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February 2022

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The City Law School

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Ethnic Minority and Migrant Women's Struggles in Accessing Healthcare During COVID-19: An Intersectional Analysis

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Abstract

This paper aims to show that the COVID-19 pandemic has amplified existing barriers to healthcare in England for ethnic minority and migrant women. These barriers include those embedded within the institution, stemming from community perceptions and relating to socio-economic factors. Though barriers to accessing healthcare have existed long before the pandemic, more attention must be devoted now because of the inequalities that COVID-19 has laid bare in England for ethnic minority and migrant women. By adopting an intersectional lens, this paper uncovers what has previously been hidden by 'intersectional invisibility', now exacerbated by the COVID-19 pandemic. Whilst the pandemic has seen an increase in focus on inequalities related to race, gender and immigration status, this paper adds to the literature by specifically considering the intersection of race and gender, and immigration status and gender, in the context of inequalities relating to healthcare. We argue that ethnic minority and migrant women experience inequalities in healthcare related to access uniquely because of their intersectional identities and the context of a public health crisis.

Keywords: COVID-19, access to healthcare, intersectionality, ethnic minority, migrant, women.

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Introduction

Since the early days of the pandemic when mortality rates and other health indicators began to reveal a disproportionate effect on marginalised communities - not only in England, but globally as well (PHE, 2020a) - significantly more attention was dedicated to uncovering the effects and causes of such inequality. The pandemic raised greater awareness of these health inequalities, in particular struggles in access to healthcare. In previous pandemics, similar socio-economic inequalities had been brought to the fore, yet these inequalities are still being reproduced and replicated today (Bambra et al., 2020, Razai et al., 2021a).

Given the volume of information that subsequently emerged, this paper seeks to fill a gap in the research agenda concerning the pandemic's impact on access to healthcare of considering the distinct intersectional experience heightened during the pandemic of ethnic minority women and migrant women as two separate groups of women who face specific barriers to accessing care. This paper argues that there is a distinct experience for ethnic minority and migrant women when accessing healthcare during the pandemic, which becomes more evident by not amalgamating the experiences of all women, all migrants, or all ethnic minorities. Although this paper does not provide an analysis of empirical data, its originality lies in its adoption of an intersectional lens from which to analyse existing secondary sources (including academic journal articles, monographs and book chapters) and grey literature (government reports and professional publications from medical organisations) on obstacles to accessing healthcare in the context of the pandemic, to draw out the invisibility of effects of regulation, or lack thereof, on ethnic minority and migrant women.

Inequalities faced by ethnic minorities were brought into sharp focus because of the higher mortality rate from COVID-19, but also due to ongoing violence against these communities as highlighted by the death of George Floyd (PHE, 2020a; Prats-Urbe et al., 2020; Crooks et al., 2021). Gender also became a factor in inequalities raised by COVID-19 as men suffered from a higher mortality rate compared to women, whilst women bore a greater burden in terms of other indicators of the day-to-day effects of the pandemic (ONS, 2021a; Germain & Yong, 2020). At the time Boris Johnson was hospitalised with COVID-19, migrants came into the spotlight as he was cared for by foreign nurses (Mason, 2020) thus highlighting the high numbers of migrant National Health Service (NHS) frontline staff. All the while, the end of the Brexit transition period and end of free movement loomed in the background, threatening further inequalities for millions of EU citizens (Fitzgerald et al., 2020). This paper breaks ground on the intersection of these most salient manifestations of inequalities as highlighted uniquely by the COVID-19 pandemic when seeking access to healthcare.

The paper is as follows. First, it outlines the existing intersectional approach that we use to analyse the experiences of ethnic minority women and migrant women bearing intersectional characteristics when seeking access to care during the COVID-19 pandemic in England. Second, it unpacks three types of barriers faced by ethnic minority and migrant women exacerbated during the pandemic. These are institutional barriers, community perceptions and socio-economic factors. Finally, it concludes that during this public health crisis, these women's intersectional identities have translated to a distinct and unique experience when seeking access to healthcare, which should trigger regulatory changes and raise awareness of barriers which existed long before the pandemic.

An intersectional framework

This paper argues that the relatively little progress made in society towards eradicating inequalities is due to the disaggregation of the data on inequalities only on a single-axis during the pandemic. It seeks to highlight the inequalities in intersectional experiences of ethnic minority and migrant women as a first step. Despite there being a great interest in a certain disease - in this case, COVID-19 - this interest does not always translate to adequate healthcare, especially not for ethnic minority and migrant women.

