The Strategy Unit.

COVID-19 and Ethnicity

A qualitative exploration of the first wave of the pandemic

NHS
Midlands and Lancashire
Commissioning Support Unit

*We couldn't identify with the national commentary on ethnicity

"I mean I don't consider myself a poor person, you know, I'm educated, I have a degree, I have a job, I'm well paid, so is my partner so we don't struggle, we don't get free school meals, we live in a three-bedroom house, we own it, it's ours. So even people like me were still dying so it wasn't all this 'well we all live in overcrowded houses' because we don't..."

^Kayla

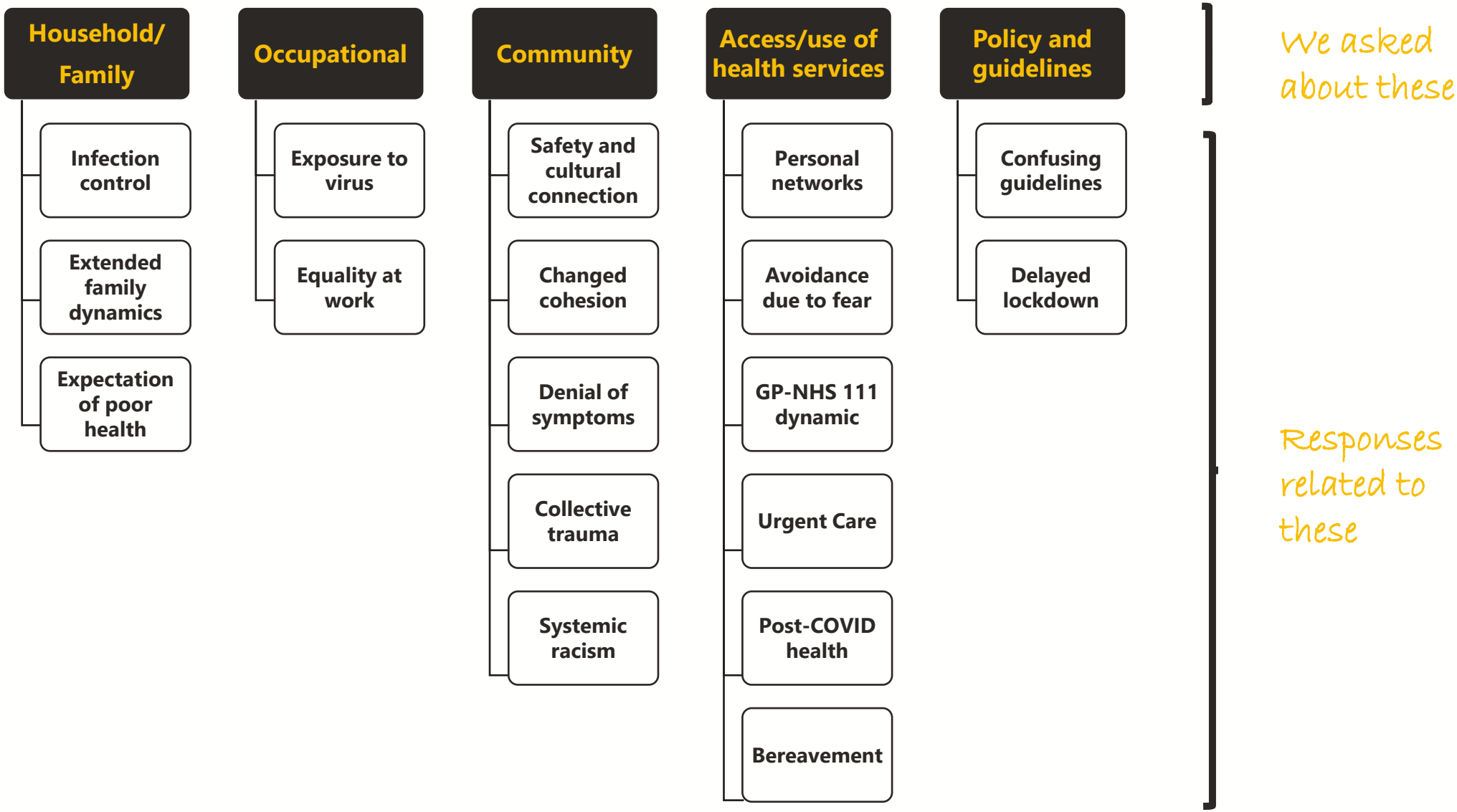
*The ethnically diverse qualitative team at the Strategy Unit
^Participant in the qualitative study (names have been changed)

We spoke to…..

