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The impact of the COVID-19 crisis on vulnerable groups in the EU

People experiencing homelessness, migrants, Roma, people with disabilities and vulnerable children

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Directorate F— Employment and Social Governance, Analysis
Unit F4 — Analysis and Statistics

Contact: Katarina Jaksic
E-mail: Katarina.jaksic@ec.europa.eu

European Commission
B-1049 Brussels

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Ides Nicaise
Corresponding author
KU Leuven (HIVA)
email: ides.nicaise@kuleuven.be
Anne Van Lancker
KU Leuven (HIVA)
Nick Verhaeghe
KU Leuven (HIVA)
Kristof Faes
KU Leuven (HIVA)
Anna Ruelens
KU Leuven (HIVA)
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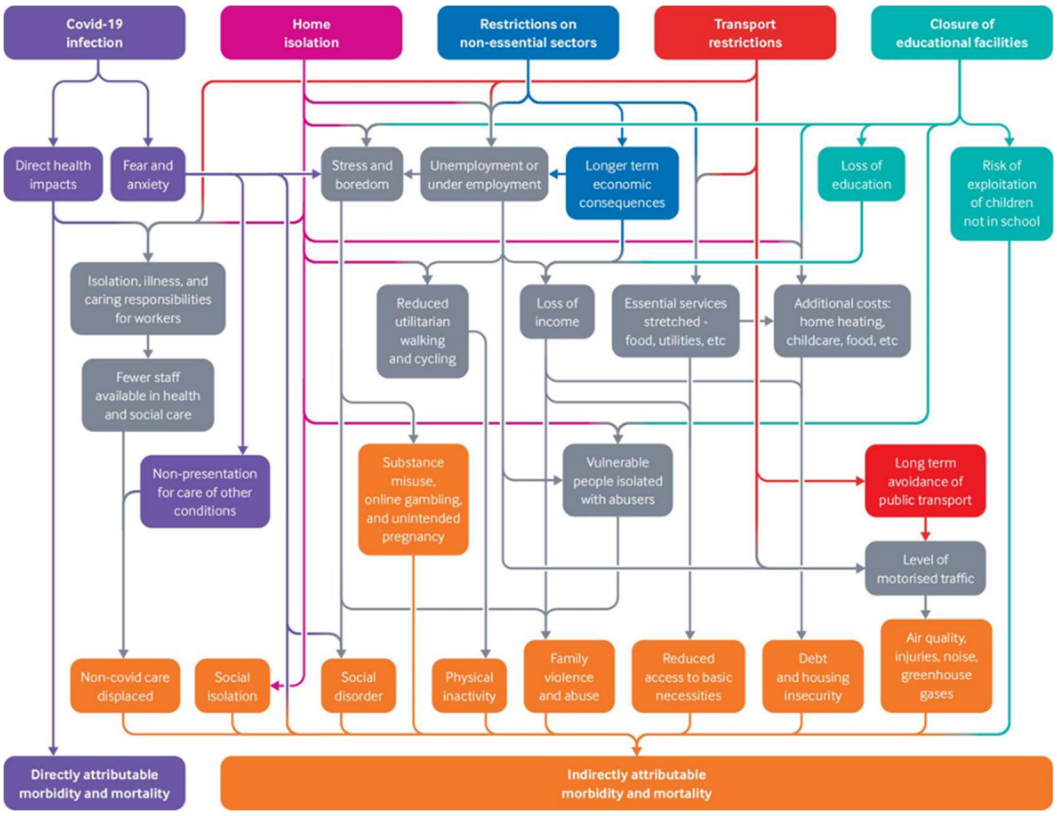
Introduction

Despite prompt and powerful policy responses, the COVID-19 crisis has had profound, complex and multifaceted impacts on the lives of European citizens. These include social and economic costs, increases in unemployment, interrupted education, social isolation and related psychosocial outcomes (Fuller et al., 2021). The largest global shock since World War II, COVID-19 has had severe effects on public health and on the economy, and very unequal impacts across the population. Population-wide restrictions were imposed to prevent further spread of COVID-19 within the general population. These measures, such as home isolation, restrictions on non-essential sectors and movement, and closure of services, had an indirect impact on lower socioeconomic groups and minorities, fuelling widening differences in social health determinants. Figure 1 shows the direct and indirect impact of COVID-19 on health and social determinants.

FIGURE 1 EFFECTS OF COVID-19 MEASURES ON HEALTH AND SOCIAL DETERMINANTS OF HEALTH



Source: Douglas et al. (2020).

Although older people have been the main victims in terms of health and isolation, young people have suffered more in respect of employment and income. Low-qualified groups are undoubtedly the hardest hit, with some within these groups working in occupations considered 'essential', putting workers at above-average risk of contamination, and others disproportionately subject to lockdown measures (see Chapter 1).

This report focuses on five vulnerable groups: homeless people, migrants, Roma, people with disabilities, and vulnerable children. It also devotes particular attention to the dynamics of the COVID-19 crisis as an accelerator of inequalities, with potentially far-reaching impacts on vulnerable groups - especially children. Unequal health risks compound socioeconomic and digital divides and a disruption of the overall economic and social fabric, and could result in severe long-term negative impacts on specific groups. More specifically, the report distinguishes between the *primary* (health) impact of COVID-19, the *secondary* impact on other health problems and dimensions of well-being (income and employment, housing, family and social ties, mental health), and *tertiary* (longer-term) impacts on future outcomes, such as children's education and shifts in social policies and practice. Chapter 1 sketches an overview, while Chapters 2 to 6 address each of the particular target groups in turn. In each case, the first section describes the primary impact of the COVID-19 crisis, the second section examines its secondary impact, and the third section addresses the expected longer-term tertiary impact, to the extent possible.

Despite remarkable scientific progress and prompt policy responses in the fight against COVID-19, the crisis is not over and continues to be characterised by unexpected developments. The literature inevitably lags behind, and this paper reflects the state of knowledge as at May 2021[1].

[1] An exception is made for the European Commission's 'Employment and Social Developments in Europe' report, which was published in July 2021 (European Commission, 2021d).

Covid-19 and vulnerable groups

PRIMARY HEALTH IMPACT

SARS-CoV-2 (COVID-19) is transmitted by droplet infection and/or aerosols. Closer direct contact with infected persons thus increases the risk of infection (Centre for Disease Control and Prevention, 2021a). This means that unequal living and working conditions for people from different social groups can contribute to an unequal risk of infection. Several European studies have confirmed that the incidence and fatality rates of COVID-19 are strongly correlated with socioeconomic characteristics. During the second wave in Barcelona, the incidence among men in the bottom income quintile was found to be 67% higher than in the top quintile, while for women that gap was 71% (Mari-dell'Olmo et al., 2021). A similar pattern was observed in Germany between deprived and wealthier areas, based on multidimensional indicators (Wachtler et al., 2020), while in the United Kingdom (UK), the share of racial and ethnic minorities among intensive care patients affected by COVID-19 was 2.4 times their share in the population (ICNARC 2021). In Belgium, Decoster et al. (2020) found that excess mortality in the bottom income decile was double that of the top decile during the COVID-19 crisis.

Overcrowded housing conditions are also a risk factor for COVID-19 infection, (The Health Foundation, 2020). A preliminary analysis of death statistics from England and Wales showed that specific occupations carried an increased risk of becoming infected and dying from COVID-19, with the ability to work flexibly and from home mainly benefitting those with a higher level of education (von Gaudecker et al., 2020; Kumar et al., 2012; Blake et al., 2010).

Although a severe COVID-19 disease course has been observed in younger people and those without pre-existing conditions, advanced age and certain pre-existing conditions are considered risk factors for serious disease progression. These include diseases of the cardiovascular system, lungs, liver and diabetes mellitus (European Centre for Disease Prevention and Control (ECDC), 2020a). People with certain cancers and a weakened immune system are considered high-risk groups for COVID-19 (Centre for Disease Control and Prevention, 2021b). Many of these diseases occur more often in lower socioeconomic groups than in groups with a higher socioeconomic status. Smoking and obesity are important risk factors for a more severe course of COVID-19 and are unevenly distributed between socioeconomic groups (Vardavas et al., 2020; Sattar et al., 2020). Indeed, tobacco consumption tends to be more frequent among disadvantaged groups: people experiencing homelessness, people suffering from mental health problems, but also those on low incomes and Roma. In the EU, 26% of obesity in men and 50% of obesity in women can be attributed to inequalities in educational status. Low socioeconomic groups appear to be around twice as likely to become obese, putting them at greater risk of Type 2 diabetes, ischaemic heart disease and stroke (World Health Organization (WHO), 2014).

In general, groups with lower socioeconomic status experience an increased risk of COVID-19 infection, combined with an increased risk of symptomatic and severe course of the disease. These inequalities are amplified by the differential impact of non-medical and non-pharmaceutical

interventions, such as contact and mobility restrictions, differences in access to optimal care, and the unequal psychosocial, health and socioeconomic consequences of the pandemic.

SECONDARY IMPACT

Employment, income and social protection

Although the overall picture of the socioeconomic impact of the COVID-19 crisis goes beyond the scope of this report, it is nevertheless useful to summarise the key research findings for vulnerable groups. Using Amartya Sen's (2005) capability approach, vulnerability is defined as a limited capability to exert basic rights, due either to lack of (material or embodied) resources such as housing, income, skills, health, or to exogenous constraints (conversion factors such as disabilities, unemployment or legal restrictions), or to limited freedom of choice. This rather abstract definition reflects the multidimensionality of vulnerability, as well as the role of personal, socioeconomic, ecological and institutional determinants.

During the COVID-19 pandemic, vulnerability on the labour market stems from wage inequality, unequal job-related health risks, the digital divide and the social protection gap. Blundell et al. (2020) showed that in the UK, all of these risks are unequally distributed by age, level of qualification, gender, race and ethnic background. Vulnerable workers not only work in low-paid and insecure jobs but are overrepresented in services that typically involve multiple close contacts (care, maintenance, passenger transportation, tourism, hospitality, catering, retail). Some of these services are deemed essential and are therefore not subject to lockdown, involving relatively high exposure to the virus, with rates of COVID-19 deaths between 2 and 3.7 times higher than average. Others are more susceptible to lockdown measures due to the lack of an option to work from home. Workers in the lowest-paid jobs in the European Union (EU) are 21 times less able to work from home than those in the highest-paid jobs (3% versus 74% (Sostero et al., 2020)). In addition, many are part-time jobs that entail limited social protection rights. These findings of Blundell et al. (2020) and Sostero et al. (2020) are - at least tendentially - confirmed by other studies (Galasso, 2020; Decoster et al., 2020; European Commission, 2021a). Others work in the shadow economy with no protection at all. Small self-employed workers, such as street vendors, lost their income altogether during lockdown periods. In rural areas, isolated farmers could not sell their products and lost part of their income (European Anti-Poverty Network (EAPN), 2020).

The income loss at household level in 2020 has been estimated at approx. 5.4% (European Commission, 2020a), despite generous government compensation measures for both employees and self-employed workers. These measures were partly backed by the European SURE programme[2], and included compensations for short-time work, income support for the self-employed affected by lockdown measures, sickness benefits during quarantine periods and 'caring allowances' for those caring for sick relatives or children during school closures.

National social protection systems have far from universal coverage and the same is true of the additional measures implemented during the crisis. Although the Eurofound (2020) online COVID-19

[2] Temporary **S**upport to mitigate **U**nemployment **R**isks in an **E**mergency (SURE), a EUR 100 billion loan fund to support measures such as compensation for short-time work.

surveys are not fully representative, they found that no more than 41% of all respondents who had lost their job due to the pandemic were receiving any kind of public income support in July 2020, which is consistent with other statistics about the limited coverage of social protection schemes[3]. An additional issue is arrears in the disbursement of social benefits due to the sudden increase in caseloads. For the most disadvantaged groups, in particular, the surveys point to a significant impact on household finances: during the first wave of the pandemic, 47% of all respondents reported difficulties in making ends meet. As the lockdown measures were relaxed in July, that figure dropped to 44%. Yet the incidence of arrears in payments (rent, utilities, internet, healthcare) continued to increase, ranging from 20 -30% depending on the type of expenditure. Such arrears may involve a risk of eviction and homelessness, utilities being cut off, or risky delays to medical treatment (Malgesini, 2020; Boobis and Albanese, 2020).

Inequalities at individual and household level are also geographically clustered. Already lagging behind before the outbreak of COVID-19, Southern European countries have been disproportionally affected because of their economic dependence on tourism, which is the sector possibly worst hit by the pandemic. Their debt-to-GDP ratios are expected to rise to record highs (Moreira et al., 2021).

