



At the deep end: COVID-19 experiences of Zimbabwean health and care workers in the United Kingdom

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ABSTRACT

Background and objectives: Black, Asian and Minority Ethnic groups (BAME) in the UK were disproportionately affected by the first phase of COVID-19 in terms of exposure, negative health and socio-economic impacts and consequences including recorded deaths. However, aggregate categories like BAME mask internal diversities and differences and limit the scope for understanding why disproportionalities occur and appropriate interventions. This paper responds to calls for disaggregated and in-depth participatory community based research to improve culturally nuanced understanding of health inequalities and COVID-19 impacts.

Methods: The paper draws from weekly zoom discussions and data from a google-forms on-line survey ($n = 103$) that the Zimbabwean community conducted to establish and examine COVID-19 experiences of Zimbabwean health and care workers in the UK. Our interpretive approach used MAXQDA software for qualitative data analysis; to code and categorise responses to open ended survey questions.

Results and discussions: Discursive analysis of this community data shows that health and social care worker experiences included recurrent and widely reported themes such as discrimination in allocation of equipment, moral injury and trauma that may lead to long-term mental health problems. These results confirm diversity of experiences amongst health care professionals when compared to other ethnic groups and by gender. They reinforce the case for monitoring, for after care research and support, including that which draws on community-based capital.

1. Introduction: calls for disaggregated and community-based understanding of COVID-19

Given what is known regarding structural, historical and prevailing socio-economic inequalities, the disproportionate effects of COVID-19 on BAME in the UK were ‘entirely predictable’ (Rose et al., 2020: 2) and preventable. The nature and cause of these differential impacts was subject of a UK government ordered enquiry (PHE, 2020) as well as commentary by several authors. Most commentary (IFS, 2020; PHE, 2020) focused on the disparities and drivers of COVID-19 case fatalities; factors that include co-morbid medical conditions, obesity, geography, lower socio-economic status, gender, occupational exposure and genetics (Pareek et al., 2020; Moorthy and Sankar, 2020: 487). But not all factors apply equally to sections of BAME communities. PHE (2020: 25) recorded that for most BAME stakeholders, ‘COVID19 did not create

health inequalities, but ... exposed and exacerbated the longstanding inequalities affecting BAME communities in the UK’ thus confirming Rose et al. (2020). There is also intersectionality between these health inequalities and austerity policies, immigration, education and housing policies with race as the ‘elephant in the room’.

The UK’s racialised socio-economic inequalities spill over into the health and social care sector where The King’s Fund (2020: 9) asserts that while the national Health Service (NHS) has the ‘most ethnically diverse workforce in the public sector’, it displays ‘long-standing race inequalities’ wherein ‘ethnic workers have reported discrimination and lack of equal opportunities for career progression’. Moreover, during the early months of the pandemic it seems these structural factors in the NHS were such that ‘BAME staff were less likely to speak up when they had concerns about personal protective equipment (PPE) or risk’ (PHE, 2020: 25). This points to an institutional context with potentially

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high risk of moral injury, namely, the psychological distress or harm resulting from actions or lack of time, in ways that contradict one's ethical and ethical beliefs or positions (Litz et al., 2009). Greenberg et al. (2020: 4) observed that 'healthcare staff are at increased risk of moral injury and mental health problems when dealing with the challenges of the COVID-19 pandemic'. However, given the prevailing structural inequalities, it is highly likely that the experiences for disadvantaged BAME health and social workers would not be fully understood or even addressed by the organisations and systems, especially when the leadership is not representative of the workforce.

When seeking to understand and address the issues (for BAME communities) exposed by COVID-19 it is important to appreciate the diversity and difference in the groups that make up this artificial grouping: there are risks of covering up and masking the differences that exist between communities with different cultures, languages, behaviours, preferences and sensitivities (IFS, 2020). With regards to COVID-19 deaths, data presented by Razaq et al. (2020: 28) show that those born in Zimbabwe made up eight percent (8%) of the known health care workers who had died of COVID-19: (those born in the Philippines had a higher percentage) yet the overall proportion Zimbabweans in the UK health sector was/is far below one percentage. Equally Black Africans in the UK are not a homogenous category. Aspinall and Chinouya (2008) and Aspinall (2011) provide a compelling case for the disaggregated approach advocated for by the IFS (2020). Such disaggregated analysis (IFS, 2020) and community based culturally aware understanding (PHE, 2020) will need to be done between and within the BAME as well as amongst the African groups. Moreover, Platt and Nandi (2020: 839–840) have made a similar call for "... better understanding of ethnic diversity and differences within and between groups..." and argue that '... detailed single country studies have much to offer to this understanding'.

Even before the PHE (2020) call for community focused studies, these were already unfolding such as the Leicester study (Moorthy and Sankar, 2020) and the Zimbabwean one whose data is reported here. Office for National Statistics (ONS, 2019) census data at January 2019 give an official estimate of those born in Zimbabwe living in the UK at 128 000 (one hundred and twenty eight thousand); the third largest African born group after those born in South Africa (251 000) and Nigeria (215,000) but higher than Kenya (121 000), Ghana (114 000), Somalia (99 000), Uganda (52 000), Egypt (29 000), Mauritius (34 000), Sudan (33 000) and Zambia (29 000). Although these figures may be small relative to the total UK population, the diversity needs to be considered in detail. The ONS (2019) estimates that 95% of African born in the UK arrived after 1981; a significant concentration of recent arrivals.

