RESEARCH
www.commprac.com
ISSN 1462 2815

THE HEALTH IMPLICATION OF RACIAL DISCRIMINATION OF AFRICAN MIGRANTS DURING THE COVID-19 PANDEMIC: A CASE STUDY OF MIGRANT RETURNEES IN BENIN CITY, NIGERIA

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DOI: 10.5281/zenodo.13120371

Abstract

The COVID-19 pandemic has laid bare the existing vulnerabilities facing the most marginalized and disadvantaged groups. COVID-19 may not discriminate, but its impact has been far from even. Even within wealthier countries, ethnic, religious and racial minorities have poorer outcomes than the rest of society. Discrimination and bias in the health care system has contributed to the pandemic's dramatic impact on Black, Latino and Native American populations. In an outbreak, such as that of COVID-19, people are labeled, stereotyped, discriminated against, treated separately, or experience loss of status because of a perceived link with a disease. Such treatment can negatively affect those with the disease, as well as their caregivers, family, friends and communities. The study assessed the health implications of racial discrimination of African migrants from Nigeria to Libya, Oman, Germany, Italy and Dubai during the COVID-19 pandemic and adopted forum focus group discussion. The population of study were migrant returnees in Benin City from which the sample size of 30 participants were drawn. The instrument of data collection was the focus group discussion guide which consisted of experiences of returnees, health challenges, psychological state, ability to access health care services and stigmatization during the pandemic lock down. Transcripts of focus groups were coded using emergent coding for code book development to classify the responses into meaningful units. The findings from this study showed that many of the migrants had negative and unpleasant experiences were psychologically unstable, the stigmatization affected them health wise and had no adequate access to health care services during the COVID-19 pandemic based on racism. Recommendations include asserting our different values, equality, non-discrimination, and mutual respect value, which are related to the affirmation of human rights.

Keywords: Health Implication, Racial Discrimination, African Migrant, COVID-19 Pandemic.

BACKGROUND

The COVID-19 pandemic comes at a crucial time for international migration. Just prior to the crisis, record-high inflows were recorded in a number of countries, and populations of immigrants and native-born children of immigrants have grown virtually everywhere (Organisation for EconomicCo-operation and Development 2020). They now account for one in five people across the Organisation for Economic Co-operation and Development. Among the many recent arrivals, refugees account for a relatively high share in some countries and this group faces particular vulnerabilities and has specific needs.

The World Health Organization (WHO) noted that the threat and experience of COVID-19 occur differently for different groups. Marginalized and stigmatized groups have more vulnerability, and disregard for this factor subjects them to a higher risk of infection and undermines the broader COVID-19 response (World Health Organization 2020). Persons belonging to racial, ethnic, and religious groups are among the groups at risk due to their lower socioeconomic status and entrenched exclusion and discrimination, making them particularly vulnerable to higher rates of infection and mortality and unequal access to adequate medical care (The United Nations General Report 2020).

Persons belonging to marginalized groups, including migrants, may be more likely to be excluded from healthcare because of stigma or discrimination, a lack of resources, or official documentation. The COVID-19 pandemic has aggravated long-standing structural inequalities regarding access to healthcare facilities, goods, and services. It is contrary to the human rights obligation to protect the right to health for everyone and to promote access without discrimination of individuals or groups of individuals who are victims of racism, racial discrimination, xenophobia, and related intolerance to health care. People of African descent, people of Asian descent, and Roma are doing worse amid the pandemic. In addition, they represent a significant percentage of - frontline workers - nurses, and health workers; delivery staff and transport drivers are more exposed to the risk of contamination.

Structural inequalities and racism manifest in access to medicines and medical procedures and are not related to COVID-19. These are likely also to have had an impact on each aspect of the diagnosis and treatment of COVID-19, beginning with who gets access to telemedicine, then whose symptoms are severe and who gets first tested for COVID-19, leads next to who gets hospitalized, and then ultimately who gets personal protection/preventive means, respiratory devices in hospitals and home care. There are also serious concerns about the potential for racial discrimination in decision-making around the testing of trial vaccines for COVID-19 and also who would have access to an eventual vaccine (United Nations Human Rights 2020).

