Challenges to accessing healthcare services faced by ethnic minority women in Reading during the Covid-19 pandemic

Donna Ma
Hemamalini Sundhararajan
Reading Community Learning Centre

May 2022

Contents

1. Introduction

This survey was carried out by the Reading Community Learning Centre (RCLC) as part of the Community Participatory Research Project (CPAR), initiated and funded by Health Education England South East and developed in collaboration with the Office for Health Improvement and Disparities (previously PHE), the Scottish Community Development Centre and NHE England and Improvement.

The purpose of the survey was to identify challenges encountered by ethnic minority women in Reading when accessing healthcare services during the Covid-19 pandemic, and to review how they have been affected physically and mentally. We aim to use our findings to make recommendations and check if further research will be necessary.

The CPAR programme offered training and mentoring to over 40 individuals from minority ethnic communities in South East England, supporting them to carry out their own research projects into the impact of Covid-19 on minority ethnic communities as well as any related health and wellbeing issues.

RCLC is a charity organisation in Reading that has the mission to reach out and empower isolated and vulnerable women to develop their skills, confidence, welfare, inclusion, social status and independence through learning, support and friendship.

RCLC collaborated with other organisations in Reading on this project, some of whom pursued related areas of enquiry. Reading Borough Council (RBC) was the lead organisation in this project in partnership with Reading Community Learning Centre (RCLC), Reading Voluntary Action (RVA), Alliance for Cohesion and Racial Equality (ACRE) and University of Reading (UoR).

2. The focus of inquiry

Currently Reading has a population of 161,780, with 35% belonging to ethnic minority communities. The aim of our research is to promote good health, education, culture and wellbeing, to make changes in accessing health care services and reduce inequalities.

Covid-19 has worsened existing health inequalities, with ethnic minority communities having a disproportionately high rate of serious illness and mortality from Covid-19 when compared to the wider population as a whole.

A range of economic, social and cultural factors are likely to contribute to the disproportionate impact of Covid-19 on ethnic minority communities. Our research has explored some of these factors. For instance, we have been interested in how people receive and interpret messages, including how they are affected by language barriers. Furthermore, we have investigated how much trust ethnic minority communities have in government authorities and public health information. Cultural factors may play a role here, such as cultural beliefs and values.

The two community researchers of this project are also from ethnic minorities. They both have over 6 years of working experience and social contacts with ethnic minority women in Reading.

3. Research methods and challenges faced

The research methods that we have adopted are a survey, phone and personal interviews. 103 women responded to our questionnaire which was distributed personally and electronically. The English questionnaire was translated into traditional Chinese, simplified Chinese, Arabic and Kurdish versions. The questionnaires were handed to learners of RCLC through staff members and the tutors. The non-learners received the questionnaires via members and leaders of social and religious communities as well as educational institutions. Those who were unable to understand the questions in English could respond with the support from somebody in their families or an interpreter arranged by RCLC in one of the following languages: Tamil, Punjabi, Hindi, Mandarin Chinese and Cantonese, Arabic, Nepalese and Kurdish.

Those with a low level of English language tended to respond better to the questions verbally in their first language. In these cases, the interpreter wrote down their answers in English either in person or over the phone. It was a challenge for the participants from countries that have a different health care system to understand the questions in the first place. The interpreter sometimes needed to explain the question before he/she could write down the answer for them.

4. Participant profile

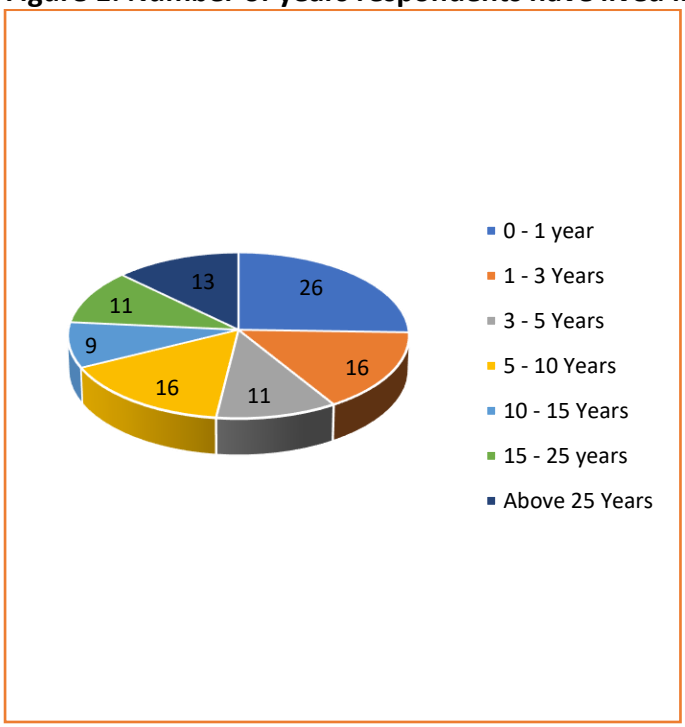
The survey covers a wide range of women from ethnic minority communities aged from under 25 to above 75. They came from 24 different countries, including China, Nepal, Pakistan, Bangladesh, Syria, Poland, India, Russia, South Korea and Kurdistan.