Furthermore, this paper also responds to the call from The King's Fund (2020: 14) for '... studies that ... [focus]... qualitatively on exploring the experiences of ethnic minority staff in the NHS'. Beyond the statistics, this is about using the lived experiences of marginalised people to put a spotlight on the biases, victimisation, bullying, inequalities and discrimination they suffer in the workplace and in their everyday life. It attempts to engage directly with the communities adversely impacted by enduring injustices (exacerbated by COVID-19) and involve more of these communities in the co-production of knowledge. The next section outlines the methods and data sources. Results and discussion are in two parts, the first provides a profile of on-online survey participants and responses discussed relative to the literature and the second focuses on issues of trauma and mental health. The conclusions are presented in the last section.

2. Methods, data sources and analysis; an interpretive and mixed methods approach

2.1. Community engagement sessions

In the first six months of the COVID-19 pandemic, guidance from the UK government 'was slow in coming', 'was shifting', 'at times hard

to digest and sometimes harder to implement'. In these 'shifting sands', frustrated, fearful and traumatised, many communities, Zimbabweans included, looked for answers elsewhere in their community and social media especially their WhatsApp groups. By April 2020, those born in Zimbabwe made up eight percent (8%) of the known UK health care workers who had died of COVID-19 (Razaq et al., 2020: 28). Thus, when the Zimbabwe Diaspora Health Alliance (ZDHA) set up a zoom discussion forum in April, the response from the UK Zimbabwean community was huge. Participants in these zoom meetings ranged from highs of over four hundred during the first two months to around 150 in some weeks after July. Most participants were Zimbabwean and UK based although in later sessions, individuals from other BAME groups and from Zimbabwe also pronounced their presence. Notes taken from these forum discussions provided useful insights for this paper and enriched the survey data.

2.2. Google forms on-line survey

Convenors of the zoom forum discussions (the ZDHA) also conducted a google forms designed online survey to capture key experiences of participants in the early period of COVID-19. The questionnaire had both pre-coded and open ended questions. The corresponding information sheet requested that respondents confirm that they were over eighteen years old, were UK based and of Zimbabwean heritage, could withdraw from the survey if they wished and did not have to provide confidential information. It was a non-randomised, self-selection cross-sectional survey that explored decent work issues, PPE, discrimination, broader personal, family and everyday experiences with COVID-19. Thus, the survey and the forum discussions were designed to raise and identify issues rather than generate data for comparative and hypothesis testing. The nature of the resultant data is such that it is useful as a source of insights and key issues for further investigation. All names of respondents in this paper are from the online survey but have been changed to pseudonyms to give respondents anonymity.

Descriptive statistics of responses to pre-coded questions were produced automatically in google forms and are used to present profiles of respondents in the results section. The MAXQDA software was used for content and thematic analysis of respondents' open ended responses. This entailed interpretation and coding of statements to identify emerging themes, range of themes, recurring themes (thematic saturation) and outlier themes. Key outcomes are presented in the results section.

3. Results and discussions: from respondent profiles to COVID-19 experiences

3.1. Spatial distribution of Zimbabwean respondents in the UK

This results section first presents profiles of respondents comparing these to other migration literature and data. Thereafter, it details key aspects of the health inequalities and respondents' COVID-19 related experiences. As shown in the distribution map (Fig. 1), while most respondents were in London and the South East, there was significant presence of Zimbabweans in most urban and coastal settlements of the UK. This reflects the areas of UK's care deficit (Perrons et al. 2006) and need especially for social care as well as spatial outcomes of the asylum seekers/refugees dispersal policies of past governments since 2000 (Mbiba, 2011).

3.2. Health and social care – a 'niche employment sector' for Zimbabwean women

The majority of survey respondents were female (78%) as opposed to the equal distribution recorded for the Leicester study (Moorthy and Sankar, 2020) or a majority of men as reported in official data for BAME in the health and social care sector (IFS, 2020). In Moorthy and Sankar

