

A black and white halftone photograph of a woman in a headscarf speaking into a microphone at a public gathering. She is the central focus, looking slightly to her right. In the background, several other women wearing headscarves are visible, some looking towards the camera and others looking away. The overall scene suggests a community meeting or a public event.

An Unequal Pandemic

Insights and Evidence from
Communities and Civil Society
Organisations

Thank you

The Civil Society Collaborative on Inclusive COVID-19 Data harnesses the potential of data generated by communities and civil society organisations (CSOs). The Collaborative aims to create a holistic understanding of how people who have been marginalised have been impacted by the COVID-19 pandemic, their responses and resilience.

The Collaborative results from many communities' and organisations' time and effort during an incredibly challenging period. We extend thanks to individuals, groups and communities who have generously contributed their perspectives and experiences to research that contributed to this report.

Over 20 CSOs are engaged with the Collaborative, representing and working with diverse groups, including ethnic minorities; Dalits; indigenous peoples; internally displaced people (IDPs); lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI); migrants; older people; persons with disabilities; refugees; religious minorities; street-connected children; undocumented people; women and girls; and young people.

The Collaborative developed a set of inclusive design principles to shape the production of the report: prioritising accessibility and useability, ensuring ethical image and content use and using inclusive language and icons. We are grateful to Impel Consultancy for leading the report development and Stephanie Schafrath for overseeing report design.

Sincere thanks to the Steering Group representatives for their leadership: ActionAid Denmark, Christian Aid, Development Initiatives, Global Partnership for Sustainable Development Data, International Civil Society Centre, Plan International, Restless Development and Sightsavers.

Members of our Collaborative:



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In a public hearing a young woman shares her worst experience in getting public and health related services during the COVID-19 pandemic and beyond.

Acronyms

We try not to use any acronyms, but the following have proved necessary to assist readers of this report:

CSO	Civil society organisation	PPE	Personal protective equipment
IDPs	Internally displaced people	SDGs	Sustainable Development Goals
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex	UK	United Kingdom
NSO	National statistical office	UN	United Nations
		USA	United States of America

Key terms

Community and civil society organisation data – data generated by communities and civil society organisations, including but not limited to: programmatic data; mixed methods research; human stories; quotes; and case studies.

COVID-19 – the disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). This report looks at both the direct health effects and indirect social and economic effects of COVID-19 and the policies put in place to curtail its spread.

Inclusive data systems – data systems that count everyone equally (especially people who have been marginalised) and does so with people's knowledge, consent and active participation. Systems built on ethical collection and use of data, ensuring personal data is not abused, misused or puts anyone at risk of identification or discrimination.

Inequality – the state of not being equal, especially in status, rights and opportunities. Inequalities are not only driven and measured by income but are determined by other factors, including age, disability, gender, race, religion and sexual orientation.


Intersectionality – the complex, cumulative way the effects of different forms of discrimination combine, overlap or intersect and are amplified when put together. It refers to the interconnected nature of social categories, including but not limited to, age, disability, gender, ethnicity, migratory or displacement status, religion and race.

Official data – data generated and/ or validated by National Statistical Offices (NSOs).

Marginalised – individuals, households and communities who are systematically discriminated against based on their descent or occupation, or marginalised due to income, gender, disability, sexual orientation, race, ethnicity, origin, religion or economic or other status (see [Box 1](#) for more information).

Non-official data – data produced by non-governmental bodies.

Resilience – the ability of individuals, households and communities to prevent, absorb and recover from crises, while continuing to function and adapt in a way that supports long-term prospects for sustainable development, peace and security and the attainment of human rights.



The COVID-19 pandemic has brought unimaginable devastation and disruption to our lives, societies and economies.

Photo: © Plan International
Plan International's emergency response team in Brazil is delivering food and hygiene kits to people living in rural communities in Piauí.

Foreword

In their own words, four community advocates share their reflections on the impacts of the pandemic, the responses of their communities and their ambitions for this report.

Daniel Calarco,
24 year old lawyer,
originally from Vila
do Vintém Favela
in Rio de Janeiro,
Brazil.



When COVID-19 arrived in Rio de Janeiro, young people from our favelas and communities who have been marginalised were some of the first to respond. We are not data scientists or specialists, but that didn't matter. We knew that by engaging with community members, listening to their stories and experiences, mapping their needs and shortages and tracking the increase of cases, we could help to deliver a better and more effective response to the pandemic.

To sustainably rebuild, we need to first understand how this pandemic has impacted our communities and their priorities for the future. We can only know this if we have the right data. Data that is intersectional, that values and validates local knowledge. Data that is collected and monitored with communities safely, as well as data that protects communities from its misuse. We need strengthened partnerships with National Data Authorities that are rooted in trust and accountability. Decisions to design strengthened and more inclusive data collection mechanisms and social policies need communities at the centre, to inform rebuilding and recovery efforts.

In many ways COVID-19 spotlighted the best and worst of our societies - it has shown the deep inequalities and marginalisation that exists, but it also demonstrated the resilience and leadership of communities. More governments must not just acknowledge the role we have played but need to invest, learn and partner with us to rebuild a fairer and better world for all. This report provides important recommendations that, if implemented, will help place communities at the centre of pandemic response and recovery.

“We must challenge the limitations of data generated and/ or validated by National Statistical Offices if we want data that truly represents the experience of all of society.”

Vappu Taipale,
81 year old female
campaigner for older
people's rights, from
Helsinki, Finland.



Governments have tried their best to find solutions to COVID-19 that protect and support their citizens - and their economies. COVID-19 has, however, challenged everyone. Here in the Nordic countries, older people mostly live alone, enclosed in small apartments, with no visitors. UN organisations have started talking about the 'shadow pandemic', the increase in domestic violence. There is another even darker shadow that is not being addressed: older people being starved of human contact. This is where civil society organisations have an important role to play. Civil society organisations have captured the experiences of older people to help guide the pandemic response and recovery.

Why is it important that civil society organisations collect such data? Because older people are not asked in statistical surveys. Our voices are not heard. Official statistics usually do not offer age-disaggregated data. Opinion polls do not include people aged 70 or 75, let alone 90 year old men or women.

My organisation, Valli, approached Statistics Finland and demanded that they deliver age-disaggregated data up to 100 years old. The answer was: it is costly, and the European Union regulations do not demand it! I hope that this report demonstrates the value and importance of disaggregated data and the value community and civil society organisation data can add to data currently generated and/ or validated by National Statistical Offices. We must challenge the limitations of data generated and/ or validated by National Statistical Offices if we want data that truly represents the experience of all of society.

“This report presents a wake-up call for all stakeholders to address gaps and barriers [...] to create evidence-based programmes and policies.”

Sulayman AbdulMumuni Ujah, 44 year old male and deaf disability rights advocate and National Project Officer at African Disability Forum, from Abuja, Nigeria.



The COVID-19 pandemic has seriously affected persons with disabilities, exacerbating the marginalisation already experienced by many of them. In Nigeria, persons with disabilities have not had access to medication, personal protective equipment, COVID-19 information, and relief materials or palliatives. This is because those in charge failed to involve persons with disabilities and their representative organisations in all levels of pandemic response decision making. The omission of persons with disabilities from many aspects of the pandemic response is a significant setback, considering the principle ‘leave no one behind’ can only be achieved through greater focus and coordinated action toward an inclusive 2030 Agenda.

In Nigeria, persons with disabilities encountered various barriers during the onset of the pandemic. Persons with disabilities faced barriers in accessing healthcare settings, including hospitals, for medical needs. Persons with disabilities also lacked access to food and hygiene products, due to lockdown measures. The livelihoods of persons with disabilities who were self-employed and working in informal employment were particularly affected by the pandemic.

This report highlights the challenges created by not having official data in a crisis focused on persons with disabilities and official data not identifying and addressing the vital gaps and barriers faced by persons with disabilities. As a result, this report presents a wake-up call for all stakeholders to address gaps and barriers and reiterates the importance for governments to use disability disaggregated data to create evidence-based programmes and policies. With hope, all stakeholders will fully implement the report’s recommendations to ensure the full inclusion of persons with disabilities in all COVID-19 interventions.

“I am hopeful that this report will lead to stakeholders undertaking more inclusive COVID-19 responses and recoveries, guided by the recommendations in this report.”

Mati Soren, 26 year old female Youth Champion at the Youth-led Digital Engagement Project. Member of the Santal indigenous community, Gonoker Daing (Godagri, Rajshahi), North-Western Bangladesh.



The COVID-19 pandemic has deeply affected the poor and people who have been socio-economically marginalised. The pandemic has caused unorganized workers, especially the underprivileged, to lose their jobs and incomes. As a result, many have migrated back to their communities and families following a complete lack of support from the Government.

It is young people that households have relied upon during this pandemic, to earn an income for the household and to care for older members of the household who are more vulnerable to COVID-19. This means that young people from poorer households losing their jobs has had a broader and deeper impact than is frequently recognised; the COVID-19 pandemic has hit hardest poor-working class families and households who have been marginalised.

This report demonstrates that COVID-19 has had an unequal impact. This report also shows that data generated and/or validated by National Statistical Offices overlooks many negative impacts of the COVID-19 pandemic on people who have been marginalised here in Bangladesh. The absence of people who have been marginalised from official data frequently excludes groups and people in my community from the national COVID-19 response. Non-official data collected by communities and civil society organisations, can increase the visibility of people who have been marginalised who are overlooked by official data and improve understanding of their coping strategies. I am hopeful that this report will lead to stakeholders undertaking more inclusive COVID-19 responses and recoveries, guided by the recommendations in this report.

Photo: © Sightsavers/Ahmed Jallanzo
Field trip for Elder Health Promotions
at Cooper farm community, Ganta,
Nimba County, Liberia.

The pandemic has built upon structural inequalities of our societies, disproportionately impacting people who have been marginalised.



Executive summary

People who have been marginalised have made critical contributions to the COVID-19 pandemic response: providing practical support to families, friends and peers (including food parcels); providing mutual financial aid; and translating or sharing official information. People who have been marginalised have demonstrated extraordinary resilience, adapting to the pandemic's effects, including finding alternative sources of income.

In contrast to communities' efforts, official government responses to COVID-19 have often overlooked or excluded people who have been marginalised. The pandemic has exposed considerable gaps and bias in official data published and used by government agencies and public bodies. These data gaps render many people and groups 'invisible', in turn excluding them from national responses. The pandemic has built upon structural inequalities of our societies, disproportionately impacting people who have been marginalised.