In May 2018, the First World Congress on Migration, Ethnicity, Race and Health was held in Edinburgh. This successful event attracted over 700 participants from 50 countries. Some of the most significant contributions to the Congress were subsequently captured in a special issue of public interest (Gruer, Stanaway& Davidson 2019). A recommendation from the meeting was to form a global society on migration, ethnicity, race, and health. With the advent of COVID-19 in 2020, evidence emerged from several countries that many ethnic minorities were at higher risk of developing and dying from COVID-19 and structural racism was indicated as a contributory factor (Gruera et al. 2021). Long before the pandemic, the Asian population in the United States had been viewed and treated as the physical embodiment of foreignness and disease. As the stress levels of society elevated with the outbreak of a China-originated virus, the increase in negative bias against the Asian population was perhaps not surprising (Jo-Hsuan 2021). Racial discrimination and health challenges from COVID-19 responses spread unevenly. Black Africans have suffered both undesirable outcomes and discrimination from the virus. Some factors identified as accountable for these were healthcare access and utilization being the main ones (Lamptey, Benita &Boakye 2022).

New federal data reveals that African Americans and Latinos in the United States have been three times more likely to contract COVID-19 than white residents and nearly twice as likely to die from it. Some counties with a majority of African American residents have **almost six times** the death rate compared to counties that are predominantly white. People from diverse racial and ethnic backgrounds react differently to healthcare in pandemic situations. These people may be unwilling to seek medical attention because they believe there are inequalities in treatments and do not trust the healthcare system they find themselves in (Lamptey, Benita &Boakye 2022). Attention had being drawn to the rapid transmission of COVID-19 within crowded jails, prisons, and detention centers (Kinner et al. 2020). Behind barbed wire and closed doors, people in lockdown facilities are incarcerated in overcrowded indoor environments with poor ventilation and sanitation. Many lack basic health care, nutritious food, and protective resources such as hand sanitizer or facemasks (Burki 2020). Outbreaks in lockdown facilities are yet another danger to racial minorities who are overrepresented among incarcerated populations. The strength of a health system is inseparable from broader social systems that surround it. Epidemics place increased demands on scarce resources and enormous stress on social and economic systems. Health protection relies not only on a well-functioning health system with universal coverage, but also on social inclusion, justice, and solidarity. In the absence of these factors, inequalities are magnified and scapegoating persists, with discrimination remaining long after. Division and fear of others will lead to worse outcomes for all (Devakumar et al. 2020). Few studies are available on COVID-19–associated racial discrimination among African migrants and the health implications especially those that are qualitative in nature. Hence the need for this study that examined the following questions: What were the migrants' experiences of racial discrimination during the COVID-19 pandemic? What was the effect of racism on the psychological wellbeing of the migrants? What was the effect of the stigmatizations on the health of the migrants and were migrants able to access health services during the COVID-19 pandemic?

Study Setting

This study was conducted in Benin metropolis, a major city in Edo State. Edo State is an inland state in central southern Nigeria. There are Non-Governmental Organizations (NGO) in Benin City responsible for the rehabilitation of migrant returnees.

METHODOLOGY

This study used a qualitative research design, that was exploratory, mainly the forum focus group to satisfy the objectives of this research on the health implications of racial discrimination of African migrant during the COVID-19 pandemic. During the COVID-19 pandemic a total of 45 migrants returnees from Libya, Oman, Germany, Italy and Dubai were enlisted into the informed greater returnees' foundation, an NGO responsible for the enlightenment and rehabilitation of migrant returnees in Benin City. 30 of this migrants willingly agreed to participate in the study. The forum focus group discussion (FFGD) was conducted in Benin metropolis. Migrant returnees from the informed greater returnees' foundation were invited to participate in a focus group discussion. The participants were made to sign a consent form before participating. At the venue the purpose of the study was highlighted and all those in attendance were reminded that participation was voluntary. The venue for the focus group was centrally

located (at a public secondary school considered a neutral ground especially for those who did not feel comfortable attending such a meeting in an open place). The researchers contacted the migrant returnees at the foundation directly and invited them to participate.

To obtain qualitative data needed for this study, the forum focus group discussion approach was used. The three step (FFGD) method started as an open forum (OF), progressed to the second step which was Focus Group Discussion (FGD) and reconvened as a closing forum (CF).

The participants were divided into three groups, with each group having a leader. Overall there were 30 participants. Each group discussed (in two session of 60 minutes each) two sets of pre tested focus group statements developed by the researchers using information from local articles and unpublished reports. Session one focused on the migrants' experiences of racial discrimination and access to health care services during the COVID-19 pandemic, while session two addressed effect of racism on the psychological wellbeing of the migrants and also effect of the stigmatizations on the physical wellbeing of the migrants.

At the end of the two sessions, the focus groups reconvened at the closing forum for 10 minutes (to share any key idea related to the topics, which might have occurred after the focus group discussion).

