

THE IMPACT OF COVID-19 ON PEOPLE EXPERIENCING POVERTY AND VULNERABILITY

*REBUILDING EUROPE WITH A
SOCIAL HEART*

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EXECUTIVE SUMMARY

"My short-term aspiration is that things get normal, that I get my job back, that I can go on vacation. To get enough money to support myself"

Kristine, 29 years old, Oslo, Norway

"I would like to see more support for single parent families like mine. I have put aside my personal and professional development to care for my son alone and thus I have come to this situation. Getting a job when you enter the "new normal" will not be easy, but you will have to try"

Maria, 43 years old, Salamanca, Spain

"I was locked up in prison for two and a half years and released just a week before COVID-19 pandemic was announced. It was a disaster. Prison authorities in our country don't have a plan for us convicts. They open the gate, give you a bit of money and say you are free. Many of us don't have anywhere to go, nobody to turn to. Corona crisis made it all worse."

Boštjan, male, 42, Ljubljana, Slovenia

In March 2020, EAPN responded immediately to the explosion of the COVID-19 epidemic by publishing an [initial statement](#), an [Open Letter to the EU institutions](#), then a campaign [letter](#) to Commissioner Schmit asking for urgent backing for a Framework Directive for Minimum Income signed by 25 MEPs and other stakeholders. EAPN decided to carry out detailed research into the COVID-19 crisis and its impact on people experiencing poverty and vulnerability with the participation of its national networks and European member organisations.

This report analyses the situation of health, social protection and minimum income systems before the pandemic and the positive and negative changes produced as a result of the spread of the virus and the measures adopted by governments to tackle it. The conditions of people suffering from poverty and vulnerability in countries participating in the study are described and analysed in detail, considering the impact that this crisis has also had on gender as well as other forms of inequality. A special section is devoted to delving into the worrying increases in population control and surveillance, carried out by some governments during the first months of the pandemic, and their possible threats to democracy and civic freedoms. After providing an in-depth analysis of the current situation, EAPN makes important recommendations to national and European authorities, in order to leave no one behind, by rebuilding a rights-based Europe with a social heart and a commitment to ending poverty and reducing inequality. Annex 1 captures key EU trends and data, whilst Annex 2 provides a Country Annex summarising detailed input from the national level regarding all areas of the report. Responses were received from 25 national networks (AT, BE, HR, CZ, DK, FI, FR, DE, EL, HU, IC, IE, IT, LT, NL, MA, NO, PL, PT, SB, SE, SK, SL, ES, UK) and 3 European Organisations (SMES, IFSW and Age-Platform).

According to the responses to the EAPN survey carried out in May 2020, before the pandemic, the healthcare systems of 20 out of the surveyed European countries were already problematic and showed significant challenges and deficiencies in providing coverage and quality services for all, particularly for poor and vulnerable groups. Insufficient investment in healthcare provision generated structural shortcomings of trained medical staff, facilities and equipment, which translated into hardship and waiting lists for specialised medical services. Low-income, rural and remote regions had worse provision than urban areas. Mental health services were underdeveloped in most of the countries surveyed. Low-income groups had more unmet medical care needs than the rest of the population: homeless people and certain categories of social services and healthcare users were not covered. Undocumented migrants and asylum seekers could not access standard health care, in many countries. Due to the blurred boundaries between "health care" and "social care", insufficient attention was given to quality services particularly for the elderly and people with disabilities. High prices of medicines and medical services negatively impacted the health of people in poverty.

Social protection systems were underfunded in half of the surveyed countries and nearly all presented serious problems of coverage as well as inadequate levels. In many countries, benefits or income transfers have a very low impact on poverty reduction.² The complexity of social protection systems prevented people facing poverty and exclusion from claiming the benefits they are entitled to. Regional disparities in accessing social protection and services were extensive. Over the last decade, there has been a tightening of eligibility criteria and a reduction in the level of working-age benefits. Pensions for older people were low and set unfairly. Problems of social protection of people with disabilities and dependency were generalised. Child benefit amounts were low or had insufficient coverage in many countries.

Minimum Income **schemes were considered challenging in different ways by 20 out of 23 surveyed countries.** There were outstanding territorial differences in the criteria used as well as the amounts of minimum income granted among certain regions or municipalities within the same country. Many vulnerable groups could not access the schemes due to restrictive criteria, namely age, origin, residence status, work history, plus other conditions such as location, education, digital skills and compliance with bureaucratic procedures. Moreover, the complexity of the procedures, means-tested access, the long waiting time to get the first payment, the stigmatisation of the recipients and other barriers, caused low take-up levels. Due to the inadequacy of minimum income amounts, most of the recipients were placed below the poverty line. Negative activation and conditionality which threaten reductions or cuts in benefits if strict conditions on job search and access are not reached, are also increasing trends.

The analysis provided above shows the characteristics and deficiencies of coverage and adequacy of the health, social protection and income guarantee systems of the countries analysed in this report, before the outbreak of COVID-19. Like an earthquake exposing a fault line, as the pandemic played out, it uncovered and deepened structural inequalities. **The already existing inequalities and structural weaknesses meant that the spread of the COVID-19 virus and the avalanche of negative social consequences has disproportionately hit those already poor or at high risk of becoming poor and vulnerable.**

The actions taken by the governments in relation to healthcare during the pandemic were evaluated quite positively by respondents to the survey. **However, there is a shared agreement regarding their negative impact on people already experiencing poverty and social vulnerability,** who started in a situation of disadvantage with regard to other groups who were not in poverty, in terms of prevalent diseases, disabilities, poorly perceived physical and mental health status and low level of wellbeing, as well as indebtedness, lack of savings, precarious jobs (if any) or low-amount benefits as the main household income, and insecure housing. The lack of sustained investment in efficient and universal health services, with well-paid staff and well prepared for pandemics, also became evident. In many countries, coordination and procurement of personal protective equipment were very problematic, which led to the over exposure of health and social care (and in general front-line) workers to the virus, as well as a consequent grave danger to their lives. The postponement of medical procedures, including essential operations in hospitals, the closure of day centres and therapeutic services for people with disabilities, in treatment or rehabilitation, is also likely to create negative health consequences in the following months.

² The 2020 Joint Employment Report (p. 126) highlights the decreasing ability of social transfers to reduce poverty in 16 Member States and this mainly due to inadequate benefit levels.

Concerning the performance of policy measures regarding their national minimum income and social protection systems, the majority of respondents considered that their functioning was “average” or “good”. **A set of similar measures were adopted in many countries:**

- income support: (extension of the unemployment benefit, income support for temporary workers and the self-employed, exceptional financial support for workers who had to stay at home to take care of the children);
- prevention of rising unemployment: (an exemption from social security contributions as an incentive for companies to avoid the shut-down, promotion of teleworking, short-time working schemes and a ban on layoffs),
- other measures: housing protection (postponement of mortgages and rent payments, ban on evictions and on utilities cuts) and social palliative measures (substitution of school meals, distribution of computers and broadband connections among students, relocation of homeless people among different facilities, funding for NGOs to reinforce food distribution and emergency assistance).

Although the efforts in general were considered good and rapid, the concern is that the response was not sufficient to prevent poverty, nor were the most excluded groups reached by those measures. There was also concern regarding the perceived temporary nature of the measures.

Prior conditions of poverty and social exclusion were decisive in increasing exposure and negative impact on homeless people, as well as on many immigrants and Roma who survived in settlements or sub-standard houses, since they were not able to avoid contagion or, if they contracted the disease, they were not able to recover in isolation. The existing structural racism and inequalities in the labour market, in housing, or in institutions such as the police, meant that some groups e.g. Black and Ethnic Minorities were being hit harder. Racial profiling and police brutality have been reported in many countries. This scenario was compounded by racist violence and speech online and offline. Unemployment, short-term retention schemes and lack of access to income support caused financial problems and anxiety that can be reflected in family life for those suffering from poverty and social exclusion. Poor children who relied on schools for support and meals were disproportionately affected.

Ethical problems have been exposed due to the appalling death toll amongst residents of care homes. There is ongoing questioning of the institutionalisation system which maintains the older people in residences with "specialised care", by separating them from their home environment, and treating them in a paternalistic way and, in general, subjecting them to a questionable approach regarding their human rights. The health crisis has also brought to light the isolation and vulnerability of people with chronic diseases and mental health problems, disabilities and functional diversity, with too few social services to protect them and the weakness of the system of formal and informal care, which has had to be complemented by extensive networks of NGO volunteers and practitioners.

Before the pandemic, women were already at a higher risk of poverty than men in all the surveyed countries, except for Norway. The pandemic had a huge gender impact, with women on the frontlines of the COVID-19 response. Women were overrepresented in the crucial and often low paid occupations in hospitals, care homes and education, while at the same time they also carried the biggest workload at home. The impact of intersectionality is particularly evident - where poor women from black or ethnic minorities, migrants or asylum seekers, including with disabilities - face a double or triple risk and burden.

Civil Society Organisations have demonstrated their crucial role in supporting people facing poverty and exclusion but have been severely impacted. The respondents explained that **many civil society organisations were forced to put planned activities on hold**; others were scrambling to shift their work online. They experienced:

1. Cuts in their funding levels, due to delays and cancellations from donors, postponed funding campaigns, lost revenue from closed social enterprises.
2. Changes in the way services were delivered, because of the reduction of volunteers' activities, the isolation of target populations and families who needed support services, the cancellation of programs, training, events, and internal operations.
3. Changes in their operation, with staff lay-offs, infected social workers, emotional trauma and low morale of practitioners and volunteers, and the inability to complete necessary reporting due to restrictive circumstances and the closures of government offices.

There have been **important positive lessons learnt**. Many respondents highlighted the clear urgent need for governments to invest in good quality, affordable and universally accessible, integrated public health and care services. Other shared positive experiences were the reappraisal of healthcare and social care workers, the immense capacity of civil society self-organisations and collaboration with the authorities, the role of volunteering and the importance of food and goods but also of social proximity to those in need. Most of the highlighted **good practices** are related to the devoted healthcare staff and the quick reorganisation of civil society support services and initiatives to provide food, protective face masks and hygienic kits to the most vulnerable.

The proposals at the national level are directed towards the promotion of rights and protection of the vulnerable groups who are negatively affected by the COVID-19 pandemic, as well as the increase in the generosity of income support schemes, building towards more effective long-term social systems and strategies to fight poverty and exclusion, in all its forms. Protecting people from poverty means taking steps towards securing affordable housing and energy, as well as the ethical management of debts. In the long term, the recommendations go hand-in-hand with social and ecological transformation, granting resources for better health care, social protection and social services for vulnerable people and those living in poverty. The anti-austerity message is also present, while the European Pillar of Social Rights is seen as the "lighthouse" and a reference point that could guide the delivery of wellbeing and rights for all.

At the EU level, it is vital that the short-term support is translated into a long-term improvement in welfare states and quality employment – guaranteeing adequate income (through social protection/minimum income and decent wages) and essential services as pillars of an effective EU integrated strategy to fight poverty. This must be set within a coherent [comprehensive post-2020 strategy](#),³ based on social rights, that supports a fairer economic model of social and sustainable development in line with the [2030 Agenda](#), underpinned by the European Pillar of Social Rights. Progress towards equality, justice and democracy - core EU values - should be prioritised, as well as the implementation of social rights, making the ending of poverty a pre-requisite. The EU must seize the moment to progress on EU obligatory rights – for example through a framework directive guaranteeing adequate minimum income in all countries, as well as a framework on minimum/living wages. It is crucial that people facing poverty and vulnerability also benefit from the ecological transition and the post-COVID recovery, and do not pay for it, including through the imposition of austerity measures to recoup the deficits. To ensure that the reconstruction funds and the adequacy of the structural funds already granted fulfil their social mission, maximum transparency and supervision are necessary. To do this, the current

3 EAPN (2019): Delivering Agenda 2030: for people and planet – EAPN Proposals for a post Europe 2020 strategy

consultative status of civil society organisations and the involvement of people experiencing poverty must be raised to a level of dialogue on an equal footing with other social actors. **The time to change is now. It is essential to rebuild Europe with a rights-based, social heart.**

1. INTRODUCTION

The COVID-19 pandemic put European welfare states under extreme pressure, attacking people's health, life and livelihoods. However, this crisis is not equal for all. Social organisations are aware of the specific factors that negatively affect people in situations of poverty and social vulnerability. They have on-the-ground experience of the concrete impact of the pandemic on the economic, social, health and wellbeing conditions of people experiencing poverty and vulnerability. Having a disability, poor health, suffering material deprivation, involuntary loneliness, homelessness, being a migrant, a single parent, etc. are some of these factors. Measures adopted by governments, such as confinement at home or social distancing, lay-offs and obligatory furloughs, have consequences on those groups of people without financial means and living in precarious circumstances. It is predicted that the health crisis will be followed by a great recession with a massive loss of jobs and income. Governments will make decisions on how to reduce their public debt and deficits in public budgets on a local, regional and national level. If the social rights perspective is not enforced, these adjustments may lead to more poverty and inequality. The role of the EU is and will be key: This may be a crucial crossroads regarding the confidence of the population in the EU and a test for the need for a more social and sustainable model.

EAPN - the only Europe-wide network of independent anti-poverty networks and organisations, made up of people experiencing poverty and civil society organisations present in all the member states, EFTA and candidate countries - has an important role in this COVID-19 crisis, by providing an in-depth analysis of the current situation and proposing concrete recommendations to European and national authorities, in order to leave no-one behind, particularly people experiencing poverty and social exclusion.⁴ In light of the COVID-19 crisis, one of the most urgent issues to undertake research into is the extent and ways in which social inequality and social protection systems interacted with the spread of the virus in European countries, and whether and how the pandemic and its economic consequences will affect European societies in the future.

1.1. Objectives

The objectives of this report are the following:

1. To assess the impact of the COVID-19 crisis on the poor and most vulnerable groups, including the policy responses by the EU and national Governments in the European countries where EAPN has membership.
2. To incorporate the experiences and testimonies of people experiencing poverty.
3. To make recommendations at the national and EU level.

1.2. Methodology

The methodological research approach was qualitative, through the following instruments:

1. An EAPN member exchange on "*COVID-19 & policy responses: What impact on poverty & exclusion?*", on the 23 April, to determine and discuss the impact of COVID-19 on vulnerable groups, to assess the policy actions taken by member states, and to analyse policy recommendations at national and EU levels.

⁴ In March 2020, EAPN responded immediately to the explosion of the COVID-19 epidemic by publishing an initial statement, an Open Letter to the EU institutions, then a campaign letter to Commissioner Schmit asking for urgent backing for a Framework Directive for Minimum Income signed by 25 MEPs and other stakeholders.

2. A questionnaire with 26 questions, most of them open-ended, aimed at capturing the key data and information from each country. The questionnaire was responded to by 25 national networks.
3. A specific questionnaire, with 11 open-ended questions, was aimed at the European organisations belonging to EAPN and was completed by three members, the International Federation of Social Workers, SMES Mental Health Europe and AGE Platform Europe.
4. Short interviews were held with people experiencing poverty in order to learn about their situation during the pandemic, with their own perspective and proposals. We obtained a total of 27 testimonies of people experiencing poverty from 23 countries.

This report was completed with desk research. Annex 2 provides the detailed national responses to all areas.

2. THE SITUATION OF HEALTHCARE, SOCIAL PROTECTION AND MINIMUM INCOME SYSTEMS BEFORE THE COVID-19 PANDEMIC

This section shows the characteristics and deficiencies of coverage of the health, social protection and income guarantee systems of the countries analysed in this study⁵, which have exacerbated the spread of the virus and the avalanche of negative social consequences on those who were already poor or at high risk of becoming poor.⁶ They refer to the situation before the COVID-19 pandemic.

2.1. Healthcare systems

EU countries hold the main responsibility for organising and delivering health services and medical care. EU health policy therefore serves to complement national policies, and to ensure health protection in all EU policies.⁷

There are two overall models of healthcare provision. The first is composed of countries with a **National Health System**, which are predominantly funded through taxes and with universal access. The healthcare is based on the general practitioner who controls the derivation to specialists and is responsible for a population list. Doctors are paid by salary and headcounts. The Government has the control and management of these NHS. The public services coexist with healthcare private providers, but they make up for a relatively small part of the health care system. In recent years, co-payments by users have been introduced. The countries with **Social Security Systems** are financed by mandatory fees paid by employers and workers or through taxes. The financial resources go to the "funds" or "health insurances", which are non-governmental organisations regulated by law. These "funds" or health insurances hire hospitals, family doctors, etc. to provide the services which are insured through contracts based on a budget or through upfront payment by the act. They have reimbursement systems and some co-payments by users (See Annex 1, Table 2).

The whole public investment in healthcare with respect the national GDP shows large differences among the countries analysed in this study, with 11 below the EU average and 11 above it. (See Annex 1, Graph 1). Those countries with a National Health System invest a higher percentage of their GDP in health. On the contrary, those countries with a tax-based system invest a percentage below the EU average, with the exception of the United Kingdom (although expenditure does not necessarily correlate to benefits to the population— i.e. where private institutions are involved in delivery, privatised a large proportion of funds goes into profits for the insurance companies or hospitals). During the last economic crisis, public expenditure on health decreased in several EU countries, as Portugal, Spain, the United Kingdom and Greece. This prolonged lack of sufficient investment weakened the capacity to address health inequalities and the ways the healthcare systems cope with demographic changes, such as population ageing, and pandemic shocks.

⁵ Regarding the budget allocation, there are striking differences among the member states with respect to social protection, health and housing expenditures, in relation to their national GDP (See Annex 1, Table 1).

⁶ The COVID-19 pandemic has demonstrated the human and financial costs of poor investment in health prevention services among vulnerable groups in Europe. Disproportionally affected by unequal access to health and preventive services and poor housing, living and working conditions, their poor health status has led to greater exposure to the pandemic's health and economic effects.

⁷ EU policies and actions in public health aim to protect and improve the health of EU citizens, support the modernisation of health infrastructure and improve the efficiency of Europe's health systems. Strategic health issues are discussed by representatives of national authorities and the European Commission in a senior level working group on public health. EU institutions, countries, regional and local authorities, and other interest groups contribute to the implementation of the EU's health strategy. Data and information on the models and characteristics of healthcare systems in the EU-28 countries come from various documents prepared by the European Commission, the Organization for Economic Co-operation and Development-OECD and the WHO European Health Observatory.

The European Pillar of Social Rights (EPSR) social scoreboard indicator “Out of pocket expenditure on healthcare” (% share of total current health expenditure) shows the different levels of effort that households make in order to get health care. In Greece, Lithuania, Portugal, Spain, Italy and Finland, households must pay between the 34.75% (Greece) to the 20.23% (Finland) of their national expenditure on healthcare. On the opposite side, France, Croatia, The Netherlands, Ireland, Slovenia and Germany, with percentages ranging from 9.38% to 12.50%, are those who demand less household input to receive healthcare (See Annex 1, Map 1 and Table 3). The EPSR indicator “Self-reported unmet need for medical examination and care” measures the share of the population aged 16 and over reporting unmet needs for medical care due to one of the following reasons: ‘Financial reasons’, ‘Waiting list’ and ‘Too far to travel’ (all three categories are cumulated). Self-reported unmet needs concern a person’s own assessment of whether he or she needed medical examination or treatment (dental care excluded) but did not have it or did not seek it. Austria, Germany, Spain, The Netherlands and Czechia perform among the best, with scores between 0.1% (Austria) and 0.3% (Czechia). On the other side, Greece, Serbia, Finland, United Kingdom and Poland range from 4.2% (Poland) to 8.8% (Greece) (See Annex 1, Table 4). An important demographic indicator of health status is, life expectancy, which shows an average of 80.9 years for the EU28. Lithuania (74.7), Hungary (76) and Croatia (77.9) are at the bottom of the selected countries of this study, while Spain (83.3), Italy (83.2) and Iceland (82.9) are located at the top. On average and in every country, women (83.6) outlive men (78.1) (See Annex 1, Table 2).

According to the information on the surveyed countries, nearly **9 out of 10 networks stated that their healthcare system was “problematic for certain groups or regions”** (Austria, Belgium, Czechia, Finland, France, Germany, Greece, Iceland, Italy, Lithuania, Norway, Portugal, Slovenia, Spain and the United Kingdom) or was **“problematic in general”** (Hungary, Ireland, Poland and Serbia). Only Croatia, Denmark and The Netherlands considered that their healthcare performed well. Before the pandemic of COVID-19, those were the reported problems faced by healthcare systems, including by vulnerable groups who were left out or suffer from specific hardships.

Insufficient investment in healthcare provision generates structural shortcomings of trained medical staff, facilities and equipment, which translate into hardships and waiting lists for specialised medical services. In Hungary, the public system is corrupted, and it is also not free.⁸ The lack of doctors and nurses is a huge problem. The doctors’ average age is very high, there are 400 municipalities and communes out of 3,200 without easily available GPs. People have to travel long distances to have access to healthcare, but public transport is expensive and also not available everywhere. Conditions in hospitals are terrible in the cities. Greece also reports a lack of medical personnel, and medicine due to a great extent due to the prolonged austerity measures). In Iceland, there are long waiting times for appointments with a specialist. Emergency services in Reykjavík are sub-standard. People with alcohol and drug abuse must wait a long time to get into detoxication and rehabilitation programmes. In Italy and in some regions of Spain and Poland, people experience long waiting times before surgery or referrals, unless they decide to choose a private clinic to carry out the procedure. In these countries there are also serious issues such as shortages of staff, long working hours, and low salaries. In Portugal, the medical care services demonstrate problems in providing access to services such as dermatology, ophthalmology, and stomatology, for example, due to their weaknesses in certain medical or geographical areas. One in four hospital consultations occur after the maximum estimated time; on average, the waiting time for a first hospital consultation is 120 days; 15% of surgeries are

⁸ “The power of “doctor-barons” is very strong, their interest is to keep this current harmful system alive. Their political influence could be easily recognised. The minister who is a doctor is apparently very weak within the government and is also representative of this old structure. The reforms are always postponed by the decision-makers. We have too many hospitals but not enough smaller institutions and GPs. The system is very corrupt, the EU support is badly used by the relevant decision-makers.” (Hungarian respondent’s explanation).

performed after the deadline; the average waiting time for surgery is 100 days. The demand for hospital emergencies keeps increasing; more than 800,000 people in Portugal do not have a family doctor (i.e. a family general practitioner).⁹ The ageing of health workers has not been compensated for by the training of new professionals. In Slovenia, the healthcare system is overburdened due to lack of doctors and lack of places for specialists. In the United Kingdom, there is underfunding of healthcare which means that access to care is effectively rationed. Primary care (general practitioners and related healthcare staff) have large numbers of patients per practice, relative to other wealthy countries, and there can be a two-week waiting time for an appointment, which in England generally lasts eight minutes and will only cover one health issue. Older people and others with co-morbidity, and those with communication difficulties, suffer most from these short consultations. There are long waiting lists for hospital care, including surgery, and the Government recently abandoned waiting list targets, as they repeatedly could not be met.

Mental health services are underdeveloped in most of the countries. In the **United Kingdom**, child and adult mental health services were areas that were amongst the least well-funded relative to need and were in crisis before COVID-19. Children were sometimes treated by non-child medical specialists and in adult care settings, even when they could get access to services. Waiting times for treatment in 2017-18 were greater than four months for more than half of the 11,482 children needing treatment and 500 children waited more than a year. The treatment for drug and alcohol abusers were similarly underfunded.¹⁰

Low-income, rural and remote regions have less provision than cities in terms of facilities, medical staff and equipment. Hospitals that ensure the availability of healthcare in remote regions of Czechia are in a difficult financial situation, including lower remuneration of health professionals and doctors and poorer technical equipment. This translates into poorer healthcare service provision, especially at the border of administrative regions (county, districts etc.) and in bordering areas with other countries. In Finland, municipalities are responsible for organising and financing healthcare, either by providing it themselves, in collaboration with other municipalities, by purchasing services from private companies or from organisations. This means that there are regional differences in access to healthcare. In the rural areas of Norway, many who struggle to make ends meet have a hard time getting to the doctor or the hospital due to high transport costs. The barrier created by high out-of-pocket payments before a person obtains an exception card has, in some cases, led to significant deterioration of people's health, and in the worst cases even to death. In Hungary, there is a massive geographical imbalance in the provision of healthcare services, with regions and subregions lagging behind, with higher proportions of people experiencing poverty and social exclusion. In Iceland, in smaller towns or remote places it is often hard to access health services. Many need to be flown to the capital or driven to the nearest town that has a hospital or a clinic. There is also a shortage of GPs and - in some places - they need to rely on open clinics or traveling GPs, where there is a lack of consistency of who sees a patient each time. In Serbia, in theory public healthcare insurance is available to broad groups of the population and for different vulnerable groups, but in practice there are huge problems with access for several reasons: there is a shortage of medical staff, and particularly doctors of certain specialisations, due to emigration which was partly supported by the state, for example through special contracts between Serbia and Germany; geographical distribution is far from optimal and access to healthcare is not good for the rural population and those living in remote areas; they witness a long waiting time for certain diagnostic examinations, particularly if more complex equipment is needed (such as MRI scanners) and for surgeries, etc. In Slovenia,

9 Arnaut, António; Semedo, João (2017), *Salvar o SNS – Uma nova Lei de bases da Saúde para defender a democracia*, Porto, Porto Editora, Outubro.

10 GOV.United Kingdom (2020) NHS entitlements: migrant health guide, updated April 27, accessed at: <https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide>

the access to specialists in some regions and rural areas (e.g. paediatricians and paedopsychiatrists) is limited. In Italy and Spain, there are huge regional differences in medical care services between the South and the North.

The detrimental effects of sustained cuts in investment affect both the quality and coverage of healthcare¹¹. In **Spain**, in recent years, regional governments applied austerity measures in four strands: 1) Cuts in capacities and in facilities devoted to the prevention of diseases and pandemic shocks (including the stocking of protective gear and equipment, the training of medical staff, the closure of healthcare preventive education and sensitisation centres, together with the dissolution of medical institutions devoted to research and disease prevention); 2) Lowering of employment conditions of staff, including nurses, assistants and doctors; these poor working conditions and underpaid staff (for example, job on demand, one-day contracts, etc.) mean that many were forced to migrate to other member states, such as the United Kingdom or the Nordic countries; 3) Low investment in research and development; 4) Extremely low coverage of mental and dental care by the public health system. These situations caused long waiting-lists to access specialised healthcare and surgical procedures, a situation aggravated by huge regional differences. Both the coordination amongst Autonomous Communities themselves, and between those and the central administration was clearly insufficient and patchy.

The mainstreamed “efficiency” in healthcare services is used as a way of excluding poor and vulnerable persons. In **Belgium**, in addition to the financial, accessibility and mobility obstacles, people experiencing poverty also indicate problems due to the ever-increasing “striving for more efficiency” in hospital facilities. People are asked “to be more self-sufficient”, thus less time is taken to explain, to inform and to be with patients by the medical staff.

