Chapter

Perspective Chapter: Impact of COVID-19 on the Health of Ethnic Minorities in the UK – Salient Features and Recouping Strategies

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Abstract

COVID-19 has affected selected population groups, professions, and regions much more than others in terms of infection rate, hospital admission rate, and intensive care rate and then premature mortality rate. Globally, the seventh highest deaths due to COVID-19 (>155,000) have been experienced in the UK. The share of Black, Asia, and Ethnic Minorities (BAME) people in the UK is >20% with a high geographical concentration in major cities (London, Birmingham, and Manchester). Government statistics show that Black and Asian people represented disproportionately higher (>3 and 2 times, respectively) than white British in admission to Intensive & Emergency Care Units and resultant deaths due to Coronavirus. This chapter explores underlying reasons for differential impacts on BAME's health and well-being including demographics, socioeconomic condition, health status/long-term conditions (LTCs), diet, and lifestyle. Compared with white British, the BAME people have higher prevalence of LTCs/obesity, lower health literacy, and living and working in most deprivation areas/occupations. These factors are important to plan for short- and long-term impact mitigation strategies to recoup BAME peoples' health and well-being they enjoyed before the Pandemic. Two studies illustrate the Pandemic effect on: BAME access to organ transplants services, and racism experienced at workplace the National Health Services BAME staff.

Keywords: pandemic, ethnic minorities, racism, organ transplants, Health & Wellbeing

1. Introduction

The Corona virus (COVID-19) was declared a pandemic by the WHO in March 2020. COVID-19 and its subsequent variants (mainly Delta & Omicron) spread exponentially across the World and globally infected over 375 million people with 5.7 million deaths as on 31st January 2022 [1]. COVID-19 has affected some population groups and countries much more than others in terms of infection rate, hospitalisation admissions and discharge, and premature mortality. Globally, the seventh highest deaths due to COVID-19 (>155,000) has been experienced by the

UK; however, in terms of fatality rate per million population the UK ranks at 30th. Both government statistics and media in the UK has pinpointed that the Pandemic has had wider and differential impacts on people from low socio-economic status and those having minority ethnic/cultural background. One in five people in the UK belongs to Black, Asia and Ethnic Minorities (BAME) groups; and they are in majority in London and Birmingham, followed by high concentration in Manchester, Leeds and some other major cities of the England.

According to the report released by the Public Health England on 2nd June 2020 [2], the COVID-19 diagnosis rate, admission to Intensive Care Units and resultant deaths are disproportionately higher among BAME. Age-standardised certified deaths rate due to Coronavirus was more than four times for Black and three times for Asian people when compared with their White British counterparts during the 1st Wave (beginning with 23rd March 2020 Lockdown). There is very limited official release of evidence to explain underlying reasons for such massive differentials in infection, hospitalisation and fatality rates across ethnic and socio-economic groups and resultant health and wellbeing inequalities emerged due to coronavirus pandemic.

This paper explores underlying reasons of differential impacts of COVID-19 on BAME's health and wellbeing. These include demographics, socioeconomic condition, health estate and long-term conditions, as well as diet and lifestyle factors. BAME people have much higher prevalence of long-term conditions/diseases, obesity, low level of health literacy, and living in most deprivation areas and above all working in low-paid occupations. These factors are pivotal in order to plan for short- and long-term impact mitigation strategies as well as to recoup BAME peoples' health and quality of life they enjoyed before the pandemic. The paper also highlights health inequalities for BAME community through two case studies depicting how the Pandemic affected their specialist health services (organ transplants) and how much and type of BAME nursing and allied staff have faced racism whilst working for the National Health Services (NHS) before and during the Pandemic. explores.

2. Underlying reasons for differential impact

In fact, due to high infection and spread rate, the coronavirus has not discriminated in terms of providing differential exposure to people with diverse socioeconomic and ethnic/cultural backgrounds. In principle the BAME people are not disproportionately affected because they are BAME in some kind of biological sense, but because of socio-economic and cultural factors which create conditions whereby they are more likely to be exposed to infection and lack the physiological infrastructure to be able to deal with it as effectively as more privileged people. These multiple disadvantageous factors, which triggered and became outrageous when BAME people got exposed to coronavirus, are related at their underlying health issues; lack of physical activity; deprived living conditions; poor hygiene practices; and being engaged in high-risk occupations including low-paid gig sector.

