SUBMISSION TO PPT BERLIN

INSTITUTE OF RACE RELATIONS

Person or collective introducing the case

This is a joint submission from the Institute of Race Relations and the PPT London hearing steering group (an ad hoc group of migrant rights organisations set up to organise the November 2018 PPT London hearing). It is based on evidence and reports from organisations including Kent Refugee Help; Lifeline Options; Migrants Organise (whose report *Patients not passports*, written jointly with Medact and the New Economics Foundation, is in turn based on evidence from 70 representatives of 53 community groups across England and Wales), the Voice of Domestic Workers (a self-help organisation of migrant domestic workers in England), the South Yorkshire Migrant and Asylum Action Group (SYMAAG), which works with asylum seekers in Yorkshire and the north-east of England and in Scotland; RAPAR and Kanlungan Filipino Consortium's report *A chance to feel safe: Precarious Filipino migrants amid the UK's coronavirus outbreak*, and on reports published on the *Covid chronicles* blog including Sisters not Strangers' *Hear Us!*, written by migrant women. We have also drawn on the insights of Wayne Farah of the National Health Service (NHS) Confederation Black and Minority Ethnic Leadership Network, on inequalities and institutional racism within the NHS, on the extensive reporting for IRR News by John Grayson of SYMAAG on asylum accommodation and health, and on IRR's news articles and fortnightly calendars of race and resistance.

Intention of giving testimony (oral/ written)

Where individuals from the organisations whose testimony is summarised in our submission wish to give oral evidence, they have contacted the Tribunal direct. Apart from that, a spokesperson from the London PPT steering group or the IRR is willing to supplement this submission if judges have questions.

Focus of the submission

Our focus is on violations of migrants' and refugees' right to health during the coronavirus pandemic, and the impact of these violations on workers, those with problematic immigration status and on migrant communities. We have organised the submission differently from the template response, which we hope does not cause difficulties; we have tried to cover all the questions relevant to the UK experience.

Introduction

From early April, evidence was emerging that Black and minority ethnic (BME) people (including migrants)[1] were disproportionately affected by Covid-19, becoming critically ill and dying in far greater numbers than their proportion in the population – up to four times more. Risk factors cited included occupation, deprivation, poor and overcrowded housing in polluted neighbourhoods, and the impacts of racism. The Intensive Care National Audit and Research Centre, the Institute for Fiscal Studies, the Office for National Statistics, the Royal College of Midwives, Public Health England, the

1[1] People who obtain British citizenship, together with their children, are no longer described as 'immigrants'; the convention is to consider individuals and communities that have their origins in immigration as 'ethnic minorities', with the term 'black and minority ethnic', or BME, referring to people of African and Asian descent. But in the context of Covid-19 deaths, the term BME (or BAME, Black, Asian and minority ethnic) is used to cover both British and migrant residents, and it is not currently possible to know what proportion are migrants.

Welsh Senedd, a cross-party inquiry by five former health ministers, the Wellcome Trust - all found the same race- and class-linked disparities.

The studies, including that conducted by Public Health England, did not separate out migrants and refugees from British Black and minority ethnic people, but many NHS medical and support staff, from doctors to cleaners and porters, are migrants, as are many staff in care homes, domiciliary care workers, and domestic workers. Migrants fill many other 'key worker' roles, in food harvesting and processing, retail, warehouses and as delivery drivers, as well as in manufacturing, over-represented in poorly regulated and exploitative textile factories and sweatshops. Migrants and refugees are also over-represented in poor, deprived and polluted neighbourhoods, and they suffer the impacts of racism.

Yet in the face of this emerging evidence, and despite the urging of dozens of migrant organisations, local authorities and parliamentary committees, and a crisis of food poverty, the government took a number of decisions which ensured the continuing exclusion and marginalisation of poor, low-paid and undocumented migrants and asylum seekers, with reckless and callous disregard for the impacts on their health and on public health:

- it refused to lift the 'no recourse to public funds' rule on visas, a decision which locked migrants who lost jobs and income out of life-saving support;
- it refused to grant any form of legal status to undocumented migrants and refugees to enable them to access work, housing, benefits and health care;
- it refused to waive 'hostile environment' policies calculated to drive undocumented people to leave the country[2] despite the impossibility of leaving the UK when borders were closed, causing immeasurable impacts on physical and mental health;
- it refused to empty detention centres (despite the impossibility of deportation), prisons, and mass asylum accommodation, exposing vulnerable detainees and hostel residents to huge physical and psychological risks;
- it failed to take seriously, or act on, the evidence of institutional racism despite evidence of its role in the health disparities exposed by the virus, and failed to clamp down on popular racism which blamed victims.

In this situation it has been migrant communities and civil society which have stepped up to create networks of mutual aid and support for the most vulnerable.

Creating the conditions for ill health

Exorbitant fees to renew visas,[3] and visa conditions which say 'No recourse to public funds'(NRPF), push migrant workers into multiple jobs, long hours, and having to work when ill as they cannot access social security benefits. Those with irregular status, unable to work or rent housing legally, are pushed into the most exploitative work and slum housing, or destitution and homelessness. Policies of indefinite detention pending deportation create and exacerbate mental illness. The contracting out of asylum housing to cost-cutting companies results in squalid and unhealthy conditions for those seeking asylum. And exposure to racism damages health by causing and/ or exacerbating stress.

'No recourse to public funds'

The Food Foundation reported in April that three weeks into lockdown, over a million people had lost all their income, of whom over a third had no access to government help, and at least 1.5 million

2 Policies criminalising unauthorised work and excluding undocumented migrants from housing, welfare benefits, social and hospital care, designed to make life impossible so they self-deport. For details see *The embedding of state hostility*, IRR, November 2018.

3 The fee to renew a migrant worker visa is over £1,000 per person, and an additional £624 per person per year health surcharge (health and care workers pay reduced fees, see text).

people had gone whole days without meals, with no money and no access to food. An estimated 1.4 million people were denied emergency support by being excluded from the Treasury-funded furlough scheme and from social security benefits during the pandemic, because of their immigration conditions.