Low-income groups have more unmet medical care needs than the rest of the population. This is the case of **Belgium**. On paper, the Belgian healthcare system is quite accessible due to the mandatory health insurance and specific measures for those low-income groups (increased reimbursement, maximum bill). Considering the unmet need for medical care indicator for different income groups, big differences emerge: 6.4% of people in the lowest income group reported going without medical care although they needed it, while this proportion is close to zero in the highest income groups. When it comes to dental care the differences are even more pronounced. For the lower income groups, which also include non-EU citizens, there are a number of additional concerns: they show lower attendance at cancer screenings, they pay fewer visits to the dentist and show a higher use of medication.¹² In **Ireland**, the current system results in unequal access to healthcare and worse outcomes for those with low incomes. The National Census for 2016 showed that men in less deprived areas lived 5 years longer than men in the most deprived areas while the difference for women was 4.5 years. Some groups in society also experience additional barriers to equal healthcare including Travellers, Roma, undocumented migrant workers etc. These groups also suffer greater negative social determinants of health. On average Traveller men die 15 years earlier than men in the general population and Traveller women die on average 11.4 years earlier. There are also barriers for those who face literacy difficulties. In **Serbia**, the Roma population faces particularly high barriers in access to healthcare, as well as informally employed persons (which count almost one-fifth of the employed population). In **Poland**, there is insurance-based healthcare, and for those without health insurance there is a procedure to determine if they should pay for medical treatment. In **Slovenia**, the supplementary health insurance is necessary for access to normal healthcare. Many people

¹¹ See also EAPN (2017) No one left behind: ensuring access for all to affordable, decent housing and quality public health services, at <https://www.eapn.eu/nobody-left-behind-eapn-booklet-on-services/>

¹² Source: ‘Analysis of the evolution of the social situation and social protection in Belgium’, Federal Public Service, Social Security 2019, at <https://socialsecurity.belgium.be/sites/default/files/content/docs/en/publications/silc/silc-analysis-social-situation-and-protection-belgium-2019-en.pdf>

cannot afford it, so they do not have full access to healthcare services (e.g. better medicines, medical equipment, some services, dentist access etc.). Children are not independent holders of healthcare insurance, they are dependent on their parent's status (if neither of the parents have healthcare insurance, children cannot get medical treatment). In the **United Kingdom**, healthcare is tax-funded and free at the point of need. However, 'free' healthcare is rather narrowly defined. For example, eye and hearing care is offered means-tested for low income people, with a limited range of options and aids. Dental care is so underfunded that preventative treatment and complex procedures are not accessible to most adult patients on the NHS and like optical services, are usually paid for privately, or not accessed. Therefore, low income people have worse access to the full range of healthcare.

Ireland is unique in the EU in not providing universal access to primary care. This has led to the emergence of a two-tier healthcare system where those who have the means to buy private health insurance gain fast-tracked access to diagnosis and treatment, usually in the private healthcare system, while those who cannot afford this make do with an oversubscribed, under resourced public health system characterised with long waiting lists and poorer and slower access to needed care. EAPN Ireland reports a particular underfunding of primary and community care.

Undocumented migrants and asylum seekers cannot access normal health care. In the case of **Austria**, despite the healthcare system being assessed as quite "inclusive", with a general health insurance for (nearly) everybody, there are around 100,000 inhabitants – 1% of the Austrian population – who are excluded from the general health-insurance. There are efforts to address this problem by involving social organisations which partly manage to establish voluntary, well-working basic healthcare (accessible, anonymous and without costs).¹³ The groups left out are low-income foreigners without legal access to healthcare and thus without insurance, coming from other cultural backgrounds (with different attitudes towards health, sickness and treatments) and who do not speak fluent German. Sometimes people lose their jobs and do not register immediately at the employment service, or do not apply for social benefits (for example, the homeless). Another relevant group are students coming from abroad, who would have to pay for their insurance by themselves.¹⁴ In the **United Kingdom**, some groups of migrants with "leave to remain" come under the rule of 'No recourse to public funds.' Unless they have "indefinite leave to remain" and are ordinarily resident, migrants cannot access free routine secondary (hospital-based) healthcare (they are charged the full amount, payable in advance; for urgent treatment, payment is sought after treatment), but can access primary care (community-based care, such as general practitioners). There is an annual health surcharge, as well as a visa charge, for those without "indefinite leave to remain". This is currently £400 per year for each adult, lower for students and children, and rising in October 2020 to £624 per year for adults and £470 for children.¹⁵ In **Italy, Spain, Greece, Portugal and France**, undocumented migrants or asylum seekers face difficulties in accessing primary health care, which leads to saturation of the emergency services in large and medium-sized cities. Other common problems are the lack of interpretation and the impact of cultural differences towards health.

Homeless people and some social services users are not covered. In **Czechia**, homeless people do not have access to healthcare (there is no legislation for street medicine - it is provided as part of occasional / non-systemic activities initiated by non-governmental services). In general, all those assisted by the social services have difficult access, because health insurance companies usually do not reimburse healthcare expenses provided by social services facilities (it is possible to provide social and healthcare marked by those services with fall between the "social care" and the "healthcare"). **Greece** and **Hungary** also reported difficulties in accessing healthcare for

¹³ For example: www.amber-med.at/en run by Diakonia.

¹⁴ http://www.armutskonferenz.at/files/fuchs-ua_nicht_krankenversicherte_personen-2018.pdf

¹⁵ "Leave to remain" regulation at <https://www.gov.uk/guidance/indefinite-leave-to-remain-in-the-uk>

children in the poorest regions, homeless persons, Roma, elderly persons in poverty, people with mental problems and with disabilities.

Healthcare usually excludes ‘social’ care. In the **United Kingdom**, adults with dementia, Alzheimer’s and other such diseases often associated with old age, must pay for care. These diseases are not defined as needing health care, but only ‘social’ care, whereas cancer care, for example, which may more often affect younger people, is free at the point of need. There are 411,000 people in care homes. Data from *Age United Kingdom* showed residential care costs from £30,000 per annum.¹⁶ This is for accommodation with no nursing staff on the premises. The staff are health care assistants, on minimum wage or little more, half of them on zero-hours contracts and not receiving holiday or sick pay. Residential homes with a nurse on the premises (‘nursing homes’), cost from about of £42,000 per year. Costs vary regionally; they are cheapest in the North West, at a weighted average of £511 per week and most expensive in London, at £741 per week. London clients are now paying up to £100 above this figure. Clients paying for care, on average for two years until death, mainly do so by selling their homes, and receive no public assistance until their savings fall below £23,250. People without assets of this level, are at least partly funded by local authorities, but with increasing difficulty. Adult social care takes up a large part of authorities’ remaining budget after the 60% cut in central government grants during the ten years of austerity, and a 40% overall average cut in local authority revenue (the cut is above 40% in the most deprived authorities). Local authorities are bulk buyers of care and pay below the average cost of a care place, and thus are cross subsidised by those paying from their own resources. Local Authorities (local government) had to sell off many of their own municipal care homes some years ago, and most care homes are now in the private sector. Some are small family businesses, but there are also larger chains, some of which are charitable entities, others are for-profit, some owned by private equity and hedge funds. In **Czechia**, healthcare is insufficiently provided to elderly persons with health problems, who live in their homes; these are health procedures at the “socio-health border”, such as injecting, preparing medications, bandages, emptying the urinary catheter, etc. Health insurance companies are reluctant to reimburse these expenses. In **Finland**, low-income retirees with long-term illnesses face long delays to access public healthcare.

People with disabilities face healthcare coverage problems. In **Czechia**, there is a problem in the availability of doctor-specialists for people with disabilities, whose health status requires more healthcare procedures, due to the reluctance to reimburse health insurance companies. In **Finland**, low-income and socially excluded people tend not to request health services, therefore they usually do not have a medical history. When applying for an invalidity pension, this lack of information is a problem. Unemployed people do not receive invalidity pensions as often as people in work. In **Serbia**, people with disabilities also face problems regarding medical care.

High prices of medicines and medical services negatively impact on the health of people in poverty. In **Czechia**, the high prices of some medicines and the limits for prescribing them also cause problems, especially for patients with more serious diseases or with more diseases. In **Finland**, vulnerable and low-income people often have challenges to access the health services they need, partly due to increases in user fees. In general, they tend to request medical help only if they are in a critical condition or if they are taken in to the care of the social services. There is also a problem of non-take up in the case of unemployed people, who have the right to local medical attention, but are frequently not aware of it.¹⁷ User fees for social and healthcare services are comparatively high in the European context, and have even been raised significantly on several occasions. Increases in user fees have been accompanied by increases of out-of-pocket

¹⁶ <https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-a-care-home/>

¹⁷ In Finland the healthcare system is divided: People who are employed are in the occupational healthcare system and they get usually quality services without queuing. People outside labour market have more problems getting the healthcare they need.

expenses for pharmaceuticals and healthcare travel. One in ten Finns have at some point not been able to afford to buy medicines. Problems tend to accumulate for people who are frequently ill but have a small income. The number of people saving money by not buying medicines has increased in recent years. In **Norway** the situation is somewhat similar. A survey by Statistics Norway from 2015 showed that the proportion of people that had refrained from contacting a doctor despite an unmet need for medical care due to money issues was 4% in the lowest income bracket (under NOK 200,000), compared to 1% in the population as a whole. Within the group with an unmet need for medical care, 13% stated transport difficulties / long distance as the main reason. This mostly applied to those with the lowest income and those living in rural areas. For many, a lack of money means that they cannot afford expensive medicines. About 3% of the population has abstained from collecting necessary medication because they could not afford it, even though they had a doctor's prescription. Among these, those with the lowest incomes are severely over-represented, and this is most evident among those who experience worse health and long-term illness.

Where other health services are financed mainly through public budgets or through full or partial reimbursement from the National Insurance Scheme, this does not apply when it comes to dental treatment for adults. The publicly funded and legally based service covers all expenses until the age of 18, and then keeps the deductible at 25% at the age of 19 and 20. Afterwards, a regular check at the dentist will cost around NOK 1000. Many cannot afford the check, nor the bill that may come afterwards. Therefore, people from low-income households in general have significantly poorer oral health than people from households with a higher income. Among those under the poverty line, 13% are unable to afford a visit to the dentist. For the population in general the share is 4%. In addition, unemployed people and recipients of financial assistance are strongly over-represented, with shares of 18 and 24% respectively. The expensive treatment means that many who experience poverty postpone going to the dentist until the pain becomes too great to endure. Moreover, it is becoming increasingly common that people choose to pull teeth instead of repairing them, because this is the cheapest solution. For those who cannot afford dental treatment, the stigma coming with poor oral health is also a major problem. For some, bad teeth become a cause of low self-esteem and social isolation, and it may also be an obstacle to finding work.

In **Greece**, the pricing of medicine is referred to as problematic as well. In **Iceland**, the increasing costs of healthcare service and medicines is worsened by the fact that the national health insurance only covers those persons on disability allowance. In **Portugal**, this problem leads the most vulnerable to opt for generic medicinal products (the Portuguese Country Report (2020) states that “2.1% share of the Portuguese population reports unmet needs due to cost, distance or waiting time”). To tackle these problems, according to the 2020 State Budget, SNS users will be excluded from paying fees for consultations in health centres and for diagnostic exams by doctors of the National Health Service.¹⁸

The claiming of sickness benefits is problematic for the self-employed (entrepreneurs). In **Slovenia** the self-employed are eligible for compensation from the 30th working day announced as sick leave. Which means that in order to claim their benefits they have to be sick for around month and a half to become eligible for it. Until then they have to spend their savings to cover their financial losses. The research of the Movement for Decent Work and Welfare Society showed that 60% of the self-employed cannot afford to be on sick leave for more than 1 month.

¹⁸ Other measures approved in the 2020 Portuguese State Budget were the increase of mental health professionals and the establishment of depression and anxiety prevention and treatment programmes at local level through the SNS and access to free antipsychotics medicine available at specialist appointments in a public hospital or general practitioners at local health centres. It was also approved public efforts for enhancing access to feminine hygiene products. Although the fee exemption has a clearer timeline to be implement, the other measures are more ambiguous and remains somewhat unclear how they are going to be implemented and how ambitious these objectives are.

2.2. Social protection¹⁹

The majority of the respondents, 19 out of 23, considered that social protection in their country was already problematic before the impact of COVID-19 epidemic: 14 highlighted that it was so “for certain groups or regions” (Austria, Croatia, Denmark, Finland, France, Greece, Iceland, Italy, Lithuania, Norway, Poland, Portugal, Slovenia and Spain) and 5 assessed the situation as “problematic in general” (Belgium, Czechia, Germany, Hungary and Serbia). Only 2, The Netherlands and the United Kingdom, indicated that it was not problematic while 2, Slovakia and Ireland, did not answer to this question.

In many countries, income transfers have a low impact on poverty reduction. On average, the impact of social transfers (excluding pensions) on poverty reduction has declined in 2018.²⁰ The lowest positions in this rating are occupied by Serbia, Greece, Italy, Spain, Lithuania, Portugal and Croatia, well below the average of the EU28 (See Annex 1, Table 5) In **Spain**, with a low score in this indicator, 26.1% of the Spanish population lived at risk of poverty and social exclusion, severe poverty affected more than 2.5 million people, almost 600,000 families lack income.²¹ Social protection investment (including pensions) represents 19.2% of the GDP in EU-28, while it's only 16.9% in Spain. This 2.3 percentage points difference accounts for more than €27 billion. In **Belgium**, this indicator was positive, above the average, but the social security system is increasingly reducing the protection against poverty, so it may change. According to the **Portuguese** Country Report (2020), changes to the social protection system have not improved the contribution of social transfers to poverty reduction. In the social scoreboard, Portugal has improved to a “watch situation” in terms of the indicator – impact of social transfers (other than pensions) on poverty reduction – however the social protection system is fragile/weak and minimum income is not adequate. The low adequacy of minimum income is also mentioned in the report and the amounts (per person and household) do “not allow people to escape poverty”.

The complexity of the social protection system prevents people with needs from claiming benefits. In **Finland**, the system of services and benefits is shattered; people would need a process which would coordinate the services they need, as it is hard to navigate alone in the current complicated system, especially for people who need many kinds of services (e.g. long-term unemployed). In **Iceland**, people fall between systems, (contribution-based and means-tested tax-based) as social protection is designed for those who know how to reach out and to use the help. Those who do not have the knowledge or the ability to seek help are left out, due to linguistic, social and health barriers. In **Italy**, there is a structural low level of social investment by the government. The weaknesses are also worsened by the lack of knowledge about social services, special rates and opportunities, and the persistent economic difficulties of NGOs. In **Lithuania**, social protection is very problematic in terms of quality and accessibility. The system is inherently discriminatory, as there is a strict list of the type of services that can be provided to determined groups, and if others not belonging to the entitled target groups also have needs, they are not assisted. Although in **Norway** the social protection coverage is comparatively good, it is problematic for certain groups. The access and level of many of the benefits are linked to participation in working life. The right to both sickness benefit and unemployment benefit in the event of unemployment is earned through work. Access to disability benefit and work assessment allowance is not dependent on work, however the level depends on previous income from work.

¹⁹ According to the EU, the overall term Social Protection refers to protection from all risks. However, the Council Recommendation on “Access to social protection” of 8 November 2019 is entirely aimed at ‘workers and self-employed focusing on contribution-based healthcare, pensions and income support (sickness, maternity leave), for example, not covering tax-based income support like Minimum Income. At <https://ec.europa.eu/social/main.jsp?catId=1312&langId=en>

²⁰ European Commission: Joint Employment Report. (17 December 2019)

²¹ EAPN España (2019), Poverty Watch Spain 2019, at: <https://www.eapn.es/publicaciones/367/poverty-watch-2019> and EAPN Spain, Valoración de la situación del empleo en el contexto de la crisis del COVID, at <https://eapn.es/covid19/publicaciones/15/valoracion-de-la-situacion-del-empleo-en-el-contexto-de-la-crisis-del-covid>

This makes it particularly challenging for those who fall out of working life and the education system early. Financial (social) assistance, which has always been intended as a temporary income that may be received when you have no other income over a shorter time-period, has now become a benefit that some groups depend on for long periods of time. These are: people waiting for access to other benefits; people who are sick and the unemployed with complex clinical symptoms or who have diagnoses that are not easily verifiable, who may fall between two stools in the social protection system; people that struggle to gain access to the labour market and have few economic resources (such as immigrants who lack language skills or the skills demanded in the Norwegian labour market); and young adults who have dropped out of or have not passed high school, who have weak ties to the labour market and thus have not earned any rights to other benefits. The proportion of recipients of financial assistance is highest among young people between the ages of 18 and 24. The need for financial assistance among young people varies to a greater extent with the fluctuations in the labour market than in the older age groups.

During the last decade, there was a tightening of eligibility/conditionality and reductions in the level of working-age benefits. In Czechia, if a person does not show up at the employment office for an interview with an employer on the required day, social assistance is withdrawn for half a year. For the whole half-year, they receive absolutely no social benefits (debts increase, risk of falling into insolvency, etc.) It is undignified, as they are forced into dependency, fed by the family and/or completely dependent on humanitarian aid. The specific situation of people with mental illness is not taken into account either, so this system is very ruthless.

In **Belgium**, the social protection system has increased conditionality with regards to unemployment benefit, sickness benefit, and disability benefit (among others), which pushes people to the social assistance system ('leefloon/revenu d'intégration sociale'). In **Lithuania**, unemployment benefits have high conditionality, as only one third of unemployed people get these benefits, which is very concerning in periods of crisis. In **Norway**, poverty amongst people who depend on social protection benefits has increased and this tendency has been reinforced by recent reforms. These include cutbacks on several benefits by introducing stricter entry criteria, cuts in rates and cuts in duration. The strategy seems to build on what economists would brand as 'strengthening labour incentives through austerity'. However, many recipients of benefits do not have the possibility to work – because they are sick, have an injury or a disability. Thus, vulnerable people are hit hard, and for some the cutbacks become a poverty trap. The introduction of stricter criteria for prolonging a person's period on work assessment allowance (AAP) in 2018 is a prime example. The benefit ensures income for people who have at least 50% reduced working capacity due to illness, injury or disability. When the benefit is received, the Labour and Welfare Administration clarifies the person's ability to work and their health situation. In the end, the person in question either receives assistance aimed at returning to work or is granted disability benefit. The implementation of the reform has led to a substantial number of people losing their benefit before the Labour and Welfare Administration has finished assessing their work ability. When this happens, there is a 52-week quarantine period before they can apply for AAP again. This has sent many former recipients into poverty with financial social assistance as their only possible source of income. Moreover, the introduction of a market-based rent for public housing in municipalities around the country has struck many vulnerable people hard. This has caused a substantial increase in rents – and combined with cutbacks in the housing allowance – it has left many tenants without enough money to cover their basic needs. For some recipients of disability benefit, the rent now eats up more than ¾ of their income. The difficult situation has forced tenants all over the country to apply for financial assistance to keep afloat.

In **Poland**, unemployment benefit is too low and not in accordance with ILO 102 Convention and Minimum Wage Convention. It is not a percentage of the previous wage with some cap, but consists of fixed amounts with three levels, dependent on the duration of the individual's work experience. In 2020 the standard benefit is at 35% of the minimum wage. **Portugal** has seen a reduction in the number of unemployed people, but a weak social protection system resulted in an increase in the risk of poverty for the unemployed. According to the latest data, only 28.9% of the unemployed looking for a new job received unemployment benefits in 2018, which reflects the high share of precarious contracts that were concluded. The unbalanced condition of the Portuguese labour market impedes access to certain social protection benefits, such as unemployment benefits, and explains the vulnerability of certain groups – like women – in old age. In **Serbia**, unemployment benefits are available for only a small portion of unemployed people and for very short period (6 months), and people who were employed informally, with temporary contracts, and for shorter period are not entitled to this benefit.

In **Spain**, the social protection level varies according to the labour market situation of the claimant. Self-employment in Spain plays a significant role in the economy, accounting for 17.6% of the total of workers affiliated to the Social Security system. The self-employed have access to most social benefits including health care, long-term care, family and sickness benefits, although certain unemployment benefits, as well as to insurance against invalidity, accidents at work and occupational injuries are sub-standard. Atypical workers, mostly women, with part-time and temporary jobs, have increased and fixed-term contracts only represent 25.7% of overall salaried workers. Over the last decade, there has been a growing convergence in access to all social benefits, but the former contributory level is still key in the amounts of the benefits perceived. Domestic service workers make up a special category. Although they contribute to the Social Security, they lack entitlements to maternal or sickness leave, unemployment benefits and are entitled to very low pensions only. Workers in the undeclared economy have no social protection rights at all (according to the OECD, the Spanish undeclared economy rates to 24% of its GDP). In the **United Kingdom** more difficulties with access to social services exist than with access to social security. If Social Protection is defined as social security (insurance-based) plus social assistance (means-tested and tax-funded) then coverage is not a mainstream problem, but it is a severe problem for certain groups, for example, migrants and asylum seekers. But there has been severe tightening of eligibility and reductions in the level of all working-age benefits, whether insurance-based or even more so, 'income-tested' (the Government's word for 'means-tested') benefits.

Pensions for the elderly are low and set unfairly. In **Czechia**, an individual must work 35 years to qualify and - at the same time - the age for retirement has been raised to 65. Because of a person's health status, it is very problematic to work in a stressful or physically demanding job for many years and to remain in it until retirement. Many people have interruptions in their career, so they do not reach the prescribed number of years of work for the old age insurance. For example, a person who has worked for 34 years and 11 months is still not entitled to a pension (unless he finds a job he could do). There are few homes for the elderly, insufficient capacity and, as there are many services at the borderline between social and health care, they do not receive care even in the field. In **Greece** pensions are not adequate, as there were cuts due to austerity measures and pensioners have to pay taxes as well. In **Spain**, the non-contributory pensions, usually granted to women who did not meet the requisites for retirement pensions based on contributions - are below the poverty line. In **Lithuania**, old age pensions are very low, below the poverty threshold. Those who do not have enough years of work and receive social assistance for old age and disability pensions are even more vulnerable, as these benefits are not adequate. In **Portugal**, the minimum monthly amount for old-age and disability pensions, as well as for survivors' pensions, is very low (€ 275.30 and € 165.18, for 2020). Portugal has more than 2 million people with an old-age pension and more than 700,000 people with survivors' pensions. Pensions play a considerable role in reducing poverty. The risk of poverty rate in Portugal before

any social transfer is 43.4%, but after transfers relating to pensions it drops to 22.7%. However, it is also true that the low value of pensions explains the existence of another benefit - the Solidarity Supplement for the Elderly, which reached 164,651 elderly people in March 2020. It is important to mention that of this total, 115,428 are women, which shows the vulnerability of this group in old age. In **Serbia**, pensions are relatively low and there is a significant portion of the older population with pensions below the minimum; they were reduced due to the austerity measures under the IMF arrangement for years, and just recently partly recovered. Agricultural pensions are extremely low, forcing rural population to work for longer to compensate for low pensions. In the **United Kingdom**, adequacy is the key problem, from social assistance to sick pay to state pensions. There is a Minimum Income Guarantee for old-age pensioners only, and it comes closest (but does not reach) a Minimum Income Standard of need, as set out by the Joseph Rowntree Foundation.

2.3. Social Services and other benefits

Regional disparities in accessing social protection and services are extensive. In **Croatia**, problems of coverage are related to regional disparities, with poor access mainly in rural areas, which are burdened with depopulation and single elderly households, who survive with very low allowances, social benefits and very low pensions. In **Lithuania**, regional services are heterogeneous as well; for example, 71.6% of children attend pre-school in urban areas, and they account only for 27.9% in rural areas. In **Serbia**, access to social services differs strongly between local communities. As social services are under the responsibility of local communities, their development depends on the development of local communities. There are municipalities without basic services such as home care for older population or similar. Programs for the elderly are widespread and to a certain extent services for persons with disabilities. Other groups are far less covered.

In the **United Kingdom**, social services are delivered locally, and supply does not meet the needs. Local authorities have lost 60% of their central government grant funding in ten years of austerity cuts and 40% or more of their total revenue. They are able to raise some income locally from business rates and housing taxes, but this is a much more important source in wealthier areas. Other sources of revenue are parking charges and leisure facilities. Poorer cities such as Liverpool have already suffered more severe reductions in income and will lose relatively more from the new change to funding formulas for local government. The new formula is based on population and revenue raising capacity, dropping need. Overall, £320 million is likely to shift out of deprived areas and there will be a £300 million gain for Tory controlled Shire counties (more rural) mainly in the south-east. Local Authorities (i.e. local government) have already severely cut 'Surestart' services for disadvantaged children, building-based youth work, support to local NGOs, including refuges for those fleeing domestic violence and support for integration of minority ethnic groups, and indeed all non-statutory services (i.e., not required by law to be delivered by them). Social work provision has been deeply cut. Local Authorities have outsourced many advice services, homelessness services and drug and alcohol services and reduced funding to bare minimums. They are struggling to provide statutory care services and have, e.g., cut eligibility, increased charges and reduced provision of services for older people, disabled people, people with mental ill-health and people with learning disabilities, so that even severe need is not always met. Local Authorities were given additional responsibilities for public health, transferred out of the National Health Service with a reduced and non-ring-fenced budget, promptly further reduced. Staffing and services for ill-health prevention, environmental health and food and factory inspection are minimal relative to pre-austerity.²²

²² JRF Minimum income Standards, see <https://www.jrf.org.uk/income-benefits/minimum-income-standard>

Problems of social protection of people with disabilities and in situations of dependency are widespread. In **Spain**, about 16,000 people who were on the waiting list to be treated for their dependency situation have died in 2020, at a rate of 106 per day (85 deceased daily - on average - in 2019). These people had recognised dependency status but did not receive any benefit or service. In June 2020, there are about 254,000 people on the waiting list. Another 150,000 are waiting to be assessed by a medical court, to find out if they recognise any degree of dependency and get social protection.²³ In **Denmark**, the opportunities for early retirement due to inability to work are very restricted. It has become very difficult to get entitlement providing access to higher economic support. In **Greece**, people with disabilities had to present themselves to Medical Committees in order to (re)establish their level of disability and therefore their eligibility for disability benefits. In recent years, they were deprived of special rehabilitation services due to the reduction and cuts of therapy sessions by the Ministry of Health. In **Austria**, they have to apply for Minimum Income, but this scheme is not “designed” to be a long-term benefit. Therefore, people with disabilities who need long-term support lack an adequate specific social benefit. In **Lithuania**, people with disabilities and their families are extremely vulnerable as they mostly have no social service provision.

Child benefits have insufficient amounts or coverage. In **Austria**, there was a setback: with the new law concerning child benefit, families receive less in total and less per additional child. In **Czechia**, these are only helpful if a person does not earn or has a very low income - the moment she/he starts earning above a certain limit, she/he loses the entitlement to benefits; the system is thus very demotivating and discriminates against parents who can earn their living in the labour market. There is a great lack of access to supportive activation services as well as low-threshold services for children and young people. This has a big impact on families who need help. At a time when the state wanted to support families with many children, it entrusted care services for the elderly, which poses great problems because the staff is not sufficiently trained to do so.

There are locations where families cannot manage, for example, childcare, farming, and cooking. They do not have the opportunity to use social support, as these services are not set up in all locations. In **Greece**, family allowances and child benefits are neither enabling nor sufficient. The Government issued a lump sum benefit of 2,000 euros per every new-born child, but it wasn't fully implemented. In **Hungary**, the low level of transfers is deepening poverty and social exclusion. The various child benefits between 0-3 years are very restricted. In **Lithuania**, child benefit is universal, with nearly 100% of coverage. The amounts differ from 60 euros to 100 euros per child, for families in poverty. In **Norway**, child benefit is a universal benefit which should be an important contribution to reducing poverty in families with children. Nevertheless, most municipalities in Norway choose to treat the child benefit as income when calculating financial assistance. This means that the poorest families in reality lose the value of this benefit. Thus, the opportunities of the most vulnerable children are worsened, and the finances of the poorest families are weakened even further. In 2018, 85% of all municipalities curtailed the rate of financial assistance equivalent to the value of the child benefit through this practice. That year, 48,000 children lived in families receiving reduced financial assistance because their municipality treated the child benefit as income. Of the 21,500 children supported by a financial assistance recipient who lived solely on this benefit, 14,000 of them lived in a municipality that curtailed financial assistance for the value of the child benefit. The parental benefit – the money parents receive under maternity leave – is currently not given to mothers who have not been in regular work for the past 6 months. These women at present receive only a one-off allowance at NOK 84,720 which is far lower than the parental benefit – full salary for 49 weeks up to about NOK

²³ The figure is an estimate of the Association of Directors and Managers of Social Services, with official data, stated by its CEO José Ramirez to the Congress. El País, 6 June 2020. At: https://elpais.com/sociedad/2020-06-05/cada-dia-mueren-106-dependientes-en-espana-esperando-a-ser-atendidos.html?ssm=FB_CC&fbclid=IwAR1ZOy_qGeVPdZx_XGBFETmWUxHo2Co0DnMMRvoq2BJr7IUIVCvHpa950

600,000. Many in this group – counting 8565 women in 2016 – end up falling below the poverty line. In **Poland**, pensions are very low as well. In **Serbia**, child allowance is broadly available, but the amounts are low. In **Spain**, the investment in social protection of families and children is low (1.2% of GDP), below the EU average (2.3% of GDP), around € 5 billion less in Spain, although the fertility rates are among the lowest and the child poverty rate among the highest. Child benefit only reaches 3,000 families, which are incomeless or have extremely low-income households; there isn't a universal child allowance, therefore having children is a risk factor for becoming poor. In the **United Kingdom**, assistance to families has changed to make child benefit means-tested and to provide no income support in social assistance benefits for the third and subsequent children, if born after 2017.