To obtain qualitative information on health implications of racial discrimination of African migrant during the COVID-19 pandemic a set of open ended statements, based on review of local articles and unpublished report, were developed. It contained four statements on the experiences, effect of racism on psychological wellbeing, effect of stigmatization on migrant health and migrants ability to access health services. To ensure that the Focus Group Discussion (FGD) protocol was reliable, sensitive and meaningful, a pilot test was conducted in Ekpoma, a neighboring town considered homogenous. The pilot study did not result in the elimination of any of the questions. The session time for the FFGD was $2^1/_2$ hours (20 minutes to convene the opening and closing forums and 120 minutes for the focus group discussion) with break of 10 minutes.

LITERATURE REVIEW

There are four basic concepts that are central to the title of this chapter. These are African migrants, racial discrimination, health implications, and COVID-19 Pandemic.

COVID-19 Pandemic

The outbreak of the coronavirus pandemic has caused many impacts which are both positive and disproportionate in some ways against humanity and fundamental human rights (Commonwealth Forum of National Human Rights Institutions 2021). This pandemic has revealed that issues of discrimination, prejudice, and intolerance are persisting and thriving at the global level (Human Rights Watch 2020). The disproportionate impacts include an increase in racism and xenophobia against Indigenous people and ethnic minorities. The situation does not only put the lives of Africans at risk because of the discrimination and xenophobic attitudes but also puts everyone on the globe at risk in any part of the world (Human Rights Watch 2020).COVID-19 is exposing social inequalities of all kinds, as well as the overrepresentation of Afro-descendants among the group living in poverty who are

employed in informal and caregiving jobs (Economic Commission for Latin America and the Caribbean 2017a).

As Afro-descendants have worse indicators of well-being than their non-Afro-descendent peers, they are seen as one of the groups most vulnerable to the COVID-19 pandemic, in terms of both infection and mortality. Various agencies and institutions, including the Pan American Health Organization World Health Organization, the United Nations Population Fund, the Office of the United Nations High Commissioner for Human Rights, the Inter-American Development Bank, the Inter-American Commission on Human Rights of the Organization of American State and the Inter-American Network of High Authorities on Policies for Afro-descendant Populations have already pointed out that the Afro-descendent population is more vulnerable to COVID-19 owing to the structural inequality and racial discrimination to which it is subjected. While each of these agencies has put forward a range of recommendations to tackle the pandemic, most highlighted the importance of implementing participatory policies that are culturally relevant, free from racism and promote equality and rights for all Afro-descendants(Organization of American States 2020b).Social epidemiologists have long recognized that disease distribution patterned by structures of disadvantage, marginalization, exclusion, and discrimination has historical roots and present-day manifestations. Where disaggregated epidemiologic data are available, rates of COVID-19 morbidity and mortality are significantly higher among people of African descent, ethnic groups experiencing discrimination, indigenous peoples, migrants, stateless persons, refugees and internally displaced persons. Beyond health outcomes, the disproportionate impact of COVID-19 on populations experiencing racial and ethnicity-based discrimination and intersecting forms of social exclusion is seen in terms of food insecurity, housing insecurity, income and job loss, and a heightened risk of leaving children vulnerable to loss of education(Frontier Dialogue consultations 2021).

Migrants' vulnerability

Migrants experience adversities at different stages of their migration, which are associated with psychological distress and even long-term mental illnesses (MekonnenMinaye&Zeleke 2017). Population movements generally render migrants more vulnerable to health risks and expose them to potential danger and greater stress. Recent migrants often have to deal with poverty, marginality and limited access to social benefits and health services, especially during the early stages of insertion into a new environment (either inside or outside their country of origin or return). For their part, low-skilled and seasonal migrant workers are often concentrated in sectors and occupations with high levels of occupational health risks (World Health Organization 2008). Family members, including children, may also be involved in this work and thus exposed to these risks.

Migration, when triggered by disaster or conflict, food insecurity, disease, or climate change and other environmental hazards, is closely linked both to the destruction of livelihoods and, often, to disruptions of the health system. Nigeria Migrants to Europe and some other parts of the world experience a range of problems at various stages of their migration, including overwork, sleep deprivation, denial of food, emotional abuse, difficulty adapting to the host culture, salary denial, sexual abuse, labor exploitation, confiscation of their travel documents, confinement, denial of medication, lack of access to legal service and degrading attitude by employers, traffickers and

smugglers (Mekonnen, Minaye&Zeleke 2017). These experiences can be associated with different types of mental disorders (Mekonnen, Minaye&Zeleke 2017).Along with evidences of mental health symptoms are physical health issues as well, although systematic documentation of specific health problems is lacking (Barrows & Finger 2008). The following are some examples of general health issues: Infectious diseases such as human immunodeficiency virus (HIV) and AIDS; Noninfectious diseases; Heat stroke or exhaustion; Cancer; Musculoskeletal trauma from awkward posture (Barrows & Finger 2008).