8 respondents out of 102 (8%) said they could not communicate in English at all. 53 (52%) rated their English (on a scale of 1-10) as 2-5; 31 (30%) rated their English 6-9; and only 10 out of 102 (10%) gave their English the highest rating of 10.

10 out of 101 (10%) lived on their own and the rest in a household of between 2-8 people. 35 out of 102 respondents (34%) said they were living with one or two children (defined as people who were under 18), 19 (19%) lived with 3-4 children, 3 (3%) had 5-6 children and 45 (44%) lived with nobody under the age of 18.

26 out of 102 people (25%) have lived in the UK for under a year and 34 (33%) for over 10 years (see figure 1).

Figure 1: Number of years respondents have lived in the UK



48% of the respondents lived in RG1, 18% in RG2 and 11% in RG6. The others spread all over the rest of Reading.

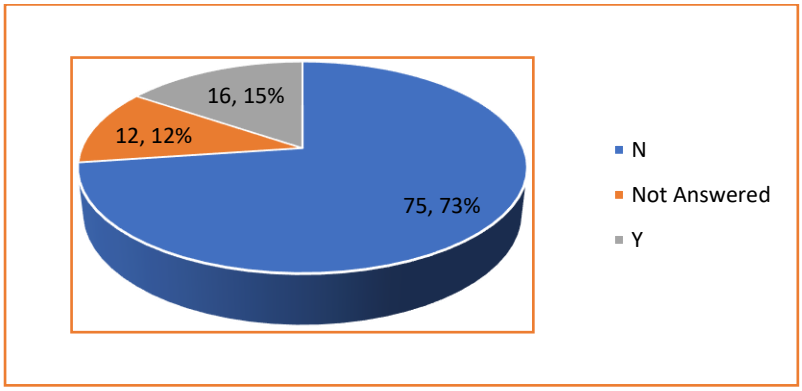
5. Findings

The key findings are presented below using charts generated from an excel spreadsheet. The total number of respondents varies slightly from question to question. This is a result of giving respondents the option of answering the questions they felt comfortable answering. Each question was answered by the majority of respondents.

5.1 Covid-19 and its impact

Figure 2 shows that 75 out of 103 respondents (73%) did not have anybody in the household who had tested Covid-19 positive. 16 people (15.5%) said someone in their household had tested positive. 12 people (12%) didn't answer this question.

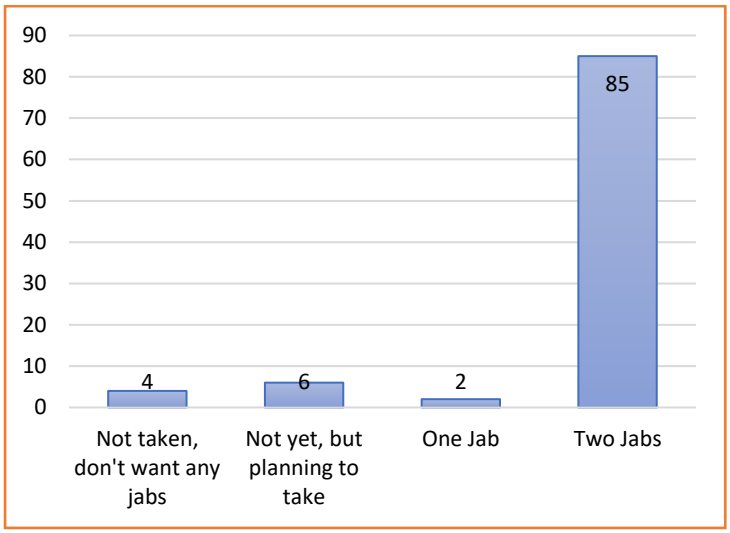
Figure 2: Whether or not anyone in the household of the respondents had tested positive for Covid-19



Out of the 18 confirmed cases reported, 10 were classified as mild, 5 bad and 3 very bad.

The research was conducted before the introduction of the 'booster' vaccination in the UK. Figure 3 illustrates that 85 out of 97 respondents (87%) said they had received two jabs. Only 2 (2%) had received one jab, and 6 (6%) had not yet taken any but they were planning to. 4 respondents (4%) said they didn't intend on being vaccinated at all.

