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dynamics Research and Modelling

**Using an intersectional  
lens to understand the  
unequal impact of the  
COVID-19 pandemic**

Bi-Monthly Report: 05

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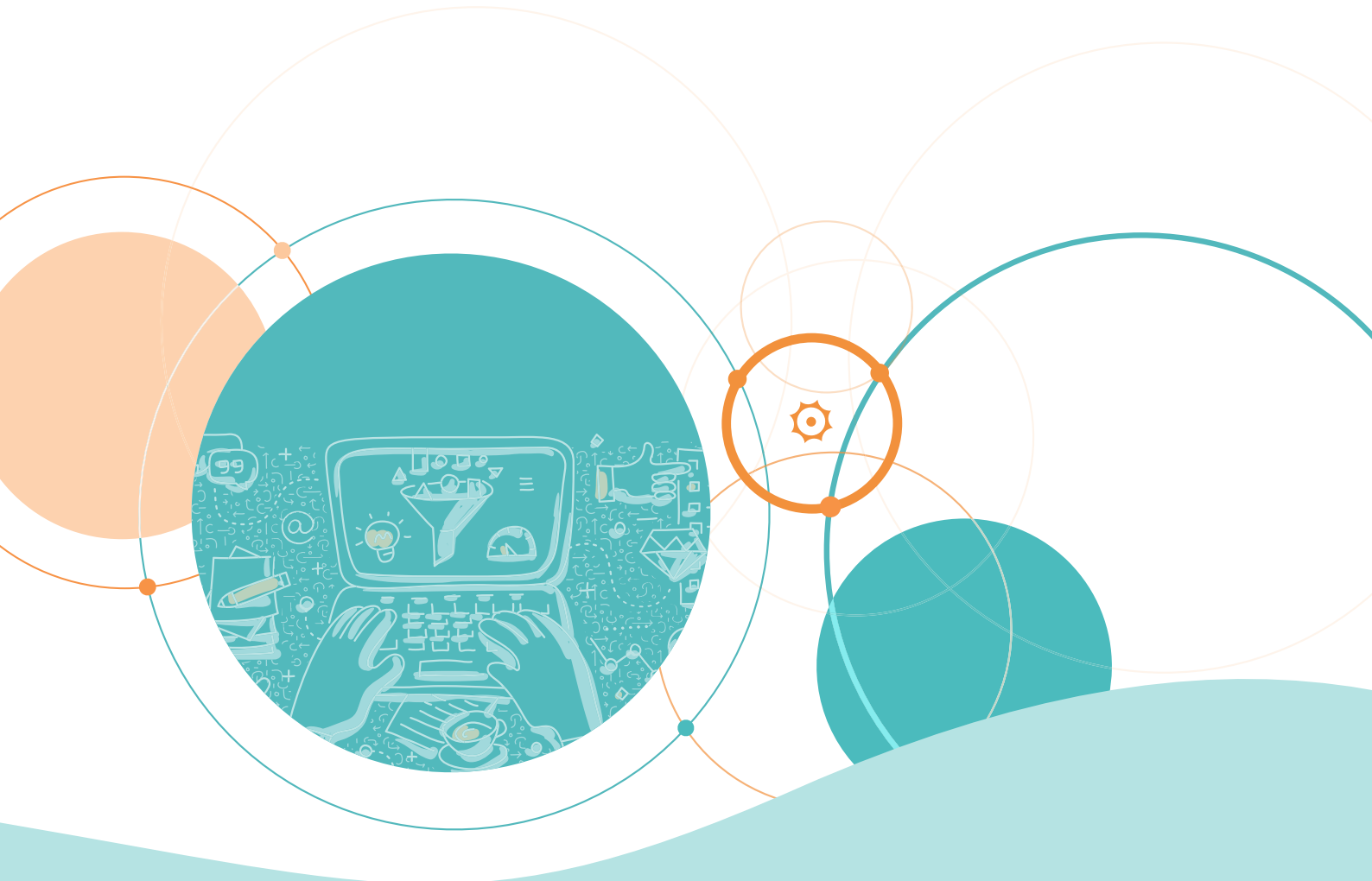
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# INTRODUCTION

