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Inequality and the impact of Covid-19: How discrimination is shaping the experiences of minorities and indigenous peoples during the pandemic

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Introduction

The Covid-19 outbreak was declared a pandemic by the World Health Organization (WHO) on 11 March 2020. It had initially spread in Wuhan, China in late 2019, before the first cases outside the country were recorded at the beginning of 2020. Today there are millions of cases of Covid-19 globally, with thousands of new cases being confirmed every day. The Covid-19 pandemic is, at root, a public health emergency, driven by its ready transmission and ability to cause severe illness and death. But while its ability to overwhelm the best of health systems has already been demonstrated, its far-reaching social, economic and political consequences are still unfolding.

Although everyone is at risk of the virus, some groups have been worse affected by the pandemic and its consequences, including in particular minorities and indigenous peoples. Especially in the global north, mounting evidence has shown that ethnic, racial and religious minorities are not only at greater risk of contracting the virus for a wide range of reasons – from their disproportionate employment in high-risk sectors such as nursing, cleaning and public transport¹ to their concentration in overcrowded housing² where social distancing is more difficult – but can also face higher rates of mortality once infected, often due to poorer health status and limited access to medical care.³ Linguistic minorities may face problems in accessing accurate public health advice. While there is so far less data available on the impact of the pandemic on indigenous peoples, particularly smaller or more isolated communities, emerging evidence from the US and elsewhere suggests that the implications of the pandemic have been ‘disproportionately devastating’ for indigenous peoples.⁴

Moreover, the severe impact of the virus on all these communities has extended to their livelihoods and security, their access to basic services including health care, education and food. In addition, women and people with disabilities within these communities are even more exposed to these negative impacts. There are fears that the implications of Covid-19 for minorities and indigenous peoples in the global south, at present largely undocumented due to a lack of data or reporting, may be even more acute.

Covid-19 has therefore developed into a crisis of human rights as well as public health, exposing deep inequalities between different communities and the fragility of health and protection systems across the globe. Minorities and

indigenous peoples now face an even more hostile environment, characterized by increasing racism, xenophobia and scapegoating. In addition, the implementation of wide ranging containment measures by governments across the world have also had profoundly discriminatory impacts on the most marginalized groups in their societies: for example, in the mistreatment, detention and deportation of migrants, refugees and asylum seekers in the name of containing the virus.

While most lockdown measures have been put in place to slow the transmission of the virus and save lives, their unintended consequences have been far reaching, with livelihoods devastated, schooling disrupted and borders closed. These impacts have also been distributed unevenly and brought renewed urgency to the situation of minorities and indigenous peoples worldwide, with many concerned that the pandemic could reverse any modest advances in improving social and economic equality. In a situation where inequalities fuel the spread of Covid-19, which in turn deepens existing inequalities and creates new ones, it is crucial to put minority and indigenous peoples’ rights at the centre of the global response to combat the pandemic and its impacts.

This briefing explores the underlying issues that have shaped the experiences of minorities and indigenous peoples during the pandemic, as well as how these may have contributed to their greater vulnerability to the virus. It also considers the social, economic and political impact of the responses to contain the pandemic on these communities, while assessing some discriminatory practices towards minorities and indigenous peoples. It concludes by proposing a number of areas to be explored further and recommendations for all actors involved in the response to the pandemic.

Covid-19 transmission and health outcomes

Since its emergence in China in late 2019, the global scientific community has worked hard to develop its understanding of the virus and its impacts on the human body in order to contain it. The WHO has identified a number of vulnerable and high-risk groups who are at disproportionate risk if they contract the virus: these include people older than 60 years or with underlying health conditions such as lung or heart disease, diabetes or conditions that affect their immune system. This

classification is aimed not only to alert highly susceptible groups, but also to allow governments and health systems to design responses sensitive to these vulnerabilities. As the virus continues to spread across communities, a more complex picture has emerged of how these different biological and medical variables intersect with ethnicity, race, religion, disability and socio-economic status. In this regard, the pandemic has only reflected the already entrenched health inequalities between different social groups, with the poorest and most marginalized communities typically facing a higher burden of morbidities and mortalities than others.

As the number of cases has grown, what disaggregated data is currently available has shown that ethnic, racial and religious minorities and indigenous peoples are generally at higher risk of contracting and dying from the virus. It is important to mention here that most of the available disaggregated data has been produced in high national income settings in the global north, while reliable quantitative data (especially reflecting ethnicity and religion) has been scarce elsewhere. Early data from the United Kingdom (UK) was instrumental in highlighting the disparities: for example, the disproportionate numbers of health workers from black, Asian and other minority communities who had lost their lives to Covid-19⁵ and the relatively high share of patients

in care units with Covid-19 from black or another minority ethnic background.⁶ Even when controlling variables such as age and geography, the number of deaths per capita is very high across all ethnic minority groups.⁷ Information on the rate of transmission of Covid-19 and its impacts among religious minorities has so far been limited. However, findings from the UK covering the period from March till mid-May 2020 show that mortality rates from Covid-19 are greater among religious minorities, with the highest levels recorded among Muslims, with Hindus, Jews and Sikhs also disproportionately affected.⁸

A similar picture emerges from the United States (US). Based on emerging data from the first weeks of the pandemic, the Washington Post reported in April 2020 that US counties with black majorities had three times the rate of Covid-19 infections and almost six times the proportion of deaths compared with counties where white residents are the majority.⁹ Hospital data from Chicago shows that over half of all Covid-19 cases and almost 70 per cent of Covid-19 fatalities occur in black communities, despite accounting for less than a third of Chicago's population.¹⁰ Sadly, these findings only confirm what previous available data already suggested: namely that an increased risk of adverse health outcomes is likely among minority populations during a pandemic.¹¹



An Emberá Indigenous woman in the makeshift camp in a park in the centre of Bogotá. At least 400 people had been sleeping in plastic tents for a month, due to the pandemic and the lack of job opportunities. Credit: Daniel Garzon Herazo

Health disparities during the pandemic have also been seen among indigenous peoples, who have a long history of excess mortality from infectious diseases. Smallpox, measles and other imported diseases devastated indigenous populations in the Americas following European contact. As with ethnic minorities, there is a paucity of specific information on indigenous mortality rates from Covid-19 in much of the world, particularly in the global south. Even in countries where some data is available, it remains incomplete: in Canada, for instance, official data on indigenous Covid-19 outcomes only includes those living on reserves.¹² In Latin America, where cases of Covid-19 are surging, indigenous organizations have highlighted the disastrous impact of the virus on their communities. In Brazil, one of the hardest-hit countries, the effect of the virus on indigenous peoples has been catastrophic, with official statistics suggesting that the mortality rate among those who have contracted the virus is almost double that of the national average.¹³ Community members report that the virus has already decimated an older generation of leaders, who play a central role in the preservation and dissemination of cultural traditions and spirituality.¹⁴ Indigenous and civil society organizations have themselves warned of potential ‘ethnocide’ as a result of the virus and called on an end to exploitative activities, such as the encroachment of extractive industries on their land, that increase the exposure of indigenous peoples to the virus.¹⁵

