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EDITORIALS

Covid-19: ensuring equality of access to testing for ethnic minorities

Programmes must ensure that “hard to reach” groups are no longer hardly reached

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Until successful vaccination programmes are in place governments will be heavily reliant on widespread testing and contact tracing to reduce the reproduction number of SARS-CoV-2.[1] Meanwhile international evidence continues to emerge about ethnic disparities in covid-19 morbidity and mortality,[2 3] echoing the unequal burdens of other global epidemics such as tuberculosis, hepatitis, and HIV. At this crucial juncture, health and policy planners must ensure that access to and uptake of SARS-CoV-2 testing is equitable across all social and economic gradients. We support the recent call for immediate inclusion of social scientists, anthropologists, leaders of marginalised communities, and experts in local social determinants of health in health policy making for this pandemic[4] so that sufficient access, trust, and cultural competence are built in to test, track, and trace programmes for covid-19.

Considerable international evidence exists on unequal uptake of medical testing and surveillance across health conditions—including assessment of cancer risk,[5] antenatal screening,[6] and HIV testing.[7 8] The disparity is largely attributable to social determinants of health, coupled with mistrust of medical institutions among those in marginalised population groups. Without appropriate action, similar disparities may hamper the success of covid-19 testing interventions.

Hostile environment and mistrust

The UK government is currently expanding its testing programme through use of self-administered swab kits, a strategy that should be informed by evidence on uptake of other self-sampling kits among target groups. For example, a 2018 study found that use of HIV self-sampling kits among ethnic minority target populations in the UK was low compared with other groups.[9] Our detailed investigations among black African people in England and community health professionals revealed mistrust of self-sampling technologies and yielded important wider lessons about self-sampling.[10] Such kits were reported to be overcomplicated, with written instructions that were inappropriate for those whose first language was not English; were perceived as being unsafe for postal transfer; and were regarded as unsuitable proxies for a sample handled by a health professional in a secure and sterile setting. Although some of our research participants thought that self-sampling was appropriate for them, most said they were unlikely to use such kits, with risks to privacy a key consideration.[10]

Health professionals often frame members of ethnic minority communities as “hard-to-reach” because of low engagement in population health screening. However, it is more accurate to say these groups tend to be “hardly reached” by those who fail to understand the needs of marginalised people who are asked to send samples of bodily fluids to unknown others for processing. A sociopolitical context where the UK government continues to promote a hostile environment[11] for “low skilled” migrants,[12] resulting in the wrongful denial of health services to thousands[13] only makes things worse. Given the disproportionate and devastating impact this pandemic has already had among our ethnic minority communities, such issues need to be immediately addressed in the rollout of covid-19 screening.

Much work needs to be done to ensure populations at risk are meaningfully prioritised for access to interventions for SARS-CoV-2 testing. Policy makers must build trustworthy surveillance programmes and give everyone the confidence that they can access healthcare equitably during the covid-19 pandemic.[14] Rolling out programmes for self-sampling without regard for these experiences of exclusion will risk exacerbating inequalities.

To help bridge this gap in trust, people from ethnic minorities and their community representatives urgently need to be included at the heart of national and local health planning. Good planning will consider the need for tailored and multilingual communications, relevant support from trained health professionals, clarity about how samples and personal data are handled, and assurances about free access to emergency healthcare regardless of residency status or the NHS surcharge for migrants.

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We urge policy makers to consider the potential harm that could arise from rushed and poorly executed testing programmes that exclude those groups at disproportionate risk of covid-19 morbidity and mortality. Planners at all levels should carefully consider the interdisciplinarity of their response teams, so that they are able to successfully confront the many challenges that social, economic, and cultural inequality can pose in responses to pandemics.

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