

Barriers to Accessing Information Report

1.0 Executive summary

Accessing public information, whether that be for council services or public health messaging, can improve people's quality of life and their health, social, and economic outcomes. This has been especially apparent during the COVID-19 pandemic, whereby public health messaging has been vital to help the public protect themselves from the virus and curtail the spread of it, and messaging on governmental and council support measures available to help people impacted by public health regulations, such as lockdowns. In turn, having access to such information can have a significant impact on inequalities, with those not being able to access information being at a considerable disadvantage. These inequalities existed prior to the pandemic, and have been exacerbated during it.

People can encounter various barriers that can make information inaccessible: digital exclusion through a lack of digital literacy or insufficient access to digital devices and/or the internet; language barriers, with insufficient translation and language support; ineffective communications strategies and methods; and a lack of cultural awareness and sensitivity in services.

Many marginalised groups can face such barriers to accessing information, including low-income households, those with disabilities, the elderly, and ethnic minority communities. Those who are multiply marginalised, e.g. the elderly from ethnic minority communities, are likely to be especially impacted by barriers to accessing information.

Accordingly, the Tameside and Glossop Inequalities Reference Group (IRG), established in 2020 with the aim of reducing inequality across Tameside and Glossop, identified barriers to accessing information as one of seven areas chosen for a focused work programme. This report focuses specifically on the barriers that ethnic minority communities face in accessing information. Diversity Matters North West (DMNW), a third sector anchor organisation and member of the IRG, were commissioned to conduct primary research on this topic, which included a questionnaire and qualitative engagement.

Diversity Matters North West's research concluded that:

- Most ethnic minority participants find it difficult to access information, particularly due to language barriers and digital exclusion. These were issues before COVID-19 and have been exacerbated during the pandemic.
 - Those who are digitally excluded particularly struggled with services migrating online during the pandemic.
 - COVID-19 communications were in English, which meant that those with low English proficiency were unable to access necessary information to protect themselves and access health services. An insufficient amount of information was translated.
 - COVID-19 restrictions inhibited people from accessing the support they would usually have prior to the pandemic, e.g. through relatives and friends. Consequently, this left some people more isolated when they needed the help the most.
 - Some support that was offered was culturally inappropriate, e.g. some women had to be seen by male GPs rather than female GPs, which contravened their religious beliefs.
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Accordingly, the Inequalities Reference Group recommend the following:

- 1. Improve digital accessibility.** Investment should be made in local, culturally sensitive, accessible support to help upskill people from diverse ethnic groups.
 - 2. Improve accessibility of translation and language support.** Reliance on family and friends providing language support is short-sighted and does not address the core issue. By ensuring key services are inclusive to the communities they serve will ensure greater access for seldom-heard and minority communities, enabling independence and a better quality of life. A one-size approach does not fit all, therefore due consideration needs to be given to targeted support and interventions, such as having interpreters available at the time of access, investing in widening workforce diversity, and/or cultural awareness training.
 - 3. Develop more inclusive and/or tailored communication methods.** To effectively engage and reach out to seldom-heard communities where language is a barrier, translated messages is key whichever medium of communication is adopted. In the survey, people stated that bilingual videos, voice messages, visual graphics (less text), and leaflets worked the best. Also, phone calls to check in on them was crucial for them feeling better both mentally and physically.
 - 4. Services need to be culturally sensitive and aware as to the barriers that people face when trying to access services.** Having a cultural awareness of the local communities will enable services to empathise and understand people's needs better. By adopting simple changes in communication will enable greater engagement and improved wellbeing as people start to feel listened to, valued, and not feel discriminated at the point of accessing a service.
 - 5. Public services need to develop and improve links with community organisations supporting those communities, and individuals who are seldom-heard and may struggle to access information.** Taking a co-produced approach to involving people's voices from the earliest opportunity is key, including allowing more opportunities to enable this to take place. This is often achieved via support through the voluntary sector due to their unique community-based position. However, the sector requires further long-term investments to improve the stability of the services they deliver, and to continue to reach and engage those that statutory services fail to reach.
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2.0 Background

Accessing public information, whether that be for council services or through communications campaigns, can improve people's quality of life and their health, social, and economic outcomes. Those who lack access to such information will be at a disadvantage, thereby likely reinforcing existing inequalities. Ethnic minority communities are one group who encounter barriers when needing to access information.

The COVID-19 pandemic has highlighted that having access to such information is vital. The Runnymede Trust (2020) stated that COVID-19 has had a disproportionate impact on ethnic minority communities in terms of severe illness and mortality. A driver behind this has been a lack of awareness of public health messaging and associated measures, which the Good Things Foundation noted, can be attributed to common barriers ethnic minority communities face when needing to access information: digital exclusion and language barriers.

The Tameside and Glossop Inequalities Reference Group (IRG) thus decided to launch a work stream on reducing barriers to accessing information for ethnic minorities in Tameside and Glossop. Established in 2020 with the aim of reducing inequality across Tameside and Glossop, this was identified as one of seven key areas of focus. The IRG is not a decision-making body, but it will be able to make recommendations for action via reports submitted through the existing governance structure of the Tameside and Glossop Strategic Commission. As part of this work stream, Diversity Matters North West (DMNW), a third sector anchor organisation and member of the IRG, were commissioned to conduct primary research on this topic.

This report begins by highlighting the barriers that ethnic minorities face in accessing information in the UK. An overview of key research and engagement is provided. Subsequently, an overview of engagement at the local level in Tameside and Glossop covering such barriers to accessing information is provided. The research that DMNW is then covered, including the methodology, findings, and conclusions, after which the IRG's recommendations are given.

3.0 Barriers to accessing information in the UK

Research and engagement has been conducted at the national level before and during the COVID-19 pandemic to discern what barriers ethnic minority communities face in accessing information.

This research and engagement has identified the following barriers that ethnic minorities face when accessing information: digital exclusion, language barriers, complex and contradictory information, ineffective communications channels and methods, and misinformation.