Ending invisibility: the importance of data disaggregation

As the issue of ethnic disparities has increasingly come into the spotlight, many have highlighted the need for better data disaggregation to guide a more targeted and appropriate response. Though there are many separate, interconnected and constantly evolving elements to take into account, one thing is certain: unless the current pandemic is viewed through a lens of minority and indigenous rights, any attempt to contain it will run the risk of failure. Developing a clear evidence base on how ethnicity, race and religion, as well as potential language barriers for members of linguistic minorities, shape exposure, vulnerability and mortality are an essential first step for any government seeking to protect its population from the virus.

The absence of widely available, disaggregated data is a longstanding barrier to equitable development that long predates the Covid-19 pandemic. In many countries, particularly in the global south, health information systems are fragmented and lacking centralized streaming channels. Limited political will and logistical capacity may be further barriers. Furthermore, some countries do not collect ethnically disaggregated data on the basis that this may

contribute to discrimination. In France, for instance, the collection of ethnic data is prohibited, a response in part to the deportation of much of its Jewish population during the Second World War: however, critics have argued that this refusal to collect disaggregated data has meant that ethnic inequalities in housing, employment and public health remain unacknowledged. This lack of visibility has become especially evident since the outbreak of Covid-19. While the UK and US were able to quickly identify disparities in outcomes such as mortality among their minority populations due to their inclusion of ethnicity as a key variable in their data, the picture in France has been more opaque.¹⁶

Furthermore, when data is disaggregated, especially according to ethnicity and race, minorities themselves may have some concerns about how the data may be used and disseminated. In many cases, local communities and groups have no access to the disaggregated data on their status, thereby denying them the right to be informed. In the US, for instance, some indigenous peoples have been unable to access official data on the spread of the virus within their territories, hindering efforts by communities to organize and tailor responses according to their needs. Some minority and indigenous representatives also fear the instrumentalization of data against their communities: one example was the accusation from a British MP that the ‘vast majority’ of cases in his constituency were members of minority and immigrant communities who ‘are not taking the pandemic seriously’. Besides contributing to negative and harmful stereotypes, his explanation failed to consider the range of structural inequalities these groups face, from overcrowded housing to high levels of employment in sectors such as health and transport where the risk of infection is higher¹⁷ – instead preferring to attribute the blame to community members themselves. Similar issues around law enforcement ‘policing the pandemic’ also highlight the potential pitfalls of misusing disaggregated data: in Canada, for instance, the release of Covid-19 testing data to police resulted in neighbourhoods with high levels of infection, disproportionately populated by ethnic minorities, being targeted with heavy-handed enforcement measures.¹⁸

This last example points to another important consideration when it comes to data disaggregation: the need, when documenting Covid-19 data according to sex, ethnicity, race, religion and language, to contextualise the results with adequate analysis. Often, what data is available is not accompanied by any explanation of the social factors that may create ‘spikes’ in some indicators among minorities and indigenous peoples. This can perpetuate harmful myths and misunderstandings that undermine the goal of eliminating health inequities. Here, a combination of quantitative and qualitative data is necessary to situate minority and indigenous experiences in the findings, especially when dealing with sensitive issues such as infection rates, to ensure that communities are not further stigmatized.

Underlying issues related to high susceptibility to the virus

The causes behind the increased vulnerability to the virus among minorities and indigenous peoples are likely to be complex and interlinked, but first it is important to recognize the social determinants placing these communities at greater risk. Since the experience of past epidemics suggests that the most socially marginalized populations will suffer disproportionately, it is crucial to investigate the way social inequalities interact and fuel health inequalities. Covid-19 is creating a vicious cycle: while existing inequalities have helped fuel its spread among already excluded groups, the subsequent health and economic impacts of the virus will deepen these inequalities even further. Evidence already shows how long-standing disparities and unequal underlying determinants of health are leaving marginalized individuals and communities disproportionately impacted by the virus – both in loss of lives and livelihoods.

Socio-economic status: The health impact of Covid-19 reflects deep-rooted patterns of discrimination in societies that create systemic barriers to the conditions needed to live a healthy life, contributing to poorer health outcomes among individuals belonging to minority and indigenous communities. It is well established that an individual's class, income and education can determine their health status, with low socio-economic status (SES) associated with poor health outcomes. Since the risk of dying from Covid-19 infection is higher for those with certain health morbidities such as type 2 diabetes that are disproportionately associated with poorer groups, the virus is potentially much more deadly for the most marginalized in the society. For example, among indigenous peoples which have been historically excluded in many countries across the world, the high mortality rate from Covid-19 has been linked to respiratory and other poor health conditions.¹⁹ While access to health care can improve outcomes, this is itself largely determined by social inequalities, with marginalized groups typically facing lower levels of access to health services. This, alongside other complex factors, has serious implications for the prognosis and treatment of Covid-19 among members of minorities and indigenous peoples.

Inability to implement preventive measures: Although Covid-19 transmission is yet to be fully understood, one measure has proven to be vital in reducing the spread of the virus: the ability to keep a safe physical distance from others. This measure has formed the basis of many governments' responses to the pandemic. Since the efficiency of such measures greatly depends on an individual's living conditions and the nature of their work, practicing physical distancing and self-isolation can be nearly impossible in some contexts where minorities and other frequently excluded groups, including migrants and refugees, reside.²⁰

While there is evidently variation in the situation of individuals belonging to minority communities, they are often more likely to live in densely populated or overcrowded areas, such as multi-generational or shared households: in the US, for instance, the proportion of people living in multi-generational households was significantly higher among the Asian (29 per cent), Hispanic (27 per cent) and African American (26 per cent) populations than among whites (16 per cent).²¹

This is particularly the case for many migrant workers and refugees across the world, from foreign workers concentrated in cramped and unhygienic dormitories and detention centres in the Gulf, to the millions of refugees and internally displaced people (IDPs) across the Middle East and Asia who already suffer from inadequate access to clean water or sanitation. In these contexts, often characterized by poor hygiene and limited access to running water, preventive measures such as hand washing and mask wearing are extremely difficult to follow. International organizations have warned that overcrowded camps and detention centres could become new epicentres for the virus without concerted action from governments to ensure safe, sanitary environments for refugees, migrants and IDPs.²² In Kutupalong camp in Bangladesh, for example, where more than 600,000 Rohingya refugees displaced from Myanmar are currently residing, there are only a few hundred hospital beds available, meaning any large-scale Covid-19 outbreak there could prove catastrophic.²³

