

Call to Action – The Pakistani Communities Call to Action (PaCCT) Project

Produced by the PaCCT research team. Co-produced with members of the Rochdale Pakistani communities in the context of COVID-19

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Introduction

This document presents recommendations, strategies, and concerns expressed by members of the Rochdale Pakistani communities who worked together with the University of Manchester on the PACCT Action project (funded by the Economic & Social Research Council). The aim of this project is to address the needs of the Pakistani communities during the COVID-19 pandemic. From the experiences and stories of the anonymous participants (**NB all names used here are pseudonyms**), we have drawn up suggestions for actions, which are in particular relevant to politicians, schools and colleges, health service providers and media outlets locally in Rochdale and also nationally.

This document presents our findings concerning the views of our participants, including 17 voices of vulnerable parents and carers of children in the Rochdale Pakistani community, who worked together with the University of Manchester on the PACCT Action project (funded by the Economic & Social Research Council).

The previous “Calls for action” focused on schools and education, alongside NHS Health and social care services have recently been published and are available to download on the [PaCCT website](#), but we have included in this document, all these suggested actions, together with the executive summary of our draft, full report.

Then – what is new here in this call - we now detail the action points suggested for discussion with the communities and all those with interests in the education (see page 6), health and social care services (page 8), and particularly the media and politicians locally and nationally, organised around

five audiences best placed to respond to them: Schools/Colleges, NHS and Health and Social Care services/ service providers, and national policy, local politicians, and the media.

Executive Summary

(This is the executive summary of the full draft research report being prepared for publication).

The COVID-19 pandemic has brought to light the increased health risks among groups labelled Black Asian and Minority Ethnic (BAME), thereby exposing stark inequalities (ONS, 2020). Top-down, lockdown measures have further exacerbated the inequalities experienced by ethnic minorities in Rochdale and across the country, where their voices have been missing (Dawson et al., 2018). These measures are impacting all aspects of life, but differentially impacting those from disadvantaged areas. As schools open up in a staggered approach, while the Department for Education (DfE) has called for sensitivity 'to the needs and worries of BAME members of staff, parents and pupils' (DfE, 2020, p.3), to date no research-based strategies have been proposed to address their concerns (BAMEed Network, 2020).

We here draw on the findings of an ESRC COVID funded impact project, focusing on the needs of the Pakistani communities in Rochdale, an area known to suffer significant social deprivation, both before and as intensified during the current pandemic crisis. This project aims to identify the voices of the communities concerning COVID-19 related health risks and barriers to learning, in order to inform policy makers, health and social care services providers and school practitioners.

The approach to documenting the perceptions of the participants drew on previously developed methodologies exploring how narratives and identities (Black and Williams 2013) inform decision-making, and took an intersectional approach to address how inequalities were understood, in particular highlighting relevant intersections of ethnicity, gender, and social class (Choudry et al., 2017 and Burman, 2020).

We identified key themes recurring across individual, often very private narratives of hurt and pain felt by those enduring racism and abuse - and we see these themes as suggesting a collective experience that calls for collective action. But what actions will we take? We here make some suggestions in relation to four themes from our study.

First theme: "Blaming the victim"

In this theme, we saw the 'blaming of the minoritised community itself' - referenced to media focusing on (often false) accounts of behaviour in the mosques, at the same time sidelining 'bad behaviour' (by others – including members of diverse non-Muslim groups and class backgrounds) in pubs and bars (compared with family gatherings in the homes). This was experienced by almost all participants, especially on social media platforms. This begins in media

gossip but then even becomes a theme within government racism, with much-voiced examples of discriminatory decision-making and policy – including closing mosques yet subsidising pubs, and the manifest differences in government attitudes to Eid and Christmas lock downs.

We suggest there is a need to take actions that bring these experiences and voices: (i) to those in positions of power in the media, in institutions including schools, and in politics where these voices are often currently marginal; (ii) to policies of affirmative action in recruitment and promotion, and (iii) in short term actions to raise the profile of these concerns in institutional governance and practice. With reference to the societal and political level, we would propose that some local scrutiny of the media and national decision-making on local racism is needed. This should not be a one-off inquiry, but a matter of continuing concern and work, reflecting the longstanding injuries and concerns around racism that pre-exist the pandemic.

