Impact of COVID-19 On Women With Multiple Discrimination
A Global Overview
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This overview explores the impact of COVID-19, including the measures taken by governments to contain it, on those who are least able to deal with its immediate effects and later consequences. It also looks at gender, age and disability inclusive policy responses and how they are integrated into the challenge of “building transformatively forward”.

As an X-ray displays illness, the pandemic has exposed the ugly consequences of existing socio-economic, civil and environmental inequalities on women, already subject to multiple discriminations. The World Bank has described COVID-19 as “a heat-seeking missile speeding toward the most vulnerable in society.”¹ What does the World Bank mean by vulnerability? The World Bank paper equates vulnerability with poverty but, while poverty is indeed a vulnerability, there are other groups who carry additional vulnerabilities. Women are the first and the largest group. Their vulnerability, differing across different societies, stems not from physical frailty, but entrenched attitudes of patriarchy and misogyny in the society around them that permit and enable discrimination and unequal treatment. Likewise, the limitations experienced by people living with disabilities, especially women and girls, should not in themselves make them vulnerable – again the cause of their vulnerability is the discrimination that flows from entrenched attitudes and beliefs and denies them the rights and resources they need to thrive. Older persons, who have experienced the brunt of infection and death due to COVID-19, ethnic minorities, migrants and refugees also experience discrimination. In all countries and regions poverty and discrimination interact with each other in a vicious circle, with discrimination intensifying poverty which in turn intensifies exclusion and further discrimination. Disabilities, old age, widowhood, an ethnic identity, location, a particular occupation or status, such as Dalits in south Asia or similar communities discriminated against by reason of their work and/or descent (DWD), can all combine and intersect to intensify discrimination. Gender and disability multiply negative impacts – women and girls with disabilities are among those most left behind in terms of health and social care, social protection and services.

Rights and protection for some groups are recognised by international human rights law. There is, as yet, no global instrument to protect the rights of older persons. However, the provisions of

the Conventions on the Rights of Women, of Children, of Persons with Disabilities and Indigenous People are included in the legislation of various countries, along with the recognition of the right to health, to social protection and to food and water. Nevertheless, the protection they offer can be very inadequate and patchy.

The vulnerability of children is widely recognised. Although protected by the Convention for Rights of Children (CRC) and supposedly afforded special legal protection, sadly in all countries the abuse of children is all too common. Evidence is now emerging on how children – particularly girls – have been affected in special ways in the pandemic, not so much by the disease itself, but by the lockdown measures taken to protect their parents and grandparents.

While the virus is affecting the way of life of all people, in all societies, the disease and lockdown measures have exacerbated pre-existing inequalities in opportunities, income, employment, health care and social protection globally. There is unequal access to quality health care and other essential services to support those confined to their homes or working in frontline occupations. People living in poverty have much greater exposure to disease, inadequate housing and overcrowding, vulnerable working conditions, high levels of air pollution, poor sanitation and water availability and lack of access to education of any kind, let alone quality education. Migrant workers as well as all those in informal work situations are particularly affected. In many places, minorities or migrant workers have also been made scapegoats and have been the object of hate speech and threats.

Gender norms and their associated inequalities in the workforce put millions of women at risk of infection, as they are classed as “essential workers”, and work on the front lines as shop workers, cleaners, carers and hospital workers, often for inadequate pay, sometimes below minimum statutory levels, and without appropriate protection. Without clear future financial and policy provision to end gender-, age- and disability-based inequalities and a process to implement human rights agreements, it will not be possible to ‘build transformatively forward’ for the world without discrimination that we aim for.

The world, in fact, already has a road map for getting rid of COVID-19. It is provided by the 2030 Agenda for Sustainable Development, its 17 Sustainable Development Goals (SDGs) and their 169 targets, the global framework to which all countries are committed.

Good and accurate data are essential to measure progress towards these goals. The pandemic has provided yet another reminder of the importance of data, needed to track the impact of the virus on different social groups, age cohorts and genders and to guide the process of recovery. The SDG targets cannot be met by 2030 without good, timely, age, gender and disability inclusive data and evidence on all people of all ages, including civil society data, indicators, analysis and recommendations that are integrated into all national implementation processes.
Introduction

“Whether we like it or not COVID is a disease of poverty, powerlessness, inequities and injustice - a disease of the disadvantaged - and gets entrenched in the poorest communities. We can only get rid of COVID if we respond together.”

Dr David Nabarro - Special Envoy to the UN Secretary General on COVID-19

There are five principal issues that arise from the COVID-19 pandemic and responses to it.