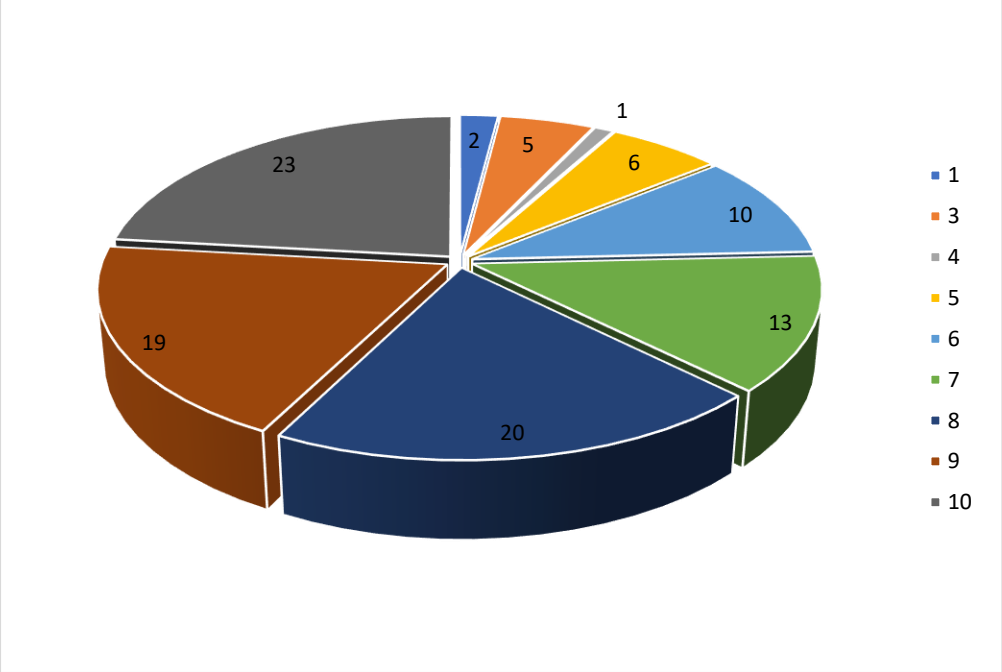
Figure 3: Covid-19 Vaccination status



A couple of respondents gave more detail on why they had chosen not be vaccinated, with one saying she avoided taking medicine in general. Normally she took it for only when it was urgent because she believed that she was fit enough to fight Covid-19. Another respondent thought she could protect herself without any jabs.

The survey asked respondents to indicate on a scale of 1-10 how well-informed they felt about the Covid-19 pandemic. Figure 4 highlights that the majority felt well informed with 85 out of 99 (86%) giving 6 or above, in contrast to 14 (14%) who gave 5 or below.

Figure 4: Knowledge level about covid-19 pandemic (1 not informed - 10 well informed)



The health of respondents was affected by Covid-19 in other ways in addition to the direct effect of the virus. For instance, 21 out of 99 people (21%) reported that their physical health had become worse during the pandemic. 26 out of 100 people (26%) said that their mental health had become worse during the pandemic.

Statements from participant's highlight some of the reasons people's physical and mental health suffered during the pandemic. For instance, some respondents found that, without their busy daily routines, it was difficult to get regular exercise, particularly in the first few months of lockdown when there were restrictions on being outdoors. As a result, some reported putting on weight and other health issues experienced by participants included stomach and skin conditions.

In terms of mental health, many found lockdown and social distancing measures difficult, with little social contact with friends and even family. This was particularly difficult for some ethnic minority women who described how they already felt isolated in the UK due to living alone or due to close family members living in other countries.

Another layer of stress and anxiety was created due to increased financial pressures. Many respondents and others in their households had been put on the UK Government's furlough scheme and had less income as a result. Some had lost their jobs, with one respondent reporting that it took 4 months to receive universal credit. Financial hardship created tension at home, made worse by being stuck indoors. One person also described how difficult it had been following the death of her father from Covid-19.

A few people mentioned positive impacts of the pandemic on health and wellbeing, including being able to find more time to exercise at home and go for walks, feeling loved and supported by family and friends and appreciating health more than before the pandemic.

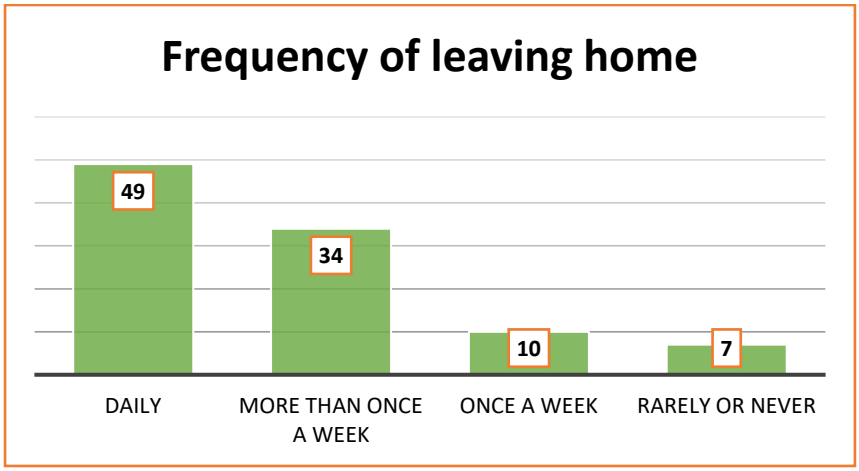
5.2. Connections outside of the home

Many ethnic minority communities place a great importance on connections outside the home, including social, cultural and religious gatherings. In addition, ethnic minority women can find themselves particularly isolated without these activities, due to some of the factors discussed in the above section.

