CHAWREC
CHESHIRE, HALTON & WARRINGTON
RACE & EQUALITY CENTRE

COVID-19

Exploring the social impact of the pandemic on **Black, Asian and Minority Ethnic Communities** in **Cheshire West and Chester**

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1 CONTEXT

This year, 2020, has been dominated by the Covid-19 pandemic. From the onset people studying the incidence of Covid-19 highlighted that Black, Asian and Minority Ethnic Communities (BAME) were being disproportionately impacted by Covid-19 in terms of susceptibility to the virus, severity of illness and increased deaths.

(PHE, 2020; Razaq et al, 2020)

The Office for National Statistics, for example, was suggesting that Black people were four times more likely to die from Covid-19 than white people. (Reported by Booth and Barr, 2020.) In addition, Public Health England argues that 'the disparity in Covid-19 mortality between ethnic groups is the opposite of that seen in previous years' (2020:6). Many Public Health Specialists and Academics are now studying why this might be the case and we await their findings.

Locally, Public Health officials will be mapping and analysing similar data on incidence, severity of disease and death rates by population characteristics in Cheshire West and Chester. This will provide the epidemiology of the disease locally but cannot inform us about the lived experiences of BAME Communities. How easy is it for Community Members to access health care for example and what are the barriers to access if any? Has the Public Health advice around Covid-19 reached Community Members, do they understand it and have they complied with restrictions? If not, why not?

These lived experiences can provide valuable information around which to design an effective public health policy for BAME Communities.

2 BACKGROUND

Triggers for this work were therefore concern about the reported higher incidence of Covid-19 infection in people from BAME communities and worse outcomes for this group once they have contracted the disease. The work has been conducted by CHAWREC [1], because of their working relationships with BAME Communities and funded by Cheshire West and Chester Council [2]. The work is exploratory in nature and was designed to understand more fully peoples' experiences and views of Covid-19, lockdown and access to health care generally to inform service delivery and begin a new dialogue with BAME communities in Cheshire West and Chester.

3 AIMS AND OBJECTIVES

The work had a number of broad objectives:

- To give some clarity about the position in Cheshire West and Chester.
- To help service delivery by eliminating barriers to accessing services
- To help policy makers and service providers understand the needs of the community and the health status of its members so that they can improve service provision
- To understand more about the effectiveness of the Covid-19 public health message in communities where English is not the first language or where literacy is poor and where support structures and family units are bigger than average.

4 RESEARCH FOCI

In order to address these broad concerns the research will focused on the following questions:

- What are the experiences of BAME Communities in terms of health and social care before, during and post lockdown?
- Do BAME Communities experience barriers in accessing health care and are these barriers the same or different in and post lockdown?
- What is the experience of Covid-19 illness and death in these Communities?
- Was the Public Health message clear and understood in these Communities?
- Did extremely vulnerable people receive messages to stay at home for their safety and does the health service have the relevant information to generate these messages in the case of BAME Communities?
- What are the community perspectives on why the death rate and transmission rate is high for BAME Communities by way of explanation of the data?
- Have Communities experienced an increase in Covid-19 related hate crime?

[1] CHAWREC- Cheshire, Halton and Warrington Race and Equality Centre
[2] As part of the National Institute for Health Research and UK Research and Innovation Rolling Programme for Covid 19 Research

5 METHOD

Limitations on contact as a result of Covid-19 placed restrictions on the study design. The work therefore centred mainly on remote data collection via a questionnaire [3]. The questionnaire was available via the post and email, through Facebook, CHAWREC's website, survey monkey and also through distribution to community focal points.

The work was also informed by remote conversations with 11 BAME Community Members, small group discussions as part of educational classes hosted at the Unity Centre and the views of teachers, volunteers and staff who work with BAME Communities at the Centre and via CHAWREC.

The data capture took place between July and September 2020. The initial planned one month capture was extended to encourage more respondents.

The questionnaire was structured around 8 domains and it offered the respondent multiple choice responses. Dialogue boxes were built into the design to encourage further explanation and scope for individualised views.

The domains were:

- Personal characteristics of the respondent
- Where people live
- Health and social care
- Experiences of the virus, lockdown and public health messages
- Impact on wellbeing and mental health
- Work and Finance
- Experience of Hate Crime
- Explanations for differential impact of the virus on BAME communities

Members of the CHAWREC Consultation Panel from Cheshire West and Chester were contacted and invited to take part either by completing a paper questionnaire or via a Facebook link to an E questionnaire. The work was also publicised on the CHAWREC website and Facebook page encouraging people to participate. In addition Community Groups linked to CHAWREC were notified of the work and asked to advertise it to their members. Community representatives were consulted and the views of tutors and volunteers working to deliver ESOL classes and to support and befriend refugees and asylum seekers were also elicited.

A small number of people took part in 1:1 dialogues to inform questionnaire design and to offer deeper insights on issues such as compliance and culture, information which would be hard to convey in a self completed structured questionnaire.

Evaluation of the method

The study was administered under a number of constraints. Postal and E questionnaires are not the best way of capturing the views of BAME Communities in general but particularly poor for eliciting more in depth explanations of behaviours and cultural mores. Due to Covid-19 restrictions it has not been possible to meet with people face to face or visit them in their homes. Also CHAWREC's base in the Unity Centre is normally flooded with community groups using the centre and therefore it would have been easy to publicise the work and gain participation with translators on site. The Centre of course is operating at limited capacity at the moment and so this source of connectivity was largely defunct.

Many BAME Communities live their lives away from the mainstream and need encouragement to talk about their lives which they see as private. There may also have been fear or suspicion about how that information would be used or even apathy because previous work has not manifested worthwhile change in communities.

The language barrier was also likely to be an issue for some older people, for those recently settled here and for those living in groups where English is seldom spoken. Furthermore, members of the CHAWREC consultation panel normally receive a high street voucher in recognition of the time they spend participating in studies. This work did not have a sufficient budget to offer payment and so participation suffered as a result.

Notwithstanding these issues, the final sample is broad and captures the views of a wide range of ethnicities, ages and circumstances (Table 1).

The next section documents the findings from the questionnaire. The data which underpins these findings can be found in frequency tables at the back of this report. The work is interspersed with the words of participants sourced either from dialogue boxes on the questionnaire or via discussions in small groups or consultations with community representatives. First, a description of the sample.

[3] The questionnaire is available from CHAWREC office@chawrec.co.uk

6 SAMPLE CHARACTERISTICS Tables 2-7

The views of 57 survey respondents are represented in this work. In addition, a further 11 Community Members offered guidance about some of the central issues facing their communities which helped to inform questionnaire development. The views of Tutors, Staff Members and Volunteers have also helped to shape this work.

Respondents span a number of different ethnicities. Bangladeshi and Arab interviewees were the most widely represented accounting for 59% of the sample. There were roughly equal numbers of men (53%) and women in the survey sample but the 11 Community members were all men apart from one woman. The most popular age group was 31-40 although 16 respondents were over the age of 50, five of which were over the age of 70. Ten respondents were under 30 years of age. The 11Community Members were over 30 years of age and half of these were over 50.

