# THE IMPACTS OF COVID-19 ON MIGRATION AND MIGRANTS FROM A GENDER PERSPECTIVE

IOM
UN MIGRATION

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Cover photo: Since 2019, the International Organization for Migration (IOM) in West and Central Africa has been using street art as a key outreach activity based on "human-centered design" to engage with migrants and community members. In 2020, amidst the COVID-19 pandemic, IOM continues the initiative in Senegal, Ghana and the Niger with the objective to improve relations between migrants and host communities, while stimulating the debate surrounding how to reduce the spread of misinformation and xenophobia, two particularly sensitive topics during COVID-19 times. © IOM 2020/Daniel Kisito KOUAWO

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# FOREWORD

The COVID-19 pandemic has ushered in new challenges for migration and accelerated global change. Amid rapid technological innovation, geopolitical transformations, and environmental changes, global mobility systems have had to adapt to a new COVID reality. As we continue to respond to these fast-changing times, it is paramount that evidence-based research on the implications of COVID-19 on migrants and migration be pursued to inform policymaking and programming at all levels.

Due to COVID-19 related mobility restrictions, migration journeys have been disrupted right throughout the migration cycle, from departure, in transit, upon entry, and return. Migrants and potential migrants in a state of immobility faced important challenges in seeking asylum, securing or retaining work, reuniting with family, accessing social protection and returning to their country of origin, among others. At the onset of the pandemic, there were also reports of increased cases of discrimination, xenophobia and racism against migrants, and a rise in the spread of misinformation. These negative implications of the COVID-19 pandemic on migration and migrants exacerbated the public health crisis, with heightened health concerns for migrant populations worldwide.

At the same time, the COVID-19 pandemic triggered the adoption of new measures, such as the implementation of temporary regularization programmes, travel exemptions for essential workers, and health care provisions for migrants regardless of their immigration status. These initiatives demonstrate the agility of States and the potential of policymaking when social, political, and economic systems are being challenged.

As we have passed the two-year mark of the pandemic, it is clear, however, that the ramifications of the pandemic continue to impact populations unequally. Building on the momentum of policymaking and programming that is inclusive of migrants are critical responses to support migration and mobility from perspectives that are inclusive of diverse identities.

Gender, for one, is central to discussions of migration as it prominently impacts migration patterns and processes. Gender influences migration decisions, including who, when, why, where, and how people migrate. Gender roles and expectations and the power dynamics that inform gender relations significantly shape the migration experience.

The impact of COVID-19 on gender and migration is complex and wide-reaching, highlighting and exacerbating diverse factors of vulnerability, including gender, (irregular) migration status and precarious working conditions. The pandemic has brought to the fore pre-existing structural and societal inequalities, including gender inequality, with a reported increase in gender-based violence due to lockdown measures.

While undermining the rights and well-being of many migrants, the pandemic has also highlighted the resilience and essential contributions of migrants in employment sectors that are highly gendered, ranging from health care to agriculture. Migrants have been acclaimed as essential workers, often working on the front line and more exposed to COVID-19 infections due to the nature of their work.

The pandemic offers an opportunity to challenge gendered norms and standards, put to test old systems that are conducive to gender inequality, while further empowering migrants of diverse genders. As echoed by the United Nations Secretary-General to the General Assembly on the Global Compact for Safe, Orderly and Regular Migration:

> *The lessons of the pandemic provide a timely opportunity to recalibrate gender-responsive and child-sensitive migration governance at the local, national, regional and global levels so that the commitments of the Compact, the 2030 Agenda and the declaration on the commemoration of the seventy-fifth anniversary of the United Nations are fulfilled for all migrants, and indeed for everyone.*[1]

As the United Nations agency on migration, IOM is committed to further advance a gender-responsive approach throughout the migration cycle and we hope that this research report will contribute thereto. The papers in this research report explore existing evidence on the impacts of COVID-19 on migration from a gendered perspective and shed light on potential lessons for policy and programmatic response.

This collection of work contributes to our efforts to bridge evidence-based research and gender-responsive policymaking and programming in the field of migration. The issue of gender equality is among our Organization's priorities to support States implementing the objectives of the Global Compact for Safe, Orderly and Regular Migration and participating in the realization of the Sustainable Development Goals. But, more fundamentally, mainstreaming gender equality throughout the migration cycle is at the core of IOM's mission to support migrants and their families, as well as origin and receiving communities.


**Ugochi Daniels**
Deputy Director General for Operations

[1] *Global Compact for Safe, Orderly and Regular Migration, Report of the Secretary-General*. A/76/642, 27 December 2021.

# ACKNOWLEDGEMENTS

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This research publication benefited from the support and advice of a range of experts in migration and gender throughout the duration of the research project. A two-day inception workshop was organized on 14 and 15 June 2020 with the authors of the thematic papers, in which experts participated. In September, three thematic webinars on "Maximizing the impact of evidence-based research" were organized, with presentations made by experts on the topic. Finally, the final thematic papers in the report benefited from review comments provided by the Expert Panel. Each paper was reviewed by two reviewers, one from the academia and one from an intergovernmental, non-governmental or philanthropic organization. The list of all experts is provided below by last name alphabetical order.

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The project was managed by Céline Bauloz (Head, Migration Research Unit), with support of Jenna Blower (Consultant, Migration Research Unit) and under the direction of Marie McAuliffe (Head, Migration Research and Publications Division). The project benefited from close coordination with the donor, especially David Léger St-Cyr (Assistant Director, International Migration Policy, IRCC) and Megan Pickup (Policy Analyst, IRCC), with strategic expert inputs from Stephanie Leung (Director, International Migration Policy, IRCC). The report was copy-edited by Simon Hay, with the publication design and layout by Harvy Gadia under the direction of the Head of IOM Publications Unit, Valerie Hagger.

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# INTRODUCTION

Since the onset of the pandemic, emerging evidence has confirmed that COVID-19 has been the "great disrupter", including in the context of migration. Most prominently, COVID-19-related border closures and travel restrictions forced aspiring migrants to remain immobile.[1] According to the United Nations Department of Economic and Social Affairs (DESA), COVID-19 has reduced the growth in the stock of international migrants by around 2 million.[2] But COVID-19 and the consequent economic downturn have more generally affected some of the 281 million migrants around the world, throughout the migration cycle (see Table 1 below).[3]

**Table 1. Impacts of COVID-19 throughout the migration cycle**

| Setting | Impacts |
|---|---|
| Departure from countries of origin | Migrants have been unable to depart on planned migration journeys, such as for work, study or family reunion.<br>People needing to seek asylum or otherwise depart unstable countries have been prevented from leaving, putting them at risk of violence, abuse, persecution and/or death. |
| Entry into transit or destination countries | Migrants (including refugees and asylum seekers) have been increasingly unable to enter transit and destination countries, as restrictions have been progressively implemented and/or strengthened.<br>Impacts have been felt acutely in specific sectors, such as agriculture during harvest seasons, and global food supply chains have been disrupted. |
| Stay in transit and destination countries | Impacts on migrants have been profound, especially for the most vulnerable in societies who are without access to social protection and health care, and have also faced job loss, xenophobic racism and the risk of immigration detention, while being unable to return home. Further, refugees and internally displaced persons in camps and camp-like settings are subject to cramped, poor living conditions not conducive to COVID-19 physical distancing and other infectioncontrol measures. |
| Return to countries of origin | Border closure announcements in some countries caused mass return to origin for fear of being stranded without income or access to social protection. The inability to return has resulted in large numbers of migrants being stranded around the world. There have been mass repatriation operations by some States, but many others have been unable to afford or organize repatriations, leaving migrants at risk. |

*Source:* McAuliffe, 2020.

These COVID-19 impacts have in fact revealed and exacerbated pre-existing vulnerabilities, linked to a range of diverse factors among which the (adverse) drivers of migration, migration routes and migration status have played a key role. But all migrants have not been affected in the same manner, as gender inequalities have also been exacerbated throughout the migration cycle.

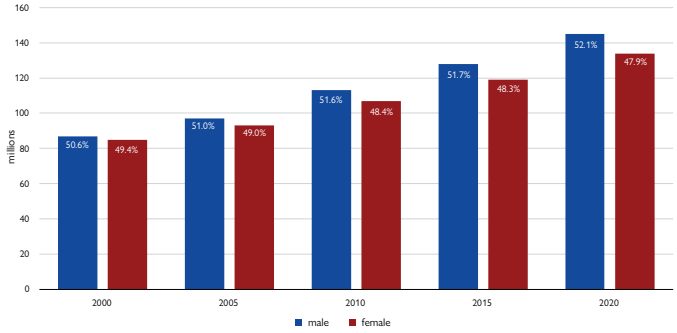
## The interlinkages between migration and gender

Gender underpins the migration cycle, from (pre-)departure, to entry, stay and return to the extent that migration is often approached as a gendered phenomenon.[4] Migration is not gender neutral. This is evident when considering the numbers and shares of international migrants worldwide over

1 McAuliffe et al., 2021.
2 DESA, 2021a.
3 DESA, 2021b.
4 Piper, 2008.

the last 20 years. While the long-term global trend has been that of an increase in the number of both female and male migrants, since 2000, the gender gap has widened, which calls into question the so-called "feminization of migration". As shown in Figure 1, in 2000, 49.4 per cent of all international migrants were female, while in 2020, that figure had decreased to 47.9 per cent.[5] The gap between the numbers of female and male migrants grew from 1.2 percentage points in 2000 to 4.2 percentage points in 2020.

**Figure 1.** **International migrants, by sex, 2000–2020**

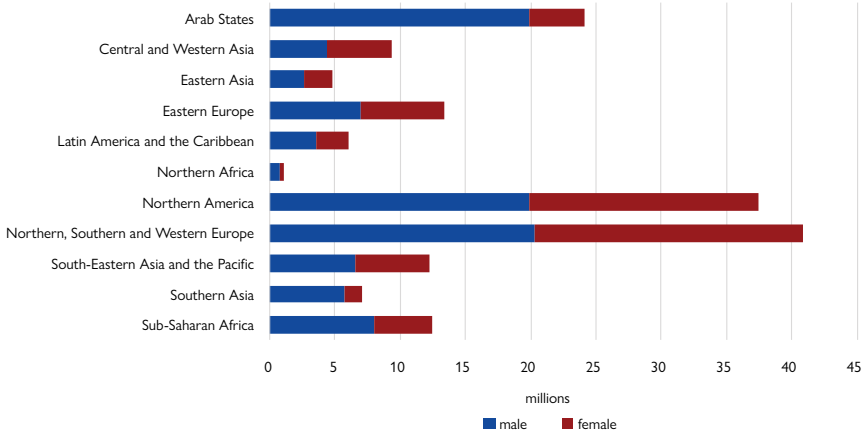



*Source:* IOM, 2021:28, based on DESA, 2021b.

A widening gap can also be observed in the share of male and female migrant workers worldwide, depicting an increasingly gendered migrant worker population. In 2013, female migrant workers made up 44.3 per cent of the migration worker population, whereas in 2019, they made up only 41.5 per cent, with a higher proportion of men in low- and middle-income countries.[6]

While almost 61 per cent of all migrant workers in 2019 resided in three subregions (Northern America, the Arab States, and Northern, Southern and Western Europe), evidence also highlights a gendered geographical distribution of migrant workers in certain regions (see Figure 2). A significant gender imbalance of migrant workers is more particularly striking in two regions: in Southern Asia, where over 80 per cent of migrant workers are male (5.7 million) and less than 20 per cent female (1.4 million); and in the Arab States, where over 82 per cent of migrant workers are male and less than 18 per cent are female (19.9 million and 4.2 million, respectively).

**Figure 2.** **Geographic distribution of migrant workers by sex (millions), 2019**




*Source:* IOM, 2021:38, based on ILO, 2021.
*Note:* The figure reflects ILO geographic regions and subregions and does not imply official endorsement or acceptance by IOM.

[5] IOM, 2021:27–28.
[6] ILO, 2021. See IOM, 2021:37.

Against this background, understanding the extent to which gender and migration interrelate is central to address gender inequalities and gender-based discrimination and violence in order to realize the 2030 Agenda for Sustainable Development, specifically sustainable development goal no. 5.[7] In the context of migration, the Global Compact for Safe, Orderly and Regular Migration is based on a set of cross-cutting and interdependent principles that guide the implementation of the 23 objectives and their related actions. Of these principles, gender-responsiveness is a key one:

> *The Global Compact ensures that the human rights of women, men, girls and boys are respected at all stages of migration, that their specific needs are properly understood and addressed and that they are empowered as agents of change. It mainstreams a gender perspective and promotes gender equality and the empowerment of all women and girls, recognizing their independence, agency and leadership in order to move away from addressing migrant women primarily through a lens of victimhood.*[8]

## Exploring the impacts of the COVID-19 pandemic

The objective of this research report is to explore and critically examine the short- and longer-term gender implications of COVID-19 impacts on migration and on the well-being of migrants worldwide. It seeks to inform policy and programmatic responses to the pandemic and beyond. The research project, of which this research report is the main output, was initially submitted to the International Migration Capacity Building Program of Immigration, Refugees and Citizenship Canada in September 2020. At the time, six months after the declaration of a pandemic by the World Health Organization on 11 March 2020,[9] there was scant evidence regarding the actual impacts of the COVID-19 pandemic on migration and migrants, and even less from a gender perspective. Research addressing these potential impacts were more exploratory in nature, although some preliminary conclusions turned out to be later confirmed.[10]

As COVID-19 has revealed and exacerbated pre-existing vulnerabilities and structural inequalities, the papers in this research report highlight the need for an intersectional approach to understanding the impacts of the pandemic on migration and migrants. Alongside other intersecting considerations, migration status, gender, gender identities and sexual orientations are indeed important interrelated factors to a comprehensive analysis of the impacts of COVID-19, and to identifying and producing gender-responsive policy and programmatic responses genuinely tailored to the diverse needs of migrants. Moreover, as some of the papers highlight, an intersectional approach not only aims at addressing cross-cutting discrimination, but also at empowering those who experience that discrimination,[11] namely, migrants of various genders, gender identities or sexual orientations.

7 UNGA, 2015.
8 UNGA, 2018a.
9 WHO, 2020.
10 See for instance Gamlen, 2020; Hennebry and KC, 2020; Freier, 2020; Foley and Piper, 2020; McAdam, 2020; and McAuliffe and Bauloz, 2020.
11 UN-Women, 2021.

## Key terms used in this research report

### Gender

The socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to males and females on a differential basis. Gender is relational and refers not simply to women or men, but to the relationship between them.

*Source*: IOM, 2019, citing UN-Women, 2014.

### Gender identity

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body and other gender expressions, including dress, speech and mannerisms.

*Source*: UNGA, 2018b.

### Gender-based violence

An umbrella term for any harmful act that is perpetrated against a person's will and is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and denial of resources, opportunities or services, forced marriage and other deprivations of liberty. These acts can occur in public or in private.

*Note*: Gender-based violence is often use in the same context as violence against women and girls, however it should be noted that gender-based violence can affect anybody.

*Source*: IOM, 2019, adapted from IASC, 2015.

### Gender mainstreaming

The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres.

*Source*: UN-Women, 2014.

### Internally displaced persons

Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

*Source*: ECOSOC, 1998.

### Intersectionality

[Intersectionality] recognises that people's lives are shaped by their identities, relationships and social factors. These combine to create intersecting forms of privilege and oppression depending on a person's context and existing power structures such as patriarchy, ableism, colonialism, imperialism, homophobia and racism.

*Source*: UN-Women, 2021.

### LGBT/LGBTI

LGBT stands for "lesbian, gay, bisexual and transgender"; "LGBTI" for "lesbian, gay, bisexual, transgender and intersex". While these terms have increasing resonance, different cultures use different terms to describe people who have same-sex relationships or who exhibit non-binary gender identities (such as hijra, meti, lala, skesana, motsoalle, mithli, kuchu, kawein, travesty, muxé, fa'afafine, fakaleiti, hamjensgara and two-spirit).

*Source*: United Nations, n.d.

### Migrant

An umbrella term, not defined in international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons who particular types of movement are legally defined, such as smuggled migrants, as well as those whose status or means of movements are not specifically defined under international law, such as international students.

*Source*: IOM, 2019.

### Migrant worker

A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.

*Source*: United Nations, 1990.

### Migration

The movement of persons away from their place of usual residence, either across an international border or within a State.

*Source*: IOM, 2019.

### Sexual orientation

Sexual orientation refers to a person's physical, romantic and/or emotional attraction towards other people. Everyone has a sexual orientation, which is part of their identity. Gay men and lesbians are attracted to individuals of the same sex as themselves. Heterosexual people are attracted to individuals of a different sex from themselves. Bisexual (sometimes shortened to "bi") people may be attracted to individuals of the same or different sex. Sexual orientation is not related to gender identity and sex characteristics.

*Source*: United Nations, n.d.

### Refugee

A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [or her] nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

*Source*: IOM, 2019, adapted from United Nations, 1951, as amended by United Nations, 1967.

## Key findings

The papers in this research report all cover diverse aspects of the impacts of COVID-19 on migration, and on migrants, from a gender perspective. The first set of papers cover different "groups" of migrants, ranging from health-care workers to agricultural and domestic migrant workers, internally displaced persons and international students. The following papers then focus on vulnerabilities of specific migrants that have been revealed or exacerbated by the pandemic, including of migrant mothers, Venezuelan female migrants, refugees and, more generally, migrants at risk of human trafficking. The last two papers explore the impacts of increasingly digitalized societies, especially during COVID-19, both in terms of the appropriation and innovation of digital technologies by refugees, and in terms of the proliferation of artificial intelligence (AI) technologies and their implications for migrants.

Key findings from each paper are provided below, with main takeaways for policy and programmatic responses. Lessons learned from the COVID-19 pandemic are important, as noted by the United Nations Secretary-General to the General Assembly on the Global Compact for Safe, Orderly and Regular Migration:

> *The lessons of the pandemic provide a timely opportunity to recalibrate gender-responsive and child-sensitive migration governance at the local, national, regional and global levels so that the commitments of the Compact, the 2030 Agenda and the declaration on the commemoration of the seventy-fifth anniversary of the United Nations are fulfilled for all migrants, and indeed for everyone.*[12]

The findings made in the different papers converge around some key useful insights for policy, as detailed in the textbox below.

### Key insights for policy

- Gendered assumptions on employment sectors and occupations remain prevalent, with the perception that women are primarily caregivers, both within and outside their home. These stereotypes heavily influence migration decisions, flows and individual experiences right through the migration cycle.
- Adopting an intersectional lens based on migration status and gender, including gender identities, is central in order to better understand the vulnerable situations and challenges in which migrants may find themselves, as well as to understand how to empower them. While papers in this research report primarily highlight the experiences of female migrants and migrants of diverse gender identities and sexual orientations, this must not be understood to minimize or exclude the experiences and situations of migrant men and boys, including single men travelling alone, who may also find themselves in situations of vulnerability and need of support.

[12] UNGA, 2021:23.

- Beyond all the challenges brought by COVID-19, the pandemic has also offered a window allowing the adoption of innovative policies, practices and programmes:
  - Temporary regularization programmes of irregular migrants adopted in certain countries during the pandemic have underscored the importance of increasing regular pathways for migration beyond the pandemic context. Most vulnerabilities experienced by migrants are indeed linked to irregular and precarious migration status, undermining their access to health care and social protection and increasing their exposure to risk and exploitation. Given highly gendered migration flows and corridors (especially labour migration), the implementation of such new pathways requires due consideration for gender dynamics at play in different geographical locations.
  - Empowering migrants of different genders, gender identities and sexual orientations calls for their active participation in policies and programmes that affect them. A bottom-up approach, relying on local and community-based initiatives, is also essential for the effectiveness of support measures, ensuring both trust and buy-in from migrant communities.
  - While digital technology solutions have been increasingly deployed throughout the COVID-19 pandemic, these solutions need to address migrants' needs and challenges in terms of technological appropriation to be effective, including from a gender perspective. Due consideration also needs to be given to their unintended impacts on migrants, especially with regard to confidentiality and data protection, which may raise real risks for migrants and refugees of diverse gender identities and sexual orientations.

## "COVID-19 implications and opportunities for migrants working in the heath-care sector"

Margaret Walton-Roberts
Hari KC
Tobi Ogundele

- The COVID-19 pandemic has revealed the extent to which care provision, including health care, is dependent on women migrants. Globally, 70 per cent of health-care workers are women. Across 80 Member States of the World Health Organization, over a quarter of doctors and over a third of dentists and pharmacists are foreign trained or foreign born.
- The adoption of gender-responsive bilateral labour agreements in the health-care sector, addressing gender-specific challenges faced by women migrant health-care workers, provides a promising avenue benefiting sending and receiving countries as well as migrant themselves. These can streamline procedures for recognizing foreign qualifications, and can be complemented by regulatory responses in the receiving country in terms of fair access to professions.
- Better health workforce data systems and more collaborative policy agendas – such as the WHO International Platform – are crucial to strengthening the health-care workforce in case of future pandemics.

### "COVID-19 and the intersections of gender, migration status, work and place: Focus on Hong Kong Special Administrative Region, China, and Ontario, Canada"

Denise Spitzer

- Gender is an important factor shaping the type of activity performed by migrant workers: among the estimated 169 million international migrant workers, 70 million are women. A total of 79.9 per cent of women migrant workers are employed in the service sector, including care and domestic work. Men migrant workers also work primarily in the service sector (56.4%), but compared to women, a greater proportion are engaged in the industrial and agricultural sectors (35.6% and 7.9%, respectively).
- While COVID-19-related travel and quarantine restrictions have undermined labour migration and the return of migrant workers to their countries of origin, the pandemic has highlighted the extent to which the precarious or undocumented migration status of migrant workers constitutes a core factor of vulnerability. Both female domestic workers in Hong Kong Special Administrative Region, China, and male agricultural migrant workers in Ontario, Canada, faced increased risks linked to their living conditions, as well as to COVID-19 infections.
- Some promising policies and practices to address the vulnerability that migrant workers have experienced during the pandemic could be taken beyond the pandemic context. These include regularizing undocumented workers, offering more permanent residence status to temporary migrant workers and extending work visas to avoid irregular status. Specific COVID-19 support measures for migrant workers also cover sheltering stranded migrants, offering free COVID-19 screening and vaccinations, ensuring paid quarantines and COVID-19 treatments, securing access to social protection programmes and providing multilingual COVID-19 information.

### "Power, protection and policy: Domestic workers in Arab States during COVID-19"

Shaddin Almasri

- There are an estimated 11.5 million migrant domestic workers, 73.4 per cent of whom are women, globally. In May 2020, the ILO estimated that 73.7 per cent of domestic workers globally were severely impacted by COVID-19 measures.
- The highest proportion of migrant workers reside in the Arab States: 35.6 per cent of all migrant workers globally. About 6 in 10 women migrant workers in the region are domestic workers. The vulnerabilities of these workers increased during COVID-19, with job losses and precarious working hours, increased risk of exposure to COVID-19, and insufficient or limited social and labour protections making female migrant domestic workers even more dependent on their employer.
- While the provision of ID cards in some countries has secured the inclusion of undocumented migrant workers in COVID-19 health measures, the pandemic has more fundamentally revealed the importance of recent measures adopted pre-pandemic to protect migrant workers, such as health insurance as a condition for employment, wage protection systems and minimum wages.

## "Gendered impacts of COVID-19 on people internally displaced due to disasters in Latin America and the Caribbean"

Roberto Ariel Abeldaño Zuñiga
Edgar Ulises Osorio Guzmán
Ana María González Villoria

- In the first year of the COVID-19 pandemic, in 2020, disasters caused nearly 2.8 million new internal displacements in Latin America and the Caribbean, of which over 2.1 million were due to three disaster events: hurricanes Laura, Eta and Iota. Their impacts happened concomitantly with those of the COVID-19 pandemic and were contingent on a range of intersecting factors, among which gender played a key role, given the pre-existing social and structural gender differences in these predominantly conservative societies.
- While available data do not evidence a clear correlation between peaks of COVID-19 infections and persons displaced by the three hurricanes in affected countries, evidence points to impacts that are differentiated by gender, in terms of (mental) health, gender-based violence, employment and food insecurity, with the differences especially marked for female-headed households.
- While internally displaced persons remain often not included in COVID-19 responses, it remains important to mainstream a gender-responsive approach into disaster risk reduction while increasing the involvement of female internally displaced persons. There is also a need for data on internally displaced persons to be disaggregated by gender, in order to better understand the different needs and responses of internally displaced persons of diverse genders.

## "COVID-19 and tertiary education: Implications for international students' mobility"

Jérôme Gonnot
Mauro Lanati

- The COVID-19 pandemic and related mobility restrictions have had a significant impact on the numbers of new international student enrolments in higher education institutions and on the numbers of student visa applications in OECD countries, with some international students deferring their studies abroad.
- While there is scant evidence regarding the gender impacts of COVID-19 on international student mobility, the pandemic may entail some gender-specific consequences when it comes to the decision to study abroad. On the one hand, female international students usually experience greater emotional and psychological challenges when studying abroad. These, during the pandemic, may further influence their decision to defer studying abroad for reasons such as personal safety, health and wellbeing in the country of destination and care responsibilities for family elders in their country of origin. On the other hand, women from developing countries may have more incentives to study abroad in more developed countries, as the pandemic and the economic downturn may have reduced their job opportunities relative to those of men in their country of origin.
- Temporary short-term policy responses have been made by countries to limit the pandemic's impact on international student mobility, including introducing online procedures to address delays in student visa applications, extending enrolment deadlines and allowing deferrals to the following academic year for international students unable to travel. Longer-term and gender-specific responses, however, remain needed, especially in promoting equal opportunities in the labour market for both men and women, as job prospects appear to be the main driver of international student mobility.

### "A trifecta of responsibility: Latin American migrant women in the United States managing job loss, children's learning and international remittances during COVID-19"

Sarah Bruhn
Gabrielle Oliveira

- In the United States of America, migrant mothers from Latin American countries have experienced a trifecta of gendered responsibilities during the COVID-19 pandemic. That is, migrant mothers were more vulnerable to job loss, given their overrepresentation in service industries not amenable to remote working; they were expected to support their children's education at home, because of remote schooling; and they were expected to shoulder the majority of care work, both domestically and transnationally, in terms of care for extended family.
- When undocumented, migrant mothers from Latin America in the United States were often unable to benefit from federal or state policies adopted in response to COVID-19 because of their undocumented status; or, when these policies did not require regular migration status, because of their fear of coming to the attention of the authorities and being deported.
- The case of migrant mothers from Latin America more generally highlights the need to strengthen support for migrant mothers, even beyond the pandemic. Among such core responses are the adoptions of support measures not linked to migration status and of firewalls between service providers and immigration authorities.

### "Venezuelan migrant women's experiences with discrimination during the COVID-19 pandemic in Colombia, Ecuador and Peru"

Luisa Feline Freier
Andrea Kvietok Dueñas
Marta Castro Padrón

- Venezuelan migrants and refugees have primarily moved to neighbouring countries: out of the 6 million Venezuelans abroad as of November 2021, over 4.9 million were in Colombia, Peru, Ecuador, Chile and Brazil. While the number of Venezuelan female migrants has tended to increase over the years, the number of Venezuelan female migrants in Colombia and Peru has decreased since 2020, likely as a result of the COVID-19 pandemic.
- The COVID-19 pandemic has exacerbated pre-existing gendered vulnerabilities of Venezuelan women living in neighbouring countries, as well as the diverse discriminations they experience in the streets and in workplaces, as well as in terms of their access to health care. Findings suggest that (1) women with diverse sexual orientations tend to experience higher levels of discrimination than heterosexual women; (2) women who self-identify as Afro-Venezuelans and mestizo experience more discrimination based on their socioeconomic status than those who self-identify as white; and (3) women with an irregular migration status tend to feel more often that they are being excluded or rejected from social activities and treated with less respect than others.
- Empowerment through education and psychological therapy is necessary to assist the heterogeneous group that form Venezuelan migrant women in processing gender-specific trauma. In addition, policy implications include increased regularization efforts, wider access to social protection and health services for displaced populations, national- and community-level mechanisms for combatting discrimination and violence, access to justice regardless of migratory status, intersectional programmes and policies, and the creation of safe spaces for migrant women.

### "Gendered assumptions of vulnerability: A case study of gendered impacts of COVID-19 on displaced populations at the borders of Europe"

Gemma Bird

- Understanding the vulnerability of refugees through a structural lens tends to portray refugee "womenandchildren" as a singular homogenized group, grounded in assumptions about gender binaries. Such an understanding often fails to recognize both women's agency and the vulnerable situations in which male refugees can find themselves. Both of these failures have implications in terms of who is prioritized for humanitarian assistance and the forms it takes.
- The COVID-19 pandemic and its impact on refugees' living conditions in camps, as well as on reception and identification centres, have highlighted the need for an intersectional approach which also understands vulnerability through a situational lens, that is, in light of individual circumstances and material conditions.
- Structural or "natural" understandings of vulnerability often underestimate the vulnerabilities of young men travelling alone, excluding them from critical assessments and decision-making around humanitarian assistance. Due considerations for individual needs, and questioning gendered assumptions, can improve policy and programmatic responses and the situation for migrants overall.

### "The migration–gender–health nexus: Mental health implications during the pandemic and beyond"

Lara-Zuzan Golesorkhi

- Refugees' mental health has traditionally been approached with a focus on pre-departure experiences, that is, persecution. The COVID-19 pandemic has, however, highlighted the need for a comprehensive approach to refugees' mental health across the whole migration journey, as other factors that influence refugees' mental health have been impacted by the pandemic. These include employment and income, housing and accommodation, asylum procedures, cultural practices and language proficiency, social support and isolation and discrimination and stigma.
- An intersectional policy analysis of refugees' mental health helps to capture their mental health needs and challenges along the migration cycle, which can translate into gender-responsive programming and policies. These include community programmes and awareness and advocacy campaigns around mental health that have proven successful, as highlighted in the different case studies of Brazil, Germany, Turkey and Uganda covered in the paper.

## "Increased vulnerability to human trafficking of migrants during the COVID-19 pandemic in the IGAD–North Africa region"

Audrey Lumley-Sapanski
Katarina Schwartz

- The COVID-19 pandemic has increased the risk of human trafficking faced by migrants along migration routes, especially in cases of irregular movement. Pre-existing intersectional vulnerabilities of migrants – such as gender and gender identities, but also migration status – were exacerbated by the impacts of the COVID-19 pandemic. Female migrants already overrepresented in informal work in the IGAD region, for example, were more likely to lose their employment or work in more precarious conditions, increasing the risk of exploitation or of human trafficking.
- The COVID-19 pandemic highlighted the central role played by organizations and institutions in identifying victims of trafficking and providing support to survivors. The identification of trafficked victims by law enforcement authorities and other entities was hampered by mobility restrictions and lockdowns, while safe houses for female survivors were closed, leaving them at risk of re-trafficking.
- Addressing these vulnerabilities, even beyond the COVID-19 pandemic, calls for increasing the availability of pathways for regular migration and regular migration status, with direct attention to the gendered implications and responses along migration routes and in destination countries.

## "Digital technology and refugees in sub-Saharan Africa during COVID-19"

Wesli H. Turner
John Bosco Nizeimana

- Although individual Internet use increased worldwide in 2021, the appropriation of digital technology remains contingent on geographical location, including differences between urban and rural locations, connectivity costs and digital literacy, which may be highly gendered.
- Due to intersecting gender, migration status and location factors, especially when in refugee camps, female refugees in sub-Saharan Africa tend to lack both access to digital technology and the skills for its use. In highly digitalized societies, this negatively impacts their empowerment; even more so during the pandemic. Limitations to their access to digital solutions as a result of mobility restrictions and lockdowns were critical, especially regarding digital payments, e-learning, public health information or health-care connectivity.
- While traditional information mediums – such as the radio – remained important to reach out to refugee populations during the pandemic, digital technology initiatives carried out by refuges and refugee-led organizations were undertaken to counter misinformation on COVID-19, to provide access to health care and legal services and to ensure children's access to information and education. Although only some of these initiatives were geared towards addressing the specific needs of female and LGBTQI refugees, they all highlighted the importance of community engagement, which ultimately increased trust and buy-in.

## "Protecting migrants against the risks of artificial intelligence technologies"

Eleonore Fournier-Tombs
Céline Castets-Renard

- COVID-19 has accelerated the deployment of AI in relation to migration and migrants for the purposes of predicting the movement of people, providing digital identities to refugees and migrants and managing visa, border and asylum processes.
- Despite their potential benefits, AI technologies can negatively impact individuals through algorithmic errors and biases; as well, there are potential risks to data privacy and protection. AI can exacerbate existing social biases, reinforcing gender stereotypes and – in the case of female and non-binary migrants – increase risks to migrants' safety, if their data are not appropriately protected.
- The adoption of new and stronger AI regulations in line with migrants' rights is central to address the negative implications AI may have for the most vulnerable populations such as migrants and refugees. These regulation processes can include the adoption of certification schemes before the deployment of new AI technologies, as well as ethical guidelines for their use.

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Sumaiya is a front-line physician at one of IOM's Health Centres in Cox's Bazar. Along with a team of trained staff, she manages suspected COVID-19 cases at the Isolation Treatment Facility. Health-care professionals are working around the clock to provide adequate support to all Rohingya refugees in Cox's Bazar. "We understand the risks and many of us leave family members at home to do this work. Seeing appreciation for what we do helps us stay strong and it is important for us to work effectively."

# 1. COVID-19 IMPLICATIONS AND OPPORTUNITIES FOR MIGRANTS WORKING IN THE HEALTH-CARE SECTOR


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## Introduction

The importance of care as well as the fragilities of global health-care systems have been laid bare during the COVID-19 pandemic.[1] The COVID-19 pandemic has amplified various long-standing systemic inequalities and disparities, based on gender, race, ethnicity, and nationality.[2] For instance, 54 per cent of pandemic-related job losses are borne by women, who constitute only 39 per cent of global employment.[3] For health-care workers, the pandemic has revealed these disparities in terms of infection and mortality rates. In Spain, 75.5 per cent of coronavirus-infected health-care workers were women (21,392 of 28,326), while in Italy, women make up 64 per cent of health workers, representing 69 per cent of the infected (14,350 of 20,797).[4] In the United States, 73 per cent of infected health-care workers were women (6,603).[5] Furthermore, analysis has shown how intersectional disadvantages have disproportionately exposed racialized female immigrant health workers to COVID-19 infection and mortality in the United States of America and the United Kingdom.[6] The pandemic has also revealed the range of care provision dependent on the labour of women, including immigrant women. As well, much of the daily health-related support provided to people with disabilities and to elderly people in diverse care sectors is performed by those who are not traditionally considered "health-care workers", but who are disproportionally women. Over half of all female workers (56%) are employed in occupations involving the "5 Cs": caring, clerical, catering, cashiering, and cleaning.[7]

This paper demonstrates how the global COVID-19 pandemic has revealed the importance of immigrant health and allied care workers in Organisation for Economic Co-operation and Development (OECD) countries, and examines some innovative policy responses to this situation that improve the integration and recognition of immigrant health and care workers. The OECD is a group of high-income market-based democratic governments; the health and care systems of these countries benefit from the global circulation of immigrant health workers, the majority of whom

1 ICN, 2021; Pappa et al., 2021.
2 Foley and Piper, 2020; UN-Women, 2021; Momani et al., 2021.
3 Madgavkar et al., 2020.
4 UN-Women 2020, data as of January 2021.
5 United States Department of Health and Human Services, 2020.
6 For the United States, see Nazareno et al., 2021; for the United Kingdom see Dean, 2020. "Racialized" here refers to the process of categorizing, marginalizing or regarding according to race.
7 Oxfam Canada, 2021.

are women. Any agendas that promote the idea of "building back better" after COVID-19 should address the structural devaluation of women's contribution to health and care, and promote their leadership and equitable inclusion in the labour market.[8]

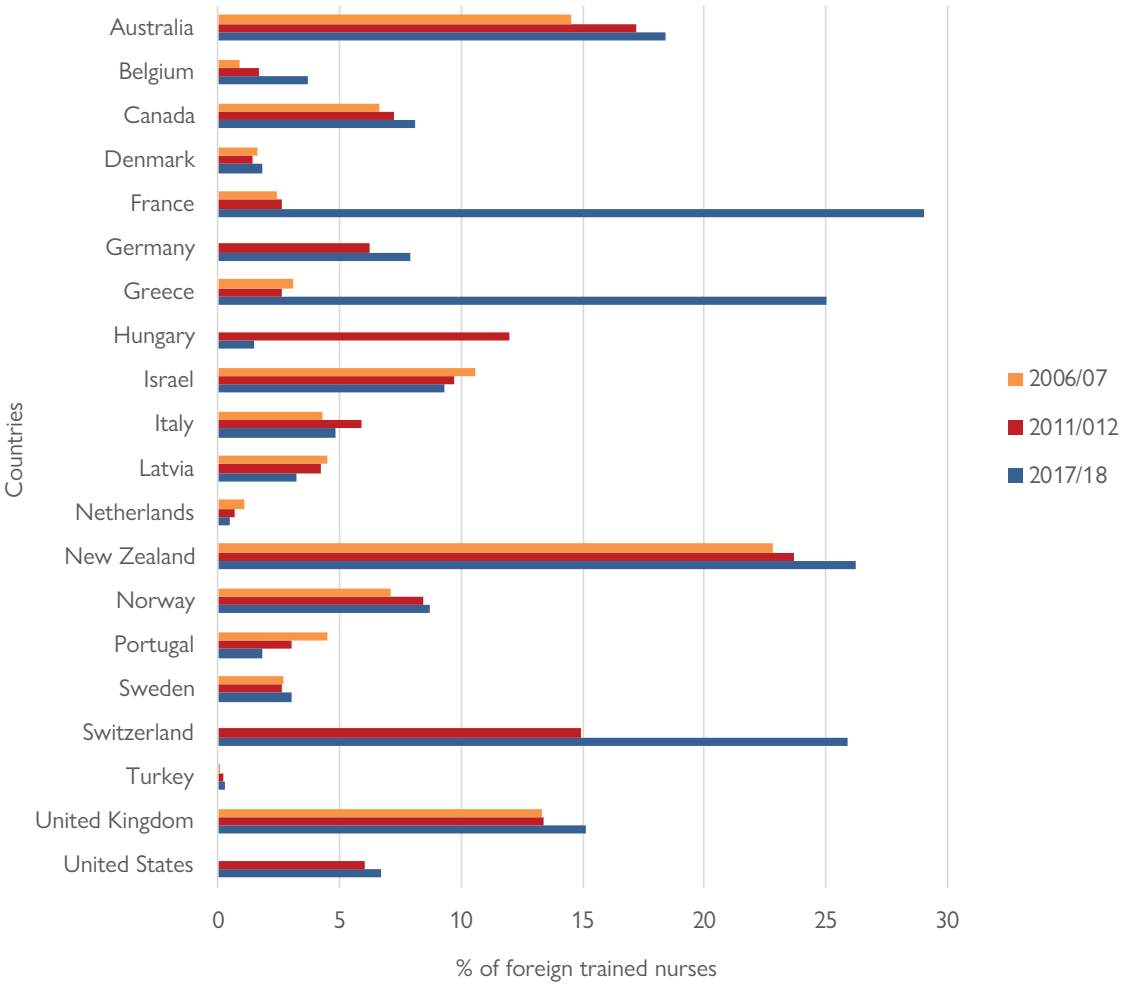
## Immigrant health and care workers

Over the past half century, the integration of immigrant health-care workers has increased in wealthy countries that have not been able to achieve self-sufficiency in the training and retention of their own health workers.[9] Indeed, the presence of immigrant health-care workers across 80 World Health Organization (WHO) Member States indicates their significant contribution to health systems globally, with over a quarter of doctors and over a third of dentists and pharmacists being foreign trained and/or foreign born.[10] Foreign-trained health professionals make up a significant portion of the total workforce in both regulated and unregulated health and care occupations. The share of foreign-trained doctors ranges from less than 3 per cent in some OECD countries, to around 40 per cent in Norway, Ireland, and New Zealand, and to nearly 60 per cent in Israel. In Canada, as of 2019, 9 per cent of nurses were foreign trained, while over a third of pharmacists and 19 per cent of doctors were.[11] On average, across OECD nations, 16 per cent of nurses and just under 30 per cent of doctors are foreign born. Immigrants make up 29 per cent of physicians and 22 per cent of nursing assistants in the United States. In the United Kingdom, 13.3 per cent of National Health Service (NHS) workers report a non-British nationality. According to the *State of the World's Nursing Report*, about one in eight of all nurses globally are practicing in a country different from where they were born.[12]

Figure 1 shows that, across OECD countries, the overall number of foreign-born nurses more than doubled between 2000/01 and 2015/16, while the overall increase in nursing workforces was around 50 per cent (see Appendix A). Appendix A shows that Canada, Ireland, and the United Kingdom are near the top of the list for the share of foreign-born nurses. The number of foreign-born doctors in OECD countries increased by almost 70 per cent between 2000/01 and 2015/16. Over this time, OECD countries such as Luxembourg, France, Switzerland, Germany, Canada, and the United States had the highest share of foreign-born doctors.[13] United States Census Bureau data show that currently there are nearly 1.7 million foreign-born medical and health-care workers in the United States, many of whom are aiding in the effort to care for the growing number of COVID-19 patients.[14]

8 WEF, 2021.
9 Bludau, 2021.
10 WHO, 2021.
11 CIHI, 2019.
12 WHO, 2020b.
13 OECD, 2021.
14 Griswold and Salmon, 2020.

**Figure 1.** **Foreign-trained nurses working in OECD countries, 2006/07, 2011/12, and 2017/18 (or nearest year)**




*Source:* Authors' elaboration, based on OECD, 2021.

The presence of global mobility for health occupations is clear, but the feminized nature of many health and care professions makes this an intersectional gendered issue involving immigrants who are predominately women. Gender here includes not only males and females but also non-binary gender identities, although existing data are usually not disaggregated in the health-care sector on this basis. These specific gendered differences are further intersected by immigrant status and other axes of difference.[15] Globally, female health-care workers constitute 70 per cent of the health-care workforce, which could increase up to 90 per cent if those working in the social care sector are included.[16] According to the *State of the World's Nursing Report*, approximately 90 per cent of the nursing workforce is female, but few leadership positions in health are held by nurses or women.[17] According to Canadian Institute for Health Information (CIHI) data, in 2019, most foreign-trained pharmacists (60%), nurses (91%), and unregulated health professionals (86%), were women, as was a significant portion of medical doctors (42.8%).[18] Further, many women working in care sectors are racialized, migrant, or undocumented.[19] For example, in 2016, 36 per cent of non-regulated health workers such as nurse aides, orderlies, and patient service associates in Canada were foreign trained.[20]

[15] OECD, 2021.
[16] Lotta et al., 2021.
[17] WHO, 2020b.
[18] CIHI, 2019.
[19] Canadian Women's Foundation, 2020.
[20] Turcotte and Savage, 2020.

## Migrant health-care workers during the COVID-19 pandemic

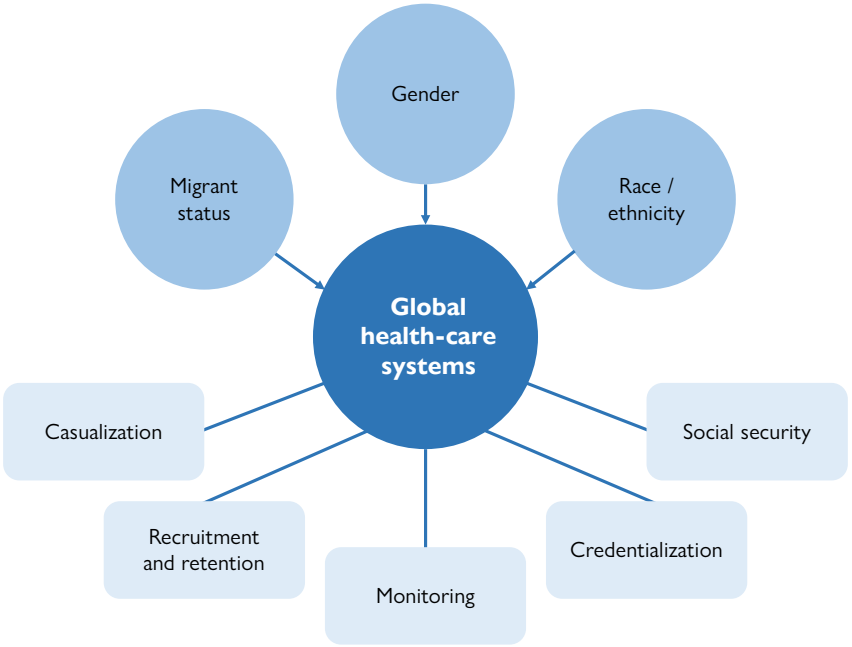
Female health-care workers worldwide are facing, through their care work, the effects of the pandemic. These include mental health issues, increased physical violence, engaging in alternative domestic arrangements to protect their families, and physical exhaustion.[21] The pandemic came on the footsteps of a decade of austerity that has seen budget cuts in the long-term care (LTC) sector, shifting care from higher to lower professional levels, and from paid to unpaid caregivers.[22] The intersection of gender and racial hierarchies in the health sector has often exacerbated existing health and safety risks.[23] Besides being on the front lines of the pandemic, immigrant nurses find themselves at the centre of intersecting gender and care dynamics, as they are often the main breadwinners, sending remittances to relatives in several countries.[24]

Numerous factors contribute to the creation of these intersectoral vulnerabilities (see Figure 2). The increased vulnerability of migrant workers stems from a combination of factors including their disproportionately high representation in (i) front-line and entry-level jobs; (ii) precarious employment that involves low pay and several casual or part-time jobs at multiple health institutions; and (iii) health sectors – such as LTC – that are severely affected by the pandemic due to years of structural neglect, chronic health provider shortages, understaffing, lack of investment in staff training,[25] and problems with personal protection equipment (PPE) access, fit and design.[26] In addition, some care workers are provided with limited or no social protections such as paid sickness leave or health benefits. For example, on average, half of LTC workers engage in shift work (such as working mornings or afternoons only) across 20 OECD countries.[27] Those who work irregular and odd shift times, on the one hand, experience greater work stresses and family conflicts,[28] and on the other hand, such shift work typically offers fewer employment benefits than does a regular workday shift. In the United Kingdom, many of those who make up the ranks of essential workers are migrants who will not be eligible to remain in the country under the current Government's new immigration policy, which deems all those who earn less than GBP 25,000 annually to be unskilled and unwelcome.[29] The overrepresentation of racialized and feminized workers in occupational care roles disproportionately exposed to infection and mortality is evidenced in various reports. This includes a report from the largest nurse's union of the United States, published in September 2020, stating that 31.5 per cent of registered nurses who died of COVID-19 were of Filipino origins, whereas Filipino nurses only make up 4 per cent of the registered nurses nationally.[30]

Racialized and ethnic minority health workers are disproportionality affected by COVID-19, but data do not always fully capture this.[31] This is a global data problem, since of 192 countries providing data only 54 per cent report data disaggregated by sex, never mind other relevant intersectional factors.[32] These data weaknesses undermine our ability to understand the differential risks the global health workforce (immigrant and non-immigrant) have faced. It is thus imperative to collect data that are disaggregated by gender, race and ethnicity, in order to understand the impacts and implications of the pandemic, including on migrant health-care workers.

[21] Lotta et al., 2021; Turquet and Koissy-Kpein, 2020; ICN, 2021.
[22] Béland and Marier, 2020; Daly, 2020.
[23] UN-Women, 2021.
[24] Nazareno et al., 2021.
[25] Gunn et al., 2021.
[26] Women in Global Health, 2021.
[27] OECD, 2020b.
[28] Golden, 2015.
[29] Stevano et al., 2021.
[30] National Nurses United, 2020.
[31] Erdem and Lucey, 2021.
[32] Ogundele and Walton-Roberts, 2021.

**Figure 2.** **Multiple axes of marginalization overlap and intersect to produce the differential impacts**




*Source:* Authors' elaboration.

## Innovative policies and practices during the pandemic: Global and national contexts

Global attention has now been focused on the need to invest in health workers for shared dividends in health, jobs, economic opportunity, and equity. The WHO designated 2021 as the "International Year of Health and Care Workers" and launched a year-long campaign under the moniker "Protect. Invest. Together".[33] The aim is to mobilize commitments from Member States, international financing institutions, and bilateral and philanthropic partners to protect and invest in health and care workers, in order to accelerate the attainment of the Sustainable Development Goals (SDGs), especially SDG 3 (good health and well-being), SDG 4 (quality education), SDG 5 (gender equality), and SDG 8 (decent work and economic growth), as well as COVID-19 recovery. The pandemic has amplified the need for more global collaboration not only between national governments but also across all stakeholders, including multilateral bodies such as WHO, the International Labour Organization (ILO) and IOM, as well as regional and subregional organizations. The COVID-19 pandemic has reinforced the arguments of the WHO's five-year action plan for health employment and inclusive economic growth (2017–2021), which draws on the recommendations of the United Nations High-level Commission on Health Employment and Economic Growth and is delivered through the joint intersectoral Working for Health (W4H) programme in partnership with WHO, the ILO and OECD.[34]

Both the United Nations High-level Commission and the 2020 *State of the World's Nursing Report* highlight the importance of strengthening the quality of health workforce related data, education, governance, and partnerships, with targeted support and safeguards for countries in greatest need. Stakeholders are encouraged to enhance health workforce policies through more careful consideration of how migrant health-care workers are recruited, integrated, and utilized within receiving country health systems. This includes greater adherence to the *WHO Global*

[33] See WHO Year of Health and Care Workers 2021. Available at www.who.int/campaigns/annual-theme/year-of-health-and-care-workers-2021.
[34] WHO, 2021.

*Code of Practice on the International Recruitment of Health Personnel* to improve the outcomes of health worker migration.[35] Improvements will require well-coordinated efforts among a range of stakeholders including licencing bodies, professional associations, researchers, research funding agencies, policymakers, and labour regulatory bodies.[36]

The pandemic has resulted in several innovative policy changes that address some of the barriers faced by internationally educated health workers. Some OECD countries have decided to expedite current applications for the recognition of foreign qualifications of health professionals (for example, Belgium, Germany, Ireland, Luxembourg), or to simplify procedures (for instance, reduced language testing in Germany, no in-person meeting in Lithuania, fee waivers in Ireland).

In response to COVID-19, many OECD countries (or states and provinces in the United States and Canada, respectively) have acted to enable migrant health professionals to help meet the surge in demand for health care. Current evidence presented suggests that in the early months of 2020, health immigrant receiving countries adopted various innovative and promising policy approaches to either increase the number of health workers in their countries or to encourage flexibility in employment requirements, especially for internationally educated health professionals. These actions may have taken the form of facilitating renewal of work authorization or recruitment, temporary and/or restricted licensure, fast-track processing of recognition of foreign qualifications, or enhancing access to some jobs in the health sector. Innovative policies for mobilizing internationally educated health professionals utilized by high health migrant receiving countries have been classified under the following categories:

- Temporary licensure. Temporary licenses are given for a short period of time, pending a health professional's ability to fulfil the normal eligibility requirements to practise in the country.
- Qualifications. Fast-track processing of recognition of foreign qualifications or reduction in postgraduate resident medical training.
- Visa timeframes. Innovative approaches that facilitate the renewal of work authorization and work visas for health professionals.
- Job market access. This includes access to jobs in the health sector and fast-tracked hiring processes.

In some cases, policy innovations were regionally encouraged. For example, in April 2020, the European Commission called upon "Member States to facilitate the smooth border crossing for health professionals and allow them unhindered access to work in a health-care facility in another Member State".[37] Table 1 shows that policy modifications were mostly geared towards increasing the number of health workers to meet COVID-19 pandemic demands. In some countries, temporary licenses were issued for physicians to work as either assistants or fully but for short periods of time (the United Kingdom, Italy, France). Other countries encouraged expedited qualification assessment processes (Belgium, Luxemburg, Germany, Ireland), while Ireland took this a step further by waiving the fee usually required during foreign qualification evaluations. In Spain, the Spanish ministries launched urgent, coordinated action for the immediate hiring of foreign health workers willing to work in Spain. About 400 people have been recruited as of the end of April 2020.

[35] Yeates and Pillinger, 2018.
[36] Gunn et al., 2021.
[37] OECD, 2020a.

