Situation assessment of statelessness, health, and COVID-19 in Europe

Acknowledgements

Foreword

The COVID-19 pandemic is more than a health crisis. As its repercussions continue to unfold, it has developed into a rights crisis that affects all of us. Yet, it does not affect all of us equally.

Since the onset of COVID-19, I have urged authorities across Europe to ensure that healthcare systems meet the needs of the entire population, including the marginalised and disadvantaged. I therefore welcome this research as the first of its kind to explore the extraordinary vulnerabilities and rights violations experienced by stateless persons in relation to health. It exposes a troubling lack of recognition of the fact that statelessness continues to constitute a powerful barrier to accessing healthcare across Europe. Filling this gap is ever more urgent in the current pandemic context.

In most countries, legal status and formal documentation are prerequisites for accessing quality healthcare. They are also prerequisites for gaining access to important social determinants of health, including employment, social protection, and adequate housing. Over 500,000 stateless persons in Europe, many belonging to minorities, do not enjoy the fundamental human right to recognition everywhere as a person before the law. Children continue to be born and to grow up without a nationality, in yet another generation of persons who are compelled to live a life of destitution, marginalisation

and extreme vulnerability to human rights abuses. I believe that States should step up efforts to put an end to the perpetuation of statelessness, in line with existing international standards. They should ensure, in particular, that children born on their territory and who would otherwise be stateless are granted the nationality of the State concerned. This is possibly one of the most effective tools to curb the number of stateless persons in Europe. I will continue to highlight human rights violations resulting from statelessness in my future work, whether at national level or in multilateral contexts, and to support the authorities in identifying and implementing effective solutions.

COVID-19 has demonstrated that the right to health cannot be protected at an individual level. It requires effective systems that provide for inclusive prevention, treatment, and rehabilitation for all, leaving no one behind and ensuring that structural inequalities are not magnified over time but disrupted and addressed. I have called on Council of Europe Member States to ensure non-discriminatory access to all pandemic response and vaccination programmes, and to base any

necessity for prioritisation on sound medical evidence and the individual urgency of the case. Health is a human right and must be treated as a public good, not a special benefit or a commodity.

Authorities should therefore strive to identify and address the specific and interrelated barriers to realising stateless people's right to health that the report identifies. Beyond their lack of legal status, these include multiple forms of discrimination, fear and mistrust of authorities, digital exclusion, and the lack of access to adequate health information. To guarantee the right to health for all requires adequate resourcing, and proactive research and outreach to ensure that diverse stateless populations participate and are made visible in health policymaking. I therefore highly appreciate this valuable research on the nexus between statelessness and health inequalities and encourage States to take its recommendations to heart in their efforts to build inclusive and resilient healthcare systems for all.

Dunja Mijatović
Council of Europe Commissioner for Human Rights

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"As Roma advocacy coordinator and member of the research Expert Advisory Group, it was important for me that not only fundamental rights, but also cultural rights be considered. I also advised specific reference to antigypsyism since statelessness and antigypsyism are intertwined. Hopefully, the report will raise awareness whilst creating more concrete actions. Bringing our voices together is crucial and knowing that the starting point of stateless people is strength, we support this respectfully and wholeheartedly."

Michelle Mila Van Burik Bihari
Individual ENS Member & Roma Activist

"The research explores how the ongoing COVID pandemic has affected stateless individuals and outlines the shocking reality of how one of the world's most vulnerable populations can be left behind in such situations. It defines vastly important areas that are worth further exploring to make sure everyone is safe and has the right to health."

Nowras Rahhal
Individual ENS Member & Stateless Activist

"Stateless communities have continually been overlooked and hidden from the public eye. With the measures implemented in response to Covid-19, this marginalised community has become even more isolated, magnifying the inequalities they face. The inclusion of stateless communities in Covid-19 responses is essential for a successful pandemic recovery, and this research is critical in informing needs and rights-based policies to ensure that stateless people are not left behind."

Anila Noor
Managing Director, New Women Connectors

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Background

Statelessness and the Right to Health

Statelessness was described by António Guterres, the UN High Commissioner for Refugees (UNCHR) in 2011, as the world's *"most forgotten human-rights problem"* (van Gilder Cooke, 2011). Article 1 of the 1954 Convention Relating to the Status of Stateless Persons defines a stateless person as *"a person who is not considered as a national by any State under the operation of its law"*. UNHCR estimates there are millions of stateless people in the world, but the true extent of statelessness globally is unknown, as fewer than half of countries submit data on their stateless populations. [1] Some people are born stateless, whilst others become stateless over the course of their lives. The main causes of statelessness include discrimination (including antigypsyism), gaps or conflicts in nationality laws, state succession, and deprivation of nationality.

When a person lacks a nationality, they lack the rights and duties attached to belonging to a State, which leads to violations of many other human rights, including the right to health. [2] According to the World Health Organization, *"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"*, with "health" being defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*. [3] The 1948 Universal Declaration of Human Rights (UDHR) refers to health as part of the right to an adequate standard of living (Article 25), which is also recognised in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 ICESCR

stipulates everyone's right to healthcare and States are under an obligation to respect this right by *"refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and irregular migrants"*. The right to the highest attainable standard of health also falls within other international human rights treaties. [4] It spans environmental determinants of health, standards of healthcare, and rights to privacy and medical confidentiality. The right to health is closely linked to the fulfilment of other rights, which stateless persons are often denied such as the right to education, social security, and food. According to the Committee on Economic and Social Rights, the right to healthcare is *"indispensable for the exercise of other rights"* [5] with universal application and with access to healthcare services ensured to every human being without regards to race, religion, or other criteria, including legal status (UNHCR, 2008; Rechel et al., 2013).

The two most important international instruments addressing statelessness are the 1954 Convention relating to the Status of Stateless Persons, which provides the definition of a stateless person and the international legal framework for the protection of stateless people, and the 1961 Convention on the Reduction of Statelessness, which sets rules around conferral and withdrawal of nationality. Whilst the 1954 Convention establishes the international legal definition of a *"stateless person"* it

does not prescribe a particular mechanism for determining statelessness. At the time of writing, 12 European States have established dedicated statelessness determination procedures in law to provide protection to stateless people under the 1954 Convention.[6] In addition to the two statelessness-specific conventions, many other human rights treaties set standards for the protection of stateless people, avoidance of statelessness, and the right to a nationality. At regional level, the European Convention on Nationality and the Council of Europe Convention on the Avoidance of Statelessness in Relation to State Succession are two key instruments for the prevention of statelessness. In the UN framework, the Universal Declaration on Human Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of all forms of Discrimination against Women, amongst others, all contain provisions to guarantee the right to a nationality. Thus, all European States have obligations under international law towards stateless people and the eradication of statelessness, regardless of whether they are party to the core statelessness conventions.[7]

Statelessness in Europe[8], as elsewhere, affects both migrants and refugees, and people who have lived in the same place for generations, but it remains a largely hidden phenomenon, due to the incompleteness and sparsity of data. Disaggregated data and data on stateless people held in immigration detention are particularly lacking (ENS, 2019).

Many stateless people have never crossed borders and find themselves stateless in their "own country" (referred to as "in situ stateless persons"). In the Balkans and countries of the former Soviet Union, many Roma and other minority groups remain stateless or at risk of statelessness because of discrimination and the legacy of state succession.[9] Others find themselves stateless in a migratory context, for example, stateless refugees are among those seeking asylum in many European countries.[10] Statelessness in Europe therefore disproportionately affects migrant, refugee, and minority groups, including Roma and ethnic Russians living in the successor states of the Soviet Union and Yugoslavia. UNHCR reported that there were 527,959 stateless persons in Europe in 2019, based on information provided by governments and other sources, although this is likely an underestimate.[11]

Statelessness prevents many of those affected from accessing fundamental rights (human, civil, social, cultural, and political) creating or exacerbating significant marginalisation and exclusion spanning access to healthcare, education, housing, employment, and other civil rights such as birth and marriage registration. Due to the lack of domestic legal frameworks to identify and solve statelessness, including mechanisms to determine who is stateless and due protection under the 1954 Convention, stateless people's enjoyment of rights varies significantly from country

to country.[12] The right to access healthcare and social security is usually contingent on residence or legal status. In the migratory context, people *recognised* as stateless (in countries with mechanisms to grant protection under the 1954 Convention) are usually permitted access to healthcare and social security in line with nationals (for example, in Spain, France, Italy and the UK).[13] Stateless people recognised as refugees or holding subsidiary protection status, are also usually granted access to healthcare in line with nationals. However, where stateless migrants hold a temporary residence permit, or a form of "tolerated" or irregular stay, they will often face significant challenges in accessing healthcare. In situ populations affected by statelessness who lack identity documents and/or legal status will also face significant barriers to accessing healthcare.

Healthcare for migrants in an irregular situation is generally restricted to emergency care through emergency care services only (FRA, 2016). In the Netherlands, several studies report that whilst undocumented persons have the legal right to access "medically necessary" healthcare; individuals may not be aware of this right. They may be wrongly denied access or experience discrimination; they may fear data-sharing between authorities; and may be unable to pay medical charges (Hintjens, Sigemann and Staring, 2020; International Institute of Social Studies, 2020). Studies in the Ukraine have also reported a lack of access to medical care for people without identity documents, including due to an inability to register with a general practitioner (UNHCR and R2P, 2020). Undocumented migrants in the UK also face many barriers to accessing healthcare, including fear and mistrust and lack of understanding, according to a recent study.[14]

The COVID-19 health emergency

On 11 March 2020, the World Health Organization (WHO) reported that the global outbreak of the corona virus disease (COVID-19) was a pandemic (WHO, 2019). At the time of writing, there are a reported 36,607,500 cases of COVID-19 in Europe with 830,948 deaths (ECDC, 2021). Europe was the epicentre of the pandemic for a large part of 2020. Success in countering the COVID-19 pandemic centres on an inclusive rights-based response, "*leaving no one behind*", with the inclusion of all populations in domestic, European, and international responses (Orcutt et al., 2020; Orcutt et al., 2020a; Lancet Migration, 2020). Particularly vulnerable populations during COVID-19 include ethnic minorities, homeless people, migrants, refugees, asylum seekers, stateless persons, and Roma communities (Lau et al, 2020; Varga, 2020; Kirby, 2020; UNHCR and R2P, 2020). Stateless people have been highlighted by UNHCR and others as a group at particular risk of being left behind in the COVID-19 response. The invisible nature of statelessness, coupled with the marginalisation and discrimination stateless people face, potentially worsens the impacts of COVID-19 (ISI, 2020a; ISI 2020b; Murray, 2020).