An overview of key research and engagement is below.

Public Health England (2020): Beyond the data: Understanding the impact of COVID-19 on BAME Groups ¹

Public Health England (PHE) conducted a literature review and stakeholder engagement sessions, with over 4000 people, to understand the impacts of COVID-19 on ethnic minority groups. Regarding COVID-19 communications, it was found that:

- COVID-19 communications and their method of distribution were not always appropriate for ethnic minority communities.
- In the engagement sessions, several participants felt that COVID-19 guidance was conflicting and difficult to interpret, with one participant saying: “People who struggle to access, understand, appraise, and apply health information, or who face barriers in navigating the complexity of the NHS, may not be able to adhere to public health messages or advice.”
- Some individuals from ethnic minority communities cannot be reached via digital means, particularly the elderly, those with mental health issues, and specific cultural or faith-based communities such as Orthodox Jews.

Runnymede Trust (2020): Over-Exposed and Under-Protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain ²

The Runnymede Trust conducted a survey with 2585 adults in Great Britain aged 18+ covering people’s experiences during the COVID-19 pandemic and first lockdown. Regarding awareness of public messaging, the survey found that:

- During the COVID-19 pandemic, there have been disparities in awareness of the UK government’s public health messaging. 87% of those identifying as white were aware of the guidance, ‘Stay Home, Protect the NHS, Save Lives’, typically accessed through television or the internet. This is higher than people from ethnic minority communities (69%). Similarly, 84% of those identifying as white had heard the guidance, ‘Stay Alert, Control the Virus, Save Lives’, compared with 66% of people from ethnic minority groups.
- There was also disparities in awareness of economic support measures. 93% of White British and 92% of Chinese survey participants were familiar with economic support measures available during the pandemic, yet only 61% of Bangladeshi respondents were aware.
- The Good Things Foundation (2021) attributed digital exclusion in combination with low literacy, health literacy, and English proficiency as playing a key role in these discrepancies of awareness. ³

¹ [Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

² [Runnymede Covid19 Survey report v3.pdf \(runnymedetrust.org\)](https://runnymedetrust.org)

³ [Good-Things-Foundation-2021-Digital-Exclusion-and-Health-Inequalities-Briefing-Paper.pdf \(goodthingsfoundation.org\)](https://goodthingsfoundation.org)

Atiya Kamal et al (2021): A Rapid Systematic Review of Factors Influencing COVID-19 Vaccination Uptake in Minority Ethnic Groups in the UK ⁴

Atiya Kamal et al (2021) conducted a systematic review of peer-reviewed databases, polling websites, and grey literature to determine factors influencing COVID-19 vaccination uptake amongst ethnic minority groups in the UK. They found that the following barriers to accessing information influenced a higher vaccine hesitancy and lower vaccine uptake amongst ethnic minority groups compared to White British people:

- Digitalisation resulting in lack of access to knowledge and communication barriers
- Poor provision of information in other languages
- Complex information and overwhelming amounts of material
- Contradiction of information between different sources
- Mistrust of scientific and medical fields
- Vaccine misinformation

Miscellaneous

- The Race Equality Foundation noted that elderly people from ethnic minority communities have been especially affected by barriers to accessing information during the COVID-19 pandemic. They noted that efforts have been made to translate materials into various languages, but they have often been ineffective due to being too long, complicated, and difficult to understand. Also, language barriers have resulted in particularly traumatic experiences for elderly people when interacting with frontline services during the pandemic. They cited a review conducted by the Greater London Authority, which informed of the experiences of elderly Somali residents (60-70% of whom are estimated to speak little or no English) admitted to hospital with COVID-19. They could not communicate directly with healthcare staff and were unable to use relatives or friends as translators, so they were severely ill and vulnerable to dying without being heard. ⁵
- Jenny Hewitt and Dharmi Kapadia (2021) from The Centre on the Dynamics of Ethnicity reported that during the COVID-19 pandemic, elderly people from ethnic minority communities have been particularly affected by the closure of communal spaces provided by voluntary, community and social enterprise (VCSE) organisations via public health measures, such as lockdowns. These served not only as means for connection and support, but as an important source of advice and information. ⁶
- Age UK have highlighted several barriers that elderly people face when accessing information for healthcare services, which can impede access, thus widening pre-existing health inequalities. These include: a lack of easily accessible, culturally appropriate information relating to different aspects of health and care, including diet, physical activity, end of life, caring and dementia; and language barriers and lack of access to translation support in written documentation and face-to-face consultations. ⁷

⁴ [A Rapid Systematic Review of Factors Influencing COVID-19 Vaccination Uptake in Minority Ethnic Groups in the UK - PubMed \(nih.gov\)](#)

⁵ [Layout 1 \(raceequalityfoundation.org.uk\)](#)

⁶ [Runnymede COVID Older people briefing FINAL.pdf \(manchester.ac.uk\)](#)

⁷ [Breaking down the barriers of ethnic inequalities in health | Discover | Age UK](#)

4.0 Barriers to accessing information in Tameside

Engagement has been conducted at the local level to discern what barriers ethnic minority communities face in accessing information in Tameside and Glossop.

This engagement identified the following barriers that ethnic minorities face when accessing information locally: language barriers, i.e. a lack of English proficiency with insufficient translation and language support, and digital exclusion, with most services being online and a lack of digital literacy. These barriers were found to be exacerbated during the COVID-19 pandemic. An overview of this engagement is provided below.