Kent Refugee Help, which supports immigration prisoners before and after release, reports that the majority of their clients living in the community post-prison and immigration detention have No Recourse to Public Funds (NRPF). Many are dependent for survival on friends and family, who in some cases became unable to work during lockdown. Churches and foodbanks were also forced to close, ending another crucial support. Four organisations - Migrant Rights Network, Public Interest Law Centre, Asirt and Project 17 – researched this situation with the University of London. Their report, *Local Authority responses to People with NRPF During the Pandemic*, described the crisis created by the extreme underfunding of local authorities combined with the destitution faced by migrants who are excluded from welfare support, and found that 'people with NRPF are more likely to become seriously ill or die if they contract Covid-19. Despite this it has been difficult for many people with NRPF to access the help they need, including food, adequate shelter and subsistence support during this public health crisis.'

The experience of migrant workers during Covid

The London hearing of the PPT (November 2018) explored the hostile environment and its effects on living and working conditions for migrants and refugees. We refer you to the evidence presented at that hearing for details.[4] These effects, as well as the impacts of racism, have been exposed and magnified by the pandemic. Low pay, inability to maintain social distancing and lack of PPE combine with pressure to work while sick to produce high death rates in sectors employing migrant workers, often on zero-hours or agency contracts, factors multiplied by precarious status and the hostile environment. In May the Office for National Statistics found that security guards and taxi drivers had some of the highest death rates from Covid-19, and cleaners, chefs and shop workers all at increased risk. *Food processing workers*, many of whom are migrants, are key workers. Cramped conditions and inadequate hygiene facilities had led to nearly 1,500 cases linked to food processing plants by late summer. The World Health Organisation's Covid-19 envoy said Britain's demand for cheap food could be fuelling the spread of the virus.

During lockdown, from 23 March, workers in non-key occupations were furloughed, with government paying 80 percent of wages. But workers in *fashion* warehouses, among other non-essential sectors, were often forced or pressured to continue working. Leicester's 'fast fashion' factories and sweatshops, where workers are paid as little as £3.50 per hour making clothes for online fashion brand Boohoo and conditions are said to be worse than China, Sri Lanka or Bangladesh, was the cradle of resurgence of the virus in June, with Labour Behind the Label claiming that workers were forced to work when ill. Labour rights groups warned that similar abuses were found in garment and other factories in Birmingham, Manchester and London, and in construction, cleaning and farming across the UK. Health and safety and minimum wage inspections are so rare as to provide no incentive for employers to comply with legal obligations.

- In July, 73 workers at a vegetable farm supplying supermarkets tested positive for coronavirus and 200 were quarantined. Three ran away, describing the impossibility of distancing in the packing shed or in the shared caravans provided for workers to live in;
- In August, nearly 300 workers at a sandwich-making factory supplying Marks & Spencer tested positive, as union representatives said staff could not afford to self-isolate;

4 *How the hostile environment creates sites without rights*, 2019. See the website of the PPT London steering group on migrant rights.

- Outsourced *cleaner* Emanuel Gomez, from Guinea Bissau, died in May because he could not afford to take time off from his job at the Justice Ministry when he fell sick.
- Three *Uber drivers* died in just over a week in April, exposing the vulnerability of migrant workers forced to continue working in insecure and dangerous employment for lack of entitlement to benefits.

Domestic workers

The Voice of Domestic Workers (VDW) reports that each year, the Home Office issues 19,000 visas for domestic workers – cleaners, cooks, chauffeurs, nannies and personal carers - in private households. Unlike other workers, domestic workers have no route to settlement: their visas are limited to six months. Of 528 surveyed by VDW, over three-quarters have suffered abuse and less than half have enough to eat, but their visa conditions make them likely to become undocumented if they leave employers. During the pandemic, live-in domestic workers have sometimes lost their jobs and homes, while those kept on are often overworked and hungry, wages have been cut, some are confined to their workplaces, with no PPE and social distancing impossible even when required to care for those infected with Covid-19. Twenty VDW members who live out, have lost jobs and income, and cannot get any state benefits or assistance. Some, who have been accepted on to the modern slavery referral scheme (NRM) and are awaiting a final decision, are given £35 per week (€38) to live on but not permitted to work.

Testimonies:

- My American employer asked me to leave the house in mid-March because of Covid-19, but said I would get my job back after lockdown. In April, they texted that they could not afford my salary and wouldn't give my job back. I am jobless and homeless. I looked for new jobs and got an interview but they wanted me to work from 7am to 9pm. It's too harsh. Another asked for my passport, but my first (Qatari) employer had kept it. I stay with a friend, I get £35 per week from the government after a positive reasonable grounds decision [ie, that I was subjected to slavery], that's it, no other income, no extra money to send to my family. It's very difficult. (Filipina woman, 26)
- I felt like I'm in a cage, in prison. Since two weeks before the lockdown, I have been forbidden to go out by my employer - not to buy food or take exercise. My life evolves in this flat. I'm locked inside. My employers are elderly people from Iraq. I only received two weeks' salary last month. I asked why, they just ignored me. Before the lockdown, I had one day off a week. Now I have none. I work from 8am to midnight everyday. They let me do online classes with VDW, but no days off. I don't have enough money to send back home to support my 3 children. I borrowed money from a VDW member and she helped me to arrange remittance. I feel very sad. (Filipina woman, 38, 2 years in UK)

Health and social care workers: impacts of racism

Many nurses, social care workers and NHS ancillary staff are migrants, required to pay huge fees to renew their and their families' visas and additionally, to pay an 'immigration health surcharge' to be treated in the NHS they work in. Early on in the pandemic, it was apparent that migrants and BME staff were at disproportionate risk of infection and death. Seventy percent of frontline NHS health workers who had died of Covid-19 by mid-April were BME. By July, over 540 health and social care workers had died of the virus, the second-highest rate of Covid-19 health worker deaths in the world, of whom up to 60 percent were BME. The Filipino Nurses Association said that more Filipino nurses and care staff had died in the UK than in the Philippines. Filipinos accounted for a quarter of all deaths in the NHS workforce and nearly one-third of deaths among nurses.

