

*Ethiopia 2022 In 2021 Boru was a beneficiary of an Ethiopian Red Cross Society multipurpose cash grant to support with food insecurity following the East Africa locust invasion. A joint assessment led by the Food and Agriculture Organization indicated that the invasion caused large crop losses and widespread destruction of vegetation and pastures. One million Ethiopians faced severe food insecurity as a direct result of the locust infestation. © Matthew Carter / IFRC*

# SOCIO- ECONOMIC INEQUITIES



**Strengthen social  
protection systems  
for communities**

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# INTRODUCTION

In the long run, communities and societies need to become more resilient to a range of hazards. This is partly a matter of developing infrastructure and policies specifically directed at hazards such as disease outbreaks, but that is not enough. The most resilient societies are those in which the great majority of the population is thriving. Such societies have fewer inequities; provide more people with full and productive employment, decent livelihoods and access to affordable healthcare; and exhibit a high degree of trust between people and institutions. To build resilient and thriving societies, countries need to improve all of their essential systems and services, not just those related to health but also others such as education, social protection, and water and sanitation. These are not only contributing factors to inequity but also critical enablers in reducing outbreak risks and impacts. In particular, **nations must expand and improve their social protection systems and remove legal and practical barriers preventing people from accessing services.**

## Definitions

**Social protection programmes:** Help individuals and families, especially the poor and vulnerable, to cope with crises and shocks, find jobs, improve productivity, invest in the health and education of their children, and protect the aging population ([World Bank, 2022a](#)). They include direct services, such as shelter or employment programmes, as well as financial assistance, notably through cash transfers.

**Drivers of disease** are the conditions that help diseases spread. They include poor nutrition, unsanitary living conditions, poor hygiene, environmental factors and other conditions that are strongly associated with socioeconomic inequity.

## 4.1 WHAT WE SAW

# THE PANDEMIC FLOURISHED ON SOCIOECONOMIC INEQUITIES

It was sometimes said that the COVID-19 pandemic was a great equaliser because everyone experienced it together, with even the most privileged feeling some of the effects. However, the truth is that the effects of the pandemic, especially the socioeconomic effects, were felt very differently across the world. Even more concerning is the fact that existing inequities were aggravated by the pandemic or by measures adopted to respond to it. In particular, the crisis had its most severe impacts on populations that were already left behind, for example those who were marginalized, forgotten, discriminated against or already affected by certain conditions of vulnerability, such as poverty, isolation and humanitarian crises. Alongside this, there have been severe impacts on government systems and services, such as social safety nets.

At the same time, the COVID virus's spread and mutation was partly driven by inequities.

The socioeconomic impacts of the COVID-19 pandemic and response are arguably as severe as the health consequences. In January 2022, the UN reported that ongoing waves of COVID-19 infections were one of the main factors slowing the global economic recovery ([UN DESA, 2022](#)). The report predicted that developing countries will take a greater long-term hit than wealthier nations, and that in Africa the absolute number of people living in poverty would rise through 2023.

Similarly, an IFRC report based on National Red Cross Red Crescent Societies' experience during COVID-19 found that millions of people were experiencing "reduced employment and loss of income; increased food insecurity; fewer protections against violence; and exacerbated mental health issues" ([IFRC, 2021b](#)). People who were already vulnerable were more severely impacted. For instance, people in insecure low-paid jobs were more likely to lose them altogether, especially in the informal economy. This held true even in countries where reported rates of COVID-19 were often low: government restrictions such as closure of non-essential businesses meant households lost income and suffered food insecurity in early 2020, while receiving little outside assistance ([Furbush et al, 2021](#)). In this way, COVID-19 amplified existing inequalities, heightened conditions of vulnerability, and undermined resilience and coping strategies.

### 4.1.1 Inequities worsened the spread and impact of the virus

One of the most apparent consequences of socioeconomic inequities was to accelerate the spread of the virus, and to unleash more severe impacts on those already most vulnerable ([OECD, 2022](#)).

For instance, in many countries women are still expected to perform their traditional gender roles such as caring for family members in the home. The Organization for Economic Cooperation and Development (OECD) estimates that women carry out up to 10 times as much care work as men ([OECD, 2020](#)). This put

them **at greater risk of contracting COVID-19** as they had more contact with infected family members ([Connor et al, 2020](#)). While death rates from COVID-19 have often been higher among men, middle-aged women are **more prone to the lingering symptoms dubbed ‘long COVID’** ([Torjesen, 2021](#)).