For this reason, the survey asked women how frequently they left their home and also about what groups they interacted with. Figure 5 shows that 49 respondents out of 100 (49%) left home daily, 34 (34%) more than once a week, 10 (10%) once a week and 7 (7%) rarely or never.

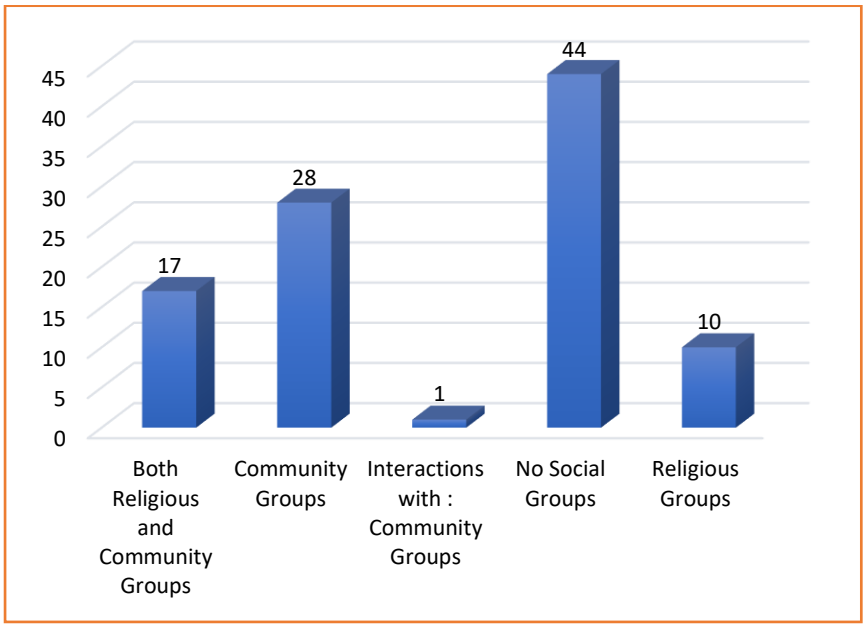
The reasons for going out included: school runs; taking children to the parks; walking for physical exercise; shopping; access to services, entertainments and restaurants; work (key worker in a supermarket); and English classes when the college was open. Some people said they only went out in their own gardens due to being vulnerable to Covid-19.

Figure 5: Frequency of leaving home



In terms of interactions with groups, figure 6 shows that 17 respondents (17%) said they belong to both religious and community groups. 28 (28%) selected community groups and 10 (10%) said religious groups. 44 people (44%) said they do not interact with any social groups.

Figure 6: Interactions with groups

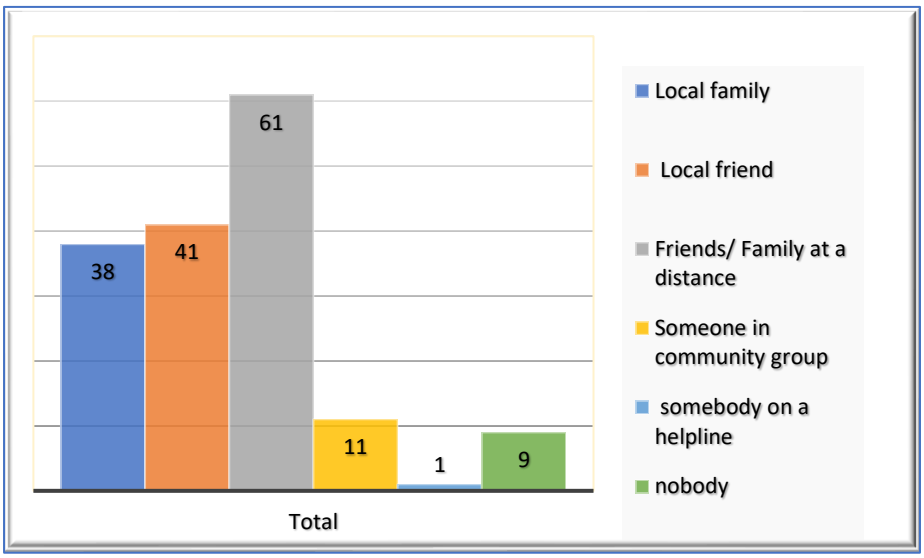


The data fits with what we know about many people from ethnic minority communities, and this form of group activity will have been largely missing during the Covid-19 pandemic.

The survey also asked respondents who they were able to talk with when feeling lonely, anxious or stressed. Figure 7 shows that a majority of respondents had at least one person they could talk to, with the most frequently selected options being friends and family (both

local and distant). However, 9 respondents (9%) said they did not talk to anybody when feeling lonely, anxious or stressed.