**Table 1.** **Innovative practices from some OECD countries for mobilizing internationally trained health workers during the COVID-19 pandemic**

| Policy response description | Target group | Country | Intervention type |
|---|---|---|---|
| Policy modification to allow international nursing students to work more than 40 hours every two weeks | Nurses | Australia | Job market access |
| Expedited process of qualifications recognition | All health professionals | Belgium and Luxembourg | Foreign qualifications |
| Modification of hiring regulations to allow non-licensed foreign-trained health professionals to work as support staff in non-medical occupations | All health professionals | France | Job market access |
| Expedited process of qualifications recognition<br>Reduced language test<br>In Bavaria, some foreign doctors were offered permission to work as assistants for one year | All health professionals | Germany | Foreign qualifications, job market access, temporary licensure |
| Expedited process of qualifications recognition<br>Adoption of fee waivers for the evaluation of foreign qualifications | All health professionals | Ireland | Foreign qualifications |
| Adopted decree to enable the temporary licensing of foreign-trained health professionals | All health professionals | Italy | Temporary licensure |
| Removed the requirement of in-person meetings for qualification recognition | All health professionals | Lithuania | Foreign qualifications |
| Urgent and coordinated approaches led by Spanish ministries for the immediate hiring of foreign health workers | All health professionals | Spain | Job market access |
| Automatic extension of timeframes for expired or soon to expire work visas (by 1 year). As a response, in March 2020, the Nursing and Midwifery Council (NMC) have permitted many foreign-trained nurses from outside the European Union/European Economic Area, who were already in the United Kingdom, to join its temporary register without completing obligatory regulatory and testing requirements | Physicians, nurses and paramedics | United Kingdom | Visa timeframes |
| In health emergencies, the National Health Service can hire foreign health professionals even if they have not had their qualifications formally recognized | | Chile | |
| The state of New York gives international medical graduates access to a limited permit after only one year of approved postgraduate training, instead of three (EO 202.10). Similar measures have been adopted by the state of Massachusetts (two years of postgraduate resident medical training instead of three), while New Jersey has created a pathway for foreign-licensed physicians to get a temporary emergency license to practise medicine. In other states such as California, Colorado or Nevada, authority has been delegated to the chief of medical services to provide waivers regarding licensing of foreign health professionals. | | United States of America | |

*Sources:* OECD, 2020a, 2021.

Countries in North America took provincial or state-specific approaches to addressing the need for health workers using temporary licensures. Table 2 shows that Newfoundland and Labrador embarked on the emergency licensing of family medicine doctors for 30 days, while Ontario allowed internationally educated medical graduates to receive a supervised short duration certification that essentially allowed medical professionals who graduated from school in the past two years to apply for a supervised 30-day medical licence. In early 2022, Ontario Health and the College of Nurses of Ontario also announced the Supervised Practice Experience Partnership to allow internationally educated nurses access to supervised work experience, in order to expedite completion of their evidence of practice and language proficiency registration requirements.[38] In the United States, California, Nevada and Colorado considered waivers of licensing requirements for internationally educated health professionals. In New York, physicians licensed in other states within the United States, as well as physicians licensed outside the United States – specifically Canada – could practise. In Utah, internationally educated medical graduates who had done medical residency in either Australia, the United Kingdom, Switzerland, South Africa, Hong Kong Special Administrative Region, China, or Singapore could practise during the pandemic. In other parts of the world such as in South America, Chile modified hiring regulations. In Mexico, on 6 April 2020, the Government announced that it was considering contracting foreign health workers with the possibility of collaborations with the Cuban Government's international health workers. Most OECD countries have exempted health professionals with a job offer from travel bans and some continued processing their visa applications.

**Table 2.** **Innovative health worker policy responses to COVID-19 in North American states and provinces**

| State/province | Policy response description | Target group | Intervention type |
|---|---|---|---|
| Quebec | The Quebec Government asked for anyone with health-care experience to join through the Je Contribue! Website, including internationally educated health personnel | All health professionals | Job market access |
| Newfoundland and Labrador | Physician Emergency Licensing (family medicine doctors for 30 days) | Physicians | Temporary licensure |
| Nova Scotia | Open call for casual relief workers[39] to be deployed to Nova Scotia Health Authority (NSHA), LTC or other publicly funded health-care entities | Personal support worker, therapist | Job market access |
| Ontario | Ontario health workforce matching portal Home (force.com): hiring regulated and unregulated health professionals, as well as internationally trained professionals who are legally authorized to work in Canada. International medical graduates (IMG) who have passed their exams to practise in Canada or have graduated in the past two years can apply for a supervised 30-day medical licence (Supervised Short Duration Certificate). Supervised Practice Experience Partnership to allow internationally educated nurses access to supervised work experience. | All health professionals | Job market access, foreign qualifications |

[38] CNO, 2022.

[39] Nursing, health-care, administrative professional's support/facility workers (housekeeping, food service, unit aide positions), and emergency support aides.

| State/province | Policy response description | Target group | Intervention type |
|---|---|---|---|
| BC | IMG with at least two years of postgraduate training and who passed the Licentiate of the Medical Council of Canada qualifying exams can work as associate physicians under supervision.<br>Foreign health professionals who passed their exams to practise in Canada or who graduated from school in the past two years could apply for a supervised 30-day medical licence (Supervised Short Duration Certificate) to help fight COVID-19. | Physicians | Supervised Short Duration Certificate |
| New York | Limited permit with one year of approved postgraduate training instead of three. Physicians licensed in other states within the United States or in Canada can practise. | Physicians | Foreign qualifications, temporary licensure |
| Massachusetts | Two years of postgraduate resident medical training instead of three | Physicians | Temporary licensure |
| New Jersey | Pathway for foreign-licensed physicians to get a temporary emergency license to practise medicine. | Physicians | Foreign qualifications |
| Utah | Foreign medical graduates do not have to repeat residency if they practised in Australia, in the United Kingdom, in Switzerland, in South Africa, in Hong Kong Special Administrative Region, China, or in Singapore | Physicians | Foreign qualifications |
| California, Colorado | Authority has been delegated to the chief of medical services to provide waivers regarding licensing of health professionals | All health professionals | Temporary licensure |
| Nevada | Consideration of waivers regarding licensing of health professionals | All health professionals | Temporary licensure |
| District of Columbia | As of 2020, the Uniform Emergency Volunteer Health Practitioners Act (facs.org) allows for the recognition of out-of-state licenses for health professionals during a state of declared emergency. | All health professionals | Temporary licensure |

*Source:* Canadian Health Workforce Network, 2021.

## Responses of the receiving countries: Canada as a case in point

Due to Canada's heavy reliance on foreign-trained workers, Canada owes a responsibility to the global community to ameliorate the consequences of health labour mobility. Moreover, Canada is well positioned to actively participate in global health workforce strategies for integrated health-care provision through forums such as the Global Health Assembly, and through paying deeper attention to global agendas on nursing and other health sector workers.[40] The significance of gender suggests an area that clearly aligns with Canada's commitment to gender sensitivity and feminist foreign policy.[41] Canada has also actively engaged in the global governance of health and migration through other agreements, alliances, and institutions to promote gender justice, including the Global Compact for Safe, Orderly and Regular Migration, which is the first globally negotiated cooperative framework that commits to the "gender-responsive" principle.[42] Canada played a leadership role in the negotiations at the 69th Session of the Office of the United

[40] WHO, 2020a.
[41] Global Affairs Canada, 2017.
[42] UNGA, 2018.

Nations High Commissioner for Refugees (UNHCR) Executive Committee in 2018, by brokering communication among reticent States, building alliance with like-minded countries, and facilitating meetings and engagement with civil society.[43] The Global Code of Practice, signed by Canada has positioned the country to promote the ethical international recruitment of health personnel to ensure benefits for both origin and destination countries as well as for migrants.

While Canada's COVID-19 response could nonetheless have been stronger with a more robust gender-based analysis and greater inclusion of women and gender-diverse people in decision-making,[44] examples of Canada's leadership in immigration policies and programmes in health-care occupations include competency testing, workplace integration, bridging programmes and bilateral agreements.[45] Canada can share best practices and provide leadership that enable the gender-sensitive treatment of migrant health workers through a recommitment to the core principles and practices of the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the WHO Code").

Because of the continued reliance of the Canadian health system on internationally trained health workers, deeper engagement with the WHO Code and the international platform on health worker mobility would be in order. This can be done in conjunction with other like-minded countries and can form the basis for modelling best practices in this area of governance.[46] The need for improving existing frameworks has increased given that the COVID-19 pandemic has exacerbated the pre-existing gender inequities in health care and migration. A gender-responsive, equitable, inclusive and transformative restructuring of global health and migration systems is therefore much needed.

## Sending countries' policy responses during the pandemic

The Philippines and India are two of the leading countries of origin of nurses and physicians in OECD countries.[47] The Philippines is the origin for by far the largest numbers of migrant nurses globally, representing more than 15 per cent (237,700) of all foreign-born nurses in the OECD area. By comparison, this is nearly three times as many as India, which is the origin for the second largest group of foreign-born nurses (87,821).

In response to the pandemic, the Philippines embargoed health worker outmigration,[48] later easing the embargo but still allowing only 5,000 health-care workers to leave the country annually. Thousands of health workers referred to themselves as "priso-nurses" and appealed to the Government to let them take jobs abroad. In response to this shortage, President Rodrigo Duterte issued an order barring all health-care workers, including nurses, from leaving the country to work abroad. President Duterte has since relaxed that ban to allow health-care workers with existing contracts to leave but prohibiting workers from applying for new contracts abroad.[49] However, in the Philippines, female nurses are reported to be underpaid, underappreciated and unprotected.[50]

India has also increased control over the mobility of health workers, but this predated the global pandemic.[51] India is a key source of health-care workers for OECD and Gulf Cooperation Council (GCC) countries. Increasingly, bilateral agreements have been signed with GCC nations to promote labour mobility and boost health investments. During the pandemic, this included the joint organization of evacuations and later repatriation of health workers in order to assist

[43] Milner, 2021.
[44] Oxfam Canada, 2021.
[45] See, for example, Esses et al., 2021.
[46] Nixon et al., 2018.
[47] OECD, 2021.
[48] *Al Jazeera*, 2020; Muir, 2020.
[49] Muir, 2020.
[50] *Al Jazeera*, 2020.
[51] Walton-Roberts and Rajan, 2020.

with pandemic efforts.[52] As with the Philippines, despite the position of India as an international supplier of health-care workers – especially nurses – attention to improving the conditions of health-worker employment at home and overseas has not been a significant policy priority.

## The way forward

Policies, programmes and practices need to be gender responsive in a way that addresses the multiple impacts of the pandemic on female and immigrant health-care workers. The pandemic has highlighted several long-standing weaknesses evident in global health workforce policies. There is a lack of comprehensive data disaggregated by gender as well as by racial and ethnic identity, sexuality, disability, age and migration status. Such data is needed to fully understand the ways that the challenges facing health-care workers are gendered and further complicated by multiple other intersecting identities. There is only weak investment in improving the conditions of work and the disproportionate exposure to risk of infection and mortality, and only weak assessment of and attention to structural barriers, evident in the credentialization and incorporation of immigrant health-care workers.

Promising policy responses include the creative use of bilateral labour agreements and skills mobility agreements to protect mutually beneficial or "triple win" outcomes for sending countries, receiving countries, and migrants themselves.[53] The adoption of ethical recruitment protocols and fair migration approaches offer one pathway to addressing some of these challenges.[54] Gender-responsive bilateral agreements address the gender-specific challenges of women migrant health-care workers. Such approaches address the risk of "brain waste" by streamlining procedures for the recognition of foreign qualifications and reinforcing bridging courses where appropriate. Regulatory responses such as ombudsmen and fairness commissioners in the destination country that regulate fair access to professions for internationally educated health professionals and encourage innovations in workplace integration and credential and professional competency assessment also need to be prioritized.

Overall, better health workforce data systems are needed at all scales, and more collaborative policy agendas such as the WHO International Platform on Health Worker Mobility needs to be championed by all Member States. Only through better data and a well-informed multi-stakeholder dialogue will it be possible to maximize the benefits and mitigate possible adverse effects from health labour mobility, as well as to inform domestic health workforce development plans designed to achieve a sustainable health workforce. These approaches are critical to strengthening health workforce systems to avoid future crises. Systems also need to attend to building women's leadership to ensure a more gender-responsive COVID-19 and post-pandemic response, which is especially critical considering the disproportionate socioeconomic impact of the pandemic on women, especially immigrant women.

[52] *Mint*, 2020.
[53] OECD, 2021.
[54] Yeates and Pillinger, 2018.

## Appendix A. Foreign-trained nurses working in OECD countries, 2006/07, 2011/12 and 2017/18 (or nearest year)

| | **2006/07** (or nearest year) | | | | **2011/12** (or nearest year) | | | | **2017/18** (or nearest year) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Year | Total | Foreign-trained (of which natives)[1] | | Year | Total | Foreign-trained (of which natives)[1] | | Year | Total | Foreign-trained (of which natives)[1] | |
| | | | number | % | | | number | % | | | number | % |
| Australia | 2007 | 263 331 | 38 108 | 14.5 | 2013 | 263 232 | 45 364 (669) | 17.2 (0.2) | 2017 | 287 405 | 52 860 (815) | 18.4 (0.3) |
| Belgium | 2006 | 150 817 | 1 290 | 0.9 | 2011 | 170 062 | 2 843 | 1.7 | 2018 | 210 506 | 7 889 | 3.7 |
| Canada | 2006 | 326 170 | 21 445 | 6.6 | 2011 | 360 572 | 26 005 | 7.2 | 2017 | 398 845 | 32 346 | 8.1 |
| Chile* | | .. | .. | .. | | .. | .. | .. | 2018 | 55 508 | 1 135 (196) | 2.0 (0.4) |
| Denmark | 2006 | 51 841 | 820 | 1.6 | 2011 | 54 408 | 744 | 1.4 | 2016 | 56 991 | 1 034 | 1.8 |
| Estonia | | .. | .. | .. | 2011 | 11 543 | 4 | 0.0 | 2018 | 13 786 | 20 | 0.1 |
| Finland* | | .. | .. | .. | 2011 | 71 160 | 1 089 | 1.5 | | .. | .. | .. |
| France | 2006 | 493 503 | 11 658 | 2.4 | 2011 | 567 564 | 14 495 | 2.6 | 2018 | 722 572 | 20 757 | 2.9 |
| Germany | | .. | .. | .. | 2012 | 814 000 | 50 000 | 6.2 | 2017 | 908 000 | 71 000 | 7.9 |
| Greece | 2006 | 10 023 | 311 (291) | 3.1 (2.9) | 2011 | 16 906 | 437 (403) | 2.6 (2.4) | 2015 | 17 770 | 451 (416) | 2.5 (2.3) |
| Hungary | | .. | .. | .. | 2013 | 53 323 | 650 | 1.2 | 2017 | 63 739 | 953 (17) | 1.5 (0.0) |
| Israel | 2006 | 46 188 | 4 907 (1 834) | 10.6 (4.0) | 2011 | 48 119 | 4 686 (1 701) | 9.7 (3.5) | 2018 | 54 361 | 5 078 (2 125) | 9.3 (3.9) |
| Italy | 2006 | 358 747 | 15 304 (403) | 4.3 (0.1) | 2011 | 397 859 | 23 621 (488) | 5.9 (0.1) | 2017 | 449 781 | 21 561 (458) | 4.8 (0.1) |
| Latvia | 2006 | 9 269 | 413 | 4.5 | 2011 | 9 032 | 381 | 4.2 | 2017 | 8 460 | 274 | 3.2 |
| Lithuania* | | .. | .. | .. | | .. | .. | .. | 2018 | 26 078 | 113 | 0.4 |
| Netherlands | 2006 | 186 990 | 2 149 | 1.1 | 2011 | 198 694 | 1 358 | 0.7 | 2016 | 181 715 | 978 (249) | 0.5 (0.1) |
| New Zealand | 2008 | 39 247 | 8 931 | 22.8 | 2011 | 44 384 | 10 532 | 23.7 | 2018 | 50 057 | 13 115 | 26.2 |
| Norway | 2008 | 70 575 | 5 022 | 7.1 | 2011 | 83 851 | 7 076 (1 060) | 8.4 (1.3) | 2018 | 97 197 | 6 065 (1 121) | 8.7 (1.2) |
| Poland* | | .. | .. | .. | | .. | .. | .. | 2017 | 291 790 | 162 | 0.1 |
| Portugal | 2006 | 51 095 | 2 285 | 4.5 | 2011 | 64 535 | 1 958 | 3.0 | 2014 | 66 473 | 1 212 | 1.8 |
| Slovenia | | .. | .. | .. | 2011 | 4 490 | 18 | 0.4 | 2017 | 6 731 | 27 | 0.4 |
| Sweden | 2006 | 98 792 | 2 695 (241) | 2.7 (0.2) | 2011 | 105 009 | 2 764 (306) | 2.6 (0.3) | 2016 | 108 185 | 3 269 | 3.0 |
| Switzerland | | .. | .. | .. | 2011 | 60 674 | 9 037 (703) | 14.9 (1.2) | 2017 | 71 005 | 18 403 (1 387) | 25.9 (2.0) |
| Turkey | 2006 | 82 626 | 118 (98) | 0.1 (0.1) | 2011 | 124 982 | 190 (153) | 0.2 (0.1) | 2015 | 152 803 | 456 (397) | 0.3 (0.3) |
| United Kingdom | 2006 | 686 815 | 91 412 | 13.3 | 2014 | 687 028 | 91 832 | 13.4 | 2018 | 693 618 | 104 365 (294) | 15.1 (0.0) |
| United States[2] | | .. | .. | .. | 2012 | 2 779 650 | 166 779[2] | 6.0 | 2015 | 2 928 810 | 196 230[2] | 6.7 |
| **OECD Total* (22 countries)** | | | | | | **6 919 917** | **460 774** | **6.7** | | **7 548 810** | **558 343** | **7.4** |
| **OECD Total for a given year** | | | | | | **6 991 077** | **461 863** | **6.6** | | **7 922 186** | **559 753** | **7.1** |
| | | | | | | (23 countries) | | | | (25 countries) | | |

*Notes:* * OECD total includes 22 countries, for which data is available in 2011/12 and 2017/18. Countries with an asterisk (*) are not counted in this total. Total for 2006/07 is not presented as it would be largely underestimated due to missing data for the United States.

[1] So far only 11 OECD countries report data on the number of foreign-trained but native-born nurses.

[2] The estimates for the United States refer only to Registered Nurses, not including lower-qualified nurses.

*Source:* OECD, 2021.

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Ehsanuddin Diawar holds his his seven year old son Kayhan Dilawar's hand as they disembark from a plane with fifteen year old Ali Aqdas Dilawar, as Afghan refugees arrive on a flight from Tajikistan at Toronto's Pearson International Airport, on Wednesday, 30 March 2022.

# 2. COVID-19 AND THE INTERSECTIONS OF GENDER, MIGRATION STATUS, WORK AND PLACE: FOCUS ON HONG KONG SPECIAL ADMINISTRATIVE REGION, CHINA, AND ONTARIO, CANADA[1]

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## Introduction

The COVID-19 pandemic has laid bare social divides and inequities within and between countries across the globe, with temporary foreign workers, predominantly racialized migrants from the "Global South" amongst the most affected. Addressing this health crisis requires an equity lens that attends to intersectionality: to the dynamic interactions amongst social identifiers, including gender and nationality as well as socioeconomic, racialized, and migration statuses, among others. Taken together, these shape experiences of both oppression and privilege, and structure access to health determinants.[2] Intersectionality highlights the constellation of axes of social differentiation that position individuals and groups of individuals in the social landscape, and does not presume that one axis (such as gender) is always the most important element in how identity and social positioning is configured.[3] Intersectionality supports the design of more appropriate and effective public health policies and programmes to reduce the negative effects of pandemics, current and future.[4]

Based on an integrative literature review and four key informant interviews with three civil society representatives and one health professional, all intimately engaged with pandemic responses, this paper highlights the interactions across four axes of intersectionality: gender, migration status, work and place.[5] Place refers to workers' relations to their location within the globalized migrant workforce, to the receiving community, and to employers and co-workers, often structured by working and living arrangements, legal frameworks, and normative practice. These issues are illustrated through two case studies: the first, of Indonesian and Filipino women migrant domestic workers (MDWs) in Hong Kong Special Administrative Region (SAR), China, who labour and live in private households; and the second, of workers – predominantly men – from Mexico, the Caribbean, and Central America, employed in Canadian agricultural industries, who reside in employer-provided congregate residences.

[1] Thank you to Sharmistha Sharma for her research support, and to the interviewees who generously shared their time and observations for this paper: Dolores Ballardares-Pelaez (chair, UNIFIL-Hong Kong Special Administrative Region, China), Syed Hussan (executive director, Migrant Workers Alliance for Change), Eni Lestari (chair, International Migrants Alliance), and the anonymous Ontario-based physician engaged in COVID-19 screening and care.

[2] Morrison, 2015; Spitzer et al., 2019.

[3] Hankivsky, 2012; Spitzer et al., 2019.

[4] Etowa and Hyman, 2021; Hankivsky and Kapilashrami, 2020; Ryan and El Ayadi, 2020.

[5] The review drew from English-language articles and reports retrieved from databases including PubMed, Academic Search Complete, and Google Scholar, as well as the websites of news agencies, IOM, ILO, and WHO and civil society organizations published in 2020–2021. A list of keywords is available upon request.

Through this lens, I illustrate how local and national pandemic public health policies and programmes impact temporary foreign workers' health and well-being. Notably, the goal is not to undertake a gendered comparison of these cases, but to examine how the constellation of these interacting axes of social differentiation work together in different contexts, which may require divergent or common policy and programme responses. To this end, the paper concludes with considerations of promising practices and policies that promote health equity amongst temporary foreign workers and argues for the deployment of an intersectional lens in policymaking and programme planning.

## The intersection of gender with migration, place, work and health during the COVID-19 pandemic

Temporary foreign workers have been particularly impacted, directly and indirectly, by the COVID-19 pandemic.[6] Many countries responded to the pandemic declaration from the World Health Organization (WHO) with lockdowns, international travel bans, and restrictions on the internal movement of people.[7] Economic slowdowns, disruptions in global supply chains, and the decline in tourism have all contributed to loss of migrant livelihoods. Unable to migrate, unable to earn an income in their receiving country, and unable to return home, an estimated three million migrants have been stranded globally.[8] In Lebanon, 78 per cent of migrants lost their jobs and 83 per cent had trouble purchasing groceries.[9] Temporary foreign workers have often been excluded from health care and from accessing pandemic-related financial supports offered by some host countries.[10] Consequently, the economic distress experienced by migrant workers has increased the precarity of households dependent on migrant remittances, further evidence of the complex transnational effects of the pandemic and of governments' policy responses.[11]

Gender plays a prominent role in shaping the type of work temporary foreign workers undertake. Of the estimated 169 million international migrant workers, 70 million are women, of whom 79.9 per cent are employed in the service sector.[12] Many of these women are engaged in health and care work – tending to children, the elderly and the infirm – in institutional and private settings as personal support, home-care attendants, nursing aides or assistants; 11.5 million are domestic workers.[13] Gender ideologies that construct care work as a labour of love to be undertaken by women devalues its economic and social worth, and positions women migrant care workers in often low-waged and precarious positions, which have become even more inequitable under the conditions of the pandemic.[14] Often engaged with populations at high risk of COVID-19 infection, migrant care workers' risk of exposure to the coronavirus has increased.[15] In Australia, where COVID-19 fatalities amongst aged care home residents have been among the highest in the world, 29 per cent of residential direct care workers are migrants, among whom more than 70 per cent are personal care attendants.[16] Migrant domestic workers who live and work in the same household reported increased workloads, employer expectations that workers provide their own (sometimes scarce and unaffordable) personal protective equipment (PPE), and greater vulnerability to abuse.[17]

6 Guadagno, 2020.
7 WHO, 2020.
8 Guadagno, 2020.
9 IOM, 2020a.
10 Lui et al., 2021.
11 Foley and Piper, 2020; Lui et al., 2021. Originally forecasting a 20 per cent decline in global remittances of nearly 110 billion United States dollars over 2019 levels, remittances decreased by only 1.6 per cent. An accurate amount, however, is difficult to determine as the mode of transfer has shifted to more formal channels such that households report receiving fewer funds while central banking data register higher flows. See Foley and Piper, 2020; Ratha et al., 2021.
12 ILO, 2021.
13 Foley and Piper, 2020; ILO, 2016; King-Dejardin, 2019.
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Of 99 million male international migrant workers, 7.9 per cent are employed in agriculture (including farming, food processing, poultry and meat packing), 35.6 per cent in industry, and 56.4 per cent in the service sector.[18] Like many women temporary foreign workers engaged in care work, who work in close proximity with care recipients, and like many live-in domestic workers, who reside in employer-provided accommodation, congregate housing for male migrant workers, including migrant agricultural workers (MAWs), enhances vulnerability to COVID-19 infection. By May 2020, migrant workers constituted 76 per cent of COVID-19 cases in Saudi Arabia, where most labourers share bunk beds in crowded labour camps.[19] In Canada, agricultural and food-processing facilities and long-term care homes, where migrant workers predominate, have been the site of some of the most significant outbreaks of COVID-19, due to their living and working conditions.[20]

The pandemic has had a profound impact on migration, and especially on migrant workers' access to health determinants, including income, social support, uptake of health services, housing and nutrition. Travel restrictions stranded some temporary foreign workers who were to depart or return to their host country, leaving them, on one hand, vulnerable to overstaying their visas, and on the other hand, unable to take up employment, thereby contributing to stress and loss of income. Quarantine and self-isolation requirements were also problematic. Some countries – Jordan, Lebanon, Kuwait, Singapore, and areas of Spain and Italy – reportedly issued more stringent lockdowns in neighbourhoods with a high proportion of migrants, thus limiting access to food, health care, and other services.[21] Working conditions and housing arrangements importantly impact migrant health and are particularly salient under pandemic conditions: specifically, the inability to socially distance at work – as is common in the food industry and in front-line care work – and at home, particularly in congregate and shared accommodations.[22] The health and well-being of temporary foreign workers is jeopardized not only by increased exposure to COVID-19 through working and living conditions, but also as targets of "pandemic-related racism", where migrants are blamed for introducing or spreading COVID-19 in both their host and home countries.[23] Thus, temporary foreign workers contend with myriad structural inequalities that have been heightened and made more visible during this crisis.[24] As a result, temporary foreign workers report high levels of stress, depression and anxiety, which – compounded by concerns about (and mistrust of) publics and policies – may reduce the willingness of some to present themselves for COVID-19 screening.[25]

In sum, the gendering of migration streams for the global labour market indicates that gender, migration, and work cannot be considered as separate categories. These factors and their attendant political processes come together to position temporary foreign workers in particular physical and social places – locally, nationally, and transnationally – to create disparate intersectional vulnerabilities that have been exacerbated during the COVID-19 pandemic.[26]

[18] ILO, 2021.
[19] Sherlock, 2020.
[20] Baum et al., 2020; CBC, 2020; Machado and Goldenberg, 2021; Perkel, 2021.
[21] Rao et al., 2021.
[22] Machado and Goldenberg, 2021; Rao et al., 2021.
[23] John and Kapilashrami, 2021; Larios and Paterson, 2021; MWAC, 2020.
[24] Dryden and Rieger, 2020; Guadagno, 2020; Machado and Goldenberg, 2021; MWAC, 2020.
[25] Attal et al., 2020; Guadagno, 2020
[26] Larios and Paterson, 2021.

## Focus on Filipino and Indonesian migrant domestic workers in Hong Kong Special Administrative Region, China

In 2019, nearly 400,000 MDWs, primarily from the Philippines and Indonesia, were employed in Hong Kong SAR, China.[27] MDWs work over 70 hours per week, for which they generally earn minimum wage.[28] Tied to a single employer for a two-year renewable contract, MDWs are required to reside with their employers, who are expected to provide "suitable" accommodation and either free food or a food allowance.[29] Sixty per cent of MDWs have reported sleeping in a bedroom with their care recipients or a non-bedroom space (for example, a storage area or kitchen).[30] Employers may also exercise control over food portion and choice.[31] Furthermore, one-third of the 1,003 respondents in a 2015 survey of MDWs in Hong Kong SAR, China claimed they were unable to avail themselves of the legally mandated weekly 24-hour rest period.[32]

Living and working in the same place as employers can heighten interpersonal tensions, as it demands self-surveillance and control over emotions and behaviours. Moreover, the ubiquity of home-based video surveillance to patrol workers when employers are absent impacts the pace and conduct of the work of MDWs, as they feel unable to take a break.[33] The lack of privacy they encounter in the workplace is not always alleviated on their rest days. MDWs are also subject to public surveillance when they publicly gather on Sundays.[34] Recruitment agencies that broker contracts may offer warranties for MDWs as though they were household objects, by providing replacements within an introductory period, and employers may dismiss MDWs if they fail to meet expectations.[35]

The tenuous conditions in which MDWs live, work, and earn for their families is underscored by the precariousness of their migration status. Contracts may be terminated by their employer with either one month's notice or pay in lieu of notification.[36] With minor exceptions, MDWs have two weeks after contract expiry or termination to leave Hong Kong SAR, China, unless they can secure another position.[37] Furthermore, although other migrant workers are eligible to apply for permanent residency status after residing in Hong Kong SAR, China for eight years, MDWs are excluded from this possibility. Overall, the working and living conditions have a deleterious impact on health and well-being, as self-reported health amongst MDWs is worse than that of other residents of Hong Kong SAR, China, worsening further with inadequate accommodation, larger household size, challenges with the sending of remittances, and abuse; importantly, regular social support from friends has been shown to mitigate these effects.[38]

The COVID-19 pandemic emerged in Hong Kong SAR, China in January 2020, engendering a series of public health measures including travel bans, restrictions on mobility and public gatherings, quarantine requirements and closures of workplaces and schools.[39] These actions led to the immobilization of migrant workers, who could neither leave nor return to Hong Kong SAR, China. Thousands of migrant workers were stranded in the Philippines unable to resume employment in Hong Kong SAR, China after their leaves.[40] To accommodate migrant workers whose contracts had expired, but were unable to leave, the authorities in Hong Kong SAR, China extended employee contracts and the period to search for employment for two months.[41] Early on in the pandemic,

27 Lui et al., 2021.
28 Spitzer, 2020.
29 Lui et al., 2021.
30 AMCB, 2021; Lui et al., 2021.
31 Ham and Ceradoy, 2021.
32 Justice Centre Hong Kong, 2016.
33 Constable, 2007; Spitzer, 2020.
34 Constable, 2007.
35 Constable, 2007; Lui et al. 2021.
36 GHKDI, 2021.
37 Justice Centre Hong Kong, 2016; Lui et al., 2021; Spitzer, 2020.
38 Lui et al., 2021.
39 AMCB, 2021; interview with Eni Lestari, chair, International Migrants Alliance, 13 September 2021; Lui et al. 2021.
40 Interview with Dolores Ballardares-Pelaez, Chair, UNIFIL-Hong Kong SAR, China, 16 September 2021; Lui et al., 2021.
41 AMCB, 2021.

PPE was in short supply and increasingly expensive; when the Government dispersed PPE to households, they were not always shared with MDWs.[42] Adult residents of Hong Kong SAR, China were provided a stipend of approximately USD 1,200 to defray pandemic expenses; however, MDWs, international students, and asylum seekers were excluded from receiving this benefit.[43]

In June 2020, authorities in Hong Kong SAR, China introduced a policy whereby MDWs were required to present a negative COVID-19 test and quarantine for 14 days (later extended to 21 days) upon arrival, the expenses of which were to be covered by their employers, although sometimes workers relied on food delivery from migrant organizations.[44] While others were able to choose their quarantine accommodation, MDWs were required to stay in overcrowded designated hostels.[45] Restrictions on gatherings of more than four people and the closure of public recreation areas meant that MDWs could no longer access the Sunday gatherings where they would normally be able to socialize, rest and connect with resources and informational support.[46] In those areas where workers once met in large numbers, police increased surveillance and issued fines if individuals were insufficiently separated or if groups exceeded four people.[47] Media reports of these interventions fed into the notion that MDWs were disease carriers and posed a threat to other residents of Hong Kong SAR, China.[48]

This discourse was reinforced when the Labour Department urged MDWs to remain at home during their rest days and refrain from using public transport and spaces.[49] Some employers interpreted this message as a directive and curtailed workers' mobility in the name of public health.[50] MDWs were compelled to work even longer hours, undertaking near constant cleaning with harsh chemicals, and some were ordered to bathe multiple times a day, which was not demanded of other household members. Increasing need from family at home for pandemic-related expenses heightened fears of job loss; as a result, some MDWs remained in abusive situations.[51]

The proposal from the authorities in Hong Kong SAR, China, for mandatory vaccinations against COVID-19 – only for MDWs – was withdrawn after migrant organizations, who promote vaccination, complained this would further stigmatize MDWs.[52] Increased demands from employers, public opprobrium, loss of rest and social support, fear of job loss, and worrying about their families at home heightened stress amongst MDWs and contributed to high levels of depression.

> *"They look at the domestic workers as virus carriers, so therefore, they should be programmed to have mandatory tests and mandatory vaccination that is not mandatory for others. … We are promoting vaccination, but to have it mandatory from the government is another thing.*
>
> **Dolores Ballardares-Pelaez, UNIFIL**

[42] HRWG, 2020; interview with Lestari (see footnote 38).
[43] Interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38).
[44] AMCB, 2021.
[45] Interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38).
[46] Interview with Lestari (see footnote 38).
[47] AMCB, 2021; Lestari, 2021.
[48] AMCB, 2021; interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38); Lui et al., 2021.
[49] AMCB, 2021; interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38); Lui et al., 2021.
[50] Interview with Ballardares-Pelaez (see footnote 39); Lui et al., 2021.
[51] Interview with Lestari (see footnote 38); Lui et al., 2021.
[52] Interview with Ballardares-Pelaez (see footnote 39).

The impact of pandemic responses reflected the intersections of gender and nationality, as well as migration status.[53] Care work and parenting work is often allocated to women, and many MDWs were engaged in transnational parenting, which intensified in this period. Furthermore, employers often display a preference for workers from different nationalities, which ultimately impacts workers' mobility in the pandemic. Filipinos are most often chosen to work with children as they are viewed as capable of teaching children English, whereas Indonesians are regarded as more suitable for working with the elderly, for whom English-language skills are deemed less important. Subsequently, in the name of keeping the elderly safe, Indonesian workers were refused the right to leave the house on their rest days at a disproportionately higher rate. [54]

Despite the challenges, MDWs are not wholly bereft. Migrant worker organizations and advocacy groups, labour unions, and other faith-based and civil society organizations provide vital support to MDWs. Organizations such as the Asia Pacific Mission for Migrants, Bethune House, the Mission for Migrants, and the Asian Migrants Coordinating Body (AMCB) have offered material support (such as PPE or food for quarantined workers), instrumental support (such as legal assistance and advocacy, vaccination scheduling, counselling, information on hygiene, health care, and labour rights) and emotional support (such as stress relief activities and small gatherings) throughout the pandemic.[55]

## Focus on migrant agricultural workers in Ontario, Canada

Canada hosts nearly 60,000 MAWs from Mexico, the Caribbean, and Central America annually, over 95 per cent of whom are men.[56] In the Province of Ontario, more than 40 per cent of agricultural workers are MAWs who enter Canada under the auspices of either the Seasonal Agricultural Workers Program (SAWP) or the agricultural stream of the Temporary Foreign Worker Program.[57] The SAWP, based on bilateral agreements with Mexico and 11 Caribbean countries, grants workers a sector-tied eight-month work permit; the agricultural stream of the Temporary Foreign Worker Program ties workers to a single employer for 24 months, after which the worker must return home for 4 months.[58]

SAWP workers generally live in on-farm housing provided by employers who further control their access to goods and services including food, telecommunication and banking services, health care and social activities.[59] Rural location, workplace regulations such as curfews and limited access to vehicular transportation circumscribe their mobility, constraining access to services, goods and supports.[60] Employers are known to post a range of regulations in workers' accommodation, including prohibiting visitors, regulating alcohol consumption, and requiring that workers keep employers apprised of their whereabouts on their time off.[61] Research suggests that women SAWP workers are subject to greater surveillance and limitations on their mobility than are their male counterparts.[62] Notably, MAWs are excluded from the protection of provincial labour laws, including those governing minimum wage, hours of labour and sick pay.[63] Overcrowded and unsanitary accommodation affording little privacy and inadequate temperature control is a major source of workers' complaints.[64] One study found that 56 per cent of respondents share a bathroom, 47.7 per cent a shower, and 49.7 per cent a kitchen with six to 12 other workers;

[53] Interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38).
[54] Interview with Lestari (see footnote 38).
[55] AMCB, 2021; APMM, 2021; interview with Ballardares-Pelaez (see footnote 39); interview with Lestari (see footnote 38).
[56] Landry et al., 2021; Preibisch and Santamaria, 2006.
[57] MWAC, 2020.
[58] Caxaj et al., 2020; Government of Canada, 2020b, 2021.
[59] Caxaj et al., 2020; Larios and Paterson, 2021; MWAC, 2020; Preibisch and Santamaria, 2006.
[60] Caxaj et al., 2020; Preibisch and Santamaria, 2006; Reid-Musson, 2018.
[61] Ibid.
[62] Caxaj et al., 2020; Preibisch and Santamaria, 2006.
[63] MWAC, 2020.
[64] Interview with Syed Hussan, chair, Migrant Workers Alliance for Change, 24 September 2021; MRN, 2020; MWAC, 2020.

56 per cent sleep in a bunkbed.[65] As SAWP workers hold employer-tied visas, many refrain from complaining about working and living conditions, in order to avoid risking termination and deportation or not being invited to return for the next season.[66]

Based on records of occupation-related fatalities and hospitalizations, agriculture is the most dangerous occupation in Ontario; however, MAWs are not covered under occupational health and safety legislation.[67] Moreover, ill workers are unpaid and may be subject to deportation. As a result, many continue to work while injured or ill.[68] SAWP workers are eligible for enrolment in provincial health plans; however, without the assistance of employers and the availability of linguistically appropriate information, navigating the system can be problematic.[69]

Canada declared the COVID-19 pandemic in March 2020, closing borders to all but essential movement, with the movement of MAWs considered "essential". The Province of Ontario shuttered some schools and non-essential businesses, issued mandatory masking and spatializing guidelines, and restricted interprovincial travel and the size of public and private gatherings.[70] MAWs were required to undergo a paid and provisioned two-week quarantine upon arrival.[71] Employers were eligible for a government subsidy of 1,500 Canadian dollars (CAD) per worker to defray these expenses;[72] however, some workers complained that costs of quarantine were offloaded to them as loans and the food provided was woefully inadequate.[73] Furthermore, the implementation of quarantines for newly arrived workers increased the workload of MAWs already on hand.[74]

> *"In the first two weeks of quarantine, workers were not allowed out of housing at all. … People couldn't leave, they couldn't get access to food. … A group of seven men were given one bag of potatoes and a loaf of bread for an entire week. … Many employers effectively created company shops to deal with, go buy things for them and then charge them.*
>
> **Syed Hussan, Migrant Workers Alliance for Change**

The power differentials embedded in the SAWP have been exacerbated during the pandemic.[75] Restrictions on movement, heightened surveillance and reports of pandemic racism – for example, MAWs being prohibited from entering local community stores – intensified after release from quarantine.[76] As a result, workers had difficulties sending remittances, purchasing groceries and accessing the Internet, health care and social interactions; some were unable to receive material support from others due to employers' prohibitions on outside visitors.[77] Despite Federal Government decrees that MAWs must be able to physically distance themselves in their living quarters, problems with the "warehousing of workers" in overcrowded and unsanitary conditions increased.[78] Working and living conditions were interrelated; according to a Migrant Workers Alliance for Change (MWAC) study, "social distancing at work is not required for individuals who live together, [therefore] employers have increased the numbers of workers bunking together

65 MRN, 2020.
66 Landry et al., 2021; MWAC, 2020; Preibisch and Santamaria, 2006.
67 Landry et al., 2021; Preibisch and Santamaria, 2006.
68 Interview with anonymous Canadian physician, 26 September 2021; Landry et al., 2021; Preibisch and Santamaria, 2006.
69 Caxaj et al., 2020; Landry et al., 2021; McLaughlin and Hennebry, 2013.
70 Larios and Paterson, 2021.
71 Larios and Paterson, 2021; MWAC, 2020.
72 Government of Canada, 2020a.
73 MWAC, 2020.
74 Interview with Hussan (see footnote 63); Landry et al., 2021.
75 Interview with Hussan (see footnote 63); Larios and Paterson, 2021.
76 Hennebry et al., 2020; MWAC, 2020.
77 Hennebry et al., 2020; interview with Hussan (see footnote 63); Larios and Paterson, 2021; MWAC, 2020.
78 Interview with anonymous (see footnote 67); interview with Hussan (see footnote 63); Mojtehedzadeh, 2021; MWAC, 2020.

post-quarantine in order to maximize productivity".[79] Although new national housing standards for agricultural workers have been promised, the current proposal lacks critical specification.[80]

Congregate housing and the close proximity of colleagues at work contributed to outbreaks of COVID-19 and amplified mental health issues.[81] While workers who exhibited symptoms of COVID-19 were to be isolated, most inspections of workplaces were based on self-reporting by employers.[82] In Ontario, the initial responses of public health units were hampered by pre-pandemic underfunding, and inspectors were sent out but were prohibited from entering bunkhouses.[83] Some employers discouraged workers from reporting potential COVID-19 cases; however, mild symptoms mimic those normally experienced due to working conditions, and the lack of sick pay meant once again that many continued to report to work.[84] A recent report by Canada's Auditor General revealed significant problems with the federally mandated inspections of MAW workplaces. Of the files reviewed, 76 per cent collected showed either no or low-quality evidence that employers were complying with COVID-19 protocols for MAWs; half of the inspectors did not interview the required number of MAWs as part of the inspection process, or spoke to none at all. At times, when serious complaints were lodged, no further action was taken, affirming claims by MAWs and advocacy organizations. Despite these serious shortfalls – and warnings issued by the Auditor General – 100 per cent of inspected employers were shown to be in compliance.[85]

An estimated 2,500 SAWP workers have contracted COVID-19, and at time of writing 3 have died.[86] One farm has been charged with public health violations and ordered to repay lost wages to a former MAW who was fired after speaking out about conditions at the site after his bunkmate died from COVID-19.[87] In addition to the immediate effects of the coronavirus, housing conditions, long arduous working hours, concerns about their families' well-being – especially as they were unable to send remittances – problems obtaining their provincial health-care cards and delayed or non-existent access to health care all exacerbated stress-related and other health issues.[88]

Despite the obstacles, migrant advocacy organizations and MAWs themselves organized supportive interventions (such as food deliveries, mobile health units and vaccination drives) while mobilizing around migration, health and labour rights, including the demand for permanent residency status upon arrival.[89] The Canadian Government has offered temporary foreign workers engaged in essential work during the pandemic a new pathway to permanent residency; however, long working hours, isolation, linguistic and financial barriers and the short time frame for completing the applications has meant that, to date, few MAWs have applied.[90] Consequently, the success of this promising initiative for MAWs and other migrant workers has yet to be determined.

79 MWAC, 2020:21.
80 Interview with Hussan (see footnote 63).
81 Landry et al., 2021.
82 Government of Canada, 2020a; Landry et al., 2021.
83 Interview with anonymous (see footnote 67); Mojtehedzadeh, 2021.
84 Interview with anonymous (see footnote 67); MWAC, 2020.
85 CBC, 2021.
86 Mojtehedzadeh, 2021.
87 Lupton, 2021.
88 Interview with anonymous (see footnote 67); Landry et al., 2021; MWAC, 2020.
89 Interview with Hussan (see footnote 63).
90 Interview with Hussan (see footnote 63); Sorio, 2021.

## Policy and programme responses to the COVID-19 pandemic for temporary foreign workers

> *"A couple of nurses who spoke Spanish as their mother tongue were the critical link between the community and … public health. … They translated material about specific questions that they [MAWs] had. … They created this kind of myth-busting information that became a living document.*
>
> **Anonymous Canadian physician**

Numerous countries have responded to the exigencies of the pandemic by addressing health inequities and COVID-19 health issues. Understanding that precarious migration status is critical to health and well-being, Italy and Kuwait (temporarily at least) regularized undocumented temporary foreign workers.[91] Portugal granted migrants rights equivalent to those of permanent residents.[92] Other nations such as Costa Rica and France extended work visas automatically.[93] Panama offered temporary shelter to 2,500 migrants transiting through the country who were stranded due to border closures.[94]

In efforts to mitigate pandemic-induced economic harms, some countries have included temporary foreign workers in social protection measures. Seasonally engaged temporary foreign workers in New Zealand were eligible for sick leave and government support if their workplace was closed or was in reduced circumstances.[95] Australia enabled temporary foreign workers to withdraw assets from their pension funds to alleviate their economic challenges.[96] A number of countries – including the United Kingdom, Canada and Qatar – offered free COVID-19 screening and vaccinations regardless of migration status.[97] Additionally, Qatari employers were required to pay the full salary of migrant workers in quarantine or treatment.[98] The United Kingdom provided multilingual information services for migrant workers, as have some Canadian jurisdictions.[99]

**Table 1. Select promising policies and practices**

| | |
|---|---|
| Regularizing undocumented workers | Offering free COVID-19 screening and vaccination |
| Offering permanent residency status | Providing paid quarantines and COVID-19 treatment |
| Extending work visas | Ensuring access to social protection programmes |
| Sheltering stranded migrants | Providing multilingual COVID-19 information |

91 Rao et al., 2021.
92 Alberti and Cotovio, 2020; Drury, 2020.
93 France in the United States, 2020; Rao et al., 2021.
94 IOM, 2020b.
95 Employment New Zealand, 2020.
96 Symington, 2020.
97 Interview with anonymous (see footnote 67); Government of London, 2021; IOM, 2020b.
98 *Al Jazeera*, 2020.
99 Interview with anonymous (see footnote 67); Government of London, 2021.

## Discussion and conclusion

The interactions amongst gender, temporary migration status, work, and place have critical implications for health and well-being under the conditions of the COVID-19 pandemic, best understood by deploying an intersectional lens. Although each component of that configuration – as well as other situationally specific components such as socioeconomic class or nationality – may have particular consequences for health and well-being, the mutually constituted nature of how and where individuals and groups of individuals are situated in social landscapes demands an intersectional understanding.

As the examples in this paper illustrate, the lives of MDWs and MAWs are shaped by gender ideologies that inform the type of occupations into which workers are likely to be recruited, and by their national origins in the "Global South" that limit their eligibility for permanent migration pathways and enhance their likelihood of enrolment in temporary migration schemes, which operate together to place temporary migrant workers in the international gendered division of labour.[100] This positioning has implications for workers' workplace and living condition exposures to COVID-19 and helps to structure their access to determinants of health. Existing migration policies, labour practices and newly instituted public health measures have further entrenched structural issues facing temporary foreign workers.[101]

Moreover, the enclosures produced by borders and reinforced by migration policies, the arrangements of confinement to employer-provided accommodation, the blurring of work and home environments, the disparities between rural and urban settings, and exposures to pandemic racism in host communities where they have been labelled as carriers of contagion have further highlighted the significance of place to the interactions amongst gender, work, and temporary migration status. As identified by researchers and key informants, these markers of social differentiation cannot be divorced from one another: women migrant workers face more stringent mobility constraints (particularly Indonesian MDWs) and surveillance than their male counterparts.

> *"A lot of newcomers who arrived last year up to now, they haven't had a day off. They were actually denied a day off. . . The impact of that is that they were not aware about anything in Hong Kong, the law, the regulations, the organization, any contact, they didn't have friends, which is so important.*
>
> **Eni Lestari, International Migrants Alliance**

The places where MDWs and MAWs reside and work both entrench dependency on their employers, to whom they are tied through their visas, and mute possible complaints or resistance (due to their precarious migration status), as they are committed to sustaining and supporting family at home. Relegation to work and home limits social interaction, communication with friends and family and access to services, resulting in increased stress, poorer mental health and unmet health needs. Despite these challenges, temporary migrant workers whose contributions help sustain households and economies locally and transnationally have sought out, aided, and been aided by a multitude of migrant worker, migrant advocate, faith-based, labour and other civil society organizations that provide an array of supports, as well as channelling complaints and concerns to authorities to investigate individual labour and health violations and to instigate policy change.

[100] Spitzer, 2016.
[101] Tuyisenge and Goldenberg, 2021.

Interviews with migrant workers and the health-care professional both reflected and were fleshed out by research and media reports, all indicating the need for a multilevel, transnational, and intersectional approach to the pandemic and its effects on temporary foreign workers. Public health measures and migration policies have potent ripple effects across borders that affect the social and economic well-being of countries, communities, neighbourhoods, families and individuals. Long working hours, lack of control over work, close proximity to others, poor housing and nutrition as well as the stress associated with a paucity of social support, worry about their families, and lack of access to health care, sick leave and adequate remuneration all contribute to conditions that make these temporary foreign workers increasingly vulnerable to COVID-19 infection and the unintended consequences of public health measures.

**Table 2.** **Suggestions for policies and programmes**

| Policies | Programmes |
|---|---|
| Address temporary foreign worker health equity by:<br>▪ Offering permanent residency and facilitating family reunification<br>▪ Regularizing undocumented workers<br>▪ Ending employer-tied work visas<br>▪ Removing live-in and live-on worksite housing requirements<br>▪ Implementing and enforcing specifications for on-worksite accommodations<br>▪ Mandating rest hours and rest days<br>▪ Including rights to Internet access in contracts<br>▪ Ensuring access to sick leave and social protection<br>▪ Increasing workplace inspections and enforcing relevant laws and workplace regulations<br>▪ Implementing a multilingual government hotline for complaints<br>▪ Supporting migrant-worker and migrant-advocacy organizations, and unionization<br>▪ Engaging in migrant-inclusive intersectional policymaking | Improve temporary foreign worker health by:<br>▪ Providing free COVID-19 vaccinations and screening, including for undocumented workers<br>▪ Offering on-site mobile testing and vaccination clinics<br>▪ Furnishing paid quarantine, sick leave, and social protection benefits<br>▪ Granting health insurance on arrival<br>▪ Enhancing migrant-sensitive health professional education<br>▪ Employing multilingual or co-ethnic staff<br>▪ Engaging diverse temporary foreign workers in programme development and delivery<br>▪ Supporting migrant-inclusive cross-jurisdictional programme development<br>▪ Deploying an intersectional health equity lens in all aspects of operations |

Examining these examples of MDWs and MAWs through an intersectional lens – which means not assuming the primacy of one social marker over another in a given context – suggests that the most impactful policy interventions for these migrant workers must be targeted towards migration policies and labour rights. Alongside flexible, multilingual, migrant-sensitive public health programmes, policies that reduce and eliminate precarious migration and labour statuses by offering permanent residency and family reunification, the right to unionize, access to social protection programmes, labour rights and health benefits, and by removing employer-tied visas and accommodation, will be widely beneficial in mitigating the negative impacts of the COVID-19 pandemic and promoting health and well-being over the long term. Moreover, support for migrant-worker and migrant-advocacy organizations, as well as for migrant-inclusive intersectional multisectoral policymaking that addresses transnational context and social determinants of health, and that meaningfully engages temporary foreign workers throughout policymaking, implementation and evaluation processes, is critical to these efforts. Importantly, ongoing vigilance towards unintended intersectional impacts of these policies and programmes is required, if countries are to move towards greater health equity for all members of society.

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IOM in Cambodia partners with a local hospitality school where students are trained in the culinary arts, hotel management and catering. Graduates from this programme are in good spots to get jobs abroad with reputable hotel chains which allows them to be able to migrate legally for work.

# 3. POWER, PROTECTION AND POLICY: DOMESTIC WORKERS IN ARAB STATES DURING COVID-19

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## Introduction

While the COVID-19 pandemic has had detrimental impacts on the global socioeconomic situation, labour conditions have especially taken a hit, as declining opportunities and income for employers have resulted in worker dismissals, late wage payments and unpaid hours. Simultaneously, care burdens worsened, especially in the initial lockdown period, with households across the globe reporting an increasing number of hours spent on care for family members.[1] This has particular implications for women: an estimated 75 per cent of care is carried out by women in a household,[2] and this work is often unpaid.

Beyond care duties within one's household or family, care work is undertaken globally by an estimated 11.5 million migrant domestic workers, 73.4 per cent of whom are women. Globally, domestic workers represent 7.7 per cent of the total migrant worker stock.[3] When disaggregated by sex, this value increases: migrant domestic workers make up 12.7 per cent of all female migrant workers globally, or an estimated 8.45 million.[4]

In the early stages of the COVID-19 pandemic, on 15 March 2020, the International Labour Organization (ILO) estimated that 49.3 per cent of domestic workers globally were severely impacted by related measures, whether by reduction in hours of work, reduction in earnings, or job losses.[5] By May 2020, this estimate rose to 73.7 per cent.[6] During COVID-19 lockdowns, women domestic workers reported increases in their workloads: in this period, an estimated 27 per cent of employers globally asked their domestic workers to work longer hours.[7] Domestic work, by its nature, is distinct from other occupations and sectors: it is technically a documented sector, through its provision of work permits and temporary residencies, but it is informalized. Domestic work is carried out in the intimacy of the household and the daily responsibilities are largely governed by the employer's preferences and routine rather than through clear duties set out in contracts.[8] Lockdowns and confinement measures further blurred lines between work and private life, especially in cases where domestic workers lived with their employers. In these instances, much like the conditions faced by factory and construction workers who reside in dormitories, employees' private time is often completely or partially controlled by employers.[9]

1 Thornton, 2020.
2 Power, 2020.
3 ILO, 2015b.
4 Ibid.
5 ILO, 2020a.
6 Ibid.
7 UN-Women, 2020.
8 Rosewarne, 2014.
9 Smith and Pun, 2006.

