Health Inequalities in the Age of COVID-19: Towards Fairer Health for Disadvantaged Communities.

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Introduction

Our research project

looked at ways of getting health information, including how to use the NHS and avoid illness, to people who need it most and have greatest difficulty accessing it. We used the lens of COVID-19 messaging as a way of better understanding effective information sharing.

Our research involved

- working with people living in some of the most economically disadvantaged areas of Newcastle upon Tyne, to generate information about whether/how health messages got through during the pandemic;
- supporting people to identify effective ways to get health information they need, including how to use NHS primary care;
- liaising with primary care and public health practitioners throughout, to identify ways of translating findings into action.

The main findings

- Accurate health information can be effectively circulated through established trusted connections
- Communication barriers can be broken down through the involvement of communities, organisations, and individuals
- Trust and collaboration between people and practitioners enables effective information sharing.

The research idea

began in our frustration with the persistence of health inequalities. The World Health Organisation announced the global COVID-19 pandemic in March 2020 and articles and reports soon began to highlight the risk of UK inequalities worsening (1). Haref's and Riverside Community Health Project's firsthand knowledge of how inequalities affect the lives of people in economically disadvantaged areas and communities in Newcastle upon Tyne equipped them to apply with Newcastle University for funding from the National Institute for Health Research, Applied Research Collaboration North East and North Cumbria.

The project group

involved eleven community partners, who live and/or work in the west end of Newcastle, one of the most economically disadvantaged parts of the city. The project involved partnership and collaboration between: local people and organisations; community partners and the rest of the research group employed by Haref, Riverside Community Health Project and Newcastle University.

Participants

129 people participated in this project. This sample reflects the range of background and socioeconomic circumstances that there always is in communities described as deprived according to official measures.

Our project is relevant

in the context of the integration of health and social care, at a time when the pandemic has brought health inequalities into sharp focus. Integration is a central feature of current health policy, as set out in the White Paper, Joining up care for people, places and populations (2) published in February 2022. Collaboration, as close to where people live as possible, is seen as essential for integrating care and reducing health inequalities. Making decisions close to, and hopefully with, people who experience the greatest levels of health inequality is likely to produce better outcomes.

Our main findings are in line with policy directions from the government's 2021 final report on progress to address COVID-19 health inequalities. It identifies the importance of:

- building on community partnerships;
- working closely with local networks to co-produce health information;
- delivering information using trusted voices.

It is crucial that the current emphasis on partnership and collaboration is accompanied by adequate, longer term funding for the community and voluntary sector organisations that have built relationships of trust with people in the most marginalised areas and communities. The following quote from one of the participants reflects this:

> ‘You need to know that people in the community - who worked tirelessly - we are still here and ready to do whatever’s needed. Funding should go to empowering people in the community.'

Project Limitations

One of the limitations of this project was the transition from our original plan to carry out the research face to face. Because of the pandemic and public health guidance we had to do everything remotely using digital technology. Some of the people we might have reached had we done the project in person may therefore not have been able to take part.

Another limitation was that a small number of men responded to the invitation to take part. This is a finding in itself, that women self-selected to be part of this research and to participate in conversations around health issues. Some of the men who did participate are Imams who are linked to very large groups of men through local mosques, and some linked through networks related to their jobs, for example a taxi driver association.

How we carried out the project

The levels of trust that local people have in Haref and Riverside Community Health Project have been crucial to the project. Through their community networks they asked for volunteers to support local people to be involved. Eleven people, referred to as community partners, joined the project group, were part of shaping the way things were done, and recruited participants. Two of the community partners suggested a short text to enable people to decide whether they wanted to take part. All of the community partners then agreed a final version which can be read below:

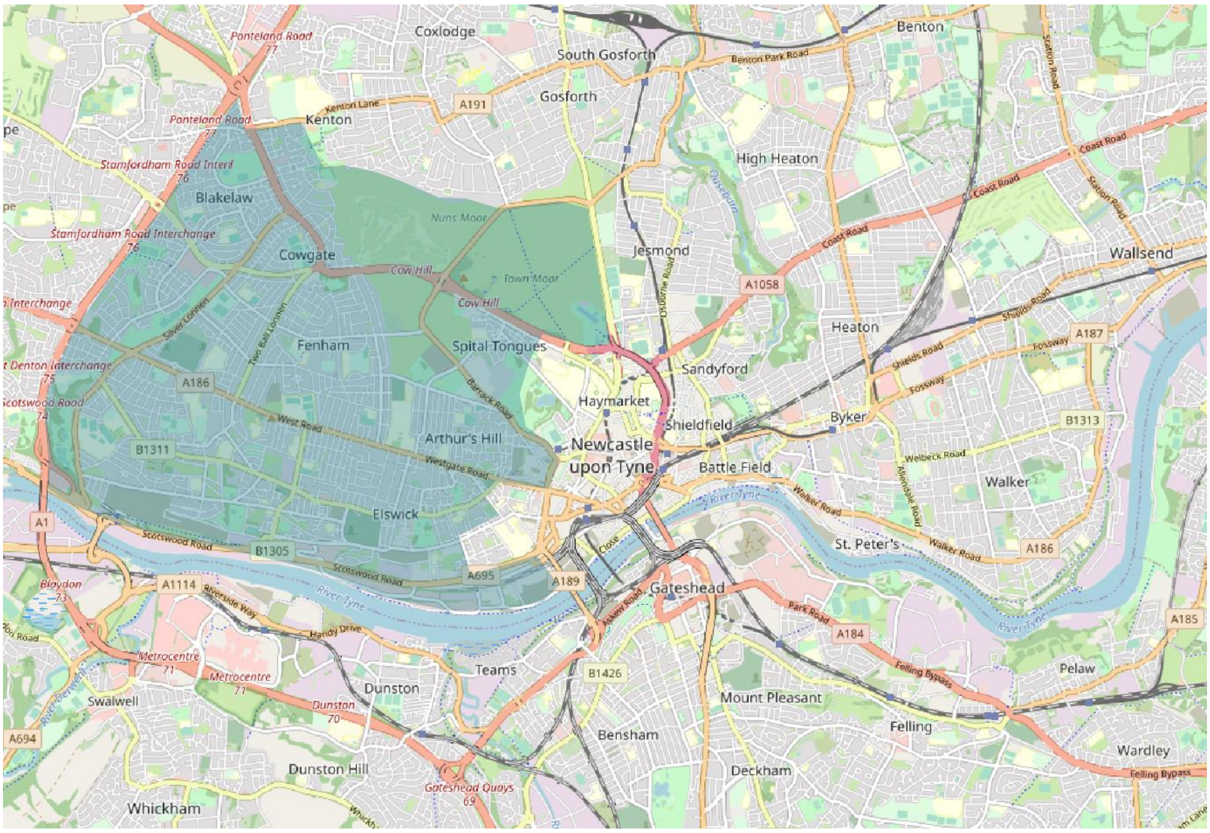
> ‘When the pandemic started none of us knew how to make sense of all the information we were hearing. People worked together to produce clear and accurate information so that each of us could make our own decisions about what to do to stay safe. Moving out of the pandemic we all still need information about being as healthy as we can. We need information, for example about how to avoid our blood pressure becoming too high, and what to do if we feel anxious or sad most of the time. Riverside Community Health Project, Haref, and Newcastle University are working with the local NHS. They need to hear your recent experiences, and your ideas about the best ways of getting health information to people who need it most.'

People from a range of communities within the Haref Network were involved in producing research questions through online discussions in March 2021. Community partners read the draft questions to make sure they were clear and easily translatable as needed, and agreed the final version. Haref organised an online preparation session for community partners in June 2021. A briefing on supporting people to respond to the research questions was drafted and finalised with them. Each community partner decided on the most appropriate way of involving people in responding to the research questions. This was particularly important to avoid potential barriers to conversation. One of the community partners said that the people they link with are often not ready to share their own ideas or views in formal discussion as they worry they might be ‘wrong’. This person introduced the research questions into regular group sessions that people in that community take part in.

The community partners used a mixture of Zoom sessions, questionnaires, and telephone calls to include people from white and ethnically minoritised communities living in west Newcastle, one of the poorest areas of the city. The research team was aware that digital exclusion could potentially be a barrier to participation. Riverside provided tablets and data to participants during the pandemic to address these barriers and community partners were able to carry out the research in a way that they felt would allow the most people to participate.