Name*	Household (Adults and Children)	Ethnicity	Hospital Admission	Bereavement	Residence (region)	Occupation(s)	Date of Interview
Ali	2A 2C	Middle Eastern, White, Mixed	No	No	Merseyside	NHS - Managerial	15/06/2020
Bilkis	4A 3C	Indian, Pakistani, Mixed	No	No	Lancashire	Social Worker, Accountant, Health Care Assistant, Take-away worker	18/06/2020
Cassim	2A 2C	Pakistani	No	No	West Midlands	Local Authority	19/06/2020
Dawood	5A 3C	Bangladeshi	Yes	Yes	West Midlands	Retired, Self-employed – Small business owner	22/06/2020
Eshan	3A	Indian	No	No	West Midlands	Consultant Surgeon, GP	22/06/2020
Fatima	4A 2C	Indian	No	No	Greater Manchester	Stay at home mum, Local Authority, Engineering apprenticies	23/06/2020
Grace	2A 2C	Black	No	No	London	NHS Primary Care – Non-clinical	02/07/2020
Hanif	4A	Pakistani	No	No	West Midlands	Take-away worker, Nursery Assistant	24/06/2020
Ismail	2A	Indian	Yes	No	Lancashire	Taxi Driver, Housewife	20/07/2020
Jamila	4A 2C	Pakistani	No	No	West Midlands	NHS Admin and Catering	09/08/2020
Kayla	1A 2C	Black	Yes	No	London	Nurse	19/08/2020

*Pseudonyms have been used

We discussed…



National Policy: Value And Visibility

There was a consensus that **lockdown was too little, too late**. Borders could've been closed earlier, rules could have been enforced better to capitalise on lockdown.

National guidance was confusing; daily briefings became '*a load of rubbish*'; different social distancing rules for different communities (garden visits not allowed but pub ok) were frustrating. **Trust in the government was lost and as a result adherence to social distancing rules**.

There was anger and frustration that many of the inequalities based on racism, deprivation, gender and the intersectionality of those **were known and not acted on.**

"I can't make my mind up whether it's because of the information, but I do feel that if things had locked down a bit more sooner then I don't think so many people would have passed away."
Fatima

"In terms of the official guidance that was given it was very confusing, it wasn't cohesive – and it ignored swathes of people that would have been disproportionately impacted by COVID. I personally felt that the official guidance was not being created with the science and the evidence that was available. It felt very – and it still does – feel very economy based, not people based"
Grace

Occupation: Risks and Representation

Most identified primary route of COVID-19 infection in their household to be related to a **family member's occupation** (followed by school, social and health services exposure)

"I started to take it seriously when my eldest daughter got sent home from work in March before lockdown. Her office had to be deep cleaned as somebody had tested positive for corona after travelling abroad. Two days later she had a fever, her symptoms were mild, but she did have a really bad cough, a high temperature and tiredness."
Fatima

Those working within the NHS described poor team/organisation management of risk or support and linked these with **broader lack of ethnic representation at senior levels**.

"The way I was spoken to wasn't normal, there was an atmosphere and I could tell it was because I'd been off. I was genuinely poorly, I wasn't making anything up, and then for my managers to be doing that, it was just out of order really. Anybody else that goes off sick, they don't have that, it's just towards us Asians."
Jamila

Community: Connection and Cohesion

A range of residential areas were described in terms of ethnic mix, religion, class, affluence or deprivation. Individuals **chose to reside within their communities due to a sense of belonging, safety or access** to relevant community spaces, for example mosques.

"I think you have to compare the people's professional roles with the ethnicity. Just so you're not falling into that trap of automatically assuming where BAME people live is because they're deprived, just because of their choice to live there. In areas of [City] it can be quite deprived, but you get people living or moving there because of the community."
Ali

Pandemic and lockdown provided a good **opportunity to confirm community values** for most, however for some community cohesion was tested when social distancing rules were not adhered to.