Second theme: “*marginalisation*” from positions of authority and power.

If the first theme is to lead to positive action, it will have to confront the problem of marginalisation of the communities from access to institutions and positions of authority which can influence policy and bring about change. We recorded accounts indicating how, in GP surgeries, some of the older people who don't speak good English find themselves cut off from their doctor by various unfortunate procedures - some exacerbated by the pandemic (e.g. over-the-phone diagnosis where only English is spoken, or surgeries not allowing accompanying family to visit the surgery with the patient), thus suggesting the call for translation services to be implemented or re-instated. In our follow up consultation, we also found out that, whereas Rochdale council was acknowledging and allowing family members to translate and book vaccination appointments for their elderly relatives who did not speak English, the national organisations had no translation services in place and refused to speak to anyone else even with the permission of the elderly. Thus, we suggest family members be allowed to continue with supporting their elderly relatives, especially where they are recognised as the usual carers for them.

The marginalisation extends to most institutions; but we are particularly concerned with schools whose staffing is perceived to fail to reflect the diversity of the communities they serve. We recommend that any school with a high proportion of minority students should consider whether their staffing and leadership is representative of this diversity, and competent to listen to, understand, and address the needs of minority voices. We also recommend that mental health provisions should be extended, for SEND home support packages to be developed and for improving home/community school communication pathways.

Third theme: *Covid aggravation of discrimination*

The lockdowns, and the particular way some rules are designed, were perceived to be particularly difficult for our participants, leading to increasing distrust of and alienation from governmental and institutional policy. For instance, in many families, parents have to work while also needing to

supervise children not easily engaged online. Additionally, teacher-parent communications need to consider non-English speaking parents, often with no access to or know-how of required technology. Hence, we ask schools to consider sending out hard copies, possibly translated in various languages (reflecting pupil diversity and needs), as well as consider local radio stations, e.g. in Rochdale those that run programs in Urdu to reach non-English speaking parents/ carers.

At such times, what emerges from our consultations is that the closure of community centres and mental health services is an extreme measure, and should only be used in extreme circumstances, as these are places where the particularly vulnerable go, sometimes in desperate need. The closure of such key arenas was highlighted as a major barrier to accessing information and services. We also heard that services and places are in danger of closing permanently, due to lack of funds rather than on health grounds. This, surely, is particularly unfortunate, especially considering the vast sums the Government is paying to keep businesses afloat. Such overlooking of key community resources in favour of business also feeds the sense of racialised grievance, hence we suggest local and national policy makers allocate funding to keep open these centres that offer particular and vital support for vulnerable and marginalised members of society.

Fourth Theme: Covid related communication vacuum

Our participants, members of the Rochdale Pakistani communities, have expressed grievances over not being heard, not being engaged in critical debates related to the Covid-19 pandemic, being expected to be obedient, and conform without questioning the statistics or Covid related information. This has led to some resistance, extending to rejection of information that is shared by policy makers. We heard that the lack of meaningful conversations creates a communication vacuum where conspiracies might take hold, as vulnerable, often isolated members of the community are left to their own devices to come up with a narrative that may explain the, often conflicting, advice by the government over time. Hence, we suggest the establishment of community-based consultations and discussions at the local level to be facilitated by local community leaders and/or local politicians to bridge this gap.

Conclusion

We note that the accounts we documented were from the context of individual experiences of abuse on the street or playground, which were sometimes compounded by denial or ignoring by those who should protect and defend the victims. What the accounts emphasised was how this could become 'normal' and institutionalised, when the victim's experience is denied, or the victim's reaction is labelled an inappropriate over-reaction. This can even lead to institutionalised abuse of the victim, and protection of the abuser (this is also seen in victims of other forms of abuse, as is well known).

Thus, each theme begins with an often very private and painful personal or family experience, but then is identified as a particular- sometimes impassioned - expression of a collective grievance and

need. We suggest this collective experience and need calls for collective action by these communities to express such needs, but also to demand change in policy and practice, to educate those with decision-making powers, and to facilitate communities' access to and influence in schools, as well as the media, health, and politics that matter.