1. The immediate impact of the disease itself, in terms of the people infected by the virus, deaths and excess mortality. Early pandemic data have shown the categories of people who are most exposed to COVID-19 and of those who are most likely to die after they have been infected.

2. The immediate, now well documented, impacts on well-being, health, socio-economic, environmental and civil rights caused by the measures taken by governments to slow and halt the disease – principally curfews and lockdowns. Immediate impacts include negative impacts on food availability for poor and marginalised groups of people.

3. Vaccination: the priority assigned by governments in the distribution of the vaccines which are seen as protection for individuals and ultimately for the whole world; and the sectors which should be given and are being given priority.

4. The long-term consequences of the disease itself, so-called ‘long Covid’, lingering pain and disabilities which can affect people who have recovered from the acute phase of the disease, and psychiatric disorders affecting people who have reacted badly to the prolonged isolation and confinement imposed by lockdowns.

5. The long-term economic impacts of the prolonged lockdown – the jobs that have disappeared and are unlikely to return, and the high rates of unemployment which will become increasingly apparent as the emergency financial supports made available during lockdowns are withdrawn.
Chapter 1

Social Protection

The pandemic has focused attention on the need for social protection for all to provide income and the services that will enable citizens to live decent lives in times of stress, helping them to meet the costs of child care, health and old age and cushioning them against the crises of unemployment and misfortune. Social protection is, or should be, a set of predictable and institutionalised government programmes and benefits which enable citizens to access services and receive assistance in times of need. They include food assistance, access to health services, unemployment benefit, pensions and child benefit which are not confined to emergency responses but which are the right of all persons and should be predictable across the life course.

The commitment of governments to provide and extend social protection floors is contained in the third target of the first Sustainable Development Goal, that of ending poverty. The pandemic has knocked the poverty target off course, with 119-124 million people more pushed back into extreme poverty, according to World Health Organisation.³

Before the pandemic, the International Labour Organisation (ILO) reported that only 45% of the global population are effectively covered by at least one social benefit. The remaining 55% (more than 4 billion people) are left unprotected, and only 29% of the global population enjoy access to comprehensive social security while the other 71%, or 5.2 billion people are only partially protected or not protected at all.⁴

Safety nets, on the other hand, are programmes that are temporarily available, often dependent on external financing, and can be activated in response to emergencies. In some countries, governments have responded to the pandemic by providing financial assistance which has saved many of their citizens from destitution. In the absence of social protection systems, emergency food distribution and other forms of temporary assistance can be

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viewed as social safety nets. In Kenya the only social assistance identified by respondents were pensions. Some reported delayed payments, though the Kenyan government allocated additional funding in April 2020 to clear arrears in payments. 

This example from Kenya demonstrates the consequence of the absence of any form of social protection.

“When we spoke to Terry in September, she was only able to afford one meal per day and her children were visiting neighbours to share meals. Lockdown measures abruptly halted her street food business as she was left without a supply of her main ingredient. She was also unable to travel around the city while maintaining social distancing in her wheelchair to sell food. Without an income, her family has been pushed further into poverty.

Despite schools reopening, she wasn’t sure where the money for her children’s education was going to come from. Her medium-term opportunities to recover were also dwindling as she was forced to sell some of her assets to pay for daily subsistence. Since the outbreak, Terry has had to sell her old wheelchair, a cooking stove, water storage containers, all her cooking utensils and some clothes. No longer able to pay rent, she has had to move in with her sister. Many people like Terry who were getting by before the pandemic have had their livelihoods upended. They are likely to face a long and arduous struggle to bounce back, even when the social and economic effects of the crisis begin to ease.”

COVID-19 has been and is a crisis for millions of people around the world, especially for women. During the pandemic women facing discrimination and lack of access to social protection have had no choice but to risk infecting themselves and their families by continuing to work.

In low-income countries, 92.1% of employed women are in informal employment compared to 87.5% of men. Women are more exposed to informal employment in more than 90% of sub-Saharan African countries, 89% of countries from Southern Asia and almost 75% of Latin American countries.

According to the ILO women in informal employment are over-represented in the most vulnerable employment categories, of contributing family workers, home-based workers doing piece-rate work in the lower tiers of supply chains (whatever their employment status), and domestic workers.