As Strid et al argue '[s]imply naming inequality is the weakest form of visibility and inclusion.' (2013, p. 561) This is true in light of the historical inequalities exposed by previous pandemics. Szczepura argues that '[a]ppropriate access to health care for a diverse population requires more than simply providing the service.' (2005, p. 142) Therefore, the additional step beyond just providing the healthcare service is that of making visible the issues exacerbated during the pandemic for ethnic minority women and migrant women when seeking access to care. Because intersections of ethnic minority status and gender and immigration status and gender have been subsumed into either being an ethnic minority, or a migrant or a woman, this analysis becomes all the more original and important when these women seek to access healthcare services. For this reason, the intersectional lens is applied to understand the unique experiences of these women when seeking to access healthcare during the COVID-19 pandemic.

The theory of intersectionality and access to healthcare

Whilst it is a welcome development that more attention has been given to the gendered effects of COVID-19 as well as the pandemic's disproportionate impact on ethnic minority and migrant communities, what is less understood is how the intersection of gender and their ethnic minority or migrant status has made their access to care more difficult during the pandemic. Intersectionality, the theory coined by Kimberlé Crenshaw, seeks to recognise that individuals are defined more than just on a single-axis of either gender or race (1989, p. 140). Although

existing studies have taken an intersectional approach to analyse the experiences of ethnic minority and migrant women (McIlwaine, 2010), this approach remains understudied in the healthcare context. For example, the Black Report (DHSS, 1980) which pioneered scrutiny of health inequalities in the UK, disaggregated data analysis only by single-axis characteristics. Though finding that disparities in health had worsened since the NHS was established in 1948 due to a variety of socio-economic determinants, it did not provide any consideration of what the situation was for those with intersecting characteristics. Bastos et al. call this '[i]ntersectional invisibility...' which they argue leads to 'worse health outcomes'. (2018, p. 210; See also: Hankivsky, 2012, p. 1717; Kapilashrami et al., 2015, p. 296) This paper bases its argument around this notion of intersectional invisibility in access to healthcare.

The early research on the COVID-19 pandemic already shows that individually, women, ethnic minorities and migrants risk being disproportionately affected by the pandemic (Galam 2020). This paper aims to make visible the struggles of women who are also ethnic minorities or migrants and their difficulties accessing care during the pandemic, which is a situation that has been worsened by COVID-19. The current recognised oppression faced by women, ethnic minorities and migrants as separate groups during the pandemic begs the question of how individuals with multiple intersections are coping given what is already clearly a difficult situation for them. COVID-19 has shown that 'burdens and inequalities are not new; what is new is how acutely these are felt by the most vulnerable, marginalized and/or discriminated against in society' (Harman, 2021, p. 620). Particular existing vulnerabilities of ethnic minority women and migrant women have already contributed to their marginalisation and discrimination when seeking access to care, and these have only become more evident during the pandemic.

Intersectionality is thus used as a context-formed analytical tool to consider an individual's varying amounts of disadvantage and privilege associated with their experiences of oppression and domination (Gkiouleka et al., 2018, p. 93). The paper considers the two groups of marginalised women - ethnic minority women and migrant women - separately, though it is recognised that there is of course a further intersection of migrant women from ethnic minority backgrounds, which falls outside the scope of our analysis. As there is some overlap in the barriers faced by ethnic minority and migrant women during the COVID-19 pandemic, the paper demonstrates that the pandemic has heightened the existing intersectional pressures faced by both. They have existed long before the pandemic but now that COVID-19 has laid them bare, this paper contributes to the existing literature on intersectionality to bring these issues of ethnic minority and migrant women seeking to access healthcare during the COVID-19 pandemic into a more visible sphere as a step towards tackling them. The next section

details what barriers have been exacerbated during this public health crisis.

Barriers to accessing care for ethnic minority and migrant women during COVID-19

An intersectional analysis is even more important to analysing inequalities raised by the COVID-19 pandemic as many health issues faced by women are often not related to biological characteristics but rather discrimination and disadvantage related to gendered activities such as care (Doyal, 2000, p. 934). It is argued to be patriarchy rather than biological, behavioural or psychological differences that explain different health outcomes for women (Gkiouleka et al., 2018). In the context of COVID-19, social determinants of inequalities are extremely wide-ranging given the permeating nature of the pandemic's effects that go beyond just medical issues.