Since its emergence in December 2019, COVID-19 has had far-reaching consequences for societies around the globe. The effects of the COVID-19 pandemic go far beyond physical health, impacting individuals' and communities' everyday lives and well-being, including in the domains of education, employment, family life, and mental health. However, the pandemic has not affected everybody's lives in the same way. Indeed, the crisis has unfolded across pre-existing social fault lines in societies, exposing and exacerbating inequalities (Kawachi, 2020). The pandemic is socially patterned not just in terms of COVID-19 morbidity and mortality rates, but also in terms of the impact of the implemented restrictions and emergency lockdown measures (Bambra et al., 2020). Intersectionality theory, a central tenet of the COVINFORM project's theoretical grounding, provides a useful foundation for exploring this socially patterned impact. An intersectional analytical approach dissects how lived experiences during the COVID-19 crisis are shaped by the interaction of different social factors such as gender, ethnicity, class, age, migration status, and religion.

This bi-monthly report draws upon insights from COVINFORM desk-based research assess COVID-19 public health impact and responses to across COVINFORM partner countries: Austria, Belgium, Cyprus, Israel, Ireland, Italy, Germany, Greece, Portugal, Romania, Spain, Sweden, Switzerland, and the United Kingdom (England and Wales). The goal of this report is to outline the usefulness of an intersectional lens in considering how pre-existing structural inequalities influence COVID-19 morbidity and mortality rates, as well as in understanding how COVID-19 containment measures interact with existing structural inequalities across partner countries.

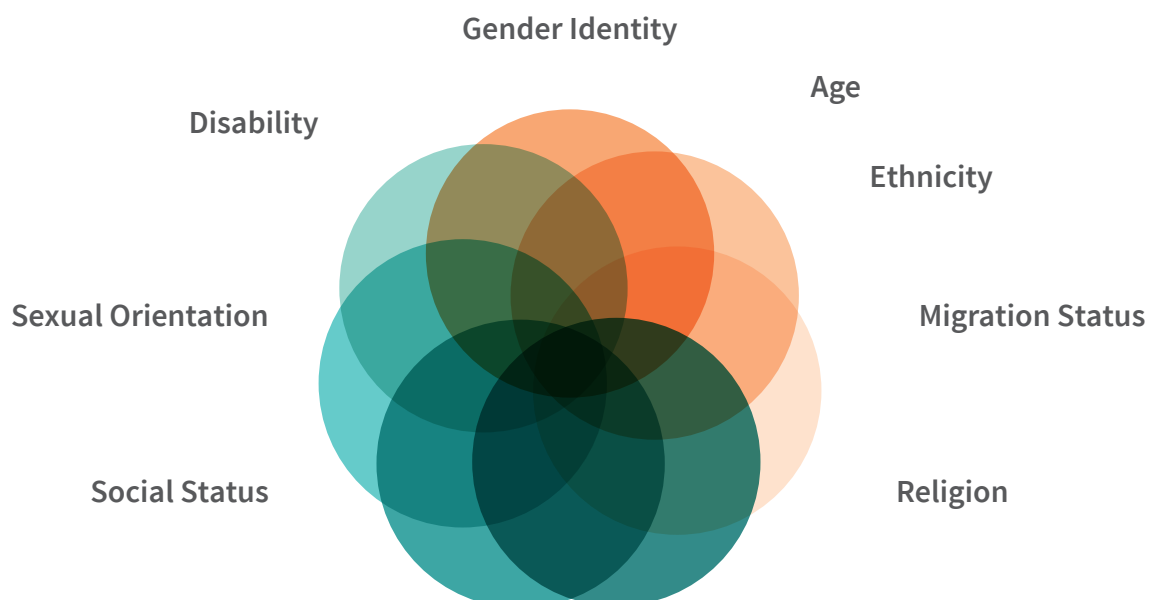
The report first provides a brief introduction to intersectionality theory, highlighting its relevance for analyses of the COVID-19 pandemic. It then considers how exposure to COVID-19, as well as risk of severe disease and mortality, are shaped by pre-existing societal structures that give rise to specific inequalities. Subsequently, it presents examples of how responses to the COVID-19 crisis, such as mobility restrictions, school closures, and restrictions on events and businesses, have been experienced differently depending on people's positions in society. Throughout this report, special emphasis is placed on how people's positions at the intersections of various axes of inequality result in specific outcomes at the individual level. The report concludes by presenting some recommendations on including an intersectional lens in responding to the COVID-19 pandemic and similar crises.

