**Protecting Human Rights during and after the COVID-19**

**Joint Questionnaire by Special Procedure Mandate Holders**

**Responses by H. B. Adediran Olaiya, M.A.**

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**COMMON QUESTIONS**

**Impact on human rights**

On 19 June 2020, 300, 717 confirmed infections and 42, 238 fatalities from COVID-19 were recorded in the UK (JHU Coronavirus Resource Center, 2020).

*•* The UK’s Coronavirus (COVID-19) Guidelines provides guidance to the general populace on social distancing, self-isolation, shielding etc, to curtail adverse impacts of the pandemic. Legal measures are implemented by the state party to respect, protect, and fulfil universal human rights for the general populace, by reducing opportunities for transmission and infection, (Legislation.gov.uk, 1984) and (Legislation.gov.uk, 2020b). Nonetheless, the government’s Disparity Review 2020 highlights COVID-19 infection and fatality rates are disproportionately higher for people of African descent in the UK than their white counterparts, (Public Health England, 2020).

Reports of racial discrimination by law enforcement associated with alleged breaches of lockdown guidelines also highlight systemic racism in meeting statutory obligations to respect, protect and fulfil human rights. For example, people of African descent in the UK have disproportionately lower educational attainment levels, higher rates of unemployment and incarceration by law enforcement, and poorer housing opportunities which all impact negatively as social determinants of (ill) health.

• Provisions of the Public Health (Control of Disease) Act 1984,and Health Protection (Coronavirus) Regulations 2020, required general lockdown of the public, private and voluntary sectors which begun to be lifted in June 2020. Police constabularies have legal powers to arrest and fine individuals breaching restrictions for conducting business, employment, or education in potentially infected premises, public conveyance, international travel, and disposal of dead bodies, (Legislation.gov.uk, 1984) and (Legislation.gov.uk, 2020b).

1. Relevant legislation enacted by the state party in response to the pandemic, include (Legislation.gov.uk, 1984), (Legislation.gov.uk, 2020a) and (Legislation.gov.uk, 2020b).
2. The UK government enacted these legal measures in response to the COVID-19 pandemic to ensure,
3. the general populace complies with lockdown guidelines for self-isolation, shielding, social/physical distancing, etc. to reduce transmission, infection, and fatality rates. For example, Arts 29-32 of the Public Health (Control of Disease) Act 1984 asserts restrictions on the use of infected premises for education, employment or other purposes (Legislation.gov.uk, 1984);
4. the Act protects the general populace from infection, through restrictions on public conveyance stated in Articles 33 & 34, and health protection regulations for international travel stipulated in Article 45b, (Legislation.gov.uk, 1984).

*c)* Some measures are proportional, e.g. reduced COVID-19 transmission, infection, and fatality rates result from social distancing, but others contribute to further social conflict.

*d)* Lockdown measures adversely impact low-income groups, e.g. people of African descent in informal or temporary employment, and immigrants. These groups generally have little or no recourse to government funds otherwise available.

•Fiscal austerity following the 2008 recession is likely to be exacerbated by the economic downturn associated with the pandemic, and adversely impact human rights of vulnerable groups. Moreover, private sector organisations have been badly affected, resulting in the loss of over half a million jobs in the UK since the beginning of the pandemic, which adversely impacts access to second generation rights. Nonetheless there has been movement towards policy solutions, including the national government’s proposed Race Inequality Commission, and the City of Bristol’s advocacy of the 2030 Agenda for Sustainable Development for inclusive post COVID-19 recovery planning.

*•* Long-term impacts of the pandemic and response measures are expected to exacerbate socioeconomic marginalisation of vulnerable groups, especially where intersectionality occurs. Thought leaders have therefore already begun to adopt a proactive stance towards post COVID-19 recovery planning.

• National economic recovery and financial assistance mechanisms are unlikely to reduce the socioeconomic impact of lockdown measures adopted, where they were not previously subjected to human rights impact assessments. There has been movement in that direction, e.g. risk assessments of vulnerable staff, (NHS England and NHS Improvement coronavirus, 2020).

**Statistical information**

*•*  Public Health England (2020) provides disaggregated epidemiological data on COVID-19 infections, recovery and mortality rates in the UK, highlighting groups which have been disproportionately affected. For example, “men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, (...) and men and women working in social care had significantly high rates of death from COVID-19,” (Public Health England,2020, p.50).