Similarly, economically disadvantaged migrants and refugees have been at increased risk of contracting the coronavirus due to their living and working conditions ([WHO, 2021](#)). They often found themselves unable to comply with preventative measures to keep themselves safe. It is virtually impossible to self-isolate and maintain physical distance when you live or work in overcrowded conditions, including in dormitories or camp or camp-like settings.

Discriminated and excluded communities in many countries were more likely to experience the primary and secondary health impacts of COVID-19, and they often experienced more severe socioeconomic impacts ([IDS, 2020](#)). In the UK, virtually every minority ethnic group faced higher risks of death from COVID-19 than the country’s white British population. Often this was because they were more likely to work in health and social care or to live in overcrowded areas – increasing their chances of exposure to the virus ([Platt, 2021](#)). In the US, Native Americans were significantly more likely to be hospitalized with the virus than white people – highlighting the risks faced by indigenous groups ([Weeks, 2021](#)).

Poverty was also a risk factor for COVID-19. In Mexico, a 2021 study revealed that the poorest population groups had lower rates of COVID-19 survival. The researchers compared nearly 250,000 COVID-19 patients diagnosed between February and July 2020. People living in municipalities with extreme poverty were at a 9% higher risk of dying compared to those living in non-poor municipalities ([Millán-Guerrero et al, 2021](#)). In Afghanistan, people often had no choice but to be outside in markets selling goods or trading them for food, risking infection ([Glinski, 2020](#)). Similarly, in England working-age adults living in the poorest areas were almost four times more likely to die than those living in wealthy areas. Two key factors were limited statutory sick pay and the difficulty of accessing isolation payments, both of which made it harder for poor people to self-isolate. At the same time, people living in deprived areas were significantly more likely to have pre-existing health conditions, making them more vulnerable ([Mahase, 2021](#)).

Some groups were also more physically vulnerable to COVID-19, and not enough was done to mitigate these risks. Persons with disabilities often have health conditions that make them more vulnerable to COVID-19. As a result, persons with disabilities died at higher rates. Older people are also more prone to severe health impacts from COVID-19 for similar reasons, and this can be exacerbated by social factors such as living conditions. Older people often live with family members in a crowded space, in contexts where other alternatives are unavailable, or in institutional settings like nursing or retirement homes. Both settings carry a greater risk of infection ([WHO, no date](#)). Alternatively, older people live alone, with reduced ability to call for help, reduced access to information, and less inclination to detect a problem ([IFRC, 2020b](#)).

## **4.1.2 Livelihoods were impacted and poverty worsened**

The socioeconomic disruptions caused by the pandemic and response led to an increase in poverty, including extreme poverty. The number of people at risk of falling into poverty increased, and this seems to be a lasting effect because of the ongoing uncertainty about the global economy. One study estimated

that the number of people living in extreme poverty rose by 115 million in 2021, largely due to the pandemic ([Mendez Ramos and Lara, 2022](#)). The World Bank has forecast that global poverty rates will be just as high in 2022 as they were in 2019, meaning several years of progress have been lost ([World Bank, 2022b](#)).

People working in informal sectors and/or without contracts were significantly impacted. As a result, several groups faced especially large livelihood losses. For example, women's livelihoods were disproportionately harmed. A 2020 report by UN Women found that women's employment was 19% more at risk than men's during the pandemic. This was partly because they were more likely to work in the informal sector without a contract and partly because they often worked in services and tourism; both were severely affected by the restrictions governments imposed to control the disease. The UN estimated that the gender poverty gap will widen by 2030 as a result. While in 2021 there were 107 women in poverty for every 100 men, by 2030 that could rise to 110 ([Azcona et al, 2020](#)).

Migrants, including asylum seekers, refugees and other displaced persons, faced similar livelihood losses. In many instances, their livelihoods were precarious and they had limited access to government support services. Those with undocumented or irregular status were at particular risk. Many migrants work in informal labour, without contracts or other protections. They were often the first to be laid off when businesses ran into difficulty and many did not have access to government-related socioeconomic support measures, or had only limited access ([Jones et al, 2021](#)). In Türkiye, by late 2021 many refugees had adopted negative coping strategies, such as eating less preferred and cheaper food ([Turkish Red Crescent, 2021](#)).

In addition, most countries' economies are not optimized for persons with disabilities. For instance, remote and hybrid working have generally been discouraged, even though they enable persons with disabilities to work. The pandemic saw a huge increase in remote working, but many employers are now pushing employees back into the workplace. Any loss of income is especially harmful for the households of persons with disabilities due to the extra costs of assistive devices and other essentials. As a result, the economic disruption of the pandemic has placed persons with disabilities at high risk of being pulled into poverty ([UN OHCHR, 2020a](#)).