However, it is the lack of interest in social drivers of health and disease (Bartley & Blane, 2015) which contributes to the problem of an entirely numbers and data-driven approach. By focusing on higher rates of disease for certain marginalised groups (such as ethnic minority women or migrant women) the data then becomes used instead to victim-blame, pathologise and stratify these individuals as being the source of the disease themselves (Cano Isaza, 2020), for example, women being labelled as 'the problem' in health circles generally (Mirza & Sheridan, 2003, p. iv). This paper thus turns instead to consider more direct causal factors that create barriers to accessing care within the health institutions themselves, due to stigma in the community or due to external socio-economic factors.

Institutional barriers

The pandemic has highlighted the role played by social institutions in reproducing health inequalities in the British society. NHS England's inability as an organisation to provide the same access to care to all individuals speaks to a lack of resources, the inability to fulfil its mission to provide equal access to healthcare for all (Germain, 2020), but also a form of institutional racism implicitly embedded in the organisation (Bradby, 2010). The public health crisis has brought attention to ethnic minorities and migrant populations' poorer experiences using the health services (Raleigh & Holmes, 2021) and the underlying 'collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin' (Macpherson, 1999, p. 49).

Although not always overtly apparent, discrimination and institutional barriers have significantly impacted women's experience of accessing services. The insufficient resources dedicated to language support, the backlog of treatment arising from the prioritisation of COVID-19 patients and the hostile environment for migrants have all hindered ethnic minority

and migrant women's ability in particular to accessing appropriate levels of care in the NHS, especially during the pandemic. The situation has only worsened, and barriers faced by these women will be considered in turn.

Institutional communication barriers

In order to guarantee adequate levels of care, effective communication is essential between the teams treating patients and patients themselves in order to build trust. However, practical issues relating to the availability of translators or the absence of signage and information brochures in foreign languages still present a significant hurdle for ethnic minority and migrant women when engaging with healthcare services (Woof et al., 2020, p. 131). Prior to the pandemic, it was reported that South Asian women were more likely to be undiagnosed or diagnosed at a more progressive stage with breast cancer than White British women (Gathani et al., 2014). Experiences with healthcare services thus significantly differed for these women who had been among the most underserved in the NHS, with poorer engagement with routine screenings (such as breast screening programmes), in part due to their lower level of fluency in English (Woof et al., 2020, p. 131). These experiences are likely to have been aggravated by the pandemic due to resources having been redirected towards services that came under great pressure during months of lockdown. It led to a backlog in breast cancer screenings in England (Maringe et al., 2020, p. 1030).

Language is another area where there has been an existing communication barrier from pre-pandemic times. Although language support is available in certain services, verbatim translation can relay inaccuracies and distort the information conveyed by healthcare providers to their patients (Woof et al., 2020.p. 131). During the pandemic, this became especially difficult because of the high volume of new information stemming from the novel situation of COVID-19, as well as the constantly changing messaging from the government. Therefore, beyond clinical interactions, the need for support in foreign languages is crucial to help facilitate administrative tasks such as appointment booking, discussing test results, managing prescriptions and engaging with telemedicine for remote appointments (Lehane & Campion, 2018; Knight et al., 2020), and even more so in a pandemic setting.

Examples of situations that could prove particularly detrimental to non-English speaking ethnic minority and migrant women during the pandemic include difficulties as simple as those posed by navigating hospital settings and understanding invitations for screening, treatment or referral letters. The pandemic has also substantially aggravated existing communication barriers for women who may previously have been able to be accompanied to hospital or emergency services by an English-speaking partner or relative, but now forced to attend alone.

Furthermore, this would be most likely to affect the most vulnerable pregnant ethnic minority and migrant women because of their different maternal health needs, and indeed, the data shows that ethnic minority women have recorded a higher maternal mortality rate compared to other groups of women during the pandemic (Esegbona-Adeigbe, 2020).

