



Submission of evidence  
on the disproportionate  
impact of COVID 19, and  
the UK government  
response, on ethnic  
minorities and women in the UK



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## Summary

- People from ethnic minority backgrounds are more likely to work in higher risk occupations and are at higher risk of infection during the COVID-19 pandemic
- Over 50% of frontline staff/key workers are people from ethnic minority backgrounds.
- Health professionals from ethnic minority backgrounds have been disproportionately affected by the COVID-19 virus through illness and death
- Scarcity and unreliability of PPE sources for frontline staff/key workers disproportionately puts people from ethnic minority backgrounds at higher risk of infection and death due to COVID-19
- Current clinical guidance exacerbates existing health inequalities, which will result in more deaths of people from ethnic minority backgrounds
- Guidance on protecting frontline staff/keyworkers is urgently needed to minimise the disproportionately higher rate of deaths among people from ethnic minority backgrounds.
- Women are further disadvantaged by lockdown measures and the restrictions they place on access to health and social services.

## Introduction

In this submission, we discuss why women and people from ethnic backgrounds (BAME) are, and will be, negatively affected by the COVID-19 virus and the government response. We describe how COVID-19 exacerbates underlying health inequalities. We highlight how existing medical guidance compound these inequalities by failing to take them into account. We discuss the negative effects that pandemic measures have had on women, in particular women asylum-seekers and women seeking reproductive health services. Finally, we present recommendations for short and long-term change to the pandemic response to avoid further harm and discrimination of people with these protected characteristics.

## 1. Ethnicity and COVID-19

The relationship between ethnicity and patients with COVID-19 is one that requires further in-depth investigation. As of April 24<sup>th</sup> 2020, the Intensive Care National Audit and Research Centre has reported that 35% of patients critically ill with confirmed COVID-19 are from the BAME population in Britain<sup>1</sup>. This is disproportionately high given that BAME groups currently comprise only 14% of the UK population<sup>1</sup>. A disproportionate number of people from the UK's BAME communities are also dying from COVID-19<sup>2</sup>. The questions raised by these numbers are not about ethnicity as such. Instead, they speak to fundamental health inequalities influenced by socio-economic position<sup>3</sup> and raise deeper questions relating to the interactions between ethnicity, living conditions, occupation, ambient air quality, cardiovascular health, health literacy, area deprivation, relative economic disadvantage, and poverty.

## 2. Exposure and Infection

**2.1 Living Conditions** People from BAME backgrounds are more likely to live in densely populated urban areas, where it is more difficult to practice prevention measures such as social distancing to avoid infection. Black (98.1%) and Asian (97.4%) minority groups are more likely to live in urban locations than the white population (79.1%), making them more susceptible to infection than the white population<sup>4</sup>. For some BAME groups, household composition also makes it more difficult to socially isolate effectively, which may increase exposures to high doses of the virus. For example, Asian households make up 21% of “other” households with a multi-generational family<sup>5</sup>. In addition, BAME groups are more likely to live in overcrowded households. The rate of overcrowding for Bangladeshi, Pakistani, and Black

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<sup>1</sup> Intensive Care National Audit and Research Centre. 2020. ICNARC report on COVID-19 in critical care. (Accessed April 28<sup>th</sup>, 2020. <https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports>)

<sup>2</sup> Barr, C., N. Kommenda, McIntyre, N. and Voce, A. 2020. Ethnic minorities dying of Covid-19 at higher rate, analysis shows. *The Guardian*, 22nd April.

<sup>3</sup> Nazroo, J. Y. 2003. The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *American journal of public health* 93(2): 277-284.

<sup>4</sup> Office for National Statistics 2019. UK Population by Ethnicity: Age Groups. London, ONS.

<sup>5</sup> Office for National Statistics 2011. England and Wales 2011 Census. London, ONS.

African households were 30%, 16% and 15% respectively<sup>6</sup>. The rate of overcrowding for all BAME groups (range 3%-30%) is higher than in White British households 2%.