### 4.1.3 Education was disrupted for millions of children

In many countries schools were closed, in some cases for many months. The extent and duration of the disruption varied greatly: some countries like Denmark only closed schools for one to two months, but others like Mexico and the United Arab Emirates kept at least some schools closed for almost a year ([Leon Rojas et al, 2022](#); [Meinck et al, 2022](#)). In September 2021, the United Nations Children's Fund (UNICEF) estimated that schoolchildren had lost a total of 1.8 trillion hours of in-person learning ([UNICEF, 2021](#)). Migrant children were particularly impacted because their education was often already disrupted by barriers such as enrolment issues and language barriers ([You et al, 2020](#)).

School closures interrupted children's education, along with physical and social activities, both of which are critical to their development. In many cases, schools adapted by switching to remote learning (see Box 4.1). However, this did not work for everyone, particularly those with poor internet access or limited space. For example, among refugees in Türkiye, 31% of children could not access their online learning

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**In many countries, social protection systems are limited, despite major boosts during the COVID-19 pandemic. Only 46.9% of the world's population is covered by social protection benefits.**

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([Turkish Red Crescent, 2020](#)). When children are temporarily cut off from education, a significant number never return ([Save the Children 2020](#)). School closures also had additional knock-on effects. For instance, the loss of access to school meals was significant for children living in poverty, who often get a significant proportion of their nutrition at school. A study by the Humanitarian Observatory of the Argentine Red Cross found that children were “particularly vulnerable” to psychosocial harms ([Argentine Red Cross, 2021](#)). Children who could not physically attend school often displayed anxiety, low mood, sleep and appetite disorders, and impaired social interactions. The researchers concluded: “In emergency situations, school is a fundamental space for emotional support, educational continuity and social and material support to students and their families”.

## 4.1.4 Social isolation was prevalent and mental health was harmed

Many people experienced severe social isolation. Often this was due to government restrictions on movement. However, even outside of enforced lockdowns, people who felt particularly vulnerable due to their higher risk of infection (as a result of underlying health conditions, disabilities or age) had to isolate themselves to avoid contracting the virus. Alongside this, many people experienced mental health impacts: in 2020 it was reported that about one in three people were suffering stress, anxiety or depression ([Salari et al, 2020](#)).

Many older people were already isolated or experiencing mobility challenges. This made it harder for them to get the information about what to do during the pandemic and to obtain essential food and medicines ([UNSDR, 2020](#)). Furthermore, their social ties with friends, family and neighbours were often severely disrupted. For example, in Armenia, older people reported that daycare centres that acted as social hubs were closed ([Armenian Red Cross Society, 2021](#)).

Mental health impacts were severe for older people, at least in some countries. In the UK, some older people experienced anxiety, depression, low mood and loss of hope. Even when restrictions were eased by the government, many were still too afraid to go out. There is also evidence of new and emerging cognitive decline, which may have been exacerbated by the pandemic ([Age UK, 2020](#)).

Children and young people have experienced similar harms ([Global Youth Mobilization, no date](#)). In a survey of adolescents and young people in Latin America and the Caribbean, 27% reported feeling depressed at some point and 15% reported feeling depressed in the previous seven days. Furthermore, 46% reported having less motivation to do things they normally enjoy. They had also become more pessimistic about the future ([UNICEF, 2020](#)).

Similarly, many persons with disabilities rely on specific support to be able to access essential services. As a result, movement restrictions sometimes had a more significant negative impact on persons with disabilities than those without ([UN OHCHR, no date](#)). For example, rules requiring people to attend medical appointments alone reduced accessibility for people who need an assistant ([UN OHCHR, 2021](#)).

There is considerable evidence of mental health impacts on children, some of which are at least partly attributable to school closures ([IFRC, 2021f](#)). A meta-analysis of 17 systematic reviews identified a wide range of mental health symptoms including anxiety, depression, sleep disorders, suicidal behaviour and stress-related disorders.

