Lessons from the pandemic: community engagement toolkit

A short guide for policy makers, third sector and charity organisations

Dr Damian Breen, Prof Imran Awan, Dr Hannah Begum

Acknowledgements

This toolkit draws upon a project funded by UK Research and Innovation through the Economic and Social Research Council under round two of the Covid-19 BAME Special Highlight call. The research focused on the impacts of the pandemic and community-led responses by Mosques, religious leaders and other Muslim community organisations in Birmingham. The research was focused on a number of wards including Washwood Heath, Bordesley Green, Alum Rock, Small Heath, Handsworth/Winson Green, and Lozells.

The aims of the research project were:

- To explore the specific impacts of the Covid-19 pandemic and adjustments post-lockdown on Muslim communities across a number of wards in Birmingham;

- Identify the principal responses both within the community and by religious leaders, Mosques and other Muslim community organisations around religious conventions, practices and participation in the observance of religious festivals such as Ramadan and Eid within the context of the pandemic, and social distancing post-national lockdown;

- Identify experiences of local government responses to the needs of Muslim communities living in Birmingham during the Covid-19 pandemic as a disproportionately impacted group post-national lockdown;

- Explore the implications of responses which have been provided through Mosques and other Muslim community organisations around collective worship, rituals around death and burial during the peak of the pandemic and thereafter, and the role of Mosques and other community organisations in community solidarity in the context of Covid-19 as a time of crisis.

Background

Who did we speak to?

The research was carried out in three stages:

Stage 1 – we distributed a scoping questionnaire across Muslim communities in Birmingham and received 72 responses with 39 participants being male and 31 being female. This allowed us to identify key areas to focus on in stages 2 and 3 below;

Stage 2 – we conducted 28 one to one interviews with Muslims living in Birmingham which included community members, Mosque leaders, and organisation leads. All participants were Muslim except 2. The non-Muslim participants were included due to their roles in organisations, with one being the lead for the Local Public Health Authority and the other having a leadership role in a community organisation with large numbers of female Muslim stakeholders

Stage 3 – we conducted 5 focus groups (group interviews) with a total of 35 focus group participants (6 of whom also took part in interviews).

Remote Sessions – across the duration of stages 1, 2 and 3 we offered online sessions with female participants which were specifically focused on women's experiences. We felt this was important as the early stages of the research indicated that the majority of community leaders would likely be male. The Remote Sessions were included to ensure the inclusion of women's voices in the research. As a result, we conducted 3 Remote Sessions with a total of 12 female participants across the 3 groups.

In total, the study included 141 participants. At stages 2 and 3 there were 6 participants who took part in both stages, which meant that we had 69 participants who took part across the interviews, focus groups and Remote Sessions. Overall, we had 58 male participants and 83 female participants.

Key insights – approaches to community engagement in the pandemic

Our research provided insights into a wide range of issues around the impacts of Covid-19 on Muslim communities in Birmingham. We also gained significant insights into how Mosques and community leaders led on the implementation of public health interventions.

This toolkit focuses on the ways in which the Local Public Health Authority worked with Mosques and community leaders to deliver public health interventions. This approach saw Muslim community leaders undertake significant roles in informing the ways that public health measures were implemented, and in the process demonstrated the importance of **community leaders** and **trusted voices**.

This toolkit presents a model based on this approach which can be implemented by policy makers, public authorities, organisations and charities to encourage engagement in communities which are perceived as 'hard to reach.'

Examples of community-led interventions in the pandemic

Our research captured a model of community engagement during the pandemic which saw Mosques and community leaders mediate between the Local Public Health Authority and the community. Community leaders led on the implementation of public health interventions, and we also saw some significant examples where interventions were adjusted to better suit the specific needs of Muslim communities.

Example 1 – Mosque closures and lockdowns

National and local lockdowns during the Covid-19 pandemic saw Mosques facing closure – an unprecedented prospect. In Birmingham, the Local Public Health Authority (LPHA) ahead of the first national lockdown start to liaise directly with Mosques on the issue of closing. Only three Muslim organisations responded initially, which included an Islamic Trust Organisation (ITO) which was highly respected within the community. The lead for the ITO took on the role of coordinating with Mosques in the city to meet again to discuss the upcoming lockdown. After compiling a contacts list and working alongside another large Mosque in the city, this resulted in representatives from around 70 Mosques in the city meeting to discuss the upcoming lockdown. Following the meeting Mosques in the city agreed to close pro-actively the week before the national lockdown was even announced.

