# EXAMINING THE FACTORS CONTRIBUTING TO INCREASING FATALITIES AMONG AFRICAN IMMIGRANT HEALTH WORKERS IN THE UNITED KINGDOM

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## Abstract
*African immigrant health workers form a vital segment of the United Kingdom's healthcare system, yet emerging evidence indicates a troubling rise in fatalities within this group, particularly among those in high-risk roles. This study critically examines the multifactorial causes contributing to these deaths, with a focus on occupational exposure, long working hours, systemic inequalities, and pre-existing or undiagnosed health conditions. Drawing from mixed methods research including analysis of recent datasets, literature reviews, and testimonies the study identifies disproportionate placement in frontline roles, chronic overwork, racial discrimination, and limited access to healthcare as key drivers of increased risk. Factors such as immigration status, socioeconomic stress, and inadequate mental health support further compound vulnerability. The paper also highlights the lack of disaggregated mortality data, impeding targeted interventions. Preventive strategies including equitable access to protective equipment, culturally competent mental health services, improved workplace protections, and structural reforms within the NHS and social care sectors are proposed. It is therefore recommended that a multidisciplinary investigation and systemic policy action to address the underlying disparities and protect the wellbeing of African immigrant health workers whose contributions remain essential to the resilience of the UK health system.*

**Keywords:** Immigrant health workers, Occupational risk, Health disparities, Workplace fatalities

## Introduction

The United Kingdom's National Health Service (NHS), private healthcare providers and social care organisations have long relied on the contributions of immigrant health workers, particularly those from African nations, to sustain its workforce and meet increasing healthcare demands. In recent years, however, growing concerns have emerged over the disproportionate number of fatalities among African immigrant health professionals, especially those who have arrived in the UK within the last decade. These deaths, often occurring in the context of high-risk work environments, systemic inequalities, and limited access to institutional support, raise urgent questions about the intersecting roles of occupational risk, immigration status, socio-economic conditions, and structural discrimination.

This paper critically examined the multifaceted factors contributing to the rising fatalities among recent African immigrant health workers in the UK. Through a combination of qualitative and quantitative methods, the study will explore workplace

safety conditions, access to protective resources, mental and physical health support systems, and the broader socio-political context that shapes the lived experiences of this demographic. By identifying key risk factors and systemic gaps, this paper aims to inform policy and practice interventions that ensure equity, safety, and dignity for all health workers regardless of their national origin or immigration status.

The key factors that may contribute to increased sudden deaths among African immigrant health workers in the UK, based on existing research in public health, occupational health, and migrant studies include:

**1. Occupational Exposure and High-Risk Roles**

African immigrant health workers are often overrepresented in frontline, high-risk, and understaffed roles (e.g., care homes, emergency departments) TUC (2023). Prolonged exposure to infectious diseases (like COVID-19) and hazardous environments increases the risk of sudden health crises (e.g., cardiac arrest, respiratory failure). Here, some of the high-risk roles identified in UK research and reports {2025}, that are thought to contribute to increased exposure, illness, or fatalities among African migrant / Black, Asian and Minority Ethnic (BAME) health workers will be discussed. These roles are often more exposed, under-protected or disadvantaged in ways that raise risk. Some caveats: Most of the data refers to COVID-19 risks, but many of the same dynamics apply more generally for "sudden" health events (cardiac, respiratory etc.), especially where occupational stress, delayed care, or poor working conditions are factors. Health workers that are engaged in high-risk roles include:

**(a) Frontline clinical staff (nurses, midwives, health visitors, nursing/midwifery associates):** These staff are in direct contact with patients, often caring for infectious diseases. They may do shift work, long hours, high workload and experience exposure to higher viral load. Reports suggest that BAME staff are over-represented in such roles, especially those with frequent patient contact (Kirby, 2020).

**(b) Care workers and home careers / domiciliary careers:** Work in care homes or visiting patients in their homes; role often involves close, prolonged exposure; may lack consistent access to PPE; job may be low paid, insecure, with less institutional support. In the pandemic, care workers had among the highest death rates relative to exposure (SpringerLink, 2023).

**(c) Hospital support staff / auxiliary roles (e.g., healthcare assistants, nursing assistants):** These staff support clinical teams, often spending large portions of their shift in patient areas, cleaning, transferring patients etc. Sometimes less training or visibility may be allocated to higher risk tasks with less choice (Morris et al., 2020). These are often less senior, so less power to refuse or decline risky assignments.

