COVID- 19 and its Effects on Refugee, Asylum Seeker and Migrant Children Aged 12-17 Years at Tongogara Refugee Camp in Zimbabwe

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Abstract

Refugee, asylum seekers, and migrant (displaced) children are at protracted vulnerability levels, and COVID-19 has exacerbated the situation. Zimbabwe accepts refugees but enforces an encampment policy, and displaced populations are encamped at Tongogara Refugee Camp (TRC). The research gap is that there is very little literature on refugees in Zimbabwe. The research objectives for the study were to explore the challenges that refugees, asylum seekers, and displaced children at TRC face, ascertain how COVID-19 has affected children at TRC, and propose solutions to these challenges. This research relied upon a mixed method of quantitative and qualitative approach considering the immediacy of the COVID-19 pandemic. Secondary data is referred from published articles and organizational reports. The population size of 2,304 children aged 12 to 17 was obtained through the United Nations refugee agency (UNHCR)'s January 2021 population statistics for TRC. A 10% sample of 230 respondents was selected. Non-probability sampling techniques were used in administering a questionnaire through individual and focus group interviews, which were fed into KoBo Toolbox. Data cleaning and analysis were conducted, with SPSS and NViVo for quantitative and qualitative data analysis, respectively. Ethical considerations of consent, confidentiality, do no harm, and statements to withdraw from the study were employed. The process involved strict observance of World Health Organization (WHO) guidelines on COVID-19. The research was conducted between April 2020 and February 2021. Results showed that displaced children suffered a spectrum of challenges before COVID-19. During the COVID-19 period, respondents had limited access to child protection services, experienced increased conflicts at home, and limited access to formal learning and entertainment: their already dire situation was exacerbated by COVID-19. The study recommends the upgrade of the local secondary school to advanced level status, adoption of educational innovations in lieu of the COVID-19 pandemic, including radio, television, and virtual learning platforms; improved child protection mechanisms; accommodation; dietary diversity; access to water and sanitation hygiene; provision of electricity; adequate street lighting; activities for entertainment; and increasing awareness against child abuse and gender-based violence (GBV).

Keywords: *COVID-19, TRC, Refugees, Emergencies, Innovations*.

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Introduction

Tongogara Refugee Camp (TRC) lies in the south-eastern part of Zimbabwe and is home to 14,750 (66.54%) of the 22,168 refugees, asylum seekers, and persons of concern in the country. Of the population at the refugee camp, 2,304 (15.62%) are minors below the age of 12-17 years (UNHCR, January 2021). The large number of refugees, asylum and displaced populations concentrated in Tongogara Refugee Camp is because Zimbabwe enforces an encampment policy, based on its reservations to Articles 17 (access to employment) and 26 (freedom of movement) of the 1951 UN Convention relating to the status of refugees (UN, 1951). The encampment policy also creates room for coordinated humanitarian response and provision of security. Long-term solutions to this temporary arrangement are voluntary repatriation and resettlement to other countries, mainly in the developed world.

Camp concentrations are, however, a rich ground for the spontaneous spread of pandemics. For a population of such magnitude, the emergence of the COVID-19 pandemic created an explosive scenario, considering the fragmented disaster preparedness levels existent at international, regional, national, and community levels. In an effort to contain the pandemic, governments across the globe adopted national lockdown strategies, including the government of Zimbabwe. The lockdown affected service delivery, with service providers retreating to the comfort and safety of their homes and families outside the refugee camp. Refugees, asylum seekers, and migrant populations were left in a quagmire of uncertainty.

Objectives of the study

The research objectives for the study were: i) to explore the challenges that refugees, asylum seekers, and displaced children aged 12-17 years and residents at Tongogara Refugee Camp face, ii) to ascertain how COVID-19 has affected refugee, asylum seekers, and migrant children aged 12-17 years who reside at Tongogara Refugee Camp; and iii) to propose solutions that refugee, asylum seeker and migrant children aged 12-17 years are facing the challenges at Tongogara Refugee Camp.

Research Gap

Although some minimal research work had been conducted on how refugee children at global levels had been affected by COVID-19, TRC remained an area that required refined study to ascertain the magnitude of the effects of COVID-19 and determine the specific interventions

which were required to mitigate or enhance these effects, depending on whether they were negative or positive in design respectively.

Contribution to the Study

This study focussed explicitly on Tongogara Refugee Camp in Zimbabwe. The contribution is an in-depth analysis of Tongogara Refugee Camp's case to inform policymakers on the corrective trajectory to take. It is also expected to inform the government and its partners as they continue with their work at TRC so that they are better informed when making decisions that affect the children in the camp.

Statement of the Problem

The COVID-19 pandemic caught governments at the global level napping. For African countries in general and Zimbabwe in particular, disaster preparedness levels were almost non-existent or dysfunctional. Although refugees in Zimbabwe are provided with very basic services, an additional crisis of the COVID-19 pandemic exposed the programing and operational gaps to the assistance rendered to displaced populations residing at Tongogara Refugee Camp.

Literature Review

Theoretical Framework

Tongogara refugee camp is a place where 14,750 refugees, asylum seekers, and persons of concern reside. The theories of social development and social and emotional learning (SEL) are considered the foundation of this study. This is primarily based on the realization by Huitt and Dawson (2011) that 'human beings are inherently social.' By this qualification, social development theories are central to understanding the interactions and dynamics within this society. SAGE (2015) records the various social development theories, including maturism, psychoanalysis, psychosocial development, behaviorism, cognitivism, socio-culturalism, bio socialism, and ecological systems theories.

Of particular interest is Freud's (1856-1939) psychoanalytic theory of the genital stage, which covers children 11-18 years. As this is the category under which the respondents fall. So, it is important to understand that there is a strong interest in the opposite sex at this stage and that with the onset of puberty, libido is very high. Likewise, Erickson's (1982) psychosocial development theory places the 12-18 years category in the adolescent stage, characterized by

identity and role confusion. According to his theory, children battle to understand themselves and how they fit into the world at this stage. Role confusion then sets in as they fail to place themselves anywhere in society.

In addition, Bandura's (1986) theory of social learning and cognition explains that social competence is achieved through,

> *'Behaviors children and adolescents observe within their home or culture, cognitive factors such as a student's own expectations of success, and social factors such as classroom and school climate'* (Bandura 1986 in Huitt and Dawson, 2011).

The above propositions confirm that children are a part of society, and who they become is shaped by their cognitive and social environments. In order to then function as constructive beings, children require to acquire social competence skills. Social competence is in itself defined by Bierman (2004) as the

> *'capacity to coordinate adaptive responses flexibly to various interpersonal demands, and to organize social behavior in different social contexts in a manner beneficial to oneself and consistent with social conventions and morals' (p. 141).*

Although the above theories have explained social development in humanity, their hiatus is that they have not considered the principles of social development in emergency and encampment scenarios. Fegert et al. (2018) acknowledge that refugees and displaced populations experience trauma before, during, and after the war and conflict flight experiences, resulting in post-traumatic stress syndrome (PTSD), which leads to dysfunctional behavior and an inability to cope with social and family life. However, again, the challenge with this principle is that it is hinged upon social relations. In the awakening of the COVID-19 pandemic, mitigation strategies such as lockdown and minimized physical, social contact created a theoretical gap on how children can develop during a humanitarian emergency and lockdown scenarios. The panacea to these challenges has been Social and Emotional Learning (SEL), which, according to Elias et al. (1997), refers to a process of acquiring competencies to recognize and manage emotions, set and achieve goals, appreciate the perspective of others, establish and maintain social relationships, make responsible decisions, and handle interpersonal situations constructively.

Empirical Framework

The researchers assume a positivist epistemology that the world must be investigated through objective means. This perspective fits into the realist ontology, wherein the researchers inquire

into the area under study using scientific methods, with the belief and understanding that there is a single truth that can be unearthed through scientific means. Due to the complexity of the study, a lighter approach of internal realism which also assumes that even though facts are concrete, sometimes it is difficult to reveal them, is also considered.