# INTERSECTIONALITY THEORY AND ITS RELEVANCE IN THE COVID-19 CONTEXT

Intersectionality theory provides a critical framework for examining how the interconnections and interdependencies between social and political identities contribute to varying modes of discrimination and privilege (Atewologun, 2018). An intersectional analytical approach allows us to view how experiences of disadvantage are shaped by the interaction of different social factors such as gender, ethnicity, class, age, religion, and migration status. These social factors create “multilayered and routinized forms of domination that often converge” (Crenshaw, 1990, p. 1245). In other words, connected systems and structures of power create interdependent systemic bases of privilege and oppression (Hankivsky et al., 2014).

The concept of intersectionality emerged from the racialised experiences of minority ethnic women in the United States, notably through the work critical race theorist Kimberlé Williams Crenshaw, who sought to draw attention to how the treatment of African American women within US law needs to consider the dual lenses of gender and race discrimination (Crenshaw, 1989). As a theory with broad relevance, intersectionality theory provides a “lens through which you can see where power comes and collides, where it interlocks and intersects” (Crenshaw, 2017).

In the context of the COVID-19 pandemic, an intersectional lens facilitates a move away from thinking merely about clearly delineated groups or single risk factors. Instead, it encourages us to take into account the multitude of inequalities and disadvantages which determine how the impact of the pandemic is experienced by communities and individuals (Hankivsky, 2020). As a result of interacting social factors, people often belong to more than one social group. For example, an elderly immigrant woman living with disability may be disadvantaged in the context of the COVID-19 pandemic in several different ways. Using an intersectionality approach provides the mindset and language for examining for how members of heterogeneous groups of people may experience the COVID-19 pandemic differently depending on their gender, ethnicity, occupation, and other social characteristics.



# EXISTING INEQUALITY STRUCTURES SHAPE THE DIFFERENTIAL SPREAD AND HEALTH IMPACT OF COVID-19



The risk of contracting COVID-19, as well as the risk of falling seriously ill or dying from COVID-19, is not equally distributed within and across societies. In exploring these differences, it is important to distinguish between the role of pre-existing health inequalities and the role of differential exposure to COVID-19.

## Health status & structural health inequalities

Firstly, some people are at higher risk of becoming very ill or dying from COVID-19 as a result of their pre-existing health status (Bradley et al., 2020). Figure 1 shows how across countries, COVID-19 death rates are typically slightly higher among men. Death rates are also unequally distributed by age: using Italian data, figure 2 highlights how COVID-19 death rates differ significantly both by sex and age. Apart from the elderly, clinically vulnerable groups are often also considered to include adults with type 2 diabetes; adults with severe chronic cardiovascular, lung or kidney disease; and adults with decreased immunity and/or cancer (e.g. see VAZG, 2020). Some countries, such as Ireland, consider a relatively wide range of other people to be clinically vulnerable, too, e.g. including individuals with a severe mental illness and people with a learning disability (HSE, 2021).