• Public Health England (2020, pp.10-19) and Public Health England (2020, pp.57-59) analyse age disaggregated data on persons infected by COVID 19, and the percentage of older persons living in care institutions, including data on deaths caused by COVID-19.

* Analysis of the Office of National Statistics data highlights high fatality rates of migrants from some countries and the homeless (Public Health England,2020, pp.54-56). This is argued to be a “consequence of being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and discrimination.”

• A substantial majority of individuals reported reduced income resulting from the economic downturn associated with the pandemic in June 2020, however this data is not disaggregated (Office for National Statistics, 2020)

• Low income groups in the UK, e.g. individuals in zero hour and contract employment are most vulnerable to socio-economic hardship as a result of the pandemic, (Farah, 2020).

•Data analysis is provided on the numbers of older persons living in residential care, homeless persons, and immigrants, (Public Health England, 2020).

*•* Abrahams (2020) reports neglect of older persons in care institutions. Notably, the percentage of deaths in care homes increased over time, accounting for (43%) of COVID-19 fatalities in the week ending 8 May 2020, (Public Health England, 2020, p.57).

**Protection of various groups at risk and indigenous peoples**

• Coronavirus (COVID-19) Guidelines are statutory measures to protect the general populace. Protection for high-risk populations from COVID-19 include a) Personal protective equipment for frontline health care and social workers, as well as restrictions to reduce the possibility of their infection by the public,

b) older persons, and c) other persons with a possibly reduced immune system, or persons living with HIV, may have restrictions on their movement outside of their residence.

I am not aware of specific measures implemented by the UK government to protect d) detained and incarcerated persons, including persons under state custody; e) persons living in care homes, f) children and adults living in institutions, camps, shelters or collective accommodation, g) persons with disabilities, j) refugees, IDPs and k) migrant workers.

The state party has reputedly provided temporary accommodation to h) homeless persons; i) persons living in informal settlements or overcrowded homes (Public Health England,2020).

*•* The *Review of disparity in risk and outcome of COVID-19,* and subsequent *Race Inequality Commission* are measures taken by the national government to mitigate the impact of the pandemic on communities’ subject to structural discrimination and disadvantage.The City of Bristol claims to advocate implementation of the 2030 Agenda for Development for inclusive post COVID-19 recovery planning.

*•* Insufficient measures were taken by public authorities to ensure continued provision of services, including food, healthcare, and education, to persons in vulnerable situations.

*•* There has been disruption in the provision of healthcare and psycho-social services, and worrying reports of increased mental ill-health.

• UK Government Coronavirus (COVID-19) Guidelines apply to single households as to the general populace. In June, the government reduced lockdown restrictions to allow directed meetings between individuals from two single households in a “bubble”.

• Racial disparities outlined in (Public Health England, 2020), and allegations of systemic racism, are subject to enquiry by the newly established *Race Inequality Commission*, e.g. Professor Mirza of University College London alleges over 50% of women infected with COVID-19 are BAME.

**Social Protection**

• No comment on planned or implemented adjustments to the social safety net for vulnerable groups.

• Small entrepreneurs and others in the informal sector are unlikely to benefit from state-sponsored social protection.

**Participation and consultation**

• “The NHS Confederation is supporting NHS England and NHS Improvement to address the impact (of COVID-19) on BME communities and will involve (…) the BME Leadership Network (…) to ensure the NHS and government respond to these issues and mitigate risks” (BME Leadership Network, 2020).

• The imposition of emergency regulations has increased public participation and consultation in responses to the pandemic and lockdown; e.g. civil society facilitates participation of vulnerable groups affected by COVID-19 and response measures, in decision-making processes.

• Place based thought leaders in Bristol claim to advocate the 2030 Agenda as a post COVID-19 recovery strategy.

**Awareness raising and technology**

• The UK government’s awareness-raising activities to inform groups in vulnerable situation of health risks, include Coronavirus (COVID-19) Guidelines published online.

•No comment on the training and briefing of law enforcement and public officials but this is likely to have occurred.