The reasons for this include the fact that maternal health services have been highly disrupted and the lack of interpreters for non-English speaking pregnant and post-partum ethnic minorities or migrant women has had an impact on their understanding of the risk of infection and health deterioration. Many of the most vulnerable women were confused about when to seek urgent medical attention in hospital (Knight et al., 2020). It was only after nine months from when the first lockdown was announced that guidance finally changed to require women have 'access to support at all times during their maternity journey and trusts should facilitate this' (NHS, 2020). However, the time taken to implement this very important change does not resolve the disproportionate negative consequences for ethnic minority or migrant women. Visitors were not allowed on postnatal wards until late Spring 2021, which leaves some ethnic minority and migrant women with limited or no support in a time during which they are vulnerable and may not be able to communicate their needs (Paton et al., 2020). Such barriers embedded in the institution itself were exacerbated by the need to prioritise resources to tackle COVID-19.

Prioritisation of COVID-19 patients in the NHS

With the virus causing significant disruption to the delivery of healthcare services in England, the suspension of the equal access approach also created an additional barrier to accessing services for ethnic minority and migrant women. Routine care and elective surgeries were either postponed or cancelled to prioritise COVID-19 infected patients in the hopes of avoiding overwhelming the system (Roberts, 2020; Iacobucci, 2020). Attention shifted to shortages in critical and intensive care beds to the detriment of services needed by other vulnerable groups of patients. Among others, essential pregnancy care resources were redirected towards fighting the pandemic (K. S. Hall et al., 2020). As a consequence, 56% of pregnant COVID-19 patients admitted to hospital in the first peak of infections in England were of ethnic minority background (Esegbona-Adeigbe, 2020).

Consultations were also moved online to reduce patients' and healthcare professionals' exposure to the virus. In this particular context, ethnic minority and migrant women were most affected by issues of digital poverty, having greater difficulty engaging remotely with healthcare professionals because of their caring duties and family settings (Costa Osanan et al., 2020). Access to sexual and reproductive health services was particularly affected by

these barriers, since many forms of long-lasting methods of contraception require at least one consultation with a medical professional. It is likely to have led to an increase in unplanned pregnancies for women in these communities (Paton et al., 2020).

Over a year later, it is now possible to appreciate that the mammoth backlog resulting from the pandemic is only adding to the NHS' existing lack of spare capacity, and it will continue affecting the system long after the aftermath of the public health crisis (Carr et al., 2021; Ham, 2020). Women with intersecting characteristics will more likely be at a greater risk of having poor health outcomes because of obstacles to accessing healthcare services during the pandemic as explained above, as well as the institutional legal barriers affecting more migrant women because of their immigration status.

Institutional legal barriers

Medical controls have played a significant role in immigration policy and implementation, stemming as far back as the Aliens Act 1905 where individuals were excluded from medical protection in the law itself (Nasar, 2021, p. 1703). The argument is that health policy now appears to be based on assimilation principles, with migrants asked to adopt the host State's customs, practices and beliefs (Green et al., 2006). Given the intersectional invisibility outlined above, this is clearly an acute problem for migrant women.

Nasar's claim that medical controls are central to immigration policy can be seen to be played out in the context of the hostile environment which created barriers to accessing care during the pandemic (2021). For example, fees levied under the immigration healthcare surcharge are a legal barrier to healthcare for migrants ever since the Immigration Act 2014. Migrant women are particularly disproportionately affected by financial requirements given their higher representation in low-income, part time and temporary precarious work (Hankivsky & Kapilashrami, 2020). Additionally, family migration favours men because of the male labour bias (Kofman, 1999), where domestic immigration law favours and rewards traditional forms of work which are typically carried out by men, whilst women take up to 60% more unpaid or atypical labour such as providing informal care (Norman, 2020).

Furthermore, due to fears of data-sharing between NHS trusts and the Home Office as to one's legal immigration status, the most precarious of migrants are in the most vulnerable situations. This problem existed long before the pandemic, but the effect of this hesitance to present for treatment during a public health emergency like COVID-19 evidently exacerbates the situation for migrant women, because as the research shows, gender is an additional factor that affects migrants' ill health. Intersectional factors are at play if migrant women are more likely to report poor health compared to non-migrant women but male migrants are the

opposite (Gkiouleka & Huijts, 2020).

As such, the insecurity of having a precarious immigration status is well-accepted as a reality, and the legal barriers that have led to this precarity drives poorer health outcomes for this group of individuals (Smith et al., 2016, p. 18). Women in particular are disproportionately affected by this because of their specific pregnancy-related, reproductive and maternal health needs. Women seeking asylum and fleeing from domestic abuse during lockdown would have had even more trouble accessing such services during lockdown (Donà, 2021, p. 910). Those refused asylum will fall within the cracks of healthcare service provision, denied eligibility for NHS services.