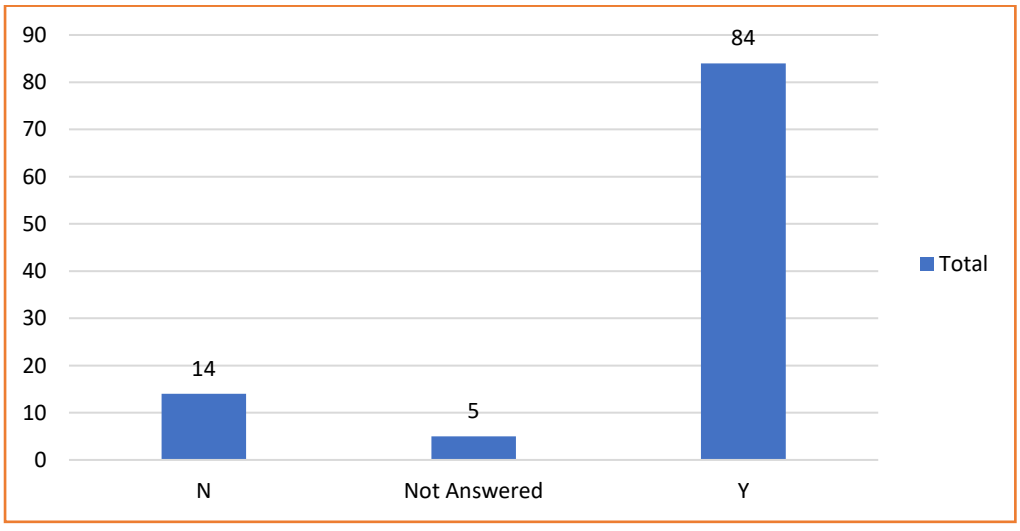
Figure 7: Who respondents talk to when feeling lonely, anxious or stressed.



Respondents were also asked what practical support they had received during the pandemic. Slightly less than 30% of the respondents said they received practical help or support during the pandemic from families, friends, community groups and social workers.

Online connectivity is another important way for people to maintain social contact, particularly during the pandemic when other forms of social contact were restricted. Figure 8 shows that 84 people out of 103 (81.5%) said they had access to the internet. 14 (13.6%) said they had no internet access, while 5 (4.9%) did not give an answer.

Figure 8: Internet access

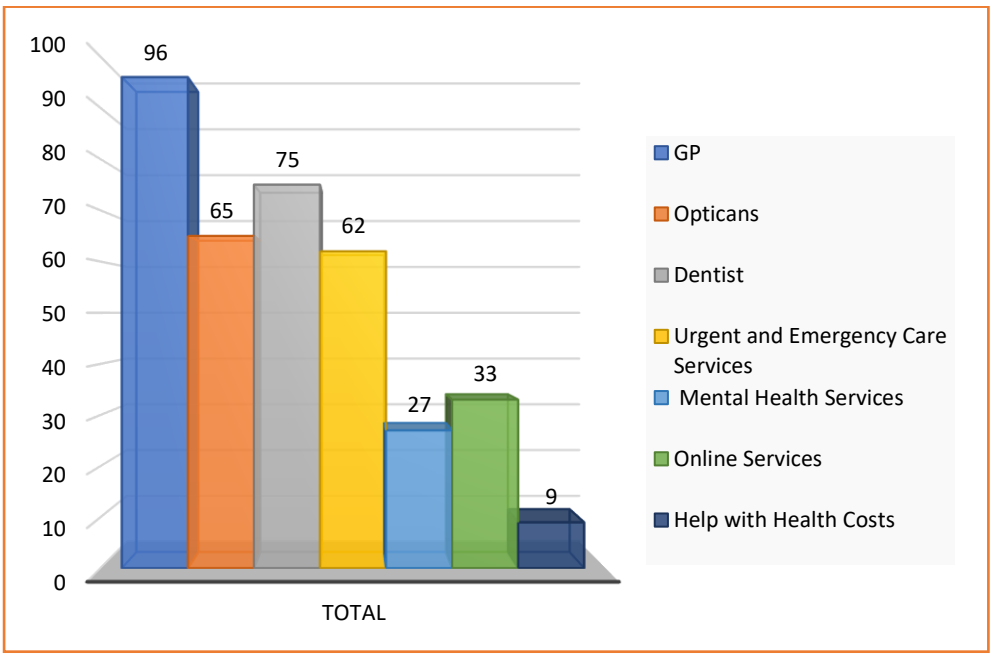


5.3 Barriers to accessing services

Ethnic minority communities are known to face a number of barriers when accessing services, and our survey sought to establish which barriers were faced by women from ethnic minority communities in Reading.