Similarly, many indigenous communities have minimal access to clean water, soap, personal protective equipment (PPE) and sanitation.²⁴ In Rwanda, for example, the Batwa communities reportedly face difficulties implementing preventive measures due to lack of sufficient washing facilities, soaps and disinfectant.²⁵ Furthermore, the principle of social distancing is unfavourable towards some people with disabilities who rely on others for support or towards indigenous communities who depend on social gatherings for many aspects of their daily life. These issues are especially acute for individuals facing intersectional discrimination on the basis of their indigenous identity and a disability. For example, people with disabilities among the Endorois community in Kenya are reportedly facing many challenges in implementing social distancing measures, especially the blind and those who require wheelchairs for mobility.²⁶

Poor access to health services: During the pandemic, minorities and indigenous peoples have faced increasing barriers in accessing health care. According to WHO, one of the key ways to fight the coronavirus outbreak is to test and isolate. Amidst a global shortage in Covid-19 diagnostic tests, access to Covid-19 testing is determined by the ability to pay out of pocket for the test in many countries. Affordability also determines access to quality care and hospitalization for those with severe symptoms of



A migrant worker looks on from a swab isolation facility as he waits for his test results at a dormitory, amid the Covid-19 outbreak in Singapore. May 15, 2020. Credit: Reuters/Edgar Su

Covid-19 who require medical care. This has profound implications not only for those living in poverty but also for millions of people who have lost their source of income.

While health inequalities long predate Covid-19, the pandemic has made them even clearer as health systems across the world have been stretched and overwhelmed. For example, local medical services are underfunded for many urban indigenous communities and are scarce or non-existent for remote rural communities. In a context where hospitals and clinics are already struggling to provide testing and treatment to the general population, the situation for indigenous communities located far from cities is especially acute when health services are still very centralized, as in Brazil or Kenya. In these instances, members of indigenous communities may have to make extended journeys to access health care, in the process increasing their potential exposure to the virus as well as the risk of further transmission to others.²⁷

Geography is only one of many barriers that indigenous populations face, however. While indigenous communities in remote rural areas face difficulties in part due to their physical location, the challenges that many indigenous community members face even when living in cities demonstrate that the same social inequalities persist. In the Colombian capital of Bogotá, for instance, hundreds of indigenous Emberá who fled to the capital to escape conflict and violence have contended with limited access to health care and widespread malnutrition – issues that have worsened since the pandemic began, with very little assistance from the government.²⁸

Other lockdown measures, such as restrictions on movement, have also affected on particular groups disproportionately. For example, restrictions on public transportation in countries such as Bulgaria, Hungary, Romania and Spain have impacted particularly on Roma communities there which are dependent on these services to access health facilities. As there have been prior reports of discrimination in the health systems of at least some of

these countries towards Roma, there is a danger that as testing and treatment capacity becomes overstretched they could be subjected to further exclusion.²⁹

Discriminatory barriers: With limited resources and health systems pushed beyond their capacity, there is a danger that authorities will prioritize some groups over others, reinforcing existing inequalities in access to care and treatment. In particular, the pandemic has deepened the divide between citizens and non-citizens, documented and undocumented, distinctions reflected in the exclusion of many migrant, refugee and stateless populations from official services. Many migrant workers in the Middle East have reported being unable to access health services and information as foreign nationals. In Lebanon, for instance, despite the free Covid-19 medical services supposedly available to all, many African and Asian workers have been denied access in the absence of documentation – a common issue for migrants who are forced to flee abusive employers.³⁰

Furthermore, many migrants and refugees fear that they will be detained or deported if they seek medical care, not only because of their residency status but on the basis that they may be suspected of carrying the virus. Reports of Nepalis and other migrant workers in Qatar being told they were being taken to be tested for Covid-19, only to be detained arbitrarily and then deported, confirm these concerns.³¹ Access to health services in the time of the pandemic has even been instrumentalized for political purposes or to consolidate a populist agenda, as with Viktor Orbán's government in Hungary, who in the early days of the outbreak described a 'two-front war': 'one front is called migration, and the other one belongs to the coronavirus, there is a logical connection between the two, as both spread with movement.'³² This added stigma could further obstruct their ability to seek medical care.

Covid-19 in conflict and fragile settings

People affected by instability and conflict are likely to be at a higher risk of Covid-19, particularly refugees and displaced people. In war-torn countries and other humanitarian settings, health systems are already fragmented and unprepared to counter the effects of a pandemic. In addition, these settings can suffer from weak governance, poor infrastructure, overcrowding and frequent attacks on health facilities. While it is unclear how hard the virus has hit populations in fragile settings to date, as testing is very limited, there is no doubt that any outbreak will aggravate the already high levels of suffering in these contexts. As cases of Covid-19 have been reported in north-western Syria, fears of its impact on already struggling health services in the area have been expressed by international organizations such as Médecins Sans

Frontières (MSF): as some of the first confirmed cases in July there were among health workers, a number of staff had to self-isolate and facilities temporarily close as precautionary measures.³³

In active conflicts and in areas where social tensions are high, health facilities are not always safe or neutral spaces. Indeed, they are frequently targeted by belligerents seeking to consolidate their power by controlling who can access much-needed medical care. In Libya, where the national health system has collapsed as a result of the civil war, emergency care facilities are considered a scarce commodity, especially outside big cities. In the south of the country, in the city of Sabha, members of the marginalized ethnic group Tebu reportedly avoid using the main hospital out of fear that they may be attacked by rival groups there.³⁴

The pandemic has already disrupted humanitarian aid flows and supply chains, leaving refugees and IDPs with limited access to Covid-19 testing and treatment equipment. Furthermore, in some crisis-affected areas the instrumentalization of aid has increased since the outbreak of the pandemic. In Syria, the number of authorized crossing points for aid to the country has been reduced, at the insistence of Russia and China, from four crossing points to a single point in the north.³⁵ This will limit the delivery of essentials even more, placing the almost one million IDPs in Idlib at greater risk not only from the virus but also its broader impacts on livelihoods and basic services.