Secondary health effects

Secondary health effects relate to health issues other than COVID-19 that were induced by the crisis context. While some countries successfully absorbed the soaring demand for health services (particularly hospitalisation), others were repeatedly overwhelmed. The necessary reorganisation of healthcare systems by postponing non-urgent care in order to reserve maximum capacity for triage and hospitalisation had unintended but important consequences for access to care, diagnosis and treatment. Wards and intensive care units were redesigned to host COVID-19 patients, while staff allocation, care pathways, diagnostic testing and hospital admissions were modified (Fuentes et al., 2020). Postponed care worsens health outcomes, with hospital avoidance among EU citizens increasing the numbers of late-presenting, serious cases. Patients experienced extensive disruption of care, with the majority of appointments and treatments cancelled, reduced or postponed. Fewer patients were admitted to the emergency departments and those admitted were significantly more urgent (ESHRE COVID-19 Working Group, 2020). Control visits for patients (both adults and children) with chronic medical complexity were postponed, increasing the burden on themselves and their families. Healthcare workers were required to add telehealth monitoring visits to their already extraordinary activity. Although telemedicine revolutionised the delivery of care, particularly for people living far from healthcare centres, its impact on important patient and clinician outcomes or on health care systems needs to be further examined. Telemedicine had a positive impact on conditions such as specific cancers (Smrke et al., 2020), but patient satisfaction decreased as a result of the switch from face-to-face medicine to telemedicine.

In regions where mental health care was already heavily medicalised and often limited to medications issued by psychiatric institutions, COVID-19 threatened burgeoning efforts to pursue a more holistic and person-centred model of care. As countries emerged from lockdown, those working in global mental health had to double their efforts, not only to make up for lost time and help

[3] Another 39% reported receiving informal support from family or friends.

individuals to cope with the added stressors of COVID-19 in their communities, but also to regain lost ground in mental health care reform in low-resource settings (Mpango et al., 2020).

A systematic evaluation of the psychological consequences of self-isolation and quarantine measures showed that such measures can have extensive and sometimes lasting effects (Brooks et al., 2020). The study found that financial losses during self-isolation are significant stressors that can contribute to sustained psychological stress. In addition, people who experienced elevated psychosocial stress levels prior to the pandemic measures were more likely to be affected. A substantial body of research has linked chronic stress and depressive symptoms, primarily in people with low socioeconomic status (Freeman et al., 2016; Lorant et al., 2003). At the same time, fears of financial loss could lead those with low material and social resources to reject or refuse to comply with these measures, increasing the risk of COVID-19 transmission within this group. The first wave of COVID-19 was associated with a system-wide drop in the use of mental health services compared to 2019, with a tendency to normalisation of activities later in 2020. 'Supply' changes may have reduced access to mental health services for some, while 'demand' changes may reflect a genuine reduction in need or a lack of help-seeking, resulting in pent-up demand (Chen et al., 2020). Existing social health inequalities could also worsen as a result of non-medical and non-pharmaceutical interventions, with inequalities in physical inactivity and obesity exacerbated by different adaptation strategies to contact restriction measures in different social groups, for example. The situation can be similar for substance-related dependencies, or for possible adverse health damage after surviving a severe COVID-19 infection. As yet, the further social and economic consequences of the COVID-19 pandemic can only be estimated.

Access to other public and social services

An important problem for vulnerable groups during the COVID-19 crisis relates to the difficulty in accessing public and social services. In addition to the constraints resulting from lockdown and social distancing measures, a significant imbalance was already evident between the growing demand for support and the pre-existing provision, following cutbacks in social expenditure in the past decade (Aluffi Pentini and Lorenz, 2020). The crisis affected all public and social service sectors, ranging from municipal administration to education, food banks, asylum centres, shelters for the homeless, and youth care (EAPN, 2020). The vast majority of workers in social services are women, with social distancing measures and the closure of schools and childcare services adding to absenteeism and bottlenecks in provision. Part of the services switched to online consultations, which were less accessible for low-income clients or those with low literacy.

EAPN (2020)[4] mentioned a number of solidarity initiatives set up by public authorities, third sector organisations or local volunteers:

- Ensure continuity of services for the most vulnerable groups: shelters for people experiencing homelessness, homes for the elderly or for children in care, etc. were identified as 'essential services'. They received priority treatment in the distribution of protective equipment, with additional funding sometimes granted to extend opening hours, enhance intensity of support, or increase numbers of applicants served;

[4] See International Federation of Social Workers Europe: https://www.esn-eu.org/news/social-services-and-COVID19-supporting-frontline

- Reinforce services: public job portals were set up to recruit additional staff and replace sick personnel or supplement existing staff. Some services engaged digi-buddies to facilitate access to digital communication tools for clients in isolation. In Scotland, additional teachers and social workers were hired to work in schools with a high percentage of vulnerable children. Local authorities in several countries used empty hotels or public buildings to provide safer accommodation for people experiencing homelessness.
- Creation of local partnerships and charity initiatives: in various countries, local projects were set up to distribute food, face masks and hygienic kits to poor families, and volunteers were recruited to deliver goods to the homes of vulnerable people during lockdown periods.

Trust in political institutions

The COVID-19 pandemic has had an impact on public trust in institutions. High levels of institutional trust in the population ensure the legitimacy of government policies and stimulate compliance with the proposed health policies and safety measures (Gilles et al., 2011; Quinn et al., 2013; Van Bavel et al., 2020). The beginning of the pandemic, in particular, was characterised by a higher level of trust in public institutions in many European countries, even those generally characterised by distrust, such as Italy (Falcone et al., 2020). This is often explained by the 'rally-round-the-flag' effect in the times of crises (Mueller, 1970; Mueller, 1973). This phenomenon of increased public support appeared to be short-lived (Baekgaard et al., 2020). Eurofound (2020) carried out two e-surveys that suggested that overall trust in government across the EU-27 was already slightly lower in July 2020 compared to April 2020. Although longitudinal studies remain sparse, the worsening of the economic situation accompanying the COVID-19 pandemic is likely a contributing factor to the decline in institutional trust, with earlier literature on political trust showing that public trust in government institutions tends to be lower among individuals in economically vulnerable positions, such as the poor, unemployed or low educated (Polavieja, 2013; Van Erkel and Van der Meer, 2016; Ruelens et al., 2018). Greater individual concerns about national economic performance tend to correlate with lower levels of institutional trust (e.g. Citrin and Green, 1986; Van der Meer and Dekker, 2011; Ellinas and Lamprianou, 2014). This suggests that the employment and income insecurity associated with the economic downturn after March 2020, as well as the inequalities between social groups (Wright et al., 2020), affected the levels of institutional trust among individuals in economically vulnerable positions. Eurofound's findings appear to support this hypothesis. conjecture. More specifically, unemployed individuals tend to exhibit less satisfaction with the way democracy functions in their countries, compared to the employed or self-employed individuals. Eurofound (2020) found a notable gap in both trust in national government and trust in the EU between individuals who received support from public services for basic needs and those whose requests were rejected.

The importance of individual trust in public institutions should not be underestimated. Aside from compliance with government policy, recent research found that higher levels of political trust were related to lower stress levels during the COVID-19 pandemic (Lieberoth et al., 2021). In addition, trust appears to partially mediate the relationship between perceived adversity, such as insecurity in employment and housing, and subjective well-being and mental health, particularly in older adults (Lee, 2020). Even more strikingly, Oksanen et al. (2020) demonstrated that institutional trust was

associated with lower COVID-19 mortality. These and other findings warrant further research to understand the dynamic relationship between the COVID-19 pandemic and institutional trust.

Role of civil society

Non-governmental organisations (NGOs) working with vulnerable groups contributed substantially to COVID-19 relief measures. A survey by the WHO (2020a) revealed the importance of NGOs and organisations supporting refugees and migrants as providers of information on COVID-19, as well as material support. Other examples relate to emergency aid, ranging from information outreach to difficult-to-reach groups, delivery of food and essential goods, helpdesks and personal support to families, including in refugee camps, organising (night) shelters and small residential centres, and organising buddy support for migrants and their children. In several countries, civil society organisations provided medical services and shelters for people experiencing homelessness (Malgesini, 2020; EAPN, 2020).

NGOs themselves are experiencing additional strain. In a period of soaring demand for support, private donations are shrinking due to the economic downturn, while organisations are unable to fundraise in public places. Churches and larger foundations (e.g. King Baudouin Foundation in Belgium) have provided a lot of financial support to organisations at grassroots level in order to help them meet the most urgent needs. Overall, according to a survey of 800 non-profit organisations in six EU countries commissioned by the European Fundraising Association (EFA), the majority of the NGOs (62%) expected their revenues to decline and one in three had already downsized their staff in 2020 (EFA & Salesforce, 2020). The financial vulnerability of NGOs has been signalled on a global scale at the World Economic Forum, where more systematic funding strategies are advocated, such as state-guaranteed loans (O'Connell, 2020).

People experiencing homelessness

Before the outbreak of COVID-19, there were an estimated 700,000 homeless[5] people in the EU (FEANTSA, 2019). People experiencing homelessness are among the highest-risk groups in the COVID-19 pandemic due to their precarious health and living conditions, while the risk of homelessness itself appears to have increased as an indirect consequence of the pandemic. Evictions, increases in intra-familial violence, and the reluctance of family and friends to offer informal shelter appear to have driven more people into the streets. Public and civil society services have made enormous efforts to offer accommodation and support to people experiencing homelessness, despite sub-optimal circumstances, during this period of increased need.

PRIMARY HEALTH IMPACT

Incidence of COVID-19 among people experiencing homelessness

The higher risk among people experiencing homelessness of becoming seriously ill can be explained by their higher prevalence of comorbidities, as well as their own risk behaviour such as smoking, alcohol and illicit drug use (Fazel et al., 2014; Badiaga et al., 2008). For example, the prevalence of respiratory disease among people experiencing homelessness is high, increasing the risk that their COVID-19 infection will result in serious illness or death (European Public Health Alliance, 2020a). People experiencing homelessness also have poorer mental health than the general population (WHO, 2020a).

To date, there are no representative COVID-19 statistics for the homeless population in Europe. Given the fragmentation of data, the overall picture remains unclear. A seroprevalence study among 800+ individuals living in temporary workers' accommodation or shelters in Paris and Seine-St-Denis revealed that more than half (52%) of those examined tested positive for COVID-19. The incidence was clearly correlated with their crowded accommodation, with the risk being more than four times higher for those sharing rooms with five others compared to those not sharing a room. However, 68% of those testing positive did not report any symptoms (Roederer et al., 2020). Save the Children (2020) referred to similar test results in a German reception centre for asylum seekers, where half of the 560 residents tested positive. A similar test was conducted in Marseille in March-April 2020 among 700 people experiencing homelessness and employees working in shelters. That study revealed a much lower seroprevalence rate (7%), with half of those testing positive showing symptoms of respiratory problems or fever (Tran Duc Anh Ly et al., 2020).

Public authorities and private shelters took prompt precautions against poor hygienic conditions in emergency shelters, with dormitories rearranged and additional accommodation opened (e.g.

[5] In accordance with the 'ETHOS light' typology of homelessness, the study uses a broad definition of the target group that includes rough sleepers, users of regular or emergency shelters, squatters, people living in inadequate dwellings such as garages or cars, and sofa surfers living temporarily with relatives or friends.

empty hostels, hotels) to facilitate quarantining. The Polish National Federation for Solving the Problem of Homelessness surveyed 98 institutions in June 2020 and found that no more than 2% of the residents had tested positive, while 0.7% showed symptoms of COVID-19 (the majority from a particular shelter in Warsaw) (Wilczek, 2020). Pleace et al. (2021) confirmed that the (known) rates of infection in European shelters are higher than among the general population, but lower than those of homeless shelters in the United States (US).

The primary impact appears to depend on precautionary measures taken by homeless services and public authorities. For example, the 'Everyone In' measure in England aimed to end street homelessness by offering emergency accommodation in hotels and hostels. During the first wave of the pandemic, it reached out to 15,000 rough sleepers and accommodated them in three categories of provision, with associated supporting services: 'COVID-care' for those testing positive, 'COVID-protect' for those testing negative but vulnerable, and 'COVID-prevent' for others (Flook et al., 2020). An evaluation of Everyone In estimated that, during the first wave alone, this measure might have avoided more than 21,000 infections, 266 deaths, 1,164 hospital admissions, and 338 intensive care admissions (Lewer et al., 2020).

Accessibility and affordability of healthcare services

People experiencing homelessness face multiple barriers in accessing healthcare, basic services or public health information (European Public Health Alliance, 2020b, WHO, 2020a). Restrictions on access to health services and a switch (in some cases) to virtual appointments made it more difficult for people experiencing homelessness to make or access appointments. In addition, the high incidence of comorbidity complicated people experiencing homelessness's access to the full range of health and other services. This makes them particularly vulnerable to infection by the COVID-19 virus (Homeless Link, 2020).

