

Beyond the COVID-19 Syndemic: Lessons Learned for Migrant and Ethnic Minority Health Summary¹ of an online meeting on November 10, 2021

Introduction

A syndemic is when two or more epidemics interact in time and place and share common underlying societal drivers. The COVID-19 syndemic is the consequence of a virulent new infection interacting with non-communicable diseases such as obesity and diabetes, and exacerbated by poverty, overcrowding, inadequate health care and other factors. Migrant and ethnic minority communities have been among the hardest hit, typically experiencing both higher hospitalisation and death rates and greater economic hardship. National and local responses have varied greatly: from inclusion and generosity to xenophobia and meanness. While a lack of reliable data and relevant research has impeded understanding, there have been some success stories in Europe and elsewhere. One thing is clear: the syndemic is far from over. New variants, long COVID and huge inequities in vaccination rates are adding to the wider social and economic damage.

This meeting tackled three key themes that seem essential to help minimise the continuing impact of the pandemic on migrant and ethnic minority health.

How can we improve data collection and research?

Without accurate data, we are in the dark. [Soorej Puthooppambil](#)² drew on a recent report he had co-authored on the Collection and Integration of Data on Refugee and Migrant Health in the WHO European Region³. Only 25 of 53 member states published refugee or migrant health data. In some countries, concerns about data protection and privacy prevented their collection or sharing. Those that did used varying definitions for migrants and ethnic minorities, preventing useful comparisons. Often health data could not be disaggregated by migrant status. Where data on migrants were available, they might not be a genuinely representative sample. The WHO's aim was to improve the collection and availability of refugee and migrant health data by providing practical guidance for integrating migration health data into national health information systems (HIS) and promoting harmonisation of data reporting across member states. Success required the presence of a number of key components in the HIS: appropriate legislation and regulations; the ability to carry out data linkage; and the routine collection of core variables. The WHO had identified four essential variables (country of birth; citizenship; year and month of arrival; and parents' country of birth) and four recommended variables (reason for migration; ever resided abroad; legal status; and knowledge of official language). Careful attention was needed to ensure accurate and complete data were collected, appropriately transformed into meaningful information and regularly published in accessible formats. This had many implications for national policy. For example, regulations had to be changed or clarified to enable the collection and use of relevant data; and measures introduced to prevent unauthorised access to or use of the data; and data collectors trained. At the European level, member states needed to agree common approaches to definitions, data collection and reporting.

[Rachel Burns](#)⁴ began by referring to a systematic review and meta-analysis of studies of international migrants published in 2018⁵. Compared with the majority population, migrants had lower all-cause standardised mortality rates and lower mortality rates for most major specific causes with the exception of infectious diseases and accidents/violence. The "Million Migrant" study is currently in progress.⁶ It has created a cohort of over 1.5 million non-EU migrants in England, identified through pre-entry screening for tuberculosis during 2005-20 and then linked to hospital episodes, death records and COVID-19 data. A second study being developed aims to use a "migration phenotype" to identify migrants among patients

included in the Clinical Practice Research Datalink, the largest UK primary care electronic health record database⁷. If the method is successful, it will be used to describe primary care and hospital-based healthcare resource utilisation and mortality in migrants compared to non-migrants.

Maria Melchior⁸ is an epidemiologist working in Paris. She said France had strict limitations on collecting data on migrants for historical reasons and a perception it would stigmatise them. Most of the information about COVID-19 among migrants and ethnic minorities came from the US and the UK. This showed most ethnic minorities had higher risks of developing COVID-19 and dying from it. The causes were multi-factorial including working in high-risk occupations, living in crowded accommodation and having underlying health conditions such as obesity and diabetes. In France, they had analysed COVID-19 mortality data using country of birth on the birth certificate. Persons born abroad were around twice as likely to have died of COVID-19, with the rates being highest among migrants from Africa and Asia, especially early in the pandemic. Migrants living in areas of high population density were particularly at risk.

What have we learned from successful approaches and interventions during the pandemic?

Tushna Vandevala⁹ said it had been established relatively early in the UK that ethnic minorities were at higher risk of developing and dying from COVID-19. Lack of knowledge and non-scientific ways of understanding COVID-19 played a part in increasing risk of exposure to the infection. The experience of racism and being treated as outsiders, a general mistrust in government and the widespread circulation of misinformation and conspiracy theories led to a reduced likelihood of adherence to protective health behaviours. She proposed a range of ways to make COVID-19 interventions more equitable:

Sense making and conspiracy theories

- Specific campaigns to counter misinformation that are culturally appropriate and easily understood
- Clear, accurate, targeted, and visible communications
- Acknowledgement of lived experience due to historical and contemporary issues

Messaging positions us as outsiders

- Use messengers with a local, authentic perspective and shared experience
- Acknowledge their reality
- Decrease stigmatisation & distrust, e.g. avoid labelling communities as “hesitant” or “infectious”
- Reduce othering in messages and acknowledge contributions of migrants and ethnic minority groups

Mistrust in Government

- Campaigns to increase trust in health services and educate on migrants’ rights without immigration checks or data sharing
- Local facilities in safe and “trusted places” to seek help
- Increased funding for and collaborations with charities and community groups

Wider historical and contemporary societal influences and inequalities

- Interventions that explore wider social determinants of health and how the environment can be beneficially modified
- Reduce structural barriers and ensure that deprived communities are financially and materially supported (for Covid and beyond).

