



## Commentary

## Migration, ethnicity, racism and the COVID-19 pandemic: A conference marking the launch of a new Global Society

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## ARTICLE INFO

**Keywords:**  
Migration  
Ethnicity  
Racism  
COVID-19

## ABSTRACT

The inaugural conference of the Global Society on Migration, Ethnicity, Race and Health COVID-19 examined the impact of the COVID-19 pandemic on migrants and ethnic minorities and the role of racism. Migrants everywhere have faced tightening immigration restrictions, more obstacles to healthcare, increased racism and worsening poverty. Higher COVID-19 mortality rates have been observed in ethnic/racial minorities in the United Kingdom and the United States. Structural racism has been implicated, operating, for example, through more crowded living conditions and higher-risk occupations. In Brazil, good data are lacking but a seroprevalence survey suggested higher rates of infection among ethnic minorities and slum dwellers. Considerable disruption of services for migrants at the border with Venezuela have occurred. National policy responses to protect vulnerable groups have been lacking. In Australia, with strict COVID-19 control measures and inclusive policies, there have been few cases and deaths reported in Indigenous communities so far. In most countries, the lack of COVID-19 data by ethnic/racial group or migrant status should be addressed. Otherwise, racism and consequent inequalities will go undetected.

### 1. Introduction

In May 2018, the First World Congress on Migration, Ethnicity, Race and Health was held in Edinburgh. This successful event attracted over 700 participants from 50 countries. Some of the most significant contributions to the Congress were subsequently captured in a special issue of *Public Health*. [1] A recommendation from the meeting was to establish a Global Society on Migration, Ethnicity, Race and Health. Taking an interdisciplinary approach, this would be an actual and virtual meeting point for individuals and organisations working in these complex and inter-related fields. It would aim to stimulate research, disseminate information, enhance understanding and promote beneficial change.

With the advent of the COVID-19 pandemic in early 2020 and consequent stringent control measures taken by almost every government, it quickly became apparent that the health of migrants and ethnic minorities including Indigenous peoples was being disproportionately

threatened in numerous ways. The lives of millions of international and internal migrants were turned upside-down by lockdowns and border controls. Evidence emerged from several countries that many ethnic minorities were at higher risk of developing and dying from COVID-19, with structural racism implicated as a contributory factor.

Against this background, the launch of the Global Society on Migration, Ethnicity, Race and Health was marked by an inaugural online conference on October 12, 2020, organised in conjunction with the European Public Health Association. This aimed to examine the impact of the COVID-19 pandemic on migrants and ethnic minorities and the role of racism. The five presentations by expert speakers and subsequent discussion are summarised below.

### 2. A global crisis for migrants

Miriam Orcutt of Lancet Migration, a global collaboration to advance

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<https://doi.org/10.1016/j.puhip.2021.100088>

Received 9 January 2021; Accepted 21 January 2021

Available online 10 February 2021

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migration health, highlighted how the pandemic had exacerbated pre-existing structural challenges facing migrants across the world. In health systems, they included a lack of capacity and inclusiveness, and obstacles to healthcare including immigration status, language barriers and inadequate or inappropriate information. Migrants often experienced crowded and unhealthy living conditions, especially in detention and reception contexts, and precarious finances. Exacerbation of existing xenophobia and racism and tightened immigration restrictions and border controls were also widely reported. Migrants were thus subject to multiple interacting factors putting them at risk of COVID-19, often compounded by high prevalences of pre-existing non-communicable diseases in some groups, weak refugee protection and pre-existing and worsening socio-economic and gender inequalities. In many countries, they found themselves omitted from public health responses due to a lack of inclusion and lack of government preparedness.