COVID-19 deaths sex-disaggregated

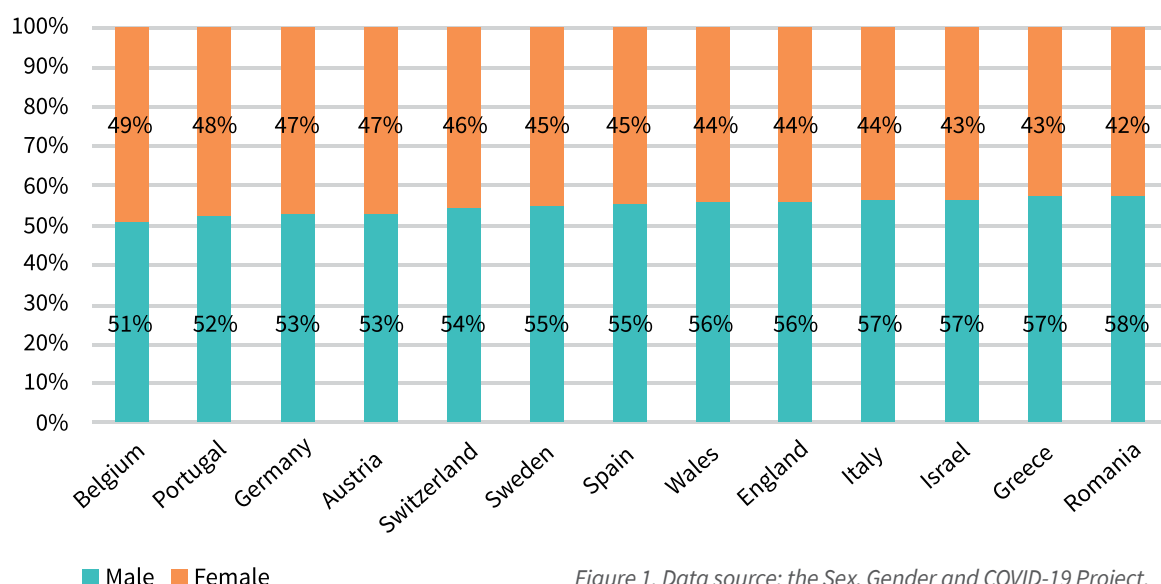


Figure 1. Data source: the Sex, Gender and COVID-19 Project.

## Italy: COVID-19 deaths by sex and age (rates per 100,000)

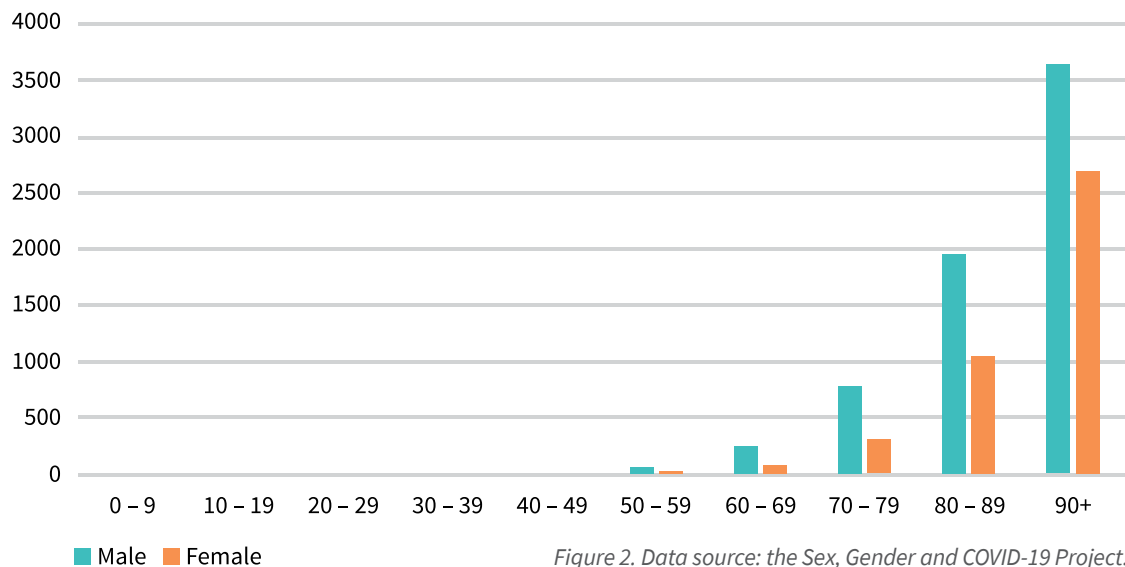


Figure 2. Data source: the Sex, Gender and COVID-19 Project.

Individuals' age and health status cannot be separated from other aspects of their identity and the circumstances in which they live. Indeed, it is important to acknowledge that being at higher risk from (severe) COVID-19 disease based on physical health status is intricately linked with structural health inequalities (Bambra et al., 2020). A range of non-medical factors influence

health outcomes, frequently grouped under the umbrella label 'social determinants of health'. Social, economic and environmental inequalities shape people's ability to prevent sickness, their risk of getting ill, as well as their access to treatment (Dahlgren & Whitehead, 1991), hereby influencing the distribution of health and illness in societies.