Vulnerable groups and migrants are largely excluded. In **Denmark**, although the system works well, homeless people experience problems in accessing social services because the system is built on identification through a person's address. In **Finland**, excluded people are those who are not able to claim their benefits, people who need a lot of different services, the long-term unemployed who don't get healthcare services, early retirees with low pensions, old women with small pensions, drug users released from prison, and undocumented migrants. Self-employed and small entrepreneurs do not have a social security for unemployment. In **Greece**, asylum seekers have not been entitled to AMKA (Register Number of Social Insurance) since July 2019 and therefore they are excluded from access to healthcare, for instance they are not entitled to medical appointments at hospitals or medicine. The lack of AMKA also prevents them from accessing the labour market. Undocumented people are not covered either. In **Hungary**, the poorest are out of the system too, including homeless people, single parents, children, old people, disabled people, and Roma people. In **Iceland**, the excluded groups include students and those in precarious work particularly on internet platforms. In **Italy**, migrants and homeless people, unemployed people and large families are left out of the system. In **Slovenia**, the groups with limited rights to receive social protection are migrants, self-employed people, single-parent families, families with sick parents (often unemployed without benefits and access to therapy) and people without permanent residence. In **Spain**, "the situation of the migrants who pick strawberries in Huelva is worse than in a refugee camp", according to Philip Alston, the UN special rapporteur sent to Spain to investigate extreme poverty and human rights. Undocumented migrants often do undeclared work, with extremely bad conditions and no rights.²⁴

2.4. Minimum income schemes

Guaranteed minimum income (MI) is a social-welfare scheme that guarantees all citizens or families an income sufficient to live on, provided that certain eligibility conditions are met, typically: citizenship; a means test; and either availability to participate in the labour market, or willingness to perform community services. The primary goal of a MI is the reduction of poverty. The majority of the respondents to the questionnaire criticised their countries' existing Minimum Income schemes in different ways. The biggest group of respondents - Belgium, Czechia, Iceland, Ireland, Italy, Poland, Serbia and Spain- stated that their national MI scheme "was not adequate or didn't exist". The second group, consisting of Finland, Hungary, Lithuania, Norway, Portugal, Slovenia and the United Kingdom, considered that "it was problematic in general". The third, composed of Austria, Denmark, France and Greece, indicated that the "MI was problematic, but only for certain groups or regions". Only Croatia, Germany and The Netherlands assessed their national MI scheme as "not problematic". The main problematic aspects or obstacles to MI that were reported were the following:

²⁴ United Nations, Human Rights, Special Procedures (2020), Statement by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights, on his visit to Spain, 27 January – 7 February 2020 at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25524&LangID=E>

Restrictive criteria and means-tested access. In **Belgium**, the minimum income scheme, called 'leefloon/revenu d'intégration sociale', is an assistance of last resort and is means-tested. The applicant must prove that he or she has no income, or that the income is lower than the amount of the 'leefloon/revenu d'intégration sociale'. Although the rules for obtaining this minimum income have been drawn up federally, a local social worker evaluates the application, which leaves room for interpretation in aspects such as "willingness to work". Research shows that different local authorities, but also different social workers within the same city or municipality, judge the admissibility of a particular application differently. A similar situation happens in **Iceland** and **Norway**, where financial assistance is provided by municipalities and the local social services both have the right to exercise discretion when assessing the MI application, as well as the capacity to set the granted amount and ask for additional requisites for accessing the benefit. In Norway, for example, the applicant may be told to sell his/her car and home, to empty his/her bank account, or can directly be referred to their spouse or parents for support. For some, such disproportionate demands create poverty traps, instead of helping the claimant. The lack of clarity in the guidelines leads to regional differences, as well as different treatment of similar cases in the same municipality. The **United Kingdom** is in transition in terms of its means-tested social assistance income of last resort. Six main benefits (for the unemployed, the disabled, those who cannot do paid work for caring reasons, those on low paid work incomes topped up by government financial credits), have been rolled up into one single benefit, called Universal Credit (UC). Claims are household-based; if one member of a household has an income above the minimum income threshold for that type of household, no member of the household has an individual right to a means-tested benefit. The transition to UC is not complete. For example, two-thirds of families on benefits are still claiming 'legacy' benefits, as are many disabled people. Many may not 'migrate' to the new benefit until they make a new benefit claim (which can be required for as little as a change in address). The previous system was less generous relative to median wages than in many other European countries and the present system is even less generous. Many premiums for children and people with disabilities have been removed, and absolute benefit caps for individuals, for households and for the total national spend, have been introduced. The system in practice never met need, and now there is no longer an ambition to meet needs. The basic rate for a single person aged over 25 is 17% of average wages. In **Portugal**, the MI applicants must prove that they are in serious economic distress and at risk of social exclusion. In addition, they must be registered in the Institute of Employment and Professional Training (IEFP) and bring proof that they are actively looking for a job. In **Finland**, social assistance is a means-tested, bureaucratic benefit. The Social Security institution "Kela" pays the basic social assistance and municipalities are in charge of "supplementary" or "preventive" social assistance. The basic social assistance does not cover housing costs sufficiently and many people have to apply for social assistance because of the cost of healthcare and medication.

There are outstanding differences in the criteria and amounts of support granted within certain regions or municipalities within the same country. In Austria, MI is in the competence of Austrian regional governments; there are significant regional differences, with a high number of non-take-up (around 30%) especially in rural areas.²⁵ In Spain, the proportion of people at risk of poverty and / or social exclusion continues to decrease, but remains high, especially for children. Labour market challenges and the low impact on poverty of social transfers result in one of the highest risks of poverty or social exclusion for children in the EU. The weakness of family benefits and income guarantee schemes limits the poverty reduction effect of social transfers. Regional minimum income schemes are estimated to only reach 20% of their potential beneficiaries nationwide, with strong regional disparities. The Basque Country reaches almost three quarters

²⁵ http://www.armutskonferenz.at/files/european_centre_non_take_up_minimum_income_in_at-2019.pdf

EAPN Austria press release on that study (in German):

<http://www.armutskonferenz.at/news/news-2019/30-bekommen-nicht-was-ihnen-helfen-wuerde-nichtinanspruchnahme-aber-in-der-mindestsicherung-deutlich-gesunken.html>

of the people at risk of poverty and Navarre reaches two thirds of its population below the threshold. Asturias follows, where one in three people below the poverty line receive the minimum income. Of the rest, only five Communities guarantee percentages greater than 10% (Balearic Islands, Aragon, Cantabria, Asturias, C. de Madrid and Catalonia). The minimum incomes of the remaining 9 Communities do not even reach this coverage, and in the case of Andalusia and Castilla-La Mancha, their percentages are below 2%. These programs have different durations, ranging from 6 months, as in the case of Andalusia, the Valencian Community, Galicia and Ceuta, to indefinite benefits, as is the case of the Country Basque, Castilla y León, and Madrid. In May 2020, a national level Minimum Income was endorsed, with the purpose of eradicating these regional differences in terms of rights.

Due to the restrictive approach, complexity, bureaucracy and other factors, take-up rates are low. In **Belgium**, as mentioned, the 'leefloon/revenu d'intégration sociale' is increasingly subject to strict conditionality, many people are left out. Their take-up of this minimum income scheme is estimated between 57% and 73%. In the **United Kingdom**, take-up varies by reason for applying for the benefit. There are little data yet for Universal Credit, but for means-tested 'legacy benefits', take-up of Pensions Credits for people on low old age income is about 60% of those entitled, but 90% for income-tested Income Support (for those fit for work) and Employment Support Allowance (for those not currently fit for work). There are differences in knowledge about benefits and attitude to any 'stigma', and whether it is the sole income or a supplement to an income, that help to explain the differences in take-up. In **Lithuania**, the law on financial social assistance is very complicated, so people often do not know what kind of support they may be entitled to. There are also extremely strong stereotypes and stigmatisation surrounding social benefit recipients. Despite the very high poverty rates, in 2018 roughly 2.6% of the country's population received income support, and this number is constantly decreasing. In **Iceland**, discrimination against recipients also pushes up non-take up rates. Additionally, a new, complex system of electronic applications has been set up, without further assistance for non-proficient users, which also acts as a deterrent. In **Czechia**, neglected groups in terms of a decent minimum income are also indebted people, especially with foreclosures, people without qualifications, single people with children, the unemployed and people returning to work after a long period without employment – for example, after parental leave, after execution of a sentence, etc.

Due to the inadequacy of MI amounts, most of the recipients are placed below the poverty line. In **Hungary**, MI is practically inexistent as a strategy to take people out of poverty or to bring people into work, despite the fact they are poor or have a problematic condition. The social transfer which is identified as MI has not been raised in the last 8 years and is approximately 60 euros per month. In **Belgium**, the amounts for the living wage are €626.74 per month for a cohabitant; €940,11 per month for a single person; €1,270.51 for a person living with a dependent family. These amounts are far below the Belgium poverty threshold. In **Austria**, the MI scheme is quite well established, but the conservative-populist government restricted it last year.²⁶ As a result, MI is too low, does not cover real living costs, nor surpass the poverty threshold. Regarding income support, the new law on children assigns low-income families with lower amounts for the household, as well as per additional child. People with disabilities also have to apply for minimum income, but MI is not "designed" as a long-term benefit. Therefore, people with disabilities who need long-term support cannot get a suitable benefit to support them. Adequacy problems were also reported in the case of **France**, as the MI amount does not allow to cover basic expenses; in accordance, social NGOs ask for an increase up to € 850 per month.

²⁶ EAPN Austria summed up their proposals /demands in a paper called "19 points for a new minimum income". At http://www.armutskonferenz.at/files/armutskonferenz_neue-mindestsicherung_2019.pdf

In **Denmark**, people who have not been in the country for the last seven out of eight years receive a much smaller amount of financial support, which is below the poverty line for certain household compositions. In **Slovenia**, the amount of MI is equal to the amount of Financial Social Assistance (FSA), €402.18 for a single person per month or €1,106.00 for a family per month (for example, family of four: two school-age children and two unemployed adults). The FSA is a scheme that lasts from 1 to 6 months, directed to meet the basic needs of individuals and families who are unable to secure their material security, for reasons beyond their control. The MI for a single person - €402.18 - is below the poverty threshold, which is €622 per adult per month.²⁷ In **Serbia**, the existing MI is also too low to lift people out of poverty and it is too narrowly targeted, so many groups in need are left out. In the case of **Portugal**, the “SII” provides a monthly amount of €189.66 per person. The “SII” has 203,749 beneficiaries and the average amount per beneficiary is €117.67 per month per person (€259.52 per family), well below the national poverty line, which is 501 euros per month per person. The **Norwegian** MI is also considered inadequate. Many financial assistance recipients do not receive sufficient funds to cover their living expenses. In addition to being the group with the highest proportion of persons below the poverty line, among those who receive Social Security benefits, they are also the group in society most likely to experience material deprivation as a result of poverty. According to the 2018 Norwegian survey on living conditions, four out of ten financial assistance recipients reported that it was “difficult” or “very difficult” to make ends meet, compared to 6% in the general population. The Oslo Met University’s reference budget established that a reasonable level of consumption for a single person between 20 and 50 years (excluding housing expenses) would be NOK 9,510 per month. Compared to this the Norwegian state-guidelines fix the amount of financial assistance for a single adult, excluding housing costs at only NOK 6,150 per month. In **Lithuania**, the amount of MI is similarly not adequate and does not ensure minimum needs. In 2018, the average financial social assistance was €81 per person. This amount only represents about one third of the absolute poverty threshold. The National Audit Office states that in 2018, 86% of the individuals (households) were not ensured minimum consumption needs through the provision of benefits, services and assistance. In **Ireland**, the main social welfare payments are not adequate to provide people with a decent income to live with dignity. Levels are set by Governments when voting on the budget and not based on adequacy. There are particular issues of adequacy for those with disabilities and those under 25 years for whom there is a lower Jobseekers Payment, unless they meet certain family or activation criteria. In **Finland**, the income support is intended to be temporary, but one third of clients receive it on a long-term basis; the amount is considered quite low as well. In **Czechia** the average prices for food and housing cannot be covered by the MI.²⁸ However, the MI is not an incentive to quickly return to the labour market because it often exceeds the amount of the low minimum wage in the sum of the benefits paid.

In addition to other factors, the long waiting time to get the first MI payment deters the application for MI. In **Austria**, the waiting time - more than 3 months to receive the first payment of MI - is another issue; this time is considered too long in an emergency situation. The so-called “emergency aid” does exist on paper but is not used by social welfare offices. In **Spain**, the average waiting time for regional MI is 6 months. In Iceland, some income support systems pay in advance, but some pay only after some time, which means that recipients can be incomeless. This “gap period” causes or increases debt. In **Czechia**, MI is calculated from the average income for the last three months or six months, which causes delays in payment.

²⁷ The main policy concept in Slovenia is that the minimum income must be inferior to the minimum wage in order to maintain the incentive to work. The problem is that the minimum wage, despite its recent increase, is still low and slightly above the poverty threshold. Many employees on minimum wage are pushed into poverty (the working poor), while beneficiaries of the financial social assistance are somehow stuck in the vicious circle of social exclusion and poverty (EMIN report for Slovenia).

²⁸ In Czechia, the purpose of the system of MI, called the “System of assistance in material need”, is to guarantee every person a minimum standard of living. This system is not built on the principle of merit, but on the principle of necessity, thus serving as the last safety net for those who currently have no other means of subsistence.

Negative activation and conditionality are increasing trends in most of the surveyed countries.

In the **United Kingdom however**, there have been recent relaxations, particularly in the context of publicity citing the massive increase in foodbank use, suicides and other deaths of people who have been ‘sanctioned’. Under current Universal Credit regulations, all benefits can be withdrawn for up to six months, though there is a possibility of hardship payments. Sanctions can arise for not meeting the ‘claimant commitment’ signed by the claimant in return for access to benefits. This failure to comply can arise due to a missed appointment with the work coach, failure to show evidence of having searched for the agreed number of jobs, failure to undertake or complete agreed training, failure to complete the online diary which may require daily input for 35 hours per week etc.²⁹ There are more people in paid work than ever before, mainly as there is a larger workforce, but also due to the benefits regime raising numbers of disabled people and mothers of very young children who must seek and accept paid work. Some of this is positive, and people now have a ‘work coach’, but the conditions are less enabling than they could be because the same person can recommend sanctions, which can reduce trust in the advice and support.³⁰ In **Lithuania**, people often spend too long in the support system because labour insertion and inclusion itineraries are lacking. Instead, social benefit recipients often have to do community service jobs that are usually not in line with their needs and competences and undermine their dignity. An enormous 94% of the individuals who completed the employment promotion programme in 2018 did not manage to get and stay in a job for more than three months. In **Denmark**, social protection has been narrowed and reduced over a long period of time, but it is still adequate. However, the conditionality for receiving support has been tightened over the last two decades, leaving some of the most vulnerable behind, i.e. homeless people.

Vulnerable groups are excluded by different criteria, namely age, origin, residence status, work history, plus other factors such as location, education, digital skills and required compliance with bureaucratic procedures. In Austria, young people (between 14 and 16 years old) who do not currently live with their parents cannot apply for themselves. Migrants who were not granted asylum but have “strengthened residence” are excluded. In Greece, asylum seekers residing in accommodation projects are not entitled to MI as well. In this country there are other exclusion factors which limit access: excessive requirements to qualify for MI and the digital gap which undermines take-up. In the United Kingdom, coverage is general (though not universal), as the benefit is tax-funded, not insurance-based, and so is eligible to all with incomes below the threshold. The following groups are examples for those facing a more restricted access: 1) Self-employed people until COVID-19 have had restricted access to minimum income. 2) Migrants from outside the EU have no recourse to public funds if they have a time-limited visa. They are excluded from all means-tested welfare benefits as well as housing allowances and allowances for particular needs, such as disability living allowance. They do have access to insurance-based benefits, such as insurance-based unemployment benefit for the first six months. 3) Asylum seekers are under the Home Office, not the Department for Work and Pensions, and have much more restrictive financial support of £37.50, a week plus allocation to housing and support for asylum seekers.

²⁹ Failure can result in sanction, even when people have very good reasons. A five-year research project by University of York, 2013-2018, funded by ESRC, found that conditionality is largely ineffective in getting people into the labour market or supporting them to progress in it and that flexibility to take account of particular circumstances is rarely implemented. For a substantial minority, conditionality induced negative behavioural changes and increased poverty and even destitution. UNIVERSITY OF YORK (2018), Final findings report, welfare conditionality project 2013-2018, ESRC, June, accessed at http://www.welfareconditionality.ac.uk/wp-content/uploads/2018/06/40475_Welfare-Conditionality_Report_complete-v3.pdf and JRF (2020) United Kingdom poverty 2019/2020, JRF, February 7, accessed at: <https://www.jrf.org.uk/report/uk-poverty-2019-20>

³⁰ The five-year York University survey referred to above, found that Job Centre Plus support is too often too generic and of inadequate quality. The work gained is too often part-time, insecure and involving no possibility of career progression. 56% of people in the United Kingdom who in 2019 were in poverty were in paid work. 12.7% of all paid workers are living with in-work poverty.

In **Spain**, the excluded groups are young people who leave the State guardianship system and are under 25 (if they do not have family responsibilities); people who cannot work due to disabilities or long-term illnesses, which are not medically certified by the health authorities (for example, cancer patients); women victims of gender-based violence without a judiciary resolution or confirmation of their circumstances; undocumented immigrants; migrants with less than 5-year residence; Spanish emigrants who return to the country and have no resources; unemployed people, over 55 years of age, entitled to a retirement benefit, who are living with working family members; people who have never entered the labour market, as they work in the informal economy; people receiving minimum benefits who find a job, temporary and / or with low wages; unemployed people who cannot attest previous insertion activities; and homeless people who cannot register in the local registers (a compulsory requisite). Accessibility is expected to be streamlined with the new federal 'Ingreso Mínimo Vital' passed in May 2020.

In **Serbia**, MI is almost inaccessible to small peasant farmers. In the case of **Portugal**, precarious and informal workers with no Social Security contributions are prevented from accessing the benefit.³¹ In **Ireland**, asylum seekers are on a specific lower allowance and are not allowed access to minimum income support. The Habitual Residence Condition also acts as a barrier to means-tested welfare supports for those entering Ireland who can face difficulties in meeting the criteria. It outlines the conditions a person must meet to show their links to the country or their permanence (time they have lived in Ireland or plan to stay). During the last crisis there were changes to criteria for Jobseekers Payments which increased the number of weeks someone had to be working to get Jobseekers Benefits as opposed to means-tested Jobseekers Allowance, and also reduced the weeks a person could remain on Jobseekers Payments before moving to Jobseekers Allowance. This results in many more people qualifying for lower payments than previously. In **Iceland**, the excluded groups are composed of people who do not know the system (young people and those with limited capabilities), undocumented migrants, those facing language barriers and those lacking information from their social environment. Although the benefit level is low, in **Hungary** around 500,000 people are out of the income support system, out of a population of 9.8 million.

As a positive example, in **The Netherlands**, for the last 51 years, the Statutory Minimum Wage is increased twice a year by following inflation and wage raises. At the moment when the MW goes up, the Minimum Income automatically increases. This tight relationship between both instruments has been jeopardised during the crisis, but it still remains as it was established five decades ago.

31 EMIN Report Portugal, 2017.

3. MAIN MEASURES ADOPTED BY GOVERNMENTS

The outbreak of the COVID-19 pandemic prompted many governments to introduce unprecedented measures to contain the contagion and prevent high mortality rates. These were priority measures imposed by the situation, which left little room for other options, as the population's health was the primary concern. These measures have led to widespread restrictions on travel and mobility, the (temporary) shutdown of many businesses, the turmoil of the financial markets, an erosion of confidence and heightened uncertainty. Millions lost their jobs or are no longer self-employed. Many households depended (or still depend) on unemployment benefits, minimum income or other emergency income support schemes such as short-time working arrangements, but these did not cover all those who needed protection, or the amounts of the benefits were not sufficient to meet household expenses and debts.³² In many countries, there was an increase in running costs, food and household products, which was aggravated by the need to buy new and expensive protection items against the virus, such as face masks, hydroalcoholic gel or gloves. Confinement and lockdown measures were implemented at different paces with respect to the contagion rate. The late introduction of these measures had consequences regarding the contagion and mortality levels, particularly in Italy, Spain and the United Kingdom.

3.1. Positive changes and lessons learnt

The respondents also highlighted positive outcomes, changes and hopes for the future, from the lessons learnt during the COVID-19 crisis in their countries. The overall benefits of adequate and timely investment in universal public services and adequate social protection systems and the problems with the privatisation of public services were highlighted during the crisis. Also, the importance of ensuring that the design and delivery of public services and social protection systems need to systematically tackle rather than reinforce inequality. Many highlighted the evident and urgent need to grant good quality, universal, affordable accessible, integrated public health and care service. Other shared positive experiences were the positive reappraisal of healthcare and social care workers, the immense capacity of civil society self-organisation and collaboration with the authorities, the role of volunteering and the importance of food and goods but also social proximity to those in need. (For the detailed national assessments, see Annex 2: Country Annex ([link here](#))).

3.1.1. Employment and income-support measures

The COVID-19 pandemic is accentuating a range of structural challenges to social protection systems which existed well before the crisis. Self-employed workers often had limited access to income replacement benefits or were targeted later. Insurance-based transfers tend to be less accessible to the poor. Even in countries with well-developed social protection systems, many workers without standard employment contracts, who have suddenly lost their income, were struggling to make ends meet.

Meanwhile, in countries with large informal sectors and weak social protection systems, such as **Spain, Italy or Greece**, many affected workers did not have access to any form of income support at the beginning of the lockdown. Most of the countries introduced new programmes to cover those whose incomes may have been unprotected while being particularly exposed to deteriorating earnings prospects, creating a complementary safety-net aimed at reaching the

³² "The COVID-19 pandemic has triggered the most severe recession in nearly a century and is causing enormous damage to people's health, jobs and well-being", according to the OECD, "Tackling Coronavirus. Contribution to a global effort", at <https://www.oecd.org/coronavirus/en/>

groups most at risk of falling through the cracks of existing social protection systems. **33 This net is an example of how it is possible to ensure that social protection systems reach all people regardless of their employment situation.**

Firstly, many governments stepped up means-tested support to bolster the incomes of those with the least resources, with new and existing job retention schemes³⁴ (**Austria, Belgium, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Italy, Lithuania, The Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, and the United Kingdom**), extensions to unemployment insurance (**Austria, Belgium³⁵, Finland, France, Germany, Greece, Iceland, Ireland, Portugal, Slovakia, Slovenia, and Spain**), extensions to means-tested programmes (**Finland, Germany, Ireland, Italy, The Netherlands, Slovenia, Spain, and the United Kingdom**), new targeted transfers to specific groups (**Austria, Belgium, Czechia, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Poland, Portugal, Slovakia, Slovenia, Spain, and the United Kingdom**) and additional direct help with expenses, including moratoria on taxes, social contributions and housing costs (**Belgium, France, Germany, Greece, Hungary, Ireland, Italy, The Netherlands, Norway, Portugal, Slovakia, Slovenia, Spain, and the United Kingdom**).

Secondly, governments provided targeted transfers to support those whose vulnerability was revealed by the crisis. Self-employed workers were clearly vulnerable due to the loss of income and the lack of formal social protection and several countries introduced new cash transfers for them. Often, these transfers depend on either previous earnings, or on losses due to the crisis. In **Austria**, the credit guarantees are mainly support for banks, whilst the self-employed had to pay back the money and get into debt.

Many countries used existing minimum-income schemes as a principal instrument to channel support to groups that do not qualify for the main earnings-replacement programs, such as unemployment benefits or short-time work schemes. Often, countries loosened the conditions for benefit receipt during the pandemic, both to deliver support more quickly and to widen the circle of potential recipients to include those with some income and / or assets. In **Austria**, the family “hardship-fund” was introduced. Originally it should have targeted only families in which one partner lost their job due to COVID-19. Because of the sharp criticism and intervention of the Austrian EAPN, the government changed the regulations and included families with a partner who could have been unemployed before the crisis and were also recipients of Minimum Income. This is really an important measure which affects the situation of people experiencing poverty.

Another important measure in **Austria** was the governmental decision that unemployed people would not lose their unemployment benefits during the crisis (normally after a certain period the unemployed only receive the so-called “emergency aid” which is lower than the unemployment benefit). However, despite the criticism, national and regional governments did not change the

33 In this sector, we follow the OECD approach. OECD, Supporting livelihoods during the COVID-19 crisis: Closing the gaps in safety nets, Table 1, Countries across the OECD have announced new, or extended existing, safety-net measures in response to COVID-19, <http://www.oecd.org/coronavirus/policy-responses/supporting-livelihoods-during-the-covid-19-crisis-closing-the-gaps-in-safety-nets-17cbb92d/> And Adapted from OECD (2020), “Supporting people and companies to deal with the COVID-19 virus: Options for an immediate employment and social-policy response”, ELS Policy Brief on the Policy Response to the COVID-19 Crisis, OECD, Paris, <http://oe.cd/covid19briefsocial>. Accessed 19 May 2020.

34 Short-retention schemes are public schemes that are intended to preserve jobs at firms experiencing a temporary reduction in business activity by alleviating labour costs for firms or supporting the incomes of workers whose earnings are reduced. They can take the form of short-time work or temporary layoff schemes that subsidise hours not worked or of special subsidies to hours worked which can also be used to top up the earnings of workers on reduce hours

35 In **Belgium**, a good system of temporary unemployment was introduced. This benefit was also slightly higher than the normal unemployment benefit. However, for people with low income or in part-time jobs, this was often insufficient to make ends meet. For people with a precarious employment contract such as artists, students, people in the platform economy this temporary unemployment was often not accessible. In **Belgium**, the unemployment benefit decreases over time. As it is impossible for many people to look for a job today, this decreasing feature of the benefit has been temporarily halted.

regulation for Minimum Income. In **Germany**, for example, the government decided to dispense with the proof of income and shortened the waiting period (which is up to three months).