"How things have come together has been amazing. There was a hell of a lot of community spirit and I'd hardly ever spoken to my neighbours across the road, in some ways it's brought communities back together again in a very localised sense."
Cassem

Community: Perspectives and Perceptions

Where community belonging was core to the individual or family, **individual coping mechanism was influenced by wider perspectives of disbelief (initial stages) and fatalism**.

"In regards to the whole thing my dad was just like "don't worry about it, 'Allah will protect us. If He means us to die then we'll die, don't worry about it".
Cassem

Many could point to others who had experienced much worse symptoms and **the relentless bad news became overwhelming**.

"People don't understand, you've got a fear of your life here. Literally every other day someone passing away, someone that I knew, or someone close to me, someone in the community. I remember thinking when will this stop? I couldn't bear that anymore. I couldn't deal with death anymore. It was just a constant, and losing someone that's personal to you, all those deaths meant so much more. I felt them."
Dawood

Families: Control and Curtail

Infection control in the household ranged, it was linked to awareness of risk in the first instance ('just a bit of flu'), individual anxiety ('disinfect everything coming into the house') and **the ability to isolate in the house when symptomatic**.

There was much angst around social distancing in families where household boundaries are blurred, for example when family decision making involves and impacts those living outside of the main household.

There was some **expectation of poor health as a consequence of being elderly**, and acceptance of being 'very elderly' when aged 60+.

"We went from just taking normal life for granted to being in the house, me having to stay in the bedroom, my partner having to look after the children, and obsessive hand washing, clothes changing regime every time he came back in from outside - there was a lot more anxiety around leaving the house, a lot more anxiety around doing normal things like shopping"
Grace

"There's also been a lot of tension on the extended family WhatsApp group around the relaxing of guidelines, questioning "what about parents and family rights in all this". My sisters are very much supportive, but a couple of my brothers have not been. Sometimes there's a bit of teasing by them to say "you're very official and legal - we can't go and see you", we've even been called the COVID police!"
Bilkis

Health and Care: Access and Advice

Individuals made **use of their own personal networks to seek professional advice** and support for their symptoms.

"Because I work in the health service, I know a Director at one of the Hospitals, so I contacted him and I said I'm a bit concerned for my son, I just need some advice. And he was kind enough to give me their top respiratory consultant. He said look don't worry, the cough can last a long time."
Ali

Most who contacted NHS 111 for symptoms were **dismissive of the advice** given, and turned to prior experience or advice of friends and family for non-medical treatment.

Reluctance to use hospital based services based mainly on **fear of suffering alone** and having a preference for being at home. Some worried about treatment and safety at hospitals too.

"Having seen the previous week when I was in the hospital, having been to the Intensive Care Unit myself [as a doctor], I was just very, very worried of going into the hospital. I know hospitals are fully laden with bacterial, secondary bacterial infections. Everyone was afraid to go to the hospital. I mean I myself was afraid to go into the hospital."
Ehsan

Health and Care: Urgent and Bereavement

Those who had personal experience of paramedics and hospital services reported **good care**.

Post-COVID-19 there were **additional mental health and wellbeing anxieties**, as well as worsening pain issues and for one person, long COVID challenges.

Most knew someone in the family or community that had died from COVID-19. Grieving was especially difficult in the **absence of usual religious or cultural practices that were dependent on social interaction**.

"The ambulance came within ten minutes and they all had PPE. They just took me in, I had breathing problems. I was the youngest person on the [COVID] ward. There were four people in the ward, I think all over 70. The doctors and nurses, did come often with everything. They put on a mask and clothes and they gave a good service"

Ismail

"Me and my four brothers went [to the funeral] we had to wear the PPE, the gloves, masks, had to wear all those things. There were two kind of volunteers who explained to us how it's going to happen. We prayed at the graveyard; it was very clinical. There was no one else there, it was just a graveyard. There were no people there. It felt very lonely, like there was just some detachment to it. That didn't help the grieving process. Everything was very cold, no emotion in it."

Dawood

To conclude….

