Global Health Council
The Collective Voice of the Global Health Community

THE HEALTH IMPACTS OF COVID-19 ON THOSE MOST LEFT BEHIND

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ABSTRACT

While the COVID-19 pandemic brought to light the gross inequities faced by marginalized and minority populations, it has also provided us with a unique opportunity to amplify the voices of these often overlooked populations. By combining an extensive review of the literature with the first hand lived experiences of those most affected, we seek to highlight the challenges, triumphs, and shortcomings of the COVID-19 pandemic response and outline recommendations for a more inclusive path forward.

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Introduction

In March 2020 the World Health Organization (WHO) declared, COVID-19* a Public Health Emergency of International Concern. Across the globe, government responses were varied and fragmented. In 2020, the WHO estimated that the death toll was nearly 2 million higher than the reported 1.2 million (WHO, 2021a). By January 2022, the death toll rose to over 5.5 million (JHU, 2022). Looking beyond death, global poverty increased for the first time in 20 years (Arias et al., 2021). As governments struggled to procure tests and provide treatment in overcapacity emergency rooms, they continuously left behind minority and marginalized population groups in their response. In most countries, members of civil society stepped in to fill in the gaps but were never formally involved in national emergency response plans (Rajan et al., 2020). As variants continue to emerge, it is clear that this pandemic is far from over.

This document analyzes the health impacts COVID-19 has had on minority and marginalized groups. In the United States (US), this includes Black, Latino, Asian and Pacific Islander, and American Indian populations. On a global level, this research looks at the LGBTQI+ community, women and girls, youth, and people living with disabilities. **The purpose of this publication is to highlight the gross health inequities (among others) minority and marginalized communities continue to experience throughout the pandemic and provide recommendations for how governments and other stakeholders can better support these communities as the world continues to battle the COVID-19 pandemic.**

Results

The topic areas highlighted below trended across many or all of the population groups both in the review of the literature and/or the GHC community focus groups. The data points discussed in various articles and publications echoed the lived experiences of the community focus group participants and vice versa. While we know there are other impacts that have affected these communities, links between race and health inequities, disruptions in the continuum of care, increased gender-based violence, rising mental health problems, lack of accessibility and inclusion, and disruptions in education and the workforce were most apparent in our review.

Links between Race and Health Inequities

Black and Latino (US)

The COVID-19 pandemic brought to light and further exacerbated the glaring health disparities in the United States. After adjusting for age, African American and Latino residents have the highest rates of both hospitalized and non-hospitalized COVID-19 infection and death rates more than double those of White and Asian residents (Bibbins-Domingo, 2020). Further, while life expectancy for White

*COVID-19 is a highly infectious respiratory illness caused by the SARS-CoV-2 virus (WHO, 2021a).

Americans dropped by 14 months in 2020, for Black and Latino Americans, the drop was 3 years. Yet this may not even capture the full extent of the problem. Data by race and ethnicity in the United States are still heavily reliant on locally reported data collection, often leading to a vast underrepresentation of the scope and magnitude of the inequities (Bibbins-Domingo, 2020).


Photo Credit: Global Citizen

The causes of these disparities are complex and vast. Black and Latino communities continue to face barriers to accessing health care. In many predominantly black communities, access to quality health care is scarce and those who are able to access care are less likely to have their pain and symptoms taken seriously. In a 2020 pilot study by Rubix Life Sciences, Black patients were six times less likely than White patients to receive COVID-19 testing or treatment when presenting to a healthcare facility (Eligon & Burch, 2020). The historical marginalization of Black and Latino Americans cannot be left out of this conversation. Racist policies like zoning laws have forced a large number of Black Americans into high-density housing, making adhering to social distancing recommendations challenging (Ruprecht et al., 2021). Black and Latino Americans also face higher levels of exposure, as many have occupations that require them to work in person. Low wages and a lack of paid sick time further compound to create economic insecurity that does not allow for time off work (Ruprecht et al., 2021).