## 4.1.5 Violence against vulnerable groups increased

Violence against women increased during the pandemic. One survey reported that since the pandemic approximately 40% of women feel more unsafe in public spaces, 25% say household conflicts have become more frequent, and 70% say verbal or physical abuse by a partner has become more common ([UN Women, 2021](#)). Restrictions such as lockdowns put women in particular at **greater risk of sexual and gender-based violence**. Women with abusive partners found themselves effectively shut in their homes, often for months on end. This meant they spent more time in contact with their abusers, while also being unable to get help. In early 2020 in South Africa, the first week of the national lockdown saw a 30% increase in gender-based violence cases compared to the same period in 2019 ([MSF South Africa, 2020](#)).

Multiple factors contributed to increased violence against children. These include “movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety” ([End Violence Against Children, 2020](#)). School closures meant some children found themselves confined to their homes with abusive relatives, and they reported more incidences of violence as a result ([Ritz et al, 2020](#)). Informal networks of support from family members and friends were disrupted. While some children were able to communicate with loved ones online, there was also an increase in online bullying ([Bhatia et al, 2021](#)).

LGBTQ+ people have also suffered increased rates of violence, for example being confined with disrespectful family members or subjected to selective arrests. In some countries, they have been “singled out, blamed, abused, incarcerated and stigmatized as vectors of disease” ([UN OHCHR, 2020b](#)).

## 4.1.6 Many groups were excluded from essential services

For those on the ground, a critical issue was lack of access to government services. Even before the pandemic, migrants living in precarious situations, including those who lacked residence documents or had irregular status, faced barriers to essential services like healthcare, shelter, food and legal assistance. Sometimes this was because they were explicitly excluded from government programmes. However, indirect factors or practical barriers also played a role. For instance, many migrants fear arrest or deportation, live in places where there are no adequate health services, or face language barriers ([IFRC, 2018](#)). The barriers were exacerbated during the pandemic ([Red Cross Red Crescent Global Migration Lab, 2021a](#)). Many migrants and refugees could not obtain COVID-19 testing and tracing to determine if they had the disease. Nor could they obtain treatment if they fell ill. In some cases, lockdowns and border closures left people stranded without support or at risk of becoming undocumented ([IFRC, 2020c](#)). Finally, migrants were often initially excluded from vaccination plans – especially undocumented migrants – and this has not yet been fully remedied (see Chapter 3) ([Red Cross Red Crescent Global Migration Lab, 2021b](#)).

## 4.1.7 The widespread harms of disasters

None of this should come as a surprise. Diseases like tuberculosis are preventable but continue to devastate lives and communities because poverty enables them to spread (Moutinho, 2022). COVID-19 is not unusual in this respect. More broadly, it is well established that disasters of any kind can have enormous socioeconomic consequences, including worsening inequities. For instance, poor people are disproportionately affected for three main reasons. First, they are more likely to be exposed to hazards as they are often forced to live in less desirable and more exposed areas, such as on river banks and in flood zones with poor shelter standards. Second, they often lose a larger fraction of their wealth when hazards occur. And third, they have less ability to cope and recover due to a lack of financial reserves and alternative places to live (Hallegatte et al, 2020). Similarly, disasters are not gender neutral; instead, women are often more severely affected than men, particularly in their economic opportunities (Llorente-Marrón et al, 2020). For example, gender-based violence often increases following a disaster (IFRC, 2015). Likewise, violence against children and human trafficking also both tend to increase (IFRC, 2021e). In this respect, the COVID-19 pandemic has operated much like any other kind of disaster, just on a vastly larger scale. If we are to minimize the impacts of future hazards like disease outbreaks, we must address these inequities now.



**Burkina Faso 2020** As the number of confirmed cases of COVID-19 increases in Burkina Faso, volunteers from Burkinabe Red Cross are carrying out series of sensitization and mitigation activities against COVID-19 in internally displaced persons' camps in Kaya. A spread of the virus among internally displaced persons could be devastating. © Burkinabe Red Cross Society

## **BOX 4.1 / CASE STUDY**

### **EDUCATING CHILDREN IN ZIMBABWE THROUGHOUT THE PANDEMIC**

The Red Cross Independent College (RCIC) in Harare, Zimbabwe, was established in 2015 ([IFRC on Facebook, 2018](#)). The school started with a small number of orphans and vulnerable children with financial support from donors. Donations ended in 2019, so the school also enrolled fee-paying students to cover its running costs.

In response to the COVID-19 pandemic, the Zimbabwean government implemented lockdowns, including closing schools ([Rwezuya et al, 2021](#)). This posed a challenge to the RCIC, both educational and financial. As a mitigatory measure, the government introduced National Radio Lessons, which increased access to learning opportunities for the learners ([Mokwetsi, 2020](#)).