Comorbid diseases, level of income and access to healthcare Pre-existing health conditions, such as cardiovascular disease, diabetes, cancer, and HIV, are more prevalent among individuals belonging to historically marginalized groups and those with low socioeconomic status. These pre-existing conditions can worsen the effects of a SARS-CoV-2 infection, resulting in a higher number of hospitalizations and deaths. Another closely related reason for the worse outcomes is limited access to healthcare. Individuals belonging to low income and historically marginalized communities are less likely to have health insurance than higher income and white populations, respectively.

Racial discrimination

Racism is an important determinant of health. Growing research shows that racism and racial discrimination have adverse effects on both the mental and physical health of those targeted by it. Racism does have similar adverse health effects across different population groups (Li&Galea 2020). During the pandemic, there have also been numerous instances where people belonging to racial, religious or ethnic minorities were subjected to physical attacks, hate speech and conspiracy theories accusing them for the spread of the virus.

The coronavirus has been a pandemic of racism, with some people believing that they are better than other people who look differently, and this undermines international human rights laws. Many Racist movements, White supremacists, Chinese people, and European elites have used this pandemic to attain their racial goals and policies, claiming to be superiors. In a nutshell, the COVID-19 pandemic has incited racial discrimination against Africans as if Africans were the virus themselves, and the virus has manifested itself in discrimination (Dooshima, Aki &Boakye 2022).As misinformation about the causes of the virus spread rapidly on social media, people of Chinese or other minority descent have been increasingly discriminated against and isolated at work, at school, and in other public places (Rich 2020). Several countries and many local businesses have decided to ban Chinese nationals from entry, which inevitably increases the stress level of those thus restricted and may have long-term mental health consequences for them (Rich 2020).Racism can expose migrants to bullying and violence. There has been an abundance of anecdotal evidence over the past two months that Asian adults wearing face masks have been assaulted in the streets and that Asian adolescents experienced bullying at school because they were considered “disease spreaders”. This mirrors violence previously documented against racial/ethnic and sexual minorities owing to fear and misinformation about other diseases, such as AIDS (Arnold, Rebchook&Kegeles 2014).

In Canada, racialized and immigrant populations are vulnerable to poor health effects arising from persistent discrimination and disparities in socio-economic domains, such as work and housing conditions (Waldron 2010). Discrimination often triggers

psychosocial stressors that lead to health problems and also forms barriers to accessing and utilizing health resources by racialized groups (Amoako&MacEachen 2021). These underlying causes of health inequities increased in the COVID-19 context. In Canada, Black and immigrant communities are disproportionately affected by COVID-19 (Guttmann et al., 2020). Then, once infected, they are more likely to die because they face built-in barriers to accessing healthcare and experience an increased burden of chronic diseases (Wallis 2020). For African immigrants, the burden of diseases is significantly higher due to the stress stemming from racism and poverty (African Canadian Legal Clinic 2008). Since COVID started, immigrants and visible minorities such as sub-Saharan Africans are three times more likely to experience harassment, attacks, and stigma than other groups because of their overrepresentation in front-line work and skin color, adding to the health and economic impacts of COVID-19 (Statistics Canada 2020). African migrants do not enjoy the same legal rights as Saudi nationals.

In Saudi, migrant workers, mainly Ethiopians, were held responsible and blamed for the spike of coronavirus cases in the country between March and May 2020 (Xinhua English. news 2021). The Saudi Government feared that these migrants could be the vector of transmission because the majority live in an overcrowded housing environment (Brown &Zelalem 2020). The actions of the Chinese authorities had been illustrated by violations of the rights of African migrants in the context of the fight against the Covid-19 pandemic. African migrants in China were stigmatized, discriminated, dehumanized and degraded (Jaquemet 2020). It was alleged that the Chinese authorities forcefully tested, quarantined and allowed degrading acts to flourish against African migrants in Guangdong province, particularly in Guangzhou. Several of them were evicted from hotels and apartments, denied access to shopping malls, shops, restaurants and imposed tougher quarantine measures. Many migrants were homeless and deprived of food because of coercive and discriminatory policies targeting them particularly. Numerous videos showed Chinese police harassing Africans on the streets of Guangzhou city where nearly 4,500 migrants from Africa lived and several others on business trips (Jaquemet 2020).

