

Better
Health
Briefing

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**Effective
methods of
engaging black
and minority
ethnic
communities
within health
care settings**

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Key messages

- 1 Evidence shows that poor engagement with black and minority ethnic communities in health care still exists, resulting in unequal access and care
- 2 Barriers to effective engagement with black and minority ethnic communities include those of language, communication and culture, as well as a lack of diversity in the health care workforce
- 3 A range of methods exists that can be utilised to enhance engagement with black and minority ethnic communities
- 4 Practical considerations also need to be addressed when using engagement methods with black and minority ethnic communities
- 5 The existence of good practice is illustrated by examples from London, Leeds and Bradford.

Introduction

There is evidence to show that poor engagement between service users and health care staff has a negative effect on access to services ([Betancourt *et al.*, 2002](#)) and on the development of relationships between service users and professionals ([Mir, 2007](#)). The need to reduce inequity and improve access to health care for black and minority ethnic communities has been recognised in recent years with significant development of policies and practices to overcome cultural incompetence and improve engagement ([Sproston and Mindell, 2006](#)).

The [Acheson Inquiry \(1998\)](#) was a key initiative for putting health inequalities on to the policy agenda. It recommended that policies need to consider and be sensitive to the needs of black and minority ethnic groups in service provision and health care. The recent [Darzi Report \(2007\)](#) also proposed a remedy for health inequalities by making services more accessible to people from these communities.

The need for effective communication between health professionals and service users has been emphasised within national policy ([DH, 2002](#)). To achieve this aim and provide the best services, an understanding of values and beliefs of different groups, and the way in which these influence expectations and assumptions, is required ([Lago and Thompson, 1996](#)).

1 Poor engagement with black and minority ethnic communities

Under equality legislation, social and health care providers, both statutory and voluntary, are required to make special efforts to reach black and minority ethnic communities ([POST, 2007](#)). However, research has identified that specific health care needs in these communities are often unmet as a result of poor engagement on the part of health care professionals.

The [Thomas Pocklington Trust \(2008\)](#) found that eye care in these communities is still neglected and that many services are 'add-ons' to existing services rather than routine. Research has also shown that black and minority ethnic diabetes patients are not accessing appropriate and adequate care for their condition, due to lack of access to interpreters, health information counselling and materials ([Baradaran *et al.*, 2006](#)). In addition, there are concerns that when cancer patients and carers from black and minority ethnic communities try to access palliative care services, their needs in many key areas are unmet and the care they receive is sub-standard and not culturally sensitive ([Worth *et al.*, 2009](#)).

Inequalities in accessing care for black and minority ethnic groups have been recognised as being due particularly to a lack of cultural competence on the part of NHS staff (Suresh and Bhui, 2006). Health care staff are either not always aware of the issues or do not know how to address them, or they believe that a 'one size fits all' approach to health care will suffice. However, evidence shows that deep-seated cultural and social beliefs held by patients from black and minority ethnic communities can give rise to discrimination on the part of health care professionals, which in turn obstructs quality care (Latif, 2010 forthcoming).

Barriers to effective engagement

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There are a number of barriers that can be detrimental to effective communication and engagement with black and minority ethnic groups (Betancourt *et al.*, 2002). Language and communication appear to be two of the largest of these.

Language barriers

Ineffective communication between health care professionals and black and minority ethnic service users can be due to language mismatch or poor interpretation services and has been described in a plethora of studies (Worth *et al.*, 2009). In a study of the end-of-life care needs of South Asian patients, poor English language skills meant that resources were not being accessed, because patients were unable to make appropriate enquiries (Worth *et al.*, 2009).

Unfortunately, research evidence focuses strongly on issues of communication and language needs of South Asian communities, while the needs of Black African Caribbean communities are ignored. Robinson (1998) found that in these groups, non-verbal gestures and nuances were also significant. In a research study of Black African Caribbean fathers' experiences of health and primary care services, good communication between fathers and health care professionals was considered crucial to addressing health care problems (Williams and Hewison, 2009). Service needs of Black African Caribbean people highlighted cultural barriers that hindered access to generic homeless provision. In particular, majority ethnic staff viewed animated discussions by people of African background as aggressive and unacceptable behaviour (ROTA, 2007). A similar scenario can arise in health care settings if health care professionals are not able to grasp the nuances of language and communication norms of Black African Caribbean service users.