Against this background, this paper explores the situation of women migrant domestic workers in one of their major regions of destination, the Arab States. Relative to other regions, the Arab States host the highest proportion of migrant workers, representing 35.6 per cent of all workers in the region.[10] The ILO estimates that, as of 2017, the Gulf Cooperation Council (GCC) States, together with Jordan and Lebanon, host a total of 23 million migrant workers, and 39 per cent of these are women.[11] More specifically, the Arab States host a significant share of the global migrant domestic workforce:[12] an estimated 83 per cent of domestic workers in the region are migrants;[13] around 19 per cent of domestic workers globally reside in the Arab States;[14] and a total of 2.1 million domestic workers reside and work in the GCC, Jordan and Lebanon.[15] The majority of migrant domestic workers in the region come from Asian and African countries such as Sri Lanka, the Philippines, Bangladesh, Nepal and Ethiopia.[16]

Furthermore, in the region, migration for domestic work is highly gendered: about 6 in 10 women migrant workers in the region are domestic workers, compared to just 1 in 10 men migrant workers.[17] The number of domestic workers in the region is expected to rise over the next several decades, as the need for care work increases, as lower fertility rates evolve into a more elderly population that will rely on care work. By 2050, the proportion of the population in the Arab States that are 60 years or older is expected to rise to 19 per cent, compared to just 7 per cent in 2010.[18]

Before exploring the situation of women migrant domestic workers, this paper first presents the power dynamics in the Arab States by analysing social protection schemes across the region and the ways they have differently impacted nationals and foreign workers. The next section explores labour law and social protection as they impact migrant workers, and specifically migrant domestic workers. Following an explanation of the labour protections prior to the pandemic, the paper then sheds light on how these impacted migrant domestic workers during the COVID-19 period of lockdowns and related measures. This paper argues that the lack of centralized legal frameworks to protect migrant domestic workers ultimately worsened their precarity during the pandemic, making their work virtually informal regardless of their documentation status.

## Power dynamics in the Arab States: Governments, citizens and migrants

The welfare State has been declining in favour of austerity measures in the region since the financial crisis of the 1990s.[19] It has been further compromised by collapses in oil prices throughout the 2010s, resulting in increased reliance on State austerity measures and, particularly in the GCC States, a movement away from redistribution of oil wealth amongst citizens.[20]

This has fostered a system of restricted social protection, where access to protection has been stratified by citizenship. The United Arab Emirates had a universal health-care system for all residents until 2001, when it became strictly limited strictly to Emirati citizens.[21] Further, in 2018, Jordan replaced the national bread subsidy with an annual cash distribution for low-income Jordanians and Gazans, thereby excluding migrant workers.[22] Governments also rely on the private

10 ILO, 2015a.
11 ILO, n.d.b.
12 This assessment covers social protection politics and policy from the *kafala* States, including the six GCC States (the United Arab Emirates, Bahrain, Saudia Arabia, Oman, Qatar, Kuwait) as well as Lebanon and Jordan. See ILO, n.d.a.
13 ILO, 2015b.
14 Kagan, 2017.
15 Aoun, 2020.
16 ILO, 2015c.
17 ILO, 2015b.
18 Kagan, 2017.
19 Pfeifer, 1999.
20 Al-Marri, 2017.
21 WHO, 2006.
22 Al-Khalidi, 2018.

sector to provide social protection needs: for example, Jordan and Bahrain are the only States in this assessment to have full social security coverage for maternity leave.[23] In other States, these payments are wholly or partially made by employers in the private sector.[24]

Over the past two decades, social protection has been rolled back even for nationals, despite rising costs. Subsidies on fuel and electricity for nationals have been gradually lifted in Jordan, the United Arab Emirates and Qatar since the early 2010s, significantly raising prices in the process. In January 2016, Qatar raised fuel prices by 30 per cent;[25] in 2012, Jordan lifted fuel subsidies, raising prices by 33 per cent.[26] In Lebanon, in August 2021, fuel prices were raised by 66 per cent to adjust for extreme supply shortages, as the country was nearing two years of financial meltdown that has wiped away 90 per cent of the currency's value.[27] While the aforementioned bread subsidies in Jordan were lifted in early 2018 and replaced with cash distributions for Jordanian families, targeting for cash aid programmes in Jordan have previously failed to reach those most in need.[28] Oman has also implemented austerity measures at key public oil companies, and implemented a value-added tax for the first time. This has eventually led to rare public protests in various Omani cities and towns against rising unemployment in the country.[29]

Through these social developments, a power dynamic has been established between government, citizens and foreign workers, where limited social protection available across the region is mostly for nationals, and nationals are privately responsible for the management and employment of foreign workers.

Systematically, labour law and policy for migrant workers across most of the region have been characterized by control, that is, work subcontracted from government to individual citizens.[30] This subcontracting works through a sponsorship system known as *kafala*,[31] a long-standing system introduced under British imperial rule.[32] Most migrant work in the region happens under private sponsorship, where sponsors have varying levels of control over employment decisions, as well as country exit and entry. *Kafala* sponsors – employers – exercise immense power over their employees, including control over their legal status and mobility through the issuance of visas, residence permits, and other relevant documents. These vary throughout the region: for instance, while one always requires permission from one's employer to change jobs in Oman, this requirement is relaxed after one year of employment in Bahrain, Jordan and Kuwait.[33] However, an imbalanced power relation is consistent throughout: communication with government agencies and duty bearers is mostly through the employer, especially due to the language barriers between the worker and the working languages of the ministries.[34] This increases risks of abuse, exploitation and human trafficking,[35] often leaving the conditions of employees and especially domestic workers at the mercy of their employers.[36]

There have, however, been recent shifts that challenge that *kafala* system across different States in the region: Qatar lifted the system entirely, by removing employer permissions to change occupations or leave the country;[37] and Saudi Arabia partially rolled its *kafala* system back. Bahrain also introduced the Flexi Permit system in 2017, which allowed migrants to work in occupations without a specific sponsor.[38] Importantly, it permitted some undocumented workers to regularize

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23 Lebanon operates a mixed-payment system between employers and the social security fund. See: GIFA, 2014; Lewis, 2020.
24 GIFA, 2014.
25 *PetrolPlaza*, 2016.
26 Buck, 2012.
27 *Reuters*, 2021.
28 Abdo and Almasri, 2020.
29 El Yaakoubi and Barbuscia, 2021.
30 Migrant-rights.org, 2015.
31 States with a history of *kafala* include the six GCC States and Jordan and Lebanon.
32 Boodrookas, 2021.
33 Robinson, 2021.
34 Malit and Naufal, 2016.
35 United Nations Office on Drugs and Crime, 2021.
36 Malit and Naufal, 2016.
37 ILO, 2019b.
38 *Gulf Insider*, 2021.

their status without an employer sponsor.[39] In 2019, Jordan introduced some flexible work permit options that would allow migrant workers to work in selected sectors without a sponsor.[40] Other GCC States have also committed to ending *kafala*, including Bahrain and Kuwait, although this has not yet occurred.[41]

## Labour standards and protection of migrant workers

Regardless of *kafala* sponsorship systems, differentiated labour protection standards for diverse categories of workers exist across the region, either including only partially or excluding entirely certain work sectors that are heavily reliant on migrant workers, such as domestic work, construction and agriculture work. These sectors tend to be the most vulnerable to abuse in the workplace, including confiscation of passports, withholding of salary payment, and charging workers for visa and flight ticket costs.[42]

### Setting minimum wages for workers: The case of Qatar

In 2020, Qatar became the first State in the GCC to support non-discriminatory minimum wages for all workers across all sectors.[43] This decision is landmark in the region, where minimum wages are often differentiated by sector or citizenship. In a region that relies heavily on foreign work, policies such as these are key to ensure inclusion and fair compensation. Further, the minimum wage is determined against standards set out in the ILO Minimum Wage Fixing Convention No. 171. These standards take into account wage protection system data (see text box below), worker consultations and the economic situation in the country, as well as enforcement mechanisms and penalties for lack of compliance.[44]

None of the countries covered in this paper have ratified ILO Convention No. 189 on Decent Work for Domestic Workers.[45] Currently, labour laws across the region mostly exclude domestic workers, or include them by way of separate legislation or instructions. This is the case in Jordan, Kuwait, Saudi Arabia and Bahrain.[46] These instructions, however, set standards that are normally lower than those set out in the national labour laws applicable to nationals.[47] None of these require social security coverage for migrant domestic workers, which also restricts access to other important benefits including in case of unemployment, worker injury insurance, and retirement pension. In Saudi Arabia, for instance, labour code provisions are not applicable to domestic workers whose work is regulated through a ministerial decision specifically on domestic work, which is separate from the general labour law for private sector workers. Importantly, this decision does not specifically prohibit the confiscation of domestic workers' passports, as is stipulated in the general labour law.[48] Similarly, in Jordan, domestic workers were technically included under the Labour Law of 2008;[49] however, they have come to be governed by separate instructions, issued in 2009, that regulate their employment.[50] And while Bahrain includes domestic workers in its national labour law, it excludes them from accessing most of the provisions relating to private sector employment.[51]

[39] Aben, 2021.
[40] Prime Ministry, the Hashemite Kingdom of Jordan, 2019.
[41] Migrant Forum in Asia, 2012.
[42] ILO, 2017.
[43] *Al Jazeera*, 2021.
[44] ILO, 2021.
[45] ILO, 2015c.
[46] Kagan, 2017.
[47] Ibid.
[48] ILO, 2019c.
[49] Prime Ministry, the Hashemite Kingdom of Jordan, 2008.
[50] Tamkeen, n.d.
[51] International Trade Union Confederation, 2017.

The exclusion of domestic workers from general labour law provisions at the national level reinforces the degree of control exercised upon domestic workers by their sponsor, or *kafeel*. Domestic workers who reside in their employers' homes are particularly vulnerable in these cases, especially when forbidden to leave their houses without permission.[52] Close proximity to the employer often puts workers at heightened risks: isolation from other workers and from their communities, a lack of private space and disconnection from outside society often mean that domestic workers do not have the information and space to ensure access to their rights.[53] While labour standards are implemented for domestic workers in regulations and ministerial decisions, the access that domestic workers have to labour inspectors and their ability to privately make complaints is significantly limited.[54] For instance, although collection of recruitment fees in the receiving country is illegal, many foreign workers are unaware of this and pay them, with little understanding that they have the right to legal remedy.[55]

Beginning in 2009, a series of instructions for employment of domestic workers was introduced throughout the region. In 2009, for instance, Lebanon introduced a unified contract for domestic workers. Prior to this, contracts were managed privately and were not unified under basic standards. These instructions fall short of general national labour standards and have few enforcement mechanisms. As another example, the United Arab Emirates introduced a domestic workers' rights bill in 2017 that included a weekly rest day, 12 hours of daily rest, and a minimum wage with the option to forgo the weekly rest day if paid. While promising, these still stray from the standards set out in the labour code, which cap weekly work hours at 48 hours and include longer paid sick leave.[56]

### Wage protection systems in GCC States

A wage protection system (WPS) is a "means of codifying, regulating and ensuring the timely payment of employee salaries as well as providing an effective method for monitoring employer non-compliance."[57] In 2009, the United Arab Emirates implemented a WPS for workers through which payment was regularized through the Ministry of Labour. The GCC States all followed, establishing similar systems to ensure timely and just payment of workers, with Bahrain being the last of the GCC States to implement the system in 2021.[58] WPSs rely on a central directive by which employers are legally mandated to pay their workers through centralized payment modalities. In the case of Qatar, wage transfers are legally mandated to be made to an account in one of 17 approved banks in Qatar.[59] This ensures that wages can be tracked, and that payment are made in full, and on time. In the United Arab Emirates, companies that violate the WPS provisions are forbidden from applying for new work permits. Across the region and particularly in GCC States, this is a powerful punitive measure due to the heavy reliance on foreign workforces.[60]

While the *kafala* system that delegates power over migrant labour from the State to private individuals cannot guarantee domestic workers' labour rights, there have been recent developments in these States to move away from the *kafala* systems, although not all have yet been successful. Despite the earlier introduction of a unified domestic worker contract in Lebanon, recent attempts to replace the *kafala* system with an improved unified worker contract that guaranteed the right to terminate employment without employer consent, and the right to a weekly rest day, sick pay, annual leave and the national minimum wage, was rejected. This was due to objections from the

52 Frantz, 2014.
53 Aoun, 2020.
54 Migrant Forum in Asia, 2012.
55 Malit and Naufal, 2016.
56 Human Rights Watch, 2017.
57 PwC, 2019.
58 *Fragomen*, 2021.
59 ILO, 2019a.
60 *Al Bawaba*, 2009.

Syndicate for the Owners of Recruitment Agencies.[61] Dismantling *kafala* systems commenced in Saudi Arabia as well; however, they do not cover the entire private sector. The new labour reforms only apply to those who are covered directly by the labour law, thereby excluding domestic workers.[62] In Qatar, changes to *kafala* system policies have applied to all sectors, including domestic workers; however, employers' use of retaliatory absconding charges against workers – as well as their power to cancel workers' residencies[63] – perpetuates power imbalances that are reminiscent of *kafala* relationships.[64]

## COVID-19 and protection of women domestic workers in the Arab States

The most common national responses to COVID-19, particularly in the initial months of the pandemic, were lockdowns and border closures. Varying degrees of border closures meant that migrant workers globally were stranded either in their home countries, if temporarily back home, in countries of transit, or in their countries of destination.[65] Support for domestic workers was generally weak, if available at all: only 40 per cent of domestic workers globally had effective access to social security that was linked to their employment.[66] Globally, domestic workers were severely impacted by job loss and reduced hours during initial COVID-19 lockdowns; more than two-thirds of those affected were women.[67] Globally, job losses were often linked to restrictions on mobility and to workers being unable to reach their workplaces. In the Arab region, domestic workers were simultaneously subject to both job losses and increases in work hours.[68] Economic constraints caused job losses, as happened in Lebanon. However, domestic workers' hours increased, and in particular, gendered care responsibilities increased, such as more cooking and cleaning duties for their employers.[69] By some estimates, care work increased by up to 22 times in the early stages of the pandemic.[70] These responsibilities then transferred to domestic workers, who had to work longer work hours due to the increases in care responsibilities for women across the region following lockdowns and school closures.[71]

Migrant domestic workers faced challenges, as their status as migrants was coupled with the challenges faced by women in the workforce across the region, particularly in accessing formal work and social protection. In the region, 62 per cent of women work in the informal economy in jobs that lack social protection and employment benefits.[72] Women workers thus faced disproportionate impacts during the pandemic: of the jobs that were forecast to be lost in initial lockdowns, 41 per cent were held by women, despite women making up only 21 per cent of the total regional active workforce.[73]

While social and labour protections for migrant workers are limited, they do exist: private sector provisions in labour codes partially cover male-dominated labour sectors such as construction or manual labour.[74] On the other hand, the nearly non-existent social protection for migrant domestic workers – of whom an overwhelming majority are women – fostered more precarious conditions, as well as abuses, during the COVID-19 pandemic and related lockdowns.[75] Despite reports of physical and sexual abuse of domestic workers during lockdowns, recourse and support for survivors of gender-based violence across the region were weak.[76] Governments across the

61 Ullah, 2020.
62 Human Rights Watch, 2021.
63 United States Department of State, 2021.
64 Amnesty International, 2020.
65 Rao et al., 2021.
66 *United Nations News*, 2021.
67 ILO, 2020a.
68 UN-Women, 2020.
69 Aoun, 2020; UN-Women 2020.
70 UNDP, 2021.
71 ILO, 2020a.
72 UNDP, 2021.
73 Abdo and Almasri, 2020.
74 Gamburd, 2010.
75 Aoun, 2020.
76 Ibid.

region introduced domestic violence hotlines during pandemic closures, as it became clear that gender-based violence was an unintended consequence of the lockdowns. However, women's rights groups highlighted that the hotlines were implemented without consultation and without gender-sensitive considerations, undermining their effectivity.[77]

While a number of government initiatives for the protection of women domestic workers in the Arab States have been promising in recent years, the COVID-19 pandemic has highlighted and exacerbated the precarious situation in which migrant domestic workers remain, most of the time. Domestic migrant workers have generally not been included in protection measures taken by States in response to COVID-19 and its socioeconomic impacts. In a recent mapping of 162 COVID-related social protection responses conducted across the Middle East and North Africa, only 25 of these explicitly included non-nationals in their implementation. More importantly, most of the social protection expansions – whether they were unemployment benefits, cash distributions, or other forms of support – built on existing mechanisms.[78] This prevented the coverage of domestic workers, as existing social protection programmes excluded them. Social security subscriptions in countries like Jordan and Lebanon guarantee access to unemployment benefits, workplace injury insurance, and pensions. While these are all essential, the first of these proved especially crucial during the COVID-19 economic crisis, during which laid off migrant domestic workers faced a difficult choice. Since residency was tied to their work status, employment termination meant that migrant workers must return home immediately,[79] or else live in their receiving countries as undocumented workers and rely on irregular daily wage work – which significantly declined during lockdowns[80] – all the while risking exposure to authorities.

**Health insurance as a condition for employment of domestic workers in Jordan**

The need for broad provision of health-care services was always essential, and was especially key during the recent pandemic. In 2014, the Government of Jordan passed a law requiring that domestic workers have proof of life insurance and health insurance before being issued a work permit.[81] In 2015, this was followed with instructions on what the health insurance policies should cover, including a mandatory minimum annual ceiling of 20,000 Jordanian dinar (equivalent to 28,600 United States dollars) in expenses.[82]

Limited social protection for migrant workers during the pandemic meant that they were reliant on their employers. However, economic constraints, in combination with poor migrant worker protections, led to employers' inability or unwillingness to pay workers, which resulted in layoffs throughout the region. In Jordan, at least one-third of an estimated total of 75,000 migrant workers in the country lost their incomes; many more are suspected to have lost their jobs entirely.[83] While protections were put in place to prevent the termination of Jordanian workers' employment, these provisions did not apply to migrant workers. For companies cutting costs during the pandemic, these measures arguably indirectly incentivized termination of migrant workers' employment over that of nationals.[84] Scenes from Lebanon showed that women domestic workers were being abandoned at embassies following the currency crash and economic collapse that left the Lebanese middle class able to afford neither their domestic workers' wages nor the cost of a flight ticket to their home country.[85] In Saudi Arabia, some African domestic workers were dismissed from their work in the early stages of lockdown in March 2020.[86]

77 UNDP, 2021.
78 Hammad and Soto, 2021.
79 Rosewarne, 2014.
80 *Middle East Monitor*, 2021.
81 Prime Ministry, the Hashemite Kingdom of Jordan, 2015.
82 Ibid.
83 Aoun, 2020.
84 Almasri, 2020.
85 Hubbard and Donovan, 2020.
86 Ibid.

Domestic workers who retained their jobs did not necessarily fare better. They reported increased workloads and care work.[87] They also experienced reduced wages and wage theft. This was the case in Lebanon, as currency depreciation meant that workers who were paid in Lebanese pounds watched their already low wages lose even more value.[88] Women in the sector – and, by extension, their households back home – were greatly impacted by this. Statistics on the status of women arriving in the *kafala* States are not readily available; however, organizations suggest that domestic worker recruitment agencies in sending countries will often deliberately target single, widowed and divorced women, as well as those whose husbands are otherwise unwilling or unable to work to support family members.[89] This means that they are often sole breadwinners,[90] thus worsening the impact and pressures of wage theft, as they extend to dependent family members. Despite migrant workers having suffered impacts from loss of income equal to, if not worse than, those faced by national citizens during the pandemic, they were usually not eligible for COVID-19 support programmes.[91] This had further impact on the ability of domestic workers to leave exploitative work situations during the pandemic.

### Inclusion of undocumented workers

Undocumented migrant workers may be at increased risks of COVID-19 infections and health complications, as they may be reluctant to get tested and avail themselves of necessary medical care for fear of deportation, due to their irregular migration status.[92] To counter this, in the early stages of the pandemic the Government of Bahrain issued temporary identity cards for undocumented workers and other short-term residents.[93] This authenticated their identity for the purposes of COVID-19 testing, mitigating concerns about exposure to authorities and allowing broader inclusion of an estimated 70,000 undocumented workers in Bahrain.[94]

Health was a particular concern for migrant domestic workers. As lockdowns increased care work for women, migrant domestic workers took on increased care workloads in their employers' homes. This increased their risk of exposure to COVID-19, as they are often expected to care for those that are ill, including the potentially infected.[95] To partially mitigate this, the United Arab Emirates allowed free testing for Emirati citizens and their domestic workers, as well as anyone who was in close contact with a confirmed case.[96] Simultaneously, many households restricted domestic worker mobility due to fear of them contracting the virus. Prior to the pandemic, interactions between domestic workers and their employers and their children were different and, in some ways, friendlier. By one Ugandan domestic worker's account in Oman, due to fear of contagion, her employers did not allow her to sit near them or touch their food.[97]

Furthermore, special measures do not consider the realities faced by migrant domestic workers by virtue of residing in their employers' homes. While employer-provided health insurance or subsidized public health services are available for all formally registered and documented migrant workers in Jordan, access to these services must be supported by the employer, as employers control their workers' movements outside.

87 UN-Women, 2020.
88 Hubbard and Donovan, 2020.
89 Cousins, 2018.
90 Ibid.
91 Almasri, 2020.
92 Migrant Forum in Asia, 2021.
93 Migrant-rights.org, 2021.
94 *Zawya*, 2021.
95 Human Rights Watch, 2020.
96 ILO, 2020b.
97 Hubbard and Donovan, 2020.

## Conclusion

COVID-19 economic downturns resulted in worker dismissals and exploitation across the globe. Domestic workers, however, were in a particularly precarious condition: their positions as care workers put them in especially difficult situations. Their services were essential to households that needed extra care, while they were simultaneously made more vulnerable to dismissal, exploitation and abuse. While many work with formal contracts, the legal code governing their status makes their work effectively informal, due to the lack of social security. Thus, the provision of unemployment benefits is a key safety measure not only for those who lose their jobs, but also for those who need to leave abusive working situations.

The management of foreign employment in the Arab region is, even with the lifting of *kafala* (or its partial lifting in some cases), still mostly conducted privately. Processes are not well centralized through government policy, and enforcement of policies is limited. Furthermore, government outreach to domestic workers is limited; communication of information is often done through embassies or community Facebook groups, once again highlighting the informality of the protection systems available to domestic workers, who must rely on alternate channels.[98] Because of this informality, the balance of power is often tilted in favour of domestic workers' employers, leaving women domestic workers vulnerable to further exploitation. The continued marginalization of domestic work in national labour legislation will only further exclude women workers from accessing social protection and decent working conditions.

Current limited and non-existent protection for domestic workers leaves them vulnerable to future crises. While this pandemic was global, situations in each country may also prompt similar responses in the future: unemployment is rising in each of Jordan,[99] Lebanon,[100] and Oman.[101] When employer wages are compromised by conditions of austerity and poor economic growth, domestic workers are first to feel the brunt of this impact as their employment status and conditions are instantly compromised. And while economic constraints are not the fault of the employer, the lack of centralized protection modalities and humane solutions in the wake of dismissals and of inability to pay wages often leave the workers to pay the price, since they are left with no unemployment insurance, legal recourse or visa support from the government.

Efforts to centralize legal and social protection for domestic workers are thus stifled by tensions over control of foreign workers. The limitations of these protection systems have been made clear during the pandemic. It is essential that the domestic care sector be governed by public or government regulation, rather than the current situation, in which workers are required to rely on each individual employer's benevolence. Centralized protection measures passed by individual States that support health insurance inclusion, independence from sponsors and wage protection systems should continue to be enacted and enforced. These measures centre workers' rights, and have clear accountability measures for employers, supporting a movement away from reliance on individual employers towards enforcing labour protections for domestic workers. Moreover, ratification of ILO Convention No. 189 on Decent Work for Domestic Workers is key in a region that hosts so many workers, many of whom lack protection and legal recourse. There is some hope in this regard: in 2021, a labour court in Jordan ruled in favour of a Sri Lankan domestic worker who had been held for 23 years without pay.[102] However, this was an extreme case,[103] emphasizing the urgency of full inclusion of domestic workers into labour laws and of mainstreaming social protection and labour rights in the daily work of all migrant workers.

[98] Balan, 2021.
[99] Weldali, 2021.
[100] Babin, 2020.
[101] Mathews, 2021.
[102] *Emarat Al Youm*, 2021.
[103] See Prieto, 2018.

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# 4. GENDERED IMPACTS OF COVID-19 ON PEOPLE INTERNALLY DISPLACED DUE TO DISASTERS IN LATIN AMERICA AND THE CARIBBEAN

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## Introduction

In 2020, disasters triggered 30.7 million new internal displacements, worldwide.[1] The Americas recorded some 4.8 million new internal displacements due to disasters, of which 2.8 million occurred in Latin America and the Caribbean (LAC). Over 2.1 million of these occurred in 13 LAC countries and territories because of hurricanes Iota, Eta and Laura.[2] Left without homes and sources of livelihood, millions have indeed been displaced, primarily internally, hosted in overcrowded shelters and relying on insufficient humanitarian assistance, while others have decided to leave their country, sometimes joining migrant caravans heading towards the Mexican border with the United States of America.[3]

Being forced to flee their homes to preserve their lives, people displaced internally as a result of disaster situations face multiple challenges,[4] and these challenges have been exacerbated in 2020 by the COVID-19 pandemic. Emerging evidence highlights the increased vulnerability of persons displaced internally by disasters during this pandemic,[5] while international organizations have called for the inclusion of internally displaced persons (IDPs) into national COVID-19 response plans.

Against this background, this paper explores the concurrence of two crises in LAC countries: the health crisis generated by the pandemic; and the humanitarian crisis generated by disasters that have triggered substantial new internal displacements. The impacts of these two concurrent crises are explored from an intersectional perspective, specifically in light of social and structural gender differences in the region.[6]

This paper first presents the scope of internal displacements in LAC due to three hurricanes that occurred in the second half of 2020. While highlighting data limitations when it comes to internal displacement, IDPs and gender, the paper presents pre-existing gender inequalities and differences in LAC using the Human Development Index (HDI).[7] The paper then analyses the differential gender impacts on persons displaced internally in LAC due to disasters during COVID-19, highlighting first the increased vulnerability of IDPs to COVID-19, before turning to other dimensions of the vulnerability of IDPs due to the concomitant crises they may have experienced. The next

1 IDMC, 2021.
2 Ibid:151. Although it was also hit by hurricanes Iota and Eta, these figure exclude the United States of America.
3 See IFRC, 2021; Kitroeff, 2020.
4 Abeldaño Zúñiga, 2021; Abeldaño Zuñiga and Fanta Garrido, 2020.
5 Abeldaño Zuñiga and González Villoria, 2021; Orendain and Djalante, 2020.
6 On intersectionality and gender differences, see Crenshaw, 1991.
7 UNDP, 2020.

section turns to promising avenues in LAC and elsewhere to improve the protection of IDPs and which, as highlighted in the conclusion, converge on the need to better include IDPs in protection frameworks and disaster risk reduction (DRR) outside the pandemic context in a gender-sensitive manner.

## Internal displacements due to disasters in Latin America and the Caribbean during 2020

In 2020, disasters have caused nearly 2.8 million new internal displacements in LAC; nearly 90 per cent of these (over 2.5 million) occurred in only five countries: Brazil, Cuba, Guatemala, Honduras and Nicaragua.[8] Table 1 focuses on the three events that caused the highest volume of displacement in LAC in the second half of 2020. Hurricanes Laura, Eta, and Iota stand out, together causing over 2.1 million new internal displacements in Belize, Colombia, Costa Rica, Cuba, the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama and Puerto Rico between August and November 2020.[9]

Although the hurricane season in LAC had registered a total of 31 events between tropical depressions and hurricanes, this paper will focus on the three hurricanes mentioned above due to the impact they had in 13 countries and territories.

**Table 1.** **Top three disasters that caused the most internal displacement in Latin American and Caribbean during 2020**

| Event name | Start date | New displacements | Affected countries and territories |
|---|---|---|---|
| Hurricane Laura | 21 August 2020 | 433 892 | Cuba<br>Dominican Republic<br>Haiti<br>Puerto Rico |
| Hurricane Eta | 31 October 2020 | 657 762 | Belize<br>Colombia<br>Costa Rica<br>Cuba<br>Dominican Republic<br>El Salvador<br>Guatemala<br>Honduras<br>Mexico<br>Nicaragua<br>Panama |
| Hurricane Iota | 14 November 2020 | 1 039 184 | Belize<br>Colombia<br>El Salvador<br>Guatemala<br>Honduras<br>Nicaragua |
| **Total** | | **2 130 838** | **13 countries and territories** |

*Source:* Adapted from IDMC, 2021.

[8] IDMC, 2021.
[9] Ibid.

Despite progress made, data collection on internal displacements and IDPs continue to suffer from important limitations, including in terms of disaggregation. Existing global data are currently not disaggregated on the basis of gender, age, disability, minority background or other indicators. As noted by the Internal Displacement Monitoring Centre (IDMC), disaggregation should ideally be done in line with the Sustainable Development Goals, to help understand the scale of internal displacements due to disasters, their differentiated impacts on displaced persons, especially from a sex and age perspective, and the needs of those displaced.[10] Going beyond gender binaries would also be important to better understand the impacts of disaster-related displacements on different gender identities, including lesbian, gay, bisexual, transgender, queer and intersex people (LGBTQI+). Indeed, data collection including such disaggregated variables is a first step towards addressing the "invisibilization" of women and girls and people of diverse gender identities, with the view to formulating and adopting gender-responsive policies.[11]

While internal displacements occur in all countries worldwide, disasters tend to have more acute health, social and economic impacts in less developed countries, due to worse structural conditions and therefore the highest risk of disaster displacements.[12] In other words, disasters "hit the poorest people in the poorest countries hardest".[13] In LAC, socioeconomic conditions have created a favourable environment for these events to produce humanitarian crises such as those caused by hurricanes Laura, Eta and Iota. Therefore, these events need to be understood as factors that intensify the "social debt" of this region.[14]

## Differential gender impacts of disasters in Latin America and the Caribbean on the health of internally displaced people

### Gender differences in countries affected by hurricanes Laura, Eta and Iota

The World Health Organization defines the social determinants of health as all "the circumstances in which people are born, grow, work, live and age, including the broader set of forces and systems that influence the conditions of everyday life".[15] These pre-existing contributing factors may have an impact on people's vulnerability to the pandemic and disasters, with a key determinant being gender. In addition to gender, class, race, disabilities and other factors further intersect to create a system of historical oppression of women.[16] The resulting social and structural gender differences in conservative societies such as those in LAC tend to assign women gender roles as mothers and primary care providers for the sick and the elderly in the family, resulting in a lack of access to formal jobs and, thus, social security.

Therefore, internal displacements of people of different genders during the pandemic call for analysing their specific condition in relation to the effects on the economy, work, education, increased violence and lack of access to health services, among other things. For instance, the Pan-American Health Organization has stated that "indigenous women's gender roles and their relationships with men, their communities, and society as a whole shape both their ability to achieve good health and their quality of life".[17] To analyse these living conditions in the 12 countries of interest,[18] we use the HDI for the year 2020 (Table 2) published by the United Nations Development Programme (UNDP).[19]

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10 IDMC, 2021:114.
11 Hennebry et al., 2021:4; Criado-Perez, 2019.
12 IDMC, 2021:66.
13 Watts et al., 2021; OCHA, 2021.
14 At the end of the eighties, at an ECLAC event, the concept "social debt" was defined, understood as the deficit of the State in essential needs, namely: health, education, employment, access to productive and social assets and democratic strengthening; in short, the levels of well-being of the most disadvantaged social classes.
15 WHO, 2019.
16 Crenshaw, 1991.
17 Pan-American Health Organization (PAHO), 2004.
18 As a territory, Puerto Rico is not included in the below analysis.
19 UNDP, 2020.

**Table 2.** **Human development indicators in 12 selected countries in Latin America and the Caribbean, 2020**

| Country | Human Development Index (HDI) and its components | | | | | | | | Health and violence | | Health and environment | | Gender Inequality Index (GII) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HDI, female | HDI, male | Life expectancy at birth, female (years) | Life expectancy at birth, male (years) | Mean years of schooling, female (years) | Mean years of schooling, male (years) | Estimated gross national income per capita, female (2017 purchasing power parities in United States dollars (PPP $) | Estimated gross national income per capita, male (2017 PPP $) | Current health expenditure (% of GDP) | Violence against women ever experienced, intimate partner (% of female population ages 15 and older) | Homeless people due to natural disaster (average annual per million people) | Mortality rate attributed to unsafe water, sanitation, and hygiene services (per 100,000 population) | |
| Panama* | 0.826 | 0.811 | 81.8 | 75.4 | 11.2 | 10.0 | 24 050 | 35 049 | 7.3 | 14.4 | 0 | 1.9 | 0.407 |
| Costa Rica* | 0.802 | 0.818 | 82.9 | 77.7 | 8.9 | 8.6 | 13 476 | 23 501 | 7.3 | 35.9 | 0 | 0.9 | 0.288 |
| Colombia** | 0.761 | 0.770 | 80.0 | 74.5 | 8.6 | 8.3 | 11 594 | 17 018 | 7.2 | 33.3 | 24 | 0.8 | 0.428 |
| Mexico** | 0.760 | 0.792 | 77.9 | 72.2 | 8.6 | 8.9 | 12 765 | 25 838 | 5.5 | 24.6 | 40 | 1.1 | 0.322 |
| Dominican Republic** | 0.759 | 0.760 | 77.4 | 71.0 | 8.8 | 8.3 | 12 449 | 22 740 | 6.1 | 28.5 | 197 | 2.2 | 0.455 |
| Cuba** | 0.754 | 0.799 | 80.8 | 76.8 | 11.2 | 11.8 | 5 714 | 11 567 | 11.7 | n.d. | 1 310 | 1.0 | 0.304 |
| Belize** | 0.706 | 0.723 | 77.8 | 71.7 | 9.9 | 9.9 | 4 896 | 7 881 | 5.6 | 22.2 | n.d. | 1.0 | 0.415 |
| Nicaragua*** | 0.663 | 0.655 | 78.0 | 70.9 | 7.2 | 6.6 | 4 656 | 5 930 | 8.6 | 22.5 | 2 | 2.2 | 0.428 |
| El Salvador*** | 0.662 | 0.679 | 77.8 | 68.5 | 6.6 | 7.3 | 6 471 | 10 501 | 7.2 | 14.3 | 258 | 2.0 | 0.383 |
| Guatemala*** | 0.639 | 0.679 | 77.2 | 71.4 | 6.6 | 6.7 | 5 451 | 11 629 | 5.8 | 21.2 | 353 | 6.3 | 0.479 |
| Honduras*** | 0.625 | 0.639 | 77.6 | 73.0 | 6.6 | 6.5 | 4 173 | 6 446 | 7.9 | 27.8 | 82 | 3.6 | 0.423 |
| Haiti**** | 0.473 | 0.540 | 66.2 | 61.8 | 4.3 | 6.6 | 1 410 | 2 016 | 8.0 | 26.0 | 710 | 23.8 | 0.636 |

*Notes:* HDI measures the possibilities that the inhabitants of a country have to choose a life in which they can fully realize their potential as human beings. For this, the United Nations uses data on life expectancy, schooling, and income per capita of each country. The final result always yields a value between 0 and 1 that determines, according to UNDP, the four degrees of human development as follows:
* Very high human development: countries with an HDI greater than 0.80.
** High human development: countries with an HDI between 0.70 and 0.80.
*** Medium human development: countries with an HDI between 0.55 and 0.70.
**** Low human development: countries with an HDI less than 0.55.
*n.d.:* No available data.

*Source:* Authors' elaboration, based on UNDP, 2020.

Human development indicators show varying degrees of gender inequalities in the concerned countries: countries with the highest level of gender inequalities have the lowest human development indices, such as Haiti and El Salvador.

In terms of gendered income differences, all countries have some level of disparity, regardless of their level of human development. However, the gender pay gap increases as the level of human development decreases. Violence against women occurs at significant levels in all countries, but in Costa Rica and Colombia, one out of every three women has experienced violence by an intimate partner. Mortality attributed to unsafe water, sanitation and hygiene (WASH) is higher in countries with a lower level of human development. Finally, the Gender Inequality Index (GII) is higher in countries with lower human development. Consequently, social factors associated with health affect women more, since their living conditions are unfavourable compared to men in their communities, also affecting girls, indigenous women and women with disabilities.[20]

## Differential gender impacts of disasters in times of COVID-19

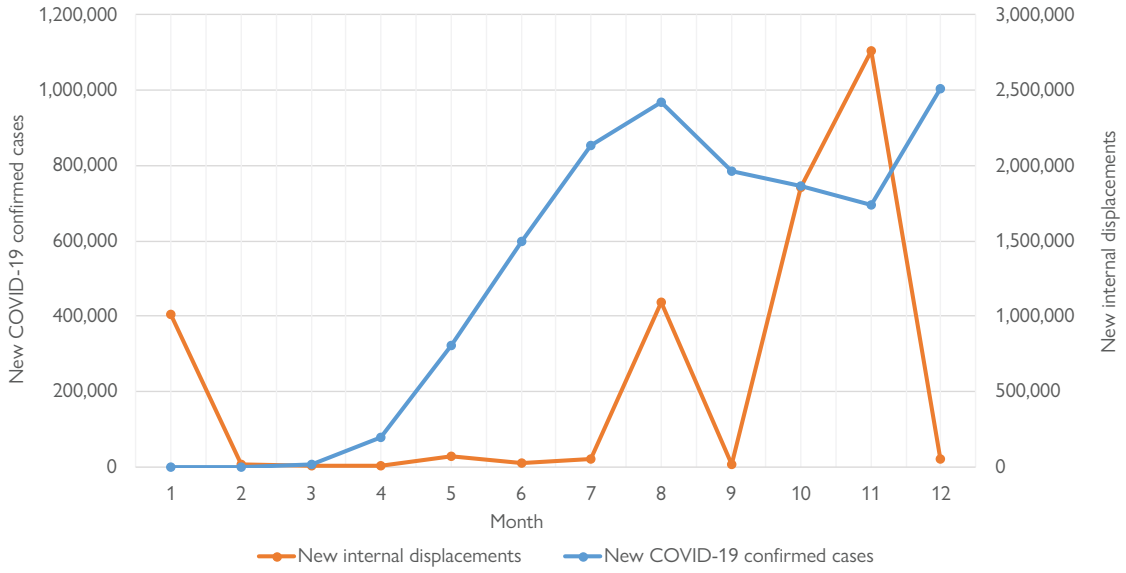
In April 2020, there were concerns in the Caribbean countries about the availability of resources to face the COVID-19 crisis, and about the implications that the next hurricane season would have that year. At that time, the United Nations Office for Disaster Risk Reduction (UNDRR) already anticipated that COVID-19 would overlap with the hurricane season, and that the emergency rescue response would be significantly affected by the virus.[21] Beginning in May 2020, more than 500,000 new cases of people infected with COVID-19 began to be reported monthly in LAC.[22] They coincided with disaster events, especially hurricanes Laura, Eta and Iota that triggered 2.1 million new internal displacements.

Unfortunately, these IDPs could not follow the main global pandemic containment measure to reduce the likelihood of potential coronavirus infection: "Stay at home".[23] They had to risk their health by leaving their homes in order to save their lives from weather-related disasters. For these people, leaving their homes for the evacuation sites set up in the cities affected by disasters had the objective of survival but, this time, it was not the same as in other years, since leaving to save their lives increased the risk of contracting an emerging and potentially deadly virus.

As can be seen in Figure 1, disasters have forced people to leave their place of refuge when the curve of cases was on the rise. Although it is not possible, based on existing data, to determine whether there was a greater number of cases of COVID-19 in IDPs,[24] nor whether cases were distributed unequally among different genders, the concurrence of disaster-related displacements and the rise in COVID-19 infections at least points to an increased risk faced by IDPs during the pandemic due to their evacuation and displacement conditions, often in overcrowded settings that did not allow the adoption of basic hygiene and social distancing preventive measures.[25] This observation is in line with some few existing studies carried out in other geographies, which point out that migrant displaced populations were generally more at risk of infections, including because of their more precarious living and working conditions, as well as language barriers to health information.[26]

[20] The Gender Inequality Index is a coefficient that can range from zero to one. Its interpretation implies that the higher the value, the greater the inequality for women.
[21] UNDRR, 2020.
[22] University of Oxford, 2021.
[23] WHO, 2020.
[24] Shultz et al., 2021.
[25] UNHCR, 2021a; OHCHR, 2020; IOM, 2020.
[26] Hintermeier et al., 2021; Hayward et al., 2021; Pernitez-Agan, 2020.

**Figure 1.** **Monthly new cases of COVID-19 and number of new displacements, by month, in Latin America and the Caribbean, 2020**




*Sources:* Authors' elaboration, based on IDMC, 2021 and University of Oxford, 2021.

Table 3 shows the increase in infections in the 13 countries and territories affected by the three hurricanes. Although the increase in cases observed is due to the dynamics of the pandemic itself and cannot be directly linked to displacements triggered by the three hurricanes, it is notable that the disasters occurred at the most critical moments during the pandemic in countries such as Colombia and Mexico.

However, these data have limitations, since it is impossible to define the end date of the displacements after each hurricane. This does not allow us to show the temporality of the emergency in the following weeks, which serves as a reference parameter for the number of COVID-19 cases.

**Table 3.** **Affected countries in Latin America and the Caribbean by hurricanes Laura, Eta and Iota, and COVID-19 cases after the start date of the disaster, 2020**

| Event name and new displacements | Start date | Affected countries and territories | New displacements by country and territory | COVID-19 confirmed cases as of the start date of the hurricane(a) | COVID-19 confirmed cases 3 weeks after the start date of the hurricane(b) | COVID-19 cases difference (b)−(a) |
|---|---|---|---|---|---|---|
| Hurricane Laura: 433 892 new displacements | 21 August 2020 | Cuba | 417 664 | 3 582 | 4 653 | 1 071 |
| | | Dominican Republic | 15 210 | 89 967 | 102 232 | 12 265 |
| | | Haiti | 957 | 7 997 | 8 429 | 432 |
| | | Puerto Rico | 61 | 16 295 | 17 598 | 1 303 |

| Event name and new displacements | Start date | Affected countries and territories | New displacements by country and territory | COVID-19 confirmed cases as of the start date of the hurricane(a) | COVID-19 confirmed cases 3 weeks after the start date of the hurricane(b) | COVID-19 cases difference (b)−(a) |
|---|---|---|---|---|---|---|
| Hurricane Eta: 657 762 new displacements | 31 October 2020 | Cuba | 187 872 | 6 887 | 7 798 | 911 |
| | | Guatemala | 184 011 | 107 939 | 118 417 | 10 478 |
| | | Honduras | 175 000 | 96 888 | 104 435 | 7 547 |
| | | Nicaragua | 71 145 | 5 514 | 5 725 | 211 |
| | | Mexico | 15 238 | 924 962 | 1 040 000 | 115 038 |
| | | Colombia | 8 000 | 1 070 000 | 1 240 000 | 170 000 |
| | | Dominican Republic | 6 725 | 127 018 | 137 770 | 10 752 |
| | | Panama | 3 551 | 133 598 | 153 577 | 19 979 |
| | | El Salvador | 2 264 | 3 487 | 5 110 | 1 623 |
| | | Costa Rica | 2 056 | 33 826 | 37 404 | 3 578 |
| | | Belize | 1 900 | 109 971 | 129 418 | 19 447 |
| Hurricane Iota: 1,039,184 new displacements | 14 November 2020 | Honduras | 743 426 | 102 555 | 111 023 | 8 468 |
| | | Nicaragua | 160 000 | 5 661 | 5 838 | 177 |
| | | Guatemala | 126 261 | 114 719 | 125 352 | 10 633 |
| | | Colombia | 8 329 | 1 190 000 | 1 370 000 | 180 000 |
| | | El Salvador | 880 | 36 358 | 39 930 | 3 572 |
| | | Belize | 288 | 4 715 | 7 601 | 2 886 |

*Sources:* Authors' elaboration, based on IDMC, 2021 and University of Oxford, 2021.

While there exist no disaggregated data on IDPs death rates because of COVID-19, more general data on deaths in LAC arguably reflect potential gender implications. Although the percentage of men and women infected by COVID-19 is similar in the LAC region, the fatality of COVID-19 is higher in men, the elderly, and people with pre-existing chronic diseases.[27]

Displaced persons have not always been explicitly included in vaccination plans, let alone declared among the priority groups for vaccinations (as were, for instance, the elderly and health personnel).[28] This suggests that, in some countries, vaccinations for displaced people have come at a later stage.[29]

Evidence also points to significant gender differences in mental health resulting from the pandemic.[30] Women have been facing physical, mental, and emotional burdens during the pandemic. They have also felt fear of contagion, work and economic stress, and the increased risk of violence and burnout due to the confinement. At the same time, they have had to assume responsibility for safeguarding their health while increasingly having to take care of household members.[31] In Mexico, the ENCOVID-19 survey on the well-being of Mexican households has described that anxiety levels during confinement are higher in women (37.3%) than men (27%).[32] The care burden on women in the region also extended beyond the private sphere: women who work in the health sector in

[27] CEPAL, 2021; IMST and EGC, 2021.
[28] IOM, 2021. See, more generally, Kaiser Family Foundation, 2021.
[29] Zard et al., 2021:note 26.
[30] PAHO and UN-Women, 2020.
[31] Red de Salud de las Mujeres Latinoamericanas y del Caribe, 2021; CARE Honduras and UN-Women, 2020.
[32] Universidad Iberoamericana, 2020.

LAC constitute 73.2 per cent of the employed persons.[33] By having to face a series of extreme working conditions – such as long working hours – their physical and mental health has been seriously impacted, in addition to the risk of contagion of the virus. In addition, many of these working women are responsible for dependents or those who need care in their homes. The burden has increased as never before.[34]

While access to health care and other support services tends already to be challenging for IDPs outside a pandemic context,[35] access has been further limited by the pandemic, with a disproportionate impact on women and girls.[36] Mobility restrictions and the priority placed on emergency health-care services have undermined accessibility to sexual and reproductive health (SRH) services for women. Disasters have also reduced access to and provision of adequate services,[37] with many roads destroyed by the hurricanes.[38] While SRH services are also essential for female IDPs in terms of maternity care, family planning and newborn care, among others,[39] women were exposed to unwanted pregnancies, unsafe abortions, or maternal deaths, among other aspects of SRH.[40] Comprehensive sexuality education programmes that help girls understand and access SRH care and rights have also been reduced with school closings.[41]

As women and girls worldwide have faced increased risk of sexual and gender-based violence (SGBV) in times of lockdowns, being sometimes confined with their abusers at home, the availability of gender-based violence services has also been impacted by the pandemic.[42] Risk of SGBV tends to increase depending on a range of intersecting factors, including because of displacement, as well as ensuing living and socioeconomic conditions.[43] Sexual abuses of women and girls were reported in shelters in Honduras, for instance.[44] To address these risks, some countries – such as Mexico and the Dominican Republic – declared some SGBV services as essential services, ensuring the continuation of shelters and care centres or hotlines.[45] Emphasis was also placed on preventing SGBV through prevention campaigns with, in some countries, consideration for the intersecting factors that may impede access to information. A bilingual campaign in Spanish and English, for instance, was developed in Belize to increase its reach to diverse female populations.[46] The Guatemalan Secretariat against Sexual Violence, Exploitation and Trafficking in Persons also visited women and girls in shelters to provide information on prevention.[47]

In the midst of an economic downturn in the LAC region created by the pandemic,[48] persons internally displaced were hosted in overcrowded shelters or lived in makeshift camps, relying on informal work and humanitarian aid to survive. As of March 2021, in Honduras, more than half of those living in shelters were female IDPs.[49]

33 CEPAL, 2020.
34 Abeldaño Zuñiga, 2021.
35 Cintra et al., 2020.
36 ECLAC and UN-Women, 2021.
37 Amiri et al., 2020.
38 Cuffe, 2021.
39 Munyuzangabo et al., 2020; Tunçalp et al., 2015.
40 Marie Stopes International, 2020; WISH2Action Programme, 2020; CARE Honduras and UN-Women, 2020; Cuffe, 2021.
41 Inter-American Commission of Women, 2020.
42 Red de Salud de las Mujeres Latinoamericanas y del Caribe, 2021; UNHCR, 2021a; Inter-American Commission of Women, 2020.
43 IFRC, 2015; CARE Honduras and UN-Women, 2020.
44 Miranda, 2020.
45 ECLAC and UN-Women, 2021.
46 Ibid.
47 Cuffe, 2021.
48 IMF, 2021.
49 Cuffe, 2021.

In general, women employed in the informal sector have been exposed to higher risks of COVID-19 contagion, often having to continue working because of lack of access to unemployment benefits, while also not being able to resort to remote working due to the nature of their activities.[50] This has especially been the case for women, children and adolescents involved in the informal sector, which is where many IDPs work.[51] Whether as street vendors, domestic workers, subsistence agricultural workers, or seasonal workers, women are disproportionately represented (59% of total employment) in the informal sector in LAC.[52]

Paid domestic work – which it is not possible to carry out remotely – has been one of the sectors hardest hit by the crisis. In the second quarter of 2020, employment levels in paid domestic work fell between 15 per cent and 46 per cent in LAC countries.

As previously noted, women, including those internally displaced, have experienced an increased care burden because of the pandemic, with women's labour participation rate decreasing from 52 per cent in 2019 to 46 per cent in 2020.[53] Thus, in 2020, the number of Latin American women living in poverty rose from 95 million in 2019 to 118 million in 2020. In LAC, women perform 76.2 per cent of all hours of unpaid domestic work (more than three times that of men).[54] This situation has worsened with confinement measures, particularly in families with children or those who cannot autonomously undertake online education. For families where a member suffers from a chronic illness or is in the care of dependent older adults, both carers and dependents are at high risk of contracting the coronavirus. This increased workload has negatively impacted unpaid work and women's health, especially in the absence of institutionalized care systems.

Measures implemented by governments to limit the spread of COVID-19, including restrictions on movement, also significantly hampered the daily lives of IDPs. Education was one of the first sectors for which mobility was restricted, through school closures,[55] while many schools were subsequently destroyed by the three hurricanes that hit the region.[56] As a result, girls, boys and adolescents were taught remotely from their homes. Although practically all educational efforts and strategies have shifted towards remote activities, this has revealed already existing inequalities in terms of access to and usage of Internet and digital technologies. It is estimated that only 40 to 70 per cent of the population in LAC has access to the Internet.[57] These differences in access are even more pronounced in rural environments where the indigenous populations of LAC predominantly live. In some regions, only 20 per cent of households thus have the possibility of developing work that can be done and delivered from home, significantly affecting the future of children and adolescents in rural areas.[58] The children displaced by a disaster are even more affected, as power and connectivity services are frequently interrupted. At least 13 million children in LAC did not have access to remote education during the pandemic, a figure that includes the displaced population without access to electricity or Internet services.[59] It has also been observed that children in displacement situations while staying in evacuation centres have less access to formal schools and technology.[60]

[50] UN ESCWA et al., 2020; OHCHR, 2020; IOM, 2020.
[51] Dempster et al., 2020.
[52] UN-Women, 2017.
[53] Narváez, 2020.
[54] Inter-American Commission of Women, 2020.
[55] UNHCR, 2021b.
[56] Narea, 2021.
[57] Statista, 2021.
[58] López-Calva, 2021.
[59] UNICEF, n.d.
[60] Caarls et al., 2021.

Another serious problem faced by IDPs during 2020 was food insecurity. The Office of the United Nations High Commissioner for Refugees estimated that at least 80 per cent of IDPs live in regions severely affected by food insecurity.[61] There is a strong relationship between displacement, food insecurity and human development, where structural conditions are aggravated by pandemics and disasters.[62] Food insecurity is more likely to affect female-headed households, and food insecurity has been exacerbated during the pandemic for displaced populations depending on humanitarian assistance for the provision of food and water. It should also be considered that climate-related disasters often cause crop loss, interruption of supply chains, and other logistical problems.[63]

## Lessons-learned from the COVID-19 impacts on IDPs from a gender perspective

This paper highlights that both the COVID-19 pandemic and disasters do not discriminate, but their impacts do, revealing and exacerbating pre-existing structural inequalities, including in terms of gender. The living conditions shown in Table 2 explain how disasters affect women differently. A study that included data from 141 countries showed that differences between sexes do not explain large-scale gender differences in mortality rates. Instead, social gender roles explain these differences.[64]

In a global public health crisis context, mitigating these impacts and improving the condition of female IDPs require first and foremost a gender-sensitive and responsive approach to COVID-19 responses. This does not only include ensuring the continuity of health services, such as through telemedicine or telenursing,[65] but also adopting an inclusive understanding of "essential health services" in times of crisis. For instance, countries such as Burkina Faso, the Democratic Republic of the Congo, Ethiopia, Mali, Nepal, Nigeria and South Africa have declared access to sexual and reproductive health services, including to contraception, as "essential" health services as part of their national COVID-19 responses.[66]

That said, the pandemic has also offered the opportunity for LAC countries to now develop gender-responsive strategies for DRR,[67] in order to strengthen women's participation in the International Health Regulations as well as gender and health aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030. Indeed, there is a need for a more gender-responsive approach to DRR, focusing on empowerment as well as inclusive, accessible, and non-discriminatory participation, particularly for those disproportionately affected by disasters.[68] A more effective implementation of relevant frameworks would constitute a first step towards improving gender-sensitive and gender-responsive DRR responses. This is especially the case for the Sendai Framework and the Bangkok Principles, which integrate health into DRR.[69] The Principles call for strengthening the design and implementation of gender-responsive and inclusive DRR policies and plans, with community involvement, to address the vulnerabilities and capacities of women, migrants, and other populations at risk, and to meet their protection needs before, during and after disasters.[70]

[61] UNHCR, 2021c.
[62] IOM and WFP, 2020.
[63] Abeldaño Zuñiga et al., 2021.
[64] Neumayer and Plümper, 2007.
[65] WISH2Action Programme, 2020.
[66] Marie Stopes International, 2020.
[67] UNDRR, 2020.
[68] Ibid.
[69] United Nations, 2015.
[70] UNDRR, 2016.