States' obligations under international law continue to apply in crisis situations such as COVID-19 except to the extent that relevant treaty obligations have been formally derogated from, through notification to the relevant international authorities (International Commission of Jurists, 2020). In line with Article 11 of the European Social Charter, which enshrines the right to health, the European Committee of Social Rights (ECSR, 2020) has stated:

> **In times of pandemic, during which the life and health of many people are under serious threat, guaranteeing the right to protection of health is of crucial importance, and governments should take all necessary steps to ensure that it is effectively guaranteed. In light of this, States Parties must ensure that the right to protection of health is given the highest priority in policies, laws and other actions taken in response to a pandemic.**

Despite these assurances, there are rising concerns around the structural underpinning of statelessness, human rights, health rights and the right to nationality worsening as the COVID-19 pandemic takes hold (ISI, 2020a; Murray, 2020; ISI, 2020b).

Statelessness is linked to political and economic marginalisation and discrimination (including antigypsyism and other forms of racism). Many stateless people in Europe face hate speech, exploitation and abuse, detention, insecurity, and restricted movement, with serious consequences for their health and well-being and livelihoods, particularly during a public health crisis (ISI, 2020; Murray, 2020). Wider social, structural and environmental determinants of health experienced by stateless people are worsened during COVID-19 and centre on the significant rise in evictions, scapegoating and hate crime during COVID-19, poor and congested living conditions, lack of sanitation and hygiene, chronic ill health and stress, overrepresentation in informal sectors where no work means no pay, and lack of access to social security, humanitarian and government aid packages, all of which compound their health disparity, and potentially grave outcomes.

These risk factors are exacerbated for many stateless people in Europe due to barriers to accessing knowledge around rights and entitlements to support their right to health and help seeking, as well as institutional mistrust, barriers to accessing health services (including language, health literacy, and logistical barriers), and discrimination by healthcare providers (Zolberg Institute, 2020; Varga, 2020; Murray, 2020). During a public health crisis, stateless people in particular may also refrain from accessing health services for fear that their lack of residence or legal status can put them at risk of detention, deportation or further discrimination (UNHCR and R2P, 2020; Murray, 2020).

Significant health risk factors are also linked to the contexts in which many stateless people live and work. For example, densely populated areas, factories, camp settings, collective shelters and informal settlements, and immigration detention settings. All these settings have been linked to an inability to adhere to public health guidance, including to self-isolate during illness (Raju and Ayeh-Karlsson, 2020; Armitage and Nellums, 2020; Hargreaves et al, 2020; Varga, 2020; Heaslip and Parker, 2020; Milkova and Larkins, 2020). Stateless people, especially children and women, who lack residence status and/or identity documents and live in relative poverty are at significant risk of social consequences of COVID-19 (such as inter-generational statelessness, evictions, homelessness, poverty, gender based violence, interrupted schooling, lack of access to online schooling, health risks) (Raju and Ayeh-Karlsson, 2020; Armitage and Nellums, 2020; Hargreaves et al, 2020; Varga, 2020; Heaslip and Parker, 2020; Milkova and Larkins, 2020; OSCE, 2020; UNHRC, 2020).

Stateless people's navigation of this public health crisis, and their experiences are also at grave risk of being omitted or indeed misinterpreted in the global response (ISI, 2020a; ISI, 2020). There are identified gaps in government engagement with marginalised communities and in the availability of translated and targeted COVID-19 risk communications across Europe (Maldonado et al., 2020). Despite government assurances to include marginalised populations, including Roma, migrants, and refugees in comprehensive COVID-19 responses, State public health guidance and measures do not necessarily reach them, particularly in the case of stateless people due to their invisibility (Varga, 2020; ISI, 2020; Zolberg Institute, 2020; Council of Europe, 2020). They may not have full access to public health information, or be included in health policies and responses during emergencies such as COVID-19, and without legal rights and access to essential services, including healthcare and public funds, many stateless people in Europe are at risk of exclusion from access to COVID-19 testing, contact tracing, and medical care (UNHCR and R2P, 2020; Junior et al, 2020; Varga, 2020; Hargreaves et al., 2020; Raju and Ayeh-Karlsson, 2020; Armitage and Nellums, 2020; Heaslip and Parker, 2020; Wood and Devakumar, 2020; Paprah, 2020; Parry-Davies and RAPAR, 2020; Aragona et al., 2020).

In relation to Roma populations in particular, there have been widespread reports of lockdowns in Roma settlements, rising hate speech against Roma, and reports of State enactment of disproportionate or militarised measures targeting Romani neighbourhoods or towns (for example in Bulgaria and Slovakia) based on a racist and antigypsyist narrative exemplifying Roma as a health threat (Holt, 2020; Matache and Bhabha, 2020; OSCE, 2020; Milkova and Larkins, 2020; Council of Europe, 2020).

Given the deadly nature of COVID-19 in *all* people with underlying health conditions, alongside the unique risk factors and discrimination already affecting stateless communities, anti-discrimination measures are vital to a comprehensive public health response (Murray, 2020). Notwithstanding the health harms in disease spread, the mental health impact of statelessness and its detrimental impact cannot be underestimated and requires dedicated action planning (UNHCR, 2020a; United Nations, 2020). In October 2020, a Communication by the European Commission on vaccine preparedness, referred to including *"communities unable to physically distance"* (such as in *"refugee camps"*) and *"vulnerable socioeconomic groups and other groups at higher risk"* (such as *"socially deprived communities to be defined according to national circumstances"*) as *"possible priority groups"* for vaccine deployment:

> ❝ Member States will need to make decisions on which groups should have priority access to the COVID-19 vaccines so as to save as many lives as possible. These decisions should be driven by two criteria: to protect the most vulnerable groups and individuals, and to slow down and eventually stop the spread of the disease.

(European Commission, 2020)

At the end of 2020, the International Organisation for Migration (IOM) stated that COVID-19 vaccination plans must include migrants, regardless of their migration status, in government vaccine deployment plans (IOM, 2020; PICUM, 2020). This was supported by two later press releases from the European Centre for Disease Prevention and Control (ECDC) (ECDC, 2020; ECDC, 2020a). On 28 January 2021, the International Romani Union released a press statement, which outlined concerns for equal access and uptake of COVID-19 vaccinations for Romani populations, and the presence of deep institutional mistrust and vaccine hesitancy.[15]

Rationale for the research

Whilst the literature base is growing, the impact of COVID-19 on stateless people in Europe is currently under researched, and there is an imperative to understand their experiences and situations. The European Network on Statelessness (ENS) responded to this need and sought and was granted funding from the Rosa-Luxemburg-Stiftung Geneva for this project.

Method

The research team conducted a rapid situation assessment (mixed method consisting of a survey, interviews and focus groups) to explore and assess the nexus between statelessness and health during COVID-19 in the Council of Europe (CoE) region. The full methodology is detailed in Annex I. The research aim was to better understand the intrinsic link between statelessness and health, and make evidence-based policy recommendations for the short, medium and long-term, inform responses and actions to protect stateless people's rights, guide inclusive policies and programmes, and tailor public health interventions and service provision accordingly.

Results

25 CoE countries

29 survey respondents

19 in-depth interviews

5 focus groups

29 key stakeholders completed the survey administered by ENS representing 20 CoE countries (UK; Romania; Czech Republic; Sweden; Georgia; Croatia; France; Netherlands; Kosovo; Greece; Italy; Belgium; Serbia; Ukraine; North Macedonia; Russia; Switzerland; Moldova; Ireland; Portugal). 19 in-depth interviews were conducted with key stakeholders identified by ENS and represent the regional and specific country level perspectives (Germany, Ukraine, Netherlands, Greece, Spain, UK, Italy). Five written reports were submitted by the focus group facilitators in priority countries.

It is important to mention that whilst perspectives were provided on the nexus between health and statelessness in general, and some survey and interview responses give insight into the picture of health and healthcare access of stateless people during

COVID-19 times, overall there was a lot of uncertainty from respondents in being able to answer questions, with many feeling they were ill-equipped or did not have the necessary information to comment on the specific situation of stateless people. Overall, whilst challenging from a research perspective, this is indicative of the lack of data and information available in the region on statelessness. This lack of specific response regarding stateless people further emphasises that statelessness is an *"invisible issue"*. The full impact of COVID-19 on stateless people and communities does not appear to be recognised or documented. On a positive note, data across stakeholders and stateless people were indicative of general consensus on the situation, with no outliers observed.