**(d) Agency / bank staff Workers**: They are not

permanently employed by one trust, but move across wards/trusts. May be used to fill gaps in high-risk wards. Anecdotal and survey data suggest agency staff from ethnic minority backgrounds are more likely to be deployed to COVID wards or high exposure roles. Also, these often fill gaps in high-risk wards and may have less influence over working conditions or PPE provision (TUC, 2023).

**(e) Cleaning, domestic, and facility staff:** These are essential support roles in hospitals and care settings. Involve exposure to bodily fluids, contaminated surfaces. Often low paid, less protected, less prioritised for PPE. May work in multiple sites, with variable access to training/protection. Reports show many BAME/migrant workers are in "elementary occupations" that had high death rates during COVID (UK Government, 2020).

**(f) Other public-facing and high exposure non-clinical roles**: e.g., porters, reception staff, transport within hospital). These roles may require interaction with many people, less ability to social-distance, and in some cases, less access to PPE or hygiene resources (Pineda-Moncusi et al., 2025). Migrant or ethnic minority workers may be more likely to be in these roles.

## 2. Long Working Hours and Physical Exhaustion

Many immigrant workers take on multiple shifts or extra hours due to financial pressure or staffing shortages. Chronic fatigue and overwork contribute to cardiovascular strain, burnout and other health complications that may result in sudden death.

**General risks for long working hours**: According to WHO/ILO (2021) "working 55+ hours a week is associated with significantly increased risks of stroke and heart disease". Overwork, fatigue and stress often lead to both increased risk of acute events (e.g. accidents) and longer-term health damage (hypertension, immune system weakening, etc.).

(a) **Excess exposure & frontline roles among BAME / migrant health & social care workers:** Migrant workers, many of whom are from ethnic minority backgrounds (including African), are over-represented in roles with higher exposure risk (care homes, patient-facing services) which typically involve long hours, shift work, less control over working conditions.

In care homes, in particular, workers from Black/African/Caribbean backgrounds make up a substantial share of ethnically minoritised staff. These settings were under-equipped initially in the pandemic, and workload and close contact put many at risk. Early in the pandemic, BAME health workers in the UK showed disproportionate death rates. For example, ~60%+ of health worker deaths were from ethnic minority backgrounds, while being fewer in number compared to white health workers overall (UK Health Security Agency, 2024).

**(b) Physical & mental exhaustion / burnout**

Burnout is documented among health workers; fatigue can worsen health, reduce immune response, make infections more likely, and raise the risk of mistakes. In nephrology in the UK, for example, >50% reported signs of burnout; many had reconfigured job plans and continued to work more or longer hours.

**How long working hours & physical exhaustion could lead to increased deaths among African immigrant health workers**

- Increased susceptibility to infections
- Exhaustion weakens immune response; long shifts especially with inadequate rest or PPE increase exposure risk.
- Delayed health seeking / ignoring symptoms
- Fatigue, insecure employment, or fear of losing pay or visa issues may lead individuals to under-report illness or delay care.
- Occupational hazards and errors. Physical exhaustion increases risk of mistakes, accidents, or strain injuries; combined with stress, this can lead to acute events.
- Chronic health effects. Long working hours (especially shift work, night shifts) contribute to hypertension, CVD, metabolic disorders, which increase mortality risk.
- Compounded socioeconomic stressors. Migrant African health workers may face extra burdens: lower pay, visa/ immigration-related insecure status, less job control, less support, which exacerbate stress and limit recovery.

**3. Underlying and Undiagnosed Health Conditions**

African immigrants may have a higher prevalence of certain non-communicable diseases (e.g., hypertension, diabetes) that are undiagnosed or poorly managed. Limited access to preventive care and routine screening increases the risk of these conditions leading to sudden cardiac events or strokes (Pareek et al., 2023).

**4. Discrimination, Workplace Stress and Mental Health**

Experiences of racial discrimination, micro-aggressions, and lack of recognition create chronic stress. This stress can exacerbate mental and physical health issues, contributing to sudden health deterioration (Morris et al., 2020; Spingerlink, 2023)

**5. Limited Access to Healthcare Services**

Immigration status or unfamiliarity with the UK health system can act as barriers to accessing care. Some workers may delay seeking help due to fear of job loss, visa insecurity, or mistrust of the system (Punch/Healthwise, 2024).