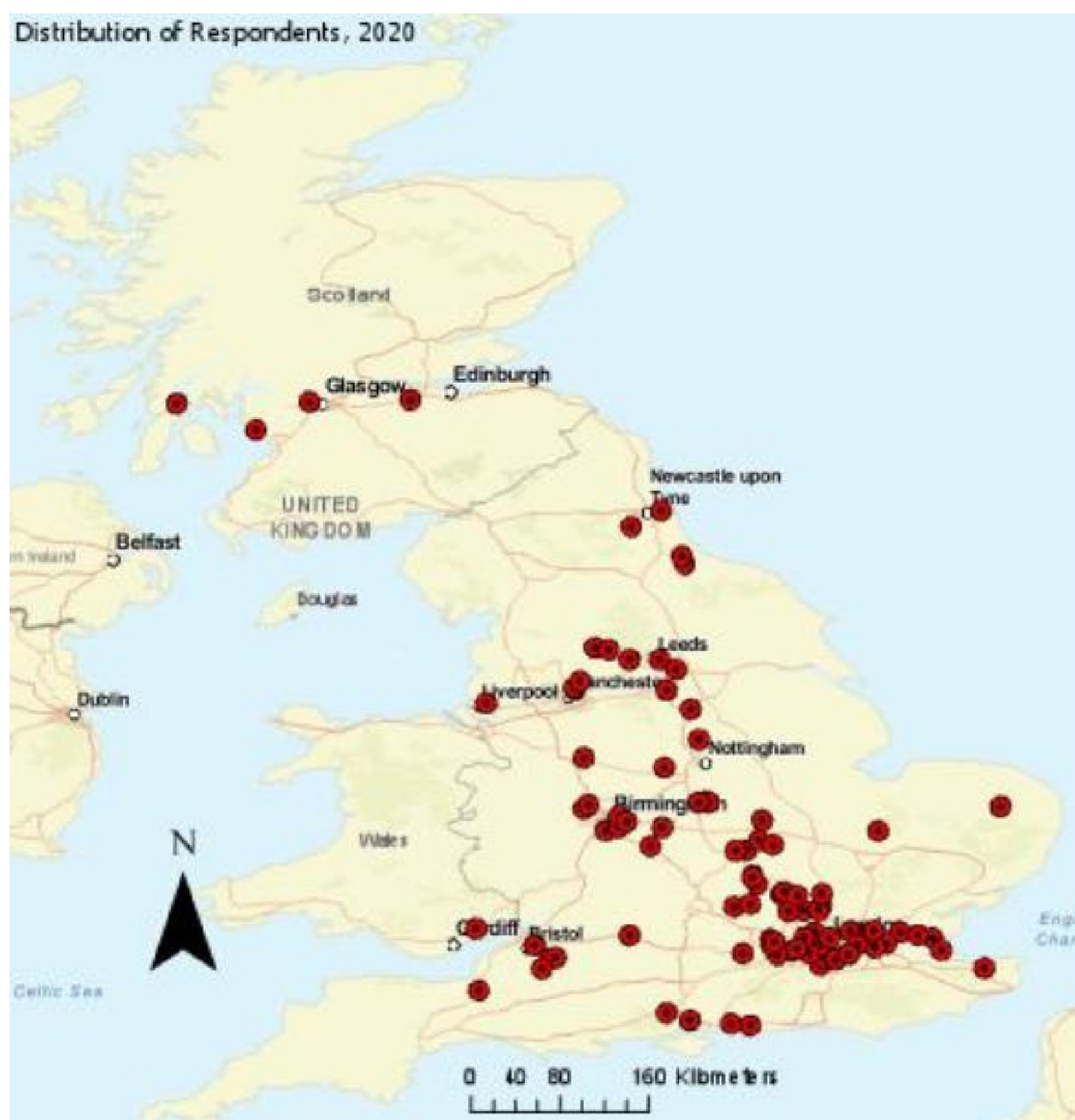


Fig. 1. Spatial distribution of respondents, March/April 2020 ($n = 103$).

(2020: 487), there was an equal distribution of male and female respondents while the IFS (2020: 14) states that men are more likely than women to work in the health and social care sector; that the share of Black African men in health and social care roles is almost double that of women. However, for the Zimbabwean community, it is females rather than males who dominate the health and social care sectors. Such data confirm the need for disaggregated approaches to understanding UK BAME (IFS, 2020) broadly and Africans in particular (Aspinall, 2011).

Explanations for these differences illustrate how health and care is intertwined with migration processes and specific conditions relating to the country of origin like Zimbabwe. Migration of Zimbabweans to the UK since the 1990s was led by women (Mbiba, 2005, 2012). ONS data estimates as of January 2019, show that sex ratios for the largest BAME groups (Indian, Pakistani, and Bangladeshi) were close to 100 or more (Table 1). In contrast in the case of Zimbabwe, there were seventy (70) men for every 100 (hundred) women. Only those from the Philippines have/had a lower sex ratio. For Zimbabweans in the UK, the survey data on gender is consistent with previously reported evidence on immigration to the UK in which the majority of the Zimbabweans currently in the UK immigrated post 1998 (Mbiba, 2005, 2012; McGregor and Primorac, 2010).

Table 1.

Sex ratio for leading African and Asian populations ('000 s) in the UK.

	Total population	Males	Females	Sex Ratio
South Africa	252	123	129	95
Nigeria	216	104	110	95
Zimbabwe	128	53	75	71
Kenya	121	62	59	105
Ghana	114	54	59	92
India	863	425	437	97
Pakistan	547	279	268	104
Bangladeshi	260	135	125	108
Philippines	153	57	95	60

Source: Population data extracted from Office for National Statistics, UK, Estimates as at January 2019 (male + female may not add up to the total due to rounding off).

Men were often the trailing spouses in this process. Unlike traditional pre 1980 Zimbabwean male-led rural-urban and regional migration to the South African gold mines of the Witwatersrand (Wenela), women