To continue the children's education, the RCIC administration decided to switch to online platforms. Prior to the pandemic, this had not been a popular option in Zimbabwe, so many schools did not have engaging online educational programmes prepared. The RCIC was no different. Students and parents were also hesitant about online education at first. Additionally, because RCIC has both boarders and day pupils, some students could not be reached as they lived outside Harare.

Online lessons began with a number of fee-paying students. Access to digital technology and the internet was an immediate problem. Some students and parents did not have smartphones or internet access, so could not join the classes. RCIC was unable to provide technological support to them, but it did provide internet access for teachers. The best solution the school found was to use Google platforms like Meet and Classroom, alongside WhatsApp messaging.

Consequently, some students opted not to join. Some parents choose to hire private tutors instead of paying school fees. Others sent their children for extra lessons in their own communities, although these were declared illegal by the government.

The online lessons made a difference, but the school shutdown still impacted the RCIC. All students were affected differently, but for many their grades have declined. Syllabus coverage was disrupted and online lessons were not as productive as in-person classes. The poorest students, unable to access the internet, were left out. Finally, students' grades in national examinations also fell as the exams continued despite the disruption to education.

The challenges of the pandemic underlined the RCIC's need for a functional and well-equipped computer lab and reliable internet services. The teachers still need support accessing technology. The RCIC also plans to use online learning during non-emergency times, alongside traditional classes, in order to normalize it ahead of future crises.

## 4.2 WHAT WE LEARNED

# WE CAN'T NEGLECT THE SOCIOECONOMIC IMPACTS OF HAZARDS

The socioeconomic impacts of COVID-19, and other disasters, highlight that we must respond to hazards in a holistic manner. They are systems problems in which a single shock ramifies throughout society, creating multiple impacts. Even if COVID-19 could somehow be eliminated tomorrow, the ripples of the pandemic would spread for years to come.

The 17 Sustainable Development Goals (SDGs) offer a framework for thinking about the whole-of-society impacts of hazards and how to reduce overall vulnerability ([UN DESA, no date](#)). The goals range from “no poverty” to “sustainable cities and communities”. While the targets are listed separately, there are many synergies. For instance, one goal is “clean water and sanitation”, which contributes to “good health and wellbeing”. The diverse impacts of COVID-19 can be seen in our progress towards the SDGs, which has been slowed and in some cases reversed ([Lekagul et al, 2022](#)). According to *The Sustainable Development Goals Report 2022*, it is unlikely that the SDGs will be achieved as intended by 2030 ([UN DESA, 2022a](#)). COVID-19 erased more than four years of progress on poverty, halted progress on universal health coverage, and contributed to 147 million children missing over half of their in-person schooling in 2020–2021 (see Box 4.2).

People who are affected by multiple discriminations are inherently more vulnerable to disease outbreaks and other hazards. Inequities lead to economic stresses, uneven access to essential services like healthcare, and political tensions. Societies in which this occurs widely have fewer capacities for coping with hazards. They are more prone to major disruptions such as collapses of essential services. In such inequitable communities, even a small hazard can be the straw that breaks the camel's back. However, by reducing inequities, bolstering social safety nets and boosting livelihoods, it is possible to reduce societal vulnerability.

Social protection systems, including social safety nets, were crucial for helping people to endure the shocks of the pandemic ([Tirivayi et al, 2020](#)). Many governments rolled out new schemes, for example making unconditional cash transfers to members of the public. A ‘living review’ by the World Bank found that 3,856 social protection and labour measures had been planned or implemented by 223 economies by January 2022. Many were introduced in a rush early in the pandemic: in March 2020, an average of 180 were created every week. During 2020 and 2021, countries invested over US\$3 trillion in these interventions. Cash transfer programmes were the most prevalent (see Box 4.5), although in-kind donations of goods like food were also common ([Gentilini et al, 2022](#)).

Unfortunately, these social protection systems were sometimes slow to respond and did not reach everyone who needed help. Slow responses were extremely problematic because many people had

limited reserves of cash or food (see Box 4.3). For instance, Malawi announced in April 2020 that it would provide urban cash transfers, roughly when the government also announced a lockdown. However, there were multiple delays and payments did not begin until February 2021 ([Bastagli and Lowe, 2021](#)).

