Wilton Park

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Report

Addressing the disproportionate impact of COVID-19 on minority ethnic communities

Tuesday 24 November 2020 | WP1861V

In association with:

GILEAD

AFRICA ADVOCACY FOUNDATION

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Introduction

"To address the disproportionate impact of the pandemic on minority groups, we must undo the generations of discrimination and neglect that have shaped its spread." United Nations High Commissioner for Human Rights, Michelle Bachelet

COVID-19 has disproportionately impacted minority and diaspora communities and vulnerable populations across the UK and globally. Rates of morbidity and mortality for COVID-19 are significantly higher in ethnic minority groups, compared to people of White ethnicity. This is attributed to a complex range of interlinking factors that are structurally embedded in our societies: social and economic inequalities - overcrowded housing, where people live, types of jobs, occupational risk, prevalence of pre-existing health conditions, systematic racism, discrimination, and stigma. The pandemic has exposed these longstanding structural inequities, which now require an effective and appropriate response from a range of people and institutions at local, national and global level.

This Wilton Park virtual dialogue brought together a group of over 60 people, from different faith leaders and community representatives, frontline health workers, healthcare bodies and institutions, policy makers, non-governmental organisations and academics from across the UK and internationally, to identify what support and action is required to protect minority ethnic groups from the adverse impacts of COVID-19.

The meeting was an opportunity for these stakeholders to listen and learn from each other. Participants shared the lived experiences of their communities from different parts of the world, deepened understandings about the kind of support needed in and across communities, and suggested strategies and solutions to achieve equitable health care to prevent the adverse impacts of COVID-19 on minority ethnic groups.

This request of bringing together faith and community representatives to support groups that are most at risk from COVID-19 is also a key recommendation in the Public Health England report Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities and Race Disparity Unit's Quarterly report on progress to address COVID-19 health inequities.

Summary: A call to action based on the dialogue

"How do we get to a position where people do not have to choose between health and wealth?"

This report summarises key points made by participants during the dialogue. The discussion did not seek consensus, rather it enabled participants to share insights and realistic opportunities for all stakeholders to collaborate and make progress. From the discussions, the problems highlighted to address the disproportionate impact of COVID-19 on minority ethnic communities are:

- **Structural racism**
- **Social and economic inequities**
- **Inadequate data and need for intersectoral data**

- **Lack of trust and spread of misinformation**
- **Struggling grassroot faith and community organisations**

To address these problems, the report summarises the urgent call to action to address the disproportionate impact of the COVID-19 pandemic on underserved minority ethnic communities and vulnerable populations.

The **call to action**, detailed further in the **Annex 2** is for governments and healthcare institutions to ensure broad and genuine engagement with faith and community organisations and leaders across the UK and in other countries. It is a call to come together, to better inform policies, programmes and practises, to address the disproportionate impacts of COVID-19 and facilitate equitable health outcomes for minority groups within the healthcare system. Equity, in the context of COVID-19, means treating minority ethnic groups according to their needs.

Recommendations

The meeting was one of collaboration, cooperation and mutual respect among all stakeholders. A number of key recommendations emerged from the dialogue as follows:

National governments:

There is an opportunity for the UK to lead in addressing these recommendations.

"We need data on testing, cases and death related to COVID-19, disaggregated by sex, age, or racial, or ethnic origin and other status so that policies can specifically target those most in need." UN High Commissioner for Human Rights, Michelle Bachelet

1. Acknowledge structural racism is a factor in causing the disproportionate impact of COVID-19 on minority ethnic communities and ensure when creating policies and programming, racial equity is taken into account to reduce inequities that result from socio-economic disadvantage. One avenue to ensure countries respond appropriately, is to turn to the United Nations (UN) through establishing a UN Special Rapporteur on COVID-19 and racism to highlight problems and disseminate good practice between countries. It was acknowledged the UN already has a Special Rapporteur on racial discrimination.
2. Collect and analyse comprehensive ethnicity and race data to improve understanding about how and why COVID-19 affects different communities, and thereby support policy and programming to tailor testing and health care to better protect minority ethnic populations. Ensure good data which is disaggregated to reflect diversity of the country and the intersectoral factors that cause inequities.

