and sanitation rules, yet most countries sheltering refugees or being at the origin of the forced displacement of their populations, fail in their duty to provide drinking water and basic social services for the populations. This failure is felt more within these fragile groups [33].

As above mentioned, refugees and IDPs usually living in remote localities do not have access to public healthcare whose services are ill equipped to deal with this pandemic, and this is a result of

limited number of trainer health personnel; weak case detection management, or inadequate treatment units [34]. Thus, in order to fill the gaps in host countries' public health systems, the support of the UN agency is materialized through the provision of medical equipment and supplies in hospitals, as well as training of personnel on the prevention; the treatment and epidemiological surveillance of COVID-19; the construction of quarantine and isolation centres, as well as health facilities. It is nevertheless important to note that the overcrowding of the sites where the majority of IDPs and refugees reside is a factor favorable to the rapid spread of the disease, and this even beyond said sites. It is also helping to reverse the efforts of governments affected by the virus to contain the evolution of this pandemic. Therefore, with the aim of lowering the disease progression curve, UN action essentially consists of decongesting these sites in order to facilitate the implementation of the most basic preventive measures by humanitarian workers. This consists of raising awareness and communicating all information relating to disease prevention and management methods in the event of infection with the corona virus; in the distribution of hygiene and sanitation products to these poor people and monitoring the application of basic hygiene measures such as frequent handwashing; wearing a protective mask, etc. In addition, the creation of favorable conditions for access to clean water for refugees and IDPs; rehabilitation or construction of water, sanitation and hygiene facilities; comprehensive hygiene and cleaning kits distribution; the establishment and maintainance of handwashing stations; as well as the subsidy of their income-generating activities represent [35] among other measures, palliatives to the challenges faced by host states in terms of the provision of social services such as water, electricity, education, access to healthy food, or even decent housing, both for these very often marginalized groups as well as to local populations.

Thus, through direct support or collaboration with the governments involved in the management of refugees and IDPs, very few people who are victims of COVID-19 and coming from these groups have been identified; the humanitarian agency favoring a proactive rather than reactive approach. The idea behind this strategy is to minimize the risk of the pandemic escalation within refugees and IDPs and beyond their areas of residence.

Some Measures to Strengthen the Protection of Refugees and Internally Displaced Persons' Right to Health during the COVID-19 Pandemic

Notwithstanding the UN's contribution to improve the living conditions of these groups, African host states with a view to comply with their treaty obligations in relation with the protection of the rights of refugees and IDPs, could use the example of some countries to achieve their right to health in particular, as well as that of their nationals. A such, in addition to communication and awareness, the United Kingdom, Peru and Thailand have adopted as measures, free management of the diagnosis and treatment of COVID-19 regardless of status for the first country; health coverage for refugees and migrants suspected or tested positive for corona virus for the second one; while Thailand allows migrants in this exceptional period, the subscription of national health insurance that allows them to benefit from universal health care [36].

CONCLUSION

If theoretically the right to health and other human rights are either constitutional rights, that is to say incorporated in the fundamental law of certain African countries including those concerned by the great mobility of people, or recognized by a law which incorporates universal legal instruments and regional organizations that protect this right, the reality is quite different on the ground. States concerned with the problems of forced displacement and refugees, because of their status as developing countries, very often struggle to fulfil their regal duty to protect human rights in general and the right to health in particular, and this in a fair way, whether in normal times or in times of crisis, as the one the world is currently going through.

At a time when COVID-19 is rampant, requiring states to draw unexpectedly from their already insufficient resources to protect their fundamental rights and to ensure quality health care specifically,

refugees and internally displaced persons find themselves more vulnerable to COVID-19 as a result of government-imposed repressive measures to contain the spread of the disease. The difficult survival of these poor people further widens the gap of inequalities between them and local populations.

The United Nations is helping, through a proactive and inclusive approach, to alleviate the suffering of these groups, which are often stigmatized by nationals. The protection of the right to health more than any other right - since COVID-19 poses a direct threat to public health - leads the humanitarian institution (UNHCR) to strengthen the capacity of the public health systems of host countries on the one hand, and to find special measures to improve the living conditions of refugees and IDPs, on the other hand. It would, however, be utopian to think that only the action of this UN agency could restore some sort of balance, or bridge the gap in inequalities between these vulnerable people and host communities, but it can count on its contribution to ensure the effectiveness of the protection of the right to health in a specific way, as well as that of other human rights in general, as required by African and international regional human rights instruments. Finally, the wait-and-see attitude of African states concerned with the flow of displacement is deplorable, in view of the demands of international law which require them to adopt more dynamic initiatives that help to protect these groups of poor individuals whose vulnerability is aggravated by the health crisis and the limits imposed on the exercise of the rights and freedoms it has generated around the world.