It was not only, as some politicians and journalists claimed, that Black and minority ethnic people, whether British or migrants, had different constitutions or metabolisms which made them uniquely susceptible to coronavirus. Institutional racism in the NHS combined with failures in provision of testing and protective equipment with deadly consequences for migrant and other BME staff. As Wayne Farah of the NHS Foundation Black Leadership Network said in April, the government 'failed to protect us by not following the basic principles of emergency planning, infectious disease control or advice from the World Health Organisation. The leadership of the NHS must also be held accountable for their role in the unnecessary deaths of NHS … workers'.[5]

Frontline medical and care staff were not provided with personal protective equipment (PPE) or tested in the first weeks of the pandemic. In March, doctors and nurses revealed they had been warned not to go public over the lack of PPE, with two doctors sent home for speaking out. In April, as it emerged that the first ten doctors to die of Covid-19 were of Asian, middle Eastern and African origin, the chief coroner told coroners in England and Wales not to address failure to provide PPE in the inquests of dead key workers. In May, BME doctors were still having problems accessing PPE and tests, and BME nurses were having more problems accessing PPE than white nurses.

Research from the British Medical Association found that BME doctors were twice as likely not to complain about safety in the workplace for fear of reprisals, while an NHS Trust official suggested that 'the system may be biased' in placing so many BME nurses and healthcare staff in coronavirus wards. Even when the risks had become obvious, a quarter of BME healthcare staff had not been risk-assessed for Covid-19.

In a survey of 2,000 BME NHS staff, one-half said discrimination played a role in the high BME deaths, with one-fifth having experienced it personally. In June, an internal investigation found systematic racism, discrimination and abuse and a toxic atmosphere in a large unit in the NHS blood and organ transplant division. And in September, another NHS hospital trust found systematic racial bullying of BME staff, who experienced high levels of discrimination by managers and were less likely to reach top jobs. Doctors' leader Chaand Nagpaul warned that the government had taken no remedial action to mitigate the disproportionate Covid-19 risks to BME staff and communities.

In care homes, early in the pandemic hospitalised elderly residents were sent back to clear hospital beds without being tested, care home staff without PPE resorted to cleaners' rubber gloves and bin liners to protect themselves, but many died. After five care workers were sacked for raising concerns about PPE shortages and understaffing, it emerged that 170 more had called a whistleblowing helpline with similar concerns.

When the government announced in April that the visas of migrant NHS frontline staff would be automatically extended for a year with no fee and no health surcharge, and that bereaved families of health workers who died fighting the virus would be granted indefinite leave to remain, porters, cleaners and social care staff were excluded. Following public and political pressure, migrant NHS staff and care workers were exempted from the health surcharge. But the government also confirmed that there would be no immigration route for workers not meeting the skills or salary threshold (normally £25,600) from 1 January 2021. This excludes most care workers from residence rights. Half of all care workers, it was revealed, are paid below the real UK living wage, set at £9.30 per hour (£10.75 in London). Unions' calls for a new minimum wage for care workers of £11.50 an hour have gone unheeded. The 'No Recourse to Public Funds' rule means care workers, like workers in other low-paid sectors, can't afford to take time off for sickness or self-isolation.

5 'Institutional racism in the NHS intensifies in times of crisis', IRR News, April 2020.

- V, a Filipina working in an NHS ward, caught the virus, then her husband caught it. She was off work for 2 months altogether. Initially the ward lacked PPE, up to half the staff were off at a time and although the hospital then employed agency staff, she worked longer hours and was depressed, tired and hungry, with no time to eat when they were busy. She was grateful for support from local restaurants.

- R, a private care home employee from India, was confronted by her manager when she wore gloves, an apron and a mask to work in March. Her employer failed to provide PPE for a long time. For several weeks after lockdown, 80 percent of the staff were off at any one time, meaning massive extra work, hours and pressure. Fifteen residents died. When she tried to relieve stress by singing to patients, the manager racially abused her, and suspended her when she shouted back. She had only been paid for one month out of three worked (at the time of interview) and was awaiting a disciplinary hearing.
- Ms C had depended on her marriage to resolve her insecure immigration status, but just before the pandemic her husband was deported. She worked in a care home, on a very low wage, to support herself and her daughter and pay solicitor's fees to renew her visa. She contracted Covid-19 at work, then lost her immigration appeal and her right to work. She was not eligible for social welfare and faced eviction.

Being undocumented during the pandemic

Early on in the pandemic, dozens of migrant rights charities and church leaders wrote to the prime minister calling for temporary leave to remain to be granted to all migrants and asylum seekers, to prevent exploitation, destitution and homelessness and to ensure universal access to benefits, public services and medical care. The government always claimed that the point of hostile environment policies was to make undocumented migrants leave the country, by making it impossible for them to live here. Obviously this logic could not apply when borders are closed. But the punitive policies continued. The government refused to grant any form of leave, and refused to suspend hostile environment policies – meaning that exclusion from subsistence benefits, sanctions for landlords letting to undocumented migrants, for those employing migrants and asylum seekers not permitted to work, and criminalisation of the workers themselves, as well as charges for medical treatment (with the exception of testing and treatment for coronavirus), all remain in place. The government knows that the effect of these policies is to make life intolerable for those subjected to them – that is their purpose. This is a violation of rights to health, to physical and psychological integrity, to livelihood, to housing, and constitutes inhuman and degrading treatment.

The work done by undocumented migrants is nearly always manual. It can't be performed remotely. It is almost always exploitative, frequently paying below the minimum wage. There is no statutory sick pay for those falling ill, no tax credits, no furlough or self-isolation allowance for those told to stay at home.

A June 2020 report by RAPAR and Kanlungan Filipino Consortium, *A chance to feel safe: precarious Filipino migrants amid the UK's coronavirus outbreak*, points out that the official reports all omit the undocumented migrant workers, many of whom work in social care and domestic work, in close physical contact with others, but invisible, and unable to benefit from any of the measures put into place to mitigate the effects of the pandemic. None could work from home. Respondents to their survey, mostly undocumented middle-aged Filipina women living in the UK for ten years on average, had an average wage of £6 per hour (the minimum wage in London is £8.72 and the London Living Wage £10.75). Some earned less than £2 per hour, working 16-hour days in private homes. Their undocumented status prevented them negotiating better pay or conditions.