To begin with, the most critical one is the low immunity levels among BAME people to fight against the infection due to unbalanced diet lacking micronutrients, widespread prevalence of anaemia and Vitamin D deficiency prevalence, and predominance of long-term conditions and early onsets of CVD, Type 2 Diabetes and Hypertension (a decade earlier in BAME compared to White British) [3]. COVID-19 affected disproportionately older people and men in the UK [4]; the median age for White British admitted due to coronavirus was above 60 as compared to 55 for BAME people during the 1st Wave. It is found that a majority of BAME people after

reaching age 55 milestone, develop a long-term condition (LTC). Among South Asians it was noticed that by age 55 most of them have been on medications for CVD and diabetes for more than 15 years [3]. The high rate of prevalence of LTCs and medications among BAME people, in turn has reduced their immunity levels and thus are unable to fight against infections (most of them even receive every year free winter flu jab from the NHS thus vouching on the prevalence of low level of immunity).

2.1 Diet and nutrition

Good nutrition is elemental to improving immunity and with ageing it is pivotal to supplement individual's diet with appropriate magnitude of nutrition. The first line of defence is to choose healthy diet packed with various micronutrients that supports optimal function of the immune system. Based on variety of systematic and evidence-based data, Vitamins: A, C, D, and minerals: Zinc and iron are particularly crucial to boosting immune response [5, 6]. Their details with main contribution, food sources and daily requirement is shown in **Box 1**.

- **Vitamin A**: is an anti-inflammatory because of key role in enhancing immune function and important for epithelial integrity and also crucial for mucosal function. Its main sources are: Animal: Liver, egg yolk, butter, cream, whole milk and cheese; Plant: sweet potato, papaya, melon, apricot, spinach, carrots, pumpkin and red palm oil. It's daily DRIs (Dietary reference intakes), RDA (Recommended dietary allowances), AI (adequate intake), RAE (Retinol activity equivalent) requirements for different population groups are: Infants and young children (AI = 400–500 RAE/day, depending on age); Older children and adolescents (RDA = 600–900 RAE/day, depending on age); Adults (RDA = 700–900 RAE/day, depending on gender); Pregnant (RDA = 750–770 RAE/day) and Lactating women (RDA = 1200–1300 RAE/day).

- **Vitamin C**: increases the production of white blood cells. It protects immunity to fight infections and prevent common cold including allergic symptoms. Its sources are: all citrus fruits, Barbados cherry (acerola), grapefruit, oranges, lemon, limes, guava, goose berries (amla), broccoli, potatoes, tomatoes, cabbage, red amaranth leaves and green peppers. Its daily requirements: Infants and young children (15 mg); Children and adolescents (25-45 mg); Adults (40–60 mg); Pregnant (85 mg) and lactating women (120 mg).

- **Vitamin D**: is thought to be effective to lower the respiratory tract infections and also boost immunity. Its sources are: Eggs, liver, fortified milk, fortified margarines, oily fish and cod liver oil; Sunlight. Its daily requirements: Infants-10 mcg (400 IU); Children and adolescents-15mcg (600 IU); Adults-15 mcg (600 IU) and > 70 age-20 mcg (800 IU); Pregnant-15mcg (600 IU) and lactating women-15mcg (600 IU).

- **Iron:** is a component of haemoglobin, myoglobin and vital in oxygen transfer. Its sources: Animal: Liver meats, egg yolk, shellfish, Plant: dried fruits, whole grain or iron fortified breads and cereals, dark green and leafy vegetables and molasses. Its daily requirements: Infant and young children-7 mg; Children-10 mg; Adolescents-11 mg/day for boys and 15 mg for girls; Adults-8 mg for men, 18 mg for women and 8 mg for menopause; Pregnant- 27 mg and lactating women-9 mg.