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Chapter 2

Vaccination

One full year into the COVID-19 pandemic, our world has faced a tsunami of suffering. So many lives have been lost. Economies have been upended and societies left reeling. The most vulnerable have suffered the most. Those left behind are being left even further behind. The United Nations will continue mobilizing the international community to make vaccines affordable and available for all, to recover better, and to put a special focus on the needs of those who have borne the burden of this crisis on so many levels — women, minorities, older persons, persons with disabilities, refugees, migrants and indigenous peoples. The global vaccination campaign represents the greatest moral test of our times.

António Guterres
UN General Secretary

Although evidence is emerging of inequity in the distribution of vaccines within countries, it is the gap between access to vaccines in rich and poor countries that is attracting most attention and comment. WHO director-general Tedros Adhanom Ghebreyesus said this gap was "growing every single day, and becoming more grotesque every day, ... and countries that are now vaccinating younger, healthy people at low risk of disease are doing so at the cost of the lives of health workers, older people and other at-risk groups in other countries," describing it as "a catastrophic moral failure". 

85% of vaccine doses have been administered in high- and upper-middle-income countries and only 0.3% of doses have been administered in low-income countries. Only 1% of the 1.3 billion vaccines injected around the world have been administered in Africa — and that comparative percentage has been declining in since May 2021.

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Organisations of people with disabilities have voiced fears about possible discrimination in the distribution and administration of vaccines and are monitoring vaccination roll-out to ensure that governments adhere to their promises to give priority to persons with disabilities. There is some evidence emerging about inequality in distribution favouring rich people, as in this example from Kenya.

“Joseph Mutisya, a physiotherapist, said he breezed through the process at Nairobi Hospital, the country’s largest private health facility. He made an appointment through the hospital’s website, and being familiar with computers was less deterred by the glitches it had.

“I came in with my booking message, I showed my doctor’s practice license to qualify, they gave me a number to wait, they called it, I registered my details, and I got the vaccine,” he said. “The whole process did not take more than 45 minutes.”

Less than half a mile away, at Mbagathi Hospital, a public institution that largely serves the sprawling slum of Kibera, hundreds of people clamoured outside the gate, where confusion reigned.

A security guard at the hospital, who spoke on the condition of anonymity because she wasn’t authorized to speak to the media, said crowds gather each day by the time she reports for work before 6 a.m. “It’s how early you wake up that determines if you get the vaccine,” she said. “Many have been turned back and told the vaccines are done for the day.”

In the United States evidence from Chicago indicates that people living in areas hit hardest by the pandemic, predominantly African Americans, are being vaccinated at a slower rate than the rest of the US population. This may be due in some part to greater reluctance on the part of these communities to register for vaccination. In Florida, just over 3% of Latino and Black residents have received at least one dose of the vaccination compared with almost 9% of white Floridians. In Texas, 2.8% of Latino residents have received a shot compared with 3.6% of Black residents, 7.2% of white residents and 9.7% of Asian American residents.

13 Financial Times – FT. Racial inequality plagues US vaccine rollout (20 02 21). https://www.ft.com/content/7b0db882-a369-4e32-a86a-eb7fda2a0da0
Chapter 3

Impact on various categories of women

The following section examines impacts on women with vulnerabilities, often multiple vulnerabilities, including women who are older, who have disabilities, who are members of ethnic minorities and who are refugees or migrants.

i. Older Women

“The crisis has exposed critical human rights protection gaps for older persons, including widespread discrimination based on older age; lack of social protection – especially for women – and of access to health services; failure to uphold autonomy and participation in decision-making; and failure to ensure that older people are free from violence, neglect and abuse.”

Michelle Bachelet
United Nations High Commissioner for Human Rights 29 March 2021

According to HelpAge International’s 2021 study of older people’s experiences in Argentina, Canada, Dominican Republic, Jordan, Kenya, Kyrgyzstan, Pakistan, Philippines, Rwanda and Spain, their rights have been negatively impacted by both age-based public health responses that discriminate against them and by population-wide public health measures. Knowing the right people or having access to certain resources has allowed some older people to enjoy their rights more than others, while others have suffered serious harm to their wellbeing from the isolation imposed on them. The responses also challenge ageist assumptions about older people’s inability to adapt, their lack of resilience and resistance to new ways of doing things.

Unequal treatment - What older people say about their rights during the COVID-19 pandemic Helpage International London 2021
Europe and North America - Deaths in Care Homes:
Older persons have been disproportionately impacted by the pandemic. According to the World Health Organisation (WHO) Europe, over 95% of the deaths from COVID-19 in the region occurred among people older than 60 years, with over half of these deaths being among people aged 80 years or older. Approximately half of all COVID-19 fatalities in Europe occurred in care homes for older persons.