1) Schools, Colleges, Educators

a) **Attendance – communication with parents needs to reflect health and safety concerns as well as measures/rules:**

“When they will ask us to go [back to school] in September, until I go and see everything for myself and speak to the teachers, I would not send them and if it came to that point, I would home school them. I have spoken to a lot of people. A lot of people are trying to home-school the children... Like our community, Pakistani, Asian, they said that if we are not comfortable then we are going to home-school” (Adnan).

b) **Need for a high-quality curriculum: has teaching been ‘watered down’? Work set for home schooling can appear inadequate. Quality review of the online provisions, and staff training in areas where gaps are presented needs to be provided:**

“They [students] have five hours in school, they have five hours of lessons and they are getting everything done within a couple of hours.... Plus, they were not really covering a new topic, right? So that was concerning me, worrying me, that the work is not challenging enough. She [her daughter] was finishing it very quickly” (Razia).

“I need to see the academic side of it... their learning... the education side of it. It has been watered down so much so that there is no point” (Adnan).

c) **Means of school-home communication:**

i) **Consider hard copies along with mobile/online media (applications such as ParentMail)/Facebook/Zoom/Teams:**

“The school where my kids go, they have been sending letters through [via online provisions such as using an app called ParentMail], but then again parents need to have smart phones... to access them” (Shumaila).

- ii) **Consider translating parental communication in various languages to enable proper participation with non-English speaking parents. Consider local radio stations that run programs in Urdu to reach non-English speaking parents/ carers:**

“I think if you don’t have a Facebook then you are really stuck. I think emails are very good, but some Asians can’t speak English. How do they know what is going on in school and colleges?... I mean there are [a] lot of people who are asylum seekers or [from] other countries...people who come here. They do not know English and what not. So yeah, this is an issue, if letters are online” (Shumaila).

- iii) **Perceived inconsistency of safety etc regulations across local primary and secondary schools. Schools need to coordinate their organisation with other local schools in terms of consistency and improvement of existing practices:**

“I suppose they have done it for everyone’s safety, but it is just like a 10 minute overlap. Taking that into account, you have to get one child from one end of the school and then you have to hang out for 10 minutes to go and pick up the other one and then at the same time you have a child at the high school who needs to be picked up. I think schools need to think about the picking up and dropping off times” (Farah).

- d) **Secondary schools emerge as appearing more disconnected from community. Secondary schools can consider Primary school practices that have helped them communicate more effectively (e.g. individual student feedback and prompt follow ups to parent queries):**

“They [the Primary school] do speak a lot to people. I can’t understand why they [the secondary school] cannot make that kind of connection” (Adnan).

- e) **Sensitivity towards the ways historical racism is reactivated by current experiences in schools needs to be developed. Consider educational activity in schools to sensitise teachers/managers to the community’s experiences of racism:**

“I had to go down with my child and have the same conversation with my son and the teacher [about being called ‘Paki’ and retaliating as a response] that my parents had to when I was in primary school” (Adnan).

- f) **For schools to address institutional and everyday racism: schools with a high proportion of minority students should consider if their staff membership is representative across all job levels of this diversity and can address, understand and listen to the needs of the under-represented voices:**

“Asians, they are there, but they will be teaching assistant, cleaners and they will be on benefit jobs. There are 99.95% Pakistani Muslim students [in my child’s school] and the staff is predominantly English. Don’t blame the community if you are putting White middle-class English in the demonstration and control of it... They rarely give the deputy headship to the Asians” (Luqman).

- g) Student motivation for online work a problem - difficulty of the tasks. We recommend teachers/schools should set up meetings to review this with parents/carers and students:**

“I don’t understand [how] you can tell a teenager to get up and come to a screen and study and be serious about it. So, I am very, very anxious about it. I am anxious and I am scared for her” (Farah).