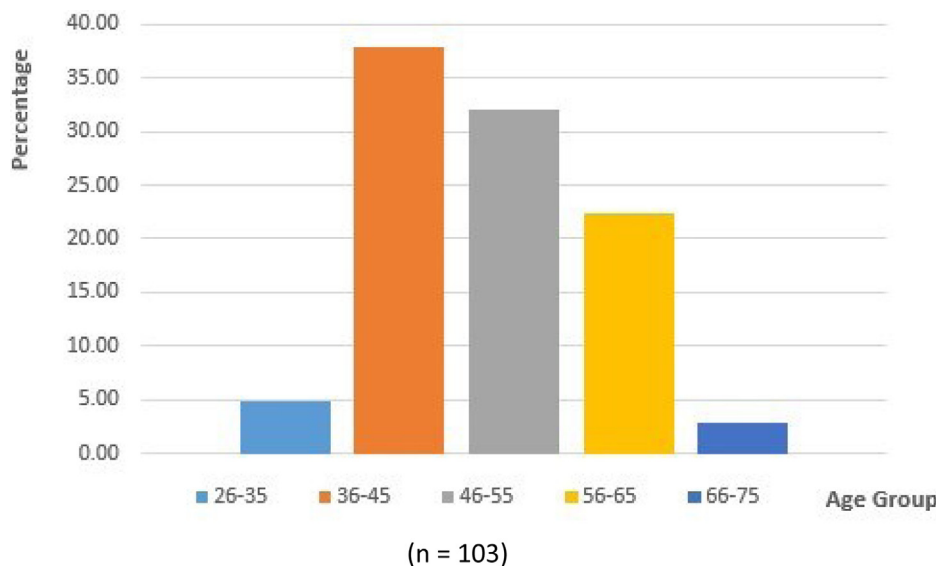


Fig. 2. Age distribution of survey respondents.

led the process of migration to the UK and filled in the ‘care deficit’ (health, social care, cleaning) where they flourished. Zimbabwean men initially considered jobs in these sectors as ‘dirty’ and ‘demeaning’; caricatured amongst Zimbabweans as the BBC ‘British Bottom Cleaners’ (Mbiba, 2005; McGregor, 2007; Mbiba, 2012). Home Office data as well as enrolments on nursing courses at universities further confirmed the dominance of women (Mbiba, 2012: 87). So, while there are no surprises here for Zimbabweans, the dominance of women is a clear difference relative to other BAME communities (IFS, 2020; Moorthy and Sankar, 2020). With health and social care a niche employment sector for Zimbabweans, it means they had a high occupational COVID-19 risk of exposure which in turn translated to risk for their families and the resultant reported hospital deaths of more than thirty in the first months (Sky News, 2020).

3.3. Still majority first generation

A key feature of the respondents was the dominance of those born in Zimbabwe (89%). This was similar to the Leicester data where up to 64% of the respondents were born in India alone while others were born in Malaysia and Singapore (Moorthy and Sankar, 2020: 487). These patterns mirror the international recruitment into the UK services sector that continues unabated. Future studies should make an effort to target UK born ethnic minority workers. Although the numbers would be small, it would enrich our understanding of intergenerational transmission of inequalities (real and perceived); to determine whether the experiences and perceptions of second-generation ethnic minority professionals differ from those of the older generations. Platt and Nandi (2020) also call for a similar investigation with regard to more established immigrants (Indians and Chinese for instance).

While the majority of respondents were born in Zimbabwe and identified themselves as such, 74% were also naturalised British citizens (a figure consistent with the 66% from ONS (2019) data) while 21% reported to be on indefinite leave to remain (ILR). The remainder were sprinkled across three groups of refugees, asylum seekers and other legal status to remain in the UK. None of the survey respondents identified themselves as students or as illegal immigrants. There were no respondents under the age of 25 years or over 75 years old (Fig. 2). The average age seems to be comparable to that of the Leicester study where the majority (47%) were in the 40 to 50-year age group.

Thus the population of Zimbabweans in the UK is a relatively young labour force; relatively few elderly migrated, and since 2000, many who wished to were refused visas while others already in the UK prefer to

return to retire and die in Zimbabwe. Still, the fate of the elderly during COVID-19 requires further investigation within the community. At the bottom end, the absence of young people amongst respondents calls for a targeted engagement with this important group. Most would have come to the UK as babies and children or were born in the UK. How they engage with policy, how they experience inclusion or discrimination relative to the rest of the community would be important to understand (Platt and Nandi, 2020).

3.4. Connections with home of origin and ‘push-pull factors’

The home country regions of origin for the respondents show that most come/came from the urban areas (31% Harare and 13% Bulawayo) and highly urbanised provinces (11% Mashonaland West, 10% Midlands and 8% Mashonaland East). Less urbanised provinces of Matabeleland South (zero percent), Matabeleland North (2%) and Masvingo (4%) had relatively low representation. Instead, people from these regions dominate migrants to nearby South Africa and Botswana. Mashonaland Central and Manicaland had 6% and 15% respectively.

The majority of respondents reported that they came to the UK for employment (34%), to further their studies (18%), for economic reasons (15%) and family reunion (16%), with only 13% reporting flight from political persecution as the major reason for exit. Although relatively a small proportion, these people fleeing political persecution need attention as they are likely to be amongst those with traumatic experiences from the contemporary socio-economic and political upheavals in Zimbabwe. However, if consideration is given to Zimbabwe’s unsettled legacy of the 1970s war of liberation, the Gukurahundi massacres of the 1982–7 period (CCJP, 1997), recurrent urban demolitions and forced evictions symbolised by the (in)famous Operation Murambatsvina (UN 2005), impoverishment wrought by Economic Structural Adjustment in the 1990s, the graves, orphans and skipped generation households left in the wake of HIV/AIDs, droughts and cyclones and cycles of election related violence, then one would not be far off the mark to suggest that Zimbabweans are a traumatised society. Only community specific research can reveal such layered and unattended to trauma which can be aggravated by the negative experiences in the UK.

3.5. The dominance of highly educated nurses

The dominance of nurses amongst the respondents is further reflected in the employment profiles at the start of COVID-19. Almost 63% of respondents were nurses while only one person was a medical doctor.