At the end of January 2021, there were 22,168 refugees, asylum seekers, and displaced persons of concern in Zimbabwe. Of these, 14,750, representing 67%, were housed at Tongogara Refugee Camp, found in the country's south-eastern part, with at least 5,411 (37%) of this population being children school-going age between 5 and 17 years. Based on its reservations to Articles 17 and 26 of the UN 1951 Convention on Refugees, Zimbabwe enforces an encampment policy. There are, however, some exceptions for travel for various reasons, but a gate pass is obtained from the Camp Administrator's office. Chikanda and Crush (2016) explain that although refugees in Zimbabwe are permitted to integrate at minimal levels into towns and villages, the government prefers to enforce the encampment policy, which permits refugees, asylum seekers, and persons of concern to receive assistance from the government and various agencies in a coordinated manner. Mufandauya (2015) challenges this position, explaining that the encampment policy infringes on refugees' human rights and freedoms and displaced populations.

Conceptual Framework

The state of being a refugee is synonymous with vulnerability. According to the International Organization for Migration (IOM, 2020), at least 25.2 million refugees and internally displaced people are in Africa. These are largely hosted in poor countries with compromised health service delivery systems and very weak support structures. Zimbabwe is no exception, as Chikohomero (2019) posits:

> *"The Zimbabwean economy has been teetering on the edge of crisis… The economy is bedeviled by many ailments…low productivity, policy inconstancy, and uncertainty and the government's inclination towards control, as well as a currency and liquidity crisis."*

The Zimbabwean government is already struggling with its own population, and the addition of refugees and displaced populations exacerbate the situation. Entreculturas (2011) adds that "life in Zimbabwe has become extremely difficult for the majority of the population. And despite this, it continues to receive refugees…internally displaced persons living in illegal settlements are in a

worse situation than refugees." According to Mbiyozo (2021), the long-term solution lies in resettling refugees into developed countries. However, the folly is that resettlement prospects have dwindled over the years, with only 22,770 out of 79.5 million refugees resettled by 20 countries in 2020 (Mbiyozo, 2021). The translation is that what was once a temporary encampment arrangement has turned into a long-term solution, with severe violations of human rights over the years.

Children in emergencies face a plethora of challenges. Constituting over half of the Tongogara Refugee Camp population, it is precarious to ignore the consequences of their state of life. UNHCR (2020) statistics show that at least 70% of refugees in Tongogara Refugee Camp are from the Democratic Republic of Congo, where war has been ongoing for over a decade. The implication is that refugees suffer from mild to severe trauma and certain dysfunctionalities, which render them both a threat to and threatened by society. Fegert et al. (2018) explain that "refugees who have fled from war zones are at significantly increased risk for post-traumatic stress syndrome (PTSD) and other trauma-related disorders." Refugees, especially children and women, experience grave traumatic experiences during three phases: pre-flight (back in their countries of origin), during flight (as they flee their homes and seek refuge), and after the flight (in the camp). These experiences may include witnessing mass shootings or man slaughtering of close family members, rape, being forced to become child soldiers, female genital mutilation, torture, discrimination, domestic violence, hunger, linguistic barriers, and other traumatic experiences which render them at the mercy of the host government and its partners.

Children who would have had their education disturbed by war or other reasons in their home country also face a plethora of challenges when they arrive in the host country. First, language barriers prevent them from direct academic engagement with educators. Their wounded psyche also makes it difficult for them to have a lengthy concentration span of at least 8 hours per day at school, and the educators, mostly local staff members, do not share in their traumatic experience and hence are less likely to empathize with them. The results are chronic absenteeism, school drop-out, and negative coping strategies, including juvenile delinquency, teenage pregnancies, and crime.

The above adverse effects are especially more heinous for unaccompanied minors in emergencies. Mhlanga, Kapesa, and Dziro (2018) summarise this vicious downward circle by arguing that "refugee life is a complex life defined by poverty, vulnerability and uncertainty,

with vulnerability at the core of the matrix. However, unaccompanied refugee minors are even more vulnerable…" The implication is that within the vulnerable population of refugees and people in emergencies, vulnerability is also stratified, with children, especially unaccompanied children, at the peak of this matrix.

The handful of agencies that work at Tongogara Refugee Camp support the Zimbabwean government in unique ways. Jesuit Refugee Service (JRS) provides pastoral education, child safeguarding, and livelihoods support. Teres Des Hommes provides shelter, education, water, and sanitation hygiene (WASH), health, psychosocial, child safeguarding, and food support. World Vision provides water and sanitation hygiene (WASH) and livelihoods support. Childline provides psychosocial and child safeguarding support, while the government of Zimbabwe, through the Department of Social Department, provides social work services is the over-arching body that coordinates activities at TRC. Additionally, the Zimbabwe Republic Police (ZRP) provides security, law, and order, considering the volatile nature of the backgrounds of the TRC population.

Temporary housing structures, mostly comprised of prefabricated material, are provided to displaced persons at TRC. These are arranged into ten housing sections, mostly dependent upon one's country of origin, year, and month of arrival. Some refugees and asylum seekers have gone to great pain to build single or double-roomed structures using self-molded bricks, an exercise that has fueled child labor and deforestation in the area.

IOM (2020) bemoans that "many live in overcrowded camps, settlements, makeshift shelters or reception centers." The Great Lakes region, especially the Democratic Republic of Congo, which contributes at least 70% of Zimbabwe refugees, has a huge family size culture. This means the average family has between 4 and 6 children. The bigger picture is that families live in overcrowded and almost squalid conditions. Their shelters are often one or two-roomed houses with very limited or no ventilation at all: a situation potentially fuels the spread of chronic infections such as COVID-19.

Water is provided through 15 bush-type boreholes and 97 communal taps, although some works are underway to improve the situation. Based on the population figure, each water pump services an average of 124 people. The limited national electricity supply and limited pumping capacity of the main borehole make it impossible for a 24-hour water supply. For this reason, water

pumped into a tank is opened between 8 AM and 3 PM on a rotational basis, based on sections in which people live, and families make the trip to the communal taps for the day's supply.

Ablution facilities are also mostly communal, each squat hole serving an average of 20 people or more, with some of them also doubling as bathrooms. A significant number of these ablution facilities are dilapidating, posing a danger of giving in while someone is in use. Additionally, the ablution facilities are naturally cited far from the makeshift houses, thereby posing a hazard to different groups of the society, especially girls and women, who are prone to physical and sexual abuse.

Health services for refugees are, by Zimbabwean standards, far much better than for local mediocre to poor people. This is largely because services for refugees are free. Medication is provided free of charge, albeit some medication being out of stock in isolated cases. They also have access to a Doctor's medical health practitioner once or twice a week, and every weekday, respectively. The two ambulances available also assist in medical referrals to the district hospital in Chipinge, where more complicated cases are treated. Regardless of this superb arrangement, specialized services such as dental care, optometry, dialysis, and others are not covered under the free medical scheme, administered by Teres Des Hommes (TDH) and funded by the United Nations High Commission for Refugees (UNHCR).

Flipping the coin, the presence of refugees in Tongogara Refugee Camp has also created avenues for boosting the Zimbabwean economy. This has been achieved through employment creation for the government and partner organizations and supporting livelihood activities for the host communities. The TRC community also provides a ready market for fresh farm produce and supply of various sundries.