**The social determinants of health are the conditions in which people are born, grow, live, work, and age. Differences in these conditions lead to health inequities.**

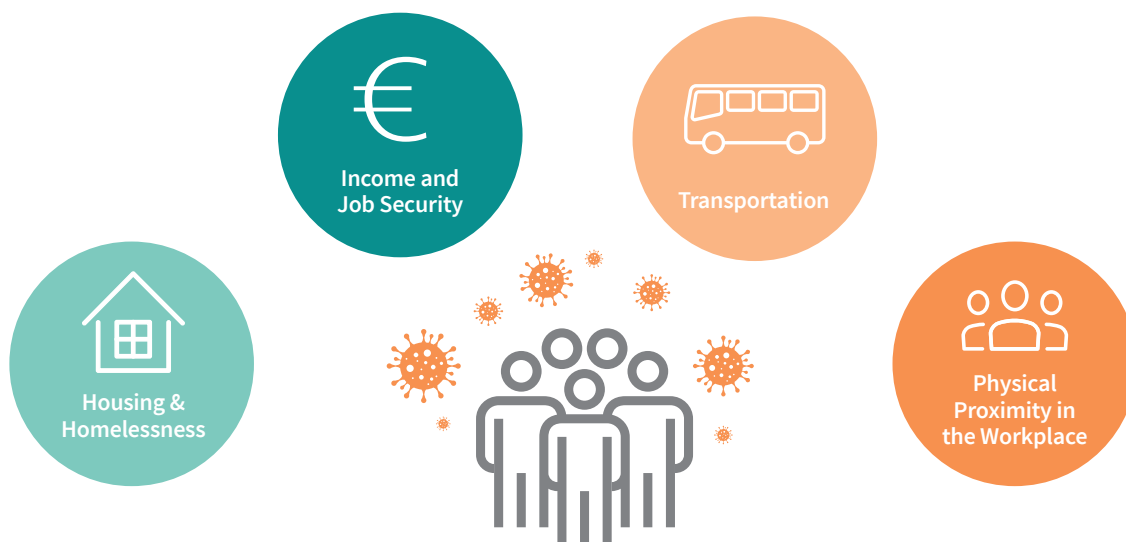
In the case of COVID-19, existing inequalities in the distribution of chronic diseases – which pose important risk factors for severe COVID-19 infections – are of particular relevance. Across Europe, people in the lowest income group are much more likely to have a chronic illness than people with the highest incomes (Scholz, 2020). Although ethnic variations in chronic disease rates in Europe remain poorly understood (Bhopal, 2009), rates of chronic diseases have also been reported to be higher among ethnic minority groups in several European countries (Modesti et al., 2016). In line with this, data from countries like the USA and the UK has revealed that individuals belonging to migrant or ethnic minority groups face systematically high levels of severe COVID-19 illness and mortality (Sze et al., 2020). In the UK, COVID-19 death rates have been reported to be highest among Black, Asian and Minority Ethnic (BAME) persons (Otu et al., 2020).

An intersectional lens helps highlight that these types of differences in rates of severe COVID-19 illness and mortality are not ‘natural’: instead, they are the outcome of a complex array of power structures and societal processes that shape the social determinants of health. As such, intersectionality theory can help us understand how the unequal health impacts of COVID-19 are avoidable and unjust. A focus on intersectionality also accentuates how people who are disadvantaged in terms of their pre-existing health status may actually face an accumulation of different drivers of disadvantage, e.g. through a combination of having a low income, having a chronic illness, and experiencing discriminatory treatment in the healthcare system. All of these drivers may contribute to an individual’s oppression and discrimination in society, and each axis of oppression is likely to reinforce and interact with other axes.



## Exposure to COVID-19

The differential spread of COVID-19 is also influenced by the risk of exposure to the virus faced by different groups in society. For instance, the extent to which people are able to adhere to physical distancing and protect themselves from viral transmission is heavily influenced by their employment and housing. Some individuals and groups of people are more exposed to contracting COVID-19 because of their job. Lower-paid workers, such as those working in cleaning, food or delivery services, are unable to work from home and have been required to travel to work even throughout lockdown periods, often by public transport (Bambra et al., 2020).



The risk of exposure to COVID-19 is affected by various factors, including employment, housing and transportation.