A precarious or even illegal status will mean migrant women are more likely not to present for treatment whether or not they are eligible, despite the government's claim that everyone is eligible for care in the fight against COVID-19. This kind of statement is ignorant of the nature of precarious statuses and those falling within the gaps such as refused asylum seekers and overstayers. It is clear that the hostile environment is to blame for difficulties faced by migrants in their response to new public health guidelines (Donà, 2021, p. 908). The stratification of these groups by governmental institutions in England has fed into the negative perceptions of their communities. It is important to note that racialised medical perceptions and stigma and cultural barriers also feed into the groups' negative perception of the governmental institutions themselves, which this paper considers next.

Community perceptions

Solidarity within a community - whether defined by a single-axis characteristics or not - becomes more important for marginalised individuals such as ethnic minority women and migrant women. However, in the context of barriers to accessing healthcare during the COVID-19 pandemic, it is both the perceptions of the marginalised communities by others as well as the stigma from both the external institution as well as within the communities themselves that have affected ethnic minority women and migrant women disproportionately. The institutional shortcomings in considering ethnic minority and migrant women's needs risks feeding into pejorative community perceptions of the healthcare services.

It is understood that women's health is often a downstream process, made up of informal health and social support (Ryan & El Ayadi, 2020). For this reason, multiple social identities, if harnessed, can help to mobilise collective support in communities (Templeton et al., 2020, p. 675). However, the enforced isolation from lockdown measures would have been an obstacle for community networks to mobilise to help ethnic minority and migrant women seek

the appropriate information needed to access healthcare, especially important during the pandemic when rules were constantly changing. The effect of community perceptions, internal and external, will be considered in detail here.

Racialised Medical Perceptions

It has already been accepted that the COVID-19 public health crisis has only further highlighted racism's significant contribution in ethnic minority and migrant communities' poorer health outcomes. Prior to the pandemic, ethnic minorities were already relaying poorer experiences of care and treatment, stemming in part from discrimination and stigma in clinical settings (Razai et al., 2021a). For women in these communities, their ethnicity creates an additional layer of discrimination to those they already face because of their genders (Williams & Collins, 1995).

Research has shown that psychological determinants - most particularly racism and feelings of subordination - are material factors contributing to immunosuppression and increasing levels of cortisol (Bartley, 2016; Bambra et al., 2020). The pandemic has certainly brought about significant psychological challenges for ethnic minority women. The fear of contracting the virus, losing employment and increased childcare saw these women record higher levels of distress, depression, anxiety and loneliness than the White British population (Nuffield Foundation, 2020). Their deteriorating mental health could thus also lead to important long-term health issues.

Troublingly, one of the biggest contributors to this overarching discrimination is ethnic minority communities' distrust in health authorities and medical professionals. This has the effect of adding to their risk of exposure to the virus and progression of illness (PHE, 2020b; Danso & Danso, 2021). This may have also reinforced communities' perception that the system will not deliver equitable healthcare services (Nelson, 2002). This damaging view of the healthcare system seriously disproportionately affects ethnic minority and migrant women from accessing care needed, which on top of what is already a difficult situation for them in the institution itself, only makes things worse.

In fact, some American studies have confirmed that medical professionals have implicit racial and ethnic bias that affects patients' health outcomes because of more negative perceptions of people of colour (W. Hall et al., 2020; Danso & Danso, 2021). In the NHS, at times, the lack of cultural awareness of some medical staff has also had an impact on patient management and may have contributed to resentment, creating a psychological barrier dissuading ethnic minority communities from seeking medical attention (Szczepura, 2005) and also liable to

affect migrant communities.

It is ethnic minority and migrant women who are most vulnerable to racialised medical perceptions, as women often see their experience of pain underestimated or denied. For example, Black women have been five times more likely compared to White women to die from COVID-19 in the UK (UK Parliament, 2020; Danso & Danso, 2021) and 88% of all women dying in the first three months of the pandemic in England were from ethnic minority groups (Knight et al., 2020). However, long before the pandemic, ethnic minority women had already experienced poorer pregnancy outcomes and COVID-19 only brought into the spotlight the stories of ethnic minority women advised to stay home in spite of their critical condition. It contributed to confirming some medical staff's prejudicial perceptions that women in these communities can sustain higher levels of pain (Marsh, 2021; Saini, 2020).