Discriminatory containment measures

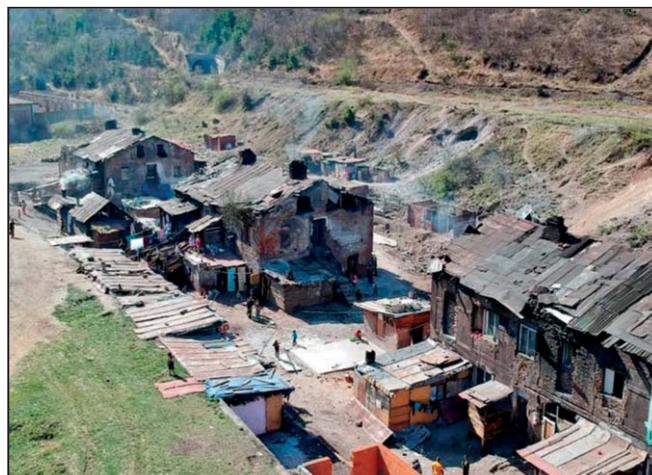
Countries have implemented a number of measures to halt the spread of the virus and limit the number of fatalities. These include, but are not limited to, closure of non-essential businesses, schools and borders, as well as other restrictions on movement aimed at enforcing social distancing such as curfews and lockdowns. Although many of these measures have been lifted or eased since, some countries have been forced to reintroduce emergency measures at a local level. Such measures should be implemented on the basis of sound public health data and be legally grounded, but the experiences so far have reflected a grim picture, with official responses in many countries characterized by discriminatory measures, institutional racism and the unlawful use of force. This effect can be seen in many areas, including the delivery of healthcare, the implementation of lockdown measures and in policies designed to mitigate the economic impacts of the crisis. Cases of excessive use of force to enforce restrictions on movement, including arrests and detentions in areas dominated by ethnic minorities, have been reported.

Some authorities have also forced additional restrictions on certain groups that do not apply to the majority of the

population. This includes selective and compulsory testing and quarantining of specific communities, often without any scientific justification. In China, for instance, African immigrants were repeatedly targeted with testing and containment measures that only served to reinforce the stigma and discrimination they already faced before the outbreak.³⁶ Similarly, in countries such as Bulgaria and Slovakia, Roma settlements have been heavily policed and subjected to mandatory quarantines. By being selectively targeted and stigmatized supposedly as public health threats, these official actions may also have contributed to a rise of anti-Roma sentiment.³⁷

There are many similar examples elsewhere of minorities being subjected to disproportionate measures against them in the name of public health. In Nice, France, neighbourhoods with predominantly ethnic minority populations were subject to a longer night-time curfew than the rest of the city.³⁹ In Lebanon, several municipalities put in place discriminatory restrictions of movement on Syrian refugees that did not apply to Lebanese citizens, further compounding the barriers they face when accessing basic care and services. Even when governments started lifting or easing some of the restrictions related to Covid-19, incidents of discrimination against some minorities have been reported. In Malaysia, even after mosques were reopened for Malaysians, Rohingya refugees and other non-citizens were still banned from entering mosques and praying alongside them.⁴⁰

Implementing lockdowns without putting in place measures to protect the most vulnerable has had a disastrous impact on minorities, indigenous peoples and other marginalized groups, including migrants and refugees, frequently amplifying the discrimination these communities already faced before the outbreak. Lockdown measures in some countries in South Asia were announced at very short notice, leaving millions of migrants without jobs or shelter and on the brink of starvation. Closure of worksites and eviction from accommodation triggered a mass exodus of migrants, who were forced to make long journeys on foot to their home villages, often across



Zabijanec, a Roma settlement in Rudňany, Slovakia. Credit: Jana Cavojska

borders. Some of these migrants were subjected to inhumane treatment along the way. Troubling images from India of returnee workers being hosed down with bleach and chlorine water expose the stigmatization that many migrant workers face.⁴¹

This highlighted the added impacts on mental and physical health brought on by the lockdown. In the wake of restrictions on movement, there has been a global surge in levels of domestic and gender-based violence. During the implementation of these measures, avenues of escape, help-seeking and coping strategies for victims and survivors have been shut off, granting people who abuse the ability to act with impunity. LGBT+ youth who have been forced to isolate in homophobic and transphobic households are at particular risk, especially in communities where sexual orientation and gender identity expression are criminalized.⁴²

Impact on incomes and livelihoods

It is extremely difficult to gauge the true implications of the Covid-19 pandemic beyond its immediate public health impact. However, one of the most disruptive consequences of the pandemic is the immense damage it has wrought on incomes and livelihoods worldwide, already reflected in soaring unemployment levels in many countries. The consequences could be especially acute in regions already characterized by high levels of informal and poorly paid employment, such as South Asia: though projections remain uncertain, estimates suggest that at least three million jobs have been lost so far in Pakistan as a result of the pandemic⁴³ and around one million in Bangladesh's garment industry,⁴⁴ for example. Lockdowns, curfews and other restrictions put in place due to the pandemic have caused thousands of people to lose their only source of income.

Without adequate measures in place to address the economic and food insecurity that has resulted, the situation of migrants, refugees and minorities and indigenous peoples already living in poverty could become even more precarious, with damaging long-term health consequences. Many have been forced to choose to abide by the restrictions and risk having no access to food or water and potentially losing their homes, or violate those restrictions and jeopardize their personal safety. In many refugee camps, death by starvation is considered to be a greater risk than the virus itself.⁴⁵ Migrant workers, while the challenges they face are generally different, have nevertheless been left out of many state support packages and even actively disadvantaged by official measures put in place in response to the pandemic that have made their situation even more insecure. In the United Arab Emirates (UAE), for example, legislation has been amended to allow employers to revise work contracts to reduce salaries and force their workers to take unpaid leave.⁴⁶

Workers in the informal sector have been especially hard hit by the economic meltdown. Although many countries have introduced some form of relief package to mitigate the consequences of the loss of income, those working in the informal sector have frequently been excluded from these protections. In addition, these schemes generally require some form of documentation that many migrants lack. For example, in Pakistan financial assistance for poor workers depends on the national socio-economic registry and national identification card – something many migrants are unable to access.⁴⁷ The efficiency of these schemes and to what extent they actually meet the needs of those without jobs as a result of the crisis remains uncertain.

The impact of Covid-19 on livelihoods is also gendered. Historically, minorities and indigenous peoples make up a large share of the workforce in the informal sector, with women disproportionately represented.⁴⁸ The experience of women in Liberia during the Ebola outbreak demonstrates the heavier impact on women, especially those working as market traders.⁴⁹ There is an increasing concern that as a result of the pandemic, many women in low-income countries in particular may be forced into extreme poverty. The economic effect of the pandemic has also been pronounced among LGBT+ communities across Africa, where the impacts of poverty and homelessness have been reinforced by deep-seated prejudice.⁵⁰

The pandemic's effect on food security is still evolving across the world. In many countries, the risks to food security can be related to disruptions in domestic food supply chains and production, and loss of incomes. Food insecurity is worsened for populations affected by conflict, climate change and economic meltdown. In addition, food prices have been rising in several countries due to measures taken to combat the spread of Covid-19.⁵¹ These alarming developments can have a disastrous impact on the poor and vulnerable. In Ethiopia, a survey of South Sudanese refugee children in July 2020 in the Gambella region found that close to a quarter were suffering from life-threatening malnutrition.⁵² The current surge of Covid-19 cases in Ethiopia is imposing further challenges to deliver food aid and humanitarian assistance. These shortages could exacerbate existing health vulnerabilities among local populations, potentially raising the risks of the virus.