Even though early in the pandemic older persons were identified by the WHO as being at particular risk, many governments felt that the COVID-19 pandemic did not merit their best efforts to contain it, precisely because it was primarily affecting older persons. And when the real magnitude of the pandemic became apparent, older persons and in particular residential care settings, were not prioritised in response measures. Deaths from Covid-19 in long-term care facilities across Europe and North America accounted for up to 50 per cent of all coronavirus-related fatalities at the peak of the pandemic (even though only up to 1% of the population lives in them).  

Of the 60,370 deaths in Spain (up to 3 February 2021), almost 30,000 were in care homes. In the UK up to 5 February 2021, Covid-19 was the cause of death of 37,875 care home residents, out of a total of 111,420 total coronavirus deaths. This resulted in the neglect and abuse of several fundamental rights of older persons, their right to life, to health, to family life, to work and participation, among others. When resources were scarce, older people were denied access to intensive treatment, such as ICU and ventilators simply on account of their age.

Although data are available, few countries have published statistics on deaths in care homes disaggregated by sex of residents. Older women, who tend to outlive their spouses, make up 70% of residents in care homes in Canada, which accounted for three quarters of the country’s 17,000 deaths up to mid-December 2020.

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16 Natalia Kanem. Executive Director, UNFPA. Protecting our elders. 23 10 2020 https://www.sustainablegoals.org.uk/protecting-our-elders/
17 Worldometer, Coronavirus cases, Spain. https://www.worldometers.info/coronavirus/country/spain/
Protection or harm?

The measures the government has taken with regard to older persons have done more harm than good. It doesn’t make sense for me, as an older person, to be quarantined alone in my house without being allowed to see my children and grandchildren. The psychological harm has been much greater than that caused by coronavirus.  

66-year-old woman living with her spouse in an urban area, Jordan

In Brazil, older age for many citizens arrives on top of a life history of health, food and welfare insecurity. COVID-19 has not forged inequalities in Brazil – it has simply brought them into the open. Under lockdowns and economic insecurity, abuse of older persons has quintupled – and the majority of victims are older women. Now, Brazilians face a grim future: in 2017 the federal government froze social expenditures for 20 years.

Women from Nepal demanding equality for old women (Photo December 2020)

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In **the Philippines**, the lack of social protection and social assistance has been highlighted by Lola Rosita, 76, “The government provided us with relief goods twice, but it's still not enough. And it seems there will not be additional assistance. We really need medicines to treat our current health conditions, hygiene kits, and face masks but we can’t buy them. Aside from the restrictions due to the enhanced community quarantine, we also don’t have the money, especially now that our children can’t go to work.”

In **Sierra Leone** the desperation caused by lack of social protection and assistance is described by James Philip Conteh, 71, “My wife is a decorator and the bread winner of the family. She has had to shut down her business because of the restrictions on public gatherings and events. We are using the little she has saved to live on and if things don’t get better, we don’t know how we are going to survive ... my eldest son in the UK was the one sending my medications for my diabetic condition but now there is no way for him to do so. A few groups are coming around to give buckets and soap, but no one has come with money and that is what we need most badly.”

In **Nepal** the social isolation of older people has resulted in them losing support networks as social distancing has left them unable to interact with the community groups they relied on.

In terms of social protection and older age, globally, women represent nearly 65% of people above retirement age (60-65 or older) without any regular pension. While many older men as well as women live in poverty and experience social exclusion, the risk of poverty increases with age, with the percentage of older persons living in poverty as high as 80% in some developing countries. Older persons may rely on multiple income sources, including paid work, savings, financial support from families and pensions, all of which may be in jeopardy as a result of COVID-19.

This economic downturn is likely to have a disproportionate impact on older women, given their limited access to income, whether through employment, assets such as land and property, or through pension provision. Women form a higher proportion of older age groups than men: globally women represent 57% of those aged 70-80 years and 62% of those above age 80. Older women tend to have lower life incomes and also lower pensions, with fewer possibilities to access care for themselves. Older women also provide a significant share of the unpaid care provided for other older persons, male or female.

COVID-19 has amplified the violence, abuse, and neglect of older people around the world, which was already on the rise. Before the pandemic, it was estimated that 1 in 6 older people was subject to abuse. Emerging evidence is indicating that this has sharply increased in many countries as a direct result of the pandemic.