The nexus between statelessness and health

Whilst the right to healthcare is a fundamental human right, with universal application and with access to healthcare services ensured to every human being without regards to race, religion or other aspects of a person's identity, including nationality status, this appears not to be the case for stateless people. When asked about stateless people's access to health services in general, a high proportion of those who responded to the survey and those interviewed detailed the requirement for people to have legal documentation, formal

identification, or health insurance to access mainstream medical care. For example, in many countries, migrants are only able to access emergency medical care, with long-term care options available only to those with certain categories of residence permits and formal documentation. In many countries, stateless migrants are among those least likely to hold identity documents or residence permits. Financial costs towards medical care are noted by many as being a huge barrier to accessing medical care, particularly for those who may not be able to self-fund care or do not hold medical insurance. As an example of this, it was reported by a stakeholder from Ukraine that:

> **Only those stateless persons who have a permanent residence permit in Ukraine are receivers of free medical care in Ukraine. Others should pay for medical services. Those persons who apply for recognition as a stateless person will not receive free medical services, because they are regarded as temporary residents in the territory of Ukraine.**

Survey responses on the differences in health service provision for stateless people as a result of their accommodation settings both in general and during COVID-19 times, highlighted marked differences in provision in different countries. This was further

substantiated in stakeholder interviews. Some examples included:

In Romania, stateless people living in government-run facilities are provided with regular access to doctors and medical personnel. During COVID-19, newcomers are placed in isolation.

In the Czech Republic, in general, if someone is detained in an immigration detention setting, emergency care is provided; but if they are asylum seekers and housed in a refugee centre, they have access to public healthcare.

Referring to COVID-19 times, a representative from Greece stated: *"Yes, there is a difference. For people who are living in the camp for settlement or reception centres, the health services provision was restricted, they didn't allow people to move out of the residence."*

In Ukraine residents of *"official"* accommodation facilities (immigration detention centres, municipal homeless shelters, etc.) are provided with better access to healthcare, as those who run the facilities are responsible for organising healthcare. *"Those who live in informal settlements has to apply for medical aid on a general basis, which in most cases is impossible without personal documents."*

Representatives from Serbia stated that: *"Roma who are at risk of statelessness living in informal settlements have difficulties in accessing healthcare services. We have not heard of any mitigating measures that have been taken to ensure accessibility of healthcare in response to COVID-19 for the inhabitants of the informal settlements."*

One stakeholder who was interviewed described how in the UK (prior to COVID) an individual (who, although not formally recognised, was very likely stateless or at least at risk of statelessness) could not access surgery to remove a cancerous tumour because it was not considered emergency care and could wait until the individual "returned to his country of origin". The likelihood of return for this person was very low given his country of origin had at that point twice refused to recognise and document him for return.

Many stakeholders observed during interviews that as mental healthcare is part of secondary (i.e., non-emergency) healthcare, this adversely affects stateless people who are disproportionately affected by poor mental health and lack of access to dedicated mental health support.

Impact of COVID-19 on the health and healthcare access of stateless people

When trying to gain an understanding regarding the prevalence of COVID-19 amongst stateless people and communities, the majority of survey respondents and those interviewed were unable to provide detailed information on this. A small number were able to outline areas where COVID-19 had impacted on groups in which stateless people are likely to be represented, such as in the Czech Republic where immigration detention centres were closed due to an outbreak of the virus; and in Ireland and Germany where meat plants (in which migrant workers and members of minority groups disproportionately make up the workforce) experienced clusters of infection. Representatives from Switzerland also responded that there were indications that migrant communities may have been disproportionately affected by the pandemic. The reasons for this inequality were linked to a number of factors, including: the population containing a higher proportion of individuals working within essential sectors such as health services or retail (which remained open throughout); these communities typically having a more densely populated housing situation; and the likelihood of more frequent travel between their country of origin and Switzerland (although in the case of stateless migrants, this may be more unlikely as they often face barriers to free movement or lack travel documentation).

Similar observations were made regarding the link to the informal economy and anecdotal reporting of COVID-19 cases in accommodation centres for asylum seekers in Ireland ("direct provision"), Roma settlements, and accommodation where migrants live in other countries. Focus group participants specifically touched on the prevalence of essential frontline workers in these population groups (migrants, refugees, minority groups), with a specific example being provided by a focus group participant from the Netherlands:

> **A large number of Filipino nurses were sent to work on the frontline in the hospitals fighting against the virus in Spain, which resulted in a high fatality record amongst them.**

Both the survey responses and interviews with stakeholders, as well as the focus groups, discussed the impact of COVID-19 restriction measures on health service provision (coverage, access, and availability) referring to the general population, groups in which stateless people are represented, and stateless people specifically. All referred to an overall reduction in health service accessibility for everyone during COVID-19 restrictions on movement and on health system operations, primarily due to the reduced availability of in-person appointments, and planned procedures being cancelled or rescheduled as health services

were overwhelmed. Whilst the general population is affected by disrupted service provision, groups such as migrants, refugees, and minorities (and stateless people within them) are disproportionately disadvantaged and vulnerable both to physical and mental ill health and contracting COVID-19. Cessation of general health services during COVID-19 surges was described as impacting on health. For example, children's vaccinations ceased in many countries. The trauma that many stateless people have experienced was described as warranting specialist mental health and medical care and was observed to be worsening during COVID-19.

In terms of specific barriers to accessing healthcare, the reconfiguration of services during the COVID-19 pandemic was described by many as impacting on the ability of stateless people (and the wider groups in which they are represented (migrants, refugees, minority groups) to engage with medical care professionals during COVID-19. During COVID-19 lockdowns, many countries operated appointments digitally, which was observed to disadvantage those without access to internet, laptops, and confined to their homes.

Environmental determinants of health and COVID-19

Many of those interviewed described how conditions of housing impacted on the ability for specific groups disproportionately affected by statelessness (for example minority groups including Roma, migrants, and refugees) to adhere to public health guidance relating to social distancing, hygiene, sanitation and mask-wearing. This was viewed as especially difficult during lockdowns for Roma living in congested settlements (for example, in Albania), with poor water and electricity supplies; and for migrants who were referred to as often living in large households in overcrowded apartments. In this sense, those interviewed described a reliance on other members of the community to ensure continued supplies of food and medicines into the settlements or other places of accommodation. Some participants referred to stateless people facing lengthy periods of arbitrary detention in conditions tantamount to degrading treatment, and conducive to the spread of disease and poor mental health.

Focus group facilitators from the Netherlands highlighted participants' experiences of the reduction in medical care within refugee camp settings and immigration detention centres, which were explained to be a direct result of restrictions on NGO service providers' access to these settings:

In refugee camps, medical care is at great shortage. Social distancing is almost impossible to be maintained, and the number of PCR tests done is not enough. NGOs are stopped from entering the camps to provide help or take interviews. Even when an interview was allowed, according to a participant based in the Netherlands, a woman was forced to take it with her children together in the room so that she does not talk honestly about her domestic violence case.

Both focus group participants and interviewees felt that the environmental conditions in which many Romani people live have often been a detriment to their ability to adapt in COVID-19 times, with close living conditions and lack of income increasing their risk of contracting the virus, creating a stressful living environment. Financial sustainability was also seen as a factor for protection from disease, with it being felt that many stateless people may not have the financial means to purchase items not provided for free (such as masks or sanitizer). Focus group participants concurred with these findings, stating the importance of financial sustainability to being able to adhere to public health guidelines. A participant from the Bulgaria focus group simply stated:

> **You pay to visit the doctor, you pay for the PCR test, you pay for medicine. We have to pay for masks, gloves etc.**

Operationalisation of public health guidance

Many of those interviewed observed that COVID-19 public health measures were targeted at the general population and were not reaching the groups to which stateless people belong; thereby heightening health risks, vulnerabilities, discrimination, and social exclusion. The invisible nature of statelessness was observed to make it difficult to target health messages specifically to stateless people. Equally relevant, is the lack of comprehensive data on statelessness in Europe making it difficult to provide evidence to inform policy and practice.

At the time of interview, no respondents from any of the data collection methods reported being aware that stateless people were specifically included in their country or region's COVID-19 information campaigns. That being said, some respondents noted that stateless populations were included on some level by individual NGOs, or with assistance from UNHCR.[16] Many instances were described of NGO-led communication of government health guidance using remote technologies (visual, digital, and multilingual mediums) and mobile health units (for example, in Roma settlements

or refugee camp settings). However, when asked if they felt the public health guidance was delivered effectively to stateless people, a number of key themes emerged.

Firstly, one significant barrier to campaign comprehension was language, with many publications not being produced in a range of languages, and in-person medical advice primarily being provided only in a country's main or official language. Secondly, those who are without internet access, or who do not access services (such as support groups, government offices etc.) may not have received the full guidance being distributed. The impact of this is further exacerbated for those populations who are not able to access medical services due to lack of residence status and documentation. However, a large proportion of survey respondents and interview participants did feel that with the exception of those residing in remote locations, or who faced language barriers, most people (regardless of statelessness) would be aware of the regulations and guidelines, if only through word of mouth and community dissemination.

Thirdly, no research participants were able to confirm whether stateless people or representatives of communities affected by statelessness were consulted in developing their country or region's COVID-19 information and wider response.

Health emergencies, morbidities, and mortalities of stateless people during COVID-19

The impact of statelessness appeared to be ill-considered by some government public health responses. Of the 29 stakeholders who participated in the survey, a large number detailed the increase in emergency health service usage during COVID-19 leading some respondents to report overcrowding in hospitals and limited access emergency care due to restrictions being placed on attendance (for example, a requirement to present a negative COVID test prior to being admitted for emergency care). It was also reported that in some countries (for example, Sweden), a digital ID was required to access a COVID-19 test. Most stateless people do not have a digital ID so are unable to access testing. In contrast to this, many other countries stated that during the pandemic, exceptions were made to such formal ID requirements, enabling all those requiring a COVID test or treatment to be seen, regardless of residence or documentation status.

There were some anecdotal reports by those interviewed of hospitals turning away those with COVID-19 symptoms and without documentation (such as a passport, ID card, stateless status, or residence permit). In COVID-19 times with hospitals overwhelmed this was observed to heighten the vulnerability of stateless people to both

COVID-19 severe disease, and also general ill-health and morbidities. It was also felt by one participant that the additional strain COVID-19 has placed on health services has increased the likelihood of stateless people and other groups being dismissed when raising health concerns, resulting in incorrect diagnosis, or poor-quality care being received. Particularly vulnerable stateless individuals were described to be the elderly; those living with several family or work colleagues in confined spaces; those with existing poor mental health or other identified COVID-19 risk factors or co-morbidities; and women affected by domestic abuse. Several UK respondents described instances of severe COVID-19 disease leading to fatalities due to inability to access medical care.