"For many minority communities the level of religious engagement is very high, so there is a blind spot in policy makers, and we need to challenge this blind spot."

3. Create meaningful partnerships with grassroots leadership and conduct honest, focused and engaged conversations with affected communities. Consider the lived experiences of minority groups, including health workers and community representatives, in policy design and decision-making processes. For example, establish a multi-stakeholder advisory board, that is representative and can lead on strategic engagement with government, faith and community groups, healthcare workers and institutions and engaged business partners to action key recommendations and support development and design of effective approaches to address the disproportionate health outcomes on minority ethnic communities.
4. Direct financial resources locally to community and faith organisations. Provide opportunities between public, private and voluntary sectors to partner and fund grassroots initiatives to address community health needs. For example, set up a racial equity fund to bring together different sources of funding, including government funds/grants, engaged private partners, other industry key players, so funding is available in one easily accessible place for community groups to better access these resources and opportunities.

"We need to upgrade the quality health care that has been undermined in many countries by austerity budgets and failures

5. Allocate sustained funding to address systematic issues of inequity and discrimination, including providing adequate support money for individuals on low income to self-isolate.
6. Develop a clear strategy and remit for engagement of key government departments

to invest in well trained health personnel." UN High Commissioner for Human Rights, Michelle Bachelet

and individuals to improve the social and economic determinants of health to support equitable health outcomes, specifically for minority ethnic populations and ensure that policies around funding connect with different aspects of society, which could better inform health service provision. For example, provide adequate funding for mental health provision, over-crowded housing and income support to increase the social security net for low-income households. Invest in the required infrastructure that is not restricted to projects and short-term goals.

7. Work alongside social media and online platforms to tackle misinformation and online harms and create appropriate policies to address the increase in misinformation, stigmatisation and scapegoating seen during the pandemic.

Faith and Community organisations:

8. Continue to reinforce public health messaging and ensure involvement in the designing of strategies to enable minority ethnic communities to make informed choices; to rebuild trust in healthcare services and government, by supporting and encouraging uptake of routine clinical services; reinforce messages on prevention, early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

"Local organisations have inroads into communities that are unrivalled and they have trust in ways that the government does not."

9. Continue to reach out to other ethnic minority communities by collaborating and coordinating with other faith and community organisations across the nation, both regionally and nationally. For example, create a community hub network, where faith and community groups can exchange good practice, demonstrate successful initiatives around COVID-19, address other issues impacting minority ethnic communities and share information on accessing funding.

10. Continue to demand from governments specific changes in policy and practice that will make a positive difference to the lived experiences of people in minority ethnic communities. Those faith and community groups represented at the meeting encouraged one another to show leadership within communities to support action that will make a difference to people's health outcomes.

Healthcare institutions and leaders:

"Health workers need to be involved in the decisions being made."

11. Ensure mainstream health services are accessible to all people, regardless of socio-economic status, ethnicity or other vulnerabilities, for example, remove linguistic, cultural and digital barriers to accessing public health information including accessing testing, use of the track and trace apps and other health and care services. Work with faith and community organisations to identify and design effective strategies and channels to disseminate public health information and provide resourcing for these groups to deliver directly to communities. Communication must be tailored to and engage different communities, to have their trust.

12. Continue building trust amongst minority ethnic communities by creating a workforce that is representative of the community it is serving. For example, conduct race audits and produce a roadmap to improve the recruitment, retention and progression of minority ethnic people.

13. Address social and economic determinants of health by ensuring health policies and interventions are co-designed, co-monitored and co-implemented by and for those most affected. For example, create a COVID-19 risk assessment passport for high-risk employees, in particular, key workers who work with a large cross section of the general public or who are in contact with those infected with COVID-19.

