Coronavirus and the Impact on the BAME Population of Hastings and St Leonards-on-Sea

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Introduction

This study and subsequent report aims to focus on assessing awareness of the personal risks faced by the BAME population living in Hastings and St Leonards on Sea in the context of the current COVID-19 pandemic. We also aim to acknowledge how these challenges have existed for many years and to establish the connection with the increased risk of infection.

The increased negative impact and risk of the COVID-19 infection on the BAME communities is still being understood and assessed by government, health services and academics. However, the Marmot Review (Marmot et al., 2020) highlighted that people living in deprived areas and those from a BAME background were not only more likely to have underlying health conditions because of their disadvantaged backgrounds, but they were also more likely to have shorter life expectancy as a result of their socioeconomic status.

Where you live, what you can afford to eat, how much green space you have, how much exercise you are able to take, and the impact of poverty and racism all play key roles in health outcomes.

Where the health issue relates to infection, BAME community members are more likely to be in higher risk vocational sectors of employment with far less opportunities to exercise choices to keep themselves safe by, for example, working from home.

The Runnymead Trust report "Over-Exposed and Under-Protected" June 2020 concluded that:

"…pre-existing racial and socioeconomic inequalities resulting in disparities in co-morbidities between ethnic groups have been amplified by COVID-19. Our survey findings unequivocally show that COVID-19 is not just a health crisis; it is also a social and economic crisis" (pg. 2)

"…the ability to cope, to protect and to shield oneself from coronavirus is vastly different for people from different ethnic and socioeconomic backgrounds." (pg. 2)

Through long-term local engagement activities and direct service user experiences, the health challenges and inequalities faced by the BAME communities in Hastings and St Leonards pre-COVID 19 were already an area of concern. Progress has been made to address these issues through local NHS equalities programmes, targeted engagement activities and efforts to improve understanding and removal of barriers to access help and advice for those from a BAME background. A key tool has been the development and maintenance of strong and lasting community relationships.

Hastings Voluntary Action has been involved for many years with work around equalities, race relations, improving access to services and health outcomes for BAME communities. It has provided extensive support to local BAME/Black-led organisation such as Hastings Mosque, the Bangladeshi Association and the Hastings Intercultural Organisation. It has also been part of the development of a number of studies, strategies and needs assessments for the BAME communities living in Hastings and St Leonards on Sea.

Executive Summary

Research Rationale

- To consider the causes, understanding and awareness within the BAME community of Hastings and St Leonards of the increased risk they faced from COVID-19
- To begin to consider the effect of increased risk of COVD-19 on the BAME community based on their pre COVID-19 experiences of using NHS services
- To look at the formal and informal networks and the sources of influence within the BAME communities

Methodology

- Development of a 14-question questionnaire
- Face-to-face interviews
- Creation of a project "Challenge Panel" made of key local stakeholders and academics partners

Limitations

- Limited development and delivery time
- Reduced opportunity for large scale engagement due to operational restrictions due to COVID-19
- Low infection rates of COVID-19 within Hastings and St Leonards

Key Findings

- The BAME communities within Hastings and St Leonards do not see themselves as a single homogenous group making the development of a single engagement strategy very difficult
- The term BAME itself creates a barrier to effective engagement
- Past direct experience of using NHS services has affected trust
- Stigma of being diagnosed with COVID-19 potentially prevented accessing support and advice
- Risk of infection from COVID-19 within BAME communities increases/decreases in line with socioeconomic factors i.e. poverty, unemployment, education and immigration status, more so than with ethnicity
- Community leaders and influential sources of information within communities are not easy to identify but are critical to reach to bring about effective change
- Effective engagement was hampered due to previous BAME engagement strategies and/or targeted health awareness raising activities that did not bring about lasting change or ended without proper feedback/community consultation

Summary Recommendations

- To critically assess previous reviews, assessments and reports on BAME access to NHS services and effectively report back to the community on results
- To support and train all frontline NHS staff to ensure fairer and better access for BAME patients
- To strengthen relationships at a grassroots community level
- To utilise new methods of online contact/engagement through social media but to acknowledge that not all communities will be able to use these due to cost, capacity and knowledge
- To develop closer working relationship with industries/local employers where there are more BAME workers

Methodology

The methodologies used were adapted to ensure maximum reach and ease of access to the questionnaire. This includes using a targeted approach relying on the community engagement resource within Hastings Voluntary Action (HVA) as well as direct access to the service users of the Links Project drop-in whose clients are asylum seekers, refugees and migrant communities living in East Sussex.