Furthermore, the confiscation of indigenous lands in many countries has left communities struggling to maintain any kind of food security during the pandemic. For instance, almost half of Batwa community members in Rwanda no longer have access to farmland of their own, leaving them dependent on the sort of informal employment that has become increasingly scarce since the pandemic's outbreak.⁵³ In Bolivia, similarly, some indigenous communities in rural areas still depend on urban markets for food items, medicine and income, and have been seen their food security severely hit by their sudden closure.⁵⁴

Other human rights concerns

Sadly, alongside many acts of striking solidarity and cooperation, the Covid-19 crisis has also provoked further stigma and discrimination against ethnic, racial and religious minorities as well as indigenous peoples. A particularly serious concern is the ‘infodemic’ of misinformation and rumours that have spread with the virus. Since the early stages of the pandemic, people of Asian descent around the world have been the target of abuse and harassment. This sort of stigmatizing behaviour has been a feature of previous pandemics: similar discriminatory practices were reported in the global north during the Ebola epidemic against people of West African heritage.⁵⁵

Moreover, the pandemic has fuelled further incitement of hatred and violence against certain minorities who were already targeted before the health crisis and have now been blamed for spreading the virus, a narrative that at times has even been encouraged and promoted by politicians, officials, religious leaders or mainstream media. In India⁵⁶ and Sri Lanka,⁵⁷ media coverage and remarks from officials

around the pandemic have helped fuel existing anti-Muslim sentiment. In Balochistan, Pakistan, the Hazara Shi’a community has been scapegoated by government officials through various discriminatory measures, including the sealing off of Hazara neighbourhoods in Quetta during the lockdown.⁵⁸

Such stigma can make it increasingly difficult to control the virus, as infected people may be forced to hide their symptoms or refrain from seeking medical care, particularly if they fear that testing positive could lead to forced isolation, detention or even deportation. In Cox’s Bazar, where hundreds of thousands of Rohingya refugees reside, an internet shutdown imposed by the Bangladeshi government since September 2019 has enabled rumours to flourish in the absence of readily available and reliable information. For instance, community members are avoiding going to clinics or even fleeing quarantine based on rumours that they could be sent to isolation facilities far from their families and community.⁵⁹

Another issue of concern is the future of surveillance of the pandemic. While the use of smart technologies for



A child belonging to the indigenous Yanomami people holds a protective face mask, amid the spread of Covid-19 in the municipality of Alto Alegre, state of Roraima, Brazil. July 1, 2020. Credit: Reuters/Adriano Machado

legitimate public health objectives can be justified, there are growing concerns regarding the potential abuse of this information by governments and companies. The deployment of big data has been unprecedented during this pandemic, ranging from monitoring social media and mobile phone tracking to the use of drones and facial recognition tools. In China, a country with a long track record of using technologies to control and monitor its Uyghur Muslim population, a facial recognition system has been developed which can identify masked people with 90 per cent accuracy.⁶⁰ Israel also announced it would be commencing the tracking of mobile phones to identify cases of Covid-19 in the country, using software originally developed for counter-terrorism purposes.⁶¹ Such powerful tools can be intrusive, especially when deployed against people or specific groups for purposes beyond the health crisis.

In some instances, the pandemic has also been exploited as a pretext to achieve other political goals. In the US, the Trump administration issued a ban on undocumented migrants and asylum seekers from crossing the border from Mexico, with the stated aim of preventing the spread of the virus. However, as there is no evidence that this particular group is more likely to spread the virus compared to other individuals entering the US via planes and ships, the measure has been criticized as discriminatory without any basis in public health.⁶²

There are also fears that the pandemic could provide an enabling environment for human rights abuses against minorities and indigenous peoples, as attention at both a national and international level is diverted towards tackling Covid-19. In Kenya, reports have emerged of security forces illegally evicting Ogiek community members in the Mau Forest by demolishing 300 homes, with huts belonging to Sengwer community members in the Embobut Forest similarly targeted.⁶³ The displacement of these communities in the midst of the pandemic has put them in an extremely vulnerable position.

Another example is the annexation of territories by the Israeli government. Plans to further annex areas in the occupied West Bank were announced by Prime Minister Benjamin Netanyahu in June 2020 after he formed a new coalition government – a move that, if implemented, would represent a clear breach of international law.⁶⁴ The plans were initially halted because of the resurgence of Covid-19 cases and divisions within the Israeli government.⁶⁵ While the recent Israeli-UAE peace agreement of August 2020 was apparently predicated on Israel suspending the annexation, Netanyahu later insisted that the extension of Israeli sovereignty remained his long-term intention. The international community should take active steps to oppose these plans.

Finally, there have been calls of alarm from the UN and numerous human rights organizations on behalf of human rights defenders currently in detention and the risk they face of contracting Covid-19. The risks are particularly

high in situations of overcrowded cells and lack of access to adequate food, water and medical care – conditions which characterise the plight of detained human rights defenders in many countries.⁶⁶

Conclusion

The Covid-19 pandemic has aggravated pre-existing social and economic inequalities for marginalized communities, including minorities and indigenous peoples. As the risk of recurrent outbreaks is still high, it is crucial to support and protect the most vulnerable in order to control the virus effectively. Though efforts by a number of governments to examine the disproportionate impact of the virus on racial and ethnic minorities are welcome, these should be scaled up and adopted by other countries and include religious, linguistic and other aspects of social identity. To understand what is behind the greater vulnerability of some groups to Covid-19, policy makers and scientists must focus more attention on the social determinants of health and explore how these intersect with ethnicity, race, religion, language and disability.

With some projections suggesting that the disease could become endemic, it is vital to assess the current measures of Covid-19 prevention and the feasibility of their implementation for communities in different settings. For communities with distinct vulnerabilities as a result of poverty or discrimination, more far-sighted approaches to the management of the pandemic are needed. Governments will need to counter the virus by investing in measures to mitigate the social determinants of poor health: for example, through better housing, reduced overcrowding and improved nutrition, as these measures have in the past been proven to be effective in controlling infectious diseases such as tuberculosis.⁶⁷ If governments are serious in their commitment to prevent every avoidable death, Covid-19 response strategies should also take into account their unequal distribution. It is necessary to integrate measures to mitigate adverse social and economic impacts on minorities and indigenous peoples into the wider policy response. This requires existing policies and measures to be assessed at the design and implementation stages according to the principles of ‘do no harm’, equity and inclusivity.