**Internet**

• The internet and social media are used for work, education, shopping for food and other goods, awareness raising and sharing of information, religious ceremonies, cultural and social interaction, consultation and political decision making, etc. Poor or no internet access adversely impacts education and employment affected by lockdown restrictions, as well as other activity, e.g.online activity facilitated peaceful protests against Afriphobia.

• No comment regarding monitoring of online information related to the pandemic.

**Accountability and justice**

• Systemic racism is a causal factor of disparities in risks and outcomes for COVID-19. BAME activists and academics foresee the economic downturn associated with the pandemic will further exacerbate this situation. This led to the launch of the UK government’s *Race Inequality Commission* in June 2020, following widespread public discontent and protests. Increased reports of domestic violence against women, children, and LGBTQ+ persons have allegedly also been made to civil society.

• No account or statistics on operation of justice system related to impact of COVID-19.

*•* No comment on preventative or other measures taken by the justice system, except to mention alleged cases of racial discrimination by law enforcement enforcing lockdown guidelines.

• The UK government’s launch of the *Race Inequality Commission* in June 2020 follows increased reports of hate crime, racial discrimination, and racism during the lockdown, as well as racial disparities in the risks and outcomes associated with COVID-19.

• Alleged increased reports of domestic violence during the lockdown, may have led to support for some victims, I do not know of the legal ramifications of the pandemic.

• Homeless persons in the UK were reputedly offered temporary shelter at the peak of the pandemic although their situation is uncertain.

• Article 52 of the Coronavirus Act 2020 grants the state party powers to give directions relating to events, gatherings, and premises which impacts on freedom of expression and assembly, e.g. restrictions on numbers allowed to attend burials, weddings, parties, etc, (Legislation.gov.uk, 2020a). Lockdown restrictions also apply to public assembly as in the case of peaceful protest, and individuals allegedly have been fined and arrested for breaching the same.

• Public or parliamentary investigation arising from the COVID-19 pandemic in the UK is illustrated by (Public Health England, 2020). As a result of its findings, the government will establish a *Race Inequality Commission* to pursue further investigations. Systemic racism is argued to be an underlying causal factor of disproportionate racial disparities in COVID-19 infection and fatality rates.

• Abrahams (2020) identifies neglect of older persons in care institutions.

• No known measures have been taken by public and judicial authorities to address allegations of neglect of older persons in UK care homes and to establish accountability.

• Enforcement of the Public Health (Control of Disease) Act 1984, Coronavirus Act 2020, and other emergency regulations are subject to ongoing review by the state party.

**Responses to questions by the Working Group on Persons of African Descent**

*1.* The UK government’s recent review, highlights disproportionately high COVID-19 infection and fatality rates impacting people of African descent in the UK (Public Health England, 2020, pp.40-49). For example, high infection and fatality rates are reported for people of African descent, in British urbanisms such as Birmingham and the London Boroughs of Brent, Lambeth and Southwark which have sizeable BAME populations.

“Co-morbidities and socio-economic status are being put forward as possible explanations for the high number of people from BME backgrounds affected”, (BME Leadership Network, 2020). For example, “Black African and African Caribbean people have higher rates of hypertension compared to other ethnic groups; BME groups overall are also six times more likely to develop diabetes compared to white British people” (Haque, 2020). Co-morbidity as a result of underlying health conditions is argued to contribute to disproportionately higher COVID-19 infection and mortality rates of PAD. This is blamed on PAD unequal access to health, housing, and employment opportunities, highlighted by disaggregated equality data. However, it is important not to assume that correlation equals causation” (BME Leadership Network, 2020).

Haque (2020) attributes higher COVID-19 infection and fatality rates in the UK’s African diaspora communities, to overcrowding in housing; e.g. 15% of Black Africans live in homes where there are more people than rooms, in comparison to 2% of their white peers. We are therefore less able to self-isolate. Moreover, African diaspora communities have lower rates of home ownership and higher numbers in rented accommodation. This contributes to disproportionately high levels of homelessness within our communities, e.g. “Black people make up 24% of homeless households despite being 6% of Bristol’s population (BSWN, 2020).”