Thirdly, the new measures targeted groups whose incomes were not protected; those with low incomes, or those with higher needs, such as families with children. Several countries introduced new cash transfers for self-employed workers (**Austria, Spain, United Kingdom, Italy, Ireland, Germany, and Spain**). Domestic workers and caregivers working in private homes were very negatively affected. Some could apply to access former or new income support (**Spain**), although those people (often women) working without a legal work permit were excluded. **Serbia** and **France** offered universal transfers, to ensure a rapid pay-out and limit the number of people that fall through the cracks. The **Serbian** government gave a one-off payment of €100 for all citizens above the age of 18 (approximately 5 million people). The French government offered 4 million low-income households at least Euro €150 each and grants up to €1,500 for frontline staff and key workers. Eligible households will receive €150 each, with an extra €100 per child. To be eligible, families must be receiving benefits, specifically at least the unemployment income support Revenu de Solidarité Active (RSA), or the further unemployment income support Allocation de Solidarité Spécifique (ASS).³⁶

Fourth, there was a set of measures devoted to providing relief to those unable to meet expenses. This includes support for regular expenses, such as the delay in the payment of bills, household utilities, rents or mortgages and contributions to Social Security. Some measures partially covered the pandemic-related expenses, such as the VAT reduction on hygienic products and face masks in most EU countries. Others were extensions of in-kind support, as with the compensation to families which usually benefit from reduced-cost school meals or canteen scholarships. These are transfers paid out automatically to eligible families together with their regular family benefits or with the substitution of these by meal distribution to the children's homes. Many countries increased their funding to Food Banks and the European Commission authorised modifications of the FEAD programme in order to cope with the increased food demand. Some local and regional authorities provided an internet connection and computers to children in poor households who suffered from the digital divide, so that they could access online education.

3.1.2. Healthcare systems

The vulnerabilities of the healthcare systems were highlighted by the COVID-19 pandemic, but this crisis also brought solutions for some of those (**Iceland**). Preparedness for further emergencies and epidemics is reappraised and now considered crucial (**Spain**). In the **United Kingdom**, there was additional funding for the NHS and there appears to be a lower risk (for now) of further privatisation. There is more evidence of the need for more integration between key services and better funding (**Ireland, United Kingdom**). The rapid, reactive and effective adaptation of some healthcare systems (hospital wards transformed in order to isolate patients with COVID-19) prevented their capacity from becoming overloaded (**Czechia, Iceland, Serbia, United Kingdom**). Early isolation of people suspected of infection and “social distancing” were considered to be effective (**Czechia, France, Italy, Spain**). **Ireland** praised the naming of many socially disadvantaged groups as ‘vulnerable groups’ for the purposes of COVID-19 therefore fast-tracking them for testing and for the provision of spaces to self-isolate in cases of infection. There is an extended belief that there should be a combination of health and social care arrangements for the most vulnerable (**Czechia, Denmark, Greece, United Kingdom**). Free access to healthcare was granted for migrants to COVID-19 treatment (**Belgium, Portugal, Spain, United Kingdom**).

³⁶ The Connection, June 27, 2020, at <https://www.connexionfrance.com/French-news/France-confirms-grants-of-150-1-500-to-key-frontline-healthcare-staff-and-low-income-families>

The development of digital services and the quick support measures to ensure the capacity of healthcare to treat COVID-19 patients was perceived as positive (**Finland, Greece, Iceland, Norway, Spain**).

3.1.3. Education

Most European countries closed schools as part of their measures to limit contact between people and to slow down the spread of the virus. In **Italy**, the European country hit first by the pandemic, schools closed on 5 March. This decision was soon followed by **Greece** and **Czechia**. Most European education systems closed their schools by 16 March. The last country to announce such measures was the **United Kingdom**, where all the schools closed their doors by 20-23 March. **Iceland** (and Sweden) bucked the trend of school closures for primary and lower secondary schools; they are relying upon stricter social distancing and hygiene measures to prevent further transmission of the virus. Only upper secondary and tertiary education institutions have been required to close.³⁷ The outbreak of COVID-19 in Europe and necessary national measures taken to tackle the spread of the virus caused significant disruption to the provision of education, training and mobility opportunities for learners, teachers and educators across the European Union. Most of the respondents to the survey praised the rapid implementation of an improved distant learning system, although noting that there was room for improvement in making it more inclusive. This was due to the digital divide related to the household's poverty, lack of access to computer equipment and the internet, inadequate and overcrowded housing, location, education attainment and availability of the parents, disability and functional diversity of students, among others.

3.1.4. Regularisation of migrants

In this period, three European governments regularised certain groups of irregular immigrants through temporary permits: Portugal, Italy and Spain. The systematic use of this tool has always postponed the bigger problem: a long-term legislative solution. In **Portugal**, the regularisation of migrants was presented as a way of extending their healthcare and monitoring the spread of the virus to the overall population. In **Italy** a similar measure was passed in May, after months of insistent opposition by the Five Star Movement, a member of the ruling coalition. Ministers in favour of the proposals praised the efforts of migrants to care for the elderly and produce food supplies during the pandemic. They also argued that the migrants would be needed to work the fields and keep food on the table as Italy emerged from the crisis in the autumn, and that giving them access to public healthcare would help contain the virus. Up to 560,000 migrants live without residence permits in Italy, but only those working as labourers or caregivers will be eligible. Under the plan, each will get a renewable six-month permit.³⁸ In **Spain**, in June, eight political parties representing less than half of the Parliament seats proposed a massive regularisation of undocumented migrants, voicing the demands of most Spanish NGOs. The Government has already issued a decree to grant permits for seasonal work in agriculture. It is estimated that between 390,000 and 470,000 people in an irregular situation live in Spain.³⁹

³⁷ EURYDICE, 2 April 2020, at https://eacea.ec.europa.eu/national-policies/eurydice/content/how-covid-19-affecting-schools-europe_en?cookies=disabled

³⁸ The New Humanitarian, 25 May 2020, at <https://www.thenewhumanitarian.org/feature/2020/05/25/Italy-coronavirus-migrant-labour>

³⁹ El País, 26 June 2020, at <https://elpais.com/espana/2020-06-26/unidas-podemos-pide-al-gobierno-la-regularizacion-urgente-de-todos-los-inmigrantes.html>

3.1.5. Civil society

There is a new appreciation of healthcare workers (**Austria, Hungary, the Netherlands, Spain**), which is extended to social services and the NGOs, who played a key role in the delivery of services vital to handling the crisis (**Hungary, Norway, Spain**). There is an increase in empathy and co-responsibility for each other, a “strengthened society” with more help and support among neighbours (**Austria, Italy, Spain**). **The Netherlands** mentioned “a wave of solidarity growing amongst neighbourhoods and groups”. The increased consciousness (and concern) about the vulnerability of the elderly and people with diseases in our societies is seen as positive (**Austria, Italy, Portugal, Slovenia, Spain**). There is a greater consensus for protecting the most socially vulnerable groups (the Spanish government launched “a social shield to protect the vulnerable”). A new kind of cooperation was rapidly put in place between NGOs, municipalities and parishes to help - for instance - elderly and homeless people (**Finland, Greece, Portugal, Spain**). In **France**, shelters were equipped with computers to help educate children. In **The Netherlands** and **Spain**, restaurants, farmers and factories offered the products that they cannot sell to food banks and others or even create meals to distribute themselves. Hotels opened rooms to homeless people (United Kingdom).

3.2. Negative changes and pending issues

3.2.1. Employment and income-support measures

The COVID-19 crisis, however, uncovered pre-existing gaps in poor social protection provision, employment protection and labour rights, particularly in the context of new precarious forms of work. The assessment done by respondents is divided in three groups: 42.9% (Austria, Croatia, Finland, Germany, Greece, Ireland, Lithuania, Norway and the United Kingdom) indicated that the government’s performance in these fields was “average”; 38.1% considered that it was “poor” (Belgium, Czechia, Italy, Portugal, Serbia and Slovenia) or “very poor” (Hungary and Poland), while 19% said that it was “good” (Denmark, Iceland, The Netherlands and Spain).

As employees became infected, were furloughed/had to reduce their work hours, or lost their jobs, paid sick leave schemes, short-term work schemes, and unemployment benefits were implemented. When the schools closed, temporary childcare permits were established although with insufficient coverage (**Czechia, Ireland, Italy, Portugal, Spain**). Teleworking has developed in a spectacular way, allowing the maintenance of certain activities and jobs, but was not available to the majority of particularly blue-collar service workers. The employment and income-support measures helped many, but even in countries with the most advanced social protection, some workers with non-standard jobs and their families were left out. The situation was worse in countries with large informal sectors where an increasing number of people who stop working are left without any income (**Italy, Greece, Portugal, Spain**).

3.2.2. Health and healthcare

The impact of the virus was heterogeneous, with some countries severely affected and thousands of deaths and others with lower prevalence. However, due to the seriousness of the disease and the initial slow reaction adopted by most European countries, the most common policy towards healthcare was to redirect most of the existing facilities, staff and resources towards the prevention of contagion and the treatment of those infected.

In countries with lower levels of contagion and good hospital facilities and equipment (Denmark), lockdown measures were preventive and not the result of lack of intensive care and medical services capacity. Most of the respondents to the questionnaire assessed the performance of their healthcare system during the COVID-19 as “good” (57.9%, **Austria, Croatia, Denmark, Finland, Germany, Hungary, Italy, The Netherlands, Norway, Portugal and Spain**) and “very good” (15.8%, **Czechia, Greece and Iceland**). A 21.1% considered that it was “poor” (**Belgium, Ireland, Poland and Slovenia**) and a 5.3% that it was “bad” (**Serbia**).⁴⁰

However, there is a generalised, shared agreement regarding the negative impact on people already experiencing poverty and social vulnerability, who started with a disadvantage compared to other groups who were not in poverty, in terms of prevalent diseases, disabilities, badly perceived health status and low levels of wellbeing, as well as lack of savings, debts, precarious jobs (if any), low-amounts of benefits, insecure housing and poor digital skills.

The lack of sustained investment in efficient, affordable and universal health services, with well-paid staff and with pandemic shocks preparedness, became also evident (particularly in Italy, Spain, The Netherlands and United Kingdom). In many countries, coordination and procurement of personal protective equipment were very problematic, which provoked the over exposure of healthcare and front-line workers to the virus as well as a consequent grave danger to their lives (Belgium, France, Italy, Norway, Spain, United Kingdom).

Regular medical treatments and scheduled procedures were cancelled or postponed (Austria, Belgium, Denmark, Finland, Ireland, Lithuania, Norway, Serbia, Slovenia, Spain and United Kingdom). Croatia mentioned that people with disabilities were at risk of losing their regular therapies and Czechia indicated that social care and healthcare proved to be inadequate. In the United Kingdom, there were 55,000 excess deaths in five weeks but 20,000 were not noted as COVID-19 being a factor. This excess could be due to lack of access to health services, including interrupted treatment plans and cancelled investigations, as well as people who were ill choosing not to go to the GP or hospital, given government messaging on not overloading the health service, or people not feeling safe to go to hospital. There were changes to national guidance on access to healthcare for very sick patients, which resulted in some additional deaths of those who were given only palliative treatment, or discharged home or to care homes, at greater risk of contracting COVID-19, or giving it to others, because they were not tested either before leaving hospital or after arriving at home or at the care home.

Some uncomfortable ethical problems have been exposed due to the appalling death toll amongst residents of care homes. There is an ongoing questioning of the institutionalisation system which maintains the elderly in residences/care homes which provide "specialised care", by separating them from their home environment, treating them in a paternalistic way and, in general, subduing them into a questionable process regarding their human rights (**AGE, Croatia, France, Germany, Italy, Portugal, Serbia, Spain**). In **Ireland**, over 60% of deaths were in long-term residential settings.

Guidelines devised by health authorities in many countries advised or ordered that the elderly who got infected should remain in care homes and were not to be transferred to hospitals, which were under strain and lacked vital equipment such as respirators (**Belgium, Spain**). In almost all the surveyed countries, visitors were not allowed in long-term facilities in an attempt to stop the spread. **Slovenia** explained that this isolation had a side-effect on the elderly's physical, social and emotional lives. **Poland** and **Spain** reported several COVID-19 outbreaks in nursing homes, and government responded with emergency measures like sending quasi-military troops to help.

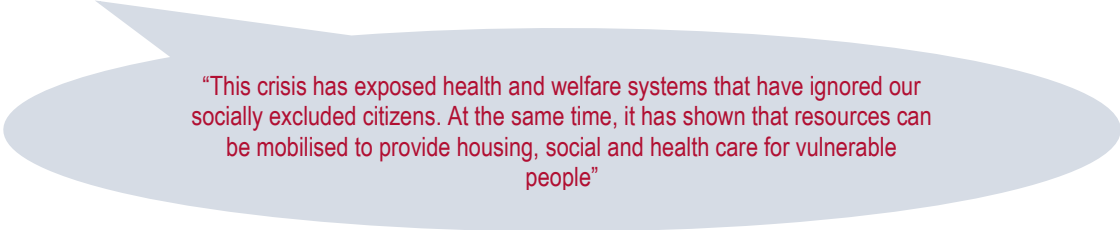
⁴⁰ The countries not mentioned, France, Lithuania, Slovakia and United Kingdom, did not answer to this question of the questionnaire.

Portugal created a State of Emergency Monitoring Structure coordinated by the Minister of Internal Affairs to follow the “national COVID-19 screening test program” that was targeted at the elderly and which exposed the situation of unlicensed care homes.

Belgium and Portugal reported that undocumented migrants and asylum seekers could access medical assistance (Portugal speeded-up the granting of the residences permits) In **Spain**, the reception and detention centres (CIE) were heavily compromised due to the easy spread of the virus.

France and Spain indicated that their governments established specific centres to isolate and treat the infected homeless people who were living on the streets and increased hospital beds for severely ill patients. In the case of **Spain**, the macro centre for the homeless was immediately dismantled when the de-escalation began. **Slovenia** reported that for homeless people it was difficult to follow hygienic rules and they easily became infected. In **Ireland**, the homeless, Travellers and Roma, asylum seekers and refugees have been named as ‘vulnerable groups’ for the purposes of COVID-19, which gave them priority for testing and for the provision of spaces to self-isolate in cases of infection.

As **SMES** summarised:



“This crisis has exposed health and welfare systems that have ignored our socially excluded citizens. At the same time, it has shown that resources can be mobilised to provide housing, social and health care for vulnerable people”

3.2.3. Poverty and social exclusion

Poverty and social exclusion are results of extensive inequalities and of the ineffectiveness of redistributive policies, the employment and social protection system, social services, education, healthcare as well as essential services like decent affordable housing and energy services. Due to the COVID-19 crisis, in many countries poverty and social exclusion have been radically exposed, with images of long lines at the overwhelmed food banks due to the sudden drop or lack of income of families who have lost their jobs, or on reduced income with increased costs. Makeshift shelters for the homeless and those with insecure housing have appeared. The lack of computers and digital skills to catch up with the rapid digitalisation of services and education has been widespread. The aggravation of the situation of homeless people, when many facilities were closed or took only a limited number of overnight stays, was also problematic in most of the countries.

3.2.4. Social and care services

The health crisis has also brought to light the isolation and vulnerability of people with chronic diseases and mental health problems (**SMES**), disabilities and functional diversity. This is because of the lack of social services protecting them, the weakness of the system of formal and informal care, which necessarily needs to be complemented by extensive networks of volunteers and NGO work. People were not able to attend social services and could only access the services online or by phone support, with limited face-to face services where staff call at people’s homes. This included community organisations where staff were also adapting to engage with people remotely (**IFSW, Austria, Belgium, Czechia, Ireland, Lithuania, Norway, Portugal, Spain, United**

Kingdom). Finland reported that child protection notifications decreased when schools and kindergartens were closed and their emergencies remained within the families, without receiving proper help unless they were able to ask for it themselves.

3.2.5. Digitalisation and education

The number of teleworkers constantly increased during the COVID-19 lockdown and quarantine. Teleworkers had not only to purchase laptops and corresponding software licenses, but also pay for the installation of the necessary infrastructure, including access and security solutions, particularly in SMES and non-profit sector.⁴¹ Furthermore, the lack of regulation of this labour modality has put workers' rights at risk. Teleworkers turned their homes into makeshift offices. Cloud-based collaboration tools experienced exponential growth, which had a side effect of invasive connectivity and disrespect for workers' schedules. Many had to juggle to reconcile caring for family members and supervising their children's online home education.

Cost, complexity, and "lack of interest" are three major factors why people are offline. Costs and availability are factors that had a negative impact on rural societies, without good internet access, as well as in low-income households that cannot afford an internet connection or to buy computers for the adults and all children of school age. For people with health conditions or a disability, a perception that the internet is too complex or difficult could be a key reason for staying offline. The perceived risk of the internet is an important reason for exclusion among older populations.⁴² The digital divide generated additional problems during the COVID-19 crisis due to the lockdown and quarantine which led consumers to buy more online, while many private and public face-to-face services were suspended. Healthcare information, guidelines, queries, proceedings – such as benefits claims - and resources related to the COVID-19 pandemic were available online and those who could not engage were excluded.

The transition to distance education is complex and uneven. No educational system was prepared to universalise effective online learning in record time in response to an unexpected pandemic, let alone ensuring quality and fairness in the process. Not all children started from the same point nor did they have the same resources or capacities to do it effectively. Access to devices is very unequal from household to household, and even more so in a period of confinement where all members of the household may need to use them; for example, in Madrid, Spain, 30% of primary and 18% of secondary students did not respond to attempts to maintain continuity in the learning process. All those services that the school usually provides, such as breakfasts, lunches or psycho-pedagogical support, aggravated these gaps.⁴³ Besides this, in many households, parents could not provide support for their children's home-schooling.

⁴¹ We could not find examples of public funding to meet these expenses.

⁴² Capgemini Research Institute, The Great DIGITAL DIVIDE. Why bringing the digitally excluded online should be a global priority, 6 May, 2020, at <https://www.capgemini.com/es-es/wp-content/uploads/sites/16/2020/05/Digital-Divide-13.pdf>

⁴³ COTEC, COVID 19 Y EDUCACIÓN I: problemas, respuestas y escenarios, 20 April, 2020 at <https://online.flippingbook.com/view/967738/>

3.2.6. Transparency and inclusivity of governments

These problems of lack of transparency and inclusivity of their government were reported by many respondents, as the “states of exception” allowed the ruling parties to take direct routes to decisions, without parliamentary consultation. In **Austria**, the government adopted various measures to support the economy and people, but on the whole this support did not target the poorest. The argument was that people experiencing poverty were poor before the crisis, so for them, the situation stayed the same. But this argumentation missed out on the fact that minimum income and other social benefits were too low before as well, and that the crisis made the situation for people experiencing poverty even harder (losing the support of social services, not getting childcare etc, increased costs.).

The interest regarding the inclusion of those groups living in poverty was unequal or not adequate, for example in the case of large Roma populations, segregated and guarded by the military (**Slovakia**), or in the case of undocumented migrants who lived in sub-human settlements and refugee camps (**Spain, Greece**).⁴⁴ The **United Kingdom** also highlighted the weak implementation of policy and in particular the insufficient specific attention and oversight to protecting vulnerable people - in care homes and receiving care in their own homes - which likely resulted in many more deaths than otherwise would have happened. People in poverty and BAME (black and ethnic minority) people suffered the highest mortality rates.

⁴⁴ See Amnesty International, Europe: COVID-19 lockdowns expose racial bias and discrimination within police, at <https://www.amnesty.eu/news/europe-covid-19-lockdowns-expose-racial-bias-and-discrimination-within-police/>

4. THE IMPACT OF THE PANDEMIC ON PEOPLE EXPERIENCING POVERTY AND SOCIAL VULNERABILITY

The respondents to the questionnaire made an assessment of which groups were most affected, and if the impact was linked only to the health crisis or to both the pandemic effects and the policy reactions to it. The elderly living in nursing residences or care homes, those living in involuntary loneliness, with chronic disease, homeless people and front-line workers were considered the most affected groups by the pandemic, with a very high level of agreement amongst respondents. The groups most negatively affected by both the pandemic and the policy reactions, always according to the assessment of the majority of respondents, were the atypical and self-employed workers, vulnerable children, low-income families, Roma, migrants and asylum seekers.⁴⁵ (For the full details of the national assessments, see Annex 2 ([link here](#))).

The data shows that not all people were on equal terms to face this new disease, nor the confinement and lockdown measures. These differences originate in individual aspects, such as their physical and mental health (age, the existence of chronic diseases, disabilities or dependency) and, especially, in their socioeconomic situation. As stated by the International Federation of Social Workers, in response to the questionnaire, “The widening of already existing inequalities means that those who need most support – such as access to adequate health, social care and education – are not receiving it and are struggling most to deal with the catastrophic economic consequences of the pandemic”.

4.1. Elderly people

The pandemic sheds light on age discrimination that existed prior to COVID-19. As EAPN members report, older people have been systematically left behind in decisions about service allocation, medical treatment, prioritisation of needs and resources. According to the report of the London School of Economics, between 42% and 57% of deaths in Italy, Spain, France, Ireland and Belgium occurred in elderly care facilities. Older people in general were considered a group particularly vulnerable to COVID-19 in terms of complications of the disease trajectory and risk of fatality. In some cases, this has led to their ‘over-isolation’ and lack of adequate protection, including mental health. In care homes, local epidemics imported by earlier visitors or care staff could develop unabated, as personal protective equipment was available neither to staff nor to residents. In a number of cases, no testing or medical treatment was provided to residential care facilities, letting residents die without any treatment, in a clear violation of their human rights. In Spain⁴⁶ and Italy⁴⁷, there are criminal investigations regarding their guidelines for nursing homes, regarding the transfer of sick elderly residents to hospitals. The COVID-19 pandemic did not only show the fragile situation of older people living in institutions, but also the lack of support for older people who receive care in the community and the risk of isolation of older people living alone. This was because home care services were reduced and suffered the same lack of protective equipment and testing amongst the remaining service providers. Informal caregivers for older people, most of them older women, in need of care and assistance themselves, were the indirect victims of this, as they had to bear the additional burden of providing care where formal services had been shut down or where the service offer had been reduced. Day-care and respite care centres closed, leaving them to struggle between caring and their employment, thus exposing them to an acute risk of overburdening and burn-out.

⁴⁵ Gender-based violence and single-parent families were also mentioned by the majority of respondents, but are analysed in the following point, on the gender impact of the COVID-19.

⁴⁶ El Mundo La Fiscalía eleva a 86 las residencias de ancianos investigadas por la crisis del coronavirus, 40 en Madrid y 20 en Cataluña, April 21, 2020, at <https://www.elmundo.es/espana/2020/04/21/5e9f0cddfc6c83ab1c8b4571.html>

⁴⁷ Euronews, Covid 19 e il ventre molle della società: i decessi nelle case di cura, 15 April 2020, at: <https://it.euronews.com/2020/04/15/covid-19-e-il-ventre-molle-della-societa-le-morti-nelle-case-di-cura>

Digital exclusion became a higher risk factor for social exclusion during the pandemic, as many services are available only online. Beyond these directly vulnerable categories, older people living alone, a large majority of them women, are facing the mental and physical health consequences of isolation and lack of activity. Several reports of older people dying because they simply gave up on living have reached NGOs, as reported by **AGE Europe**.⁴⁸ In **Finland**, elderly people with multiple illnesses and people with physical disabilities and long-term illnesses were the most vulnerable. Many suffered from loneliness, anxiety and had lost the meaning of life because most of their normal activities were not permitted or had been stopped. Being mainly indoors, by themselves, caused a drop in their physical and mental condition and health. People with dementia were particularly vulnerable. For people with long-term illnesses there was a bigger risk of becoming seriously ill with COVID-19 and protecting themselves from the virus brought extra expenses. There was a risk that chronic diseases could get worse because there were less health services available than usual, and there was also a risk in using those which were available. Experts from the Finnish Institute for Health and Welfare reported that the services needed were accumulating and the queues were getting longer. This had a negative impact on the wellbeing of many groups of people. People with disabilities and with low income had mostly stayed or isolated at home. There were problems in getting protective equipment for their personal assistants and this was why they had not always gone to work to take care of the person with disabilities. The limitations caused by the pandemic in support services, as well as the COVID-19 itself, put a great deal of mental and physical strain on the caregivers who also had to look after their family members. Therefore, the situation was also stressful for the person being cared for.

4.2. Front-line workers and medical staff

In **Ireland**, many of the essential workers were those who were earning on or close to minimum wage (€10.10 per hour), including retail workers and care assistants. These groups were putting themselves and their families at a greater risk of infection from COVID-19. However, their income was not reflecting the essential role they played in maintaining vital supports and services. A similar situation happened in **Spain** and **Portugal**. **Spain** ranked first for COVID-19 infections among healthcare workers (20% of all registered cases in Spain, compared with 10% in Italy) and experts blamed lack of foresight by authorities for this high impact on Spanish professionals, basically the absence of the indispensable safety measures that should have preserved their health.⁴⁹ In **Croatia**, the high contagion rate was due to their intense exposure to the virus. In **Norway**, low-income households often belong to those workers more exposed to the virus. Bus drivers, cleaners and shop staff are in this category, which experienced increased risk of infection. In addition, they often work in the service professions where most people had been laid off, such as hotels and tourism, restaurants and bars etc. Before this crisis, they were the lowest paid and are now among the hardest financially hit by the governmental measures. Also, these groups generally live in smaller dwellings, which increases the risk of the virus spreading. Those with weak ties to the labour market, such as temporary workers and those working in staffing agencies, are struggling financially. In the **United Kingdom**, three in four workers whose jobs involved frequent contact with people were women; black and minority ethnic groups (BAME) were also over-represented and suffered higher mortality. Healthcare workers were most likely to be exposed, but their death rate is not greater than the general population, possibly linked to better infection control, e.g. some protection from PPE. Male and female care workers' death rates are significantly higher than people of the same age and sex in the general population. The

⁴⁸ AGE Europe, a member of EAPN, responded to this questionnaire. On 19 May, AGE published the report (also consulted), "COVID-19: Older persons' rights must be equally protected during the pandemic", at <https://www.age-platform.eu/policy-work/news/covid-19-older-persons%e2%80%99-rights-must-be-equally-protected-during-pandemic>

⁴⁹ El País, 25 April 2020, at https://english.elpais.com/spanish_news/2020-04-25/spain-ranks-first-for-covid-19-infections-among-healthcare-workers.html

highest death rates from COVID-19 were amongst low paid working men: male security guards, male taxi drivers and chauffeurs, chefs, cleaners or bus drivers.

4.3. Homeless people

Existing poverty and social exclusion were decisive in the social and health impact on homeless people, who lived on the street, as well as many immigrants and Roma who survived in settlements or sub-standard houses, since they could not avoid contagion or recover in isolation in cases of contracting the disease. Homeless people have been a medically high-risk population, disproportionately affected by poor health and disability and therefore face higher risks of dying if they contract COVID-19. Furthermore, they face multiple barriers to accessing healthcare as well as public health information. Transmission from this high-risk population was also difficult to contain, meaning that protecting people experiencing homelessness was an important element of managing the wider public health crisis.⁵⁰

In most of the surveyed countries, crucial day services for the homeless such as services that provide food or medical services for this group ceased to operate due to the pandemic, increasing their insecurity. **Belgium, Ireland, The Netherlands, Norway** and **Spain** made temporary efforts to house homeless people in alternative facilities, such as hotels or vacant housing. In **Finland**, however, shelters and housing services were mostly open but more crowded, which increased the risk of contagion. Because of this risk, friends and relatives could not offer them a place to stay overnight. In **France**, volunteers at shelters, often elderly, were no longer active. The shelters struggled to function and to isolate infected people, lacking social workers because they did not have priority childcare, or they could not get to the places due to the minimum functioning of public transport. People in squats and slums were the most affected: no access to water and hygiene, some public fountains closed at the start of the crisis. In the **United Kingdom**, funding was available to all local authorities which could be directed to front-line NGOs. 95% of street homeless people were housed in rooms in hotels, which were otherwise empty. Central Government cash to implement a “housing first approach” was successful in keeping COVID-19 from spreading amongst street homeless people. Agencies and NGOs working with homeless people used the opportunity to support access to health, benefits and progress to reintegration. However, some countries (**Belgium, Spain, United Kingdom**) reported that homeless people were chased out of public spaces and harassed by the police, without being escorted to a shelter.