Asian and Pacific Islander (US)

Similar to the Black/Latino population, studies have shown that Asian American individuals had a significantly higher risk of contracting COVID-19 and an increased risk of disease severity (Magesh et al, 2021). As such, Asians were 57 percent more likely to be hospitalized and 49 percent more likely to die compared to Whites with similar sociodemographic characteristics and underlying health conditions. However, these alarming statistics received little coverage across mainstream media, among academics, and public health experts alike. This lack of attention affected the allocation of resources provided to this population group for the prevention and treatment of COVID-19 (Yee, 2021).

Data on Pacific Islanders are even more scarce. Until late April of 2020, many states grouped Pacific Islanders under the “other” racial demographic category. Consequently, our understanding of how COVID-19 has impacted this population is limited. However, in California, where data is more readily available, Pacific Islanders were reported to be “dying at a rate that is fourfold their population share and the most disproportionate of any population group within the state” (Wang et al., 2021). Factors like limited language proficiency contribute to this, as they create additional barriers to accessing health care (Wang et al., 2020). Many individuals in this group face higher levels of exposure, working in professions that do not allow them to work from home and commuting on public transportation. These risks were only further exacerbated by a lack of health insurance and other financial safety nets. Additionally, these populations often live in intergenerational residencies where social distancing is not possible (Yee, 2021).

American Indian (US)

Similar to the population groups above, COVID-19 has amplified health inequities in American Indian (AI) communities. These inequities are primarily due to "underfunded and under-resourced health systems, limited access to health services, poor infrastructure and underlying health disparities." (JHU Hub, 2021). According to the CDC, people with heart disease, diabetes, and lung cancer "are 6 times more likely to be hospitalized and 12 times more likely to die due to COVID-19," (Sun, 2020). Native American adults have disproportionately higher rates of many of these health conditions.

For example, according to the Infectious Disease Society of America, Native Americans are three times more likely to be diagnosed with diabetes, fifty percent more likely to be obese, and are more likely to have high blood pressure than non-Hispanic Whites. Similarly, Native American children are sixty percent more likely to have asthma than non-Hispanic White children. These health factors have put this population group at higher risk for serious illness if they contract COVID-19.

"We struggle day to day with an invisibility issue...The only thing most people really understand about our communities is what they get from their middle or high school textbook, which is not much and that's often a really bad narrative." – Erik Stegman (Carry the Kettle First Nation – Nakoda) CEO of Native Americans in Philanthropy (NAP)

Data from the literature review has shown that the cumulative incidence of confirmed COVID-19 cases was 3.5 times higher in indigenous populations and that these groups were "three times as likely to die from the virus" when compared to White Americans," (CDC, 2020). The US Navajo Nation, the largest Indian reservation in the US, "surpassed New York numbers per capita of COVID-19 cases". In surprising contrast to White populations, the AI population had a disproportionate number of COVID-19 cases in those under 18 years of age with 12.9% cases among AI vs 4.3% among the White population (CDC, 2020).

Disruptions in Continuum of Care

Women and Girls (Global)

In a 2020 commentary written in the Maternal and Child Health Journal, researchers concluded that "women experience[d] the most devastating social, economic and health tolls due to the COVID-19 pandemic" (McCloskey et al. 2020). Participants from the GHC community focus group for women reported a significant lack of access to non-COVID-related services such as maternal, neonatal, child, and reproductive healthcare. The literature echoed and supported these statements. In March 2020, the US government called for the halt of nonessential medical procedures and, against the advice of medical experts, including abortion services in that category. This led to an increase in illegal and unsafe

"Women lead as the dominant gender of the healthcare force and women make up a disproportionately greater percentage of the service industry. We know that women have taken on a majority of the impact of COVID-19." – Community Focus Group Participant

abortions, which only further put a strain on the resources needed to fight the pandemic. Other countries faced a steep increase in unintended pregnancies and maternal mortality (McCloskey et al. 2020). In Kenya for example, teen pregnancy rates in some counties tripled in the first months of the pandemic (Filipovic 2022). It soon became clear that the pandemic was being used as an excuse to limit access to critical reproductive health services (McCloskey et al. 2020).