Diversity Matters North West: Covid-19 Community Consultation Report

Diversity Matters North West published the “Covid-19 Community Consultation Report” during the COVID-19 pandemic which focused on “Hyde BAME Women’s Training, Learning and Employment”. The report found:

- 24% of respondents reported a lack of English speaking skills was a barrier to career progression. These respondents highlighted that they were disadvantaged by not being able to identify available job opportunities and that they could not access information or seek the help and support that they required. The services that they did contact were often not equipped with the right language support, cultural sensitivity or basic customer service skills such as empathising with the customer. These negative experiences eroded trust in statutory services and led to reduced engagement.
 - A lack of culturally appropriate, accessible opportunities, including language as a factor, was identified as an issue that went beyond opportunities for employment and included loss of existing income, debt, mental health, accessing key services, and lack of communications reaching them.
 - In conjunction with language, digital literacy was often mentioned by the same people as barriers to accessing information.
 - 22% of respondents were aged 21-30 and this group found language to be much less of a barrier for opportunities. This could indicate that the barriers faced by people from marginalised communities in Tameside may differ based on age group, and as such potential solutions may need to be tailored to specific age groups.
 - COVID-19 was viewed as having caused a migration of communication, information and services online, which placed it out of the reach of some women who had language and/or digital skills challenges.
 - One-to-one language support was identified by many women as something that would help them to get online and engage with services.
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Partnership Engagement Network Sessions 2020

In summer 2020, the Partnership Engagement Network – which is co-led by Tameside Council, Tameside and Glossop Clinical Commissioning Group and Tameside and Glossop Integrated Care NHS Foundation Trust – conducted virtual engagement sessions with local public sector and voluntary, community, faith and social enterprise (VCFSE) organisations. Some feedback from these engagement sessions pertained specifically to barriers to accessing information and included:

- Tameside Council Covid-19 Humanitarian Relief Hub fell short for people with language barriers.
- The hub could have linked in better with local community organisations such as Mosques.
- During Covid-19 restrictions, people who were attending hospital appointments may not have been able to have a family member or friend accompany them, this restriction has a worse impact on people for whom English is not a first language.
- During Covid-19 restrictions, initial phone calls to access care would have been more difficult for people with language barriers as they could not have family or friends in the house who are able to translate for them, suggesting that existing translation provided by the service is not adequate.
- People in marginalised communities have experienced difficulties reaching services due to language barriers, generational barriers, and lack of contact with family, which all interrelate. This makes people who do not speak English as a first language more isolated.
- Asylum seekers and refugees often have language barriers and also a lack of support networks, and during Covid-19 have had no recourse to public funds or ways of contacting people for help.

Action Together's Diversity Network

The Diversity Network is led by Action Together and involves VCFSE groups from across Tameside and Glossop. They have discussed barriers to accessing information at network meetings and identified some clear themes, with language barriers to accessing services being a consistent consideration. In particular:

- Access to hospital services: Many service users face language barriers when trying to access hospital services. Some public sector organisations have a relatively diverse workforce, which may contribute to better outcomes for service users from ethnic minorities. Tameside Hospital have been trying to increase the recruitment of people from ethnic minorities, but recruitment itself is compounded by potential language barriers.
 - Access to GP services: During the first wave of the COVID-19 pandemic, face-to-face access to GP services was reduced, with guidance at the buildings explaining how to access services largely being in English. There is a significant cohort of people who may be able to speak English but not necessarily read written English. It was recommended that translated leaflets could be placed in GP surgeries or elsewhere to increase access to services.
 - Digital exclusion: People face barriers to accessing services due to a lack of digital skills, access to digital devices, or access to the internet/data. These barriers may be economically based, but this barrier often compounds pre-existing barriers such as language proficiency.
 - Availability of languages: When translated resources are available from Tameside Council and other local services, it is expectedly translated into the most popular languages in Tameside. Yet, very little is translated into Farsi, Arabic or Swahili, which also have many speakers in Tameside.
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Action Together's Early Help Community Connections

Action Together's Early Help Community Connections have had a focus on asylum seekers and refugees in Tameside. The barriers they face to accessing services are heavily based around language proficiency:

- Asylum seekers in Tameside are usually housed in Serco properties on their own and rely on Migrant Help for support, but both of these organisations are commissioned nationally, not locally. The majority of asylum seekers do not speak English and face barriers contacting Migrant Help via the phone and reading important letters they receive through the post.
- There is a lack of provision for English language courses for asylum seekers, which would enable them to become more self-sufficient and a lot of services do not have interpreters.

Audit of Tameside Council's Access Channels

An audit was conducted of the accessibility of channels to access Tameside Council's services. The findings of the audit are presented in the following tables:

Website	
Language	People can translate any of Tameside Council's webpages into one of 100 languages, 30 of which can be spoken aloud, using the "Recite Me" icon, which can be found on the "Accessibility Toolbar" of the website in the top left-hand corner.
Visual	Accessibility Toolbar can increase and decrease font size, change font, change colour scheme, use screen mask functions, magnifying glass functions, ruler functions, enable/disable text mode.
Audio	Accessibility Toolbar can read text from the website out loud and make audio files downloadable.
Other	Accessibility Toolbar has a user guide, can enable dictionary tool, enable text mode.

Call Centre -8355

Language	Tameside Council uses an interpreter service, if people need help talking, explaining or understanding council documents. Tameside Council has access to a bank of Interpreters covering over 140 different languages. This facility is delivered via Conference Call where 3 way conversation takes place over the phone between the council official, interpreter and customer. If you ring the council with your needs then we will arrange for an interpreter of your required language. (Language line - but very rarely used).
Visual	-----
Audio	We offer an enquiry service via webchat and email.
Other	-----

Customer Services – Face-to-Face

Language	No longer offering a face-to-face service since the onset of the COVID-19 pandemic.
Visual	No longer offering a face-to-face service since the onset of the COVID-19 pandemic.
Audio	No longer offering a face-to-face service since the onset of the COVID-19 pandemic.
Other	No longer offering a face-to-face service since the onset of the COVID-19 pandemic.

Libraries

Language	Limited support for language translation.
Visual	Tameside Council have Large Print books but do not offer a contact service in this way
Audio	Tameside Council offer an enquiry service via webchat and email. Hearing loop systems at some libraries.
Other	Tameside Council also have the Home Library Service to assist customers receiving books by delivering them to their door.