Ana Martinez-Donate¹⁰ presented examples of grassroot approaches and participatory research methods to reduce COVID-19 disparities in the US. Her focus was on the 20 million+ Latinos who make up 50% of US immigrants. Many have multiple disadvantages, including 30% whose status is unauthorised and 32% who have no health

insurance. Because of greater exposure to the coronavirus and greater vulnerability to its effects, they were 1.7 times more likely to get COVID-19, four times more likely to be hospitalised and three times more likely to die than non-Hispanic Whites.

A community-researcher partnership had been studying health disparities affecting Latino immigrants in Philadelphia since 2017. They developed a multi-level community-wide intervention to mitigate the impact of COVID-19. This included an online directory of resources in Spanish and a peer-driven programme based on the Popular Opinion Leader model. Trusted community members were trained to educate peers, dispel myths, model healthy behaviours, connect peers to services and bring feedback to organisations. Fourteen community leaders were trained of whom 11 were active over a nine-month period, generating more than 8000 interactions with community members. A wide range of topics was discussed and help offered – mainly but not all COVID-19 related. A Latino Health Collective was set up. Bringing together Latino-serving agencies, City officials and others, it met monthly with ongoing email communication. Twenty-three meetings were held involving 60+ organisations and 150+ individuals and covering a wide range of issues such as protective equipment for staff, testing supplies and sites and community vaccination. These initiatives were associated with a substantial increase in COVID-19 testing by Latinos compared with White and African American communities. By November 2021, Latinos had higher vaccination rates than non-Hispanic Whites, especially among 45-64 year olds. She concluded that community-based, grassroots responses tailored to local needs can reduce disparities in COVID-19 in ethnic and migrant communities. Involving multiple partners brings complementary resources to reduce the gaps.

Yusuf Ciftci¹¹ of Doctors of the World UK (DOTWUK) presented an NGO perspective on providing services for marginalised migrants during the pandemic. Among 1098 migrants attending a COVID-19 clinic in London, 84% were below the poverty line, 69% were undocumented and 65% homeless. Their clients were at higher risk of COVID-19, more likely to have poorly managed health problems, less likely to have access to timely healthcare and less able to self-isolate. DOTWUK translated COVID-19 guidance into 60+ languages. They created a Vaccine Confidence Toolkit to enable migrants to make an informed decision on the vaccine. They trained over 150 migrants to act as health advisors who could meaningfully engage with other migrants. The main lessons they learnt were to collect robust, consistent data; constantly seek and address gaps in provision; and thereby build a tailored response through involving migrants themselves and linking with their communities.

Marie Mallet-Garcia¹² drew on a report on how the pandemic had impacted migrants with irregular status in European Union cities¹³. It sought to explore how local authorities responded to the crisis; foster dialogue and knowledge-exchange on the best practices to implement in a crisis such as the COVID-19 pandemic; and reflect on longer-term solutions for policy on how to best govern the presence of migrants with irregular status. Before the pandemic there had been no consensus across Europe but a tendency towards exclusionary policies, leading to criminalisation and marginalisation and access to a minimum of healthcare services. With the arrival of COVID-19, the vulnerability of irregular migrants generally increased. However, policy makers and service providers began to see the importance of including irregular migrants in the pandemic response. Thus, most EU countries granted access to treatment – generally for free. Some ensured no data were shared with immigration authorities. Access to vaccination programmes varied. Some EU countries offered temporary regularisation and most offered temporary residence permits. Most countries halted deportations and some released those in detention centres. A few

countries increased entitlement to social services with one offering pandemic unemployment pay. Some programmes were created to provide food and other basic necessities and access to emergency shelter. Most offered COVID-19 related information in migrants' native languages. Initiatives included providing free consultations at newly created medical centres; setting aside funds to cover hospitalisation costs of uninsured irregular migrants; and collecting and distributing medicines. Other initiatives at the city level included increasing the availability of accommodation, using hotel rooms, new facilities or repurposed municipal buildings. City authorities moved online, developing partnerships with NGOs, e.g. to provide access to internet; phone credit vouchers; free access to a phone or a computer and communication Apps in guest centres. Some cities took the opportunity to advocate for irregular migrants' rights, campaigning to include irregular migrants in relief measures; widen their access to public assistance; and call for their regularisation. Dr Mallet-Garcia concluded that more inclusive policies and practices had typically been introduced during the pandemic in relation to public health, public order, the national immigration system and the economic sector. There was greater awareness of the need to include irregular migrants in policy responses and some cities had become more confident in their support of irregular migrants. Whether this trend will continue after the pandemic remains to be seen.