Below are some proposals and illustrations of how a gender-responsive approach could be further mainstreamed into DRR and be integrated into preparedness and responses to emergency situations such as pandemics:

- Ensuring a whole-of-society and intersectoral approach to DRR to reinforce participation by and involvement of women: In countries such as Viet Nam, Serbia, Bosnia and Herzegovina, Pakistan and Kenya, intersectoral work between local governments, civil society and international actors has been essential to strengthening the role of women in disasters. These alliances for governance allowed a decree to be promulgated in Viet Nam that provides an official space for the Women's Union in the decision-making bodies of the Committee for Flood and Storm Control. In Pakistan, the Gender and Child Cell is a permanent body of the National Disaster Risk Management Authority. In Kenya, Kenyan parliamentarians advocated for the inclusion of gender equality in that country's Disaster Risk Act.[71]

- Strengthening women's participation in emergency response committees: In the context of COVID-19, government recovery plans must be evidence based, participator, and take a whole-of-society approach. However, the lack of disaggregated data often means that programmes are not based on adequate and quality data. As a result, the gendered impacts of the pandemic are not fully visualized. At the same time, women's leadership in the recovery from COVID-19 is lacking, since women make up less than a quarter of the national committees established to respond to COVID-19. Women need to be part of local, regional and national emergency response committees.[72]
- Adopting comprehensive actions and approaches: The Government of Chile has adopted a comprehensive approach during the COVID-19 pandemic, where health issues have been addressed, specifically the mental health of affected people who, as noted, can suffer from depression, anxiety, excessive alcohol (or other substance) use, and gender violence.[73] In Mexico, the programme of action related to epidemiological emergencies and disasters identifies and addresses the different risks involved with various epidemiological emergencies and disasters, and the vulnerability of the health of Mexico's people during these emergencies. The programme of action highlights that maintaining an adequate level of preparation and response at the national, state and local levels is a main challenge, as is ensuring effective coordination and implementation of health-related measures.[74]
- Developing practical guidelines: In May 2020, and in view of that year's hurricane season, in the United States, the Federal Emergency Management Agency (FEMA) and the Red Cross published practical guidelines that were later updated throughout the development of the pandemic.[75] Part of FEMA's response was to define which essential community services would enable the continued operation of critical government and business functions that are essential to human health and safety or economic security. The seven essential community services are general in nature, for the entire population, and there is no mention of IDPs throughout the document. However, there are strategies that are replicable in other countries and could address the specific needs of IDPs: safety, security, food, water, shelter, health and medical care, energy (electricity and fuel), communications and transportation.

[71] UN-Women, 2015.
[72] UNDRR, 2021.
[73] Gobierno de Chile, Ministerio de Salud, 2020.
[74] Gobierno de México, Secretaría de Salud, 2015.
[75] FEMA and USDHS, 2020; American Red Cross, 2020.

- Ensuring a better understanding of IDPs' needs, especially women:
  - There is a need for disaggregated data: In Chile, a gender-responsive approach to disaster risk management is incorporated through the disaggregation of data by sex in the reports of the Basic Emergency Cards. This provides relevant information on the impact of emergencies on women and girls.[76] In Yemen, a survey has collected data on the real and immediate needs of displaced people, which allowed the specific needs of women, children, adolescents, elderly people and people with disabilities to be understood. This survey has reported that 45 per cent of IDPs had symptoms compatible with COVID-19, compared to 30 per cent of non-IDPs.[77] Such surveys have been used to produce estimates of basic needs for water and hygiene, and of overcrowding, and thus to provide humanitarian assistance more in line with those needs, as well as enabling analysis of barriers to access to testing and treatment in positive cases.
  - In India, when Cyclone Amphan made landfall in 2020, 818,000 people initially had to be evacuated, which later rose to 2.4 million. In cases such as this, IDMC has recommended increasing the number of shelters to reduce overcrowding, testing for COVID-19 at the beginning and end of displacement, providing isolation rooms for positive cases, providing hygiene and sanitation essentials, using schools, hotels, gymnasiums, religious buildings or other existing infrastructure.[78] In terms of hygiene essentials, it is necessary to provide for adolescent girls and women to receive a menstrual hygiene kit, and it is also important to provide for the specific hygiene needs of people with disabilities.
- Adopting tailored economic recovery programmes: Although there are economic policies to try to remedy the economic problems caused by the pandemic, there are still no well-established programmes for women who were displaced.[79] Some measures recommended by the Economic Commission for Latin America and the Caribbean are the increase of cash transfers, exemption from the payment of basic services, and the delivery of food either directly, through schools, or through community kitchens. Mortgage payment facilities should also include IDPs who have lost their homes due to a disaster.[80]

## Conclusion

This paper has provided an overview of the number of new internal displacements due to hurricanes Laura, Eta and Iota in 13 LAC countries and territories during 2020, as well as a gender analysis of the implications of these disasters in times of COVID-19. It also explored some actions to address the vulnerability of IDPs; 2.1 million new internal displacements were at increased risk of COVID-19 infection because they had to leave their homes due to the impact of hurricanes.[81] This is not the same in all countries, since it is not only a matter of increased exposure to a biological agent; rather, populations in different living conditions are impacted differently by health and humanitarian crises.

Gender inequality increases risk exposure and vulnerability, and restricts women's capacity for resilience. Gender-specific barriers rooted in gender inequality in disaster management are the same barriers that affect women's ability to act, or to prevent and respond to COVID-19. Women earn less, save less, and are more likely to be employed in the informal sector, making their access to savings or social protection in times of disaster or COVID-19-induced recessions more limited than that of men.

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76 Gobierno de Chile, Ministerio de Salud, 2020.
77 Yasukawa, 2021.
78 Kurkaa, 2020.
79 CEPAL, 2020.
80 González Franco and Ojeda Chamba, 2021.
81 IDMC, 2021.

On the one hand, the COVID-19 pandemic increased the risk of exposure of women forcibly displaced by disasters, and showed their vulnerability in these situations. But on the other hand, the COVID-19 pandemic can be seen as providing a window of opportunity to improve the effective implementation of guiding principles (d) and (e) of the Sendai Framework in the LAC region. These two guiding principles promote, respectively, gender equality and good governance in disaster risk management.

As laid out in guiding principle (d) of the Sendai Framework, and in line with the Sustainable Development Goals, there is a need to ensure that women play a leading role in emergency response committees at local, regional, and national levels. It is also essential for humanitarian coordination in disaster situations and epidemiological coordination in response to the pandemic that continuity of SRH services is ensured, and that the basic needs of women are met. One key way to achieve this is to ensure that women participate in planning and implementing these responses.

Through illustrations of some good practices and lessons learned, this paper has highlighted some aspects of good governance of disaster risk reduction and of disaster management, as advocated by guiding principle (e) of the Sendai Framework. This calls for collaboration and alliances between mechanisms and institutions, and integration between countries in the same regions to reduce disaster risks and consolidate the path towards sustainable development. In other words, governance requires an intersectoral collaboration between local governments, civil society, international agencies, and private sectors to increase the participation of women in disaster risk management.

More generally, the concurrence of these global health, economic and humanitarian crises have shed light on the urgent need to seriously address the plight of those displaced by climate-related disasters at the global level. The issue goes beyond internal displacement, as recovery tends to linger after disasters; today's IDPs may well become tomorrow's migrants.[82]

[82] Narea, 2021; Greenfield, 2022.

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One of the students at Masepla Composite Learning School.

# 5. COVID-19 AND TERTIARY EDUCATION: IMPLICATIONS FOR INTERNATIONAL STUDENTS' MOBILITY

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## Introduction

Over the past two decades, annual growth rates in international student mobility averaged 10 per cent: from 2.2 million in 1998, the number of international migrants studying abroad for the purpose of tertiary education reached 5.6 million in 2018.[1] This exponential growth was driven by economic and demographic shifts taking place in both receiving and sending countries. Although the number of tertiary-aged people has been increasing in non-OECD sending countries,[2] greater student demand for higher education and limited educational capacities have led many to look for opportunities abroad. Average wealth has also increased significantly, and the growing middle class can now afford international education. At the same time, the number of young students as a proportion of the total domestic population in high-income destination countries is decreasing, and the large economic and financial revenues from international education have led to increased global competition among receiving countries looking to attract foreign students. As a result, in 2020, the vast majority of international students originated from developing countries, with China and India alone accounting for 24.3 per cent of the total, while OECD countries hosted the largest share of international students, 60 per cent of whom were studying in one of the following countries: the United States, the United Kingdom, Canada, Australia, France and Germany.[3]

Against this backdrop, the outbreak of the COVID-19 pandemic has caused a huge, unprecedented break in global student mobility, reducing the number of international students crossing borders as well as the opportunities for those already studying abroad prior to the pandemic. Among the six abovementioned receiving countries, international student enrolment declined by between 10 and 25 per cent in 2020.[4]

This paper provides an overview of the effects of COVID-19 on international student flows to OECD countries, and how the global health crisis has comparatively affected students from different regions. As every crisis tends to exacerbate the disparities in economic, social and educational opportunities that exist between men and women, it also discusses the implications of COVID-19 from a gender perspective.[5] The final section comments on the main policies implemented in major

1 UNESCO, 2020.
2 Particularly in China, India, Indonesia, Nigeria and Vietnam. See UNESCO, 2020.
3 Institute of International Education, 2021.
4 The drop in international student enrolment remained lower than that of permanent or temporary labour migration flows, which decreased respectively by 30 and 40 per cent on average in OECD countries between 2019 and 2020. See OECD, 2021.
5 Figures and gender-specific insights in this paper rely primarily on Australia and Canada as country examples because of the absence of comparable and readily available data from other major destination countries at the time of writing.

receiving countries to address the needs of international students and to prevent the collapse of student mobility flows.

## Factors affecting international student mobility in times of COVID-19

First and foremost, the global health crisis forced governments and higher education institutions (HEIs) to implement various contingency measures, some of which had an equal or greater impact on international students admitted prior to the pandemic. Several popular study destinations – including Canada, Australia, the United States, and the United Kingdom – were virtually closed to international entrants, as a result of lockdowns and travel bans. In these countries, HEIs also drastically reduced campus operations, creating logistical and regulatory barriers that prevented students from completing administrative procedures. With consulates, administrations and other public bodies with competencies in migration matters running at limited capacity, national governments in the United States, Australia, Canada and France publicly warned of COVID-related delays in the processing of new applications, the renewal of study permits and language testing; as well, other obligations imposed on international students were hindered or suspended.[6]

At the same time, issues regarding the practicalities and costs of international travel, visits to and from their home countries, as well as concerns about their health and those of their relatives considerably reduced students' incentives to pursue education in a foreign country. The COVID-19 pandemic also had a significant impact on international students' ability to sustain themselves through part-time jobs and reduced the number of work opportunities following their graduation.[7]

As a result, many of them chose to defer their entry at a foreign university, picked a different destination country, or abandoned their plans altogether, with potential long-term effects on the international higher education sector. A survey conducted in May 2020, among 2,739 students from Mainland China and the Hong Kong Special Administrative Region (SAR), China, found that 84 per cent of respondents were less interested in studying abroad after the pandemic would end.[8] Given the leading share of Chinese students in international student flows,[9] the survey raised awareness of a potential shift in the mobility of international students, with Asian regions and countries – specifically Hong Kong SAR, China, as well as Japan and Taiwan Province of the People's Republic of China – emerging as the new favourite destinations of students who wish to continue to study abroad. This shift resonates with the impact that the 11 September attacks in the United States had on international student mobility 20 years ago. Indeed, over the three years that followed the event, student visa issuance in the United States decreased by 10 per cent, which according to some opinions led to shifting the competitive advantage in international education away from the United States and toward a more equal distribution among the top receiving countries.[10]

However, the vaccine roll-out, although still dangerously slow in some of the poorest regions of the world, has progressed rapidly over the past months in both sending and receiving countries. While it is too early to assess quantitatively their impact on international student mobility, vaccination requirements and coverage rates will inevitably affect higher education policies and prospective students' plans to study abroad. In this respect, a recent cross-country survey suggests that over half of international students are likely to change their plans based on the introduction and implementation of the vaccine roll-out.[11]

6 IRCC, 2021.
7 ILO, 2021.
8 Mok et al., 2021.
9 Chinese students represent 20 per cent of all students pursuing higher education outside of their country of origin worldwide (UNESCO, 2020).
10 Johnson, 2018.
11 Quacquarelli Symonds, 2021.

## How big is the break? Evidence of the impact of COVID-19 on international student mobility

As the global pandemic is now in its second year, recent statistics can help document the magnitude of the effect of COVID-19 on global mobility flows. For the academic year that began for southern hemisphere HEIs in January 2020 and for northern hemisphere HEIs in September 2020, the anticipated drop was not as steep as initially expected in several OECD countries.[12] However, the data show that HEIs experienced a significant decrease in international student enrolment.

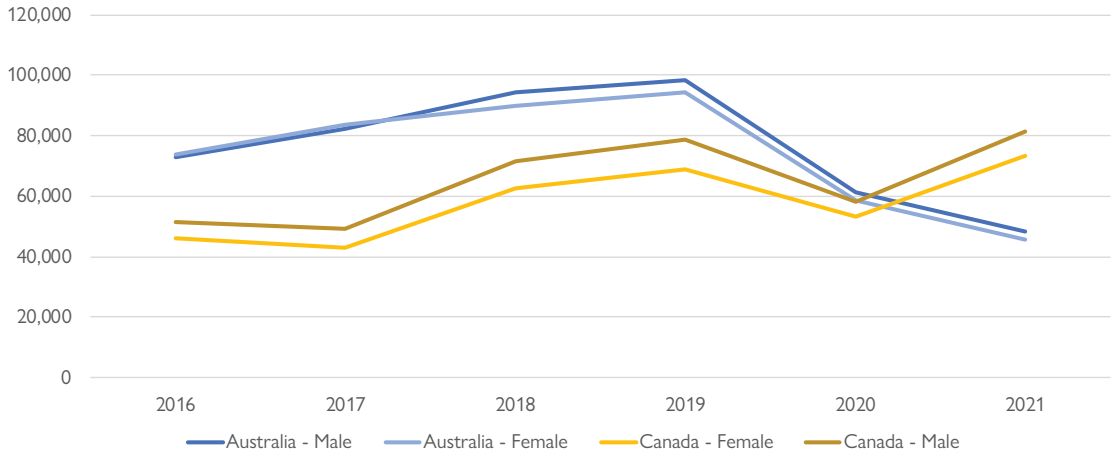
In Australia, the total number of international students residing in the country decreased by 9 per cent, and aggregate international enrolment dropped 7 per cent in 2020, while averaging an annual growth rate of 7 per cent over the preceding five years.[13] Chinese students, who account for nearly a third of all international students in Australia, were particularly affected, with a 11.8 per cent reduction. A sizable decline in enrolment was also reported in the United States, where total international students at HEIs and studying online outside the country decreased by 16 per cent. This trend was particularly pronounced among new international students attending United States HEIs, with a combined 43 per cent decrease in enrolment of students living in the United States and those pursuing full-time coursework virtually outside the country.[14]

Visa statistics for the same period follow a similar pattern. As of September 2020, six European Union Member States – Belgium, Spain, Estonia, Lithuania, The Netherlands, Portugal, and Sweden – as well as Norway reported a negative impact of the pandemic on the numbers of prospective international students based on the number of applications to HEIs and the number of applications for visas or residence permits.[15] In particular, Spain experienced a drop in student visa applications from 92,306 in the first six months of 2019 to 13,777 in the first six months of 2020, while the United Kingdom Home Office reported that the number of student visas issued to international students in 2020 dropped 21 per cent from the previous year. In Finland, a recent survey conducted by the Finnish National Agency for Education has shown that only 27 per cent of Finnish students enrolled at foreign universities continued to study abroad after the pandemic started, while 53 per cent of them returned to their home country.[16] Outside of Europe, the number of new study permits granted over the first six months of 2020 decreased by 38 and 25 per cent in Australia and Canada, respectively, compared to the same period in 2019.

Figure 1 shows, however, that in the first six months of 2021 the number of study visa reverted to pre-pandemic levels in Canada, propped up by Indian students, and decreased at a slower rate in Australia.[17] At the aggregate level, these trends are very similar for male and female students in both countries, with women being only slightly underrepresented among the international student population. Students' resilience and revived interest in pursuing a higher education degree for the 2021/2022 northern hemisphere's academic year are observed in other major destination countries such as the United Kingdom and the United States. In particular, a recent report from Navitas Insights indicates that countries where the health crisis has been managed well and vaccine roll-out has progressed rapidly are the ones that are most likely to benefit from this rebound.[18]

[12] ACE, 2020.
[13] Australian Government, Department of Education, Skills and Employment, 2020.
[14] Institute of International Education, 2021.
[15] EMN, 2020.
[16] Finnish National Agency for Education, 2021.
[17] Australian Government, Department of Education, Skills and Employment, 2020; IRCC, 2021. The same pattern is observed for study permit applications.
[18] Navitas Insights, 2021.

**Figure 1.** **Number of new student visas issued for the first and second quarters, Australia and Canada, 2016–2021**

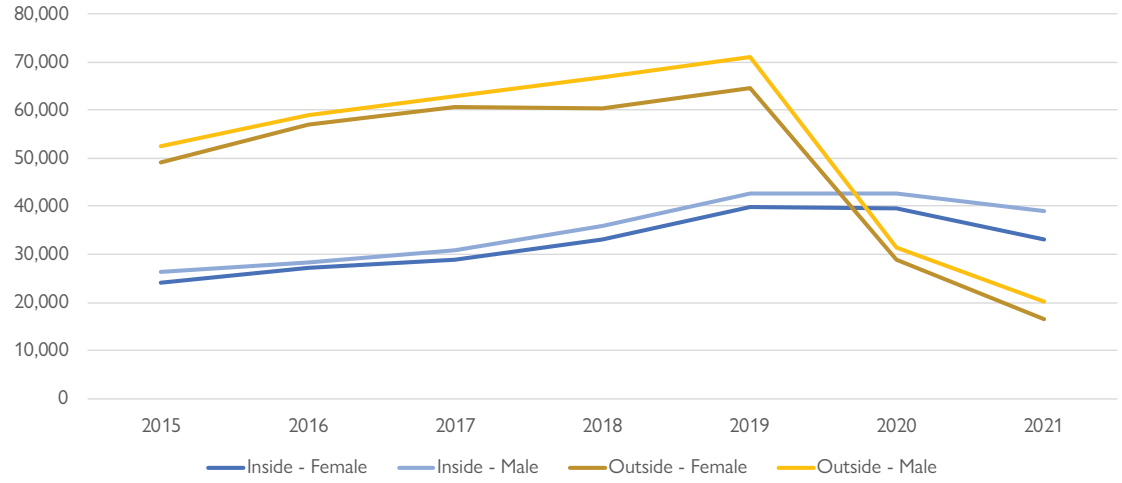



*Source:* Authors' elaboration, based on Australian Government, Department of Home Affairs, n.d.; and IRCC, 2021.

Moreover, the reduction in international mobility was mostly driven by the decrease in the number of newly admitted students, while enrolment among continuing international students already present in their receiving country prior to the pandemic remained stable across OECD countries. For instance, the numbers of short-term exchange enrolments decreased markedly in Europe, where more than half of the students participating in the European Region Action Scheme for the Mobility of University Students (ERASMUS) programme – which facilitates exchanges between countries in the European Union – were not able to travel to their destination country.[19]

As highlighted in Figure 2 below, visa application numbers from Australia tell a similar story. Among both male and female students, applications from within the country did not falter in 2020 and 2021, while applications from students outside of the country dropped by almost 50 per cent.[20]

**Figure 2.** **Number of student visa applications by location for the first and second quarters, Australia, 2015–2021**




*Source:* Authors' elaboration, based on Australian Government, Department of Home Affairs, n.d.

[19] EAIE, 2021.
[20] Australian Government, Department of Education, Skills and Employment, 2020.

This trend can be explained by the fact that many prospective international students paused or slowed the pace of their academic study: in Australia, 90 per cent of HEIs reported international student deferrals for the beginning of the 2020 academic year, and in the United States, likewise, 90 per cent of HEIs reported international student deferrals for the beginning of the 2020/2021 academic year, with plans to enrol in a future term. Meanwhile, receiving countries' institutions provided support for continuing international students that helped lower the pedagogical, financial, and health costs of the pandemic.[21] These policies are reviewed and discussed in greater detail in the last section of this paper.

## A gender perspective on the international student mobility "crisis"

The evidence to date indicates no gender-specific patterns in international student mobility. This is relatively unsurprising if one considers that the gap in enrolment between male and female students in sending countries is likely to be much larger among low-income households, the children of which represent but a small share of international students. However, there are reasons to believe that the COVID-19 pandemic may bear gender-specific consequences for international students at destination and in their home country by posing additional constraints on their decision to study abroad.

First, female international students usually experience greater emotional and psychological challenges than their male counterparts when studying abroad, and the COVID-19 pandemic is likely to intensify this gap.[22] Against this backdrop, the pandemic has changed the weighting that potential students will give to each factor affecting their choice of country in which to study, giving priority to health security and safety away from home. A survey taken by the British Council asking 10,000 Chinese students about their major concerns when conceiving their plans for overseas learning has shown that a large majority rated "personal safety" (87%) and "health and well-being" (79%) as their major worries, following the outbreak of COVID-19.[23] By increasing health risks for elders, the pandemic also involves negotiations within the family, as parents may have different expectations for their sons and for their daughters. If the role of caring for ageing parents is expected to be carried out by children of a specific gender, this might influence the decision to study abroad. For instance, in the Indian case, men's mobility requires as much negotiation as women's, due to the expected role of the son in caring for ageing parents.[24]

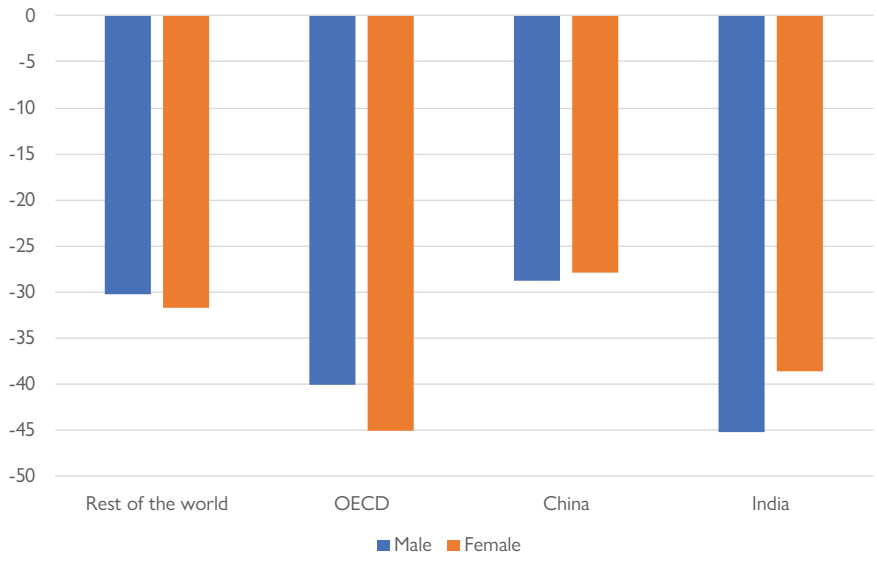
Sending and receiving countries' labour market structures are another channel through which COVID-19 may affect male and female international students in specific ways. In developing countries, where labour markets often fail to value and incorporate women's knowledge and skills, the economic downturn has presumably reduced female students' job opportunities relatively more than it has reduced those of their male counterparts. Since women's human capital translates more easily into job opportunities in OECD countries,[25] women might have more incentive to continue to study abroad in countries where they have better chances of employment, on average.

While there is a paucity of information on whether women are more or less likely to study abroad in times of COVID-19, recent data from Australia provide evidence consistent with both sides of the argument (see Figure 3).[26]

[21] Institute of International Education, 2021.
[22] Pelch, 2018.
[23] Durnin, 2020.
[24] Sondhi and King, 2017.
[25] OECD, 2016.
[26] Australian Government, Department of Education, Skills and Employment, 2020.

On the one hand, the data from Australia shows that among Indian students, study visa applications from men dropped by 45 per cent between the first half of 2019 and the same period of 2020, as compared with only a 38 per cent drop in applications from women, which suggests the relatively greater cost for women of abandoning international study plans. On the other hand, among students from OECD countries, the decrease in visa applicants was greater for women than for men, 45 per cent as against 40 per cent. No gender-specific pattern, however, is observed among international students from China or other developing countries over the same period. On the one hand, the relatively greater cost of abandoning international study plans for women finds some echo among Indian students, where male study visa applicants dropped by 45 per cent from the first six months of 2019 to the same period in 2020, against a drop of only 38 per cent for women. On the other hand, the decrease in visa applicants was greater for women than men among international students from the OECD (45% vs 40%). No gender-specific pattern, however, is observed among international students from China or other developing countries over the same period.

**Figure 3.** **Percentage change from first and second quarter 2019 to first and second quarter 2020 in student visa applications to Australia by region of origin**




*Source:* Authors' elaboration, based on Australian Government, Department of Home Affairs, n.d.

Whether these differences (and similarities) are significant and meaningful is still unknown at this point, and more quantitative research on the gender-specific impact of COVID-19 on international student mobility is undoubtedly necessary. Moreover, as public health responses to COVID-19 are evolving rapidly, there is still a lot of uncertainty about how the structural and contextual drivers of migrant experiences abroad are affecting international student mobility, and about whether significant gender differences will materialize eventually. In this context, there is a risk that recommendations formulated today become obsolete once the pandemic is over. In the last section of this paper, we try nonetheless to review current contingency measures and offer policy advice based on what the scientific community and policy experts have identified to this day as the short- and long-term risks for international students during the COVID-19 pandemic.

## Policy responses

Following the outbreak of COVID-19, receiving countries' national governments have had to support international students while trying to prevent the spread of the virus at the global level.

In terms of mobility, these governments have tried to minimize the drop in the number of applications to HEIs, and have dealt with considerable delays in the application process of visa and study permits for prospective foreign students. Many international students returned to their country of origin; others were blocked in their receiving countries due to travel restrictions, experiencing limited physical presence on campus, as HEIs moved teaching and learning activities online. Moreover, public authorities have had to deal with international students' anxiety and mental health issues, which may have limited their ability to complete their studies and reap the full benefits of international education. In this respect, 70 per cent of international students worldwide reported increased stress and anxiety during the pandemic, and over 57 per cent actually sought mental health support from their institutions.[27] Likewise, in an Australian study, 94 per cent of international students enrolled in Australian HEIs who were locked out of the country experienced stress as a result of COVID-19.[28]

These challenges require an appropriate policy response, both at national and local levels. Contingency measures specifically aimed at preventing a fall in the number of applications and supporting foreign students residing on their territory have already been put in place by several OECD countries. These temporary, short-term responses cover the admission of prospective students, support mechanisms for international students admitted prior to the pandemic, and the extension of visa and residence permits.

In order to limit the impact of COVID-19 on current and prospective foreign students, destination countries have addressed delays in the application procedure for visas or residence permits of international students by implementing corrective measures such as the introduction of online procedures, extensions to enrolment deadlines and increases in the number of allowed deferrals to the following academic year for international students who could no longer travel to their receiving country. By December 2020, some governments had also introduced special exemptions for international students to prevent the withdrawal of visas and permits.

Canada, for instance, has adopted a new two-step, fast-track procedure for study permit applicants that allows some foreign students to begin their studies at a Canadian HEI online from abroad, without final approval of their study permit. They have suspended in-person filings and moved all study permit applications online, with individual applicants invited to explain and provide information on any documents missing due to COVID-19.[29] What is more, all studies up to 31 December 2021 now count towards a future post-graduation work permit, potentially allowing international students to complete their entire curriculum online from abroad while being eligible to this programme, which grants foreign graduates the right to stay and work in Canada after their graduation.[30]

In response to the drop in the number of new international student visas and residence permits, Australia has introduced a fee waiver for visa extensions directly related to COVID-19, and has granted foreign students additional time to provide English language test results as well as biometrics and health checks. Moreover, Australian HEIs were instructed to make sure that a change from face-to-face to remote delivery of online studies would not impact compliance with study visa conditions.[31] The Australian Government has also increased approval rates for

[27] Quacquarelli Symonds, 2021.
[28] Council of International Students Australia, 2021.
[29] EMN, 2020.
[30] ibid.
[31] ibid.

study permit applications to 95.7 per cent in the first six months of 2021, from between 91 and 92 per cent over the preceding five years.[32]

In Europe, several European Union Member States – such as Italy, Belgium and Ireland – introduced some extensions regarding the validity of residence permits, with Slovenia going as far as allowing electronic applications without a qualified electronic signature.[33]

Governments have also provided financial support to disadvantaged international students through various measures, such as introducing targeted, State-funded social benefits and health insurance, increasing the number of maximum working hours for self-sustaining students, and providing access to national relief funds. In Canada, international students already residing in the country have been granted the right to work full-time in federally recognized essential services until the end of summer 2020, while the means-tested student grant for full-time students, including international students, has been increased to 6,000 Canadian dollars (4,053 Euros) for 2020 and 2021.[34] Similarly, Australia has lifted its 40-hour weekly cap for international students working in certain occupations in the health-care and agricultural sectors and opened the Australian superannuation (pension contribution) programme to students struggling financially who have resided in Australia for more than 12 months. In Europe, Italy, France, Finland and Belgium have improved financial support for international students. For instance, in November 2020, the French Government granted a 150 Euro cash transfer to merit-funded students and those benefiting from housing assistance.[35]

In several countries, HEIs have also directly supported international students. These local measures include financial assistance through reduced dormitory fees, the deferral of the payment of tuition fees, food and accommodation support, as well as mental health and other forms of medical support. Over 40 per cent of HEIs in the United States and Germany, as well as 90 per cent of Canadian HEIs, reported providing emergency student funding in 2020.[36] In Spain, online and telephone psychological care services have been provided to the general public, including foreign students residing in the country, through the online platform "Connected to university from home".[37]

Although necessary, most of these contingency measures are short lived and do not address the long-term needs of international students, in particular the consequences of the pandemic on job prospects, which are regarded as the main driver of international student mobility.[38] Furthermore, these measures not only lack long-term perspective but also fail to incorporate a gender dimension in a context where the COVID-19 pandemic is likely to bear gender-specific consequences for international students, as described above. First, mental health and wellness support should be designed, where applicable, in ways that accommodates the gender-specific needs of international students. Second, early evidence shows that the COVID-19 pandemic recession might have had a disproportionate impact on women workers.[39] Without corrective and compensating measures in the labour market, the risk is that this economic penalty lowers female students' incentives to study abroad. In this regard, policies aimed at reducing the gender gap and promoting equal opportunities in the labour market – such as a more affordable and reliable childcare system, making family leave available for equitable use by both men and women, or allowing more flexible working hours – are critical to restore a level playing field between female and male international students in the aftermath of the COVID-19 pandemic.

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32 Australian Government, Department of Education, Skills and Employment, 2020.
33 EMN, 2020.
34 IRCC, 2021.
35 EMN, 2020.
36 Institute of International Education, 2021.
37 EMN, 2020.
38 Rozenzweig, 2008; Beine et al., 2014.
39 Bluedorn et al., 2021.

## Conclusion and final remarks

This paper provides early evidence of the impact of the COVID-19 pandemic on international student mobility and its gender-specific consequences for prospective and currently enrolled international students. It also intends to help policymakers take stock of the magnitude of the financial, social and health consequences of COVID-19 for these students.

We explore various channels through which COVID-19 has affected the lives of those pursuing higher education abroad, as well as the opportunities and incentives associated with foreign education. Although it is still too early to draw firm conclusions, our review of preliminary evidence points to a large decrease in international student enrolment in OECD countries in the second half of 2020 and the first half of 2021, which is mostly driven by a reduction in the number of newly admitted students. In particular, although we are not aware of any evidence documenting the effect of the pandemic on the likelihood of students returning home after completing their studies, the most recent data from Australia and Canada show that continuing enrolment was affected less severely than first-time enrolment, suggesting that students already at destination when the crisis broke out were not particularly likely to abandon their studies.

While we find the impact of COVID-19 to be quite heterogeneous across destination countries, further analysis based on the data currently available reveals no gender-specific patterns two years into the pandemic. This finding, however, should be interpreted with caution because of the scarcity of gender-differentiated data to date. Moreover, we expect the gender-specific consequences of COVID-19 on employment and wages to materialize once the pandemic is over and governments gradually abandon the ad hoc safety nets and contingency measures that support international students. Indeed, while necessary, most of these support mechanisms are short lived, and a renewed effort by OECD governments to address the structural needs of international students in the medium and long term is therefore required. In this regard, we expect women to bear a disproportionate burden of the consequences of the global health crisis in the next few years, and our intuition is that the resilience and well-being of current and future international students require, at the very minimum, a gender-inclusive policy response. In particular, this calls for governments to adopt and strengthen specific measures aimed at reducing the gender gap and promoting more equal opportunities in the labour market in origin and destination countries. Finally, we want to draw the attention of the scientific and policy communities to the lack of data and academic research on international student mobility from a gender perspective. In our opinion, a concerted effort by all stakeholders in this direction is both urgent and necessary.

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Mashenka and Vedangi both arrived in Georgia in January 2020 as international medical students. They study at the Tbilisi Open University and upon graduation are hoping to become surgeons. Both like their professors, who they find friendly and always available for help or advice. They love to attend weekly practical trainings at one of Tbilisi clinics, where students can communicate with patients and learn from the experience of practicing doctors. The outbreak of COVID-19 pandemic saw most universities and students across the globe adjusting to the distance learning process. This was also the case with Vedang and Mashenka. Although they seem quite satisfied with the quality of online classes, they still miss the practical trainings and hope to get back to physically attending classes again soon. The COVID-19 pandemic is first and foremost a health crisis. The threat remains the virus: not people, not migrants, not stranded, or displaced persons. The pandemic is borderless; people are affected regardless of their nationality, ethnicity, religion, or status. Migrants are not inherently more vulnerable to, or at heightened risk of, contracting infectious diseases. Rather, it is the conditions in which they migrate, live, or work that influence or compound health risks, including access to health services.

# 6. A TRIFECTA OF RESPONSIBILITY: LATIN AMERICAN MIGRANT WOMEN IN THE UNITED STATES MANAGING JOB LOSS, CHILDREN'S LEARNING AND INTERNATIONAL REMITTANCES DURING COVID-19

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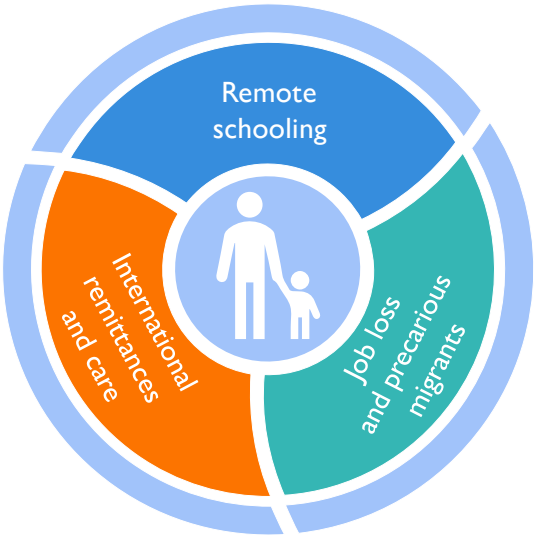
## Introduction

Karla migrated to Somerville, Massachusetts in 2005 from Guatemala, one of a growing number of Central Americans who came to the United States of America in the early years of the twenty-first century.[1] Undocumented, she had worked multiple jobs until the birth of her oldest son, when she began cleaning homes because it offered more flexibility. Her youngest son was born in 2019, and she had just returned to work to supplement her husband's income when COVID-19 became a household word worldwide. Karla's work stopped immediately because her wealthy clients did not want someone in their home who might pass on the dangerous virus. Schools were closed and Karla was concerned about bringing her infant to another person's home, given risks of infection in the densely populated city where she lived. So, even if her employment had continued, she would have been unable to work. Her husband, also from Guatemala and undocumented, was let go from his job in construction, leaving the family with no income. Then, several months into the pandemic, both parents contracted COVID-19. Although they were both ill, Karla described herself as the primary caregiver during this time, shouldering the burden of keeping the children fed and the household running, as well as holding the weight of concern about her family's well-being. Meanwhile, back in Guatemala, her parents were subsistence farmers and relied on her and her siblings' remittances for any cash needs, but Karla reported that she was able to only send an occasional 20 United States dollars (USD 20), significantly lower than her previous remittances.

Karla is at the centre of what we conceive of a trifecta of gendered responsibility for migrant mothers from Latin American countries living in the United States as the COVID-19 pandemic escalated globally. Based on our ethnographic studies in the Boston, Massachusetts metropolitan area,[2] in combination with data describing national level trends, we demonstrate how this trifecta was, and continues to be, comprised of three interrelated realms (see Figure 1).

1 Tienda and Sanchez, 2013.
2 Bruhn and Oliveira, 2021. Our research has been previously published in one co-authored publication; solo-authored manuscripts from each research project are forthcoming or in progress. All names in this study are pseudonyms to protect our participants' privacy.

**Figure 1.** **A trifecta of gendered responsibilities for migrant mothers in the United States during COVID-19**




First, migrant women, and particularly migrant women who identify as ethnically Latina or Hispanic, were vulnerable to job loss.[3] This stemmed from multiple factors, including the fact that, pre-pandemic, they were overrepresented in jobs in the service industries that were not able to be performed remotely. In addition, cultural norms related to childrearing position women as best situated to care for children, and in response to these cultural expectations, some women voluntarily left their jobs or chose not to return to work.

Second, migrant women were expected to support their children's education at home in languages they did not speak and through technology they had little experience with, which they feared would hurt their children's learning and opportunities. Our data reveal that for Latina migrant women, many of whom had migrated to provide better futures for their children, watching their children struggle academically produced significant stress and anxiety, especially when their children's schooling remained completely remote for much of the 2020–2021 school year. The stress around schools intersected with broader mental health challenges faced by Latina migrant women; knowing someone who was undocumented and who had been infected with COVID-19 raised the likelihood that women would struggle with mental health, and nearly all the women in our studies fell into both these categories.[4]

The third dimension of the trifecta of responsibilities comprises the additional care obligations that women strove to maintain throughout the pandemic. School closures and migrant women's exclusion from the work force led to diminished remittances sent to kin living in women's countries of origin. Additionally, migrant women in the United States worried about the well-being of family members in countries with limited access to adequate health care, which heightened their anxieties and deepened the weight of caregiving throughout the pandemic.

In this paper, we explore the three dimensions of the trifecta of responsibilities, highlighting the secondary implications of migrant women's exclusion from the workforce during the pandemic and revealing how school closures and inability to access paid labour diminished remittances to families in their countries of origin. We conclude by identifying several promising practices implemented at the state level and highlight further considerations for policymakers to reduce the multiple forms of gendered vulnerabilities faced by migrant women during the pandemic.

[3] In the United States, these terms refer to an ethnoracial category comprised of migrants from Latin American countries and their descendants, which faced increased racism during the time of our research. See Canizales and Vallejo, 2021.

[4] Coley and Baum, 2021; Gomez-Aguinaga et al., 2021.

The primary data for this report come from two ethnographic projects that were ongoing at the time of the pandemic's onset in March 2020 and include over 100 interviews with 63 mothers. Both authors began collecting data for studies exploring the role of schools in Latina migrant mothers' experiences of belonging in 2018, and had conducted over 18 months of in-person participant observations and interviews at schools, district offices, and city programmes when a stay-at-home order was issued. Having recruited interview participants through in-person events and observations, Sarah Bruhn pivoted towards follow-up interviews with existing interview participants, in order to understand how women were experiencing the pandemic. These interviews, averaging about 45 minutes, were conducted on the phone with 36 out of 40 original participants. A subset of 11 mothers, representing the diversity of the sample, were interviewed again in April 2021 about their perspectives on school re-opening. When school buildings and broader social life shut down in March of 2020, Gabrielle Oliveira adapted the methods of data collection in order to continue the research. Oliveira's interviews were conducted via phone and social network platforms like WhatsApp with the 23 Latina migrant mothers from the original research, and she had formal or informal conversations at least three times with each participant between March and December 2020. While we weave in data from other sources, such as the Migration Policy Institute and the Pew Research Center, these ethnographic studies shine important light on dynamics experienced by Latina migrant mothers during the pandemic.

Importantly, the COVID-19 pandemic ravaged migrant lives across the United States at a time when one of the most openly anti-immigrant presidential administrations in recent history was in power. Although prior presidential administrations had ushered in restrictive policies that harmed migrant families, the Trump administration's xenophobic rhetoric and a chaotic approach to immigration policy created a climate of exceptional uncertainty and fear.[5] This further exacerbated the strain migrant mothers felt as they strove to keep their families safe while meeting their basic needs throughout the pandemic. While the Biden administration was inaugurated in January 2021, migrant women are still contending with the reverberations of the Trump era. We situate our discussion of the trifecta of responsibility within this broader context to emphasize how policymakers globally should be cognizant of the gendered and unequal impacts of wider anti-migrant discourses and policies on migrant families.

## Migrant women's labour force exclusion during the pandemic

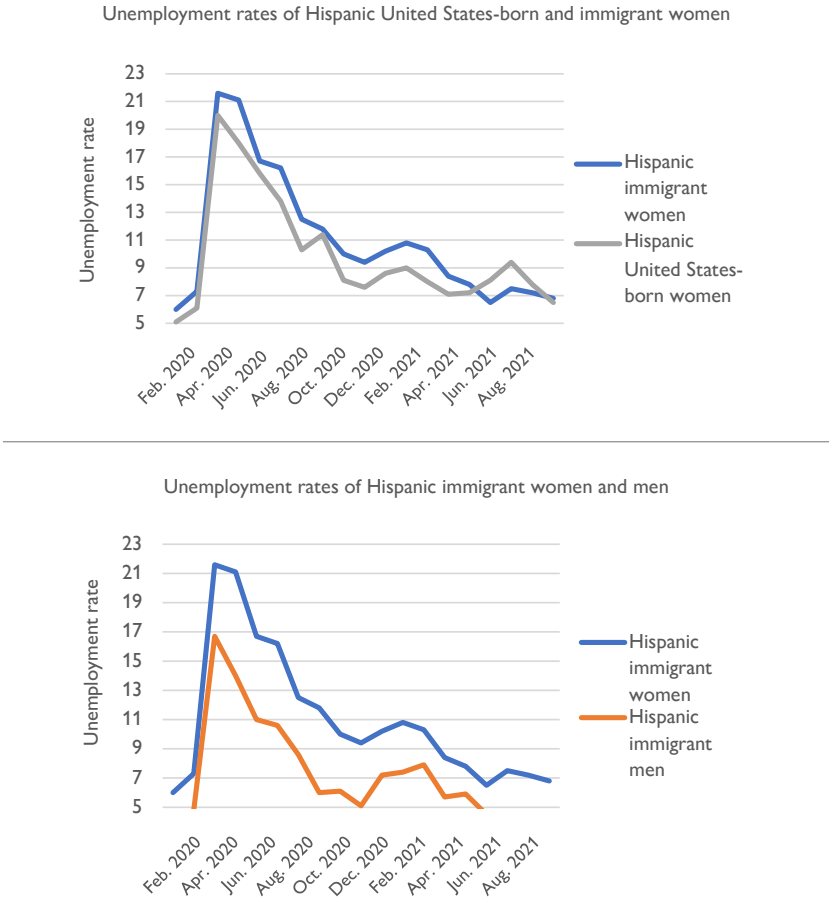
Globally, according to the international migrant stock data of the United Nations Department of Economic and Social Affairs (DESA), women make up approximately 48 per cent of international migrants,[6] while in the United States women comprise about 52 per cent of the total immigrant population, in large part due to family-based immigration policies.[7] When the pandemic unravelled social and economic norms and overwhelmed health-care systems, migrant women in the United States were already unequally situated within the highly stratified labour market. Prior to the pandemic, migrant women, including those in our study, were more likely to hold low-wage jobs compared to their male or native-born counterparts. For undocumented women, who are estimated to comprise approximately 12 per cent of the total immigrant population in the United States, lack of work authorization compounded their vulnerable social and economic position.[8] Undocumented women were especially overrepresented in employment that was immediately terminated by the onset of the pandemic; for instance, maids and housecleaners, who are almost all female, are estimated to be comprised of approximately 22 per cent undocumented workers.[9] Ethnoracial discrimination, on a personal and institutional level, compounds Latina migrant women's marginalization across immigration statuses, as Latinx migrants and citizens in

[5] Simmons et al., 2020; Canizales and Vallejo, 2021.
[6] DESA, 2021.
[7] Halim et al., 2019; Batalova et al., 2021; Batalova, 2020.
[8] Batalova et al., 2021; Batalova, 2020.
[9] Svajlenka, 2020.

the United States frequently encounter racism and assertions that they are "un-American".[10] This pre-existing discrimination shaped migrant women's ability to navigate the pandemic and imposed additional barriers to their well-being during the pandemic.

The onset of COVID-19, then, both created new layers of inequality and exacerbated existing inequities based on the intersection of race and gender for Latina migrant women in the labour force. Although there was little federal guidance about responding to the pandemic, with then-President Trump downplaying the significance of the crisis, nearly all states of the United States implemented some forms of school and economic closure in the spring of 2020. Immediately, migrant women lost jobs at a higher rate than their migrant male counterparts, as well as than women born in the United States.[11] Unemployment rates stayed extraordinarily high for several months across demographic groups, but migrant women remained the hardest hit (see Figure 2). Latina migrant women have seen the highest rates of decline in employment since the onset of the pandemic, and they are still facing an unequal recovery, especially in regions where migrants make up a larger share of the population. This points to the importance of policymakers' awareness of geographic differences as they design policies to sustain migrant women post-pandemic.

**Figure 2.** **Comparison of Hispanic immigrant women's unemployment rate by gender and nativity**




*Source:* Authors' elaboration based on MPI, 2020.

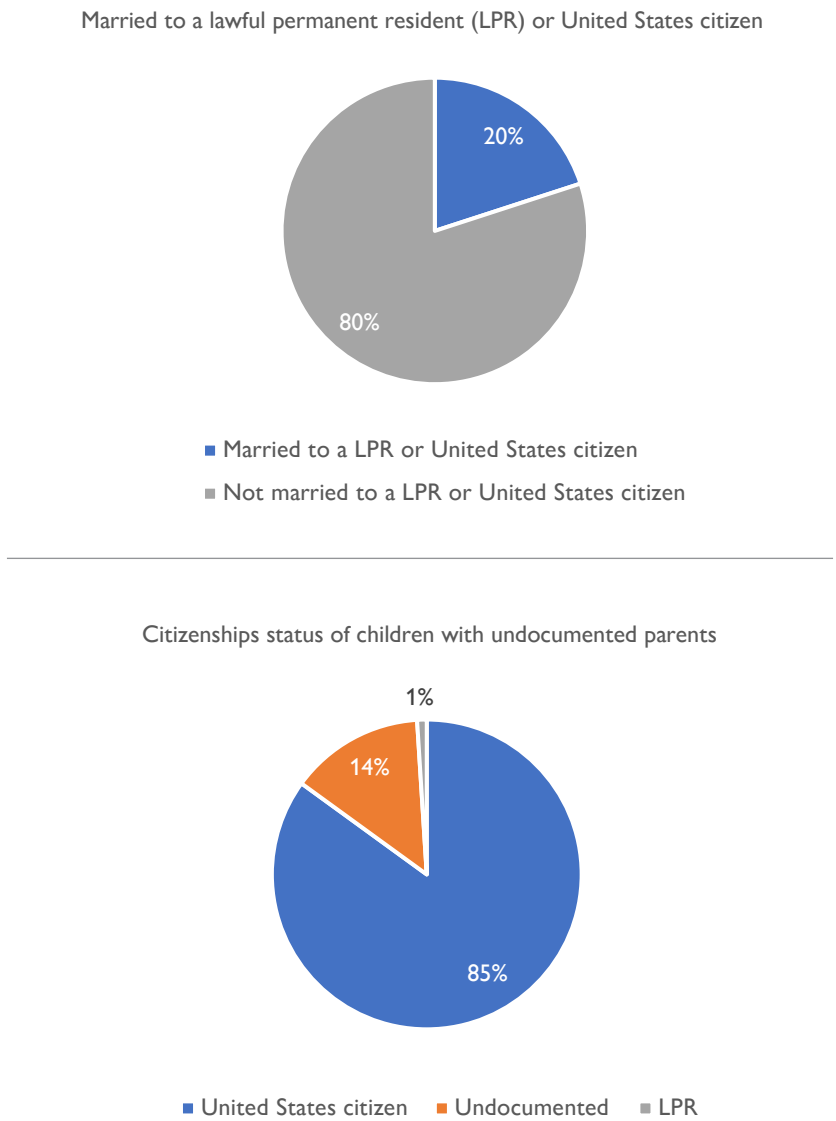
*Note:* In these charts, we use the term "Hispanic", as it is the term used in the original data source. The lines for immigrants depict unemployment for Hispanics not born in the United States.

[10] Chavez, 2008; Flores-González, 2018. The term "Latinx" is a gender-neutral descriptor referring to immigrants from Latin American countries, a region defined by the United Nations Statistics Division as encompassing Mexico, Central America, South America, and the Caribbean.

[11] Capps et al., 2020a; MPI, 2020.

While migrant women lost jobs at higher rates than other demographic groups, the first federal relief bill passed in March 2020 to address the economic fallout from the pandemic, the Coronavirus Aid, Relief, and Economic Security Act – more commonly referred to as the CARES Act – denied many migrant women access to emergency support measures. The Republican-dominated Congress intentionally excluded not just unauthorized migrants but also families that included an unauthorized adult. Because many migrants are embedded in mixed-status households (see Figure 3), these restrictions left approximately 5 million children, including 4 million United States citizen children, without vital aid. Thus, while many Latina migrant women in the United States have made their way back to the workforce, the months of lost income, especially for those who were ineligible for federal benefits, are not easily overcome for women whose low-wage, inflexible jobs do not allow them to accumulate a safety net.

**Figure 3.** **Undocumented United States residents' familial relationships with United States citizens and lawful permanent residents**




*Source:* Authors' elaboration based on Capps et al., 2020b (data from Migration Policy Institute analysis of American Community Survey Data, 2014–2018).

The women in our studies experienced many of these hardships. Nearly three-quarters of our participants were undocumented, which meant they were more vulnerable than the United States population of Latina migrant women as a whole, of whom approximately half are living in the United States without authorization. Additionally, the women in our research had lower levels of educational attainment when compared to the broader population of migrants; many of our participants only had access to an elementary education and completing high school was atypical. Like women across racial and ethnic groups, mothers' gendered roles within their families made them particularly vulnerable to job loss, as they left the work force at much higher rates than fathers or women without children throughout the pandemic. Among the women in our study, only 5 per cent (3 out of 60) of our participants maintained the same jobs with no reduction in hours, and several previously unemployed mothers had not returned to work as of December 2021. Importantly, our studies took place in relatively expensive housing markets in a large metropolitan area in the north-eastern United States which meant their wages were necessary to pay the rent, as none were homeowners. These dimensions of our participants' lives point to the importance of examining inequities that exist even within broad demographic categories, and policymakers should be cognizant of the intersectional forms of marginalization faced by various migrant groups.

### Portraits from the field: A citizen mother in a mixed-status family

Flor arrived in the United States in 1998 from El Salvador to the Boston metropolitan area to join her mother, who had migrated years beforehand. She had a son, but her husband was abusive, and they divorced. Eventually, she remarried and had twin boys, at which point she left the labour force to raise her young sons. When they started preschool, she returned to work. Because she had naturalized as a citizen, it was relatively easy for her to find employment. She had just begun a part-time job she enjoyed at a retail clothing store when the pandemic hit. Because she had naturalized as a citizen, she could collect unemployment benefits. In part because women are relegated to lower-paying sectors of the labour market, and in part because of the gendered division of labour in her household, Flor and her husband decided that she would stay with the children while he worked for as long as possible, even though the unemployment income from her part-time job was low.

Although Flor and her three sons were United States citizens, her husband was undocumented. He worked long hours in construction to support his family pre-pandemic, and as Flor emphasized, always paid his taxes (unauthorized migrants in the United States can use a tax identification number to pay taxes). Yet because the CARES Act of March 2020 excluded families with an unauthorized adult filing taxes individually or jointly, no one in the family received emergency funds. In turn, this jeopardized Flor's efforts to regularize her husband's immigration status, as the family had to use their savings to meet basic needs, savings which they had planned to use to pay for a lawyer and the associated fees of applying for a green card.

Although Flor was one of only a few women interviewed who had naturalized as United States citizens, her story illustrates how Latina migrant women in the United States are integrated into mixed-status communities and families, shaping their access to resources during the pandemic. Her experiences also shed light on the intersections between childrearing responsibilities and exclusion from the work force during the pandemic, one of the three elements of the trifecta of responsibilities faced by Latina migrant women.