Children's Centres

Language	Translation for Children's Services is contracted to D.A. Languages Limited: "A national, dedicated language services agency with 19 years of experience delivering first-class translation & interpretation services. Providing expert support to both private and public sectors, covering 450 languages and dialects." Their "innovative technologies and award-winning customer solutions help" their "diverse client base reach their audience via face-to-face, video and phone interpreting or in written translation". 10 Tip for Talking has been produced in 15 different languages that are most popular across Greater Manchester to support SLC pathway and key messages.
Visual	Written translation for Children's Services is contracted to D.A. Languages Limited Virtual Pathways set up with videos that are visually appealing, are combined with informative slides and that have translated voice over's for targeted communities. Information can be paused and repeated, returned to at leisure.
Audio	-----
Other	-----

5.0 Commissioned research into barriers to accessing information in Tameside

Tameside Council commissioned Diversity Matters North West (DMNW) to conduct primary research into barriers to accessing information in Tameside. DMNW are a local, independent charity based in Hyde working across Tameside with diverse communities to combat health inequalities and social exclusion, and to promote community cohesion.

This research aimed to gain a better understanding of the barriers facing residents in accessing information, focusing particularly on such barriers before and during the Covid-19 pandemic. The research was designed to capture people's lived experiences, and a particular focus was placed on language.

Methodology

A questionnaire was developed consisting of both open and closed questions. This was transferred onto Microsoft Forms to capture the results and to track diversity of responses.

Bearing in mind the high levels of COVID cases in Tameside, the approach was carefully planned to keep both staff and residents as safe as possible. Undoubtedly, this meant that engagement would be limited by this additional challenge. Therefore, DMNW aimed to think 'outside the box' to ensure engagement with people as much as possible.

The methods adopted were to operate remotely and/or face-to-face where it was safe to do so. A place-based approach was taken where the questionnaire was taken to people via organised outreach stalls, and attending sessions and groups across Tameside, where participants were already engaging.

The approach adopted various engagement methods ensuring the questionnaire was accessible, and where required, language support was provided via bilingual staff, volunteers, and paid interpreters to enable people to complete the questionnaire, fully informed. This included:

- One to one semi-structured informal interviews conducted over the phone and face-to-face (when safe to do so or on Zoom) to existing DMNW service users
 - Circulating the questionnaire link via WhatsApp broadcast groups with bilingual voice messages, specifically in Bangla
 - Circulating the link on DMNW's social media platforms
 - Outdoor market stall outreach was organised to reach wider audience and target groups, specifically those that are not engaged with DMNW
 - Indoor venue outreach stalls were organised in areas where minority communities are already accessing / present / visiting, including local primary schools, cash and carry's, local community groups
 - Focus groups: face to face and online via Zoom
 - Engaging with community leaders and local faith centres
 - Identified and targeted hubs where target groups would engage in, leaving questionnaires for lead volunteer or group leader to complete with their service users
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- Hard copies of the questionnaire were made available with pre-paid envelopes, these were left with key organisations for people to access / pick up across Hyde and Ashton
- Emailing the questionnaire link to volunteers and partners via DMNW, Action Together, GM Equality Alliance CRM, and newsletters
- Attending Network Events to capture wider feedback such as the PEN networks

The questionnaire was conducted over 4 months, spanning across Tameside and targeted specifically, but not exclusively, to ethnic minority groups.

Findings

175 residents successfully completed the questionnaire. Out of this, 37 people completed it online. The rest were done on hard copies with assisted support, which were then transferred onto Microsoft Forms. 34% of those who engaged with the questionnaire were males compared to 65% female. (This has frequently been the case with DMNW's community consultation research and activity programmes). Also, 66% reported that they were married, 10% were widowed, 16% were single, and people who were divorced made up 4%.

Age Groups. 135 people completed the response for age. The age groups that engaged with the questionnaire generally reflected the users of DMNW's services. This was essentially due to targeted work, and that older generations were prone to face additional barriers to access relating to lack of language and digital skills than younger generations. From previous conversations within these communities, it was known that the main challenges faced by people from the minority ethnic groups were predominately for the older age ranges.

Ethnic Diversity. 40% of the questionnaire participants were of Bangladeshi heritage, 14% identified as Indian, 13% Black African, 12% Pakistani, 12% White British, 3% Polish, and 6% were from various other backgrounds including Nigerian, Kashmiri, Arab, Afghani, Irish, and mixed race, and 1% not applicable. This reflects DMNW's strong relationship and connection within the South Asian communities of Tameside.

Religion. Most of the participants who completed the questionnaire were Muslims (56%), then Christians, including the Church of England, Protestant, Catholic, and other denominations (16%), closely followed by Hindus (14%). Those who identified as Buddhist, Jewish, Sikh, Orthodox, and Spiritualist all accounted for 1% each. People with no religion accounted for 6%. People who preferred not to say made up the remaining 1%. The big difference between some of the results are due to the questionnaire being targeted mainly at the ethnic minority communities.

Language. The largest language spoken amongst people who took the questionnaire was Bengali as their first language, which was followed by English. This was mainly because other members of the family completed the questionnaire on behalf of their elderly parents and family members whose first language was not English. In Ashton, the most common language spoken by people of Black African heritage was Portuguese, whereas in Hattersley, Yoruba was most used language within this ethnic group.

Location. Most people who completed the questionnaire resided in Hyde (42%). 27% of people were from Ashton, 14% from Stalybridge, and 14% from Dukinfield. These high percentages were due to targeted work, identifying hotspot areas where main outreach interventions were focused to reach and engage with minority ethnic communities. The remainder of the respondents resided in Denton, Audenshaw, Droylsden, Mossley, Hattersley, Manchester, Chorley, Sale, Bolton, and Stockport. This demonstrated reach wider than the targeted areas.



Volunteers and interpreters. DMNW recruited and inducted 3 bilingual volunteers who supported the research, gathering the information via telephone, supporting outreach, and with data input. On average, when volunteers conducted the telephone and outreach stall questionnaires in a different language, each questionnaire took approximately between 30 minutes and 1 hour to complete. Paid interpreters reported taking 1 hour to complete 3 questionnaires.