Some national/local authorities and civil society organisations created additional shelter and quarantine possibilities, including extra services. For example, the Lisbon City Council (Portugal) set up four temporary accommodation centres that also provided daily health screening. By contrast, the first results of a survey on the situation of people experiencing homelessness in Germany[6] suggested that shortages in the supply of medicine and emergency assistance for people experiencing homelessness were not being considered (European Union Agency for Fundamental Rights (FRA), 2020b). With vaccination campaigns reaching a maintenance level, concerns have risen about how best to reach out to people experiencing homelessness, who by definition have no (operational) registered address. Although the obvious solution may be to reach out through homelessness services, the extent to which Member States are prioritising this target group remains unclear. Another concern is the difficulty in providing long-term treatment in the event of long COVID[7] (FEANTSA, 2021a).

[6] Survey by the Federal Association for Assistance to Homeless People – based on replies from 91 facilities and services for people experiencing homelessness in March and April 2020.

[7] Long COVID refers to prolonged illness due to lasting vulnerability (Mahase, 2020).

SECONDARY IMPACT

Increased homelessness

There is as yet little statistical evidence about the rise of homelessness since the outbreak of the COVID-19 crisis in Europe. Generally speaking, however, economic crises fuel poverty and overindebtedness, leading to evictions as people are unable to continue paying their rent. Although many governments have banned evictions by law for a certain period, social services fear that such measures may postpone rather than prevent evictions, or indeed simply be ignored.

Another driver of homelessness is breakdown of familial relationships and domestic violence, which clearly increased as a result of the economic and psychological strain of COVID-19. Several sources (WHO, 2020b; Usher et al., 2020; Boobis and Albanese, 2020) report sharply rising numbers (20-60%) of calls for help received by emergency services following intra-family conflicts. This is reflected in the shifting profile of new people experiencing homelessness towards more women with children (Pleace et al., 2021). More young people are excluded by their families as their orientation becomes more visible at home and tensions surrounding their sexual identity result in violence, exclusion or escaping behaviour (Shorunke, 2020). At the same time, many 'hidden' homeless (so-called sofa surfers) have been forced onto the streets as relatives and friends became more reluctant to offer shelter, due to the perceived health risks involved and/or contact restrictions imposed by the public authorities (Boobis and Albanese, 2020; Doctors of the World, 2020).

Homeless migrants - asylum seekers and undocumented migrants in particular - are another extremely vulnerable category, as many earn a living with undeclared work and have little or no access to social protection. For example, those dwelling in their workplaces became unemployed and homeless simultaneously. With decreasing employment, isolation and language barriers, services and centres closing under lockdown measures, empty streets and no possibility to beg for change, and above all, no place to 'stay home', some became depressed, while others turned to crime to survive. In many EU countries, public policies deny undocumented migrants the right to shelter services. Returning home is sometimes impossible due to mobility restrictions and also raises tensions with their communities of origin (FEANTSA, 2021b).

Some piecemeal statistics tend to confirm that homelessness has increased overall, even though rough sleeping may have been (temporarily) reduced. In the Brussels-Capital Region, for example, a 28% increase was noted between November 2018 and November 2020. Looking at the breakdown by category of homelessness, the number of rough sleepers appears to have decreased whilst the numbers squatting increased disproportionately, reflecting permission from local government to use uninhabited buildings. The numbers in emergency shelters have increased very substantially, as a result of efforts to keep people experiencing homelessness off the streets (Bruss'Help and Koning Boudewijnstichting, 2021). In the UK, Boobis and Albanese (2020) surveyed 130 services in September 2020: 68 of those (53%) reported an increase in homelessness and 95 (73%) experienced an increase in demand for their services. In the London area alone, the inflow of new rough sleepers between April and June 2020 rose 77% compared to the same period in 2019.

Living conditions of people experiencing homelessness

Lockdown measures drove a wedge between those lucky enough to secure a place in a shelter and those who were not. Shelters reorganised themselves to reduce 'shared air' sleeping, sometimes by renting additional accommodation, including separate provision for clients that tested positive for COVID-19. During periods when shelter users needed to stay inside during the day, they had to extend the range of services on offer (Pleace et al., 2021), with public authorities renting rooms in empty hostels or hotels, for example. The crisis thus improved housing conditions for those who could secure a place. In a number of countries (Germany, UK, Denmark, Poland, Ireland, France, Portugal), big cities effectively managed to reduce rough sleeping (FEANTSA, 2021c). Social workers also realised the advantages of this more stable housing, in that it became easier to reach their clients during the day. In addition, some reports suggested improved nutrition and health conditions among shelter users (FEANTSA, 2020; Pleace et al., 2021).

Despite the improved quality of services, residents experienced more stress due to isolation, language barriers, lack of information and further confinement of their freedom. This led to more frequent tensions within services and explains why residents 'escaped' from their shelters (FEANTSA, 2021c). For those sleeping rough, life became much harder. With many bars, shops and/or public buildings closed, they experienced greater difficulty accessing toilets or showers. Although soup kitchens closed, reducing the availability of food, voluntary organisations stepped in to take over food distribution. In addition to the hazardous health conditions, spending time in public spaces risked fines or sanctions (ECDC, 2020b; FEANTSA, 2020).

Secondary health effects

Recent literature suggests that the secondary health impacts of the COVID-19 crisis on people experiencing homelessness may be more severe than the primary impact. People experiencing homelessness suffer from multiple and complex needs, severely poorer health, social exclusion, and early death. Poor health is often a cause and an effect of homelessness, and the two tend to interact in complex and mutually reinforcing ways (Cream et al., 2020). Higher mortality from communicable and non-communicable diseases is observed compared to the general population. People experiencing homelessness before the age of 65 years have all-cause mortality that is 5–10 times higher than that of the general population (Baggett et al., 2013). The potential exposure to the COVID-19 virus may negatively affect their physical and mental health as well. The COVID-19 pandemic is likely to further increase this mortality disparity.

Based on a survey of the literature, Martin et al. (2020) estimate that half of people experiencing homelessness suffer from mental health disorders, partly related to substance abuse. The disruptive effect of the pandemic (including on drug trafficking) further destabilised many of them (Vasylyeva et al., 2020). The 'everybody in' measures presented an additional challenge for shelters that needed to remain open 24/7 while imposing restrictions on their users. By contrast, most psychosocial guidance services reduced their activities, switched to online consultations only, or simply closed. Several authors referred to rising tensions in centres where alcohol or substance use is forbidden under normal circumstances. While some services relaxed their policies to some extent (e.g. admitting light alcohol consumption or use of therapeutic drugs), the most addicted people ended up sleeping rough again or were admitted to psychiatric hospitals.

Impact on social services

Homeless services are caught in a quantitative tension between soaring demand and resource constraints. Their financial problems were exacerbated by a lack of protective equipment and staff shortages (partly due to illness among staff). In many places, local governments stepped in to provide additional accommodation and funding in order to reduce the fallout for public health services.

The pandemic increased awareness of the poor hygienic conditions in some reception facilities. New sanitary regulations will likely force shelters to invest in infrastructure, thereby contributing to enhancing the quality of services on offer.

Lockdown measures revealed the need for more integrated service provision. With residents staying in shelters 24/7 and for longer periods, centres suddenly needed to provide services in addition to the standard bed-shower-breakfast, including consultation with social workers, housing support, medical services, rehabilitation, and leisure activities. At the same time, continuity in psychosocial support (if available) became more feasible, as people experiencing homelessness were easier for services to reach. The COVID-19 crisis provided an opportunity for a more holistic and sustainable reintegration strategy of people experiencing homelessness (ECDC, 2020b).

Several good practices in the field of mental health care for people experiencing homelessness are worth noting. At the time of the COVID-19 outbreak in Europe, the City of Salamanca was just launching an outreach programme of intensive mental health care for people experiencing homelessness, in collaboration with the University of Salamanca Healthcare Complex and the municipal shelter. The aim was to screen all residents (including for COVID-19) to detect mental health problems, to prevent worsening and facilitate cohabitation during the forced lockdown. Some 60% of the residents were diagnosed with mental disorders or substance abuse. Regular on-site visits alternated with phone consultations, individual care plans were established, and, after the lockdown, tailored psychiatric treatment continued if necessary. The people experiencing homelessness also received financial and housing support. With one exception, none of the residents needed emergency intervention despite the crisis context, and almost all diagnosed residents voluntarily pursued treatment after the lockdown, pointing to the success of the initiative (Martin et al., 2020).

TERTIARY IMPACT

Despite the lack of statistics, the evidence so far points to a two-pronged and cumulative impact: increased homelessness and increased physical and mental vulnerability of people experiencing homelessness. A wide range of protective measures have been taken, but services are apprehensive about what might happen when the ban on evictions is lifted, or when the additional emergency accommodation in hostels and hotels becomes unavailable (Boobis and Albanese, 2020). The worst-case scenario would consist of a return to the pre-COVID policy context. Indeed, in the aftermath of the crisis, increased poverty, overindebtedness and the accumulation of rent arrears would likely trigger further growth in the numbers of evictions and related homelessness. Although the legal bans on evictions cannot be perpetuated, lifting them unilaterally could mean an imminent threat of homelessness for hundreds of thousands of families (Pleace et al., 2021).

The rising need for support, combined with the financial strain on the homeless services sector, would aggravate destitution and rough sleeping, further erode the quality of services, extend waiting lists and worsen discrimination against immigrants. To some extent, this scenario already applies to undocumented migrants: in some countries, as soon as the 'everybody in' measures were lifted and travel restrictions were relaxed, irregular migrants (including jobless intra-EU citizens) were denied emergency support and forced to leave (FEANTSA, 2021c).

The best-case scenario is one in which lessons are learned from the COVID-19 experiments in Salamanca or Lisbon, with more intensive, integrated and high-quality services. There is greater awareness that (a) even basic hygienic standards in shelters need to be improved in order to prevent cluster infections in future; (b) more stable housing services greatly facilitate social and mental health care; and (c) more integrated approaches, using individualised care plans, can yield effective rehabilitation in a relatively short timeframe. Actually, these lessons are not new; they have informed the Housing First (or housing-led) approach that is gradually being rolled out in many EU countries. Denmark, Portugal and The Netherlands now seem to have taken that route, following the successful example of Finland (Pleace et al., 2021). In other countries, large-scale implementation is hindered by a lack of public funding. Nevertheless, service providers are optimistic that the COVID-19 crisis will trigger a leap forward in this direction (FEANTSA, 2019; FEANTSA, 2021a; Pleace et al., 2021).

More fundamentally, the COVID-19 crisis has emphasised the need for a structural, preventive approach. This begins with a housing investment agenda that aims to guarantee access to decent and affordable housing for all. According to EU standards, 10% of all European households face an excessive housing cost burden (more than 40% of household income), 15.5% live in overcrowded dwellings, and 4% experience severe housing deprivation (FEANTSA, 2021a). The COVID-19 crisis has spotlit the link between decent and affordable housing and the right to healthy living conditions.

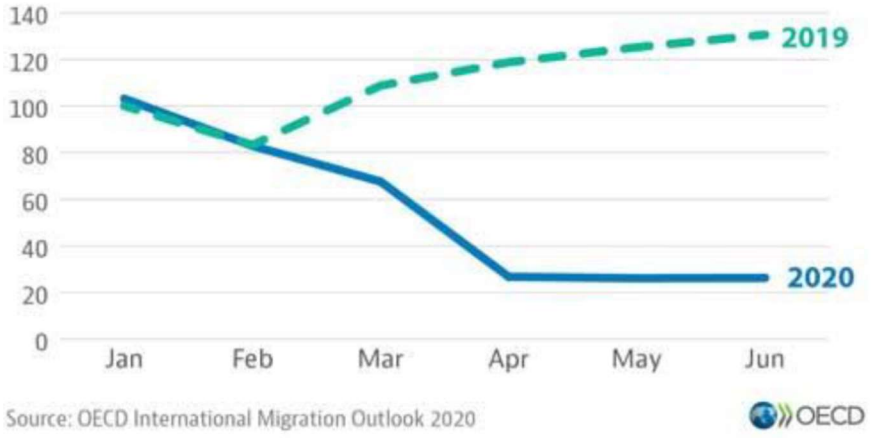
Finally, prevention of homelessness necessitates national action plans that combine housing investment with targeted services and legal protection measures against overindebtedness, eviction, discrimination in the rental market, and housing exclusion. Prevention also requires continuity in support services, such as when vulnerable people are released from institutions.

Migrants and refugees

This chapter uses the words 'migrants', 'immigrants' and 'foreign-born' interchangeably, in line with the Organisation for Economic Co-operation and Development (OECD) definition. It includes all persons born abroad, both EU-born (increasingly referred to as 'EU mobile workers' in EU literature) and non-EU-born[8], regardless of their migration category, legal status, or nationality. Native-born includes all people born in the country, regardless of the country of birth of their parents or the ethnic minority to which they may belong. 'Children of immigrants' includes all people with foreign-born parents, as well as children who are born in the country but who have immigrant parents.

The COVID-19 crisis has had unprecedented consequences for migration flows. Permanent migration flows to OECD countries amounted to 5.3 million in 2019. There were fewer refugees admitted, but permanent labour migration rose by more than 13% in 2019 and temporary labour migration rose by more than 5 million. Following the start of the pandemic, almost all OECD countries restricted admission to migrants, with visas and permits dropping by 46% in the first half of 2020, compared to the same period in 2019. Overall, 2020 is expected to show historically low international migration figures.