Racism and health implication

The right to health is recognized in various international human rights instruments. They highlight the importance of addressing health from a comprehensive perspective that considers emotional, physical and social well-being, as defined by the World Health Organization (WHO), where the relationship between health and its social determinants is taken into account (WHO/UNICEF 2020). The relevant chapter in the Durban Programme of Action urges countries to eliminate disparities in health status which might result from racism (United Nations 2002). The COVID-19 pandemic has drawn new attention to and compounded these existing disparities in health and health care. Despite recognition of the right of Afro-descendants to equality in all areas, existing discriminatory and racist practices lead to worse living conditions for this population, especially in health matters.

The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality as COVID-19 has unequally affected many racial and ethnic minority groups, putting them more at risk of getting sick and dying from COVID-19 (Stokes et al. 2020). The term "racial and ethnic minority groups" include people of color with a wide variety of

backgrounds and experiences.People are familiar with negative experiences within these groups, and some social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health (U.S. Department of Health and Human Services, 2020).Social determinants of health are the conditions in the places where people live, learn, work, play, and worship that affect a wide range of health risks and outcomes. Racism, either structural or interpersonal, negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of our nation (Centers for Disease Control and Prevention 2021). A growing body of research shows that century of racism in the United States of America had a profound and negative impact on communities of color.

The COVID-19 pandemic and its disproportionate impact on people from some racial and ethnic groups is a stark example of these enduring health disparities. COVID-19 data shows that Black/African American, Hispanic/Latino, American Indian and Alaska Native persons in the United States experience higher rates of COVID-19-related hospitalization and death compared with non-Hispanic White populations (Centers for Disease Control and Prevention 2021).These disparities persist even when accounting for other demographic and socioeconomic factors. Stigma to certain foreigners has been observed so far during SARS and Ebola outbreak (Taylor 2020). Similar to other countries that were heavily impacted by the pandemic, Japan observed a rise in xenophobia and discrimination towards people from outside of Japan (Shimizu 2020).

Although no foreign minorities were reported to be infected in Japan, considering that they are routinely exposed to prejudice and discrimination, they may be pushed even further into a corner if they are reported to be infected among minorities. In fact, there have already been reports of ethnic minorities being trapped and even suicidal under COVID-19 (Mamun& Griffiths 2020).Racism may lead to underutilization of health care services, which makes it more difficult to contain the spread of the virus. For example, HIV-related stigma has affected homosexual African Americans and partially contributed to the low likelihood of obtaining HIV testing or care among this group (Arnold, Rebchook&Kegeles 2014). Similarly, the COVID-19–related stigma among people of Chinese and other minority descent may discourage this population group from seeking medical services if they have related symptoms, which may increase the risk of virus infection for the public (Li &Galea 2020). In the midst of the COVID-19 pandemic, racism and racial discrimination against people of color may have the following adverse health consequences. Racism causes mental health problems—such as depression and anxiety—among those targeted (Bailey et al. 2018).

THEORETICAL FRAMEWORK

This study made use of one of the Intra-personal Level Theories, which is the psychoanalytic theory.

Psychoanalytic Theory

Psychoanalytic theory is the theory of personality organization and the dynamics of personality development. It was first laid out by Sigmund Freud in the late 19th century.Sigmund Freud's psychoanalysis was the original psychodynamic theory, but the psychodynamic approach as a whole includes all theories based on his ideas, e.g., Carl Jung (1912), Melanie Klein (1921), Alfred Adler (1927), Anna Freud (1936), and

Erik Erikson (1950) (McLeod 2017). The words psychodynamic and psychoanalytic are often confused. Freud's theories were psychoanalytic, whereas psychodynamic refers to his theories and those of his followers. Freud's psychoanalysis is both a theory and therapy. All behavior has a cause, usually unconscious therefore behavior is determined. Personality is tripartite: the id, ego, and superego. Parts of the unconscious mind (the id and superego) are in constant conflict with the conscious part of the mind (the ego). This conflict creates anxiety, which could be dealt with by the ego's use of defense mechanisms (McLeod 2017).