Forty per cent of the sample was from central Chester, 25% from Ellesmere Port, 14% from South East Chester, 5% from South West Chester and 5% from North West Chester. There was one respondent from the Northwich area. Thirty per cent of respondents had been born here and a third had been here over 20 years. English and Arabic were the most commonly spoken languages although over 12 different languages were spoken in people's homes.

In terms of household size, the most common was 5 closely followed by 4. These households accounted for 52% of the sample. There were 6 people living alone, 5 living as a couple and 16 living with children under the age of 18.

7 THE RESULTS

7.1 HOUSING - Tables 8-13

Four-fifths of respondents reported living in a house. The remainder lived in flats. In terms of ownership, 27 properties were owned by the respondents or their family and 28 were rented either from a housing association (71%) or a private landlord (29%).

Eighty-four per cent of these properties had a garden. The average number of bedrooms (mode) per property was 3 (49%) followed by 2 and 4 bed properties (both accounting for 15% of responses. Five respondents lived in 1 bedroom properties and these were all flats. The majority of properties had one bathroom (69%) a further 10 properties had 2 bathrooms and 6 had 3 bathrooms.

7.2 HEALTH - Tables 14-17

We asked people about their general health and their interaction with health services. All respondents were registered with a GP and three quarters of all respondents described their relationship with their Doctor as good. The remainder, however, felt that either the Doctor could not understand them or that they could not understand the Doctor. In all cases the reason given for this was the language barrier.

When asked about 111 service use, 40% had never used it and 18% had never heard of it. Of the 17 people who had used it, 12 said it was easy to use and 5 said they had found it very useful. Three people had tried to use it but couldn't due to the language barrier.

Thirty-one people (61%) said they had needed medical treatment during lockdown. Half of these had been dealt with over the 'phone by the GP. In some cases (3) a video call had taken place. Two respondents had a face to face appointment and a further 2 attended A&E. Two people had made a 999 call and found the advice helpful. We asked respondents whether they had any health conditions. Almost half of the sample said that they had no health conditions. The most commonly reported condition was Diabetes (n=8). Mental health problems were reported by 3 people although other questions around mental well being suggest undiagnosed mental ill health is much more prevalent than this number suggests (Table 36). Small numbers reported heart problems, muscular/skeletal problems and respiratory problems.

Two people identified themselves as carers and 3 people said they considered themselves to have a disability. Only one person said they had a support package.

7.3 COVID-19 - Tables 18-31

A third of respondents said they or someone close to them had contracted the virus. A third of these felt they had probably had the virus but were never tested. A fifth of respondents knew someone who had died as a result of the virus. The local Gypsy Traveller community in Cheshire contributed the following:-

> *There have been a few deaths locally from Covid 19 and quite a few have been hospitalised. My .....[relative] was in a coma for 7 weeks and is still in ...hospital but there are more who were too scared to go into hospital and stayed at home because they didn't want to die alone. They've all recovered.*
>
> **MALE ENGLISH GYPSY AGED 51-60**

These comments illustrate the fear that people in self contained communities felt over the possibility of dying away from their loved ones. There is a possibility then that under these circumstances people would not get the care they need.

We asked a number of questions about vulnerable people, shielding and why people had decided to shield. The responses were complex because some people were shielding themselves, some a relative and some said their relative was shielding but they were not involved directly with their care. Four people said they were self shielding. All of these people were over 60, had health problems and had been advised by the Doctor to shield.

Eleven respondents said a family member was shielding. Seven of these said they weren't sure if there had been a letter but they had decided to shield based on the information available to them.

We asked several questions about the public health messages around Covid 19. Most respondents said that the message was confused (48%) although a third of respondents said the information was clear.

In terms of media coverage the majority thought there was too much information (48%) but just under a third thought the coverage was perfect.

We asked people to consider what they could recall about the public health message. The majority, almost 2/3rds, said that they had perfect recall regarding the instructions. Only 2 respondents said that they couldn't remember anything although ten respondents did not complete this question which might suggest that more people had imperfect recall about the message.

We asked respondents about their knowledge of symptoms and if they would know when to get help. Two-thirds said they either lacked confidence in understanding the symptoms or they didn't really know what they were. Despite this just over half of the sample said they would be clear when to get help if they or a relative fell ill with suspected Covid-19 which could be seen as a contradiction.

We asked people to assess the danger that Covid-19 posed compared to seasonal flu. Four-fifths of respondents said the virus was **more** or **much more** dangerous than Flu.

We asked people where they heard about Lockdown and the restrictions which accompanied this. Social media (34%) and the News (39%) were the most commonly cited sources followed by family and friends (18%).

We asked people to say which Covid-19 safe behaviours they followed. The most commonly cited behaviours were staying at home and wearing a mask. There was wide variation in how people described their actions. Some were very thorough like the first respondent in the box below. Others were quite cursory in their response only quoting a single action like 'face masks' or 'hand sanitiser'.

What have you done personally to stay Covid safe?

We have been staying at home since the lockdown as my husband is considered high risk. We have been having grocery deliveries; we do not go to crowded places. I only go to shops if I really need to. We wear a mask every time we go out of the house, maintain social distancing and make sure we disinfect our hands religiously when outside. We haven't eaten out at any restaurant. We only entertain friends in our front yard observing safe distance and for a limited time. I disinfect all items arriving in our house. When we do food deliveries I make it a point to transfer the food onto our own plates, dispose of all the take away containers properly, wash hands thoroughly and reheat the food either in the oven or microwave before consuming.

SOUTH-EAST ASIAN WOMAN AGED 31-40

Staying home. Wearing a mask and gloves at the shops, regularly sanitising hands and cleaning more

ANGLO-ARAB WOMAN AGED 21-30

Don't go out. Stay in all the time following Government instructions

INDIAN MAN AGED 31-40

Shopping early or late when crowds can be avoided. Attended teaching job by observing safe distancing and frequent hand washing. Used key worker times in supermarkets/ shops. Avoided being in busy areas.

INDIAN WOMAN AGED 51-60

the rules are hard to comply with when it's a closed isolated community that the outside world doesn't seem care or bother about

GYPSY/TRAVELLER MAN AGED 51-60

7.4 IMPACT ON RESPONDENTS' LIVES

We asked respondents to consider what the impact of Covid-19 had been on their lives. People identified positive and negative impacts on their lives. Positive impacts were spending more time with the family and the convenience of working from home. The impact on children's education and socialisation were by far the most commonly cited concerns people had. Many of our respondents were learning English and so the loss of classes for them and exposure to English for their children was deemed a great loss. Twelve respondents identified mental health symptoms due to money worries and stress at home from everyone being in one place. Several people commented on how much more expensive it was feeding a family that was at home constantly and where 'the budget just wouldn't stretch'. Some people were also scared in the workplace if they were in forward facing roles. Stress also came from not being able to see friends and family as well as work colleagues.

How have you and your family been affected by the virus?

None of our close relatives could visit us. Not being able to meet family members has been unbearable for all of us

INDIAN MAN AGED 71+

It's been difficult financially but got to spend more time together as a family.