- h) Mental health provisions put in place by school prior to Covid-19 should have continued and need to be resumed, e.g. mentor allocation, Healthy Young Minds, etc.:**

“The [my] Year 8 [child] is also worried, because when he was in Year 7, he got anxiety... So, we helped him with a mentor, but now...coronavirus unfortunately came [and this stopped]” (Shumaila).

- i) For families with children with Special Educational Needs and Disability issues, home support packages need to be developed and provided to parents/carers:**

“My eldest son [with autism], he doesn’t understand much, and gets frustrated easily... I don’t get much home support anyway for the older son” (Sameera).

2) Health and Social Care Services, NHS & GPs

- (a) NHS/GPs, physical and mental health and social care services should work together with community organisations to proactively anticipate and identify individuals who are likely to be excluded or out of communication networks and in need of support.**

Lockdown measures and the pandemic have exacerbated mental health and pre-existing physical health and wellbeing conditions.

These actions are suggested to support, in particular:

- i) Elderly members of the Pakistani and other communities** by creating unnecessary degrees of isolation: “Actually, for grandparents, are you [addressing policy makers imposing

lockdown measures] doing more harm? Because you want to protect them but you see them deteriorating...” (Saira).

- ii) **Working people who could no longer go to work:** “Even my husband was used to going to work every single day. It was hard for him staying in and then just basically it was like a jail” (Tania, mother of a primary school-going child).
- iii) **Children:** “Obviously, children have put a lot of weight on... They can’t go out for exercise because [the rate in] Rochdale is so high and most of the Asian people are so worried that they are going to catch the virus, if I’m walking out” (Shumaila).
- iv) **The elderly in general:** “The problems [health and well -being issues] have increased during lockdown. I have no company [isolated]. I live alone. I can’t walk. I can’t walk from staying inside so much [referring to weight gain impairing mobility capacities]. I can’t go shopping. Just keep sitting. With lockdown, I have got so many more increased issues [referring to health problems related with walking]” (Asma Begum, grandmother living alone in a residential home, original interview in Urdu).

b) Face to face GP appointments need to be protected/prioritised, especially for the elderly and most vulnerable, and those for whom telephone or video consultations are difficult:

“I am thinking about the elders. I’m struggling to make appointments. They are going to local doctors and they are finding that a bit difficult to have medical consultation. But sometimes they need to be seen and they are just not being offered this at all. I think something has to be said and done about it. I think they only offer phone consultation but sometimes they need to be seen they just not been offering it at all” (Farah).

c) Where face to face appointments are not available, video calls should be made more consistently:

“Our GPs are very...We ring them in the morning at 9 am. They give you a phone consultation... And the GP called me on video call. And I was like, eh. She called me and she said show me the blister. So, it depends on the GP surgery. I have some friends who have families and their GPs are not that good. Some are unfortunate, then” (Shumaila).

d) Health services should allow or invite another member of the family to attend face to face health consultations and GP appointments where language is a barrier and/or provide translation services:

“I have an issue with speaking [English] language. Have always had this issue. Dr speaks my home language [Punjabi], so that’s ok. But it is really difficult to make an appointment with

the receptionists at the GP...Now they don't allow or invite female translators to help with the language issues. So, you have to go there [to the GP] and speak by yourself [even if you don't speak English]" (Asma Begum, grandmother living alone in a residential home, original interview in Urdu).

- e) ***For specialist mental health services working with children and young people (such as Healthy Young Minds) to continue and extend their work with schools to address increasing and long-term mental health effects of the lockdown on children's wellbeing:***

"Definitely, definitely, there is anxiety at home. I could see their [Year 8, Year 11 and college students] personality is changing. I could see, they are all more angry and answering back" (Shumaila).

3) National policy regarding local/institutional implementation

- a) ***Action: we suggest there needs to be an inquiry into how national and local policies have exacerbated racism and mistrust in policy makers:***

"You [the government] have considered us as a culprit. Now you're not going to consider us as a victim" (Adnan).

"There was a lockdown just the day before Eid. It was done on purpose. They [government] can't say that they have not done it on purpose. So, you can go to the pub sit down have a meal and get pissed, but you can't go to the mosque where people would follow the rules to the letter" (Luqman).