COVID-19 Pandemic

Zimbabwe's Statutory Instrument (SI) 77 of 2020, section 2 defines COVID-19 as 'the Novel Coronavirus (2019-nCov), which is an infectious disease caused by a virus which, having emerged during 2019, was declared a global pandemic by the World Health Organisation on the 11 March, 2020.' The pandemic has symptoms almost similar to the common flu, inclusive of headache and sore throat, but also causes shortness of breath and chest pains, leading to severe pneumonia in aggravated cases. WHO (20 April, 2020) situational report 91 stated that there were 2,314,621 confirmed COVID-19 cases globally, with 157,847 deaths, the majority of which in European countries. As of 26 April, 2020, Zimbabwe recorded 31 cases, 5 recoveries, and 4

deaths. The transmission was sporadic, except for one case of international travel in the near distant past (WHO, 20 April, 2020). With no cure in sight, the World Health Organisation recommended vaccination as the most effective way to curtail this virus. Additionally, strategies to curtail the spread of the virus were adopted. These included national lockdowns, social distancing to a minimum distance of 1 meter between people, regular washing of hands with soap and water, sanitizing hands with an alcohol-based rub, not to touch one's face, sneezing into one's flexed elbow, discarding tissue paper immediately after use, quarantining and self-isolating for between 14 and 21 days of persons who would have been in contact with some positively identified cases, and proper wearing of face masks.

COVID-19, Globalization and Refugees

COVID-19 is an infectious disease that has demonstrated to the world that it is non-selective. Anyone can get infected, and this includes the young, old, rich, and poor. However, it is also true to say that because of the nature of the spread of the virus, through close contact with an infected person, the conditions in which refugees find themselves are desirable for the spread of the pandemic. IOM (2020) records COVID-19 as the largest mobility crisis, wherein migrants and displaced populations are at the highest risk of infection. Although it has come with technological advantages, such as virtual technology to conduct business and learning, the concept of globalization has, in this scenario, worked largely against humanity. A virus that began in Wuhan, China, has terrorized the entire globe to gigantic proportions, evidence that all nations have a meeting and melting point. Despite economic status or global location, there is some interaction, and the human being is the greatest disease vector.

The impacts of the virus are pretty frightening: human capital loss, economic meltdown, a threat to human security, disruption of the general functioning of the global village, and several others. Notably, Ambrose (2020) recorded that by 20 April, 2020, the United States crude oil prices plunged from $ 18 a barrel to - $38. In an ironic turn out of events, suppliers were paying buyers to relieve them of unwanted stocks for which they could no longer find storage. All this being part of the economic crunch caused by COVID19, as consumption decreased, industries closed, and human capital also became seriously affected or infected in one way or the other.

For refugees, the impact is far outreaching, as IOM (2020) hammers that "refugees, those forcibly displaced, the stateless and migrants, are at heightened risk." With already compromised immune systems due to nutrition deficiencies, stress, and squalid living arrangements, refugees remain vulnerable to infectious diseases such as COVID-19. At Tongogara Refugee Camp and other refugee camps in Africa, the squalid living conditions make it practically impossible to observe the recommendations for the social distancing of at least 1 meter between two people. Similarly, several governments adopted lockdowns, including the Zimbabwean government, which also led to increased child and gender-based abuse.

Yaker and Erskine (2020) confirmed increased incidents of gender-based violence due to quarantine, lockdown, and social distancing measures related to stress and tension, brought about by COVID-19, an indication that the pandemic has far-reaching impact than what meets the eye. The global focus shifted towards responding to the health emergency of COVID-19. This negated other services, inclusive of sexual and reproductive health, antenatal and post-natal care. Women and girls were disproportionately affected as they were disabled to negotiate safer sex (UNFPA, 2020). The prolonged enclosures also confirmed Freud's (1856-1939) psychoanalytic theory, with agencies recording an increase in teenage pregnancies and sexual interactions amongst children in TRC, including cases of incest.

COVID-19 and Refugee Children

Refugee children have not been spared in this matrix. Their lives are extremely complicated, as they are disproportionately at the pinnacle of the vulnerability index. Zimmermann and Curtis (2020) posit that the symptoms of COVID-19, which include fever, cough, sore throat, fatigue, shortness of breath, and gastrointestinal symptoms, are more aggravated in children. Daily, children's lives are a real struggle, as observed by UNICEF (2020) that "every day, refugee children, migrant children and children affected by conflict face unspeakable threats to their safety and well-being, and this in the absence of the pandemic." Henceforth, COVID-19 exacerbated the complexity of refugee children's lives. The Alliance for Child Protection in Humanitarian Action (2020) explains that diseases of an infectious nature disrupt children's daily routine, affecting their well-being and progression. The 51% of children living in Tongogara Refugee Camp were subjected to a national lockdown of up to 5 consecutive weeks in March and April 2020. The results showed that their daily lives were excessively disrupted.

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At least a week before the scheduled holidays, the closure of schools on 24 March, 2020 disrupted examinations and revision lessons, with some uncertainty over the way forward regarding the national examinations for Form Four and Six learners at the end of the year. It was unclear how long it would be before schools re-opened or the transmission mode of lessons after that. According to Mandikiana (2020), the COVID-19 pandemic affected 4.6 million, and 127,000 learners and educators in Zimbabwe, respectively.

Chances for nutrition needs to be met further distanced from them, as the lockdown disrupted their parents and caregivers' small livelihood activities. These same livelihood activities would provide dietary variety, albeit in a small way, as parents would outsource for some unanticipated amenities such as their monthly food rations, which comprise cereals, pulses, and vegetable oil.

Violence against children increased to figures which could not be confirmed during the national lockdown, largely due to the absence or minimal presence of child protection agency workers and government social workers subjected to the lockdown. With service providers retreating from the frontline, children were left exposed to a plethora of abuses, with limited hope of reporting to relevant authorities.

Refugee families in TRC are quite huge, with an average of four to six children per family, and all are living in a single or double roomed house. The implication was that children were subjected to pornographic nuances as their parents, caregivers, or siblings engaged in conjugal activities. Children's inherent right to play, in accordance with article 31 of the United Nations Convention on the Rights of the Child, was also taken away from them due to the COVID-19 induced lockdowns. There were very limited options to pose as indoor recreational activities. Although health services continued, these were reduced to emergency cases, and regular health care such as HIV/AIDS testing and counseling services, sexual and reproductive health services, and teenage psychosocial counseling sessions were suspended.

The community-based 97 water taps and 15 bush-pump type boreholes also meant that children, especially girls, who do most of the reproductive chores, were exposed to COVID-19 through contact with others at the water-points, as no fumigation was done. Although social distancing was observed, contact with others was not wholly removed. In the absence of COVID-19, for children, the trip to the water taps was associated with an opportunity to meet and socialize with friends. For this incentive to be taken away, the effects were daunting to children.

Some unprecedented levels of stigma and discrimination were also experienced, as the community shunned the disease and any suspected cases. Suspected cases were not clinically confirmed, but there was some form of stigma within the community over individuals with some symptoms, even those for common influenza. Children of the suspected cases were also shunned by others, thereby affecting their psychological well-being.

Knoll and Bisong (2020) argued that 'social distancing means less support, less access to necessities or services.' Examples include how food aid has come to a halt in Italy and that refugees in Libya were completely cut off from aid. For refugees already living in the encampment, the impact is grave as they heavily rely on the services and amenities provided by the government and its partners for survival. Summarily, with their only source of livelihood and support removed, the vulnerability of refugees, especially unaccompanied refugee children, is exacerbated.

Refugee Children's Education and Social and Emotional Learning (SEL)

While education can be damaging and fuel conflicts in that it can be manipulated to promote hatred, resentment, and stereotypes, it is also a means towards achieving peace and post-conflict reconstruction. The World Bank (2005) has acknowledged the significant role that education contributes towards restructuring the minds of broken children. The experience of forcible recruitment as child soldiers, being manipulated into prostitution, being brainwashed into hating one's own family, and several other vices used as machinations to significantly cause damage to children, all have lasting effects, which children regrettably haul with them into the classroom. There are three formal schools at TRC: an Early Childhood Development (ECD) Centre, primary and secondary schools with enrolments of 694; 2 486 and 862 children respectively, and two non-formal courses comprised of a language class and after-school homework classes offered by Jesuit Refugee Service in support of St Michael's secondary school. The enrolment for these two classes varies, but the average is 50 and 299 learners, respectively. Added together, this brings to 4,391 the number of children that are in school in TRC. Of the total of 7,576 children below the age of 18 years in TRC, 2,165 are under 5 years, leaving 5,411 the total number of school-going aged children in the camp. Of these, 81% are receiving either formal or non-formal education.