BANGLADESHI MAN AGED 21-30

Not enough money as food and bills more expensive when everyone is at home

SYRIAN MAN AGED 31-40

I was very stressed at work and sometimes felt anxiety

FEMALE ARAB AGED 41-50

I had panic attacks and my mental health has been affected. I have obsessive behaviour around cleanliness

ARAB MAN AGED 61-70

It's had a serious impact on my well being

PAKISTANI WOMAN AGED 41-50

The loss of income has been difficult and my personal relationships have been affected. Not being able to work and not seeing loved ones has impacted on my mental well being.

ANGLO/ARAB WOMAN AGED 31-40

We've had little direct effect and a broadly positive experience. We are concerned about schools going back and are reluctantly considering home education

AMERICAN WOMAN AGED 41-50

It's caused terrible damage with weddings being cancelled funerals with limited mourners and those in hospital for whatever reason having no visitors
Appleby and Stowe horse fairs were cancelled as well as many other traditional events as well as the church meetings all being closed

GYPSY /TRAVELLER MAN AGED 51-60

Lack of education has had a huge effect on me and my child

SYRIAN WOMAN AGED 41-50

7.5 MENTAL HEALTH - Tables 32-36

We asked people if they were worried about the virus. The majority (94%) said they were. Two-fifths of these were very worried. When asked about concern for others, more respondents said they were very worried (75%). When asked to define those worries respondents were basically worried about family members because they were vulnerable. Young people were worried about their parents because of age and health conditions and older people were worried about their children because they felt they were not careful enough or lived/worked in busy places.

Are you worried about Coronavirus?

Just anxious about our safety especially when the children go back to school. We really don't want to get the virus as its just us here in the UK

SOUTH-EAST ASIAN WOMAN AGED 31-40

There has been a lot of stress and anxiety caused by the worry and uncertainty that the virus has caused. We are finding it hard to come out of Lockdown. I also worry about my parents who are elderly because I have to go to work and I live with them.

ANGLO/ARAB WOMAN AGED 21-30

The main feedback that comes back to us on Covid is how it is affecting family and friends in the students' country of origin. Some students have already lost family members to Covid and that is, of course, very distressing, and the students feel a long way from home and experience great sadness and increased anxiety. Also, family members have been lost who are young and do not have underlying health problems.

ESOL TUTOR

More generally when we asked people to specify why they were worried loss of life was the most common response followed by general concerns about the future. Much smaller numbers were concerned about loss of income and freedom.

We asked people some standard public health questions about mental state and asked people to consider to what extent they were motivated and interested in daily life.

Fifty-seven per cent of respondents said that they found they had little interest in daily life for more than half of the week, 2/5ths of these felt like this every day.

In terms of feeling down fewer people reported symptoms. Forty-seven per cent said they felt depressed for more than half of the week, over half of these felt depressed every day. The most common response was a score of 1. This was cited by 18 people and indicates down feelings on several days. This result suggests low level depression in 2/5ths of the sample.

We asked respondents if they had adopted any coping mechanisms or new behaviours to get through Lockdown. Surprisingly half of all respondents said they hadn't adopted any special mechanisms to help them cope. Smaller numbers (14%) had started a new hobby, done some DIY or started regular exercise.

7.6 WORK AND FINANCE - Tables 37-40

We asked people about their occupation. Twenty three were in paid work or looking for work. Five were in unpaid roles caring for family. Ten people were unable to work because they were refugees with poor language skills undertaking mandatory English classes in preparation for the workforce. Seven were retired and 1 was in full time education. During and after lockdown the working environment changed for some. Five people were furloughed and 3 had lost their jobs. Thirteen were going to work as normal and five people were working from home.

We asked people about their financial position before and after Lockdown. The proportion of respondents describing their state as comfortable or desperate was roughly the same numerically, a fifth and less than 1% respectively. However the number saying they were desperate had doubled in real terms. Those describing their state as stable had decreased by a third. The number of respondents reporting their state as fragile had trebled.

Nine people said they had accessed a grant to help their business but many people complained they had not known how to access help because there was a lack of information about how to do this. Several respondents said there was no-one to help them. Others said they had trouble accessing help because offices were closed or opening hours reduced and telephone lines blocked with callers.

How has your job and finances been affected by Lockdown?

I haven't seen or heard of any help or assistance being offered

MALE ENGLISH GYPSY AGED 51-60

I have been laid off from work and so on a reduced income but I still have to pay my bills.

ANGLO/ ASIAN MAN AGED 61-70

Lockdown has affected my business badly and Im struggling to make ends meet at work

INDIAN MAN AGED 31-40

I have had to work more hours as some of my colleagues were very stressed and had to take days off

ARAB WOMAN AGED 41-50

My health and business have been badly affected.

BANGLADESHI MAN AGED 51-60

Still having to work through the Pandemic with people who don't abide by the safety rules and an employer who is not enforcing them. Scared to say anything in case I lose my job.

ANGLO-ARAB WOMAN AGED 21-30

Made redundant

BANGLADESHI MAN AGED 21-30

.....most people have to go out to work as they are self employed even though most are nervous of catching the virus and passing it on

7.7 HATE CRIME - Tables 41-42

Just over half of respondents said that they had experienced hate crime at some time in their lives.

Have you ever been abused because of your ethnic background?

Been called names at work by some of the customers

ARAB WOMAN AGED 41-50

Yes name calling, things thrown at the windows and threats made. We had to move house.

ARAB MAN AGED 61-70

My scarf was mocked.

TURKISH WOMAN AGED 31-40

Verbal abuse. 'Go back to your own country' and 'take that tea towel off your head.

BLACK AFRICAN WOMAN AGED 21-30

I was called racist names like Paki when I was growing up. Feel racially profiled as terrorists due to the part of the world we are from. 'Have you got a bomb in your back pack..That sort of inane thing!

ANGLO-ARAB WOMAN AGED 31-40

Ignorant stares from people. My neighbours won't engage with me. Some young people on bikes block my way.

INDIAN WOMAN AGED OVER 70

Called Paki, Terrorist, Curry Cruncher, Sooty and had comments referring to my Muslim heritage.

PAKISTANI WOMAN AGED 61-70

Physically attacked due to my race and verbally abused due to my ethnic background.

ANGLO-ARAB WOMAN AGED 21-30

Racist words such as the 'P' word, Terrorist, Curry Muncher, Coco Pop!

BANGLADESHI MAN AGED 21-30

Most of these incidents had involved name calling. Just over a quarter said that this had happened in the last 12 months. Ten per cent had experienced this in the last 4 months. Only one respondent attributed racist abuse to the Corona outbreak.

Been told I am contagious, {that} I'm responsible for the increase in Covid-19

PAKISTANI WOMAN AGED 41-50

7.8 VIEWS ON THE DISPROPORTIONATE IMPACT ON BAME COMMUNITIES

Most people did not answer this question. Those who did offered speculative explanations about cultural leanings, frontline occupations, language barriers and genetic disposition:

Explanations for differential impact on BAME communities

People may need more advice and guidance in their own language as many can't fully understand English. We need more awareness workshops. Cultural stereotypes of BAME people have a big impact.

