

Analysis

Focused action is required to protect ethnic minority populations from COVID-19 post-lockdown

BACKGROUND

Since the association between COVID-19 and ethnicity was first noted in April 2020,¹ numerous large-scale national datasets have been analysed.²⁻⁶ The evidence is clear – ethnicity is a key risk factor for adverse COVID-19 outcome, alongside age, male sex, obesity, deprivation, and comorbidities.⁷ There are significant ethnic inequalities in the risk of admission to hospital and risk of death from COVID-19. Black and South Asian ethnic groups are at greatest risk, although most ethnic minorities have been shown to have increased risk when compared with white populations.⁷ Beyond admission to hospital and mortality risk, there is also concern over longer-term impacts, that is, post-acute COVID-19,⁸ which could significantly impact ethnic minority populations.

As a result, Public Health England (PHE) released two evidence reviews and recommendations to address the disparities in COVID-19 outcomes in ethnic minority populations.^{9,10} PHE made only seven recommendations and these were lacking in detail, featuring issues that were already well articulated in minority health literature. The recommendations gave limited attention to the wider determinants of health that underpin ethnic disparities in COVID-19 outcomes, and gave no indication of timeframes for delivery or methods of implementation.¹⁰ In addition, the recommendations did not address how ethnic minority populations could best protect themselves during the pandemic. This was a significant oversight because personal and community responsibilities are imperative social determinants to protecting the health and wellbeing of ethnic minority communities when national (and regional) lockdown is eased.

Subsequent to the PHE report there was an inevitable resurgence in COVID-19 cases over the summer months in areas with a high density of ethnic minorities such as Leicester,¹¹ Blackburn, and Oldham. From mid-September, local COVID-19

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restrictions were introduced across parts of the North West, North East, Midlands, and West Yorkshire. As cases rose nationally, a growing list of localities were placed in a three-tiered restriction system, before a second nationwide lockdown was implemented from 5 November in England. In late October the UK government published a summary of work completed since the initial PHE reports, and a further 13 recommendations for addressing COVID-19 health inequalities.¹² Like the initial PHE report there was limited attention on wider structural determinants of inequality in COVID-19 outcomes, and the recommendations are largely related to data monitoring, evidence reviews, and broad policy consideration. However, importantly the government has made headway in enhancing community communication strategies (for the most at risk) with the introduction of the new Community Champions scheme.

A CAUTIONARY TALE FROM LEICESTER

When England initially began to lift out of lockdown from 4 July 2020, restrictions were continued in the city of Leicester from 30 June, thus making Leicester the first city in England to have lockdown measures re-imposed. These restrictions included the continued closure of schools (although this was lifted from 24 July), pubs, and restaurants, non-essential travel restrictions, and meetings with individuals from other households only allowed outdoors. Continued restriction in the city was implemented due to a rise in infection cases in late May, such that Leicester had the highest case count of any

local authority in England in mid-June.¹¹ Despite the local public health response suppressing infection rates throughout the later summer and early autumn, residents of Leicester City, unlike any other region in the UK, have faced some degree of COVID-19 infection control restrictions since 23 March until the time of writing.

There was significant media speculation that local factories (particularly the textile industry) may have contributed to the rise in cases. The narrative was that employers did not implement adequate infection control procedures in the workplace, as well as exploiting workers, many of whom are from minority backgrounds, by not providing paid sick leave to permit self-isolation with suspected COVID-19 symptoms. In addition, celebrations of the religious festival of Eid were suggested to have contributed to a rise in local infection rates. However, these assertions were not borne out in local public health data, and the media coverage (particularly how discouraging visiting friends and family during Eid was discussed) likely increased feelings of stigmatisation and blame in ethnic minority communities within Leicester, and nationally.¹³

The reasons for the marked rise in cases are not clear, although it is likely social deprivation, overcrowded housing, and the multi-ethnic population of the city are key contributory factors. Leicester is one of the most ethnically diverse cities in the UK (almost half of Leicester residents are of non-white ethnicity), and many ethnic minority populations are at greater exposure to COVID-19 due to overcrowded and multi-generational housing. This is supported by data from a retrospective cohort study in Leicester.¹⁴ Ethnic minority populations were found to be over two times more likely to test positive for COVID-19 (both before and after 30 March 2020) than the white ethnic group, and to have a higher number of household residents. Ethnic minorities were still at increased infection risk when household size and a

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Figure 1. Prevention and protection of South Asian communities from COVID-19 (www.sahf.org.uk). Copyright © South Asian Health Foundation. Used with permission.

range of other factors (overlapping biologic and socioeconomic pathways through which ethnicity may have its effect) were statistically taken into account (for example, age, gender, illness severity at presentation, deprivation, estimated household size, and comorbidities).¹⁴ Over-representation in essential occupations such as health and social care,¹⁵ and linguistic, cultural, and social class barriers to accessing public health messaging,¹⁶ could explain this increased risk of infection found in adjusted analyses.