Similarly, social protection schemes often did not cover everyone. In many countries, the COVID-19 handouts were far more comprehensive than previous mechanisms. However, this was often regarded as a temporary necessity for the duration of the emergency, rather than a shift towards a more inclusive form of social protection for the long term. In some cases, negative stereotypes about recipients were created and/or reinforced. In South Africa, women were primarily contacted as a means to reach the people for whom they cared, rather than to address their own welfare. Women were also disqualified from receiving grants if they were already receiving a child support grant. Gender advocates have expressed concern that these arrangements will negatively affect women's rights. Meanwhile, in Peru, marginalized urban populations were sometimes perceived as 'dirty' or 'disorganized' and therefore a public health threat, and these perceptions were exacerbated during the pandemic ([Bastagli and Lowe, 2021](#)).



**South Africa 2020** The South African Red Cross Bloemfontein branch and the South African Department of Health have set up screening and testing mobile labs, where South African Red Cross volunteers assist patients with temperature readings and medical history in cases of possible COVID-19 exposure. © Moeletsi Mabe / IFRC

## BOX 4.2 / CASE STUDY

### SUSTAINABLE DEVELOPMENT GOALS DELAYED IN LATIN AMERICA AND THE CARIBBEAN

The Sustainable Development Goals (SDGs) were agreed by the United Nations in 2015, and nations committed to achieve them by 2030. However, the COVID-19 pandemic contributed to delays in multiple targets.

In a 2022 report, IFRC found that multiple SDG targets are now set to be missed in Latin America and the Caribbean. It assessed the pandemic's impact on six SDGs and concluded that all had been delayed, some by decades. For instance, the eradication of extreme poverty in the region had been set back by 30 years (SDG 1), diets had deteriorated (SDG 2), and 10% of jobs were lost (SDG 8) (IFRC, 2022d).



**Brazil 2021** The Brazilian Red Cross is responding to the COVID-19 emergency by delivering humanitarian assistance to vulnerable populations and carrying out psychosocial support and hygiene promotion tasks.  
© Brazilian Red Cross

## BOX 4.3 / CASE STUDY

### DELAYS IN SOCIAL PROTECTION DURING THE PANDEMIC

In May 2020, Peru announced that it would roll out a quasi-universal scheme of cash transfers called the Bono Familiar Universal. This replaced three pre-existing emergency schemes, each of which was aimed at a limited group of recipients.

Households that were already registered began receiving payments in May. However, those who needed to register for the first time had to wait until August for their first payment. These people had to endure a strict lockdown that lasted from mid-March to the end of June (Lowe et al, 2021). People who were not previously registered were mainly informal workers and informal domestic employees from disadvantaged backgrounds and vulnerable groups.



**Peru 2020** The Peruvian Red Cross have been distributing food supplies, kitchens and utensils to different Ollas Comunes (spaces self-managed mainly by women, where they organize to cook for their community, prioritizing children and the elderly) in different parts of Lima, capital of Peru. This distribution was in Villa Maria del Triunfo. © Peruvian Red Cross



## 4.3 WHAT WE NEED TO DO BOOST SOCIAL PROTECTIONS TO HELP COMMUNITIES THRIVE

Another crisis like COVID-19 will surely arrive, and it could take many forms (see Chapter 1). Before it happens, we need to strengthen all of our systems, if we are to be ready.

Much of the focus of this report is on health systems: how to bolster them at the community level (Chapter 2) and the international level (Chapter 3), how to improve our collection and analysis of health data (Chapter 5), and how to improve health law (Chapter 6). However, we need to go further. COVID-19 has been a multidimensional crisis and the same will be true of future major hazards ([UNDP, no date](#)). Much like COVID-19, the next crisis will have its most severe impacts on the most vulnerable; cause lost livelihoods and worse poverty; disrupt children's education; threaten everyone's mental health; and increase violence against vulnerable groups. That means all of society needs to become more resilient.

If we again consider the SDGs, the delays caused by COVID-19 can be reversed by strong action. A 2021 report by the UN Development Programme concluded that, even before the pandemic, we were unlikely to achieve many targets by 2030 as planned ([Abidoye et al, 2021](#)). However, the report also argued that progress can be accelerated by targeted interventions in key areas, including social protection. This would be enough to overcome most of the losses caused by COVID-19 and enable many more countries to reach their targets by 2030.

Similarly, some of the disruptions to education have been ameliorated by concerted action. 33 National Red Cross and Red Crescent Societies supported the education of 4.2 million people, either by continuing their education and/or by enabling them to safely return to schools ([IFRC, 2022a](#)). This was achieved through a number of programmes, including: risk communication and hygiene promotion in schools; in-kind or cash assistance for distance learning equipment and materials; and home-schooling support to learners.