ARAB WOMAN AGED 41-50

Ethnic minority cultures with their emphasis on family means that it is hard to stay away from family and friends

BANGLADESHI MAN AGED 21-30

I believe it is linked to the larger families amongst BAME people and the way they congregate more closely. Also it could be a language barrier for those whose first language is not English, maybe misunderstanding the safety advice.

PAKISTANI WOMAN AGED 61-70

Poverty amongst BAME communities can affect their lifestyles. They may be more hesitant to take Government advice and therefore not take it as seriously

SYRIAN MAN AGED 41-50

I don't believe it

TUNISIAN MAN AGED 61-70

It's a designer virus!

CARIBBEAN MAN AGED 31-40

No idea! Socio-economic factors, genetics? Lack of Vitamin D?

AMERICAN MAN AGED 41-50

Minority ethnic communities do not follow the rules. They are careless. Cultural differences mean we live in extended families and we also like to socialise together

SYRIAN MAN AGED 31-40

BAME communities don't believe it exists

ARAB MAN AGED 21-30

The BAME communities have underlying health issues which make them more likely to get the virus

BANGLADESHI MAN AGED 61-70

I have never heard about the effect of the virus on small minorities. Lifestyle and genes might have an effect

SYRIAN WOMAN AGED 31-40

Minorities have more chronic illnesses which might contribute to their tolerance to Coronavirus. The way of living in groups or all together in one house may also be a reason.

ARAB WOMAN AGED 31-40

I believe people from BAME communities are more emotionally fragile and therefore prone to illness and to catching the virus.

SYRIAN WOMAN AGED 41-50

South Asians are prone to high blood pressure and diabetes. Also Afro- Caribbean' carry the sickle cell gene and these things may be factors.

INDIAN WOMAN AGED 51-60

I believe that lack of information or information not passed in the right way to Ethnic Minority Communities is partly to blame. The language barrier has never been completely addressed and I believe that the authorities have not really tried to reach BME communities.

BANGLADESHI MAN AGED 51-60

I think maybe because most of the people from BAME communities are front liners. If not, then maybe they are scared of seeking medical help or may feel that they are OK even when they are not. I think there are a lot of factors really.

SOUTH-EAST ASIAN WOMAN AGED 31-40

8 DISCUSSION

In section 4 a number of research questions were identified. This section revisits those questions and addresses them using the survey results and supplementary information from other sources such as small discussion groups, consultations with Community Members and CHAWREC staff and volunteers. Findings from other studies will also be highlighted to contextualise the data from this study.

Health and social care experiences of BAME Communities

Most respondents were registered with a GP and described their relationship with their Doctor as good. A quarter, however, did not and cited the language barrier as the reason for not understanding or being misunderstood. In local Healthwatch studies (2020a and 2020b), only 1 person out of a total of 1028 needed access to information in another language which suggests that the language barrier was not a significant issue for respondents in that study. **It was a significant problem for a quarter of people** in this study and it is clear that lack of understanding and not being understood colours the experience of health care and impedes access to it.

As far as Covid was concerned, those teaching English for Speakers of Other Languages (ESOL) in the Unity Centre in Chester have been working hard to help with this:

> *As teachers, we update the Covid information in the class constantly with every change and development, making sure we use illustration, graded language and appropriate questioning to check understanding. We also always ask 'how do you feel (about this) and we teach vocabulary to try to express feelings e.g. worried, scared, apprehensive and show how the expressions might express stronger feelings*
>
> **ESOL TUTOR**

Access to services was identified as a real concern for those supporting people whose first language is not English. Although Language Line can be accessed once an appointment is made it is the lead up to making appointments which is difficult 'with sometimes up to 2 minutes of rapid English and options to select and when booking on line a lengthy process with complex language.' This might be a particular barrier and deterrent to getting tested.

> *I feel we need a permanent, well publicised 'walk in only' centre that everyone knows they can access without having to call or fill in an online form*
>
> **ESOL TUTOR**

With regard to health conditions, half of respondents did not identify any conditions. Only 2 people identified themselves as having a disability, 3 said they were carers and only 1 identified themselves as having a care package.

The most commonly reported condition was Diabetes. Small numbers reported heart problems, muscular/skeletal problems and respiratory problems.

Mental health problems did not really feature as an identified medical condition but other questions about mental state and the information offered in dialogue boxes suggested many people were feeling anxious, worried, isolated and uncertain because of the impact of the Pandemic. Most respondents said they were worried about the virus because of loss of life and for the future.

In an earlier study with the Gypsy and Traveller communities in Cheshire , Halton and Warrington the proportions declaring chronic health conditions was much higher with mental health conditions (53%) and muscular skeletal problems(17%) of particular concern (CHAWREC, 2020.) The higher incidence reported in this study may be due to the more in-depth data collection adopted.

In terms of service use, two thirds of people were regularly using services before and during Lockdown. In Lockdown respondents had their needs met over the phone, over zoom, in face to face consultations, in A&E and by dialling 999. Most people were satisfied with the treatment they received.

In contrast to the Healthwatch sample most respondents in our study had either never heard of NHS111 or never used it. Over a third of those who had used it could not manage because of the language barrier, the others, however said it was easy to use. Healthwatch also found mixed feelings about online appointments but the language barrier was not the principal course of this.

Surprisingly half of all respondents said they hadn't adopted any special mechanisms to help them cope during Lockdown. This is in contrast to the findings of the Cheshire Healthwatch surveys (2020a; 2020b) where half of the sample had talked about the positive impact of exercise and hobbies and social contact on their mental health.

Positive impacts in this study were spending more time with the family and the convenience of working from home. By far the most prevalent negative impact was the affect on children's education and socialisation.

Money worries, uncertainty about the future and stress at home from everyone being in one place were identified as triggers for mental health symptoms. In addition, the increased expense of feeding a family that was at home constantly 'with a budget that wouldn't stretch'.

> *Students are very relieved that the schools are remaining open in this second lockdown. Home-schooling was incredibly difficult for them and our impression was that the families received little additional support. We tried to help where we could with this in our online sessions in lockdown 1.*
>
> **ESOL TUTOR**

Some people were also scared in the workplace if they were in forward facing roles. Stress also came from not being able to see friends and family as well as work colleagues.

What is the experience of Covid-19 illness and death in BAME Communities?

At the time of capture just over a third of the sample said they or someone they knew had had Covid-19. A fifth knew someone who had died from Covid-19. These figures are likely to be higher now.

The experience of those who had come more recently to this country was different linked as it was to family in their country of origin or elsewhere in the world and often involved the loss of close family members. This was very distressing for them and had an impact on their mental health.

Did extremely vulnerable people receive messages to stay at home for their safety?

Fifteen respondents were either shielding themselves or shielding a relative. When asked about the decision to shield there was not a clear link between advice from the Doctor to shield as many people could not recall having a communication. Most people had decided to shield based on the information they heard or because of their age or health.

Does the Health Service have the relevant information to generate these messages in the case of BAME Communities?

Many respondents who identified serious medical conditions and were over 60 did not appear to have received a communication asking them to shield. There was a degree of vagueness about whether a communication had been received and this could be down to poor language skills or reliance on others to read communications for them. This requires more investigation.

Was the Public Health message clear and understood in BAME Communities?