LGBTQI+ Community (Global)

In two GHC hosted community-focus groups, members of the LGBTQI+ community shared challenges in accessing healthcare due to the cessation of non-COVID-19 related health services. For example, HIV prevention, testing, and treatment services were temporarily put on pause or interrupted as resources, healthcare providers, lab technicians, etc. were diverted to COVID-19 services. HIV-positive patients were forced to travel longer distances to access their medical treatment or opt to go without their medications. To avoid stigma and discrimination, some of these patients were already traveling outside of their communities to access HIV medications, but lockdown policies this option nearly impossible. HIV-positive patients were not initially considered a priority group for vaccination which made high-risk patients even more vulnerable to contracting COVID-19 and experiencing disease severity. Additionally, a significant reduction in sexually transmitted disease (STD) testing, created a false reduction in STD cases.

The literature review supported many of these experiences. In a 2020 study among Latinx sexual minority men and transgender women, 33 percent of participants reported disruptions in Pre-Exposure Prophylaxis (PrEP) while transgender women reported significant delays in gender-affirming care. Additionally, 35 percent of participants reported generally receiving less medical care than usual and 78 percent reported worsening mental health (MacCarthy et al. 2020).

Youth (Global)

The pandemic has impacted youth in ways that could follow them across the life course. Disruptions in immunization services due to a lack of available health works and other resources as well as parents' fear of contracting COVID-19 at a healthcare facility have reduced the rate of childhood vaccination. This has put "at least 80 million children at risk of contracting vaccine-preventable diseases" (WHO, 2020).


Photo Credit: UNICEF

Increased Gender-Based Violence

Women and Girls (Global)

Lockdown policies contributed to a striking increase in gender-based violence (GBV), mental stress, and poor mental health among women and girls. Both the literature and the focus group participants reported that this increase in GBV, other household stressors, and poverty when coupled with the childcare obligations and a lack of adequate social support have made females more vulnerable to major depressive disorders and anxiety than men during the pandemic (Pinchoff et al., 2020). In many developing countries, women were also left behind in telehealth initiatives and vaccine registration due to lack of access to digital devices.

LGBTQI+ Community (Global)

"People who already are not treated well in the context of a public or even sometimes private healthcare system are [going to] be already reluctant to [access healthcare] unless they are absolutely in an urgent situation... Even people exhibiting COVID symptoms were reluctant to put themselves in a context where they might not be treated respectfully." - Community Focus Group Participant

Participants from the GHC community focus group shared that gendered policies during lockdown and triage made transgender individuals even more vulnerable. People living on the streets, especially transgender people, were forced indoors into unsafe and violent home environments. Members of the queer community also reported being scapegoated and blamed for the pandemic by secular organizations and community leaders, leading to an increase in violence against the LGBTQI+ community. This also contributed to this community's avoidance of the healthcare system.

Youth (Global)

As mentioned in the section above, lockdown policies and school closures have led to a loss of safe spaces. Community focus group participants shared how many children and youth experienced an increase in violence at home, yet were rarely in a position to report violence, abuse, and harm, especially during a pandemic where social services are scarce. In addition to increased home-based violence, school closures have resulted in an uptick in childhood marriage and early pregnancy. These issues have been further compounded by the reduction in access to family planning and reproductive health

"It is estimated that 10-16 million children are at risk of not returning to school due to economic impacts of COVID-19 alone. Parents may pull children out of school to work, or they may be forced into early marriage." – Save the Children and UNESCO

This also left adolescent girls responsible for managing and caring for children and their households during a public health emergency. These impacts, among others, have contributed to the rapid increase in mental health problems among youth (Singh et al., 2020).