"They are doing more tests here... In the previous week they had these tents in the market road. You know in the car park. In front of Medina market. They had a tent there. There were so many Asian people there. They said more than half of them were Corona positive... My feelings are that the tests are also coming fake as well. I think they are just giving positive to everybody" (Tania).

- b) ***National lockdown policies that apply a 'one size fits all' approach to ethnically minoritised groups does not work in deprived areas such as Rochdale and need to offer localised interpretations of national policies:***

"They keep giving national guidelines and not localised guidance. Remember, when we listen to the national guidelines, we forget this is national guidelines, not localised guidelines. You

know a lot of our community can't read or write, they don't know what they need to look at for localised guidance" (Razia).

c) **National policy needs to consider how the social 'costs' of isolation outweighs benefits: local communities like the Pakistani community in Rochdale are built and function on the principles of community and family support.**

i) **For social 'bubbles' to operate at all levels of lockdown to prevent isolation and maintain mental health:** "For them to at least have that little safety bubble of immediate family members at least.... They are important to us [Pakistani families]" (Farah).

ii) **For continuation of measures (including in any subsequent lockdowns), that allow a designated family member, friend or carer(s) to assist with living and medical needs of the elderly and others in need of support, e.g. administration of insulin injections, alongside putting in place additional practical and emotional support for these essential carers:** "I go to my mum to give her medication [insulin injections]. She is old and she cannot go to the pharmacy herself. In a way she is a bit depressed" (Asad referring to his 90 year old mum).

iii) **For community centres to be allowed to remain open during the lockdown with health and safety measures to help the most vulnerable:** "Even pubs were opened, [when] community centres were not" (Shumaila, who works at a community centre for women in Rochdale).

- **To support with language:** "My opinion is that most of the people in the centres, such as community centres, are vulnerable people, isolated people.... I mean I had a lady ring [up], she is stuck because she had an electric and gas bill. They have taken her to court, and she is panicking.... She had two little children. She lives on her own. Obviously, she must be vulnerable. So, there are no services out there to help her. I do think our community centre; our council need to do something. There is nothing in place" (Shumaila, who works at a community centre for women in Rochdale).

- **To support vulnerable women:** "I feel that you are a prisoner in your own house. It's not that I used to go out that much, but I used to go to centres" (Aamna, original interview in Urdu).

"I have been in lockdown for 20 years...but in this lockdown I feel suffocated... The little bit I used to go [out] to [were] centres [voluntary local centres], even that, I feel now, as it has been closed they [the council] should open up the [voluntary local] centres" (Sameera, original interview in Urdu).

4) Local Rochdale Policy/Action

- a) ***For the government to work with local Rochdale council to acknowledge, and carry out an official review of, confusing and contradictory lockdown measures since March 2020 in order to re-establish trust of the community and ensure the appropriate impact of any ongoing and future Covid-19 related restrictions and recommendations:***

“Now on social media people are getting more and more aware because they know that what the government is doing is not working. They are manipulating everything and they are trying to force people to do things [referring to lockdown measures] which are not having positive outcome” (Salman).

- b) ***To hold workshops/consultations with local Pakistani community members when devising local lockdown measures and/or reviewing impact of measures:***

“It is your fault and it is your responsibility. I feel if it is our responsibility as a nation or as a community, whatever, we do need to have more of a voice. We need more of a platform...” (Adnan).

- c) ***Language: For translation services to be re-instated, especially where council services and staff interact with local communities:***

“... translation services should be provided for us elderly for council related issues as well. Those of us, who have kids, we need help, too. I have kids, dear, but now I can't even understand them anymore [English language barrier]” (Asma Begum, grandmother living alone in a residential home, original interview in Urdu).

- d) ***For culturally appropriate local food packages to be delivered to vulnerable people, e.g., for elderly residing in 60+ accommodation):***

“ .. the place where my mum lives [old people's home]. There is no help from the government at all. I think once they gave food packages and that is all” (Asad, referring to his 90 year old mum).