Given the severe impacts of inequities during the pandemic, there is an urgent need to significantly improve social protection, including social safety nets ([Cuevas Barron et al, 2021](#)). In many countries, social protection systems are limited, despite major boosts during the COVID-19 pandemic. Only 46.9% of the world's population is covered by social protection benefits ([ILO, 2021](#)). Yet social protection systems are essential to help people survive disasters and thrive afterwards, so they must be built up ([Climate Centre, no date](#)). The Risk-informed Early Action Partnership (REAP) has argued that social protection is crucial for climate-vulnerable populations ([REAP, 2021](#)); their arguments apply equally well to pandemics and other hazards. Similarly, from an early stage IFRC's Emergency Appeal for COVID 19 included socioeconomic impacts as one of its three main pillars (see Box 4.4).

## **BOX 4.4 / CASE STUDY**

### **EMERGENCY SOCIAL SAFETY NET**

### **SOCIAL PROTECTION FOR REFUGEES IN TÜRKIYE**

Social protection schemes can help the most vulnerable people through a severe shock. This is illustrated by the experience of refugees living in Türkiye during the COVID-19 pandemic.

Türkiye is home to more than 4 million refugees: the largest refugee population in the world. Many have fled the ongoing conflict in Syria. Despite major efforts from Türkiye's government, many are living in precarious circumstances. In response, the Emergency Social Safety Net (ESSN) launched in 2016. As of late 2022 it hands out monthly cash donations to over 1.5 million of the refugees (see Box 4.5). Funded by the European Union, it is run by the IFRC and the Turkish Red Crescent Society, alongside government institutions ([IFRC, no date](#)).

The ESSN is the largest humanitarian programme in the histories of the EU and IFRC ([ECPHAO, no date](#)). It exemplifies how humanitarian organizations can bolster national social protection schemes by reaching vulnerable people that would otherwise be excluded – thus improving **equity**.

When the COVID-19 pandemic began in early 2020, many refugees became unable to work due to restrictions. 78.4% of ESSN beneficiary households and 81.2% of non-beneficiary households reported that at least one household member lost their job due to COVID-19.

In response the ESSN distributed the IFRC's largest cash transfer ever. Money was given to 1.8 million refugees: each family received the equivalent of about EUR 128. For many, this was their only income during lockdowns. A report published in 2021 found that refugees who received the cash transfers were less likely to resort to negative coping strategies compared to non-recipients. They also had lower average debt ([IFRC, 2021a](#)).



The best social protection systems are shock responsive, meaning they automatically begin providing assistance when certain warning signs of a disaster are observed. Aid is often best delivered in the form of cash or vouchers (see Box 4.5) ([UNDP, 2021](#)).

It is essential to ensure that everyone is registered with the social protection system. This ensures people do not fall into poverty, or suffer disproportionate impacts on their health, as a result of future crises ([World Bank, 2022c](#)). In many countries, governments are unable to reach some communities. Furthermore, some individuals may not have identity documents or regular immigration status and so cannot register. In some cases, people may simply be unaware that the social protection system even exists. Humanitarians and other local actors with strong ties to local communities can play a key role in connecting people, including migrants, with social protection systems, helping them to register and ensuring they receive help ([CashHub, 2020b](#)).

The COVID-19 era has demonstrated that social protection systems can be improved dramatically if the political will is there. For example, the government of Ecuador worked with the World Bank to expand and improve its social protection systems. Emergency transfers were expanded in early 2020, first delivering two monthly installments of US\$60 to 400,000 vulnerable households, and then a one-off payment of US\$120 to over 400,000 additional beneficiaries. Alongside this, the government reduced the average time needed to access unemployment benefits from 60 days in 2019 to 6 days. It also created a Migratory Registry to ensure public services were provided to Venezuelan migrants and refugees ([World Bank, 2021](#)).

However, social protection systems by themselves are not a solution to all inequities. Discrimination and violence demand other solutions. One is to protect people's rights in law (see Chapter 6). More broadly, the shift towards thriving communities must prioritise equity and inclusion. It is essential to reach everyone – especially populations that are marginalized, underrepresented or discriminated against, and groups that experienced higher or increased vulnerabilities in the COVID-19 pandemic and other recent disasters, and suffered disproportionately as a result. There is a complex interplay between violence, discrimination and exclusion: they are inseparably linked and must be addressed together ([IFRC, 2022c](#)). The more this vicious cycle of violence, discrimination, exclusion and vulnerability can be broken, the better the chances of holistic, sustainable and equitable solutions for the next disease outbreak and other hazards.