Following the easing of national restrictions, a return to broad lockdown measures in multi-ethnic areas such as Leicester is unlikely to have the anticipated impact as in less diverse communities,¹⁷ because it does not address underlying sociodemographic and cultural factors. Indeed, by 30 July in Leicester, although cases had dropped markedly in the weeks prior, continued restrictions on household meetings were imposed. In addressing the rise in cases in Leicester over the summer, there were calls for improved access to local data, and a much more agile and robust testing system,¹⁸ but there has been much less discussion of specific culturally focused actions that may help mitigate localised flare-ups in infection rate in multi-ethnic locations.

FOCUSED SHORT-TERM MEASURES

Public health messaging on social distancing and isolation etc. has likely had limited reach and been hard to implement in minority communities, especially in cities such as Leicester where many residents are born outside of the UK and there are a wide range of spoken/written languages. Furthermore, the aforementioned media stigmatisation of minority communities may have decreased trust in communications from government and public health authorities. It is crucial that minority communities can access public health information on COVID-19 prevention and control measures (for example, hand washing, social distancing, mask wearing, and so on). This requires adaptation to ensure that appropriate and inclusive messaging is available in a wide range of written and spoken languages, and that it covers culturally relevant measures, for example, faith-based locations, religious rituals and greetings, etc. (see Figure 1 for an example in English). Multiple avenues of spoken and written communication are required to reach across ethnic communities, because health literacy and access to conventional mainstream media cannot be assumed. The government's new Community Champion scheme may well address this issue.

A cornerstone of easing regional or national lockdown restrictions is the delivery of an effective test, trace, and isolate strategy (TTI), but by the time the first national lockdown was due to be eased across the UK, there was not a fully functioning TTI system. The PHE Rapid Investigation Team Report¹¹ shows that most positive cases were tested under the commercial Pillar 2 and there were delays in getting these data to PHE and to local public health teams, which was the case in Leicester. The delivery of timely localised (that is, postcode level) and detailed (that is, broken down by age, gender, and ethnicity) case data would have allowed earlier targeted action, which could have prevented the need for a full-scale city-wide lockdown, and no doubt contributed to a reduced likelihood of the second national lockdown from 5 November.

As part of localised action, TTI will require adapting and targeting for minority communities, without which it may have poor efficacy. Ethnic minority communities are heterogeneous in language, culture, and behaviours, and therefore TTI will need to be aligned to the particular needs of each community. There are also a range of barriers to uptake in past screening programmes among ethnic minorities that may require addressing, such as

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fear and stigma, a lack of knowledge and awareness on screening, beliefs and attitudes, and access issues.¹⁹ Embedding TTI within existing local infrastructure such as community and religious groups and schools may increase trust and support for testing, and take advantage of these groups' knowledge of their local population, languages, and cultural differences.²⁰

With the involvement of public health and infectious diseases specialists, local training and education could be delivered to help facilitate this process and improve knowledge of how best to control local outbreaks.²⁰ When religious and community centres open up again, communication on TTI should be increased with local minority communities, alongside social media, radio, and other means. In addition, there is a clear need for accessible contact tracing (especially for those unable to read/write English), and temporary accommodation or financial provision to isolate those at risk, keyworkers, symptomatic individuals, and the homeless. This will require cooperation from employers, so that individuals who are isolating are paid and do not face financial difficulties. Temporary accommodation facilities have been implemented successfully in other countries, such as in New York, where, at the height of the first wave of the pandemic, thousands of individuals, particularly homeless, were re-located into empty hotel rooms to ensure safety and social distancing.

As ethnic minorities are over-represented in a range of keyworker and healthcare roles, and are more likely to be employed in lower-pay and less secure occupations, they are at increased risk of exposure to COVID-19 and subsequent infection.²¹ To help support self-isolation, increases in statutory sick pay could be implemented (although substantial proportions of minority ethnic populations work in unorganised sectors and on zero hours contracts that make it difficult to access this), as well as widening access to the isolation pay support scheme to include marginalised migrant populations. Also, a substantial proportion of minority ethnic populations are self-employed in the retail sector and

therefore either disadvantaged by the rules on furlough schemes or potentially affected by lockdown requirements.

