Working and engaging with minority ethnic communities in an urban setting

Mags Moss, Kamila Hawthorne, Nicola Hughes, Debbie Lavelle, Mui Chen Tan

Article points

1. Twelve general practice teams in the South-West locality of Cardiff were linked to the HeartLink Project and they worked together with the project team to improve access to health care.
2. The link-workers are key people within their communities. With an increased knowledge of specific conditions and the risk of diseases their communities face, they are able to convey and reinforce key health messages.
3. Preparation of link-workers and other advocates within communities, in peer-led education and the Link-worker Healthcare Course will enhance the sharing of key health messages.

Key words

- Minority ethnic
- Link-worker

Author details can be found at the end of this article.

The HeartLink Project, a Welsh Assembly Government Inequalities in Health funded project aims to raise awareness and knowledge of diabetes and heart disease in the Black and Minority Ethnic (BME) communities in the South-West locality of Cardiff in South Wales. The city of Cardiff has significant numbers of BME communities, making up 9% of the population (in excess of 25 000) (Cardiff Health Alliance, 2005). This article discusses the establishment of a network of link-workers, bringing BME communities and the healthcare system closer together.

People of South Asian origin have higher prevalence rates for cardiovascular disease (CVD), diabetes and its complications (Mather, 1998) and have a higher risk of developing them at a younger age (Raleigh, 1997). Therefore, specific actions are needed for these groups. One of the main objectives of the project was to work with the different Black and Minority Ethnic (BME) communities living in the South-West locality of Cardiff, in order to raise their awareness of these conditions and facilitate their access to health care services. These specific objectives were realised in a variety of ways.

A core team was established consisting of a project manager, a nurse, a dietitian and a podiatrist. The team worked to build links with community leaders with the aim of raising awareness of diabetes and CVD, and the effects of lifestyle on health. Twelve general practice teams in the South-West Cardiff locality were linked to the HeartLink Project and they worked together with the project team to improve access to health care. HeartLink supported clinicians in these practices with training and accreditation in diabetes and CVD management, and also in cultural diversity training. Practices involved with the project were able to directly refer people for dietetic advice, podiatry assessment and also for diabetes patient education. These were all provided by the team members.

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1. Initially, large-scale health awareness-raising events for several of the communities were organised. The emphasis was on CHD, diabetes and hypertension and the sessions covered lifestyle aspects of diet and activity.
2. The involvement of community leaders, particularly in organising the timing of an event, the venue and in promoting the event to their community was essential.
3. Working in partnership with voluntary bodies and NHS services ensured good attendance and response to the event.
4. Further funding allowed a second phase of the project. Working with smaller groups of people, we explored other ways to deliver the healthy lifestyle message.

Initiating relationships with BME communities

The BME groups were introduced by identifying and approaching the leaders (usually religious leaders) of the community. The established local Multicultural Health Resource Information Centre (MHRC), funded by Cardiff and Vale NHS Trust, also offered a starting point for gaining an understanding of the various communities by the provision of link-worker and interpretation services. Other government-funded projects working with BME communities provided links to the communities. Developing these relationships was the beginning of an understanding of the attitudes and health beliefs of the different communities in order to provide appropriate and acceptable health education programmes.

Community events

Initially, large-scale health awareness-raising events for several of the communities were organised. The emphasis was on coronary heart disease, diabetes and hypertension, and the sessions covered lifestyle aspects of diet and activity. The aim was to encourage changes in lifestyle and therefore modify the risk factors of developing these conditions. Information stands, displays and advice were available from different healthcare professionals and organisations. Some of these resources were available in a number of languages. Screening, in the form of a full cardiovascular risk assessment, was provided in partnership with the Wales Heart Research Institute at the University of Wales College of Medicine. In our first community event for example, 52 people underwent a risk assessment, which identified high blood glucose levels in a few individuals, indicative of likely (undiagnosed) type 2 diabetes. These individuals were referred to their GP for further investigation. Opportunistic screening was offered in part to demonstrate to participants what they could expect from their primary care health teams. Although the event was not community specific it was well attended by people from the Pakistani and Somali communities. Such events attended by a diversity of communities had their place in raising awareness but certain cultural restrictions (such as the segregation of men and women) meant that some communities could not access the health promotion effectively. We soon realised that full cardiovascular screening was time consuming. However, we did learn that the involvement of community leaders, particularly in organising the timing of an event, the venue and in promoting the event to their community was essential. Working in partnership with voluntary bodies and NHS services ensured good attendance and response to the event. An example of the organisation of an event is given in *Box 1*.

Several other community-specific events were organised to enable us to deliver the key health messages of the impact of a healthy lifestyle on preventing ill health.

Working with smaller groups

Further funding allowed a second phase of the project. Working with smaller groups of people, we explored other ways to deliver the healthy lifestyle message. Some of the communities were approaching us to bring information and education to specific groups within their networks. HeartLink has worked with women's groups such as Minority Ethnic Women's Network, with the BME section of the Carer's Association and the Chinese elderly community. The advantage of working with these groups is that they are already established, and provide an established and familiar venue for the target community. The key health information in these groups was still one of a 'generic' healthy lifestyle.