Rising Mental Health Problems

Black and Latino (US)

Although the rate of behavioral issues among Blacks and Latinos does not differ from the general population, they have significantly less access to mental health services (SAMSHA, 2020). For example, while Blacks and Latinos have similar rates of opioid misuse as the general population, Blacks have experienced the greatest increase in rates of overdose deaths from opioids (SAMHSA, 2020). This can be attributed to Blacks' and Latinos' limited access to prevention, treatment, and recovery services for substance use disorders. In addition, due to the historical medical mistreatment of this community, the Black population is more vulnerable to COVID-19 induced psychological distress (along with distrust of vaccines and other treatments) than other population groups. Because

of the lack of access to mental health care and high rates of posttraumatic stress disorders, policymakers and healthcare providers need to prepare for and address the increased mental health needs of Black Americans in the aftermath of COVID-19," (Novacek et al., 2021).

American Indian (US)

Our therapists were inundated...I think the pandemic has definitely triggered this historical trauma that Native people do experience."- Adrianne Maddux, Executive Director at Denver Indian Health and Family Services

In an October 2021 poll conducted by NPR, seventy-four percent of American Indian and Alaskan Natives (AN) reported that someone in their household has struggled with depression, anxiety, stress, and sleep problems due to the COVID-19 pandemic. This translates into three out of four Native American households reporting mental health-related problems. Similar to the Black population, the Native American population suffers significant posttraumatic stress due to historical inequities, violence, and discrimination against this population. As the Native American population continues to address historical traumas, the COVID-19 pandemic has only exacerbated stress, leading to an increase in rates of anxiety, depression, and post-traumatic stress disorder. This increase is highlighted by the Denver Indian Health and Family Services Primary Health Care Clinic. Providers are seeing an increase in demand for behavioral health services including addiction treatment.

LGBTQI+ Community (Global)

Research has shown that sexual gender minority populations had a "significantly higher proportion of depression and anxiety scores exceeding the clinical concern threshold" (Moore et al., 2021). Many of these individuals rely heavily on social support systems, which were impacted by lockdown and social distancing policies.

Photo Credit: Adobe Creative Cloud

Youth (Global)

Youth participants from our community focus groups reported that COVID-19 has had the greatest impact on their mental health. Quarantine, Isolation, and lockdowns have kept youth from socializing with their schoolmates, friends, and family. Youth feel isolated, depressed, and anxious, yet often do not feel empowered to talk about their mental health because it is either taboo or not a priority given the death toll of the pandemic. Loss of employment and family income has also left Youth with the responsibility to work to sustain their families, only further exacerbating rising rates of anxiety and depression. Lastly, as education went virtual, youth are spending more time in online communities where they experienced higher rates of cyberbullying.

"Youth are suffering in silence to depression, anxiety, and overall mental health issues that they do not feel empowered to talk about amidst a pandemic." - Community Focus Group Participant

People Living with Disabilities (Global)

The pandemic has also taken a toll on the mental health of people living with disabilities. Separated from their family, friends, aids, and therapists, disabled people felt isolated during lockdowns, especially since most were unable to fully utilize virtual platforms. Without their aids and support, families of disabled individuals felt overwhelmed. Parents took on full-time caregiving roles while also stepping into other roles as special educators, speech therapists, behavior therapists, and more. This led to an increase in rates of depression and suicide among disabled individuals as they began to feel like more of a burden to their families (Baumer, 2021). Similar to other marginalized groups, disabled individuals also experienced an increase in domestic violence as lockdowns isolated them with their abusers, further adding to the burden on their mental health.

Lack of Accessibility and Inclusion

People Living with Disabilities (Global)

People living with disabilities have experienced devastating impacts as a result of the pandemic. Many people with disabilities are at increased risk of contracting COVID-19 or severe COVID-19, not only due to their chronic conditions, but also behavioral limitations. For example, a person with autism or other intellectual disabilities will have a more difficult time practicing preventive measures such as wearing a mask, social distancing, and handwashing (Baumer, 2021). In the US, 44 percent of people living with disabilities that were Medicare beneficiaries reported that they did not receive adequate food and other social support services during the pandemic. This and other systemic social inequities have also resulted in a higher likelihood of living in congregate settings, further increasing the potential to contract and spread the disease (Friedman, 2021).