This briefing has also raised concerns about the rights of minorities and indigenous peoples as a result of the pandemic. The use of new technologies during the pandemic and their potential impact on these communities should be carefully monitored and documented. Another area to be followed is the impact of the pandemic and related responses on civil society, especially in countries where this space is already shrinking.

Lessons from this pandemic should be learned, and opportunities for possible synergies with human rights and development agendas must be taken. From what has been

observed globally during the pandemic, a conclusion can be drawn: in order to reverse inequalities and discrimination brought on by the pandemic, it is important to prioritize measures to guarantee social and economic rights, while delivering on the commitment of 'leave no one behind'. In immediate terms, this should include issues relating directly to the pandemic. For example, governments should ensure that vaccines, when developed, will be delivered on the basis of vulnerability to exposure, including due to socio-economic or health roles, rather than on the ability to pay or membership of a dominant ethnic, religious or linguistic group.

However, there are also broader potential synergies between the immediate crisis response and the longer-term realization of the SDGs, especially those associated with health, hunger poverty and adequate shelter, that also must be addressed. Efforts should be intensified to guarantee the right to health and the achievement of SDG 3, including the targets of universal health coverage for all countries, while addressing the national and local barriers that minorities and indigenous peoples, as well as refugees, migrants and people with disabilities, experience when accessing health care. Ultimately, one of the most fundamental steps we can take to address the current crisis and strengthen resilience for any future public health challenges is to push for a more inclusive and equitable development landscape for all.

There have already been some notable approaches by some governments to the crisis that stand as positive examples of the role states can take in supporting minorities, indigenous peoples, refugees and migrants themselves. For example, while across much of Europe the pandemic appears to have accelerated hostile or exclusionary policies towards refugees and migrants, with asylum services suspended and violent pushbacks at borders, Portugal announced in March that migrants in the country would receive the same health services and benefits as permanent residents for the duration of the pandemic.⁶⁸

However, the ability of communities to play a central role themselves in addressing the crisis is equally important.



An Ogiek man walking in the Mau Forest in Kenya. Credit: Diana Takacsova

The potential impact of integrating community-led responses to the pandemic is well illustrated by the approach of Aboriginal and Torres Strait Islander peoples in Australia who, building on their experiences during the 2009 H1N1 influenza when many were badly affected by its spread, took early and decisive actions to lobby authorities for support and investing in training, resources and public information strategies. As a result, bucking the trend evident in much of the world elsewhere, Australia's indigenous peoples appear so far to have experienced lower infection and mortality rates than the national population as a whole.⁶⁹ Even in some of the most trying circumstances, community members have demonstrated their capacity to contribute to solutions and ways forward: in the refugee camps of Cox's Bazar in Bangladesh, for example, where official health care is desperately under-resourced, around 1,400 Rohingya residents have been trained to deliver door-to-door health care to their neighbours.⁷⁰ Empowering minorities, indigenous peoples, refugees, migrants and other marginalized groups to play a part in prevention and treatment strategies can therefore deliver real and immediate impacts in the fight against the virus – and help reduce discrimination in other areas for them too.

Recommendations

Equitable and inclusive health systems

- Recognize and address the disproportionate impact of Covid-19 on minorities and indigenous peoples through local and national response and recovery strategies that incorporate a range of measures. These should include improved access to safe housing, clean water, adequate sanitation and other services that address the underlying factors that can increase exposure to the virus.
- Ensure the most vulnerable are protected by providing Covid-19 diagnostic and treatment services to these groups without discrimination and regardless of the ability to pay, provision of documentation or residency requirements with prioritization based on socio-economic vulnerabilities. Emergency response and medical care for those with severe symptoms should also be provided on an equitable basis, with special attention to those who are socially isolated or living in rural and remote areas, refugee and displaced camps, and detention centres.

Effective data collection and communications

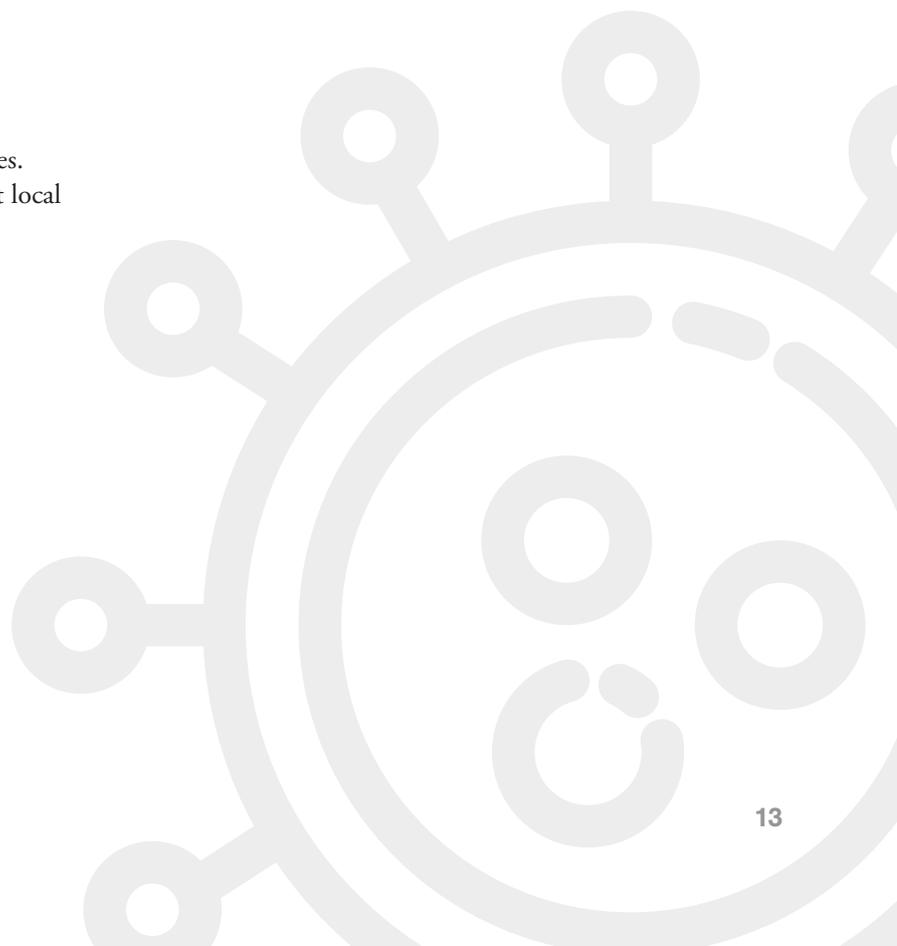
- Disaggregate data to reflect different aspects of social identities and give a wider context for understanding disparities between communities. This should also help diagnose a range of problems and guide the design of tailored safeguards.
- Ensure the availability of accurate and consistent information accessible to all communities, with translations into minority and indigenous languages. The general guidelines should also be tailored to fit local circumstances.