- **Zinc:** is essential mineral to boost immunity and prevent depression. Its sources: Animal: oysters, shellfish, dairy and eggs; Plant: Legumes, wheat bran, seeds (black sesame, garden cress seeds, pumpkin seeds). Its daily requirements: Infants and young children-3 mg; Older children and adolescents-5 mg-8 mg; Adults:11 mg for men and 8 mg for women; Pregnant-11 mg and lactating women-12 mg.

Box 1.
Immunity booster vitamins, food sources and daily requirement.

2.2 Physical activity

Daily exercise also boosts immune system and improve physical and mental health wellbeing. WHO recommends regular exercise including brisk walking for adults for at least 30 minutes for five days a week. There is extensive evidence in the UK that physical activity level is low among BAME population with majority of mid-aged do not meet the recommended daily exercise level. NHS health professionals also advice light to moderate intensity exercise daily including Yoga for people suffering from long-term conditions to remain energetic, less stress and manage the condition better. Meditation and breathing exercise especially the *Bhramari* pranayama, a meditative breathing technique, improves immunity, reduces stress, fatigue and also regulates the endocrine glands. Some other breathing techniques are also effective i.e., Pursed lip breathing, diaphragmatic breathing, breath focus technique, lion's breath, alternate nostril breathing, known as *nadi shodhana* pranayama, equal breathing, resonant and coherent breathing and *shitali* breath and deep breathing [7].

2.3 Socioeconomic status

The pertinent issue still remains among BAME is their low-income level, poor economic status, employed in low-paid and high risks jobs, and continue to live in poor housing conditions and deprived areas. This in turn directly affects their purchasing power to buy healthy and nutritious food, maintain hygiene and sustaining good health. The level of health literacy among them is low, therefore the key challenge is how to change their food habits, improve their nutrition level and raise their immunity level in order to prepare them against the subsequent waves/variants of the coronavirus and other infectious diseases.

2.4 One year with the pandemic

The updated report on the changes in population mental health & wellbeing in England during the COVID-19 pandemic using the UK Household Longitudinal Study showed that mental health deteriorated significantly during the two national lockdown periods [8]. The psychological distress rates increased from 20.8% in 2019 (pre-Covid) to 29.5% in April 2020 (1st Lockdown), then eased at 21.3% by September 2020 and then gone up again to 27.1% in January 2021(2nd Lockdown), then eased at 24.5% in March 2021 end. Mental distress rates were found to be higher among young vs. older adults and women vs. men; During the pandemic period self-reported levels of loneliness were much higher especially during winter lockdown of 2021. Among the young adults who had a pre-existing mental health condition and belonged to lower income group had experienced much worse mental health during the pandemic together with increased alcohol consumption and smoking. Similarly, those with poor physical health reported feeling more socially isolated during the first wave (June-July 2020) than the second (Nov-Dec 2020). It was devastated to observe that the mental health outcomes during the pandemic were found to be worse among minority ethnic groups (BAME) compared to their White counterparts.

According to UCL COVID-19 Social Study the 38 week per week data (starting from 1st Lockdown in 23rd March 2020) showed that both anxiety & depression rates were constantly higher for BAME compared to their White counterparts; the latter group also experienced a faster decline in those rates. It was also noticed that the loneliness rates, Covid stress, Financial stress, thoughts of suicide/self-harm rate were consistently higher for BAME compared to their White counterparts. Finally,

Compare to White community, the life satisfaction rate during the pandemic period was found to be consistently lower for the BAME people. Overall, the deterioration in mental health condition during the pandemic period was higher in BAME, especially among men when compared to White individuals; thus, ethnicity predicts mental health deterioration when interacted with gender [9].

2.5 Impact mitigating strategies

Both short- and long-term strategies are thus required to mitigate the devastating impact of COVID on their health and quality of life. These could also be designed according to risk factors and preventable measures including social distancing, maintaining hand hygiene, working remotely and avoiding gathering, clubbing, partying and in groups entertainment. Within BAME community the population is extremely heterogeneous; therefore, any behavioural change strategies need to be contextualised in the six G's framework. The six G's (gender, generation, genes, geography, God/religion, and gaps in resources) in the context of management of diabetes and CVD among BAME through diet and lifestyle behavioural change are discussed in a separate publication [10].

Short-term strategies using social marketing approach are:

- Imparting knowledge through regional language radios and tele-channels through short key messages, expert interviews, talks and discussions on promoting balanced and nutrient diets to raise immunity at the community level.