The pandemic has had catastrophic effects. More than half of the respondents had lost all work and all income, and were relying on informal loans and charity. As three-quarters had no formal tenancy agreement, they could not benefit from the government-imposed ban on evictions. Remittances home – after rent, the main priority – had become impossible, and awareness of the hardships this caused family back home was a source of huge distress. Those who still had work could not afford to stop, even if they had Covid symptoms.

The stresses of being undocumented and the fear of discovery, and the added stresses of unemployment or overwork, no or scant income, debt, homelessness or the fear of it, and the inability to support family, exact a toll on mental as well as physical health.

Testimonies

- I'm a live-out domestic worker. I worked for three employers before the lockdown. One was a doctor. I cleaned his house. He was very sick and hadn't been to work for long time … I started feeling unwell. I lost my appetite, had low fever and body ache and coughed a lot. These are symptoms of Covid-19. I was so scared. Because I'm undocumented, I have never registered GP. I can't go to hospital. For a month, I was unwell. I took care of myself. I lost all my jobs, I don't have any income. My family asked, 'when are you going to send money?' I said, 'I can't. I don't have jobs now.' I feel very stressed. I don't know when I will have my jobs back. I started looking for new jobs. Last week I had an interview. They said they could offer me a live-in job, but the conditions are so hard. … I won't be allowed to go out at all before September. It is too hard. I feel like I'm in jail. I didn't accept the job offer. The stress has made my asthma even worse. I can't get any help from doctors because I'm hidden. I'm staying with my friend. There is no internet in the house. I feel very lonely. I can't even talk with my family and friends online. (Filipina woman, undocumented, 6 years in the UK)
- I'm a live-out domestic worker. I had three part-time jobs, they all cancelled my service. I don't have income at all. It has become difficult to pay my rent and food. I don't have any access to public funds. Overseas Workers Welfare Administration of Philippine Overseas Labour Office has given me $200. VDW is going to provide me £250. They are good, but I don't have any other income now. I'm really worrying about my 4 children and family back home. I'm their only source of income. If I don't work, who will feed them? Some friends gave me cash. It's difficult. I don't know whether my employers will give my jobs back. They say they will, but I don't know when. Social distancing is not possible in our workplaces. I have started looking for new jobs and asking people I know, but I haven't got any response. I feel stressed every day. (Filipina woman, 46, undocumented, 7 years in UK)

Migrant, refugee and asylum seeking women in the pandemic

Most domestic and care workers, nurses, cleaners and hospitality workers are women, as are workers in garment factories and in food processing plants. As migrant or refugee women, they face additional problems over and above those encountered in the workplace.

The Public Health England review found that BME women were almost three times more likely to die from Covid-19 than white women. Asylum seeking and undocumented women are among those most affected, with charities closing and their small hardship payments and meals no longer available. A survey of 115 asylum seeking women, and those helping them, by the coalition Sisters not Strangers found that while one-third had serious health conditions, three-quarters were going hungry and one-fifth were homeless or 'sofa surfing', unable to socially distance. Seventeen had shared a room with someone with Covid-19 symptoms, and sixteen had been forced into exploitative

work in exchange for shelter and food. The requirement to make applications to local authorities for housing online was impossible for destitute homeless women.

With schools, nurseries and other forms of childcare closed for most children, women with young children who were unable to access benefits because of their status, and unable to work, struggled to feed themselves and their children, with many resorting to food banks. The inability to afford fresh food exacerbated health problems. Women on asylum support could not find staple foods because of panic buying at the beginning of lockdown, and could not afford bus fares to look further afield. And digital exclusion meant inability to access vouchers for free school meals for children that were emailed to them, as well as impacting on the education of these children while schools were closed, as learning moved online on the assumption that families can access the internet. Laptops promised to poor families did not reach many of those needing them most.

A report by Women for Refugee Women published in February, based on the experiences of over 100 refugee women, found that nearly four-fifths had fled gender-based violence in their own country, and one-third had been raped or sexually abused in the UK. Their vulnerability is hugely amplified by unsafe and insanitary living conditions, and denial of claims arising out of the 'culture of disbelief' at the Home Office, leading to destitution homelessness and despair. Almost half of WRW respondents were street homeless; 95 percent had experienced hunger and destitution. One-third had attempted suicide.

Sisters Not Strangers point out that since then, the pandemic has created 'tinderbox conditions' for women in society at large – increased economic hardship, blocked escape routes and the closure of services providing help. Migrant women who are undocumented or have no recourse to public funds are more trapped than most in violent and abusive relationships, unable to move to mainstream women's refuges, unwilling to go to the authorities and with no other recourse.

- In August, the body of Mercy Baguma, a Ugandan asylum seeker, was found beside her crying, hungry infant son. Glasgow migrant support group Positive Action in Housing said Mercy had lived in 'extreme poverty', after she had to stop working weeks previously as her right to remain had expired. She had claimed asylum and had received food from African Challenge Scotland.

Housing and health

People from ethnic minorities are twice as likely as white British people to live in areas of environmental and housing deprivation. Low-paid migrant workers generally live in older, poorer and more crowded neighbourhoods, often in multiple-occupation houses sharing kitchens and bathrooms with other families. Early on in the pandemic, studies found such areas had seen 70 percent more Covid-19 cases than less crowded areas, and later on a leaked Public Health England document indicated that the virus could be 'endemic' and ineradicable in areas of severe deprivation, poor housing and large BME communities. According to one community group, the local council called Covid-19 'the housing disease'.

Brent Poverty Commission, examining local inequalities, poverty and the pandemic, said in August that appalling housing conditions and crippling rents in the north-west London borough, where two-thirds of the population is BME, turned it into a Covid-19 hotspot, after the second-worst cluster of coronavirus deaths in the country occurred in June in Brent's Somali Church End district, where one-third of residents are in poverty, half through housing costs.

Evidence also emerged that these were areas of the highest air pollution, cited in a number of studies as a significant exacerbating factor in the death rate.[6] In July, the north London waste authority announced a huge expansion of its Edmonton incinerator, in an area where two-thirds of residents are BME and air pollution already breaches legal limits. Waste incinerators are three times more likely to be sited in deprived and ethnically diverse areas, damaging the health of residents.