Economic support and poverty prevention

- Design economic aid packages that target the most affected by loss of livelihoods and income. These should pay special attention to those in the informal sector, women and people with disabilities, and be inclusive of all workers in the country regardless of citizenship or documented status.

Human rights protections

- Ensure that any emergency measures are justified by reasonable public health objectives and are legally grounded, proportionate, necessary and non-discriminatory. In particular, authorities should suspend the forced return and deportation of migrant workers, refugees and asylum seekers, and ensure the safety and dignity of those in detention centres.
- Involve all stakeholders, including politicians and religious leaders, to work together to prevent discriminatory actions including hate speech, racism, xenophobia, stigmatisation, and gender and domestic violence.
- Provide guarantees for data protection and safeguards while new technologies are being used for tracking and surveillance purposes during the pandemic.



Notes

- 1 Kline, R., 'NHS Covid 19 and health care worker deaths: questions that need asking', Race Equality Foundation, April 2020.
- 2 UK Government, 'Overcrowded housing', 10 October 2018.
- 3 Centers for Disease Prevention and Control, 'Health equity considerations and racial and ethnic minority groups', 24 July 2020.
- 4 Curtice, K. and Choo, E., 'Indigenous populations: Left behind in the Covid-19 response', *The Lancet* 395(10239), 6 June 2020, p.1753.
- 5 Kirby, T., 'Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities', *The Lancet*, 8(6), 2020, pp.547-8.
- 6 ICNARC, *COVID-19 Report*, 2020.
- 7 Platt, L. and Warwick, R., 'Are Some Ethnic Groups More Vulnerable to COVID-19 Than Others?', Institute of Fiscal Studies, 2020.
- 8 Office for National Statistics, 'Coronavirus (COVID-19) related deaths by religious group, England and Wales: 2 March to 15 May 2020'. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyreligiousgroupenglandandwales/2marchto15may2020#religious-group-differences-in-deaths-involving-covid-19-adjusted-for-socio-demographic-factors>
- 9 Thebault, R., Ba Tran, A. and Williams, V., 'The coronavirus is infecting and killing black Americans at an alarmingly high rate', *The Washington Post*, 7 April 2020.
- 10 Yancy, C.W., 'COVID-19 and African Americans', *JAMA*, 323(19), 2020, pp. 1891-2.
- 11 Hutchins, S., Fiscella, K., Levine, R., Ompad, D. and McDonald, M., 'Protection of racial/ethnic minority populations during an influenza pandemic', *American Journal of Public Health*. 99(Suppl 2), 2009, S261-70.
- 12 Robertson, G., 'As countries move into the recovery stage, how will Indigenous rights be protected post-COVID?', LSE blog, 7 July 2020.
- 13 Curtice, K. and Choo, E., 'Indigenous populations: Left behind in the Covid-19 response', *The Lancet* 395(10239), 6 June 2020, p.1753; Wallace, S., 'Disaster looms for indigenous Amazon tribes as COVID-19 cases multiply', *National Geographic*, 15 June 2020.
- 14 Phillips, D., '"We are facing extermination": Brazil losing a generation of indigenous leaders to Covid-19', *The Guardian*, 21 June 2020.
- 15 Ávila, R. and Guereña, A., *Averting Ethnocide: Indigenous Peoples and Territorial Rights in Crisis in the Face of COVID-19 in Latin America*, Oxfam, June 2020.
- 16 McAuley, J., 'How France's aversion to collecting data on race affects its coronavirus response', *The Washington Post*, 26 June 2020.
- 17 Hockaday, J. 'Tory MP slammed for blaming Muslims and BAME people for coronavirus surge' *Metro*, 1 August 2020.
- 18 Black Public Health Collective, 'Race-based data is not racial justice', 18 June 2020.
- 19 Kaplan, H. *et al.*, 'Voluntary collective isolation as a best response to COVID-19 for indigenous populations? A case study and protocol from the Bolivian Amazon', *The Lancet*, 395(10238), 2020, pp.1727-34.
- 20 Subbaraman, N., '"Distancing is impossible": refugee camps race to avert coronavirus catastrophe', *Nature*, 24 April 2020.
- 21 Cohn, D. and Passel, J., 'A record 64 million Americans live in multigenerational households', *Pew Research Center*, 5 April 2018.
- 22 Amnesty International, 'Global: Ignored by Covid-19 responses, refugees face starvation', 13 May 2020.
- 23 Burki, T., 'COVID-19: A multifaceted threat to refugee camps', *Lancet Microbe*, 1(3), 2020.
- 24 Ferrante, L. and Fearnside, P.M., 'Protect indigenous peoples from Covid-19', *Science*, 368(6488), 2020, p.251.
- 25 Testimony from IAMPO, Rwanda, March 2020.
- 26 Kandie, C., 'I am indigenous, a woman and living with a disability. COVID-19 highlights the intersectional discrimination I face daily', *MRG*, 21 May 2020.
- 27 Soares, J., 'Brazil: Indigenous people in the Amazon brace for coronavirus', *DW*, 6 April 2020.
- 28 Iriarte, R.C., 'Colombia's Emberá: From rainforest violence to urban want', *The New Humanitarian*, 29 July 2020.
- 29 Korunovska, N. and Jovanovic, Z., *Roma in the Covid-19 Crisis: An Early Warning from Six EU Member States*, Open Society Foundations, 2020, p.4.
- 30 Azhari, T., 'Undocumented in Lebanon: No papers, no coronavirus test', *Al Jazeera*, 28 March 2020.
- 31 Amnesty International, 'Qatar: Migrant workers illegally expelled during Covid-19 pandemic', 15 April 2020.
- 32 France24, 'Hungary's Orban blames foreigners, migration for coronavirus spread', 13 March 2020.
- 33 MSF, 'COVID-19 provokes fears over further health system decline in northwestern Syria', 21 July 2020.
- 34 Amnesty International, 'Libya: Historic discrimination threatens right to health of minorities in the south amid COVID-19', 20 April 2020.
- 35 Al Jazeera, 'Russia and China veto UN extension of cross-border aid to Syria', 8 July 2020.
- 36 HRW, 'China: Covid-19 discrimination against Africans', 5 May 2020.
- 37 Amnesty International, *Policing the Pandemic: Human Rights Violations in the Enforcement of Covid-19 Measures in Europe*, June 2020.
- 38 Amnesty International, *Policing the Pandemic: Human Rights Violations in the Enforcement of Covid-19 Measures in Europe*, June 2020.
- 39 HRW, 'Lebanon: Refugees at risk in Covid-19 response', 2 April 2020.
- 40 Choong, J., 'Minister says sorry foreigners barred from Malaysian mosques, insists not an excuse to discriminate', *Malay Mail*, 11 June 2020.
- 41 Mahajan, G., 'In India, the pandemic is creating new borders', *OpenDemocracy*, 27 April 2020.
- 42 ILGA, 'LBTI Caucus statement in response to the Covid-19 pandemic', 6 April 2020; Munir, M., 'How Covid-19 is affecting LGBT communities', *Stonewall*, 21 April 2020.
- 43 Qureshi, Z., 'COVID-19: Pakistan Finance Ministry reveals 3 million jobs have been lost', *Gulf News*, 5 June 2020.
- 44 Frayer, L., '1 million Bangladeshi garment workers lose jobs amid COVID-19 economic fallout', *NPR*, 3 April 2020.
- 45 Francis, E., 'Lockdowns pile job losses and hunger onto Syrian refugees' plight', *Reuters*, 10 May 2020.
- 46 Allison, T. and Sanders, L., 'Coronavirus deepens risks for migrant workers in the Gulf', *DW*, 5 May 2020.
- 47 Kapilashrami, A. *et al.*, 'Neglect of low-income migrants in covid-19 response', *BMJ*, 29 May 2020.
- 48 UN, 'Indigenous peoples and ethnic minorities: marginalization is the norm', in *Promoting Inclusion through Social Protection: Report on the World Social Situation 2018*, 2018.
- 49 Burki, T., 'The indirect impact of Covid-19 on women', *The Lancet* 20(8), August 2020, pp.904-5.
- 50 Ghoshal, N., 'LGBT Africans share challenges of life during pandemic', *Human Rights Watch*, 19 May 2020.