Racial disparity was therefore identified in risks and outcomes associated with COVID-19, regarding people of African descent and other ethnicities, despite statutory provisions for the general protection of the UK populace from infection, (Legislation.gov.uk, 1984) and (Legislation.gov.uk, 2020b). As a result, “immediate action is needed to mitigate risks to BME communities and health and care workers. This needs to include an examination of the availability of personal protective equipment (PPE), testing, cultural and religious observances and data collection for BME communities,” (BME Leadership Network, 2020).

*2.* To ensure explicit bias is not motivating medical and policy decisions during this pandemic,“there needs to be better and more transparent collection and reporting of ethnicity data to understand the full impact of COVID-19 on BME patients (…) when health and care staff and patients are tested for the virus” (BME Leadership Network, 2020).This requirement for fully disaggregated equality data collection and analysis, is in accordance with UN GA Res. 68/261. In relation to ethnicity, disproportionately high COVID-19 infection and fatality rates can be identified for recommendations and policy interventions in the government’s recent review, (Public Health England, 2020, pp.40-49). For example, “the NHS Confederation is supporting NHS England and NHS Improvement to address the impact (of COVID-19) on BME communities and will involve (…) the BME Leadership Network (…) to ensure the NHS and government respond to these issues and mitigate risks” (NHS Confederation Leadership Network Briefing).

*3.* (a) Infections and fatalities amongst essential staff have been identified from African migrant communities in the UK. Black health activist Farah (2020), reports “70% of front-line workers who have died are BME, and they make up 34 percent of the critically ill patients. Efforts made to address this by the NHS reputedly include BAME staff risk assessments and involvement in decision making, (NHS England and NHS Improvement coronavirus, 2020)

*(b)* Social determinants of health such as poverty and Afriphobia have not been adequately addressed by the state party. For example, “low-paid, BME and migrant women currently putting their lives on the line to deliver vital care, were previously told they are low-skilled and therefore undeserving of settled immigration status, liveable wages or stable contracts,” (Farah, 2020). Culture-related health issues such as multi-generational African households where self-isolation is not the only answer to protect the elderly, are also amplified by the pandemic (BSWN, 2020). See also (NHS England and NHS Improvement coronavirus, 2020)

*(c)* The UK government’s multi-billion package of economic measures published in March 2020, includes fiscal spending for self-employed individuals and furloughed employees, to support the economy. However Black Britons are predicted to be less likely to weather any economic fallout resulting from the COVID-19 pandemic, as they are twice as likely to be in precarious employment, including zero hour and contract employment which do not qualify, (Haque, 2020). Afriphobia in the right to adequate employment illustrate breaches of Article 23 of the Universal Declaration of Human Rights 1948. People of African descent “will remain disproportionately adversely impacted by the lockdown, because they will not qualify or be sufficiently covered by the government’s wage-support scheme, mortgage-holiday package, Statutory Sick Pay or means-tested Universal Credit programmes,” (Haque, 2020).

*4.* Firstly, in order to address social invisibility and racial disparities identified in the impact of COVID-19 on people of African descent, “there needs to be better and more transparent collection and reporting of ethnicity data to understand the full impact of COVID-19 on BME patients. This could include recording ethnicity when health and care staff and patients are tested for the virus” (BME Leadership Network, 2020). Staff risk assessments and staff representation in decision making, are therefore recommended by the NHS to address disproportionately high infection and fatality rates for its’ BAME staff including people of African descent, (NHS England and NHS Improvement coronavirus, 2020).

Secondly, African diaspora communities are disproportionately and adversely impacted by the pandemic, because of our historic and contemporary vulnerabilities as a result of Afriphobia. The “comorbidities proposition essentially suggests that the vague social construct of race is an inadequate explanation for mortality and morbidity in diverse populations” which is not universally acceptable, (Farah, 2020) and (Yancy, 2020). An alternative explanation is that,

“pernicious effects of adverse social determinants of health, and the absence of privilege that does not allow a reprieve from work without dire consequences for a person’s sustenance, does not allow safe practices, and does not even allow for 6-foot distancing,” (Yancy, 2020).

Thirdly, community participation by the African diaspora is an imperative response to address social, economic, and environmental threats posed by the pandemic and economic crisis caused by the ensuing lockdown. This is in accordance with SDG Target 16.7 of the 2030 Agenda for Sustainable development that advocates community participation for efficient policy development and decision-making. Global response to COVID-19 by thought leaders from the African diaspora requires

“ongoing analysis of the narratives emerging about outbreaks and about disease response – whose voice is dominant and what power dynamics are at play – remains critical, as is analysis of the longer term social, political and economic impacts” (Leach, 2020).