- Explaining the natural intake of nutrients (through food sources, fresh air, alkaline water and sunlight) to raise levels of Vitamin A, C and D along with Zinc and Iron for adults and children and adolescents.

- Information sheets (possibly in multi-lingual) on promoting these immunities enhancing nutrition to be provided by the organisations and institutions on the basis of their usual/work activities (namely, schools, local government, public and private large employers, charities, places of worships and also through NHS and pharmacies).

- The other critical immunity raising factor is to make people more physically active in accordance with their stamina as well as bring them back into healthy weight threshold. Many successful examples of group walking and gym activities need to be expanded in scope and scale (in order to include BAME people according to their gender and age group).

- It is very important to encourage and introduce indoor activities including Yoga, Meditation and breathing exercises. There are now several mode & medium to teach and deliver these remotely.

- Promote effective vaccine and reduce hesitancy in uptake of COVID vaccines among adults and children from BAME community [11].

Long-term strategies

- Re-emphasise the role of state (Central and local governments) in initiating these preventative strategies at large using the Nobel nudging approach [12].

- To improve health literacy among BAME and people living in deprived area through short courses in colleges which could be delivered remotely or through community centres (this approach has already been used in improving computer and IT skills).

- To promote participation and recruitment of BAME people in new COVID-variants vaccine trials and antibody therapies.

- To regularise and provide greater economic security and employment conditions for people in low-paid, casual and contract jobs particularly to those who are already in the gig-economy.

- Special CPD courses and training programmes for both healthcare professionals and the community on how to manage better specific long-term conditions (such as diabetes, CVD, Asthma, chronic kidney disease, organ transplants recipients, etc.) which get aggravated due to COVID infection.

- Rolling out already successful initiatives to Improve health behaviour in regard to drugs, smoking, and heavy and binge drinking (alcohol intakes).

3. Access to organ transplant services during the pandemic

The Pandemic severely affected the UK organ transplant services as the whole NHS (National Health Services) was overwhelmed in treating COVID-19 infected patients in hospitals. In order to treat the heavy influx of COVID patients into respiratory wards and Intensive & Emergency Care Units (ICUs) several speciality hospital services were suspended, and NHS staff and resources were transferred to newly created COVID wards. To ensure the safety of patients transplant centres were also closed during the 1st Lockdown (Mar-Jun 2020) phase and with very limited access during the 2nd Lockdown (Jan-March 2021) period. Our previous study demonstrated that compare to April 2019 there was 73% reduction in deceased donor (DD) transplants and 100% reduction in living donor (LD) in the April 2020 lockdown month; and it was estimated that in the 1st Lockdown quarter 904 fewer transplants were done compared to the pre-pandemic quarter (This shortfall accounted for 16% of waiting list cases) [13].

During the Pandemic period new organ transplants guidelines were implemented with respect to stopping procurement of organs from deceased donors especially those died due to COVID as well as complete suspension of live donor list. This new guideline thus has directly impacted the number of transplant procedures done during the Pandemic affected year 2020–2021. The NHS Blood and Transplant (2021) annual activity report covering the whole Pandemic affected 2020–2021 financial year has reported that due to COVID reason 5307 patients from previous years backlog on transplant lists were temporarily suspended and 4256 new patients were added on the transplant lists during 2020–2021 [14]. Compared to pre-Pandemic 2019–2020 level, 1882 (31%) less patients were newly enrolled on the transplant list with much fewer donors (DD and LD) in 2020–2021. During the Pandemic 2020–2021 number of DD fell by 400 and LD fell by 618 comparted to 2019–2020 (pre-Pandemic year); both together accounted for fall of 1014 (38.4%) donors due to the Pandemic. Consequently 815 (22%) fewer DD transplants were done during 2020–2021. Further, due to temporary suspension of backlog patients on transplant list, their waiting time regrettably got extended further by 12 months

and in this process 26% excess deaths occurred whilst waiting for their transplants in the pandemic year (474 vs. 377 in 2019–2020).