Also notable is the lack of medical research on ethnic minorities, migrants and women. In the past, their underrepresentation and at times their reluctance to participate in clinical trials has led to some less effective therapeutics and vaccines for women from ethnic minority groups (Danso & Danso, 2021; Liu & Mager, 2016; Connor et al., 2020). The deliberate exclusion of pregnant and lactating women from clinical trials has also meant that this segment of the population experienced a lag in receiving their COVID-19 vaccines (Shields and Lyerly, 2013). Migrants' health is also understudied even compared to ethnic minority groups, especially those classified as falling under the 'broader categories of migrants' - beyond just asylum seekers and refugees (Jayaweera, 2010). The lack of disaggregation has hidden the needs of migrant women in particular, given their relative intersectional invisibility (Jayaweera, 2018) leading to further stigma and cultural barriers that impede both ethnic minority and migrant women's access to care.

Stigma and cultural barriers

Stigma and cultural beliefs often act as substantial barriers discouraging ethnic minority and migrant women from engaging with healthcare services. Culture and religion impact their willingness to seek help with the NHS (Szczepura, 2005) and the stigma associated with certain lifestyles makes getting in touch with service providers even more challenging in the context of lockdown. For instance, the prejudice associated with premarital or non-normalised sex affects ethnic minority women's access to contraception. It may discourage women from engaging with outreach and prevention programmes that have gone online during the pandemic. The worry of discussing intimacy from home where privacy is often limited may create a barrier to accessing sexual health and other services for ethnic minority and migrant women. This has translated into an increase in sexually transmitted infections such as HIV

and HPV and greater difficulty to access menstrual hygiene during the pandemic (Behar, 2020).

Certain ethnic minority communities have also internalised negative stereotypes relating to some health conditions. This 'internalised racism' has been linked to developing comorbidities and poor mental health, particularly psychological and emotional distress (Razai et al., 2021a). Cultural perceptions around healing and treatment methods also negatively influence some of the communities' encounters with medical professionals and their attitude toward providers as they feel that their views are not respected or valued in the diagnosis and treatment of illness (Szczepura, 2005). It is the anticipated negative attitude of medical professionals towards their cultural beliefs in relation to illness and treatment that discourages them from seeking professional medical advice.

Anecdotal reports of women in ethnic minority communities and their hesitancy to take up the COVID-19 vaccine signal that cultural beliefs are also playing an important role in health prevention (House of Commons, 2021). As the vaccination campaign was rolled out in the UK, vaccine hesitancy in ethnic minority communities was higher than in the White British population (Razai et al., 2021b) with Black and Black British adults most likely to report hesitancy (ONS, 2021b). Public health officials made a concerted effort to reach out to these communities to encourage vaccination take-up, particularly as anti-vaxxers were targeting women on social media with false claims around the vaccine being linked to infertility and medical problems in pregnancy (RCOG, 2021; Royal College of Nursing, 2021). Unfortunately this messaging was also reinforced by older female members of the community discouraging young women to take up the vaccine (House of Commons, 2021, Q63).

The situation faced by ethnic minority and migrant women as described above is a difficult one to reconcile with the pandemic, for it has clearly impacted their experiences in accessing healthcare. Cano Isaza has also argued that the social stratification of the marginalised groups because of high infection rates in their communities has entrenched an existing barrier to accessing care (2020). The fear associated with leaving the household, mixing with society at large or even getting vaccinated during a global public health crisis like COVID-19 only exacerbates what is already a difficult starting point for these women due to their stigmatisation. For this reason, targeted messaging must truly recognise the root causes of the issues faced by ethnic minority and migrant women, which largely stem from socio-economic factors, to which this paper now turns.

Socio-economic factors

The disproportionate number of people from ethnic minority backgrounds dying from COVID-19 has been widely reported (ONS, 2020; PHE, 2020a). This tragedy has brought into sharper focus existing health inequalities stemming from various socio-economic factors that also contribute to ethnic minority and migrant women's experience of barriers accessing healthcare services, which are also exacerbated by class, though not exclusively. Environmental factors and practical aspects of life such as transport, caring duties, housing segregation as well as health illiteracy all act as barriers for many ethnic and minority women in need of care.