**6. Poor Mental Health and Psychological Distress**

The burden of migration, separation from family, and acculturation stress may lead to anxiety, depression, or suicidal ideation. Inadequate mental health support within the healthcare sector contributes to neglected psychological needs (Islam et al., 2024).

**7. Socioeconomic Pressures**

Low wages, debt, and family obligations (both in the UK and abroad) increase stress and reduce the ability to prioritize personal health. Some workers may avoid taking sick leave due to financial necessity or fear of losing employment (Rhead et al., 2024).

**8. Inadequate Health and Safety Protections**

Lack of proper personal protective equipment (PPE), training, or adherence to health and safety guidelines can raise health risks. Workers may be less likely to report unsafe conditions due to fear of retaliation or immigration concerns (Impact of COVID-19 on Ethnically Minoritised Carers in UK's Care Home Settings, 2023).

**9. Systemic Inequalities in the NHS and Social Care Sector**

Structural racism and marginalization within the healthcare system result in African workers being disproportionately placed in more hazardous roles with less support. Their concerns may be overlooked or deprioritized by institutional leadership (Tipping et al., 2022).

**10. Delayed Emergency Response or Misdiagnosis**

Racial disparities in emergency medical response, treatment, and clinical decision-making may contribute to higher mortality. Symptoms may be misdiagnosed or not taken seriously due to racial bias in clinical settings (BMC Medicine, 2023).

**Specific Evidence Relating to African Immigrants**

- The UK Disparities report noted *Central & Western Africa* and *South & Eastern Africa* as birth-places with some of the **highest relative increases in deaths** during COVID-19 for ages 20-64 (UK Government, 2020).
- In the study *"COVID-19 and Challenging Working Environments: Experiences of Black Sub-Saharan African (BSSA) Front-Line Health Care Professionals Amid the COVID-19 Pandemic in the English Midlands Region"*, sub-Saharan African professionals reported being more likely to work in social/care homes, with longer hours, lower pay, and higher daily exposure (Mathew et al., 2025).
- In care home/social care settings, Black/African carers are over-represented; these settings saw high mortality and risk early in the pandemic.

**Strategies for Reducing Fatalities Among African Immigrant Health Workers in the United Kingdom**

**1. Strengthen Occupational Health and Safety.**

Strategies relating to strengthening occupational health and safety as highlighted by TUC (2023) include:

* Ensuring equitable access to Personal Protective Equipment (PPE) and enforce compliance with workplace safety standards.
* Conducting regular risk assessments in high-risk roles/settings where African immigrant workers are concentrated.

* Mandating and monitoring adequate rest periods to prevent overwork and fatigue-related health issues.
* Improving reporting mechanisms for unsafe working conditions, ensuring protection from retaliation.

**2. Improve Access to Healthcare and Early Diagnosis**

Strategies to improve access to healthcare and early diagnosis as identified by Islam et al., (2024) include:

* Implementing routine health screenings (e.g., for hypertension, diabetes, cardiovascular risk) specifically targeting new and at-risk healthcare staff.
* Facilitating health assessments upon arrival for newly arrived immigrant health workers.
* Providing free or subsidized access to primary care services, regardless of visa or job status.

**3. Address Structural and Institutional Racism**

Morris et al (2020) highlighted the following strategies:

* Develop anti-racism policies and training at NHS Trust and care home levels.
* Create safe reporting channels for racial discrimination and microaggressions, with meaningful consequences for perpetrators.
* Include African health workers in decision-making and leadership structures to influence institutional culture and policies.

**4. Mental Health and Psychosocial Support**

According to SprigerLink (2023), the following could improve mental health and offer psychosocial support

* Offering culturally appropriate mental health services, including counselling and group therapy led by or inclusive of African professionals.
* Training managers to identify and respond to signs of burnout, trauma, or distress.
* Setting up peer support networks within NHS trusts and professional associations to build community and reduce isolation.

**5. Immigration and Employment Protections**

According to Rhead et al (2024), the following strategies could offer immigration and employment protections:

* Advocating for immigration reforms that decouple work visas from single employers to reduce vulnerability and exploitation.
* Ensuring clear pathways to permanent residency for long-serving immigrant health workers.
* Strengthening employment rights education for newly arrived workers to ensure they are aware of their protections and entitlements.

**6. Cultural Competency and Induction Programmes**

* Offering tailored orientation and integration programmes for new African immigrant health workers that address UK health system navigation, rights, and local healthcare norms.
* Training UK-born colleagues in cultural competency to improve communication, team cohesion,

and reduce workplace bias (Pineda-Moncusi, 2025).