## School closures and gendered responsibilities: Maintaining aspirations for children's education

Political instability, conflict, the climate crisis, and structural gendered violence are critical factors in women's decisions to leave their countries of origin. In addition, aspirations for their children's futures remain an important motivator for women's international migration,[12] a factor that also holds true among the migratory trajectories of our participants, who come from Latin American countries to the United States. While our research is set in a wealthy nation with relative political stability, the United States is also a highly unequal environment among comparable countries, with a 2017 Gini coefficient of .434.[13]

The women in our studies are positioned at the bottom of this highly stratified socioeconomic ladder and contend daily with this inequality. Once in the United States, language use, cultural differences, and structural barriers such as employment in low-wage, inflexible work can prevent Latina migrant mothers from meeting schools' expectations for parent involvement, expectations which are typically designed around white, middle-class, English-dominant, heteronormative family structures.[14] Yet Latina migrant mothers, like mothers worldwide, maintain high hopes for their children's educations, even when their goals and caregiving are unacknowledged by the dominant culture of the schools. This is critical context to understanding the gendered impact of school closures during the pandemic. Beyond immediately measurable outcomes, such as higher rates of adolescent pregnancy in nations in the "Global South,"[15] school closures had both immediate and long-term ramifications for mothers whose care routines and hopes for realizing their aspirations for migration were transformed when schools shuttered.

In the United States, the process of school closures and re-openings were highly politicized, with then-President Trump downplaying the dangers of the virus, even as public health officials and state and municipal leaders sought to impose restrictions and policies to prevent the spread of the highly transmissible disease.[16] This led to substantial variation among migrant women's childcare responsibilities across geographic locations, with children in urban, Democratic-leaning States more likely to experience fully remote instruction than their peers in other regions. In addition, the localized nature of schooling in the United States meant that even within one geographic region, students had vastly different access to in-person school.

These differences were exacerbated by racial inequalities. As of December 2020, 62 per cent of children who had Latinx parents without a bachelor's degree, like the families in our study, had no access to in-person school.[17] Even as of March 2021, when many schools worldwide had re-opened before the emergence of the Delta variant, 58 per cent of white students and 35 per cent of Latinx children in the United States attended full in-person school. Among Latinx families, 64 per cent of foreign-born parents compared to 52 per cent of parents born in the United States reported that their children were in full remote instruction in the spring of 2021.[18] Under these conditions, it is unsurprising that 66 per cent of Latina mothers with children under 12 declared it to be "very difficult" or "somewhat difficult" to manage childcare during the pandemic.[19]

Our data reflect these broader national trends and reveal the importance of considering the particular political, social and economic factors at national and local levels that shape migrant women's gendered responsibilities. When schools first closed in Massachusetts in March 2020, our participants, the majority of whom had worked outside the home, immediately took full

[12] Burrone et al., 2018.
[13] OECD, 2020. The Gini coefficient is a commonly used measure of income inequality. A Gini coefficient of .434 points to endemic economic inequality in the United States.
[14] Carreon et al., 2006; Hong, 2019.
[15] WHO, 2021.
[16] Kolata and Rabin, 2020.
[17] Calarco, 2021.
[18] Ibid.
[19] Noe-Bustamante et al., 2021.

responsibility for childcare. Following hegemonic gender norms in Latin America and the United States, it was seen as a natural extension of their motherhood to take on the increased care work; very few women reported discussing this issue with their spouses. While a few participants enjoyed the sudden free time with their children, the vast majority were overwhelmed and stressed by the enormous responsibility of managing children's learning in a language that many of them understood only poorly. "It was only in English, and I don't understand", was a common refrain throughout conversations with the mothers in our research.

The two school districts in our studies strove to distribute tablets and computers, as even within the wealthy metropolitan area most of the families in our studies relied on their phones as their primary means to access the Internet. Yet the distribution was frustratingly slow, and some mothers reported being unable to use the district-issued device because they had limited technological skills. As Andrea, a formerly undocumented El Salvadoran mother of two said, "The most difficult thing has been to teach my daughter in the house. It's been terrible. Stressful. Exhausting." In the 2020–2021 school year, both districts made vast improvements in remote teaching, and for many students, their learning was significantly better than the sporadic meetings that took place in the first half of 2020. But like other urban districts across the United States, most students were still remote until the state of Massachusetts required students to return in-person in April 2021. In this context, Rosa, an undocumented mother of two whose youngest had been diagnosed with autism during the pandemic, reflected on her son's learning. "It's really worse for him [to be home;] … for me, it's like he's not learning like this, like he should be learning."

In sum, Latina migrant mothers felt pressure to support their children's remote learning to align with their beliefs about good motherhood and their gendered motivations to migrate to provide better futures for their children. They sacrificed significantly to do so, forgoing wages that would have provided their families with more stability in a highly unequal context. As they sought to ensure their children did not lose English and content skills they had worked hard to develop, they managed another aspect of the trifecta of pandemic responsibilities.

### Voices from the field: Care and support among migrant women in anti-migrant times

One powerful insight from our research is the importance of schools establishing relationships with families in order to function as a social safety net when a crisis emerges. For instance, Irma, a Chilean woman who had worked with migrant families in one of the school districts in our studies, had spent years establishing relationships with migrant mothers, including those who had been in the United States for a significant time, and those who had just arrived from the United States–Mexico border. Long before the pandemic, Irma and her colleagues provided support for migrant families, almost always mothers, including clothing, food and referrals to immigration legal services. They were highly cognizant of the shifting political situation and offered migrant mothers accurate, up-to-date information about what resources would be used as part of the so-called "public charge" rule, which permitted the United States Government to deny legal status to migrants who had used designated resources, a rule that had a profoundly chilling effect on women's use of resources for which they are eligible. When COVID-19 ravaged migrant communities in the United States, these relationships were critical. Irma explained that "when the pandemic started, they didn't know if they could go to pick up food from the school or they were unsure when they started an application for rental assistance. They were afraid about the [immigration] status, that it could be a problem."

Irma's pre-existing relationships and her awareness of the challenges of being an undocumented mother enabled her to be a critical resource throughout the pandemic. Karla, the Guatemalan mother we describe at the beginning of this paper, had known Irma since her youngest son was born. She explained, "She always called me and asked how I was. … She helped me so much with applications for the city [a municipal emergency fund], finding food for us … she helped me so much with this." Because undocumented mothers were excluded from initial rounds of federal aid, they were especially reliant on relationships with school district employees like Irma, whose focus was on meeting basic needs rather than instruction. Throughout interviews, we heard frequent reference to the importance of resources provided by Irma and her colleagues. This support in turn allowed the mothers to fulfil the expectations they held for themselves as mothers who had migrated to provide better lives for their children.

## Breakdown in chains of care: Diminishing remittances to family in countries of origin

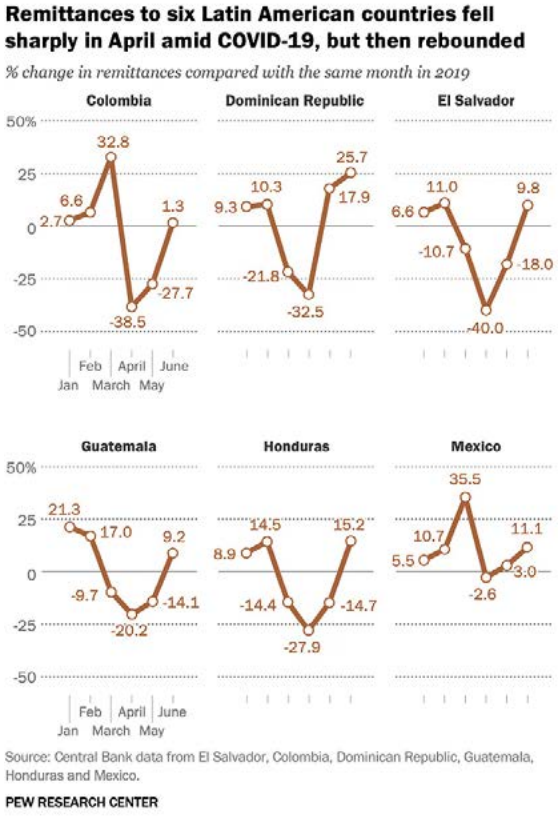
Disruption in migrant mothers' participation in the formal and informal labour market affected their ability to send international remittances to family members in their countries of origin. In 2019, money sent by migrant workers back to low- and middle-income countries reached USD 554 billion, overtaking foreign direct investments, according to the World Bank.[20] Because Latina migrant women are more likely than men to remit regularly, especially when separated from their children, their lack of wages has secondary implications in communities across the globe.[21] Based on interviews during the pandemic with migrant mothers whose remittance payments declined, we discuss possible ramifications for migrants' families, including access to health care and stable food sources.

According to UN-Women, there are 136 million women who are migrants in the world. Approximately 66 million of those women work in paid jobs.[22] Migrant women are more likely to be employed in the informal economy, especially in essential low-paid jobs as domestic workers, cleaning crews and kitchen workers in restaurants. Consequently, women have limited rights with regard to health insurance, savings, stability in work and other government-sponsored benefits. Thus, while COVID-19 had monumental economic impacts worldwide, these existent vulnerabilities became more pressing and visible for women migrants in the United States.

In the United States, the Pew Research Center showed how remittances dipped right at the beginning of the pandemic in March and April, but then rebounded with variation in gains depending on country of origin. However, dynamics of gender complicate the figure below.

[20] World Bank, 2021.
[21] Abrego, 2009; Oliveira, 2018.
[22] UN-Women, 2021.

**Figure 4.** **Remittances to six Latin American countries, January–June 2020**




*Source:* Noe-Bustamante, 2020.

Our work surveyed 60 women who were migrants in the United States with a range of different immigration statuses. Over 30 women interviewed shared the fact that their ability to send money home during the months of April, May, June and July came to a halt. They then resumed sending money home but at a much lower rate. Other studies have pointed to the fact that while women make less money than their male migrant counterparts, they tend to send a larger percentage of their income to family in their countries of origin.[23] In our research, undocumented migrant women and women under Temporary Protective Status described the struggle to tap into their small savings to send money home. One migrant woman from Brazil, Neide, explained, "if we don't work, we don't have money to pay rent, if we don't pay rent, we have no place to live, if we have no place to live, we won't be sending money home".

According to data collected through a survey with 433 immigrants in Massachusetts in 2020 looking at the impact of the pandemic, 76.4 per cent of immigrants in the state experienced at least one job loss in their household: most commonly, a temporary shutdown or staff reduction, though months later, many are still jobless or on reduced hours.[24] Additionally, 83.9 per cent of households with undocumented members had a job loss. The responses also revealed that 60 per cent of households said at least one person who lost a job or had hours cut back did not collect unemployment benefits; among households with undocumented members, it was 82 per cent. The main reason cited by respondents was ineligibility due to immigration status.

The same research pointed to gender disparities and breakdowns in care. Women with small or school-age children disclosed that lack of childcare was one of the main reasons for them to leave their jobs.[25] Our findings mirror these results from the larger survey in Massachusetts. Migrant women could not work from home since their place of work was usually someone's house, a

[23] Abrego, 2009.
[24] Massachusetts Immigrant and Refugee Advocacy Coalition, 2020.
[25] Ibid.

restaurant, or a grocery store. Thus, they were faced with the fact that without childcare for children who were now at home full-time, they had to quit their jobs. This arrangement impacted their transnational economic ties with families that stayed in their countries of origin.

In our research the average amount remitted by women up until March 2020 was USD 453 per month. That amount got reduced to zero for the following three months. According to Mari, 44, "I couldn't send money at a time when my son needed it the most". Her son was five-year-old Nino who had a heart condition and lived in Guatemala. Her partner in the United States, Felipe, was able to continue his work in the construction industry in the months of April and May and contributed to Mari's transfers to Guatemala. Felipe was not Nino's father, which left her as she called herself "pendiente" (or in charge) of her son's support for health issues in Guatemala. Mari, along with other mothers, was able to resume sending remittances home in June, but they were significantly lower.

These migrant women care for their children in the United States, and also care for family members in their countries of origin, through what we call their "multidirectional caregiving".[26] Thus, in order to continue caring for children, parents, and family members that are "here" and "there", women needed to resume their work in 2020. However, without childcare or child supervision at home as online learning began, migrant women felt trapped in a cycle that interrupted their reliable flow of remittances home. Liana, a migrant mother from El Salvador, explained, "It's survival now, we need to make sure we are surviving everyday and helping our children here. But for me to do that, I can't help my family survive in El Salvador." Her comment stressed the paradoxical condition of being a migrant in the United States while trying to support family in her country of origin.

## Federal and local policies that affect migrant women's lives

In this section we address policies that migrant women in our combined research studies mentioned or discussed during our interviews and observations. The table below, showing both federal and local policies, is not a comprehensive list of legislation that has affected undocumented or documented migrants in the United States. The table includes a brief discussion of how each of these policies affect the trifecta of responsibilities addressed in this paper. We document how policies related to health care and social supports can both constrain and assist women's ability to manage their multiple responsibilities as caregivers to children in the United States and family members in their countries of origin. The table is an abridged version of policies that, if modified or expanded, could ease the multiple forms of vulnerability faced by migrant mothers in the United States as a result of the pandemic, including access to food, technology, childcare and re-entry into the labour force.

We also note that there is a clear need for larger legislative immigration reforms to support vulnerable migrant families in the United States. Earlier in 2021, the White House unveiled President Biden's ambitious immigration agenda, the United States Citizenship Act. Introduced simultaneously in the House and Senate, the bill would provide an eight-year pathway to citizenship for 11 million undocumented immigrants, give legal status to Deferred Action Childhood Arrival (DACA) recipients, and increase limits to the percentage of green cards issued to each country. However, the immigration provisions in President Biden's Build Back Better agenda are still under negotiation and their future is unknown.

The women in our combined studies held different jobs in diverse industries in the United States. Many were informally employed in the domestic work industry and could benefit from the rights recognized under the ILO Convention 189, which recognizes domestic work as work in national law, with all of the labour rights accorded under federal law.

[26] Bruhn and Oliveira, 2021.

**Table 1.** **Policies affecting migrants in the United States**

| Area of focus | Abridged list of federal policies | Abridged list of Massachusetts state policies that reflect federal policies | How did the policies affect the trifecta of responsibility faced by Latina migrant mothers? |
|---|---|---|---|
| Employment | Coronavirus Aid, Relief, and Economic Security (CARES) Act. This programme provides additional funds for workers who have lost their jobs. | As a result of CARES, the Massachusetts Department of Unemployment Assistance (DUA) implemented three programmes: Federal Pandemic Unemployment Compensation (FPUC), Pandemic Unemployment Assistance (PUA), and Pandemic Emergency Unemployment Compensation (PEUC). Entailed stimulus payments of up to USD 1,200 per taxpayer and USD 500 per dependent child. | Individuals must have a social security number, pay taxes in the United States. For undocumented migrant women it meant that they were not included in the emergency response by both the Trump and Biden administrations' policies. For example, PUA is not available for migrants without a lawful immigration status in the United States. |
| Infrastructure | Coronavirus Capital Projects Fund (CCPF). This fund was dedicated to providing access to the high-quality modern infrastructure, including broadband, needed to access critical services. | Massachusetts focused funds to support the Remote Learning Technology Essentials, which benefited populations that lived in high poverty towns. | Migrant women who lived in high-poverty neighbourhoods were able to benefit from the infrastructure support for schools and broadband that allowed their children to access the Internet at lower costs. These programmes were not focused on individuals; thus, the women were able to benefit from this support. |
| Housing | The American Rescue Plan: funds for states, territories, and tribes to provide relief for the country's most vulnerable homeowners, renters. | State policy: To qualify for rental assistance in Massachusetts, the individual must have an income no more than 80 per cent of the area median income (AMI) and must be able to prove a financial hardship related to COVID-19 and be at risk of homelessness or housing instability. | While the state of Massachusetts enacted a temporary moratorium on evictions, migrant women struggled to apply and secure support for rent. The application contained steps that asked for official information that instilled fear for undocumented and immigration status-vulnerable families. |
| Nutrition | Federal policy Supplemental Nutrition Assistance Program (SNAP) aimed at families that experience high poverty rates in the United States. | An expansion of SNAP, as well as the Women, Infants and Children (WIC) nutrition programme for pregnant women and small children. | Food stamps are available only to United States citizens and limited categories of lawfully residing migrants. Undocumented migrants are not, and never have been, eligible for food stamps. WIC, however, is not included in the federal Government's public charge rule and is available regardless of immigration or citizenship status. |
| Nutrition | Pandemic Electronic Benefit Transfer (P-EBT) is a federal programme created in Spring 2020 to provide additional funds for families to buy food during COVID-19 while schools were closed to in-person learning. | Massachusetts implemented the P-EBT, a programme to provide food support to the families of schoolchildren who had been getting free or reduced-price school meals prior to the pandemic and needed that support. | P-EBT is available regardless of immigration status. Migrant women were eligible to this service; however, other barriers in place persisted. Issues such as unlocking funds from the card, checking the balance, and driving to school to pick up lunches resulted in underuse of services. |

| Area of focus | Abridged list of federal policies | Abridged list of Massachusetts state policies that reflect federal policies | How did the policies affect the trifecta of responsibility faced by Latina migrant mothers? |
|---|---|---|---|
| Paid leave | No available federal policy. | Massachusetts enacted paid sick leave and extended family and medical leave for employees unable to work due to COVID-19-related illness, mandatory quarantine, the need to care for a sick family member, or the need to care for a child whose school or childcare provider closed due to COVID-19. | There are no immigration status-related restrictions on eligibility for paid sick leave or paid family and medical leave; employees are entitled to both types of leave, regardless of their immigration status. However, in practice, undocumented domestic workers and essential workers were not part of any larger programme dedicated to them, which resulted in not many opportunities for paid leave. |
| Benefits | Federal policy on Paycheck Protection Program (PPP). | The PPP, providing low-interest loans to small businesses that were forgivable if borrowers spent at least 60 per cent on payroll and kept up staffing levels. | Most Latinx migrants in the state are essential workers, and not business owners; thus, this funding did not benefit migrant women directly. We could not find data that discussed the impact of the PPP on migrants in the United States. |
| Health | United States Department of Health and Human Services (HHS) provided claims reimbursement to health-care providers generally at Medicare rates for testing uninsured individuals for COVID-19, treating uninsured individuals with a COVID-19 diagnosis, and administering COVID-19 vaccines to uninsured individuals. | Massachusetts provides resources to pay for COVID-19 testing and treatment for low-income Massachusetts residents, regardless of their immigration status. For example, MassHealth Limited is available on an emergency basis to all Massachusetts residents who do not qualify for public health insurance programmes due to their immigration status, and will cover the costs of testing and treatment for COVID-19. The Commonwealth's Health Safety Net programme is also available to qualifying low-income Massachusetts residents no matter their immigration status and will pay for testing and treatment for COVID-19 provided by hospitals and community health centres. | Migrant women were able to use local clinics in their neighbourhoods to get tested and vaccinated. However, going to the hospital when ill remained a fearful exposure not only due to vulnerable immigration status, but also for fear of any additional bill that may result from an emergency room visit. Small local health clinics with Portuguese and Spanish speakers remained the best option for access for women and their children. |
| Support for community organizations | No specific federal policies that orient the activity of organizations. | The Massachusetts COVID-19 Relief Fund partnered with local organizations and leaders to support those across the state most impacted by the COVID-19 health crisis, particularly essential workers and the homeless, migrant populations, and people with disabilities. It was an initiative launched by the first lady of Massachusetts in collaboration with regional businesses and foundations. | Most migrants were eligible to receive this assistance from organizations since these regional and local non-profits already worked within communities. This is a promising model of support since it does not depend on larger United States immigration legislation and allows families access to the assistance. |

Two key points complicate the table above:

1) The lack of consideration of how these policies impact migrant women, specifically;
2) The root and origins of many of the policies that affect migrant populations in the United States fall under the public charge rule.

Since 1999, immigration officers have adopted the guiding principle that a public charge is someone "primarily dependent on the government for subsistence", as demonstrated by either (a) using public cash assistance for income maintenance, or (b) institutionalization for long-term care at government expense. The women in our research are all mothers of school-age children. Thus, while children may be United States citizens and qualify for government assistance, the public charge rule, even though revoked by the Biden administration, continues to inform the ways that many policies are designed and disproportionately affect women who are also caregivers.

While migrant Latina women were deeply affected by the exclusionary design of both federal and state policies, the United States revised statement on the adoption of the Global Compact for Safe, Orderly and Regular Migration may in the future impact federal and state approaches and policies to generate a more inclusive environment for migrant families.[27] While highlighting the non-legally binding nature of the Compact, the Biden–Harris administration endorsed the Global Compact for Migration and its commitments, highlighting that some actions, including in terms of social protection, are addressed across multiple levels of the United States federal government system.[28] In particular, the administration affirmed its support for improving the protection of migrants' human rights and "migrant workers' equal enjoyment of labor rights", both regardless of immigration status, and highlights the importance to the federal Government of "eliminat[ing] sources of fear and other barriers that prevent non-citizens from accessing government services available to them". Federal policies and larger immigration reforms may be possible in the long term. However, in the short term it remains clear that the local organizations that already have a relationship with migrant communities may be able to foster relationships of trust and counter the fear many individuals have of interacting with government-sponsored policies. At the same time, these organizations depend on fund raising and dedicated funds, and may suffer from lack of sustainability for the future.

## Conclusion

Our analysis reveals that Latina migrant mothers in the United States faced a complex trifecta of gendered responsibilities that they had to manage throughout the pandemic. These include managing remote learning, transnational family obligations, and job loss as precarious migrants. Given current global case counts, it is likely that these mothers – and women globally in comparable positions – will continue to endure these challenges, even if schools across the United States are mostly providing in-person instruction throughout the 2021–2022 school year. To respond to the intersectional inequalities faced by Latina migrant women, there is a need for design policies with minimum restrictions based on immigration status to support migrant women managing the trifecta of gendered responsibilities that we identify. Relatedly, the implementation of firewalls between service providers and immigration enforcement would constitute a first step to address the specific gendered and racialized harms endured by Latina migrant mothers during the pandemic. If they fear deportation and family separation, they will avoid using even the resources they are eligible for, which in turn strains the entire family system.

[27] UNGA, 2018.
[28] Government of the United States of America, 2021.

But our research also highlights how policy changes alone are not enough. Local educators, social and community workers, nurses and other professional caregivers must develop trusting relationships with women prior to any crisis. This includes but is not limited to prioritizing multilingual professionals; providing training on the impact of immigration policies on women and their families; dedicating resources so that classrooms and caseloads are manageable; and facilitating communication through accessible technologies, such as messaging applications. For instance, as federal funds in the United States are distributed to school districts to help cope with the pandemic, resources for non-instructional staff focused on family support and relationships would help ameliorate the additional burdens faced by migrant mothers, as they are frequently the ones managing school relationships. These relationships are the foundation of understanding and accessing available resources and of limiting the damaging impact of health, environmental and economic crises on migrant women and their families.

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Daniela (25) has walked through the Bolivarian Republic of Venezuela and Colombia with her boyfriend Samuel (23) and two friends for almost one month. They are trying to reach Peru where her mother is waiting for her. She left behind her four-year-old and eight-month-old children and while in Bogota, she learned she was pregnant with twins. When I was growing up in Venezuela, life was good and the education was high quality. I could go to the park, go out to eat a burger at McDonalds and I had toys. Life is so different for my children. When I talk to my daughter on the phone, I ask her what I should bring back for her, but she tells me, Don't bring anything back. I want you to be here and bring me to school. Come home and put me to sleep. My baby couldn't talk when I left but now when I call he says, "mama" on the phone. Sometimes when I find soup or something to eat, I wonder to myself what they are eating at home in Venezuela. I have complicated feelings about being pregnant, but I have no choice but to move forward. It's been difficult to be pregnant. We walk along the highway all day and take rides in the back of trucks at night. Often we are sleeping on the street. The doctors told me it's a high-risk pregnancy. We arrived to Ipiales and we plan to leave later today on a trocha since the official border is closed. We stopped at this shelter to get a meal and so I could have a health check-up, said Daniela who is staying at Albergue Sol de Pastos a transit centre in Ipiales, Colombia before she travels onward to Ecuador. IOM and other agencies provide shelter, medical and psychosocial assistance, food and other services at this transit centre.

# 7. VENEZUELAN MIGRANT WOMEN'S EXPERIENCES WITH DISCRIMINATION DURING THE COVID-19 PANDEMIC IN COLOMBIA, ECUADOR AND PERU

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## Introduction

The literature on the social relations between receiving populations and women migrants has started to proliferate in recent years. Existing studies point to the prevalence of sexism and sexist attitudes towards migrant women in South America,[1] and have begun to explore how these women experience, and make sense of, discrimination based on a range of identity markers.[2] Regarding the displacement of Venezuelan women across the region, scholars have identified that this group experiences significant discrimination, based on combinations of the following identity markers: gender, socioeconomic class, nationality, and condition as (irregular) migrants.[3] In addition to this multilayered discrimination, a common thread in related studies is that Venezuelan women's integration experiences are deeply marked by misogynistic stereotypes, such as "prostitutes" and "husband snatchers", as well as by criminalizing perceptions of Venezuelan displacement in general.[4]

Regarding the region's management of, and reactions to, Venezuelan displacement during the COVID-19 pandemic, scholars have described an increase in xenophobia and restrictive migration policy shifts – as evidenced by the implementation of border militarization efforts to curb migratory flows – as well as an increased exclusion of Venezuelan migrants and refugees from State-led socioeconomic assistance programmes.[5] Concerning Venezuelan asylum seekers in Peru, a recent study highlights the role of the Peruvian State in contributing to irregularity, mainly by restricting access to the refugee system and by failing to apply the regional refugee definition (provided in the 1984 Cartagena Declaration), exacerbating their vulnerability.[6] Regarding the effect of the COVID-19 pandemic on migrant women's livelihoods, another study conducted in Peru during the first weeks of the 2020 lockdown found that media reporting sharpened the feelings of concern, fear, terror and anger of Venezuelan migrant women.[7] Venezuelan women in Chile felt less prepared to face the pandemic than their male counterparts.[8] International organizations like IOM and Plataforma de Coordinación Interagencial para Refugiados y Migrantes de Venezuela (R4V) have also pointed out the increased risks for Venezuelan women, specifically highlighting their limited ability to access personal protective equipment (such as face masks and hand sanitizer), their

1 Oxfam, 2019.
2 Fernandez Labbé et al., 2020; Stang and Stefoni, 2016; Stefoni, 2017; Varela, 2020.
3 Oxfam, 2019; Pérez et al., 2019; Ramírez Lasso, 2018.
4 Blouin, 2019; Freier and Pérez, 2021; Pérez and Freier, 2022; Pineda and Avila, 2019; Ramírez Lasso, 2018.
5 Acosta and Brumat, 2020; Vera Espinoza et al., 2021.
6 Castro Padrón and Freier, 2021.
7 Angulo-Giraldo et al., 2021.
8 Cabieses et al., 2021.

greater tendency to live in overcrowded conditions, their overload of care work, their reduced access to reproductive health,[9] and their increased exposure to gender-based violence and sexual exploitation.

Contributing to the study of migrant women's integration experiences in the "Global South," specifically in the context of the COVID-19 pandemic, the present paper uses both qualitative and quantitative data to analyse the discrimination experiences of Venezuelan migrant women in Colombia, Ecuador, and Peru during the pandemic. Our analysis is based on an understanding of gender as not only a social system that shapes migration processes and experiences, but also as a system of difference centred on intersecting oppressions, such as sexuality, race, ethnicity, age, and socioeconomic class.[10] The narratives and voices of Venezuelan migrant women, as well as the perspectives of key government and civil society stakeholders, give us insight into how the intersectionality of identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+) and working class intensified the vulnerability to violence and discrimination of displaced Venezuelan women, which was also shaped by their condition as (irregular) migrants, their age and their race. Importantly, this multilayered discrimination has taken a detrimental toll on Venezuelan migrant women's mental health.

## Background

As of 24 November 2021, Venezuela's humanitarian, political, and economic crisis has led to the departure of over 6 million people,[11] constituting the second largest – after the Syrian Arab Republic – and fastest escalating displacement scenario worldwide.[12] The nature of this displacement is largely regional, with over 4.9 million remaining in neighbouring countries, specifically in Colombia (1.8 million), Peru (1.2 million), Ecuador (508,000), Chile (448,000) and Brazil (261,000).[13]

Over the years, Venezuelan emigration flows to Colombia, Ecuador, and Peru have revealed two main developments: (1) an increasing feminization and higher levels of vulnerability;[14] and (2) a substantial decrease in the number of women migrants since 2020, in the cases of Colombia and Peru, likely as a result of the COVID-19 pandemic.

Data from IOM Displacement Tracking Matrix (DTM) surveys[15] in Colombia show that, as of December 2018, more Venezuelan men than women entered the country (53% compared to 47%). Regarding the overall sample (N 16,716), the majority (64%) migrated with family members, 52 per cent had completed high school, and 67 per cent did not have any documents to certify their immigration status.[16] By November 2019, the proportion of Venezuelan women had increased to 59 per cent. Out of the overall sample (N 61,903), 68 per cent were travelling with family members. However, only 40 per cent had completed high school, and only 54 per cent were living without documentation.[17] With the COVID-19 pandemic, as of August 2021, the proportion of Venezuelan women in the total sample surveyed (N 11,048) decreased to 37 per cent (Table 1).[18]

[9] Albornoz-Arias et al., 2021.
[10] Crenshaw, 1989; Taha, 2019.
[11] R4V, 2021.
[12] Freier and Parent, 2019.
[13] R4V, 2021.
[14] Castro Padrón and Freier, 2021; Freier et al., 2019.
[15] DTM surveys employ convenience sampling.
[16] IOM, 2018a; in the case of Colombia, the results of the DTM survey include individuals coming from Venezuela (Venezuelans, Colombians, and Vene-Colombians).
[17] IOM, 2020a.
[18] IOM, 2021a.

**Table 1.** **Sociodemographic data of Venezuelan migrants entering Colombia, 2018–2021**

| | December 2018 | November 2019 | August 2021 |
|---|---|---|---|
| Women entering the country | 47% | 59% | 37% |
| Individuals travelling with family members | 64% | 68% | – |
| Individuals who completed high school | 52% | 40% | – |
| Individuals entering without documentation | 67% | 54% | – |

*Source:* Authors' own elaboration based on IOM, 2018a, 2020a, 2021a.

In the case of Ecuador, as of September 2018, the percentage of Venezuelan men entering the country was greater than that of women (54% compared to 46%). Regarding the overall sample (N 1,953), 47 per cent had travelled with family members or friends, 60 per cent had finished high school, and 3 per cent entered the country without some form of identification.[19] By June 2019, the percentage of Venezuelan men continued to exceed that of women (60% compared to 40%). Out of the overall sample (N 2,234), 54 per cent travelled with family members or friends, 43 per cent had finished high school, and only 2 per cent did not hold any identification document.[20] With the COVID-19 pandemic, the percentage of Venezuelan men entering the country, as of November 2020, decreased to 54 per cent. Of the overall sample (N 3,448), 60 per cent had travelled with family members or friends, 58 per cent had finished high school, and 1 per cent entered Ecuador without a valid form of documentation.[21] The most recent DTM survey results, from June 2021, detail an increasing presence of Venezuelan women entering the country (49%),[22] as shown in Table 2.

**Table 2.** **Sociodemographic data of Venezuelan migrants entering Ecuador, 2018–2021**

| | September 2018 | June 2019 | November 2020 | June 2021 |
|---|---|---|---|---|
| Women entering the country | 46% | 40% | 46% | 49% |
| Individuals travelling with family members or friends | 47% | 54% | 60% | – |
| Individuals who completed high school | 60% | 43% | 58% | – |
| Individuals entering without some form of identification | 3% | 2% | 1% | – |

*Source:* Authors' own elaboration based on IOM, 2019a, 2019b, 2021b, 2021c.

In the case of Peru, data from the DTM surveys depict that, in November 2017, more Venezuelan men than women entered the country (63% compared to 37%). Regarding the overall sample (N 781), the majority (68%) held a university or technical degree, 76 per cent were single, and only 28 per cent migrated with their children.[23] By December 2019, the proportion of Venezuelan women entering Peru surpassed that of men (55% compared to 45%). Out of the overall sample (N 1,235), only 31 per cent held a university or technical degree, and 61 per cent were travelling with family members. Of the 45 per cent of Venezuelans travelling with minors, 75 per cent were

[19] IOM, 2019a.
[20] IOM, 2019b.
[21] IOM, 2021b.
[22] IOM, 2021c.
[23] IOM, 2017.

women, and 40 per cent of these women were single or divorced.[24] As in Colombia and Ecuador, the COVID-19 pandemic brought about changes to the average profile of displaced Venezuelans arriving in Peru. Between January and February 2021, the number of Venezuelan women in the total sample surveyed (N 1,011) decreased to 42 per cent, and the number of Venezuelans travelling with family members changed to 58 per cent[25] (Table 3).

**Table 3. Sociodemographic data of Venezuelan migrants entering Peru, 2017–2021**

| | November 2017 | December 2019 | February 2021 |
|---|---|---|---|
| Women entering the country | 37% | 55% | 42% |
| Individuals who were single | 76% | – | – |
| Individuals travelling with family members | 28% | 61% | 58% |
| Individuals who held a university or technical degree | 68% | 31% | – |

*Source:* Authors' own elaboration based on IOM, 2017, 2020b, 2021d, 2021e.

Regarding the integration experiences of Venezuelan migrants and refugees in the region, it is important to emphasize that this group was already living in precarious conditions before the pandemic. The rapid increase in the arrival of Venezuelans, which accelerated in 2016, led to a range of policy responses and, in some cases, provoked restrictive changes in countries' immigration and refugee legislation.[26] Instead of systematically applying the regional refugee definition of the 1984 Cartagena Declaration, or the Mersocur 2002 Residence Agreement, governments haphazardly responded to Venezuelan displacement with a series of ad hoc policies that circled between wanting to protect Venezuelans and controlling – or limiting – their arrival. The implementation of these policies led to volatile legal status and irregularity for millions of Venezuelan citizens.[27] While some policy reactions, such as temporary work visas, have offered innovative alternative pathways to protection, concerns have also been raised about their sustainability and the ways they undermine (regional) refugee protection mechanisms.[28]

Within this context of legal precarity, the socioeconomic conditions in which Venezuelan migrants and refugees were living made them especially vulnerable as the COVID-19 pandemic hit the region: they were more likely to work in the informal sector and earn less per hour than the national population performing similar tasks.[29] The precarious economic status of this group can be primarily attributed to the difficulties associated with the regularization of their migratory status,[30] the recognition of their professional and educational qualifications,[31] and their need to earn money to send remittances back home.[32]

These experiences have a gendered, multilayered dimension. Venezuelan women were more negatively impacted by pre-existing structural gender gaps in the region's labour markets,[33] where they disproportionately work in more precarious employment and receive lower pay.[34] Data from a multi-country DTM survey (N 12,304), which was implemented in Brazil, Colombia and Peru between 2017 and 2018, estimate that, at the time of survey administration, Venezuelan women

[24] IOM, 2020b.
[25] IOM, 2021d; The most recent DTM survey results detail a decreasing number of Venezuelan women entering Peru (see IOM, 2021e).
[26] Freier and Doña-Reveco, 2022.
[27] Acosta et al., 2019; Jubilut et al., 2021.
[28] Freier and Doña-Reveco, 2022.
[29] INEI, 2019; Olivieri et al., 2020; World Bank, 2019.
[30] IOM, 2020a; Luzes et al., 2021; Vásquez et al., 2020.
[31] Briceño et al., 2020.
[32] Blouin and Freier, 2019.
[33] Observatorio Proyecto Migración Venezuela, 2021; Vásquez et al., 2020.
[34] Foley and Piper, 2020.

had higher rates of unemployment compared to their male counterparts (47% compared to 38%), despite having higher academic qualifications (33% compared to 27%).[35] In addition, Venezuelan migrant women were more likely to be employed in the informal sector, specifically in highly feminized jobs,[36] and to earn less.[37] The literature on migrant workers also points to women being more likely to experience various instances of violence in the workplace,[38] including the case of Venezuelan women in Peru.[39]

Prior to the COVID-19 pandemic, regional attitudes towards Venezuelan immigration were marked by ambivalent, contradictory opinions. While the public understood that the majority of displaced Venezuelans fled their country out of necessity and in vulnerable situations, they also harboured feelings of concern about potential competition with this group for economic resources and the association between human mobility and insecurity.[40] Regarding Venezuelan migrant women, the attitudes and perceptions of the populations of receiving countries were deeply gendered and marked by misogynistic, xenophobic stereotypes of this group. A 2019 nationally representative study,[41] conducted in Colombia, Ecuador and Peru, found that almost half of respondents of a survey (N 1,200) considered that the majority of Venezuelan immigrant women would end up engaging in prostitution.[42] Relatedly, the survey results (N 116) of a mixed methods non-representative study, conducted in five Peruvian cities, which was applied to 44 men and 72 women between 2018 and 2020, indexed Venezuelan women experiencing nationality-based discrimination more so than men (77% compared to 61%), followed by gender-based discrimination (16% compared to 2%).[43] Interviews also revealed this group's experiences with being hypersexualized and sexually harassed in public spaces or the workplace (31% and 25%, respectively).[44]

While the "othering" of Venezuelan migrant women in receiving countries of the "Global South" still merits further examination, some mechanisms are explained in the literature. Focus groups from the 2019 Oxfam study in Colombia, Ecuador and Peru reveal that participants' framing of Venezuelan women as "prostitutes" was based on perceptions surrounding economic insecurity, women and sexualization. More specifically, there is an "explicit acknowledgement that migrants from Venezuela face insecurity and vulnerability, in the face of which – the interviewees assume – prostitution and sex work offer a 'way out'".[45] Relatedly, interviews from the 2018–2020 study in Peru reveal that, in addition to experiencing higher rates of nationality- and gender-based discrimination compared to their male counterparts, Venezuelan migrant women were devalued both in public and in the workplace, through hypersexualization and criminalization practices that were grounded on constructions of moral integrity and identity stereotypes at the intersection of gender, sex appeal, nationality, age, and migratory status.[46]

Against this background, the effects of the COVID-19 pandemic in the region have been immeasurable, primarily due to pre-existing weak social protection mechanisms and profound inequalities, which have had a differential impact on the livelihoods of migrants and refugees. The literature on the effects of pandemics on immigration and refugee legislation evidences an increase in discrimination and stigmatization of people on the move, which results in government inaction to implement inclusive policies.[47] Initially, this has been the case in all three countries, with the pandemic contributing to the implementation of increasingly restrictive migration policies like border closures and the exclusion of migrants and refugees from State-driven socioeconomic

35 IOM, 2018b.
36 Espinosa and Pérez, 2020.
37 Castro Padrón and Freier, 2021; Observatorio Proyecto Migración Venezuela, 2021.
38 Foley and Piper, 2020.
39 Freier and Pérez, 2021; Pérez and Freier, 2022.
40 Freier et al., 2021b; IDEHPUCP and IOP, 2020; Ipsos and UNHCR, 2018.
41 With a margin of error of ± 4.9% and a confidence level of 95.5% under the least favourable conditions (p=q=0.5) for the overall data from the sample; 1,200 surveys in total.
42 Oxfam, 2019.
43 Freier and Pérez, 2021.
44 Pérez and Freier, 2022.
45 Oxfam, 2019:11.
46 Pérez and Freier, 2022.
47 Crawley, 2021; Dionne and Turkmen, 2020; Ghezelbasch and Tan, 2020.

assistance programmes.[48] Displaced Venezuelans have also been affected by the loss of jobs and the reduction of their incomes, limited access to health services, the risk of eviction, and increasing xenophobia and discrimination.[49]

Nonetheless, there have also been remarkably inclusive policy developments in the region, such as Colombia's decision to grant temporary protection and legal status to approximately 1.7 million Venezuelans in early 2021 through a Temporary Protection Status, even though the programme excludes all Venezuelans who entered irregularly after this date. The Office of the United Nations High Commissioner for Refugees (UNHCR) and IOM praised Colombia's initiative, as it would provide access to basic services, including the national health system and COVID-19 vaccination plans, as well as to the job market, which would aid in lessening the dependence of people on the move on humanitarian assistance, while also contributing to the country's post-COVID-19 socioeconomic recovery.[50] This decision has the potential to set a precedent for the region.[51] Throughout 2021, the Peruvian Government implemented a new regularization programme for foreigners in an irregular situation for a period of one year. And in September 2021, the Ecuadorian Government announced that a proposed regularization scheme would be implemented by the end of the year. However, while Colombia had approved 456,000 temporary protection cases by the end of the year,[52] the Peruvian process has been slow, with around 60,000 approved cases by late 2021. And by late November, Ecuador's regularization programme had not yet started.[53]

Crises are never gender neutral, and the integration experiences of Venezuelan migrants and refugees during the pandemic pose no exception to this rule. Within a region with the highest level of restrictions affecting workers,[54] the COVID-19 pandemic laid bare women's unemployment, discrimination experiences and low pay; as well, the pandemic further exacerbated each of these issues. In the case of Peru, after the quarantine period ended, the construction and transportation industry began rehiring men, yet the sales and customer service sectors, which tended to employ more Venezuelan women, were more severely impacted by the pandemic and have had a slower and lesser recovery.[55] A survey conducted in June 2020 (N 159) found that 55 per cent of interviewed Venezuelan women continued to be unemployed, and 64 per cent reported they had considered taking on a job that they were previously unwilling to do to avoid mistreatment and discrimination (for example, street vending, household work, or prostitution), exacerbating their precarious, vulnerable condition.[56] The burden of unpaid domestic work also fell disproportionately on women during lockdown periods, further limiting their access to employment opportunities.[57] This phenomenon is part and parcel of a broader regional trend, as a representative survey (N 1,851) found that around 70 per cent of Venezuelan women in Colombia and Ecuador declared spending most of their time in the first quarantine period on unpaid domestic work, compared to 44 per cent of their male peers.[58]

Although media coverage initially prioritized the pandemic over the Venezuelan exodus,[59] negative public attitudes towards Venezuelan migrants and refugees continued, indexing ongoing instances of xenophobia and discrimination. A representative public opinion survey (N 1,085) conducted in February 2021 revealed that 70 per cent of Peruvians considered that Venezuelan displacement had a negative impact, emphasizing insecurity and crime (63%), as well as a higher level of informality

48 For border closures, see Mixed Migration Centre, 2020. For exclusion from assistance programmes, see Acosta and Brumat, 2020; Blouin et al., 2020; Freier and Vera Espinoza, 2021; interview with key actor from Bogota's District Secretariat of Women; Vera Espinoza et al., 2021.
49 Equilibrium CenDE, 2020, 2021; Freier and Kvietok, 2022; Mixed Migration Centre, 2020; Zambrano-Barragán et al., 2021.
50 UNHCR, 2021.
51 Freier, 2021.
52 https://bitacoramigratoria.co.
53 Freier and Doña-Reveco, 2022.
54 ILO, 2020.
55 Espinosa and Pérez, 2020.
56 Ibid.
57 Freier and Kvietok, 2022.
58 Castro Padrón, 2020.
59 Freier et al., 2021a.

and fewer jobs in the country (39%).[60] Finally, instances of sociolabour exclusion and precarity, both prior to and during the pandemic, negative public opinion towards Venezuelan immigration, and discrimination have all significantly affected the mental health of displaced Venezuelans in Colombia and Peru, which is compounded by the hardships experienced in Venezuela and throughout their migratory journeys.[61]

## Methods

We draw on quantitative and qualitative data collected between August and October 2021 through a representative survey with Venezuelan migrants and refugees in Colombia, Ecuador and Peru (N 1,416),[62] as well as 14 semi-structured interviews with Venezuelan women migrants and key stakeholders in Colombia and Peru.[63] The survey's methodology was based on a stratified probability sampling of Venezuelan migrants, refugees and asylum seekers of legal age in each of the three countries.[64] It collected data on their migration journey, employment experiences, access to health care, trust in governmental institutions and discrimination experiences.[65] Survey data was then processed using the Stata data analysis software.

The demographic data collected in our survey reflect the sociodemographic characteristics described for Venezuelan immigrants in the region in larger studies.[66] Over 40 per cent arrived in 2018 and 2019, and 15 per cent arrived in 2019 and 2020. Our participants were predominantly women (48%) and young adults (74% of respondents were between 18 and 44 years old). The majority (64%) lived with children in the receiving countries. Participants had high levels of education: 30 per cent had completed some university education, and 16 per cent had received a technical education. The majority (88%) self-identified as heterosexual. Regarding their racial self-identification, 32 per cent identified as Afro-descendant, 31 per cent as *mestizo*, and 37 per cent as white. Regarding respondents' economic situation, 41 per cent did not have a job and were actively seeking employment at the time of survey administration, and 43 per cent had no regular migration status.

From the survey data, we selected a sample of seven Venezuelan women for in-depth interviews via purposive sampling.[67] To gain a deeper understanding of discrimination experiences, we chose interviewees based on the criteria of having been discriminated against at least once in the receiving country. More specifically, we selected survey respondents for interviews if they had responded "always," "most of the time" or "sometimes" to the questions regarding discrimination experiences based on sexual orientation, race and gender identity. Semi-structured interviews were then conducted virtually via WhatsApp or Zoom, lasting an average of 90 minutes. During the interviews, we collected data on the following seven domains: perceptions of discrimination before the pandemic; perceptions of discrimination during the pandemic; intersectionality and discrimination; impact of discrimination experiences on well-being and integration; places where discrimination occurred; resilient strategies; and the identification of available resources. To analyse the data, we systematized the information contained in the transcripts and notes, which we coded inductively according to emerging themes in an Excel document. Throughout this chapter, we use pseudonyms to preserve the safety and anonymity of migrant women.

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60 In contrast, 8 per cent framed the arrival of Venezuelan migrants and refugees as having a positive impact, highlighting the friendly and hardworking personality of Venezuelan people, and greater cultural diversity as a result of Venezuelan displacement (Freier et al., 2021b).

61 Bird et al., 2020a, and Bird et al., 2020b; Carroll et al., 2020; Castro Padrón and Freier, 2021; Espinel et al., 2020; Freier and Kvietok, 2022.

62 See Equilibrium CenDE, 2021, for the overall preliminary analysis. The design, data collection, and preliminary data analysis was done by Equilibrium CenDE. However, the authors constructed the discrimination domain, and disaggregated and analysed the data regarding the variables of interest.

63 For migrants, see Appendix 1; for stakeholders, see Appendix 2.

64 Stratified sampling designs involve partitioning a population into strata based on a certain characteristic that is known for every sampling unit in the population, and then selecting samples independently from each stratum. With a margin of error of plus or minus 5 per cent and a confidence level of 95 per cent, the design treated the country of origin and gender as strata. Then, the design constructed the weighting factors so each observation was assigned a certain weight according to its characteristics. This technique allowed for the balancing of observations and the maintenance of the population proportion.

65 See Appendix 3 for the survey guide on discrimination domain.

66 IOM, 2020a, 2020b, 2021a, 2021b.

67 See Appendix 4 for the interview guide.

> *"When I attended university 10 years ago, there were no problems with Venezuelan migrants, as they came to spend money. Now there is a gigantic socioeconomic dimension. Discrimination is linked to this. There is a cycle between poverty and racism.*
>
> **Interviewee, Bogota's District Secretariat of Women**

> *"In Peru, there is very strong discrimination against migrants with low resources and against migrant women; we cannot speak of generalized xenophobia. Venezuelan women are discriminated against for being "prostitutes", which is the generalized idea [of this group].*
>
> **Interviewee, Asociación Protección Población Vulnerable (APPV)**

As these quotations exemplify, a common thread during interviews with migrants and key government and civil society stakeholders was that discrimination against Venezuelan migrants and refugees is linked to the increasing socioeconomic vulnerability of this group. Overall, both in Colombia and Peru, Venezuelan migrant women's experiences with discrimination are widespread, taking place in both the public and private spheres. According to the survey data, 70 per cent of women tend to face discrimination in public spaces, as well as in workplaces (37%), health-care centres (21%) and the neighbourhoods where they reside (15%). Discrimination was also framed as a multidimensional, intersectional phenomenon. A combination of several identity markers – gender, sexual orientation, age, educational and socioeconomic status, race, nationality and condition as migrants, among others – thus conditions displaced Venezuelan women's experiences in receiving countries.

Our survey results show that the majority (93%) consider their Venezuelan nationality to be the main cause of discrimination, followed by their economic condition (20%), linguistic repertoire (17%) and dress style (6%). Women with diverse sexual orientations tend to experience higher levels of discrimination than heterosexual women in the workplace (48% compared to 38%), as well as in their neighbourhoods of residence (23% compared to 14%). In addition, a much higher proportion of women who self-identify as Afro-Venezuelans and *mestizo* declared they experienced discrimination due to their socioeconomic status, than did those who self-identify as white Venezuelans (26% and 23% compared to 9%). Interviews also revealed that hypersexualized tropes of Venezuelan women, primarily as "prostitutes", were often identified as the root cause of discrimination, which puts this group at higher risk of harassment and sexual violence.

While discrimination towards Venezuelan migrants and refugees predates the pandemic, the epigraph identifies a particular kind of framing during the COVID-19 pandemic. In light of widespread socioeconomic precarity, nationalistic and xenophobic attitudes (such as the idea that "they are not from here") merged with economic interests (such as the idea that "we have to be first; they are not as poor as us"). Thus, Venezuelan women's experiences with discrimination were conditioned not only in relation to gender, but also in relation to nationality and to their migratory and socioeconomic status. Our survey results indicate that Venezuelan women with an irregular migration status tend to feel more frequently that they are being excluded or rejected from social activities and treated with less respect than others (26% and 20% respectively), as compared to those with a regular migration status (17% and 13% respectively). The following sections highlight the multilayered nature of Venezuelan migrant women's experiences with discrimination in different spheres of society, and reveal its detrimental effect on this group's mental health.

## Street

> *Once on the bus … I was calmly looking at the screen of the phone of a man who was watching videos and I felt a tickle on my butt, and over my shoulder I see that it was that man. I gave him a slap and told him he was a "marico" and not to touch me. … You walk in the street and they shout at you, "veneca, look at that ass".*
>
> **Carolina, 26, Peru**

> *One day my husband asked me if I could go to buy coffee. … [On my way,] I saw a man approaching me, I told myself: "well, as it is the avenue, he is passing by." When I was heading back, the man was following me and literally told me "when I see you alone [next], I will rape you." I got scared. What scared me the most [was that] he could know where I live. But well, the police arrived, they scared the boy.*
>
> **Marleni, 24, Colombia**

Most generally, and least connected to the specific context of the COVID-19 pandemic, Carolina's and Marleni's testimonies resemble a common narrative during the interviews with migrants and key actors: the street is not a safe place for Venezuelan women, given instances of sexual harassment, which are based on sexualized stereotypes of their bodies. In response, migrants' testimonies evidenced the normalization of this type of discrimination. As many stated: "you learn to live with it." While some women, like Carolina, fight back against their aggressors, many opt to naturalize situations of violence and discrimination as a coping mechanism.