5.3.1 Awareness of services

Figure 9: Awareness of NHS services



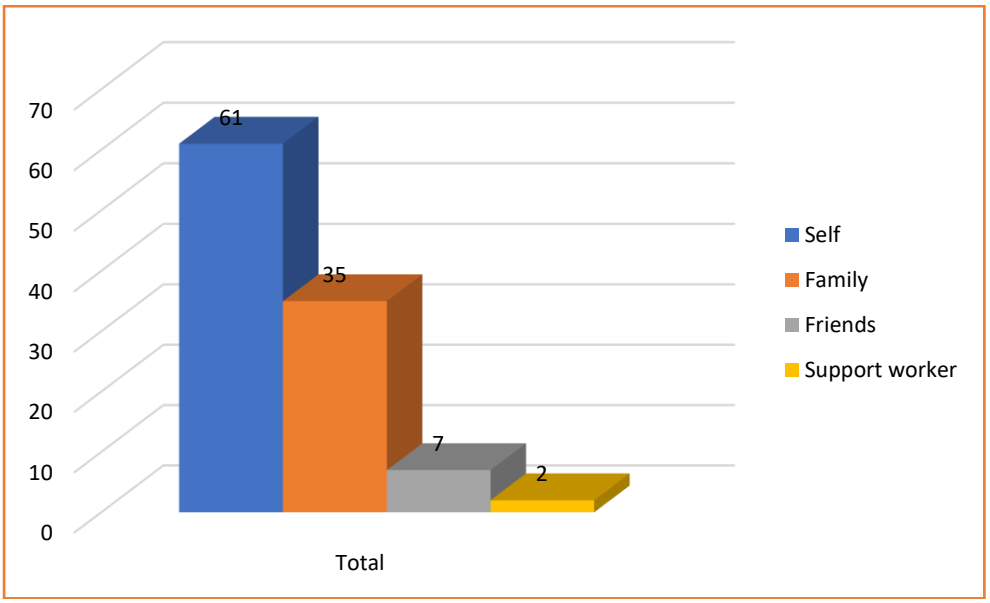
As illustrated in figure 9, almost everyone who responded was aware of the GP service. A majority was aware of the optician, dentist and emergency services. Online services, services to do with mental health and help with health costs were less recognised.

When asked which emergency numbers they were aware of, 88 respondents (85%) knew 999 and 77 (75%) knew 111, whilst only 51 (50%) knew 119.

5.3.2 Challenges faced when accessing GP

Just over half the respondents had visited the GP in the last 12 months.

Figure 10: Booking of GP appointment



As shown in figure 10, more than half of the respondents, booked their doctor appointments by themselves. Around a third did it through their family members. Only 7 people said they were helped to do this by friends and 2 by social workers.

Figure 11: Whether or not respondents avoided visiting doctor/hospital due to pandemic

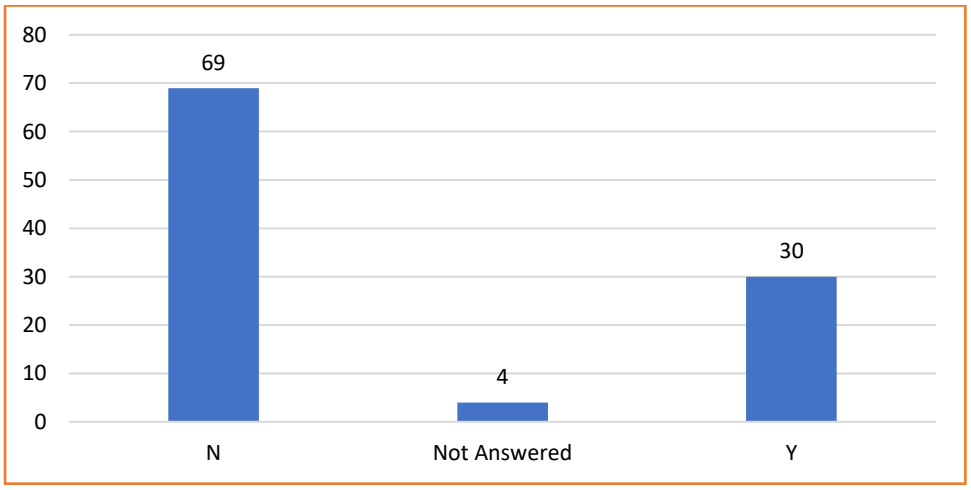


Figure 11 highlights that 30 out of 103 respondents (29%) said they had avoided going to the doctor or the hospital because of the pandemic, compared to 68 respondents (67%) who said they did not. 8 (3.9%) did not answer this question.

Figure 12: Whether or not respondents didn't contact GP despite having genuine requirement

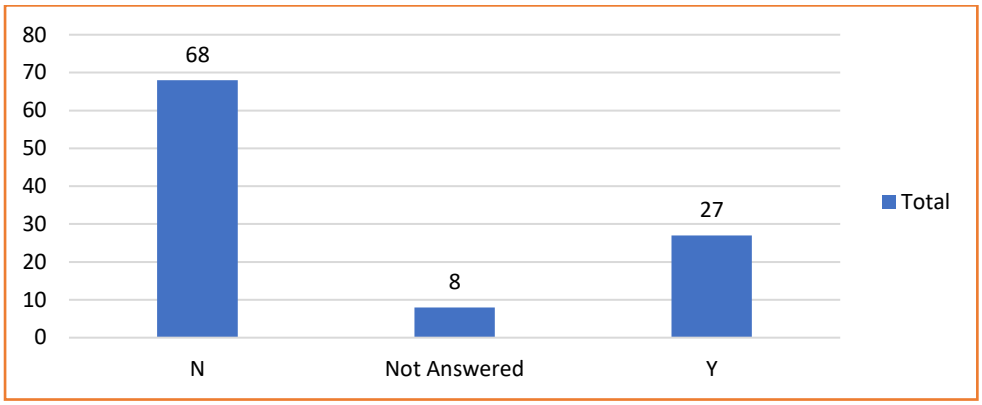


Figure 12 shows that 27 out of 103 respondents (26%) stopped contacting the GP even when they had a genuine requirement whilst 68 (66%) didn't. 8 respondents (8%) did not answer this question.