Effective COVID-19 pandemic responses and recoveries require a comprehensive understanding of both the impact of COVID-19 on people who have been marginalised and the strategies used by communities to adapt to and manage these impacts. Data collected by communities and civil society organisations (CSOs) can increase the visibility of people and groups overlooked by official data, improving understanding of their situations and coping strategies.

To understand the unequal effects of the COVID-19 pandemic and chart the pathway to an inclusive recovery, a group of CSOs formed the Civil Society Collaborative on Inclusive COVID-19 Data. Working alongside communities, the Collaborative advocates for a more holistic approach that values using community and CSO data to help meet the diverse needs of people and groups who have been marginalised. This report uses insights from community and CSO data collected by Collaborative partners, often in close cooperation with communities, to provide a clearer picture of the impact of the COVID-19 pandemic on people who have been marginalised and their responses. This report highlights five common issues and impacts for people who have been marginalised: access to health; income and livelihoods; food insecurity; education; and violence, abuse and discrimination.

This report is not intended to provide a comprehensive picture of the realities experienced during the pandemic by people who have been marginalised or overly critique government responses to COVID-19. Instead, the focus is on using insights from communities and CSO data to motivate more inclusive COVID-19 pandemic responses and recoveries and demonstrate the value of this data.

Insights in this report highlight that official data provide an inadequate picture of communities experiencing marginalisation in this pandemic. The insights also indicate the enormous challenges that people who have been marginalised have had to respond to, often without adequate support from governments.

Government responses to COVID-19 must complement and strengthen the efforts of communities experiencing marginalisation to prevent further widening of inequalities and reversal of progress on the Sustainable Development Goals (SDGs).

To help prevent inequalities from deepening further through more inclusive data systems, the Civil Society Collaborative on Inclusive COVID-19 Data calls for:

Use of data from communities and CSOs to inform plans and monitor COVID-19 response and recovery.



Urgent disaggregation of COVID-19 data to identify, address and report inequities and prioritise advancing the inclusivity of official data systems.



Strengthened partnerships and coordination mechanisms between governments, communities and CSOs to increase the use of community and CSO data.



Accelerate investment into the production of community and CSO data and development of more inclusive official data systems.



People who have been left behind to be prioritised in COVID-19 responses and long-term recovery planning, implementation and budgeting.



Inclusive and participatory decision-making processes on COVID-19 response and recovery and longer-term policies and programmes.



The effects of crises are never evenly felt; the effects of COVID-19 are no exception.



Photo: © Plan International
In Bolivia, Plan International responds to the COVID-19 crisis by delivering food and hygiene kits to 800 families in Tarija.

1. Introduction

The COVID-19 pandemic has brought unimaginable devastation and disruption to our lives, societies and economies. What started as a health crisis also rapidly escalated to become a social and economic crisis; for some communities compounding other shocks including floods, locust swarms and low yield harvests. Measures to stem the spread of the virus have kept people at home, limiting livelihoods and education and creating or exacerbating threats to wellbeing and safety. Pandemic responses have also seen communities work together and individuals or households adapt to changes imposed upon them.

Inequality is the defining challenge of our era

The effects of crises are never evenly felt; the effects of COVID-19 are no exception. As this report highlights, those most at risk of marginalisation or discrimination have been disproportionately affected by the pandemic and official responses. The pandemic has layered upon and deepened long-standing structural inequalities (including inadequate and inequitable access to health care, housing and sanitation) to catastrophic effect. The pandemic has highlighted and amplified the pervasive inequalities that prompted the 2030 Agenda for Sustainable Development and the commitment to 'leave no one behind'.

Globally, government responses to the pandemic have been diverse and rapidly evolving. Some governments have strived to deliver inclusive responses or have listened to calls from advocates and adjusted harmful practices. At times, government responses have discriminated against specific communities, disproportionately exposing people who have been marginalised to COVID-19 or opportunistically enacted oppressive policies that may outlast the pandemic. As a result, COVID-19 has derailed progress towards the SDGs; progress that was already not enough to meet the targets¹. Further responses to the pandemic, vaccine distribution and recovery from this crisis require governments to put the promise to 'leave no one behind' into practice. Emerging evidence suggests that vaccine distribution is also inequitable, overlooking or presenting barriers for people who have been marginalised.

Resilient communities and responsive civil society

People who have been marginalised or at risk of marginalisation have demonstrated extraordinary resilience during the COVID-19 pandemic, from diversifying sources of income and increasing entrepreneurship to supporting each other financially and through practical initiatives, such as food distribution. People who have been marginalised have been agents of change during the crisis, addressing challenges and driving solutions that meet their own and their communities' needs.

Civil society organisations (CSOs) have played a critical part in driving more inclusive COVID-19 responses: filling gaps overlooked by governments and businesses, such as providing essential services and safety nets; defending human rights; enabling political participation; and challenging misinformation². In providing support throughout the pandemic, CSOs have needed to evolve modes of delivery (e.g. to online working) or shift their focus (e.g. from long-term development projects to emergency relief). Local CSOs have also stepped into the space vacated by larger international non-governmental organisations that evacuated staff at the start of the pandemic.

What do we mean by 'marginalised'?

By 'marginalised' we refer to communities who are systematically discriminated against based on descent or occupation; or marginalised due to income, age, gender, disability, sexual orientation, race, ethnicity, origin, religion or economic or other status within a country or context.

Marginalisation manifests through intersectional and compounding attitudinal, environmental and institutional barriers. Marginalisation is not presupposed or fixed, rather it is a fluid concept, differing over time and geographies in ways that intersect and reinforce each other.

We recognise there is no perfect term to refer to the diverse and varied population groups who face systemic discrimination, oppression and marginalisation globally. Language is loaded, reductionist and too often reinforces unbalanced and unjust power hierarchies. We strive for the language of this report to be progressive, considered, inclusive and locally led, reflecting the overall aims and ethos of the Collaborative. The use of 'marginalised' was subject to much discussion and debate by Collaborative members. It was deemed necessary to have a broad term that recognises structural inequalities that gave rise to the stark inequity and disproportionate effects of the COVID-19 pandemic, while appreciating that affected population groups vary across countries and contexts.

In this report, we use the language of 'people who have been marginalised' to recognise that being marginalised is not an inherent trait, rather a past and ongoing condition imposed by societies and economies. Where appropriate, we have named specific population groups, their responses and the impacts they felt during the pandemic.

1

Official data is masking inequalities

Data has been at the forefront of the fight against COVID-19. Governments have used data to track how the virus is spreading, inform what response is needed and gauge whether policies are working. Yet many people who have been marginalised are absent or 'invisible' in the official data used to inform government decision-making.

The invisibility of people who have been marginalised in official data predates the pandemic. People who have been marginalised have been inadvertently or purposefully excluded from official data for diverse, complex and varied reasons - ranging from weak civil registration systems to exclusionary survey methodologies and language to individuals' fears of becoming more visible to officials.

Inequities and disparities are further hidden and obscured when data is not disaggregated to reveal the situations and needs of different population groups. Only with age disaggregated

COVID-19 data has it been possible to identify that the risk of severe disease rises with age, information which has driven government responses. COVID-19 data disaggregated by race and ethnicity has also revealed concerning trends of people from racial and ethnic minority groups facing disproportionate adverse impacts in Australia, Brazil, Norway, the United Kingdom (UK) and the United States of America (USA)³.

Many national statistical offices (NSO) have renewed focus on generating disaggregated data, alongside pioneering new and remote ways of generating data. Yet, globally, we lack disaggregated data on COVID-19 cases, fatalities and the social and economic impacts of the pandemic by important factors, including but not limited to: caste and race, disability, gender, geography, migratory status and economic status. In April 2021, only 51% of 196 countries (accounting for 99.9% of all COVID-19 confirmed cases and reported deaths globally) published any COVID-19 data disaggregated by sex⁴.

Civil society and communities' data is key to increasing inclusivity

CSOs have collected qualitative and quantitative data with communities, using the data to demand or drive positive change. This 'non-official data' is data collected by communities and/or CSOs, including but not limited to programmatic data, mixed methods research, human stories, quotes and case studies. There is enormous potential for this data to complement and enhance official data: addressing data gaps; capturing deviations from national averages; and better depicting the full impact of COVID-19 on people who have been marginalised to strengthen the response to and recovery from the pandemic.

To harness the potential of community and CSO data, the Civil Society Collaborative on Inclusive COVID-19 Data shares and integrates data-driven insights to create a more holistic understanding of the impacts of the pandemic. The Collaborative works with communities and activists to understand the unequal effects of the COVID-19 pandemic and advocate for an inclusive recovery.

The Collaborative recognises the need for localised solutions and community participation to ensure inclusive recoveries and hope this report leads to dialogue and prioritisation on inclusive data and equitable policies.

This report is intended to:

Share insights generated by community and CSO data to highlight the effects of COVID-19 on people who have been marginalised or are at risk of marginalisation and the impact of associated policies and programmes.

Use insights from community and CSO data and the experiences of the people most impacted by COVID-19 to motivate more inclusive COVID-19 responses and recoveries.

Demonstrate the value of data generated by communities and CSOs, so that it is more routinely used to complement official, government-collected data.

It is not intended to:

Provide a comprehensive picture of the impact of the pandemic on people who have been marginalised or critique responses to COVID-19.

The pandemic has exposed considerable gaps and bias in official data that renders many people and groups 'invisible'. Community and CSO data can address this.

Photo: © ActionAid
"We will rebuild it" Campaign
for cleaning the rubble in Gaza
(Palestine).

2. Report methodology

The evidence presented in this report is taken from community and CSO data captured in March and April 2021 using two strands of data collection:

- An **online survey** was sent to all Collaborative partners to identify studies they had undertaken or supported. Questions focused on the objectives, focus and partners of any studies; the methodology used; high-level insights; and key findings by theme. Forty-one responses were received, sharing 38 studies (see [Annex 1](#) for a list of studies, including the timeframes and methodologies).
- A **desk review** of 60 resources containing relevant community and CSO data, including published reports, case studies and blogs (See [Annex 2](#) for the list of resources).

The 38 studies provide data and insights from 91 countries across Africa, the Americas, Asia, the Caribbean, Europe and Oceania. In total, 34 of the 91 countries (37%) that were the focus of one or more of the studies are African countries. 24% of the 81 countries are countries in Asia (n.22), and 18% are Latin American and Caribbean countries (n.16).