Further, access to priority testing should be implemented in all (where possible) private and public sector employment for ethnic minorities. In combination, employers should risk assess all staff and take measures to protect them (risk assessment tools to help employees assess workplace and personnel risks are available online).²² Such measures include temporary furlough, modified working practices, working from home, and guaranteeing sick leave will not impact on employment status. The current heterogeneity of risk assessments and risk reduction practices by employers cannot be condoned. In some cases, there is clear breach of health and safety legislation and, even in the NHS, risk assessments differ across organisations.

A BROADER LONG-TERM APPROACH IS ALSO REQUIRED

Although immediate remedial action may mitigate the impact of the current pandemic for ethnic minorities, longer-term planning is required to tackle structural inequality that continues to exist, and will increase vulnerability to future waves of COVID-19 or other such diseases.⁷ Minority populations are partly at greater exposure to the virus because of over-representation in keyworker roles, or precarious and low-paid employment.²¹ As well as increasing exposure to COVID-19, this occupational disadvantage is a determinant of health inequality. A priority in the long term should be to develop a national strategy to identify and remove barriers that constrain entry to higher-income occupations for ethnic minorities, and address bias in the recruitment process.^{23,24} Likewise, ethnic minorities are at increased likelihood of living in overcrowded housing, with multiple generations under the same roof — increasing viral transmission risk. For disadvantaged and ethnic minority communities in future, there is a need for greater investment in new and existing affordable housing and social housing.⁷ In addition, housing providers could take

steps to release larger accommodation through strategies such as rehoming under-occupiers, and incentives for tenants to purchase property in the private sector.⁷

A recent review has stressed the importance of addressing racial equality by implementing race equality strategy developed with ethnic minority communities and with the confidence of all those it affects. The government should implement this with ministerial oversight and accountability.²⁵ In addition, more must be done to provide strong and representative organisational leadership within the NHS, as ethnic minority staff are under-represented in many roles, and there is a distinct need for training of all NHS staff and students on recognising and addressing racism.²⁶

CONCLUDING REMARKS

When countries ease COVID-19 lockdown measures, areas with high proportions of ethnic minorities will again be increasingly vulnerable to localised resurgence of infection if culturally aware/focused public health intervention and infection control measures are not implemented. There is also potential for renewed stigmatisation and scapegoating of ethnic minority communities in the media. In response we have outlined a series of exemplar-focused short-term measures, and broader long-term measures that could help to mitigate the present and future vulnerability of ethnic minorities to COVID-19.

Kamlesh Khunti,

Professor of Primary Care Diabetes and Vascular Medicine, Diabetes Research Centre and Centre for Black Minority Health, University of Leicester, Leicester; Trustee, South Asian Health Foundation.

Ash Routen,

Research Associate, Diabetes Research Centre, University of Leicester, Leicester.

Kiran Patel,

Chief Medical Officer and Consultant Cardiologist, University Hospitals Coventry and Warwickshire NHS Trust, Coventry; Honorary Chair, Warwick Medical School, University of Warwick, Coventry; Honorary Chair, Coventry University, Coventry; Chairman of Trustees, South Asian Health Foundation.

Sarah N Ali,

Consultant in Diabetes and Endocrinology, Royal Free London NHS Foundation Trust, London; Trustee, South Asian Health Foundation.

Paramjit Gill,

Professor of General Practice, GP, Warwick Medical School, University of Warwick, Coventry; Trustee, South Asian Health Foundation.

Amitava Banerjee,

Associate Professor in Clinical Data Science and Honorary Consultant Cardiologist, Institute of Health Informatics, University College London, London; Trustee, South Asian Health Foundation.

Amal Lad,

GP; Trustee, South Asian Health Foundation.

Vinod Patel,

Professor, Diabetes and Clinical Skills, Warwick Medical School, University of Warwick, Coventry; Hon. Consultant Endocrinology and Diabetes, George Eliot Hospital NHS Trust, Nuneaton; Trustee, South Asian Health Foundation.

Wasim Hanif,

Professor of Diabetes and Endocrinology, Consultant Physician, CSL Diabetes, University Hospitals of Birmingham, Birmingham; Trustee, South Asian Health Foundation.

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Kamlesh Khunti is Director of the University of Leicester Centre for Black and Minority Ethnic Health, Trustee of the South Asian Health Foundation, Chair of the Ethnicity Subgroup of SAGE, and Member of Independent SAGE.

ADDRESS FOR CORRESPONDENCE

Kamlesh Khunti

University of Leicester, Diabetes Research Centre
Leicester General Hospital, Leicester LE5 4PW, UK.

Email: kk22@leicester.ac.uk

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