“At first, I had a problem wearing a scarf, but I got used to it. I was not afraid of infection. At the beginning of the pandemic I was lying in a hospital with another disease, there I was not afraid of infection, I felt safe. Since I live on the street, I had a problem that I had nowhere to hide, because the department stores, waiting rooms and libraries were closed and the city police drove us homeless everywhere. I was happy to take the opportunity to be in the Mother Teresa Asylum House all day, where we were allowed to stay soon after the beginning of the emergency. I have been here for almost two months and I am happy to be here. I don't miss anything. Measures of support? I didn't know anything at first, until I came back from the hospital. Specifically, I can't name anything. I try to exercise every day so that I don't have to walk on a cane, I will continue to take care of my health, I'm not afraid of COVID infection. I think I have strong immunity. I think that everyone should continue to be careful and follow the government's recommendations so that the disease does not return to us.”

CZECHIA, Aleš, male, 53 years old, homeless, Hradec Králové

50 FEANTSA, “COVID-19: “Staying Home” Not an Option for People Experiencing Homelessness”, at <https://www.feantsa.org/en/news/2020/03/18/covid19-staying-home-not-an-option-for-people-experiencing-homelessness?bcParent=26>

"My problem during the COVID-19 crisis was to find a good accommodation. I have used my experience as a homeless person. The government did not provide support for the homeless people. My short-term needs and aspiration: That I can live my life the way I want again. The de-escalation should be available as soon as possible."

GERMANY, Schneider, man 56 years old, Cloppenburg (for the moment)

"I was locked up in prison for two and a half years and released just a week before COVID-19 pandemic was announced. It was a disaster. Prison authorities in our country don't have a plan for us convicts. They open the gate, give you a bit of money and say you are free. Many of us don't have anywhere to go, nobody to turn to. Corona crisis made it all worse. Since it's hard to get a job fast if you have a criminal record, we have to fend for ourselves as best one can. Social transfer funds we get from the state (around € 400) is the only income we got to make a new start and it's not easy I'll tell you. There are also no halfway house programmes in Slovenia. Rents are sky high, so I knew I'll end up homeless and eventually be forced on my old paths. For the first two weeks I was a rough sleeper, streets were empty, people were scared, and I was a nervous mess. Then I got a bed in a homeless shelter but the biggest thing I got there was support. I was able to find a room just as the restrictions were loosened. I could hardly do it without the help of the NGO. It's not just about COVID-19. All things related to released convicts striving for a decent and better life without crime work against them instead in their (and the public's) interest. I couldn't do much by myself and was truly struggling. I had to look for help at different NGOs and humanitarian organisations that were still working without interruptions. Governmental offices were mostly closed. Regarding my case I got a € 150 Corona Crisis Bonus. That was it. Most of all I want to reconnect with my daughter. She's kind of angry at me for being locked up. I want to take care of her properly, so my first aspiration is finding a paying job. Regarding my case there's a big need for programmes regarding convicts reintegrating into society."

SLOVENIA. Boštjan, male, 42, Ljubljana

4.4. Atypical and self-employed workers

Atypical workers (on internet platforms, in temporary jobs), the self-employed (including artists) and those who work outside trade union coverage who are always at risk of losing their jobs and income were highlighted as vulnerable by **Austria, Belgium, Denmark, Iceland, Lithuania, The Netherlands, Spain**. In **Poland**, some atypical workers with civil law contracts were not eligible for the crisis benefits for atypical workers due to the obligation of their employer to participate in the application procedure. In **Portugal**, these workers were the first to be dismissed, with very short notice, and in many cases without being able to access unemployment benefits. The effect of unemployment on housing is high: in April the main Portuguese banks received more than 210,000 requests for a moratorium from customers having difficulties in paying rents/credits because of the new pandemic. In **Serbia**, according to a survey conducted in mid-April by SeConS, member of EAPN Serbia, 8% of people who were employed in February 2020 lost their jobs. Almost half of them (46%) got fired because the employer ceased operations, 20% had temporary contracts which expired and new contracts were not offered to them, 12% left the job because they could not organise child care or care for older or sick people at home, 11% got fired or left the job because they could not organise transport to work, and 5% for other reasons. The highest share of those who lost their jobs was among workers employed in the hospitality and tourism sectors, construction and personal services. Also, job loss was more prevalent among informally employed, people employed with short term contracts and the self-employed. People employed in micro and small enterprises were affected much more than those employed in big enterprises.

"I was anxious to keep strict hygiene rules, washing my hands all the time. I was not allowed to get out of my house only for a few reasons. I faced traffic restriction, I could not visit any family member or friend. I live alone and I felt isolated and depressed. My job contract ended and the renewal of it delayed due to COVID-19 crisis. I pay a bank loan for my house which now I cannot pay for long time. I was wearing face mask that covers mouth and nose. I was trying to avoid overcrowding. I stayed home as much as possible. I was working from home till the end of April 2020 then my job ended. Used telephone and video calls more often to communicate with family, friends and colleagues. I was trying to do e-shopping where it was possible. Personally, I didn't have receive any support from the government. I happened to become unemployed in the middle of crisis, late April 2020. The government gave a kind of benefit (€ 800) to the employees who lost their jobs due to the lockdown of the companies. They also gave a benefit of € 400 to some of the unemployed people, to the newly unemployed, not to all... The government reduced V.A.T. in the public transport tickets and in the non-alcoholic drinks from 1st of June until 31st of October 2020. In short terms, I will need to get free masks. I am waiting to get the unemployment benefit of approximately € 400 per month. I have to reduce my expenses to minimum. I need the banks to freeze the payments of the loans for unlimited time, till we get the money to pay back. It is not possible for me to survive on unemployment benefit and pay the bank at the same time. I hope the extra economic allowance to be increased as soon as we get the EU funds agreed to be given to all the countries affected by the COVID-19 crisis. I hope the unemployment allowance to be increased in amount and time. I hope the government to reduce V.A.T. in all basic products. If we have to keep on the face masks, the government should provide them to the vulnerable people for free. The payments of the bank loans for housing should be frozen for a number of people experiencing poverty and other vulnerable people for long time. The government should increase economic allowance for everyone who have been affected of the COVID-19 crisis, the unemployment allowance, include more beneficiaries to economic allowance and reduce VAT on all products."

GREECE. Dimitris, male, 54 years old, unemployed, Athens.

"I have a disability and I participated in the programme to change my qualification. I started to work in accounting but lost my job as soon as the quarantine started. I am not sure if it was because of the quarantine or not. It was my probationary period and one day they just came to me and said that I have to go. I asked why but never got a concrete answer. One time they mentioned that it was because of the COVID crisis, the other times they said that I make a lot of mistakes at work. Then I asked what mistakes and they didn't say anything! Then we had a conflict, I asked them to put on paper why they were firing me, but they refused to do it. So, it was very painful and upsetting for me. Even now I don't know what I did wrong. I filed a complaint to the Labour Disputes Commission where these matters are being resolved. So, my complaint is still being processed but as far as I know, they still cannot name a concrete reason why they fired me. I still don't know what mistakes I did make. I wouldn't have complained but they really hurt me with how they fired me. I felt insulted. Well now I still get my disability benefit as before. I also registered to the Employment Agency. I heard about jobseeker's allowance on the news, but I am not sure if I will get. I don't understand anything about it. I really hope to find a job soon. To be employed, leave the house, communicate with people. But you know, it was never easy for me to find a job. Now it is even more difficult. I also don't want to work remotely, at least not for a few months. I just started to work in accounting, and I need someone to consult with, to ask questions. So... this quarantine is very unfortunate for me for this matter. I am not sure how, but the state should pay more attention and help to maintain work for people. Of course, additional benefits or other help for those who suffered during quarantine would be also good. As for me, I get my disability benefit, but it is just for food and housing, but people should also have other things. They should have normal lives which also means some entertainment, to have hobbies. It brings just other quality of life. But of course, you need money for this. Even you just buy a book. It is also quite a luxury."

LITHUANIA, Jelena, 33 years old, female, Vilnius

4.5. Low-income households

The COVID-19 pandemic and lockdown or confinement measures had an overwhelming, negative impact on already poor households, whose incomes were already inadequate for them to afford a decent standard of living. Unemployment, compulsory furloughing and lack of access to adequate financial support, particularly with increased costs, caused financial problems and anxiety that could be reflected in the internal life of families and other households, particularly in single parent families. In Belgium, as happens in other countries, even before the health crisis, people living on benefits had to make ends meet with an income far below the EU poverty line. They saw their expenses rise (for example, the prices of food and other basic goods), the food banks closed their doors, they consumed more energy, internet and telephone, and many had extra health costs. It was also much more difficult to claim benefits, as many social institutions closed their doors and could only be reached by telephone. Also due to the increase in applications, it took much longer to process them. Both the federal and regional authorities have taken many measures to prevent more people ending up in poverty. For example, a system of temporary unemployment was introduced and people who saw their income fall as a result of the crisis can obtain a moratorium on the payment of their loans. So far, people living on benefits have not received any additional financial support and because they are often unable to demonstrate a loss of income, they are not entitled to these exceptional measures.

Czechia reported that families in poverty faced difficulties in accessing social inclusion services. In **Finland**, many households lost their incomes, which was a source of severe stress. The COVID-19 crisis showed that the level of basic social security is too low. People depending on it have no chance of coping with extra costs: buying food, hygienic products, feeding the children who usually ate at school. Municipalities have provided food support, but not enough. Single parent families had particular challenges in coping. As a result of rising unemployment and furloughs, the crisis also increased people's over-indebtedness.

In **Ireland**, before the pandemic, the main welfare payments were below the poverty line and poverty levels were still higher than before the 2008 crash. 1 in 7 people were in material deprivation and 14% were still in poverty. Many families were already dependent on food banks. A survey published by the Central Statistics Office over April 2020 on the Social Impact of COVID-19 showed that 37.5% of respondents reported a negative impact on their household's ability to meet their financial obligations and almost half of these reported major to moderate impact. A survey on the social impact of COVID-19 reported an increase in the percentage of respondents who felt downhearted or depressed, rising from 13.4% in 2018 to 32.4% in April 2020. Mental health was a particular issue for those experiencing other forms of disadvantage, who had access to fewer resources or spaces during the lockdown phase. In **Norway**, families with children appear to be more at risk than families without children. Children in families whose incomes are below the poverty line have access to fewer resources than children in families with parents of higher socioeconomic status. Smaller dwellings, parents being more exposed to layoffs and unemployment or already living on benefits, means that they are struck harder than others by the consequences of the virus. In **Spain**, the Economic Population Survey acknowledged that more than 1 million people (570,000 households) lived without any regular income. These households, which often survive due to unregistered work, did not qualify for the crisis protection measures, which targeted those who lost their jobs or ceased their activity as self-employed workers.

"I live on minimum income in a shared flat. Anxiety has increased a lot day by day due to the very restricted lockdown at home, for 50 days approximately, with the only exception of shopping at the supermarket or the grocery, and without knowing when it will finish. I'm a man that likes reading and culture overall. So, the first days of lockdown were not a problem for me, because I learnt a lot of new things, to be honest. Also, communication online with family and friends, with people of the organisations that support me and with whom I often collaborate really helped me a lot. I am waiting on the future Minimum Income Scheme that Prime Minister Sánchez wants to settle up. I'm a beneficiary of a Minimum Income Scheme from my Autonomous Community and only receive an amount of 457 euros, absolutely not enough to survive at all. I hope that this Minimum Income Scheme can be enough - at least in the amount of money - to survive with some decency, improving what I receive from my Autonomous Community. I also hope this could be a permanent measure, and not a temporary one. People in situation of poverty must have masks and individual protection equipment for free (it is only happening in some Autonomous Communities, and not in the overall country). The Minimum Income Scheme (from the State level) must be complementary with benefits from Autonomous Communities. They must try to relieve the burden of bureaucracy that beneficiaries of these regional Minimum Income Schemes have to suffer, indeed."

SPAIN. Antón, man, 50 years old, A Coruña

"The fear is getting into even deeper poverty, the survival problems of children (one child losing his job, the other is unemployed for longer period before COVID-19). The fear of infection by Corona. We have addressed the humanitarian NGO charity.org for additional support, but it was rather difficult to get supplies because at the time of Corona crisis there were more people in need; many have lost jobs and had become poor. For me, personally, there was no measure that could meet our needs as one of my children had lost a job and that had lowered our income (the Government had ensured financial support only for certain part of economy where the overall income was lowered). For persons at the edge who hardly survive, the loss of a job is an enormous challenge. My wish and hope are that the situation will change, that the pandemic will disappear, and we shall go on with our normal way of living. I hope that the same scenario will not be repeated in Autumn and Winter... And if it happens that it will not have the same intensity as the current situation. First of all, people should respect measures proposed in order to as quickly as possible get out of crisis. Second, I hope that the Government will ensure additional measures of support for those that are deeper in poverty situation and in debts."

CROATIA, Jasna, female, 68 years old, Zagreb.

"We live with a partner and four children. The partner could not go to work at the factory due to the virus. We began to have a shortage of baby food, diapers and food for everyone. We had to borrow money to rent. I wrote to various charities about food. A friend looked for occasional jobs but found nothing much. We did not have to go to the employment office and provide new documents for benefits. Maybe a friend will get a job in a factory again so he can make money. I hope the charity will provide me with more food. We would like more money in benefits."

CZECHIA, Kristýna, female, currently on a maternal leave, 23 years of age, Svitavy

"The problem are the rising prices in little shops, problems in free meal delivering for children, losing jobs... We have been active before COVID as well, in our village, we could create an NGO, so we could be partners of donation campaigns. I also applied for different funds as a civil actor. Our village didn't receive any extra help from the government, just from donations given by ordinary people. We have to get prepared for the next phase of COVID. We have to save some money, we hope that the government will learn the lessons well from this first phase, because we were just lucky. We need fixed, easily distributed local social transfers; we need better coordination methods, we need micro-regional pandemic plans, mostly for segregated areas, where people have chronic diseases, malnutrition problems, drug, alcohol-addictions, etc. In the long-term, we need sustainable strategic plans and actions, alternatives of public work scheme."

HUNGARY, Jana, woman, 32 years old, in a small village in the countryside

4.6. Children in poor families

Children who relied on schools for support and meals were disproportionately affected.

Children were also at a disadvantage because of lack of access to digital resources and devices and often living in overcrowded conditions. Children in the poorest of families often had no access to the internet or to basic IT equipment and hence no access to online information, including from the schools, and other resources. In many countries, social services were increasingly being organised remotely through IT tools like apps and the internet; visits and face-to-face conversations were replaced with videoconferencing. Whilst undoubtedly there were some very positive and creative developments, there was also evidence that the most vulnerable, who were unable to access IT tools or develop the skills to use these tools, were left behind. Families who already had a need for child protection and special help were a particular risk group, but even families who survived on their own without support from social services and/or social workers might be in the need of social assistance.

In **Belgium**, a survey answered by vulnerable young people showed that 81% of the respondents had problems with their school assignments, almost 66% did not have a laptop or a computer at home, 76% had too little space at home and 61% had no one in the neighbourhood who could help with school tasks. 30% of the interviewees felt targeted by the police and 60% of the youngsters were afraid to go out and receive a fine. More than half of the respondents reported they felt unhappy.⁵¹

In **Denmark**, children with mental health problems had potentially suffered from less access to help due to the closing of schools and social services, and the lack of access to local psychologists. In **Finland** and **Norway** children in families with problems (substance abuse, mental health etc.) and who were left neglected or at risk of violence were a risk group as they lacked the support from day care, school, sports or other activities/hobbies, or from the support of their grandparents for over two months. In **Lithuania**, for many children the only warm meal was taken at school or at the day centre. Additional dry food packages could not compensate for this loss. Since the beginning of the quarantine, there were a lot of signals about food shortages. Education inequalities have always been a serious issue in Lithuania and now this problem will become even worse and will have long-term consequences.

In **Norway**, vulnerable children may also be children with special care needs or disabilities or children and young people with a short residence time in Norway. Other vulnerable groups are youth who commit offences. The effect of long-term home-schooling and limitations on important services will reinforce the differences between children of parents with low socioeconomic status and/or problems at home and of others without these issues. In the **United Kingdom**, children in receipt of Free School Meals come from households with the very lowest incomes. As in most of the surveyed countries, the school meal may be their only, or only hot meal, of the day. These children already suffer 'holiday hunger', a gap that charities and schools try to fill, and are at even greater risk of hunger during lockdown, especially as families' food and utility bills rise, and incomes fall. The Government launched a scheme, with implementation locally, to provide a substitute for the school meal. But there were few places providing cash direct to families. In Scotland, the Chief social worker highlighted the higher risks that children were facing with "stay at home" measures. This partly resulted in a sharp rise in the number of calls to ChildLine from distressed young people struggling to deal with the COVID-19 pandemic and its impact on their lives. Demand for help has been "unprecedented", according to the

⁵¹ Uit De Marge, "De impact van de COVID-19- maatregelen op kinderen en jongeren in maatschappelijk kwetsbare situaties. Hoe overleven kinderen en jongeren in kwetsbare posities de lockdown?" At <https://www.uitdemarge.be/wp-content/uploads/2020/05/DOSSIER-De-impact-van-COVID-19-op-kinderen-en-jongeren-in-kwetsbare-situaties-3.pdf>

children's helpline, which provides counselling sessions for children and young people. Callers said they felt anxious and isolated, particularly with the loss of support that school and other services would usually provide (ISFW). In **Slovenia**, the national helpline TOM telephone (helpline for children and young people) detected more contents on family conflicts, psychological issues, depression and destructive behaviour and loneliness.⁵²

"I can't go to school because of COVID-19, because I have a medical condition that place me in a high-risk group. I have Autism, I am blind, have bad hearing and a rare disease that I burn insulin very fast. Because of my last disease I had a feeding tube for around 11 years. Now I don't need it anymore because I eat solid food. I have a large wound of the removal of the feeding tube, that means I need surgery which has been delayed for a maximum of 6 weeks because of COVID-19. It really hurts every day because when I eat or drink some of it comes out of my wound combined with gastric juices. Because I need surgery I can't go to school anymore, but my classmates can after the relaxation of the lockdown rules. I really miss my friends at school, but the surgeon doesn't want to take any risks that I can get COVID-19. I don't have much contact with other people beside my parents. I can't do much about the situation, but I try to make the best of it. I do my homework at home, with some help from my parents. My teacher comes every week to bring my homework and to check my homework. I received from school a typewriter for braille so I can do my homework. And further, I try to call my friends with voice calls with the help of my parents. My parents have saved some money for me to buy a second-hand iPhone 7, there are apps on the phone that allow me to call without help of my parents. In my free time I listen to my Audiobooks and play darts in the shed. I hope the government can help me with speeding up the surgery. At the moment the COVID-19 patients get a lot of priority, I understand they also need a lot of help from the doctors, because they can die from the disease. But I also need help from a doctor so I can have the surgery. When I have recovered from my surgery I can go back to school, to and play with my friends again, I really miss them. The proposal I make is to have medical treatment outside COVID-19, that the hospitals help other patients as well."

THE NETHERLANDS, Ties, boy, 11 years old, Groningen. His parents earn the minimum wage.

"I have a teenage daughter with special needs that has to attend school from home. The spending on food increased significantly until schools started delivering food packages, or you could pick them up from school. Many food banks were closed but the family has got some food help home from NGOs. The problem with these is that she has severe allergies and cannot always use all the food we get. It is hard not to be able to influence the food delivery, you have to be pleased with what you get. As being herself of risk group, Anna-Maija cannot go around looking for special offers etc. The teenage daughter had to stay longer periods than normally with her father to get enough food – teenagers eat a lot. The child is always number one so Anna-Maija has eaten less. She applied for social assistance because there was no school food but didn't get any (during the Summers the family has to cope without school-food as well). Anna-Maija has not got a smartphone or a scanner and as the libraries and day centres were closed, she has had problems in getting annexes for social assistance applications. She has many illnesses and as being in the risk group cannot travel to different places, where she could do the scanning, buy food etc. Because of her allergies she cannot wear a mask in spring. All this caused a lot of stress for her and her daughter. Older people get help to buying food and their medicine is brought for them, but not Anna-Maija's age group. Her daughter cannot help by going to pharmacy as she is underage. The pharmacies have a home delivery but Anna-Maija can't afford to use it. It has also been a problem that all the flea markets have been closed, as they buy many things second hand. Anna-Maija's daughter's hobbies ceased so she has more free time but no money to do anything special. Cosplay is her hobby and she would need some money to get wigs, make clothing etc. She would have time for it but the flea markets where one can get material are closed and the money scarce. Her strategy is asking friends for help. Being active in many NGOs and getting food help and also mental support from them. Also actively bringing up problems people experiencing poverty face in the Corona situation: contacting politicians with friends from NGOs. The price of food is rising because of Corona. This should be taken into account in social assistance. Also, other risk groups than older people should get help in running errands. Getting a pension, even if it was small, one would know that the sum that one is getting every month. The level of social security benefits should be lifted. It should be ensured that everyone could afford the equipment and broadband/wifi to use digital services."

FINLAND, Anna-Maija, female, 56 years old, Helsinki

⁵² Source: European Social Network Seminar (ESN) May 22, 2020. Quoted by the IFSW to this study.

4.7. Travellers and Roma

In **Ireland**, there have been COVID-19 related deaths in the Traveller and Roma communities, both of which already had poorer health outcomes than the general population. However, there was no ethnic identifier being used to gather data related to testing, so the exact impact is difficult to monitor. Travellers and Roma also experience high levels of educational disadvantage. This disadvantage was further reinforced through the closure of schools and dependence on distance learning, without access to any additional supports. Many had limited access to technology to engage with schools, lack of adequate space to study and experience intergenerational educational disadvantage, meaning that many parents are not well equipped to support their children's learning. Unemployment is also high as they face many barriers accessing the labour market. The closure of most businesses and a sharp increase in unemployment posed significant challenges to Travellers compared to the wider population. Many Travellers and Roma were living in overcrowded conditions. These people were particularly at risk because they could not comply with social distancing regulations and many had underlying health conditions. These groups had been recognised as vulnerable groups by the Government in relation to the COVID-19 crisis, but the approach varied across them. Those who tested positive for COVID-19 could avail of facilities set up by the Government to facilitate people to self-isolate.

In **Spain**, the Roma community as well as that of other parts of Europe, has entered the pandemic from an exceptionally disadvantageous position. According to a study, "more than 80% of this community lives in poverty, and almost 50% have a monthly income of less than €310. This community also experiences higher levels of obesity, and diabetes, and is more likely to experience serious health problems that may impact the survival of these individuals to COVID-19."⁵³ Poor housing conditions in urban centres or slums, residential segregation in ghettos specially built for it, and overcrowding disproportionately affect the Roma community, the report attests. More than 60% of Roma live in multigenerational homes, with two or more nuclei of related families living together in small apartments. This makes it extremely difficult to avoid contagion through self-isolation. In addition, almost 44% of Roma men and 27% Roma women obtain their income through street sales, either in open-air markets or on foot. Mandatory quarantine makes it impossible for large numbers of these families to earn a living. In addition, many have little access to the limited financial aid that the Spanish government provides to self-employed workers. All these factors combined place large sectors of the Roma community in a highly vulnerable situation. According to a statement from the *Fundación Secretariado Gitano* (EAPN Spain member), of 24 March 2020, approximately 47,000 people lack basic food or the necessary supplies to survive.

In **Serbia**, Roma is one of the most excluded groups, which suffered the consequences of COVID-19 in multiple ways. They are mainly employed in informal temporary jobs which were interrupted, or they work in public communal services and were exposed to health risks. Their children could not follow online education due to the digital divide. In **Slovakia** communities were immediately controlled and tested after the first infections. The sudden lockdown of five Roma settlements in the middle of the pandemic raised concerns about racial discrimination and stigmatisation of vulnerable communities.⁵⁴

53 Gay y Blasco, Paloma and Félix Rodríguez Camacho, María (2020), COVID-19 and its Impact on the Roma Community: The Case of Spain, in Somatosphere, March, at <http://somatosphere.net/forumpost/covid-19-roma-community-spain/>

54 Reporting Democracy, COVID-19 lockdown of Roma villages creates unease in Slovakia, Balkan Insight, 9 June, 2020, at <https://balkaninsight.com/2020/06/09/covid-19-lockdown-of-roma-villages-creates-unease-in-slovakia/#>

“During my work in Great Britain I became ill with COVID-19. But without symptoms. So, I returned bringing some members of my family home to Slovakia, and I returned back (ill) for a second group of family members. And when they tested me, my family members and neighbours in Krompachy had already become ill with COVID-19. And because of our way of living and meetings other neighbours became ill, circa 34 persons. All the Roma village was closed. For one month. And many problems appeared as less food, no shopping in the village, no traveling, no income from seasonal job. Many soldiers rounded the village. And policemen. It was a hard time for all Roma community, and we lost trust, one day free and moving for shopping, for job, for other friends and common events. Thanks to our community worker Vladko who gave us optimism I survived, and we became all healthy. Nobody died and we learned new hygienic habits, we became disciplined and not running to other villages through the mountain. We understood how important it is to listen to instructions. Our government helped very much. They created a camp with doctors, nurses, volunteers and living near for some days to test us, to help us be disciplined and obedient. When some people became still ill, we stayed all in quarantine the next week. We gave trust to our government that one day nobody will be ill. Some moving shops were opened, and even postmen brought pensions to the village under strong hygienic law. Teachers came again to our village to teach children when schools were closed. After finishing quarantine. I wish keep trust and be helpful to my village. Thanks to this event next Roma communities kept rules and hygiene better than I before. I hope that British and their Prime minister are aware how we suffered because of them not listening to experts and epidemiologists. It was good that our government focused on health, healing us, and giving us new habits, new cooperation between the majority and us. It is possible that we change our way of living. Our children prefer education and is time to teach them and give our young people jobs.”

SLOVAKIA. Josef, man, 56, Krompachy

Austria highlighted the problem of irregular migrants in quarantine. They had unclear information due to language problems, were stigmatised by populist politicians (“migrants are bringing COVID-19 to Austria”), could not protest or participate in society, had no jobs and lived in precarious and overcrowded housing situations, with not enough space to keep distance from others. In Belgium, undocumented migrants do not have easy access to healthcare and the procedure for urgent medical assistance is often complex. The lockdown measures removed most forms of informal work that undocumented, long-term residents of Belgium are forced to take up, in order to secure a minimum subsistence income. In order to submit a residence application, there is compulsory proofing (copies of identity cards, photos, official documents, etc.). As many of these public administrative services were closed, it was very difficult for people to gather and present this documentation. Moreover, it was virtually impossible to demonstrate various conditions (willingness to work, subsistence conditions of 120% of the living wage, etc.) to keep a residence permit. The proper course of justice was not assured as well, regarding timing, appeals, etcetera. Asylum seekers could only submit an asylum application online. A place in a refugee centre was not always guaranteed. When someone was granted refugee status, this person has the obligation to leave the refugee centre and find regular housing after 2 months, but due to the COVID-19 situation, this was impossible as the rental market did not work.

In **Denmark**, immigrants are hugely overrepresented in the unemployment statistics. This group has several negative characteristics that make them particularly vulnerable to losing their job: lower education, language barriers, little job experience (especially among women) and more health issues. Moreover, according to the Statens Serum Institut under the Ministry of Health, immigrants from non-Western countries made up 18% of the COVID-19 contagion, even though they only accounted for 9% of the population. These were primarily from Middle East countries. The reason is not properly studied, but the hypotheses are the following:

- 1) The Danish language is poor among some groups, making it difficult to understand the official guidelines on COVID-19.
- 2) People live closer together in smaller apartments and neighbourhoods, thus increasing the infection risk.
- 3) A larger proportion have chronic diseases, which worsen the symptoms.