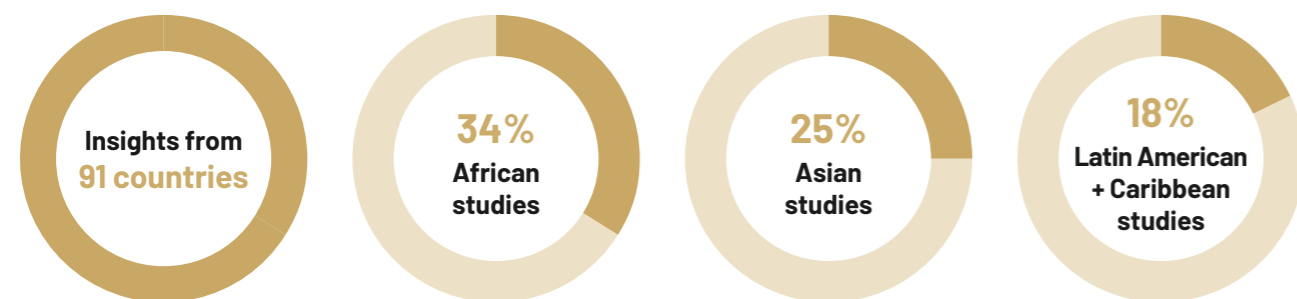
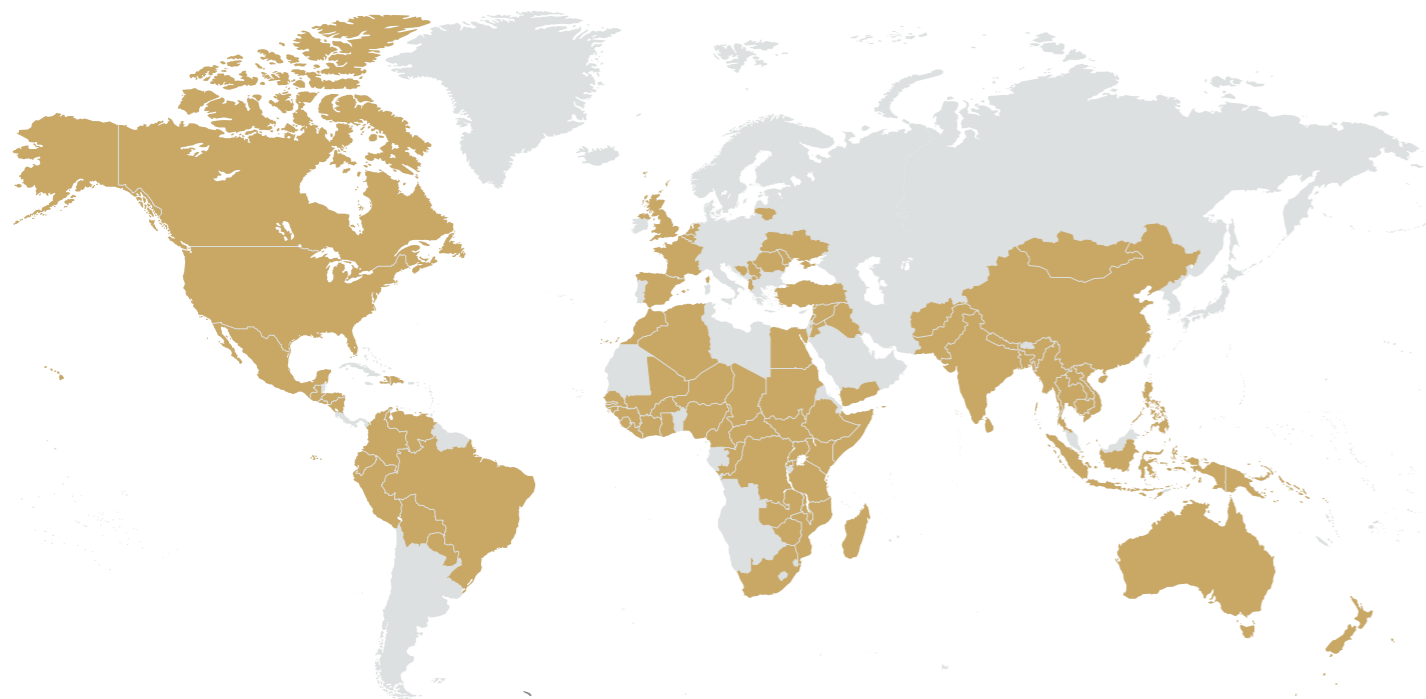
Data regarding 12 countries were collected by five or more studies: Kenya (n.16), Bangladesh (n.13), Uganda (n.12), Nigeria (n.10), Nepal (n.9), India (n.7), Brazil (n.6), Zimbabwe (n.6), The Democratic Republic of Congo (n.5), Ethiopia (n.5), Pakistan (n.5), Sierra Leone (n.5), Somalia (n.5), and Tanzania (n.5).

The analysis presented in this report draws on data and insights from all 91 countries.

The 38 studies provide data and insights regarding a wide range of people who have been marginalised (see [Box 1](#) for a definition of 'marginalised'). While the 38 studies recognise the impact of intersectionality, they primarily focus on specific people and groups, including: ethnic minorities; Dalits; indigenous peoples; internally displaced people (IDPs); lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI); migrants; older people; persons with disabilities; refugees; religious minorities; street-connected children; undocumented people; women and girls; and young people.

Data was collected by the studies between January 2020 and March 2021, often using innovative methodologies to collect data remotely because of the pandemic; some studies used in this report remain ongoing at the time of analysis (See [Annex 1](#) for the status of studies).

■ Study countries



Limitations

The time available for secondary data collection limited the contributions to this report. While the existing evidence demonstrates the richness of community and CSO data, it is outside the scope of this report to compare diverging results or gather additional data to triangulate findings. The analysis is subject to the respondents' knowledge and the quality of the original studies and analysis. Most of the studies are not representative, although the insights provide a body of evidence from which key themes can be inferred.

The impact of COVID-19 is also ongoing at the time of publication, meaning that insights and evidence drawn from the data collected provide only a limited snapshot of the impact of the pandemic. Longer-term impacts of COVID-19 might only become apparent in the months and potentially years to come.

COVID-19 is not impacting communities in isolation. For some communities, COVID-19 is aggravating and/ or being compounded by other shocks (e.g. conflict). It is not possible to identify issues that are the result only of COVID-19, other drivers are highly likely to contribute to the issues highlighted in this report.

“[COVID-19] has affected me very badly, I am an IDP and we don't have healthcare or finance to access healthcare services, we also don't have local administration that looks out for us.”

— Man, 19, Internally Displaced Person (IDP).

Taken from Africa's Voices SMS survey on COVID-19 in Somalia.



Photo: © ActionAid

A youth champion in Kenya collecting data and evidence from her peer on the effects of the pandemic.

3. Benefits of harnessing community and CSO data

The COVID-19 pandemic has tested our ability to harness data to address a global crisis. The interest in and scrutiny of COVID-19 data has been very high from individuals to organisations and governments. Official data has proved, and remains, critical. Still, the pandemic has emphasised the added value of community and CSO data to complement and address official data gaps and biases, especially in relation to people who have been marginalised. Community and CSO data is a form of non-official data, meaning it is produced by non-governmental entities.

Communities, CSOs and individuals collect data to monitor, demand or drive change on issues that affect them. Community and CSO data can often be more current; it can spotlight, describe and help address otherwise unnoticed problems in existing data collection, including producing data that may otherwise be ignored or overlooked. Importantly, dealing with community and CSO data usually involves much more than just 'producing' data. These efforts can open new relationships between individuals, civil society and public institutions, with communities and CSOs seizing new pathways to unite, advocate and inform decision-making.

Community and CSO data efforts often rely on more participatory human-rights based approaches that can better engage with and capture current experiences of people and communities who have been marginalised. This is a distinct value of community and CSO data as these communities are usually considered 'hard-to-reach' by official data producers; individuals may also avoid official data collection processes because of fear, lack of trust and disinformation (e.g. migrant populations who may avoid testing and medical treatment for COVID-19 because they fear it could lead to deportation). Community and CSO data can also help present the realities of transient populations (such as people experiencing homelessness) and people living in institutions who often lack access to COVID-19 testing and/ or unconnected communities overlooked by digital contact tracing platforms.

Methods used to collect community and CSO data vary widely, including questionnaire surveys; incident reporting; community mapping; desk research; workshops; PhotoVoice™; and interviews. The 37 studies used in this report used various methodologies, including: desk reviews; key informant interviews; surveys; focus group discussions; 'Community Score Cards'; SMS data collection; and Most Significant Change. Most studies reported using remote or online data collection due to COVID-19 restrictions.

While the methodologies used vary, there are common principles and best practices to guide the generation and use of community and CSO data, including (but not limited to):

1. Dynamic accountability to ensure inclusive, participatory and continuous engagement with stakeholders.
2. Protecting people's rights, ensuring personal data is not misused or puts anyone at risk of identification or discrimination.
3. Defining what data quality means in specific instances so that data is fit for its intended purpose.
4. Consistency with guidelines and national codes of practice for producing statistics or the United Nations (UN) fundamental principles where possible.

The limitations of community and CSO data also vary widely, depending upon the methods used. Overall, most community and CSO data is not statistically representative. However, community and CSO data provides indicative insights, impacts and experiences of specific groups, which can be triangulated to uncover common findings and overall trends. The resulting conclusions drawn from community and CSO data can help to create better targeted COVID-19 responses and recoveries.

“Non-official data collected by communities and CSOs can increase the visibility of people who have been marginalised, who are overlooked by official data and improve understanding of their coping strategies.”

— Mati Soren, 26 year old female Youth Champion at the Youth-led Digital Engagement Project, North-Western Bangladesh.

4. Key COVID-19 impacts, responses and challenges for people who have been marginalised

Community and CSO data shared from across the Collaborative shows that people who have been marginalised have been greatly affected by the health, social and economic impacts of the COVID-19 pandemic. In many cases, the impacts on people who have been marginalised, resulting either directly from the disease or policy responses to the pandemic, have been disproportionate. The data also demonstrates that people who have been marginalised have spearheaded responses to the COVID-19 pandemic: providing food parcels; translating and sharing official information; and providing broader support networks.

People who have been marginalised are experiencing unequal direct health risks.