In order to better document the impact of the pandemic on migrants, refugees and asylum seekers, Lancet Migration commissioned and published 22 situational briefs covering 16 countries and four regions, with two further reports covering deportations and irregular migrants in Ethiopia and Niger, and migrant children in East Africa [2]. A number of themes emerged: a bio-security approach to the pandemic has prevailed rather than one based on public health principles of inclusion and a right to health; there has been insufficient resource allocation to include migrants and refugees; and restrictive lockdown measures have had a disproportionate impact on migrants and refugees, who typically also have poorer access to health services and health promotion. These issues are epitomised by the situation in Greece's Eastern Aegean Islands. By September 2020 around 27,000 refugees were on the islands, most in facilities designed for only 6000. In response to several cases of COVID-19 on the island of Lesbos, the Greek authorities placed these facilities in strict quarantine from the beginning of September. Amid rising tensions, fire largely destroyed the Moria camp on Lesbos several days later, leaving 13,000 people homeless. While most were rehoused in a new camp, often unwillingly, the number of cases of COVID-19 continued to rise in Moria and other island facilities. Remaining in overcrowded conditions, with poor sanitation and limited access to healthcare, the refugees' future remained precarious and uncertain.

### 3. Ethnic minorities in the United Kingdom

Raj Bhopal, from the University of Edinburgh, highlighted the disproportionate impact of COVID-19 on ethnic minority groups in the UK. Due to the availability of reliable quantitative data by ethnic group, this became apparent at a relatively early stage in the pandemic [3].

Table 1 shows the substantially higher mortality rates among all the larger ethnic minority groups, aged 65 and older, particularly among males. Although the rates are lower among those aged 9–64 years, the disparities are even wider. Relative poverty, crowded living and working

circumstances, service orientated occupations, and fewer opportunities to work from home, are all thought to have contributed to increased risk. Type 2 diabetes, coronary heart disease and overweight/obesity may all disproportionately potentiate the risk of severe COVID-19 among ethnic minorities. Bhopal also highlighted the plight of migrants without settled status in the UK who typically have no right to work or access to state benefits and limited access to healthcare. Whilst the academic community had acted quickly to describe the problems, translation of the evidence into effective practical policy has so far been very limited.

### 4. Structural racism in the United States

Sharelle Barber, Drexel University, Philadelphia, presented similarly high age-adjusted COVID-19 mortality rates among ethnic/racial minorities in the US, being at least three times higher than Whites among African Americans, Latinos and Indigenous Americans. Defining racism as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks" [5], she set the current situation in the US in the historical context of four centuries of oppression of Blacks and other people of colour. One element of structural racism still embedded in US society is segregated housing. Blacks are much more likely to live in crowded accommodation where the spread of SARS-CoV-2 is facilitated. For example, in Philadelphia, cases per 100,000 population were 3.6 times higher in the neighbourhood with the highest proportion of Blacks (93.6%), compared with the least (2.3%). Blacks and Latinos are also more likely to work in occupations at higher risk of COVID-19 and less likely to have access to high quality health care. "I can't breathe", were the last words of George Floyd, asphyxiated by a White policeman's knee in May 2020, but also the end-of-life experience of thousands of US citizens in ethnic minorities who died from COVID-19 as a consequence of systemic racism.