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Bernadette’s story – Kinshasa, Democratic Republic of Congo

I was at home and I went outside to the toilet as we don’t have one in my house. An armed soldier saw me and asked why I was not wearing a mask. He forced his way into the house, along with four other soldiers, and asked my husband why we didn’t have masks and then started to harass him.

The men had guns and knives and attacked us. They pinned us down. One man raped me in front of my husband and my five children. Other men raped my three daughters. My two youngest tried to fight them off but they attacked them with knives and they got badly injured.

They stole all our belongings and then arrested my husband. Then they forced us out of our own home, without giving me time to get dressed. I was naked from the waist up. They told my neighbours I was a witchdoctor and they believed them because of the state I was in.

I started walking with my two children through the bush to the neighbouring houses and no one was willing to help us because, they told them that I am a witchdoctor.”

ii. Women with disabilities

An estimated 19% of women across the world have a disability compared to 12% of men. In the global South, women constitute three quarters of people with disabilities. This higher prevalence is often attributed to ‘women’s longer life expectancy, the later onset of dementia and the impact of poor maternal health care, particularly in developing countries’. Christian Blind Mission (CBM), a global disability organisation, suggests that “the higher prevalence of disability is not a facet of being female per se, but a result of social and cultural norms relating to gender, such as ‘systemic exclusion from health care and education, poorer nutrition and gender-based violence’. For example, whilst blinding conditions such as cataracts normally occur later in

life, thus affecting numerically more women than men, women are less likely to receive sight saving cataract surgery. CBM has found that fewer women access surgery because their economic status within the household weakens their value and bargaining power.  

The impacts of COVID-19 and outcomes for women and girls with disabilities have been very negative. Lockdowns, curfews, wearing of masks and restrictions on movement have resulted in lack of health and social care, and higher risks of violence, deprivation and destitution. Women and girls with disabilities have been subject to increased levels of violence and sexual assault; lost or deprived of their livelihoods and denied access to social protection.

The following comments made by women with disabilities participating in focus groups in India will resonate with women with disabilities in other countries and other continents. They were collected by telephone and zoom focus groups, so do not reflect the experiences of women living in poverty without access to phones and computers.

Livelihoods

I have a sewing shop but due to the lack of customers, I am not able to make ends meet.” (A 24-year-old woman with locomotor disability, state of Chhattisgarh, India)

“I used to sell banana leaves, but now since the shops are closed, it has really affected our business.” (A 35-year-old woman with locomotor disability, Betul, state of Madhya Pradesh, India)

Life in lockdown: “A few friends (with disabilities) have told me they don’t get even a single minute to spend on themselves, because there is so much work - they are working like a machine. And they cannot even quit because that is their own home. As a woman all the responsibility comes to them, the family members are not helping.” (A 42-year-old woman with scleroderma (a wheelchair user), Faridabad, state of Haryana, India)

Making ends meet

I get Rs. 700 per month as pension. What can I do with so little? I need to buy medicines, food, clothes. It is not enough. I have to buy things on credit. I have spent all my pension. We have some land for agriculture but because of lockdown even that has stopped. I can only get things on credit now.” (A 29-year-old blind woman, Orissa, India)

Health

All the government hospitals in our village are only seeing Corona patients. Even if we go to them, they will not see us. There are some private hospitals, but they are far away.” (A 23-year-old woman with locomotor disability, Raygada, state of Orissa, India). As a result, women with disabilities from these locations are forced to spend money for tests which would otherwise have been free at the government hospitals.


Domestic violence

A participant with locomotor disability, also associated with a Disabled Persons Organisation, from a village near Bikaner, state of Rajasthan, India, shared the challenge of learning about domestic violence cases because of the hesitation, shame and stigma attached to reporting something that is considered a ‘private matter’.

Mental health and wellbeing

The government is not at all paying attention towards us, which makes us feel that we are not the citizens of this country. Even after living between 10 people, I feel alone.” (A 29-year-old DPO leader, Bikaner district, Rajasthan, India)

iii. Widows

Mortality from the virus tends to be higher for men. In March 2021 the Sex Gender and COVID-19 Project presented country-by-country data showing that men accounted for the majority of coronavirus deaths worldwide, ranging from 77% in Bangladesh, 76% in Thailand, 74% in Pakistan, 70% in Kenya, 68% in Uganda to 48% in Slovenia and South Africa. In general deaths are more evenly balanced between women and men in high income countries. These data indicate that it is likely that across the world of tens of thousands of women have been newly widowed at just the time when they are cut off from their usual socio-economic and family supports.