5.3.3 Reasons for being reluctant to contact services

Although most respondents were able to contact health and care services during the pandemic with relatively little difficulty, the proportion of respondents choosing not to, even though they had a health-related concern, is significant and concerning.

The reasons for this will be varied, but a reluctance to contact services may be tied in with uncertainty about whether to make use of services at a time of national emergency, such as during the Covid-19 pandemic. For instance, one person related that they were:

> *"feeling very stressed as not easy to make appointments to see the doctor and having medical examinations at hospital" (Interview respondent)*

One person also commented that they "prefer[ed]" seeing people in person rather than online meetings" (Interview respondent)

Issues of trust and fear are also important when it comes to being confident enough to contact services. Sometimes, a lack of trust stems from prior negative experiences. For instance, one respondent was charged for using maternity services because her visa application was delayed due to the pandemic.

5.3.4 Translation and interpretation

The responses to questions around translation and interpretation may shed some more light on why people have not contacted required health and care services.

Figure 13: Whether, and how, interpretation was arranged for GP consultation

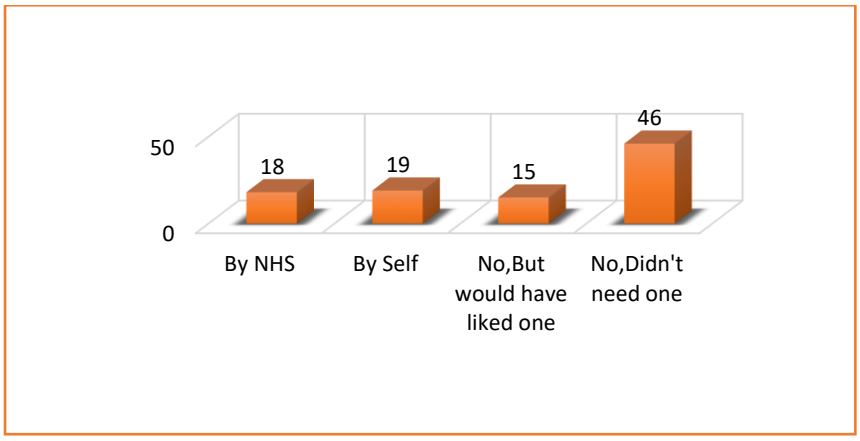


Figure 13 shows that 46 respondents out of 98 respondents (47%) didn't need an interpreter. 37 (38%) were arranged by NHS or themselves. 15 (15%) would have liked to have an interpreter.

Some respondents described this issue in more detail.

> *"Poor quality of translation service: imperfect and inaccurate"*
>
> *"Relying on translation by a family member could cause a lot of inconvenience"* [the daughter had to travel more than an hour to come to speak to the GP for a phone consultation]

The following case study, conducted as part of this research, illustrates how language barriers exacerbate other issues, including Covid-19, pre-existing health conditions and financial hardship.

Case study: MR

I am MR from Nepal living with my step-mum. I am a 66-year-old widow. During February 2021, I got affected by Covid, with the symptoms of digestion problems. These symptoms were very severe and I couldn't digest any food. I was admitted in Royal Berkshire hospital for one month and 26 days. I have difficulty in walking due to my ankle being operated twice in the past.

During the Covid treatment, I had the problem with understanding the English language when I was at the hospital. Sometimes a Nepali nurse talked to me but other times clinicians called my nephew to interpret on the phone. The language challenge also continued when I went for physiotherapy.

I was asked to come every day to the hospital for exercise as my lungs were severely damaged and I had to have a surgery. I was unable to travel on buses and had no one to take me to the hospital. I am on universal credit and could not afford the taxi, so I only visited 2 to 3 times a month using the taxi.

Mostly, I got help from friends and family members. Also, I received support from RCLC staff with booking GP appointments and coordinating with RVA, who provided me with a laptop for online language proficiency improvement classes. RCLC also supported me to register for Redibus (Reading Council provided bus facility) which I am using to visit the GP.

In summary, it has been very difficult due to limited mobility issues with COVID related illness and a broken ankle. I need help with shopping, transport to hospital, cooking and other household chores. Furthermore, language barriers are adding to existing difficulties of life.