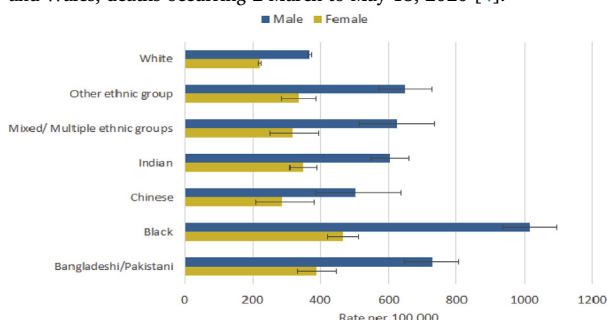
### 5. Vulnerable groups in Brazil

Mauricio Barreto, Federal University of Bahia, Brazil, said that Latin America in general and Brazil in particular have exceptionally high levels of inequalities, by almost every indicator. The population of Brazil is extremely diverse, including around 1 million Indigenous peoples in 7000 tribes and 16 million Quilombolas (Afro-Brazilians living in around 6000 villages). Brazil experienced rapid and widespread transmission of SARS-CoV-2 from February 2020, with a comparatively high reported death rate. Unfortunately, the official COVID-19 notification form does not record whether the individual is in a vulnerable group and stating race/ethnicity is not mandatory, making objective analysis of the distribution of cases among different social and ethnic groups difficult. However, national seroprevalence surveys conducted in May and June indicated relatively high rates of infection among ethnic minorities and slum dwellers. The closure of the border with Venezuela led to the suspension of reception and other services for Venezuelan migrants, with many difficulties experienced by migrants in the border area in particular. There were no specific national policy responses to protect vulnerable groups. While some emergency financial aid did include migrants, several benefits earmarked for Indigenous peoples were not approved.

### 6. Indigenous peoples in Australia

Anthony Zwi, University of New South Wales, focused on how COVID-19 had impacted on the Indigenous peoples of Australia. Against a background of centuries of oppression by White colonialists, and currently subject to severe disadvantage as measured by almost every health and social indicator, there had been grave concern that Indigenous people would be more vulnerable to the effects of COVID-19 than the majority population. So far this has not happened. First, the country as a whole has managed to control importation of SARS-CoV-2 and its transmission within the country. Second, the Australian Government has

**Table 1**  
Age-standardised mortality rates for deaths involving COVID-19 at ages 65 years and over by sex and ethnic group, per 100,000 people, England and Wales, deaths occurring 2 March to May 15, 2020 [4].



involved Indigenous people in shaping the emergency response. This acknowledged the links with historic disadvantage, emphasised the importance of health services controlled by the community and promised early and continued engagement. Non-essential travel to remote communities was minimised. Indigenous peoples were given priority in national guidelines, with efforts to protect Indigenous workers, prioritise COVID-19 testing for Indigenous communities where required and provide appropriate health promotion materials [6]. As a consequence, there have been very few cases and deaths reported in Indigenous communities so far.

## 7. Discussion

The presentations generated debate on several issues. These included the value of the concept of syndemics (the interaction of two or more concurrent or sequential epidemics or disease clusters in a population) as a means of understanding the interaction of COVID-19 with migration, ethnicity and racism [7]; the case for granting temporary citizenship to undocumented migrants and asylum seekers, enabling them to engage in preventive initiatives and access healthcare [8]; but, above all, the lack of COVID-19 related data on migrants and ethnic or racial groups in most countries. This meant the analyses in the US and the UK would be difficult or impossible to reproduce elsewhere. For example, in mainland Europe, European Union and many state directives prohibit or severely inhibit the collection of data on race and ethnicity on the grounds that doing so would infringe personal data protection and could itself foster discrimination [9]. It was argued that with proper safeguards these risks could be minimised but, without such data, racism and consequent inequalities would prosper unseen.

## 8. Conclusions

We support Lancet Migration's call for urgent access to healthcare for all migrants and refugees throughout the pandemic and their inclusion in COVID-19 preventive measures. We advocate public communication strategies that are relevant and accessible to migrants and ethnic minorities, providing linguistically and culturally appropriate information [10].

We strongly recommend other governments follow the example of the US and the UK by conducting rigorous analyses of COVID-19 data by racial/ethnic group in order to identify causal mechanisms, inform preventive initiatives and enhance healthcare responses. Anonymous linkage to national census data offers a robust and powerful method [11].

The good attendance, excellent presentations and active participation suggest the Global Society's inaugural meeting was timely. It showed why sharing information and collaborative action across the world is essential, not just for COVID-19, but for all the complex issues the Society

intends to embrace. The speakers' presentations and more information about the Society are available at [gsmherh.org](https://gsmherh.org). Please join us!

## Funding

The preparation of this article did not require any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Acknowledgements

We are extremely grateful to Miriam Orcutt, Sharelle Barber, Anthony Zwi and Mauricio Barreto for their presentations; and to Gwenetta Curry, Aziz Sheikh and Vittal Katikireddi (Raj Bhopal's co-authors).

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