The role of civil society and best practices in supporting the health response

Both the survey and interviews revealed that whilst some countries did provide some additional measures for identified vulnerable populations such as migrants, minority groups, and the homeless, none specifically targeted stateless people, and the vast majority of actions to protect vulnerable groups were not government-led. Instead, this gap was backfilled by NGOs who operationalised public health information sharing, community support via WhatsApp groups, engaged in the provision of mobile health units, and provided

direct relief (including food packages and other basic necessities). This was further validated by focus group participants. NGOs were reported by many as having been actively providing sanitation and hygiene supplies, masks and food aid to those in need in many countries, however, this was limited due to overwhelming demand for such items. In Serbia, organisations such as the Red Cross distributed food and basic hygiene items to the residents of informal settlements. However, as a representative from Serbia explained, these packages came with a requirement that individuals have personal documentation, which excluded stateless people or those at risk of statelessness from such relief measures.

One example of government intervention in health service delivery was detailed in Croatia, where essential hygiene products, running water and electricity were distributed to a segregated Roma community. Assistance from the government was also reported in France, with free masks and sanitiser being distributed in the streets, as well as increased support being offered in government-run accommodation centres. However, this was not available for those outside of official procedures, including those with irregular residence status or without accommodation. Focus group participants from Estonia also reported that pensioners in the country had received a one-time delivery of 50 disposable face masks, to help them protect themselves.

The Government of Portugal temporarily granted all migrants and asylum seekers residing in the country with pending immigration applications full access to the country's healthcare services. Other good practice government responses mentioned included new ways of surveillance and monitoring of disease spread via "track and trace" Apps; the use of technology to support vulnerable groups; and the extension of residence permits and visas so that individuals could access healthcare during COVID-19 times. Support responses were described as difficult to mobilise, and very dependent on community organisations with existing trust and credibility with stateless people and groups disproportionately affected by statelessness (migrants, refugees, and minority groups). The use of cultural mediators and interpreters was deemed as essential. Other best practices included free COVID-19 testing without any requirement for residence or documentation checks, and the "*Patients not Passports*" toolkit in the UK, accessible regardless of immigration status. There were some reports of exemptions from medical charges when people present with COVID-19 symptoms, but these were not deemed to have been communicated sufficiently by governments.

Institutional mistrust and fear of data sharing between healthcare and immigration authorities

Some interview participants observed that COVID-19 has amplified institutional mistrust, thereby exposing stateless people and groups disproportionately affected by statelessness, to increased health risks. Cultural and language barriers to accessing medical care were described by many. Roma in particular were described as having lasting historical experiences of being turned away from hospitals. Both survey and interview respondents described a heightened fear amongst stateless people and communities of contracting COVID-19 when accessing a medical service, as well as fears of refusal of services, and that information would be shared between the medical practice or hospital and immigration authorities. A resulting reluctance to access healthcare on the part of stateless people was observed by many to contribute to increased levels of ill health.

Legal and immigration processes

Delays in statelessness determination, residence permit, and asylum procedures during COVID-19 were observed by many stakeholders. It was highlighted that this in turn had an impact on the universal right to health and access to healthcare due to the link between proof of residence or identity documentation and health rights.

Civil registration services, such as birth registration, were reported to have continued using adapted formats in many countries (for example, in France procedures were adapted at city levels with cities developing specific guidance to ensure continued birth registrations). However, there were certain time periods during the pandemic when this was not always the case. For example, in Moldova, between 15 March-15 May 2020, only registration of deaths took place, with births being backdated after this point. It was highlighted by some participants (in the Netherlands and Serbia), that whilst civil registration procedures such as birth and death registrations continued to take place, procedures for the acquisition of nationality ceased, resulting in many people being left "*in limbo*" with regards to their nationality status and, in some cases, access to services. COVID-19 restriction measures also impacted on access to lawyers and legal representation.

Additionally, it was reported by the majority that, where applicable, statelessness determination procedures were delayed by COVID-19, with some halting completely, and others moving to online platforms. There were some reports of ceased or interrupted asylum and residence permit procedures during COVID-19; and some reports of extended deadlines. Some governments shifted to online renewals of residence permits, potentially excluding those without access to the internet or a computer. Digital exclusion was described by many as impacting severely on those without access to laptops and the internet.

A small number of respondents detailed varying practices with some governments automatically extending temporary residence permits (for example, Portugal, Croatia and France) at the onset of national lockdowns and restrictions of movement. Others, such as Switzerland, failed to provide any amnesty to those with expiring temporary residence permits. One participant from the Netherlands focus group who was residing in what they described as a "refugee camp" detailed their experience of delays as a result of COVID-19:

> 66 It took me 9 months to have my case proceeded, during these months I was at risk because I was sharing rooms and bathrooms with other people and it was very risky and hard to be safe. There were loads of cases in the camp without proper precautions, so I left.

The majority of research participants indicated that no attempts had been made by governments to create a firewall between health and immigration authorities during COVID-19. One participant referred to Ireland, where the Irish Government has firewalled their national health service data from other government departments.

There were also some reports of people being released from immigration detention during the pandemic. However, concerns were raised with regard to the lack of housing and food

aid support offered to those released. Others described extensions so that people could stay on in asylum reception centres. However, it was also reported that some asylum reception centres were shut down during this time due to staff shortages.

When asked what solutions could be operationalised to support stateless people during COVID-19, an overwhelming majority of interview participants recommended that governments grant residence permits and identity documents to all affected. As one UK participant said:

> **"** It makes absolute sense for all those in the legal process or who are undocumented to immediately be given "Indefinite Leave to Remain" so that their personal safety and the safety of the community generally is on a better footing.

Socio-economic exclusion, and lack of access to government support packages

Many participants observed how COVID-19 and its restriction measures have exacerbated the existing discrimination, social exclusion and deprivation experienced by many stateless people. For example, the impact on living conditions; loss of informal employment;

working whilst sick and without adequate protection from disease; and inability to access government pandemic employment assistance and non-emergency or "medically necessary" healthcare were mentioned. Many also described the difficulties in supporting children's continued home schooling due to lack of space, access to laptops, and internet. There was a huge variation in the financial assistance made available to people in their country or region. There was consensus across the survey and interview respondents that stateless people are impacted by lack of access to public services and social security systems. This impacted on their ability to meet their financial and basic needs during COVID-19 lockdown measures. Focus group participants from Albania reported that whilst two government financial grants had been made available during the pandemic, at the point of interview, only one had been paid out. Additional examples of responses from the survey regarding government pandemic support packages, and their eligibility criteria include:

The Netherlands: "*No, only Dutch companies and employees are receiving financial support packages; people with a migrant background are often left out, and for Roma it is even worse, they are not being supported financially from the government in any way for extra help and such.*"

Ukraine: "*There was no financial support available for anyone.*"

France: "*Exceptional financial support was proposed to precarious households and young persons who already benefit from other financial allowances (requiring legal stay). These are not applied to asylum seekers or irregular migrants which can include stateless persons. However, persons benefiting from a stateless status by the OFPRA could benefit of this support if they meet the criteria.*"

Georgia: "*Stateless persons were among the beneficiaries of the government anti-crisis/economic recovery plan but unfortunately not all can benefit. There is a distinction between stateless people with permanent and temporary residence permits. Those with permanent residence permits qualify for assistance, others can't.*"

Serbia: "*In April 2020, the Government brought a decision to pay 100 euros to all citizens in order to reduce the negative effects of the epidemic. However, stateless persons, persons without permanent residence and a valid identity card (the vast majority being of Roma nationality [sic]) were excluded from this measure.*"

Stigma, scapegoating and hate crime

Some observations were made by research participants about a prevalence of political rhetoric blaming Roma or migrants for the spread of disease. Some participants in the survey and during interview reported anecdotal instances of scapegoating, hate speech and discrimination against several groups which are disproportionately affected by statelessness. This was especially the case for Roma and Irish Traveller communities, ethnic Russians, refugees and migrants. Five out of eight (Romani) participants from the Albania focus group reported that on social media they had seen hate speech against their communities such as calling them dirty and being responsible for spreading the virus. Survey respondents provided further examples:

"Not specifically against stateless persons. More generally there were some negative media reports about persons with migrant background travelling to their countries of origin (mainly on the Balkans) and "bringing in/bringing back" the virus."

"Whilst not definitely a proven link, for the first time ever, the exterior walls of CPR's reception centre for asylum seeker have been vandalised three times with racist and xenophobic messages targeting refugees."

"Hate speech against Roma and Travellers rose in some countries during the COVID-19 lockdown measures. Politicians would use them as scapegoats for the spread of the virus based on stereotypes. (ex. Bulgaria and Ireland)."

Vaccination roll out: universal?

At the time of this assessment, no stakeholders were able to provide information around the COVID-19 vaccination protocol, and whether stateless populations would be included in vaccination programmes.[17] One participant observed; *"the virus is invisible and so are stateless people"*. Their realities are hidden and forgotten.

The lack of institutional trust among many stateless populations was observed by many to be a factor that is likely to hamper government roll out of a comprehensive public health vaccination programme spanning test, trace, contact, and vaccinate. The challenges highlighted in this regard included how to address discrimination in access to healthcare, how to reach those invisible to the system, how to secure consent to vaccinate, and how to ensure follow up for second doses of vaccinations. A particular challenge highlighted was how to reach stateless people who are homeless or living in informal settlements. NGOs and mobile health units travelling to communities were seen as crucial to vaccination rollouts to reach stateless people in the community and ensure dose continuity.