**2.2 Occupation** People from BAME backgrounds are over-represented in higher-risk, person-facing occupations. Doctors from BAME backgrounds represent around 40% of the existing medical workforce in the UK<sup>7</sup>. As of 21<sup>st</sup> April, an estimated 64% of COVID-19 related deaths were healthcare workers from BAME backgrounds<sup>8</sup>. Broken down by major professions, 71% of nurses, 56% of support staff and 94% of doctors/dentists who had died from COVID-19 by this date were from ethnic minority backgrounds<sup>8</sup>. In addition, BAME workers are over-represented in the transport and distribution, and retail sectors<sup>9</sup>. Employees from these sectors have continued to work and interact with the public throughout the pandemic. Analysis of COVID-19 related deaths among BAME groups within these sectors is undeveloped.

**2.3 Social security** The current legal challenge by the Independent Workers Union of Great Britain over sick pay and wage protection for precarious workers<sup>10</sup> highlights key gaps in government measures to financially support workers, and suggests that work insecurity is likely to increase pressure on workers to continue working even where they are unable to practice social distancing. According to a recent analysis by the Trades Union Congress, BAME workers are over a third more likely than white workers to be in temporary or zero hours work. One in eight black workers is in these forms of work, compared to one in 20 white workers<sup>11</sup>. Workers without paid sick leave beyond the statutory minimum are more likely to continue to work even when they have symptoms associated with COVID-19. This can increase workers exposure to other workers who may have COVID-19, or, in turn, expose others if they themselves have COVID-19, due to economic pressures to continue earning.

### 3. Underlying Health and Living Conditions

**3.1 Heart health** Ischaemic heart diseases were the most common main pre-existing condition in COVID-19 deaths occurring in March 2020<sup>12</sup>. Cardiovascular disease has a higher prevalence in three ethnic minority groups well represented in the British population: South Asian, African and African Caribbean<sup>13</sup>, thus disproportionately affecting the clinical outcomes

<sup>6</sup> Ministry of Housing 2015, 2016 and 2017. English House Survey. London, Ministry of Housing, Communities and Local Government.

<sup>7</sup> Nagpaul, C. 2020. The disproportionate impact of covid-19 on ethnic minority healthcare workers. The BMJ Opinion. [https://blogs.bmj.com/bmj/2020/04/20/chaand-nagpaul-the-disproportionate-impact-of-covid-19-on-ethnic-minority-healthcare-workers/?utm\\_source=twitter&utm\\_medium=social&utm\\_term=hootsuite&utm\\_content=sme&utm\\_campaign=usage](https://blogs.bmj.com/bmj/2020/04/20/chaand-nagpaul-the-disproportionate-impact-of-covid-19-on-ethnic-minority-healthcare-workers/?utm_source=twitter&utm_medium=social&utm_term=hootsuite&utm_content=sme&utm_campaign=usage) (Accessed April 21<sup>st</sup>, 2020)

<sup>8</sup> Cook, T., E. Kursumovic and S. Lennane. 2020. Exclusive: deaths of NHS staff from covid-19 analysed. Health Service Journal, 22.04

<sup>9</sup> McGregor-Smith, R. 2017. Race in the Workplace: The McGregor-Smith Review. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/594336/race-in-workplace-mcgregor-smith-review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/594336/race-in-workplace-mcgregor-smith-review.pdf)

<sup>10</sup> Independent Workers Union of Great Britain. 2020. Legal challenge: Sick pay and wage protection for precarious workers. <https://iwgb.org.uk/page/support-our-campaign> (Accessed April 24<sup>th</sup>, 2020).

<sup>11</sup> Trades Union Congress. 2017. The Gig is Up. London, Trades Union Congress.

<sup>12</sup> Office for National Statistics, 2020. Deaths involving COVID-19, England and Wales: March 2020. London, ONS.

<sup>13</sup> British Heart Foundation. <https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity/south-asian-background> (Accessed April 21<sup>st</sup>, 2020).

of these groups due to ethnicity. The relationship between ethnicity and socio-economic status also suggests that more people from ethnic minority backgrounds who are also of low-income households are more likely to be at risk of poor health outcomes during the pandemic. For example, richer South Asian people have low rates of cardiovascular disease; however, poorer South Asian people continue to be at higher risk<sup>14</sup>.