What are the likely long-term consequences of the pandemic and how can they be mitigated?

Marie Norredam¹⁴ said that "long-COVID" has been defined as new or persisting symptoms occurring more than four weeks after the onset of COVID-19. A multiplicity of symptoms of varying severity and duration can occur. Predictors of long-COVID include older age, greater severity in the acute phase and underlying co-morbidities such as diabetes and obesity. Many migrants and members of ethnic minorities have these predictors and thus would seem at higher risk of long-COVID. However, there have been few studies of long-COVID among migrants and ethnic minorities so far. A study of a random sample of 366 adults in California who had had a positive PCR test found that African Americans were more likely than other ethnic groups to have any persisting symptom, including shortness of breath and joint or muscle pain.

The research agenda for long-COVID among migrants and ethnic minorities should include investigating whether they are disproportionately affected; the impact on their socio-economic circumstances and wellbeing; and whether they have access to appropriate services. Such a study is being planned, led by the Universities of Amsterdam, Copenhagen and Stockholm and funded by the Novo Foundation. It will study the incidence, nature, duration, and risk factors of long COVID among migrants and ethnic minorities compared to the majority population; the experiences of symptoms of those with long COVID; their health care seeking behaviour, including referral to rehabilitation; and the social and economic impact. Cross-national comparisons will be made where possible. It will be a multi-methods study using nationwide, register-based data; surveys of and clinical data from COVID-19 follow-up cohorts; and interviews with long-COVID patients. She called for similar studies to be carried out in other parts of the world.

Mohammad Razai¹⁵ began by highlighting the higher risk of cases of COVID-19 and related hospitalisations and death among Black and Asian people in the UK compared with the majority White population. He suggested that 80-90% of the differences could be explained

by social factors. These included structural racism manifested in the higher proportion of ethnic minorities living in poor or crowded accommodation or working in higher risk jobs. For example, ethnic minority health care workers were more likely to work in front-line clinical roles and had experienced disproportionately high COVID-19 death rates. He pointed out that COVID-19 death rates were higher in areas of London with a higher proportion of Black and ethnic minority residents, which were also typically areas with insecure unemployment. However, social inequalities in health in the UK had deep historical roots: areas of England and Wales with the highest age-standardised death rates in 2020-21 were broadly similar to those with the highest child mortality rates in 1851. He thought the longer-term impact of the pandemic would be felt more heavily by ethnic minorities through higher unemployment, lower incomes and greater child poverty. A disproportionate lack of access to the internet was one way in which inequalities were widening. Refugees and asylum seekers were particularly vulnerable.

Dr Elisabeth Waagensen¹⁶ provided an overview of the impact of the pandemic on migrants and refugees across Europe. A full understanding is not possible due to a lack of reliable data, but all the indications are that they are disproportionately adversely affected in many respects. She said they were more likely to live and work in higher-risk conditions, often with little protection or health insurance. They had reduced ability to access healthcare and social services. They typically had a limited knowledge of health systems, a lack of information about health issues and inadequate access to hygiene facilities or personal protective equipment. Certain migrant sub-groups had higher rates of underlying conditions such as diabetes and obesity. They were subject to increased stigmatisation and discrimination. The mental health consequences had often been heavy for many reasons including loss of employment, lack of information and restriction of movement. Looking ahead, there was an ongoing need to address the health needs of refugees and migrants with the aim of their inclusion into national health systems. Everyone should have the right to be treated with dignity and be able to exercise self-care. This included having access to culturally and socially acceptable communication and treatment options and being made aware of their entitlements.

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² Dr Soorej Jose Puthooppambal, Senior lecturer, Uppsala University, Sweden

³ Collection and Integration of Data on Refugee and Migrant Health in the WHO European Region: Technical Guidance. WHO Regional Office for Europe. 2020.

<https://www.euro.who.int/en/publications/abstracts/collection-and-integration-of-data-on-refugee-and-migrant-health-in-the-who-european-region-2020>

⁴ Dr Rachel Burns, Research Fellow, Institute of Health Informatics, University College London, UK.

⁵ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32781-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32781-8/fulltext)

⁶ <https://wellcomeopenresearch.org/articles/4-4>

⁷ <https://wellcomeopenresearch.org/articles/5-156>

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¹³ <https://www.compas.ox.ac.uk/2020/impact-of-covid-on-access-to-services-for-irregular-migrants/>

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