Many national statistical systems, especially in low-income countries, have not routinely disaggregated COVID-19 cases and fatalities (including sex, age, disability, ethnicity, migratory status and other key characteristics), making it impossible to understand the global impact on the health of these groups. The countries that have provided disaggregated COVID-19 data on morbidity and mortality impacts have stark disparities by age, income, race and ethnicity⁵. These inequities largely replicate existing inequalities in mortality rates, highlighting their structural nature and bringing social and racial injustice to the forefront of public health. Community and CSO data also indicates unequal COVID-19 morbidity and mortality among people who have been marginalised:

- The Consortium for Street Children reports that many street-connected children have underlying health conditions that may predispose them to severe COVID-19. A lack of access to health and hygiene services for prevention and treatment can increase this risk⁶.
- The Internal Displacement Monitoring Centre found a higher proportion of IDPs and their families surveyed in Yemen had experienced COVID-19 symptoms than non-displaced people⁷.
- People living in institutions are at greater health risk from COVID-19 (see [Box 2](#)).

Increased health risks for people living in institutions

Children in residential schools or homes, older people living in care homes, persons with disabilities in residential institutions, people experiencing homelessness but in shelters, as well as persons in prisons and detention centres are often living in conditions that exacerbate health risks.

In some settings, physical distancing and self-isolation measures are unfeasible, because of large numbers of people living near to each other, unsanitary conditions or a reliance upon carers or officials to prevent and respond to COVID-19 outbreaks. Data provided by the Institute for Global Homelessness recognised that ten shelters in India for people experiencing homelessness had required extra care services after a study by Azim Premji Philanthropic Initiatives found a higher number of older shelter residents.

People living in institutions have often been overlooked or actively put at risk by COVID-19 responses. The Disability Rights Monitor reported receiving a high number of testimonies from around the world highlighting insufficient or no steps being taken to minimise infections and deaths in institutions. In the UK, limited availability of Personal Protective Equipment (PPE) has been reported by residential institutions. Many cases have also been reported of residents returned from hospitals without being tested and later found to have COVID-19 and to have spread COVID-19 to other residents. A staff member from a Moldovan institution reported having to buy their own PPE, without reimbursement from either the institution or the Government.

Based on data from The Disability Rights Monitor and provided by the Institute for Global Homelessness.

2

Photo: © Plan International
Plan International is distributing educational and play kits in the Dominican Republic to sponsored children currently out of school due to the COVID-19 crisis.

4.1. Embedding unequal access to health services

Existing inequalities and discrimination are negatively impacting access to medical treatment for COVID-19 for people who have been marginalised.

While the pandemic forced tough choices because of limited resources, health systems appear to be failing people who have already been marginalised. The Disability Rights Monitor collected testimonies from nine countries reporting triage procedures that exclude persons with disabilities from critical care in the event of a shortage of intensive care unit beds⁸. In the UK, older people and persons with disabilities have also had blanket 'Do Not Attempt Resuscitation Notices' placed on them and refused hospital admission⁹.

Health information regarding COVID-19 has not been readily available to groups who have been marginalised or who are at risk of marginalisation.

Official information has rarely been shared through networks or channels that reach street-connected children, rural and remote settings, persons with disabilities, indigenous peoples, refugees and persons in institutions. The Consortium for Street Children also found that official information was often not child-friendly¹⁰, and that the inaccessibility of official information facilitated the spread of misinformation and rumours among street-connected children. REACH found that in Borno State in Nigeria, radios (often the only means of communication that transcends local boundaries) are prohibited in some IDP sites; individuals reported secretly listening to radios and distributing the information among the community through hand-written letters and notes¹¹. Persons with disabilities widely reported that official information regarding COVID-19 was inaccessible¹². The World Blind Union found the inaccessibility of official information raised fear and anxiety among persons with disabilities¹³.

"I live with my brother and my parents, who have chosen not to talk about such topics as sexual health because they are very traditional. I fear that if the coronavirus does not go away soon, many girls who grow up in families like mine will not be able to have access to useful information we get in school girls' clubs."

– Lucilene (16 years old, Mozambique).

Taken from Plan International, Halting Lives: The Impact of COVID-19 on girls and young women (2020).

"When we get ill and have no money for treatment, we will have to sell some of the rations we receive. There are so many diseases, and so many people are getting ill in the camp at the moment, we don't have any money for treatment, and we couldn't see any doctors. So we have difficulty getting any treatment."

– Male Rohingya refugee (Ukhiya Refugee Camp Cox's Bazar, Bangladesh).

Taken from the Inter Sector Coordination Group (ISCG) (Cox's Bazar, 2021) Joint Multi-Sector Needs Assessment (J-MSNA), Rohingya Refugees, Cox's Bazar, Bangladesh, May 2021.

People who have been marginalised face worsening access to routine medical care due to the burden of COVID-19 on health systems and the diversion of resources for the pandemic response.

World Vision has shown remote, rural communities in Uganda have less access to maternal and child health services because of COVID-19; as a result, the number of babies delivered by skilled health workers has fallen, putting the lives of mothers and newborns at risk¹⁴. Persons with psychosocial disabilities have lacked access to medication and counselling, routine immunisations (e.g. for measles) have been disrupted among IDPs and rural communities and women and girls have faced barriers in accessing menstrual products^{15,16,17}. Restless Development reported that young people in India accessing counselling or psychiatric services before the pandemic, lost access to services because of lockdown¹⁸.

The challenges experienced by people who have been marginalised in accessing routine medical care have been compounded by the cost of medical care at a time of financial insecurity (see section 4.2. for more information).

Among refugees in Ukraine and Iraq, REACH found that households had reduced essential healthcare spending to cope with a lack of money to buy food^{23,24}. World Vision reports that the increased cost of transport has prompted a rise in the unskilled delivery of babies in remote communities in Uganda²⁵. The Stakeholder Group of Persons with Disabilities reports that the cost of medicines has also proved prohibitive for persons with disabilities²⁶. The World Blind Union reports that PPE and/ or the absence of sign language interpreters or carers when accessing healthcare has negatively impacted communication and access to information for persons with disabilities²⁷.

Between February and June 2020, antenatal care visits by women to one clinic in Uganda fell by 60%; deliveries in another clinic reduced by 40%¹⁹.



62% of IDPs surveyed in Yemen said their treatment for other chronic conditions had deteriorated because of COVID-19, compared with 46% of non-displaced people²⁰.




In one global survey of persons with disabilities, 30% (641) of respondents said they did not have access to medication during the pandemic²¹.



Nine in 10 (89%) of more than 20,000 respondents to a global survey reported that their access to healthcare, medicine, and medical supplies had been negatively impacted due to the COVID-19 pandemic²².





“When they use megaphones to convey the information, [people with hearing impairments] won’t understand it. People who have language barriers have to find someone to translate for them.”

— Older female refugees (West Nile region, Uganda).

Taken from U-Learn Consortium, Uganda COVID-19 Risk Communication and Community Engagement Assessment (2020).

Photo: © ActionAid / Appiya Marandi

A young woman is announcing public services among the community people in a market place in Rajshahi, Bangladesh.

4.2. Worsening precarious economic situations

Plummeting economic activity because of the pandemic has highlighted the income insecurity of groups who have been marginalised, exposing people to falling incomes and loss of livelihoods.

In Kenya, businesses surveyed reported closing unexpectedly during COVID-19, nearly two-thirds closed several times, and 21% of businesses had shut down completely²⁸. Low-paid workers, persons with disabilities, street-connected children, women, ethnic minorities, the self-employed, migrant workers, informal and fixed-term workers are among those whose livelihoods have been hit hardest by the pandemic. Estimates show that informal workers globally lost 60% of their income in the first month of the pandemic; in Africa and Latin America, informal workers lost 81% of their income in the first month of the pandemic²⁹. Some families are also receiving less in remittances from those working abroad³⁰.

Restless Development has highlighted the impact of COVID-19 on people's livelihoods in Rio's favelas, where people depend on informal work and have little access to government support, unionisation, or labour protection; for many people living in favelas, quarantine and lockdown was unaffordable³⁴.

Zimbabwe's large informal economy has also been impacted, resulting in the loss of income and livelihoods for many women, who account for 70% of Zimbabwe's informal workers. Christian Aid and its partner, the Women's Academy for Leadership and Political Excellence reported that the Zimbabwe Government's requirement for people travelling to possess an 'employment letter' alienated women from the production chain; for example, women who are farming could not transport their products for sale³⁵.

Save the Children found that persons with disabilities are more likely to lose their source of income than persons without disabilities³⁶.

80% of families living in favelas reported losing much or all their income during the pandemic³¹.



14% of IDPs surveyed in Yemen had been forced to leave their homes because of financial difficulties resulting from COVID-19; twice the figure for non-displaced people³².



Poorer households are more likely to suffer income losses than those not classified as 'poor'³³.



Islamic Relief reported that many refugees in Turkey are losing their jobs and income, pushing them into accepting jobs other people refuse to do because of potential exposure to COVID-19³⁷. Similarly, REACH found that 96% of displaced and non-displaced vulnerable households in Afghanistan faced a considerable decrease or total loss of income due to the pandemic³⁸.

Environmental migrants and refugees on the move in the Sahel commonly reported a rise in expenditures and reduced income as direct impacts of COVID-19, in turn limiting their ability to send and receive remittances. The impact was two-fold; increasing use of erosive coping strategies, in turn degrading resilience to future shocks and limiting the ability to migrate as a coping strategy in the future. At the same time, the closure of borders had a more immediate impact on communities that traditionally engage in cross-border seasonal migration patterns³⁹.

People who have been marginalised, who generally spend a greater proportion (if not all) of their incomes on essentials, have found it necessary to adopt short-term coping strategies.

Food insecurity (see section 4.3. for more information) and eviction have been frequent outcomes of income insecurity experienced by people who have been marginalised. Migrants and refugees interviewed in Libya commonly reported renting their current accommodation without the security of tenure or relying on other forms of precarious occupancy, such as living in the work environment⁴⁰.

Among many groups who have been marginalised, a key strategy has also been borrowing from friends and family. The Bandhu Social Welfare Society found that most people among the transgender and Hijra community in Bangladesh had needed to borrow money to respond to the pandemic's impact⁴¹. VSO also found that the primary coping strategy in several countries was borrowing money from family, friends and neighbours; many respondents said their strategy could not last more than three months⁴².