**3.2 Poor air quality** Recent research indicates the existence of an association between ambient air quality and COVID-19 related deaths<sup>15,16</sup>. There is an existing association between area deprivation and ambient air quality<sup>17,18</sup>. A recent analysis by Public Health England, which ranked areas in England into deciles of deprivation, found that 50% of the Pakistani population, 54% of the Bangladeshi population, 45% of the Black African population and 46% of the Other Black population lived in areas falling within the two most deprived deciles<sup>19</sup>. Further research exploring associations between air pollution, socio-economic characteristics, and ethnicity confirms this relationship<sup>17</sup>.

**3.3 Asthma** Several studies have indicated higher rates of asthma among BAME groups<sup>20,21</sup>, which reflects their over-representation in more deprived areas with higher rates of ambient air pollution<sup>22,23</sup>. A strong relationship exists between ethnicity, socio-economic status and complications arising from asthma. One study of hospital admissions in the West Midlands, for example, found that BAME groups, particularly those of lower socio-economic status, had higher asthma-related hospital admission rates than the white population<sup>24</sup>. Severe asthma is currently one of the risk criteria for COVID-19 requiring individuals to shield for a minimum of 12 weeks<sup>25</sup>, and can lead to hospitalisation requiring critical care if these individuals fall ill with the virus.

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<sup>14</sup> Nazroo, J.Y. 2001. South Asian people and heart disease: an assessment of the importance of socioeconomic position. *Ethnicity and Disease*, 11(3): 401-411.

<sup>15</sup> Ogen, Y. 2020. Assessing nitrogen dioxide (NO<sub>2</sub>) levels as a contributing factor to coronavirus (COVID-19) fatality. *Science of The Total Environment*, 726: 138605.

<sup>16</sup> Travaglio, M., R. Popovic, Y. Yu, N. Leal and L. M. Martins 2020. Links between air pollution and COVID-19 in England. medRxiv.

<sup>17</sup> Fecht, D., P. Fischer, L. Fortunato, G. Hoek, K. de Hoogh, M. Marra, H. Kruize, D. Vienneau, R. Beelen and A. Hansell (2015). Associations between air pollution and socioeconomic characteristics, ethnicity and age profile of neighbourhoods in England and the Netherlands. *Environmental Pollution*, 198: 201-210.

<sup>18</sup> Brunt, H., J. Barnes, S. J. Jones, J. W. S. Longhurst, G. Scally and E. Hayes. 2016. Air pollution, deprivation and health: understanding relationships to add value to local air quality management policy and practice in Wales, UK. *Journal of Public Health*, 39(3): 485-497.

<sup>19</sup> Public Health England. 2017. Public Health Outcomes Framework: Health Equity Report. London, Public Health England.

<sup>20</sup> Netuveli, G., Hurwitz, B. & Sheikh, A. 2005. Ethnic variations in incidence of asthma episodes in England & Wales: national study of 502,482 patients in primary care. *Respiratory Research* 6, 120.

<sup>21</sup> Sheikh, A., Steiner, M.F.C., Cezard, G. et al. 2016. Ethnic variations in asthma hospital admission, readmission and death: a retrospective, national cohort study of 4.62 million people in Scotland. *BMC Medicine* 14, 3.

<sup>22</sup> Guarnieri, M. and Balmes, J. 2014. Outdoor air pollution and asthma. *Lancet*. 383(9928):1581-92.

<sup>23</sup> Cai, Y., Zijlema, W.L., Doiron, D., et al. 2017. Ambient air pollution, traffic noise and adult asthma prevalence: a BioSHaRE approach. *European Respiratory Journal*. 49 (1) 1502127.

<sup>24</sup> Githorpe, M. S., R. Lay-Yee, R. C. Wilson, S. Walters, R. K. Griffiths and R. Bedi. 1998. "Variations in hospitalization rates for asthma among black and minority ethnic communities." *Respiratory Medicine*, 92(4): 642-648.