In **Greece**, one of the gigantic challenges of the government was to deal with the overcrowded mobile population on the Greek islands, mostly Lesbos, Chios and Samos. Due to the EU-Turkey Agreement, asylum seekers could not leave the islands and go into the mainland. As a result, there were thousands of people confined on the islands with minimum or without access to basic services, hygiene, water and food. However, no COVID-19 cases were reported. On the mainland, cases were reported on two camps and a hotel used by asylum seekers. Lockdown and confinement were imposed on every asylum seekers' facility. Measures were taken immediately, with the support of NGOs.

In **Ireland**, the majority of asylum seekers live in Direct Provision centres. This involves various types of buildings, but all with congregated settings, where in most cases individuals share rooms with strangers. The Government facilitated some asylum seekers to move from mixed use facilities to hotels and also opened four facilities where asylum seekers could self-isolate. However, many asylum seekers continued to live in centres where social distancing was not possible and where sharing of rooms was the norm for single people. Many Direct Provision centres have been reported as having clusters of contagions.

In **Norway**, due to language barriers and digital illiteracy, it was extremely difficult to reach older immigrants with important information and other measures. This also created a gap that complicated the contact with the Labour and Welfare administration and prevented people from accessing the existing assistance measures. Differences in living conditions, education and income levels lead to health differences. Statistics show that immigrants have lower education, earn less, more often live in persistent poverty and in overcrowded dwellings, compared to the rest of the population. The immigrant population lives and works under conditions that make them more susceptible to the COVID-19 virus.

In **Spain**, Centres for Internment of Foreigners (CIE) were closed, as it was not possible to deport the inmates. On the other hand, administrative procedures were paralysed in general, as were those those related to the documentation of migrants and asylum seekers. On social networks, false job offers began to appear for foreigners. For immigrants with a health work profile who were in a regular situation, the Government announced the granting of an "express" work permit (to at least 200 doctors and nurses). Meanwhile, street vendors, commonly known as the "manteros", organised in Catalonia to produce masks and gowns, a solidarity initiative that joined the "manteros food bank" that delivered food and basic necessities to more than 150 vulnerable families. Minors who migrated alone continued to be interned in the juvenile centres, supplementing the educational dynamics that they usually do with various activities offered by their educators, their references and their points of support.⁵⁵

According to a report by the European Network Against Racism, this pandemic and the associated policy responses exacerbated and shed a light on existing structural racism and inequalities, particularly in the labour market, in housing, or in institutions such as the police, meaning that some groups are being hit harder.⁵⁶ Regarding employment, due to existing racial discrimination and structural barriers, racial and ethnic minorities were more likely to be in low-paid and precarious jobs or front-line workers. They were therefore more at risk of contracting the virus and of facing financial insecurity as a result of government measures. Many migrants and Roma people in particular did not have access to social protection from their governments and found themselves without any source of income. Housing was another problem faced by many black

55 "El Coronavirus también afecta a los migrantes", El País, 30 March 2020 at https://elpais.com/elpais/2020/03/27/migrados/1585311484_330092.html

56 According to figures from the Office for National Statistics in the United Kingdom, quoted by the IFSW in the response to our questionnaire, black and Asian men and women are nearly twice as likely to die from coronavirus than white men and women. The impact of COVID-19 on BAME communities has been stark.

and ethnic minority groups, who lived in overcrowded accommodation and neighbourhoods. In Spain and Italy, this was particularly acute in agricultural settlements of migrants, Roma and refugee camps, with extremely limited access to basic services, such as water or sanitation, and without any access to alternative housing. These conditions prevented them from following quarantine measures and avoiding the spread of the virus. Racial profiling and police brutality were reported in most EU countries. This scenario was complemented by racist violence and speech online and offline. Denial of access to the healthcare system affected undocumented migrants, while in refugee accommodation and detention centres, access to basic services, including healthcare services, was provided to a very limited extent.⁵⁷

“As an asylum seeker I feel worried and I ask myself when will this pandemic end and how long can I survive like this? It could be a slow death for an asylum seeker. We are aware of the effort of the government to eradicate this pandemic. But let them also remember that there are people who do not receive 80% of their salary in this time of crisis. Because we were never allowed to work. We have just £37.50 for all our needs. When I go to the shop, I can't afford the food there as the prices have gone up. I see people with masks outside, but I don't have money for this. Before we had charities, we could go to and eat there or get food from food banks, but we can't access these now. Before I could access wifi at the charities I visited but now I can't go out and we don't have internet in the asylum accommodation. I am worried about my family back home and how to stay in touch with them yet is not possible to pay for a top-up for my phone as the minimum amount is £10 which is too much out of £37.50. One more effort from the government would help to save asylum seekers from this threat. Ensure that all in the United Kingdom have access to basic food and support and healthcare regardless of immigration status. The future United Kingdom will need the contribution of all”.

UNITED KINGDOM. Testimony provided by The Migrant Voice, a member of EAPN England

⁵⁷ European Network Against Racism, Interactive Europe-wide map, at <https://www.enar-eu.org/Evidence-of-the-impact-of-COVID-19-on-racialised-communities-exposes-need-to>

5. THE IMPACT ON WOMEN AND GENDER INEQUALITY

The COVID-19 virus has lower mortality in women than in men. However, the consequences of the pandemic and the measures adopted by governments on structural inequality meant that the impact on women was more prominent. 86% of respondents to the questionnaire considered that the pandemic and the measures adopted by governments to tackle it had negative consequences for women: 50% indicated that gender inequality increased a lot (Austria, Belgium, Czechia, Germany, Italy, Poland, Portugal, Serbia, Slovakia, Slovenia and Spain) and 36.4% that it increased a little (Finland, France, Greece, Hungary, Lithuania, The Netherlands, Norway and the United Kingdom). Only 13.6% considered that this aspect was unaffected in their countries (Croatia, Denmark and Iceland). (For the full details of the national assessments see Annex 2: Country Annex ([link here](#))).

5.1. Higher risk of poverty and exclusion

Before the pandemic, **women were already at a higher risk of poverty than men in all the surveyed countries, except for Norway**. For the EU27 there was a difference of 2.1 percentage points between the AROPE rates of men and women (1.7 percentage points for EU28) (See Annex 1, Graph 2).

“Like an earthquake exposing a fault line, as the pandemic plays out it is exposing deep structural inequalities.” COVID-19 has aggravated this previous situation, affecting everyone - but not equally so. Women and girls are disproportionately affected by the economic effects of global pandemics, especially those in the poorest and most marginalised communities. 58 Millions of women lived in poverty, at the verge of the precipice, and suddenly the COVID-19 outbreak threw them over it. The number of homeless women increased due to poverty, insecure housing and violence. In May 2020 a European Parliament building in Brussels housed 100 homeless women, many of them victims of domestic abuse, who were severely affected by Belgium's COVID-19 lockdown. The parliament's kitchens were also providing 1,000 meals a day for charities helping the homeless. Now, these buildings, as other temporary shelters around Europe, are opening to their usual business, leaving these people behind.⁵⁹

“I did not have anywhere to stay so on March 9th, so I went to a reception centre near Brno. Me and my landlord agreed on the date upon to I will move out all my belongings. My husband stayed with family, so I cleaned up the flat all alone. I should have applied for a material distress benefit, but I was more focused on cleaning up the flat. I found some storage unit for rent and move the belongings there, but I have to pay too much money for it. All the belongings I could not move to the storage unit my landlord I had to throw out. While I have been trying to clean up the flat the workers from the reception centre urged me to go back to the centre because of the state of emergency. But I wanted to stay in Brno. A while later the workers informed me that I need to stay at the place where I was for a while. I could not do that because the landlord already had taken my keys. I managed to find a room in a boarding house. I paid myself for two nights, other two nights were paid by the charity. I wanted to go back to the reception centre, but I had to get tested for COVID-19 before. I did not know what to do, so I called the 1212 hotline and asked for help. The hotline worker contacted workers from the charity and from the reception centre and they agreed that I did not have to get tested for COVID to come back to the reception centre...

58 COVID-19 Could Drive Millions of Women into Poverty, When They are Agents of Recovery, 6 May 2020, at: <https://businessfightspoverty.org/articles/403754/>

59 BBC, “Coronavirus: European Parliament shelters 100 homeless women”, 1 May 2020, at: <https://www.bbc.com/news/world-europe-52500342> Freek Spinnewijn, Director of FEANTSA commented “I guess the homeless women will be happy that they have a secure place to stay. But remember, a shelter is not a solution to women’s homelessness, or any other form of homelessness. These women need to be rehoused with support.”, The Parliament, “Coronavirus: Charities welcome European Parliament’s homeless initiative” at: <https://www.theparliamentmagazine.eu/articles/news/coronavirus-charities-welcome-european-parliament%E2%80%99s-homeless-initiative>

...After that, I had to apply for benefits so I could take care of myself and my child. The reception centre workers helped me with the application. I am staying at the reception centre right now. What survival strategies did I use? At first, I had no idea what to do. Then I contacted the Authority for Social and Legal Protection of Children, and my friend and I found a room at a boarding house. My husband did not help me at all. Then I applied for the benefits. My short-term needs: I need to earn money so I can pay for the storage unit. I would propose that there would be some financial support from the foundation to help me to pay off my debts for the services. I had money which I wanted to use to pay for the service, but I had to pay for storing my belongings. **I am in a vicious circle** and I do not know how to get out of it. I do not want to lose my belongings or place where I live now, so I have to pay for the service and the storing.”

CZECHIA. Nikola, female, married, 25 years old, pregnant, Brno

5.2. Health care and front-line workers

Women make up the bulk of health and social care workers, family caregivers and low-paid workers such as cleaners. These areas are on the frontline in dealing with COVID-19, so women are at a higher risk of contracting the virus (See Annex 1, Graph 3). The care sector is also highly affected. Workers in this field are potentially exposing themselves or the people they work with to the virus. The proportion of women is very high in care occupations. Research carried out by EIGE found that about 76% of the 49 million care workers in the EU are women. These figures are probably underestimated due to the large share of undeclared employment, especially in the domestic care sector. Women make up: 93% of childcare workers and teachers’ aides; 86% of personal care workers in health services; 95% of domestic cleaners and helpers. These professions are some of the most undervalued, and underpaid jobs in the EU. When it comes to providing formal long-term care in people’s homes, it is estimated that 4.5 million out of 5.5 million workers in the EU are women. Caregivers provide different types of care depending on their qualifications and job functions. They might be providers of nursing care and carry out basic medical services. They could be personal caregivers, helping people to eat, bathe or dress. Or they could be domestic workers carrying out tasks such as cooking and cleaning. Most of the workers providing home-based professional care to older people and people with disabilities are women. Across the EU, it’s estimated that of these 1.8 million caregivers, about 83% of them are women.⁶⁰

In **Croatia**, the overwhelming majority of nurses are women, which puts Croatian women at the frontline of efforts to contain the pandemic and limit the death toll in the country. This often also means increased psychological stress and increased risk of exposure to the virus.⁶¹ In **Serbia**, 86% of the ‘front-liners’, i.e. the occupations that were in the first line of the health risks, including medical staff, persons employed in supermarkets, pharmacies, hygiene, were women, according to SeConS survey on the impact of COVID-19 on employment in Serbia. Not only were they exposed to higher health risks, but they also had to struggle with the management of everyday life, to organise transport to work in the situation when public transport was cancelled, to organise child care as children stayed at home and to cope with health risks at the workplace, particularly since they did not have the proper health protection equipment during the initial days of the crisis. Even after a month of martial law around 4% were still missing protective equipment.

⁶⁰ Although both women and men working in this sector are exposed to the virus, women are potentially more at risk of infection because they make up the majority (76%) of healthcare workers in the EU. EIGE, “Front-line workers”, at <https://eige.europa.eu/covid-19-and-gender-equality/frontline-workers>

⁶¹ OECD, “The COVID-19 crisis in Croatia”, 8 June 2020, at: <https://www.oecd.org/south-east-europe/COVID-19-Crisis-in-Croatia.pdf>

In the **United Kingdom**, men were twice as likely to die as women and older people (of both sexes) with co-morbidities were at greatest risk. But where women are in front-line and public facing roles, for example in care roles especially in nursing homes, or to a lesser extent in retail, their death rates from COVID-19 are above average. The respondents from **Austria, Denmark, Finland, France, Germany, Ireland, Slovakia** and **Spain**⁶² highlighted that women are more often working in front-line jobs such as in hospitals and care homes. This most likely explains why the virus is more widespread amongst women, although men have a higher mortality rate.

"In recent days, we have had a lot of screenings for caregivers, our colleagues. They have small symptoms: cough, headache. But many of the tests came back positive. And we feel ashamed and "guilty". We in the emergency room, we were protected. We had equipment. From the beginning. But all of our colleagues who were not really thought of, who were also on the front line, were infected. And all these colleagues are stressed because they must have infected their loved ones, but also their patients. I feel very privileged when I see that in hospitals in the Grand Est or in Île-de-France they work with trash bags as gowns. But soon, it will also be our turn to be infected. We receive memos which tell us that, at the smoke break, we must keep a 2 meters distance between us. But they had to equip us before telling us to go away while smoking. And COVID-19 continues to spread. I saw a lot of people when I was shopping on Saturday. COVID is becoming increasingly virulent. We have 50-year-old patients who come with completely white lungs. I don't think we've seen everything the virus can do yet."

FRANCE; Louise, emergency nurse from Montceau-les-Mines, Département Saône-et-Loire (6April 2020)¹

5.3. Precarious jobs and low salaries

Women are the lowest paid. This group is more likely to have jobs with the biggest health risks and economic risks during the crisis.⁶³ For example, out of 8.6 million key workers in the United Kingdom, women were twice as likely to be in these roles. Parents are also more likely to be key workers including up to 2 in 5 working mothers. In **Belgium**, parents can apply for special COVID-19 parental leave. For example, they work one day less in a week and receive an allowance for this. Vulnerable families are at risk of being left out because the benefit is too low and always requires the employer's approval. In **Finland**, furloughs hit young women hardest, as they work more in low-paid service sector jobs. In **Germany**, workers in economic sectors with a high proportion of women workers were more affected, in comparison to the financial crisis in 2009.⁶⁴

Greece depends heavily on tourism, i.e. seasonal and part-time work. Official statistics show that the vast majority of those working part-time are women (with a 32% share for women and a share of only 9% for men).⁶⁵ In **Norway**, the situation is different, as although women are predominant in the health sector, they are not more at-risk than others. Health care workers are more exposed to the virus than most but are tested regularly and followed up according to strict guidelines; 54% of those who have died of the virus are men. In **Poland**, women are predominantly working in low paid jobs in primary and personal services.

62 In Spain, according to the latest data from the Active Population Survey (EPA), women represent 66% of health personnel, reaching 84% in the case of nurses. There are similar percentages of participation of women and men in residential establishments for the elderly and dependent persons, where the most serious cases and the highest number of deaths are found. 334,300 people work, of which 280,400 are women, representing 84% of the contracted staff.

63 According to The Resolution Foundation Thinktank, at <https://www.resolutionfoundation.org/our-work/coronavirus/>

64 Five out of the ten economic sectors for which a particularly large number of people were reported for short-time work in March and April 2020 have an above-average number of women in employment. See: https://www.diw.de/documents/publikationen/73/diw_01.c.789749.de/diw_aktuell_42.pdf

65 We do not know how things will go in summer and if tourists will come (although the government has recently announced measures in favour of the economy and tourism) but as it seems, the gender pay gap will increase and seasonal work will provide with less salaries, income and benefits. This will women more than men.

In **Portugal**, 82% of nurses are women and 55% of doctors are women. The OECD indicators show that the average wage of nurses is lower when compared to doctors. Whereas the ratio of the remuneration of hospital nurses to average wage in Portugal is 1.1, for general doctors this ratio is 2.7 and for specialists' doctors it is 2.6. Apart from these professionals, there are also the unqualified assistant staff in hospitals and healthcare centres with lower wages, many of them receiving the national minimum wage. Women are also overrepresented in these jobs. For example, in the report of Santa Maria Maior Hospital in Barcelos, a public hospital, 78% of these workers were women. In **Serbia**, a large portion of women employed in low paid services (hairdressers, cosmeticians, cleaners in households), in personal care services (childcare, care for older people, sick, persons with disabilities) were left without work and incomes. In **Slovenia**, research shows that the consequences of the pandemic have been and will continue to affect women to a greater extent than men. There are several reasons for this, including the higher proportion of employed women in the most affected sectors, such as health care, care in elderly care home, catering and tourism.

"I was a half-time worker and I was laid off from my job because of closing the office. So, I am now unemployed. I am living alone and had livelihood difficulties after the layoff. I contacted the employment agency to get unemployment benefits. While waiting for compensation I get food aid and I agreed with my landlord to pay the rent as soon as I get the benefits. Normally when losing a job an employee has a two-week deductible period. Now there is no such kind of quarantine period and the benefits will be paid immediately. The government has also added officers to the employment agency to reduce congestion. My aspiration is to get my job back when the crisis ends. At my age is not easy to find a new job. I hope that the crisis will not change the labour market and the employer affords to continue his business."

FINLAND. Eila, female, 55 years old, Turku

The differences in pay, income and working conditions widened. These gaps were highlighted by **Austria**. In the case of **Belgium**, the situation is similar: women earn 6% less per hour than men, are more likely to work part-time and therefore are less protected when jobs are lost. Part-time jobs are prevalent in sectors where great flexibility with regard to working time is expected, such as hospitality workers, domestic help, cash register clerks and workers, and where wages are often low. The irregular hours make it more difficult to combine work with family life, forcing people to switch to part-time work. For many people, part-time work is therefore not a choice of their own. In **Germany**, short-time work is intended to cushion the effects of the crisis on the labour market by preventing immediate unemployment for many people. Marginally employed people are not entitled to benefits from the statutory unemployment insurance, since they are exempt from payment of these social contributions. Among the marginally employed, the overall proportion of women is around 61%.⁶⁶ A study by the German Economic Institute shows that almost 75% of all employees in essential services professions are women. Their share is even significantly higher in the services/retail professions with little recognition and where low wages are paid.⁶⁷

In **Italy**, due to the closure of schools, children are at home and women are taking care of them, more than men. This condition has probably pushed mothers to quit their jobs, reduce their working hours or become overloaded (with health consequences). In **Lithuania**, it is likely that it will be women who will choose sick pay, unpaid leave, which will lead to lower incomes in the short term and lower social guarantees and pensions in the long term. Among other things, it is important to mention that a large proportion of women work in the social and service sectors. These occupations very often limit opportunities to work remotely, which will also result in women losing part of their income.

⁶⁶ See: https://www.diw.de/documents/publikationen/73/diw_01.c.789749.de/diw_aktuell_42.pdf

⁶⁷

https://www.diw.de/de/diw_01.c.745511.de/nachrichten/wer_waren_noch_mal_die_leistungstraeger_der_gesellschaft.html

See:

The Netherlands acknowledges that care jobs are occupied mostly by women, that childcare is taken up more by mothers and that this fact increases the likelihood that they work from home. Women are also amongst flexible and part time workers and are over-represented in low paid jobs. Finally, EAPN Netherlands considers that, once the crisis is over, the lockdown ends and the labour market opens, women will not be the first to occupy well-paid, adequate jobs.

In **Spain**, men have a part-time employment rate of 7%, while the rate for women is 23.9%, this means 4 times more and 1 in 4 women. The differences are most notable among elementary occupations (hospitality, agriculture, and domestic service), which have a higher level of precariousness, with temporary jobs and in sectors where the payment is made per hour worked. If there is no work, there is no salary. This generates a cascade of negative consequences regarding family income. These employees are not fully included in the general Social Security system, so they do not have recognised unemployment benefits. They also suffer a high exposure to contagion, which makes them one of the most vulnerable groups. Many of them are also undocumented immigrants who work in the informal sector. The crisis affects more women with small businesses, with significant inequalities with respect to men. These differences are fundamentally conditioned by two criteria: the sector of activity and the type of company. The most competitive companies are dominated by men, therefore they have much more margin for action in times of crisis, since they are stronger and more solvent companies. On the contrary, the most feminised sectors are the weakest, in which high competitiveness is observed. An example of this is the service sector. The second criterion in these inequalities is the size of the companies. Generally speaking, women work in smaller companies. Entrepreneurs invest less in their projects, because they also risk less. This trend is quite common among female entrepreneurs. Therefore, being smaller businesses, they have less margin, and a smaller financial cushion to face this type of crisis. This causes them to be the businesses that most overcome difficulties and survive situations like this.

Denmark offered a different perspective, by saying that “they do not have reasons at the moment to think that the crisis will deepen the gender gap in the job market and income distribution. On the contrary, this crisis may have given the typical women’s job (nurses, paediatric workers in nurseries) better arguments to influence wage negotiations in the nearer future.”

“I have been through many courses under the auspices of NAV [the Labour and Welfare Administration]. Finally, I got the chance to get into vocational studies. I was going to become an apprentice and there was hope of getting a Summer job. Unfortunately, I've lost everything. I have had difficulties with the application process for unemployment benefit and it has been difficult to get in touch with the case workers and long waiting times. The price of food is increasing, and I am struggling financially. My short-term demand: I'm just waiting for society to open up again, that the society opens again so that I can get an apprenticeship and a Summer job. I need an income. What we need is the creation of more jobs.”

NORWAY. Aisha, woman, 43 years old, Drammen

5.4. Full time caregivers

Caring for the wellbeing of people inside the home is a fundamental social and political responsibility but is usually considered a task that does not deserve to be paid or compensated. During the recent economic crisis, families and, within them, women have compensated with their reproductive work for cuts in social expenditures, particularly in the area of care.⁶⁸ In **Austria and Finland**, women carry most of the reproductive and care work at home, which increased during the lockout measures and closure of schools and day centres. In **Belgium**, as women often take care of their children or dependent family members, they have to work more part-time contracts (43.6%) than men (11.8%). If the income from part-time work is further reduced by the temporary unemployment due to COVID-19, they are even more at risk of poverty. A study by the Free University of Brussels shows that women kept the household running during the lockdown. The traditional division of roles between men and women hasn't changed. Moreover, gender stereotypes have been reinforced. Women spend on average half an hour more for household work and the care and support of children. Men also appear to have one hour more free time per day than women. The closure of schools, kindergartens and summer camps, as well as the increased need for assistance from older relatives (including the closure of day activities), have an impact on the working life and wellbeing of working women, as unpaid care is unequally distributed between the sexes in **Finland**. In **France**, despite both women and men managing to telework from home, it was more difficult for women since they have to juggle between home-schooling, household chores, with videoconferences and new work control methods.

In **Germany**, even in this exceptional situation generated by COVID-19, women continue to be almost naturally responsible for the care work they have to do, both privately and professionally: Women/mothers take on the additional care and educational work caused by the closure of day-care centres and schools to an indefinitely greater extent than men/fathers. In return, they reduce their working hours to a much greater extent or shift them to the early morning or late evening hours. In **Ireland**, women bear most of the responsibility for care. With schools and creches closed due to the crisis parents have full responsibility for childcare. During the lockdown phase, and where two parents are involved and at home, this should lead to more equitable caring arrangements. However, in general women take on greater caring roles and face the additional challenge of home-schooling and balancing care and working from home. For those mothers who have literacy and numeracy difficulties these challenges are increased.

In **Lithuania**, women - especially from poor households - are facing higher social risks. Primarily because women are stereotypically burdened by the home care and care for dependents. During the quarantine, women faced enormous challenges while trying to balance work and family responsibilities, especially in the absence of other relatives or without access to public services. In **Norway**, researchers have found that women have increased their workload at home compared to men, during the crisis. In **Poland**, it is estimated that women are now more burdened by care and education work for their children due to lockdown of kindergartens and schools for younger children. In **Portugal**, before the pandemic, women worked around 13 hours on average per day, of which just 7 were paid and around 6 were unpaid (spent in household tasks, childcare and shopping/errands). This dedication of time and effort worsened with the pandemic due to homeworking and the presence of children at home. This situation puts more burden on women, exposing them to greater exhaustion that can also have an impact on their health.

⁶⁸ Researchers at the University of Sussex found 72% of mothers described themselves as the "default" parent for all or most of the time during lockdown, while 67% of women with work commitments also described themselves as such. In addition, 70% of women reported being completely or mostly responsible for home schooling.

In **Serbia**, a survey revealed that regardless of the fact that families were confined to the home for almost two months, there were no significant changes in division of unpaid household work and care for family. In Serbia, the majority of household chores are dominantly the responsibility of women. During the martial law, in 70% of the households there was no change in division of labour. Amongst the households where changes were reported, in about half of the cases actually the burden on women has increased, and only in small portion of households other family members 'assisted women in household work', and only in one of every ten households the main workload was transferred from women to men, mainly because women had to go to work, while men stayed at home. In **Slovenia**, due to the closure of kindergartens and schools, home schooling, and the still prevalent traditional division of gender roles in families and households, women take on most of the burden and are more likely to be unable to return to work. Women are at higher risk regarding health. They dominate in listed areas of work as well as they also dominate as schoolteachers. During the pandemic, women have played a greater role in helping school-age children, doing household work as well as telework.

In **Spain**, the latest data available indicates that 91.9% of women (10 years old and over) perform household chores and take care of children, elderly or disabled dependents for 4 hours and 29 minutes a day, compared to the 74.7% of men who spend an average of 2 hours and 32 minutes. With this health crisis, this process of overload on women has become more acute. As part of this process, women are "responsible" for managing the educational crisis, due to the closure of schools and educational institutions in order to address the spread of the disease. Whilst some families can count on grandparents and grandmothers, others cannot, because the grandparents have passed away, there is no contact with them, they are not nearby, they are still working and / or because they are a risk group due to age or health problems. In other words, in nuclear families (who do not have supportive relatives or financial resources to hire help), women will tend to extend their usual share of reproductive work by staying at home, which will have an impact on their jobs and their income.

"I still think it is early to point out the impacts that this situation (COVID-19) will bring. At this moment, the biggest impact is even the social isolation and everything this entails in my case. We are 5 at home so that we are "going crazy" together. The second impact is the lot of fake information that comes out in social communication and social networks, the panic of some and the disbelief of others that put us all at risk. As for social support, I do not have at the moment any support. The main change continues to be social isolation, healthcare disinfection we had to adopt hand washing -is simple- but the alcohol-gel is almost non-existent, when you enter the house there are whole new proceedings to minimise the risk of infection. Washing clothes, shoe soles etc. Since the schools closed, I stayed at home more seriously. I had a few hours of cleaning in offices, I don't have it since everyone is in teleworking. My husband stayed at home because the grill (restaurant) temporarily closed, my eldest daughter worked until now, but at this moment she also saw her employment contract suspended (this is new for me) temporarily and without any remuneration, only my son continues to work. My difficulties at this moment have been trying to not to think too much about the future, keep calm and live one day at a time and it starts to be difficult. Now we are fine, we are healthy, we have food and a roof and don't think too much about what's coming because it does scare me. We are already in mid-April, my husband has been at home since March, he has not been fired, but we also do not know if he will be paid or under conditions, he will continue his work. In March I managed to answer to all my responsibilities (payments), but at the end of April I don't know. We spend much more with food, electricity, water, gas (more than usual). And what is worse is the reduction in income. Help or support? It has not been necessary, but we have been the support of some neighbours and my mother-in-law who are old and belong to the risk group. Go shopping for them, or the pharmacy, ask for recipes etc. Right now, the only support is from my family and friends and it comes down only to emotional support. However, like I said at this moment it is still very early even though we can already foresee the different situations that come there. I want to believe that the government is really committed to protecting families and for that it must protect jobs and the economy to the fullest. The measures presented so far for which I have tried to inform myself and understand are due to excessive bureaucracy, high interest rates in the case of credit offered to companies and are failing to secure jobs. There are serious situations already happening, mass dismissals without any control, it is serious. Government measures may even have very good intentions, but ... I don't think they are enough...