When analyzing people's behaviors, the psychoanalytic theory could be utilized to decipher or interpret the concealed meaning in deeds, or to better understand the people's intentions. Through the analysis of motives, Freud's theory can be used to help clarify the meaning of the behaviour as well as the actions of the characters (Lye 2013).The justification of this theory is that from the perspective of Psychoanalytic theory, people tend to behave aggressively toward minority groups as a result of social (e.g., wars and famine) and individual frustrations. These can be considered a kind of “displacement of aggression.” This perspective argues that there is a motivational and adaptive dimension underpinning prejudice, and that people increase their own self-esteem through acts of prejudice, and that discriminatory behavior has an adaptive ego defensive function (Whitley & Kite 2009). Additionally, according to the psychodynamic approach, as anxiety increases, others are labeled as evil. It occurs based on anxiety re-invoked from early childhood experiences (Joffe 1999). Splitting, a deep-seated mentality is employed as a means to cope with this anxiety. This unconscious defense mechanism emerges in early childhood to keep the bad away from the good by associating good experiences with oneself while projecting the bad to others. This defense mechanism comes to the surface when faced with anxiety-provoking situations such as a pandemic 'Joffe' (1999) asserted that the social representational framework could be complementary to connecting the sociocultural and psychodynamic explanations as responses to anxiety. Framework of Joffe (2003), as a psychodynamic extension of the social representation theory, posited that individuals faced with potential danger operate from a position of anxiety that motivates them to represent dangers in a specific way, linking threats to others and based on the unconscious responses. Both the self-protecting needs and the drive to externalize anxiety are from a sociocultural basis. This hybrid model highlights the effects of the cultural context and especially Western cultures' handling of the “individual” in terms of behavior (Demirtaş-Madran 2020). Some claim that the theory is lacking in empirical data and too focused on pathology. Other criticisms are that the theory lacks consideration of culture and its influence on personality (Mahmood et al. 2012).

Presentation of Findings

Data Analysis

Data Analysis was conducted on all transcribed responses from the focus group discussion (FGD) and the closing forum (CF). It was not seen as necessary to transcribe and analyse the open forum (OF). The OF was to serve as an introduction to the later discussions, as well as a platform for the researchers to explain the goals, procedures and scope of the study, go over confidentiality and focus group rules, and entertain questions regarding the nature of the study. Dudley’s and Phillip’s (2007) guide was used in this analysis. The field assistants transcribed the data shortly after

the Focus Group Discussion (FGD). The researcher reviewed the topic guide, listened to the tapes, read the transcripts and notes from the two sessions, including data from the closing forum (CF).

Transcript of focus groups were then coded using emergent coding for code book development to classify the responses into meaningful units. As mentioned earlier for data analytic purposes the Closing Forum (CF) narrations were treated the same way as the Focus Group Discussion (FGD) narrations and combined to make up our qualitative data set. To maintain data integrity, other co- researchers reviewed, revised and validated the data in constant comparison with the transcript using the code book developed by the original coder (Aja, Modeste& Montgomery 2012). In all cases the whole context of the narration was considered after reading the transcript repeatedly. To ensure that no data was intentionally or unintentionally omitted, and to guard against adding irrelevant data Kristiansen, Hellzen and Asplund (2006) we compared the themes and sub themes back and forth.

Data analysis revealed that the experiences of the migrant returnees during the COVID 19 pandemic were quite difficult for the study participants. Their health and psychological wellbeing was affected and they hardly had access to health services.

The migrant returnees used for this study were at the time of the COVID 19 pandemic in the following countriesDubai, Omar, Libya, Italy, and Germany.

The analysis of data from the FFGD with the participants and key informants yielded four main themes as illustrated in table below. Under each of these main themes, relevant sub-themes were discussed.

Themes	Topic
One	Migrants experiences of racial discrimination
Two	Effect of racism on psychological wellbeing of migrants
Three	Effect of stigmatization on the health of migrants
Four	Migrants ability to access health services during the covid-19 pandemic

Migrants' experiences of racial discrimination during the COVID-19 pandemic.

The experience among the participants was discrimination, which they saw either in themselves or their relatives. Fear and exclusion lead to the construction of an atmosphere of discrimination. Several participants described their experiences. Some talked about be hated and detested just because of their skin colour or race.

"We were detested (hated) just because we are blacks".

Not being friendly with us because we are blacks and some even called us black ass".

Some of the migrants experiences also include be dehumanized based on the treatment they were given while in the foreign land. Some were arrested based on illegal migrations and fell sick based on the ill treatment but were not given medications.

"Kidnapped, being arrested and not given treatment while we were in prison"

"we were not accepted and not treated like human".

My experiences were very bad, we were treated like criminals".

It was very bad all through my stay in Libya

"I was being locked up and denied associating"

"Some migrants were kept in prison even without commiting any offense and the reason given by the officials was to curtail the spread of the covid- 19 disease.

"We were in prison all through the COVID-19 pandemic".