<sup>25</sup> <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19> (Accessed April 24<sup>th</sup>, 2020)

## 4. Existing Guidance on Clinical Care and Frontline Staff Safety

4.1 *Decision-tools for Treatment* Research into decision-tools for treatment during pandemics have found that when emphasis is placed on long-term survival and co-morbidity to determine priority of care, these decision-tools disproportionately disadvantage people from ethnic minority backgrounds<sup>26</sup>. BAME groups are more likely to have a higher incidence of many of the health conditions used in these decision-tools to decide if critical care is appropriate. For example, in population terms, people of South Asian background are at a higher risk of cardiovascular problems, such as angina<sup>27</sup>. In their “Information to support decision making” during the pandemic, N.I.C.E. focuses on mortality in cardiovascular co-morbidities, explicitly naming angina as a co-morbidity that could be used to determine whether escalation to critical care is appropriate for COVID-19 patients<sup>28</sup>. The focus on cardiovascular co-morbidities is just one example of how BAME groups will not receive the same care as white British patients if existing guidance fails to take account of the relationship between ethnicity and health. Any guidance on clinical decision-making during the pandemic must mitigate the relationship between ethnicity, health and COVID-19, to ensure that it does not simply exacerbate existing structural disadvantages faced by BAME patients<sup>29,30,31</sup>.

4.2 *Frontline NHS and Social Care Staff* Currently the safety of NHS and social care staff from ethnic minority groups relies on guidance for PPE that does not account for their increased risk of contracting COVID-19. Due to a shortage of sufficient and appropriate PPE across the country, all staff are potentially working in unsafe environments; however, frontline staff from ethnic minority backgrounds carry a great risk. Reporting on lack of PPE and a safe working environment current relies on individuals speaking out on issues of concern, and reporting shortages to superiors. This may be more difficult for staff from BAME groups, as previous work by the BMA has found that BAME doctors are twice as likely not to speak out about workplace safety concerns, as they do not feel secure enough to do so, further compromising the safety of this already potentially at-risk group<sup>7</sup>.

## 5. Gender and the Government Response to COVID-19

Government measures tackling the spread of COVID-19 are disproportionately affecting women, exacerbating gender inequality<sup>32</sup>. Women provide around 80% of unpaid labour and are disproportionately affected by the current isolation and mobility restriction measures and

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<sup>26</sup> Daugherty Biddeson et al., 2019. Too Many Patients. A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters. *CHEST*. 155(4): 848-854.

<sup>27</sup> British Heart Foundation. <https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity/south-asian-background> (Accessed April 21st, 2020).

<sup>28</sup> NICE guideline [NG159]. <https://www.nice.org.uk/guidance/ng159/resources> (Accessed April 28th, 2020).

<sup>29</sup> Postnote. 2007. <https://www.parliament.uk/documents/post/postpn276.pdf> (Accessed April 21st, 2020)

<sup>30</sup> BMJ special issue on racism. 2020. *BMJ* <https://www.bmj.com/racism-in-medicine>

<sup>31</sup> Byrne, B. et al. 2020. Ethnicity, race and inequality in the UK: State of the Nation. Polity Press: Bristol.

<sup>32</sup> UN Women (2020) Policy Brief: The Impact of COVID-19 on Women. <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406> (Accessed April 28th, 2020)

consequent crisis of care, with potentially far-reaching implications for their mental health<sup>33,34</sup>. Women's access to healthcare has been particularly affected by the current government measures<sup>35</sup>. Among BAME women, migrants have been disproportionately affected<sup>36</sup>. This section illustrates the impact of the pandemic on women, focusing on the effects of the government's measures on women's reproductive health and on women asylum seekers.

## 6. Reproductive Health and Maternity

**6.1 Contraception** Many forms of contraception, such as contraceptive pill, injections or implants, usually require a consultation with a healthcare professional. Whilst the provision of contraception is seen as an essential service, the refocusing of health services towards COVID-19, coupled with the lockdown has led to restricted access, with the more effective long-acting reversible contraception methods particularly difficult to access. Prior to the lockdown, many women faced difficulties accessing a full range of contraception due to cuts in public health funding, which have now been exacerbated<sup>37</sup>.