In terms of Public Health messages around Covid-19 most people heard their information from the News or Social Media. Government and NHS websites were not an important source of information in contrast to the Healthwatch survey (2020 a; 2020 b) where 2/3rds of respondents cited this source as important. Instead Social Media featured more strongly. If the only source of information is Social Media then there is potential for misunderstanding, fake news or at least multiple truths.

Many of the results suggest knowledge of the Public Health message which is positive; recall of the message and appreciation of the seriousness of Covid are examples of this. There was some dissonance however between uncertainty about symptoms and certainty about when to get help. In respect of respondents more recently resident in this country CHAWREC is aware that poor language skills probably meant that many families were mainly relying on Social Media for information and also potentially guidance from other countries. In those early days when guidance was rapidly changing the wider community were exposed to constant news and governmental statements

about the wider context – risk to the NHS for example. This broader picture and the complexity of rapid English and technical medical language would probably have passed them by whereas the general community had a high level of exposure to all of this on a regular basis. Lack of resources, the absence of translated guidance, and the closure of schools, often the vehicle for information to families and the strictures of Lockdown meant that it was more difficult to reach out to people.

Remedial work in class since reopening is helping to explore and rectify some of these misconceptions and clarify the guidance.

Respondents have indicated that even where people have lived in this country for some years their English skills are still poor and they are reliant on younger family members to translate for them. For many reasons this might be problematic in some cases.

In other words **it is likely that not all Communities were clear about the Public Health message because of the language barrier.**

Community explanations of poorer health outcomes for members of BAME communities

Baroness Lawrence (2020:4) in her review of the disproportionate impact of Covid-19 on BAME Communities argues that structural racism has resulted in health and societal inequalities which mean that BAME communities are more susceptible to the virus and more likely to have a poorer outcome. She argues BAME people are:-

> *...more likely to work in frontline or shutdown sectors which have been over exposed to Covid-19, more likely to have co-morbidities which increase the risk of serious illness and more likely to face barriers to accessing healthcare.*

The views of our Community Members echo these assertions pointing to longstanding inequalities and the interconnectedness of factors.

These long standing inequalities pervade all aspects of people's lives. Poor housing and multi-generational households which are overcrowded in legal terms are assumed to be the norm for BAME Communities. Razaq, et al (2020:15) in their Rapid Review of Covid knowledge state that:-

> *Ethnic minorities are more likely to live in 'overcrowded' housing as well as multigenerational households; 30% of Bangladeshi households and 15% of Black African households are overcrowded compared to 2% of white British households*

Our findings contradict this view. In terms of living conditions the people in this sample were not living in overcrowded conditions as defined in statutory guidance and explained by Shelter (Shelter, 2020). We did not measure square footage of properties but in terms of number of bedrooms, household size, gender and age, overcrowding did not appear to be an issue. In addition most households had outside space.

Many respondents, however, referred to the cultural preference for meeting with other family groupings to socialise and for extended families living close by:-

> *Cultural differences mean we live in extended families and we also like to socialise together*

This preference can make it hard to isolate and distance:-

> *Ethnic minority cultures with their emphasis on family means that it is hard to stay away from family and friends*

> *The rules are hard to comply with when it's a closed isolated community*

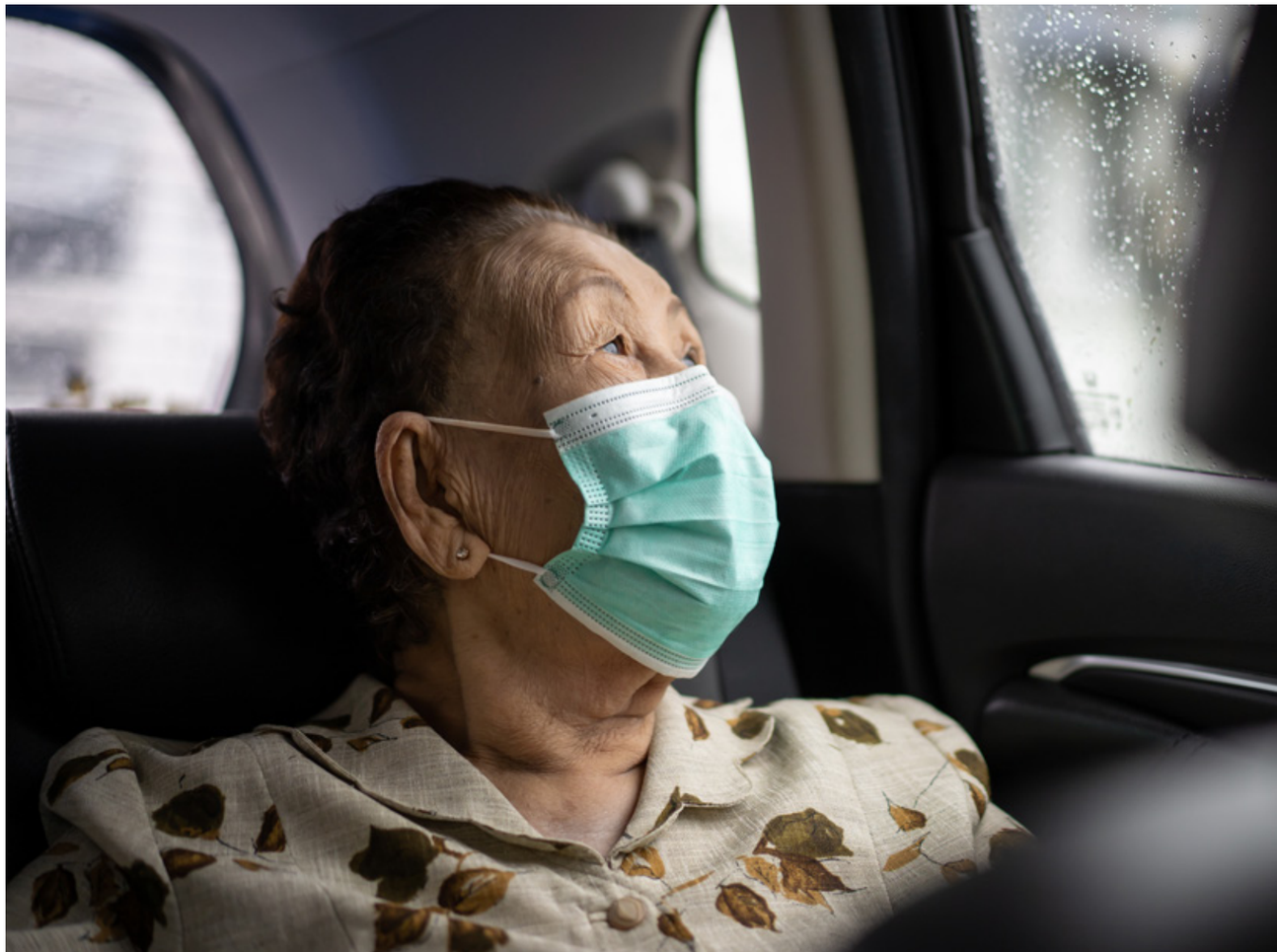
Experience of Covid related hate crime

Baroness Lawrence raises the stigmatization of BAME Communities and the targeting of BAME people as scapegoats as a key impact of the Pandemic. (2020:19)

At the time of capture we did not discover that BAME Communities had experienced an increase in Covid-19 related hate crime. However, we did discover that over half of the sample had experienced racist abuse at some time.