"The gains we had on human rights really got washed away by the immediate pandemic response. People are saying it is too hard to look at persons with disabilities, we don't have the resources. I think this excuse should not be allowed anymore." - Community Focus Group Participant

Disruptions in Education and the Workforce

Black and Latino (US)

Beyond the glaring health inequities, Black and Latino population groups also shouldered a disproportionate level of financial hardship. According to a 2021 poll by the Harvard T.H. Chan School of Public Health, more than 55 percent of Black and Latino households reported serious financial problems compared to 29% of White households (Wamsley, 2021). The racial wealth gap, fueled by years of systemic marginalization, has resulted in a lack of liquid assets and financial safety nets. While 19 percent of US households reported draining their savings to stay afloat during the COVID-19 pandemic, for Black households that number was a staggering 31 percent (Wamsley, 2021).

Asian and Pacific Islander (US)

Asian and Pacific Islander populations experienced harsh economic impacts due to lock-down policies as many of these individuals work in restaurants, salons, housekeeping, factories, and construction. In many cases, these jobs do not offer paid sick leave and/or went out of business, leaving this group facing widespread unemployment (Yee, 2021). Also important to note, due to the origin of COVID-19, there was a steep increase in racially motivated violence ranging from racist tirades and rants to assaults and brutal stabbings (Wang, 2020).

Women and Girls (Global)

Women represent 70 – 80 percent of the health workforce. This means that the lack of PPE, burnout and mental health strain that health workers have faced during this pandemic have predominantly affected women. Globally, community health workers have been left out of official government response strategies. Thus, in ignoring the needs, recommendations, and experiences of these health workers, we are ignoring the voices of women.

"In developing nations, the pandemic is undermining decades of progress in young women's education and health." - Jill Filipovic, Author of The Lost Girls of COVID

Disruptions in education have also negatively impacted both women and girls. With increasing rates of unemployment and illness, women and girls were expected to leave school to seek employment to sustain their households. Many schools either shut down or went remote during government lockdowns. Students who did not have access to technology or the internet were unable to attend virtual classes. Many female students were also unable to continue their education due to sweeping unemployment rates that prevented their families from being able to afford school fees.

The sobering reality is that once lockdowns were lifted, many women and girls did not return to school. In Kenya, researchers found that this population group did not return to school not only due to cost, but also unplanned or early pregnancy (Filipovic, 2022). The consequences of leaving school prematurely are steep. Women and girls who leave school are at elevated risk for childhood marriage, female genital mutilation, early pregnancy, and a decreased lifetime earning potential – further widening the poverty gap between men and women. (Filipovic, 2022).

LGBTQI+ Community (Global)

Equally important are some of the economic and social impacts this population group has faced. In the 2020 study by MacCarthy mentioned above, half of the participants reported losing their job during the pandemic. Participants in the GHC community focus groups emphasized the impact lockdown policies had on LGBTQI+ sex workers, especially those who are transgender. Because sex workers are not recognized as legitimate workers in many countries, they were consequently left out of unemployment benefits and assistance. Many of these individuals had limited opportunities in other work due to discrimination, education, etc. As such, various transgender sex workers were pushed to accept low-wage positions in hostile and unsafe work environments.

Youth (Global)

School closures have and will continue to negatively impact education among Youth. Community focus group participants emphasized how virtual learning has left a large portion of youth behind, as many do not have access to the technology or internet required for virtual learning. In September 2021, the United Nations (UN) estimated that "for the first time in history, about 1.5 billion children were out of school…, with at least a third unable to access remote learning". In places like sub-Saharan Africa, this has created a growing fear over "a lost generation of learners" (Davies, 2021).