Children in emergencies experience all sorts of traumatic experiences before, during, and after their flight experience. In TRC, as of July 2019, the trend was a high school drop-out, truancy, teenage substance abuse, teenage pregnancies, and general juvenile delinquency. An inquiry made by JRS through an education project baseline survey indicated that refugee learners faced language barriers at school, found it challenging to learn the Zimbabwean curriculum delivered to them in a third language, and were naturally demotivated as they felt they were not heard, understood and that they were discriminated against (JRS,2019). It was learned that in addition to the national curriculum, Social and Emotional Learning (SEL) was a required method to address the psychosocial and emotional well-being of learners, youth, and children at Tongogara Refugee Camp.

Social and Emotional Learning (SEL) is described by the International Network for Education in Emergencies (INEE, 2016) as fostering interrelated cognitive, affective, and behavioral competencies of 'self-awareness, self-management, social awareness, relationship skills, and responsible decision making.' It is a way in which both learners and educators understand individual and social dynamics. Elias et al. (1997) explain that it is 'the process of acquiring core competencies to recognize and manage emotions, set and achieve goals, appreciate the perspective of others, establish and maintain positive relationships, make responsible decisions, and handle interpersonal situations constructively.' As part of Social and Emotional Learning, the Inter-Agency Standing Committee (IASC, 2007) designed a pyramid for psychosocial support programming. Basic services and security form the base, followed by community and family support, focused and non-specialized support, and specialized services at the top or pinnacle of the pyramid. Therefore, it follows that COVID-19 response mechanisms supersede the more specialized psychosocial healing process, which is a vital component for displaced populations.

Designed to function in rather normalized emergency or refugees' setups, at least more than 70% of SEL interventions rely on physical contact or provision of services in the vicinity of each other. The global COVID-19 pandemic presents a rather daunting scenario wherein social distancing has become mandatory to prevent the further spreading of the virus. Newer and more innovative ways of providing Social and Emotional Learning and psychosocial support programming which do not necessarily require physical contact must be designed. Such interventions must include the use of toll-free numbers, suggestion boxes, and social media

platforms, such as WhatsApp, Facebook, Twitter, and Instagram. Social and Emotional Learning and Psychosocial support provisions may also be adopted through Information and Education Communication (IEC) material, and folktales or culture dances, relayed through radio or television. In the family setup, such messages can be adopted in play, using indoor activities such as skipping ropes, snakes and ladders, chess, darts, and others, adopting innovating means of relaying such vital messages.

Materials and Methods

Study Area and Variables

The research was a case study that focussed on refugees, asylum seekers, and migrant children aged 12 to 17 years who are residents at Tongogara Refugee Camp (TRC). The camp is situated in Chipinge district, in the south-eastern part of Zimbabwe. The study area was human rights, with a specific focus on refugee children and COVID-19.

The dependent variable for the research study was children aged between 12 and 17 years who were residents at Tongogara Refugee Camp during the study period. COVID-19 was the independent variable, whereas the variables included access to education, health, child protection, water and sanitation, accommodation, and other amenities.

Data Collection Techniques

Ramamurthy (2011) explains a research design as

> *"The specification of methods and procedures for acquiring the information needed. It is an overall operational pattern or framework of the project that stipulates what information is to be collected from which source by what procedures" (p.50).*

This research study triangulated emerging literature on COVID-19: how it affects children in general; children in vulnerable situations, particularly girls, orphans, and migrant populations. This was obtained through published journal articles and various situational reports from agencies that operate in the camp. Additionally, the researchers also conducted action research through observation and inquiry. Murairwa (2016) explains that observation "is a primary data source for acquiring knowledge about an individual or unit in the research sample or population…This source of research data allows certain phenomena to be accessed and properly understood."

Population and Sample Size Determination

UNHCR (January 2021) population statistics for Tongogara Refugee Camp were used to obtain children aged between 12 and 17 years. From this population, the researchers chose the standard 10% population sample size. According to Murairwa (2016), the research sample size is determined by the population size. For this study, this was calculated as follows:

N = 2,304 (1,101 females and 1,203 males)
n = 10% of 2,304
n = 230
Sample Size: 230 participants

Based on the above sample size selection, the researchers collected data from 230 respondents. However, it should be noted that in the collection of data, no cognizant was given to the sex of the respondents.

Data Collection and Sampling Techniques

For the data collection process, the researchers designed an interview tool administered to various stakeholders in the camp. A questionnaire for children living in TRC was designed and fed into KoBo Toolbox. The link was shared to refugee children WhatsApp platforms for completion. Additionally, and more effectively, copies were also printed and shared with respondents for completion. Two multi-lingual and clean child protection records research assistants from the community were hired to assist with this process. Despite the advantages of physical data collection, because of the severity of the COVID-19 pandemic, hard copies could have been a severe vector in spreading the virus. This mainly was because children at TRC mentioned constraints with access to smartphones and data to complete the online questionnaire. Care was taken to observe COVID-19 regulations, including sanitizers, face masks, and social distancing.

Non-probability sampling techniques were employed in the process of data collection. These included voluntary, collision, convenience, snowball, judgmental, and quota sampling designs. The researchers and research assistants targeted private but open spaces for child protection issues. The Camp Administrator granted consent to speak to children, who represent the government, being the overarching duty bearer. In cases where it was also expedient to do so, permission was sought from the guardians and parents of the children in question. Despite consent being granted, the sensitive nature of some of the questions made it quite difficult to

conduct interviews in the children's homes and in the presence of parents and guardians. Likewise, the accommodation situation at Tongogara Refugee Camp (TRC) was not ideal for observing COVID-19 regulations. For this purpose, most of the data were collected in open spaces. Respondents were debriefed on the research objectives and the overall advocacy goal towards improving their lives and stay at Tongogara Refugee Camp. Informed consent was sought from them too, and they were sufficiently informed of the option to withdraw from participating if they felt the need to do so.

The collected data, which was captured in KoBo Toolbox, was cleaned and analyzed. Quantitative and qualitative data were analyzed through SPSS and NVivo, respectively. All three research questions were qualitative, whereas some aspects were quantitative. The study responds to the gap in the literature on Tongogara Refugee Camp, especially on how COVID-19, as a new pandemic, has affected children aged 12- 17 years.

Results and Discussions

TRC Demographic Status

As of 31 January 2021, Tongogara Refugee Camp was home to 14,750 refugees, asylum seekers, and displaced persons. Of these, 2,304 (15.62%) comprised 1,203 males, and 1,101 females were minors aged between 12 and 17 years. The demographic data, disaggregated by age, was shown in Figure 1 below:

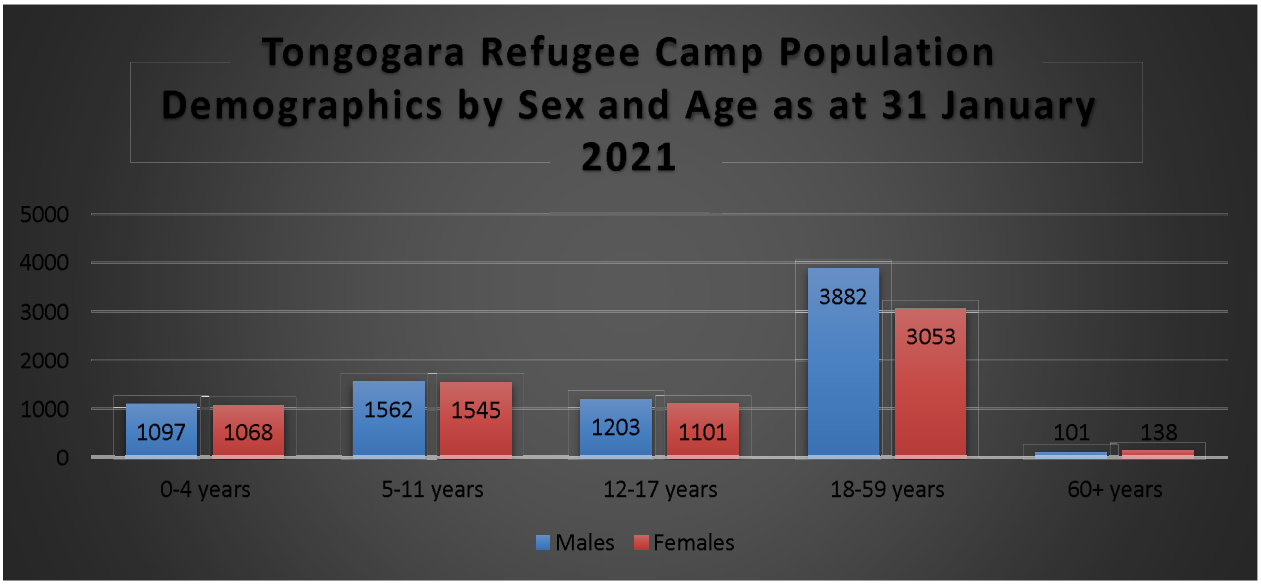


Figure 1. Tongogara Refugee Camp Demographics as of 31 January 2021.