Fourthly, community empowerment is central to discourse on the achievement of IDPAD’s thematic objectives, in the light of the pandemic, and likelihood of economic crisis resulting from the lockdown of global economies. Fully disaggregated statistical data advocated by SDG Target 17.18 can enable state parties to be held accountable for alleged disparities.

“The NHS Confederation is supporting NHS England and NHS Improvement to address the impact of COVID- 19 on BME communities and will involve organisations from across its membership and the BME Leadership Network (…) to ensure the NHS and government respond to these issues and mitigate risks,”(BME Leadership Network, 2020). However only plans to address impact on BAME staff have been highlighted to date (NHS England and NHS Improvement coronavirus, 2020).

*5.* Notably, an all-white management team for London’s Nightingale Hospital was recruited, despite BME staff comprising approximately 50% of London NHS staff, and the hospital being located in the most diverse European local authority (Farah, 2020).This illustrates an inappropriate response to the pandemic that disproportionately impacts people of African descent and NHS staff from our communities.

In that regard, the UK government has done little to address racial disparities identified in its review of risks and outputs resulting from COVID-19, beyond launching a Race Inequality Commission in June 2020.Very few measures have been taken to ensure equal protection, including ensuring that interventions that appear neutral on their face do not license or facilitate racial bias and stereotypes*.* “We need to suspend NHS charges, support detained migrants and overall, understand the significant racial disparities not only in the virus but in the government’s lockdown strategies,” (BSWN, 2020).

*6.* Unequal access to third generation rights to self-determination and development, as well as to first- and second-generation rights demonstrably marginalises representation of African diaspora communities following fiscal austerity measures enacted by the UK state party in the recent global recession. However, members of civil society such as the Runnymede Trust, and Bristol NGOs Black South West Network (BSWN) and African Voices Forum (AVF) published COVID-19 support online. In that regard, the City of Bristol purports to leverage existing civil society expertise towards the urbanism’s post COVID-19 recovery, through community participation in implementation of the 2030 Agenda for Sustainable Development. For example, AVF is committed to achievement of IDPAD thematic objectives in Bristol and provides a weekly bulletin on COVID-19 issues, to the local African diaspora communities.

A dynamic process has therefore evolved during the pandemic where research, data collection, and community engagement facilitates networking, knowledge exchange, community participation, and community empowerment of the African diaspora, as responses and actions that address effects of the pandemic and lockdown. This also recognises the racially discriminatory intent and impact of some new policies on people of African descent globally.

*7.* People of African descent do not generally have equal access to justice as other ethnicities in the UK and are disproportionately represented in the criminal justice system similarly as in the USA.The UK state party has demonstrably failed to implement SDG Target 16.b, i.e. to enforce non-discriminatory policies that achieve social justice and equality for marginalised, “invisible” African migrant communities. There have been disproportionate arrests and fines of people of African descent by law enforcement for alleged breaches of COVID-19 lockdown guidelines, including Black men who remain vulnerable to Afriphobia from law enforcement. For example, a Mancunian of African heritage was arrested on suspicion of breaching lockdown measure, whilst trying to assist self-isolating family members, as a result of stereotyping by law enforcement. According to Professor Natalie Darko of the University of Leicester, the datafication of injustice remains a key area to address, i.e. the way ethnicity is recorded to avoid racialised outcomes, as challenges and lack of competence exist in understanding and recording ethnicity.

The Runnymede Trust, International Coalition of people of African Descent, and others have engaged in independent investigations around the disproportionate impact of COVID-19 on people of African descent and alleged racially motivated breaches of human rights. For example, Professor Darko critiques the PHE report for excluding narratives from many BAME communities, as we need to better understand people’s experiences and intersectionality. Improved education in healthcare is required to engage underrepresented groups. Moreover, bearing in mind the ongoing ethnocide, dispossession, and capitalistic overexploitation of African peoples, reference to COVID-19 should be included in claims for reparative justice made by the African diaspora. Knowledge exchange between Diaspora academics, activists, and policymakers can enable response to social, economic and environmental impacts of COVID-19. We have therefore begun to speak of potential changes to the way we work and conduct our daily lives, i.e. a new reality which we contribute to shaping, e.g. recent responses to police brutality in the USA and Europe.