Some detailed observations were made by interviewees about vaccine hesitancy and the impact of historical mistrust of State institutions, particularly among Roma communities. One participant referred to a PICUM (Platform for International Cooperation on Undocumented Migrants) press release, which highlights the complexities of excluding those who fear to engage with public officials for fear of deportation, even when gravely ill and states:

> ❝ Any vaccination campaign, to be effective, has to cover virtually everyone. Including undocumented people is not only humane, it's also public health common sense. We're all in this together, and only together can we win this battle.

Conclusions

Above all, it is the *invisible* nature of both the COVID-19 virus in the community, and of stateless people in European policy, practice and research that is highlighted in this rapid situation assessment conducted in late 2020 and early 2021. Whilst groups disproportionately affected by statelessness in Europe, including refugees, migrants, Roma, and minority groups are identified here as severely affected by COVID-19 (and in many cases neglected in public health policy responses to the pandemic), the statelessness aspect, which overarches the European context, is omitted almost entirely. In practice, State policies and measures that intend to demonstrate inclusive support for all, including those particularly vulnerable during COVID-19, are not necessarily translating into the inclusion of stateless people.

Despite strong advocacy by civil society and international organisations including UNHCR during the pandemic, the data retrieved illustrates that stateless people experience extraordinary vulnerabilities and rights violations in relation to health. It draws attention to their invisible nature in communities, policies, countries, and at the European level. It reveals a clear absence of specific empirical evidence and attention, by States, on the implications of statelessness for effectively addressing COVID-19. Our findings underscore the importance of exercising the right to a nationality (and the concomitant realisation of the right to health, housing, food, and access to healthcare, education, legal, and other public services without discrimination) during COVID-19 and beyond in order to realise a comprehensive and inclusive public health response.

Whilst the right to healthcare is a fundamental human right, with universal application and with access to healthcare services ensured to every human being without regards to race, religion or other criteria, including legal status (UNHCR, 2008; Rechel et al., 2013), the review of literature and primary data collected here is unequivocal: this is not the case for many stateless people.

Stateless people and communities in Europe are at great risk of *being left behind*. Their often-precarious legal status underpins a profound reluctance or acute anxiety about help-seeking, grounded in experiences of discrimination, mistrust of authorities, fear of detention or deportation, and distress at the threat of separation from their survival support relationships and systems. Being stateless leaves many politically, socio-economically, and culturally marginalised, discriminated against and vulnerable to exploitation and abuse. Without legal rights and access to essential services, including healthcare, many are precluded from or face obstacles in accessing COVID-19 testing and medical care. Their long-term physical and mental health is compromised.

During the COVID-19 health emergency, as illustrated in this report, the nexus between existing adverse environmental determinants of health has compounded the barriers stateless people face to accessing healthcare; their lack of access to public services (health, social, housing, financial, legal, educational, and food aid)

and the concerning rise in scapegoating of populations that include people affected by statelessness are further inhibitors. There are significant health vulnerabilities pertaining to context, whether in densely populated areas, such as camps, collective shelters and informal settlements, social housing, or in immigration multiple occupancy or detention settings. Such environmental, social, and structural determinants of health, which fuel the health disparity of stateless people, are crucial to address during and beyond the COVID-19 pandemic.

The necessity of an inclusive human rights and public health response during the COVID-19 health emergency is underpinned through the emphasis that the "*primary focus should be on the preservation of life, regardless of status*".[18] A joint statement released by 84 civil society organisations released on 27 May 2020 states:

> **Denied nationality and deprived basic rights and welfare, the stateless were already marginalised before the crisis. They now face even greater, life-threatening marginalisation, with potentially disastrous consequences.[19]**

Throughout the pandemic, UNHCR has encouraged a focus on inclusion and access to testing, treatment, and vaccination of all "persons of concern"[20] on a par with

nationals, whilst alerting countries of any potential practical barriers for stateless persons, including due to lack of legal status and documentation (ID documents, proof of residency, health insurance etc.). In its COVID-19 preparedness and response (UNHCR, 2020b) of 9 June 2020, UNHCR recommended a focus on accessibility of health services, particularly COVID-19 testing and treatment regardless of legal status; enabling people to access services without fear or risk of arrest or detention, including them in accessible information campaigns; minimising risks of statelessness due to lack of documentation during the pandemic, addressing arbitrary immigration detention; ensuring response measures do not fuel racial discrimination, antigypsyism, hate crime and xenophobia, and extending COVID support packages to all, regardless of legal status. UNHCR also called on the EU to step up its role in the protection of refugees, forcibly displaced and stateless people, inside and outside its borders, by ensuring adequate health and socio-economic service access, financial support, and empowerment of refugees and stateless people to support the response.

Recommendations

Based on our findings and building on the recommendations of others, we make the following detailed recommendations, which are focused on guaranteeing the right to health for stateless persons, improving the public health response to COVID-19 for stateless communities, and leveraging the COVID-19 pandemic to secure policy reform towards ending statelessness and the discrimination and rights violations experienced by stateless people.

1. The Right to Health

1.1

States must guarantee the right to health of all on their territory, including stateless persons during and after COVID-19.

1.2

States should consider regularising all stateless people during public health emergencies in order to guarantee the right to health. In the longer-term and where they have not yet done so, States should introduce mechanisms to identify and resolve cases of statelessness on their territory as well as statelessness determination procedures to guarantee stateless migrants the protection they are due under the 1954 Convention.

1.3

States must uphold the protection of life and health for all stateless persons via appropriate disease mitigation and support measures in camps, shelters, settlements, social housing and immigration detention settings; and including those who are homeless. Stateless people and their communities no matter what setting (spanning community, accommodation centres, and immigration detention settings) must be provided with personal protective equipment (masks) and other basic necessities (handwash, soap, hot and clean water, towels).

1.4

States must not detain stateless people under the pretext of disease prevention or containment. States are obliged to take steps to prevent the arbitrary detention of stateless people and ensure full access to rights and services whilst providing sufficient housing, health, and social care (including childcare) support on release from immigration detention.

2. Access to COVID-19 testing, treatment, and vaccines

2.1

The absence of formal documentation cannot be a barrier to COVID-19 testing, treatment, or vaccination. In close cooperation with trusted community-based NGOs, and fully supported through direct involvement by individuals and groups from these communities themselves, COVID vaccination deployment must target and include those who are stateless or at risk of statelessness. In the course of assuring informed consent and providing care, clear assurances must be made that any information informally or formally obtained about a person's residence or legal status will not be shared with other government departments or used against them in any way, including in immigration proceedings.

3. Immigration, nationality, international protection, and civil registration procedures

3.1

States must uphold the norms of due process in administrative and legal procedures during a pandemic and desist from any that increase risk to health and life due to transmission of COVID-19.

3.2

States should consider automatically extending residence permits during a pandemic to avoid discrimination in access to healthcare and other essential services.

3.3

States are recommended to designate civil registration activities, including birth registration, as essential services, allowing their continuation during a public health emergency and minimising the risk of statelessness owing to a lack of legal proof of identity or nationality. Where delay to legal procedures, including immigration, nationality and international protection procedures is unavoidable, no-one should be disadvantaged or penalised as a result.

3.4

States must take urgent action to guarantee children born in Europe during COVID-19 and

beyond, their right to acquire a nationality by improving knowledge and awareness of officials, ensuring statelessness is identified and addressed, and accurately determining every child's nationality.

4. Addressing discrimination, racism and antigypsyism

4.1

Notwithstanding and recognising the significant challenges faced by healthcare services during a pandemic, States must take action to ensure all persons, including stateless persons, have equal access to preventive, curative and palliative health services, regardless of their residence or documentation status, or any aspect of their identity. COVID-19 testing, tracing, treatment, and vaccination should be free and accessible for all regardless of nationality or residence status. Emergency and follow-up care should be provided in a non-discriminatory manner including the provision of essential medicines, prevention, treatment, and support.

4.2

States must take steps to address the increase in hate speech, xenophobia, racism and antigypsyism that has emerged during the pandemic and ensure that public health and law enforcement response measures do not fuel xenophobia and racism.

4.3

States are advised to put in place measures to eradicate institutional racism, including antigypsyism, by involving people affected by statelessness in the development of learning opportunities for healthcare providers on accessing the right to health and healthcare, developing E-learning modules in medical schools, and continuing professional development.

4.4

Stateless people and representatives of communities affected by statelessness, including Romani people and Roma advocates, should be represented and able to participate in planning and decision-making process that affect their lives.

5. Health information and digital inclusion

5.1

States should ensure that stateless people are included in public health information campaigns taking account of location, language, and communication preferences.

5.2

States and non-State actors are recommended to operationalise innovative ways to engage and reach stateless people with information, supporting access to COVID-19 testing, tracing, treatment, and vaccinations. This could include mobile health units, health mentoring, cultural mediation using translators and interpreters, and a range of media outputs in different languages and formats.

5.3

States are recommended to take steps to reduce digital exclusion, particularly as it impacts on access to health information, appointments, or registration with healthcare services. Support should be provided to access the internet, information, and digital equipment where needed.

6. State aid and humanitarian response packages

6.1

States should ensure that those stateless people who have lost their income and/or residence status because of COVID-19 have access to social security providing the minimum essential level of support to include housing and shelter, education, healthcare, water, sanitation, and food, while their residence or nationality status is regularised.

6.2

States are recommended to ensure access to financial and food aid support packages to all on the territory who meet the criteria, regardless of residence or documentation status. Humanitarian aid packages should be distributed based on need and reach all populations, regardless of legal status.

7. Addressing the invisibility of statelessness whilst upholding the right to privacy

7.1

States are recommended to take steps to address the invisible nature of statelessness by improving available data, including (anonymised) health monitoring data, to generate evidence-based policies and support all stakeholders working to monitor the impact of the pandemic on stateless communities and ensure stateless people access their rights.