The postponement and delay in transplant services have affected the Black, Asian and Minority Ethnic (BAME) patients the most. Compared to 2019–2020, from BAME background 672 (35%) less patients were enrolled; the number of donors fell by 125 (46%) {28 in DD & 97 in LD}; and as a result, 437 (36%) less patients received DD transplants during 2020–2021 [7]. Similarly, 31% excess deaths were recorded for BAME whilst waiting for their transplants in 2020–2021 (169 vs. 100 in 2019–2020). These statistics comparisons (illustrated above and shown in **Table 1**) clearly reflect that BAME patients got affected the most during the Pandemic.

Finally, the Pandemic has impacted the BAME patients unfavourably in terms of waiting time for transplant. For instance, in the pre-Pandemic year the median time to transplant a kidney was 830 days for Asian and 965 days for Black and only 640 days for white patients [13]. Black patients continued to wait almost a year longer for a kidney transplant compared to white patients. Interestingly, 35% of white patients had received their transplant within one year after being listed for a kidney transplant whereas this figure was ironically low at 19% for BAME patients [15]. Thus, due to Pandemic, closer of transplant and suspension of backlog list has resulted in disproportionately extending the wait time for BAME patients; and increased the probability of dyeing whilst waiting for transplant.

4. Racism at work during the pandemic

According to the British Medical Association the racism at workplace experienced by BAME staff in the NHS is widespread; however, a surge in such cases during the Pandemic is unfortunate. In our recently concluded online survey of racism cases experienced before and during the Pandemic by the nursing and other healthcare professionals highlights a much wider and deeper problems in such a novel organisation. It is unfortunate to record and report such racism behaviours at the NHS despite several legislations are in place. The online survey conducted during January-May 2021 recorded responses of 308 BAME nurses, midwives and other allied healthcare staff who have faced racism at their workplace any time

	Pre-Pandemic (2019–2020)			**Pandemic (2020–21)**		
	All	**BAME**	**BAME per million population**	**All**	**BAME**	**BAME per million population**
Waiting List	6040	1909	28.5	4189	1237	18.5
Total Donors	2621	271	4.0	1579	146	2.2
1. Deceased donors	1566	112	1.7	1144	84	1.3
2. Living donors	1055	159	2.4	435	62	0.9
Total Transplants	4749	1204	18.0	3344	767	11.4
1. Deceased donors	3710	1010	15.1	2903	682	10.2
2. Living donors	1039	194	2.9	441	85	1.3
Total Deaths while waiting	377	100	1.5	474	169	2.5

Table 1.
Number of donors, transplants and waiting list in the UK, pre- & during Pandemic Financial Year for BAME & all Ethnicities.

- Job role (Nurse/Nursing Associate, Midwife, Medical staff, Clinical Support Worker, Allied Health Professional, Social Care Worker, Ancillary staff).
- Employed by (NHS, Agency, Private)
- Type of Care Setting (Hospital, Community, Primary Care, Nursing home/residential, Intermediate care)
- Experience of any forms of racism at work BEFORE the pandemic (Verbal abuse, Physical abuse, Excessive scrutiny/punishment, Prevented from progressing, other harassment, None of these). PROVIDE details of experiences.
- Experience of any forms of racism at work DURING the pandemic (Verbal abuse, Physical abuse, Excessive scrutiny/punishment, Prevented from progressing, other harassment, None of these).
- Treated unfairly regarding any of the following DURING the Pandemic (Distribution of PPE, Physically unsuitable PPE, Working in Covid19 positive environments, Access to risk assessment, Reasonable adjustment following the risk assessment, None of these). Provide details of experiences.
- Ever challenged racist treatment at work (Yes/No). If Yes, were treated fairly (Yes/No).
- Has workplace racism led to any of the followings (Poorer mental health, Took sick leave, Difficult to do job, Left job, None of these)?
- If ever been employed on a work visa, do you believe your immigration status made you more vulnerable to racism and exploitation? (Yes/No/NA).
- Ethnic origin (Black African, Black Caribbean, Black British, Black mixed heritage, Asian Indian, Asian Pakistani, Asian Bangladeshi, Asian Filipino, Asian Other, Asian mixed heritage, Arab, Other –Specify, White British, White Other).
- Age, Gender, Contact email.