People Living with Disabilities (Global)

School closures also negatively impacted people with disabilities, as many online/virtual learning platforms were inaccessible. According to our community focus group participants, many disabled people lost their jobs during the pandemic and in some countries, were not asked to return to work when employers reopened their businesses. In India, government work subsidies were scaled back during the pandemic. Some individuals were even questioned over their disability status and those who had received disability payments prior to the pandemic were deemed ineligible for additional COVID-19 relief payments.

Photo Credit: WHO

Recommendations

In each community focus group, participants discussed recommendations for how governments and other stakeholders can address the impacts of COVID-19 and better support marginalized communities. Much of the literature GHC reviewed also shared thoughts and perspectives on these topics. Based on our discussions and findings, GHC developed the following recommendations.

Address Racial and Health Inequities

Governments must directly address structural racism, which results in health, economic, and social inequities. The COVID-19 pandemic has revealed the racial inequities that have always existed and have now been exacerbated, both in the US and globally, by this pandemic. Addressing racial inequities will require a culture shift. While achieving systemic change will take time, we must begin to action this goal with steps like increasing the collection, disaggregation, and sharing of health data to learn about racial inequity (what it is, what it looks like, and how society continues to perpetuate the problem) and how to address the problem. It is not enough to monitor the health and health resources needed for the general population. To achieve health equity, it is key to gather data that allows for routine comparisons between more and less advantaged population groups (Braveman et al., 2017). Although health indicators for "average levels of health are important…they can hide large disparities among subgroups of people" (Braveman et al., 2017).

Ensure the Continuum of Care

Governments must ensure the continuum of care of all other essential health services during a public health emergency. While it is important to funnel resources into a pandemic response, governments cannot do so by jeopardizing and diverting resources from other essential health services. Governments should have a reserve or pandemic fund set aside to ensure the sustainability, access, and quality of essential health services during a public health emergency.

Combat Gender and Home-Based Violence

Governments need to talk about and address the increase in gender and home-based violence. Included in those conversations should be violence against the LGBTQI+ community. Law enforcement officials, social workers, and other first responders should be trained in how to identify and report GBV. Governments should provide survivors of GBV with the necessary health, social, and economic support needed to treat the impacts of violence. Governments should also strategize with other Civil Society Organizations (CSOs), Non-Governmental Organizations (NGOs), and the media to amplify the voices of women, girls, the LGBTQI+ community, youth, and people living with disabilities who are survivors of violence.

Support Mental Health

Governments and stakeholders must prioritize and fund mental health. Mental health appears as a major impact across all population groups in this review. The WHO estimates that aside from the human costs of mental health disorders, mental health problems "cost the global economy $1 trillion each year…[and] notes there is a return of $5 for every dollar invested in treating these conditions" (Schlein, 2021).

Ensure Accessibility and Inclusion

All public health strategies must be accessible and inclusive to people with disabilities. There are 1 billion people with disabilities in the world. About 1 in every 7 people has a disability (Inclusive Futures, 2021). As our data shows, people with disabilities are also more likely to develop severe illness. Governments should ensure they are collecting data about people with disabilities and are involving this community in their policy design to ensure that people with disabilities can access services, especially during a pandemic (Inclusive Futures, 2021).

Protect Education and the Workforce

Governments must provide economic protections and security to the most vulnerable populations. This is particularly important if the pandemic response includes lockdown policies and stay-at-home orders. In countries where there is a significant number of people working in the informal workforce, this type of containment strategy can have detrimental long-term health, social and economic effects.