In Cox's Bazar (Bangladesh), local vendors reported to REACH a noticeable increase in customers requesting to purchase items on loan or credit⁴³. Africa's Voices found that the pandemic has affected existing resilience and self-help community structures, such as table-banking groups and informal cooperatives based on community solidarity (known as *chamas*)⁴⁴.

"For those of us who depend on lip reading, it's exhausting. We spent so much time reading the room, by the time we have grasped the conversation, we are exhausted. There are so many calls I must attend...No one turns on the video. When they talk fast, I totally lose track of the conversation. At the end when they say, "we decided this", - I just agree. Later I call a colleague to find out what I actually signed up for."

— A woman who is hard of hearing (35 years old, Mumbai, Maharashtra, India).

Taken from Rising Flame and Sightsavers, *Neglected and Forgotten: Women with disabilities during the COVID crisis in India* (2020).

"The government social protection programme, Ehsaas, is distributing and tracking relief based on information related to national identity cards. This excludes unregistered refugees of Afghan origin in cities like Islamabad and Peshawar and stateless communities such as Bengali communities and Rohingya in Karachi. It also excludes children living on the streets who have lost their livelihoods."

— Consortium for Street Children Network Member, Cities for Children in Pakistan, April 2020.

Taken from Consortium for Street Children and network members. Submission to the International Development Committee inquiry into Humanitarian crises monitoring: impact of coronavirus (2020).

While some people have benefitted from remote working, a 'digital divide' has grown, disproportionately affecting people who have been marginalised (see Box 3).

Many poorer households lack good internet access, reliable electricity or the technology required (e.g. computers or mobile phones). Online platforms are frequently not accessible to persons with some impairments; for example, document sharing systems, apps and presentations are often unusable for people with sight impairments.

People who have been marginalised have not received equal access to social protection.

Countries responded to the precarious economic situations faced by some households through social protection measures, but many people already marginalised were excluded from government support or unable to access social protection schemes. Street-connected children have been unable to access social protection schemes for lack of birth registration or identity documents⁴⁵. Christian Aid reported that informal and migrant workers have particularly struggled to access social protection⁴⁶. Sightsavers found that women with disabilities in India were ineligible for benefits because they lacked disability certificates or ration cards⁴⁷.

“For young people in favelas, the fight against COVID-19’s spread became a fight for survival. The majority of people here are labour force workers, in informal positions or in atypical contracts. They can’t work remotely and they have little or no access to government support and labour protection. The youth stood up and filled the gap of public support to save lives, spread awareness, and create new realities.”

– Daniel Calarco (24 years old, law student, originally from Vila do Vintém Favela in Rio de Janeiro, Brazil).

Taken from Restless Development, Resilient realities: How youth civil society is experiencing and responding to the COVID-19 pandemic (2020).

“Since the outbreak, I have less work and less income. The orders for the garment factory I work for have dramatically dropped, people are staying at home and spending less. The factory is selling less products, so they send less orders to me.”

– Supin (67 years old, Thailand).

Provided by HelpAge International



Benefits and implications of 'digital delivery'

Social distancing during the pandemic has led to some activities moving to the online environment, including for work; education; and political participation. This 'digital delivery' has provided a lifeline for many people, enabling them to retain their jobs and income or continue their education. Restless Development found that adapting activities to online provided some benefits, more young people in remote areas have been able to engage in political advocacy and it has enabled greater collaboration across different groups and geographies.

While a 'digital divide' existed before the pandemic, the move to online of many activities has compounded existing inequalities. People who have been marginalised are more likely to have inadequate internet access, low literacy and insufficient information technology skills or be unable to afford the technology required (e.g. computers or mobile phones). The Stakeholder Group of Persons with Disabilities found growing concern among persons with disabilities about losing their jobs because they're unable to work as effectively using the internet as their colleagues without disabilities. Africa's Voices found that people in refugee camps in Kakuma and Dadaab, Kenya, could not follow remote schooling due to inadequate resources; and ActionAid found the unequal care burden on women stopped many women and girls from engaging in online activities. Sightsavers found that many parents are unable to support the online education of their children because the parents themselves often have limited exposure to technology.

Based on data from ActionAid, Africa's Voices, Restless Development, Sightsavers and the Stakeholder Group of Persons with Disabilities.

“Beyond just financial resources, I fear that this pandemic can be used by some to curtail important human rights and rights to civic engagement. The space for operations of civil society organisations is necessarily affected by the lockdowns, confinements, closed borders.”

— Local peacebuilder.

Taken from Peace Direct, Humanity United, Conducive Space for Peace, COVID-19 and the Impact on Local Peacebuilding (2020).



4.3. Driving food insecurity

Food insecurity is already a real threat for many groups who have been marginalised, but COVID-19 has pushed more people toward food insecurity.

Among Venezuelan migrants and refugees in Trinidad and Tobago, the proportion of surveyed households eating three meals a day went from 93% prior to COVID-19, to 49% after the outbreak⁴⁸.

Falling incomes and loss of livelihoods (see section 4.2. for more information) has increased food insecurity. Data shared by VSO shows that financial challenges have made it harder for people in Nepal, Malawi and Pakistan to buy food and essential items⁴⁹. The Consortium for Street Children found that food insecurity, from loss of earnings or difficulties accessing food during lockdown, was the most reported impact of COVID-19 by street-connected children⁵⁰. The Consortium for Street Children found that food insecurity for street-connected children was especially severe in South Asia⁵¹.

Increased food prices resulting from (among other reasons) disruptions to supply chains have compounded challenges around food security for many people. Islamic Relief reported a 10 to 15% price increase in basic goods in Syria, making some goods unaffordable for households who have already been marginalised⁵². ActionAid reports that youth-led households have struggled to afford food because of increased food prices⁵³.

Persons with disabilities are also impacted by food insecurity, not just because of food prices or loss of income but also because of shielding requirements and the accessibility of shops that remain open. The Disability Rights Monitor Report found that most governments had not taken steps to safeguard access to food for persons with disabilities, including in high-income countries. Almost one third (n.633) of the survey respondents in 81 countries said that persons with disabilities in their country could not access food⁵⁴.

“I am delivering vital meals to orphans in our communities as they continue to negotiate an incredible lack of options and lack of assistance during the COVID-19 government-imposed lockdown. Quite simply put, they’re unable to fend for themselves, and hence they’re unable to eat. Our teams in both the city and the village are doing an incredible job to deliver food.”

– *Isiiko (Uganda).*

Taken from Restless Development, Resilient realities: How youth civil society is experiencing and responding to the COVID-19 pandemic (2020).

“We are losing produce due to spoilage because we have nowhere to sell it. We are also losing our produce at police roadblocks on our way to Harare. It is very difficult to access customers due to lockdown... because of lockdowns few people are coming to the Harare Mbare Musika market. Because of the reduced family income, we are now eating twice a day instead of three times.”

– *Mavis Gofa, (25 years old, a smallholder farmer, Zimbabwe).*

Taken from ActionAid, World Food Day 2020.

Numerous cases have been documented of persons with disabilities breaking curfew to find or deliver food and being beaten by the police. The Disability Rights Monitor captured stories of a mother of a child with Cerebral Palsy in Nigeria, who police officers harassed on the way to a food distribution centre and a woman with a disability assaulted when looking for food after curfew⁵⁵.

“Hunger is a major problem because children cannot study on an empty stomach. Many young girls are lured into sexual activity with the promise of food. As a parent, it pains me so much.”

– *Woman (Kakuma Refugee Camp, Kenya).*

Taken from Africa’s Voices, interactive radio programming on education and girls’ rights in refugee camps of Northern Kenya (World University Service of Canada, local radio stations)(2020).

“Coronavirus is difficult for us who do daily labour to get by. We don’t have any savings; we’re not able to buy plenty of food. If the quarantine remains, we don’t know how we will get food.”

– *Zafor (62 years old, Bangladesh).*

Provided by HelpAge International.

Photo: © ActionAid

A young Nigerian farmer with his harvest.

4.4. Deepening learning gaps in education

School closures disproportionately impact children and young people who are marginalised or who are at risk of marginalisation.

School closures resulting from public health measures have caused significant disruption to education. Plan International found that in November and December 2020, only 6.3% of the schools it works within 13 countries across the Caribbean and Latin America were functioning regularly⁵⁶.

In Yemen, the Internal Displacement Monitoring Centre found that IDPs reported that COVID-19 had interrupted their children's education more than non-displaced people⁵⁷. ActionAid found that young women are more susceptible to dropping out of school, particularly if the learning environment does not consider care burdens or gender inequalities amplified by the pandemic. ActionAid concluded that a generation of young women is at risk of being left behind, depriving them of education that can be the route to better income, jobs and gender equality⁵⁸.

The unequal impact of school and university closures on learning is driven by the accessibility, availability and effectiveness of alternative education methods.

Plan International's data suggests that the main methods used by schools in the communities they support in place of class-based teaching are teachers sending homework or educational materials via WhatsApp™, booklets and learning materials being distributed directly to households, digital learning platforms, and online classes⁵⁹.

In Uganda, World Vision reported that booklets and learning materials often created additional problems when not written in the local language or distributed to all households⁶⁰. The World Blind Union found that learning materials distributed directly to households were often not accessible to people with sight impairments⁶¹.

“Coronavirus is a big complication for our daily learning because all our schools are closed. To continue learning, we can just read books and do some research on the internet. But having access to the internet is not possible for all children in Mali because many of them live in poor conditions and therefore they can't study online”.

– Salimata (15 years old, Mali).

Taken from World Vision International, Children's voices in the time of COVID-19: Continued child activism in the face of personal challenges (2020).

“A lot of schools have been closed because of the pandemic. So it has really affected education [for] those that are outside the camps, I believe those that are in the camps... it's a double thing because you're displaced [and] you're not in school, then COVID hit again. It's really not good.”

– Monitoring and Evaluation Officer at a CSO (Plateau State, Nigeria).

Provided by the Internal Displacement Monitoring Centre.

The shift to 'digital delivery' (including WhatsApp™ or online classes) also excluded some children and young people from education (see [Box 3](#)). Restless Development found that university students in the UK could not participate in classes, record presentations or submit coursework due to limited access to technology and library spaces⁶².

Groups who have been marginalised have experienced significant impacts on health, safety and wellbeing from the disruption to education.