14. Maintain mechanisms to continually address racism and discrimination within the health system, impacting both workers and patients, for example, mandatory unconscious bias training, cultural awareness of issues facing different minority ethnic people. This requires honest, focused and deep listening with those that are

most impacted.

15. Work alongside social media companies to tackle misinformation and promote vaccines and prevention messages on COVID-19 to tackle misinformation. Include community organisations in designing this messaging and provide these groups with support to deliver this messaging to their communities.

Issues raised that have resulted in the disproportionate impact of COVID-19 on minority ethnic communities

Social and economic determinants and structural racism

"People won't isolate if they need to put food on the table. Even the £500 incentive to isolate is not enough and is a disincentive for people to not know their status."

Social economic determinants: COVID-19 has shone a light on the structural inequalities within today's societies. In a recent Public Health England report, it was stated that minority ethnic communities are more likely to live in overcrowding housing and therefore fail to self-isolate, making it easier for the virus to spread within these communities. In London, 30% of Bangladeshi households, 16% of Black African households, and 18% of Pakistani households have more residents than rooms compared with only 2% of White British households. Equally, many individuals and families from minority groups do not have income support or an adequate social security net to be able to stop working if they are required to do so, Pakistani and Bangladeshi households are more likely to have men working in 'shut-down' sectors (restaurant work, taxi driving) which could lead to high levels of financial insecurity in this group. Those able to work from home may not have adequate means to do so, due to lack of space and/or access to WIFI and equipment. Another example is the Roma community in Europe who are experiencing a perfect storm of deprivation, are least likely to receive social security support, are asked to isolate in crowded conditions, and children lack access to essentials like the internet for educational purposes and in some cases even water.

"When COVID-19 hit, members of discriminated groups were over-exposed to contagion because of low paid and precarious work in specific industries including healthcare. They were under protected because of limited access to health care and social protections such as sick leave and unemployment or furlough pay." UN High Commissioner for Human Rights, Michelle Bachelet

A number of factors result in ethnic minorities having a higher rate of underlying chronic conditions which increases the risk of death from COVID-19. Many Black men in the UK in a lower socio-economic status have a greater risk of co-morbidities than White British people in similar circumstances. Targeted and culturally appropriate public health strategies to combat deprivation, chronic conditions such as obesity, heart disease and diabetes, which lead to more serious health complications and death by COVID-19 should be prioritised by governments.

Structural racism: In England, research has found that minority ethnic groups have experienced racism in the health service; this has created long-term barriers to engagement and eroded trust. The report also states that National Health Service (NHS) staff from minority groups are less likely to have received personal protective equipment, are more likely to be bullied and driven into a position where they work longer hours and have to do the more dangerous jobs. Many from overseas are not able to reject the work they are offered because they are indebted due to expenses of gaining a visa to work in the health system. The NHS is a celebrated institution where the heroism of healthcare workers during this pandemic has been cemented across Britain, despite this, participants urged healthcare institutions to address historical racism, stigma and discrimination of minority groups at different levels.

It was noted the UK government's response to COVID-19 has not shown an appropriate and targeted response to the evidence on structural racism and the social and economic inequities. Whilst data shows minority ethnic people are disproportionately affected by COVID-19, they have not been prioritised as a group for testing or vaccination or social security support. Participants urged policy makers to use the data to inform policy changes which result in meaningful, equitable health outcomes for everyone.

The UN High Commissioner for Human Rights urged governments to 'build back better and not go back to normal.' The High Commissioner emphasised the need for social protection schemes not just for the transitional period during the pandemic, but long-term

adequate support which delivers universal and equal access to social welfare protections, including housing and health care, without any form of discrimination. This is important particularly in the context of the killing of George Floyd in May 2020, which prompted the High Commissioner to request a report on systemic racism to be presented at the Human Rights Council in June 2021.

Struggling grassroots

"There is a small amount of money to local communities for public health messages, but it is few and far between. The funding should be commensurate to the scale of the crisis in the UK."