In a recent study examining the needs and preferences of Gypsy/Traveller communities the incidence of abuse was huge and had doubled since an earlier study in 2006 (CHAWREC 2006 and 2020.) These increased levels ran alongside increasing mental ill health including addiction and suicide.

The connection between abuse and the impact on health should not be underestimated.



9 CONCLUSION

This work was developed with 4 objectives in mind. Two of these were general in tone:-

- To give some clarity about the position in Cheshire West and Chester.
- To help policy makers and service providers understand the needs of the community and the health status of its members so that they can improve service provision

The others more specific:-

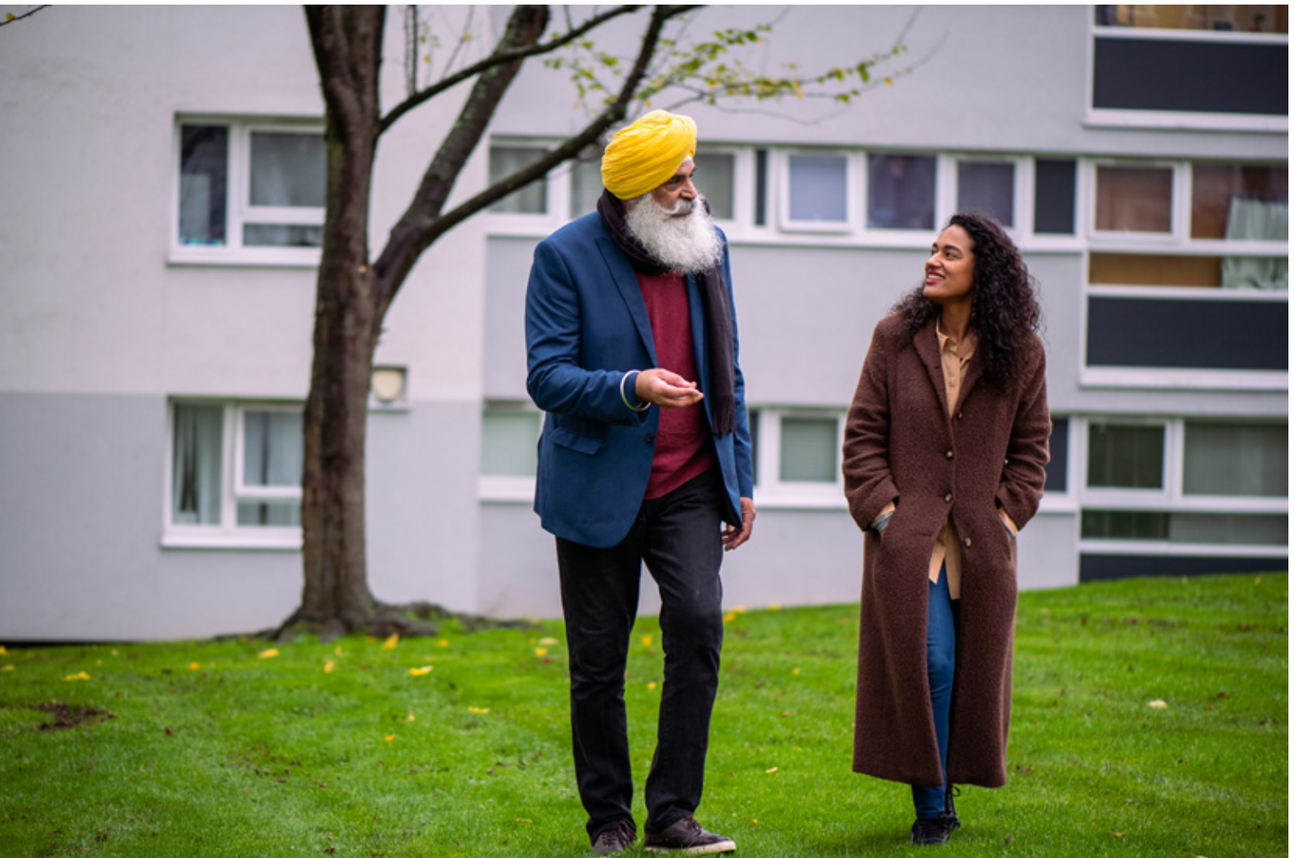
- To help service delivery by eliminating barriers to accessing services
- To understand more about the effectiveness of the Covid-19 Public Health message in communities where English is not the first language or where literacy is poor and where support structures and family units are bigger than average.

In terms of the general objectives the data presented here gives a good overview of the experiences of respondents during lockdown, the impact on their lives, their health needs and how they were met. The survey collected data about physical and mental health as well as social care needs but these questions were only partially answered by some respondents and therefore not fully comprehensive.

In terms of the specific objectives regarding access to services and effectiveness of public health messages some interesting evidence emerged which will help service providers to develop more effective services.

Poor language skills for example emerged as a real barrier to access for many BAME Communities. This was not just the case for people who had recently come to this country but also for people who had lived here for many years.

This was a particular problem at the beginning of Lockdown before material in other languages became available. CHAWREC staff did their best to inform people about the guidance which was rapidly changing. Information sources at that time were largely via daily news bulletins and the Government website. **We now know from this research that these are not the information sources which many of our respondents were listening to.**



The language barrier, however, is an enduring problem. Pre Covid-19, it is clear that some people from BAME Communities had been struggling to make themselves understood or to understand when attending the Doctor or Dentist or attending a hospital appointment. Community Staff and Volunteers often report back that Language Line has not been utilised by health professionals and unless a Community Interpreter is available then there is room for misunderstanding. Indeed it is often the case that in later discussions it becomes clear that the patient has completely misunderstood what has been said to them about a health problem for themselves or their children. Perhaps the use of some written materials like a **Patient Passport** [4] would aid understanding and the patient could show the material to an interpreter later.

Lockdown posed particular problems because Staff and Volunteers could not visit families and they could not come into the Unity Centre for education and support. **Supporting people remotely would be a way forward but new technology is needed to establish this.**

Some survey respondents and discussions with community members raised the issue of apathy in terms of initiatives for BAME Communities. Highlighting the need to address barriers to access is not new. In 2013 the NHS BME Leadership Forum produced a paper documenting examples of practices designed to improve access to services for BAME communities. The rationale for this was explained thus:-

'The guiding principles of the NHS make it clear that embracing and promoting equality and diversity are crucial to delivering the highest quality service. ..{but}.....There are significant barriers to accessing healthcare for large sections of our society' (BME Leadership Forum: 2013:13)

This imperative is still as important in 2020.

The perception of many Community Members is that nothing will change and despite previous research, reports lie on the shelf and action is not taken.

> *The language issue has been talked about for years but no one has really taken it on*
>
> **BANGLADESHI MAN AGED 51-60**

The position of many is therefore disengagement from the mainstream. A prime example of this inaction is a recommendation to address worsening mental ill health in Gypsy/Traveller communities (CHAWREC 2006). This was not addressed but in a recent follow up study (2020) very serious mental health issues and a high suicide rate now requires urgent attention and intervention.