Photo Credit: Flickr/UN Women Asia and the Pacific

Closing

To create effective health policies and programs related to the recommendations in this paper, governments and stakeholders should actively engage and fund civil society organizations and communities in pandemic planning and response strategies. One of the most impressive findings from the literature review and community focus groups are the heroic efforts civil society organizations and communities have made to address the serious inequities and gaps minority and marginalized populations faced during the pandemic. Yet despite being a valuable resource, CSOs continue to remain uninvolved in national emergency response plans. In a 2020 study of civil society participation in the COVID-19 response, civil society organizations have stepped in to provide the following services to minority and marginalized populations:

1. Implementing communications programs on prevention, testing, and treatment of COVID-19
2. Ensuring continuity of other non-COVID related care in health facilities
3. Distributing resources and supplies (including soap, water, food, PPE, etc.)
4. Advocating for the community (prioritizing vulnerable groups, increasing access to information and care, etc.)

Civil society and communities understand the needs of their populations, particularly those population groups most left behind. Through their work, they have gained the trust of these populations, which can lead to the successful and effective implementation of pandemic response strategies.

Secondly, governments and other stakeholders must increase the representation of women in pandemic response and recovery teams. While no one was immune to the devastation of the COVID-19 pandemic, the experience was not universal. Thus far women have shouldered much of the health, social and economic impacts of this disease. Yet women have been barely included in the national pandemic response. There must be more female representation in pandemic policy development and implementation (Rajan et al., 2020). Women's voices must be heard, respected, and prioritized to properly respond to the health, social, and economic welfare of our populations.

Thirdly, our community focus groups revealed the critical role young people play in the dissemination of COVID-19 related information to their families, elders, and communities. Because many young people have more experience accessing knowledge and tools through social media channels and other online platforms, they have become a source of information for other generations in their families. Moreover, Youth are often responsible for taking family members to health facilities and in many cases translating for their families during health visits. Thus, investing in developing youth advocates by educating them in prevention, testing, treatment, and rehabilitation is an important public health response, particularly to help combat intergenerational hesitancy and distrust of the medical system and government.

Lastly, no one can deny the link between Universal Health Coverage (UHC) and pandemic preparedness. UHC means that ALL people have access to quality health services (including promotion, prevention, treatment, rehabilitation, and palliative care) when they need it without suffering financial hardship (WHO, 2021b). Governments must commit to and invest in UHC. To achieve UHC, governments should engage with civil society organizations and communities to understand their populations' needs and the persisting health system gaps. They must invest more money in primary healthcare, healthcare workers, health infrastructure, and essential health services. Without UHC, minority and marginalized populations will continue to experience

devastating health, economic, and social inequities hindering the global health community's ability to achieve its goals.

Methods

Global Health Council (GHC) conducted a literature review of articles, editorials, peer-reviewed journals, and opinion pieces focused on the impacts of COVID-19 on minority and marginalized communities from March 2020 to December 2021. Keywords used for this literature search included, but were not limited to: COVID-19, disparities, health, marginalized, minority, impacts, inequities, pandemic response, women, gender, race, Latino, indigenous, Asian, youth, immigrants, refugees, LGBTQI+, global, US and civil society and communities. In addition to the literature review, Global Health Council, in collaboration with its members and global partners, conducted seven virtual community focus groups with civil society organizations, Youth (in both English and Spanish speaking countries), women, the LGBTQI+ community (in both English and Spanish speaking countries), and people living with disabilities. These focus groups ranged from 10 – 15 participants from each population group. The discussions captured their first-hand accounts and lived experiences of the COVID-19 pandemic.

Limitations

This research only includes information on the aforementioned populations' groups. There are other minorities and marginalized population groups that were not included in this study. The research covers the period between March 2020 – December 2021. As the COVID-19 pandemic continues to quickly evolve, the results of this study may not include the most recent qualitative and quantitative data. Because of this short period and small research team, the GHC had limited time to review all the literature available and thus may have inadvertently excluded certain data. Due to time constraints, availability of participants, and budget, GHC was not able to conduct community focus groups with every population group mentioned in this study. Lastly, because the number of participants in our community focus groups was small, the data from the community focus groups are not generalizable. However, the personal accounts do provide context, life to numerical data, and examples of what many of these population groups are experiencing during this pandemic.

"There's so much more than the data points we present to truly understand COVID-19" – Community Focus Group Participant

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