The strongest response to crises comes from faith and community organisations in communities. Minority ethnic communities increasingly look to their own local community networks and leaders for meaningful guidance and support.

The UK government understands the value of community organisations; however, inadequate funding has meant many community organisations have simply been unable to cope and have closed down as a result. For those community organisations that are surviving, many are struggling to continue to operate, and there is a real fear that many more will disappear, and communities will lose this critical support. It was highlighted funding has been funnelled through a nationally-led recovery process, and therefore largely distributed centrally rather than locally, not reaching those community grassroots organisations who have been protecting minority ethnic populations from the adverse impacts of COVID-19.

Participants discussed local authorities could potentially coordinate and work with many community-and faith-based organisations to increase support to vulnerable populations, but there are few mechanisms and funding sources to allow them to do so, resulting in potential paralysis at the local level.

Lack of trust and spread of misinformation

"There are people saying that if I get Covid I will not go into hospital as I do not trust the system."

Many people in minority communities do not have trust in their governments, health services, hospitals, in public health messages or in vaccines. Trust has been eroded over a long period of time because of minority communities' experiences of structural inequities, racism, stigma and discrimination. During the pandemic, minority ethnic communities look to their own community leaders and groups for support instead. Distrust in COVID-19 vaccines may be as a result of mistrust within the healthcare system, and therefore mistrust in other vaccines. Participants noted that in the Somalian community in East London, the biggest issue is trust. Some people are saying that 'if I get COVID-19 I will not go into hospital as I do not trust the system'. This also includes the belief-mirrored in reality -that minority ethnic groups are under-represented in research and clinical trials. It was also discussed that decisions made by leaders in public health often do not represent the communities it is serving. Participants urged health institutions to create health policies and interventions that are co-designed, co-monitored and co-implemented by and for those most affected and to improve the recruitment, retention and progression of minority ethnic people, so leaders in health institutions are representative.

"Trust in government was declining before COVID-19 was taking place, and trust has been eroded, accelerated by misinformation and narratives on social media which can and has been weaponised."

Distrust of government and health systems has been further exacerbated through spread of misinformation, hate speech and false narratives circulating online through social media, which can and has been weaponised, and as a result, minority ethnic communities' have been falsely blamed for the spread of the virus. Governments and all those in positions of power should dispel any form of misinformation and scapegoating seen during the pandemic, including online, which could and has resulted in discrimination against people from minority ethnic backgrounds.

Inadequate data

"We need evidence to roll out meaningful policy, that means ethnic desegregation. In some EU member states there is a

Data collection on race and ethnicity in countries including the UK and the United States of America serves an important purpose to identify the problem. In some EU member states there is a deep reluctance to gather ethnically aggregated data. The European Union Agency for Fundamental Rights is gathering data where some EU states do not, but participants urged more needs to be done by these countries so there can be a

deep reluctance to gather ethnically desegregated data."

greater understanding of the issues and collective solutions found.

The current data collected in the UK does not capture the disparities of experience among different groups of people, nor is the collected data being used to adequately address the disproportionate impact on COVID-19 on minority ethnic communities. The impact of the COVID-19 crisis is not uniform across ethnic groups, and aggregating all minorities together misses important differences. Understanding why these differences exist is crucial for thinking about the role policy can play in addressing inequities. For example, within the Asian community in the UK there is much diversity, including but not limited to Bangladeshi, Pakistani, Indian, Chinese and people can fall into multiple groups with males, older people and those with underlying health conditions at greater risk. There is a need to act on the recommendations by community, faith and public health bodies for implementing disaggregated data collection to analyse the intersecting factors that cause multiple stigma and inequities.

Addressing the challenge: Harnessing the power of community

Community and faith organisations in the UK and elsewhere in the world play a critical role in protecting people in times of crisis, particularly supporting the most marginalised and vulnerable during the COVID-19 pandemic. There is consensus from all stakeholders that governments and healthcare institutions need to work in partnership with and provide adequate resourcing to faith and community led organisations to mitigate the adverse impacts of COVID-19 and form long term strategies for equitable health outcomes for minority ethnic groups. These meaningful partnerships are critical to saving lives; reinforcing individual and household risk reduction strategies; rebuilding trust within governments and healthcare institutions; strengthening messages on early identification, testing and diagnosis; and preparing communities to take full advantage of interventions, including contact tracing, antibody testing and ultimately vaccination.