Working with community groups and organisations. To reach as many people as possible, leading staff members contacted and/or visited 17 groups, organisations, and businesses, holding over 34 conversations and/or meetings face-to-face and over the phone. The group leaders ensured their service users participated and helped to complete some questionnaires, which eliminated some challenges around language.

Groups engaged with	No. of contacts made
Diversity Matters North West Ltd	3
KhushAmdid	3
Deepak Drishti	3
Infinity Initiative	3
West African Development	3
Cash and Carry: (Ahmed Brothers, Sylhet store and Al-Amin Food store)	3
Shree Bharatiya Mandal, Indian Association Tameside	2
Hyde Bangladeshi Welfare Association	2
Hyde Jamia Masjid	2
Hamza Masjid	2
Hattersley African Group	2
Local Primary School	2
Hyde Past and Present Facebook group	2
Hyde Bloom Facebook Group (Gee Cross)	2
Ashton Central Masjid	1

We successfully managed to organise 2 workshops with local community groups: in Hyde at DMNW, and in Ashton with Deepak Drishti. The workshops were facilitated in English, Bengali, and Urdu. This enabled us to break down initial barriers, build trust, increase confidence, and encourage two-way dialogue. Participants talked openly about what, how, and why the barriers affected them in accessing services both pre- and during the pandemic. Many expressed that it was an extremely frightening time for everyone. They also stated that it was frustrating at a time where they needed to access services more than they ever had to, they found that they couldn't. People found it difficult in getting essential things like needing to book an appointment with a GP, requesting repeat prescriptions, especially those who lived alone or did not have English as their first language.

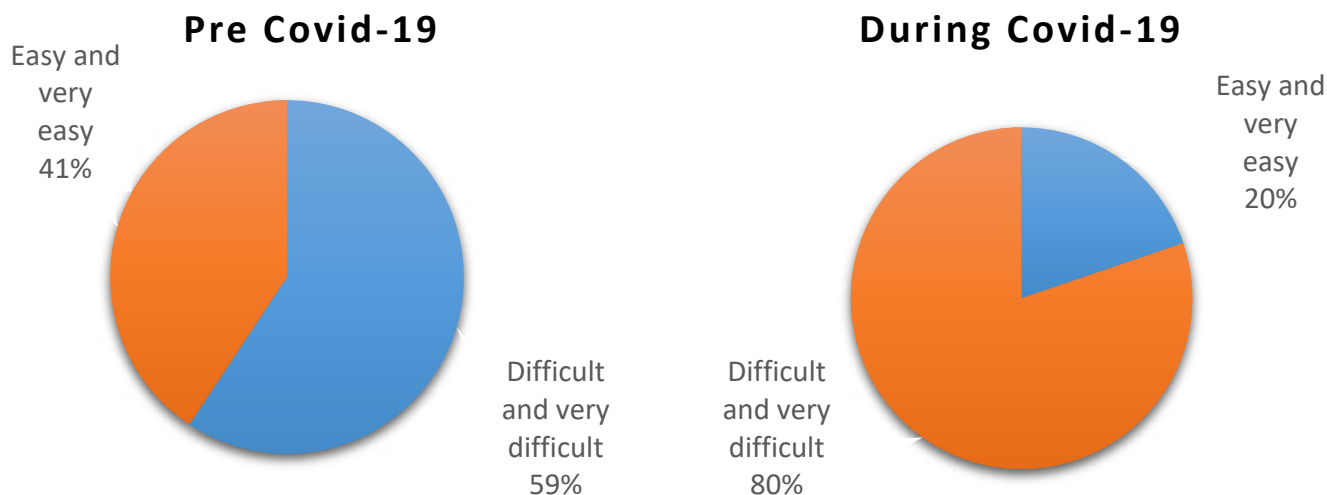
Responses included:

- *"I had to stay home as the government guidelines said I couldn't request for my medication from the GP because I couldn't provide my address or date over the phone even."*
- *"I had to ring people, but they couldn't help because they had to get permission from me. Because of lockdown nobody could go to each other's house. Eventually it was sorted out by local councillor, who could speak in my language – she registered me on the council for food hub."*

Many spoke about their concerns about:

- Financial struggles because of people losing their jobs: This had a negative impact on their lives and mental wellbeing. People couldn't apply for universal credit even after they let HMRC know that they stopped working. This was due to a lack of English language and having a lack of digital skills. This meant people had their benefits stopped. People continued to pay mortgages/rent by borrowing from family and friends, or some ended up in huge debt.
 - Lack of trust in the government: People didn't go for Covid tests in the first lockdown because they were fearful if they tested positive, they would have to isolate and those members of their family that could work would not be able to. They were scared because most of the earners of the families were either taxi drivers, self-employed, or were a part of the catering business. Support services that were available were inaccessible.
 - Accessing essential services: When people were isolating, they couldn't access food banks or hubs. It was a scary time for many, often feeling alone and forgotten about, that their lives and health did not matter. The food banks that were open did not provide culturally sensitive or appropriate, healthy food. This further prevented people from an Islamic faith to access food banks. In addition, there existed a cultural stigma around accessing food banks and the fear of being seen to access a food bank. The participants of the workshops and people we spoke to over the phone all mentioned that there was a lack of cultural awareness. There was a general assumption that people had to fit in with services without the help and support they need to do so. If you didn't engage then you didn't need the service. The survey showed that most people found it difficult or very difficult to access information because either of a lack of digital skills or language barriers.
 - Impacts on children's education: The expectation for parents who did not have English as their first language to home school their child put them at a further disadvantage and contributed to increased anxiety and poorer mental health. These families often tended to be lower income families. Coupled with the struggle of providing healthy or any food for their families, the situation only worsened for some.
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Difficulty of accessing information and services. One of the questions asked was how people found accessing information and key services pre- and during COVID-19 to understand the depths of the challenges they faced.