Meanwhile, charities were reporting an alarming number of newly homeless people on the streets, despite the government's provision of hotel rooms for rough sleepers during the pandemic, as workers in the hospitality sector, many migrants, lost jobs at the beginning of lockdown. illegal evictions continued, despite a government ban, with right-to-rent checks under hostile environment policies driving migrants into the 'shadow' rental sector where rogue landlords thrive. The Home Office made the problem worse, by failing to provide any accommodation for migrants released from immigration detention early in lockdown, leaving them potentially street homeless.

Consequences of living standards in mass accommodation on mental and physical health

Migrants and refugees might find themselves in mass accommodation as asylum seekers, in asylum hostels, hotels or repurposed barracks; or as refused asylum seekers, undocumented migrants or offenders awaiting removal or deportation, in immigration removal centres (IRCs).

Early on in the pandemic, the IRR noted[7] that while the government (belatedly) sought to suppress the virus in the population at large, it seemed a different strategy was adopted for asylum seekers, immigration detainees and prisoners, who were merely contained, without regard to their health needs, to protect the 'British public'. This mirrored the strategy in Greece, where camps such as Moria were locked down, with residents unable to leave but unable to practice hygiene without water or soap, and the even more draconian 'military quarantine' of Roma settlements in the Czech Republic and elsewhere. Mass asylum accommodation, whether in Initial Accommodation (IA) or in hotels, offered no opportunity for social distancing, or for frequent hand-washing or sanitising, which not only increased the risk of transmission of Covid-19 but created huge psychological stress for residents. Additionally, IA residents had no access to medical care.

Asylum hostels, hotels, barracks: John Grayson of South Yorkshire Migration and Asylum Action Group (SYMAAG) has interviewed hundreds of asylum seekers over a number of years in the course of campaigning for decent and dignified conditions. His many articles for the IRR[8] detail the squalid conditions in which they live, and much of this section draws on his work.

Most asylum seekers live in hostels or houses in multiple occupation, sharing bathrooms, kitchens and sometimes bedrooms with strangers. They are often filthy, squalid, dangerous and infested with cockroaches, bed bugs and rats, often with no hot water, frequently with no soap or hand sanitiser, run under a system which appears positively to encourage profiteering by landlords and squalor and ill health for residents. Mears has the Home Office contract for asylum housing in the north-east of England, Scotland and Northern Ireland. Conditions in their Yorkshire hostels were so bad that in January, Sheffield City Council decided to take asylum housing back from the Home Office and tell it to end its contract with Mears.

In late March, the Home Office bowed to pressure from refugee rights groups and suspended evictions of asylum seekers, who are normally required to leave their accommodation after a grant or

6 See eg the studies cited in 'Is the war on Covid-19 morphing into a war on the poor?' *IRR News*, April 2020
7 'From Windrush to Covid: another scandal in the making', *IRR News*, April 2020.
8 See list of articles in Sources.

refusal of refugee status. But as no extra housing was provided, as new asylum seekers came in, accommodation became overcrowded, with residents having to share cramped rooms.

Urban House, Yorkshire: Urban House in Wakefield, west Yorkshire, is an Initial Accommodation (IA) centre where asylum seekers are sent before being dispersed to flats and houses. Since they are expected to spend no more than 2-3 weeks there, they get no money, are completely dependent on the centre for meals, toiletries, bedding and transport, and are unable to register with a doctor or to enrol children in school. In fact, residents stay for several months.

When lockdown began in March, 264 people were living at Urban House. Many had serious health conditions including asthma and kidney disease. Unrelated adults shared rooms, toilets, bathrooms and canteen facilities. Despite evidence that crowding vulnerable people with poor health into hostels with shared bathrooms, dining rooms and bedrooms could be catastrophic, Mears' argument that it was one household, whose members did not need to practice social distancing among themselves, was accepted by the local public health authority. With little soap and hand sanitiser, dirty toilets and showers and no cleaners or health staff at weekends, an outbreak was inevitable. It happened in early July. Residents were told to stay in the centre, but then, as up to 35 people tested positive, everyone were dispersed throughout the north-east.

Asylum seekers in Glasgow, Birmingham, London: In late April, at the height of the pandemic, the Home Office, through its contractor Mears, moved 321 asylum seekers in Glasgow out of their self-contained accommodation, at less than an hour's notice, in shared vans, to the city's hotels and guesthouses, where they were forced to share facilities, eat the (frequently inedible, sometimes mouldy) meals provided rather than cooking for themselves, and live with absolutely no money, their meagre allowance being withdrawn because they were in 'fully catered' accommodation. Social distancing was impossible. Two weeks later, Adnan Elbi, a 30-year-old Syrian refugee, died in one of these 'hotels'. He was in great mental distress, having been offered no help to cope having suffered torture in Libya, lost his father, his younger brother kidnapped, his mother suffering colon failure, unable to have his wife join him, to help pay his mother's hospital bills or even to call his family. He was a known suicide risk. The following month a Sudanese asylum seeker, Badreddin Abdella Adam, stabbed six people at the hotel he was in and was shot dead by police. Other residents had told staff Adam's mental health was breaking down under multiple strains. The asylum housing contractor, Mears, admitted it had not carried out vulnerability assessments on asylum seekers before moving them.

A similar move took place in May, when the Home Office moved 238 asylum seekers into a 'budget' hotel in Birmingham city centre, and in August, after a coronavirus outbreak in an asylum hostel in Edgbaston (Birmingham), 44 asylum seekers were bussed to Hammersmith.

In September, just as cases began to rise exponentially again, the Home Office announced the resumption of evictions of refused asylum seekers.

Channel crossers: The Home Office has recently begun repurposing disused military barracks and training camps to house asylum seekers who have recently arrived after crossing the English Channel on small boats. Whether these camps will be open or closed, the mass, institutionalised accommodation they offer is the worst way to house people during a pandemic, and as Stand Up to Racism West Wales protested, 'completely inappropriate for vulnerable people who have fled terror and suffering'.