7.2

States must uphold the right to privacy of medical records and are recommended to adopt a firewall between health and other government departments, including immigration authorities, to enable stateless people to access services (including COVID-19 vaccinations) without fear and risk of arrest or detention. Sharing data with immigration

authorities undermines data collection as it causes individuals to avoid accessing services and withhold data from health services. It may also lead to NGOs withholding data from data collection mechanisms to protect patients. Rights-based legal safeguards must govern the appropriate use and handling of personal health data.

8. Support for civil society

8.1

States and non-State actors should support and involve trusted networks of NGOs and community organisations in public health responses to ensure stateless people access timely social and health rights awareness from trusted sources, encourage face-to-face and virtual mentoring, operationalise hotlines, support health literacy and informed consent regarding COVID-19 vaccinations, and facilitate access to public services and support.

8.2

States and non-State actors should support the involvement and representation of stateless people and communities in State policy, programmes, and activities.

9. Further research

9.1

The availability of robust evidence to inform policy and practice is an imperative; and more research on stateless populations in general across Europe spanning all aspects of human rights law, health and social justice is recommended. Communication and dissemination of academic outputs is vital to inform and achieve greater visibility in policy and advocacy related actions.

9.2

Researchers should take a rights-based approach to research design, and participatory action research methodologies to ensure the voices of stateless people are heard, are crucial. Sensitive and ethical approaches to conducting research on stateless populations is important. Detailed research investigating gendered and cultural aspects of the nexus between health rights and statelessness is also warranted, as is further research on the impact of statelessness on mental health, access to mental health support structures, and the effects of repressive rules and regulations governing access to rights and public services for stateless individuals and families.

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Annex I: Methodology

Overarching Aim of the Research

The design of this situation assessment was underpinned by a robust multi-stakeholder, inter-sectoral and participatory focus allowing the voices of those most affected to illustrate the impact of statelessness on the right to health, health inequality and health outcomes in different contexts, and across different European countries.

The key overarching research objectives were:

- To better understand the barriers in access to healthcare faced by stateless people both generally and in relation to COVID-19, and how these may be similar to – or differ from – other marginalised groups.
- To explore the impact of these barriers on health outcomes taking an intersectional approach to identify the different factors that may impact on the health rights and outcomes of stateless people.
- To identify common themes across different European countries to inform recommendations for policy responses that are relevant regionally and internationally.
- To identify areas of the health nexus with statelessness that require further focused research and attention.

Scoping Review

In the first instance, a rapid scoping review of extant literature on statelessness, health, and COVID-19 in the 47 Council of Europe (CoE) member states was conducted. A six-stage step by step protocol was used to identify and analyse all relevant available sources of information (Levac, Colquhoun and O'Brien; 2010; Arksey and O'Malley, 2005; Daudt, van Mossel, Scott, 2013). The underpinning research question was: "*What is known about the nexus between statelessness and health in the context of COVID-19 in CoE member states?*"

Key objectives were to map and describe all literature pertaining to:

- Barriers in access to healthcare faced by stateless people both generally and in relation to COVID-19, and how these may be similar to – or differ from – other marginalised groups.
- Impact of these barriers on health outcomes taking an intersectional approach to identify the different factors that may impact on the health rights and outcomes of stateless people.
- Identification of common themes across different European/CoE countries to inform recommendations for policy responses that

are relevant regionally and internationally.
- Identification of the health nexus with statelessness that require further focused research and attention.

This review[21] subsequently informed the development of a mixed-method research design (interview/focus group guides/data collection sheet), the generation of a listing of key stakeholders and prioritisation of countries, recruitment, ethical and translation procedures, and data collection and analysis approaches.

Research Approach

The project was supported by an Expert Advisory Group who brought additional expertise in relevant areas to the project, supported a nuanced analysis of the research findings, and ensured as wide as possible relevance of policy recommendations in Europe and globally.

The project was first introduced to approximately 50 ENS members by Professor Marie Claire Van Hout[22] and Researcher Charlotte Bigland[23], Liverpool John Moores University, and ENS Head of Policy & Research, Nina Murray[24], with an interactive session at the ENS Online Annual General Conference

held on 5 November 2020. This discussion was used to raise awareness of the project among ENS members and inform data collection instruments and priority countries. It also supported the recruitment and assessment process.

Key research questions underpinning the rapid situation assessment were:

- What are the barriers in access to healthcare faced by stateless people both generally and in relation to COVID-19, and how are these similar to – or different from – other marginalised groups?
- What is the impact of these barriers on health outcomes taking an intersectional approach to identify the different factors that may impact on the health rights and outcomes of stateless people?

Key stakeholders for interview were identified by the ENS Secretariat, research team, the advisory group, and the scoping review. They consisted of European country stakeholders (e.g., health policy makers, national and regional non-governmental organisations (NGOs), justice, immigration, public health/health inequalities experts/officials), regional stakeholders, international organisations, and other identified key informants.

Priority countries were identified for focus group discussions based on a variety of factors, including the desire to cover countries with different stateless populations, legal systems, geographic spread across the region, and the availability of ENS members with links to stateless communities to facilitate the focus group discussions. The five priority countries identified were: Albania, Bulgaria, The Netherlands, Estonia, and France.

Data Collection

The situation assessment consisted of three phases of data collection (see Annex III for data collection instruments).

Phase One: An online survey consisting of a series of open-ended textual questions was circulated to identified key stakeholders in all CoE member states in which ENS has subscribed contacts (n=2000). The survey contained a variety of open-ended questions around each stakeholder's perceptions of the wider nexus between statelessness and health rights, and how the COVID-19 pandemic affected stateless people in their country or region. Contacts were encouraged to disseminate the survey beyond direct ENS contacts to their networks.

Phase Two: Interviews and small focus group discussions of 2-3 people of 45-60 minutes were conducted via MS Teams with the agreed listing of key national and regional stakeholders in Europe. Discussion centred on perceptions of the wider nexus between statelessness and health rights, and how the COVID-19 pandemic affected stateless people in their country or region.

Phase Three: Peer-led participatory research led by community organisations and/or NGOs was conducted in the five priority countries. Each community organisation or NGO used an identified gatekeeper to host a virtual focus group of 60-90 mins with adult stateless persons using the questions provided. Each gatekeeper was interviewed prior to hosting the focus group and received training from Charlotte Bigland on how to facilitate the focus group, as well as obligations around gatekeeper consent. All focus group participants were fully informed via the information sheet provided to them by the gatekeepers and provided verbal consent to the gatekeeper prior to agreeing to take part. They had three days to reflect on whether they wished to participate. The focus group focused on (stateless) community perceptions of the wider nexus between statelessness and health rights, and the impact of COVID-19 for their communities. After the focus group, the gatekeeper was asked to write a concise report indicating general responses to each question.

Ethical Approval

Ethical approval was sought and acquired from Liverpool John Moores University, UK, on 29 October 2020.

Data Analysis and Synthesis

Triangulated data consisting of *Phase One, Two* and *Three* were combined and analysed textually and thematically. The analysis identified common themes across the region and are presented to inform recommendations for relevant and targeted policy responses for regional, national, and international application. Areas of the health nexus with statelessness that require further focused research and attention are presented in the Conclusions and Recommendations chapters.

Participants and NGOs who acted as gatekeepers and facilitated the focus groups were given the opportunity to review the presented findings to clarify any issues arising, and to confirm presentation and interpretation.

Findings were presented to the EAG for discussion, and the report was subsequently provided to EAG members for written comments and input.

Annex II: EAG Members & Country Partners

Expert Advisory Group Members

Name	Organisation
Amal de Chickera	Institute on Statelessness and Inclusion
Michelle Van Burik Bihari	Roma Association Utrecht
Christiana Bukalo	Creator of statefree.world
Nicole Seguy	World Health Organisation (WHO) Europe
Lena Haap	UN High Commission for Refugees (UNHCR) Europe Bureau
Anna Miller	Doctors of the World (UK)
Talha Burki	Health Journalist

Priority Countries & National NGO Partners

Country	Partner
Albania	Roma Active Albania
Bulgaria	Foundation for Access to Rights
The Netherlands	New Women Connectors
Estonia	Legal Information Centre for Human Rights
France	Forum Réfugiés-Cosi

Annex III: Data Collection Instruments

1. CoE-wide survey to all ENS Subscribers

About the research

COVID-19 is a serious challenge to public health systems around the world and has serious consequences for the situation and health of stateless people in Europe.

We want to understand the barriers in access to healthcare faced by stateless people both generally and in relation to COVID-19, and how these are similar to – or different from – other marginalised groups. We also want to understand the impact of these barriers on health outcomes, identifying the different factors that may impact on the health rights and outcomes of different groups of stateless people.

Our research concerns all stateless people in Europe (whether legally recognised as such under a statelessness determination procedure or not) including those with undetermined nationality.

The project is led by the European Network on Statelessness. The research is being carried out by consultants commissioned by ENS from the Public Health Institute, Liverpool John Moores University (UK). The project is funded by Rosa Luxemburg-Stiftung Geneva.

Instructions for completing the survey

Please answer the questions according to the information currently available to you.

You do not need to answer all questions. You can skip any questions that you do not wish to, or are unable to, answer.

You may submit the survey anonymously if you wish simply by not completing the "About You" section at the end of the survey.

The deadline for completing the survey is **Monday 21 December at 5pm GMT.**

Survey

In all your answers, please provide details and disaggregation of data related to stateless population (for example ethnic Russian, Roma, or other ethnic minorities) or legal status (e.g. asylum-seeker, refugee, migrant, worker, undocumented), and women, children/minors, elderly, sexual orientation and gender identity (SOGI), persons with disabilities or other relevant data whenever possible and applicable.

Page 1 – general info

1. What is your country/region of work?

2. How has the COVID-19 situation affected health services in your country/region in terms of coverage, access and availability to all who require them?

3. Are health services in general in your country/region accessible to stateless people? Please state if this is applicable to all stateless people or only those formally determined to be stateless under a Statelessness Determination Procedure (if relevant). Are COVID-19 testing and treatment services accessible to all regardless of nationality status?