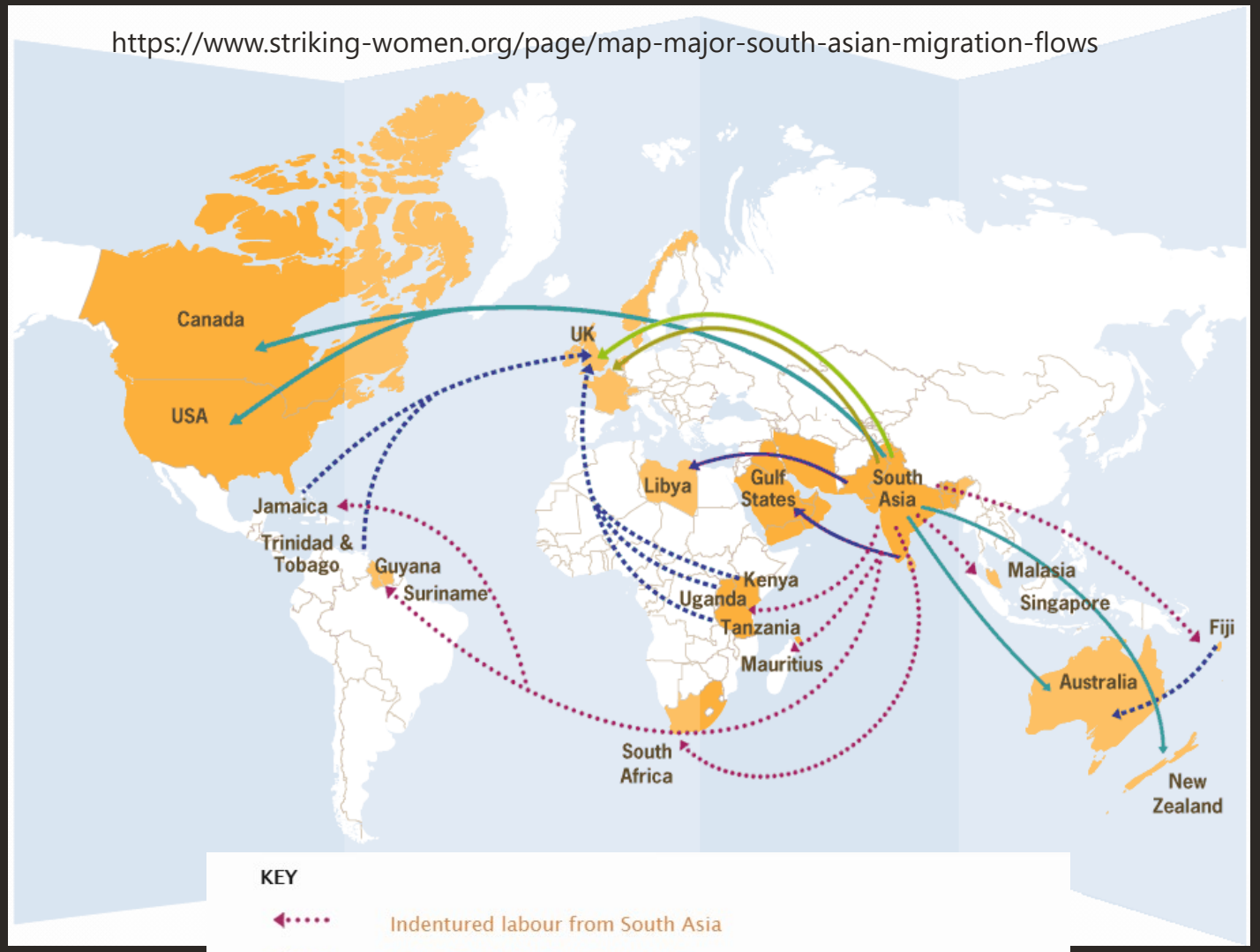
"We need to start looking at different ethnic needs on a case by case basis. I think that there are very unique needs from different communities… This BAME approach to research seems to bung everyone together and thinks that there's a silver bullet"
Grace

When examining inequities in access and inequalities in outcomes:

- Don't make assumptions about population groups
- **Disaggregate the data by relevant intersectional elements, such as: gender, ethnic sub-group, age/generation, religion, occupation, salary, educational attainment, housing**
- Think carefully about the labels used
- Inform yourself, ask questions about the origins, cultures and lives of the different population groups
- Engage relevant communities, if people are 'hard to reach' it means we all have to try harder

The (South Asian) migration behind the labels

https://www.striking-women.org/page/map-major-south-asian-migration-flows



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