Women from the LGBTQI+ community find themselves in an especially complex situation, as they face added risks while on the street. Referring to the specific case of trans women in Colombia, a key actor from Bogota's District Secretariat of Women stated:

> *Trans women suffer a lot of violence in Colombia because breaking with gender norms generates many situations of discrimination. What surprised me when talking to a Venezuelan trans woman was that these situations of violence and discrimination are naturalized and normalized: "oh, it's already happened to me."*

Others decide to pass as heterosexual to avoid unwarranted attention. As Lisette, a self-identified lesbian, explained: "I'm a lesbian, but I'm not a public lesbian. For most people, I'm normal, I'm hetero." The need to hide one's identity has a marked impact on one's mental health and integration experiences, as Brailyn, a non-binary person, stated:

> *In the end you are afraid of being yourself in this country. There are super silly things, such as being afraid of putting on a pearl necklace because I know people that have been attacked. I doubt a lot about whether to dress the way I want, whether to have expressions that I want or not, it has been quite a psychological impact.*

Discrimination experiences were also conditioned by migrants' race. Brailyn, who self-identified as Afro-Venezuelan and was living in the fishermen's cove of Pucusana, commented that they received discriminatory comments and stares, and people often told them they are from Chincha.[68] Commenting on the lack of Blackness in Pucusana, Brailyn stated: "sometimes I feel like I'm a black dot on a white sheet of paper." Furthermore, Marleni's testimony sheds light on the criminalization of Afro-Venezuelan migrant women's race:

> *I'm dark skinned, but my children are lighter skinned. One day they asked me if I had stolen my son from someone else because he was very pretty. "That kid is too pretty to be your son" [they told me]. They've told my father-in-law that he would be imprisoned for stealing [his grandkids].*

## Workplace

> *"During the pandemic there are very few opportunities, and those available go to nationals. There used to be more businesses in which we as [migrant] women were hired, mainly in the customer service sector. But now, it's purely prostitution businesses, they want to hire you in a different way, they tell you: "look, call this job" and when you get there [you realize] that you're going to be doing something else.*
>
> **Lilith, 41, Peru**

> *"If you don't have the [Special Residence Permit], they exploit you a lot. The minimum wage is 35 pesos, but for not having a document they give you 20–25 a day. … If the majority of Colombians are unemployed it's not our fault, it's the fault of Colombians for taking advantage of us.*
>
> **Edith, 57, Colombia**

These two quotations speak to two main and interlinked issues identified in interviews: labour exploitation and the hypersexualization of Venezuelan women, which lead to the assumption that they would be willing to work as prostitutes. In both Colombia and Peru, the COVID-19 pandemic affected Venezuelan migrant women's employment and income more negatively than Venezuelan men, given their higher likelihood of being employed in the informal sector. According to our survey results, 34 per cent of Venezuelan women in Colombia, Ecuador, and Peru had a job by August 2021, in comparison to 63 per cent of their male counterparts. Their gendered socioeconomic precarity, especially given their condition as migrants, in combination with sexist stereotypes, paved the way for instances of discrimination in the workplace. These not only resulted in violations of their labour rights, such as longer working hours and lower pay, but also in harassment and sexual

[68] These remarks do not reflect the actual geographic distribution of Afro-Peruvians, as, by 2017, the department in which Chincha is located (Ica) ranks sixth in terms of Afro-descendant (INEI, 2018).

abuse. This scenario also has material consequences as it significantly impacts their ability to seek future jobs, which exacerbates their already precarious condition. As Gladys summed up:

> *When I arrived here, I started working at a cevichería [seafood restaurant] and the owner did not want to pay me because he offered me to be with him, he wanted to pay me only if I accepted to be with him … I had to block him from WhatsApp because I did not stop texting me … after what happened to me, I lasted a very long time without working. I was afraid of going out and looking for a job on my own because of the fear it could happen again.*

Migrant women's higher likelihood of performing additional care duties also limits their access to the labour market and exacerbates their socioeconomic precarity. As Marleni shared: "I've been offered several jobs, [but I haven't taken any] because I don't know anyone [trustworthy] to take care of my children." Venezuelan women who self-identified as LGBTQI+ faced additional discrimination because of their sexual orientation. During the pandemic, trans women living in both Colombia and Peru have increasingly resorted to prostitution in order to support themselves, putting their health and safety at risk.[69] In addition, Lilith, who self-identified as lesbian, explained why she kept this part of her identity secret in the workplace:

> *I had an altercation with a person who demanded money from me daily; I had no way to give him the money. This person started [informing people about] my sexual orientation, even though I never disclosed it. That embarrassed me a lot but I couldn't say anything, I had to handle the issue in an intelligent way. … I felt very bad, not because I doubted [my identity] but because of what it means here. You have a job and you have to take care of that.*

At play here are different – yet interrelated – types of discrimination and violence. First, the structural socioeconomic violence to which Venezuelan women, like Lilith, are exposed, which is characterized by job precarity. Second, already in a vulnerable economic position, she is taken advantage of and extorted. Third, she is denied disclosing her own identity to others, and faces backlash and prejudice. Venezuelan women's regular migration status, or the lack thereof, also conditioned their experiences with discrimination, as it deterred them from accessing jobs, and amplified their lack of protection and sense of vulnerability. In both Colombia and Peru,[70] key government and civil society actors affirmed that the lack of a regular migration status inhibited Venezuelan women's access to report instances such as the above-mentioned cases, for fear of being rejected or deported.

Venezuelan migrant women's experiences with discrimination in the workplace affect their mental health, creating a sense of fear that carries through to how they go about their daily lives. Recounting a discrimination incident in the workplace, Lilith exemplified how experiences of discrimination take a detrimental toll on the well-being and mental health of Venezuelan migrant women.

[69] Interviews with key actors from Red Somos and Bogota's District Secretariat of Women.

[70] For Colombia, see interview with key actor from Red Somos. For Peru, see interviews with key actors from the Ministry of Women and Vulnerable Populations.

> *It hurts a lot; every time I have been a victim of discrimination it feels really bad – feeling that I am not at the right place. I have felt frustrated because of not having the right to address this issue in a better way but anyways, you have to be very strong.*

Finally, while not the subject of our interviews with migrants, given that they were all over the age of 18, it is of utmost importance to consider the implications of age, specifically regarding minors. As a key actor from Quinta Ola stated, "a lot of teenagers have experienced violence and harassment in their workplaces, leading them to change jobs."

## Health care

> *"I lost my stable job, I got another [one] and well, I have this Parkinson's disease and I have not had access to health care because of the lack of proper documentation in this country, I want to have a better document to be able to access health services, and another type of job.*
>
> **Lilith, 41, Peru**

> *"I felt impotence, annoyance. … When they took me to the hospital the first thing they asked was about payment and insurance … they didn't want to send me to surgery because of the insurance, … they told us no, because you are Venezuelans … they made me wait 12 hours after the accident, I got surgery 10 days later, I almost lost my leg … if you are not affiliated and you are irregular, it is a health problem.*
>
> **Edith, 57, Colombia**

These two quotations exemplify the barriers to health care for Venezuelan migrants and refugees. Even before the onset of the pandemic, displaced Venezuelans' legal and socioeconomic precarity hindered their access to health care in both Colombia and Peru.[71] According to our survey data, the main limitations when accessing health services cited by women were the lack of economic resources (65%), the lack of required (legally or de facto) documentation (36%) and the geographic distance to health centres (12%). As in the testimonies of Lilith and Edith, a common narrative during the interviews was that Venezuelans were discriminated against by the health sectors in both countries because of their nationality and migratory status.

During the COVID-19 pandemic, Colombia, Ecuador and Peru each approached the inclusion of migrants in emergency socioeconomic assistance programmes, national vaccination plans and medical treatment differently, based on individuals' nationality and migratory status. Regarding emergency socioeconomic assistance programmes, Colombia was the only country to include foreigners, specifically those who held a Special Permanence Permit. In the case of national vaccination plans, all countries included – albeit at different capacities – migrant populations. Regarding medical treatment, Peru granted access to an integral health insurance for those who showed COVID-19 symptoms, irrespective of their migratory status. Based on their legislation, Ecuador should grant access to general public health services to all migrants, and Colombia should grant public medical treatment in case of emergencies, irrespective of migratory status (Table 4).

[71] Zambrano-Barragán et al., 2021.

**Table 4.** **Inclusion of migrants in emergency socioeconomic assistance programmes, national vaccination plans, and medical treatment during the COVID-19 pandemic in Colombia, Ecuador and Peru**

| Country | Inclusion of migrants in emergency socioeconomic assistance programmes | Inclusion of migrants in national vaccination plans | Inclusion of migrants in medical treatment |
|---|---|---|---|
| Colombia | Only migrants who held a Special Permanence Permit (PEP) were eligible for assistance. | Migrants are included. Initially, the TPS (Temporary Protection Status) was made available so that Venezuelans could regularize and access the vaccine. Irregular migrants can also access the vaccine, but an identity card or passport is required. | Under Colombian law and as part of the guarantee of the fundamental right to health (Statutory Law 1751 of 2015), the provision of emergency services should not be denied to any person regardless of their immigration status or ability to pay. This is the only access pathway for irregular migrants.<br>In the case of regular immigrants with the ability to pay, they can join the General System of Social Security in Health contributory scheme under the same conditions as Colombians, while those who do not have the capacity to pay can opt for affiliation to the subsidized scheme (Resolution 3015 of 2017). |
| Ecuador | Only nationals were eligible. | Migrants are included. An identity card (*cédula de identidad*) or passport is required. | The right to health is constitutional in Ecuador, in addition to guaranteeing universal access to comprehensive health care in the public sector, which covers the health needs of the immigrant population at all stages: transit, stay, departure and re-entry. |
| Peru | Only nationals were eligible. | All migrants are included, regardless of their migratory status. | All foreigners, irrespective of legal status, were granted access to the Integral Health Insurance (SIS), in case of showing COVID-19 symptoms. |

*Sources:* Authors' own elaboration based on Fajardo and Vargas, 2021; Mazza, 2020; Ministerio de Salud, Colombia, 2021; Lobo-Guerrero , 2021; and Zambrano-Barragán et al., 2021.

However, in practice, challenges remain in all three countries to guarantee appropriate access to health services, such as discrimination by health officials or the inability to pay the indirect costs. In our study, we found that discrimination and violence in the health sector has significant implications for the LGBTQI+ population, specifically trans women. Predating the COVID-19 pandemic, this group experienced multiple instances of physical and symbolic violence.[72] In addition, trans women and gay men were more vulnerable to contracting HIV, and experienced a "triple stigma" based on their nationality, gender identity and health condition. Commenting on the deadly effects of this stigma in the context of the pandemic, a key actor from Red Somos recounted:

> *There were situations of transgender women who died from Covid, but as they were trans it didn't matter, it took them more than 24 hours to pick up the body. … A trans person called because they were suffocating from Covid, when the paramedics arrived they said she was a trans woman under the influence of drugs and the trans woman died, a lot of transphobia.*

[72] Interviews with key actors from Red Somos and Bogota's District Secretariat of Women.

In addition, during the pandemic, LGBTQI+ individuals were not prioritized in national vaccination campaigns, despite their increased vulnerability. In Colombia, during the initial stages of the country's vaccination campaigns, irregular migrants were not considered in order to prevent a "stampede"[73] of people on the move seeking vaccines. As Edith shared: "we have not been able to get the vaccine because we are irregular, here one has to be affiliated to a Health Promotion Agency." Exacerbating this group's lack of protection and vulnerability, migrants' access to complaints processes was also limited by their irregular migratory status.

Our interviews further confirmed previous findings of increased barriers to sexual and reproductive health services for Venezuelan women during the pandemic.[74] More specifically, Colombian civil society organizations identified migrants' irregular status as a key barrier to such services for women, girls, and teenagers during the COVID-19 pandemic. As a key actor from Women's Link Worldwide discussed:

> *We litigated a case where a pregnant adolescent girl was denied access to prenatal care because [these] were not considered emergency services. The [Colombian] Supreme Court ruled that they should be considered. Also due to capacity issues in Colombia, Women's Link is currently presenting a petition to the Inter-American Commission on Human Rights on behalf of a Venezuelan woman who was denied access to a voluntary termination of pregnancy because of her irregular immigration status.*

## Policy implications

Based on our findings, a series of policy implications can be identified.

### Increased regularization efforts

- A key determinant of Venezuelan migrants' socioeconomic vulnerability and precarity has been their irregular status, both prior to and during the COVID-19 pandemic, which can be addressed through the sustainable regularization of Venezuelan migrants and refugees across the region.
- Other important avenues for avoiding irregularity include applying the regional refugee definition, from the 1984 Cartagena Declaration, to displaced Venezuelans, as well as offering sustainable alternative pathways to protection.

### Wider access to social protection and health services for displaced populations

- Providing Venezuelan migrants and refugees with wider access to social protection mechanisms, irrespective of migratory status, is key to avoiding precarious socioeconomic conditions and negative perceptions, including discrimination and xenophobia, from local populations.
- The COVID-19 pandemic has demonstrated the importance of providing all essential health services to migrants and refugees, irrespective of migratory status. Such services should not only include emergency services, but also vaccination programmes, as well as reproductive, prenatal and paediatric health.

[73] *France 24*, 2021.
[74] Albornoz-Arias et al., 2021.

**Combating discrimination and violence**

- Recent immigration and refugee legislation across the region includes non-discrimination and special protection clauses reflecting traditional categories such as sex/gender; race/ethnicity/colour; nationality; economic/social condition; and religion.[75] Sexual orientation and gender identity are important grounds of discrimination. Adherence to the law regarding non-discrimination and special protection needs to be duly monitored.
- There remains a need for increased ratification of the International Labour Organization (ILO) Convention No. 190 by South American States, but also for the establishment of the necessary legislation to prevent and address violence in the work sphere.
- Given discrepancies between legislation concerning migrants' access to health services and actual practice, instances of discrimination could be prevented through closer monitoring of the implementation of existing legislations.
- There is an urgent need for programmes that work with receiving populations to combat xenophobia and critically unlearn the pernicious stereotypes often attributed to the Venezuelan population, as this is often a deterrent for the successful implementation of policies.[76]

**Access to justice regardless of migratory status**

- Access to justice is a universal human right to which all individuals are entitled, irrespective of migration status. Close collaboration between government and civil society actors is important to ensure migrants are able to report cases of discrimination and violence without fearing rejection or deportation.

**Intersectional programmes and policies**

- There is an urgent need for States to develop and implement programmes and policies from an intersectional perspective to recognize the multidimensional nature of the discrimination faced by Venezuelan women and the differential needs within this group. The increased vulnerability and precarity of LGBTQI+, working-class migrant women of colour who hold an irregular migratory status needs particular attention.

**Creation of safe spaces for migrant women**

- There is a need for spaces where migrant women can discuss their gendered experiences and how they are similar, or different, with regards to their intersecting identities. Topics of discussion could include experiences with discrimination and bodily self-perceptions, specifically in relation to the hypersexualized images of Venezuelan women's bodies, as well as coping mechanisms to overcome discrimination. It would be useful for these spaces to also include psychologists and mental health professionals, to help women process gender-specific trauma and empower them to make informed decisions with a rights-based approach.[77]

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[75] Freier et al., 2022.

[76] The work conducted by Freier et al. (2021a, 2021b) in collaboration with UNHCR serves as an example of a joint academia-international organization initiative to address this objective. Based on the results of the media analysis and public opinion study, the authors conducted workshops with journalists and editors from some of the main Peruvian newspapers to create a more sensitive understanding of the complexities of the Venezuelan displacement phenomenon.

[77] In Peru, the project "Chamas en Acción" aims to create safe spaces for Venezuelan children and teenagers to discuss their multiple identities, as well as their bodily self-perceptions.

**Greater thematic and geographic diversity in academia**

- There is a need for more mixed methods studies on how migrant and refugee women experience, make sense of and respond to instances of discrimination, from an intersectional perspective.
- Geographically, there is a need for more studies on these topics that highlight the dynamics of "South–South" flows in order to counteract the long-standing "South–North" bias that continues to underlie the field of migration studies.
- In Latin America, the experience of Venezuelan women should be juxtaposed with that of other migrant groups, such as Haitians and extraregional migrants and refugees.

## Conclusion

As evidenced in the preceding pages, the discrimination faced by Venezuelan migrant women in Colombia, Ecuador and Peru is a multidimensional, intersectional phenomenon. Although these experiences extend beyond streets, workplaces and health centres, these spaces – commonly cited by interviewees – give us insight into how the intersectionality of identifying as LGBTQI+ and working class intensified displaced Venezuelan women's discriminatory experiences, which were also shaped by their condition as (irregular) migrants, by their age and by their race. More specifically, our study reveals three main findings: (1) women with diverse sexual orientations tend to experience higher levels of discrimination than heterosexual women; (2) women who self-identify as Afro-Venezuelans and *mestizo* experience more discrimination based on their socioeconomic status than those who self-identify as white; and (3) women with an irregular migration status tend to feel more often that they are being excluded or rejected from social activities and treated with less respect than others.

A common narrative during the interviews was that the street is not a safe place for Venezuelan migrant women, given instances of sexual harassment. In the workplace, Venezuelan migrant women's job precarity continues to be marked by a higher likelihood of being employed in the informal sector, receiving lower pay, and performing additional care duties, in comparison to their male counterparts. Based on their hypersexualization, they experience sexual harassment, often in the form of the assumption that they would be willing to work as prostitutes. In this realm, trans migrant women of colour find themselves in a position of increased vulnerability. Regarding the access to public health services, despite the inclusion – albeit at very different levels – of migrants in national vaccination plans and medical treatment, the testimonies of Venezuelan migrant women point to instances of discrimination based on their migratory status, nationality and gender identity during the COVID-19 pandemic.

While it is important to recognize migrant women's normalization of discriminatory episodes as a necessary coping mechanism, empowerment through education and psychological therapy is necessary to assist this heterogeneous group in processing gender-specific trauma. The concrete policy implications include: increased regularization efforts; wider access to social protection and health services for displaced populations; national- and community-level mechanisms for combating discrimination and violence; access to justice regardless of migratory status; intersectional programmes and policies; the creation of safe spaces for migrant women; and greater thematic and geographic diversity in academia.

## Appendix 1. Key government and civil society stakeholders

| Organization | Country |
|---|---|
| APPV | Peru |
| Ministry of Women and Vulnerable Populations | Peru |
| Quinta Ola | Peru |
| District Secretariat of Women of Bogota | Colombia |
| Red Somos | Colombia |
| Women's Link Worldwide | Colombia |
| Clínica Jurídica – Universidad de los Andes | Colombia |

## Appendix 2. Self-identification of Venezuelan migrants

| Name | Sexual orientation | Migratory status | Race | Country |
|---|---|---|---|---|
| Lilith | Lesbian | Regular | Afro-Venezuelan | Peru |
| Carolina | Heterosexual | Irregular | N/A | Peru |
| Lisette | Lesbian | Regular | Mestiza | Peru |
| Brailyn | Lesbian/Gay | Regular | Afro-Venezuelan | Peru |
| Gladys | Heterosexual | Irregular | Belonging to an indigenous group | Peru |
| Edith | Lesbian | Irregular | Afro-Venezuelan | Colombia |
| Marleni | Bisexual | Irregular | Mestiza | Colombia |

## Appendix 3. Survey domains and questions regarding discrimination

| Domains | Questions |
|---|---|
| Frequency of discrimination | In your daily life, how often do you experience the following situation(s)? (Choose never, almost never, sometimes, most of the times, always)<br>▪ Exclusion or rejection from social activities<br>▪ You feel uncomfortable or received awkward looks that make you feel uncomfortable<br>▪ You receive insults or teasing that bother you<br>▪ You receive threats or experience abuse or shoving<br>▪ You are treated with less respect than others<br>▪ You receive a poor service compared to others<br>▪ People treat you as if you were not intelligent<br>▪ People treat you as if you were dishonest<br>▪ People treat you as if they were afraid of you<br>▪ People treat you as if they were better than you |
| Reasons for discrimination | Why do you think the abovementioned situations happened to you? Do you believe it was because of the following reason(s)?<br>▪ Sex or gender<br>▪ Sexual orientation<br>▪ The way you speak<br>▪ Nationality<br>▪ Race<br>▪ Disability<br>▪ Religious beliefs<br>▪ Physical appearance<br>▪ Age<br>▪ Socioeconomic status<br>▪ Others |
| Places where discrimination happen | Where did you experience the abovementioned situations?<br>▪ Public spaces<br>▪ Work<br>▪ Educational institute<br>▪ Family<br>▪ Neighbourhood where you live<br>▪ Health facility<br>▪ Government offices<br>▪ Banks<br>▪ Social media<br>▪ Others |

## Appendix 4. Interview domains and questions

| Domains | Questions |
|---|---|
| Perceptions of discrimination before the pandemic | ▪ What do you understand as discrimination?<br>▪ As a migrant and woman, what was your experience with discriminatory acts before the pandemic?<br>▪ Why do you think you were discriminated against before the pandemic? What were the main reasons? |
| Perceptions of discrimination during the pandemic | ▪ How do you think the COVID-19 pandemic impacted your experiences with discrimination?<br>▪ How do you think the COVID-19 pandemic changed the reasons/factors that led to you experiencing discriminatory acts and attitudes? |
| Intersectionality and discrimination | ▪ Do you think your [age, gender, gender identity, sexual orientation, race, migratory status, socioeconomic status] influences your experiences with discrimination? In what way(s)? |
| Impact of discrimination experiences on well-being and integration | ▪ How do you feel when being discriminated against?<br>▪ How do your experiences with discrimination in [Colombia, Peru] impact your well-being and integration experiences? |
| Places where discrimination happens | ▪ Could you elaborate further on your experience(s) with discrimination at/ in [work, home, public spaces, health sector, education sector, social media, etc.]?<br>▪ What kind of comments and actions have you received? |
| Resilient strategies | ▪ How did you react to the discriminatory experiences you faced?<br>▪ How do you think we can reduce discrimination towards migrant women? |
| Identifying available resources | ▪ Have you asked for help to address the cases of discrimination?<br>▪ Or to overcome these episodes? |

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# 8. GENDERED ASSUMPTIONS OF VULNERABILITY: A CASE STUDY OF GENDERED IMPACTS OF COVID-19 ON DISPLACED POPULATIONS AT THE BORDERS OF EUROPE

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## Introduction

This paper recognizes that the effects of COVID-19 have been experienced differently by people of different genders, ethnicities, age groups and health statuses, among other intersecting factors. We know that for displaced people at the borders of Europe the complications are multifaceted. Bringing a gendered lens to bear on the analysis enables researchers, non-governmental organizations (NGOs) and State and international actors to identify the various and disparate needs faced by individuals. Taking such an approach in this paper ensures that the research considers intersecting and complex identities and experiences that lead to inequalities in support for people seeking asylum. It also provides the groundwork for critiquing the focus on structural vulnerability more broadly, and questioning the role it plays in establishing policies that affect access to support. What is being argued for here is not necessarily a new approach but rather the need to carry out impact assessments in a way that recognizes the influence of the material conditions in which people find themselves, and does not rely on stereotypes focused on group vulnerabilities linked to gendered ideas of strength and weakness. To be clear: this paper addresses the need for support providers to fully take into account situational as well as structural vulnerabilities.

Although vulnerability assessments have reaffirmed the centrality of the concept of vulnerability in the early stages of asylum procedures,[1] a number of points of concern remain. This became clearer in the context of the lockdown measures adopted in response to the COVID-19 pandemic, which led to reduced opportunities to access asylum procedures. However, even prior to the pandemic, vulnerability assessments have been criticized for the "essentialized manner" in which they consider vulnerability, "categorizing certain groups as 'naturally' [or structurally] vulnerable".[2] Such an approach, as will become clear throughout this paper, can lead to binary assumptions of vulnerability that negatively affect the support available to those not seen as structurally vulnerable, such as young men.[3] A simplistic understanding of vulnerability ascribes to individuals and groups, rather than to their circumstances and surrounding policies and practices, a responsibility for prescribed weakness or dependence. These effects were further exacerbated during the early stages of the pandemic when asylum procedures were put on hold and lockdowns were imposed on refugee camps and on reception and identification centres (RICs), justified on the basis of limiting the spread of COVID-19.

1 See EASO, 2018.
2 Freedman, 2021:6.
3 Anonymous interview, July 2019; anonymous interview, June 2021. See also Bird, 2019a.

Taking this into account, this paper draws on a case study of the situation facing displaced people on the island of Samos to highlight the broader implications beyond this geographical context, making the following suggestions:

- That international actors reframe their focus when assessing vulnerability, taking into account the role that material conditions play in making people situationally vulnerable and avoiding overly simplistic assumptions about "natural" or structural vulnerability.
- That international actors recognize the specific dangers faced by groups – such as young men travelling alone – often excluded by assessments and decision-making focused on structural or "natural" understandings of vulnerability.

To support these policy suggestions, this paper opens with a brief review of the literature focusing on questions of vulnerability, challenging gendered assumptions surrounding vulnerability, such as who is deemed vulnerable, what makes them vulnerable, or when they are vulnerable. By way of evidencing the need to more fully take into account situational vulnerability, the paper then focuses on specific examples from the island of Samos, one of the Greek "hotspots"[4] that, at its height of overcrowding in January 2020, housed over 7,800 people in a space intended for only 648. At that time, 43.8 per cent of the displaced population in Greece were adult men, 22.3 per cent adult women, and 33.9 per cent children.[5] The situation on the island of Samos provides a powerful example of the consequences of the designation of certain groups as structurally vulnerable, and, by default, others as not vulnerable. In practice, this approach actually makes some of those people deemed to not be vulnerable more vulnerable, based on the situation and material conditions they face.[6] The arguments and policy implications in this paper, whilst based on interviews and observations from the island of Samos, have broader implications for approaches that aim to support displaced people throughout Europe.

This paper is based on the author's ongoing research on the island starting in 2018 and most recently including a 10-week period of patchwork ethnography between May and July 2021.[7] The work draws on over 40 in-depth qualitative interviews collected over three years that engage with officials, displaced people,[8] the local population and NGO staff and volunteers, as well as detailed ethnographic notes from multiple periods of research.

## Situational and structural vulnerability

The first step in developing an intersectional analysis of the impacts of COVID-19 on displaced people is to understand the risks that can be generated by gendered assumptions of structural vulnerability. One central aspect to this is the damage that a gendered portrayal of refugee "womenandchildren" as a singular homogenized group can have on women's representation of themselves and of their situation and agency, not least because they are being referred to in the same context as children, often the same children for whom they are the primary carers.[9] Such an approach focused on women and children is grounded in assumptions about gender binaries – femininity and masculinity – that often fail to recognize important power dynamics that put individuals at risk, instead focusing on assumed "natural" or structural vulnerabilities.[10] "[T]his creates narrow categories of who is most vulnerable to violence owing to their gender".[11] This narrow understanding can harm those whose situation may not be what the gender stereotype

4 Tazzioli and Garelli, 2018.
5 UNHCR, 2021a.
6 Bird, 2019a.
7 For "patchwork ethnography" see Gökçe et al., 2020.
8 The fully anonymized interviews with members of the displaced community include interviews with adults between the ages of 18 and 60, at different stages in their asylum cases.
9 Enloe, 2014.
10 Freedman, 2021.
11 Hagen, 2016:318.

would lead one to expect, when making decisions about procedure, placement and priority. When "refugees are discursively located as 'victim' and/or 'threat'",[12] deserving or undeserving, migrant or refugee, this risk is further exacerbated. As one young male interviewee reminded me, "that's how they demonize, they police. The European[s] think that refugees are terrorists, they are rapists, they are criminals … and we are not. We are human beings".[13]

Relying on prejudices or stereotypes when deciding who should and should not be helped is a broader structural issue embedded within the humanitarian sector. "[S]eeing refugee men as objects of humanitarian care would disrupt prevailing humanitarian understandings of refugeehood as a feminized subject position".[14] This is a position that not only delineates who is or is not supposedly deserving of support, or who should be understood as an agent and who as a subject, but that also has broader financial implications for the aid sector, which may rely on these traditional understandings of gendered vulnerability to apply for support and funding. Within a system that relies on external capital to enable it to function, "vulnerability becomes a commodity [and] humanitarianism needs people's suffering to sustain its operation politically and economically".[15] The depiction of refugee "womenandchildren" as being supported and helped, drawing on feminized and gendered language to evoke empathy from donors, has implications for both those presented as a homogenized group – refugee "womenandchildren" – and those presented as other. They highlight the inherent need to challenge the reliance on stereotypes and assumptions when assessing vulnerability, and instead focus on the material and situational conditions that may make someone vulnerable at a particular time.

Relying only on a structural understanding of vulnerability can also negatively affect access to support for LGBTQI+ (lesbian, gay, bisexual, transgender, queer and intersex) groups. "At the NGO level, most funding for aid to [for example] survivors of SGBV [sexual and gender-based violence] continues to be based on an essentialist categorization that defines rape primarily as perpetrated by men against women, leaving many … out of the equation".[16] This is not because these cases do not exist, but rather because in doing the necessary work to draw attention to violence against women as a serious issue, "a strategic decision may be taken to define women only in what was perceived as less threatening terms, namely as cisgender[17] heterosexual women".[18] As one interviewee on Samos noted, this has in the past led to less support being available for the LGBTQI+ community, as well as to a lack of safe spaces for men who are survivors of violence, including gender-based violence. The situation is further complicated by the fact that there is often a stigma attached to men reporting violence in camps, due to dominant norms of masculinity and self-reliance. This, in turn, makes men less likely to report violence to camp authorities.[19] Awareness of this is vital for camp management decision-making and policy implementation, particularly when thinking about broader questions of safety and security for displaced people in these spaces.

Strategic decision-making processes by NGOs and international organizations applying for donor support, or by well-meaning policymakers looking to improve situations for vulnerable groups, can have secondary implications for individuals and groups understood to exist outside of structural framings of vulnerability, as well as those categorized as vulnerable. It can leave gaps in provision where NGOs focus on providing specialist support, leaving some groups, such as young men, "still vulnerable and ignored", as one interviewee discussing the situation on Samos told me.[20]

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12 Gray and Franck, 2019:276.
13 Anonymous interview, September 2021.
14 Turner, 2019:595.
15 Dadusc and Mudu, 2020:11. See also, Bird and Schmid, 2021.
16 Hagen, 2016:324.
17 A person whose sense of personal identity and gender corresponds with their sex assigned at birth.
18 Hagen, 2016:324.
19 Anonymous interview, July 2021.
20 Anonymous interview, July 2021.

Assumptions about vulnerabilities can therefore lead to individuals being treated as having a lack of agency, in the case of women treated like children;[21] being passed over for humanitarian support, which often assumes that "men experiencing displacement can perform a vision of masculinity replete with agency and independence, obscuring refugee men's actual and varied lived experiences";[22] or failing to be considered in either binary grouping. It is vital, then, for policymakers, international organizations and NGOs to draw on an intersectional lens when establishing approaches to support and to policymaking surrounding protection and support. To achieve this, I suggest, requires a different approach to thinking about vulnerability, one that takes into account contexts,[23] as well as intersecting identities that effect situational vulnerability.

If we take the role of situational precarity seriously in our understanding of vulnerability, recognizing that, "without shelter, we are vulnerable to weather, cold, heat, and disease, perhaps also to assault, hunger and violence", the link between material conditions and levels of vulnerability becomes clear.[24] While of course gender plays a role in how the realities of material conditions play out in people's lives, or how people come to find themselves existing under these conditions, it is also important to take material situational conditions into account when carrying out intersectional analysis, not relying on stereotyped assumptions about who can be thought of as vulnerable.

Front-line actors are often under-resourced and undersupported, with limited time in which to assess individual cases. This can lead to a need to focus limited resources or to rely on assumptions regarding vulnerability that require less time than a deeper investigation of circumstances. "[T]hinking about vulnerable contexts rather than vulnerable people"[25] can provide the foundations for an alternative approach.

Such an alternative approach would recognize the effects of material conditions on individuals, regardless of gender, age, race and other intersecting identities relies on dialogue.[26] By focusing on dialogue and recognizing the subjectivity of individual circumstances and changing political situations, vulnerability assessments could better understand the effects of material conditions on displaced people's lived reality. In situations where these material conditions include living in informal shelter for multiple years with limited ability to change those circumstances, such an approach can move our focus away from automatically categorizing people as being vulnerable, towards recognizing the conditions that establish said vulnerability and how these need to be changed.[27] Such an approach, then, allows for a more intersectional understanding that has the space to focus on situational vulnerability as well as structural.

## Case study: The island of Samos

To illustrate the need for a more targeted approach to vulnerability, focused on both structural and situational concepts, this paper turns now to a discussion of the island of Samos, and in particular the effects of COVID-19 felt by displaced people who were "stuck" in the asylum process on the island between January 2020 and September 2021. In September 2021, the island saw a dramatic change in the provision of shelter on the island with the closure of the Vathy RIC and the opening of the Zervou Multi-Purpose Reception and Identification Centre (MPRIC), a "closed" facility seven kilometres from the central town where much of the NGO support was based, and, at time of writing, is still based.

[21] Enloe, 2014.
[22] Turner, 2019:597.
[23] Poopuu, 2020.
[24] Butler, 2016:13.
[25] Poopuu, 2020:32.
[26] Poopuu, 2020.
[27] Freedman, 2021.

Prior to September 2021 the RIC on Samos had been somewhat unique amongst State shelter structures in Greece and on the wider "Balkan Route" in that it was located close to the island's main town, Vathy. Elsewhere, camps are generally located either in remote locations, with long walks to the nearest urban centre, or on the outskirts of towns, making access to resources and the labour market more difficult.[28] Vathy RIC, however, was located only a short walk from the centre of town. This is not to suggest that the conditions in the RIC were good; one interviewee told me, "life is not easy … like how we sleep in the tent, if winter, summer, very dangerous, we sleep with mouse and other wild animal … it's not, humanity or human rights for human being to sleep in that situation".[29] At times, there were queues for food of five hours or more, food that was often mouldy or inedible, broken toilets, no access to schooling, queues for showers.[30] All of this was further exacerbated by the start of the COVID-19 pandemic.

As Refugee Rights Europe stated, "the general lack of hygiene facilities available in the hotspots, detention centres and police detention cells highlights the difficulties faced by detained and movement restricted refugees during the COVID-19 pandemic. Social distancing is simply not possible in an overcrowded space".[31] As lockdown restrictions came into effect in March 2020, the situation got worse on Samos, with many of the NGOs and support organizations that usually filled some of the gaps in State provision forced to close, and freedom of movement from inside the camp heavily restricted with curfews, limits on the number of people who could leave, and on the reasons for leaving. These restrictions stayed in place long after they were lifted for the rest of the island residents.[32]

These conditions were then further exacerbated in situations of heightened struggle, such as extreme weather conditions coinciding with the COVID-19 pandemic. As a result of the pandemic, Greece, along with other European border States, suspended their asylum processes.[33] Similarly, transfers to other European States were delayed, and people housed in RICs on the Aegean islands of Lesvos, Samos, Chios, Leros and Kos found themselves under the harsh lockdown previously referred to, for a more extended period than the rest of the country. This meant that people were required to remain within the confines of RICs, with limited access to appropriate shelter, water and hygiene facilities, throughout the different seasonal weather conditions. As summer turned to winter this then meant surviving freezing cold temperatures, snow, wind and rain in overcrowded unsuitable shelter. The material conditions that this established led to situations in which vulnerabilities could not be properly assessed and considered only along structural lines, but required an intersectional and situational analysis that recognized the precarious and dangerous positions people found themselves in. These situations were heightened due to intersecting factors such as age, health status or disability, but also exposure to COVID-19, quarantine conditions, and the length of time "sheltered" in insecure and inappropriate tent-like shelters in the outer section of the RIC referred to as "the jungle".

As winter conditions on Samos worsened in 2020/2021, and after negotiations with camp management about what constituted an emergency situation, community centres run by NGOs were able to open up their spaces in the evenings, when the temperatures were at their lowest, to provide suitable heated emergency shelter.[34] It was only possible to make this emergency response available to a small number of people due to pressures on space. This meant that it was only possible to support those who were deemed to be most at risk from the conditions, such as pregnant women, the elderly and children. What smaller organizations were able to do in this situation, which State provision did not, was to recognize the precarity caused by the material conditions faced in the RIC and "the jungle" and the increased vulnerabilities this caused with the cumulative risks of COVID-19 and freezing winter temperatures. What, however, remained

[28] Bird et al., 2021.
[29] Anonymous interview, September 2021.
[30] Bird, 2019b.
[31] Refugee Rights Europe, 2020.
[32] Bird et al., 2020.
[33] Wallis, 2020.
[34] Anonymous interview, May 2021.

impossible to solve were the increased risks for individuals who were not able to find a space in emergency shelter provision, those who remained in makeshift tents, often alone with very little support in freezing temperatures. In some cases, young men travelling alone, who had often had lengthier asylum procedures and had faced these conditions for three years in a row,[35] with little planning to prevent these predictable yearly instances of increased situational vulnerability.

In the absence of sufficient State support and with limited resources, time-pressed organizations may be forced to rely on understandings of risk based on assumptions of structural vulnerability along gendered lines. The decisions made as a result of these assumptions, then, can exclude individuals who, due to situational factors, are at an increased risk; for example, young men whose mental and physical health has been severely affected by the length of time they have lived under these conditions. This intersectional reading of vulnerability reminds us of the need for camp and RIC structures to plan for and implement proper seasonal structures that do not enhance risk and situational vulnerabilities for all people sheltered there.

Beyond a focus on the more extreme and severe situations which were brought to the fore by the additional restrictions and worsened material conditions associated with COVID-19, I was also told by one support organization that "[we] don't want to say women and children are not vulnerable [they often are], but it is so hard to see men left behind. Sometimes it feels like lives of young men are not as important", and that the narratives surrounding vulnerable groups present women as vulnerable and men as perpetrators, with very little nuance to the accounts given.[36] This reading is supported by Gray and Franck's gendered analysis of media narratives in the United Kingdom,[37] which reports on the changing, gendered depiction of displaced people in the media.

The same interviewee pointed out the gendered nature of certain types of NFI (non-food item) distribution and how exclusionary it can be. They referred to the generic hygiene packs handed out, which often lacked razors, including instead sanitary towels, failing to make a gender-sensitive needs analysis for NFI provision on the island. This point was raised at the time of the interview, since 67 per cent of the displaced people on Samos were men.[38] The goal was not, however, to argue against the provision of female hygiene products; rather, it was to emphasize the need to meet the needs of changing populations and the importance of gender-sensitive analysis to achieving this. Whilst COVID-19 has brought to the fore many of these issues and gaps in provision, these also existed prior to the pandemic. In fact, in 2019 one interviewee told me they felt that "single men always get ignored … they end up being the most vulnerable in the camp".[39] This perception highlights the need for a different approach to thinking about vulnerability, one that is sensitive to changes in context and situation, alongside the need for effective dialogue, will also be of benefit for changing future approaches to the provision of support and policymaking, beyond the pandemic.

As the approach of the governments of Greece and of the European Union to managing the asylum procedure on Samos changes, with the inauguration of the Zervou MPRIC on 18 September 2021 and the large reduction in the number of people "sheltered" on the island to around 400, the importance of focusing thinking around situational vulnerability alongside structural vulnerability will increase. As of September 2021, around 65 per cent of the population "housed" on the island are male. In a situation where NGOs find themselves relying on a certain image of vulnerability to attract donor funding,[40] or governments and policymakers rely on a perceived image of "womenandchildren" as the main groups on which to focus support, this risks an even more vulnerable situation forming on the island as people find themselves forgotten or left behind by support and policy mechanisms. As such, it is vital that our approach to vulnerability starts to change.

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35 Anonymous interview, June 2021; anonymous interview, July 2021.
36 Anonymous interview, June 2021.
37 Gray and Franck, 2019.
38 UNHCR, 2021b.
39 Anonymous interview, 2019.
40 Bird and Schmid, 2021.

## Conclusions

In the context of COVID-19, situations of high risk and increased vulnerability only became worse, as displaced people struggled to access vaccines,[41] or were quarantined in precarious conditions in which social distancing was impossible, and with limited medical support,[42] a problem of resource availability that had been ongoing for many years in the RIC.[43] Engaging with these increased problems through a gendered lens that focuses on situational as well as structural vulnerabilities is key to fully recognizing these risks. The COVID-19 pandemic brought to the fore already-existing issues with an approach to support and policymaking that was failing displaced people on the island of Samos. COVID-19 further emphasized and exacerbated the failure of border States, often overburdened because of the scheme of allocation of responsibility for asylum claims among EU Member States and associated States,[44] to properly support individuals, to plan effectively to shelter people from predicable weather conditions, to provide appropriate and properly resourced medical support, and to maintain hygiene and security standards. It also made clear how heavily reliant on NGOs and voluntary organizations the system was to respond to changing situations. In cases when these NGOs were unable to fill the gaps in State provision, as COVID-19 restrictions limited their ability to do so, this became even clearer. What also became clear was the need for a rethinking of vulnerability that could take into account both situational and structural factors, recognizing the role that gendered assumptions can play in realizing effective support, in order to provide a more nuanced, granular and intersectional approach to thinking about and overcoming vulnerabilities on a global scale. As such, drawing on the findings within this paper I conclude by reiterating the key suggestions:

- That international actors reframe their focus when assessing vulnerability, taking into account the role that material conditions play in making people situationally vulnerable and avoiding overly simplistic assumptions about "natural" or structural vulnerability.
- That international actors recognize the specific dangers faced by groups – such as young men travelling alone – often excluded by assessments and decision-making focused on structural or "natural" understandings of vulnerability.

Each of these suggestions sits alongside a broader need to approach support for displaced people differently in the future. Such an approach calls for a focus on smaller-scale housing and support mechanisms, outside of a system of encampment, and is grounded in dialogue that supports displaced people in making their own life choices, within a framework in which they have the resources and support to achieve this.

41 Author's fieldnotes, 2021.
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# 9. THE MIGRATION–GENDER–HEALTH NEXUS: MENTAL HEALTH IMPLICATIONS DURING THE PANDEMIC AND BEYOND

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## Introduction

Emerging research on COVID-19's gendered implications for migration suggests that refugee women have been significantly impacted by the pandemic, including in terms of their mental health. According to the ApartTogether survey,[1] which provides a preliminary global overview of the self-reported impact of COVID-19 by refugees and migrants, at least half of all respondents indicated that the pandemic brought about greater feelings of depression, anxiety, and loneliness (see Appendix 1). Uncertainties about the future, specifically with regards to family reunification and financial security, constituted primary concerns amongst those surveyed.[2]

Gender dynamics are relevant in this context, as refugee women are at heightened risk of mental health problems. As an integrative review of literature about refugee mental health shows, cultural factors (such as language proficiency), social and material factors (such as employment and housing), as well as personal factors (such as family separation) all have gendered implications in that they affect refugee women's mental health in specific ways.[3] For instance, a lack of female interpreters and safe reporting spaces (cultural factors) poses challenges to addressing refugee women's mental health. During the pandemic, gendered effects have prevailed, and have even intensified. Indeed, as a recent comparative study found, refugee women who are survivors of gender-based violence (GBV) have faced increased precarity and intensified psychological distress.[4]

In this paper, I address COVID-19's gendered implications for refugee mental health. By conducting a regional comparative case study analysis (on Brazil, Germany, Turkey and Uganda), I highlight lived experiences and identify practices in the field as they pertain to gendered factors in refugee mental health (cultural, social and material, and personal). Based on my analysis, I offer outlooks with regard to intersectional approaches in research and policy at the migration–gender–health nexus.

1 WHO, 2020.
2 Ibid.
3 Shishehgar et al., 2017.
4 Phillimore et al., 2021.

## The migration–health nexus: Overview

The migration–health nexus provides a framework to understand and further explore the impacts of COVID-19 on refugees, before this paper turns to specific gendered implications for refugee mental health. The migration–health nexus generally operates around three key elements: disease control; migration management; and human rights.[5] First, regulations designed to limit or mitigate the spread of diseases are one of the earliest public health measures that directly affect migration, as manifested during the COVID-19 pandemic.[6] IOM estimates that by October 2020, a total of 219 countries, territories, or areas had issued travel-related measures, including entry conditions and restrictions.[7] Furthermore, the Office of the United Nations High Commissioner for Refugees (UNHCR) reported that 156 countries had implemented full or partial border closures by September 2020, with 75 providing no exceptions for persons seeking protection.[8]

Second, in terms of migration management, migrant-specific health policies have been implemented across institutional levels.[9] For instance, health status may be used to determine "fitness" for migrant workers' entry, or may generally constitute an admission criteria. For persons seeking international protection, these criteria are often waived, except in situations where communicable disease concerns are identified, such as during the COVID-19 pandemic.[10] In this context, the WHO found that national responses have varied, ranging from the release of asylum seekers from detention centres and the suspension of forced returns to more restrictive policies than those in place before the pandemic (see Appendix 2).[11]

Third, in matters of human rights, health-care coverage and the accessibility of services, communication strategies and information sharing, as well as vaccine distributions have all also varied during the pandemic. Persons seeking protection, living in camps and camp-like settings, are particularly affected by these policies.[12] Rights that exist at the intersection of migration and health are covered by different areas of international law (for instance, international human rights law, international labour law, international humanitarian law), yet health as a "human right for all" – thus including refugees – was first established in the constitution of the WHO and then reiterated in the Universal Declaration of Human Rights (article 25).[13] Several legally binding international human rights treaties have further reinforced this right to health, and these remain plainly applicable during the pandemic, although they can be subject to limitations.[14]

In addition to legally binding international human rights treaties, several guidelines, as well as the 2018 Global Compact on Refugees, offer further health provisions for persons seeking protection.[15] The Global Compact on Refugees states that "in line with national health care laws, policies and plans, and in support of host countries, States and relevant stakeholders will contribute resources and expertise to expand and enhance the quality of national health systems to facilitate access by refugees and host communities, including women and girls."[16] This involves resources and expertise to build and equip health facilitates or strengthen services as they pertain to mental health and psychological, as well as physical, care.

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5 WHO, 2010.
6 WHO, 2021.
7 IOM, 2021.
8 UNHCR, 2020a.
9 WHO, 2005.
10 WHO, 2010.
11 WHO, 2021.
12 Ibid.
13 IOM, 2010.
14 See article 12.1 of the International Covenant on Economic, Social and Cultural Rights, which provides the central formulation of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", including the requirement that health facilities, services and goods must be available in sufficient quantity, be accessible to everyone without discrimination, be culturally acceptable and be of good quality. See also: International Convention on the Elimination of all Forms of Racial Discrimination, article 5; the Convention on the Rights of the Child, article 24; the Convention on the Elimination of All Forms of Discrimination against Women, article 12; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, articles 28, 43 and 45; and the Convention on the Rights of Persons with Disabilities, article 25. WHO, 2010 and 2021.
15 See also: UNHCR, 2009, 2011.
16 United Nations, 2018.

As noted, during the pandemic, national responses within these global frameworks have varied considerably, with heightened gendered implications for migration being reported, not least as it pertains to mental health, as is explored below.[17]

## The migration–gender–health nexus: Spotlight on mental health

Research on refugee mental health has historically focused on trauma, and has emphasized events that occurred in pre-displacement contexts.[18] Studies show that refugees have elevated rates of mood disorders, psychotic illness and post-traumatic stress disorder (PTSD), relative to non-migrant populations, when they first arrive.[19] Yet research also indicates that the mental health of refugees is impacted by experiences in destination countries.[20] Indeed, it has been argued that the trauma-focused discourse fails to capture important aspects of refugee experiences, which are "characterized by multiple events occurring in multiple contexts that persist over time" along the migration continuum (that is, in origin, transit and destination countries).[21] These compounded stressors point to the importance of understanding varied factors in refugee mental health.[22]

Across the literature, several factors have been identified that affect refugees' mental health: employment and income; housing and accommodation; asylum procedures; language proficiency and cultural practices; social support and isolation; and discrimination and stigma.[23] These factors carry gender dynamics as refugee women's mental health is informed by specific cultural, social and material, as well as personal aspects (gendered factors in refugee mental health).

With regard to cultural factors, lack of language proficiency, for instance, reduces the ways that refugee women – who often have less language proficiency than refugee men – can share their experiences and challenges, while at the same time increasing the risk of social isolation and depression.[24] Another important aspect is the role of interpreters, as refugee women may not be willing to share their personal experiences with male interpreters. A lack of female interpreters and a lack of safe reporting spaces, as well as a fear of misinterpretation and exposure, can also have consequences for the mental health of refugee women (see below the case studies on Brazil, Germany and Turkey).[25]

In terms of social and material factors, it has been well documented that economic opportunity (such as labour market access) is a critical factor in refugee mental health, yet pervasive gender gaps in employment exist amongst refugees (see Appendix 3).[26] Furthermore, difficulties in securing housing beyond reception centres often involve stigma and discrimination, with perceptions of refugee renters not being able to pay rent, or expectations that multiple children will damage properties (see the Uganda case study).[27] Overcrowding and inadequate housing have consistently been linked to poorer mental health outcomes (see Appendix 1 and the Germany case study), not least given the heightened risks of GBV in these contexts (see the Brazil and Uganda case studies and Appendix 4).[28]

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17 UNHCR and IOM, 2020; Chetail, 2020; UNDRR, 2020; UNODC, 2020; United Nations Sustainable Development Group, 2020; IFRC, 2020.
18 Ryan et al., 2008; Porter and Haslam, 2005.
19 Hynie, 2018; Porter and Haslam, 2005.
See also: Fazel et al., 2005; Silove et al., 2017.
20 Ryan et al., 2008, Porter and Haslam, 2005. See also Li et al., 2016.
21 Ryan et al., 2008, Porter and Haslam, 2005. See also Hollifield et al., 2002.
22 Hynie, 2018; Alfadhli and Drury, 2016.
23 Hynie, 2018; Porter and Haslam, 2005.
24 Baird, 2012; Hashimoto-Govindasamy and Rose, 2011.
25 By introducing another person (the interpreter) into mental health assessments, that person's own opinions and views may be interjected and decisions about what questions are appropriate to ask the patient might compromise confidentiality. See also: Casimiro et al., 2007; Pain et al., 2014; Kirmayer et al., 2011.
26 Shishehgar et al., 2017.
See also: Sossou et al., 2008; Pavlish, 2007; Allsop et al., 2014; Bakker et al., 2014.
27 Perera et al., 2013; Khawaja et al., 2008.
28 Allen et al., 2014.

With regard to personal factors, loneliness and isolation are common concerns in refugee mental health.[29] These concerns can be brought about by family separation, in that refugee women find leaving family behind a particularly traumatic experience.[30] Research has shown that uncertainty about the condition of family members who have been left behind is a key source of distress amongst refugee women.[31] As well, exploitation and abuse of refugee girls has been identified as a great concern to refugee mothers (see the Turkey case study).[32]

These gendered factors in refugee women's mental health have manifested in different ways across regions before, during, and after the pandemic, and deserve focused attention and response from policymakers. They are explored in the following case study analyses.

## Mental health and refugee women in Brazil

In Brazil, refugees generally have access to the public health system, in the sense that they have the same rights as Brazilians according to the 1997 Asylum Law and the 2017 Migration Law. However, factors informing mental health – such as language proficiency and employment opportunities – remain unaddressed, as Brazil does not have, for instance, a national language-learning programme. These pre-existing challenges have been heightened during the COVID-19 pandemic with border closures, the suspension of migration services, and emerging research points to significant impacts on mental health.[33]

Research on refugee mental health has largely focused on the "Global North" and high-income countries. As a result, conceptualizations around mental health are informed by this geographical partiality. While research on migration in Latin America has been established, inquiries into the mental of refugees remain limited. As found in a qualitative study on psychologists' perspectives on refugee mental health in Brazil, mental health stressors operate along the migration continuum.[34] All interviewed psychologists emphasized how the post-displacement context has caused substantial mental health concerns. In speaking to the importance of language proficiency and safe reporting spaces as gendered cultural factors in mental health, an interviewed psychologist shared the experiences of a female refugee as follows: "… a state of complete loneliness. She feels disconnected from people. She feels that no one will understand her. And she feels that she won't understand anyone."[35]

The interviewed psychologists also specifically addressed the prevalence of racism and phobia towards lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) experienced by refugees, gesturing to the importance of intersectional perspectives at the migration–gender–health nexus. In this context, the case study of Casa Miga provides further insights.

[29] Hynie, 2018.
[30] Shishehgar et al., 2017.
[31] Catolico, 2013.
[32] Perera et al., 2013.
[33] Martuscelli, 2021. See also: UNHCR, 2019; Riggirozzi et al., 2020.
[34] Duden and Martins-Borges, 2021.
[35] Ibid.

### Shelter at Casa Miga

Casa Miga was established in 2018 by a local charity (Manifesta LGBT) as a non-profit shelter run by LGBTQI+ volunteers. It is currently supported through private donations and resources from UNHCR. Located in Manaus, the shelter provides LGBTQI+ asylum seekers support in the form of health care, educational opportunities, and employment training.

Cowper-Smith et al. studied the impact of the COVID-19 pandemic on LGBTQI+ asylum seekers in Casa Miga in Brazil.[36] Based on semi-structured interviews with Venezuelan LGBTQI+ asylum seekers and key service providers and politicians, Cowper-Smith et al. found that pre-existing challenges for LGBTQI+ asylum seekers such as labour market access have been exacerbated during the pandemic, accentuating the "lack of preparedness and desire of the national government to address asylum seekers' needs."

As part of the interviews, in regard to gendered social and material factors in refugee mental health, pervasive LGBTQI+ phobia was reported. Indeed, Cowper-Smith et al. stress that the mental health of LGBTQI+ asylum seekers has significantly suffered due to the pandemic, not least by increased stigmatization, halted asylum processing, and economic insecurity. With government support strained, many LGBTQI+ asylum seekers have found themselves in financial binds as their livelihood resources (often sex work or informal work) have been restricted. In this context, a trans Venezuelan woman noted:

> *I can't work and have no access to money. The government needs to come up with a plan to help people who don't have money and can't access emergency funds.*

Cowper-Smith et al. point out that refugee centres such as Casa Miga have also been affected by this lack of financial assistance. Yet Casa Miga has continued to support LGBTQI+ asylum seekers by prioritizing cases of people who face threats to their safety (for example, housing), as Casa Miga's manager shared:

> *They [LGBTQI+ asylum seekers] are forced to be together for long periods of time, in high levels of stress with very little privacy or ability to hide their sexuality and gender identities. When these things are revealed they are often expelled during the pandemic, so the prejudice is stronger than ever before.*

## Mental health and refugee women in Germany

Germany is one of several European Union countries that restrict access to health care for refugees for 15 months upon arrival.[37] This limitation dates back to the 1993 Asylum-Seekers' Benefits Act, which separated social protection provisions for refugees from the general social protection system.[38] Access to health care for refugees is determined based on legal residence status and a "waiting time regulation", and initially only includes emergency medical care, treatment for acute and painful conditions, care during pregnancy and childbirth, vaccinations and other "necessary preventive measures."[39] Mental health-care provisions generally fall beyond this scope.[40]

[36] Cowper-Smith et al., 2021.
[37] Norredam et al., 2006.
[38] Bosswick, 2000.
[39] Bozorgmehr and Razum, 2015.
[40] Ibid. Additionally, administrative barriers (that introduce delays or extra mechanisms), such as receiving a "health care voucher" for any kind of ambulatory or specialist care (for example, mental health), pose further challenges.