Achieving this form of resilience requires joined-up action from humanitarian, development, health, peace and climate actors. There also needs to be contributions from civil society, including faith-based institutions. While these fields are distinct, they should not be siloed. Only by taking this holistic whole-of-society approach will we truly recover from the COVID-19 pandemic. It was not simply a health crisis: it caused enormous economic harm, set back human rights and triggered social crises. If we want to ensure that such a calamity does not happen again, a truly coordinated effort is necessary. The focus must be on enhancing communities' capacities and helping them to take the lead in shaping their own futures.

## BOX 4.5: CASH TRANSFERS AS A FORM OF SOCIAL PROTECTION

One of the most important forms of assistance is cash transfers. Compared to other forms of aid, cash transfers often offer the greatest possible flexibility to recipients, granting them dignity and agency. Such transfers have been a crucial form of social protection during the COVID-19 pandemic ([CashHub, 2020a](#)). They have helped people escape falling into poverty, or falling further, when their livelihoods were impacted.

Like all forms of aid, there are limits. Cash transfers are only viable if factors like local market conditions are suitable. Furthermore, they require a high degree of **trust, both by donors and by recipients** – the latter because cash transfers necessitate handling personal data like bank account details and legal status.

However, these issues are offset by the enormous advantages of cash transfers. A key plus point is their scalability. It is possible to help large numbers of people quickly, with relatively minimal resources and staff. For example, in early 2020 the IFRC paid out the largest set of cash transfers in its history: EUR 46.4 million to more than 1.7 million refugees living in Türkiye (see Box 4.4) ([IFRC, 2020a](#)). Similarly, in the Caribbean, IFRC National Societies provided thousands of people with cash and similar forms of aid such as supermarket vouchers. By April 2022, the Jamaica Red Cross had provided 805 cash cards. It has also distributed food packages to 10,000 families. Similarly, the St Lucia Red Cross provided cash cards, supermarket vouchers and food packages to over 3300 affected families ([IFRC, 2021c](#)). Many National Societies used cash transfers for the first time. The Azerbaijan Red Crescent Society gave cash and vouchers to nearly 1,000 vulnerable families who were badly affected by the pandemic ([IFRC, 2021d](#)).

Cash transfers are continuing to grow in usefulness. For example, the ongoing conflict in Ukraine has driven millions of refugees to neighbouring countries, and IFRC and National Societies have responded in part with cash transfers ([IFRC, 2022b](#)). By late May, over CHF 4.3 million had been delivered. The response was accelerated by a new self-registration app that enabled thousands of refugees to enrol themselves, allowing volunteers the time to support individuals with more complex needs ([Polish Red Cross, no date](#)).



# KEY RECOMMENDATIONS

**Include responding to inequalities in every health emergency and disaster response.** It is crucial to tackle inequities in preparedness and response for every crisis, disaster and pandemic. It is necessary to assess, analyse and respond to inequities during every disaster response. Key actors (including local actors) must have the attitude, motivation and capacity to analyse who is most affected because of inequities, exclusions and barriers – and they must develop strategies to ensure those people's needs are met. To achieve this, we need a much stronger focus on tackling inequity in relevant public health emergency/disaster law, policy and planning (see Chapter 6); specific data collection methods to identify areas of inequity; as well as bespoke training for responders.

**Expand and improve social protection systems as much in advance of crises as possible.** The COVID-19 pandemic highlighted that societal inequities can exacerbate hazards like disease outbreaks. Therefore, reducing inequities by boosting social protection can contribute to improving the overall resilience of society. Social protection systems must be built up so they cover more of the global population, particularly those who need it most as identified by inclusive vulnerability and risk assessments. They must be shock responsive and serve as an agile tool of crisis response, delivering aid in a way that people can use flexibly, such as cash. Local actors have a key role to play in ensuring everyone is registered, including vulnerable and marginalized people.

**Address formal and informal barriers to essential services like health.** Inequities are often perpetuated by discrimination and other barriers to access that are systemic and less tangible. During the pandemic, groups like undocumented migrants often struggled to get COVID-19 testing, treatment or vaccines. Sometimes systems legally exclude some groups or communities; sometimes they create disincentives, such as fear of arrest or unaffordable services. Just as often, services are unavailable in – or do not prioritise – certain communities, which fuels disaffection and mistrust. All of these barriers must be addressed in laws, policies, plans and training to ensure the safety, dignity and wellbeing of all members of society.

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