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2. The International Covenant for Civil and Political Rights (art 6;9 (1); 12 &13); the International Covenant for Economic social and cultural rights (art2(1) & (2); art 12, etc. art 5 of the International Convention on the elimination of racial discrimination; the Convention on the elimination of all discrimination against woman (CEDAW); art 3 of the Convention against torture; Arts. 2;4;11; 15; 16& 17 of the African Charter on Peoples and Human Rights (ACPHR),etc. constitute amongst other universal and regional instruments, the general framework on which provisions protecting the rights of refugees; IDPs and migrants lie
3. The 1951 Convention to the status on refugees in its Arts. 3;23;21;22;26 &33(1) specifically establishes the nature of states obligations to safeguard human dignity of refugees in exceptional periods. The 1967 Protocol made the 1951 Convention a universal instrument for all refugees in the world, by removing the geographical and temporal provisions set out in the original text according to which only European victims of events that occurred before 01/01/1951 could benefit from refugees' status.
4. The 1969 Convention of the Organisation of African Union governing specific aspects of refugees Problems in Africa and the 2009 Kampala Convention on the assistance and protection to IDPs, set the framework for the protection of these categories of persons: Arts 2(3); 4;5 (1); (5); (6), as well as Art 9 (1a); 9 (2a; b & c) of the 2009 Convention respectively refer to rights and freedoms that require increased protection in times of crisis.
5. UNHCR. Impact of Covid-19 on the protection of displaced and stateless populations. West and Central Africa. [Internet] 2020 May 5 [cited 2020 Dec 09]; 2p; Available from http://data2.unhcr.org/fr/documents/download/75706.
6. Art 12(2) of the ICESCR.
7. UNHCR. Impact of Covid-19. See above at note 5.
8. UNHCR. Policy Brief. Covid-19 and people on the move.[Internet] 2020 Jun[cited 2020 Nov 27]; 25p. Available from: https://data2unhcr.org/fr/documents/download/76793.
9. The Kakuma refugee camp in Kenya has a population density of about 1000 times that of the host Turkana community; in Somalia, there are half a million IPDs, living in crowded settlements throughout Mogadishu. See Policy Brief at note 8 above.

10. West and Central African regions recorded a 40% increase in covid-19 contaminated cases from March to July 2020; for details on this issue, see UNHCR. Covid-19 emergency response. West and Central Africa. [Internet] 2020 Jul 1st [cited 2020 Nov 09]: Available from: http://data2.unhcr.org/fr/documents/download/76435.
11. UNHCR. Policy Brief. Above at note 8.
12. This is the case of Cameroon. Read Ministry of Public Health. Health Sector Strategy 2016-2017. Report. Yaoundé; MINSANTE; pp 68-69.
13. These practices are in total contradiction with the provisions of art 9(a) of the Kampala Convention which provides that: "States parties shall protect the rights of IDPs regardless of the cause of displacement by refraining from or preventing the following acts (…) discriminations against such persons in the enjoyment of any rights or freedoms on the grounds that they are IDPs (…)".
14. In Cameroon, direct payment of care accounted for 95% of private health spending in 2018, and the total household contribution was 66% of the total health spending in 2014. Source : Wathi. La situation sanitaire au Cameroun : Stratégie sectorielle de santé 2016-2017. [Internet] 2018 Sept [cited 2020 Dec 1st] : Available from : https://www.wathi.org/election-cmr-2018/contexte-election-Cameroun-2018/la-situation-sanitaire-au-Cameroun.
15. Jacquemot P. Les systèmes de santé en Afrique et l'inégalité face aux soins. De Boeck Superieur « Afrique contemporaine », 2013; 3 (243) : 97. This author reveals that in Mauritania, 72% of the subsidies paid to hospitals benefit 40% of the richest inhabitants; in Ghana 1/3 of public health spending benefits the richest quintile while 12% goes to the poorest quintile. This uneven distribution of spending is also found between those devoted to cities and rural areas.
16. Art 3& 23 of the 1951 Convention and art 9(1) of the African Union 2009 Convention.
17. Art 12.
18. Agence Française de Presse. L'Ouganda lève prudemment certaines restrictions contre le covid-19. *Voix d'Afrique.* [Internet] 2020 May [cited 2020 Dec 07]; Available from : https://www.voafrique.com/&/l-ouganda-1%C3%A8ve-prudemment-certaines-restrictions-contre-le-covid-19/5046231.html.
19. According to a UN survey, food insecurity among refugees, as measured by the share of households that ran out of food, was higher than in host communities (64 versus 9%). Uganda hosts the largest refugee population in Africa, with some 1.5 million people coming mainly from South Sudan and the Democratic Republic of Congo (DRC). For more details on the devastating effects of COVID19 on refugees in Uganda in particular and Africa in general, read ONU Infos. La pandémie de Covid-19 aggrave le dénuement des réfugiés établis en Ouganda, selon le HCR. [Internet]2021 June 17 [cited 2021 Sept 06] ; available from https://news.un.org/fr/story/2021/06/1098292.
20. According to paragraph 2 of the UN Convention on refugees, states shall accord to refugees treatment "as favourable as possible" and in any event, not less favourable than that accorded to aliens generally in the same circumstances with respect to education (…)".
21. Art 11 & 12 (2).
22. The inability to derogate from the Charter rights was reaffirmed by the African Commission on Human and Peoples' Rights in that case. "In contrast to other international law instruments, the African Charter does not contain a derogation clause. Therefore, limitation on the rights and freedoms enshrined in the Charter cannot be justified by emergencies or special circumstances (…)"
23. Art 32 & 33(1) of the 1951 Convention. Art 2(3) of the 1969 African Convention.
24. Art 3 and art 4 of the 1951 and 1969 Conventions respectively.
25. Cameroon; Central African Republic; Burkina-Faso; Sierra-Leone.
26. Mali; Senegal; Chad.
27. Niger and Nigeria. For more detail on this issue, read UNHCR. Impact of covid-19 on protection of displaced and stateless populations. West and Central Africa. See above at note 5.
28. Read art 9 (1a) of the Kampala Convention of 2009. Arts 3 & 23 of the 1951 Convention establish the principle of non-discrimination for the first provision, and equal treatment for the second one.