"I was told we were being kept in prison to minimize the spread of the covid-19 pandemic".

From the above responses it can be concluded that many of the participants that took part in this study had negative and unpleasant experiences because of racial discrimination during the COVID-19 pandemic.

Effect of racism on the psychological wellbeing of the migrants.

Some experiences of the study participants were the behavioral changes they witnessed in those around them. These changes are shaped by a combination of fear, concern, suspense, and compassion, though mainly due to fear of being infected with the disease. No psychological support from people around them. These migrants were seen as alien and observed that they were alienated from others. Despite the social distancing, family, friends and other racial groups had some form of contact but this was not so for these migrants. Racism can cause depression in the short or long term due to the social disrespect that accompanies it.

"I feel depressed and feel rejected for not having freedom to associate with others".

Because of the discrimination I lost my self-confidence and now feel inferior".

"My self-esteem was affected, am no longer confident".

Racism may not only affect the mental health and behavior of these migrants but also change and reconstruct their feelings and beliefs.

"It affected my mental health, I could no longer think properly because of discrimination".

"I was sick and traumatize"

My mental health was affected because we were discriminated and rubbish.

Some were not affected by the racism based on their strength of resilience and be used to the whole situations.

"It did not affect me".

" The racism did not affect me, am used to be stigmatized based on my race".

"It is not new, so I expected it".

The above responses from the participants deduce that majority of the migrants were psychologically affected based on racial discrimination during the Covid-19 pandemic. The deteriorated psychological health was mainly attributed to the lockdown and the associated difficulties.

Effect of the stigmatization on the health of the migrants.

A key issue raised from the beginning of the COVID-19 pandemic was stigmatization. The term stigma refers to a social process that results in devaluation and discrediting. COVID-19 associated stigma went beyond personal and social aspects and turned into an international stigma against races and countries. Stigma and discrimination lead to social exclusion, which affects mental health.

"It affects my social life and health, because there was no access to medical treatment because we are blacks.

"It affected my general life, I was always sick and no adequate treatment".

"It affected me physically because I lost one of my eyes due to improper treatment during the pandemic lockdown".

The above responses from the participants showed that the stigmatization they experienced affected their health wise. While lockdown and social distancing enforced by the government in the prevailing pandemic have contributed to an extent in curbing the spread of the virus, it has also contributed in the people experiencing depression, anxiety, terror, panic, heart disease arising out of loneliness, and committing suicides.

Migrants' ability to access health services during the COVID-19 pandemic.

Some protective measures against COVID-19 pandemic had negative social effects on low-income individuals (including migrants) due to inadequate access to health facilities. Persons living in high-poverty areas and majority Black, are less likely to have access to COVID-19 treatment facilities.

The following were the responses from the participants;

"We were not well taken care of at the hospital the ways whites were been treated specially"

"I was able to access health services when I was sick but the hospital workers were hostile to me just because I was black".

"I couldn't access any health services so I resorted to self-medications".

"I could not access any health services"

"I came back to Nigeria almost dead because there was no treatment".

From the above responses of the participants, it showed they had no adequate access to health care services during the COVID-19 pandemic based on racism. Multiple factors which likely contributed to the observed disparities are minority patients' previous negative experiences with health care services could influence their decisions regarding use of treatments, or racism and implicit biases among health care providers might have contributed to treatment disparities.

DISCUSSION OF FINDINGS

The study revealed that most of the migrants that participated in this study experienced racism and had negative and unpleasant experiences like being dehumanized, hated and locked up, because of racial discrimination during the COVID-19 pandemic. This confirmed the findings of Omozusi, Olaoye and Ndisika, (2021) which found that migrants had very terrible experiences to share as far as their travelling abroad was concerned and this include being starved and dehumanized. This finding is also in tandem with Jaquemet (2020) report that African migrants in China were stigmatized, discriminated, dehumanized and degraded. This study also corresponds with the findings of Statistics Canada (2020), which found that since COVID-19 started, immigrants and visible minorities such as sub-Saharan Africans are three times more likely to experience harassment, attacks, and stigma than other groups because of their over-representation in front-line work and skin color, adding to the health and

ISSN 1462 2815

economic impacts of COVID-19. It is in tandem with the finding of the U.S. Department of Health and Human Services (2020) that negative experiences are similar to many people within minority groups, and some social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health. The finding is in consonant with the study of Jaquemet (2020) who found numerous videos showed Chinese police harassing Africans on the streets of Guangzhou city where nearly 4,500 migrants from Africa lived and several others on business trips.