**Responses to questions by the Special Rapporteur on extreme poverty and human rights**

*1.* The UK government’s multi-billion package of economic measures published in March 2020, supports the economy through fiscal spending on self-employed and furloughed employees adversely impacted by the pandemic. However, there is little evidence of strengthening social protection for vulnerable groups, in accordance with ILO Social Protection Floors Recommendation No. 202 (2012).

*2.* Economic recovery plans in the UK do little in consideration of the specific situation of people working in the informal sector, and the need to improve working conditions or formal social protection; e.g. there has been little improvement in immigration status for limited numbers of essential workers.

*3.* Although priority is given to education by the government, I am unaware of prioritized investments and gender budgeting specifically aimed at skill development of women and girls, although this may exist.

*4.* I am unaware of tax provisions made by the UK government to reduce socioeconomic inequality, as part of national plans for post COVID-19 recovery.

*5.* The City ofBristol claims it will facilitate human rights principles of participation, transparency and accountability for socioeconomically marginalised communities, in the design, implementation and assessment of its post COVID-19 economic recovery plans. The urbanism purports to do so through inclusive implementation of the 2030 Agenda for Sustainable Development, e.g. One City Plan and One Bristol Curriculum.

**Responses to questions by the Independent Expert on the human rights of older persons**

*1.* Abrahams (2020) accuses the UK government of failing the majority of the 400, 000 older people living in care homes, e.g. through lack of adequate personal protection equipment for care staff, and care homes poor access to funding from local authorities*.* Existing problems in the care home sector were exacerbated by the pandemic, including low levels of quality care staff recruitment and retention due to fiscal austerity, and inability to adequately monitor accountability in largely privately rather than state-owned care homes (Abrahams, 2020). See also (Public Health England,2020, pp.10-19 & pp.57-59).

1. Age UK is one of a few NGOs that represents the interests of older people living in the UK but does not provide this information.

*3.* See (Abrahams, 2020) & (Public Health England,2020, pp.10-19 & pp.57-59)

*4.* No Comment.

**Responses to questions by the Independent Expert on protection**

**against violence and discrimination based on sexual orientation and gender identity**

*1.* Various factors contribute to LGBT+ persons vulnerability to COVID-19, including their high levels of poor heath and homelessness, (LGBT+, 2020a).In that regard, a survey of the LGBT+ community found disproportionately high need for support from organisations working with these communities during the pandemic, with over 40% of respondents also requiring mental health support (LGBT Foundation, 2020b).

*2.* However, the UK government allegedly did not enact any specific measures to ensure LGBT persons were not subjected to discrimination during the pandemic (except recently banning conversion therapies). LGBTQ+ nongovernmental organisations sought to offer specialised social and wellbeing support to LGBTQ+ COVID-19 victims.

*3.*  Alfred Kennedy Trust publishes an online blog with COVID-19 resources for 16-25-year-old youths threatened with homelessness. Other LGBTQ+ civil society organisations participated in the design of measures to respond to the pandemic but most were not required.

*4.* See (LGBT Foundation, 2020a) *and (*LGBT Foundation, 2020b)

*5.* Bristol’s *Voice and Influence Partnership* allocated funding: to *Kiki* that works with BAME members of the urbanism’s LGBTQI+ community, to organise online activities for their members: and *OutStories* who collated LGBTQ+ narratives in their Queer Quarantine project.Freedom Youth’s online work with local LGBTQI+ youth further illustrates good practice stemming from civil society’s actions. Youth were supported for their heightened vulnerability to domestic violence, mental health, and homelessness, during lockdown restrictions. There are no known state interventions on behalf of the community during the pandemic.

Lessons learnt from the pandemic include that the state party put nothing in place specifically for LGBTQI+ communities, e.g. where they may face potential discrimination in their care. It is alleged LGBTQI+ individuals sometimes do not get treated in a manner that respects their dignity and self-identity in health care settings. Moreover, the gender in which people die, and how that is managed and respected in terms of their legal gender or recognition by family, remains cause for concern.

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