29. According to art 3 (1) (j), "(…). States Parties shall ensure assistance to internally displaced persons by meeting their basic needs as well as allowing and facilitating rapid and unimpeded access to humanitarian organisations personnel. Concerning the modalities organising the institutional partnership, see § 2(b) of the same provision.
30. Art VIII (1) provides that "States Parties shall cooperate with the office of the High Commissioner for Refugees".
31. Closure of local markets; postponement of food distribution; restrictions on free movement in and out refugees and displaced persons' sites; isolation requirements, etc. were measures, amongst others restricting the mobility of these vulnerable persons. Source: Inter-Agency Standing Committee (IASC). Scaling-up covid-19 outbreak readiness and response operation in humanitarian situations. Version 1.1. *Report*. New York: IFRC, IOM, UNHCR, WHO [Internet] 2020 Mar [cited 2020 Dec 02]; 8 p. Available from: https://interagencystandingcommittee.org/system/files/2020-04/IASC/InterimGuidanceonCovid19foroutbreakReadinessandResponseOperationsCampsandCamp-like_Settings.pdf.
32. In general, more than half of Africans have to leave their houses to access water, and only ¼ has access to sewage infrastructures. Also, 54% of Africans live in areas served by a piped-water system; while 26% live in areas with sewage systems. This represents a challenge for achieving the sustainable goal for development n°6 targets to "provide access to adequate and equitable sanitation and hygiene for all". In most countries hosting refugees and IDPs, such as Cameroon or Nigeria, 40% of the population have always gone without clean water; 21% did not access it several times, while only 10% of the population did not access it once or twice, in a year for the first country, while 10% has always gone without clean water; 14% has gone without it several times and 17% once or twice, for the second country. Source: Howard B, Kangwook H. African governments failing in provision of water and sanitation, majority of citizens say. *Afrobarometer Dispatch* [Internet] 2020 Mar [cited 2020 Dec 09]; n° 349:19. Available from: afrobarometer.org/sites/default/sites/publication/Dispatches/ab_r7_ dispatchesn 349_ pap14_water_and_sanitation_in Africa.pdf.
33. Ibid. pp 14-19. In Mali for example, only 32% of the population find it easy to obtain water, sanitation or electricity, while 67% find it difficult or very difficult. In Sudan, which is a country hosting a very huge number of refugees and IPDs, 42% find the access to those accommodations easy, and 58% find it difficult; in Uganda receiving several waves of refugees, 32% find it easy, and 68%, very difficult. Concerning governments' performances in providing water and sanitation services, 32% of the Cameroonian population find that governments' performance is fairly well, while 64% find it very bad. In Nigeria, 40% find it fairly well, whereas 59% find it bad.
34. UNHCR. Impact of Covid-19 on the protection of displaced and stateless populations. West and Central Africa. Above at note 5.
35. As concerns livelihoods activities, the UNHCR provided refugees and IDPs with seed, tools and animal husbandry, in the aim of protecting food security. Also, as regards income-generating activities, the UN organisations often subsidized the manufacture of protective masks by these marginalised populations. Read for this purpose UNHCR. Covid-19 emergency response. [Internet] 2020 Aug [cited 2020 Nov 3]. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/Africa%20Sitrep%20_Nov11_20200813.pdf.
36. UNHCR, Policy Brief, see reference above, at note 8.