Community partners invited people they know and/or work with to respond to the questions. 129 people took part across an age range from late teens to 80s. The people in the project group who are employed by Haref, Riverside and Newcastle University did preliminary analysis of people’s responses to the research questions, and discussed this with community partners in an online session in January 2022. The community partners read and fed back on draft report sections as they were written and were sent the final draft for comments and suggestions.

Project Context



Illustrative map of the inner west of Newcastle

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The project was mainly carried out in the west end of Newcastle, an area shaped by deindustrialisation and migration. Areas of west Newcastle are among the most disadvantaged in the UK. In these wards socio-economic disadvantage influences the health of people in the majority white community, and across minority communities (3). This affects people's confidence to easily access information and use primary care effectively (4). UK health needs assessments and evidence reviews have identified particular information gaps for people in minority ethnic communities, including around managing weight, care during pregnancy, vaccination and mental health (5, 6, 7, 8, 9)

The project focuses on this geographical area. Although relatively small numbers of people from different countries have migrated to Newcastle overall, a 2000 Primary Care Group briefing paper described west Newcastle as an increasingly ethnically diverse area with people of South Asian, Turkish, Iranian, Malaysian, Chinese, and African Caribbean background, and emerging Afghani, Croatian and Kurdish communities. 2011 census data (2021 census data not yet available) showed a third of Benwell residents as born in countries other than the UK (up from 2.2% in 1971). Benwell, Elswick and Scotswood have been identified as Newcastle wards with the highest numbers of people who have migrated from central and eastern Europe.

Participants

Respondents=129

Bangladeshi Group:

- 5 men
- Ages 35-50

Chinese Group:

- 25 women and 6 men
- Cantonese-speaking people
- Ages 50-81

Czech-speaking Group:

- 5 women
- Ages 35-50

Healthworks Questionnaires:

- 61 respondents
- 74% White
- Ages teen-60s
- majority ages 20- 40

Black African Group:

- 3 women. 2 men
- Ages 30-45

Romanian-speaking Group:

- 5 women
- Ages teen-60s

Women's Organisation:

- 6 women
- 30s-70s
- North African and Indonesian

Libyan Group:

- 11 women
- late teens to 40s
- Arabic-speaking

Defining 'Community Partners'

There was meaningful discussion with the community partners about how to refer to their role. Initially the term 'community connector' was proposed and floated with the project collaborators. One of them suggested the term community partner and after collective discussion this is the term we all decided to use. 'Community partner' recognises the active role they had in this research and in their communities. The community partners dedicated time and knowledge to this project. They contributed to the research at all stages, providing insight, feedback, and suggestions on how to shape, undertake, and present the research.

Community partners’ words about their role:

> 'Bringing communities together and creating value for others, working with the community, for the community, through communication, empathy, support and understanding the feeling of others, their needs and their hearts.'

> 'My role is like a bridge to connect various cultures and languages that live in the same environment and use the similar services in order to bring them together, and convergence of views. This may help to reduce the gap between them and improve the services.'

> ‘A community partner acts as a connector to connect cultures, communities, and serves an important role to bridge communication and knowledge between communities and institutions that want to be engaged with communities.'

> 'A community partner serves an important role to bridge communication and knowledge between communities and institutions that want to engage with communities. Furthermore, they translate messages between communities and organisations in a manner that will create value for both groups, without which there would be miscommunication and both groups would be inaccessible to each other.'

9 Research Questions

Research questions were developed by the team of researchers in consultation with the community partners:

1. What have been the effects of the pandemic for you and your family and for people in your community?

2. Are there things you’re particularly worried about at this point in the pandemic for example your physical health; your mental health?

3. Where have you been getting information and support/advice on COVID-19?

4. What is your feedback on this information? Did it make sense?

5. Do you feel you know what COVID-19 is, and how to avoid getting the virus?

6. Who are the people in your community who have had the most influence on your views of COVID-19?

7. How do you feel about the vaccine?

8. Where do you usually get information about things to do with your health?

9. What do you think about services being available on-line, during the pandemic and afterwards?

The Three Themes

- Trust
- Partnership and Collaboration
- Health and Wellbeing

Summary of Themes

Getting health information to people who need it most

Our findings suggest that effective communication happens when there is trust. Collaboration and partnership working help to achieve effective working relations. The research has produced useful information for public health and primary care professionals in the current policy context of reducing health inequalities through an integrated approach to health and social care.