There was an emphasis on the use of interpreting/translating support to ensure fair and wide reaching representation.

We adopted a qualitative method involving semi-structured interviews with 15 participants from a number of ethnic minority groups.

The effect of the lockdown on access to and being able to have meaningful face-to-face contact with the relevant population in Hastings and St Leonards was a significant challenge for this study.

The following methodologies were used:

- Development of a 14-question questionnaire aimed at gathering experience of using NHS during the Coronavirus pandemic as well as to gather experience of accessing NHS for other non-CV19 reasons.
- Face to face assistance to complete the questionnaire during the weekly Links Project drop-in session
- One to one interviews with 15 individuals carried out by HVA staff and volunteers
- Development of a "Challenge Panel" to review results and develop recommendations.

  Members of the panel are:

  - Alex Ntung - is a PhD researcher at the School of Politics and International Relations at the University of Kent, UK. He is investigating the interplay between religious beliefs and modern politics in the Democratic Republic of Congo (DRC). Author of Not My Worst Day, a fellow of the Royal Society of Arts, a professional member of the UK Expert Witness Institute, and a DRC political and security analyst. Alex has been involved in political mediation for civil society organisations in conflict-affected areas, for which provides insights into issues of war, security, and cultural insensitivity in conflict resolution. Alex was born into a family of cattle herders, semi-nomadic, pastoralist people in South Kivu in the DRC.
  - James Johnson - Retired. Background in social work and mental health management. Visiting lecturer and mentor to Black students Brighton University. Trustee, HVA and member of the Sussex Police Independent Advisory Group (Strategic and East Division).
  - Dr Daniel Burdsey - a sociologist at the University of Brighton. His research explores the relationship between racism and place, especially in non-urban

environments (such as coastal and rural locations) and non-traditional sites of immigration.

- Steve Manwaring – Director of Hastings Voluntary Action. His research has focused on a number of key areas including HIV/AIDS, access and shared care arrangements, Community Resilience. Steve currently chairs the Hastings COVID 19 Community Response Hub

Data received from the questionnaire has been statistically analysed using Survey Monkey.

Result from the one to one interviews assessed by report author.

Due to the lockdown restrictions and operational changes to service delivery, the opportunity to carry out interviews in person was problematic. For example, no community venues were available to hold group discussions involving more than four people. We also struggled to find willing participants to agree to meet face-to-face in groups and so the decision was to taken to focus on single person interviews.

Our intention is to hold the group discussions at some point in the future as all the face-to-face contact we managed to have gave very useful and important results.

Although there has been a significant increase in the use of online discussions platforms, i.e. Zoom etc. the short timescales for the engagement activities for this study meant that this restricted the opportunity to use this medium due to access, knowledge/skill and limited funds of participants to pay for data. The challenges around effective engagement are also included in the recommendations.

Demographics

Hastings (and St Leonards on Sea) is a seaside town on the South Coast of England approximately 50 miles south of London. It has 16 electoral wards and has a population of 92661.

Hastings and St Leonards is ranked 13th in the Indices of Multiple Deprivation and has two wards in the 1% most deprived LSOAs in the UK.

61% of the population are of working age (16-64), 19% aged 16 or under and 20% aged over 65.

In the 2011 census, 94% of those who responded gave their ethnicity as White (British, Northern Irish, White Irish and other White). 2% recorded their ethnicity as mixed heritage and 4% as Black, Arab or Asian. For the purposes of this report into the risks faced by the BAME community with consideration given to skin pigmentation, the relevant population is approximately 3706 individuals (men, women and children).

Anecdotally, there are wide ranges of nationality groups within the town but there is no single “largest” group by ethnicity.

Hastings has operated as an asylum dispersal area since 1999, which has brought in a very wide range of nationalities to the town. Some of these individuals chose to settle here once their asylum applications were determined. The largest of these groups are Kurdish (Iraqi and Iranian), Albanian and Chinese. There was already an established Bangladeshi

community in the town and there are a number of African nationality groups including Zimbabwean, Congolese, Nigerian, Eritrean and South African.

Within Hastings, there are a small number of communities of shared interest that have a significant proportion of their membership from BAME groups. These include the Hastings Mosque, FACE (Friends of African and Caribbean), HopeG and the Bangladeshi Association. There has been no single BAME representative group since the Hastings Intercultural Organisation (HIO) ceased to exist.