**7. Data Collection and Monitoring**

* Mandating ethnicity-disaggregated data collection on health worker mortality and workplace incidents.
* Conducting longitudinal studies to track the health outcomes of immigrant health workers over time (BMC Medicine, 2023).
* Use data to inform targeted interventions and continuously refine prevention strategies.

**8. Financial and Social Support Systems**

* Providing access to hardship funds, housing assistance, and debt counseling for struggling health workers.
* Encouraging NHS trusts and unions to offer financial literacy workshops and support services to reduce economic stress (Punch/Healthwise, 2024).

**9. Public and Professional Awareness Campaigns**

* Launching public awareness campaigns highlighting the contributions and challenges of African immigrant health workers. This can promote respect and equity within the health sector through national campaigns endorsed by professional bodies and regulatory agencies (TUC, 2023).

**10. Collaboration with Community and Faith Groups**

* Partner with African diaspora organizations, faith institutions, and cultural associations to provide support, education, and advocacy. These groups can also act as trusted intermediaries in delivering health information and mobilizing collective action (Impact of COVID-19 on Ethnically Minoritised Carers in UK's Care Home Settings, 2023).

It should however be noted that for these strategies to be effective, they must be implemented systemically and not as isolated interventions. This requires cross-sector collaboration among the NHS, government departments (e.g., Home Office, DHSC), professional bodies, unions, community organizations, and the workers themselves.

**What would help to strengthen understanding, and potential policy / mitigation measures**

**To address / reduce risk, these are needed:**

**1. Improved data collection**

* Deaths (and morbidity) broken down by immigrant status, country of origin, number of hours worked, role, shift patterns.
* Data on exhaustion, burnout, rest periods, sleep quality, etc., among health workers.

**2. Workplace protections**

* Limit excessive overtime; ensure rest breaks; enforce maximum shift lengths.
* Ensure appropriate PPE, especially in frontline / high exposure roles.

**3. Support services**

* Mental health, physical health check ups; screening for cardiovascular risk, etc.

* Ensuring migrant workers have access to healthcare without fear.

**4. Addressing systemic inequalities**

* Fairer pay, job security, ability to refuse unsafe work, safer workplace culture.
* Proper risk assessments for BAME and migrant staff.

**5. Policy / regulatory enforcement**

* Ensuring that labor laws concerning working hours, rest, health and safety are enforced regardless of immigration or job status.

## Conclusion

Based on the review of the existing data used in this research, there are strong evidence that African immigrant health workers in the UK, are involved in roles with high exposure and long / exhausting working conditions, have borne disproportionate mortality during COVID 19, and that overwork, burnout, fatigue, and systemic inequality are likely contributing factors in this increased risk.

## Recommendations:

Based on the review of existing data, the following are recommended to reduce fatalities among migrant health workers in the United Kingdom:

1. Urgent establishment of a multidisciplinary investigation (adopting a public health and occupational safety lens, social, economic, and systemic factors that may disproportionately impact this group), into the factors contributing to sudden and unexplained deaths among African immigrant healthcare workers in the United Kingdom.
2. Comprehensive data collection on circumstances surrounding sudden deaths in this population over the past decade.
3. Occupational health and workload assessment to **e**xamine working conditions, shift patterns, exposure to workplace stress, and prevalence of burnout or underlying health conditions.
4. Investigate access to preventive healthcare and occupational health services.
5. Conduct cardiovascular and stress-related risk analysis to explore the potential role of undiagnosed or poorly managed hypertension, diabetes, and other cardiovascular diseases, particularly given known disparities in these conditions among African populations. Assess the impact of chronic stress, including racial discrimination and micro-aggressions in the workplace.
6. Evaluate the effects of immigration status, housing, financial stress, and support networks on health outcomes. Consider the impact of visa restrictions, multiple job holding, and limited access to support services.
7. Investigate whether cultural and language barriers affect health-seeking behaviour, engagement with preventive care, or follow-up of medical advice.
8. Engage stakeholders and include testimonies and lived experiences of affected families, community leaders, healthcare worker unions, and relevant advocacy groups to ensure a holistic and inclusive

perspective. This investigation should be led by an independent body, with collaboration between the NHS, public health authorities, professional regulatory bodies, academic researchers, and representatives from African diaspora communities.

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