It was also found that the migrants were psychologically affected based on racial discrimination during the Covid-19 pandemic. This finding agreed with the study of Amoako and MacEachen (2021) that found discrimination often triggers psychosocial stressors that lead to health problems. The finding also is in tandem with the study of Mekonnen, Minaye and Zeleke (2017) who found that migrants experienced adversities at different stages of their migration which are associated with psychological distress and even to long term mental illnesses. The findings of the study correspond to the findings of the African Canadian Legal Clinic (2008), which found that for African immigrants, the burden of diseases is significantly higher due to the stress stemming from racism and poverty. It was also in tandem with the findings of Bailey et al. (2018) that found racism causes mental health problems such as depression and anxiety among those targeted.

From the study it was revealed that the stigmatization the migrants experienced affected them health wise. The finding is in tandem with the findings of Waldron (2010), who found in Canada, racialized and immigrant populations are vulnerable to poor health effects arising from persistent discrimination and disparities in socio-economic domains, such as work and housing conditions. The findings also correspond to the study of Centers for Disease Control and Prevention (2021) that found racism, either structural or interpersonal, negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of our nation. It also correspond with the findings of Bailey et al. (2018) who found that in the midst of the COVID-19 pandemic, racism and racial discrimination against people of color may have the following adverse health consequences.

Finally the study showed that the migrants had no access to adequate health care services during the COVID-19 pandemic based on racism. This correspond with the findings of Wallis (2020) which found that once minority groups are infected, they are more likely to die because they face built-in barriers to accessing healthcare and experience a greater burden of chronic diseases. The findings is also in tandem with the findings of Arnold, Rebchook and Kegeles (2014) which found racism may lead to underutilization of health care services, which makes it more difficult to contain the spread of the COVID-19 virus. The finding was also in consonant with the findings of Li, and Galea (2020) that found COVID-19–related stigma among people of Chinese and other minority descent may discourage this population group from seeking medical services if they have related symptoms, which may increase the risk of virus infection for the public. This finding also correspond to the findings of Liz et al. (2020) who found black adults are also more likely than those who are White to report some specific negative experiences with health care providers, including providers not believing they were telling the truth or refusing to provide pain medication or other treatments they thought they needed.

CONCLUSIONS

COVID-19 has further exposed the strong association between race, ethnicity, culture, socioeconomic status and health outcomes and illuminated monumental ethno-radicalized differences reflecting the 'colour of disease'. Racism, segregation and inequality have been invisibly and pervasively embedded in dominant cultures and social institutions for decades. Anti-Black racism/discrimination is one of the top longstanding social prejudices that hinder Black immigrants' successful integration (Galabuzi 2006). And the COVID-19 pandemic has also exposed the systemic inequalities underlying Black immigrants' experiences (Bowden & Cain 2020). The pandemic has transcended from a medical crisis to a pressing social injustice issue, and addressing this requires an intersectional approach. Implementing COVID-19 risk measures alone will not ensure protection. Targeted interventions are required to address the underlying causes of socio-economic and health inequities associated with racism and structural discrimination. Structural inequalities and racism may affect each aspect of the diagnosis and treatment of COVID-19, beginning with who gets access to telemedicine, whose symptoms are severe, who gets tested first for COVID-19, leading next to who gets hospitalized, who gets personal protection means, respiratory devices in hospitals and home care, and ultimately who gets vaccinated (COVID-19 panel 2021).

RECOMMENDATIONS

Controlling racism is the responsibility of everybody, not only 'Africans' everybody must appreciate and understand that people are from different cultures. Individuals must embrace this concept and treat all equally with respect. There should be an end to the notion of white supremacy and the stigmatization of Africans as well as marginalized people. We must all stand against ideologies of scientific and systemic racism in our various societies. Hate speeches and racial intolerance need not be entertained in any part of the world. We are to assert our values, the values of equality, non-discrimination, and mutual respect, values that linked to the affirmation of human rights. It is time to revitalize our actions as multilateral bodies and as nations for racial justice. We can begin by showing leadership, and speaking and manifesting our commitment to equality and non-discrimination.

The world cannot be satisfied with simply reacting to crises but rather should address the root causes of structural racism. The racial discrimination associated with the coronavirus pandemic needs both continental and international solidarity to address it. African states need to work together and align with each other in the fight against racial bias. Future versions of federal COVID-19 legislation should address these gaps in access to care and public health education. The COVID-19 pandemic provides an opportunity for clinicians, health systems, scientists, and policy makers to address social disparities, and thereby improve the health and well-being of all persons for both known and future illnesses.

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