Sightsavers reported children going hungry and getting sick in the absence of school-based meals and support services⁶³. ActionAid reported that more young people are dropping out of school completely, sometimes to contribute to their households' income⁶⁴. The Consortium for Street Children found that school closures have resulted in street-connected children spending more time on or returning to the streets⁶⁵. School closures have also generated concerns around violence and safeguarding (see [section 4.5](#) for more information), pregnancy and early marriage and mental health and wellbeing (see [Box 4](#)). Africa's Voices collected reports from refugee camps of Kakuma and Dadaab suggesting an increase in girls' pregnancies during the first closure of schools and an increase in substance abuse and/or anxiety among out-of-school children⁶⁶.

“Poverty will affect that program [schooling from home during COVID-19] in a negative way since not all learners will access internet and digital electronic assets.”

– Man (27 years old, Kakuma Refugee Camp, Kenya).

Taken from Africa's Voices interactive radio programming on education and girls' rights in refugee camps of Northern Kenya (World University Service of Canada, local radio stations).

Challenges around mental health and wellbeing

The COVID-19 pandemic has exacerbated challenges already experienced by persons with psychosocial disabilities, including through additional stress and anxiety as well as poorer access to routine supports and services. Data from the Institute of Development Studies underscores that people without pre-existing psychosocial disabilities have also experienced impacts on their mental health and wellbeing because of the pandemic. Many of the negative emotions (fear, shock, anxiety) are reported to stem from the impacts of COVID-19 and disproportionately affect groups who have been marginalised:

- The Institute of Development Studies found that persons with disabilities unable to attend school or access remote learning felt that they had 'lost their futures' and had a feeling of hopelessness.
- The World Blind Union reported high levels of anxiety among blind and partially sighted people because of the isolation they experienced during lockdowns while also unable to benefit from 'digital delivery' (see [Box 3](#)).
- Christian Aid and its partner the Women's Academy for Leadership and Political Excellence identified that the national gender-based violence hotline in Zimbabwe recorded increased cases of psychological violence (See [section 4.5](#)).
- World Vision International reports that a large majority of children surveyed across multiple countries felt isolated and lonely due to school closures; they also acknowledged feelings of distress, anger, anxiety and worry due to uncertainty around how long the pandemic will last.
- REACH found that most refugee households in the Gawilan refugee camp in Iraq reported feelings of anxiousness, stress, nervousness and being overwhelmed or angry, but only 12% of households reported having received any mental health or psychosocial support since the onset of the pandemic.
- Country programmes supported by the International Rescue Committee observed a significant increase in demand for mental health services, particularly in Myanmar, Syria, Libya, Somalia, Uganda, and South Sudan. In contrast, country programmes in Thailand, Nigeria, and Jordan had observed decreased access to mental health services.

Based on data from Christian Aid, the Institute of Development Studies, International Rescue Committee, REACH Initiative, World Blind Union, and data shared by World Vision International.

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Photo: © World Vision International

“Poverty will affect that program [schooling from home during COVID-19] in a negative way since not all learners will access internet and digital electronic assets.”

— Man (27 years old, Kakuma Refugee Camp, Kenya).

Taken from Africa's Voices interactive radio programming on education and girls' rights in refugee camps of Northern Kenya (World University Service of Canada, local radio stations).

4.5. Intensifying violence, abuse and discrimination

Increasing violence against people who have been marginalised has been reported during the pandemic.

UN Women has reported a growth in cases of violence against women and girls since the outbreak of COVID-19; data from across the Collaborative underscores this trend. Plan International reports increased violence against women and girls in 13 countries across Latin America and the Caribbean⁶⁷. ActionAid's partners in Bangladesh have seen a ten-fold increase in reports of gender-based violence across 25 districts during the pandemic⁶⁸. ADD International found that three-quarters of persons with disabilities surveyed in Uganda perceived a greater risk of violence since the pandemic began⁶⁹.

Multiple cases of violent or discriminatory enforcement of curfews and travel restrictions by police have also been reported, targeting human rights activists, street-connected children, LGBTQI+ people, persons with disabilities, migrants and IDPs⁷⁰⁻⁷⁴.

Groups often discriminated against due to their jobs (e.g. Dalits) are frequently targeted as 'spreaders of the virus'. Manual work performed by many Dalits, usually without adequate personal protection, exposes them to additional risk of COVID-19 and stigma (e.g. cleaning, disposal of corpses, sanitation and waste disposal)⁷⁵.

Peace Direct points towards the broader impact of COVID-19, reporting that COVID-19 and the response to it are exacerbating the underlying roots of conflict (particularly inequality). In some places, Peace Direct has found that COVID-19 is reigniting violence and threatening peace processes⁷⁶.

People at medium to very high risk of economic violence before COVID-19 are 2.3 times more likely to report increased risk; for psychological violence, people are 1.6 times more likely⁷⁸.



Households that incur an income loss are more likely to include a child reporting violence in the home than households that do not incur any income loss⁷⁹.



Violence in the household reported by children was double the rate when schools were closed than when schools were open, and the child was attending in person⁸⁰.



People who have been marginalised and already at risk are increasingly exposed to incidents of violence and discrimination.

ADD International reports that people who were already at risk of violence before the pandemic are now at greater risk of violence⁷⁷. In part, cases of violence and discrimination are the result of the restrictions imposed to combat COVID-19. Some people in lockdown are more exposed to domestic violence and have fewer social contact opportunities or access to community support. Unemployment, poverty and the high cost of living during the pandemic also drive increases in violence.

"They [maternal family] told me that they could not support me physically or my expenses anymore and asked me to return to my husband's house with my small daughter."

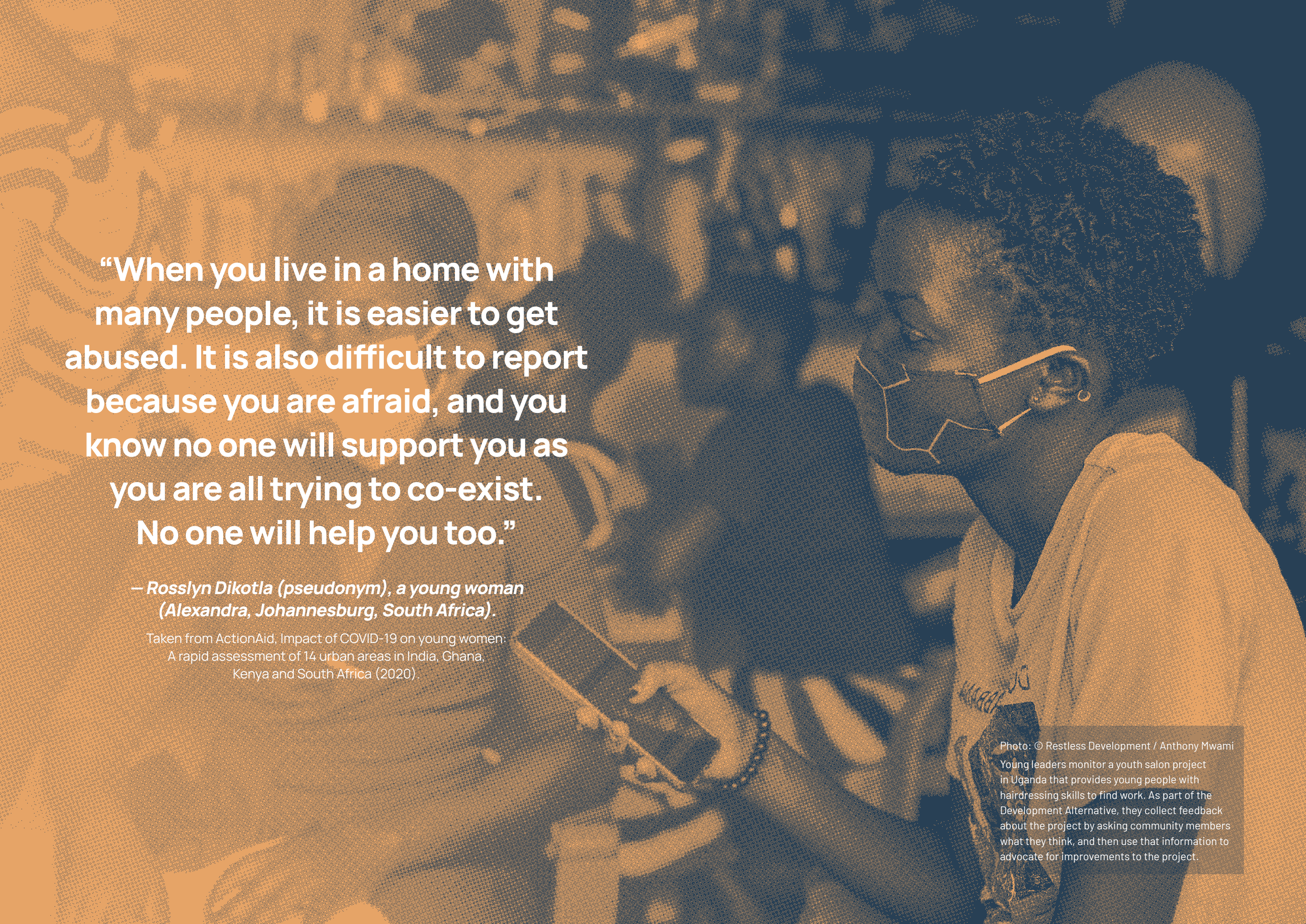
– A 42-year-old woman with locomotor disability (Scoliosis), Thane, Maharashtra. She had moved out of her husband's house because of domestic violence.

Provided by Sightsavers.

“The government has resorted to violent means of removing street-connected children from the streets. This situation has escalated in the past weeks in response to the COVID-19 situation. Our team members have witnessed first-hand how children were brutally beaten by police officials for being on the streets.”

– Consortium for Street Children Network Member, Education for Purpose (Nigeria).

Taken from Consortium for Street Children, COVID-19 and street-connected children: Impacts, responses and opportunities (2021).



“When you live in a home with many people, it is easier to get abused. It is also difficult to report because you are afraid, and you know no one will support you as you are all trying to co-exist. No one will help you too.”

— Rosslyn Dikotla (pseudonym), a young woman (Alexandra, Johannesburg, South Africa).

Taken from ActionAid, *Impact of COVID-19 on young women: A rapid assessment of 14 urban areas in India, Ghana, Kenya and South Africa* (2020).

Photo: © Restless Development / Anthony Mwami
Young leaders monitor a youth salon project in Uganda that provides young people with hairdressing skills to find work. As part of the Development Alternative, they collect feedback about the project by asking community members what they think, and then use that information to advocate for improvements to the project.