5.3.5 Removing barriers

In addition to asking what barriers people faced, the survey asked respondents what could be done to help them access healthcare services. They were given a range of options to choose from, which were prioritised as follows:

- 50 people selected "translation support (face-to-face or on the phone)"
- 39 selected "longer opening hours for the health service"
- 36 selected "translated information on the services in your area"
- 33 selected "health care staff who understand your culture"
- 25 selected "better transport to the health services"
- 22 selected "reducing the cost or free travel to access health care"

The survey asked respondents how they would like to receive information about the health services they can access. The options provided were prioritised as follows:

- 69 selected “text messages”
- 48 selected “from the GP surgery”
- 22 selected “translated leaflets”
- 18 selected “websites”
- 6 selected “Facebook page”

6. Actions and recommendations for Reading Borough Council, NHS and Reading Community Learning Centre (RCLC)

6.1 Actions

- Encourage vaccination by inviting someone from the NHS to speak to ethnic minority communities in community or religious settings about the facts and the consequences.
- All partners should use a range of methods to provide information about health and wellbeing, including text messages, their website, social media and translated leaflets.
- Longer opening hours at GP surgeries would be beneficial to women from ethnic minorities.
- Assign more staff to answer the phone to shorten the waiting time on the phone when making an appointment at GP surgeries.
- Translated information about helpline numbers and how to use them should be made available.
- Better support and training for helpline staff to make this service more accessible and culturally sensitive.
- Shortening waiting times of hospital appointments will be beneficial.
- Face-to-face consultation should be an option for ethnic minority communities who face additional barriers to accessing services online or over the phone.
- Patients should be made aware that there are opportunities to express their views if they have been treated unkindly or indifferently.
- Translators supplied by the agencies must be qualified to ensure high quality of service.
- Prevention is better than cure. NHS staff could be invited to go to communities and religious groups to give information about common medical problems which may affect that group e.g. diabetes and hepatitis.
- Patients aged 60 and over should be provided with regular health check-ups and be made aware of the availability of these checks and how they can increase quality of life. This will involve efforts to remove the language barrier in communicating medical information.
- Awareness of NHS mental health services should be increased by publicising that this support system is available, especially to ethnic minority women.

- Interpretation services should be available to those who don't speak English as their first language. These should be available throughout a patient's journey, beginning at the moment they book a GP appointment.
- RCLC should be supported to continue to provide courses and activities to meet with the needs of the women of ethnic minorities e.g. IT course, Mindful Stress Management course, Psychological First Aid workshop, exercise classes, visit to the Museum of English Rural Life (MERL)

6.2 Recommendations for further research

- It would be interesting to see if attending groups makes a difference to mental health or resilience.
- Another survey targeted at men and women of non-ethnic minority backgrounds will reveal if there are any significant differences in their responses.

7. Researcher reflections

7.1 Donna Ma

During my 24 years after moving from Hong Kong to England, I always have a mission to serve ethnic minority communities particularly the Chinese immigrants. The opportunity came in April 2021 through RCLC which is one of the three charity organisations in this CPAR project. Becoming a CPAR researcher has enabled me to go beyond the religious, the social and the educational sectors.

The trust and respect that I have gained from ethnic minorities help the respondents feel more comfortable to share their views and life experiences. My working experience as a qualified ESOL tutor has also provided me knowledge about different ethnic minority cultures. When I started my first online training session in April 2021, I was anxious and not sure whether I would be able to do a good job. The support which I have received in this CPAR programme has provided me the skills to design the questionnaire, do the data entry and data analysis as well as compiling the final report. After taking part actively in this programme for a year I am feeling empowered and confident. Working with a colleague and other people in this project, I have learnt to be more patient and open-minded; and also picked up some IT skills.

I am glad that through this research the women respondents had the chance to speak their mind despite of the language barrier, the lack of IT knowledge and social contacts as the findings of this research will inform future communication plans for all health and wellbeing issues within Reading's diverse communities, and facilitate the development of accessible health care services.

Apart from this programme, I also participated in the Town Centre Research led by the Reading Borough Council and hosted a focus group online.

I would like to continue my learning journey to become a competent community researcher; and contribute more to the ethnic minority community.

7.2 Hemamalini Sundhararajan

With a deep sense of commitment to do something for the society, I had taken up different roles over the last 8 years in Reading Community Learning Centre (RCLC), which has enabled close interactions with Ethnic Minority Women.

As an outreach support worker, I was able to establish a level of trust with Ethnic Minority Women, wherein open conversations could be had about their day to day challenges. Some of these challenges were generic and systemic in nature, especially on education and healthcare support with deeper impact due to COVID.

It was at this juncture, CPAR research initiative at RCLC was talked about and I got enrolled as CPAR Researcher. Even though I had no prior experience of conducting research, the CPAR program team ensured that appropriate guidance was being provided through all the phases of the research. This research opportunity provided me the platform to have a structured approach in summarising the challenges faced by Ethnic Minority Women and formulating an action plan for implementation. Personally, this has helped me to improve my social & IT skills around conducting research in formulating questions, data collection, data analysis and reporting.

The eagerness with which the research team, RCLC and external respondents offered their time and support for this research initiative, indicated the collective spirit and a sense of togetherness for the common objective of the Community Development. The research findings and recommendations has highlighted the need for additional focus on education and steps to improve the reach of healthcare services. I hope that the research findings would be looked at as the voice of Reading Ethnic Minority Women and the recommendations taken in earnest for their improvement.

I thank for this opportunity and look forward to more such engagements to contribute to the society.