Results and Key Themes

The questionnaire results were broken down and assessed in four categories:

1. User data
    a. Ethnicity
    b. Location
2. Experience/knowledge of CV19
    a. CV19 status
    b. Using the NHS specifically for CV19
    c. Experience of using the NHS for CV19 and/or reason for not accessing the NHS for support
    d. Source of information about CV19
    e. Risk of being infected with CV19
3. Information received about potential increased risks to BAME population
4. Experience of using general NHS services
    a. Using NHS for non-CV19 related issues during lockdown
    b. Experience of using NHS for non-CV19 issues

The overall response to the questionnaire (53 responses) was slightly lower than hoped but it was felt that the responses represented a wide enough range of the various BAME communities within in the town based on HVA/The Links Project; this is supported by the available ethnicity data.

We completed 15 face-to-face interviews that were based on an open discussion around four questions:

- *Have you or any of your family had Coronavirus?*
- *Where do you get information on how to protect yourself from Coronavirus?*
- *Did you know that some ethnic groups have a higher death rate from Coronavirus?*
- *What would you like in place now so you and your family feel safe and protected as possible*?

Some of the longer free text responses from the questionnaire have been consolidated with the face-to-face interview results.

Questionnaire Results

1. *User Data*

a. *Ethnicity*

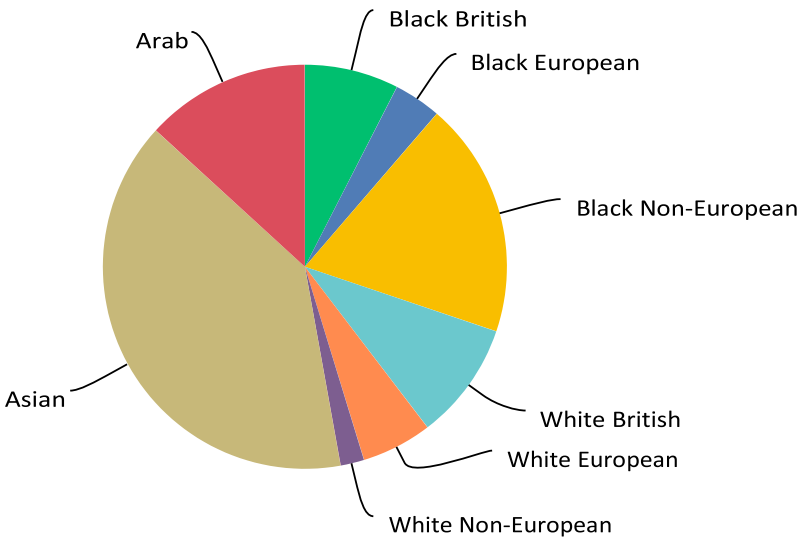
Figure 1. below, gives a breakdown of the ethnicity of the participants that completed the questionnaire.

The ethnicity categories used within the questionnaire were simplified although still based on standard categories used in surveys, questionnaires and public engagement activities. It should be acknowledged that there could be a cross over between the groups "Asian" and "Arab" from a geographic perspective.

The overall response was reflective of the known existing ethnicity groups within the town as captured through the 2011 Census, attendance statistics of the Links Project drop-in and HVAs engagement activities

Leading up to and during the active engagement period of the research, it became obvious that term "BAME" was being met with some confusion but also resistance. This resistance was based on the unjustified need for there to be a category to define non-whites as a single homogenous group, which it is not. Although this result is not relevant for the purposes of this study, it was felt important to capture and will form part of the recommendations.

Q1 Which cultural group do you identify with?



ANSWER CHOICES	RESPONSES	
Black British	7.55%	4
Black European	3.77%	2
Black Non-European	18.87%	10
White British	9.43%	5
White European	5.66%	3
White Non-European	1.89%	1
Mixed Heritage	0.00%	0
Asian	39.62%	21
Arab	13.21%	7
TOTAL		53

b. Location

64% of responses came from postcodes TN37, and TN38. These postcodes include Central St Leonards and Hollington both of which can be found in the top 13% of deprived areas in the IMD.

TN34 received 21% that covers Hastings town centre, Broomgrove and Ore. These also include LSOAs included in the top 13% most deprived.

TN35 had 9.6% responses that covers Old Town but also areas out of Hastings.

The location information matches exiting data of the postcodes for Hastings/St Leonards with lower quality more affordable housing which are also areas where the majority of BAME communities live.