This is a huge contrast to the Leicester study (Moorthy and Sankar, 2020: 487) where the majority of respondents were medical doctors – a feature reflecting the dominance of Indians in that study. Why UK based Zimbabwean doctors did not participate in larger numbers is unclear. Another surprising result was that only six percent of respondents were Health Care Assistants and another four percent social workers. Elsewhere, it has been observed that many Zimbabweans work as Health Care Assistants on zero-hour contracts through agencies. Most of these workers will be qualified as nurses but work as care assistants (mainly as a second job/Agency and Bank staff) so would most likely identify themselves as nurses rather than Health Care Assistants. Five percent reported that they were key workers other than in health care. Meanwhile the rest were in health-related sectors and identified themselves as health visitors, radiographers, physiotherapists, occupational health workers, bio-scientist, college lecturer and midwives. The numbers in each of these were very small.

Related to the employment features are the highest academic qualifications where 8% had a Diploma/Vocational qualification, 36% had a Bachelor's Degree, 33% had a Master's degree and eight percent had other professional qualifications. Given that most of these were nurses and that Zimbabwe did not provide nursing degrees (until recently), it is most likely that these degree qualifications were obtained in the UK. This would be consistent with the data from the first decade of the millennium where significant numbers of Zimbabweans arrived in the UK on student visas before converting to work permits as well as the high number of Zimbabweans registered on university nursing courses over the same period (Mbiba, 2005, 2012). The community in this study reported high academic qualifications: almost 70% had at least a Bachelor's degree qualification most likely obtained in the UK. Consequently, lack of education as a barrier to integration or understanding COVID-19 related health messages would need to be considered differently for such a group relative to others where poor English language skills and low educational attainment are a barrier (Kar, 2020; Razaq et al. 2020).

Regarding COVID-19 experiences, the dominance of female nurses means that insights from this study will be useful for comparison against medical doctors-based studies such as the Leicester study (Moorthy and Sankar, 2020). The survey did not have questions on neither the employment rank/grades of the respondents nor the employer. However, most Black African nurses are employed in the lower grades where they make few management decisions even though they have years of experience in the sector. The majority (57%) had over fifteen years of work experience, most of this in the UK. At least 68% had been in the UK for eleven to twenty years and another 27% had been in the UK for over twenty years as of March 2020. How they interacted with management during the COVID-19 emerged as a key issue for interrogation.

3.6. Household conditions and characteristics

A key feature of the COVID-19 transmission is through close contact with infected individuals. This is more likely where an infected person lives with other people; spouse, household members, family or others who share the same accommodation even if they are not relatives. Twelve percent of the respondents reported that they lived with someone aged sixty years or more; the people at high risk. The proportion of those living in rented accommodation of 40% was much lower than those in own homes (60%). This 60% proportion of homeowners is much higher than the 25% for Black Africans reported in Razaq et al. (2020: 15). However, the study did not enquire into the quality and location of the homes. The location and housing quality aspect is important given that according to ONS, 2020, 'Black people are four times more likely to inhabit homes without gardens or outdoor space' and are disproportionately exposed to air pollution and have less access to parks and nature than their White counterparts' (The Guardian, 2016). Such unhealthy environments could partly explain why, migrants who tend to be healthier at the point of arrival in the UK, lose that advantage over time (Razaq et al., 2020).

Most respondents were married and unlike in the early immigrant years, they lived with their spouses in the UK (62%) compared to two percent whose spouses were living in Zimbabwe. Twenty seven percent (27%) were single, four percent divorced, two percent separated, one percent unmarried living with a partner and two percent widowed. One of the widowed mentioned that their spouse had died recently of COVID-19. The high level of married respondents, many of whom were nurses with high risk of occupational exposure to COVID-19 implies that their spouses were also at high risk of contracting the virus. As many as 54% respondents had a child born in the UK with 40.6% reporting at least two or more children born in the UK. Crucially, only 49% of respondents lived in households without children (below sixteen years of age). This is much lower than the 70% for White households reported by Razaq et al. (2020: 15). How the 51% of Zimbabwean respondents (especially the 34.6% with two or more children) addressed the burden of caring for children during this COVID-19 period is a candidate for deeper interrogation. Single parents may have more difficulties in managing children compared to couples, another issue that needs further exploration.

4. Decent work and COVID-19 experiences of Zimbabweans in the UK: early days

4.1. Personal protective equipment: availability, access and utilisation

The availability, accessibility and utilisation of (Personal Protective Equipment) PPE in the workplace was a major issue. For 63% of the respondents, PPE was an issue of concern with 20% indicating that it was of extreme concern in March 2020. Nurses especially agency staff were scared and anxious about availability of PPE and being deployed to work in COVID-19 wards. Jenny, an agency nurse highlighted that:

'... It was awful to work without PPE and I felt vulnerable. I work full time agency and I cannot risk being sick because I would not have an income. Information about COVID was trickling down to the public but a lot of things were not certain...'. (Jenny, On-line survey respondent)

Jenny's testimony on vulnerability shows the link between health and livelihoods; the precarious nature of incomes for those on zero hours contracts such as agency staff.

In the zoom forum discussions, it became clear that even where such workers were ill or where there was no PPE, some would still go on to work. Consequently, like the poor and informal workers in developing country cities, their choice was to either die of hunger or die of COVID-19. In the forum discussions, some participants urged colleagues not to put their lives at risk for money in the short term. However, other participants who were agency staff/zero hours contracts also reported that when faced with the risk of being made to work without PPE or in COVID-19 wards, they opted to stop working and forego the money. Determinants of these varied decisions need further investigation as they point to neglected diversity within groups (Aspinall, 2011; IFS, 2020; Platt and Nandi, 2020).