Box 2.
Items of information collected in online survey for Nursing & Allied NHS staff.

during their work-life and including during the on-going Pandemic period [16]. The details of information collected is shown in **Box 2**.

4.1 Demographics

Out of 308 BAME respondents, majority of them were working for the NHS (267, 86.7%) and the rest 41 respondents with Non-NHS organisations. Three-fourths of respondents were women and nearly half of the respondents (48.05%) belonged to 31–44 age group which was followed by the middle age group of 45–54 (29.87%). These 308 respondents reported 11 types of ethnic backgrounds which are broadly represent as Black, Asian, and Mixed heritage. The largest number of respondents belonged to Black African (82, 26.62%) which is followed by Asian Indian (45, 14.61%), Black Caribbean (40, 12.99%), Asian Pakistani (39, 12.66%), and Asian Filipino (34, 11.04%). Overall, 165 (53.6%) respondents belonged to Black race. In terms of job role 190 (61.69%) of them were engaged as Nurses or Nursing Associates; the next clustering was of Allied Health Professionals (44, 14.29%). A majority of them were working in a hospital setting (200, 64.94%), which was followed by community setting (71, 23.05%). Out of 308 respondents 140 (45.45%) worked in this country on work permit whereas the remaining 168 (54.55%) did not need the permit.

4.2 Types of racism experienced at work

Table 2 shows the distribution of racism experienced by types at workplace before and during the across seven broad categories of BAME groups. Before the

Ethnicity	Verbal abuse	Physical abuse	Excessive scrutiny/ punishment	Prevented from progressing	other harassment	None of these	All
Before Pandemic							
Black African	32	2	47	51	30	12	174
Black Caribbean	9	0	23	29	20	5	86
Black Other	12	1	20	20	19	13	85
Asian Indian	11	0	12	28	14	8	73
Asian Pakistani/ Bangladeshi/Sindhi	14	2	15	27	14	13	85
Asian Filipino	14	1	8	15	15	7	60
Asian Other	6	1	7	16	12	2	44
All BAME (Count)	98	7	132	186	124	60	607
All BAME (Row%)	16.14	1.15	21.75	30.64	20.43	9.88	100.0
Black (Count)	53	3	90	100	69	30	345
Black (Row %)	15.36	0.87	26.09	28.99	20.00	8.70	100.0
Asian (Count)	45	4	42	86	55	30	262
Asian (Row %)	17.18	1.53	16.03	32.82	20.99	11.45	100.0
During Pandemic							
Black African	19	1	31	33	33	23	140
Black Caribbean	3	0	16	12	17	10	58
Black Other	6	2	7	11	12	20	58
Asian Indian	5	1	7	16	10	20	59
Asian Pakistani/ Bangladeshi/Sindhi	8	1	15	14	13	21	72
Asian Filipino	12	1	7	10	15	6	51
Asian Other	5	1	4	5	11	6	32
All BAME (Count)	58	7	87	101	111	106	470
All BAME (Row%)	12.34	1.49	18.51	21.49	23.62	22.55	100.0
Black (Count)	28	3	54	56	62	53	256
Black (Row %)	10.94	1.17	21.09	21.88	24.22	20.70	100.0
Asian (Count)	30	4	33	45	49	53	214
Asian (Row %)	14.02	1.87	15.42	21.03	22.90	24.77	100.0

Table 2.
Types of racism experienced at work before and during pandemic by BAME groups.

Pandemic, the main racism type experienced was 'prevented from progressing' which was reported by 186 people. This was followed by 'excessive scrutiny/ punishment' (132), and 'verbal abuse' (98). Compared to Black, a relatively higher proportion of Asian staff reported the main type of racism as 'prevented from progressing' (32.82% vs. 28.99%). The order of importance of next two reasons 'excessive scrutiny/ punishment' and 'verbal abuse' was slightly different between Black and Asian groups; Black staff experienced more 'excessive scrutiny/punishment' whereas Asian staff faced more of 'verbal abuse'.