**6.2 Abortion** The lack of access to suitable methods of contraception is likely to increase unintended pregnancies. Telemedicine access to medical abortion up to 10 weeks is now allowed in England, Scotland and Wales. However, although some services have now started in Northern Ireland, this does not include a local telemedicine, despite clinical evidence that self-management is safe and effective<sup>38</sup>. The lack of a telemedicine service will increase the risks for women who are, or care for people, more vulnerable if they need to leave travel to access abortion care. Whilst provision of abortion pills by post will enable many women to access abortion early in their pregnancies, it is not suitable for all women. There is likely to be an increase in women needing to access abortions later in pregnancy. It is important that services plan for this increase, both in terms of the numbers needing services and their geographic availability.

**6.3 Maternity Services** Some antenatal appointments are now offered via telemedicine, and if face-to-face appointments are available, women who are self-isolating are usually asked not to attend in person. Some antenatal screening, such as nuchal scans, are not currently available. Changes such as these could mean delayed diagnosis of some pregnancy complications. Partners and family members can no longer attend many antenatal appointments, which may

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<sup>33</sup> Battyany, K. 2020. The Covid-19 pandemic reveals and exacerbates the crisis of care. OpenDemocracy 13 April 2020.

<https://www.opendemocracy.net/en/openmovements/covid-19-pandemic-reveals-and-exacerbates-crisis-care/> (Accessed April 28<sup>th</sup>, 2020).

<sup>34</sup> Chidambaram, P. 2020. The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation, 21 April 2020. <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/> (Accessed April 28<sup>th</sup>, 2020).

<sup>35</sup> Beech, P. 2020. The COVID-19 pandemic could have huge knock-on effects on women's health, says the UN. World Economic Forum, 2 April 2020 <https://www.weforum.org/agenda/2020/04/covid-19-coronavirus-pandemic-hit-women-harder-than-men/> (Accessed April 28<sup>th</sup>, 2020).

<sup>36</sup> Norman J. 2020. Gender and Covid-19: the immediate impact the crisis is having on women, LSE Blogs 23 April 2020.

<https://blogs.lse.ac.uk/politicsandpolicy/gender-and-covid19/> (Accessed April 28<sup>th</sup>, 2020).

<sup>37</sup> White, C. 2017. Sexual health services on the brink. *BMJ*. 359: j5395

<sup>38</sup> Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., & Gemzell-Danielsson, K. 2019. Telemedicine for medical abortion: a systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*. 126(9): 1094-1102.

inhibit some women from ethnic minority backgrounds from properly communicating their concerns and wishes. In addition to these general issues, migrant women may be particularly at risk. Many migrant women ineligible for free NHS services (such as refused asylum seekers) do not access maternity services due to concerns about the cost<sup>39</sup>. As migrants are often in precarious employment, they are less likely to be paid via furlough schemes, making any paid health services they need difficult to obtain, thus exacerbating any existing risks during pregnancy.

**6.4 Care during labour** The increased risks due to scaled-down maternity services may have a disproportionate impact on BAME women. BAME women are at an increased risk of dying during or shortly after pregnancy, with Black women having five times the risk of white women<sup>40</sup>. In some areas, women no longer have the option of home births or birthing centres. Whilst birth partners are usually allowed to be present when a woman is in labour, they are currently not allowed to visit postnatal wards. This reduces the support available to these women at a crucial time, especially if they require help caring for the baby due to poor outcomes, or need help communicating in English.

## 7. Women Asylum Seekers<sup>41</sup>

**7.1 Reduced access to charity services** Asylum seekers rely heavily on charities<sup>42,43</sup>. Lockdown has affected a number of crucial services that charities offer to asylum seekers, as these are normally offered in person. Interpreting and translation support has been considerably affected. Whilst many services have been effectively moved online and via phone, many women asylum seekers are not able to access to these remote services due to their limited knowledge of English language. With no easy access to charity support, many women struggle to find someone who can help during periods of self-isolation (e.g. going to the pharmacy or doing shopping). Asylum seekers also rely on charity organisations for food or clothes donations to fill in gaps that have opened up from insufficient National Asylum Support Service (NASS) support.