- An asylum seeking woman placed in accommodation by the Home Office was forced to leave as the place was filthy, overcrowded, infested with cockroaches and rats, with no hot water,

and men came uninvited into her room, sometimes when she slept. During lockdown, she spent a week just travelling on buses at night (which were then free). She was then placed in a local authority homeless persons' hostel, with mould on walls and bed bugs. Her medical problems meant she could not eat the food, and it took two weeks for her to get supermarket vouchers.

- A young asylum seeker with a 3-month-old baby, in the UK since she was 11, was sent in September to an east London hostel housing 30-40 people who 'share everything including washing facilities', with no social distancing. She cannot bathe the baby as there is only a shower, and she can't sleep as the baby has to share her bed and she is terrified of rolling over her in her sleep. In the move, she lost her GP, her social worker and the support of friends and family, now too far away. She has no money, can't buy formula milk and the stress is causing her milk production to slow. She wants to be a good mother but has no one to turn to for support.
- An asylum seeker moved to a Glasgow hotel noted: 'It's impossible not to get close to people when you're in the lift or getting your food, and there are two bottles of hand sanitiser among 80 people. There are many Muslims here and Ramadan begins in two days. The evening meal stops at 8pm, so what happens when we start fasting?'
- 'Anne', forced to leave her husband and oldest child in France after a three-year odyssey across Europe from the Middle East, was in Urban House with her four young children including Becky, 5, born with learning and physical disabilities. They were sharing toilets, showers and a canteen and public areas, with no social distancing. The management refused to provide a buggy for Becky, and Anne, who is diabetic, was told she could not see a doctor or hospital for herself and Becky.
- 'Simon', in Urban House, texted, 'Please help me. I've been here for 40 days and have been told twice I am moving to a home but both cancelled. I have no security here and have a heart problem and no one is here to help me … I have no money no disinfectants, no proper clothes and I'm afraid of the Corona virus and I'm worried about my wife and daughter …'

Immigration removal centres (IRCs): Immigration detention is allowed for identification of migrants, decisions on admission, and in order to carry out deportation, and uniquely in Europe, can be indefinite. Not having a release date has a huge adverse impact on detainees' mental health. Some people have spent years – up to five years – in immigration detention. The courts frequently order the release of vulnerable detainees, and have ruled on several occasions since 2010 that prolonged detention of severely mentally ill people constituted inhuman treatment, breaching Article 3 of the European Convention on Human Rights. In 2019, 474 incidents of self-harm were recorded in IRCs.

In response to the pandemic, the Home Office banned all visits to detainees, increasing their isolation and stress, but continued to detain migrants, including those with underlying health conditions. In May, it asked immigration judges to explain why they had released so many detainees on bail since 1 January, resulting in a reduction by three-quarters of the numbers detained. Detainees reported poor sanitation, shared rooms and no social distancing in communal areas, and detainees and staff in several IRCs contracted the virus. In April, a leaked letter from contractor G4S revealed that vulnerable detainees at risk of dying if they contracted Covid-19 would be placed in solitary confinement for at least three months, exacerbating mental health risks.

Prisons: Kent Refugee Help supports foreign national prisoners in Kent and London, in prisons and facing deportation. Their clients' mental and physical health is affected by loneliness and social isolation, reduced access to GP and hospital care, and lack of legal advice due to legal aid cuts – problems exacerbated by the pandemic. All visits were suspended, leaving prisoners without access to a lawyer and face-to -face support from family and friends. Video links for legal appointments were unreliable. Terrified prisoners reported a failure to observe social distancing, long delays in

accessing health care, and a general sense of chaos and lack of availability of prison staff to assist them. Staff shortages meant more time in cells, sometimes up to 23 hours with only a short break for exercise. Prisoners worried about mixing with those who might have the virus, and that prison officers were bringing it in. In one prison, the death of two prison officers from Covid-19 caused huge trauma. Prisoners with conventional flu symptoms shared cells with those who had tested positive for Covid, according to Prisoners Advice Service, who also campaigned for the early release of prisoners with health conditions. Although the justice secretary agreed to release up to 4,000 'low risk' prisoners, as of 12 May, only 55 had been released, and when the scheme was 'paused' at the end of August, only 275 had been released.

Prisoners relied on the charitable sector as front- line support. Kent Refugee Help operated a remote service by telephone, email and letter, and distributed an emergency grant of £3,000 to assist prisoners and former prisoners with essential needs. Those needing to contact families outside the UK were grateful for assistance with telephone calls.

- Mr A, an EU national awaiting trial, was held for unspecified immigration reasons after the criminal court granted bail. He had breathing difficulties symptomatic of Covid-19 but was not tested. He was granted immigration bail after KRH secured legal representation.
- Mr B, a stateless person with serious pre-existing medical conditions, was held in prison for deportation. Despite becoming ill and needing ventilation in a local hospital, he was not deemed eligible for Covid-related early release. He was eventually released on immigration bail after KRH secured legal representation.

Impact on mental health

We referred above to the legal rulings that the mental health effects of prolonged detention were sufficiently severe to breach Article 3 of the European Convention on Human Rights. Being in detention with no visits, has exacerbated the deterioration in the mental health of migrants and refugees which occurs in normal times.[9] While immigration detention probably has the most profound and widespread effects, living in squalid, overcrowded conditions harmful to physical health also damages the mental health of those subjected to it – as the deaths of the two asylum seekers in Glasgow hotels in May and June attests. Nearly all the asylum seeking women interviewed by Sisters not Strangers said they felt alone during lockdown, and most of the staff and volunteers had seen women experience flashbacks to past traumatic experiences, with many women self-harming or attempting suicide. Mental health is also affected by worsening access to communication and information by those who can't afford to eat and top up phones.

Denial or obstruction of access to health care

The impact of 'hostile environment' policies which stop migrants accessing medical treatment has been exposed and exacerbated by the coronavirus pandemic. The main obstacles to health care are the NHS charging regime and fear of debt; for undocumented migrants, the fear of detection, detention and deportation; language and digital exclusion. Over half (57 percent) of respondents to the Patients not Passports coalition (Medact, Migrants Organise and the New Economics Foundation – hereafter PNP) research say migrants have avoided seeking NHS care – even when they are entitled to it – for fear of data sharing between the NHS and the Home Office, charges for treatment, or both.