Page 2 – COVID-19 response measures

4. Were there any government measures introduced to help health service delivery or accessibility to health services in general during the pandemic (e.g. free masks, gloves, disinfectants, extra funding for services, exemption from charging/ health insurance for certain groups etc.)? Were these available to stateless people? Please state if this was applicable to all stateless people or only those formally determined to be stateless under a Statelessness Determination Procedure (if relevant).

5. Have stateless people and communities experienced COVID-19 outbreaks in your country/region?

6. Were stateless people included in your country/region's COVID-19 information campaigns (language, location, communication preferences)?

7. Were stateless people and/or representatives of communities affected by statelessness consulted in developing your country/region's COVID-19 information/ wider response?

8. Have they been fully informed in terms of the public health guidance? If not, why?

9. Have stateless people in your country/ region been able to protect themselves during the pandemic (social distancing, handwashing, wearing of masks)? If not, why?

Page 3 – access to healthcare services

10. Do stateless people in your country/ region experience barriers to accessing healthcare in general? If yes, what are they? Are there any differences between groups (e.g. stateless people with residence permit or otherwise), or between ages, genders, sexual orientation and gender identity, persons with disabilities? Are there any differences between services (e.g. primary and secondary care, reproductive and maternity services, mental health, prescriptions, etc.)?

11. Have stateless people in your country/ region experienced barriers to accessing healthcare (either COVID-specific or non-COVID healthcare) during the public health emergency? If yes, what are they? Are they any different (better/worse) than before COVID-19? Are particular services more difficult to access than others (e.g. mental health, maternity care, primary/secondary care, COVID-19 testing and treatment, etc.)?

12. Has your government/governments in your region created a firewall between health and immigration services during the pandemic to enable stateless people to access services without fear and risk of arrest or detention?

Page 4 – specific impacts on stateless populations

13. Did your government/governments in your region designate statelessness determination procedures (where relevant) as "essential" services allowing their continuation and minimising risk of people facing delays in decision-making?

14. Did your government/governments in your region designate civil registration (e.g. birth registration), as "essential" services, allowing their continuation and minimising the risk that people may end up stateless owing to a lack of proof of identity or entitlement to nationality?

15. Is there any difference between health service provision to stateless people living in different accommodation settings (e.g. in the community compared to immigration detention or other closed settings like reception centres or camps) or based on their housing status (e.g. living in informal settlements, homeless, etc.)? Have any

mitigating measures been taken to ensure accessibility of healthcare in response to COVID-19 regardless of housing status?

Page 5 – wider impacts of the pandemic

16. Has your government/governments in your region extended financial support packages to all who are resident on the territory who meet the eligibility criteria, regardless of nationality status?

17. Have COVID-19 response measures in your country/region fuelled xenophobia, hate crime and racial discrimination against stateless people (including online/in the media)?

18. Has your government/governments in your region taken any steps to ensure future treatments and vaccines for COVID-19 will be available to all, regardless of nationality status?

Page 6 – examples of good practice

19. We would like to collect practical examples of how governments, NGOs, healthcare providers and others have responded to the pandemic to learn about best practices that could be useful in the future in supporting stateless people. Please provide an example of how your government/ governments in your region or NGOs or another organisation changed something or did something differently that had a positive impact on the health rights of stateless people in your country/region.

• Can you describe any examples of good practice responses?
• Can you propose any recommendations for policy, practice (response) and research going forward?

Page 7 – about you

You do not need to provide us with any information about you if you wish your survey response to remain anonymous. If you would like us to keep you informed about the project and research findings, please provide your contact details. Please indicate if you consent to your survey responses being attributed to you in the research report and other related publications.

Please choose one of the following options I would like my survey response to remain anonymous

☐ I would like to receive updates about this research, including the research report but I do not wish to be quoted in the report
☐ I would like to receive updates about this research, including the research report and I am happy for my survey response to be quoted/attributed to me (tick box, provide field for name, affiliation, country/region, and email address)

Name:

Organisation/affiliation:

Email:

Thank you very much for taking the time to respond.

How we will use the survey responses

We are seeking the views of a range of stakeholders through the survey, interviews, and focus groups taking place in December and January. Survey responses will be analysed alongside the interview and focus group data and written up into a report and policy briefing. We will publish and disseminate our findings online, setting out a series of policy recommendations to inform the global response to the pandemic and help protect the rights of stateless people.

Data Protection Notice

The data controller for this study is the European Network on Statelessness (ENS). ENS provides oversight of activities involving the processing of personal data and can be contacted at info@statelessness.eu. This means that ENS is responsible for looking after your information and using it properly. ENS will process your personal data for the purpose of research. Your rights to access, change, or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and

accurate. You can find out more about how we use your information by contacting info@statelessness.eu. If you are concerned about how your personal data is being processed, please contact ENS in the first instance. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

The data that we collect from you may be transferred to and processed by staff working with ENS as research consultants or in another capacity. Any such data sharing will be covered by the same conditions as specified above.

For more information on how we process data please read our online privacy notice or contact us on info@statelessness.eu.

2. Virtual interviews and Focus Group Discussions with national and regional stakeholders and NGO/community gatekeepers in priority countries

Thank you for your participation in this focus group discussion/interview.

COVID-19 is a serious challenge to public health systems around the world, and has serious consequences for the situation and health of stateless people in Europe. We want to understand the barriers in access to healthcare faced by stateless people both generally and in relation to COVID-19, and how these are similar to – or different from – other marginalised groups. We also want to understand the impact of these barriers on health outcomes, taking an intersectional approach to identify the different factors that may impact on the health rights and outcomes of stateless people.

Our research concerns all stateless people in Europe (whether legally recognised as such under a statelessness determination procedure or not) including those with undetermined nationality.

In all your answers, please provide details and disaggregation of data related to stateless population (for example ethnic Russian, Roma, or other ethnic minorities) or legal status (e.g. asylum-seeker, refugee, migrant, worker, undocumented), and women, children/minors, elderly, sexual orientation and gender identity (SOGI), persons with disabilities or other relevant data whenever possible and applicable.

Please answer these questions according to the information currently available to you.

We would like to discuss the nexus between health and statelessness in your country/context with a particular focus on COVID-19.

- Can you tell me a little bit about the stateless population in your country/context (for example ethnic Russian, Roma, migrant, refugee, or other ethnic minorities)?
- How has the COVID-19 situation affected health services in your country/region in terms of coverage, access, and availability to all who require them?
- Are health services in general in your country/region accessible to stateless people? Please state if this is applicable to all stateless people or only those formally determined to be stateless under a Statelessness Determination Procedure (if relevant). Are COVID-19 testing and treatment services accessible to all regardless of nationality status?
- Were there any government measures introduced to help health service delivery or accessibility to health services in general during the pandemic (e.g. free masks, gloves, disinfectants, extra funding for services, exemption from charging/health insurance for certain groups etc.)? Were these available to stateless people? Please state if this was applicable to all stateless people or only those formally determined to be stateless under a Statelessness Determination Procedure (if relevant).
- Have stateless persons and communities experienced COVID-19 outbreaks in your country/region?
- Were stateless people included in your country/region's COVID-19 information campaigns (language, location, communication preferences)?
- Were stateless people and/or representatives of communities affected by statelessness consulted in developing your country/region's COVID-19 information/wider response?
- Have they been fully informed in terms of the public health guidance? If not, why?
- Have stateless people in your country/region been able to protect themselves (social distancing, handwashing, wearing of masks)? If not, why?
- Do stateless people in your country/region experience barriers to accessing healthcare in general? If yes, what are they? Are there any differences between groups (e.g. stateless people with residence permit or otherwise), or between ages, genders, sexual orientation and gender identity, persons with disabilities? Are there any differences between services (e.g. primary and secondary care, reproductive and maternity services, mental health, prescriptions, etc.)?

- Have stateless people in your country/region experienced barriers to accessing healthcare (either COVID-specific or non-COVID healthcare) during the public health emergency? If yes, what are they? Are they any different (better/worse) than before COVID-19? Are particular services more difficult to access than others (e.g. mental health, maternity care, primary/secondary care, COVID-19 testing and treatment, etc.)?
- Has your government/governments in your region created a firewall between health and immigration services during the pandemic to enable stateless people to access services without fear and risk of arrest or detention?
- Did your government/governments in your region designate statelessness determination procedures (where relevant) as "essential" services allowing their continuation and minimising risk of people facing delays in decision-making?
- Did your government/governments in your region designate civil registration (e.g. birth registration), as "essential" services, allowing their continuation and minimising the risk that people may end up stateless owing to a lack of proof of identity or entitlement to nationality?
- Is there any difference between health service provision to stateless people living in different accommodation settings (e.g. in the community compared to immigration detention or other closed settings like reception centres or camps) or based on

their housing status (e.g. living in informal settlements, homeless, etc.)? Have any mitigating measures been taken to ensure accessibility of healthcare in response to COVID-19 regardless of housing status?
- Is there any difference between health service provision to stateless persons in the community compared to immigration detention settings or other closed settings (e.g. reception centres, camps)? Have any mitigating measures been taken in these settings in response to COVID-19?
- Has your government/governments in the region extended financial support packages to all who are resident on the territory who meet the eligibility criteria, regardless of nationality status?
- Have COVID-19 response measures in your country/region fuelled xenophobia, hate crime and racial discrimination against stateless people (including online/in the media)?
- Has your government/governments in your region taken any steps to ensure future treatments and vaccines for COVID-19 will be available to all, regardless of nationality status?
- We would like to collect practical examples of how governments, NGOs and others responded to the emergency situation to learn about best practices that could be useful in the future in supporting stateless people. Please provide an example of how a government or NGO or another organisation changed something or did something differently that had a positive

impact on the health rights of stateless people in your country.
- Can you describe any examples of good practice responses?
- Can you propose any recommendations for policy, practice (response) and research going forward?