Indeed, many of the COVID-19 outbreaks in non-healthcare workplaces have been reported in industries deemed ‘essential’ where conditions do not allow for adequate physical distancing under the same productivity targets, such as meat processing plants (MPPs) and other food production and processing facilities. Outbreaks in MPPs have been reported in many COVINFORM partner countries, including Germany, Ireland, the UK, Spain, Belgium, Italy, Austria and Sweden (EFFAT, 2020). Such COVID-19 outbreaks are thought not only to result from working conditions in the MPPs, such as the close proximity of workers, but also from workers’ shared transportation and housing, which facilitate transmission of the virus (Dyal et al., 2020). Health workers also face a higher risk of contracting COVID-19 compared to the general population (Gómez-Ochoa et al., 2021). Female health care workers, and black women in particular, face higher rates of COVID-19 infections than their male counterparts (Lotta et al., 2021). Apart from working conditions, housing is an important factor to consider in

COVID-19 transmission as well. People living in poverty typically have poorer quality and smaller housing (or are homeless), which means they are more exposed to the virus and are likely to struggle more with stay-at-home orders. Evidence from the UK revealed that living in crowded housing is associated with an 11% increase in age-adjusted COVID-19 mortality rates (Daras et al., 2021).

The intersectionality framework helps shed light on how it is typically the multiply disadvantaged that are at highest risk of exposure to COVID-19. Those who are disadvantaged in various ways – e.g. those with lower-paid jobs, without car access and living in cramped housing – are most exposed. Going beyond a focus on a single socio-economic factor such as ‘low-income’, the framework demonstrates how the simultaneous and interconnected influence of issues like the gendered division of labour (e.g. the overrepresentation of women in lower-paid care jobs) and the overrepresentation of ethnic minority groups among frontline ‘essential workers’ (Sze et al., 2020) contribute to the unequal health impact of the COVID-19 pandemic.

# COVID-19 CONTAINMENT MEASURES INTERACT WITH EXISTING SYSTEMS OF INEQUALITY



Across COVINFORM partner countries, the measures enacted to curb the spread of COVID-19 have been associated with significant disruption and socio-economic consequences. Examples of such measures include travel restrictions, quarantine measures, shop and restaurant closures or restrictions, school closures or distant learning, and work-from-home orders. A consideration of the impact of COVID-19 responses on various domains of everyday life highlights how some individuals have disproportionately faced far-reaching negative consequences. We provide a brief, non-comprehensive analysis of such intersectional disadvantage in the contexts of work and care responsibilities, impacts faced by children, digitalisation, and experiences of discrimination and policing.





## *Work and care responsibilities*

Firstly, the COVID-19 containment measures have had far-ranging consequences for people's working realities and caring responsibilities. Key drivers of change in this domain have been work-from-home recommendations, closure of childcare facilities, and remote learning for children and young people. According to an EU survey, the negative impact of COVID-19 on work-life balance has been felt most strongly by women, particularly those with young children (Ahrendt et al., 2020). In

Belgium, a research study on the impact of lockdown measures on the division of responsibilities within Belgian households during the first lockdown in spring 2020 revealed that traditional role divisions had been reinforced (Glorieux & Van Tienoven, 2020). Women have been more likely to have been forced to sacrifice paid work in order to compensate for the loss of childcare during lockdowns (Allmendinger, 2020). Data from Switzerland indicates that these gendered role divisions led to more stress and mental health complaints for women compared to men during the COVID-19 crisis (Kuhn et al., 2021). An intersectional lens allows us to note that some women have fewer resources to allow them to cope with increased care burdens (e.g. more responsibilities, lower savings, less support), with racialized women, single parents, and women with disabilities among the groups who are disproportionately hit (Hankivsky & Kapilashrami, 2020).

As a result of the distinctly gendered nature of existing professional and care structures in society (UNFPA, 2020), the economic impact of the COVID-19 crisis has also played out differently along intersections of profession and gender. For example, the pandemic has led to a loss of jobs in many women-dominated professions, such as hairdressers, flight attendants, and workers in restaurants and shops (Buikema, 2020). The economic impact of the pandemic has been particularly significant for women working in the informal sector, compared to women in formal sector work (Birchall, 2021). Disadvantage at the intersection of profession and gender is frequently combined with having a migrant background and/or belonging to an ethnic or racial minority in society, as some ethnic/racial minority groups and/or migrant groups are overrepresented in specific professions. For example, women of colour and women with fewer years of education are overrepresented in the most precarious 'frontline' healthcare and homecare jobs (e.g. Belgium: Furia, 2020; Austria: Wölfl, 2020).