This restricted access to health care has affected the mental health of refugees during the COVID-19 pandemic. Emerging research indicates that the stress levels of refugees remained high in the first months of the pandemic, with feelings of loneliness being omnipresent. Significant factors in this context involve limited language proficiency, low income and social isolation, all factors that also tend to have gender implications at the cultural, social and material, personal levels.[41] These findings align with pre-pandemic representative studies on refugee women's mental health indicating that refugee women in Germany face a range of mental health concerns such as "pronounced" sadness, a tendency to cry, difficulty sleeping, nervousness and anxiety.[42]

Similar patterns emerged in a qualitative study on Syrian refugee women's mental health. In the interviews, the women described their health as impaired by post-displacement stressors such as discrimination, loss of social status and worries about the future. Many women also felt disempowered to navigate the German health-care system. As one woman explained, "I feel like people avoid … helping me since I wear hijab. That's why I don't feel comfortable going with my son to see the doctor, and I let his father take him."[43] Other women experienced doctors declining to treat them, and when treated, they often did not feel taken seriously (gendered cultural factors):

> *The problem is that everything is in German [language], even when the target group is immigrants. … I've been living here for two years and didn't know that this family-centre in my neighbourhood exists. They could've helped me with my pregnancy or told me about the midwife thing.*[44]

Indeed, the intersectional needs and challenges of pregnant refugee women have been highlighted across the literature, pointing to poor mental health being overrepresented in pregnant refugee women, especially in reception centres (gendered social and material factors), as the case study of the psychological walk-in clinic at the Patrick-Henry Village (PHV) shows.[45]

### Psychological walk-in clinic at Patrick-Henry Village

The Patrick-Henry Village (PHV) psychosocial walk-in clinic for pregnant refugees and new mothers was established as part of a State-funded research programme. It was opened in November 2017, to provide refugees who are pregnant or who are new mothers with low-threshold mental health support. The PHV is a former United States military barracks, converted into a reception and registration centre in Heidelberg-Kirchheim, offering general, paediatric, gynaecological, midwifery and psychosocial care services.[46]

At the time Kaufmann et al. studied the maternal mental health-care needs of refugee women at PHV, the psychosocial walk-in clinic offered counselling three times a week (1 hour per patient). The study found that nearly 70 per cent of the women reported physical and mental health problems during pregnancy, with 90 per cent reporting at least one traumatic event. PTSD was the most frequent diagnosis, followed by adjustment disorder, depressive disorder and anxiety disorder.[47]

41 Entringer et al., 2021.
42 Charité-Universitätsmedizin, 2017; Jesuthasan et al., 2018. The study also inquired about actions taken with regard to mental concerns. The most common response was to be passive in the form of isolation, for instance.
43 Kikhia et al., 2021.
44 Ibid.
45 Heslehurst et al., 2018; Malebranche et al, 2017; Correa-Velez and Ryan, 2012.
46 Manok et al., 2017; Nikendei et al., 2017.
47 Kaufman et al., 2021.

In response, a range of psychosocial and psychotherapeutic interventions were applied, depending on each woman's particular needs.[48] Furthermore, patients were referred to other care providers outside the PHV such as specialists, midwives, mother–child facilities, churches, as well as counselling and outreach centres (gendered cultural, social and material factors).[49]

## Mental health and refugee women in Uganda

In Uganda, health services for refugees mainly operate as first-line facilities or health centres in refugee settlements and camps and are implemented and organized under the supervision of the UNHCR. Specialized care for refugees with serious health concerns (including mental health provisions) is often provided by NGOs.[50]

During the COVID-19 pandemic, additional psychological services in the form of tele-psychosocial counselling have been provided through the Uganda Refugee Response Plan (RRP). According to UNHCR, there has been a drastic increase in attempted and completed suicides, with the majority of attempted suicides involving refugee women, accordingly linked to a rise in GBV. Indeed, the UNHCR found that physical assault was the most reported incident, followed by rape and psychological abuse.[51] The heightened mental health concerns of refugee women during the COVID-19 pandemic were also documented in refugee settlements. A UNHCR study in the Impevi and Rhino Camp refugee settlements found that the greatest sources of distress and suicidal ideation included GBV, limited access to basic needs, reduction in food and cash assistance, and limited support from parents or caregivers (gendered social, material, and personal factors).[52]

It is important to note that mental health concerns of refugee women were already pervasive before the COVID-19 pandemic, and not only in refugee settlements. As a qualitative study found, nearly three quarters of all interviewed self-settled Congolese refugee women met symptom criteria for PTSD, with more than half reporting depression and 65 per cent reporting thoughts of ending their life. These results highlight the need for mental health support for refugee women who are largely excluded from direct assistance since they do not reside within refugee settlements.[53]

Programmes and research by the Refugee Law Project (RLP) on Mental Health and Psychosocial Well-Being (MHPW) indicate that mental health concerns of refugee women prevail inside and outside of refugee settlements, as shown in the case study below.

[48] The most commonly applied interventions were trauma- or resource-orientated, followed by psychoeducational- and social counselling-orientated interventions and specific interventions, including crisis support and couples-consultations, brief consultations or phone-consultations and accompaniment to authorities.
[49] Kaufman et al., 2021.
[50] Orach and De Brouwere, 2005; Mwenyango and Palattiyil, 2019.
[51] UNHCR, 2020b.
[52] Ibid.
[53] Familiar et al., 2021.

### Mental health and psychosocial well-being programmes at Refugee Law Project

The mental health and psychosocial well-being (MHPW) programmes at the Refugee Law Project (RLP) provide refugees with mental health assistance such as individual, family and group counselling, as well as home visits. These activities are closely related to the RLP's refugee support groups, partners in the mental health field in Uganda, and the project's Gender and Sexuality Programme. The RLP is a community outreach project of the School of Law at Makerere University, and has been running since 1999. A key component of the project is research.[54]

As the RLP's 2014 qualitative study report on the psychosocial challenges faced by refugee women in Kampala highlights, intersectional experiences heighten mental health concerns. This includes refugee women with disabilities, who identified specific difficulties in accessing resources and services, and in sustaining their livelihoods (for instance, housing), as key gendered social and material factors in their mental health. A Congolese refugee woman shared: [55]

> *The landlords usually accept to take us in but after they realize that I have this [epileptic] child, they come up with indirect ways to chase me out of the house. I have lived in nine different houses over the last two years. When my child experiences an epileptic attack, all the neighbours gather around.*[56]

Discrimination and social isolation presented further common themes in the study report, as is exemplified in the recounting of Somali woman with a physical disability:

> *I can sit in the same spot from morning to evening without anyone caring to speak to me. This kills my spirits and my abilities as a person. … I do not eat food with the rest of the family as I am taken to be unpleasant. I have a lot of anger and sometimes I feel like I am developing a mental problem.*[57]

To address these mental health concerns of refugee women with disabilities, the RLP has recommended improving accessibility to offices and hospitals, reducing bureaucracy in accessing services, and addressing negative attitudes towards persons with disabilities, especially at community levels and among service providers.[58]

## Mental health and refugee women in Turkey

Turkey did not sign the 1967 Protocol to the Refugee Convention, which abolished the geographic limitation attached to the definition of "refugee" that had initially circumscribed the definition to only refugees from Europe. As a result, refugees in Turkey are still defined as European refugees. Persons seeking protection from outside of European countries are assessed under "conditional refugee status", and are provided temporary protection. While access to health services and resources is generally granted to those with temporary protection status, this access is restricted to the same city where temporary protection was registered ("satellite cities"). As such, health services and resources are mainly provided through primary health-care centres, tent hospitals, medical emergency stations and State hospitals.[59]

[54] Refugee Law Project, n.d.
[55] Refugee Law Project, 2014.
[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Özvaris et al., 2020.

During the COVID-19 pandemic, access to health services and resources has become more restricted in that even in satellite cities, health insurance had to be purchased, due to changes in regulations (January 2020).[60] According to a report by the Regional Refugee and Resilience Plan, refugee women have experienced increased stress and conflict within the household during the pandemic (gendered personal factors).[61]

These regulations and legal definitions affect refugees of different genders differently, having especially consequences for women living outside of camps where some health provisions do not apply (before and during COVID-19). For instance, a community-based survey on Syrian refugee women's health in Sanliurfa found that nearly 90 per cent of women reported at least two mental health symptoms.[62] Relatedly, a study on Syrian refugee women in Konya indicated that women had higher hopelessness and lower social support levels than refugee men.[63] Qualitative inquiries further show that insecurity and stigma about mental health hinder usage of services, even where it is accessible (gendered cultural factors).[64] UN-Women reported that amongst Syrian refugee women less than 20 per cent access mental health services, while more than half are not aware of their existence. Those who are completely unaware of such services live mostly in Istanbul and Gaziantep, with the latter showing remarkably low access rates.[65]

While these data demonstrate that psychosocial services need to be improved all around, in cities such as Gaziantep near the Syrian border this need is particularly pressing, as exemplified in the case study of the Women's Committee of the Future.

### Women's Committee of the Future at the Women's Empowerment and Solidarity Centre

In response to the lack of a forum for Syrian refugee women to discuss their challenges and needs, the Association for Solidarity with Asylum Seekers and Migrants (ASAM) began hosting weekly tea hours in 2015. Syrian women used the tea hour to share their challenges with each other and a female psychologist from ASAM (gendered cultural factors). In 2016, the women decided to establish the Women's Committee of the Future, a committee that has since grown in membership and scope.

Members of the network (50 in 2019) serve each other as a support group, engage in volunteer work to increase Syrian refugees' access to mental health services, and enhance their own protection through advocacy, rights education and community-based campaigns. As one Committee member shared (gendered personal factors): [66]

> *Most of us on the committee are victims of early marriage. So it is both a community issue and a personal issue as well for us. Knowing about the negative impact of early marriage in our lives helped us a lot in leading awareness-raising campaigns against early marriage. We succeeded on many occasions in preventing such acts from happening.*[67]

This connection between intersectional experiences, community efforts and advocacy campaigns forms a unique aspect of the committee. Indeed, committee members participated in the preparatory event for the first Global Refugee Forum in 2018. Speaking about this event, and the importance of community and advocacy, one committee member noted: "We continue believing that 'if a blow does not bring you down, it will strengthen you'. That is why we came together".[68]

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60 Özvaris et al., 2020. Family health centres and migrant health centres (MHC), however, have continued to provide primary health-care services free of charge, irrespective of the legal status of migrants.
61 3RP, 2020.
62 Şimşek et al., 2018.
63 Çankaya et al., 2018.
64 Salami et al., 2019.
65 UN-Women, 2018.
66 UNHCR, 2017.
67 Ibid.
68 UN-Women, 2019.

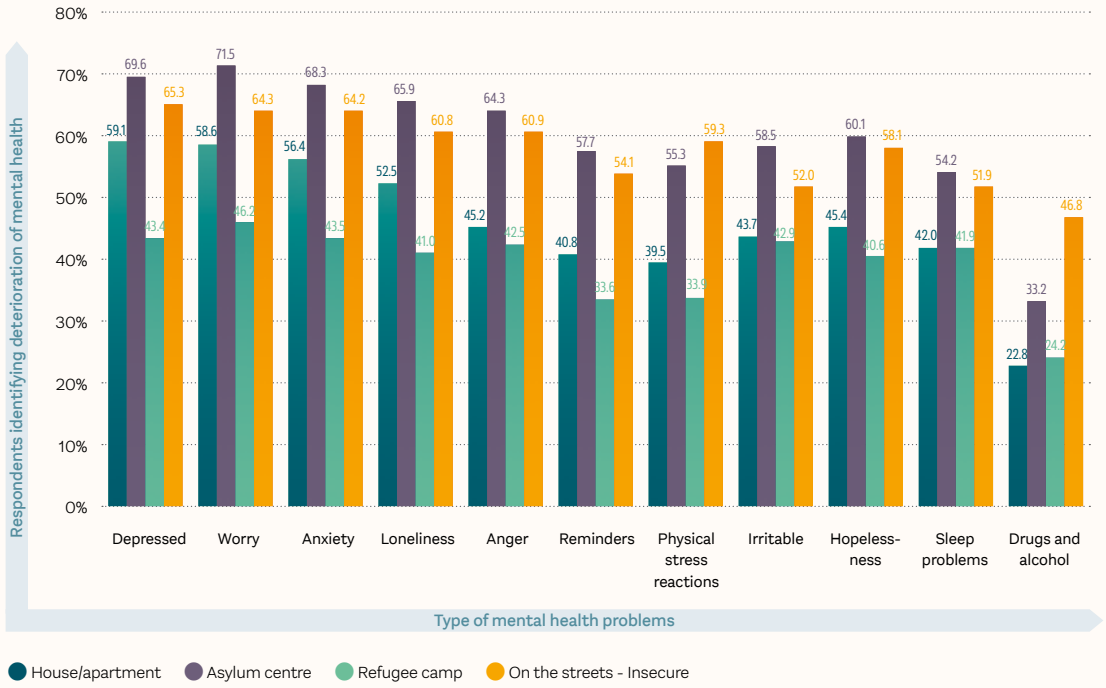
## Conclusion

With research on COVID-19's gendered implications for migrants still emerging, this regional comparative case study analysis on lived experiences and practices in the field (Brazil, Germany, Turkey, and Uganda) points to several implications that ought to be considered to provide a more comprehensive understanding of refugee women's mental health during the pandemic and beyond. As demonstrated throughout my analysis, gendered factors in refugee mental health (cultural, social and material, personal) operate across intersectional dimensions and deserve further and more targeted attention in migration research and policy.

Studies on refugee women's mental health during the pandemic and beyond must be broadly situated within existing literature that speaks to gendered factors in refugee mental health along the migration continuum, rather than solely focusing on pre-displacement. The mental health of refugee women is shaped by compounded stressors along this continuum, and requires intersectional inquiries into the various gendered factors that inform the women's experiences. Indeed, while broader patterns of factors informing the mental health of refugees provide an important framework for analysis, specific attention needs to be paid to intersectional dimensions as demonstrated in the case studies. An intersectional approach to refugee women's mental health research allows for specific measures to be developed in order to address mental health concerns in a direct and responsive manner.

Refugee women's mental health during the pandemic and beyond needs to be included in national health systems and national COVID-19 response plans. Restricted access to health resources and services severely hinders proper treatment of mental health concerns and furthers already existing stigmatization around mental health. Intersectional policy analyses, as provided in this paper, are needed to capture mental health needs and challenges along the migration continuum. These can then translate into targeted action. This can include offering gender-sensitive and gender-responsive community programmes on mental health, as well as awareness and advocacy campaigns around mental health that speak to the identified gendered factors in refugee mental health.

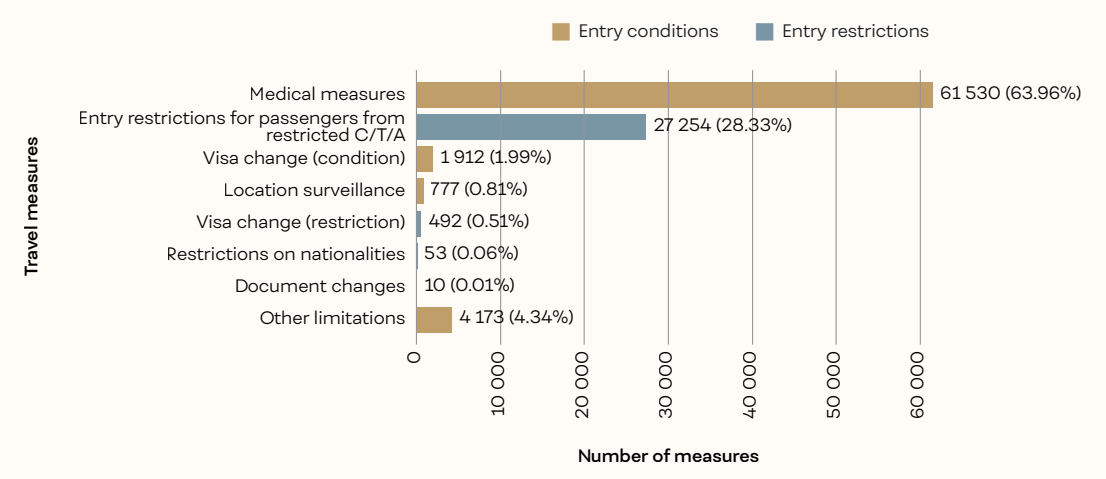
## Appendix 1. Global self-reported mental health impact of COVID-19 by refugees and migrants




*Note*: number of respondents for each issue: 15 278 depressed, 15 483 worry, 15 291 anxiety, 14 730 loneliness, 13 340 anger, 13 454 reminders, 12 344 physical stress reactions, 13 343 irritable, 13 314 hopelessness, 13 232 sleep problems, 8915 drugs and alcohol (survey question used this term); number of participants differed by housing situation, e.g. for depression the numbers responding were 13 562 for house/apartment, 359 for asylum centre, 1190 for refugee camp, 167 for on the streets or in insecure accommodation

*Source:* WHO, 2020.

## Appendix 2. Entry conditions and restrictions across the world




*Source:* WHO, 2021.

## Appendix 3. Comparative gender gaps in refugee employment

| Host Country | Employment rates | | | | Hourly earnings | | | | Pay gap *** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Female | | Male | | Refugee men & refugee women | Host women & refugee women |
| | Host | Refugee | Host | Refugee | Host | Refugee | Host | Refugee | | |
| Turkey | 29 | 7.7 | 65.6 | 51.2 | 12.38** | 0.78* | 12.57** | 0.84* | 0.07 | 0.94 |
| Uganda | 65.7 | 36.9 | 74 | 46.6 | 1.21** | 0.24 | 1.89** | 0.31 | 0.23 | 0.80 |
| Lebanon | 21.2 | 6 | 67.4 | 47 | 2.71** | 1.53 | 2.96** | 1.84 | 0.17 | 0.44 |
| Germany | 53.5 | 6 | 63.8 | 27 | 17.09 | 10.67* | 21.60 | 12.92* | 0.17 | 0.38 |
| Jordan | 10.9 | 6 | 55.4 | 36 | 4.35** | 1.10 | 4.97** | 1.77 | 0.38 | 0.75 |
| USA | 53.9 | 40.2 | 65.4 | 73.5 | 13.56 | 10.80 | 15.20 | 12.20 | 0.11 | 0.20 |

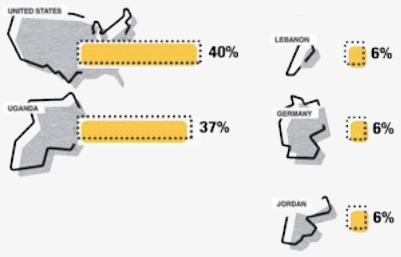
*Sources: Sources specified for each column and country in Annex table 2.*

*Notes: * Indicates gender-disaggregated wages unavailable. To calculate these values, we use the overall average wages of refugees and assume the gender gap for host country workers applies to refugees. [x + a(y)]/2=b, where x and y are the gender disaggregated wages, a is the gender gap, and b is the average wage.*

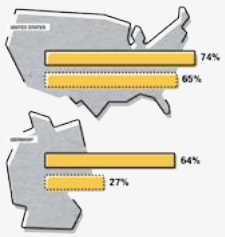
*** Only monthly wage rates available; hourly estimated assuming 40-hour week and 4-week month (details in Annex tables 2 and 3).*

**** The pay gap is calculated as [(x – y)/x], where x is either refugee-men earnings or host-women earnings, and y is refugee-women earnings. In the case of Turkey, for example, for every dollar earned by a refugee man, the gender pay gap is 7 cents for refugee women.*

**Among refugee women, we see the highest employment rates in the U.S. (40 percent) and Uganda (37 percent), to a low in Germany, Jordan and Lebanon (6 percent in each country).**




**Among refugee men, outliers are the U.S., where employment rates are higher than for host country men (74 versus 65 percent, respectively)[12], and Germany, with a low of 27 percent (compared to 64 percent among host country men).**




**Refugees' hourly pay ranged from $0.27 (Uganda) to $12.20 (Germany). For refugee men, pay ranged from $0.31 (Uganda) to $12.92 (Germany); for refugee women, from $0.24 (Uganda) to $10.80 (U.S.)**


*Source:* Kabir and Klugman, 2019.

## Appendix 4. Sexual and gender-based violence in European asylum reception facilities

| Causes of reported SGBV | Residents | | | Professionals | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Female *N* (%) | Male *N* (%) | *p* | Female *N* (%) | Male *N* (%) | *p* | Resid *N* (%) | Profs *N* (%) | *p* |
| Coping (frustration & stress management) | 14 (8.7) | 24 (14.9) | 0.709 | 30 (22.6) | 20 (15.0) | 0.369 | 38 (23.6) | 50 (37.6) | **0.008** |
| Different cultural/ethnic backgrounds & practices | 15 (9.3) | 16 (9.9) | 0.310 | 14 (10.5) | 13 (9.8) | 0.831 | 31 (19.3) | 27 (20.3) | 0.884 |
| Communication problem | 8 (5.0) | 8 (5.0) | 0.426 | 8 (6.0) | 7 (5.3) | 1.000 | 16 (9.9) | 15 (11.3) | 0.849 |
| Asylum procedure related | 5 (3.1) | 17 (10.6) | 0.102 | 1 (0.8) | 4 (3.0) | 0.179 | 22 (13.7) | 5 (3.8) | **0.004** |
| Bad accommodation | 8 (5.0) | 6 (3.7) | 0.252 | 5 (3.8) | 1 (0.8) | 0.218 | 14 (8.7) | 6 (4.5) | 0.170 |
| Multifactorial | 1 (0.6) | 8 (5.0) | 0.088 | 4 (3.0) | 5 (3.8) | 0.732 | 9 (5.6) | 9 (6.8) | 0.808 |
| Competence staff | 0 (0.0) | 9 (5.6) | **0.012** | 7 (5.3) | 5 (3.8) | 0.774 | 9 (5.6) | 12 (9.0) | 0.363 |
| Alcohol Abuse | 1 (0.6) | 1 (0.6) | 1.000 | 2 (1.5) | 5 (3.8) | 0.246 | 2 (1.2) | 7 (5.3) | 0.084 |
| Food | 3 (1.9) | 4 (2.5) | 1.000 | 0 (0.0) | 0 (0.0) | – | 7 (4.3) | 0 (0.0) | **0.017** |
| I don't know | 7 (4.3) | 3 (1.9) | 0.053 | 0 (0.0) | 0 (0.0) | – | 10 (6.2) | 0 (0.0) | **0.002** |
| Others | 2 (1.2) | 1 (0.6) | 0.563 | 1 (0.8) | 1 (0.8) | 1.000 | 3 (1.9) | 2 (1.5) | 1.000 |
| Missing | – | – | – | – | – | – | 214 | 54 | – |
| TOTAL | 64 (39.8) | 97 (60.2) | **0.013** | 72 (54.1) | 61 (45.9) | 0.501 | 375 (66.7) | 187 (33.3) | **0.000** |

Bolded significant *p*-value < 0.05

*Source:* Oliveira et al., 2018.

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# 10. INCREASED VULNERABILITY TO HUMAN TRAFFICKING OF MIGRANTS DURING THE COVID-19 PANDEMIC IN THE IGAD–NORTH AFRICA REGION

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## Introduction

The Intergovernmental Authority on Development (IGAD)[1] and North Africa regions[2] are transit regions for northbound migration, but also experience high rates of intraregional mobility encouraged by regional economic blocs and designed to facilitate economic integration and free movement across borders.[3] Intersecting crises, like the current conflict in Tigray and the coup in the Sudan, further fuel ongoing large-scale displacement and migration. Between them, the Sudan and Ethiopia alone host 2 million refugees and 7.1 million internally displaced persons (IDPs).[4] Migrants in this region are known to be particularly vulnerable to human trafficking, especially those travelling across the Sahara and into Libya via the Central Mediterranean Route.[5] Prior to the COVID-19 pandemic, it was estimated that human trafficking was more prevalent in this area than elsewhere in the world. Estimates from IOM surveys in 2016 indicated that 73 per cent of migrants along the central Mediterranean route experienced human trafficking or a form of exploitation.[6]

This paper employs a gender-responsive lens to explore the ways in which the COVID-19 pandemic has impacted the risk of human trafficking and migrants' experiences of human trafficking in the IGAD–North Africa region. Findings are based on an extensive review of evidence and a series of interviews held with stakeholders, completed in 2021. A first round of interviews was held with 22 stakeholders working in government, criminal justice, migration governance and humanitarian organizations in March–April, exploring the impact of COVID-19 on human trafficking in and through the Sudan. Analysis of these interviews suggested that (a) the gendered dimension required further analysis, and (b) a regional approach was needed. Thus, a further round of targeted interviews was held in September 2021 with 12 additional stakeholders in Libya, Tunisia, Ethiopia, and the Sudan to elicit further information on the gendered impacts of COVID-19 on migrants.

1 IGAD includes Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, the Sudan and Uganda.
2 Chiefly here we refer to the Common Market for Eastern and Southern Africa (COMESA), which has stated its desire to eliminate visas and open borders; see COMESA, 2018.
3 McAuliffe and Kitimbo, 2018; IGAD, 2020.
4 UNHCR, 2021a, 2021b; IOM, 2021a, 2021b.
5 UNHCR, 2020a.
6 IOM, 2017.

### The definition of human trafficking

In international law, human trafficking is defined in the 2000 Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, on the basis of three cumulative elements:

1. **An act**: "… the recruitment, transportation, transfer, harbouring or receipt of persons";
2. **A means**: "… by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person";
3. **The purpose of exploitation**: "Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs".

Only the act and the purpose of exploitation are required as elements of trafficking in cases of the trafficking of children.

Our analysis indicates that the pandemic exacerbated vulnerabilities to human trafficking across migrant populations, but with particularly severe effects for displaced persons. Intersecting factors – namely migratory status, gender and livelihood strategy – increased vulnerability to trafficking and exploitation of individuals. Migratory status already restricts livelihood options. The pandemic further negatively impacted common livelihood strategies and led to increasingly restrictive (and hostile) border regimes. The combination of reduced incomes and limited legal migration routes encouraged riskier and more hidden migration pathways. These entailed increased risk of trafficking and sexual or gender-based violence. In turn, the pandemic-induced reductions in institutional presence – such as police, schools and health care – reduced opportunities for victim identification and limited survivor care.[7] Implications for policy and practice to address the risk of human trafficking and exploitation for migrants and migrating populations are proposed in the concluding section.

## Research methods and approach

This paper is based on two strands of qualitative research to understand the gendered impacts of the pandemic on the risk of human trafficking and on people's vulnerability to human trafficking, focusing on migrating populations.[8] The first strand explored the impacts of COVID-19 on human trafficking in the Sudan (February to May 2021), combining a systematic review of existing and emerging evidence with 22 in-depth semi-structured interviews.[9] The systematic review mapped the current state of knowledge, compiling and analysing relevant literature, as well as relevant legal, regulatory and policy standards. Due to the recent and rapidly changing nature of the COVID-19 situation, newspaper articles and other forms of popular media were also included. A total of 94 pieces of evidence were selected for inclusion and thematically coded. Evidence reviewed was limited to that published in English from 2018 to 2021 and accessible online.

[7] Within the text of the paper, victim is used to refer to someone still experiencing human trafficking while survivor is used to refer to people who have exited human trafficking. The exception is in the use of first-person quotes where victim of trafficking and survivor of trafficking are being used interchangeably.

[8] Gender refers to the "socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to people based on their assigned sex." It is important to emphasize that gender is not used interchangeably with "women", but rather the concept refers to women, men and other gender groups, and the often unequal relations between them. See IOM, 2019, citing UN-Women, 2014).

[9] Rights Lab, 2021.

Building on this initial research, a further targeted evidence review and 12 additional interviews were conducted with stakeholders working in migration and women's rights within Libya, Tunisia, and the Sudan (September 2021). This supplementary research focused specifically on impacts on migrants and migrating populations, and the role of gender in shaping vulnerabilities and risk in the pandemic world.

Together, interviewees represented organizations working on issues of gender, migration, and governance across the IGAD and North Africa region, including Better Migration Management (BMM), Danish Refugee Council, the German Society for International Cooperation (GIZ), Global Partners Governance (GPG), Iteru, Midanik, the Mixed Migration Centre (MMC), Office of the United Nations High Commissioner for Human Rights (OHCHR), United Nations Children's Fund (UNICEF), Salmmah Women's Resource Centre, The Refugee Law Initiative and the University of Addis Ababa. Interviews lasted between 45 minutes and two hours, and were held via video conferencing software due to the pandemic. All interviews were recorded, transcribed, and thematically coded.

Additionally, in response to data requests, the Mixed Migration Centre provided specific analysis of survey data collected in Tunisia and the Sudan. This is referenced to support findings. The data and analysis are drawn from 370 interviews with refugees and migrants in the Sudan and 2,523 interviews with refugees and migrants in Tunisia undertaken by the centre in the context of its Mixed Migration Monitoring Mechanism Initiative (4Mi), conducted between 2020 and 2021.[10]

## Increased risk along migration routes

On 14 February 2020, the first case of COVID-19 was identified in Africa (specifically, in Egypt).[11] Cases were quickly identified elsewhere, precipitating implementation of COVID-19 restrictions including bans on public gathering and widespread school and border closures.[12] This had a number of effects on migrants, limiting possible transportation options, increasing security at borders,[13] and restricting access to "regular migration" (including through reduced access to visas, reductions in the number of flights, and halted refugee processing).[14] Simultaneously, migration aspirations increased, driven by socioeconomic deterioration and violent conflict.[15]

The combined reductions in income and limited access to transport encouraged the use of smugglers to circumnavigate border restrictions,[16] with implications for the risk of human trafficking and exploitation.[17] As one interviewee put it, under COVID-19 the available legal routes for movement were very limited: "the only option is different forms of fake visas … or to go through irregular or illegal routes using smugglers and traffickers."[18] This shift towards irregular routes was evidenced after the Sudan closed its borders in March 2020 to agricultural workers entering from Ethiopia. Seasonal agricultural workers from Ethiopia were initially prevented from entering the Sudan by the Ministry of Health. Dependent on their incomes and access to work, this group of (predominately) men found less populated border crossings, using more dangerous irregular routes with the help of facilitators (smugglers).[19] An interviewee from GIZ described the ways in which the COVID-19 restrictions in particular impacted the ability of this population to move, with implications for trafficking:

[10] MMC, 2021a, 2021b.
[11] BBC, 2021.
[12] IMREF, 2020; MMC 2021b.
[13] Interview with representative from the University of Addis Abada, 2021.
[14] UNODC, 2021a.
[15] Ibid.
[16] Ibid.
[17] Schofberger and Rango, 2020; Sanchez and Achilli, 2020.
[18] Interview with representative from the Forum for Social Studies, Addis Abada, 2021.
[19] Comparatively, Italy relies on 370,000 migrant workers, and Canada 60,000. See IOM, 2020.

> *Every year there are hundreds of thousands who cross into Sudan to work in the agricultural sector in El Ghadaref. Seasonal labourers play a critical role in agricultural production on the Sudanese side. Sudan cannot afford to close the border. There is no alternative to Ethiopian labourers, so they had to find a way of letting these people in to Sudan, while ensuring like, full compliance with COVID-19 related safety measures. … What is at stake here is also a major food security issue, because if there is no production, as you know on the Sudanese side which is very fragile … so there are definitely more people who have crossed than in previous years irregularly. Which comes along with the vulnerabilities which are associated with crossing into a country irregularly, at human trafficking level.*[20]

As this indicates, travelling as an "irregular" migrant along these more hidden routes and the nature of engaging a smuggler to facilitate "irregular" movement increases the risk of human trafficking and exploitation.[21] Why?

First, although smugglers are to be differentiated from traffickers, smugglers often abuse migrants, through violence or even exploitation, and can thus easily turn into traffickers.[22] As a representative of the Office of the United Nations High Commissioner for Refugees (UNHCR) stated, "we cannot deny it … individuals, migrants, or persons of concern who use the help of smugglers to move from one country to another, they become the victim of trafficking."[23]

Second, travelling on irregular routes through ungoverned areas – areas virtually void of national or international law[24] – in order to avoid identification increases the exposure to dangers, including to targeting by traffickers.[25]

Third, the need to stay invisible has further implications for victim identification: migrants are unlikely to seek help from authorities given their irregular migration status. Traffickers leverage this power to maintain control, allowing them to act without police reprisal. An interviewee working for OCHCR summarized: "… you never go to the police if you have an issue. If you are a victim of a crime, we would not turn to the police or to the State because you risk being arrested because of the law criminalizing irregular, illegal migration."[26]

Fourth, the difficulties in travel caused by border closures and other limitations on movement led to longer routes, increasing the length of individual journeys and the period of engagement with smugglers and traffickers. Prolonged journeys and longer periods of engagement with smugglers or traffickers are known to increase the risk of exploitation, as well as the number of deaths and disappearances.[27]

Interviewees cited several other examples of COVID-19 restrictions impacting the mobility of individuals and groups in the region, encouraging use of irregular routes and simultaneously increasing the risk of trafficking. These included migrants who, according to interviewees, had been "forcibly expelled" from Libya and abandoned at the Libyan border,[28] Ethiopian women trapped

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[20] Interview with representative from German Society for International Cooperation (GIZ), 2021.
[21] Sanchez and Achilli, 2020.
[22] See Appendix A for discussion of distinction between smuggling and trafficking.
[23] Interview with representative from UNHCR, 2021.
[24] For a further discussion of the governance structure in this geography, see Kuschminder and Triandafyllidou, (2020), which explores southeast Libya, which is governed by different and competing tribal regimes.
[25] UNHCR, 2021c.
[26] Interview with representative from OHCHR, Libya, 2021.
[27] Sanchez and Achilli, 2020:6.
[28] Interview with representative from UNHCR, 2021.

in the Middle East after their domestic work evaporated and with it their housing,[29] and women with domestic contracts for work in the Middle East travelling "irregularly" and abandoned in the Khartoum airport when restrictions suddenly went into effect.[30] As the UNHCR representative noted, these groups had no legal option to "go back or move forward, because of border restrictions and closure of the airport",[31] leaving them dependent on alternative (irregular) modes with associated dangers.

Initially, COVID-19 also contributed to prolonged periods of time spent in refugee camps and immigration detention settings. UNHCR initially stopped formal processing of applications for resettlement (May–June of 2020), and relocations of refugees were slowed or halted.[32] Elsewhere, migrants were unable to disembark from transit vehicles, leaving them trapped at sea.[33] In both cases, this extended the period of displacement and detention.[34] According to UNODC, individuals are "stuck in precarious conditions in camps or shelters or on the streets. These individuals are likely to try and continue their journeys, which may create a surge in demand for migrant smuggling services as some borders reopen", with associated risk of trafficking.[35]

The increased duration of detention that resulted from government COVID-19 policies increased the risk of exploitation and violence. This was particularly true in Libya, a State where ongoing conflict problematizes oversight and impacts governmental capacity. Interviewees in Libya described the impact that the security situation had on the ability of the State or civil society organizations to protect survivors, once identified. In addition to the dangers noted above, interviewees spoke of alleged detention centre raids by militias or security forces.[36] Women and underage girls were targeted: "we've seen groups … forcing their way into detention centres and abducting the women." The interviewee went on:

> *We had a group of women who had been victims of trafficking and who had spent some two years in Beni Walid in the hands of traffickers. That's a major trafficking hub. Eventually they were released from the hands of traffickers, but the response of the authorities was to send them to a detention centre, even if officially that centre was called the Centre for the Vulnerable. And they were also wanted by the authorities in relation to a criminal investigation into trafficking, they were witnesses. They were Somali girls … underage, [who] ended up in a detention centre under the Department for Combating Illegal Migration … where they were repeatedly raped by, by the guards. In detention centres where you don't have women guards and I think it exemplifies everything that's wrong in with the systems and the laws in Libya. The fact that victims of trafficking might end up in a detention centre simply because they are still considered by the authorities … as illegal migrants. The fact [is] that they there's no comprehensive framework for victims of trafficking. You're released from the hands of your traffickers, and you end up in a detention centre where you are still at risk.*

[29] Henry, 2021.
[30] Interview with representative from GIZ, 2021.
[31] Interview with representative from UNHCR, 2021.
[32] Migration Data Portal, 2021.
[33] Ibid.
[34] UNODC, 2021a.
[35] Interview with representative from University of Addis Ababa, 2021; UNODC, 2021a.
[36] See coverage from *The Guardian* for further similar examples of dangers to migrants in Libyan detention. For instance, www.theguardian.com/global-development/2021/oct/08/reports-of-violence-libya-arrests-5000-migrants.

Both the duration of detention and the lack of adequate victim care were impacted by COVID-19, prolonging the period of detention and thereby increasing the risks faced by migrants. This example demonstrates the intersecting vulnerabilities faced by certain individuals: in this case, both the lack of survivor services and an adequate framework for victims of trafficking increased the risk of further exploitation for migrant women caught up in a system of immigrant detention.

Smugglers and traffickers also raised costs for migration facilitation during the pandemic.[37] As one interviewee summarized, "what I've noticed … when things get tough to cross the border then the costs also get higher."[38] To extract payment, traffickers are known to kidnap migrants and hold them hostage, or use debt bondage.[39] The form of exploitation is often gendered, and women are more likely to experience sexual exploitation.[40] A UNICEF official described the impact on cost for one woman: in exchange for moving her across the Sudan to Khartoum, a trip which took something like ten nights, the trafficker forced her into commercial sexual exploitation in each of the places he hid her to "recoup" his costs.[41] Diasporic networks were also asked to pay more for the release of their peers through ransom payments:

> *Either people can leave if they pay money for smugglers to get them to Libya and then onwards, or if they don't have money, they'd need to earn it en route or … through family means. … [Y]ou know extended families to transfer some … no one in the camps has much money. They may have some wealthier family elsewhere, or you know, in diaspora.*[42]

Working to pay smugglers for transit is known to increase the likelihood of trafficking, highlighting the risk created by COVID-19 restrictions.[43]

In sum, the use of smugglers, reliance on alternative migratory routes, and prolonged processing times increased for migrants the risk of exploitation and human trafficking. The gendered nature of these processes resulted from differences in industry distribution and form of exploitation. In general, migratory routes and access to visas are gendered by the migrants' livelihood strategy. Women in this region are more likely to work as domestic workers or caregivers, while male migrants are more likely to travel to work in the informal agricultural sector, security, or construction.[44] Both domestic workers and agricultural labourers often rely on tourist, temporary, or sponsored work permits.[45] COVID-induced restrictions temporarily altered these normal flows, causing increases in irregular movement with impacts on both the location and the type of exploitation experienced.

[37] UNODC, 2021a.
[38] Interview with representative from University of Addis Ababa, 2021.
[39] Interview with representative from The Regional Operations Centre in Support of the Khartoum Process (The ROCK), 2021; UNODC, 2021a.
[40] Interview with gender consultant from OHCHR, 2021.
[41] Interview with officiant from UNICEF, 2021.
[42] Interview with representative from the Danish Refugee Council (DRC), 2021.
[43] Interview with representative from the Mixed Migration Centre (MMC), 2021; UNODC, 2021b.
[44] Gezahegne, 2020.
[45] Ibid.

> *I don't think there's been sort of high levels of fear or anxiety from COVID itself in … the camps that we've worked in. … I think it just contributes to the economic deprivation of that situation and … more limited, you know, labour or livelihood prospects and people feeling forced to … seek their basic needs being met elsewhere in the world.*[46]

The pandemic has restricted options for regular migration while encouraging migration, in many cases by negatively impacting socioeconomic conditions. Restrictions on freedom of movement, the closure of workplaces, and migrants' overrepresentation in particularly hard-hit industries increased economic precarity for migrants, and with it the risk of exploitation. This was exacerbated where migrants lacked access to work permits.[47] Initially, for instance, in Libya, 90 per cent of migrants who relied on day labour experienced difficulty finding work.[48] In Tunisia, around half of the total migrant populations surveyed reported COVID had reduced access to work, and 38 per cent in the Sudan reported loss of employment income.[49]

These effects have been acutely felt in the informal economy. Informal employment is common in the IGAD–North Africa region. The ILO estimates that 67.3 per cent and 91.6 per cent of workers are employed in the informal sector in Eastern and sub-Saharan Africa respectively.[50] Migrants – in particular refugees and especially those in camp situations – are disproportionately represented in informal work, and frequently rely on informal day labour.[51] In States like the Sudan where refugees cannot hold legal employment, they rely on informal or day labour to support themselves. In cities like Khartoum, migrants frequently work in poorly regulated industries including hospitality, domestic work, and the service sector.[52] Within camps, the forms of employment available are further limited due to the encampment policy and further restrictions on mobility:[53] In general, refugees in camps work within the camp or immediate surroundings in income-generating activities like laundry, markets, construction, or agriculture.[54]

When the informal sector was hit by pandemic restrictions, many refugee and migrant households lost all household income. MMC reports indicate that, within the Sudan, "most informal and service sector jobs had vanished" by March, leaving many refugees and migrants without income.[55] These impacts were gendered, with disproportionate impacts on activities where women were more likely to work. Women who work in the informal sector in the public sphere – such as tea sellers and those with market stalls – were heavily affected by lockdown restrictions on public gatherings, preventing them from working. COVID-19 also impacted the demand for labourers in service industry roles reliant on expendable income, like laundry, another female dominated area.[56] For male refugees and migrants, the primary industries differed. In addition to seasonal agriculture, construction work was negatively impacted. The pandemic impacted growth, slowing investment and with it the need for labourers. This reduced available work for men, and with it, their incomes.[57]

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46 Interview with director-level representative from a non-profit refugee service, 2021.
47 OCHCR, 2020b.
48 OHCHR, 2021.
49 MMC, 2021a, 2021b.
50 ILO, 2018.
51 Interview with representative from GIZ, 2021.
52 Interview with United Nations gender consultant, Libya, 2021.
53 Interview with representative from DRC, 2021.
54 Ibid.
55 MMC, 2021b.
56 Interview with representative from DRC, 2021.
57 Ibid.

Interviewees noted that in addition to the impacts of COVID-19 on the informal sector and agricultural labour, domestic workers were severely impacted by both job loss and increases in exploitation. Migrant domestic workers are heavily concentrated in urban areas like Khartoum or Tripoli, where they live in private homes. Social distancing regulations restricted their mobility to their employers' homes, as one interviewee describes:

> *[Domestic workers] were already more, quite vulnerable, in terms of human exploitation. When it comes to human exploitation, the crisis has made the level of vulnerability more acute, due to worsening of the isolation, and disconnection from the rest of the community … the impossibility to move freely.*[58]

Increased social isolation and a lack of support was believed to have contributed to an increase in abuse and exploitation. In addition, COVID-19 response measures limited their ability to seek safety or assistance and contributed to an underreporting of abuse resulting from restrictions.

Overall, Mixed Migration Centre data suggest that losses in labour opportunities led to concurrent increases in risk of labour and sexual exploitation.[59] More than 50 per cent of migrants in North Africa reported increased risk of labour exploitation due to COVID.[60] Sixty per cent of migrants surveyed in Khartoum had lost their income, and women were more likely to report increased risk of labour exploitation (59%) and sexual exploitation (53%) because of the pandemic. Women in Libya, Tunisia, and the Sudan reported that COVID increased the risk of labour and sexual exploitation.[61] Again, this has impacts for migrants working to pay their smuggler fees. Many migrants engage in day labour during their travel to pay back costs; as noted, migrants who work to pay off the cost are more at risk of exploitation and trafficking than those who pay in advance.[62]

## Impact of COVID-19 on survivor care and institutions

COVID-19 also contributed to the reduction in and suspension of existing forms of victim identification and survivor support. This had particularly severe consequences in places with already limited care and assistance infrastructure for survivors of trafficking. These impacts interacted with structural factors shaping experiences of support along gendered lines.

The pandemic reduced institutional presence and capacity, affecting both identification of trafficking victims and access to services. Organizations and institutions that consistently interact with populations and are thus more likely to recognize signs of exploitation or abuse – such as schools – were closed.[63] In the Sudan, where survivor care and support are limited, provision was further reduced during the pandemic with the closure of safe houses.[64] Interviewees indicated that at the start of the pandemic there were no publicly funded safe houses for survivors due to negative gendered preconceptions about "independent women" (women without a present guardian), as they are perceived to "encourage broken homes."[65] A small number of safe houses or shelters existed, administered by non-governmental entities. However, due to a failure (or inability) to meet COVID-19 health requirements, at least one of those safe houses was closed.[66]

58 Interview with representative from a multi-state anti-trafficking organization, North Africa/Horn of Africa, 2021.
59 MMC, 2021a.
60 OHCHR, 2021.
61 MMC, 2021a; OHCHR, 2021.
62 IMREF, 2020.
63 UNODC, 2021c.
64 Interview with representative from The Rock, 2021.
65 Interview with former director of a women's organization in Khartoum, 2021.
66 Interview with representative from The Rock, 2021.

Survivors – all women – were immediately released from the safe house without appropriate supportive infrastructure, exposing them to the risk of re-trafficking or, for undocumented women, deportation.

COVID-19 also altered the nature of services available to victims of trafficking, prolonging wait times and access to forms of care. Entities positioned to identify populations of concern and to provide services to victims – for instance, the International Planned Parenthood Federation and UNHCR – closed their doors to in-person services. Services were provided via a hotline instead.[67] A UNHCR interviewee flagged that this slowed service delivery, increasing the wait time for services to persons of concern. Elsewhere, slowed processing of asylum claims lengthened the period of uncertainty and time spent without legal status.[68] These temporal interruptions again encouraged legal precariousness, encouraging reliance on informal work (for which possible options were reduced) and increasing the likelihood of exploitation.

Multiple interviewees raised concerns about the impacts of COVID-related reductions in international aid budgets on support services addressing vulnerability to exploitation. Initially, at least, money was redirected from humanitarian projects to COVID-related health needs. As a camp director underscored, these cuts came at a time of reductions in aid more broadly from States: "it also happened at a time where you know multiple governments for different political reasons were reducing their global aid budgets".[69] The reductions in aid further reduced the resources that supported populations of concern, such as refugees in camp settings. This encouraged outward migration and increased the likelihood that a refugee would choose to move with the help of a smuggler via an irregular route, given pandemic restrictions.

Finally, criminal justice presence and policing was halted in many areas out of a concern over the threat of COVID-19.[70] This had immediate short-term consequences for victim identification and for the criminal prosecution of traffickers. Within the Sudan and Libya, most courts were temporarily closed in early 2020, reducing the processing of trafficking cases. Police were also informally told not to conduct operational activity in the Sudan due to social distancing.[71] A severe lack of protective equipment for the police led to the cessation of operational work.[72] The lack of policing contributed to missed opportunities to identify cases of exploitation and to connect identified survivors with care.

[67] Interview with representative from UNHCR, 2021.
[68] MMC, 2021a.
[69] Interview with representative from DRC, 2021.
[70] Interview with representative from The Rock, 2021.
[71] Ibid.
[72] Ibid.

## Conclusions

The COVID-19 pandemic has evidenced intersecting impacts at multiple levels that increase the risk of human trafficking for migrants within the IGAD–North Africa region. COVID-19 has contributed to acute economic vulnerability, increasing migration aspirations while simultaneously limiting mobility by closing borders and slowing visa application or processing. This has had multiple ramifications for individual safety, exacerbating the existing risk of exploitation, including the risk of trafficking.

The lack of opportunities for individuals to access legal temporary or seasonal labour visas, international protection, or refugee resettlement is driving reliance on smugglers and traffickers. While this was the case before the pandemic, the pandemic has shown that drastic border closures are not stopping migration but rather fuelling the use of irregular migration routes and increasing migrants' risk of experiencing trafficking. More than ever, this echoes the need for enhancing the availability and flexibility of pathways for regular migration.[73]

The pandemic and its economic impacts have also highlighted the centrality of addressing and reducing migrants' vulnerabilities, including in a gender-responsive manner when those may relate to gender identities.[74] The risk of exploitation and trafficking faced by migrants, refugees, and other displaced persons are distributed unequally. Those with existing vulnerabilities were more likely targets. Those with intersecting identities associated with increased vulnerability face compounding risk. For instance, migrants without legal status working in day labour and the informal sector were vulnerable to livelihood loss and had limited access to alternative forms of formal labour. The impacts of pandemic restrictions further exacerbated those existing precarities. Gender played a role in determining vulnerability, shaping the sectoral distribution and the form of exploitation. Women were overrepresented in informal work and therefore more likely to have lost their income, resulting in increased risk of targeted exploitation. Other industries or sectors with large impacts and particular gendered labour distribution included seasonal agricultural and construction workers (who are largely male) and domestic workers (predominantly women).

Finally, the pandemic has highlighted the importance of support organizations and the need for victim-oriented responses to anti-trafficking measures that are central for the identification and protection of victims. The impacts of the pandemic – including the closure of schools, of services in camps, and of survivor shelters – were particularly significant in areas where there was limited existing institutional presence, including for refugee support organizations and services for women and children. Processing times for refugees were prolonged, contributing to extended displacement and increased risk of targeting by smugglers and traffickers. Reductions in law enforcement and criminal justice activities limited the opportunities for victim identification and for the criminal prosecution of perpetrators.

[73] This is in line with objective 5 of the Global Compact for Safe, Orderly and Regular Migration. See UNGA, 2018.
[74] This is in line with objective 7 of the Global Compact for Migration. See UNGA, 2018.

## Appendix A

The UNODC created the following table to illustrate the differences between smuggling and trafficking in persons, as well as their similarities. Both smuggling and trafficking are considered crimes that endanger the lives of the individuals concerned, and hence persons who have experienced smuggling or trafficking benefit from assistance and protection measures. The UNODC notes that smuggled migrants are particularly vulnerable to trafficking during their journeys, due to the unequal power relationships between smugglers and their customers. Additionally, while smuggling is considered a voluntary process (as opposed to trafficking in persons), migrants often have no other options given limitations on legal migratory routes.[75]

**Table 1.** **Differences and commonalities between smuggling and trafficking in persons, from the United Nations Office on Drugs and Crime**

| | Smuggling of migrants | Trafficking in persons |
|---|---|---|
| Geography | Smuggling always involves the crossing of international borders. It is a transnational crime. | Trafficking may occur entirely within the borders of one country or may occur transnationally. |
| Purpose | Migrant smugglers act to obtain a "financial or material benefit". | The purpose of trafficking in persons is the exploitation of the victim. |
| Consent | Consent is not an element of the definition of smuggling of migrants. It should be noted that, in practice, smuggled migrants generally consent to be smuggled. | Victims of trafficking in persons may consent to the act or exploitation, but consent is irrelevant if means have been used (and always if the victim is a child as means need not be established). |
| Exploitation | Exploitation is not an element of smuggling of migrants. Where smugglers do exploit migrants, this may constitute aggravated smuggling or, in some cases, trafficking in persons. | Exploitation is the purpose element of trafficking in persons. |
| Profit | Profit ("financial or other material benefit") is the purpose element of smuggling of migrants.<br><br>Profit is generated by provision of a service (facilitation of illegal border crossing, enabling stay, or document fraud) to smuggled migrants. | It should be noted that, in practice, traffickers likely aim to generate profit through exploitation of the victim. |
| Victimization | Smuggled migrants are not "victims" under the Protocol against the Smuggling of Migrants. While the term "victim" is not used in the Protocol, they may be considered victims of crime in situations of aggravated smuggling, where their lives and safety are endangered, or where they are subjected to inhuman or degrading treatment including exploitation. | Persons who are trafficked are seen as victims of the crime of trafficking in persons. They may also be victims of other crimes committed in the course of trafficking. |
| Perpetrator | Smugglers may be opportunistic individuals, organized criminals, the migrant's own family or friends or others, *but only* where they act for financial or other material benefit. | Traffickers may be organized criminals, the victim's own family or friends or others. |

*Source:* UNODC, 2019.

[75] UNODC, 2019.

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As part of community reintegration under the EU-IOM Joint Initiative IOM partnered with a local NGO called RCDO to rehabilitate a multi-purpose community centre. This centre is located in Omdurman and aims to support host communities and returnees in the area. It provides them with the space and support for various income generation activities such as soap making and laundry services. The centre is a very popular meeting space in the neighbourhood, for various interactions. It also has a reading room and a sports court utilized by the youth, mainly for volleyball and basketball.

# 11. DIGITAL TECHNOLOGY AND REFUGEES IN SUB-SAHARAN AFRICA DURING COVID-19

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## Introduction

The World Health Organization's declaration of the COVID-19 pandemic on 11 March 2020 has triggered a surge in the use of digital information systems and networks.[1] This has resulted in a massive change in usage patterns and people's behaviour regarding digital technology,[2] as the Internet has become more essential than ever before to work, learn, obtain information and remain in contact with family and friends. According to the International Telecommunication Union, the number of individuals using the Internet increased by 800 million in 2021, amounting to 4.9 billion people worldwide, which is 63 per cent of the global population.[3] Video conferencing services like Zoom reported a tenfold increase in use.[4]

Even prior to the pandemic, the use of the Internet, including mobile technologies, was already central to the day-to-day lives of migrants, including refugees. Mobile phones, particularly smartphones with Internet access, play an important role throughout displacement, including as means of communication and tools to seek information and assistance.[5] Prior to COVID-19, it was estimated that 68 per cent of refugees living in urban centres globally and 22 per cent of refugees in rural areas had access to a smartphone.[6]

During the pandemic, refugees without access to a smartphone and the Internet faced multiple challenges in terms of access to information, including government measures to curb the spread of COVID-19, as well as in terms of access to support services.[7] Barriers to accessing and using digital technology are often referred to as the "digital divide" and include financial, infrastructural, skill or educational and gender barriers.[8] Among refugees, those barriers are often exacerbated by displacement. For refugee women, the barriers to accessing technology are often compounded by gender in addition to their displacement.[9]

1 Cucinotta and Vanelli, 2020.
2 De et al., 2020; Feldman et al., 2020.
3 ITU, 2021a.
4 De et al., 2020; Branscombe, 2020.
5 McAuliffe, 2021.
6 UNHCR, 2016.
7 Interview with Chris Monk, Phones4Them, 25 September 2021; Personal communication with Francesco Taskayali, volunteer with the Red Cross, Italy, 5 October 2021; Shah et al., 2019.
8 van Deursen and van Dijk, 2020.
9 Gender is understood here as "a social and cultural construct, which distinguishes differences in the attributes of men and women, girls and boys, and accordingly refers to the roles and responsibilities of men and women." See UNICEF, 2017.

