

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

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## **Background**

Since the association between COVID-19 and ethnicity was first noted in April (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 hospitalisation 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 to White populations (7).

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 (8, 9). 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 time frames for delivery or methods of implementation (9). In addition, the recommendations did not address how ethnic minority populations could best protect themselves during the pandemic. This was a significant oversight since personal and community responsibilities are imperative social determinants to protecting the health and well being of ethnic minority communities when national (and potential regional) lockdown(s) 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 (10), Blackburn and Oldham. From mid-September local COVID-19 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 November 2<sup>nd</sup>. 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 (11). 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 July 4, restrictions were continued

in the city of Leicester from June 30 2020, 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 July 24), 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 2020, such that Leicester had the highest case count of any local authority in England in mid-June 2020 (10). 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 March 23<sup>rd</sup> until the time of writing.

There was significant media speculation that local employers (particularly in textile factories) may not have implemented adequate infection control procedures in the work place, as well as exploiting workers, many 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 al-Adha (July 30-August 3), 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 (12).

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 multigenerational housing. This is supported by data from a retrospective cohort study in Leicester (13). Ethnic minority populations were found to be over two times more likely to test positive for COVID-19 (both pre-and three weeks into the initial UK lockdown) 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 range of other factors were statistically taken into account for (e.g. age, gender, illness severity at presentation, deprivation, estimated household size and comorbidities (13). Overrepresentation in essential occupations such as health and social care (14), and linguistic, cultural and social class barriers to accessing public health messaging (15) could explain this increased risk of infection found in adjusted analyses.

Following the easing of national restrictions, a return to broad lockdown measures in multiethnic areas such as Leicester is unlikely to have the anticipated impact as in less diverse communities (16), because it does not address underlying sociodemographic and cultural factors. Indeed by July 30 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, there have been calls for improved access to local data, and a much more agile and robust testing system (17), but there has been much less discussion of specific culturally focused actions that may help mitigate localised flare-ups in infection rate in multiethnic 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/writing languages. Furthermore, the aforementioned media stigmatization 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 (e.g. hand-washing, social distancing, mask wearing etc.). 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 e.g. faith based locations, religious rituals and greetings etc. (See Figure 1 for an example in English). Multiple avenues of spoken and written communication is required to reach across ethnic communities, since 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 Public Health England (PHE) Rapid Investigation Team Report (10) 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 (i.e. postcode level) and detailed (i.e. 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 lock down, and no doubt contributed to a reduced likelihood of the second national lockdown from November 2nd.

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 fear and stigma, a lack of knowledge and awareness on screening, beliefs and attitudes, and access issues (18). 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 (19).

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 (19). 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, key workers, 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 overrepresented in a range of key worker and health care roles, and are more likely to be employed in lower pay and less secure occupations, increasing risk of exposure to COVID-19 and subsequent infection (20). 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), as well as widening access to the isolation pay support scheme to include marginalized 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](#)). 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**

While immediate remedial action may mitigate exposure to 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 overrepresentation in key worker roles, or precarious and low paid employment (20). 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 national strategy to identify and remove barriers that constrain entry to higher income occupations for ethnic minorities, and address bias in the recruitment process (21, 22). 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 implanting Race equality strategy developed with ethnic minority communities and with the confidence of all those it effects. The government should implement this with ministerial oversight and accountability (23). 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 (24).

### **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.

**For figure 1 – see attached image file. Caption: Prevention and protection of South Asian communities from Covid-19 ([www.sahf.org.uk](http://www.sahf.org.uk)).**

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### **Contributors and sources**

All authors conceived the idea for the article and the recommendations that form the basis for the article. KK and AR led on drafting, editing and revising the content. All other authors contributed to editing the content, and all authors approved the final version and are accountable for all aspects of this work.

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### **Conflicts of Interest**

We have no relevant conflicts of interest to declare. KK is director of the Centre for Black and Minority Ethnic Health, University of Leicester, and is a trustee of the charity South Asian Health Foundation and co-chair of their Diabetes Working Group.

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