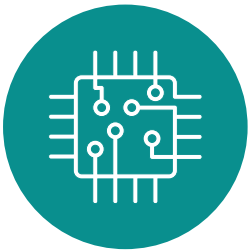


## Children and education

Lockdown measures and home schooling have posed challenges to all children and their families, but some experience a greater accumulation of various layers of disadvantage.

Across partner countries, single parents or large families were considered to experience disproportionate impacts, particularly those families who also face poverty and social exclusion (e.g. see FPS Social Security, 2020; Prainsack et al., 2020). As schools have closed for prolonged periods in many partner countries, existing educational inequalities are likely to be exacerbated (Markowitz, 2021). Online learning environments usually require a computer for each learner, a reliable internet connection and a suitable calm place to study, which not all families can offer (UNIA, 2020). In Romania, for instance, a study conducted in March-June 2020 revealed that only 3% of Roma children participated in online lessons (Hackl, 2020). Similarly, an Irish research review by Darmody et al. (2020) suggests that students from migrant backgrounds, including Irish Traveller students, were likely to be more heavily impacted by the impact of COVID-19 school closures than children from Irish backgrounds. This is related to families' resources and skills to assist their child's learning at home, families' time availability (e.g. essential workers are typically able to spend less time on home-schooling), as well as to school closures' impact on students' access to additional support (e.g. literacy support and special needs support) (Darmody et al., 2020).





## *Digitalisation*

The COVID-19 crisis has accelerated the ongoing digitalisation of society, as many services and vital systems have been forced to use virtual platforms and solutions (Miladinovic, 2020). However, not everyone has been able to take advantage of such technologies, which means the digitalisation sparked by COVID-19 has effectively cut some people off from social contacts, public services, cultural experiences, and educational opportunities (Coene et al., 2020). For example, there seems to be an emerging ‘digital gap’ for learning as a result of the increased reliance on remote learning and home schooling for children. As such, intersectional disadvantage related to digitalisation may be experienced particularly by children who do not have the appropriate resources/facilities for home-schooling (e.g., laptops, separate rooms, reliable internet connection), and whose parents do not speak the language of instruction or are not familiar with the curriculum (e.g. Italy: Marchetti & Guiducci, 2020; Belgium: UNIA, 2020). For many older people, isolation and loneliness has been worsened by their lack of digital skills or access to digital technologies. As such, disadvantage linked to digital gaps may lie at the intersection of age, socioeconomic status, low literacy, disability, and mental illness (Coene et al., 2020).



## *Discrimination & policing*

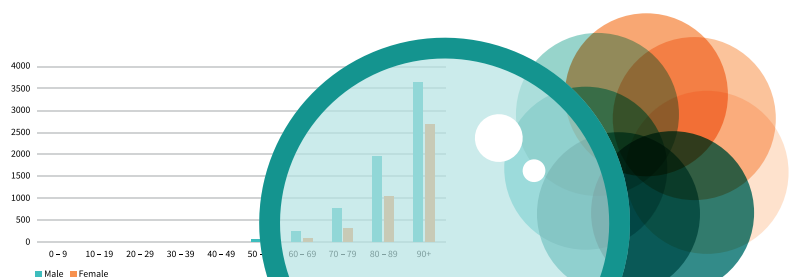
For some groups of people, the COVID-19 has also been associated with an increase in discriminatory experiences. In Belgium, for instance, many people with an Asian appearance or physical characteristics faced racist remarks and aggression at the beginning of the COVID-19 pandemic (Slaats, 2020; Struys, 2020). In Austria, an increased occurrence of discrimination based on religious grounds was also noted (SOS Mitmensch, 2021). Many reports of discrimination also relate to the discriminatory enforcement of lockdown rules, e.g. in the context of stop and search and identity checks as police enforced lockdown measures. In the UK, London police registered a 22% increase in stop and searches between March-April 2020, and the proportion of black people searched increased by nearly a third (Amnesty International, 2020). As many of the government measures have been vaguely defined, considerable room for interpretation of the rules remains, which seems to facilitate ethnic profiling in their enforcement (Clementi, 2020; Van Thienen, 2020). To sum up, experiences of discrimination and unfair policing in the context of the COVID-19 pandemic are frequently positioned at the intersection of race/ethnicity, gender, class and religion.