FIGURE 2. EVOLUTION OF NUMBER OF RESIDENT PERMITS GRANTED, 2019-2020



Source: OECD International Migration Outlook (2020).

The COVID-19 pandemic has had a disproportionately strong impact on refugees and certain groups of migrants, both with and without legal residence status. They are often exposed to the virus, with limited tools to protect themselves and limited access to public health measures. Refugees and certain subgroups of migrants may live highly insecure lives on the fringes of society, often in fear and without access to essential health and other services. Women face the threat of violence and lack access to sexual and reproductive health services or social and financial

[8] EU-born mobile workers and non-EU born migrants are two distinct groups. They are treated separately to the extent possible (i.e. to the extent that the sources separate them).

protection. These vulnerabilities were further exacerbated by public health and social measures taken during the COVID-19 crisis, such as stay-at-home orders and border closures.

The pandemic compromised the response capacities of health systems and highlighted existing inequities in access and utilisation. Additionally, although fear of contagion has not led to a noticeable increase in xenophobia, racism and stigmatisation in the EU, there have been cases where it gave rise to attacks against refugees and migrants. COVID-19 has entrenched restrictions on international movement and the curtailment of their rights.

PRIMARY HEALTH IMPACT

Incidence of COVID-19 among migrants

It is clear that both the COVID-19 disease itself and the social, public and economic consequences are likely to affect the lives of migrants throughout Europe. While some migrants may be healthier than their native peers in their receiving community, others have health vulnerabilities as a result of socioeconomic status, living in crowded or otherwise sub-optimal environments, restricted eligibility or access to services, including health services, or cultural-linguistic barriers to health information. A WHO report (2020c) on migrants' and refugees' self-reported impact of COVID-19 in the European region found evidence of poor health outcomes among refugees and migrants.

An important issue for the successful management of the COVID-19 pandemic relates to migrants' compliance with strategies to diminish or avoid COVID-19 consequences (Wernly et al., 2020). Health literacy is a cornerstone here (Magnani et al., 2018), but language barriers, different perceptions of risk factors and concepts of health and disease are likely to contribute to a lack of adequate healthcare among migrants (Nutbeam, 2000). Health literacy limitations thus present challenges in protecting migrants at risk of COVID-19 infection and secondary health effects (Spiegel et al., 2020). Underlying medical conditions and unhealthy lifestyles contribute to the likelihood of worse health outcomes in refugees compared to the general population. In Sweden, for example, obesity and smoking rates are more prevalent among refugees (Mangrio et al., 2020), and are risk factors for COVID-19 (WorldObesity, 2020; WHO, 2020d). Many of these problems might be intensified during the COVID-19 crisis.

Due to a range of vulnerabilities, such as higher incidence of poverty resulting in overcrowded housing conditions and high concentration in jobs where physical distancing is difficult, immigrants are at a much higher risk of COVID-19 infection than the native-born (OECD, 2020b). Studies in a number of OECD countries found that infection risk was at least twice as high among immigrants. COVID-related mortality rates for immigrants could also be significant, exceeding those of the native-born population.

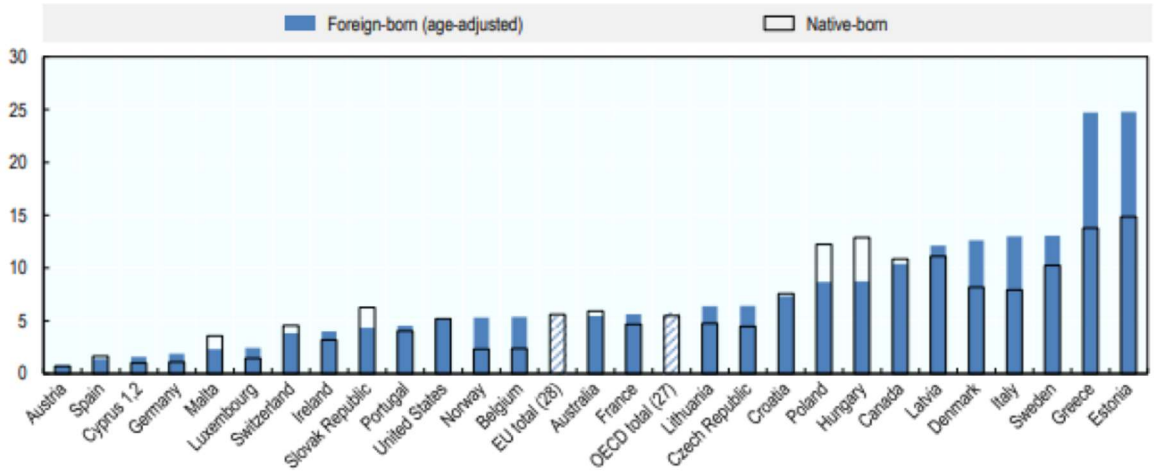
Undocumented migrants are at high risk of getting COVID-19, especially if they are homeless or living in cramped, precarious conditions where physical distancing is impossible (Platform for International Cooperation on Undocumented Migrants (PICUM), 2021). Being undocumented means they are unlikely to qualify for non-emergency healthcare or for the social or income protection schemes available to others. Some lost their jobs because of the pandemic, while others

had to keep working, frequently in essential sectors and without adequate protection (see Section 1.2.1).

Accessibility, affordability and quality of healthcare

Even when legally residing refugees and migrants enjoy the same human rights and right to health as any other person in society, the evidence suggests that they may face difficulties in accessing such rights and have limited tools to protect themselves. They may experience additional stigmatisation and discrimination, as well as relative income instability. There are important differences between refugees and migrants, depending on a wide range of factors such as their legal status, their integration in the hosting society, their educational background, country of origin, etc., all affecting their health status (WHO, 2020c). Before the COVID-19 crisis, similar shares of foreign and native-born people reported unmet medical needs across both the OECD and the EU (5.5%). However, the incidence for non-EU-born is significantly higher than among native-born in the Nordic countries and Italy, as well as in Greece, Belgium and Estonia (OECD, 2018). Immigrants' higher rates of unmet medical needs can be attributed to socioeconomic factors such as poorer education, incomes, working conditions, and social integration, all of which tend to adversely affect access to healthcare services.

FIGURE 3. PERCENTAGE OF FOREIGN-BORN VERSUS NATIVE-BORN ADULTS (AGED >16) REPORTING UNMET MEDICAL NEEDS



Source: OECD (2018).

Refugees and migrants, especially those in irregular situation and those living on the streets or in insecure accommodation are less likely to seek medical care in case of (suspected) COVID-19 symptoms. Lack of financial means (35%), fear of deportation (22%), residence status and uncertain entitlement to healthcare were most often cited as reasons for not seeking medical care (WHO, 2020c).

Language barriers, misinformation about vaccines on social media, and cultural and religious barriers seemed to create higher vaccine hesitancy among some migrant communities. Researchers and practitioners have recommended prioritising these groups (undocumented migrants, those in reception centres and refugee camps) in sensitisation and vaccination campaigns, e.g. by translating information sheets into multiple languages, collaborating with NGOs

and actively involving communities in designing and executing tailored action plans (Crawshaw et al., 2021). The success of such action plans also depends on the availability of staff, particularly cultural mediators and interpreters, who are essential to ensuring effective and inclusive healthcare service delivery (Bartovic et al., 2021).

COVID-19 related travel restrictions and lack of available flights curbed the ability of the Member States to implement forced returns, prolonging migrants' stays in detention centres. Within Europe, refugees and migrants held in detention have limited access to healthcare, meaning that they are more exposed, more likely to catch the virus and have serious symptoms or die from it (European Council on Refugees and Exiles (ECRE), 2020a). Emergency healthcare and essential treatment of illnesses, including COVID-19, remained accessible for migrants subject to a return decision, and no restrictions were put in place. Several Member States, particularly those still carrying out return decisions, implemented specific sanitary procedures (European Migration Network (EMN) and OECD, 2021a).

Collective accommodation, such as reception and transit centres for asylum seekers, pose particular challenges in terms of physical distancing and hygiene measures required to prevent the spread of COVID-19. Country cases from EAPN members and European Network Against Racism (ENAR) suggested that asylum seekers in reception centres and detention centres struggled to access quality healthcare (Malgesini, 2020). The sanitary situation in refugee camps on the Greek Islands was so dire that any outbreak of the COVID-19 disease could have had severe dimensions (Veizis, 2020).

For the benefit of both individuals and public health, it is essential to ensure that everyone can and does access healthcare services. In the WHO survey, the fear of deportation was cited by respondents without documents as a barrier to seeking healthcare. Human rights organisations recommend that the needs of refugees and migrants should inform their medical care (rather than their legal and/or migratory status) in order to realise the goals of universal access to healthcare and the right to health. Policy and legal principles have been developed to overcome barriers and remove any linkage between immigration enforcement systems and healthcare provision (a so-called firewall).

Many countries in Europe took special measures to extend access to healthcare to migrants. Entitlement to COVID-19 care was covered under COVID-19 specific emergency healthcare or linked to insurance-related healthcare entitlements. In general, the cost was met by public health insurance or social security and/or from State public health funds. Underlying rules were maintained in respect of access to general healthcare for regular migrants who experienced a drop or loss in income, allowing access to general healthcare in most reporting Member States. Access to healthcare information was made available in different languages, with services and treatment in most countries open to all, including irregular migrants. Most OECD countries offered access to treatment for COVID-19 for all categories of migrants. In Italy and Spain, the national health system is free of charge to any person and guarantees medical care regardless of status, thereby including migrants whose permits had expired or who had lost their income. Some countries (e.g. France, Belgium) already offered free universal access to healthcare, while others (e.g. Portugal)

temporarily regularised migrants in an irregular situation to ensure full access (OECD, 2020a; OECD, 2020b; EMN and OECD, 2021b).

Protective measures

The lack of appropriate health insurance, often the result of insufficient financial resources, may lower migrants' ability to take preventive measures against highly infectious diseases such as COVID-19 and to receive medical care if contaminated. The operationalisation of emergency shelters or isolation areas was crucial to mitigating this risk, not only to address the spread of COVID-19 but also for the development of solid contingency plans (EMN and OECD, 2021b). Some Member States decided to shift to independent private accommodation or smaller collective centres, or adapted existing centres to reduce the risk of transmission. Others adopted successful measures to limit the number of COVID-19 cases in detention centres for migrants with no legal basis to remain in the country. Nevertheless, the implementation of these measures in detention centres presented challenges, prompting Member States to consider and implement alternatives to detention and to release detainees when their numbers went over a certain threshold (EMN, 2020). On the Greek islands, by contrast, protective measures had an adverse effect on the well-being of asylum seekers, as their mobility was further restricted (Veizis, 2020).

Most refugees and migrants surveyed by the WHO said they took precautions to avoid COVID-19 infection and followed government-initiated preventive public health social measures. Increased handwashing, maintaining physical distance and wearing face coverings were widely followed. Around 20% of respondents said that it was difficult to avoid public transport or leaving the house. Younger respondents were less likely to follow risk reduction measures. Refugees and migrants relied on different sources of information about COVID-19, including the news, friends and family and social media, and accessed information in both their home and host countries, People living in more precarious housing situations (i.e. homeless, insecure accommodation, asylum centres, refugee camps) had fewer sources of information on COVID-19. NGOs, civil society organisations, and other supporting organisations played a key role in disseminating accessible information on COVID-19 to refugees and migrants (WHO, 2020a).

SECONDARY IMPACT

Employment, social protection and income

Socioeconomic factors explain the possible stronger impact of the COVID-19 crisis on migrants. In all Member States, immigrants have higher unemployment rates than their native-born peers (European Commission, 2021a). The differences are particularly marked for non-EU migrants in the EU. Over the last decade, differences in unemployment rates of immigrants and native-born widened in EU countries, most notably in Southern Europe, due to the difficult economic situation. While there has been progress in educational outcomes of young people with immigrant parents, this is less evident in employment. In all Member States except Portugal and Lithuania, young immigrants and the native-born offspring of immigrants are less likely to be in work than their peers with native-born parents. The overall employment gap between the native-born and those with foreign-born parentage is 6 percentage points (p.p.). Immigrants who arrived as children are 8 p.p. less likely to have jobs.

COVID-19-related containment measures disproportionately impacted migrant workers because of their disadvantaged position (International Labour Organization (ILO), 2021). On average in the EU and OECD, over one in four low-skilled jobs is held by an immigrant. This figure rises to over 40% in Austria, Germany, Sweden and Norway, and over 60% in Switzerland and Luxembourg. Immigrants are overrepresented (18%) in the lowest income decile in virtually all Member States (OECD, 2020a). Migrant workers are overrepresented in sectors such as hospitality and security, and in low-skilled so-called essential professions, such as cleaning and other domestic work (38%), personal care (19%), as well as transport and retail sectors, supermarket staff or delivery riders. They are more likely to be in temporary employment and to earn lower wages, all characteristics tied to a greater degree of disadvantage during the COVID-19 crisis, and often work in non-teleworkable professions and in crowded work settings (Fasani et al., 2020). This was confirmed through country evidence from EAPN members (EAPN, 2020) who found that migrants and ethnic minorities made up a large proportion of those employed in precarious but essential jobs.