Environmental factors

Comorbidities leading to long term health conditions such as diabetes, hypertension and arthritis have been proven to significantly raise the risk of dying from COVID-19 (Raleigh & Holmes, 2021). Although ethnic minority groups have an increased prevalence for these conditions (PHE, 2020a; Ravi, 2020; Abuelgasim et al., 2020) they are in no way genetically or physiologically predisposed to them (Roberts, 2008). However, other health determinants and environmental factors need to be accounted for in order to understand poorer health outcomes in these communities during the pandemic. These include those related to being on lower incomes than men, having caring duties, transport and housing and deprivation.

Women occupy 69% of lower paid jobs in the UK and tend to do more unpaid work than men, leaving them in a more precarious financial situation (Norman, 2020). Low-income migrant and older women have also been significantly more affected by the pandemic economic downturn globally, recording greater job losses (Bachman, 2020). The aforementioned male labour bias (Kofman, 1999) is exemplified in the Deaton Review which shows that it is single mothers who are likely to work for sectors that were shut down or key workers unable to work from home (Platt & Warwick, 2020), and more likely to quit or lose their jobs, or be put on furlough (Blundell et al., 2020). For migrant women, COVID-19 has increased the likelihood of added precarity, which discourages them from accessing care due to the government largely medicalising what are typically social problems (Taylor, 2009, p. 769).

Ethnic minority and migrant women are most often the primary carers of children. These duties have significantly increased during the months of lockdown and school closures (Fisher and Ryan, 2021), aggregating an already significant barrier to accessing healthcare services (Paton et al., 2020). The fear of spreading the virus to members outside the household has made securing childcare more challenging during the pandemic. These women would also be reluctant to attend medical appointments accompanied by their children and exposing them further to the virus in clinical settings. Due to the overrepresentation of ethnic minority and

migrant women in the NHS workforce (Norman, 2020), there would likely be a disproportionate impact of the pandemic on any of these women with caring duties because of their key worker roles and being more likely to need childcare.

It has also been reported that economically deprived areas of the country have lower levels of access to healthcare services (Todd et al., 2015). This starts at the primary care level with ratios of patients per practitioner 15% higher in these marginalised areas than in the rest of England (Iacobucci, 2019; Bambra et al., 2020). Geographical location also directly and indirectly impacts levels of access to healthcare. Where treatments are unavailable in certain areas, individuals are forced to commute. This particularly affects ethnic minority communities that have gone through a process of suburbanisation (Szczepura, 2005).

Lockdown and social distancing measures would aggravate these barriers, with reduced services and fears of catching the virus on public transport. It is also more likely that women in precarious employment would be unwilling to forfeit income or risk losing their jobs to attend a medical appointment. The cost of public transportation itself may also be prohibitive and has been reported as a stressor and barrier for migrant women in particular to accessing healthcare services (Nellums et al., 2021). This is especially if they have already been subject to the immigration surcharge, or fear hostile environment measures such as immigration checks, as mentioned above.

As Fineman argues that women are essentially relegated to the private sphere (1990), this may explain why they are most likely to be exposed to COVID-19 if it is brought back into the home, a private space, especially if these women hold household caretaker status. This was also shown in the Ebola outbreak (Ryan & El Ayadi 2020, p. 2). Given that there are many more Bangladeshi and Pakistani women looking after the home and family (Nazroo, 2001, p. 9) the logical conclusion is that these ethnic minority women are at disproportionately high risk of exposure. Indeed, ethnic minority and migrant groups have a greater risk of contracting COVID-19 if they are also more likely to live in overcrowded housing (Devakumar et al., 2020).

The risks posed by inadequate overcrowded housing are most prevalent in the migrant worker community (Morris, 2020) as well as in Bangladeshi, Pakistani, Indian and Black African households (UK Government, 2020). They include potentially leading to developing respiratory diseases and a precedent for higher transmission rates due to urbanity (Bambra et al, 2020). Ethnic minorities have also been exposed to the virus because of the low-paid service sector's working conditions, leading to further transmission of COVID-19 to members of their households (Devakumar et al., 2020). This deprivation faced by ethnic minority and

migrant women also adds to their overall health illiteracy.