Takeaway

The difference in engagement here between the result of the LPHA directly liaising with Mosques, and the result of community leaders doing so demonstrates how important trusted voices are in achieving community engagement. Closing Mosques was a sensitive issue, however, involving trusted voices in the process led to a pro-active engagement with closing for lockdown.

Example 2 – Gender and engagement in the research

Throughout the research we found Mosques to be critical not only in contributing to the research, but also assisting us in finding participants. As the project progressed through stages, we found that we were recruiting fewer female participants. Analysis on our stage 1 data indicated that women were more likely to pray at home, and with this in mind we started to approach local support organisations which had large numbers of female Muslim stakeholders. The support that these organisations offered was wide-ranging, and often focused on addressing vulnerabilities. Our approach to recruitment was facilitated through female leaders in these organisations and resulted in many more women being involved in the research. Participation in the research was facilitated within the organisations with female leaders being present to support around clarifying questions and assisting where English was a second language. This allowed women to take part in a familiar environment where they felt safe and supported.

Takeaway

Our project went from having a significant under-representation of women's voices to recruiting more female than male participants overall, with 58 participants being male and 83 being female by the end of the project.

Example 3 – Vaccine uptake in Muslim communities

Perhaps one of the areas where interventions around Covid-19 were met with resistance was in vaccine uptake in Muslim communities. Our stage 1 findings revealed that the proportion of participants who were unvaccinated was 18%, which was 5.5 percentage points higher than the national average for Bangladeshi groups of 12.5%, and 2 percentage points higher than the national average of 16% for Pakistani groups (ONS 2022c). When broken down across ethnic group, 25% of participants who identified as Bangladeshi were unvaccinated compared with 13% of Pakistani participants. This shows that whilst the proportion of participants who identified as Pakistani that were unvaccinated is lower than the national average by two percentage points, the proportion of Bangladeshi participants who were unvaccinated was double the proportion of Bangladeshis who were unvaccinated in the national population.

One of our most significant insights around vaccination uptake came through data we collected around an initiative in and around Lozells, Birmingham. A community leader, and founder of a community empowerment organisation, initiated the establishment of multiple vaccination centres to increase uptake in the Bangladeshi community. Networking with local GPs led to vaccination centres being set up in venues for hire which the Bangladeshi community would use for weddings and other events. Facilitating access to vaccinations in these familiar spaces led to 300 vaccinations being taken in the first week alone.

Takeaway

Vaccine uptake went from 48% in the South Asian community in the surrounding area to 58% as a direct result of this initiative.

Key questions for organisations looking to connect...