Migrants in essential work, but often in poor working conditions

Migrants working in essential jobs have played an important role in maintaining the fabric of our societies (Reid et al., 2020; Nivorozhkin et al., 2021). The pandemic has redefined the meaning of 'essential work'. Essential workers might work in frontline healthcare and the policing or emergency sector, but since the beginning of the COVID-19 crisis, it has also included supermarket shelf stackers and cashiers, food handlers, truck drivers and public transport workers, agriculture workers and those slaughtering and processing meat. They have worked throughout the pandemic and have often been infected with COVID-19 as a result of poor working conditions and poor workplace adherence to rules on health and safety at work (ILO, 2020a). Survey data from the Panel Study Labour Market and Social Security (2016-2018) in Germany showed that 64% of workers in essential jobs (e.g. logistics, driving, cleaning) characterised as insecure, with limited pay, rather poor working conditions and workplace relations, are migrants (Novorozhkin et al., 2021). Cases in meat processing in Germany, Ireland and Spain, with subcontractors from Eastern Europe or (mostly undocumented) migrant workers, and with agricultural workers in Germany, France, Italy and Spain, illustrate that workers have limited rights and no protection, live in cramped shared apartments and temporary accommodation (Reid et al., 2020).

In poorer countries and regions, large groups of poor workers are 'self-employed' (bogus and other), shifting between short-term, insecure 'legal' employment and the shadow economy, with no protection, and are particularly at risk of losing their jobs and ending up without any legal source of income (Fasani et al., 2020).

Migrants are more often employed on temporary contracts (15% for all non-native workers and 18% for non-EU workers, compared to 12% for EU native workers). Immigrant women are particularly vulnerable, due to their high share of temporary contracts. During the COVID-19 crisis, they had fewer opportunities to find a new assignment if they lost their job. While it was expected that new arrivals would lack strong networks to help them find work (OECD, 2020b), recent EU Labour Force Survey (EU-LFS) data suggest that this risk did not materialise[9].

[9] See lfsq_egacob, 17 September 2021.

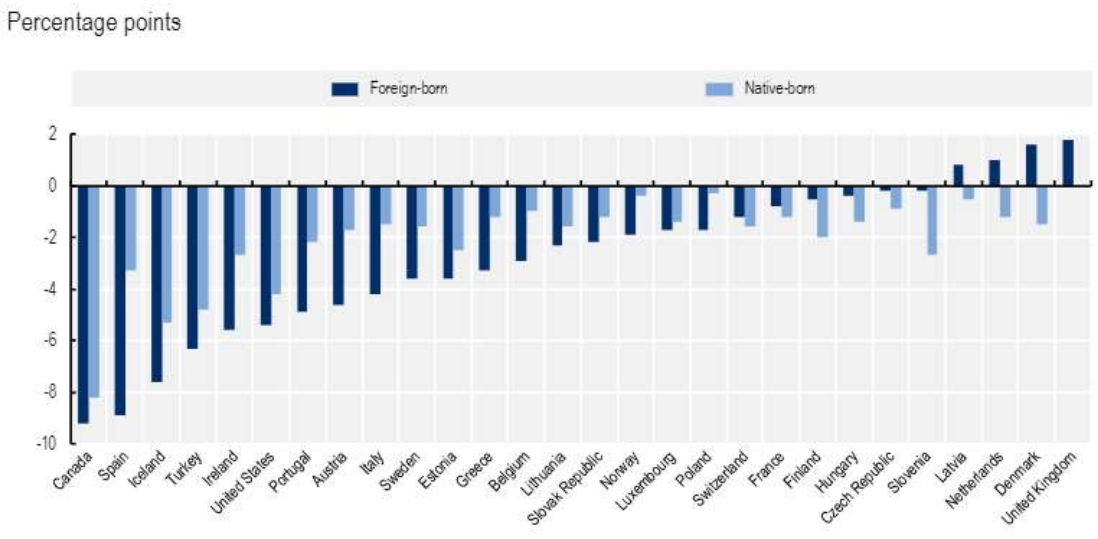
Undocumented migrants particularly at risk

Many migrants work in sectors defined by informality or underregulation, doing jobs that cannot be done from home, and where they have few rights and benefits. For non-EU workers, four of the five most common occupations are in the category of high temporary/low teleworkability professions (Fasani et al., 2020). Particularly when undocumented, losing their source of income is simply not an option, because they are excluded from most government financial support. This means they have no choice but to continue to go to work, exposing themselves to greater risk of infection. If that work is suspended, they often have to rely on communities to provide a safety net. Those communities are already facing difficulties in providing services due to the crisis, leading to extreme poverty and destitution. Migrants who lose their jobs often risk losing their residence, where both permissions are linked. For many, their right to remain in the country where they live and work depends on their job. Job losses resulting from the economic fallout of the pandemic will leave people without status and facing possible deportation (Fasani et al., 2020). In most EU Member States, there were no changes to the laws regulating the withdrawal of residence permits due to loss of employment during the pandemic crisis. However, most Member States were more flexible in applying these general rules (EMN and OECD, 2020a).

Labour market effects of the pandemic

The available evidence on the initial impact of the COVID-19 pandemic on the labour market shows a disproportionately negative toll on immigrants in the vast majority of European countries for which data are currently available, especially in the Southern European countries, Austria, Belgium, Ireland, Norway and Sweden (OECD, 2020b).

FIGURE 4. CHANGE IN EMPLOYMENT RATE BETWEEN Q2 2019 AND Q2 2020, BY PLACE OF BIRTH



Source: European Union Labour Force Survey (EU-LFS, Eurostat), US Current Population Survey.

Refugees and migrants participating in the WHO survey reported a significant impact of COVID-19 on their access to work, safety and financial means. This was confirmed by the ILO (Silas, 2020), which found that migrant workers across the world, including in the EU, were among the hardest hit by the economic downturn associated with the COVID-19 pandemic, both in terms of

employment losses and a decline in earnings for those who remained in employment. However, many countries encouraged new entrants or eased restrictions on third-country nationals already residing in the country, granted or extended the right to work in essential sectors for asylum seekers, facilitated changes in status (from student to worker), or even regularised undocumented migrant workers to work in sectors considered as essential, such as healthcare, agriculture and transport, and to address labour shortages in seasonal work (EMN and OECD, 2020b; EMNOECD, 2021b).

Poverty and social protection

Having a job affords protection against poverty in all countries, although less so for immigrants. There was a clear record of higher incidence of poverty, including in-work poverty, among the migrant population compared to the native population in EU Member States before the COVID-19 outbreak. The immigrant in-work poverty rate was about 19% in the EU, twice that of natives. Gaps were particularly wide in Denmark, Belgium, the Netherlands, Luxembourg, Austria and the Southern European countries. Around 30% of immigrants lived in financial poverty[10] in the EU. Poverty rates were much higher than those of natives in all EU countries, except Bulgaria and Poland. They were at least twice those of natives in longstanding immigration destinations in Europe that hosted large numbers of low-educated foreign-born, as well as in the Scandinavian and Southern European countries (except Portugal). In Spain and Greece, more than 40% of immigrants lived below the poverty threshold. Among the immigrant population, non-EU migrants were particularly affected, with an EU-wide poverty rate of 31%, and were more likely to be poor in all countries except Czechia. Rates were three times those of the native-born in Austria, Belgium, the Netherlands and Luxembourg. The share of children of immigrant families living in relative poverty in the EU was 40%, twice the level of children in native households (OECD, 2018).

When unemployed, immigrants are generally less likely to receive unemployment benefits than the native-born in the EU. This was confirmed by a SIRIUS survey in the UK, which showed that while regular migrants and refugees could, as British citizens, access the furlough scheme provided by the government, migrants with irregular jobs, including asylum seekers and undocumented migrants, could not and therefore lost their income completely. A more precarious legal migrant status is often compounded by a more precarious employment protection status (Baglione, 2021). Nevertheless, in over half of the Member States and Norway, third-country nationals who lost their jobs were entitled to unemployment benefits on the same basis as EU citizens, subject to the fulfilment of certain criteria. Several countries made the normal rules on access to unemployment benefits more flexible in response to the COVID-19 crisis and/or introduced alternative mainstream financial support measures that could also benefit third-country nationals who experienced a drop/loss of income. Other policy responses included easing and extending the periods of residence permits and extending work rights to other sectors, broadening coverage of support measures to migrant workers, and more flexible recognition of health professionals' credentials (EMN and OECD, 2020a).

[10] At-risk-of-poverty (AROP) rate.

Isolation, mental health and other secondary health effects

The public health and social measures to manage and curb the COVID-19 pandemic have seriously impacted refugees' and migrants' connections to their social networks, in particular in their host countries. At least 50% of the respondents to the WHO survey reported that COVID-19 brought about greater feelings of depression, anxiety, loneliness and increased worry. Refugees and migrants living on the street, in insecure accommodation or in asylum centres are at high risk of experiencing mental health problems in the aftermath of the COVID-19 pandemic. Respondents' primary anxieties are uncertainty about their future, whether they or one of their family members or friends will get sick, or whether they will suffer serious financial consequences. Fostering relationships between refugees and migrants and their social networks is crucial to avoid isolation and loss of connectedness.

Access to other services

The living conditions of many migrants are risk factors for contamination, as they often live in densely populated areas and in overcrowded and/or substandard accommodation. The immigrant housing overcrowding rate for migrants is 17% in the EU, compared to 11% for the native-born, with the widest gaps in Austria, Greece, Italy and Sweden. One in four of foreign-born people live in substandard housing in the EU, compared to one in five among native-born. Gaps between the two are particularly marked in Southern Europe and in some longstanding European destinations, such as Belgium, the Netherlands, the UK and Austria (OECD, 2018).

Migrants without legal status, pending or post asylum decisions, cannot access social and economic rights (such as adequate housing and healthcare) (ECRE, 2020). Refugees and migrants living in insecure housing situations or in asylum centres reported a strong deterioration in their access to housing, food, work, clothing, medical care and support from NGOs. Irregular migrants have experienced a stronger deterioration in their daily living conditions than other groups as a result of the pandemic. Living situation is an important determinant of mental health and social well-being, as is discrimination. Those living on the streets or in insecure accommodation face a significantly higher impact from the pandemic. They are also much less likely to be able to follow precautions against COVID-19. Therefore, initiatives to improve housing conditions and providing accommodation or shelter for those living on the streets or in insecure accommodation are essential (WHO, 2020).

In the field of adult education, the COVID-19 pandemic saw a push towards remote language learning. However, online learning has proved difficult for low-educated immigrants, especially in the early stages of language learning, leading to delays in language acquisition and in broader social integration. Language and integration courses were very often interrupted, reducing migrants' possibilities to become more empowered or to participate in society. This often increased their social isolation. Member State policy responses included the provision of devices, online language mentorship programmes and support from buddies. Nevertheless, for some subgroups of migrants, such as recent arrivals with little or no knowledge of the host country language, the transition to distance learning poses particular challenges, sometimes leading them to abandon their studies (OECD, 2020b).

Many organizations providing social services shifted to online accessibility and information provision. Given the limited means of many refugees and migrants, their resources for internet connection are often limited.

Impact on social and political climate

The COVID-19 pandemic required Member States to implement exceptional measures to curb the spread of the virus and protect public health, including in the event asylum seekers arriving at their borders. Efforts sought to limit access to asylum in several countries, notably in Belgium, the Netherlands, Greece, and Cyprus. By contrast, positive measures included a form of regularisation through granting people legal status pending asylum decisions (Portugal), easing detention measures and releasing from detention those who could not be returned (Spain), a less punitive approach to undocumented persons seeking to access healthcare (Ireland), and suspension of Dublin transfers (Germany), along with proposals to grant the right to work to those in the asylum process (Germany) (ECRE, 2020; OECD, 2020b).