Diabetes patient education groups

HeartLink also now offers patient education groups for people newly diagnosed with diabetes. The shift of emphasis to working with smaller groups also reflects the increasing recognition of the importance of providing people with diabetes a structured

Box 1. An example of a community event: African–Caribbean.

The African–Caribbean community is formed of peoples who originate from several of the Caribbean Islands. They are a well-established group in Cardiff and have largely integrated with the Welsh community. They have strong community affiliations and are largely represented by the African Caribbean Community Group (ACCG). In health terms this particular group of people are known to be at greater risk of certain diseases than the indigenous population. In particular there is a high incidence of hypertension among the African–Caribbean community.

Preparation

Preparation by the Barefoot Health Workers Project (a partner project working with BME communities in the same locality addressing lifestyle issues) and a focus group discussion informed us about the culture and health beliefs of the community, the ACCG enabled contact with people willing to participate in the focus group. The African–Caribbean population is a very diverse one that encompasses a variety of unique cultural and dietary habits. Such diversity persists in first and later generations. The focus group was useful in identifying the health beliefs and the cultural approaches to diet, and to health and diabetes in particular. Discussions were held with partner organisations, for example, Diabetes UK, The Stroke Association and the dietetic and podiatry departments of the local health care trust who all agreed to be present on the day. Shiloh Church, one of the community's places of worship, was chosen as a suitable venue.

The event

On the day, the venue was prepared to allow for privacy for health screening and equipment was organised. A period of screening in the morning was followed by brief presentations by healthcare professionals on diabetes and hypertension, diet, and the patient experience of these conditions followed by a question and answer session. Partnership with healthcare professionals from the locality and with a dietitian who was also a member of the African–Caribbean community was an important factor. The screening consisted of measurement of height, weight, body mass index, blood pressure and blood glucose. Each individual was given a card with their results. A record was kept of these results so that GPs could be informed of those with abnormal results. Clinicians and professionals from the African–Caribbean community participated in the day.

The day ran from 10.30am to 4pm with people coming and going throughout the day. Thirty-nine adults and 10 children attended the event and a crèche was provided. Lunch was provided by the African–Caribbean community and our dietitian was involved in the choice of menu for this.

education about their condition within six months of diagnosis (NICE, 2003; Diabetes UK, 2006). Few people are given this opportunity at present and education is rarely available to those from BME communities (Leedham, 2000). Significant numbers of people (particularly from minority ethnic groups) are poorly informed about their condition which affects perception of their condition and their use of health care services (Hawthorne, 1990; Baradaran and Knill-Jones, 2004). The inclusion of lay health workers with the appropriate language and cultural knowledge is essential if education programmes are to be tailored to the needs of the community (Diabetes UK Cymru, 2005). The link-workers from the MHRC were always part of the early planning of the educational groups. They act as co-organiser, interpreter and advocate, and generally facilitate the session together with the healthcare professional. The link-worker is both role model and part of the team.

Patients are referred for diabetes group education to HeartLink by their GPs and practice nurses. The link-worker may also invite people in the community that would benefit from attending. The link-worker is given an introduction to the course. A suitable local venue is chosen – usually a place of worship or community hall. The courses are community and gender specific. People are invited by letter that includes information about the course and the contact name and telephone number for the relevant community link-worker. The names of the invitees are shared with the link-worker for the community and they in turn meet with

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2. Link-workers act as co-organiser, interpreter, and advocate and generally facilitate the session together with the healthcare professional. The link-worker is both role model and part of the team.
3. People are invited by letter in English along with information about the course and the contact name and telephone number for the relevant community link-worker.

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1. The educational resource used is the Taff Ely Diabetes Education Programme which HeartLink has adapted for use with BME communities.
2. A key factor in attendance seems to be the persuasive power of the link-worker and also the importance that the GP or practice nurse gives to the intervention when they invite participants to attend.
3. The link-worker service provision has helped in overcoming language and cultural communication problems and also acts as an advocacy service to help people obtain the most from their health and welfare system.
4. The link-workers are key people within their communities. With an increased knowledge of these conditions and the risk of diseases their communities face, they are able to convey and reinforce key health messages.

the person with diabetes or contact them by telephone and encourage them to attend the group. The link-worker then helps the team members to deliver the education.

The educational resource used is the Taff Ely Diabetes Education Programme (Husband and Chegwidden, Rhondda Cynon Taff Local Health Board) which HeartLink has adapted for use with BME communities. The programme is a Microsoft PowerPoint presentation using graphics and few words. Where possible some of the on-screen words have been translated and this has been appreciated by the participants. The course consists of two 3-hour sessions held a week apart. The primary care teams are very much a part of the process. Practice nurses have the course content on CD and are able to use this to reinforce learning points with their patients. The practice teams are informed when their patients have attended a course.