"The strongest response comes from communities on the ground."

Legitimacy and representation

Across the UK, community and faith groups are providing crucial local support to minority ethnic people. Leaders of these communities, whether faith or otherwise, have the deep respect, trust and recognition of the people in the communities they serve.

It is time to harness the power of these critical organisations and leaders. Governments globally are not tapping into this vital set of knowledge, expertise and skills, their legitimacy, and their ability to effect positive change at the local level. There were calls for governments to ensure community organisations are represented in the decision and policy-making circles and to do this, the government needs to have more honest, focused and engaged in conversations with communities.

"Your voice matters, your engagement matters. Is it through this that we will obtain the change that we need."

Communicating with authority

Governments, particularly in the UK are taking steps to provide culturally appropriate public health messaging, but it was acknowledged that this is not enough, and more targeted approaches are required. Trusted members of the community need adequate resources to continue communicating COVID-19 messaging in the right way, in the right language, so that they will land well and be acted upon. It highlights the urgent need for more collaboration with religious leaders who can help with community-level communication and health literacy where it is needed. This is especially important as the COVID-19 vaccine becomes available. The need to dispel myths and increase trust in medical science and the UK public health system is urgent and necessary within minority ethnic groups.

In light of the huge challenges ahead, faith communities and leaders of churches, mosques and synagogues are coming together to talk, to collaborate, and to find ways to respond and communicate meaningfully about COVID-19 in their own localities. Participants urged for this continued collaboration and coordination, possibly through a creation of a community hub network to exchange good practice, demonstrate successful initiatives around COVID-19, address other issues impacting minority ethnic communities

and share information on accessing different funding mechanisms.

"There is a small amount of money to local communities for public health messages, but it is few and far between. The funding should be commensurate to the scale of the crisis."

Funding the grassroots

There was a call for governments to stop relying on community and faith groups performing essential support and communication work for free. These organisations and their leaders, including youth leaders, need proper financial support and development to continue their work.

It is also important to create opportunities for grassroots organisations to diversify their funding base. Developing and making available funding resources in one easily accessible place, so that community groups can access these funding opportunities easily and quickly would help small community groups in particular. This could be through setting up a racial equity fund, which could include and engage government, private partners who have shown interest and real commitment to addressing the disparities and other key industry players, including Black and minority ethnic owned businesses.

Local authorities also need increased resources and support to provide a locally effective response. While many local authorities provide culturally sensitive services, the demand is greater than availability, particularly for COVID-19 responses, and communities understand that funding might be cut at any time.

It was acknowledged there is no quick fix. Communities need deep, honest, and sustained investment that includes empowering community-based workforces to do critical COVID-19 work on outreach, testing, tracing, and vaccine distribution.

Conclusion

"Power concedes nothing without a demand. It never did and it never will." Frederick Douglass, 1857

Participants in this dialogue showed great desire to move from sentiment to strategy to implementation of actions to achieve equitable health outcomes for all in this time of crisis. It is critical for efforts to connect and engage policy makers with community and faith leaders so everyone can better understand and address the issues which are resulting in the continued disproportionate impact of COVID-19 on minority ethnic communities. Everyone has a role to play in supporting and enabling authentic and meaningful engagement across communities, faith and grassroot organisations, the government, healthcare service providers and the private sector to take forward actions to address the disproportionate impact on COVID-19 on minority ethnic communities. The call to action is for everyone to play their part.