Many Member States restricted registration and documentation of asylum seekers and refugees, which are essential processes to establish or extend legal stay and access to services, causing backlogs in asylum determination procedures and in access to refugee centres (United Nations High Commissioner for Refugees (UNHCR), 2020). Anecdotal reports in the media suggested discrimination, stigmatisation and xenophobia against refugees and migrants since the onset of the COVID-19 pandemic. Many countries witnessed stigma, discrimination and hate speech directed towards minorities, and even healthcare workers of foreign origin, suspected of carrying the virus. Anger and mistrust of migrants, refugees, people living in poverty and from specific religious and ethnic groups increased during the pandemic. Verbal assaults, vandalism of homes and businesses, physical attacks, and banishment from schools and public places were reported across Europe (Oxfam, 2021). More than one in five respondents to the WHO survey reported being treated worse or called names because of their origin or religion. Many refugees and migrants reported a perceived increase in discrimination since the pandemic. Respondents living in asylum centres, and especially people living on the streets, in insecure accommodation or in other precarious conditions, reported worsening discrimination. Unemployed refugees and migrants reported greater discrimination than those who continued working (WHO, 2020a). Contradictory positions were evident in public attitudes to migrants and refugees: on the one hand, the healthcare sector relies significantly on immigrant labour, with many immigrants working in other essential jobs (agriculture, shop clerks, delivery services), highlighting their economic and social contribution; on the other hand, however, cross-border movement was a key factor in the initial spread of the virus, with immigrants then blamed for its spread. The OECD has highlighted the importance of public information campaigns to reduce discrimination and stigmatisation (OECD, 2020a).

TERTIARY IMPACT

In the medium term, a number of migration management issues will arise, linked to the management of backlogs, attractiveness for international students and highly-skilled migrants, adoption of new health criteria, and the adjustment of return and humanitarian assistance

operations. Previous economic crises suggest that the economic downturn associated with the COVID-19 pandemic may have disproportionate and long-lasting negative effects on the integration of immigrants and their children unless appropriate support measures are put in place. In the context of a severe economic recession and increasing challenges in maintaining social cohesion, there is a risk that support for proactive migration policies will decline (OECD, 2020a).

The economic consequences of the COVID-19 pandemic may set back recent progress in the labour market inclusion of immigrants, with the pandemic revealing and reinforcing migrants' vulnerabilities in the labour market (OECD, 2020c). Given the economic impact of the COVID-19 crisis, with more migrant workers returning to their home countries or prevented from going abroad for work, low-income countries will see a decline in remittances (ILO, 2021).

High-skilled labour migration in Belgium significantly decreased during the COVID-19 crisis, partly because of travel restrictions, but also because many jobs could be done through digital work at a distance. Posting of workers from EU Member States declined, especially in the information and communications technology (ICT) sector, with workers from Asia or North America. There was a far lower decrease in posted workers in the transport, metal and construction sectors, however, where mostly middle and low-skilled workers are employed. Researchers expect a similar trend in the composition of labour migration, with a possible increase in low-skilled workers and a decrease in medium to high-skilled workers in the wake of the crisis (COVIVAT, 2021). Developments in labour immigration will impact the further evolution of job vacancies in the aftermath of the 2020 and 2021 peaks of the COVID-19 pandemic in the EU.

Roma and Travellers

'Roma and Travellers' is used as an umbrella term in the definition of the Council of Europe, encompassing Roma, Sinti, Kale, Romanichals, Boyash/Rudari, Balkan Egyptians, Eastern groups (Dom, Lom and Abdal) and groups such as Travellers, Yenish, and the populations designated under the administrative term 'Gens du voyage', as well as people who identify as Gypsies. The Roma population (not including Travellers) living within the EU is estimated at six million people. Roma and Travellers are among the most marginalised and poorest groups in the EU: 80% of Roma live below the AROP threshold and 22% report having gone to bed hungry at least once in the last month. They live in overcrowded, substandard dwellings and in poor hygiene conditions (30% have no tap water in the house) (FRA, 2017; FRA, 2020a). Unemployment rates are extremely high and children still drop out of education in substantial numbers after primary school.

PRIMARY HEALTH IMPACT

Incidence of COVID-19 among Roma and Travellers

Higher rates of infectious diseases are commonly observed among Roma people and they are disproportionally affected by such diseases compared to the general population. There is evidence that Roma and Travellers also suffer disproportionally from health issues such as diabetes, elevated cholesterol or blood pressure, cardiovascular disease, pulmonary disease, and disability (COVID-19 NGO Group, 2020; Department of the Taoiseach, 2020; Seidler et al., 2018). Roma people die 7-20 years earlier than the general population (European Commission, 2014). They often live in overcrowded accommodation, with limited access to tap water, where it is difficult to comply with requirements for social distancing, isolating those who are infected, and applying hygiene rules. In Member States with large numbers of Roma, the return of thousands of Roma migrant workers further increased overcrowding, making it practically impossible to isolate anyone infected at home (FRA, 2020c). The air pollution where Roma settlements are located, to explain the higher risk of infection[11]. Roma living in segregated localities also lack access to information on preventive measures due to physical segregation, lack of education, lack of health or digital literacy, and lack of access to the internet (European Commission, 2020b).

It is thus not surprising that Roma and Traveller people are at an increased risk of morbidity and mortality due to the COVID-19 pandemic (Armitage and Nellums, 2020a). Given the already considerable burden of morbidity and mortality among Roma people, they are highly likely to be disproportionally affected by the current pandemic, although it is possible to quantify this impact due to the absence of epidemiological or mortality data (FRA, 2020c). In Sweden, the UK and the US, where these data are available, the rates of infection and hospitalisation are considerably higher in the Roma population than among the general population.

[11] https://epha.org/combatting-inequalities-in-healthcare-a-first-step-towards-health-equity-for-roma/

Accessibility and affordability of healthcare

Roma people and Travellers are less likely to engage with healthcare services such as primary care, preventive care (e.g. vaccinations), child healthcare and maternal care (McFadden et al., 2018). This is due to mistrust stemming from negative experiences, poor information, language barriers, or a lack of familiarity with the conditions and procedures for accessing medical services (FRA, 2020c).

In all 15 Member States covered in that FRAreport, Roma and Travellers reported facing barriers in accessing healthcare services. The share of Roma covered by medical insurance was 84% on average in the six EU Member States surveyed in 2019 (Belgium, France, Ireland, the Netherlands, Sweden, UK), falling as low as 45% in Bulgaria and 54% in Romania, according to FRA 2016 data. Nevertheless, the evidence suggested that healthcare providers in the EU do provide care and treatment to the most vulnerable, including Roma and Travellers. Regardless of health insurance status in the 15 Member States examined, anyone with COVID-19 symptoms could consult a doctor, take a COVID-19 test, and, when necessary, be hospitalised (FRA, 2020c).

In the six EU Member States (Belgium, Spain, Hungary, Italy, Romania, Slovakia) and the UK covered by the Open Society Foundation survey, soldiers, police personnel and drones were more prominent in Roma communities in Bulgaria and Slovakia than nurses, doctors and medical supplies (Korunovska and Jovanovic, 2020). Access to healthcare for Roma is also hampered by the collapse of the healthcare system in rural areas in many countries in Eastern Europe and by the absence of healthcare provisions in segregated settlements. Serious questions arise about equity in access to vaccines and other health essentials, as Roma are often unregistered and therefore not known by public authorities, limiting their access to digital health programmes[12].

In a number of countries (e.g. Ireland, France, Belgium, the Netherlands), Roma and Travellers were subject to the general restrictions on free movement. Consequently, they could not leave the sites and camps where they stayed, except for urgent reasons such as accessing medical care. Given the importance of free movement for mobile communities such as Roma and Travellers, the general restrictions applying to the entire population has specific adverse consequences. In numerous Member States, Roma and Travellers also faced administrative and financial barriers in accessing healthcare services.

A study from Ireland (Villani, 2020) explored the contribution of health promotion strategies, specifically wide-ranging interventions by NGOs and community-health partnerships, in mitigating the inequalities in exposure to the virus and in access to healthcare for Travellers and Roma. The study found that targeted public health measures, economic and social support, culturally sensitive communications through a partnership approach, including representatives of Travellers and Roma and combining NGOs' knowledge of grassroots needs with the expertise of partners from the healthcare sector, were particularly effective in delivering comprehensive COVID-19 mitigation interventions and advocacy strategies.

[12] https://epha.org/combatting-inequalities-in-healthcare-a-first-step-towards-health-equity-for-roma/

SECONDARY IMPACT

Employment, social protection and income

Lockdowns and movement restrictions disproportionately affect the types of work that many Roma and Travellers engaged in, such as working as street vendors, at markets, in construction or in recycling. That resulted in loss of income, exacerbates their precarious living conditions and deepens inequalities (FRA, 2020c). Many Roma were not covered by social protection and the most vulnerable are informal workers and emigrants[13]. Those working in low-skilled and low-paid jobs in the informal economy or in seasonal work, without a labour contract, could not access the benefits provided by these countries and are not eligible for COVID-19- related supports, while current measures prevented them from earning an income. Roma who emigrated to Western Europe to work and who were up until now economically independent and sending remittances to friends or family in their countries of origin, also lost their jobs. Non-EU migrant workers are not covered by support measures, they are not eligible for unemployment benefits, and they cannot register with employment offices.

Secondary health effects

Roma and Travellers disproportionally suffer from health issues such as diabetes, elevated cholesterol or blood pressure, cardiovascular disease, pulmonary disease, and disability (see Section 4.1.1). Taken together with the fact that Roma and Travellers already experience several barriers in accessing healthcare services, this puts them at particular risk of health complications and premature death from concomitant diseases in periods when healthcare services need to prioritise COVID patients (FRA, 2020c). Prophylactic medical examinations, such as mother-and-child healthcare programmes, were often temporarily suspended. The inability to communicate face-to-face with physicians created tension and anxiety, in particular among pregnant Roma women, mothers of infants and their families. This is likely to increase health problems in these already vulnerable people (European Commission, 2020b).

Access to social services

Shortly after the onset of the COVID-19 pandemic, evictions from camps, sites and other informal accommodation were banned in most Member States. Some took measures to provide shelter and social isolation for the homeless, including Roma. Local authorities took targeted measures to mitigate the consequences of COVID-19 for Roma and Travellers, including distribution of food and drinking water, hygiene and sanitation, face masks and disinfectants. In most of Member States examined, Roma health and education mediators played a crucial role in distributing food packages and supporting marginalised and socially excluded Roma in many ways (FRA, 2020c). In the countries covered by the Open Society Foundation survey, governments introduced measures to provide basic goods to those most in need. This assistance, however, was mostly limited to food and hygiene packages, and was delivered through organisations that lacked accurate information about the Roma most in need and with no route to obtain these data. The inadequacy of these measures, amid conditions already worsening before the COVID-19 crisis, means that the need

[13] In the six EU Member States in the Open Society Foundation survey, States provide social assistance, but the assistance does not cover those who made a living in the informal economy and those who returned to their countries of origin from Western Europe (Korunovska and Jovanovic, 2020).

for humanitarian and emergency support could grow exponentially. Some countries postponed mortgage and credit payments, but these measures did not cover non-financial and short-term lenders, which are key sources of credit for Roma (Korunovska and Jovanovic, 2020).

The pandemic highlighted the importance of formal residential status as a criterion for eligibility for social support even as basic as food vouchers. Lack of municipal registration or a permanent address is an obstacle to the issuance of an identity card and hinders the exercise of a number of fundamental rights, as all administrative, banking, notary and other services require formal identification (FRA, 2020c).

Isolation and discrimination

Many EU Member States introduced measures to restrict the movement of people and enforce social distancing in order to avoid the spread of the COVID-19 virus. Although these measures applied to everyone, they took a heavier toll on the daily life of marginalised and socially excluded Roma and Travellers. These restrictions disproportionately affected Roma and Travellers because caravans offer very limited living space for families, and authorised camps and sites are overcrowded (FRA, 2020c).

There was evidence of an increase in anti-Roma rhetoric across the media and social networks since the first cases of COVID-19 in the 15 Member States examined, except in Czechia and Sweden (FRA, 2020c).

The Organisation for Security and Co-operation in Europe (OSCE) - Office for Democratic Institutions and Human Rights (OSCE, 2020), and the Council of Europe (2020a) issued statements drawing attention to the disproportionate risks faced by Romani people in relation to contracting COVID-19. The EU Commissioner for Equality, Helena Dali, called on EU Member States to implement urgent measures for Romani communities, because COVID-19 exacerbates their exposure to structural inequality (Human and Health Rights Journal, April 2020).

During the pandemic, some Member States applied discriminatory restrictions to their Roma communities in the form of stricter lockdowns exceeding the principle of precaution (e.g. walls built, roadblocks put in place, drones used for surveillance purposes or policed checkpoints established to prevent residents from entering and leaving Roma villages) (European Parliamentary Research Service (EPRS), 2021). Roma people were also sometimes framed as a public health threat, thus reinforcing negative attitudes and stereotypes (FRA, 2020c). The fear engendered by the pandemic often fuelled anti-Gypsy discourses, discrimination and anti-Roma rhetoric across the media and social networks, sometimes also echoed by the public authorities themselves (EPRS, 2021). In several countries, the media reported an increase in discrimination, rejection and hatred against Roma, who were blamed for the increase in COVID-19 infections. Media also focused on alleged non-respect of restrictive measures by Roma or on their negative reactions to lockdowns (Cretan, 2020; FRA, 2020c; Korunovska and Jovanovic, 2020; Matache, 2020). The EQUINET database on COVID-19 response of national equality bodies registered

several complaints, including complaints related to discriminatory treatment of people from the Roma community in different countries[14].