Health illiteracy

The concept of health illiteracy concerns a general lack of awareness and understanding of the information on healthcare services, including how to access them. Given the evidence showing that historical negative experiences of healthcare for ethnic minorities means they will be less likely to seek care in future (PHE, 2020b, p. 13), there is an undesirable knock-on effect during the pandemic of ethnic minority and migrant women having poorer health outcomes because of failing to access the treatment they need. This has been especially heightened during the pandemic as mentioned above for reasons related to lockdown, quarantine and isolation, both social and physical, leading to an increased reliance on telemedicine and virtual communications. Socio-economic factors have meant there is a differential impact of these measures on ethnic minority and migrant women.

Any illiteracy in the health context is severely undermined by low literacy rates and poor education. There is evidence that the ability to speak English is lower for women than men, much poorer for those born outside the UK, and declines with increasing age. Despite English language information sometimes being translated into other languages, a high 50% rate of illiteracy for women compared to 20% for men from a Bangladeshi or Pakistani background nonetheless prevents them from accessing this information even when translated to their own mother tongues (Szczepura, 2005). This is confirmed by more recent data that shows that women of a Bangladeshi background had the highest rate of poor English language skills at 21.9% (UK Government, 2018). Divergences in the type of literacy thus severely affects access to healthcare, which undermines the government strategy for combating COVID-19 and also explains why there is a differential impact on ethnic minority and migrant women.

An overemphasis was also placed on remaining at home in the earlier stages of the pandemic, which changed when the government realised that COVID-19 guidelines were to the detriment of getting treatment for other long-term health conditions. By this point, there was anxiety and confusion about attending hospital due to the fear of catching COVID-19 (Knight et al., 2020). Esegbona-Adeigbe highlighted how not attending crucial antenatal and postnatal appointments would disproportionately affect the hardest to reach women, including precarious migrants (2020). Any ethnic minority or migrant women who did attend appointments alone would likely face the difficulties outlined above such as communication barriers or discrimination (Taylor, 2009). Pareek et al (2020) is right to suggest that ethnicity interplays with viral spread through cultural, behavioural, and societal differences, including lower socio-economic status, health-seeking behaviour and intergenerational cohabitation.

It is thus clear that combating health illiteracy in the female ethnic minority and migrant communities is the key to overcoming their barriers to accessing care. The lack of clear messaging during the pandemic from the government and relatively little done in the way of community-specific targeted campaigns to encourage social distancing measures would affect more ethnic minority and migrant women. Even homogenising ethnic minorities into the widely used but problematic Black, Asian and minority ethnic (BAME) label hides a multitude of sins in the way of intersectional invisibility (Lawrence, 2020). This paper sought to highlight these barriers to accessing healthcare as intersectional questions that the COVID-19 pandemic has exposed.

Conclusion

The COVID-19 pandemic has undoubtedly proven to be the stark wakeup call needed to take inequalities in healthcare seriously given the magnitude and scale of their impact in society today in England. However, our analysis has revealed that during this particular public health crisis, some inequalities remained invisible. By adopting an intersectional approach to considering questions of inequality in healthcare, our original contribution lies in our ability to bring forward inequalities as they presented as barriers to access to healthcare faced by ethnic minority and migrant women during the COVID-19 pandemic. In this way, it is hoped that there can be space made for the needs of these women to be considered more widely when designing regulation at a macro (policy and law making), meso (institutional) and micro level (grassroots), leading to more equality in accessing healthcare.

With these aims in mind, the paper outlined three types of barriers to accessing healthcare - institutional barriers, community perceptions and socio-economic factors - and how ethnic minority and migrant women have experienced these barriers during the COVID-19 pandemic. Institutional barriers from within the organisation itself included communication and language barriers in the NHS, the prioritisation of COVID-19 patients and legal barriers under the Home Office's hostile environment policy. Community perceptions, in part stemming from institutional barriers both internally and externally, included racialised medical perceptions and stigma and cultural barriers. Socio-economic factors included environmental factors contributing to health illiteracy.

The paper highlighted a clear lack of attention on women of ethnic minority backgrounds and migrant women, possibly as a result of policies being designed by those in power with privilege (Ryan and El Ayadi, 2020). Our analysis showed that bearing these intersecting characteristics has translated to a distinct and unique experience of access to healthcare services as

exemplified by the COVID-19 pandemic in England. Whilst these inequalities have existed for many years prior to the COVID-19 pandemic, they have yet to be addressed appropriately. Using an intersectional lens to analyse ethnic minority and migrant women's experience of access to healthcare is an essential first step towards combating intersectional invisibility.

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