The online survey did not have questions on how long respondents suspended working and what savings or alternative savings of income they resorted to during the work suspensions. This is a line of further investigation in community research where saving during good times should be encouraged; the IFS (2020:25) reported that only 30% of Black Africans 'lived in households with enough saved in current accounts, savings accounts and ISAs to cover one month of household income and around 10% (to) cover three months income'. The IFS (2020: 24) reasoned that, with a high share of employment in the health and care sectors, Black Africans would be less economically vulnerable than other minority ethnic groups. However, we suggest that in practice the evidence from the Zimbabwean group shows that they were indirectly vulnerable especially if they were agency staff on zero hours contracts. The occupational risk to infection forced many to suspend going to work and, in the process, lost income earnings – though this may have been for

a few months. Therefore, such diverse routes into vulnerability should not be missed.

A nurse with years of working experience observed that ‘...as most of the Zimbabwean nurses work with agency, there tends to be a common law that agency nurses are placed in high risk areas. I am a previous nurse and have experienced this...’ (Online respondent MaNdlovu). These experiences and perceptions when shared within the community in the absence of timely official information heightened the fear and anxieties amongst health care workers and those they lived with. The ‘common law’ referred to by MaNdlovu, is about unwritten informal institutional practices of unfairness deployed to particular roles.

Some Zimbabwean nurses also reported being or feeling victimised when they requested PPE before deployment to wards. Again, this was acute for agency staff as narrated by Jane:

‘... Being an agency nurse, I realised I was more likely to be asked to go to General hospital, to a COVID-19 ward to look after a mental health patient 1–1. Some agency staff were stopped from working at the hospital for some time because they had refused to go to ‘COVID-19 wards’ because they had underlying illnesses or they lived with a vulnerable person...’ (Jane, On-line Survey respondent).

Even where PPE was available, there were problems in early days with staff and managers not conversant with procedures of ‘donning and doffing’ particular types of equipment especially in areas where use of such equipment was previously not a routine procedure. In her response, mental health nurse Bocha, captured these concerns with PPE at the time in March 2020; concerns that included:

‘... Misinterpretation of what PPE is to be worn under what circumstances by senior managers and at times shortage of PPE. In mental health, staff are not as conversant with wearing PPE as general nurses who are used to nursing patients suffering from infectious diseases. Apart from that, in mental health, there is no time for individuals to wear full PPE if someone is putting themselves or others at risk and need to be restrained. Sometimes, the person they will be restraining is Covid-19 and so they get exposed during the period of restraining. Full PPE is used for those with Covid-19 diagnosis but donning full PPE in an emergency is a challenge and half the time, the patients will not have been tested...’ (Bocha, On-line Survey respondent)

A subsequent zoom forum was devoted to discussing PPE procedures in mental health and how to engage managers should there be concerns in this area. The passionate experiences and views aired were similar to those of PPE. It was encouraging to realise that despite these anxieties and experiences, there were many who shared positive experiences and gave advice on how to handle the use of PPE in mental health and other situations. Crucially, the zoom forum interlocutors were able to identify members who provided reliable information on procedure and regulations. Equipped with this knowledge members were able to engage with their managers more productively. A key observation in contexts where official information was slow to come and not trusted, the members seemed receptive and trusting of the information provided at the forum. This community space is important to maintain as a continuous complementary way of sharing knowledge on controversial issues. Crucially this suggests that government should enhance more use of community platforms and leaders in dissemination of policy information especially under conditions of mistrust and uncertainty.

Survey respondents and forum participants reported that in some cases, when Bank/Agency staff brought their own PPE, duty managers would ask them to take it off. It required knowledgeable and empowered colleagues to intervene and rectify the situation as reflected in Farirai’s survey response:

‘... This did not happen to me but happened to 4 BAME colleagues. They were asked to remove the PPE by the head of health, which was wrong. I supported these nurses to take the issue further and ‘datixed’ and escalated to the medical director, RCN and Public Health Eng-

land. Situation was then resolved though this head of health is still not happy with the action taken’ (Farirai, On-line survey response).

The resultant strained relations may be at the detriment of health workers especially where the options to change employers are limited especially in areas outside London or major urban conurbations or for those where life-cycle circumstances may also make moving to another employer unfeasible.

4.2. Experiences and perceptions of discrimination

The COVID-19 period was traumatic for the majority of those of African heritage worldwide. Not only were they confronted with a ravaging virus but the murder in the USA of George Floyd at the hands of police officers left many angry, traumatised and feeling helpless. It became clear that institutional racism against Black people was an endemic pandemic that was killing Black people every day and in particular that it underpinned the disproportionate COVID-19 deaths amongst those of African heritage.

About a fifth (22.2%) of the online survey respondents were of the view that from their ‘shop floor’ experience, PPE allocation favoured Whites relative to Blacks. Respondents like Muranda were forthright, asserting that ‘allocation of PPE to non-Caucasians was limited’. Crucially, the enduring nature of racial discrimination was summarised by Shirley who responded as follows:

‘... Yes, very much so. It (racism) has always been there, and Covid-19 made it all the more evident. The NHS is institutionally racist’ (Shirley, On-line Survey respondent).