...Support for housing rents will be an escape, although those who ask have to prove that their income is below the social index, which leaves a huge fringe outside of these aids, and those who can access these aids for the year will have an added problem having taking into account that an unemployment rate above 14% is expected. In the coming months I would like to believe that we are going to get over this quickly and get back to normal, but the people who are losing their income now at the end of March will not be able to bear their burden, and there are many. There will be no money for food, if we remain depressed at home, the states of revolt and nervousness will create problems. I am much more concerned with this than with the virus. It is certain that as long as this lasts there will be no evictions or power cuts, but ... what then? With unemployment or poorly paid precarious jobs that barely reach the right bills every month, how do you pay water and gas bills, accumulated rents?"

PORTUGAL, Female, Évora

5.5. Single parent families, more at high risk than ever

Single-parent families are very vulnerable and nearly half are at risk of poverty and social exclusion in the EU. In **Belgium**, 41.3% of all single-parent families live at or below the poverty line. That is four times as many as households with two adults and two children who accounted for a share of risk of poverty of 9.8%. In 8 out of 10 cases these families consist of a single mother with children. Many countries, such as **Belgium and Finland**, considered that the current COVID-19 crisis is hitting single mothers and their children hard. Those who work and now are surviving on technical unemployment went from 'just making ends meet' to drowning. Those who have to combine teleworking with caring for their children face an impossible task. In **Germany**, single parents in particular, in most cases women, are faced with sometimes immense challenges in this situation, as they have to cope with home office, home schooling and care of small children on a daily basis. Due to the closure of the day-care centres, mothers in particular are making sacrifices to their careers in order to meet the need for care. Women are thus forced back into traditional gender roles. This can lead to long-term disadvantages in professional life. As a consequence of the COVID-19 crisis, the gender pay gap at work could potentially widen. In **Ireland**, they find themselves in a very precarious position, without the fallback of family and friends for support and no access to childcare. Poverty increases vulnerability and lone parents are already at greater risk of poverty. There are additional challenges for those who needed to go shopping and had to bring their children as no other adult was available to care for them. In **Lithuania**, half of the single-parent households (the absolute majority of which are single mothers with children) lived below the at-risk-of-poverty threshold in 2018. In the context of the virus outbreak, women as the sole breadwinners of the family face the greatest burden in reconciling work and family responsibilities. There is thus a risk that this group will find itself in extreme poverty and social exclusion if social services are not ensured. In **Spain**, in single-parent families the responsibility for managing the crisis rests with more than 80% of women (also corresponding to 10% of the total of households).

"I had to stop going to work because my employer told me to stay at home with my son in the Czech Republic. So, I've been at home for two months. Due to the small paycheck in March, I had trouble paying my rent and I was very stressed about it. I asked for food help from Caritas and they also helped me from the Nora Friedrich Foundation. They bought me a lot of food and domestic products. I also asked the landlord to wait for me to pay the rent. The government has raised the OCR to 80% since April, and I didn't have to prove anything to the benefits at the Labour Office. I hope that I will go to work soon and that I will receive money from the Czech Republic."

CZECHIA, Olga, female, single-parent, 38 years old, Chrudim.

"I've been in financial troubles for some time, I'm clearly in debt. I own my house, but I still pay for it, I have different credits running. My salary was no longer enough to pay for everything, so I took an extra job as a freelancer. I distribute small newspapers. It's a hard job and doesn't pay much, but it keeps my head above the water. During the crisis, I was unable to work in this job, so I lost this source of income. Because of my debts I have a budget meter for my electricity. During the covid crisis they do not cut off the electricity anymore but now I don't know what I've consumed. I am afraid for what I will need to pay afterwards. All prices have gone up, even in cheaper stores. So... to eat, you have to be satisfied with little. Besides, there are often only the brands left, which are more expensive, of course. Everybody is at home all the time, we are permanently connected to the internet, we will have consumed more. The children are now all the time with me. My ex-husband works outside his house so he can't take care of them as the schools are still closed, but I didn't get any financial compensation for this. I needed to go with my daughter to the emergency room even if we didn't want. She had a big ear infection. She needed to see a specialist already in April, but she only had an appointment at the end of July. We think we were contaminated with the virus at first, but we were not tested, so we don't know. The only good news is that I don't need to drive my car so much as I am teleworking now. We didn't move, we didn't dare leave the house. We're careful with everything. We are very afraid, especially regarding the exams of my children. One of my daughters has been sick during the year. We don't know how they will make her evaluation in the end of the year as there were only few ratings at the beginning of the year."

BELGIUM, Marie, female, 53 years old, Wallonia. Marie is a single mother with 3 children. She is working part time.

5.6. Isolation and loneliness

Older women are more affected by the risk of isolation as there are more older women living alone than men. They are more likely to suffer the negative consequences of increasing informal care duties for older persons in need for care and assistance, persons with disabilities, children and grandchildren. Women are the majority of residents in residential care facilities due to differences in life expectancy, as many move in after the passing away of their partner, exposing them to a higher risk related to infection (although medical evidence seems to suggest that virus infections are more fatal to men than to women).

"Problems: Not being able to test, when having light symptoms of Coronavirus. Feeling lonelier because of having little contact with other human beings. Feeling of being restricted in movements. Feeling fear when going shopping in supermarkets. Feeling of confusion because governments new rules often too vague or multi comprehensible. Not being able to visit my parents, of old age, specifically my mother who is in a mental hospital for dementia. Feeling of emptiness and uselessness for missing my work. I decided to ask for test for immunity as soon as possible. I am helping in garden work and other work outside to feel more connected to earth and living beings. I am going cycling in the countryside to see living creatures and nature surroundings. I have restricted shopping times. I listen to media news and speak to people by mobile phone or facetime to hear other opinions about government rules. I am going to hand over flowers as gift for my mother at the entrance of her hospital. I am starting to have facetime contacts with father and other relatives, starting to order and clean up in my house. No measures of support. Only information about new rules for social distance and images of how people are dealing with Corona, mostly from hospitals, all this by media as television, radio and newspapers, and on cell phone, reading news. My short-term aspirations: to start work with social distance. To visit my mother in the mental hospital, with social distance meet my relatives. To shop more frequently with face mask on. To take part again in religious meetings and celebrations in my own church. For the near future, to have more tests available to all public for testing immunity for Corona. To restrict the import of food and products from countries with bad public healthcare and with no clear quality conditions. For the long-term: To make people more aware of necessity to travel or have holidays in their own country or in near countries. To make governments and businesses aware of the necessity to produce medicines and other products in own country or nearby countries, with good conditions for quality, honest salaries and clean working areas."

THE NETHERLANDS, Carry, widow, 66 years old, Zutphen

5.7. Gender-based violence under lockdown and/or quarantine

According to the European Parliament, cases of domestic violence have risen by one-third in some EU countries in response to the lockdown, which makes it more challenging for victims to contact support services or the police while forced to remain under the same roof as their abuser. Traditional reporting tools, such as a national hotline may be more difficult to use. For example, in **Italy**, calls to the national helpline have dropped sharply since the lockdown was introduced, but there has been a parallel rise in reports via other channels such as email. Witnesses can be a crucial source of support for victims, but social distancing means that fewer witnesses will become aware of the violence or might be able to provide direct help. Furthermore, the support services for victims and witnesses, the police and other relevant authorities are stretched to the limits because of staff shortages, sickness leave, travel restrictions or other demands related to COVID-19. Victims may also be deterred from visiting refuge shelters, their doctor, or accessing emergency healthcare for fear of contracting the virus, as well as being uncertain as to whether they are allowed to leave the home during lockdown. Governments are taking different approaches in how they act to stop the violence and help victims to be heard during the lockdown. For example, **France** offers hotel accommodation for victims to avoid abusers having to live under the same roof as the victims. And in **Italy**, authorities aimed to remove the abuser instead, to spare the victim the additional trauma of having to leave the home.

The European Parliament called on member states to increase capacity in women's shelters during the pandemic, and to provide flexible tools for reporting domestic abuse such as text messages or online chats. **France** implemented a text message service, and a reporting app was recently introduced in **Italy**. Since lockdown was introduced in **Spain**, a new system was set up where women can inform pharmacists of abuse by using the code word 'mask 19', allowing pharmacy staff to alert the emergency services. This system has now been adopted in other countries such as **France, Germany, Italy and Norway**. However, further action must be taken to share information and develop evidence about the effectiveness of new initiatives introduced in the context of the lockdown. It is important that lessons learned during this period are retained and integrated into future decision-making, since measures introduced are likely to benefit victims even after restrictions are lifted. A number of studies show that many who have experienced domestic violence for the first time are likely to experience it again within a few weeks or a year. This evidence suggests that if the lockdown triggered more first-time abuse, this increased scale of violence may persist after the restrictions are over. Therefore, securing adequate resources for support services is vital. Following COVID-19, governments in some countries, including the **United Kingdom, France, Belgium and Ireland**, have promised to increase their financial commitments, but in some countries, these promises are still viewed as insufficient to meet the demands. Finally, it is important to acknowledge that it's not just support services or local to national authorities who have the opportunity and/or duty to help victims of domestic abuse. Extended families, friends, neighbours and co-workers can reach out to make sure their close ones are safe during this time – and not just from COVID-19.⁶⁹

In this survey, many countries have reported an increase in levels of **gender-based violence**. Due to pre-existing risks of exposure to domestic violence for women, older women in abusive family settings were even more exposed to this risk during quarantine or lockdown. AGE mentioned that the effects of stress, mental health effects of isolation and overburdening due to care could turn a previously non-abusive household setting into an abusive one. In **Austria**, women experienced an increment of gender-based violence at the beginning of lock-down. In **Belgium**, there was an increase of calls to the helpline by victims. In **Germany**, domestic isolation, combined with existential worries and needs, increased the risk of violence from partners and fathers for women

⁶⁹ EU Observer, "Resources for COVID-19 abuse victims 'insufficient'", <https://euobserver.com/opinion/148294>

and children. Social distancing, home office and the closure of day-care centres and schools also meant that those affected had even less opportunity to seek personal help and that no one notices their injuries. In **Iceland**, those already living in threatening or unbalanced conditions felt the effects particularly strongly and immediately. There was an increase in domestic violence reports. Women of foreign origin or of poorer social status are always more vulnerable as a group in those cases. In **Ireland**, social isolation and increased tensions among couples and households during lock-down has led to an increase in domestic violence, where the majority of victims are women. The reduction in access to other family, friends and wider support services makes this situation worse. Organisations have reported increased calls to services, but also highlighted that women may be prevented from calling services as they are constantly in the presence of their abusive partner. Police have reported an increase of almost 25% in domestic violence, with a 30% increase in some areas. In **Croatia, Denmark, Finland, France, Portugal, Spain and the United Kingdom**, gender-based violence also grew during the lockdown. In **Norway**, the situation is different: Help lines for victims of domestic violence reported significantly fewer inquiries than in a normal situation. However, based on experience, they expect to get a significant increase as the society starts re-opening again.

"Chloé goes into the bathroom of her house in Madrid to be able to speak while her abuser watches television. "One second, he is coming," she says as she momentarily interrupts her message on WhatsApp. "I am like his slave. I have to do everything he wants and how he wants. If I speak it bothers him, if I sleep it bothers him, if I don't clean the bathroom as he wants, it bothers him... It is a 24-hour non-living", she types. When the state of alarm was decreed by the COVID-19 crisis, Chloé was already in the process of separation from her ex-partner, but her divorce, like all civil proceedings, was paralysed: "My daughter and I live with him; he is putting us at risk because he comes and goes when he wants. I'm disabled and I can't go out, so he controls my food and medication, and when he gets angry, he plays the music as loud as possible to punish us."

SPAIN, Chloé, 37, Madrid1

5.8. Other vulnerabilities and intersectionality

Some groups of women face intersectional inequality, due to their sexuality, gender, class, race, ethnicity, and physical or mental ableness. **Sexual and reproductive health rights, medical follow-up in pre and post-natal care** are likely to be disproportionately impacted by the public health crisis and have a long-term impact on gender inequalities and women's health making them more vulnerable to employment precariousness, poverty and discrimination.⁷⁰

In **Portugal** and **Spain**, women in prostitution were particularly affected by the COVID-19 pandemic. Not only are they an increased risk group due to intimate contact with sex buyers, but there is a lack of specific support and protection measures. **Women (and men) living in refugee camps** are especially vulnerable to COVID-19 and other diseases as a result of living in overcrowded conditions, lack of sanitation, and lack of access to decent healthcare or vaccination programmes. Physical distancing and permanent hand washing are simply impossible. The risk of sexual abuses, the suspension of medical attention of gynaecological and communicable diseases, and the risk of intimate-partner violence grew as a result of the increased isolation.⁷¹ **Migrant women** can face barriers to accessing healthcare, such as language, financial costs, legal restrictions and lack of awareness of available services. Pregnant refugees and migrants in Europe face a higher maternal mortality rate than non-migrant women, which may be exacerbated when healthcare services are stretched due to the COVID-19 pandemic.

70 European Public Health Alliance, at <https://epha.org/wp-content/uploads/2020/04/epha-covid-statement-on-vulnerable-groups.pdf>

71 Women deliver, 1 May 2020, at <https://womendeliver.org/press/opinion-to-end-covid-19-refugee-girls-and-women-must-be-part-of-the-solution/>

In **Spain**, there have been many complaints of increased exploitation during the confinement by migrant women who work as caregivers, often without a registered contract, by those families that have hired them.⁷²

Women with disabilities cannot follow the recommended physical distancing measures. There are 61 million women and 47 million men with disabilities in the EU. Many of them depend on help from others to eat, dress or shower, which makes physical distancing almost impossible. When it comes to domestic violence, women with disabilities are more vulnerable. 34% of women with disabilities have suffered intimate partner violence, compared with 19% of women without disabilities. They often are not physically able to access shelters and other facilities, so they remain in violent situations. **Roma women** in several countries face worse living conditions than men: across the EU, 30% of Roma households live without any access to tap water. Without running water in the house, it is very difficult to frequently wash hands, which is one of the ways to prevent infection with COVID-19. Regarding **black and ethnic minority women**, in the **United Kingdom**, a study found that 56% of pregnant women hospitalised because of the virus were from black and ethnic minorities.⁷³

⁷² Social care, the 'second frontline' but the poor cousin of the healthcare system, has been ravaged by the virus while receiving delayed attention from government. In the United Kingdom, this workforce is predominantly (83%) female and migrants make up 16% of workers in the sector. Care workers are highly exposed to the virus and access to PPE has been very limited. Domiciliary care workers are potential vectors of infection because they visit multiple homes to provide care. Reis, Sara (2020), Migrant women and the economy. May. At https://filia.org.uk/news/2020/5/4/migrant-women-and-the-covid-19-crisis?fbclid=IwAR1XJTvXoB3sj4OU7bZjdK4VsdRAvp4FUnU_2y4xWQFztnNqInGiC6YnSKM

⁷³ BBC News 8 June 2020 <https://www.bbc.com/news/health-52965722>

6. THE PERFORMANCE OF NGOS

During the spread of the COVID-19 pandemic, the lockdown, the restrictive measures and the de-escalation to the “new normal”, civil society adapted and was transformed in order to cope with the crisis, while governments adopted specific policy measures or decisions which negatively affected civil society organisations, frequently without involving them (**Czechia**).

The activism that emerged as results of this crisis varies widely across contexts, but several common dimensions stand out. The first is mutual aid or self-help, which is characterised by the spontaneous organisation of individuals on a voluntary basis, with the purpose of helping each other or helping others. The second is repurposing, the transformation of long-term projects, with ambitious inclusion aims, to short-term emergency and assistance. The third is a renewed dedication to fighting misinformation, fake news and the confusion, as well as the criminalisation, racism and xenophobia exacerbated during the pandemic, which mostly developed through online media and social networks.⁷⁴

However, many civil society organisations - including EAPN members - were generally negatively affected. EAPN respondents to the questionnaire explained that many civil society organisations were forced to put planned activities on hold; others were scrambling to shift their work online. Firstly, they experienced changes and cuts in their funding levels, due to delays and cancellations from donors, postponed funding campaigns, lost revenue from closed social enterprises. In the cases of **Austria, Belgium, Croatia, Czechia, Finland, Lithuania, the Netherlands, Slovenia, Spain and the United Kingdom**, the lockdown measures had a big impact on the funding of NGOs which work directly with vulnerable people or provide services, as in women, youth and homeless shelters. On the other hand **Austria, Denmark, Finland, Ireland and Norway**, reported the reception of additional funding support, while **Poland and Portugal** mentioned the access to new funding sources. For example, the Finnish Ministry of Social Affairs and Health opened additional funding for NGOs to alleviate the psychosocial impact of the crisis as well as implement food aid.

Secondly, they reported changes and reductions in their way of delivering services, because of the reduction of volunteers’ activities (**United Kingdom, Spain**), the isolation of target populations and families who needed support services (**Iceland**), the cancellation of face-to-face services, programs, training, events, and internal operations (**Austria, Czechia, Finland, Spain, The Netherlands, United Kingdom**). Thirdly, they changed their ways of operation, with staff lay-offs, infected social workers, emotional trauma and low morale of practitioners and volunteers, and the inability to complete necessary reporting due to restrictive circumstances and the government office closures (**Spain**). In **Lithuania and Spain**, most NGO were not offered protective equipment. These countries also reported food insecurity.

74 Brechenmacher, Saskia and Carothers, Thomas, “How is Covid-19 affecting Civil Society worldwide? How is it Responding?”, Oxfam Blogs, 23 April 2020, at <https://oxfamblogs.org/wp2p/how-is-covid-affecting-civil-society-worldwide-how-is-it-responding/> LINC (2020), How civil society organizations in the global South are impacted by COVID-19. April, at: https://linclocal.org/wp-content/uploads/2020/04/COVID-19-Impact-on-CSOs_LINC-report.pdf

6.1. Good practices

There have been three main types of measures implemented across countries to assure the continuity of care services in this crisis including legislation and policies to support provision, the development of local partnerships for service delivery, and reinforcing services for the most vulnerable.⁷⁵

6.1.1. Reported by European Organisations

During COVID-19, many countries in Europe decided to identify the services and the people that are a priority to receive support. According to the information published by The **International Federation of Social Workers Europe** member organisations, the following categories of essential services have been identified⁷⁶: Community social services that deliver food and goods; Social services that provide and support a place for someone to live (e.g. night shelters, family homes, residential centres for elderly and people with disabilities, residential centres for children); Crisis support for people who are unsafe (e.g. shelter for victims of domestic violence) and provision of care and support in people's homes. Many countries in Europe decided to declare the social services as "services essential to preserving life, health, public safety and basic societal functioning". In some countries, the local administration supported essential social services with access to personal protective equipment (PPE) and guidance on using it safely. Nevertheless, this did not happen everywhere and national association of social workers started campaigning for personal protective equipment (PPE) For example, the Associazione Nazionale Assistenti Sociali in Italy (AssNAS), the British Association of Social Workers (BASW), the Polish Federation of Social Workers and Social Service Employees Unions (PFZPSiPS) organised national campaigns calling for protective equipment for front-line social workers and social services and staff. The following are some examples of good practices from national networks that have been developed in their countries:

In **Ireland** there have been increased payments to those unemployed or furloughed because of COVID-19; greater awareness campaigns about domestic violence support and much more online support and information for the general public. In **Italy**, essential social services have focused on ensuring continuity of home care for people with disabilities and older people linked with street operations such as goods and food delivery for those with reduced mobility. Emergency programmes for the homeless have been set up with centres operating and open 24/7 as well as anti-poverty schemes with €6 billion in emergency income for 10 million workers.

In **Spain**, the government declared social services 'essential', which meant that professionals must have access to personal protective equipment (PPE) and be able to undertake their duties such as travel to a home where there is suspicion of domestic violence, supporting a child who may be in foster care or provide support to families. This has made it easier to allocate workers to where they are needed the most, has provided flexibility for public authorities to set up longer shifts if needed or re-organising work to respond to the emergency. The national government has issued measures and recommendations covering all regions, in relation to emergency accommodation distinguishing between the responsibilities of local and regional authorities, home care, and nursing homes for older people. A protocol was issued to support health services in the discharge of older people; in each region, buildings are being adapted to accommodate old people who are discharged after having been in hospital with COVID-19.

⁷⁵ <https://www.esn-eu.org/news/social-services-and-covid19-supporting-frontline>

⁷⁶ https://www.ifsw.org/social-workers-response-to-covid-19-in-europe/?fbclid=IwAR1qAUTpPmN0f8GeDRClhRfRf7fMXJ5-VQyod_VZr90Z-fNUbAUZ9QC6d8

In **Denmark**, emergency response teams were set up in residential services for people with disabilities at the beginning of the crisis to ensure that the necessary staff were available. So far, this has ensured an adequate flow of workers. Job portals have been set up by the municipalities to look for additional staff to replace those who may become sick as well as volunteers, and agreements with the unions have been reached to make it possible for public employees to be transferred between social services. Some municipalities have opened a combined service of shelter and healthcare for homeless people who may have become infected with COVID-19.

In the **United Kingdom**, Councils have to submit a care home support plan to the Department of Health and Social Care (DHSC), which should confirm the support they are providing and that they are undertaking a daily review of their local social care market. Following the figures showing so many people were dying in care homes, the government announced £600m of funding for councils to spend on improving infection control in care homes, taking overall COVID-19 spending on councils to £3.8bn. In **Scotland**, the Government have introduced a package of measures to help families cope with the economic impact of the pandemic. They have set up a £350 million emergency funding package which includes £45 million to the Scottish welfare fund, which provides grants for people facing a crisis, a £70 million food fund to help local agencies address food insecurity and £50 million directly to councils to help with hardship measures. Education Secretary Gavin Williamson has announced nearly £10 million for projects aimed at boosting the educational outcomes of vulnerable children, and to keep them safe from harm. This followed the news that reports of domestic abuse incidents have been on the rise during the COVID-19 pandemic, with some children also experiencing exposure to drug and alcohol misuse or at risk from online harms. Social workers will be placed in schools to help spot the signs of abuse and neglect more quickly and work with teachers to support children at risk. This includes £6.5 million to involve more than 150 schools in a project that will place social workers in schools to work with teaching staff, reflecting that the second largest source of referrals to children's social services is schools (18%).⁷⁷

Other measures implemented across many countries included reinforcing telecare and phone calls with people who regularly use social services and additional monitoring measures for those at risk of violence at home. In many countries, local communities have come forward to deliver food and support to people locally. In urban areas, resilience hubs have been set up to take phone calls from people in the community who are struggling to get supermarkets to deliver their online shopping. Councils are deploying volunteers and council staff into ensuring that food and medication reach those who need them the most. A number of national associations of social workers in Europe created ethical guidance to support practice in different areas of intervention or service provision based on the regulation published by their governments. Social workers practitioners are working in emergency situations and may face choices and decisions that go far beyond the bounds of usual ethics and practices, including rationing of support and resources and more stringent prioritisation. The guidance responds to the very specific circumstances generated by COVID-19 which disrupts health, care, safeguarding and support services. Some examples of consistent guidance to support professional practice include: The British Association of Social Workers (BASW) published the **Practice Guidance for Children and Families Social Work during COVID-19 Pandemic**⁷⁸ and with support from the Approved Mental Health Professional Leads Network and the Chief Social Workers office, prepared and published the **Information and support for Approved Mental Health Professionals**.⁷⁹

77 <https://www.gov.uk/government/news/social-workers-to-work-with-teachers-in-schools>

78 BASW (2020), Practice guidance for Children and Families Social Work during Covid-19. Guidance to support professional practice with children and families. At <https://www.basw.co.uk/practice-guidance-children-and-families-social-work-during-covid-19>

79 BASW (2020), Information and support for Approved Mental Health Professionals Resources by BASW for the AMHP role as the country responds to the Covid 19 pandemic. At <https://www.basw.co.uk/information-and-support-approved-mental-health-professionals>

The Polish Federation of Social Workers and Social Service Employees Unions (PFZPSiPS) launched a special website⁸⁰ where they answer the most frequently asked questions from social workers. The French National Association of Social Workers (ANAS) also ensured a Help Desk for social workers.⁸¹ AGE Platform Europe collected good practices relating to the immediate crisis response and the human rights of older people, among which is social inclusion.⁸² Further practices, structured by areas of concern, are also explained in our overall position on the human rights of older people and COVID-19:⁸³ These include state-sponsored, NGO-promoted and entirely private practices of solidarity and social inclusion during lockdowns. In particular, our members highlight the following aspects as good practices: Helplines for older people who feel lonely or are lacking care and assistance; initiatives facilitating access to digital communications to isolated older people; support services to do the shopping or other necessary activities for older people and/or people in self-isolation; practices to promote physical and mental activities during the lockdowns and free delivery of food or calls by public authorities to deliver food by volunteers during the lockdowns. Regarding social inclusion of older people in long-term care facilities, several member states have issued guidelines for allowing visits, thereby encouraging visits and further social inclusion where possible.⁸⁴

6.1.2. Reported by national networks

Most of the highlighted good practices are related to civil society organisations' services that provide food, protective face masks and hygienic kits to the most vulnerable (**Austria, Croatia, Czechia, Hungary, Lithuania, Portugal, Serbia, Slovenia, Spain**). EAPN Portugal launched the SOS Roma Communities Campaign that donated 659 hygienic and protective kits to 659 families.⁸⁵ The School of Hotel and Tourism of **Porto** that together with the Associação Saber Comprender and the Projeto Porta Solidária prepared hot meals to be distributed to people who are homeless or who resort to these responses in situations of loss of income and reduction of income: "Solidarity Boxes. Take what you need, leave what you want". In some countries, the distribution of electronic devices for children to follow online education was also promoted (**Austria, Hungary, Lithuania, Spain**). **Slovenia** reported the positive use of the digital platform OPIN.ME for child participation.⁸⁶ The local authorities cooperated with local NGOs on handling some of the problems for the most vulnerable – especially homeless people, who suffered from closed day shelters and less access to the official information. Specifically, a good practice was the utilisation of empty houses, hotels and facilities for homeless people during the pandemic (**Denmark, Germany, Spain**).

In **Finland**, the NGO working for the homeless VVA did not lock down: group functions became online and virtual cafés received individual customers to help them make applications. Psychological sessions were given online to prison inmates, by the Finnish Foundation for Supporting Ex-offenders. The city of Helsinki collected an information group of homeless service providers which gathered three times a week and made decisions based on that knowledge. The Government's "COVID-19 situation group" constantly collected information (also from NGOs) to support decision-making.