NHS charges: since 2015, nearly everyone who is not a permanent resident of the UK must pay for NHS non-emergency hospital treatment. (Asylum seekers, refugees and – until 31 December 2020 – EEA nationals are exempt.) Those on student, family reunion and work visas pay an annual

9 See Mary Bosworth, *The impact of immigration detention on mental health: a literature review*, HMSO, 2016.

'immigration health surcharge', £470 for students and £624 for others since 1 October. Others – visitors, refused asylum seekers and undocumented migrants – must pay 150 percent of the cost of treatment. Since 2017, they are required to pay the charges before treatment, and hospitals are legally obliged to implement the charges. PNP respondents report that migrants deemed (rightly or wrongly) ineligible for free NHS hospital treatment are denied vital treatment if they cannot pay for it upfront – sometimes tens of thousands of pounds. This applies even for life-threatening conditions including cancer. Pregnant women and newborn infants are not exempt.

PNP reports that fear of incurring a debt which could impact on a future application to the Home Office, or being deported, leads to avoiding treatment, avoiding scans including for cancer, and women not having antenatal care or leaving hospital immediately after giving birth. Babies are born with serious and preventable complications as a result. Parents avoid seeking treatment for children who need acute care.

Refugees, asylum seekers and people with infectious diseases (including Covid-19, see below) are sometimes wrongly charged despite being exempt, as the regulations are complex and also because the charging regime severely damages the relationship between medical staff and patients. There is evidence that staff are racially profiling patients, who often don't know or are afraid to assert their right to free treatment. Survivors of trafficking, for example, are exempt from charging but will not want to reveal something so personal and stigmatising.

PNP say charging legislation has introduced a culture of discrimination in healthcare which has seeped into emergency treatment and doctors' (GP) surgeries (which are both exempt from charging). Sometimes, GPs simply don't refer those who need referral to hospital because of their status. They frequently refuse to register newly arrived asylum seekers (who have no proof of address or ID) and refused asylum seekers.

- A diabetic man, a refused asylum seeker who did not realise he could seek GP treatment, went blind for six months for lack of treatment;

Coronavirus exemption from charging: The PNP coalition reported that few migrants are aware that coronavirus treatment is exempt from charges. Information about the exemption has not been widely publicised, it was unavailable in languages other than English until April, and even medical staff are not always aware of it. In addition, treatment for other illnesses and conditions identified during a coronavirus test are still chargeable. And awareness of the exemption does not override the fear that coming forward may result in detention and deportation. It concludes that the coronavirus exemption is not working.

- A man receiving treatment for coronavirus and unable to talk was sent a letter to his home asking him to prove his immigration status and entitlement to care.

Data sharing: It emerged in 2018 that for several years, the NHS had been sharing confidential patient information with the Home Office for enforcement purposes. It included details of anyone with a debt of over £500. Although the government said it had been suspended, migrants are still extremely fearful that if they owe money for treatment and/ or are undocumented, they will be detained and deported. This is a powerful deterrent to seeking treatment for hard-pressed, low-paid and/ or undocumented migrants.

- A woman hurt in a car accident and taken to hospital by ambulance fled before she could be seen by doctors for fear of incurring a debt and being reported to the Home Office.

In the RAPAR/Kanlungan survey, only one of the 13 respondents who had been infected sought medical treatment, for fear of being reported – none were aware of the government's assurance that no charges or immigration checks would be made in the diagnosis or treatment of Covid-19. Even when told, the response, based on previous experience, was 'we don't really know if it's true'.

Language and digital exclusion: The PNP research shows how the Covid-19 pandemic exposed language and digital exclusion of migrant and refugee communities from access to healthcare, which in normal times are mitigated by family and community provision 'filling in the gaps'.

The PNP respondents noted that in normal times, non-English speakers have been asked to provide their own interpreter in consultations (in breach of NHS guidelines). The NHS produced no or little information in languages other than English, and the emergency services are inaccessible to those who don't speak English. PNP graphically described the language and digital problems caused when doctors' surgeries closed and consultations moved to telephone or internet:

- Many GP surgeries, which closed during lockdown, had notices, usually in English only, advising those with symptoms to go online – which failed to cater for non-English speakers and those with no internet access (very often the same people).

- Poor and destitute migrants, and asylum seekers with £37.50 to live on,[10] are effectively excluded from phone and online services when libraries, community centres and support organisations where they could previously get free internet access are closed. Internet access is 'vital, but far from universal'. Most have phones but don't have enough phone credit to wait several minutes to get through. Even if they have smartphones or laptops, asylum hostels don't generally have wifi, or the privacy needed to discuss sensitive health issues.

- For non-English speakers, explaining symptoms and negotiating automated 'menus' in English makes phone consultations very hard.

- The government failed to make guidance available promptly in languages other than English on Covid symptoms, health services during lockdown and how to access them, social distancing and other preventive measures. When it was translated it was not distributed effectively, and community groups attempting to fill the gap have had to keep up with constant changes.

- Many non-English speakers cannot read in their native language. The closure of community centres makes it very difficult to provide advice to this group.

- Forms need to be filled in to claim exemption from high prescription charges. This is usually done face-to-face in community centres; it is very difficult to do over the phone.

For hospitalised elderly non-English-speaking patients and their families, separation causes immense distress. Sometimes there is no one in the hospital able to communicate with the patient, so relatives have to ring and check whether staff have taken patients to the toilet, given their medication, fed them.

- An asylum seeker with little English called a community organisation with chest pains, fever and shortness of breath. They couldn't reach his doctor so told him to ring 111. He recorded the call. An algorithm kept asking him his nearest tube station as he tried to describe his symptoms and ask for a Tamil interpreter. Eventually he got through to an operator, but it

10 The rate of asylum support, which was increased by £1.85 to £39.60 during the pandemic.

took a while for the operator to realise he needed an interpreter. Eventually the operator got him an ambulance, but the experience was extremely stressful and time-consuming.

Other factors affecting access to healthcare: The PNP reported that homelessness, or the frequent moves of asylum seekers shunted around the country, create more problems in accessing health care and make continuity of treatment and care impossible. The closure of community centres, used to register with a GP, as a mail address and to collect prescriptions etc, made registration and access to treatment and prescription medication very difficult.