Thus COVID-19 can be viewed as an opportunity to put racism back on the policy agenda in the UK where it seems to have been a disappearing discourse since the first decade of the millennium.

However, there were some nuggets of positive work experiences and support from managers. Vuhle reported that she felt looked after in her workplace:

‘...as the news circulated that BAME staff were more at risk of catching Covid-19, I got encouraged to wear more/extra PPE to protect myself to the extent I would feel more safe. Generally, I felt well looked after (Vuhle, On-line Survey Respondent)

More of these positive experiences need to be captured and lessons shared just as much as those from where things have not worked well. Guest speakers at the zoom fora shared personal experiences demonstrating how progress can be made by both Blacks and Whites to dismantle institutional racism in the NHS. Steps are ongoing to document these presentations and no further details can be provided here.

4.3. Moral injury, mental health issues and anxieties

The early months of 2020 found most institutions and individuals unprepared for COVID-19’s health and social impacts. In response to how they would summarise their COVID-19 experiences at a personal level, the recurring words from the online survey respondents were ‘traumatic’, ‘fear’, ‘anxiety’ ‘stress’ and ‘scary’. These are presented in the word cloud in Fig. 3. Clearly, individuals were under extreme stress, felt fearful and helpless. They felt that if infected, they would die. The uncertainties and lack of clear leadership in the workplaces exacerbated anxieties. Workers (and managers) were not properly prepared for what they would experience during COVID-19; a gap that heightened risks of moral injury and mental ill-health especially as heavy workloads and ‘burnout’ would aggravate the situation. In this context, workplace decisions in the use of limited resources caused stress as Mvula experienced:

‘... very traumatic when client is high risk and already has respiratory problems, with consultants forcing a DNR on disabled client saying they don’t deserve a ventilation when there are other people



Fig. 3. Experiences of COVID-19: Zimbabweans health & care workers in the UK March/April 2020.

who are not disabled who need it...'. (Mvula, On-line survey respondent).

There were also allegations of 'discriminatory' decisions which prioritised White patients ahead of those of African heritage especially in the period when friends and family were not allowed to visit COVID-19 patients. This lack of access to family heightened the mental torture and fear of getting infected or dying in a foreign land. Furthermore, seeing their colleagues motionless and dying of COVID-19 made the situations unbearable for health care workers. The experiences captured in Fig. 3 clearly indicate moral injury and ill-health were a reality for many.

Now that the damage has been done, focus should turn to implement formal and informal measures to care for those in need.

Some respondents reported testing positive and falling ill due to COVID-19. Charity was one of them. She narrated that:

'... I tested COVID-19 positive myself and had all those symptoms that left me suffering all the panic attacks, lack of confidence, depression, stress, vulnerable and did not know where to restart from so that I can gain myself back'. (Charity, On-line survey respondent)

Many feared taking the workplace infection to their children and families. Death was not far away for health and care workers during this period. Many lost work colleagues and close relatives. The respective testimonies of Mpini and Miranda are typical and apt in this regard. For Mpini:

'... People I know have died due to the Corona Virus. The time I was in the clinical area, I lived in fear of being more exposed to the virus as some members of the team contracted the virus and some of them with symptoms were asked to report to work then leave the work place to go and be tested and come back to work whilst waiting for their results. One of them tested positive after being asked to come back to work before the results were known. I still live in fear of contracting the disease from colleagues I share office space with...'. (Mpini, On-line survey respondent)

The protocols (or lack thereof) in this situation were exacerbating the risks of infection in the workplace.

Miranda experienced stress at work as a frontline worker. However, when the virus 'came home', that experience turned into a positive. She reflected:

'I work as a front-line worker and dealt with COVID-19 cases that have left a traumatising effect in my life. But on the other hand, it has made me a strong person when I was faced on a personal level nursing my husband'. (Miranda, On-line survey respondent)

So, experience can prepare and fortify some individuals. This may only happen if the 'shock' is not persistent and victims have had time

to recover. Clearly, needed is analysis of the factors that determine resilience during COVID-19 relative to previous pandemics like HIV/AIDS.

There were reports of many cases who did not survive COVID-19. Mrs Huku is a survivor but her husband died of the disease. In the zoom forum discussions, the issue of how to support such individuals and families did not get a convincing response. In part, the mechanisms for support amongst Zimbabweans in such cases were emasculated by the COVID-19 lock down and social distancing policies implemented to slow down the spread of the virus. This remains a pending issue. The likelihood of moral injury and mental ill-health was noted.

A fifth of Zimbabwean respondents in this study perceived that workplace racial discrimination in the allocation of PPE was extreme during the early months of COVID-19. But like [The King's Fund \(2020\)](#) some were able to articulate that COVID-19 only exposed longstanding inequalities. This realisation is likely to have exacerbated the stress amongst the health workers. Writing on how to manage expected mental health challenges faced by health care workers during COVID-19, [Greenberg et al. \(2020: 1\)](#), warned of the moral injury and mental health risks for health care staff and that the workers would grapple with:

'... how to balance their own physical and mental healthcare needs with those of their patients, how to align their desire and duty to patients with those to family and friends and how to provide care for all severely unwell patients with constrained or inadequate resources. This may cause some to experience moral injury and mental health problems.'