- 51 World Bank, 'Food security and Covid-19', 7 August 2020.
- 52 Action Against Hunger, 'Ethiopia: 1 in 4 refugee children in Pagak are dangerously malnourished', 6 August 2020.
- 53 Thoompail, M., 'The contrasting experiences of Indigenous groups during Covid-19', MRG, 14 July 2020.
- 54 Kaplan, H. *et al.*, 'Voluntary collective isolation as a best response to COVID-19 for indigenous populations? A case study and protocol from the Bolivian Amazon', *The Lancet*, 395(10238), 2020, pp.1727-34.
- 55 Zurcher, A., 'Ebola, race and fear', BBC, 21 October 2014.
- 56 Yasir, S., 'India is scapegoating Muslims for the spread of the coronavirus', *Foreign Policy*, 22 April 2020.
- 57 Suleiman, O., 'Like India, Sri Lanka is using coronavirus to stigmatise Muslims', *Al Jazeera*, 20 May 2020.
- 58 USCIRF, 'USCIRF troubled with targeting of Hazara Shi'a in Pakistan amid coronavirus lockdown', 31 March 2020.
- 59 Ratcliffe, R. and Ahmed, R., 'Bangladesh urged to lift Rohingya internet ban as Covid-19 rumours swirl', *The Guardian*, 11 June 2020.
- 60 Swart, M., 'How the coronavirus has deepened human rights abuses in China', *Al Jazeera*, 12 March 2020.
- 61 Holmes, O., 'Israel to track mobile phones of suspected coronavirus cases', *The Guardian*, 17 March 2020.
- 62 Physicians for Human Rights, 'Ban on asylum seekers at the border is illegal and lacks basis in public health', 23 April 2020.
- 63 MRG, 'Kenyan communities report illegal evictions during COVID-19 – CLAN press release', 23 July 2020.
- 64 Holmes, O., 'What would Israel annexing the West Bank mean?', *The Guardian*, 9 June 2020.
- 65 <https://uk.reuters.com/article/uk-israel-palestinians-annexation/coronavirus-resurgence-sidelines-israels-annexation-planning-idUKKCN24G1QM>
- 66 Joseph, J. and O'Donovan, E., 'Defending rights during a pandemic: Impact of Covid-19 on the safety and work of human rights defenders', *Front Line Defenders*, 17 April 2020.
- 67 Butler-Jones, D. and Wong, T., 'Infectious disease, social determinants and the need for intersectoral action', *CCDR* 42 (Suppl 1), 2016.
- 68 InfoMigrants, 'Portugal to treat migrants as residents during coronavirus crisis', 30 March 2020.
- 69 Eades, S. at al., 'Australia's First Nations' response to the COVID-19 pandemic', *The Lancet* 396(10246), July 2020, pp.237-8.
- 70 Rahman, A.T. and Yeasmine, I., 'Refugee health workers lead COVID-19 battle in Bangladesh camps', UNHCR, 24 July 2020.



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Inequality and the impact of Covid-19:

How discrimination is shaping the experiences of minorities and indigenous peoples during the pandemic

The Covid-19 pandemic is, at root, a public health emergency, driven by its ready transmission and ability to cause severe illness and death. But while its ability to overwhelm the best of health systems has already been demonstrated, its far-reaching social, economic and political consequences are still unfolding.

Mounting evidence has shown that ethnic, racial and religious minorities and indigenous peoples are not only at greater risk of contracting the virus for a wide range of reasons, but also face higher rates of mortality once infected due to poorer health status and limited access to medical care. Moreover, the disproportionate impact of the virus on all these communities has extended to their livelihood, security and access to basic services including health care, education and food.

Covid-19 has therefore developed into a crisis of human rights as well as public health, exposing deep inequalities between different communities and the fragility of health and protection systems across the globe. This briefing explores the underlying issues that have shaped the experiences of minorities and indigenous peoples during the pandemic, as well as how these may have contributed to their greater vulnerability to the virus. It concludes by proposing a number of areas to be explored further and recommendations for all actors involved in the response to the pandemic.

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Minority Rights Group International (MRG) is a non-governmental organization (NGO) working to secure the rights of ethnic, religious and linguistic minorities worldwide, and to promote cooperation and understanding between communities. MRG has consultative status with the UN Economic and Social Council (ECOSOC), and observer status with the African Commission on Human and Peoples' Rights. MRG is registered as a charity, no. 282305, and a company limited by guarantee in the UK, no. 1544957.

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