Although no special care was taken to balance off the gender of the research participants, table 1 below shows that 12.2% more males participated in the research study.

Table 1. Disaggregation of Research Participants by Gender

GENDER

		Frequency	Percent
Valid	Male	129	56.1
	Female	101	43.9
	Total	230	100.0

This same data is represented by figure 2:

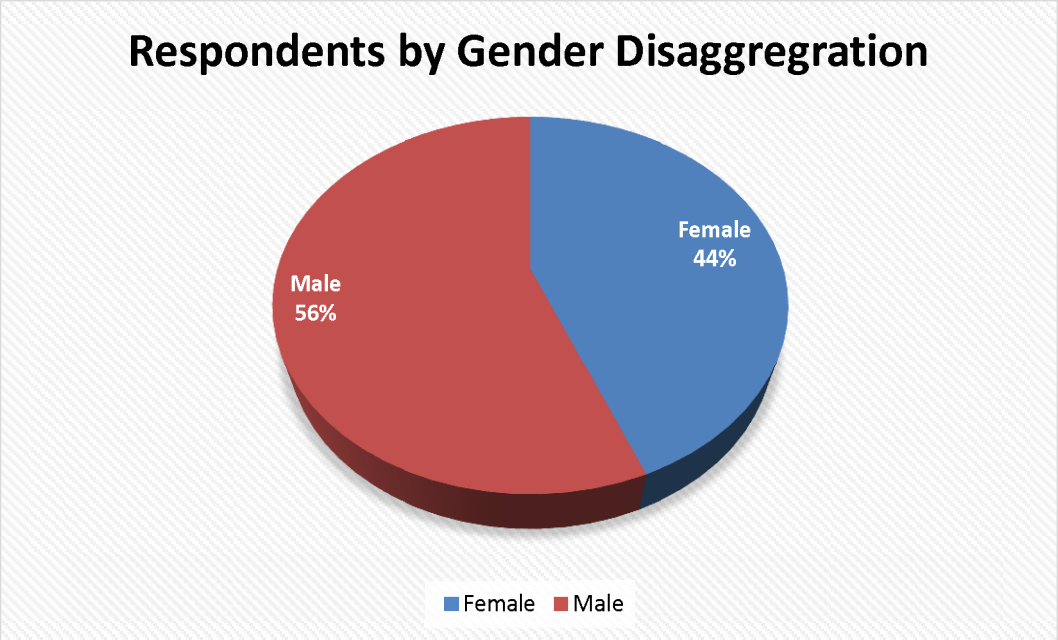


Figure 2. Gender Disaggregation of Respondents

The ages of participants varied from 12 to 17 years. The below frequency distribution table shows that those aged 16 years constituted 31.3%, translating to the highest percentage, whereas children aged 13 participated the least, constituting 6.1% of the respondents, as shown in Table 2 below:

Table 2. Age Frequency Distribution of Respondents

Age

		Frequency	Percent
Valid	12	18	7.8
	13	14	6.1
	14	24	10.4
	15	45	19.6
	16	72	31.3
	17	57	24.8
	Total	230	100.0

The study also inquired about the duration of stay at TRC. The majority of respondents, represented by 73.5%, had stayed at TRC for over five years. 25.2% had stayed between twelve months to five years, whereas the least percentage of 1.3% had stayed between 0 and 11 months.

Table 3. Duration of Stay at TRC

Duration at Tongogara

		Frequency	Percent
Valid	+5 years	169	73.5
	1 - 5 years	58	25.2
	Up to 1 year	3	1.3
	Total	230	100.0

Most of the refugees that participated in the survey were enrolled at school, with school students occupying 86.1% of the sample population. A small number argued that they were not enrolled in school for various reasons, including their being new arrivals, having no refugee status, not wanting to go to school, and language barriers.

Table 4. School Enrolment

School enrolment

		Frequency	Percent
Valid	Out of school	32	13.9
	In school	198	86.1
	Total	230	100.0

Figure 3. School Enrolment for Respondents

Although the population of the respondents comprised of different nationalities, it can be seen from Table 5 below that the majority were from the Democratic Republic of Congo (DRC). The remaining population was almost evenly distributed among the remaining countries, although a small number was seen on respondents of Sudanese and Eritrean origins.

Table 5. Respondents Disaggregated by Country of Origin

Country of Origin

		Frequency	Percent
Valid	Burundi	23	10.0
	Democratic Republic of Congo	121	52.6
	Eritrea	8	3.5
	Ethiopia	15	6.5
	Mozambique	16	7.0
	Rwanda	19	8.3
	Somalia	19	8.3
	Sudan	9	3.9
	Total	230	100.0

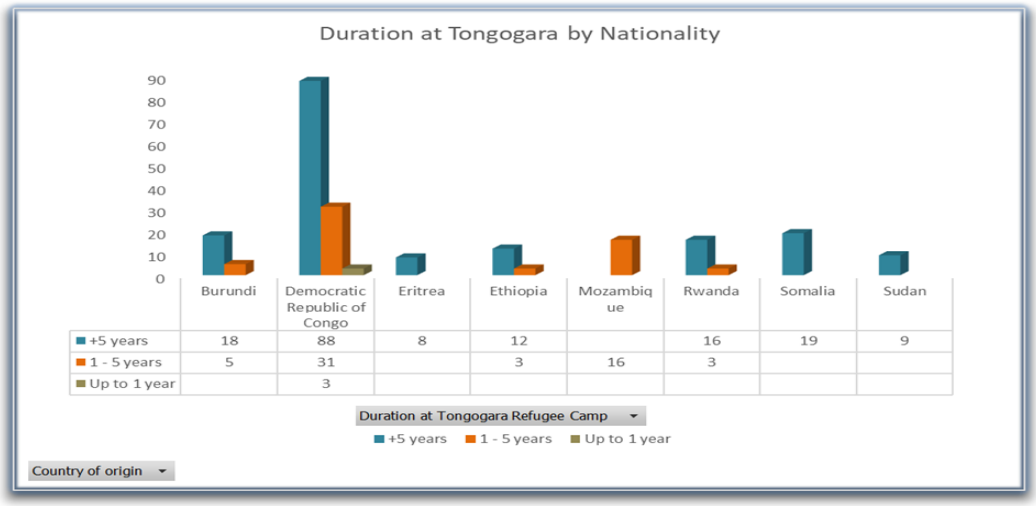


Figure 4. Duration of Stay at TRC, Distributed by Country of Origin

Hypotheses Tests on Demographics

Treatment of TRC Children *versus* Host Community Children

An inquiry was made on whether respondents felt discriminated against or not compared to children in the host community. Hypotheses were made as follows:

H0: Refugees living at Tongogara refugee camp are not equally treated against children in the host community.

H1: Refugees living at Tongogara refugee camp are equally treated against children in the host community.

The binomial test shows a calculated value of 0.059, which is greater than 0.05. With these results, we fail to reject H0 at a 5% level of significance and therefore conclude that children living at TRC are not equally treated compared to children from the host community.