In line with the needs expressed here and the wider political conversation and pressure to meet BAME Communities' **needs, policy development now needs to be proactive rather than reactive.**

With regard to this, an important outcome of this work has been the interest it has created in those who participated to cooperate with research and consultation in the future. Twenty people volunteered to take part in more in-depth interviews and 12 people said they would like to join the CHAWREC Consultation Panel. **This meets one of the objectives of the work which was to re-open a dialogue with BAME Communities and needs to be acted upon.**

[4] A useful tool first developed for people with learning disabilities to help them communicate with health professionals. can also be adapted to assist where communication is difficult due to limited English skills

10 RECOMMENDATIONS

Addressing the language barrier

- The Language barrier to accessing services needs to be urgently addressed. Systems which have a complex unsupported lead in are particularly difficult for someone with poor language skills to access.
- Any guidance, Covid-related or not, needs to be available in several languages and widely distributed to different groups

Knowledge of vulnerabilities and health conditions

- The study indicates that there are gaps in knowledge about who is vulnerable and what those vulnerabilities and needs are in BAME Communities. This requires further investigation so that service providers can reach these people perhaps by developing a Vulnerable Persons Register.

Improving communication

- Emergency planning needs to take place with partners to ensure that important Public Health messages and offers of financial support are transmitted early in languages and via mechanisms that BAME Communities are likely to access.
- It is important that these messages are unified and given by someone in authority to give them gravitas.
- CHAWREC needs to develop better channels of communication with BAME Communities. Ideally as a response to the Covid outbreak a team should have been able to ensure that Communities had information in a language they could understand followed up by either a remote conversation or a knock on the door just checking that the information had been received and understood.
- Early work has begun developing networks of communication using Whatsapp to deliver translated materials to different communities. This needs to be further developed as does the acquisition of new technologies so that we can teach and inform remotely without people coming into the Centre.

Investigating what's not working

- This work has only skimmed the surface of respondents' experiences when they engage with health services. These experiences need to be more fully investigated to understand which practices and systems would help to improve access and understanding. Further research speaking to families directly would help or perhaps a project where people having difficulties accessing services can report this to a single officer who can investigate what the problem has been in order to gather data on what's not working.
- In addition a retrospective look at hospital and GP complaints from BAME Community Members might also highlight common problems. A GP system for example that flags up, before the patient arrives, that they might need an interpreter.
- Alternatively a Public Health worker either funded at CHAWREC or seconded from the Local Authority could have a specialist role working with Communities to more fully understand their experiences and report back on strategies which could help.

Consultation

- A **full consultation programme** on different aspects of access to health services should be organised to take advantage of the interest generated by this work. CHAWREC could assist with this building on the interest generated by this study.

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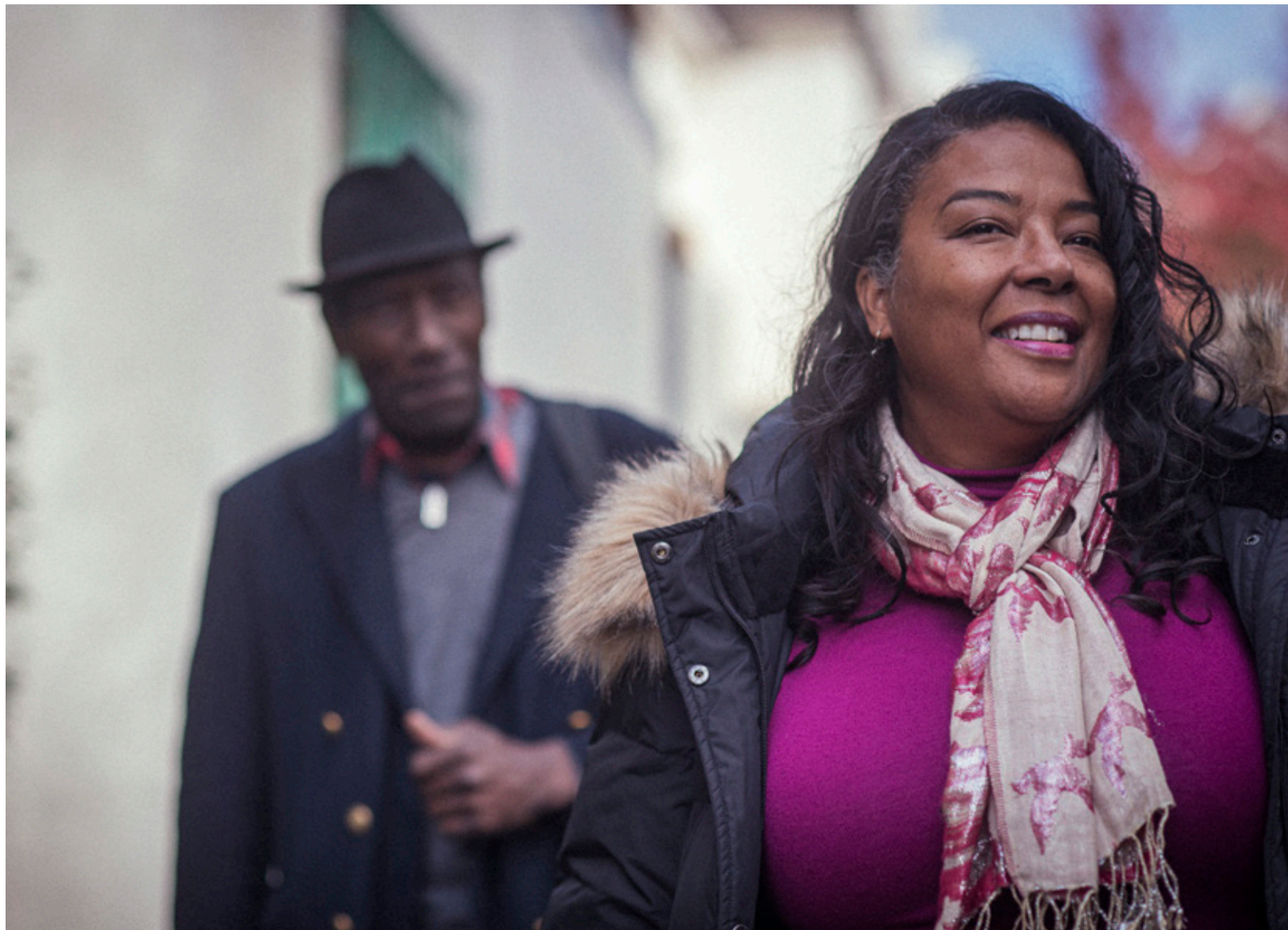

12 FREQUENCY TABLES

SOURCE OF DIFFERENT DATA TYPES

Table 1 Data Sources

Source	Number
E questionnaires via Facebook link	28
Postal questionnaires	7
Telephone interviews	11
Questionnaires distributed by community members	11
Discussions with community members	11
Small group work with Tutors	4