During the Pandemic, the share of 'other type of harassment' was the highest (111 people) followed by 'none of the listed reasons' (106 people reported). The share of 'prevented from progressing' which was the prominent type before the Pandemic for 186 people was reported by fewer people (101) during the pandemic. Further, 'excessive scrutiny/ punishment' and 'verbal abuse' were reported by 87 and 58 people respectively during the Pandemic. Black people experiencing more of 'excessive scrutiny/punishment' and Asian people facing more of 'verbal abuse' continued during the Pandemic as well. Thus, the important types of racism experienced differed between 'before the Pandemic' and 'during the Pandemic'.

4.3 Number of types of racism at workplace

As shown in **Table 2**, 308 respondents mentioned various types of racism at workplace which totalled as 607 before the Pandemic and 470 during the Pandemic. This shows that several of respondents reported more than one type of racism. **Table 3** shows the distribution of 308 respondents by number of types of racism experienced before and during the Pandemic separately for Black and Asian groups. Before the Pandemic, a majority of Asians experienced one (53.15%) or two (20.98%) types of racisms whereas among the Black a relatively higher proportion of them experienced three types (4.24% vs. 14.69%) or 4 types (13.33% vs. 8.39%) of racism. Thus, before the Pandemic Black overall experienced more types of racism compared to the Asian group. The scenario during the Pandemic is bit at a lower intensity as most of the Asians reported only one type of racism and for the Black the portion reporting two types of racism is higher compared to the Asian group (14.55% vs. 9.09%).

Number of Types of Racism	Black		Asian		All BAME	
	Count	%	Count	%	Count	%
Before Pandemic						
0	1	0.61	1	0.70	2	0.65
1	73	44.24	76	53.15	149	48.38
2	27	16.36	30	20.98	57	18.51
3	40	24.24	21	14.69	61	19.81
4	22	13.33	12	8.39	34	11.04
5	2	1.21	3	2.10	5	1.62
All	**165**	**100.00**	143	**100.00**	308	**100.00**
During Pandemic						
0	0	0.00	0	0.00	0	0.00
1	113	68.48	106	74.13	219	71.10
2	24	14.55	13	9.09	37	12.01
3	18	10.91	16	11.19	34	11.04
4	9	5.45	6	4.20	15	4.87
5	1	0.61	2	1.40	3	0.97
All	**165**	**100.00**	143	**100.00**	308	**100.00**

Table 3.
Count of types of racism at workplace before and during the pandemic.

BAME	Respondents		Before Pandemic		During Pandemic	
	Count	%	Count	%	Count	%
Black African	82	26.62	174	28.67	140	29.79
Black Caribbean	40	12.99	86	14.17	58	12.34
Black British	23	7.47	39	6.43	30	6.38
Black mixed heritage	20	6.49	46	7.58	28	5.96
Asian Indian	45	14.61	73	12.03	59	12.55
Asian Pakistani	39	12.66	71	11.70	58	12.34
Asian Bangladeshi	5	1.62	14	2.31	14	2.98
Asian Filipino	34	11.04	60	9.88	51	10.85
Asian Other	12	3.90	25	4.12	18	3.83
Asian mixed heritage	2	0.65	6	0.99	2	0.43
Arab	6	1.95	13	2.14	12	2.55
All BAME	308	100.0	607	100.0	470	100.0
Black Race	165	53.57	345	56.84	256	54.47
Asian Race	143	46.43	262	43.16	214	45.53

Table 4.
Distribution of racism types at work before and during the pandemic by BAME group.

Table 4 shows the distribution of respondents reporting various types of racism experience before and during the pandemic at workplace (607 and 470, respectively) by detailed ethnic groups. The distribution of respondents across 11 categories of BAME group was surprisingly the same as those for the distribution of reporting total types of racism experiences; this implies that quantum of racism experiences was observed across the board by all 11 BAME groups people. Further, there was hardly any difference in the proportion of types of experiences across 11 categories of BAME between "during the Pandemic" vs. "before the Pandemic". Compared to Asian group, the Black group reported lower proportion of types of experiences during the pandemic vis-a-vis before the Pandemic (Black – 54.47% vs. 56.84% and Asian – 45.53% vs. 43.16%).