Thank you for your responses.

3. Focus Group Protocol

Step 1: **Recruiting and Informing Participants: We are asking you to recruit participants for focus groups through your known network, or by appropriately advertising participation through your organisation's available channels. When recruiting, it is very important that participants are given a participant information sheet.** Participants should have seen and understood the participant information sheet prior to agreeing to participate in the focus group. Please ensure the sheet is read out/discussed further if required. Participants should be informed about the topics that will be discussed, how the information will be used, and who will participate in the focus group so that they may make an informed decision to participate beforehand, all of which can be found in the participant information sheet.

Step 2: **Rules, Risks and Confidentiality: At the start of the focus group, the facilitator should explain that this is a confidential focus group, and that what is discussed should not be talked about outside of the group. Additionally, please ask that people respect other participants' views and answers.** Please reiterate that the data will be anonymised and that participants do not have to answer any questions that make them feel uncomfortable and can withdraw at any point. The researcher will also explain that,

if participants give them cause for concern about their own or anyone else's safety that they will have to break confidentiality.

Step 3: **Facilitate:** Please be considerate and respectful of people's different experiences and viewpoints and try to encourage all to be involved. Ensure that the focus group is conducted in a timely manner and participants are thanked at the end for taking part. Please also seek participants' consent to contact them after the focus group to share the research findings and inform them about future work on this issue.

Virtual Focus Groups with stateless people facilitated by NGO/community gatekeepers in priority countries[25]

Thank you for agreeing to take part in this research on statelessness and health, and the impact of COVID-19 on you, your families, and your community.

COVID-19 is a serious challenge to public health, with serious consequences for the entire population, including you, your families, and members of your communities.

We want to understand the barriers in access to healthcare that you and your community face both generally and in relation to COVID-19, and how these are similar to – or different from – other groups. We also want to understand the impact of these

barriers on the health of different people and communities affected by statelessness.

Please answer these questions from your perspective on the situation for your families and communities. The questions are not necessarily directed at you personally, and your answers are confidential, anonymous, and you have the right to withdraw from the focus group at any stage (see Information and Consent Sheet). We would like to discuss with you and better understand how being stateless may affect your access to healthcare, particularly at this critical time of a pandemic.

- Can you tell me a little bit about yourself and your community (are you ethnic Russian, Roma, migrant, refugee or other ethnic minorities)?
- Can your family and/or your community access health services if you feel unwell (in general)? If not, can you describe why they can't access healthcare?
- Do you know what COVID-19 is and how it is spread?
- Have you seen/understood any national public health information on COVID-19?
- Do you know how the COVID-19 situation affected the provision of health services in your country?
- Is COVID-19 testing and treatment accessible to your family and/or your community?

- Do you and/or other members of your family/community have access to free masks, gloves, disinfectants, extra funding, etc.?
- Has anything changed with regards to your/your family/community's access to healthcare since COVID-19?
- Have services been interrupted for your family or your community, for example ante-natal care, medical care for elderly or persons with disabilities in your family, your children?
- Have your family or your community been able to protect themselves (social distancing, handwashing, wearing of masks)? If not, why?
- Has your family/community been able to access covid-19 services (testing, treatment, contact tracing)?
- Can you describe what happened?
- Do you know if civil registration activities (e.g. birth registration) and other legal procedures (e.g. relating to residence permits) have been maintained in your country? If not, has this affected your family or your community?
- Do you know anyone released from pre-removal detention since the COVID-19 emergency?
- Have your family or your community experienced an increase in hate crime, racial discrimination, antigypsyism or xenophobia, either directly or indirectly since the COVID-19 pandemic happened in your country?
- Are your family or your community able to access government financial support packages since COVID-19 happened?
- Has your government/governments in your region taken any steps to ensure future treatments and vaccines for COVID-19 will be available to all, regardless of nationality status?
- Do you have any recommendations for decision-makers (or others) to ensure stateless people are included in COVID-19 responses and they can access their right to healthcare?

Endnotes

1   In its latest *Global Trends* report, UNHCR reported on a global number of 4.2 million stateless persons including those of undetermined nationality in 76 countries at the end of 2019. The true extent of statelessness is estimated to be much higher, as fewer than half of all countries in the world submit any data and some of the most populous countries in the world with large suspected stateless populations do not report on statelessness at all. See, https://www.unhcr.org/5ee200e37.pdf

2   ISI, The World's Stateless 2014, p.6, https://files.institutesi.org/worldsstateless.pdf

3   World Health Organization, Constitution, Preamble, https://www.who.int/about/who-we-are/constitution

4   For example, International Covenant on Civil and Political Rights Article 6 (right to life) & Article 10 (right to humane treatment); European Social Charter Article 11; Charter of Fundamental Rights Article 11; Convention on Economic and Social and Cultural Rights Article 10.

5   Committee on Economic, Social and Cultural Rights, General comment No. 14 on the highest attainable standard of health E/C.12/2000/4 (2000)

6   Information provided by the European Network on Statelessness (Bulgaria, France, Georgia, Hungary, Italy, Kosovo, Latvia, Moldova, Spain, Turkey, Ukraine, United Kingdom)

7   At the time of writing, of the 47 Council of Europe Members States, 43 are party to the 1954 Convention (Cyprus, Estonia, Poland, and the Russian Federation are not yet party to the 1954 Convention), and 38 are party to the 1961 Convention (Cyprus, Estonia, Poland, the Russian Federation, Turkey, Greece, France, Slovenia, and Switzerland have not yet acceded to the 1961 Convention).

8   For the purposes of this report, "Europe" refers to the region encompassing the 47 Council of Europe Member States.

9   See www.statelessness.eu

10 See www.statelessjourneys.org

11 See UNHCR Global Trends in Forced Displacement 2019, https://www.unhcr.org/uk/statistics/unhcrstats/5ee200e37/unhcr-global-trends-2019.html

12 For detailed comparative information on law, policy and practice in 27 European States, see: https://index.statelessness.eu

13 See https://index.statelessness.eu

14 Medact, Migrants Organise, New Economics Foundation (2020), *Patients Not Passports: Migrants' Access to Healthcare During the Coronavirus Crisis*, https://neweconomics.org/uploads/files/Patients-Not-Passports-Migrants-Access-to-Healthcare-During-the-Coronavirus-Crisis.pdf

15 See, International Romani Union IRU - https://iromaniunion.org/

16 In correspondence with the report authors, UNHCR provided an update reporting that as of March 2021, mass information and communication with communities efforts were ongoing in 31 countries in the region, with information material for "persons of concern" to UNHCR (including stateless persons) being developed, translated, and disseminated on COVID-19 vaccination (as well as on risk mitigation, available services, and government restrictions), in support of government efforts. UNHCR and its partners are playing an active role in several of these countries, including through translation and dissemination of material through the UNHCR HELP pages, internet pages, hotlines and social media channels, as well as through volunteers and community workers. For example, UNHCR Greece has worked with its partner RefugeeInfo to develop Q&As on the COVID vaccine in five languages (Arabic, Farsi, French, English and Urdu) and UNHCR Italy has worked with its partner ARCI to translate practical information on how to access vaccines (by region) in 20 different languages for the JUMA Refugee Services Map. UNHCR Switzerland has drafted a dedicated UNHCR webpage to share information about the national vaccination plan with "persons of concern", and UNHCR Cyprus has translated the national COVID-19 vaccination plan information into Arabic, French and Somali and made this available on the UNHCR HELP page.

17 In correspondence with report authors, UNHCR provided an update in February 2021. UNHCR is part of the global COVAX Alliance, an international collaboration that facilitates equal availability of the vaccine across the world, and is contributing to work to ensuring all nations get access to the vaccine in a timely manner, including all "persons of concern" (which includes stateless persons). UNHCR is also working with Gavi, the Vaccine Alliance, to strengthen collaboration on immunization at global, regional, and country levels with a focus on refugees, asylum seekers, returnees, internally displaced persons, and stateless persons. In Europe, UNHCR is working closely with national governments in advocacy efforts towards ensuring inclusion of stateless persons in their national vaccination plans. A number of European countries have committed to including stateless persons in their vaccination plans, but it remains to be seen what practical obstacles may arise during vaccine rollouts as the situation is still evolving and constantly changing.

18 *UNHCR warns stateless people risk being left behind in coronavirus response.* 11 May 2020.

Available at: https://www.unhcr.org/en-ie/news/press/2020/5/5eb952222ec/unhcr-warns-stateless-people-risk-behind-coronavirus-response.html

19 Joint statement, "*In solidarity with the stateless: An urgent call to states, donors and other stakeholders to promote and protect the rights of stateless persons in their COVID-19 responses*". 27 May 2020. Available at: https://files.institutesi.org/Joint_Statement_in_Solidarity_with_the_Stateless.pdf.

20 Defined as, "A person whose protection and assistance needs are of interest to UNHCR. This includes refugees, asylum-seekers, stateless people, internally displaced people and returnees". See: https://reporting.unhcr.org/glossary/p

21 Reported elsewhere.

22 Marie-Claire Van Hout | Liverpool John Moores University (ljmu.ac.uk)

23 Charlotte Bigland | Liverpool John Moores University (ljmu.ac.uk)

24 Secretariat | European Network on Statelessness

25 Short report to be provided by the "gatekeeper" with key findings.

European Network on Statelessness

The European Network on Statelessness is a civil society alliance of over 170 organisations and individual experts in 41 countries. We are committed to ending statelessness and ensuring that everyone living in Europe without a nationality can access the rights they are entitled to under international law.

At the heart of our strategy is an understanding of the need to raise awareness about statelessness, support legal and policy development and build civil society's capacity to act. We are dedicated to working alongside stateless people and their communities to strengthen their voices and together advocate for full respect of their human rights.

For more information visit www.statelessness.eu

Thanks

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