The first pie chart above shows that 59% of participants found it difficult to access information pre-lockdown, even with the help of family, friends, and relatives. At that point, despite knowing about services, people living outside of Ashton said accessing services face-to-face was difficult even then, as no local services were available, travel was required, and at the point of accessing a service, no language support was available or very difficult to get. Older people, particularly first-generation migrants, are not likely to have English as a first language compared to second- or third-generation children of migrants who may be bi-lingual or have English as their first language. Some of the comments were:

- *“Gujarati language support or services are not available.”*
- *“I always needed help from family and friends, without them I cannot access the help I need.”*

The second pie chart above shows a dramatic increase to 80% (n=115) of people who found it ‘difficult’ and ‘very difficult’ to access information or services during Covid-19. This was particularly due to language barriers, lack of digital skills, and having no face-to-face services as most of the services and community centres shut down, leaving people unaware of where to go and ask for help. In contrast to pre-pandemic, many of those who would normally rely on friends and extended family members to help with accessing services found themselves even more isolated as they could not get this support when they needed this the most. Government lockdown restrictions put an end to interactions with others during the pandemic. Some respondents did not answer this question. Some of the comments were:

- *“It was very hard to access information because of language barriers and lack of digital skills.”*
 - *“Very difficult because I couldn’t do online doctors’ consultation and upload photos because I didn’t know how to.”*
 - *“It isn’t just covid time it’s also before then. It’s hard when people don’t translate into other language – how am I able to get the help I need so my family don’t suffer, that my children don’t suffer?”*
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Main barriers to accessing information. Respondents were asked what the main barriers were to accessing information. They could select more than one answer.

Barriers to accessing information		%	Quote
1	Digital skills	18%	“Couldn’t access the internet” “Everything being online made it very difficult for me.”
2	Written English / reading	17%	“I couldn’t do online information and fill in the form”
3	Covid related restriction	16%	“Because my children live far away and I live on my own”. “I don’t know who to ask for information” “Very hard to actually speak to someone to get help”. “It was so bad that the bereavement team didn’t have any contact number to reach them on”. “I had to make a complaint to get this raised and it still wasn’t satisfactory”.
4	Verbal English / Language	15%	“Very difficult to access information via phone such as GP appointments.” “I have very limited knowledge of what’s going on. I can’t speak English or understand.”
5	Lack of access to digital device	10%	“Difficult doing online because no digital device.” “My children live faraway; I am still learning to use my mobile phone. I live myself I don’t know who to ask for any information”.
6	I do not know what to do to access information	10%	“I didn’t know where to look or go on website to look for Covid related information”.
7	Lack of access to internet, e.g., no Wifi, or broadband at home, limited data on smartphone etc.	10%	“Difficult doing online because no digital device” “I don’t have mobile phone and much help”.
8	Lack of available family or friends who can help and/or support me	8%	“Family lives faraway”.
9	Unhelpful or non-co-operative staff	6%	“Very hard to actually speak to someone to get help. It was so bad that the bereavement team didn’t have any contact number to reach them on. I had to make a complaint to get this raised and it still wasn’t satisfactory. I did however manage to speak to someone who helped me eventually. This was the last thing that I needed when my son had died”.

The top three main barriers came out as:

- 1. Lack of digital skills:** Digital skills including lack of access to digital devices and internet came as the top barrier amongst nearly 50% of respondents. The data shows and reflects that there was a lack of digital skills amongst ethnic minority respondents. As most services were online during Covid-19, this made it difficult to access services, especially the GP, hospital appointments, and Covid-19 tests or registering for vaccinations. Tameside Council's Digital Inclusion Report highlighted that women, disabled people, people who are economically inactive, and people from Bangladeshi, White, or Pakistani ethnic backgrounds are all more likely than other groups to be digitally excluded. In recent years, digital exclusion across ethnic groups has varied considerably. For example, in 2011, 31.4% of Bangladeshi adults were estimated to be non-internet users, whereas in 2019, that figure had reduced to 11.7%. The report also highlighted that digital exclusion was closely linked to income where "only 51% of households earning between £6,000-£10,000 have home internet access compared to 99% of households earning over £40,001".
- 2. Written, reading, and verbal language barriers:** It has been difficult for ethnic minority communities to access information and overcome language barriers. During Covid-19 lockdowns, people were not able to get the support they usually would get from family members, relatives, friends, and local community centres. Few elderly members found it difficult to ring the GPs and pharmacies for repeat prescriptions because they couldn't speak English; some managed to say their address or date of birth. Although some people could speak English, they still struggled to access support information because of their inability to read effectively, so they could not navigate through the mass of information and complex use of English language. This made it difficult to access information and key services when they needed it the most.
- 3. Covid-19 related restrictions:** People found it difficult to access services due to lockdown restrictions. Vulnerable elderly members who lived on their own found it difficult to register for the food bank and getting medication delivered to their house. This was because they were already depending on their family members, friends, and relatives because of the language and lack of digital skills pre-pandemic. With the social distancing guidelines in place, family and friends could not help.

It is important to note that 57 people just did not know where or how to get the information they needed during the pandemic. 49 people also said that the lack of available family or friends who could help and/or support them were inaccessible due to the social distancing government guidelines.

Caring for someone. The vast majority of respondents said they did not care for anyone (83%). In the Bangladeshi, Pakistani, and Indian communities, most people do not see looking after an elderly member, or a relative with long-term illness, physical disability, or end of life care as a "caring responsibility". Culturally, this is more of a duty. People told us that the cultural stigma around declaring the caring responsibilities is damaging for many families in these communities. Therefore, they refrain from seeking the help and support they need, ultimately worsening their own health. Some people spoke to us about how some parents within these communities struggle with accepting their young child as being in need of educational support, thinking this will reinforce the concept that their child will be singled out, and will ultimately affect their future.

Communication. A question was asked regarding the best way to reach and communicate with people in the future. 82 participants wanted to receive information through translated leaflets in their own language. The second largest group of people wanted to receive information through text and SMS messaging as this was easy to receive and keep on their phones. This was mainly those who could read messages and use their mobile handsets.