Table 6. Binomial Tests

Binomial Test

		Category	N	Observed Prop.	Test Prop.	Exact Sig. (2-tailed)
TREATMENT AT TONGOGARA	Group 1	Yes	73	.32	.50	.059
	Group 2	No	157	.68		
	Total		230	1.00		

Knowledge on COVID-19 *versus* School Enrolment

A test was run on whether there is any relationship between COVID-19 knowledge and school enrollment, assuming that the categories occur with equal frequency. The hypotheses were as follows:

H0: There is no sufficient evidence to prove that refugees enrolled at school are more likely to have knowledge of COVID-19 than those that do not go to school.

H1: There is sufficient evidence to prove that refugees enrolled at school are more likely to have knowledge of COVID-19 than those that do not go to school.

Table 7. Knowledge on COVID-19 *versus* School Enrolment

SCHOOL ENROLMENT * KNOWLEDGE ON COVID-19 Crosstabulation

			KNOWLEDGE ON COVID-19			
			Very well	Average	Not at all	Total
SCHOOL ENROLMENT	Yes	Count	3	159	36	198
		Expected Count	2.6	150.7	44.8	198.0
	No	Count	0	16	16	32
		Expected Count	.4	24.3	7.2	32.0
Total		Count	3	175	52	230
		Expected Count	3.0	175.0	52.0	230.0

Table 8. Chi-Square Tests on Knowledge on COVID-19 *versus* School Enrolment

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	16.145	2	.000
Likelihood Ratio	14.322	2	.001
Linear-by-Linear Association	15.730	1	.000
N of Valid Cases	230		

The results above show that the calculated p-value is less than 0.05, which means we reject H0 at a 5% significance level. Therefore, we conclude that there is sufficient evidence to prove that refugees enrolled at school are more likely to know COVID-19 than those who do not go to school.

Test of Q.1: Challenges Faced by Refugee, Asylum Seeker and Migrant Children at TRC

Respondents were asked about the challenges they face at Tongogara Refugee Camp, and the results show a spectrum of them. These range from child abuse of various forms (sexual, emotional, and verbal abuse, child labor, early marriages, and other forms), poor accommodation, limited privacy, no access to alternative learning, poor sanitation and hygiene,

and others. The least cited challenges were limited access to career guidance, entertainment, scholarship opportunities to further studies, and no advanced level facilities at the local (St Michael's) secondary school.

Figure 5. Word Cloud on Challenges Faced by Children at Tongogara Refugee Camp

The frequency distribution table and graph below zoom into the occurrence of these challenges:

Table 9. Frequency Distribution of Challenges Faced by Refugees at TRC

	Frequency
Abuse (Sexual, verbal, emotional and physical)	42
Poor accommodation with no privacy	36
No access to alternative learning	35
Poor sanitation & limited access to water and health	35
No access to electricity	30
Hunger & poor diet	29
Early marriages	24
Child Labour	22
Tribalism & discrimination	20
Teachers do not attend lessons	16
No representation at important fora	15
Conflicts in the community	13
No refugee status	10

Not allowed to participate in sports activities at the national level	10
No access to scholarships	7
No entertainment	7
No access to career guidance	5
No Advanced level at St Michaels (local) secondary school	4

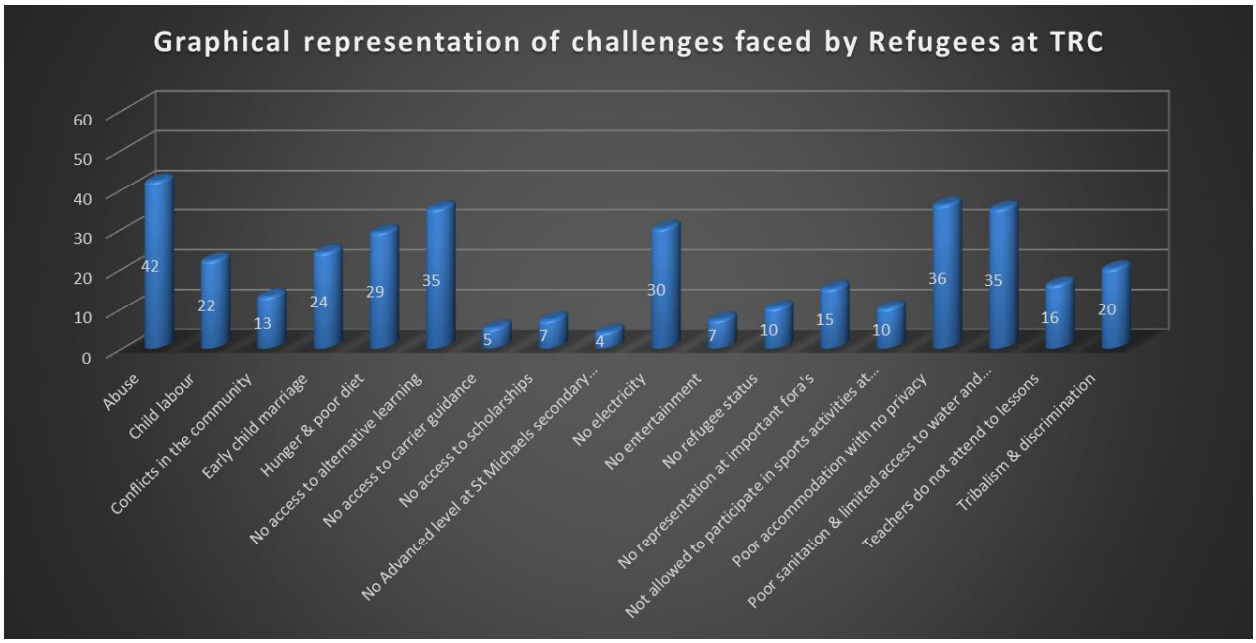


Figure 6. Challenges Faced by Children at Tongogara Refugee Camp

Test of Q.2: Effects of COVID-19 on Refugee, Asylum Seeker and Migrant Children TRC

Effect on Education

Research results unearthed that COVID-19 greatly affected respondents. 33.9% were worried that "they will not cover the expected ground for the various syllabi." This resulted in fear of underperforming in their year-end national examinations, which would hugely affect their academic and professional future. A small percentage (5.6%) argued that shutting down schools might result in learners' not getting child protection services from the school.

Table10. Shutting Down of Schools Due to COVID-19 on Children Resident at TRC

EFFECTS OF SHUTTING DOWN SCHOOLS

		Frequency	Percent
Valid	Worried that we will not cover expected ground for the various syllabi	78	33.9
	Worried to either not perform well or to miss examinations at the end of the year	47	20.4
	Miss teachers, competition, interaction and playing with other learners	19	8.3
	Worried that I am not getting child protection services from the school	13	5.7
	All of the above	41	18.3
	Total	198	86.5

The study also investigated learning alternatives provided during COVID-19 lockdowns. The following hypotheses were made:

H0: COVID-19 induced lockdowns did not affect refugees that are enrolled in school at TRC.

H1: COVID-19 induced lockdowns affected refugees that are enrolled in school at TRC.

Table 11. School Enrolment *versus* Learning Alternatives during COVID-19

SCHOOL ENROLMENT * LEARNING ALTERNATIVES PROVIDED DURING LOCKDOWN Crosstabulation

			LEARNING ALTERNATIVES PROVIDED DURING LOCKDOWN				
			Learning material from other partners working in the camp	Online lessons offered by the school	Library services offered by NGOs/ educational partners	No access	Total
SCHOOL ENROLMENT	Yes	Count	32	9	5	151	197
		Expected Count	32.8	9.0	5.0	150.2	197.0
	No	Count	1	0	0	0	1
		Expected Count	.2	.0	.0	.8	1.0
Total		Count	33	9	5	151	198
		Expected Count	33.0	9.0	5.0	151.0	198.0

Table 12. Chi-square Tests on Learning Alternatives Provided during COVID-19 Period

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.025	3	.017
Likelihood Ratio	3.609	3	.031
Linear-by-Linear Association	4.011	1	.045
N of Valid Cases	198		

The above results show that the calculated p-value (0.017) is less than 0.05, leading to rejecting H0. We, therefore, conclude that COVID-19 induced lockdowns affected refugees that were enrolled at school in TRC. Most students stated that they had no access to any learning alternatives, which made them fear not being able to cover expected ground for the various syllabi.