Alison Dunn and Aneka Hussan
Wilton Park | December 2020

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Resources shared during the dialogue:

UK Government Quarterly report on progress to address COVID-19 health inequalities

BJGP article – "Racism and Health"

BMJ article – "Ethnic Monitoring and equity: Collecting data is just the beginning"

Health Leads USA Joint Statement on "Ensuring Racial Equity in the Development and Distribution of a COVID-19 Vaccine"

ARCC Report: "#COVID-19 Community Report" ARCC website

Bangla Britain Lockdown 2020 Report

BritBanglaCovid blog

Reuters article – "COVID toll turns spotlight on Europe's taboo of data by race"

CAHN COVID-19 Impact Survey Report "A Picture of Inequality – The Impact of COVID-19 on the Caribbean & African Community in Greater Manchester"

The Independent Panel for Pandemic Preparedness and Response

Annex 1 - Extract from speech during the dialogue by Michelle Bachelet, United Nations High Commissioner for Human Rights:

"I'm convinced we must make this a turning point for minority communities and societies across the world. It has been shocking to see the disproportionate toll of COVID-19 on individuals and groups who are marginalised and who suffer discrimination based on dissent, particularly people from religious or ethnic minorities, as well as indigenous people.

Shocking but not surprising. People who have been pushed behind and rendered powerless by generations of discrimination, have systematically unequal access to services and opportunities including nutrition, shelter, sanitation, access to employment, justice and participation in issues that affect them. They are placed in a structural disadvantage when it comes to any threat.

When COVID-19 hit, members of discriminated groups were over-exposed to contagion because of low paid and precarious work in specific industries including health care. They were under protected because of limited access to health care and social protections such as sick leave and unemployment or furlough pay. They were structurally less able to isolate themselves if they have been infected due to inadequate living conditions and inadequate access to sanitation meaning the virus could spread much more easily within their communities. Meaning the pandemic kept making all these factors worse.

We have got to learn the lessons of COVID-19. I believe in the possibility of change because I have seen it; transformative social change that brings reconciliation and a better future to an entire nation.

But to effect change we must learn the lessons of disaster and COVID-19 very clearly demonstrates that inequality and discrimination don't only harm the individuals who are directly and unfairly impacted, they also create shock waves that harm everyone across society.

To address the disproportionate impact of the pandemic on minority groups, we must undo the generations of discrimination and neglect that have shaped its spread. We need policies that uphold equality, and which deliver universal and equal access to social welfare protections and health care without any form of discrimination.

We need to upgrade the quality healthcare that has been undermined in many countries by austerity budgets and failures to invest in well trained health personnel. We need immediate and longer-term work to advance the right to social protection. Even in times

of crisis, states have a duty to allocate resources to protect the economic, social and cultural rights of marginalised people. And we need data on testing, cases and death related to COVID-19, disaggregated by sex, age, or racial, or ethnic origin and other status so that policies can specifically target those most in need."

Annex 2 - A call to action based on the dialogue:

From the discussions emerged an urgent call to action to address the disproportionate impact of the COVID-19 pandemic on underserved minority ethnic communities and vulnerable populations. The **call to action is for governments and healthcare institutions** to ensure broad and genuine engagement with **faith and community leaders and organisations** across the UK and in other countries. It is a call to come together, to inform for better policies, to address the disproportionate impacts of COVID-19 and facilitate more equitable health outcomes for minority groups within the healthcare system. Equity, in the context of COVID-19, means treating minority groups according to their needs.

To do this, faith and community leaders and organisations need far greater immediate and long-term support from the government through more effective targeted policy directions in public health and community engagement, and through the provision of financial resources.

There is also a clear **call to action for governments** to recognise the structural and systematic racism that exists, to acknowledge the causes of the disproportionate impact of COVID-19 on minority groups and to provide an appropriate and effective response in the light of this recognition and acknowledgement.

Many of the suggestions for action that participants made during the meeting echo a set of key recommendations for the UK from Public Health England (see Annex 3), reinforcing some powerful steps that can be taken to effect change in the UK and in other countries where appropriate.

The question is how and when these actions will be taken? Who will come forward in both community and policy arenas to collectively promote and facilitate the best possible outcomes in relation to minority groups who are disproportionately affected by COVID-19?