Research limitations and challenges. The research experienced several limitations and challenges:

- The process started at a time where we faced triple barriers of school holidays, religious festivals and navigating through the government guidelines on social distancing.
 - Completion of questionnaire: Where people completing the questionnaire identified as younger, they were often completing the form on behalf of another person, so a true account of individual demographics could not be obtained. Some questions were not always completed – consistent data was not obtained. Those supported at a one-to-one level completed all sections. More women completed the questionnaire than men, given more time, we would have dedicated targeting men specifically to ensure fairer representation.
 - Outreach: Engaging with people during outreach in the marketplace was particularly challenging as people were hesitant to speak. The nation had just come out of lockdown, and they were cautious about ‘close’ contact meetings.
 - Face-to-face community sessions/groups: Many of the community sessions, workshops, and face-to-face events had been postponed due to Covid-19. When they restarted, there was a backlog of booked guest speakers. Therefore, opportunity to attend these groups to conduct the consultation was limited. Despite all the hurdles, DMNW managed to complete 175 questionnaires.
 - Translations: Support was sought from bilingual volunteers and paid interpreters to help capture feedback and engagement from different ethnic groups where language was a key barrier to participation. This meant further coordination and planning was required to ensure safety of all those who participated.
 - Time consuming: The questionnaire itself had 25 questions, and within this, multiple choice and open questions requiring free text. Interpreting the questionnaire to residents on a one-to-one basis was time consuming, which meant that to complete one questionnaire would take double the time. Ultimately, not as many people were reached as initially desired.
 - Volunteers were hesitant to engage with early on after lockdown restrictions were lifted. Risk assessments were conducted for all sessions where volunteers came into contact with staff or local people to ensure their safety was paramount. Commitment levels were up and down, so a lot of work was directed towards keeping motivation, ensuring safety, and maintaining regular communication.
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Conclusions

The research reached the following four conclusions:

- 1. Accessing information:** More than 75% of participants could not access information, and even the 25% who did needed help from others to do so. This was an issue pre-Covid-19, particularly language barriers (verbal or written) or a lack of digital skills. Prior to Covid-19, people were able to get support face-to-face with their GP, hospital, offices, community services, and family or friends. During Covid-19, this has been very difficult because of restrictions – support was mostly online or over the phone. People had difficulty in applying for benefits, and elderly members couldn't register for food banks. When bereavements occurred, the problems were worse:
 - “Very hard to actually speak to someone to get help. It was so bad that the bereavement team didn't have any contact number to reach them on. I had to make a complaint to get this raised and it still wasn't satisfactory. I did manage to speak to someone who helped me eventually. This was the last thing that I needed when my son had died.”
 - 2. Lack of digital skills:** The impact of digital exclusion and a lack of digital skills has been highlighted by the shift towards digital services during Covid-19:
 - When people had a lack of knowledge in digital skills, they found themselves at a disadvantage. The lockdown further restricted people from learning how to use technology properly, particularly ethnic minority communities. Lack of digital skills closely correlated with people not being able to read and speak English. The people who struggled with this felt as if they couldn't do anything on their own and constantly needed the help of others. Some examples of this problem were that people were not able to make GP appointments, not able to access the internet, and register for vaccinations
 - Digital exclusion is linked to income, therefore, accessing better employment opportunities should help alleviate digital poverty experienced by many during the pandemic.
 - 3. Language – written and verbal:** The language barrier was a very wide- spread issue that many were finding difficult to overcome. Being in lockdown didn't help this either. People couldn't fill in documents online nor written forms to the best of their ability, simply because they didn't understand what it was asking or saying. All communications were in English, so those that did not understand English or could not read English did not get the crucial information they needed to keep themselves safe and access health services at a time when they needed it the most.
 - 4. Covid-19:** Many people said there was an insufficient amount of information translated into languages people could understand. This led to a lack of knowledge in Covid-19 related issues. The situation became more difficult because there was no one-to-one contact and most services went online. During Covid-19, people were more scared and needed support from services. Many of those who would normally rely on friends and extended family members to help with accessing services, found themselves even more isolated during the pandemic, as they could not get the support when they needed it the most, due to government lockdown restrictions putting an end to interactions with other people. Minority communities found themselves on their own, scared, and isolated. When trying to access health services, many women were forced to be consulted by a male GP, due to their inability to request a female GP, compromising their religious belief and their own identity. Often, the actual ailment goes undiagnosed and any underlying health issues missed. This raises the issue of cultural awareness, whether more investment is required to educate frontline staff.
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6.0 Approaches to tackling barriers in accessing information

Advice and recommendations have been provided by bodies at the national level for organisations to improve access to information for ethnic minority communities, a select extract of which is provided below.

Independent Scientific Pandemic Insights Groups on Behaviours (SPI-B) ⁸

SPI-B provides independent behavioural science advice to the Scientific Advisory Group for Emergencies (SAGE), which has played a key role in advising central government during the COVID-19 pandemic. This advice on behavioural science is aimed at anticipating and helping people adhere to interventions recommended by medical and epidemiological experts. In terms of reducing barriers to accessing information, they have advised that:

- Translation alone is not sufficient. Messaging should be co-produced and pre-tested with target communities; this will allow consideration of cultural contexts and identification of language that will retain the meaning of core messages. Messages should also be available in audio and video format.
- Messaging should be linked to the socio-cultural identities of target communities. In the COVID-19 pandemic, risks to specific groups and surrounding particular cultural/religious events (e.g. Eid) should be highlighted.
- Messaging should be localised, illuminating local help and services available to target communities, as well as stories of local people.
- Local authorities should have active engagement cells with ethnic minority communities which should include political, health, community, legal, and academic representatives. This will improve relationships with community partners who can act as trusted sources of communication.