5. Conclusions

Community and CSO data from across the Collaborative underscores that the COVID-19 pandemic has presented a public health, economic and social crisis that will reverberate for many years to come. The pandemic has worsened existing inequalities. While the full impact and cost of the pandemic are not yet known, community and CSO data included in this report already makes the following clear:

Children in residential schools or homes, older people living in care homes, persons with disabilities in residential institutions, persons in prisons and detention centres and IDPs in camps **often live in conditions that worsen health risks for COVID-19.**

Significant inequalities in access to health are a common experience for people who have been marginalised; for COVID-19 treatment and routine medical care during the pandemic.

Plummeting economic activity exposes people who have been marginalised to falling incomes and loss of livelihoods, generating higher levels of food insecurity. Low-paid workers, street-connected children, women, ethnic minorities, the self-employed, migrant workers, informal and fixed-term workers are among those whose livelihoods have been hit hardest by the pandemic.

The shift to 'digital delivery' has been both a lifeline and a barrier for groups who have been marginalised. Socio-economic inequalities will worsen, including employment rates and learning outcomes, if these barriers remain unaddressed.

The unequal impact of school closures is driven by the availability and effectiveness of alternative education methods to different communities. Online classes are inaccessible for many, and learning materials shared with households are often inadequate. The impact of school closures on children who have already been marginalised includes hunger, ill-health, child labour, early or forced marriage, poor mental health and violence.

People at risk of violence before the COVID-19 pandemic are now at greater risk of violence than their peers. Violence takes many forms during the pandemic, including gender-based violence, early and forced marriage, child labour, neglect and violent or discriminatory enforcement of curfews and travel restrictions by police.

People who have been marginalised have demonstrated remarkable resilience during the COVID-19 pandemic; 'building back smarter' requires better understanding and consideration of the support systems used during the pandemic.

A more active use of community and CSO data in governments' response planning can help to address some of these gaps:

People who are marginalised will remain invisible and uncounted unless data collection efforts become more inclusive. Data on COVID-19 cases, fatality and the socio-economic impact disaggregated by race, disability, migrant status or other key characteristics need to be freely available. Inclusive data collection enables a robust COVID-19 pandemic response and recovery based on data sources that reinforce the effectiveness of policy decisions and support the principle of 'leave no one behind'.

Community and CSO data can strengthen the pandemic response and recovery by providing insights and evidence on the impact of COVID-19 on people who have been marginalised and disproportionately affected.

Community and CSO data emphasises the importance of complete birth registration and employment data to guarantee access to social protection and highlight where social protection coverage falls short.

6. Recommendations

The targets of the SDGs and the principle of ‘leave no one behind’ continue to provide a relevant framework for action, but one that is off-track⁸¹.

While the insights in this report provide a snapshot of the impact of the COVID-19 pandemic on some people and groups who have been marginalised, they highlight the fragility of progress toward the SDGs and the importance of achieving them. Coordinated action is needed to ensure the health, economic and social needs and demands of people who have been marginalised are addressed to move toward an equitable recovery.

The insights shared in this report also emphasise the relevance and added value of community and CSO data in strengthening our understanding of one global crisis. The COVID-19 pandemic has exposed some of the weaknesses of official data systems, sparking a broader and deeper discussion on more inclusive data systems. If harnessed correctly, community and CSO data can further our understanding not just of COVID-19 but of many other global crises. However, it is important to ensure current discussions lead to systemic change in data systems and societies.

To help prevent inequalities from deepening further through more inclusive data systems, the Civil Society Collaborative on Inclusive COVID-19 Data calls for:

Use of data from communities and CSOs to inform plans and monitor COVID-19 response and recovery.



SHORT TERM

National COVID-19 taskforces and similar government coordination bodies to actively seek and use community and CSO data to inform the development and monitoring of national and sub-national response and recovery plans and policies.

SHORT TERM

Communities and CSOs increase the sharing and dissemination of COVID-19 related data according to best practices, alongside transparent discussion of the methodologies used, limitations and strengths.

Urgent disaggregation of COVID-19 data to identify, address and report inequities, and prioritise advancing the inclusivity of official data systems.



SHORT TERM

Government ministries and National Statistical Offices (NSOs) to strengthen the collection, use and reporting of COVID-19 case, fatality and socio-economic impact data disaggregated by age, disability, gender, geographic location, income, migratory/ displacement status, race or other characteristics as relevant in local and national contexts, using internationally validated and comparable tools.

LONG TERM

NSOs, in coordination with government departments, to strengthen official data systems to be inclusive of all and prepared for future crises, including advancing civil registration systems, deepening data disaggregation and increasing the generation and use of qualitative data.

Strengthened partnerships and coordination mechanisms between governments, communities and CSOs to increase the use of community and CSO data.



SHORT TERM

NSOs to appoint a senior-level lead responsible for working with communities and CSOs to gather, analyse and assess the quality of community and CSO data to complement analyses and reports delivered using official data.

LONG TERM

NSOs and other government departments to establish and strengthen data partnerships and working groups with communities, CSOs and other key producers of relevant non-official data (such as Human Rights Institutes) to establish effective and transparent systems for producing, sharing, analysing and using community and CSO data alongside official data.

LONG TERM

NSOs, communities and CSOs to work together to develop national guidelines and quality standards for community and CSO data, thereby supporting active use of such data in policy planning, implementation and crisis response. Communities and CSOs to assess and report on the quality of their data.

Accelerate investment into the production of community and CSO data and development of more inclusive official data systems.



SHORT TERM LONG TERM

National governments and donors should encourage, facilitate and allocate funds for the generation of community and CSO data to develop more efficient, targeted and accessible programmes that help to address the situation of communities experiencing marginalisation.

LONG TERM

Governments and donors to increase funding to NSOs and government departments to strengthen comprehensive and inclusive official data systems.

LONG TERM

Donors to support knowledge exchange and capacity building between NSOs, communities and CSOs to strengthen data quality, sharing and use.

To advance an equitable COVID-19 recovery and fulfil the leave no one behind commitment, the collaborative calls for:

People who have been left behind to be prioritised in COVID-19 responses and long-term recovery planning, implementation and budgeting.



SHORT TERM

COVID-19 taskforces and similar government coordination bodies to critically assess all planned and recently adopted sub-national and national COVID-19 response strategies on whether they adequately respond to the situation of people who have been marginalised.

LONG TERM

National governments to strengthen and improve targeting of social protection measures based upon an intersectional analysis of the economic impact of the pandemic on people who have been marginalised.

LONG TERM

Governments to ensure economic recovery plans and other national and sub-national COVID-19 strategies, budgets and implementation plans fulfil the principle of leaving no one behind. Introduce more participatory budgeting cycles at subnational and national levels to follow up and review the implementation of programmes and targeting of communities experiencing marginalisation.

Inclusive and participatory decision-making processes on COVID-19 response and recovery and longer-term policies and programmes.



SHORT TERM

National COVID-19 taskforces and similar government coordination bodies to partner with **communities and CSOs** to jointly develop accountability mechanisms to identify and engage representatives of people who have been marginalised to actively participate and engage in decision making and implementation processes.

LONG TERM

Community representatives and CSOs to strengthen intersectional connections and collaborations at local, national and global levels to support inclusive decision-making processes and streamline engagement with governments.

LONG TERM

Government departments to co-develop coordination mechanisms with communities experiencing marginalisation to ensure their leadership and full, effective and equal participation in decision making on the design, budgeting, implementation and monitoring of policies and programmes.

Photo: © Sightsavers/Ahmed Jallanzo
Community Health Services Supervisor
in Ganta, Nimba County, Liberia.

Only through greater focus and coordinated action is it possible to 'leave no one behind' both now and in future crises.

The Collaborative hopes this report and its recommendations help spark the change needed in official data systems and COVID-19 pandemic responses and recoveries.



Annex 1: Detailed list of studies

This section lists the sources of information shared by CSOs for this report.

Note: Some sources may not be included where CSOs have indicated they cannot be shared.

Lead organisation (study partners)	Title of study/project	Country focus	Data collection period	Type of data collected	Methodology	Publication status
ActionAid	Youth Digital Engagement	Bangladesh, Ethiopia, Kenya, Nigeria, Palestine and Zambia	August 2020 - June 2021	Quantitative and qualitative	Nationally representative surveys, Key Informant Interviews, Data Review, Pulse Survey	Forthcoming
ADD International	COVID-19: Impacts and Response among Persons with Disabilities and their Representative Organisations	Bangladesh, Cambodia, and Uganda	June - August 2020	Quantitative and qualitative	Key Informant Interviews	Published
Africa's Voices <i>(World University Service of Canada, local radio stations)</i>	Education and girls' rights in refugee camps of Northern Kenya	Kenya	September 2020 - January 2021	Quantitative and qualitative	SMS feedback to an open radio question	Published
Africa's Voices <i>(World University Service of Canada, local radio stations)</i>	Trusted two-way mass and individual health communications and rapid socio-epidemiological insights	Kenya	March-May 2020	Quantitative and qualitative	SMS feedback to an open radio question	Published

Africa's Voices <i>(World Vision Kenya)</i>	World Vision Kenya's (WVK) Emergency Response in Kitui and Makueni counties project	Kenya	July - December 2020	Quantitative and qualitative	SMS feedback to an open radio question	Published
Africa's Voices	Africa's Voices Foundation Somalia Phase II Diagnostic Results	Somalia	August 2020	Quantitative and qualitative	SMS poll	Published
Disability Inclusive Development (DID) <i>(BRAC, ADD International, Light for the World, Sense International, Institute of Development Studies, Humanity and Inclusion, BBC Media Action, Sightsavers, International Disability Alliance and local OPD partners)</i>	Disability Inclusive Development (DID) COVID-19 response	Bangladesh, Kenya, Nepal, Nigeria and Tanzania	July - December 2020	Quantitative and qualitative	Rapid assessments, Case Studies, Impact Assessment, Key Informant Interviews	Forthcoming
Christian Aid	Evidence and Collaboration for Inclusive Development Baseline	Myanmar, Nigeria and Zimbabwe	February - June 2020	Qualitative	Perception Surveys, Key Informant Interviews, Focus Group Discussions	Forthcoming
Christian Aid <i>(Financial Transparency Coalition, Centre for Governance and Budget Accountability, Centre for Policy Dialogue, Instituto Centroamericano de Estudios Fiscales, Studies in Poverty and Inequality Institute, Tax Justice Network Africa, Centre for Economic and Social Rights)</i>	People's recovery - tracking government fiscal responses to COVID-19	Bangladesh, El Salvador, Guatemala, Honduras, India, Kenya, Nepal, Sierra Leone, South Africa and Zimbabwe	January 2020 - January 2021	Quantitative and qualitative	Desk Review, Key Informant Interviews	Published