Numbers attending these groups have been few. A key factor in attendance seems to be the persuasive power of the link-worker and also the importance that the GP or practice nurse gives to the intervention when they invite participants to attend. When we did succeed in getting a group of people together, participants appeared to enjoy and value the information and education they received. Written evaluations were all very positive and enthusiastic (see *Box 2*).

Box 2. Written evaluations from participants.

"Feel much more confident learning about effects of diabetes and managing my illness."
Bangladeshi woman

"I am confident enough now because before sometimes I will not take medication."
Somali woman

"Have started to wear shoes rather than sandals and am more active around the house."
Bangladeshi woman

"I've gained peace of mind by coming to these sessions and am not as afraid of my illness."
Bangladeshi woman

The essential factor of link-workers

The BME communities are disadvantaged in that they are less likely to know about the health services that are available and are unlikely to use them for preventative care (Hawthorne, 1990; Hoare, 1992; Naish, 1994).

The link-worker service provision has helped in overcoming language and cultural communication problems and also acts as an advocacy service to help people obtain the most from their health and welfare system. Currently, Cardiff's MHRC employs part-time link-workers from the Somali, Bangladeshi, Arabic and Pakistani communities. The link-worker service is provided by the local NHS trust and the provision is primarily for the secondary health care service. However, the HeartLink project contributes financially to the service and we are able to utilise the link-workers as necessary.

The HeartLink team provided education for the link-workers to maximise their effectiveness in helping to deliver key healthcare messages. For example, for the diabetes group education programme the link-worker is given training in the educational tool used and is fully involved in encouraging people to attend and in delivering the course content. The link-worker's presence is important not only to interpret the language but also to assist in delivering the important healthcare messages. They need to understand for themselves what is being taught so that correct and consistent information is given to the participants.

The link-workers are key people within their communities. With an increased knowledge of these conditions and the risk of diseases their communities face, they are able to convey and reinforce key health messages. The link-worker's role is enhanced by this increased knowledge (see *Box 3*).

The positive experiences of the link-workers, and their enthusiasm for a better

Box 3. A link-worker's opinion of the system.

"We have been working closely with the team who prepared the course in terms of the translation and general preparation of the cultural side of it and that helped me."
"…I especially liked that [the slides] *were in Somali, as I can speak, read and write Somali and it showed the seriousness of the people who organised it."*
*"Since the course I often use the information I have learnt (*about diabetes and healthy lifestyle*) in my dealing with clients."*
Female Somali Link-worker

understanding of health and disease led us, as a HeartLink team, to develop training programmes for them. A link-workers healthcare course of four half-day sessions covering aspects of chronic disease was established. Sessions included heart disease, diabetes, hypertension, respiratory conditions, dermatology and screening services for women as well as sessions on healthy eating, podiatry and information on the Expert Patient Programme. Peer-led dietetics and podiatry courses have also been developed for link-workers by the project. This not only aims to increase the link-worker's knowledge but also enhances their development as role models and advocates in their communities.

Conclusion

Over the last 5 years we have learned a great deal about ways of working with ethnic minority groups (see *Box 4*). Much of what we have learned is generic and would apply in any context of health care of minority ethnic groups. We expect that much of the work we have done will continue. Working directly with primary care teams will add to their

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knowledge and understanding of cultural differences and particular needs of BME communities. Raising awareness within BME communities of the particular health issues they face will, we hope, lead to consideration of a healthy lifestyle. Preparation of link-workers and other advocates within communities, in peer-led education and the link-worker healthcare course will enhance the sharing of key health messages. ■

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1. Raising awareness within BME communities of the particular health issues they face will, we hope, lead to consideration of a healthy lifestyle.

Author details

Mags Moss is a Nurse Facilitator for the HeartLink Project; Kamila Hawthorne is a Clinical Senior Lecturer at Cardiff University; Nicola Hughes is a Manager for Chronic Disease/HeartLink Project Manager, all based in Cardiff; Debbie Lavelle is a Dietitian and Mui Chen Tan is a Podiatrist, both at Cardiff and Vale Trust/HeartLink Project.

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Box 4. Lessons learnt and things to avoid.

Lessons learnt

- Working in partnership with communities, primary care colleagues and health trust colleagues is vital.
- Working with community leaders and link-workers improves access and acceptability.
- Identifying groups or organisations within communities is useful.
- Utilizing the potential of link-workers as advocates is pivotal.
- Adapting to suit the needs of the communities, for example gender segregation, choice of venue or timing of events encourages attendance.
- Utilizing opportunities for health education is helpful, for example catering for healthy eating.
- Patience and time is required to build relationships (sometimes up to 5 years!).
- To maintain the relationship you must deliver what you promise.

Things to avoid

- Presenting complicated risk assessment is unproductive to large numbers of people in a noisy environment.
- Underestimating the difficulty of mobilising people to come to group events.
- Assuming communities will be the same – approach each community with an open mind and check your information with them.
- Trying to do it all on your own – value partnerships!
- Organising the event on the same day as another local event or during a religious period (unless invited specifically by the community).

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