2. <u>Experience/Knowledge of CV19</u>

a. CV19 Status

90% of those who responded to the question about their Coronavirus status did not have any symptoms and were not tested. There was only one individual who had symptoms and was positively tested for CV19.

b. Using the NHS specifically for CV19

26% tried to get specific help from the NHS about CV19 either about themselves or family members.

c. Experience of using the NHS for CV19 and/or reason for not accessing the NHS for support

71% reported specific CV19 support provided by the NHS as being either adequate or good.

28% reported that their experience was poor or very poor.

83% responded that they did not feel the need to go to the NHS for CV19 specific enquiries

3% responded that they did not got go to the see their GP as they previously had had a bad experience

8% were unable to get an appointment with their GP

d. Source of information about CV19

81% responded that the internet was the main source of information

57% said UK television and/or radio

48% Friends and family in the UK and 40% friends and family outside the UK

e. Risk of being infected with CV19

47% believed that they were high risk of being infected and 56% believed they were low risk.

Responses explaining high-risk status included:

"*I work in the health sector"*

"Because other people don't use masks and use precautions"

"Age ethnicity medical conditions"

"Racial background and type 2 diabetic"

"The media says I am"

"I am black and disabled"

"I'm foreign"

3. *Information received about potential increased risks to BAME Population*

   76% felt that they had been given or had enough access to information to keep themselves and their families safe.

4. *Experience of using general NHS services during the lockdown*

   48% used the NHS for non-COVID medical issues and 90% of these were to see the GP. 22% to access secondary/hospital care. 4% used the dentist. No other health services were accessed by any of the respondents i.e. maternity, sexual health or mental health support.

   52% felt that the response they got was good or very good and 25% felt that the response was poor or very poor.

   Free text response of experiences included:

   "*My wife who has dementia was not examined before diagnosis of urinary infection and had 3 failed antibiotic treatments…Not good. So very mixed."*

   "I got a phone call and was told not to worry"

   "They guess what you have as telephone consultation was not thorough enough and superficial"

   "My appointment was cancelled and I have not been able to get another one"

   "I only got one phone call and did not understand"

   "It will take too long"

Face-to-Face Interviews

We carried out 15 face-to-face interviews in the following languages

- Russian (x1)
- Arabic (x4)
- Tigrinyan (x3)
- English (x5)
- Kurdish Sorani (x1)

- Farsi (x1)

The ethnicities of the interviewees were:

Eritrean, Russian Federation, Syrian, Iraqi, Bangladeshi, British and Chinese

Conversations were wide ranging and started with a question about current and past CV19 status. However, none of the participants had direct experience of having the virus. It is worth mentioning that there remain very low infection rates in Hastings, which is somewhat anomalous and will likely require further study.

Main discussion topics were:

- effectiveness of messaging from Central Government and NHS/other "official" sources
- general experience of using the NHS as non-Whites
- differences between white and non-white communities

Central Government messages were largely felt to be contradictory and mixed. All of the participants said they watched the BBC News of the government briefings. However, all broadcast discussions and briefings were delivered in English, which meant that translations needed to be sought from other members of the household or community. It was acknowledged by two of the participants that this often resulted in an "interpretation" of what was said where the meaning could be changed especially when the messaging was contradictory.

Only one of the participants was aware that their ethnicity could make them more of risk of infection. None of the participants had received any official information directly about personal risks due to ethnicity. Two of the participants said that this interview was the first they were aware of increased risks due to skin pigmentation.

In the discussions with participants where English was not their first language, there was unanimous agreement that this continues to be a major challenge and barrier when accessing health care not just during the pandemic.

Although access to interpreters for GP appointments has improved, there was still an element of embarrassment to ask for an appointment with one but also one of the participants said they were made to feel that they were being "difficult" by asking.

Two of the participants said they received different treatment to white patients when they spoke with white friends and shared/compared their experiences.

The biggest challenge (pre-CV19) for those without English as a first language was with engagement with practice/administration staff and not necessarily medical professionals. However, there was an example given where a GP was using "Google Translate" during an appointment.

Booking GP appointments during lockdown became more problematic for those without English as a first language especially when asked to explain the reason for needing an appointment, or requesting an interpreter for a phone consultation. One participant said this made them only ask for help only when absolutely necessary and the thought of contacting the GP for reassurance about CV19 risks was dismissed.

There was an awareness of the risks specifically faced by the BAME community by some of the participants although again, information on this was largely delivered in English. Technical details about risks associated with skin pigmentation/Vitamin D levels were not well known, even by those with English as the first language.