> 'The language barrier is still there, the trust issue is still there, so some people can still be isolated. You need to be there to meet the people, to know them, to let them voice their needs … people have ownership when it’s done like that.'

The themes of trust, partnership and collaboration were interwoven in people’s responses to the research questions, as they are in the three following sections.

Trust

For those who are most marginalised in relation to accessing information and services, people in their close networks bridge the gap.

> 'What informs people is the person next to them, and also their countries of origin. The grapevine is more important than information coming down to the people. To be impactful, you need to tap into that.'

The importance of services getting accurate information to people became starkly apparent in the first phase of the pandemic when there was uncertainty and confusion about the virus and about government restrictions, as well as separation from usual face to face networks.

> 'There was a lot of fake information, and we'd lost our relationship with others which made it difficult for us to work out how to understand the pandemic on our own. There wasn't enough information and the language was a problem.'

> 'I had a neighbour of mine, who was volunteering somewhere where they give vaccine, so she came and gave me a lot of information … from NHS … you know when you speak one to one with a person who is now trained and has information in health … it was really very eye-opening and enlightening information that has changed my own view and perspective about the vaccine itself.'

Some people said that they checked social media information against what was on the government, NHS, and local GP websites before passing it on.

> ''The NHS website and also the GP practices themselves, like our GP practice, they had loads of information.'

> 'Most of the information first I seek from the social media, then I go to the government guidelines and find out what is the real thing … and after that I spread this information. Most of the time I rely on the guidelines of the government.'

An effective channel for health services is in developing relationships with community-led groups, congregations, and local organisations, so that individuals and groups receive accurate information in a way that fits into their routines.

Communication is a two-way process relying on services listening to people, trusting their knowledge of themselves and their communities, and delivering messages that reflect the listening.

Example of effective communication:

South Mountain Chinese Older People’s Association, Newcastle Chinese Healthy Living Centre and Newcastle Chinese Women's Association groups provide a platform for the Chinese community to meet and learn, at the same time the groups provide a platform for service providers to meet and inform the Chinese community.

Case Study:

The community organisation that supports a group of Romanian women made it possible for them to produce a video about COVID-19 in their first language, when they said that this was what would work for people in their community. '… The group thought that short videos were a good idea because we were confused, getting different news between the UK and Romania. Everyone was quite keen to have clear messages. The video in Romanian was much appreciated.'

Partnership and Collaboration

Participants described working together within communities to support/inform each other:

> 'A new challenge for us was that we don't have family here. We were sharing information all the time within our community. People weren't clear about what they could do. '

> 'We (women's group and support worker who is a member of the same community) made a messenger group and every morning we were in touch with each other, asking: "How are you?", and there were questions about the regulations and things.'

There were examples of collaboration with local organisations:

> '[Organisation A] arranged a session with the GPs, where they were going more in-depth about the vaccines … the women were then sharing information through family, through friends, through media.'

> 'Partnership between mosque management committees, congregations, and community activists, and collaboration where you have a group, an organisation fully involved with the NHS, and connecting through the Imam with the local congregation … this was what really showed people that this (vaccination) was OK … working together made it easier for people to walk away from misinformation.'

Case Study:

An example was given of an effective model of circulating information about cervical cancer in areas of low screening uptake. West Newcastle based community health organisation Healthworks has worked in partnership with Northern Cancer Alliance and Cancer Research UK to train and support local people to be cancer champions, with scope now for circulating information about other cancers, and a range of health conditions.

> 'Primary care data shows a 6% increase in cervical screening uptake in targeted areas. Health professionals have said that a 1% increase is usually seen as a success. Champions circulate information via social media. Everything is joined up and coordinated.'

Community partners highlighted the crucial role that people across communities have played during the coronavirus pandemic, and shared their thoughts about developing collaboration to reduce inequalities and improve health. They suggested that this would involve local statutory organisations appreciating the expertise of people across communities, and going on 'a journey of turning things around in terms of power.'

> 'I think probably what would help is an event, something saying “We now have information about (health issue)”. Those interested in it would come, and the information would filter through to other people. It’s a slow process, overhearing information from others in the community, particularly older people and people with health conditions who are unwell, that is, fifty-year-olds with diabetes or poor lungs because of smoking. We have to go around the subject. We could use older people as a way in …Humour helps as well.'