# PROMISING PRACTICES FOR INCLUDING AN INTERSECTIONAL LENS



Our analysis has shown how pre-existing structural inequalities influence COVID-19 infection and mortality rates, as well how COVID-19 containment measures interact with existing systems of inequality. The intersectionality framework has helped highlight how some individuals are simultaneously impacted by various axes of oppression, placing them in a particularly vulnerable position in the context of the COVID-19 pandemic. Intersecting factors which seem to be of particular relevance in analyses of the COVID-19 crisis are gender, age, socio-economic status, disability, family composition, race/ethnicity, and migrant background.

Although some COVID-19 policy responses and measures have acknowledged that some groups of people face multiple, simultaneous drivers of disadvantage and marginalization, policy initiatives rarely explicitly take an intersectional approach. Indeed, policy responses typically assume a subject who only faces one type of social difficulty or barrier (Crenshaw, 1989), which arguably leads to a fragmentation of the responses. In this section, we provide some recommendations on promising practices for including an intersectional lens in responding to the COVID-19 pandemic and similar crises.



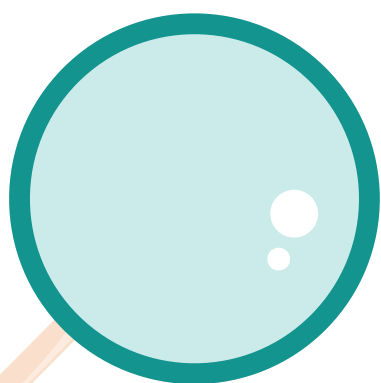
Firstly, intersectional approaches require the collection of diverse data that is aggregated by various social characteristics. Data disaggregated by gender, ethnic identity, occupation, disability, age, and migration or refugee status would shed more light on which groups experience disproportionate impacts (Berkhout & Richardson, 2020; Hankivsky, 2020). Data should also be collected from multiple sources, including by practitioners, governments, and civil society. Multiple methodologies should be used, including qualitative and mixed-methods approaches which are well-suited to capturing the lived experiences of diverse groups of people (Ryan & El Ayadi, 2020). Data should be contextualized by considering how the effects of the crisis/pandemic are situated in socioeconomic and political contexts, and are linked to societal and cultural values and norms (Hankivsky & Kapilashrami, 2020).

Intersectional responses are inevitably cross-sectoral. Addressing interlocking outcomes of unequal power systems requires coordination of policies across sectors like education, housing, social protection, employment and legal services (Hankivsky & Kapilashrami, 2020).

Although the COVID-19 pandemic has demonstrated that welfare state policies can play an important role in cushioning the unequal impact of crises (e.g. through specific

support or compensation measures), the crisis also revealed how policies in different sectors often remain siloed. Placing intersectional perspectives at the heart of social welfare states would serve the dual aim of addressing social inequalities at the root and prioritising assistance for those facing intersectional disadvantage.

Furthermore, intersectional responses should include efforts to support and promote leaders from a range of communities and local organizations. Such strategies can facilitate the involvement of disadvantaged communities to be part of the development and implementation of solutions, instead of merely prescribing them (Berkhout & Richardson, 2020). Moving beyond a deficit model, policy and decision-makers should use resilience and asset-based approaches, and prioritize participatory engagement mechanisms among affected communities. This also requires a commitment to leadership diversity, including substantive participation of women, people living with disability, and people from minority religious and ethnic backgrounds (Hankivsky & Kapilashrami, 2020). Only by fostering community participation can interventions be tailored and adapted to address the unique intersecting inequalities faced by individuals in various local contexts.



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# The COVINFORM project

<b>Acronym</b>	COVINFORM
<b>Title</b>	Coronavirus Vulnerabilities and INFORMATION dynamics Research and Modelling
<b>Coordinator</b>	SYNYO GmbH
<b>Reference</b>	101016247
<b>Type</b>	Research and Innovation Action (RIA)
<b>Programme</b>	HORIZON 2020
<b>Topic</b>	SC1-PHE-CORONAVIRUS-2020-2C Behavioural, social and economic impacts of the outbreak response
<b>Start</b>	01 November 2020
<b>Duration</b>	36 months

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