Christian Aid (Ekkisiyar Yan Uwa A Nigeria, Mercy Vincent Foundation, Legal Awareness for Nigerian Women, Community Links, Human Empowerment Initiative)	C19 NALPER	Afghanistan and Nigeria	May - September 2020	Quantitative	Mobile data collection using Kobotoolbox	Forthcoming
Christian Aid (Women's Academy for Leadership and Political Excellence, Imba Mukadzi Trust, Chitungwiza Residents Trust)	State of women's rights and wellbeing in the era of COVID-19 in Zimbabwe	Zimbabwe	Ongoing	Quantitative and qualitative	Key Informant Interviews, Desk Review, Questionnaires	Published
CIVICUS	Civic freedoms and the COVID-19 pandemic	Global	March-August 2020	Qualitative	Narrative submissions directed by guiding questions	Published
CIVICUS	People Power Under Attack 2020	Global	November 2019 - October 2020	Qualitative	Narrative submissions directed by guiding questions	Published
Consortium for Street Children	COVID-19 and street-connected children: impacts, responses and opportunities	Bangladesh, Belgium, Brazil, Cambodia, Cameroon, Democratic Republic of Congo, Ghana, Guatemala, India, Indonesia, Kenya, Madagascar, Malawi, Mali, Morocco, Mexico, Nepal, Nigeria, Pakistan, Peru, Philippines, Rwanda, Senegal, Serbia, Sierra Leone, Spain, Sri Lanka, Tanzania, The Gambia, Turkey, Uganda, United Kingdom and Uruguay	March 2020 - Jan 2021	Qualitative	Online Survey, phone calls, emails with Consortium for Street Children Network Members	Forthcoming

Development Initiatives (World Vision; BRAC; ActionAid; ADRA; CBM; International Institute for Sustainable Development; Transparency International; Plan International; Save the Children; VSO; Islamic Relief)	LNOB partnership - Making Voices Heard and Count	Bangladesh, India, Kenya, Nepal and Vietnam	Ongoing	Quantitative and qualitative	Differs by country	Published
institute of Development Studies (Sightsavers, ADD International and local NGOs/ OPDs)	Understanding the experiences of people with disabilities during COVID19 times in Uganda, Kenya, Nigeria, Bangladesh: a qualitative study using narrative interviews	Bangladesh, Kenya, Nigeria and Uganda	October 2020 - March 2021	Qualitative	Key Informant Interviews	Forthcoming
Internal Displacement Monitoring Centre	Impacts of COVID-19 on IDPs and non-displaced people in Yemen	Yemen	November 2020	Quantitative	Online Survey	Published
International Rescue Committee	Health Facility COVID IPC Assessment	Bangladesh, Burkina Faso, Central African Republic, Chad, Democratic Republic of Congo, Jordan, Kenya, Mali, Niger, Nigeria, Somalia, South Sudan, Sudan, Syria, Uganda and Yemen	Ongoing	Quantitative	Mobile data collection	Unpublished
International Rescue Committee	COVID-19 Organizational Research & Learning Agenda (ORLA)	Bangladesh, Burkina Faso, Central African Republic, Chad, Democratic Republic of Congo, Ethiopia, Jordan, Kenya, Myanmar, Nigeria, Pakistan, Somalia, South Sudan, Tanzania, Thailand, Uganda and Yemen	Ongoing	Quantitative and qualitative	Data review, Focus Group Discussions	Unpublished

International Rescue Committee	Adapting organization of care to prevent secondary complications of Non-Communicable Diseases (NCDs) during the COVID-19 pandemic: A global case study	Jordan, Kenya, Somalia, Thailand and Uganda	Ongoing	Quantitative and qualitative	Online Survey, Focus Group Discussion, Key Informant Interviews	Forthcoming
Peace Direct	Pioneering Peace-Digital Inclusion Fund	Global	April 2020	Quantitative and qualitative	Survey, testimonies	Published
Plan International	Halting Lives: Part Two	Australia, Brazil, Ecuador, Egypt, Ethiopia, France, Ghana, India, Mozambique, Nicaragua, Spain, United States of America, Vietnam and Zambia	July 2020 - January 2021	Qualitative	Key Informant Interviews	Forthcoming
Plan International	Regional Evaluation of the Response to COVID-19 Emergency in Latin America and the Caribbean	Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Paraguay, Peru and Venezuela	November - December 2020	Quantitative and qualitative	Survey, Focus Group Discussions, Key Informant Interviews	Forthcoming
Restless Development	Digital Best Practice - Internal Learning from Restless Development Programmes	India, Nepal, Sierra Leone, Tanzania, Uganda, United States of America, Zambia and Zimbabwe	March 2020 - February 2021	Quantitative and qualitative	Comms and network mapping, Data Review	Unpublished
Restless Development (RECREAR)	Resilient Realities: How youth civil society is experiencing and responding to the COVID-19 pandemic	Algeria, Bangladesh, Brazil, Canada, China, Colombia, Netherlands, New Zealand, Papua New Guinea, United Kingdom, United States of America and Zimbabwe	April - August 2020	Qualitative	Youth-led virtual cooperative inquiry	Published

Rising Flame and Sightsavers	Neglected and Forgotten: Women with disabilities during the covid crisis in India	India	July 2020	Qualitative and quantitative	Focus group discussions and consultations	Published
Save the Children	The Hidden Impact of COVID-19 on Children Research Series	Afghanistan, Albania, Bangladesh, Bolivia, Brazil, Burkina Faso, Cambodia, Colombia, Dominican Republic, Egypt, El Salvador, Ethiopia, India, Indonesia, Kenya, Kosovo, Laos, Lebanon, Malawi, Mozambique, Myanmar, Nepal, Niger, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Senegal, Sierra Leone, Solomon Islands, Somalia, South Sudan, Sri Lanka, Syrian Arab Republic, Uganda and the United States of America	May - June 2020	Quantitative and qualitative	Survey	Published
Sightsavers (Ministry of Education, Science and Technology, Teachers Service Commission, County Ministries of Education, Educational Assessment & Resource Centres, Kenya Institute of Special Education)	Pamoja Inclusive Education Project End Term Evaluation	Kenya	September 2020 - January 2021	Qualitative	Key Informant Interviews, Focus Group Discussions	Forthcoming

Sightsavers <i>(National Union of Disabled Persons of Uganda, Uganda National Association of the Blind and National Union of Women with Disabilities Uganda)</i>	The Economic Empowerment of Youth with Disabilities in Uganda and Improving Livelihood for Youth with Disabilities in Uganda Joint End Term Evaluation	Uganda	August 2020 - February 2021	Quantitative and qualitative	Focus Group Discussions, Key Informant Interviews, Most Significant Change, Data Review	Forthcoming
Sightsavers	Initial assessment of where Mass Drug Administration treatment rounds for neglected tropical diseases may have been skipped	Burkina Faso, Cameroon, Chad, Cote d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Niger, Nigeria, Rep. Congo and Zimbabwe	Ongoing	Quantitative	Data Review	Unpublished
Stakeholder Group of Persons with Disabilities for Sustainable Development	The experience of persons with disabilities with COVID-19: a case study	Global	May - June 2020	Qualitative	Key Informant Interviews, Focus Group Discussions	Published
Transparency International	Improving integrity of COVID-19 procurement	Colombia, Kenya, Lithuania, Mexico, Moldova, Ukraine and United Kingdom	Ongoing	Quantitative	Scraping of national portals	Forthcoming
Validity Foundation, European Network on Independent Living, Disability Rights International, University of Pretoria, International Disability and Development Consortium, Disability Rights Fund, Disability Rights Advocacy Fund, International Disability Alliance	Disability Rights Monitor Report	Global	April - July 2020	Quantitative and qualitative	Online Survey, Written testimonials	Published

VSO <i>(Local implementing partners in 12 countries in Asia and Africa)</i>	Wellbeing in COVID-19 Pandemic: How are primary actors coping?	Bangladesh, Cambodia, Ethiopia, Kenya, Malawi, Nepal, Nigeria, Pakistan, Philippines, Tanzania and Uganda	April - September 2020	Quantitative and qualitative	Surveys, Rapid Assessment	Published
VSO	Well-being in the context of COVID-19 in Nepal	Nepal	April - May 2020	Quantitative and qualitative	Online survey	Published
World Blind Union	Amplifying Voices: Our Lives, Our Say	Global	April - May 2020	Qualitative	Online survey	Published
World Vision International	Citizen Voice and Action for Maternal and Child Health, Uganda	Uganda	February - June 2020	Citizen/Community generated data	Community Score Card tool, Focus Group Discussions, Household Interviews	Published
World Vision International	Children's voices in the time of COVID-19: Continued child activism in the face of personal challenges	Albania, Bangladesh, Bosnia and Herzegovina, Brazil, Democratic Republic of Congo, Mali, Mongolia, Nicaragua, Peru, Philippines, Romania, Sierra Leone, Syrian refugee children living in refugee camps near the Turkish-Syrian border	March - April 2020	Qualitative	Key Informant Interviews, Focus Group Discussions	Published

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“This crisis is shaking some of the foundations of society and our role is to push for that shake-up to challenge existing power structures that are unsustainable and exclusionary.”

— *Local peacebuilder*

Taken from Peace Direct, Humanity United, Conducive Space for Peace, COVID-19 and the Impact on Local Peacebuilding (2020)

The Global Partnership for Sustainable Development Data (the Global Partnership) and the International Civil Society Centre (the Centre) who have shared the secretariat role for this collaboration want to thank again all partners who have contributed to this report with their data and knowledge. Our special gratitude goes to the communities who stand in the foreground of this report and who have actively contributed with their insights and feedback. For this joint report, we brought together partners from the Centre's Leave No One Behind partnership and the Global Partnership's Inclusive Data Charter. Together with all partners in this report, we share the belief in the benefits of partnering, and in the added value of civil society data as a strategic tool for a meaningful engagement of civil society in the wider development discourse.

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#UnequalPandemic

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