During the pandemic, many migrants have not sought help when unwell for fear of catching the virus. This fear is linked with awareness, experience and/ or fear of discriminatory treatment which also deter migrants from seeking treatment. The disproportionate BME deaths in hospitals reinforce these fears.

- A woman went without HIV medication for two weeks as the clinic was closed and the medication was sent to the address she had given, the community centre, which was closed.
- An asylum seeking torture survivor was moved to a hotel outside London, far from the doctor who had been treating him. The pharmacy which dispensed his medication could not post it, so he had to travel back to London by train (which he could not afford, and the community organisation had to pay for him) to collect his prescription, putting him at risk.
- A refused asylum seeking woman who tried to take her own life after becoming destitute, was unable to register with a GP and so could not obtain medication for nearly two months, while she slept on floors, sometimes in the room of a male stranger, cooking and cleaning to avoid street homelessness.

Blaming the victims

We referred earlier to the way government sought to downplay the disproportionate BME deaths from the pandemic by blaming 'co-morbidities', susceptibility to diabetes, or other biological factors. The suggestion that institutional racism played a part was rejected out of hand by some senior politicians and right-wing think tanks. Comment pieces in the Conservative press sought to paint those insisting on the reality of institutional racism as whingeing ingrates,[11] and when the prime minister was compelled to act, he simply set up yet another inquiry into racial disparities, whose organiser and chair were both known for their denial of structural racism. These denials have served to reinforce the truculent, defiant response to the Black Lives Matter movement, which in turn comes out of and feeds white nationalism and popular racism.

Early on, as media and politicians blamed China for the virus, racial attacks on Chinese people and businesses soared in the first quarter of 2020, according to police figures. Chinese restaurants and takeaways and their staff suffered physical attacks, racist abuse and hate mail. Later on, it was 'multi-generational immigrant families' who were blamed for spreading the virus, rather than poor and overcrowded housing, and 'Muslims ignoring lockdown', particularly at Eid. Then, migrant and BME workers were blamed for their working conditions, with the home secretary claimed that 'cultural sensitivities' prevented police and government agencies from dealing robustly with the outbreak in Leicester's garment factories for fear of being labelled racist. Tory MPs and councillors claimed that the 'vast majority' of people breaking lockdown rules were Muslims, 'illegal immigrants' and Asians. These inflammatory comments fuelled racial tensions in towns with large BME and migrant populations where local lockdowns were imposed, as Covid-19 began to be seen as a 'brown problem' and those most at risk were stigmatised.

11 See eg, 'Campaigners are twisting BAME Covid data to further their "victimhood" agenda', *Telegraph*, 4 May 2020.

Extending the hostile environment: racialised policing of the pandemic

The government's response to the pandemic (and its own failures in controlling it, due in large measure to its fetish for privatisation, which saw it bypass experienced local health officials in favour of hugely expensive tech test-and-trace packages) is to blame and punish the public. Police were given sweeping new powers in March to ban gatherings, forcibly quarantine suspected coronavirus carriers and issue fixed penalty notices to those breaking lockdown rules. With policing so highly racialised, the measures were bound to impact most on BME communities. In London, twice as many fines were issued to BME people for alleged breaches, and in some parts of the UK seven times as many. In its June report, *Policing the pandemic: human rights violations in the enforcement of Covid-19 measures in Europe*, Amnesty International included the UK in the 12 European countries where racial bias in policing the pandemic had led to 'marginalisation, stigmatisation and violence'.

- A homeless man, Sultan Monsour, was charged in May with 'being outside the place he is living, namely no fixed address'. Despite a judge querying the charge, prosecutors opt to proceed with it.

Impact on migrant communities

For individuals, the result of the denial of the right to health may be death, or severe and lasting injury, physical and/ or psychological. For communities and community organisations, it means working flat out to remedy or mitigate the problems caused by policies creating poverty, destitution, homelessness and ill health and denying or obstructing access to health care. It also means battling over-policing, stigmatisation and racial attacks, on the streets and through campaigning and advocacy.

Migrant communities have been in the frontline battling the virus as key workers, living in conditions putting them at more risk, battling institutional, media and popular racism, and attempting to maintain their traditions of solidarity and mutual support. They have maintained and extended the networks of support and solidarity developed to counter hostile environment policies, providing food, shelter, financial and emotional support to those losing income, jobs or homes, or self-isolating, or bereaved.

Thousands of charities and community groups across the UK have attempted to fill the gaps caused by closure of statutory services and community centres during lockdown which left many vulnerable people with no work, nowhere to go, no hot meals, no companionship, no help. They have stepped up with local food distributions, shopping for those self-isolating, telephone welfare calls to mitigate isolation, and online and telephone advice including attempting to ensure that the government's Covid-19 guidance reaches as many community members as possible, particularly non-English speakers. Many groups have organised Zoom meetings, webinars, classes and online singing groups. Many have provided cash, loans and phone credits, providing a lifeline to desperate people. They have intervened with doctors' surgeries reluctant to register patients, with hospitals wrongly seeking to impose charges. They have badgered asylum housing providers to do repairs, and have taken toys, toiletries, clothes and food to asylum seekers in hotels and hostels.

Some groups have been overwhelmed by the scale of the need and the distress of community members, with inadequate resources to support all those needing help, including those with complex mental health issues. Community groups and civil society have also been advocating and bearing witness to the desperation of members and service users, and trying to get the government to reverse decisions and policies which deny rights to health and human dignity. The Patients not passports coalition calls for the abolition of charges for NHS treatment, an end to the sharing by the NHS of patient data with the Home Office, and an urgent information campaign to ensure patients

know they can access treatment safely and freely, and they, NHS staff and the public are aware of migrants' right to treatment and to translation and interpreting services. The British Medical Association, six Royal Colleges representing doctors and midwives, and over 100 civil society organisations support the call to end NHS charges and data sharing.

Several community and migrant support groups, including RAPAR, Migrants Organise and Kent Refugee Help, have issued calls for regularisation, indefinite leave to remain and free movement rights for all migrants. The PPT London Steering Group has called for a rights-based approach to immigration policy in its Manifesto for migrant and refugee rights.[12]

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