**7.2 Mental health and wellbeing** Lockdown is exacerbating the isolation and feeling of loneliness of many women asylum seekers<sup>44</sup>. Women refugees and asylum seekers are already subject

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<sup>39</sup> Bragg, R. et al. 2018. What Price Safe Motherhood? Maternity Action. <https://www.maternityaction.org.uk/wp-content/uploads/WhatPriceSafeMotherhoodFINAL.October.pdf>

<sup>40</sup> MBRRACE-UK. 2017. Saving Lives, Improving Mothers' Care—Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. Oxford: National Perinatal Epidemiology Unit, University of Oxford.

<sup>41</sup> Evidence were gathered with the support of Birmingham-based charity Baobab Women's Project ([www.baobabwomensproject.net/](http://www.baobabwomensproject.net/)).

<sup>42</sup> All Party Parliamentary Group on Refugees. 2017. Refugees Welcome? The Experience of New Refugees in the UK. A report by the All Party Parliamentary Group on Refugees. <https://www.refugeecouncil.org.uk/information/resources/refugees-welcome-the-experience-of-new-refugees-in-the-uk/>

<sup>43</sup> Mayblin, L. and James, P. 2019. Asylum and refugee support in the UK: civil society filling the gaps? *Journal of Ethnic and Migration Studies*, 45(3): 375-394.

<sup>44</sup> Reehal, R., Taal, S., Maestri, G. 2019. Seeking Asylum. Women's Experiences of Home Office Decision Making, Destitution and Mental Health Issues. Baobab Women's Project, CARAG, Coventry migrant Women's Houses, Meena, Refugee Rights Europe, Women With Hope. [https://10e63215-2dd3-4e6d-9557-c25b54f85be4.filesusr.com/ugd/e490a6\\_0af442422e0f46e2b7c3413d4d5b9ce6.pdf](https://10e63215-2dd3-4e6d-9557-c25b54f85be4.filesusr.com/ugd/e490a6_0af442422e0f46e2b7c3413d4d5b9ce6.pdf) (Accessed April 23<sup>rd</sup>, 2020).



to isolation, because of dispersal policies, which often relocate them to areas far from their support network<sup>45</sup>. During the current situation, women who live in areas where they do not know anyone will feel more isolated, as they cannot travel to socialise, nor access face-to-face support. Additionally, many of these women rely on public Wi-Fi networks to communicate and engage in distance learning. During the lockdown, public Wi-Fi and public spaces are becoming increasingly harder to access. As many female asylum seekers have school-aged children, this will negatively affect any home schooling, possibly putting these children at a disadvantage when they return to full-time education.

*7.3 Supply shortage of staple food items* The scarcity of basic ranges of food products, such as flour and rice, has devalued NASS money allowance – already considered insufficient prior to the pandemic<sup>46</sup>. The limited weekly allowance means that women asylum seekers may have to shop more often, increasing their risk of exposure. Further, ASPEN cards are not accepted in all shops, so some women struggle to shop close to where they live and cannot buy cultural foods. With travel restricted during the lockdown this may result in poor nutrition and even malnutrition for these women and any dependents.

*7.4 Safety during the lockdown* Already characterised by substandard conditions<sup>47</sup>, women asylum seekers have reported feeling unsafe in their accommodation due to other residents not respecting self-isolation and social distancing. There have been a number of complaints about residents spending time outside or having guests. Women have reported that they cannot find facemasks, nor cleaning products with which to sanitize the communal areas in NASS accommodation. This generates anxiety and exacerbates the already vulnerable mental and physical health of asylum seekers. Because of this, some women have temporarily moved out of NASS accommodation, so as not to expose themselves to the risk of infection. Further, landlords have stopped repairing non-urgent faults in NASS accommodation, although there are also reports of urgent problems being ignored. For example, one woman reported that there was no cooker in the flat she recently moved to with her new-born baby, as this was not considered urgent, and there was no council approved fitter available to install it<sup>41</sup>.

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<sup>45</sup> Kamel, Y. 2014. Mental Health Among Refugee And Asylum Seeking Women, 3 June 2014, Initiatives for change. <https://uk.iofc.org/mental-health-among-refugee-and-asylum-seeking-women>. (Accessed April 23<sup>rd</sup>, 2020).