Some key quotes:

"White *British culture is more reserved when compared to most Black cultures. We visit each other's homes more, we are more tactile and we share everything with friends and family"*

"Black people do all the jobs that white people don't want to do"

"I worked as a carer for many years and even then we are understaffed and under-supported. I have heard from old colleagues that they were not being given any protection equipment during the lockdown – I'm not surprised they were infected more"

"Reading up, it seems BAME backgrounds disproportionately affected (although how much this is due to living/working conditions as opposed to genetic factors/vit D am unsure. I am a keyworker as is my husband, so risk of exposure greater. However, am lucky that I don't need to use public transport or live in multi-generational home"

"I had a job in a restaurant but I was furloughed and then quickly made redundant – a lot of my friends lost their jobs as well and some even lost their homes. One friend does not have any papers – I do not know what he will do."

"I have felt very isolated and lonely during the lockdown. I have not been able to pray or see my friends."

"I am confused why you want to know my ethnicity. When can I be just "British"?"

The overall experience of the carrying out face-to-face interviews was very positive and as mentioned previously in the report, there is an intention to facilitate group discussions in the future. The topics raised by the participants were challenging and included some anger as to why there was a need to do more engagement work when previous similar activities either ended without results or brought about no change. As mentioned above, the term BAME was confusing for some. The differences between participants were more pronounced when considered through socio-economic factors rather than ethnicity and it would have been useful to explore these with groups.

Level of English spoken, employment conditions, housing, income and immigration status all had an impact of impact, perceptions and awareness of CV19. Economic factors had a significant impact on risks taken and as a consequence increasing the chance of infection. One participant had just completed a 70-hour working week as a carer, which left little time to rest and eat let alone watch governmental briefings or to make technical considerations of risk of infection.

Conclusions

This was a small-scale piece of research put together in a relatively short period of time. The strength of the study was being delivered in a small geographic area by a trusted CVS and local project allowing us to reach into and engage with the BAME communities in a way that made them feel comfortable to give honest answers. 95% of those who completed the questionnaire and 100% of the face-to-face interviews were from the target group.

Although ethnicity was common amongst the participants in that they were all "non-White", what we found were that the factors that consistently increased risk were poverty, education and experience of life in the UK. Those with English as a first language or who had worked long-term in the UK were on the whole more informed about the risks of COVID-19 on the BAME community. They also tended to live circumstances that meant they could manage the risks more safely.

What came out very obviously in the face-to-face interviews, as well as the free text answers in the questionnaire, was that the strongest connecting factor between all participants was experience of accessing health services as a person of colour. This experience was unanimously seen as different from those with white skin and subsequently felt to reduce the likelihood of using NHS services and in some cases trusting the advice/messages.

Resistance to the term "BAME" was obvious from the start of this piece of work especially in the face-to-face work. Although the term "BAME" has been used throughout this report, it should be said that for the majority of the participants, it was seen as a barrier that needed to be overcome before we are able to begin to achieve meaningful engagement.

There was also a lengthy discussion within the "Challenge Panel" about the use of the term "BAME". This included reference to the long running debate within academic circles over the need to have a single defining category for "non-white" that creates a group with no homogeneity. In addition, how the term "BAME" had been changed from "BME" without discussion and the negative impact this had on the engagement activities carried out for this report.

The stigmatisation of COVD-19 as a "BAME virus" needs to be avoided at all costs and it was agreed that this would be specifically highlighted within the report.

Recommendations

1. A commissioned critical literature review of previous race equalities, Comprehensive Needs Assessments and other research in East Sussex over the previous 10 years
2. NHS to work with local employers around COVID-19 awareness raising but in particular looking at the caring profession, manual labour, hospitality and seasonal work industries to ensure that their most at risk staff members are fully aware of COVID-19 risks
3. Developing better/more effective first experience of contacting GP/Primary Care especially when English is not the first language i.e. appointment booking apps in languages, option to speak to an interpreter to book appointments.
4. Re-promotion of Bilingual Advocacy service to GPs and local communities
5. NHS partnership with HBC Housing to promote COVID-19 awareness to all residents targeting areas where higher proportions of the housing is occupied by BAME households
6. NHS Commissioners to work with CVS partners to look at developing better commissioning opportunities/strategies for local black-led community groups and organisations.
7. Working with public and voluntary sector partners to develop and test culturally competent community based engagement and/or culturally sensitive awareness raising activities.
8. Ensuring that equalities is at the heart of recovery work undertaken at a local level by public, private and voluntary sector partners.

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Appendices

Questionnaire

HVA CV19 Survey.pdf