

Understanding and addressing long-COVID among migrants and ethnic minorities in Europe



Marie Norredam,^{a,b*} Sally Hayward,^{c,d} Anna Deal,^{c,d} Charles Agyemang,^e and Sally Hargreaves^c

^aDanish Research Centre for Migration, Ethnicity and Health, Section of Health Services Research, Department of Public Health, University of Copenhagen, Denmark

^bDepartment of Infectious Diseases, Hvidovre University Hospital Copenhagen, Denmark

^cThe Migrant Health Research Group, Institute for Infection and Immunity, St George's, University of London, London, United Kingdom

^dFaculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, United Kingdom

^eAmsterdam UMC, Department of Public & Occupational Health, University of Amsterdam, United Kingdom

Several European countries have observed an increasing number of patients with long-term health consequences of COVID-19, popularly termed long-COVID. In the UK alone, recent numbers have shown around 860,000 people with self-reported long-COVID at least 12 weeks after infection, symptoms of which include persistent fatigue, neurological difficulties such as depression, headache, and memory loss as well as cardiopulmonary symptoms including cough, dyspnea and chest pain.¹ A wealth of evidence suggests that migrants and ethnic minorities have been disproportionately impacted by COVID-19, in terms of cases, hospitalisations, deaths and mental health outcomes in many European countries.^{2,3} In addition, emerging data have suggested inequities in the delivery of vaccines to these populations.⁴ We here describe migrants and ethnic minorities combined because these groups overlap and share common characteristics including socioeconomic and psychosocial vulnerabilities. The term 'migrants' is used as an umbrella term encompassing all the different subgroups of people who immigrated including asylum seekers, undocumented immigrants etc. The extent to which migrants and ethnic minorities are impacted by long-COVID is, however, not known, despite an increasing literature identifying a number of relevant risk factors for long-COVID including older age, disease severity, comorbidities and admission to Intensive Care Units.^{1,5} The few studies on long-COVID that do include data on migrants and ethnic minorities suggest that they are disproportionately impacted by long-COVID, but data are lacking in European countries and beyond.^{6,7} One UK study found that among 100 patients assessed by telephone interview 4-8 weeks after discharge from admission for a severe COVID-19 infection, those belonging to Black, Asian, and minority

ethnic groups were more likely to experience dyspnea than White individuals (42.1% versus 25%) whereas rates of Post Traumatic Stress Disorder (PTSD) were similar.⁶ A US study based on 711 telephone interviews done among individuals at least 2 months after a positive test result for COVID-19 found that individuals reporting as Black were at higher risk of having 'any long-COVID symptom' and specifically dyspnea and arthralgia/myalgia compared to other ethnic groups including those reporting as White.⁷ These ethnicity datasets are highly heterogeneous and rarely disaggregated by migrant status, making it difficult to assess the impact on more recent arrivals from overseas, who may have a range of unique risk factors for worse health outcomes, including restricted access to health and vaccination systems.^{8,9}

A large number of migrants and ethnic minority individuals suffering from long-COVID is a major concern for equity in health. It is already well known that migrants and ethnic minorities are more likely to experience informal and formal barriers to health services, diagnosis, and treatment in general, which may also be the case in terms of their ability to access services for long-COVID with unknown impact on long-COVID related morbidity among this population. Further, long-COVID may have more far-reaching implications among these populations as they are often more socioeconomically vulnerable, holding more temporary jobs with a greater job insecurity, in the absence of safety nets and financial support.¹⁰ Consequently, unattended long-COVID among migrants and ethnic minorities is likely to exacerbate existing social inequalities and inequalities in health.

Addressing long-COVID among migrants and ethnic minorities will require a multisectoral response and funding. Public health authorities should ensure that COVID-19 health consequences and their impact and prognosis are communicated to the entire population, including migrants and ethnic minorities facing barriers to health systems, which requires taking a culturally competent approach to public health

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*Corresponding author.

E-mail address: mano@sund.ku.dk (M. Norredam).

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communication and effective translation of health resources. In addition, special efforts should be made to ensure easily available, affordable and accessible access to diagnostic workup and care for people with long-COVID with a migrant and ethnic minority background. These groups must be better considered in referral from primary care and after admission to diagnostic work up and rehabilitation.

Another critical gap is the need to ensure inclusion of migrants and ethnic minorities in research on long-COVID, so we can understand the long-term consequences of this pandemic on a population group that experienced disproportionate clinical outcomes to other populations groups; the COVID-19 pandemic has itself highlighted longstanding underrepresentation of migrants and ethnic minorities in clinical research. This should include assessing if migrants and ethnic minority groups are disproportionately affected by long-COVID compared to the majority population, in order to ensure their access to follow-up care including multidisciplinary rehabilitation care. Further, greater focus must be placed on experiences of symptom diversity across minority and majority groups and on assessing and understanding the impact of long-COVID on socio-economic circumstances among migrant and ethnic minority groups – for example, the impact on work life, disability, and income – as well as exploring the impact in terms of levels of stigma and discrimination. Together, a better understanding of long-COVID in migrants and ethnic minorities will enable us to take action to address inequities in the long-term clinical outcomes of this and future pandemics, in line with the principles of equity implying justice and Universal Health Coverage.

Contributors

MN: Conceptualization of commentary, first draft and revision of drafts.

S Hayward: Revision of drafts and review of literature.

AD: Revision of drafts and review of literature.

CA: Conceptualization and revision of drafts.

S Hargreaves: Conceptualization and revision of drafts.

Declaration of interests

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