The emotional and social experiences of the Zimbabweans were dominated by trauma, stress, anxiety and fear (Fig. 3). These are all conditions that have psychological impacts. The zoom forum meetings showed that sharing these experiences in an environment of trust had a therapeutic effect on some participants. As suggested by [Greenberg et al. \(2020: 2\)](#) there is a clear case for active monitoring and after care in the workplace to ensure mental well-being of workers. Furthermore, this monitoring should emphasise the good practice, positive outcomes and experiences that should be shared; an activity that the community should engage in.

The Zimbabwean workers like Mvula experienced 'moral injury' when workplace decisions were taken to allocate resources in ways that violated their moral or ethical dispositions. Furthermore, moral injury extended to decisions on whether to go to work and risk infecting loved ones at home. And when they decided not to work, this had implications for resources available to send to family back in Zimbabwe at this time of great need when many were in lockdown and not working. Information from respondents suggest that their mental stress was compounded by not being able to travel to be with family in times of illness and death back in Zimbabwe. Community therapy should be supported to provide care in this regard. Equally however, as described above by respondent Miranda, the negative experiences and mental injury could be converted

into useful capital and knowledge or mental growth (Greenberg et al., 2020:1; Brooks et al., 2020).

Furthermore, like most UK citizens of recent immigrant heritage, Zimbabweans faced the extra burden and trauma of being away from their families in Zimbabwe during the COVID-19 period. During this period there was hardly any international airlines into Zimbabwe except Ethiopian Airlines. On arrival, in Zimbabwe, passengers would be placed in quarantine for up to 21 days. The government quarantine centres turned out to be high risk for infection. Alternatively, individuals could quarantine in private centres at a whopping daily charge of US\$100.00 (one hundred dollars) to which one would add extra costs for periodic tests (up to \$US65.00 per test).

Thus, where travel was possible, the costs were prohibitive. The thought and experience of family dying in Zimbabwe and not being able to bury them left many traumatised during this period. In dealing with the mental health of people of immigrant origin the trauma associated with events in the country of origin is often not considered in the treatment regimes. This is another issue that research in partnership with communities should examine to help provide support for those who need it.

5. Conclusions and recommendations – pivoting the community

This paper contributes critical insights from lived experiences (Rose et al., 2020: 4) and perspectives of marginalised Africans at the deep end of the UK's COVID-19 response: at the deep end, anything including death, is possible. The paper confirms the need for policy makers to consider diversity within and between BAME groups, for instance dominant and large BAME groups such as the Indian, Pakistani and Bangladeshi compared to the Zimbabweans reported in this study. While the share of Black African men in the health and social care sector is double that of women (IFS, 2020), the opposite prevails in the Zimbabwean case. Moreover, unlike the Leicester study dominated by male Asian medical doctors of Indian origin (Moorthy and Sankar, 2020), the data for this study was dominated by female nurses. We conclude that Zimbabwean women have been at high risk of occupational exposure to COVID-19 infection; a point supported by profiles of the reported hospital deaths for Zimbabweans in the UK.

Furthermore, the paper showed that overall satisfactory reports regarding PPE and support from managers reported for the Leicester study (Moorthy and Sankar, 2020) risk obscuring some critical negative experiences of other minorities such as the Black Africans represented by the Zimbabweans in this study. We recommend that policy makers should go beyond the broad statistics and listen to the qualitative testimonies of different groups such as the workers in this study so as to minimise their epistemological and policy displacement.

In an era of 'fake news', mistrust of workplace team leaders, managers and governments the study illustrates how community groups have emerged as trusted and effective alternatives. We recommend more support be provided to community based social formations so as to enhance their role in the co-production of disaggregated knowledge on old-age health, childcare, decent work, mental health and behaviour change issues occasioned by COVID-19.

The study confirms that the need for monitoring of and support to traumatised workers is key. We recommend monitoring of and research on how both individuals and institutions dealt with moral injury and mental health in different phases of COVID-19 and beyond. As Rose et al. (2020: 4) concede, the already vulnerable, excluded and discriminated (as the health care workers and their families in this study) may have worse long-term outcomes. We need to better understand the vulnerabilities of foreign born workers who carry legacies of trauma from their home: trauma exacerbated by concerns with what happens in the home countries including inability to participate in critical rituals such as burial of loved ones while facing daily experiences of racism (The King's Fund, 2020) in the host land.

Further areas of in-depth enquiry that we recommended include delicate issues of dealing with bereavement in the diaspora, issues of resilience and the role of cultural resources, the role of spirituality in communities faced with disasters in western societies; and how to build bridges with knowledge from developing nations. There are opportunities too, to frame this work in the context of sustainable development goals (for example SDG3 on mental health and SDG8 on decent work) language and concepts that facilitate partnerships across the globe (UN, 2015). In addition, COVID-19 forced change of behaviours world-wide. In monitoring the health outcomes, there is need to examine the differential ways in which social and health behaviours (Pareek et al., 2020) have shifted and determinants of inertia where positive change has not occurred. Above all, COVID-19 has given everyone an opportunity to take action to dismantle global and local structures perpetuating racism and inequality.

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There are no conflict of interests to declare.

CRedit authorship contribution statement

Beacon Mbiba: Conceptualization, Data curation, Writing - original draft. **Brighton Chireka:** Writing - review & editing. **Edward Kunonga:** Writing - review & editing. **Kudzai Gezi:** Writing - review & editing. **Paul Matsvai:** Writing - review & editing. **Zeb Manatse:** Data curation, Formal analysis.

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