Actions for governments and policy makers

1. Acknowledge causes - Governments are urged to acknowledge and recognise that structural racism exists and is exacerbating the COVID-19 crisis among minority groups in the UK. Health inequities, stigma and discrimination and socio-economic deprivation have left minority groups at a structural disadvantage and more vulnerable to both COVID-19 infection and the social and economic impact of COVID-19 restrictions. This harms everyone across society, not just those directly affected.

2. Listen to policy requests and act - Governments of citizens with minority ethnic populations should listen to recommendations and policy requests from cross-sectoral stakeholders, and act to ensure that the national COVID-19 response is re-directed at those who are most affected and who need the strongest level of support, instead of pre-determined hierarchies of vulnerable groups. Importantly, this includes minority communities across the UK. Recommendations from the dialogue include addressing determinants of health in public health programming, embedding diversity and inclusion in all COVID-19 responses, and ensure representation and meaningful engagement of minority communities in policy and decision-making.

3. Connect with and fund community responses - Governments should recognise the vital significance of community and faith groups and leaders, their legitimacy, and their ability to effect positive change at the local level. People have deep trust and respect for their local faith and community leaders, who not only provide support, but can act as communicators of vital public health messages, including on vaccines, and work to dispel

myths and build trust. Governments need to provide deep, honest and sustained financial investment to grassroots organisations, which perform critical work and can transform communities.

Actions for faith and community organisations and leaders

1. Reach out - Faith and community leaders and organisations are urged to continue to reach out to ethnic minority communities and collaborate and connect with other faiths and communities across the nation, so that these groups speak and act with one voice and have more power in doing so. Community and faith leaders must continue to take this agenda forward to provide challenge to government and work with government to address causes of disproportionate impact of COVID-19 and more broadly, inequities within the health system.

2. Collaborate and Advocate - Faith and community organisations across the UK who are supporting communities being disproportionately affected by COVID-19, are urged to continue to demand specific changes in policy and practice that will make a real difference to the lived experiences of people in minority ethnic communities. Those faith and community groups represented at the meeting encouraged one another to show leadership within communities over actions that will make a difference to people's health outcomes, including tackling existing systematic barriers and preparing communities to receive vaccinations for COVID-19.

3. Build trust - It is in everyone's interest to build trust within and among communities most affected by COVID-19, so that people can gain or regain trust in health and other support systems. This is especially important as COVID-19 vaccines become available progressively within and across communities. However, trust will be more easily earned when government actions correspond to meeting minority communities' real needs.

Actions for healthcare institutions and leaders

1. Know your populations - To provide people-centred health services, healthcare institutions should identify all their sub-populations and address health issues at a real population level.

2. Ensure representation in the workforce - Healthcare workplace and workforce policies need to respond to diversity in the whole population; therefore, ensure the health workforce is representative including diversity in leadership positions. Policies need to be co-designed with minority ethnic frontline health workers.

3. Address stigma and discrimination - Healthcare institutions should address the stigma and discrimination of minority groups which happens at different levels: develop and design community health interventions that support people to access services without these barriers.

4. Ensure universal access - Ensure mainstream health services are wholly accessible to all people, regardless of socio-economic status, ethnicity or other vulnerabilities.

5. Improve health literacy - Health institutions could do more to improve health literacy among their populations, combat false information circulating on social media, and increase trust in the health system and services.

Annex 3 - Key recommendations from Public Health England, issued 2020:

1. Mandate comprehensive and quality ethnicity data collection and recording in NHS and social care data collection systems, including at death certification.

2. Support community participatory research to understand the social, cultural, structural, economic, religious, and commercial determinants and to develop solutions.

3. Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services; including audits, equity in workforce and

employment and rebuild trust.

4. Accelerate development of culturally competent occupational risk assessment tools for a variety of occupational settings.

5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns in partnership with local BAME and faith communities.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases.

7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long-term sustainable change.