Q. How can we encourage underserved or 'hard to reach' communities to engage with what we have to offer?

A.   Getting the information out to communities is only the first step and is unlikely to lead to significant or pro-active engagement. Communities which are underserved or deemed 'hard to reach' will probably benefit more from building relationships based on trust. This takes time but is likely to have a bigger impact on engagement.
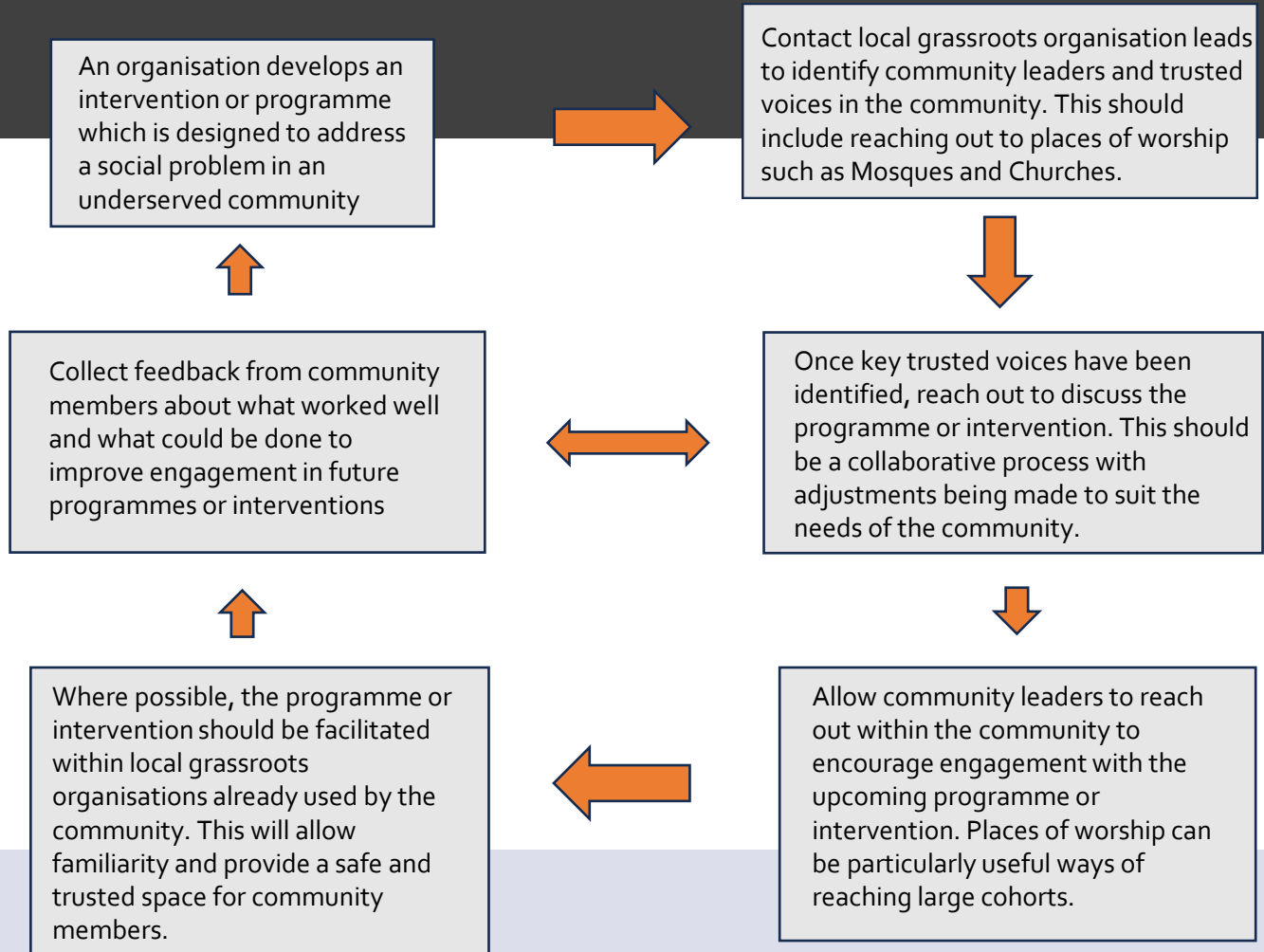
Q. Why are we finding some underserved communities 'hard to reach' as an organisation?

A.   If communities are 'hard to reach' then it can be due to a lack of trust in authorities and formal organisations. Being too formal can come across as a barrier and trigger mistrust. Relatability and cultural competency will likely yield better results than being overly formal.

Q. How do we build trust with those communities?

A. Within communities there will be individuals and community leaders which people trust and will listen to. Identify and approach them to discuss what your organisation has to offer and listen to their feedback. It is likely that community leaders will be seen as trusted voices, and they will know how best to engage the community. It is also important that collaboration allows for programmes or interventions to be adjusted to suit the needs of the community. Trust building works two ways – it is not just about winning the trust of a *community*. It is also about *organisations* trusting feedback from community leaders about how to engage.

Collaborative engagement in action

An organisation develops an intervention or programme which is designed to address a social problem in an underserved community

Contact local grassroots organisation leads to identify community leaders and trusted voices in the community. This should include reaching out to places of worship such as Mosques and Churches.

Collect feedback from community members about what worked well and what could be done to improve engagement in future programmes or interventions

Once key trusted voices have been identified, reach out to discuss the programme or intervention. This should be a collaborative process with adjustments being made to suit the needs of the community.

Where possible, the programme or intervention should be facilitated within local grassroots organisations already used by the community. This will allow familiarity and provide a safe and trusted space for community members.

Allow community leaders to reach out within the community to encourage engagement with the upcoming programme or intervention. Places of worship can be particularly useful ways of reaching large cohorts.

TOGETHER

Recommendations

The toolkit presents a model for organisations to apply in engaging underserved and/or 'hard to reach' communities. Our recommendations for increasing community engagement are as follows:

- Community leaders are trusted voices in underserved or 'hard to reach' groups – scoping within the community to identify leaders can be invaluable for achieving engagement

- Initiatives or programmes should be discussed in consultation with community leaders and adjusted to suit the community

- Trust building enhances engagement. This process should be reciprocal – trust building is not just about convincing a community to trust an external organisation. Organisations/policymakers also need to trust the feedback they receive about their proposed programmes or interventions and how they can be implemented suitably in the community

- Safe spaces enhance engagement – delivering programmes or interventions in spaces familiar to or frequently used by community members can have a significant impact on engagement.

- Community leaders and community members should be invited to provide feedback where they do engage to identify what worked well and what could be improved to enhance engagement for future initiatives.