80 <http://federacja-socjalnych.pl/index.php/824-specjalny-serwis-federacji-dotyczacy-pomagania-w-zagrozeniu-covid-19>

81 https://www.anas.fr/Solidarite-numerique_a1602.html

82 <https://www.age-platform.eu/age-news/covid-19-good-practices-and-initiatives>

83 AGE Platform (2020), COVID-19 and human rights concerns for older persons, at: https://www.age-platform.eu/sites/default/files/Human%20rights%20concerns%20on%20implications%20of%20COVID%2019%20to%20older%20persons_Final_18May2020.pdf

84 One example is France at: https://www.ehpa.fr/pdf/Rapport-Guedj.pdf?utm_source=sendinblue&utm_campaign=Protocole_Guedj&utm_medium=email

85 <https://www.eapn.pt/campanha/38/campanha-sos-comunidades-ciganas-relancada-a-1-de-maio>

86 <https://opin.me/en/>

Different civil society's experiences showed what voluntary work means for society and especially the importance of the work delivered by informal caregivers (**The Netherlands, Portugal, Spain**). In **Norway**, there were outreach efforts (such as going from door to door) to disseminate information, especially from immigrant organisations. New services were provided by NGOs, for example a free helpline for questions about the social protection system. Some foodbanks reported an increase of food supplies (and of better quality than before), as more businesses see the value of the work they do during the crisis. The **Spanish** Red Cross launched a very ambitious assistance plan for vulnerable people (Cruz Roja responde contra el COVID-19), with a 'Special follow-up Campaign', monitoring the needs of 400,000 clients. Caritas **Madrid** launched the campaign "Charity does not close: become a supporting neighbour", which recruited volunteers for assisting and accompanying vulnerable people.⁸⁷ In the **United Kingdom**, there has been a rapid growth in local mutual aid groups, which brought food and other necessities, or did small tasks, for local people who were shielded or sheltering and supported food bank delivery. In **Serbia**, several NGOs denounced the decrease of human and citizen rights during the martial law. Many NGOs continued providing support to refugee camps even during the pandemic. In Spain, the **Women Institute** launched a contingency plan against gender-based violence during COVID-19, which incorporates the possibility of alerting the police by WhatsApp, using geolocation. The plan includes a series of measures to prevent a possible increase in gender-based violence.⁸⁸ (For more details from the national assessments see Annex 2: Country Annex) ([link here](#)).

⁸⁷ <https://www2.cruzroja.es/-/lanzamos-el-plan-cruz-roja-responde-frente-al-covid-19>

⁸⁸ . Ministerio de Igualdad, Instituto de la Mujer y para la Igualdad de Oportunidades (2020), La perspectiva de género, esencial en la respuesta a la COVID19. [http://www.inmujer.gob.es/disenov/novedades/IMPACTO_DE_GENERO_DEL_COVID_19_\(uv\).pdf](http://www.inmujer.gob.es/disenov/novedades/IMPACTO_DE_GENERO_DEL_COVID_19_(uv).pdf)

7. AUTHORITARIAN TRENDS AND FUNDAMENTAL RIGHTS

During the pandemic, around the world, 40% of people living in democracies believe that their country is not actually democratic.⁸⁹ Leaders in many countries are taking advantage of the crisis to tighten their political grip by weakening checks and balances, imposing censorship, and expanding state surveillance — all at a time when civil society groups are less able to fight back. Such measures pose a significant threat to civic activism. The pandemic risks providing a convenient cover for governments to further tilt the balance of power in their favour.⁹⁰ The threat of authoritarian regimes taking advantage of the COVID-19 crisis to close down democracy and attacks on the rights of individuals and NGOs is a real one. In the survey, there was a specific question to capture and assess this worrying trend, which was divided into three parts: Is the "war analogy" being utilised in the political discourse by your government? Is there an abnormal, increased surveillance and data control of citizens? Do you think that there is an increased risk of authoritarianism and/or attacks on reproductive rights or other regressive measures in your country?

At a press conference on 11 April, the Spanish Prime Minister Sanchez expressed: "When we win this war - and we are going to win it, I am convinced - we will need all the forces of the country to overcome the post-war period." Similar phrases were repeated by several EU leaders during the first months of the pandemic. Such dramatic rhetoric could help rally a strong effort to fight the pandemic and could highlight the sacrifices citizens had to make. But this may imply a dangerous turn: **The virus is not an army, and evoking war can transform a health crisis into a security one.** Many countries (**Austria, France, Greece, Hungary, Italy, Serbia, Slovenia, Spain, United Kingdom**) mentioned that their governments and/or the media utilised the war analogy with respect to COVID-19, either in the sense of "war against the virus", as a remembrance of former military battles, of joint efforts against "invaders" or in other warlike references. As in the case of **Czechia**, this analogy was utilised in justification of extraordinary measures which implied the suspension of liberties. In **Serbia**, the war discourse was very prominent in the government. Symbolically, at the beginning of the martial law, there was an action to distribute national flags to households, instead of dispensing masks and gloves. In **Iceland**, the war analogy was not utilised but the government repeated the phrase "we are all in this together". This was quite insulting to people experiencing poverty, who looked at government handouts to all kinds of projects that they were not a part of, while not much was done to protect them or meet their needs.

The liberties which were curtailed in most countries were freedom of assembly and of movement, by means of the declaration of "states of exception", "states of alarm", "states of emergency", "martial law" or specific new laws devoted to impose lockdown and quarantines, often reinforced by the use of military or police forces. The increased surveillance and control of civil society, including fines, detention or prison to those who did not comply, were indicated by **Belgium, Germany, Greece, Hungary, Italy, Slovenia, Spain. Ireland** reported that in some situations the police used the extraordinary powers to negatively target some social groups. In **Poland** there were several acts of repression against social protests due to social distancing

⁸⁹ Democracy Perception Index, the world's largest annual study on democracy. Quoted by the European Parliament, Public Opinion Monitoring at a Glance in the time of COVID-19, 16 June 2020, page 4, at <https://www.europarl.europa.eu/at-your-service/files/be-heard/eurobarometer/2020/covid19/en-public-opinion-in-the-time-of-covid19-20200616.pdf>

⁹⁰ Brechenmacher, Saskia and Carothers, Thomas, "How is Covid-19 affecting Civil Society worldwide? How is it Responding?" , Oxfam Blogs, 23 April 2020, at <https://oxfamblogs.org/fp2p/how-is-covid-affecting-civil-society-worldwide-how-is-it-responding/> According to Amnesty International "Many states in Europe have implemented measures restricting human rights, including freedom of movement and assembly, the right to work, and the right to private and family life. The rights of marginalized populations, including refugees and migrants, have also been affected." Amnesty International (2020), Europe at a crossroads. Do's and don'ts for authorities when responding to the COVID-19 pandemic, page 4, at <https://www.amnesty.org/download/Documents/EUR0120792020ENGLISH.PDF>

orders. People participating were sentenced to high fines. In **Portugal**, the state of emergency removed the right to strike and - as stated in a Decree - “the right of workers’ commissions, trade unions and employers’ associations to participate in the drafting of labour legislation, in so far as the exercise of such right may delay the entry into force of urgent legislative measures for the purposes provided for in this Decree, may be limited in terms and conditions of consultation”. This decision limited the rights of workers and may have contributed to abusive situations.

Applications which can be voluntarily downloaded to personal mobiles, for monitoring and tracking individuals in relation to COVID-19, exist or are being developed in Austria, Czechia, Denmark, Germany, Iceland, The Netherlands, Norway, Slovenia, Spain and United Kingdom.

National and regional elections have been postponed in many countries, their regions or municipalities. This might deprive governments of their legitimacy, while allowing them to use the delay to strengthen their power and hold elections when it suits them. In **Austria**, municipal elections which should have taken place on 15 March were postponed to 13 September. In **Czechia**, Senate elections should have taken place in March or at the beginning of April: the new date is not confirmed. In **France**, municipal elections and of overseas advisers and consular delegates were postponed. In **Germany** municipal elections were delayed from March to (probably) November. In **Italy** a March referendum and municipal elections were suspended, with the new dates still unknown. In **Poland**, May’s presidential election has not been rescheduled. In **Serbia**, the parliamentary elections were moved from April to the end of June. In **Slovakia**, local elections which were to take place in April were postponed until October. In **Spain**, regional elections in Basque Country and Galicia which would have happened in April, were rescheduled to 12 July. In the **United Kingdom**, local elections in England were rescheduled from 5 July 2020 to the same date in 2021, and local government by-elections in Scotland (Kincorth/Nigg/Cove and Craightinny/Duddingston) were put-off indefinitely.⁹¹ In **Belgium** and **Spain**, the populist political parties on the right of the political spectrum, which are often associated with more authoritarian rhetoric and aspirations, heavily criticised the prolongation of lockdown and quarantine measures. In **Lithuania** the government tended to bypass the Parliament. The **Hungarian** respondent expressed that “we have become a fully non-democratic country in the last three months.” There was no democracy in **Serbia** prior to the pandemic, but the situation worsened. Only a few media are currently out of the control of the ruling party, all the media with national coverage are severely controlled, the political clashes are on the rise, citizens protests are confronted by organised supporters of the ruling party and SeConS (member of EAPN Serbia) was harshly publicly attacked by the President for publishing the survey results according to which 200,000 persons lost their jobs during the pandemic and the application of the martial law. In **Slovenia**, the freedom of press was limited as well, as journalists were not allowed to attend the government press conferences. In the **United Kingdom**, the populist approach of the government, which has included elements of press manipulation and bypassing of Parliament, is expected to continue and perhaps strengthen as they approach a hard Brexit or crash-out of Europe on 31 December 2020. The Government also showed itself and others that in the current crisis it can impose draconian restrictions on freedom of movement and had them accepted by the population.

⁹¹ International Foundation for Electoral Systems, Elections Postponed Due to COVID-19 - As of June 17, 2020, https://www.ifes.org/sites/default/files/elections_postponed_due_to_covid-19.pdf

8. PROPOSALS AND RECOMMENDATIONS TO THE NATIONAL AND EU LEVEL

8.1. Can the pandemic crisis be “a gateway” to a fairer world, through a new social and green deal?

The Slovenian philosopher Slavoj Žižek expressed that the origin of the pandemic is not something that “*simply happened*”, but is an event caused by capitalism, our way of life and modes of production: “*Maybe, this is the most disturbing thing we can learn from the ongoing viral pandemic: when nature is attacking us with viruses, it is in a way sending our own message back to us. The message is: what you did to me, I am now doing to you.*”⁹² “*Humanity will be finished*” if we fail to drastically change our food systems in response to the COVID-19 pandemic and the climate crisis, warned the prominent naturalist Jane Goodall.⁹³ Along the same lines, Canadian activist Naomi Klein has indicated that the forces of big capital will use the current shock to deepen their dominance. She has, therefore, called for the economic stimuli that have been announced around the world to go in the opposite direction and activate a “New Green Pact” for the world and the climate, one that drives the construction of fairer societies and a more sustainable relationship with nature: “*This crisis - like earlier ones - could well be the catalyst to shower aid on the wealthiest interests in society, including those most responsible for our current vulnerabilities, while offering next to nothing to the most workers, wiping out small family savings and shuttering small businesses. But many are already pushing back*”.⁹⁴ The French philosopher Bruno Latour has also warned that what makes the current situation so dangerous is the profitable opportunity that opens up for those who had already built a system that is increasingly distant from the Earth, with terrible social and environmental consequences. But he also pointed out that, if the opportunity presents itself for them, “*it also presents itself for us.*”⁹⁵ There are others who have pointed out the potential of the pandemic to cause a fundamental change in the relationship of humanity with the planet and humans with ourselves. This is the case of the Indian writer Arundhati Roy. In a painful chronicle on how the current crisis is punishing those who are themselves the victims, who suffer the most from the caste system and the class divisions of her country, **she concludes that the pandemic is a portal**: “*We can choose to walk through it, dragging the carcasses of our prejudice and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it.*”⁹⁶

92 Slavoj Žižek, “Monitor and punish? Yes, please!”, The Philosophical Salon, 16 March 2020, at <http://thephilosophicalsalon.com/monitor-and-punish-yes-please/>

93 “Jane Goodall: humanity is finished if it fails to adapt after COVID-19”, The Guardian, 3 June 2020, at <https://www.theguardian.com/science/2020/jun/03/jane-goodall-humanity-is-finished-if-it-fails-to-adapt-after-covid-19?fbclid=IwAR2BBuFW0icrRACvYgdbYZXgRcXgwjccQhAILHMhFGXmJYzvp-mAZy32QW0>

94 Naomi Klein, “Coronavirus capitalism — and how to beat it”, 16 March 2020, The Intercept, at <https://theintercept.com/2020/03/16/coronavirus-capitalism/>

95 Bruno Latour, “Imagine the gestures-barrières against the retour à la production d'avant-crise”, 30 March, 2020, AOC, at <https://aoc.media/opinion/2020/03/29/imaginer-les-gestes-barrieres-contre-le-retour-a-la-production-davant-crise/> and interview in The Guardian, 6 June 2020, at: https://www.theguardian.com/world/2020/jun/06/bruno-latour-coronavirus-gaia-hypothesis-climate-crisis?utm_source=dlvr.it&utm_medium=facebook&fbclid=IwAR0-P-GRkeIMBE6Df6rqTBRrAPEiwQ2QOise1d2cC1fXfdqq5gd6eYrgts

96 Arundhati Roy, ‘The pandemic is a portal’, 3 April 2020, Financial Times, at <https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca>

8.2. Recommendations at the national level

As countries begin easing COVID-19 pandemic lockdown measures, calls to not “go back to normal” are getting louder.⁹⁷ The pandemic has exposed systemic flaws and highlighted the drastic inequality in our global neoliberal system. Most of the respondents agreed that the COVID-19 crisis demonstrated the weaknesses of national health systems, territorial and social inequalities, which is why they consider it absolutely urgent that their governments strengthen and invest more resources in universal, affordable health care. Safety in the management of the pandemic was also pointed out.

Among others, the **United Kingdom** proposed to strengthen the procurement and distribution of personal protective equipment, as well as efficient tracking and tracing, so that families with schoolchildren, their teachers, other workers - especially in public-facing roles - are safer to go back to school and work. There was also a strong consensus on the need to strengthen social and care services, as well as personalised care services, as they were shown to be weak during the crisis.

Slovenia particularly highlighted the importance of establishing a good, public, long-term care system. The main proposals made by respondents to their national governments are directed towards the protection of vulnerable groups who are negatively affected by the COVID-19 pandemic, by increasing the duration and generosity of social protection systems and minimum income benefits, particularly extending measures beyond ‘temporary benefits during the pandemic’ and avoiding leaving anyone behind.

As expressed by **Denmark**, the proposal would be to maintain large financial help packages compensating for (lost) wages, as well as to have a stronger focus on financial aid for those who are not organised. Protecting people from poverty means taking steps towards implementing rights that guarantee adequate income (through decent work and/or income support), affordable housing for all and ethical management of a way-out for debtors.

Austria proposed an increase of the minimum income amounts as well as easier access to the so-called “help in special living conditions”, to make it more adequate and accessible. **Belgium** recommended that all minimum income benefits must be lifted above the EU poverty threshold, in order to avoid people with limited incomes having to pay the costs of this crisis. **The Netherlands** proposed the increase of the minimum income by 5% and make 150 million per annum extra available for local poverty policy, as well as stronger social housing. **Portugal** recommended the improvement of minimum income schemes for all and that a National Strategy to fight poverty and social exclusion be launched.

In **Czechia**, the recommendation is to constantly review the benefits system in order to grant a decent life, focusing on the mitigation of the COVID-19 effects. **Finland** proposed measures to ensure an adequate livelihood for the most vulnerable groups, with extra support for poor families. In order to address the important issue of housing costs, **France** also recommended not only increasing the minimum income but the individual housing allowance (Aide Personnalisée au Logement) as well.

⁹⁷ A YouGov opinion poll asked residents in 21 European countries on their willingness to return to pre-COVID air pollution levels and a clear majority did not want to go back. 74% said cities must take effective measures to protect citizens from air pollution, among other answers. Quoted by the European Parliament, Public Opinion Monitoring at a Glance in the time of COVID-19, 16 June 2020, page 4, at <https://www.europarl.europa.eu/at-your-service/files/be-heard/eurobarometer/2020/covid19/en-public-opinion-in-the-time-of-covid19-20200616.pdf>

Norway recommended that the gaps in the welfare system must be closed to include all who are not sufficiently covered by the existing schemes, during and after the crisis. They proposed a temporary universal basic income (until the Labour and Welfare Administration finds a solution for faster pay-outs of unemployment benefit). **Poland** called for the improvement of existing anti-crisis measures by making the emergency benefit more accessible for all affected employees and to set the level of the unemployment benefit at 50% of the minimum wage, at least.

Iceland also focused on housing, indicating the need for more protection of vulnerable tenants and those who struggle to pay their homes' mortgages. **Ireland** demanded that their government avoid the introduction of austerity measures and ensure that all policy measures that address the economic impact of the crisis undergo transparent and effective poverty and equality impact assessment.

In **Hungary**, the proposal was to create multi-sectoral pandemic plans, to provide extra, quick financial aid for the poorest people and to secure the involvement of civil society in the debates on next steps. Germany also agreed to deliver better financial support to poor families. **Lithuania** recommended transferring a significant part of COVID-19 mitigation funding directly to the population through social security mechanisms. It also called for immediately bringing the level of state-supported income closer to the level of minimum consumption needs and ensuring adequate minimum income, while expanding coverage of social insurance benefits.

Spain requested the implementation of the approved anti-poverty strategy and the new, more inclusive MI scheme (Ingreso Mínimo Vital). In order to tackle social exclusion, a regularisation of undocumented migrants is also proposed.

Many countries mentioned the need to prioritise the wellbeing of children and young people by safeguarding resources for child protection, mental health and support health services. Improved access to universal education and investment in digital inclusion were proposed by several respondents as well.

In the long term, the recommendations are in line with social and ecological transformation, achieving better redistribution through greater tax collection, and more progressive tax systems to finance better universal social protection and social services for vulnerable people and those living in poverty. The European Pillar of Social Rights and the UN Sustainable Development Goals are presented as key instruments to ensure a balanced and integrated approach to social, economic and environmental policy.

8.3. Recommendations at the EU level

On 13 March 2020, the European Commission set out its immediate response to mitigate the socio-economic impact of the COVID-19 pandemic, based on a European coordinated response.⁹⁸ It endorsed the use of EU State aid rules to enable Member States to take swift and effective action to support citizens and companies, in particular SMEs, faced with economic difficulties due to the pandemic. On 16 March, the Eurogroup (finance ministers of the eurozone countries) – now extended to all EU Member States – announced an agreement on the overall economic response to the COVID-19 outbreak.⁹⁹ This included the exclusion of temporary fiscal measures taken in response to the COVID-19 crisis when assessing compliance with fiscal principles and making full use of the Stability and Growth Pact’s general flexibility clause for all Member States. The Commission launched its Coronavirus Response Investment Initiative on 18 March, aimed at mobilising cohesion policy to respond to the rapidly emerging needs in the most exposed sectors, such as healthcare, SMEs and labour markets, and help the most affected territories in Member States. On the same date, the European Central Bank announced the launch of its Pandemic Emergency Purchase Programme.¹⁰⁰ The new EU Recovery Plan (27 May) was launched “to protect lives and livelihoods, repair the Single Market, as well as to build a lasting and prosperous recovery”, with a reinforced long-term budget and a new recovery instrument of € 750 billion.¹⁰¹ EAPN celebrates this new and reinforced commitment.

The experiences analysed in this study have highlighted positive policy measures, but also the structural inequalities and violation of human rights which were exacerbated by the impact of the COVID-19 pandemic and that urgently need to be addressed. EAPN demands that urgent, coordinated action is taken by the EU and Member States, as well as other European countries (EFTA and candidates), to adequately protect and support the poor, the sick and highly vulnerable groups.

Short-term Recommendations

On 17 March, EAPN sent a Statement¹⁰² addressed to the EPSCO Council and, on 24 March¹⁰³, an open letter to the European Council, highlighting the following key priorities in the short-term:

1. Urgent and coordinated health action, focusing on protecting the most vulnerable. National authorities must undertake immediate, extra targeted actions in the field of physical and mental health, food security, housing and accommodation and guarantee access to clean water and hygiene products, accessible information, free access to testing and treatment for patients affected by COVID-19 to ensure the protection of disadvantaged communities and vulnerable socio-economic groups during the pandemic.
2. Urgent action to protect workers and ensure adequate income for all, including financial support to keep people in their jobs, with guaranteed income, increased minimum income support to address additional costs, guaranteed income support to self-employed or those in atypical work who are losing income due to the crisis.

98 European Commission, Coordinated economic response to the COVID-19 Outbreak , 13 March.

99 Eurogroup, Statement on COVID-19 economic policy response , 16 March.

100 ECB, ECB announces €750 billion Pandemic Emergency Purchase Programme (PEPP), 18 March.

101 Recovery Plan for Europe, at: https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/recovery-plan-europe_en

102 eapn.eu/wp-content/uploads/2020/03/EAPN-EAPN-Statement-on-Covid-19-4163.pdf

103 <https://www.eapn.eu/eapn-calls-for-european-leaders-to-clearly-focus-on-protecting-the-most-vulnerable-from-the-impacts-of-covid19-letter-for-european-council-26-march-2020/>

3. Urgent action to protect people at risk of poverty, including suspension of evictions due to non-payment of rent and mortgages, supporting payment of energy bills, and continued free provision of school meals for those who need it.
4. Action to mitigate the social impact of containment measures on social isolation and loneliness, including urgent support to social NGOs who provide care and support services, and setting up of nationwide helplines for social and psychological support to address an increased risk of domestic violence and abuse, especially against women, under quarantine conditions. All EU MS should allocate and earmark specific funds at European and national level to target the needs of women and girls from vulnerable and excluded groups, to take account of their particular needs, especially to tackle gender-based violence and intersecting forms of inequality and discrimination faced in access to healthcare, employment, education and housing that may intensify during the pandemic.

Mid-Term Recommendations

EAPN also wrote a letter to Commissioner Nicolas Schmit¹⁰⁴, asking him to provide leadership and to propose a Framework Directive on Minimum Income, as soon as possible, and to ensure that Minimum Income is in the European Commission’s work programme. The following are the mid-term proposals:¹⁰⁵

1. Embed poverty and social impact assessment.
2. Reinforce quality public health and social care services.
3. Prioritise adequate minimum income and social protection.
4. Protect employment, prevent precarious work and revalue front-line work.
5. Ensure that poor and vulnerable groups do not pay through austerity measures.¹⁰⁶

In the mid- and long-term perspective, EAPN calls for priority investment in universal affordable or free public health services. Public policy on health systems does not only need to take into account the social determinants of health, wellbeing and health inequalities, it also needs to be designed in a way to effectively reduce them. Public health investment for vulnerable groups must be a top political priority, including funding specifically allocated to health prevention and protection, both physical and mental, and backed by a common broad agreement and commitment to reduce health inequalities. National authorities should recognise and address the impact of the crisis on excluded and vulnerable groups and ensure that “a holistic concept of health and wellbeing, including freedom from racism and xenophobia” guides national actions aiming to tackle the public health crisis and limit its socio-economic effects.

Long-term Recommendations

Finally, EAPN makes the following long-term recommendations, an **EU Action for a Social and Green Recovery**:

¹⁰⁴ <https://www.eapn.eu/letter-to-eu-commissioner-nicolas-schmit/>

¹⁰⁵ EAPN EU (2020), Putting Social Rights and Poverty Reduction at the heart of EU’s COVID-19 response. At: <https://www.eapn.eu/putting-social-rights-and-poverty-reduction-at-the-heart-of-eus-covid-19-response-eapns-assessment/>

¹⁰⁶ EAPN EU (April 2020) Assessment of 2020 Country Reports: Putting Social rights and poverty reduction at the heart of the EU’s COVID-19 response at <https://www.eapn.eu/wp-content/uploads/2020/05/EAPN-EAPN-Assessment-of-2020-Country-Reports-with-alternative-CSRs-4405.pdf>

1. Adopt an overarching EU social and sustainable strategy – AGENDA 2030 - underpinned by the Social Development Goals and the European Pillar of Social Rights, as a Green and Social Recovery, that makes ending poverty a pre-requisite and ensures the poor benefit and do not pay for transition.¹⁰⁷
2. Agree an integrated EU antipoverty strategy, as the main goal and framework for the European Pillar of Social Rights Action Plan in 2020, that reinforces integrated support to social rights. This should guarantee adequate income (through quality jobs, adequate social protection and minimum income) and essential public and universal services (particularly health/social care, housing and education) with an ambitious poverty target of 50% and of ending extreme poverty. ¹⁰⁸ Specific targets and strategies should be set for key at risk groups e.g. a Child Guarantee underpinned by the 3-pillar “Investing in Children” approach, developing national strategies to tackle homelessness and housing exclusion based on ‘housing first’.
3. Implement a comprehensive assessment of the impact of COVID-19 epidemic on poverty and equality in the EU, and the key groups affected. Develop clear guidance for Member States to implement a transparent and effective assessment to minimise poverty, gender inequality and guarantee equality at state level, reducing the differences in development and wellbeing of the population that exist within each country.
4. Establish “strong and balanced” coordination throughout the European Semester, so that the Member States fulfil their obligations to reduce poverty and inequality, as well as to implement social rights and social cohesion, and guarantee equal opportunities for all, based on the revised social and sustainable objectives of an ambitious AGENDA 2030 strategy.
5. Make progress on obligatory rights: adopt a European Framework Directive on Adequate Minimum Income, as part of the European commitment to guarantee adequate income¹⁰⁹ and protect households from poverty and vulnerability, and support an EU framework on Minimum/Living Wages. Establish mechanisms for monitoring compliance, with the help of civil society organisations and EU funds.
6. Ensure that the EU recovery plan benefits the poor and vulnerable, investing 30% of ESF+ on social inclusion, gender equality and the fight against discrimination, and investment priorities in affordable, and social housing, universal affordable public health/care services and personalised social services targeting key at risk groups.
7. Ensure meaningful participation of people experiencing poverty and civil society organisations. Recognise civil society organisations as social partners at EU level, supporting the direct participation of people directly facing poverty and social exclusion. Implement the changes in the Employment Guidelines to this affect and ensure their incorporation as full members, on equal terms with other stakeholders, including with obligatory guidance, specific resources to build capacity and increase the effectiveness of engagement.
8. End the era of austerity in Europe and work towards a macroeconomic framework that prioritises the fight against poverty and inequality, invest in wellbeing and in the preservation and protection of the natural environment that supports us. Impose taxation that makes wealthier businesses and individuals help pay the costs of rescue and recovery packages.

107 EAPN: Delivering Agenda 2030 for people and planet: EAPN proposals for a post Europe 2020 strategy. (2019)

108 EAPN Input to the consultation on the Action Plan for the European Pillar of Social Rights (June 2020)

109 EAPN: Position Paper on Adequate Income (Minimum Income and Minimum/living wage), May 2020 at: <https://www.eapn.eu/eapn-position-paper-on-adequate-income/>

STATUS OF THE DOCUMENT

This report was developed by the EU Inclusion Strategies Group, in consultation with the EAPN EXCO and People Experiencing Poverty Coordinators. The report was drafted by Graciela Malgesini, social inclusion expert working with EAPN Spain, and co-chair of the EUISG. The Terms of Reference were exchanged in early April. This was followed by an EXCO discussion, then EUISG member exchange on “COVID-19 & policy responses: What impact on poverty & exclusion?”, which took place on the 23 April, to analyse the impact of COVID-19 on vulnerable groups, to assess the policy actions taken by member states, and to analyse policy recommendations at national and EU levels. A questionnaire with 26 questions was circulated on 4 May aimed at capturing the key data and information from each country, with a 2-week deadline, which was extended until the 25 May. The questionnaire was responded to by 25 national networks. Short interviews were held with people experiencing poverty in order to learn about their situation during the pandemic, with their own perspective and proposals. We obtained a total of 27 testimonies of people experiencing poverty from 23 countries. A specific questionnaire was aimed at the European Organisations Members of EAPN and was completed by three members: the International Federation of Social Workers, SMES Mental Health Europe and AGE Platform Europe. The draft report was circulated to members on 15 June. All inputs were incorporated. The draft report was finalised on the 29 June 2020.

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The European Anti-Poverty Network (EAPN) is an independent network of nongovernmental organisations (NGOs) and groups involved in the fight against poverty and social exclusion in the Member States of the European Union, established in 1990.



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