TERTIARY IMPACT

The most long-lasting impact can be expected to fall on Roma workers and entrepreneurs, many of whom worked in the informal economy, in low-skilled and low-wage jobs, or in the arts and culture industry. This is because they are often invisible to policy makers and their situation risks remaining unaddressed in social and economic recovery plans (Korunovska and Jovanovic, 2020).

The evidence collected by FRA and confirmed by stakeholders shows that the COVID-19 pandemic disproportionately affected Roma and Travellers, particularly those living in socially excluded and marginalised settings. Without a holistic and inclusive approach, including attention to Roma in all policies, the COVID-19 crisis will increase existing structural inequalities. To achieve this inclusive approach, the new EU Roma Strategic Framework places a focus on seven key areas: equality, inclusion, participation, education, employment, health, and housing, and formulates recommendations for Member States' achievement of those targets.

[14] In particular, in Croatia, Ireland, Poland, Slovakia and Spain, https://equineteurope.org/COVID-19-response/#data

Persons with disabilities

The UN Convention on the Rights of Persons with Disabilities includes long-term physical, mental, intellectual or sensory impairments, which, when interacting with various barriers, may hinder their full and effective participation in society on an equal basis with others (UN, 2016). People with disabilities are a population with a higher prevalence of chronic conditions. Disability also often results in lower economic status during adulthood and frequently necessitates living in group communities (Turk and McDermott, 2020).

The number of people with disabilities in the EU is estimated at over 100 million. Based on the EU-SILC 2018 data, a considerable percentage of individuals with disabilities were in precarious situations, with more than 28% living in poverty and experiencing social exclusion. Evidence on the health, social and economic impact of the COVID-19 crisis on people with disabilities remains scarce, with the European Disability Forum noting that such information is not collected by governments (Uldry and Leenknecht, 2020).

PRIMARY HEALTH IMPACT

Incidence of COVID-19 among people with disabilities

The COVID-19 pandemic is likely to have a great effect on people with disabilities (Armitage and Nellums, 2020b). Individuals with disabilities are at a greater risk of infection, severe illness and death, or find themselves isolated, impoverished, and facing increased hardship due to the virus (Uldry and Leenknecht, 2021; Office for National Statistics, 2021; Tummers et al., 2020). Important factors include medical conditions and unmet needs for healthcare, barriers in access to healthcare, older age, barriers in implementing hygiene and protection measures, and discrimination (Uldry and Leenknecht, 2021). In addition, people with disabilities often live in groups in care facilities, and many rely on physical contact with caregivers for their daily life activities (Tummers et al., 2020). In England, for example, people with disabilities made up 59.5% of all COVID-19-attributable deaths in the population aged 30+ for the period up to 20 November 2020. Age-standardised rates of death involving COVID-19 among males and females (aged 30+), per 100,000 of the population at risk, showed significantly higher death rates in people with disabilities (Office for National Statistics, 2021).

People with disabilities also suffer from worse clinical outcomes (Tummers et al., 2020), due to physical health problems, social circumstances and disadvantage, and limitations in understanding (Grier et al., 2020; Emerson and Hatton 2008). Many individuals with disabilities suffer from comorbidities such as lung problems, obesity, diabetes and heart disease, which can increase the severity of the COVID-19 infection, giving rise to increased case-fatality rates (Singh et al., 2020; UN, 2020). Limitations in understanding may hinder adherence to public health measures such as self-isolation, handwashing or physical distancing to reduce the spread of the virus (Courtenay and Perera, 2020).

Even without the COVID-19 context, individuals with disabilities face difficulties in carrying out daily life activities, experiencing barriers to community mobility, public transport and access to healthcare services (Bezyak et al., 2019; Jonasdottir and Polgar, 2018; Gudlavalleti et al., 2014). A global pandemic therefore has the potential to significantly increase the challenges for individuals with disabilities, and it is likely that it will have a greater impact than on the general population. Such challenges include a reduced ability to communicate wearing face masks, the need for close contact with caregivers or health professionals to achieve daily routines, and dependence on public transportation. People with disabilities are very likely to experience problems in advocating for themselves and rely on others to keep them safe from infection.

Accessibility, affordability and quality of healthcare

According to the WHO (2018), people with disabilities are often directly impacted by deficiencies and gaps in the healthcare system. The COVID-19 pandemic increased this problem substantially (WHO, 2020a).

According to the international non-profit organisation, 'Inclusion Europe' (Portal et al., 2020), access to healthcare and treatment in hospitals was not guaranteed for individuals with disabilities in many EU countries during the COVID-19 crisis. In some Member States, triage protocols were established by the government or hospitals to determine patient priority, taking into account age and comorbidity factors. For some patients with disabilities, regular care stopped during the COVID-19 crisis because there were no resources, no transport, other priorities and restrictions, or no possibility for staff to come to people's homes. The report emphasised that lockdown measures saw a lot of community-based care and support stop during the COVID-19 crisis, for example closure of day care facilities. This created enormous difficulties for people with disabilities living independently. Some had to live with their families, who took over their care in the absence of any other support services. The findings of the COVID-19 Disability Rights Monitor[15] suggested that persons with disabilities did not have access to essential healthcare, therapies, rehabilitation or medication (Coordinating COVID-19 DRM-group, 2020).

Evidence suggests that there were differences in access to care and support between the first and second waves of the COVID-19 crisis. According to the European Association of Service providers for Persons with Disabilities (EASPD) report on the impact of COVID-19 on disability services in Europe, there was significant progress in the provision of care and support during the second wave, with most forms of residential care, homecare, day care, respite care, work integration enterprises and other services re-opened. This typically reflected the flexibility of many service providers. New ways of delivering services were introduced, including a shift to digital supports. Nevertheless, the continuity of disability care remains a sensitive issue (EASPD, 2020a).

Protective measures

At the onset of the COVID-19 crisis, providing accessible information on protective measures for people with disabilities was a problem. Information was not provided in easy-to-read and

[15] The COVID-19 Disability Rights Monitor took place between April and August 2020 by means of an online and print survey. The target population included (1) persons with disabilities, (2) governments, and (3) national human rights institutes. It received 2,152 responses from 134 countries, of which 2,112 were from people with disabilities. 53% of the answers originated from Europe.

understandable language. Difficulties include the need for support to access the internet, reading problems and problems understanding the guidelines. Such information was crucial to understanding the situation, the risks and preventive or mitigating measures. In addition, individuals with disabilities were often considered more vulnerable and at increased risk of becoming infected, yet, paradoxically, the information was not made clearly accessible (Portal et al., 2020). For example, people with disabilities were at greater risk of contracting COVID-19 and becoming severely ill as a result of the infection, but often did not know whether or not they were eligible for priority vaccination. In general, people with comorbidities and older people were given priority on the vaccination lists. National rules about who belonged to non-age-priority groups, together with the acute shortage of vaccine supplies and vaccine hesitancy, led to confusion and chaos, leaving many people with disabilities waiting for vaccination. The situation varies from country to country, but also from one region to another (European Economic and Social Committee (EESC), 2021).

SECONDARY IMPACT

Employment, social protection and income

In general, individuals with disabilities are less likely to be employed and when employed, they are more likely to be employed in the informal sector. According to Eurostat statistics, the employment rate of people with disabilities remains below that of people without disabilities, at 50.8% and 75%, respectively (Eurofound, 2021a), Consequently, they also have less access to social insurance based on employment, which in turn decreases their economic resilience in the current COVID-19 pandemic (Office of the UN Commissioner for Human Rights (OHCHR), 2020a).

For many people with disabilities, the lockdown measures meant they were unable to go to work or to participate in their communities, centres and services, disrupting their routine activities (Hughes and Anderson, 2020). According to Inclusion Europe, people with intellectual disabilities were disproportionately affected by unemployment because they tend to work in industries such as hospitality. Many were working in the open labour market prior to the pandemic and lost their jobs due to lockdown measures. In the UK, for example, disabled men's employment fell by 3.8 p.p. between December 2019 and December 2020, more than double the rate for non-disabled men, widening the male disability employment gap. Although the impact on disabled women's employment was smaller, the decline in their employment was nevertheless double that of non-disabled women (Holland, 2021). Some European countries took measures to prevent people with intellectual disabilities from losing their jobs, while in others, they were protected under general measures (Inclusion Europe, 2020). The majority of the measures were tax-financed, with few linked to social insurance (except in higher income countries) or related to labour market policy (United Nations Partnership on the Rights of People with Disabilities (UNPRPD, 2021).

Those working in sheltered employment were often left behind because many day care centres and enterprises temporarily closed. In April 2020, EASPD undertook a study on the impact of COVID-19 on disability services in Europe[16] and found that many sheltered workshops and

[16] Data collection occurred between 16-23 April 2020 by means of a survey. 47 responses were received, covering 23 countries: 19 EU Member States, the UK, and three non-EU Member States.

vocational education and training services had to close in at least 19 countries. A mixed picture was evident in several countries, depending on the regionalised nature of the countries or the complex nature of how services were organised (EASPD, 2020b). Many people with disabilities were very anxious about losing their employment, given the likely difficulty of finding a new job (Portal et al., 2020).

The COVID-19 pandemic led to a considerable increase in telework. Unfortunately, people with disabilities do not appear to have followed this shift and transitioned to telework. The use of teleworking could represent a huge step forward for their employment situation, encompassing several advantages, such as flexibility (particularly valuable to people suffering from physical or mental impairments that make it more challenging to work in traditional workplace settings) and reducing commuting time and expenses (beneficial for people experiencing mobility impairments, who find it difficult or costly to travel to work). It also has advantages for those with fragile health and/or frequent medical appointments that may hamper continuous presence at the workplace. Potential downsides to telework such as increased social isolation, blurred lines between work and home, and being 'out of sight' for promotion and training opportunities have been recognised as well (Schur et al., 2020).

Isolation and mental health

The mental health of people with disabilities was affected in similar ways to that of the general population, albeit with a possibly greater impact due to the potential for triggering behavioural and other problems as a result of less face-to-face professional support. When professional care is put on hold, cancelled, or reduced, people with disabilities need to rely on the support of their family (if they have one). When it was not possible to attend day centres or voluntary projects, these individuals were sometimes left with no one to meet (Shakespeare et al., 2021). Indeed, they suffered from the isolation and the lack of ability to participate in society and live with dignity (EASPD, 2020b), increasing their levels of anxiety and paranoid thinking, resulting in behavioural changes (Narzisi, 2020). The results of an online survey of 582 people with intellectual and developmental disorders in Spain found that the most reported consequence of lockdown was impact on social relationships. Loss of contact with family and friends was the most prominent factor, reported by 75% of participants (Navas et al., 2021).

TERTIARY IMPACT

Across Europe, social care and support services are struggling to cover the increased costs incurred as a result of the COVID-19 pandemic. This includes increased staff costs (more staff, extra time, sick leave, salary increases to remain attractive) and the need to adapt services due to organisational changes. Evidence also suggests that fundraising and charity from private sources have dramatically reduced. There are clear concerns about the longer term, both in terms of the extent to which public authorities will cover losses, and the impact of the economic crisis on the business model of the service itself (EASPD, 2020a). Indeed, the EDF has highlighted the need to develop new care models to support more community-based living for people with disabilities (Uldry and Leenknecht, 2020). Independent living, autonomy and inclusion in the community is one of the main themes in the European Commission's Strategy for the Rights of Persons with Disabilities 2021-2030.

Vulnerable children

This reports uses the definition of vulnerable children adopted in the context of the EU's Child Guarantee study, i.e. children in institutions, children with disabilities, children of recent migrants and refugees, and children living in precarious family situations. Given the lack of homogeneous identification criteria and statistics, it is impossible to provide an estimate of the overall number of children covered by this definition. The only clear-cut criterion that is commonly used in EU-27 statistics (risk of poverty or social exclusion) applied to 18 million children or 22.2% of all under-18s in 2019 (European Commission, 2021b).

PRIMARY HEALTH IMPACT

Extent to which children escaped COVID-19

The direct health impact of the COVID-19 pandemic on children (ages 0-18) has been less severe than on adults. Less than 5% of all positive cases reported in the second half of 2020 were children, and the impact on their health was mild compared to adults (with no more than 10% of the seropositive cases hospitalised in the 0-4 age group, and 3-4% in the 5-18 age group). Case fatality rates have been extremely low (0.03%). Nevertheless, children with symptoms can transmit the disease, which explains the strict precautionary measures taken in childcare services and schools. Disadvantaged children appear to be at greater risk and that new variants of the virus tend to affect children's health more directly (Eurosurveillance, 2021). Overall, children appear to have escaped the direct health impacts of the pandemic (ECDC, 2020c). The main impact of the crisis on children has been indirect.