> 'All of them (men in one community group) were directly involved in talking about COVID vaccines and challenging misinformation. They came up with things themselves, and we shouldn’t forget their involvement and how they bravely came out and did things … there’s a need for positive messages to get back to people, a recognition of the impact of what we have done. We were there because other groups failed. They don’t understand that we made it happen … Why not empower the people who got together and did things throughout.'

Community partners gave feedback about people’s positive response to the opportunity to be part of the research project, and and about their perception of the value of collaborating.

> 'It was a pleasure to contribute. We owe it to ourselves and future generations to improve our communities. Future generations should not be seized with these issues.'

> 'It was a great learning experience that stretched me to reach out to people who are strangers and talk about this topical issue at a deeply personal level.'

The following sequence of quotes from the person who was the community partner with the group of Arabic-speaking women, shows the time and trust needed to enable some people to be partners in research, and the value of investing appropriately. The first quote follows initial discussion with the women about the research and whether they might be interested in being part of it. The second is from just before the planned online discussion of the research questions, and the third is after the session had taken place:

> 'I have talked and discussed with them about their ideas and if they would like to be a part of the research. They all are happy to join and share their experiences.'

> 'Just before the session some women got in touch to say they didn’t feel able to take part because of not feeling confident about their language skills. They said “We can’t” and I said “You must”. I said to them not to be shy and that everyone speaking a language that isn’t their first makes mistakes all the time. I told them that if they got into difficulty in English they could speak in Arabic and I would interpret. '

> 'After the session finished the women said they had liked it a lot. It was the first time they had done anything like this. They did try, and they were happy to share information. Their feeling was like the effect of volunteering, doing something for other people. They were proud of themselves.'

Removing Communication Barriers

The pandemic underlined the importance of people across communities having health messages that are easy to understand, consistent and accurate, an issue emphasised in recent Public Health England research. The PHE research report suggests producing clear communication materials in partnership with people across communities: ‘Messages must be delivered with clarity, with locally created messages likely to have greater uptake/impact’. (10).

Messages that contained concrete actions such as ‘wear a mask’ and ‘stay 2 feet apart’, ‘stay at home’ were easier to understand than messages such as ‘the virus is dangerous.’ Some participants said they prefer videos and images over text. Romanian respondents produced a video about COVID-19 in their first language and in Romany language to fill gaps in knowledge. The community organisation where they meet invited professionals to a question and answer session.

> 'The way it (COVID-19 information) was transmitted was not really clear … so you are protecting yourself but then at the same time you are doing it with anxiety because you don’t know whether what you are doing is actually right. '

Some people talked of anxiety about online access to GP consultation. For example, one of the community partners said that if she has a pain, even though she has a good level of English language, sometimes she can’t really describe it.

Using networks and organisations that people trust means being able to get information to them in ways that are appropriate to their needs.

> 'People face a problem with the language, and it’s hard to translate and give the meaning of words exactly, for example sometimes there are abbreviations and it’s hard to translate.'

There are particular barriers to information for people whose first language is other than English. Participants' examples of barriers to health information and services have been identified in previous research (11,12), for example interpreters not having the appropriate language dialect. Language issues include the complexity of translating some official health messages, for example when they include sets of initials and specialised vocabulary.

Health and Wellbeing

Our research shows the wide-ranging effects of the pandemic on people’s mental, physical and spiritual wellbeing.

> 'Lot of anxieties and fear, you don’t understand what is going on around you.'
>
> 'not being able to make sense of what’s happening around you .'

People’s mental health was particularly affected, and a range of difficult feelings were mentioned in response to the question about the effects of the pandemic. We counted the frequencies of emotional words used when discussing the pandemic. The most commonly mentioned words were:

- Worried
- Confused
- Isolated
- Scared
- Anxious
- Fear
- Depressed
- Concerned
- Lonely
- Stressed
- Bored
- Overwhelmed
- Sad
- Frightened
- Restless

> 'I’d say the pandemic has affected every area of our lives … and mainly attacks on mental health, because … it is an invisible enemy so it is hard to manoeuvre yourself around something that you cannot see and you’re only hearing about … it really messed up our mental health.'
>
> ‘I suffered from no social relationships with others and the isolation. I was scared for myself and my family in (name of country). There was more and more anxiety and worry about what will happen.'