Statistics are not being routinely gathered on widowhood. The latest figures are from 2015, with an estimate that globally some 258 million women were widows. Both UN Women and widows’ groups have repeatedly noted that widows of all ages are ‘largely unseen, unsupported and unmeasured in our societies’. The actual number of widows is now likely to be much higher than the 2015 estimate and will grow further as the pandemic and its related effects on health continue to rage around the world, including in conflict zones and in refugee camps.

The continuing violations of widows’ rights have most recently been documented in a 2020 dossier for the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) by Widows for Peace through Democracy, which provides reports and evidence detailing the denial of inheritance rights, the theft and appropriation of widows’ property after the death of a partner and extreme stigma and discrimination, as perceived ‘carriers’ of disease.

Supporting widows worldwide

The COVID-19 pandemic has strained health systems, widened socio-economic gaps, and shifted strategic, political, and funding priorities, all of which disproportionately affect women and girls, particularly those who are most marginalized. The doubled risk of death for men from COVID-19 has not only created more widows; the pandemic has in many cases magnified the impact of the challenges they face, for example when confronted by extreme poverty from being disinherited from land and property with no alternative source of support. Even before the pandemic, women struggled to find a livelihood after the death of husbands. In 40 per cent of countries, unequal legal inheritance rights and authority over assets persist. Without secure access to land and resources to support their independence and autonomy, widows are hard-pressed to provide for their day-to-day needs and those of their families, with implications for the realization of other rights, such as to food, health, housing, water, work and education. The challenges widows face present a focused lens through which to understand the broader picture of the issues that must be definitively addressed for women of all ages and conditions to thrive. It is a key moment for gender equality advocates from every sector of society – governments, civil society, private sector, entrepreneurs, trade unions, artists, academia and social influencers – to drive urgent action and accountability for gender equality and to bring about change that would be experienced by widows the world over.

Extracted from the statement for International Widows Day by Under-Secretary-General of the United Nations and Executive Director of UN Women, Phumzile Mlambo-Ngcuka June 23, 2021
iv. Migrants

Before the onset of the pandemic, in terms of employment, migrant women fared worse than migrant men and native-born women. They were more likely to be employed part-time and in low-skilled jobs. The large concentration of immigrant workers (of both sexes) in low-skilled jobs is one of the main drivers of in-work poverty.\(^{35}\) Across OECD member countries, nearly one in five immigrant workers held a low-skilled job in 2017, compared to one in ten native workers. In-work poverty rates were the highest in southern European countries and the United States. In 2017, in the European Union, around 18% of immigrant workers were poor compared to 8% of their native counterparts.

The International Labour Organisation estimates that as of 4 June 2020, 72.3% of domestic workers (55 million) were at risk of losing their jobs, many of whom were migrant workers and therefore at higher risk.\(^{36}\) Women are also estimated to be doing three quarters of the unpaid care work that has resulted from the closure of schools and childcare services during COVID-19 and the increased care needs among older people.\(^{37}\)


Studies on migrants emphasize that not all migrants are equal. Nevertheless, it is clear that incidence rates of COVID-19 among migrants and forcibly displaced persons appear to be consistently higher than among non-migrant groups and that migrants in high-income countries are at increased risk of infection and death due to COVID-19. The higher mortality rates are attributed to limited access to healthcare in addition to migrants’ living and working conditions.  

The lockdowns in many countries can have disproportionate impacts on the socioeconomic status of migrant women who, compared with men, are overrepresented in service sectors, accounting for almost 80% of foreign born service sector workers in the United States and over 70% in Italy. Lockdowns are particularly difficult for migrant domestic workers who find that their leisure time disappears and their mental health deteriorates when they are confined seven days a week, twenty four hours a day, with their employers and their families, often in quite small apartments, as in Singapore. One domestic worker, Benilda, said, “it just means I am being watched all the time”. She explained that she does not have a bedroom of her own and sleeps on the floor of her employer’s child’s room, so has no space of her own to rest in the day when she is given time off. When usually she would have the house to herself, and would be able to sit at the table or on the sofa to relax, she felt unable to do this in front of her employer and so would not sit down all day, other than to briefly eat in the kitchen.

Another migrant domestic worker in Singapore, Margielyin said that even after the circuit-breaker measures had lifted, her employer would not allow her outside on her day off, “Ma’am thinks I will meet with friends and bring back the virus so she doesn’t allow me out.”