Accessibility and affordability of health services

The obstacles described in the previous chapters for other vulnerable groups apply similarly to children (EU Alliance for Investing in Children, 2020). Confinement and restrictive measures saw services discontinued, including medical and mental health care providers, or working at reduced capacity. In other cases, services were able to continue remotely, with reduced functionality (Council of Europe, 2020b). In the short term, disrupted access to healthcare services worsens health outcomes in vulnerable children and youth. However, longer-term effects on health, well-being, literacy, income, professional opportunity are potentially devastating (Kyerematenge et al., 2021). The COVID-19 crisis and public health restrictions have had an adverse impact on children's health and well-being, compounded by difficulties in accessing primary and community services. The impact was more acute for children with disabilities and chronic conditions, and raised child protection issues for vulnerable children. Mixed findings in respect of healthcare use were reported in a qualitative study of Emergency Department staff in four Irish hospitals. While emergency care was reduced during the first months of the pandemic, respondents identified an increase in admissions for mental health issues, suggesting enhanced psychosocial implications of the COVID-19 crisis for children (Conlon et al., 2021). Eurofound's 'Living, working and COVID-19 e-survey'[17]

[17] Eurofound's Living, working and COVID-19 e-survey was conducted in two rounds over 2020. The figures refer to data from the second round, conducted in July 2020.

revealed that single parents reported lower use of healthcare services compared to two-parent households, especially consultations online or by phone (Eurofound, 2021). In the UK, lower healthcare use was also reported in children living in temporary or insecure accommodation (e.g. shelters, staying with friends or family). In some places no face-to-face contact with general practitioners or health outreach services were available. This hampered routine checks such as early detection of needs and risks, and health and development reviews (Rosenthal et al., 2020).

SECONDARY IMPACT

Child poverty

Based on initial signals from its national correspondent, Eurochild (2020) alerted public opinion to food uncertainty affecting children in some EU countries. For example, the closure of schools meant that many poor children had to do without their free daily meal. The OECD (2020d) pointed to the harmful effects of poverty on children's nutrition and health, overcrowded housing and homelessness, domestic violence, family breakups and out-of-home placement. In several countries (Greece, Hungary, Romania, Slovakia), the numbers of children placed in alternative care is increasing rapidly (up to 30%) as a consequence of poverty and ensuing family tensions. The OECD (2020d) has also warned that the combination of increased child poverty and school closures enhanced the risk of child labour and exploitation, although there is no hard evidence on this risk in the EU as yet.

Indirect health impacts

Families that were already in vulnerable situations before the outbreak of COVID-19 and the ensuing socioeconomic crisis have been devastated by the pandemic, with a dramatic impact on children's well-being and mental health (EU Alliance for Investing in Children, 2020). Indeed, long-term home confinement and/or school closures have had adverse effects on children's physical and mental health, with children more likely to experience sleep disorders, behavioural problems, depression and stress symptoms (Ye, 2020; Eurochild, 2020). A study of 1,126 families in Italy showed that parents of children with mental and physical disabilities were more likely to report changes in their child's behaviour, such as distractibility, inability to concentrate, irritability and general discomfort (Fontanesi et al., 2020). A survey in seven European countries showed that parents of children with mental disabilities struggled with their additional homeschooling tasks, reporting associated stress and tensions in the children and among other family members (Thorell et al., 2021). Children in residential care missed regular contact with their families (and sometimes classmates) due to lockdown measures. At the same time, the additional burden on the staff in residential care created stress and illness among staff, increasing absenteeism, tension and conflict (Eurochild, 2020; OECD, 2020d).

Another indirect effect of the COVID-19 pandemic is the increase in domestic violence and related effects on the mental (and physical) health of children. The WHO highlighted an increase in interpersonal violence, including against children, according to reports from some European countries such as Belgium, France, Ireland and Spain (WHO, 2020e). Such violence during pandemics is associated with economic stress, disaster-related instability, increased exposure to exploitative relationships, fear and uncertainty, and reduced options for support (Peterman et al., 2020; Usher et al., 2020). Containment measures such as social isolation or mobility restrictions

exacerbated the incidence of neglect, as well as emotional, physical, sexual and domestic abuse (National Society for the Prevention of Cruelty to Children, 2020). At the same time, the COVID-19 crisis resulted in a decline of regular access to professionals such as general practitioners, health visitors, social and youth workers, increasing the likelihood of harm to children. In the UK, a nationwide decline was observed in Emergency Department and general practitioner visits, yet there were increased calls to child support lines (Hennessy, 2020) and increased police attendance at domestic abuse incidents (Green, 2020).

Some European countries lacked specific guidance for children with special needs in the context of the pandemic. This includes children with disabilities, as well as others with pre-existing health issues (Council of Europe, 2020b). Many undocumented children have underlying medical conditions, but do not access healthcare for fear of being returned to their country of origin (Save the Children Europe, 2020). Lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ), homeless, maltreated and runaway young people are at a very high risk of suffering from depression, suicidal ideation, suicide and self-harm (Gewirtz et al., 2020, Toorney et al., 2018, Jonson-Reid et al., 2012). It is very likely that these risks increased during the COVID-19 crisis due to social isolation measures, additional stress and instability (Salerno et al., 2020; Silliman Cohen and Bosk, 2020).

Services for vulnerable children

Vulnerable children (and their parents) need comprehensive and continuous support to safeguard their health, well-being and development. However, confinement and restriction measures also impacted basic services that are essential for children's safety and well-being, such as antenatal care, routine vaccination, home visits for young parents, primary medical care, supporting services for disabled children, and family counselling. The interruption of ambulatory support shifted an additional burden towards parents in difficult circumstances (Eurochild, 2020). In addition, the necessary supports were compromised when parents or caregivers became ill or when families depended on the functioning of social and healthcare services (United Nations Children's Fund (UNICEF), 2021; Council of Europe, 2020b). In several countries, this led to suspension of deinstitutionalisation measures or indeed - as illustrated above - increased institutionalisation of children (Eurochild, 2020).

Impact on education

The most dramatic impact of the COVID-19 crisis on children was undoubtedly the intermittent closure of schools and the massive shift to distance learning. During the first year of the pandemic (mid-March 2020 to mid-March 2021), the average school in the EU was fully closed (i.e. no distance education and no classes open) for 60 school days. There was a wide variation between levels of education, with shorter closures at (pre-)primary than at (upper) secondary level, as well as between Member States: in less wealthy countries, the full closures typically lasted longer (Slovakia: 50 days in primary schools and 115 days in upper secondary; Denmark: fewer than 20 days at all levels (OECD, 2021)). This is understandable given the difficulty for less wealthy countries to organise distance education, in addition to the differential impact of the pandemic itself. As the pandemic continues, the risk of further school closures without any educational activity or distance learning remains a reality.

Even when schools are open, they cannot operate normally due to extensive safety measures, with the resulting loss of effective learning time and many thousands of teachers and students quarantining or becoming ill. Distance education cannot make up for this loss, given the greater difficulty for students to focus during online lessons. This means that the learning loss as a consequence of the pandemic will be far larger than the duration of closures suggests.

The COVID-19 crisis has amplified educational inequality (Carretero-Gomez et al., 2021; Di Pietro et al., 2020). A substantial part of the supervision of pupils was shifted from schools (which treat all learners equally) to parents, who are unequally equipped for this task. Specialised services for children with special needs were also discontinued for safety reasons, as were third sector initiatives, such as school-community liaison and homework classes, at least, during the first lockdown. This shifted an additional burden onto parents (Thorell et al., 2021). Parents differ enormously in their own level of education and many lack the pedagogical skills to cope with homeschooling (Vuorikari et al., 2020). Their housing conditions, material and financial resources are unequal. Many parents with an immigrant background do not even understand the school language. These inequalities were widened abruptly by the crisis, which pushed families into (deeper) poverty. The sudden shift to digital learning posed new challenges that could not be overcome by disadvantaged families. In Romania, for example, 900,000 students (32%) had no access to online learning – more than three times the number estimated by the Ministry of Education (Save the Children, 2020; Eurochild, 2020).

Although it is too early for a comprehensive statistical assessment of the social and educational loss to vulnerable children, some national studies can give an indication. Based on a comparison between standardised tests at the end of primary school in June 2019 and June 2020 in the Flemish Catholic education sector (catering for roughly two-thirds of all pupils), Maldonado and De Witte (2020) estimated an average learning loss of approx. half a school year by the end of the school year 2019-2020. That loss was one-fifth higher in lower socioeconomic status schools. A more detailed analysis of the same data revealed that the learning loss was significantly related to the number of closure days, which varied between schools. The loss per day appeared to be 2.5 times higher in the most disadvantaged schools, where the majority of pupils had an immigrant background and did not speak the instruction language at home. In the UK, Juniper Education (2021) examined the results of standardised tests in 6,000 primary schools serving 1.47 million children. Between autumn 2019 and autumn 2020, there was a large drop (20%) in the percentage of pupils meeting the expected standards for their age, primarily in maths (21.4%). The drop was 3 p.p. larger in Grade 1 and relatively small in Grade 6, and was significantly larger among disadvantaged children (3-5 p.p.) and children with special educational needs. In the Netherlands, Engzell et al. (2021) made use of yearly standardised test scores among pupils aged 8-11 between 2017 and 2020. They estimated the learning loss attributable to the eight-week lockdown period at one-fifth of a school year. For children of low-educated parents, that loss was 60% higher.

These findings reflect education systems that perform relatively well, in wealthy countries, and that underwent relatively short school closures compared to the EU as a whole. In other words, the damage to the average student in the EU is expected to be worse. All three studies described above should be seen as snapshots 'halfway' through the COVID-19 pandemic, with questions remaining about how learning losses will volve in the current school year, how schools might

reorganise to avoid further losses, and any measures that might be taken to minimise the damage for the most vulnerable groups.

The OECD (2021) provides an overview of related policy measures and policy options to minimise the impact of COVID-19 on children. They outline the generic measures taken to mitigate learning losses, including safety measures enabling schools to remain open, priority vaccination of teachers, extending the school year or organising summer schools, investing in technology and training for distance education, hiring additional staff. In addition, many countries have targeted support to the most disadvantaged schools and students and used the most accessible educational technologies. Other solutions included encouraging schools to mutualise digital learning resources, and to use 'take-home packages' as an alternative to digital education, national radio and television producing additional school programmes, providing disadvantaged schools with support to invest in computer and internet classes, using accelerated learning methods (or teaching focussed on the most essential learning contents) to remedy the greatest losses, social tariffs for internet use, and distributing computers or tablets free of charge.

TERTIARY IMPACT

The long-term damage of the COVID-19 crisis to vulnerable children may be severe and, in some cases, irreparable. On the one hand, the stress and traumatic experience of isolation, violence and separation from parents can generate lasting mental health problems such as depression, addiction, or an inability to engage in stable (family) relations during adulthood. These effects can go hand-in-hand with large socioeconomic losses (Goodman, Joyce and Smith, 2011). However, the learning loss incurred during one or two school years will likely undermine students' entire school career and affect the earnings capacity of an entire generation. Indeed, underperformance on tests often results in grade repetition or forced re-orientation, increasing dropout risks and weakening labour market positions in adulthood. Based on panel studies of the long-term labour market effects of previous problems in education, Hanushek and Woessmann (2020) estimated the average earnings loss associated with a three-month school closure at 3% throughout the whole future career of today's school-going children, with the average loss expected to be greater among disadvantaged groups.

Conclusion

Although this report does not cover all vulnerabilities, a number of cross-cutting conclusions will also apply to other categories of vulnerable citizens:

- The methodological framework distinguished between primary, secondary and tertiary impacts. Strikingly, the secondary impact of the COVID-19 crisis affected different groups and was much more multidimensional than the primary impact. The analysis of tertiary impacts is necessarily somewhat speculative.
- The main risk of the COVID-19 crisis is that it has amplified - and may continue to amplify - socioeconomic inequalities, both directly (impact on income and employment) and indirectly (unequal harm to health and education).
- Social protection systems have played a very important role as 'built-in stabilisers', not just for the economy at large but also for millions of individuals and households directly or indirectly affected by the crisis.
- The shock of the COVID-19 crisis disrupted public and social services that are important for the general population but indispensable to vulnerable groups, especially during the first wave (daily support for people with disabilities, mental health services, family counselling, learning support to children at risk, etc.). This exacerbated the vulnerability of those groups and the social impact of the crisis.
- The link between housing and health is clear. The higher risk of contagion among people experiencing homelessness, migrants, Roma and even people living in institutions was due to a large extent to overcrowding and/or substandard accommodation.
- The crisis triggered some positive innovations. For example, services for people experiencing homelessness (supported by public authorities) are now investing in more decent accommodation and more integrated service delivery, education providers embraced digital methods, not just as an emergency solution but also to tailor teaching to specific learning needs of disadvantaged students, and services for people with special needs were reorganised to ensure more continuity in crisis periods.
- Finally, the crisis revealed the lack of essential monitoring data, including on homelessness, vaccination rates, or access to key social services. Even the scientific emergency programmes to examine the impact of COVID-19 on the population largely overlooked the most vulnerable groups. Reliable and timely monitoring data are not a luxury, but are essential inputs for swift and effective policy responses and can help to save thousands of lives.

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