Effects on Child Protection and Conflicts during COVID-19 Lockdown Period

The study also made an inquiry on child safety and conflicts at home during the COVID-19 lockdown period, with the following hypotheses being formulated:

H0: There is no evidence to support the argument that staying at home during COVID-19 lockdown increased the magnitude of conflicts at home.

H1: There is evidence to support the argument that staying at home during COVID-19 lockdown increased the magnitude of conflicts at home.

Table 13. Conflicts at Home during COVID-19

HAVE CONFLICTS INCREASED BECAUSE OF LOCKDOWN * DO YOU FEEL SAFE AT HOME DURING COVID-19 Crosstabulation

			DO YOU FEEL SAFE AT HOME DURING COVID-19		
			Yes	No	Total
HAVE CONFLICTS INCREASED BECAUSE OF LOCKDOWN	Yes	Count	95	129	224
		Expected Count	97.4	126.6	224.0
	No	Count	5	1	6
		Expected Count	2.6	3.4	6.0
Total		Count	100	130	230
		Expected Count	100.0	130.0	230.0

Table 14. Chi-square Tests on Conflicts at Home and COVID-19

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.982	1	.046
Likelihood Ratio	4.168	1	.041
Linear-by-Linear Association	3.965	1	.046
N of Valid Cases	230		

From the results, since the p-value is less than 0.05 (0.045), we reject H0 and conclude that there is sufficient evidence to support the argument that staying at home during COVID-19 increased the magnitude of conflicts at home.

Commensurate with the learning gaps during COVID-19 lockdown periods, 16.2% of the children explained that they needed learning material for use during schools closure. 15.1% highlighted the need for entertainment, 14.2% needed someone to talk to, 14.1% required child protection services, 12.4% wanted access to play, 11.5% needed access to the internet, while 10.7% mentioned the need to access more food, with the least (5.7%) requesting access to medical supplies. The results are shown in Table 15 below:

Table 15. Areas for Support during COVID-19 Lockdown

$Support Frequencies

		Responses	
		N	Percent
Support needed during COVID-19 period	Child Protection Service	181	14.1%
	Someone to talk to (Psychosocial/ Social and Emotional Learning/ Wellness support)	182	14.2%
	Medical Supplies	73	5.7%
	More Food	137	10.7%
	Study (school) Material	208	16.2%
	Internet Service	148	11.5%
	Playing With Friends and Family	159	12.4%
	Entertainment (Watching television/ listening to the radio/ reading novels or magazines)	194	15.1%
Total		1282	100.0%

Of the children who reported the need for protection services and someone to talk to, the majority (87%) feared that access to services was limited. 10.7% said the areas were inaccessible, whereas 2.23% said they had complete child protection services.

Table 16. Areas for Reporting Concerns

AREAS FOR REPORTING COVID-19 CONCERNS * IS THE PLACE(S) ACCESSIBLE Crosstabulation

Count

		IS THE PLACE(S) ACCESSIBLE			
		Yes	No	Limited access	Total
AREAS FOR REPORTING COVID-19 CONCERNS	Yes	5	24	195	224
	No	0	6	0	6
Total		5	30	195	230

Effects on Sickness during COVID-19 Period

60.9% of respondents reported suffering from significant sickness during the COVID-19 lockdown period, whereas 39.1% indicated that they experienced no health challenges at all. Although a significant number of children fell ill during the COVID-19 period, only 5.7% requested extra medical support. Table 16 below shows sickness during the COVID-19 period:

Table 16. Sickness during COVID-19 Period

DID YOU GET SICK WITH NOTABLE SIGNS

		Frequency	Percent
Valid	Yes	140	60.9
	No	90	39.1
	Total	230	100.0

Test of Q.3: Solutions to Challenges Faced by Children at TRC

Research respondents listed a host of possible solutions to the challenges children face 12-17 years at TRC. These included the provision of alternative learning material, especially online sources, through access to Wi-Fi, increased access to child protection services, provision of decent accommodation which permits privacy. Besides, increased food ration and dietary

diversity, provision of cash to meet other household needs, access to electricity, the building of a safe house, prosecution of perpetrators, awareness campaigns against child abuse, recruitment of refugee teachers at the local schools, non-discrimination of refugee children in the provision of identity documents, provision of scholarships to further education, provision of vocational skills training, direct distribution of sanitary wear to women and girls, upgrading the local secondary school to Advanced level status, and allowing refugee children to participate in sporting activities, in order of preference. The below word cloud, frequency table, and word string represent the findings of the research.

Figure 7. Word Cloud Showing Panacea to Challenges Faced by Children at TRC

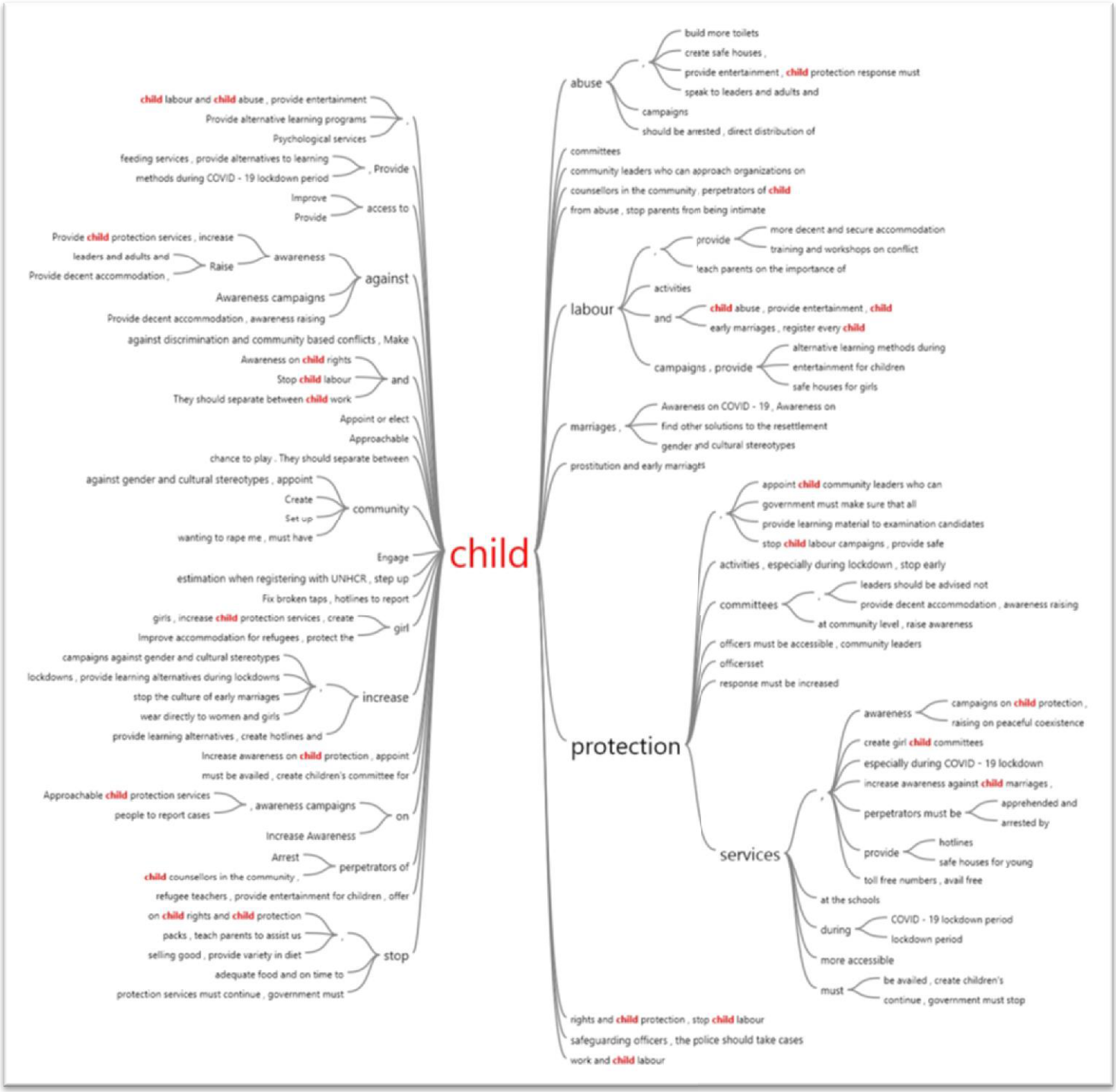
Below is:

Table 17. Distribution of Suggested Panacea to Challenges Faced by Children at TRC

	Frequency
Provide Wi-Fi, internet cafe and alternative learning methods	57
Make child protection reporting more accessible	38
Provide decent accommodation	37
Increase food rationing and provide cash	22

Provide access to electricity	22
Build safe houses	19
Perpetrators must be arrested	19
Stop Child abuse campaigns	17
Hire refugee teachers	15
Stop Child labor campaigns	15
Provider ID's and passports for refugees and asylum seeker	15
Improve access to water	14
Awareness campaigns against child marriages	13
The Ministry of Education must supervise teachers	13
Provide entertainment	13
Offer specialized services	10
Provide access to scholarships	9
Offer Vocational Training facilities	8
Distribute sanitary pads directly to women and girls	7
Provide A level at St Michael's Secondary School	7
Awareness campaigns against COVID-19	6
Participate in sporting activities at all levels	5

Figure 8. A Word String on Proposed Solutions to the Children at TRC



Summary, Conclusion, and Recommendations

Aim of the Study

The study aimed to explore the effects of COVID-19 and its mitigatory strategies on refugees, asylum seekers, and migrant children who are residents at Tongogara Refugee Camp, with the purpose to influence policy change towards closing any programming gaps.

Major Findings

The study unearthed that refugee, asylum seeker, and migrant children at TRC had pre-existing challenges before COVID 19. These included inadequate access to water and sanitation, poor accommodation, language barriers at the schools, discrimination and conflicts in the community, child labor, and different forms of abuse.

Based on the research question on the effects of COVID-19 on children at TRC, they explained that during the lockdown period, they had no access to learning material, feared not to complete syllabi, and failed end-of-year examinations. The children also cited increased conflicts at home due to prolonged lockdown periods, inaccessibility of child protection services, and generalized increase in significant sickness during the COVID-19 period.

In response to the question on the panacea to challenges faced, children explained the need for alternative learning methods, increased access to child protection services, provision of entertainment facilities, improved accommodation, awareness campaigns on thematic areas such as ending child labor, sexual abuse, child marriages, upgrading the local secondary school to Advanced level status, recruitment of refugee teachers at the local schools, increased scholarship opportunities and improved health services.

Conclusion

Refugees flee their countries for various reasons, inclusive of war and conflict. This renders them vulnerable as they experience mild to severe trauma during three phases: pre, during, and after the flight experience. The effects are far daunting on refugee children who have to cope with a new lifestyle and adapt to a new school and social and economic setups. COVID-19 has further aggravated their vulnerability, throwing refugee children into a dungeon of not enjoying school, observing social distancing, and not experiencing play, in accordance with Article 31 of the UNCRC. They also experience compromised nutrition status, increased exposure to violence and exploitation, and psychosocial trauma, among other challenges. There is uncertainty and a

prevailing somber atmosphere at Tongogara Refugee Camp. As the United Nations Department of Economic and Social Affairs (2020) observes, if not adequately addressed through policy, the social crisis created by the COVID-19 pandemic may also increase inequality, exclusion, and discrimination.

Research Gap and Further Research Avenues

Although Zimbabwe's government and its partners have made significant strides towards addressing the physical needs of refugees, asylum seekers, and persons of concern, there is a yawning gap in the provision of holistic psychosocial support. The response to traumatic experiences of children and other complex situations which involve the psyche of children in particular and refugees, in general, is weak, and some thorough work must be needed in this arena. There should also be significant investment in the provision of inclusive and holistic education for displaced children at Tongogara Refugee Camp. This should include upgrading the local secondary school to advanced level status and the provision of meaningful support towards displaced children's access to tertiary education.

Recommendations

After discussing the context, challenges faced, and responses on the ground, the study proposes a new model to respond to displaced children's needs during an emergency.

The Children in the Humanitarian Emergency Model

The 'children in humanitarian emergency model' hinges on the notion that children are at the pinnacle of the vulnerability index. The mere fact exacerbates this social status of refugees and in a health emergency such as the COVID-19 pandemic.

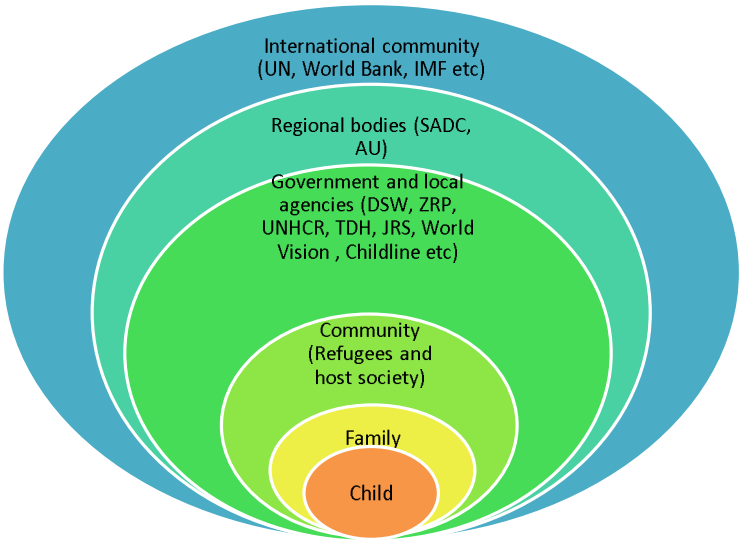
The model proposes that children require a holistic approach to support, wherein the family, community, host government and partner agencies, the regional bodies, and the international community all converge to meet the needs of children in humanitarian emergencies. The major drive, in this case, would be the best interests of the child (Article 3 of the UNCRC), taking into account their rights, responsibilities, and protection from exploitation and abuse. Additionally, the model recognizes that children also learn from each other at the peer level.

In the interest of children's safety, it cannot be feasible to have all these partners and support structures directly in contact with them. Henceforth, it is proposed that in lockdown and travel restriction situations emanating from health-related or other humanitarian emergencies, it is important to build a task force to interact with children directly. In Tongogara Refugee Camp, as

is the case in most, if not all refugee camps in Africa, there is in existence a Child Protection Committee, comprised of Child Safeguarding Officers and Social Workers from the government, members of the police force, and other agencies which support and complement government efforts. This committee should nominate representatives who can engage with children based on the urgency and gravity of matters reported.

For the reporting system, toll-free numbers which voice calls can access, text messages or WhatsApp messages, suggestion boxes and, in grave circumstances, a physical visit, accompanied by a strict observance of health protocols such as the washing of hands with soap or sanitizer, use of face masks, temperature checks and social distancing, must be adhered. Child-friendly spaces and means of collecting data must also be employed. These include photo voices, child-friendly notice boards or walls, peer-to-peer, positive parenting engagements, and safe houses. Photo voices are a way of data collection, wherein children take pictures of all the spots or areas that threaten their safety and share them with policymakers or Child Protection Officers. The same applies to children's voices, wherein children write on pieces of paper their fears and threats to their security, and the same papers are stuck onto a chart or wall for policymakers and relevant authorities to review and take necessary action.

Figure 9: The Children in Humanitarian Emergency Model



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