4.4 Covid-kit related unfairly treated cases by types

Table 5 presents the unfairly Covid-kit related cases by six types. The highest share of the reason was by 'None of the Listed Reason' (30.97%); which was followed by working in 'Covid 19 positive environments' (18.58%), adjustments after risk assessment (17.26%), and access to risk assessment (14.16%). These reasons did not differ much between Black and Asian staff; however, Asian staff relative to Black experienced discrimination in regard to distribution of PPE.

4.5 Impact on Health & Wellbeing

The results from the survey clearly highlights that NHS BAME staff had experienced racism both before and during the Pandemic; and several of them had gone through that traumatic experience more than once. The Pandemic period which covered just a span of one year and thus reported a high spurt of work-related and COVID-kit related cases when compared to the whole work-life span before the

Ethnicity	PPE Distribution	Unsuitable PPE	Covid19 positive environments	Access to risk assessment	Adjustment after risk assessment	None of these	All
Black African	10	13	27	23	19	38	130
Black Caribbean	5	7	9	8	12	19	60
Black Other	6	2	8	10	11	20	57
Asian Indian	7	5	7	4	9	23	55
Asian Pakistani/Bangladeshi/Sindhi	7	7	14	9	13	21	71
Asian Filipino	5	6	15	5	8	9	48
Asian Other	4	2	4	5	6	10	31
All BAME (Count)	44	42	84	64	78	140	452
All BAME (Row%)	9.73	9.29	18.58	14.16	17.26	30.97	100.0
Black (Count)	21	22	44	41	42	77	247
Black (Row %)	8.50	8.91	17.81	16.60	17.00	31.17	100.0
Asian (Count)	23	20	40	23	36	63	205
Asian (Row %)	11.22	9.76	19.51	11.22	17.56	30.73	100.0

Table 5.
Distribution of Covid-kit related unfairly treated cases by types.

Pandemic. More than half of respondents (53%) had experienced unfair treatment in the Pandemic in relation to COVID PPE kit, risk assessment or COVID-ward placement. The experience of racism has severely affected their current or previous placement as well as their health: 59% reported difficulties in doing their job, in 53% cases impacted mental health, and in 36% cases they left the job. Several BAME staff were scared and reluctant to report racism to their superiors/managers. Only about 60% of them reported to the management of which a majority (four-fifths) did not receive a fair response/deal from the management. This clearly reflects that several of BAME nursing and allied staff were deployed to COVID-risk wards and were treated unfairly with respect to both provision of PPE and other safety issues. These instances have affected their health and mental wellbeing and compromised their self-esteem and undermined the confidence to carry-out such a novel healthcare profession for the healthier society.

5. Conclusion

COVID-19 has shown widespread impact on social an economic life of people in the UK. The consequences are felt much more on the health and economic livelihood of minority ethnic groups living in the UK. We observed that both Black and Asian background people had experienced much larger COVID-19 and its variants infection rates with greater incidence of hospitalisation and use of Intensive Care Units and resultant high fatality rate when compared to their White counterparts. Men from BAME groups experienced high disability and mortality rates compared to White adults. Even after one-year living in the Pandemic environment both health and mental wellbeing of BAME people continue to remain far below than those of White population; thus, indicating a slow recovery among BAME people when compared with the pre-pandemic levels. Similar slow recovery was noticed in the case of life satisfaction indicator over a year or so. In terms of accessing specialist health services (organ transplants), the Pandemic has pushed up waiting times for transplant for BAME patients and in several cases waiting time has been extended to three years. In this process BAME patients have experienced much higher mortality whilst waiting for their organ transplants when compared to their White counterparts. Finally, a spurt in racism at work for BAME staff in the UK health sector has been noticed during the 12 months of Pandemic period. COVID-19 environment has also contributed enormously towards racism to BAME healthcare staff. Despite working in high risk-Covid wards under difficult time, their health and wellbeing has been affected severely. Unless we cannot adopt and implement zero tolerance racism policy at workplace, the racism against BAME workers cannot be halted. Behind all of these devastating impacts, the real issues lie in the fundamental socio-economic inequalities typically faced by BAME people over several generations caused by the high risks and low-paid employment and inferior living conditions. We will not be able to address the widespread differentials in health outcomes including mortality from COVID-19 until we tackle the disparity in the all-round life opportunities that BAME people have to deal with every day.

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