CHARACTERISTICS OF THE SAMPLE

Table 2 Gender Profile Of Respondents

Men	Women	NR
30	26	1

Table 3 Age Profile Of Respondents

Age band	Number
16-20	3
21-30	7
31-40	21
41-50	9
51-60	4
61-70	8
71+	4

Table 4 Ethnicity Given By Respondents

Ethnicity	Number
Arab	13
Turkish	4
Bangladeshi	14
Pakistani	3
Indian	6
Any other Asian background	4
Black African	5
White and Black Caribbean	1
White and Black African	1
White and Asian	1
Any other Mixed/Multiple Ethnic background	2
Any other white background	1
Nil response	2
TOTAL	**57**

Table 5 Where Respondents Live

Postcode	Number
Ch1	8
Ch2	12
Ch3	10
Ch66 (Ellesmere Port)	14
Ch4	3
Ch15 (Blacon)	3
WA6 (Warrington)	2
CW (Northwich)	1
Other L8 (Liverpool) and W9 London	2
Nil response	2
TOTAL	**57**

Table 6 Length Of Time Living In The Uk

Length of time	Number
Born here	17
1-5 years	10
6-10 years	1
11-20 years	9
21-30 years	10
Over 30 years	9
Nil response	1
Total	57

Table 7 Languages Spoken

LANGUAGE(S)*	NUMBER
English	37
Bengali	13
Arabic	20
Hindi	2
Turkish	4
Other	7
Nil response	1

*34% of the sample cited more than one language

HOUSING

Table 8 Respondents By Housing Type

House	Flat	Nil Response
45	9	1

N=55

Table 9 Number Of Beds In Respondents' Homes

1	2	3	4	5	6	7	Nil Response
5	8	27	8	5	0	2	1

N=56

Table 10 Number Of Bathrooms In Respondents' Homes

1	2	3	4	5	6	Nil Response
38	10	6	1	0	0	2

N=57

Table 11 Respondents' Homes By Ownership Type

Owner Occupier	Family ownership	Privately Rented	Housing Association	Nil Response
19	8	8	20	2

N=57

Table 12 Respondents' Household Size

1	2	3	4	5	6	Nil Response
1	2	3	4	5	6	Nil Response
7	5	6	13	15	6	2

N=54

Table 13 Does The Property Have A Garden?

Yes	No	Nil Response
46	9	2

N=57

HEALTH AND SOCIAL CARE

Table 14 Communication With Doctor

Good	Bad	Nil Response
39	13	5

N= 52

Table 15 Health Conditions Cited By Respondents

Diabetes health	Mental skeletal condition	Muscular/ problems problems	Heart problems	Respiratory	None cited
8	3	1	2	2	24

N=

Table 16 Use Of 111 Service

Not used	Used it	Nil Response	
28	20	9	
N= 48			
Never heard of it	**Easy to use**	**Very useful**	**Couldn't use because of language barrier**
9	12	5	3

Table 17 Methods Of Accessing Medical Help In Lockdown

Video call	Phone call	Visit to GP	Visit to A&E	999 call	Nil Response
3	14	2	2	2	6
N=31					

EXPERIENCES DURING THE PANDEMIC

Table 18 Contact With The Virus

I believe I have had it	Yes I have had it or someone close to me has	No I have not had it	Nil Response
5	11	32	9
N=48			

Table 19 Knowing Someone Who Has Died

Yes	No	Nil Response
10	39	8
N=49		

Table 20 Number Of Respondents Shielding

Yes	No	Nil response
16	33	8
N=49		

Table 21 Number Of Respondents Shielding Themselves

Yes	No	Nil response
4	25	7

Table 22 Number Of Respondents Shielding Others

Yes	No	Nil response
11	36	8

Table 23 Reason For Shielding

Received a letter	Can't remember /I'm not sure	Decided based on information available to me/them	No letter received
13	7	6	

Table 24 Judgment On Amount Of Media Coverage

Too much	Too little	Perfect amount	Nil response
26	7	15	9
N=48			

Table 25 Respondents' Recollection Of The Public Health Message

I can remember everything perfectly	I remember some things	I don't remember anything	Nil response
30	15	2	10
N=47			

Table 26 View Of Public Health Message

The message is confused	The message is too complicated	The message is clear	Nil response
26	7	16	8
N=49			

Table 27 Knowledge Of Symptoms

I would know what the symptoms were	I would not be confident that my knowledge is right	I wouldn't really know	Nil response
18	14	16	9
N=48			

Table 28 Knowing When To Get Help

Yes	No	Nil response
25	23	9
N=48		

Table 29 Respondents' View Of How Dangerous Covid-19 Is Compared To Seasonal Flu

Less dangerous	The same level of danger	It is more dangerous	It is much more dangerous	Nil response
1	9	23	17	7

N=50

Table 30 Where Respondents Heard The Public Health Message About Covid-19

Family and friends	Social media	The News	Word of Mouth	Letter /text from GP	Nil response
15	29	33	7	1	6

N= respondents could cite more than one source

Table 31 Covid Safe Behaviours Identified By Respondents

Increased hygiene	Wear a mask	Stay at home	Limit contact with others	Sanitise	Do nothing	Nil response
8	21	28	9	3	2	5

N= respondents could give more than one answer

MENTAL HEALTH AND WELL BEING

Table 32 Are You Worried About The Virus?

Very worried	Somewhat worried	Not at all worried	Nil response
19	26	3	12

N=45

Table 33 What Are You Worried About?

Type of worry	Number
Loss of Freedom	5
Loss of Life	24
Loss of Income	3
Having to change behaviour	3
Loss of a Future	15
Nil response	7

N=50

Table 34 Are You Worried About Others?

Very worried	Somewhat worried	Not at all worried	Nil response
35	11	2	9

N=48

Table 35 Coping Mechanisms During Lockdown

None	Play with the children	DIY/Painting/ gardening	New hobby	Exercise and walking	Nil response
21	2	6	7	6	15

N=42

Table 36 Self Assessment Of Mental Health In The Last Week

	Not at all	Several days	More than half the week	Nearly every day	Nil response
Little interest in doing things	6	14	15	11	
Low mood and depression	6	18	13	8	8

WORK AND FINANCE

Table 37 Financial Position Before And After Lockdown

	Comfortable	Stable	Fragile	Desperate	Nil Response
Before	11	29	4	1	12
After	10	20	13	2	9

N=45

Table 38 Respondents By Occupation

Occupation	Number
Retired	7
Employed- manual	10
Employed- non manual	10
Self employed	1
Homemaker	5
Unable to work*	10
Looking for work	2
Student	1
Nil response	11

*all of these respondents currently learning English so that they can work

N=46

Table 39 Work Situation During/Post Lockdown

Work situation	Number
Retired	7
Homemaker	5
Unable to work	10
Looking for work	2
Furloughed	5
Lost my job	3
Working from home	5
Going to work as normal	13
More hours	4
Nil response	3

N=54

Table 40 Did You Access Any Financial Help During Lockdown?

Yes	No	Nil response
9	36	12

HATE CRIME

Table 41 Number Identifying Hate Crime

Yes	No	Nil Response
25	23	9

Table 42 When Did This Occur?

Experienced in the past	In the last 12 months	In the last 4 months
7	13	5

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