Local Government Association ⁹

To mitigate the impact of health inequalities at the local level during the COVID-19 pandemic, the Local Government Association have recommended the following in terms of accessing information:

- Translation: Where possible, make guidance available in multiple languages in written format. Also, videos with spoken guidance can help where there are issues with illiteracy in first languages as some languages are primarily oral, e.g. Sylheti. Audio-only guidance can be shared easily among communities.
- Cultural Norms: Provide access to information that addresses the challenges of COVID-19 for different domestic arrangements and cultural norms, such as multi-generational households.
- Faith and religion: Engage with faith and community leaders who may be seen as trusted sources of information in their communities. Furthermore, connect with faith and belief organisations who may be in contact with vulnerable groups, can provide insight into their needs, and identify actions already in place or that need to be enacted to assist them.

Local authorities have taken varying approaches to improving access to information during the COVID-19 pandemic. An overview of some of these is provided below.

⁸ [Public health messaging for communities from different cultural backgrounds - 22 July 2020 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/544442/public-health-messaging-for-communities-from-different-cultural-backgrounds-22-july-2020.pdf)

⁹ [COVID-19 Suggestions for mitigating the impact on health inequalities at a local level \(2\)](#)

Manchester City Council ¹⁰

As part of the COVID-19 Health Equity Manchester programme, Manchester City Council aimed to develop infrastructures through which culturally competent, targeted public health messages could be delivered to “at-risk” groups rapidly, and to engage with these at risk groups in two-way dialogues. Herein, VCSE sounding boards have been co-designed for each at-risk group with a supporting list of “community influencers”, comprising largely a bottom-up approach. This has been designed so that the best mediums and approaches are used to deliver messages in the most culturally competent way to each at-risk group. Examples of initiatives through this programme include:

- Culturally specific COVID-19 and flu vaccination uptake campaigns
- Tailored and targeted messaging to prevent spread ahead of events such as Eid, Diwali, and Yom Kippur
- Social media and community radio campaigns for staying safe in community languages, led and delivered by community leaders and trusted sources
- Place-based community led awareness raising with Pakistani and Bangladeshi communities in Longsight, Levenshulme, and Cheetham Hill
- Community-based small grants projects to improve Covid awareness and prevention measures across our Black African and Pakistani communities, including for asylum seekers and refugees
- Myth busting campaigns across Black African and Caribbean communities, via social media, local radio and webinars – the most recent of which hosted by CAHN (The Health Hour) which resulted in over 1000 participants, and brought together over 20 black clinicians to dispel myths and provide trusted source intelligence to communities

Newcastle City Council ¹¹

During the COVID-19 pandemic, Newcastle City Council turned key public health messages into videos and targeted ethnic minority communities in Bengali, Urdu, Hindi, Arabic, Romanian, Czech and Romani. These were reportedly viewed over 30,000 times. Specific public health messages regarding cultural norms and religious celebrations were also distributed, e.g. safe fasting practices during Ramadan.

Other public health messages have been tailored to ethnic minority communities, such as the Cervical Screening Saves Lives ‘No Fear’ initiative. This promotes cervical screenings to women from ethnic minority communities taking into account cultural sensitivities. This has reportedly resulted in a 4% increase in uptake inside the first year.

Camden Council ¹²

During the COVID-19 pandemic, they convened the Black, Asian and other ethnicities VCS network, which focuses purely on communications to enable a two-way dialogue, helping to share and develop culturally competent and accessible information, provide reassurance and tackle misinformation about COVID-19 and about public health interventions.

¹⁰ [COVID Health Equity Manchester.pdf](#)

¹¹ [Report sets out how city is tackling inequality | Newcastle City Council](#)

¹² [7fef673a-e633-5245-1eec-a9d34e4c72e7 \(camden.gov.uk\)](#)

7.0 Recommendations

- 1. Improve digital accessibility.** With an increasing number of statutory services now going online as a bid to cut costs, we are seeing seldom-heard communities further isolated from society, resulting in increased poor mental and physical health. By investing in local, culturally sensitive, accessible support to help upskill people from diverse ethnic groups, where language is a key barrier to engagement and accessing information and services, we could be saving lives and giving people a better quality of life, therefore, increase life expectancy amongst vulnerable groups.
 - 2. Improve accessibility of translation and language support.** Language was a barrier pre-pandemic, only exacerbated by the pandemic, highlighting the widening inequalities and equitable access to services. Reliance on family and friends providing language support is short-sighted and does not address the core issue. By ensuring key services are inclusive to the communities they serve will ensure greater access by seldom-heard and minority communities, enabling independence and a better quality of life. A one-size approach does not fit all, therefore due consideration needs to be given to targeted support and intervention to allow true justice in our systems. This could be having interpreters available at the time of access, investing in widening the diversity of a workforce, and/or providing cultural awareness training.
 - 3. Develop more inclusive and/or tailored communication methods.** To effectively engage and reach out to seldom-heard communities where language is a barrier, translated messages is key whichever medium of communication is adopted. People stated in the survey that bilingual videos, voice messages, visual graphics (less text), and leaflets had worked the best. Also, phone calls to check in on them during such a scary time in their lives was crucial for them feeling better both mentally and physically.
 - 4. Services need to be culturally sensitive and aware as to the barriers that people face when trying to access services.** Many of the group conversations within the workshops and when we spoke to people over the phone mentioned that there was a lack of cultural awareness. There was a general assumption that people had to fit in with services without the help and support they need to do so. If you didn't engage then you didn't need the service. Having a cultural awareness of the communities we serve, will enable us to empathise and understand peoples need better, by adopting simple changes in our communication will enable greater engagement and improved wellbeing as people start to feel listened to, valued and not feel discriminated at the point of accessing a service.
 - 5. Public services need to develop and improve links with community organisations supporting those communities, and individuals who are seldom-heard and may struggle to access information.** Taking a co-produced approach to involving people's voices from the earliest opportunity is key. Therefore, allowing for more opportunities to enable this to take place is crucial to ensuring we do not repeat the same mistakes twice. This is often achieved via support through the voluntary sector due to their unique community-based position. However, in order to achieve this, the sector requires further long-term investments to improve the stability of the services they deliver and to continue to reach and engage those that statutory services fail to reach.
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