<sup>46</sup> Refugee Action and NACCOM. 2019. Missing the Safety Net. <https://www.refugee-action.org.uk/wp-content/uploads/2019/09/Missing-The-Safety-Net-Report.pdf> (Accessed April 23<sup>rd</sup>, 2020).

<sup>47</sup> Gerlach, F.M., Welander, M. 2018. Finally Safe? Experiences of Women in Asylum Accommodation in Birmingham. Refugee Rights Europe, Meena, Baobab Women's Project. [https://10e63215-2dd3-4e6d-9557-c25b54f85be4.filesusr.com/ugd/e490a6\\_b481989b60644cdb867fbd72fff15d6.pdf](https://10e63215-2dd3-4e6d-9557-c25b54f85be4.filesusr.com/ugd/e490a6_b481989b60644cdb867fbd72fff15d6.pdf). (Accessed April 23<sup>rd</sup>, 2020).

## 8. Recommendations

We believe that further consideration of both the effect of the virus itself and the measures employed to contain the virus on BAME groups and women is needed. We outline a range of short and long-term measures to address the impact of COVID-19 on these groups.

9.1 *In the next three weeks, we recommend that the government take the following actions:*

- Collect data on ethnicity, gender, and where possible, socio-economic status on hospital admission COVID-19, and for all deaths related to COVID-19, with immediate effect.
- Companies overseeing high rates of agency and zero hours contracts should be required to offer workers protective equipment, including protective gloves, masks, full body protective clothing, and hand sanitizers.
- Workers in higher risk occupations (e.g. couriers, those working in essential retail, frontline medical and care home staff, and transport) should be prioritised for testing on a regular basis. Given the frequency of person-to-person contact of this group of workers, this is likely to have wider health benefits by minimising the risk of them unknowingly spreading the virus.
- Companies in sectors with workers in higher risk occupations (e.g. couriers, those working in essential retail, frontline medical and care home staff, and transport) should be required to provide workers with protective equipment.
- Require that all clinical guidance determining long-term survival based on co-morbidities be limited to those patients whose underlying conditions mean they are expected to live no more than 12 months. Those with co-morbidities who will live beyond 12 months should not have their co-morbidities used to determine eligibility for escalation of care or treatment.
- Produce guidance on the provision of PPE that explicitly addresses the increased risk of COVID-19 in frontline/keyworker staff from ethnic minority groups across all sectors.
- Produce guidance on shielding that explicitly addresses the increased risk of COVID-19 in frontline/keyworker staff from ethnic minority groups across all sectors.
- Increase NASS cash allowance to allow asylum seekers to cover the increased price of food and to allow recipients to buy in bulk.
- Provide all asylum seekers in NASS accommodation with facemasks and cleaning items.
- Guarantee internet access to asylum seekers, by either providing phone credit or internet connection in NASS accommodation.
- Increase access to the full range of contraceptive services by enabling face-to-face appointments where necessary to prescribe or administer the contraception.
- Bring abortion provision in Northern Ireland into line with the rest of the UK (by, for example using telemedicine)

- Begin planning for increased need for abortions in the second trimester.
- Increase capacity for antenatal face-to-face appointments.

9.3 *In the next six months, we recommend that the government take the following actions:*

- Make all data collected on ethnicity and gender freely available for research, to allow rapid evaluation of the relationship between ethnicity, gender, health inequalities and COVID-19.
- Increase the terms of paid sick leave for all frontline staff/key workers with short or long-term illness that is a result of their service during the pandemic.
- Government should seek to repurpose the textile sector to produce protective equipment for workers at higher risk of infection. Reports in the industry press suggest that British textile firms have expressed an interest in producing protective equipment for the NHS, for example, but that the government has been slow to take up their offers of help.
- Develop a clear transition phase for the end of the lockdown to avoid people remaining homeless due to them leaving NASS accommodations.
- Commission a comprehensive review of contraception provision in the UK to ensure all women requiring it have access to contraception during the pandemic.
- Review abortion services across all four nations to ensure that needs are met, including for later gestation and those who need telemedicine services.
- Ensure that antenatal and postnatal services are delivering full support, especially for women more at risk of complications, such as those from ethnic minority backgrounds.