- e) ***For local council members to continue to energetically dispel rumours and myths, as well as updates on latest lockdown measures via various platforms such as local radio stations, as well as social media:***

“I hear [about information related to COVID] on the radio [Crescent Radio in Urdu in Rochdale]. I can't listen to news in English [due not speaking the language]. So, I only listen

to our Rochdale radio station” (Asma Begum, grandmother living alone in a residential home, original interview in Urdu).

5) Media

- a) ***Consider the community’s need for media education to access good sources of online support to address distrust in mainstream media:***

“Mainstream media in my opinion is obsolete. Quite frankly. I have applications. And when I say I am following the media... I watch what is going on for the main narrative, but I won’t follow that. I will watch it for some of the information. Then I need to know where I am looking and where I am not looking. What bits are am I not seeing. What are you saying that they are not saying? If you are speaking about them, I want to see their perspective. Only like that you can have informed judgement about what is going on” (Adnan, father of 2 secondary school going children).

- b) ***Call for balanced reporting on disease related deaths to dispel myths, rumours and re-establish public trust and credibility:***

“When they tell you about it in the news and when you read about it, it’s like they’re exaggerating about it a bit too much... because for me, like, so many people die of the flu every year, but they don’t put that in the picture” (Tania, mother of a primary school child).

- c) ***For a local media watch to be put in place through government funding in order to ensure responsible reporting – impact of media reporting on coronavirus on public’s perception of risks leading to panic and, referring to next point (d): perceptions of racial and ethnic discrimination:***

“With coronavirus they’re [media] exaggerating about it so much with coronavirus they’re exaggerating about it so much... And then we saw these people panic buying” (Tania, mother of a primary child).

- d) ***For media outlets to moderate their posts: to consider that biased racial reporting on Covid-19 related issues can incite further, or feed, the grievances of racialised/minoritised people in local communities:***

“There was an article with a restaurant being fined, there was another institution being fined too but they chose to show Manzil Banqueting [a Pakistani restaurant in Manchester] as their main picture [in this article], so I thought that they should have put both on, but one

is on and geared towards the Pakistani community, and the other one wasn't, something very simple like that, just read the title and look at the picture. If you're going to have a portrayal, have a fair portrayal, don't just put in the negatives of COVID cases rising and pictures of Asian people walking around, you will always have someone from the BAME community in the pictures, and people are automatically making an assumption, this is a classic example" (Saira, NHS nurse).

Conclusion: from private voice, to collective voice and action

The voices represented in this *Call to Action* document have told of the pain and hurt of many in the Pakistani Rochdale communities who are suffering from racism and abuse exacerbated by the Covid Pandemic, at multiple levels: individually (on the street, playground, and at work); institutionally (in schools, workplaces, and the NHS); and at societal levels (in government policy/decisions and rhetoric, and in the media, both mainstream and social media).

Each account, generated from our consultations, begins with talk about Covid, but extends to an often very private and painful personal or family experience, and then is identified as a particular - sometimes impassioned - expression of a collective grievance and need. We suggest this collective experience and need calls for collective action by this community to express these needs, but also to demand change in policy and practice, to educate those with decision-making powers, and to facilitate community members' access to and influence in schools, as well as the media, health, and politics that matter.

Thus, our consultation led to the construction of themes:

Blaming the victim; Marginalisation from positions of authority and power; Covid aggravation of already existing discrimination; and Covid-related communication vacuum (both from friends and loved ones, and from health, education, and social care agencies).

The 'voices' at individual, institutional and community levels suggest the need for discussion to lead to new demands and actions across (i) schools; (ii) NHS, health and social care services, GPs and mental health services; (iii) national policy regarding local/institutional implementation; (iv) local Rochdale policy/action; and (v) the media.

What's next?

We will be further discussing these reports and actions with interested groups in the coming weeks, and will extend our website, tweets, and blogs with a full research report in due course. We realise this work is just the start for us and we look forward to benefitting from dialogues on these concerns.

A small grant has been made available to extend our work to the creation of some materials that aim to help families of children with special needs.

We look forward to hearing your thoughts and comments.

As our Primary Investigator (PI) is currently on maternity leave, we invite you to contact Julian.williams@manchester.ac.uk about any matters to do with the PaCCT project.

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