> 'A physically (and also mentally) draining increased workload through combination of having the whole family at home all the time and extra cleaning because of risk of bringing the virus into the house.'

Impact of the pandemic:

- Disruption of usual routines
- People living on their own were suddenly isolated, and families had to be at home together, with more cooking and housework, and home schooling for those with children
- Effects of not being able to go out as usual and interact with people
- Worrying about work and lack of income
- Trying to manage financial difficulty including not having enough food
- Rapidly changing government information
- Uncertainty about the safety of vaccines
- Lack of direct contact with extended family

People with babies and young children felt cut off from support, including health visitor input, childcare, groups and family support, and parents of older children talked about feeling unprepared and unequipped to home school. The need to use public transport for hospital appointments added another layer of worry for a woman who was pregnant.

A worker in one of the community organisations involved with the research shared her sense that some people used the process of responding to the research questions to let out feelings about the pandemic for the first time. The same worker described two older people at a community event, Ageing Well Beyond COVID, breaking down because it was the first time they had been in a group with other people since the pandemic began. One of the women talked about contacting her GP because she had suicidal thoughts.

People described the dilemma of weighing the risk of infection against the risk of not being able to get on with their lives during the pandemic.

> 'You had to stay with children all the time at home … then it was so challenging, so terrible as well to take them out. It was so risky.'
>
> 'Effects on mental health of having to isolate at home, not having a chance to go out, not being able to interact with people, and not able to have some fresh air. '

Similarly in relation to vaccines, participants talked about the stress of trying to balance fears about reported side-effects with the knowledge that vaccination decreases the risk of getting very ill or dying with COVID-19.

A number of people’s responses to the question about the effects of the pandemic showed how they were protected by their circumstances. Some older people enjoyed a break from family responsibilities, while others living in a family household appreciated more time together, and felt less isolated. People with resources, for example those with a computer or smartphone, were able to benefit from technology enabling them to connect more with family in other places, to participate in online sessions, and to gain confidence through learning new skills like emailing.

Physical Health

Although some people referred to losing weight because they were not socialising and eating with others due to restrictions, the main theme related to physical health was anxiety about weight gain because of lack of exercise.

Actions and Recommendations

Throughout this project there were meetings between community partners, employed members of the research team, and health and social care managers and practitioners, including people from Collaborative Newcastle, public health, and primary care. Our collective discussion produced the recommendations and planned action below, which are supported by the literature referenced in the End Notes section, pages 25 and 26.

Recommendations for commissioners and providers:

- Meaningfully support third sector organisations that have relationships of trust with people across communities, including the most disadvantaged and marginalised
- Collaborate with communities via existing organisations and groups, and with each other across agencies, to develop trusting relationships and produce health information together
- Recognise the knowledge and expertise of community partners, groups and individuals in co-creating and delivering health messaging
- Produce clear, focussed, health information in appropriate and accessible formats. Make the information as simple and concrete as possible, so that it can be easily translated, as well as passed between people in communities
- Recognise the ways in which health and wellbeing are affected by aspects of everyday life such as employment, migration status, housing

Action planned by Haref, Newcastle University, Healthworks, Primary Care Networks, and Newcastle Collaborative:

- Information/education sessions covering health issues identified by people who took part in the research
- Health checks with community groups
- Production of information about access to health services, including primary care and the 111 service, so that people can manage the change to a mix of face to face and digital provision, and understand current capacity issues
- Circulation of information about how to feed into development of Integrated Care System
- The Newcastle University team will publish a peer-reviewed article based on the research

End Notes

(1) Examples of literature produced during 2020:

- Abi Adams-Prassl and colleagues present evidence of the large and unequal impact of the COVID19 pandemic. Reference: Adams-Prassl et al, 2020, Inequality in the impact of the coronavirus shock: New survey evidence for the UK, Social Sciences Information Technology Services Group.
- Clare Bambra and colleagues reflect on the longer-term public health policy response needed to avoid a further widening of health inequalities. Reference: Bambra et al, 2020, The COVID-19 pandemic and health inequalities, Journal of Epidemiology and Community Health.
- Jo Bibby and colleagues discuss the uneven starting points from which people faced the virus and entered lockdown, and how the pandemic has brought health inequalities into sharp focus. Reference: Bibby et al, 2020, Will COVID-19 be a watershed moment for health inequalities?, The Health Foundation.
- Richard Blundell and colleagues present evidence of the effects of the COVID-19 crisis on inequalities. They discuss how the COVID-19 crisis will affect inequalities in the long term. Reference: Blundell et al, 2020, COVID-19 and inequalities, Institute for Fiscal Studies and Nuffield Foundation, Fiscal Studies, Vol. 41, Issue 2.
- Independent SAGE’s Report 21 puts COVID-19 inequalities in the wider context of health inequalities. The report summarises epidemiological evidence of socio-economic inequalities related to the pandemic, in the UK and internationally. It ends with recommendations for local government, devolved authorities, the NHS and national government in relation to reducing inequalities. Key messages are that the pandemic has magnified and exacerbated health inequalities, and COVID-19 has highlighted the significance of social determinants of health, Reference: Independent SAGE, 2020, Report 21: COVID-19 and Health Inequality.
- Doreen Lawrence’s review describes the pandemic as thriving on persisting inequalities, including barriers to accessing healthcare. There is reference to lack of community specific information materials. Reference: Baroness Doreen Lawrence, 2020, An avoidable crisis: The disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities.
- Margaret Whitehead and colleagues show that the people hardest hit by the pandemic are the already disadvantaged: ’The pandemic arrived at a time when UK inequalities were already increasing, exposing underlying vulnerabilities, that are a consequence of years of austerity. Urgent action is now needed to prevent a further dramatic increase in health inequalities following this crisis.’. Reference: Whitehead et al, 2020, Covid-19: We are not “all in it together” - less privileged in society are suffering the brunt of the damage, May 22, British Medical Journal, blogs.bmj.com

(2) The Health Secretary and Secretary of State for Levelling Up introduce the white paper which sets out the government's proposals for health and social care integration, to level up access, experience and outcomes across the country. Reference: Department of Health and Social Care, 2022, Joining up care for people, places and populations.

(3) Marmot Michael, Allen Jessica, Boyce Tammy, Goldblatt Peter and Morrison Joana, 2020, Health Equity in England: The Marmot Review 10 Years On, Institute of Health Equity.

(4) Riverside Community Health Project, 2018, Working with communities in transition and people who have migrated from central and eastern Europe.

(5) Evandrou Maria, Falkingham Jane, Feng Zhixin and Vlachantoni Athina, 2016, Ethnic inequalities in limiting health and self-reported health in later life revisited, Journal of Epidemiology and Community Health, 70(7), pp.653-662.

(6) Healthwatch Gateshead, 2016, Black and Minority Ethnic (BME) Groups: Health Needs Assessment.

(7) Gateshead Healthwatch, Newcastle Healthwatch and Regional Refugee Forum, 2016, Health issues of asylum seekers and refugees in Gateshead and Newcastle.

(8) Carr Susan, Lhussier Monique, Forster Natalie, Goodall Deborah, Geddes Lesley, Pennington Mark, Bancroft Angus, Adams Jean, Michie Susan, 2014, Outreach programmes for health improvement of Traveller Communities: A synthesis of evidence, Public Health Research, 2(3), Nat. Inst. for Health Research.

(9) Haref, 2014, Exploration of the health needs of people who have arrived in Newcastle upon Tyne from central and eastern countries.

(10) The research report suggests producing clear communication materials in partnership with people across communities: 'Messages must be delivered with clarity, with locally created messages likely to have greater uptake/impact'. Reference: Public Health England, 2020, Beyond the data: Understanding the impact of COVID-19 on BAME groups.

(11) Newcastle Local Involvement Network, 2011, Using interpreters when accessing health and social care. One recommendation is that providers stay in touch with ethnically minoritised communities via community groups and community development workers, for development of services in partnership with users.

(12) McAreavey Ruth, 2010, Transcending cultural differences: the role of language in social integration. Translocations: Migration and Social Change Volume 6(2) pp.596-601. Inadequate language accommodation can neglect cultural and clinical nuances, reinforcing barriers, which means that different social groups are isolated from one another.