This paper examines the role digital technology played in the lives of refugees in sub-Saharan Africa during COVID-19, in order to inform gender-responsive policies and programmes. In 2020, there were some 6.5 million refugees in sub-Saharan Africa, 51.3 per cent of whom were women and girls.[10] The paper first explores access to and usage of Internet and digital technology in (sub-Saharan) Africa, including for and by refugees, prior to the COVID-19 pandemic. It then highlights the importance of digital technologies during the pandemic, and the challenges at this time related to digital technologies for refugees, before turning to promising practices in terms of digital innovations for and by refugees. The paper concludes with some suggestions for policy and programmatic responses, highlighting the need for an intersectional approach giving due consideration to refugee-related vulnerabilities and gender.

This paper is based on a literature review of the topic and on interviews and communication exchanges undertaken with key stakeholders representing 10 different organizations.[11] Stakeholders were identified through the literature review and online search using these key phrases: "digital technology and refugees during COVID-19"; "digital technology and refugees in sub-Saharan Africa"; "digital technology and migrants in sub-Saharan Africa"; "digital technology and COVID-19". Semi-structured interviews and communication exchanges were carried out between May and October 2021. However, the research for this report was significantly limited by the lack of available data on mobile data usage by location disaggregated by gender, as well as the lack of household data on refugee and migrant use of technology disaggregated by age, sex and type of location (such as refugee settlement or destination community). Communications with the Africa Peering and Interconnection Forum (APIF) revealed that data on mobile and Internet usage is proprietary, hindering access for the purposes of this paper.[12] Efforts were made to reach out to telecommunication companies present in refugee settlements and across sub-Saharan Africa, but without success. This highlights the growing need for partnership between telecommunications companies, researchers, and humanitarian and non-profit organizations for the benefit of programming to meet the needs of vulnerable populations.

## Multidimensional barriers to refugees' access to and use of digital technology in sub-Saharan Africa

While individual Internet use increased worldwide in 2021, Africa remains the region with the lowest percentage of individuals using the Internet (33%). There also remain wide disparities in the region in terms of Internet use between urban (50% of individuals) and rural areas (15%).[13] The different infrastructures available in urban and rural locations thus remain one factor impacting access to and use of the Internet and digital technology.

Mobile phones remain the most common form of digital technology that enable users to access information through the Internet, and they are seemingly more affordable than a computer. Mobile broadband subscriptions have increased in Africa for the past four years, although 18 per cent of the population in the region is still lacking access due to lack of mobile network coverage.[14] An estimated three quarters of people living in sub-Saharan Africa (747 million people) have a mobile phone connection, but only a third (250 million) use a smartphone, enabling them to access the Internet.[15]

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10 UNHCR, 2021a.

11 Interview with Monk (see footnote 7); Interview with Dhalie Foundation LBQ Refugees, 29 July 2021; interview with Edward O'Dwyer, UNHCR Tunisia, 5 May 2021; interview with Jean-Marie Ishimwe, Youth Voices Community, 3 August 2021; interview with Mary Wangui, training manager, Refuge Point, 4 August 2021; interview with Mark Kayizzi, executive director, Refugee Action Initiative, 23 August 2021; interview with Patrick Chandiga Justine Abure, co-founder and chair of the board of directors, Community Empowerment for Creative Innovation (CECI), 27 July 2021; interview with Zakaria Odawa, Youth Initiative, Kakuma Refugee Camp, 20 September 2021; personal communication with Michuki Miwangi, Africa Peering and Interconnection Forum Secretariat, 7 September 2021; personal communication with Taskayali (see footnote 7; personal communication with Michuki Miwangi, Africa Peering and Interconnection Forum Secretariat, 7 September 2021.

12 Personal communication with Miwangi (see footnote 11).

13 ITU, 2021a.

14 Ibid.

15 Turianskyi, 2020.

**Figure 1.** **Individuals with mobile phone in sub-Saharan Africa**


*Source:* Authors' elaboration, based on Turianskyi, 2020.

The costs of connecting to fixed or mobile broadbands remain particularly high in Africa, despite the steady global decline of costs.[16] Coupled to differences in connectivity for urban and rural locations, these costs further limit refugees' access to and use of Internet. A global study conducted by the Office of the United Nations High Commissioner for Refugees (UNHCR) in 2016 found that refugees have similar access to mobile networks as the global population. Indeed, location matters: refugees in urban areas have higher connectivity than those in rural areas, where rural refugees are often overlooked in connectivity initiatives.[17] Research has found that 20 per cent of refugees and migrants in rural areas are without a form of connectivity, and even where there is coverage, services are often not affordable, with refugees spending up to a third of their income on connectivity.[18]

**Figure 2.** **Refugees' global access to smartphones, by type of location**


*Source:* Authors' elaboration, based on UNHCR, 2016.

While Internet use is reported to be "moving closer to gender parity", the gender divide remains important in Africa, where 24 per cent of women use the Internet, against 35 per cent of men.[19] This "gender digital divide" relates to gender-based digital exclusion, often associated with gender inequalities, gender-based discrimination or preconceived notions of what interests specific gender should have or what skills they should obtain.[20] It includes access, but as well it includes questions of appropriation and usage types, linked to digital literacy, and differentiated by gender.[21] In other words, beyond the issue of who has access, the gender digital divide also relates to the (underresearched) different manner in which the Internet is used by differently gendered individuals, and the ways this usage reflects and impacts social relations and gender dynamics.[22]

The gender gap in connectivity in terms of access and use of the Internet and mobile phones is significant.[23] Women in low- and middle-income countries are 20 per cent less likely than men to own a smartphone and 20 per cent less likely than men to use mobile Internet.[24] In Africa, women are 34 per cent less likely than men to own a smartphone and 15 per cent less like than men to use mobile Internet.[25]

16 ITU, 2021a.
17 UNHCR, 2016.
18 UNHCR, 2020a.
19 ITU, 2021a.
20 Alencar, 2020.
21 "Appropriation is the process through which technology users go beyond mere adoption to make technology their own and to embed it within their social, economic and political practices": Bar et al., 2016.
22 Said, 2021.
23 USAID, 2018.
24 GSMA, 2020a.
25 OECD, 2018.

This is reflected in mobile phone ownership among refugee women. Research by UNHCR found that refugee women in Bidibidi camp in Uganda are 47 per cent less likely than men to own a mobile phone.[26] In Kiziba refugee camp in Rwanda, the gender gap is 13 per cent.[27] Lack of identity documentation, which is often an issue for refugees, can be an obstacle for refugees to register for mobile services in their name.[28] For refugees who do not personally own a phone or smartphone, sharing or borrowing phones has become a practice, with some refugees carrying multiple SIM cards to accommodate different phones.[29]

Digital appropriation and skills may also be highly gendered.[30] Research conducted in Ghana among adolescents showed that 16 per cent of boys possessed information and communication technology (ICT) skills, compared to only 7 per cent of girls.[31] Women and girls who lack access to digital technology and the Internet also lack opportunities for economic independence, access to information and telemedical services, education, and empowerment that technology can provide.[32]

For refugees, and refugee women in particular, the challenges linked to a lack of digital literacy and accessibility can adversely affect their ability to access information and services as well as impact their empowerment and participation in a "mediatized" society.[33] Failure to address the gender digital divide will increase gender inequalities and have negative implications for development and in particular for Sustainable Development Goal number 5.[34]

## Digital technology and refugees in sub-Saharan Africa during COVID-19: Importance and challenges

Preliminary research conducted by the World Bank found that across sub-Saharan Africa, COVID-19 negatively impacted livelihoods, food security and human capital.[35] To compound the situation, in sub-Saharan Africa, strict lockdown measures resulted in the closure of refugee camps, which increased isolation and vulnerability.[36] Within refugee populations, interviewees highlighted that lockdown measures exacerbated pre-existing racial, ethnic and class disparities as well as gender inequalities in sub-Saharan Africa.[37]

In addition, across the African region, direct in-person humanitarian relief efforts were halted, refugee resettlement cases were suspended, and asylum application processes were in some cases moved online, and in others stopped completely.[38] For lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) and women refugees and migrants there has been an increase in gender-based violence (GBV) and homophobia.[39]

### Digital tech initiatives for refugees during the COVID-19 pandemic

Amidst this situation, digital technology became critical for refugees to obtain information, thereby helping them to identify resources and circumvent emerging problems caused by COVID-19 in real time. For example, digital technology was important for locating relief services, including mental health services, and for communicating with family members and friends.[40]

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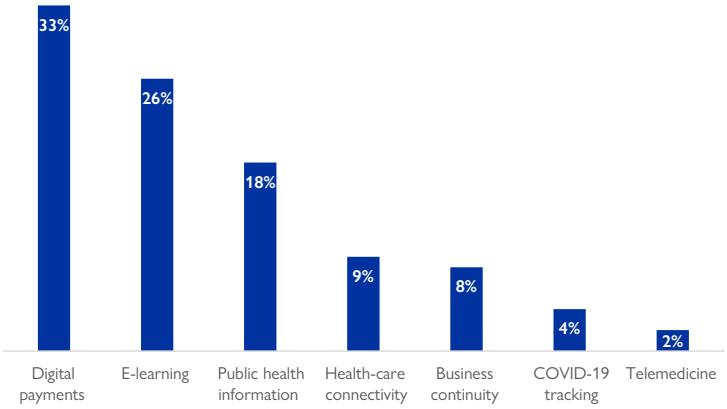
26 UNHCR, 2016.
27 GSMA, 2019.
28 Ibid.
29 Ibid.
30 GSMA, 2020b.
31 Amaro et al. 2020.
32 ITU, 2021b.
33 Alencar, 2020.
34 Sustainable Development Goal number 5 sets out to achieve gender equality and empower all women and girls, including in terms of the "use of enabling technology, in particular information and communications technology" (target 5.B). See www.un.org/sustainabledevelopment/gender-equality/.
35 Paci, 2021.
36 Raju and Karlsson, 2020; Interview with Odawa (see footnote 11).
37 IOM, 2020; Hall, 2020.
38 Interview with O'Dwyer (see footnote 11).
39 Interview with Dhalie (see footnote 11).
40 Interview with Abure (see footnote 11); interview with Ishimwe (see footnote 11); interview with Wangui (see footnote 11).

Digital responses to COVID-19 by the private sector and governments in sub-Saharan Africa focused on three key areas: business, health care and education.[41] An evaluation of 144 digital policy initiatives across 31 countries in Africa – the majority in sub-Saharan Africa – found most digital responses to COVID-19 by governments focused on digital payments, e-learning and public health information.[42]

**Figure 3.** **Focus of 144 digital policy initiatives adopted across 31 African States during COVID-19**




*Source:* Authors' elaboration, based on Saleh, 2021.

To support the COVID-19 responses, new technologies were developed or existing technologies modified. Of those developed worldwide, 12.8 per cent of innovations were in Africa, and the majority of these were in the sub-Saharan region.[43] Countries with the most innovations were South Africa (13%), Kenya (10%), Nigeria (8%) and Rwanda (6%).[44] The most successful initiatives during COVID-19 expanded or adapted existing technologies that had been tried and tested before the pandemic.[45]

## Challenges to refugees' access to and use of digital technologies amidst the COVID-19 pandemic

Due to the loss of disposable income attributed to closed businesses and unemployment resulting from COVID-19 lockdown, as well as social distancing measures and the nature of the pay-by-byte mobile Internet data, connectivity became less accessible to economically vulnerable populations such as refugees within sub-Saharan Africa, particularly women and girls.[46] As a result, information on COVID-19 and measures regarding how to avoid transmission were disseminated by African governments not only through online information platforms, but also through radio stations, motorcycle announcements via loudspeakers, and in person or by word of mouth.

Access to information varied according to the type of community refugees lived in, such as refugee camps or within destination communities. Limited access to the Internet meant that refugees relied heavily on word of mouth to access information related to COVID-19. However, language was an additional barrier to overcome when relying on word of mouth. Much of the information on COVID-19 was produced in the dominant local language, creating a linguistic barrier for refugees

41 Saleh, 2021.
42 Ibid.
43 WHO Africa, 2020.
44 Ibid.
45 Bryant et al., 2020.
46 AfPIF, 2020.

needing to access information but who spoke tribal, minority, or other national languages.[47] The lack of understanding often resulted in the inadvertent promulgation of misinformation about the virus and its transmission.[48] The ability to access public services and stay connected during lockdown was also impeded.[49] For refugees with visual and hearing impairments, as well, information was difficult to access.

Access to information is critical during a pandemic, but how it is disseminated can be just as important as the information itself. In two of the largest refugee camps in sub-Saharan Africa, language became the biggest barrier to accessing information. In the Kakuma Refugee Camp in Kenya, home to 160,000 refugees and more than 20 languages,[50] international organizations and local authorities worked to disseminate information about COVID-19 to inhabitants. The information was disseminated in four languages: Arabic, Swahili, French and English. Language was also a problem at the refugee camp at Bidibidi in northern Uganda, with over 233,000 refugees.[51] Here, the primary languages used to disseminate information were Swahili, Luganda, and English, but these languages are not commonly used among refugees.[52]

Illiterate refugees, as well as refugees who did not read or speak one of these languages, were left to receive information by word of mouth. This practice generated misunderstandings and misinformation. Rumours that surfaced at Kakuma camp included, "COVID-19 is only contracted by white people", and "if you drink tea without sugar, you will become immune to COVID-19". Some rumours were attributed to specific religions, associating devout faith with immunity.[53] In addition, refugees with visual or hearing impairments were left out. Youth Voices Community, a refugee-led organization in Kenya, provided support for hearing impaired refugees and migrants by developing posters and videos with sign language about COVID-19, how to access services, and including information on how to report and get help for GBV.[54]

Refugees and migrants living in destination communities also faced language barriers, but lacked the community resources that were within the camps to access information in their native language. Compounding the issue of information dissemination, both for refugees in the camp as well as those in destination communities, was the lack of access or limited access to digital technology such as smartphones, television, radios, newspapers, or the Internet.[55]

Radios play an important role in information dissemination across Africa, reaching more people than any other media forum.[56] This is in large part due to the ability of radios to operate on batteries irrespective of power supply or Internet connections, making them more reliable forms of information sharing, particularly in areas with limited infrastructure. Some mobile phones have built-in FM radio receivers, enabling mobile phone users to also listen to the radio through their devices.[57] In Uganda, for example, radio served as a means of providing remote learning to children during lockdown, with the Government broadcasting lessons at specific times throughout the day as an alternative to online learning for those who owned a radio.[58]

Within refugee camps, Wi-Fi access is concentrated at learning centres and main office buildings, requiring migrants to physically move to these buildings to access Wi-Fi. During lockdowns, limited mobility therefore created an additional barrier to information. An alternative to Internet access is the use of mobile data, but the cost is often prohibitive for refugees and migrants, costing upwards of 1.00 United States dollar per day.[59]

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47 Interview with Dhalie (see footnote 11); interview with Abure (see footnote 11); interview with Wangui (see footnote 11).
48 Interview with Wangui (see footnote 11); interview with Kayizzi (see footnote 11); interview with Abure (see footnote 11).
49 Interview with Wangui (see footnote 11); interview with Kayizzi (see footnote 11); interview with Abure (see footnote 11).
50 Pape and Beltramo, 2021.
51 UNHCR, 2021b.
52 Interview with Dhalie (see footnote 11).
53 Interview with Odawa (see footnote 11).
54 Interview with Ishimwe (see footnote 11).
55 Interview with Dhalie (see footnote 11); interview with Odawa (see footnote 11); interview with Ishimwe (see footnote 11).
56 Wihlem and Lorgerie, 2020.
57 Ibid.
58 Interview with Dhalie (see footnote 11); interview with Abure (see footnote 11); interview with Kayizzi (see footnote 11).
59 Interview with Abure (see footnote 11); interview with Kayizzi (see footnote 11).

COVID-19 has highlighted the importance of being able to obtain information on the pandemic and related health measures. As well, it has highlighted the importance of being able to adapt asylum processes, including through online processing of refugee status determination (RSD). Around 100 countries adjusted to remote processing of RSD.[60] Some countries, such as South Africa, extended or implemented automatic renewal for asylum documentation during COVID-19.[61] Others have put their processes on hold entirely, leaving refugees and migrants in limbo, unable to apply for asylum or renew their documentation.[62]

Failing to adopt a technological approach to asylum processes can increase refugee and migrant vulnerability, as seen in Kenya. As of August 2021, in-person meetings for renewal of refugee identity documentation or to assign new identity documents to migrants who arrived during COVID-19 have not been reinstated. Application processes in Kenya are not available online, according to refugee and migrant advocates.[63] Unable to renew documentation or register their arrival, migrants and refugees were left at risk of arrests because of lack of or expired documentation.[64] To help curb arrests, refugee-led organizations have been working with local authorities to inform law enforcement of the current challenges associated with getting appropriate documentation. Documentation provides refugees and migrants access to public services such as health care; for women and girls, this includes access to GBV services. In addition, documentation allows for refugees and migrants to obtain mobile phone contracts, banking and the right to work, in addition to the right to remain in the destination country. Lack of documentation is also problematic for organizations providing housing services to refugees and migrants, because organizations can be charged with trafficking if they house individuals who do not have proper documentation.[65]

In contrast, to curb arrests and enable refugees and migrants to access services, some countries extended documentation during national lockdowns or permitted the use of expired documents. The South African Government introduced a "blanket extension" of documentation. This blanket extension enabled refugees, asylum seekers and migrants to continue accessing essential services such as education, banking and employment.[66] Following the end of COVID-19 lockdown measures, both the governments of South Africa and Angola implemented online processes for documentation renewal.[67] And in Zambia, the Minister of Home Affairs ordered entry and exit restrictions at refugee settlements, limiting the issuance of mobility passes for refugees.[68]

In other countries – such as Malawi and Zambia – refugee movements were restricted, preventing access to refugee status determination processes and livelihoods. In Malawi, the Government has recalled thousands of refugees, including refugee business owners, back to the Dzaleka refugee camp, citing national security risks.[69] And in Zambia, the Minister of Home Affairs ordered entry and exit restrictions at refugee settlements, limiting the issuance of mobility passes for refugees.[70] In addition, due to travel restrictions, RSD committees were unable to travel to camps with newly arrived refugees, preventing the initiation of asylum applications and RSD processes.[71]

These examples highlight some of the measures adopted by countries in sub-Saharan Africa that affected refugees and migrants during the outbreak of COVID-19.

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60 UNHCR, 2020b.
61 Currie-Roberts and Savage, 2020.
62 Interview with Dhalie (see footnote 11); interview with Ishimwe (see footnote 11); interview with Wangui (see footnote 11); interview with Kayizzi (see footnote 11).
63 Interview with Wangui (see footnote 11); interview with Dhalie (see footnote 11); interview with Kayizzi (see footnote 11).
64 Interview with Wangui (see footnote 11); interview with Dhalie (see footnote 11); interview with Kayizzi (see footnote 11).
65 Interview with Wangui (see footnote 11); interview with Kayizzi (see footnote 11); interview with Dhalie (see footnote 11).
66 Angop, 2020.
67 Kateta, 2021.
68 UNHCR, 2020c.
69 Kateta, 2021.
70 USDS, 2021.
71 UNHCR, 2020c.

## Promising practices in digital technology for and by refugees during COVID-19

Recognizing the lack of digital technology as a barrier to information and services, refugees and refugee-led organizations took it upon themselves to develop programmes to address the gap. Refugee-led initiatives have been of particular importance in supporting refugee communities, although they have not all targeted specific gender populations. These initiatives used existing technologies and networks, targeting three key areas during COVID-19: countering miscommunication or misinformation; providing access to health care and legal services; and ensuring refugee and migrant children have access to education.

An observed gap was that existing response strategies were not informed by the actual needs and limitations of the population they aimed to serve; nor were they gender inclusive. There is no one-size-fits-all approach, and failure to recognize relevant differences led to inefficient or even harmful responses. As highlighted by the success of the refugee-led responses, localizing assistance and facilitating community engagement increases in significance during a crisis. Without dialogue and community input, vulnerable populations are left to fill gaps on their own.

The case study below and Table 1 highlight innovative programmes that were driven by refugees to address issues related to the digital divide among refugees and women and girls. Additional innovative programmes likely exist, despite not being identified during the course of this research.

### Language matters: COVID-19 information sharing in Bidibidi Refugee Settlement

The Community Empowerment for Creative Innovation (CECI), a refugee-led organization in Bidibidi Refugee Settlement in north-western Uganda, developed an awareness-raising campaign with two purposes: combating misinformation, and offering messages of peaceful coexistence and peaceful dispute resolution between refugees and destination communities. The programme used multiple media platforms to reach refugees, including the Internet, radio, audio towers, bicycles loaded with megaphones and printed materials. In total, it reached over 50,323 refugees.[72]

Two video messages and ten audio messages were recorded and distributed online and through various online platforms, such as Facebook – where the organization reaches 5,776 followers – Twitter, YouTube and WhatsApp. The online messages targeted youth audiences, with the idea that they would then save the recorded messages and share them with their families and friends. Key messaging was around the origins of COVID-19, how it spreads, signs, symptoms and prevention. Audio messages were recorded in Acholi, Arabic, Aringa, Bari, Dinka and Kakwa, local languages that are commonly spoken and understood by refugees and the destination community.

Other methods of information dissemination included using a "blue messenger bicycle", equipped with a battery-powered loudspeaker mounted to the front of the bicycle that is loaded with messages. The cyclist rides throughout the communities, spreading the messages along the way.

[72] Interview with Abure (see footnote 11).

**Table 1.** **Illustrations of innovative programmes conducted by refugees, migrants and refugee-led organizations in sub-Saharan Africa**

| Organization | Programme objective | Target population | Programme innovation |
|---|---|---|---|
| Refuge Point | Business training | Refugees and migrants in Nairobi | Online skills training enabled refugees to learn how to become financially self-sufficient through income generation. Courses were provided through Zoom. |
| Refuge Point | Communication and smartphone distribution | Refugees and migrants in Nairobi | A messaging campaign – estimated to have reached some 1,500 refugees living in Nairobi – used COVID-19 updates from the Ministry of Health and information on best hygiene practices and ways to keep safe during the pandemic, using WhatsApp. Smartphones were given to vulnerable migrants who would not have otherwise been able to obtain one. |
| Foundation for LBQ Refugees | Counselling | LBQ refugees and women refugees | Psychosocial support – entitled "Freedom from within" and "Unlimited potential" – through group counselling session using Zoom enabled LBQ refugee women to access mental health services during COVID-19. For those who did not have access to digital technology, space was made available at the organization's shelter for participation in the counselling sessions, where a large screen projected the Zoom call. Around 20 women completed the programme. |
| Kakuma Youth Initiatives | Countering misinformation | Refugees and destination communities in Kakuma Refugee Camp | COVID-19 rumour tracking was conducted by deploying community data collectors with software installed on tablets to document rumours heard within the community. Rumours were then evaluated by programme leaders and used to inform targeted messaging and programmes by the organization and partner organizations. |
| Kakuma Youth Initiative | Countering misinformation | Residents in Kakuma Refugee Settlement | COVID-19 information dissemination through a WhatsApp group with community leaders and youth community leaders. Youth generated video and audio recordings were shared through social media and WhatsApp groups, and disseminated at water points and other important locations within the refugee settlement. |
| Youth Voices Community | Education | Refugee children | Education through Short Message Service (SMS): Youth Voices Community enrolled students in an educational platform that produced education content for distribution through mobile phones. Subjects include English and Math. The platform sent SMS materials to read as well as assessments, enabling students to continue learning during lockdown. |
| Refugee Action Initiative | Legal education | HIV+ and LGBTQ | Facilitated online trainings for migrants on their legal rights, and provided assistance related to legal questions or concerns. Around 70 refugees and migrants attended the trainings. |
| Refuge Point | Prescription delivery | Refugees and migrants in Nairobi | Home delivery of prescriptions were provided through volunteers. Refugees and migrants could send a digital copy of their prescriptions along with a picture of their identification to volunteers. The prescription would be filled and delivered to their homes. |
| CECI | Wi-Fi access | Refugees and destination communities in Bidibidi Refugee Settlement | A Wi-Fi and charging station was established within the Bidibidi refugee settlement. The station included seats to sit in while charging phones or using the Internet. An estimated 250 refugees and destination community members accessed the station. The majority were between 18 and 35, and 60 per cent were estimated to be men. |

*Sources:* Interview with Monk (see footnote 7); interview with Dhalie (see footnote 11); interview with Ishimwe (see footnote 11); interview with Wangui (see footnote 11); Interview with Kayizzi (see footnote 11); interview with Abure (see footnote 11); interview with Odawa (see footnote 11).

## Conclusion

COVID-19 exacerbated vulnerabilities and highlighted inequalities. Refugees and migrants across sub-Saharan Africa faced economic insecurity, GBV, lack of documentation (both new and renewed), inability to access services – including essential services for GBV survivors – as well as lack of information related to COVID-19 and how to access services.

This paper highlights the vital role that technology could play in enabling refugees to access services online and to communicate with family and friends. Programmes – especially when they were refugee led – that were successful in helping migrants and refugees to address these issues built on existing trust and community buy in, and adapted existing technology. Beyond such programmes, however, insufficient consideration appears to have been given to unequal access to technology, to the cost or use of mobile data, to language, to community dynamics, or to the different needs of differently gendered populations, including women and girls and LGBTQI+ refugees.

Based on the above research, below are some suggestions for operational and policy responses:

- Conduct needs assessments to understand the barriers that contribute to the digital divide within communities, with a focus on female-headed households and refugee and migrant communities.
- Increase Wi-Fi connectivity within refugee camps through additional hotspots, with special consideration for secured spaces that are accessible to women and girls.
- Advocate and operationalize distribution of smartphones in programming that targets information sharing and connectivity among vulnerable groups, specifically women and girls and LGBTQI+ refugees.
- Diversify project responses in accordance with actual needs disaggregated by age, sex and gender, education and household income.
- Ensure project sustainability strategies are formulated to ensure communities – specifically women and girls – are empowered in the use of technology, its functional requirements and maintenance.
- Annual or biannual assessments on access to and use of digital technology by refugees in refugee camps, destination communities and in urban and rural settings, with data disaggregated by race, ethnicity, age, sex and gender, education and household income.
- Encouraging information sharing on technology use between telecommunications companies, humanitarian organizations and non-profit organizations, for the benefit of programming and meeting the needs of vulnerable populations, specifically women, girls and LGBTQI+ refugees.
- Increasing the focus on the unique needs of individuals with intersectional factors of vulnerability, specifically women, girls and LGTBQI+ refugees, as well as the importance of digital technology for safety and empowerment.
- Encouraging programmes and funding aimed at increasing smartphone connectivity for refugees, especially women and girl refugees.
- Fostering gender-responsive policy formulations to eliminate gender-blind or discriminatory strategies related to technological advancement and infrastructural development, in line with SDG no. 5.

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# 12. PROTECTING MIGRANTS AGAINST THE RISKS OF ARTIFICIAL INTELLIGENCE TECHNOLOGIES

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## Introduction

In recent years, increasing attention has been paid to the potential of new technologies in the field of migration governance, whether to support the deployment of humanitarian aid for migrants, including refugees, or to better manage administrative processes. There has been notable interest in developing artificial intelligence (AI) technologies to make predictions related to migrant movements and to automate visa processing. However promising, these technologies are also currently weakly regulated, in that they do not yet benefit from the regulatory framework that other innovations might have to protect human beings against unintended consequences.[1]

Although these technologies were used before the pandemic, COVID-19 has accelerated the deployment of AI in relation to migrants globally, both in higher-income countries and in those already experiencing humanitarian crises.[2] COVID-19 has, in fact, been named a data-driven pandemic.[3] The use of AI models to mitigate the spread and severity of the disease has been largely driven by predictive and scenario-based models, which aim to work as support for public health agencies' decision-making.[4] Artificial intelligence has also been used to track and control border crossing,[5] and to administer social protection and vaccines.[6]

During COVID-19, we have also seen the vulnerability of certain migrants exacerbated, with women and gender non-binary persons adversely impacted globally.[7] They tend to be at further risk of marginalization, as well as physical and sexual assault.[8] Many non-binary persons, for example, may be fleeing persecution, and are at risk of violence even inside camps.[9]

1 Molnar, 2019.
2 McAuliffe et al., 2021.
3 Term first coined by Roberto Rocha; see Rocha, 2020.
4 Khemasuwan and Colt, 2021.
5 Bastani et al., 2021.
6 Greig, 2021.
7 On women, see, for example, UN-Women, 2021; on non-binary persons, see Tschalaer , 2021.
8 Obradovic, 2015.
9 UNHCR, 2021b.

Risks based on gender are further exacerbated by the mere fact of being a migrant.[10] In fact, migrants are rarely consulted when it comes to AI or other technologies. For example, during the pandemic, citizens of Canada were extensively consulted when their Government deployed COVID-19 tracking applications.[11] Migrants have often not been extended the same opportunity to voice their concerns in relation to data collection, privacy, or algorithmic decision-making.[12]

In addition, AI-related risks for some migrants, go beyond the technology itself. Rather, these risks are impacted by the convergence of migration status with diverging objectives in migration management. Migrants are often negotiating complex visa and asylum systems, while also facing challenging immigration policies from destination countries. In this sense, governments tend to have less incentive to consult them in the development of AI policies, since they may not even be on a path to citizenship.

There are possible benefits to using AI in a migration context, such as protecting girls and women from trafficking,[13] or predicting displacement to prepare humanitarian logistics.[14] However, there are also many risks in doing so. Many organizations have recently warned against the unrestricted use of AI in migration contexts, particularly during the COVID-19 pandemic.[15] Michelle Bachelet, United Nations Human Rights Commissioner, recently pressed for national and international AI regulations that would protect the human rights of vulnerable populations.[16] In this context, it is critical to consider the possible risks that these technologies generate or enhance for migrants, not only to mitigate them in the short term but also to inform future policymaking and regulatory frameworks.

With this in mind, we discuss the impact of AI technologies used in the COVID-19 context on migrants. In this paper, we discuss uses of these technologies in relation to migrants, focusing on four types of technologies: migration forecasting; biometric identification; satellite image recognition; and automated decision-making for immigration processing. We then examine the risks in using these tools in a migration context, and detail examples of biases, errors and other issues, and their impacts on female and non-binary migrants. Finally, we detail the current legal and regulatory framework governing these technologies, and point to further policies that could mitigate the risks that artificial intelligence technologies pose for migrants.

## Defining relevant artificial intelligence technologies

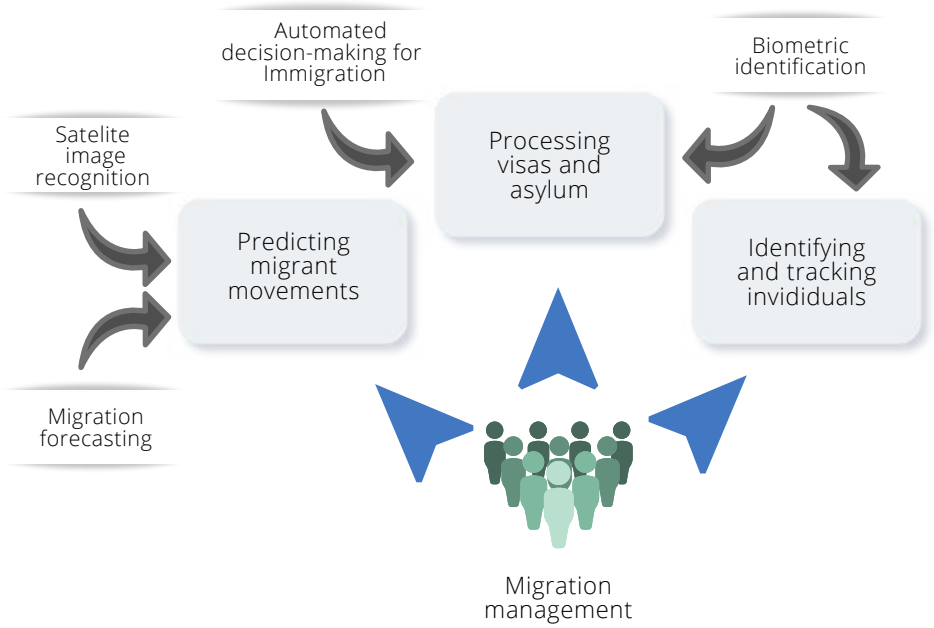
In this paper, we use the OECD definition of artificial intelligence: "a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments".[17] While this definition can include a broad range of technologies, we focus here on those that have direct application to migration, notably in relation to:

1. Predicting the movement of people;
2. Providing digital identities to refugees and migrants;
3. Managing visa and border processes;
4. Managing asylum processes.[18]

[10] See the discussion on vulnerability and migration as discussed in Beduschi, 2018.
[11] Gamache, 2020.
[12] Latonero el al., 2019.
[13] Zinser and Thinyane, 2021.
[14] UNHCR, 2021b.
[15] EDRi, 2020.
[16] OHCHR, 2021.
[17] OECD, 2019.
[18] See Bither and Ziebarth, 2020.

Each one of these technologies uses entry data, which comes from a variety of sources. These might include photos and fingerprints of migrants, remote photos of informal dwellings or land, social media posts and survey results. This entry data is then used to make a variety of predictions impacting migrants. These can include identifying an individual migrant, predicting natural disasters impacting groups of migrants, or predicting the movement or needs of the migrant. Artificial intelligence systems can integrate enormous volumes of disparate data and make many kinds of predictions that influence human decision-making.

**Figure 1.** **Uses of artificial intelligence technologies in migration management**




*Source:* Authors' elaboration.

"Biometric identification" applies mathematical measurements to biology in order to provide a unique personal record.[19] Biometrics are typically separated into three categories: biological (measuring DNA and blood patterns); morphological (measuring facial images, fingerprints, iris and retina features, and even voice patterns); and behavioural (measuring gait, handwriting, or keyboard strokes).[20] Although experimentation is happening in all categories, morphological biometrics are most used in relation to migration, notably facial recognition, fingerprinting and iris recognition. AI is used to build models that will identify a match between a person's features and those stored in a central database.

"Satellite image recognition" is a means of using artificial intelligence to interpret satellite imagery, notably by recognizing certain entities in images, such as buildings, people and land cover, often to measure changes over time. Like biometric identification, satellite image recognition uses artificial intelligence to build models that will recognize certain patterns in the images based on a database showing features of informal and formal dwellings, for example. Unlike biometric identification, however, satellite image recognition does not aim to identify individuals, but rather is used to make general predictions about what is contained in a particular image.

[19] OPC, 2011.
[20] Different categories of biometrics are discussed here by the biometrics company Idemia; see Idemia, 2021.

"Migration forecasting" involves developing artificial intelligence models that will predict the number of migrants arriving in certain locations,[21] usually in a 1- to 6-month horizon.[22] It can also involve predicting the needs of those migrants, allowing for preparation of food, water and medical supplies, along with shelter.

"Automated decision-making systems in immigration" rely on algorithms, and are used by governments to make a decision about a migration visa or claim for international protection, for example, to determine either the public security risk of accepting a migrant across its borders, or the possibility of fraud through misrepresentation. These tools use the information provided in the migrant's case file, as well as, occasionally, external information, to recommend a decision to the case officer.[23]

## Impacts of artificial intelligence technologies on migrants

International organizations and governments have, over the last few years, invested considerably in technological innovation that affects displaced persons. This investment has increased during the pandemic.[24] Governments have also increased the use of technologies to monitor borders, notably to restrict the movement of migrants to limit the spread of the virus.[25]

### Predicting movements of people: Forecasting and satellite imagery

During the COVID-19 pandemic, national governments and international organizations alike used artificial intelligence methods to predict the number of infections and severity of illness among migrants, notably in refugee camps. These methods can be categorized into three types:

1. Predicting new migration flows related to compounding disasters or economic crises;[26]
2. Including migration into epidemiological models to predict the spread and severity of the disease;[27]
3. Predicting the spread and the severity of the disease among migrants who were not necessarily moving between borders, for example, those in informal dwellings.[28]

Many of these forecasting models included satellite imagery data, which allowed for the inclusion of climatic factors as well as the visual observation of migration patterns. These data can be accessed relatively easily from Google Earth Engine,[29] as well as through partnerships with space agencies such as the European Space Agency.[30]

While some of these models served to inform humanitarian interventions for the benefit of migrants,[31] others resulted in an increase in movement restrictions for migrants. For example, researchers in India found that the unplanned movement of migrant workers threatened to increase the number of COVID-19 cases in the country. They recommended that the Indian Government limit internal migration and implement smartphone tracking systems, similar to COVID-19 tracking apps.[32]

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21 UNHCR, 2021a.
22 See United Nations Global Pulse, n.d., for numerous examples of this kind of research.
23 For a more detailed description, see Citizen Lab, 2018.
24 See, for example, the partnership between Google and the United Nations for Artificial Intelligence for crisis response: Google, 2021.
25 European Union, 2021.
26 This has been explored, for example, in disaster risk early warning systems. See ITU, 2020.
27 Centre for Humanitarian Data, 2020.
28 United Nations Global Pulse, n.d.
29 Google Earth, 2021.
30 ESA, 2021.
31 United Nations Global Pulse, 2020.
32 Pal et al., 2021.

### Providing digital identities: Biometric identification

Biometric identification is increasingly used in migration management. The technology has the potential to facilitate border crossings and case management by reducing fraud and maintaining accurate and transferable records.[33] For those crossing internal borders, it can also facilitate the transfer of social protection services from one jurisdiction to the next. India, for example, has implemented Aadhar,[34] a biometric identification system used to access welfare, manage voting, and move between states while retaining access to services.

However, there are some concerns in relation to the use of this technology. Biometric identification systems that are built for the population at large may accidentally exclude some migrants, making it more difficult for them to access services than before. For instance, biometric identification systems that are built for the population at large may accidentally exclude some, such as migrants, making it more difficult for them to access services than before. The problem of exclusion was documented in the case of Aadhar, which did not account for those who might not physically be able to provide biometrics, such as manual workers who had damaged fingerprints.[35] The exclusion of those speaking indigenous languages, which are not currently supported by the platform, has also been described, as has the effects on migrant workers inside the country, who may also struggle with access.[36]

### Automated decision-making systems

Visa requests, asylum claims and other processes related to establishing short- and longer-term residency in new countries are increasingly processed by automated decision-making systems. These systems can take data provided by migrants in their case file – such as personal information, images and past locations – to provide a recommendation to the case officer. New data, such as data provided by a lie detector, are also sometimes collected.[37] These systems have also been known to include social media analysis or other analysis of Internet data to provide a bigger picture of the migrant's life and to identify whether the migrant could pose a security risk in the destination country. This, for example, is known to be the case for visa applicants to the United States, who may be asked to provide their social media accounts.[38]

Several issues have been raised in relation to these activities, notably concerning the fairness and transparency of the decision-making.[39] These systems have also been critiqued for lacking nuance, particularly in cases of intersectional identities, as would be the case with female and non-binary migrants.[40]

Furthermore, this type of analysis falls in the category of artificial intelligence technologies known as behavioural analytics, which typically try to predict human behaviour based on certain factors. A migrant may, therefore, be categorized as a potential public security risk and denied a visa, causing significant upheaval in their own lives. A study by the University of Toronto's Citizen Lab has raised concerns about the potential for racial and gender discrimination in these tools, which would increase the vulnerability of already vulnerable migrants.[41]

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33 IOM, n.d.
34 Government of India, 2021.
35 Krishna, 2018.
36 Panigrahi, 2019.
37 Molnar, 2019.
38 Lazzarotti and Peck, 2020.
39 Citizen Lab, 2018.
40 Maat for Peace, 2018.
41 Citizen Lab, 2018.

## Risks of artificial intelligence technologies for female and non-binary migrants

During COVID-19, women and non-binary migrants have had worse economic outcomes than other groups, increasing any pre-existing vulnerabilities they may have had.[42] Inappropriate uses of AI technologies during the COVID-19 pandemic have also been shown to increase their vulnerability, notably due to algorithmic errors, biases and lack of privacy.

Table 1 shows the types of data used by each category of AI, their potential benefit for migrants and the risks associated with their use.

**Table 1.** **Data used by types of artificial intelligence, and their benefits and risks for migrants**

| Artificial intelligence technology | Input data sources | Potential benefits to migrants | Potential damages to migrants |
|---|---|---|---|
| Biometric identification | Facial images, fingerprints, iris and retina scans | Ease of identification without requiring documentation | Misidentification, resulting in economic effects and deportation, surveillance |
| Automated decision support | Visa and asylum case files, social media data | Increase speed of visa and asylum processing | Inappropriate decisions with no possibility of appeal, surveillance |
| Satellite image recognition | Images of informal camps, urban dwellings, land cover | Preparing humanitarian community for migrant arrival, natural disasters | Misinterpretation, leading to logistics errors, privacy breaches |
| Forecasting | Social media data, socioeconomic data, public health data | Preparing humanitarian community, governments and border agencies for migrant movements | Forecasting errors, leading to logistics errors, privacy breaches |

### Managing errors and uncertainty in artificial intelligence

AI tools are predictive, in that they use past data to inform a decision which will always have a certain rate of error and uncertainty. If a certain indicator was not included in the model, or if the data used are flawed or biased, the prediction can be wrong.[43] Similarly, AI models predict future events, such as the arrival of migrants, based on certain assumptions and past data. In migration settings, there are high amounts of uncertainty,[44] in relation to unexpected events and conditions and mistaken assumptions. The forecasts made using artificial intelligence models can be useful in informing decision-making, but there is always the possibility of error.

In using artificial intelligence models, it is important to clearly communicate error rates and uncertainties to decision makers. Error rates are usually calculated by reserving a portion of data for testing.[45] On these test data, the model's results will then be compared to actual results, and two numbers will be calculated: the number of false positives, which is the number of – for example – entities that were identified as informal shelters but are really something else (for example, a car); and the number of false negatives, which is the number of informal shelters (in our example) that were not recognized by the algorithm.[46] AI models can be calibrated to be

[42] UN-Women, 2021.
[43] Cortes et al., 1995.
[44] Napierala et al., 2021.
[45] Techopedia, n.d.
[46] Google, 2020.

more tolerant of false positives or to false negatives.[47] It is therefore important for policymakers to consider not only whether an entity is wrongly identified as something of importance, but also whether it goes unseen by the model.

In their research, Buolamwini and Gebru found that women and people of colour suffered both effects in common facial recognition software.[48] They were either not identified at all, or they were assigned by mistake to a different person. They found that the software was trained on faces that were more than 83 per cent white and 77 per cent male, resulting in misidentifications of up to 46 per cent for women of colour. This finding is particularly relevant to our analysis, where vulnerable migrants already face gender-based discrimination and racism.[49]

Misidentification errors in facial recognition and other biometric processes such as fingerprinting have been documented,[50] whether they are matches with the wrong person or simply no match at all.[51] These have been linked to migrants having their asylum cases rejected or delayed, as well as having problems accessing basic services.[52]

### Tracking, surveillance, and privacy

In addition to error management, one of the most important issues for some migrants is the possibility of personally identifiable information being shared widely. This can be due either to improper consideration of the right to privacy of migrants,[53] or to cybersecurity breaches that put the migrants at risk.[54] Data identifying migrants personally can include their location, age, sexual identification, gender identification, ethnicity and disability. In many cases, this information can be dangerous when shared, leading to discrimination, violence and even trafficking or re-trafficking.[55]

Although there are many initiatives using AI to locate trafficked migrants,[56] there are also concerns that data about vulnerable migrants can be used to identify, recruit, and track them.[57] Smugglers who use social media to propose safe passage to Europe for work, for example, can begin to sexually exploit women and unaccompanied children as repayment.[58] Sex traffickers are also known to use exploit data available online to identify future victims.[59]

A considerable amount of data is required when developing an AI tool. The United States, for example, is said to have a database that includes data about hundreds of millions of individuals who can be identified through remote biometrics systems.[60] In certain cases, a broader use of biometric tools – including not only facial recognition and fingerprints but also image recognition through social media – has enabled governments to arrest and detain undocumented migrants. A striking example is the United States Immigration and Customs Enforcement agency, which has partnered with the analytics firm Palantir since 2016 to track and apprehend undocumented migrants in the country.[61]

47 Russell, 2020.
48 Buolamwini and Gebru, 2018.
49 Astles, 2020.
50 Kaurin, 2019.
51 Oxfam and The Engine Room, 2018.
52 Gelb and Clark, 2013.
53 Sandvick, 2021.
54 ICRC, 2022.
55 Kosevaliska, 2021.
56 See, for example, Global Emancipation Network, n.d.
57 UNODC, 2019.
58 Zenko, 2017.
59 Wulfhorst, 2017.
60 Djanegara, 2021.
61 Amnesty International, 2020.

A 2021 report by Transnational Institute and Stop Wapenhandel documents the border surveillance industry,[62] highlighting the activities of 23 companies and several investment firms lobbying governments to take a more "militarized" approach to border control involving artificial intelligence. Notably, the report documents the "Smart Borders" sector,[63] which involves biometric identification as well as phone and social media tracking.

More recently, the deployment of vaccine passports in numerous countries has accelerated the implementation of digital identity management, with governments now tracking access to restaurants, bars, public spaces, and social services through a combination of identification and health certification. This is of concern to anyone in vulnerable social positions, especially undocumented migrants who will see their access to public spaces nearly entirely curtailed.[64]

## Protection of migrants' rights to non-discrimination and privacy

Migrants are currently protected under different international conventions. As we will see below, the rights to privacy and non-discrimination, which are included in the Universal Declaration of Human Rights and the 1966 International Covenant on Civil and Political Rights, are the rights most often cited as threatened by artificial intelligence.[65] However, migrants are also protected internationally by the 1951 Refugee Convention and its 1967 Protocol,[66] the 1954 Convention Relating to the Status of Stateless Persons,[67] and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.[68] Women's rights are also protected under the Convention on the Elimination of All Forms of Discrimination Against Women,[69] which includes further detail on non-discrimination.

Artificial intelligence is known to have the tendency to reinforce existing societal biases, if left unchecked.[70] Uses of AI that reinforce gender stereotypes and propagate discrimination against women exist even outside of the migration context.[71] For example, as we have seen, there are certain cases in which AI systems are less accurate for women than for men.[72] Some AI systems used for human resources were also found to recommend against the hiring of women,[73] and some that were used to assess loan applications approved lower financial amounts for women,[74] other indicators being equal. From a legal perspective, however, proving discrimination can be difficult.[75] Although the principles of equality and non-discrimination are protected under international law, they are particularly challenging to put into practice when AI is involved.[76]

There have been several attempts recently to use existing legal instruments to protect human rights when using AI. For example, the Court of Justice of the European Union[77] has had requests for a preliminary ruling concerning the interpretation of exceptions on privacy and data protection by Member States,[78] read in light of the Charter of Fundamental Rights of the European Union.[79] Notably, these requests argued that national governments' automated analysis of traffic and location

62 TNI and Stop Wapenhandel, 2021.
63 EDRi, 2018.
64 Renieris, 2021.
65 CDPDJ, 2021.
66 United Nations, 1951.
67 United Nations, 1954.
68 United Nations, 1990.
69 United Nations, 1979.
70 Noble, 2018.
71 Fournier-Tombs and Castets-Renard, 2022.
72 Buolamwini and Gebru, 2018.
73 Dastin, 2018.
74 *The Guardian*, 2019.
75 Bathaee, 2017.
76 Xenidis and Senden, 2020.
77 CJEU, 2020.
78 Article 15(1) of Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 concerning the processing of personal data and the protection of privacy in the electronic communications.
79 Articles 4, 6, 7, 8 and 11 and article 52(1) and article 4(2) of the Treaty of the European Union.

data should be limited to serious threats to national security. Privacy related to geolocalization, which could relate to satellite detection and data used in forecasting, might therefore become a more important consideration in the next few years.

In the meantime, national and international bodies have worked towards stronger regulations that would protect the most vulnerable. A notable example is the European Commission's recent regulatory proposal on AI (the European Union Artificial Intelligence Act),[80] which takes a risk-based approach, categorizing AI systems into four groups: no risk, low risk, high risk, and unacceptable risk. Many of the high-risk uses of AI are relevant in the context of international migration. These include biometric identification; management and operation of critical infrastructure; education; employment and access to employment; access to services; law enforcement; migration asylum and border management; and administration of justice and democratic processes. Companies and organizations wishing to deploy high-risk AI solutions in the European Union market will be required to obtain certification first. This certification process will involve providing technical documentation demonstrating that data biases, errors, privacy considerations and discrimination have been addressed before deployment.

The Office of the United Nations Commissioner for Human Rights recently called for a ban on all uses of artificial intelligence threatening human rights.[81] In doing so, she cited several international instruments, including article 12 of the Universal Declaration of Human Rights,[82] which protects privacy, and the International Covenant on Civil and Political Rights. Echoing the European Commission's regulatory proposal, she also called for the regulation of high-risk uses of AI.

Some national governments are currently considering how to develop their own regulatory frameworks. For example, the Government of Canada published a directive on automated decision-making,[83] which sets standards for the use of AI by the federal Government. This directive applies to automated decision-making in the case of migrants. The United States has also released two drafts of guidance for regulating AI applications, which set out some of the values, such as fairness and non-discrimination, which should be prioritized when developing a regulation.[84] China has also released, in the last few years, several documents related to AI regulation, including one on ethical norms for new AI generation,[85] which contains six ethical requirements including fairness, justice and privacy.

In addition, many organizations working with migrants have also developed ethical guidelines for their uses of artificial intelligence, such as the Humanitarian Data Science and Ethics Group (DSEG), which published a framework for the ethical use of advanced data science methods in the humanitarian sector.[86] On a larger scale, the United Nations Educational, Scientific and Cultural Organization (UNESCO) spearheaded the adoption of a recommendation on the ethics of artificial intelligence,[87] which will serve to inform standards and regulations globally. Although non-binding, these guidelines may serve to inform humanitarian standards, which would regulate the way that organizations provide support to migrants.

A key distinction in these existing human rights frameworks, in the European Union Artificial Intelligence Act and in these ethical frameworks is where they position themselves in relation to the deployment of artificial intelligence systems. The European Union Artificial Intelligence Act will require certification of these systems before they are deployed to the public. Like the European Union Artificial Intelligence Act, ethical frameworks attempt to pre-empt human rights

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80 European Union, 2021.
81 OHCHR, 2021.
82 Article 12: "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks."
83 Government of Canada, 2021.
84 United States Government, 2020.
85 People's Republic of China Ministry of Science and Technology, 2021.
86 DSEG, 2020.
87 UNESCO, 2021.

violations by providing a verification process that should take place before the technology is used. Certification schemes such as these highlight the need to prevent violations of non-discrimination and privacy in the first place, rather than bringing cases to human rights tribunals after deployment. In such cases, it may be difficult to repair violations to human rights, particularly when it comes to non-discrimination and privacy.

## Moving forward in a context of weak citizenship and divergence of intents

As we have seen, migrants are particularly vulnerable to the risks presented by certain uses of AI, especially during COVID-19. Some migrants may be in situations of high uncertainty in which they cannot advocate for their rights. They may be unable to express their privacy preferences clearly and safely, or negotiate algorithmic errors. As such, they may have very little recourse when technologies that affect them are deployed.

Furthermore, one of the greatest challenges in using AI in the context of migration is the divergence of intents amongst the various actors involved. Humanitarian organizations might want to support migrants and mitigate threats to them. National governments might have diverse intentions, supporting humanitarian work, encouraging some forms of migration while limiting others. Private companies, in turn, that develop a large portion of AI technologies that affect migrants, may be driven by a profit motive and unequipped to protect the rights of migrants without guidance.

In this paper, we examined four AI technologies: migration forecasting, satellite image recognition, biometric identification and automated decision-making for immigration. These are used in migration management, notably to predict migrant movements, process visas and asylum claims, and identify and track migrants. We presented several risks in using these technologies, such as managing errors and uncertainty, issues related to surveillance and privacy, and discrimination. We further showed that the legal framework protecting migrants' rights when it comes to AI is not yet adequate, although it is changing rapidly.

Female and gender non-binary migrants are particularly vulnerable to inappropriate uses of artificial intelligence, as well as to technological errors. During the COVID-19 pandemic, not only has this vulnerability increased, but so has the use of artificial intelligence and other new technologies, leading to an increased risk of harm to members of this group. This can be addressed primarily in two ways: by considering migrants' rights when developing new AI regulations; and by working directly with migrants to mitigate some of these risks.

Technological innovation has always been a part of the international community's response to migration. As the regulation of AI systems continues to evolve, paying attention to the protection of migrants will help to distinguish between innovations that will support migrants and those that will put them at risk.

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