In some countries migrant women are more likely to be the victims of abuse and violence. They face stigma and hostility in both origin and destination countries as many believe they are responsible for spreading the virus. One front line worker in Vietnam, providing assistance to migrant women, said that the worst fears of many service providers were coming true, “Unfortunately, our prediction that the number of calls would skyrocket during COVID-19 was right, it doubled, then tripled.”

v. Refugees and displaced women

Around 85% of the world’s refugees are hosted in developing nations and are largely dependent on humanitarian aid or day labour. Many have now lost fragile livelihoods and have been thrust into abject poverty with disastrous and wide-ranging impacts. The United Nations Human Rights Commission (UNHCR) said, “In addition to the mounting risks of violence, abuse, sexual exploitation and trafficking, all of which are consequences of gender inequality, the effects of the pandemic are also proving catastrophic on refugee girls’ education. Many girls are being forced to drop out of school and into work, sold off or married.”

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38 Migration Data Portal. Migration data relevant to COVID-19. Updated 04 March 2021  

39 ibid.

40 Dr Laura Antona. The New Normal or Same Old? The Impacts of the Covid-19 Pandemic on Live-in Migrant Domestic Workers in Singapore.  


42 UNHCR UK. COVID-19 pandemic worsening gender inequalities for refugee women and girls. 08 03 2021  
"My name is Sofara. The Rakhines and the Burmese Military surrounded our village and set fire and started to shoot people. They have shot my husband and took young girls in groups to the school and raped them. They have further hit the injured people with knife till death. Afterward they have put all the dead people in a hole and burnt them with petrol. Young children were taken away from mothers and thrown into the fire and they raped the mothers. They shot my husband. But he was alive, then they beheaded him. I flew away with my three kids. Afterward I survived by collecting woods and fishing. But now I cannot even go for that because of the fight between the Arakan Army and the military. Now I work as cleaner to other people’s house. If I feed my children for a day, I cannot feed them for many days. I cannot buy them clothes in this cold weather. I cannot provide them any education and cannot give them any medical treatment".  

Widows Speak Out: Abuse and Discrimination, Resilience and Agency: Alice Lees and Margaret Owen, Widows for Peace through Democracy 2020

As a result of the pandemic, refugee families facing destitution are already resorting to child marriage. According to United Nations Population Fund (UNFPA), COVID-19 will disrupt planned efforts to end child marriage, and result in an additional total 13 million child marriages taking place that otherwise would not have occurred between 2020 and 2030. This is the general situation of child marriage during the pandemic. One can well imagine the situation among refugee populations.

Refugee women are also burdened with extra caregiving at home, turning to precarious jobs in the informal sector, or on the streets. Increased household demands are also diminishing their opportunities for education while increasing exposure to the virus.


Refugees and displaced persons in crisis torn countries are more likely to have a disability than non-refugee populations. A survey in Jordan found that, although UNHCR’s standard registration system had only identified around 2% of registered refugees as having a disability, in 2016 over ten times that number had some kind of disability – closer to 28%. Disability prevalence in Syria is similar. 27% of the population over the age of 12 is living with a disability. This is nearly twice the overall global prevalence of 15%. Women make up nearly half of refugees and displaced persons living with a disability in Syria.

A large number of women with disabilities in Syria are widows. They face significant difficulties in providing for their families. Females earn on average 38% less in monthly wages than men, and 84% are unemployed (as compared to 22% of males). The combined socio-economic stress of widow-status with disabilities can increase negative coping strategies like dependence on humanitarian assistance, child employment or child marriage, negatively impacting the entire household.


Disabilities, marginalization, diverse sexual orientation and gender identities are also compounding discrimination and risks of violence for refugee, displaced and stateless women and girls. Programmes to combat gender violence and inequalities are severely underfunded.

According to the Women’s Refugee Commission’s report on global disability inclusion, women and girls with disabilities are most likely to experience instances of sexual violence, while men and boys with disabilities are more likely to suffer increased physical or psychological harassment.48

vi. Ethnic minorities

The Covid-19 pandemic has highlighted that precarious work, and exploitative and adverse working conditions intersect with multiple factors, including ethnicity, migrant status, class, and gender, to influence which population groups are most exposed to COVID-19 infection. While unpicking the causes of ethnic inequalities in health outcomes is difficult, available evidence suggests a complex interplay of deprivation, environmental, physiological, behavioural and cultural factors.

Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism can reinforce inequalities among ethnic groups, for example in housing, employment and the criminal justice system, which in turn can have a negative impact on

Mobilisation by women belonging to Indigenous community during Global Week of Action “Act4SDGs” 2020 organised by LEADS, India

health. Evidence shows that racism and discrimination can also have negative impacts on the physical and mental health of people from ethnic minority groups. In Sao Paulo in Brazil, people of colour are 62% more likely to die from COVID-19 than white people. In the United States, Latino people are 2.4 times more likely to die from COVID-19 than white or Asian people, indigenous Americans 2.2 times, and black Americans twice as likely.49

Ethnic minorities and migrants across the EU are more likely to be poorer, to live in over-crowded accommodation and to be in insecure jobs – e.g., as delivery drivers, in factories and warehouses, where physical distancing is challenging – which put them at greater risk of contracting COVID-19. They are also more likely to have underlying health conditions which put them at greater risk of dying when they do fall ill with COVID-19.

In the United Kingdom, the Institute for Fiscal Studies found that “the death rate for people of black African descent was 3.5 times higher than for white British people, while for those of black Caribbean and Pakistani descent, death rates were 1.7 times and 2.7 times higher, respectively.”50 Government data for England and Wales show a death rate for black, Pakistani and Bangladeshi people that is nearly double that of white people, even when class and some health factors are taken into account. African and Caribbean populations and people of South Asian heritage are more likely to have front-line jobs, to live in over-crowded accommodation and to have poor diets51 and also to suffer from diabetes and hypertension.52 Black and minority ethnic medical staff also report that they had greater difficulty in obtaining good personal protective equipment than white colleagues.53
Health inequalities in Paris, France

In metropolitan Paris, the department of Seine-St Denis is home to many non-European immigrants (23% of the local population) and has some of the worst social conditions in France. Excess mortality rates in Seine-Saint-Denis are dramatic: almost 130% overall (compared with a national excess death rate of 26% and for people over 65 years of age - 44.6%). Insecure employment, insufficient medical facilities, co-morbidities and over-crowding are key features of social and health inequalities. Risk is increased by travel to and from work: just over half of residents have to travel outside their department to their place of work - twice the average proportion for metropolitan Paris as a whole.

Roma communities, facing discrimination based on Work and Descent (DWD), have difficulty in implementing key measures to reduce the spread of COVID-19 such as maintaining physical distances, self-quarantine and regular handwashing: 30% live in households with no tap water and up to 80% in some countries live in overcrowded housing. They have been made scapegoats for the propagation of the virus and have faced hate speech and threats. It was reported that "soldiers, police personnel, and drones have been more present in Roma communities in Bulgaria and Slovakia than have nurses, doctors, and medical supplies" and “distance learning measures leave more than half of Roma children out of school and will likely lead to an increase in the already high dropout rates among Roma students.”

A 2020 survey of 11,000 Roma in Spain showed that the closure of street markets, and the impossibility of collecting scrap metal, selling fruit and other informal jobs have left many families facing a situation of acute emergency. One third of Roma in paid employment lost their jobs, another third was temporarily laid off and 12% saw their working hours reduced.

In France it is prohibited to collect data on ethnicity, so the figure for immigrants is an approximation and an underestimate because it does not include minority ethnic people who are French citizens (non-immigrés)

55 Le Monde. 17 May 2020. Coronavirus : une surmortalité très élevée en Seine-Saint-Denis


57 Le Monde. 17 May 2020. Coronavirus : une surmortalité très élevée en Seine-Saint-Denis

58 EEB. Time to reach for the moon – the EU needs to step up action and lead the transformation to sustainability.


The pandemic is a wake-up call for change. It has thrown a harsh light on the structural injustices caused by the intersecting issues of age, gender, ethnicity, location and disability. It has highlighted the urgency of formulating and implementing robust and well financed policies for strong social protection, universal health and social care, decent housing and inclusive employment. The deep inequalities that persist within and between countries and regions must be tackled for a transformative recovery to take place.

Vaccines are a public good and must be made available to all, to all ages and to all social groups, in all countries without discrimination. COVID-19 should not prevent progress, or be an excuse for not reaching the SDGs by 2030. COVID-19 should serve to accelerate government efforts with ambition, urgency and scale.

The SDGs link economic and social priorities with the call for urgent environmental measures to tackle the climate, biodiversity and pollution crises. They provide the framework to ensure the well-being of all people, across the life course and in all their diversity, and are a guide to the creation of genuine and accountable global partnerships for sustainable development, founded on human rights principles, redistribution and an end to austerity.

We know what is needed and why it must happen now. There is no time to waste.
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