Cultural barriers

Barriers such as racism, cultural ignorance and stigma need to be challenged when engaging with Black African Caribbean people and their families. For example, underlying psychological and social factors arising from racism and memories of slavery can lead to a general mistrust and suspicion of health care professionals (Breaking the Circles of Fear, 2002). Understanding of and sensitivity towards the behaviours of people from this community are therefore essential when engaging with them. Similarly, spirituality can be an important factor in the health and well-being of older Black African Caribbean people and must also be considered when deciding on methods of engagement.

Culturally competent staff are important for a variety of reasons. Firstly, as the UK becomes more diverse, health care professionals will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds. For instance, these patients may present their symptoms in ways that differ from standard medical textbooks. They may have limited English proficiency, different thresholds for seeking care or different expectations about their care, and beliefs that influence whether or not they adhere to providers' recommendations (Berger, 1998).

Secondly, research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes (Stewart *et al.*, 2000). Thus, poorer health outcomes may result when socio-cultural differences between patients and providers are not reconciled in the health care encounter (Williams and Rucker, 2000).

Engaging with family members is also important. As a result of the myth that black and minority ethnic communities 'look after their own', health care professionals may wrongly consider that people from these groups do not require the same support and care as the rest of the population (Welsh Assembly Government, 2003).

Access to service provision can be limited by family attitudes, norms and values. If underlying attitudes are understood, it is easier both to address them and to engage with individuals. For instance, different social, cultural and spiritual beliefs about death and dying are expressed in the South Asian community (Gatrad *et al.*, 2003). In this community the diagnosis of a life-limiting illness may not be discussed (Gunaratnam, 2007) and they may find it difficult to accept care from someone from outside of their community.

Lack of diversity in the workforce

A lack of diversity in the health care workforce has been described as a barrier to culturally competent care (Betancourt *et al.*, 2002). Research has shown that when racial concordance exists between patients and health care professionals, there is greater patient satisfaction (Saha *et al.*, 2000) and higher quality of care. There is evidence to show that some black and minority ethnic service users prefer to see black and minority ethnic health care professionals (Saha *et al.*, 2000). It appears that shared culture and language are important factors in creating both rapport and positive experiences of engagement between the health care professional and the service user. Service users also perceive the quality of care they receive to be better when such concordance exists (Betancourt *et al.*, 2002).

3 Methods of effective engagement

Effective engagement can be achieved by making changes to the ways in which health professionals carry out their work and ensuring that health care staff are not only aware of, but also understand and are sensitive to, the range of norms and values of black and minority ethnic groups.

A range of methods and initiatives exists that can be utilised to enhance engagement with black and minority ethnic communities. In the first instance, it is important to research the communities in question and engage proactively with them in a culturally sensitive manner (NeLM, 2010).

Focus groups

The use of focus groups can be productive in allowing health care professionals to elicit the attitudes underlying certain health behaviours. For instance, a focus group of young men from black and minority ethnic communities in Bradford identified embarrassment as a major factor in not accessing sexual health services. The findings pointed to the need for more advertising of sexual health services in places frequented by these young people, and more services to be offered in non-traditional locations (Samangaya, 2007).

Focus groups are also effective in challenging stereotypical perceptions of black and minority ethnic communities held by organisations and staff. In a research study of Muslim peoples' experiences of health care and levels of satisfaction with health care services, a focus group of Muslim participants identified a few cases where they had been stereotyped for wearing traditional clothing, such as the headscarf for Muslim women (OSI, 2009).

Patient forums

Patient forums can be a good way to enhance engagement with black and minority ethnic communities on health care matters. Not only do they give the communities an opportunity to voice their opinions on the areas of health care that matter to them, they also allow health care providers to gain a deeper understanding of cultural issues and practices. This increases the cultural competence of the health care workforce and enhances engagement with the communities. Forums encourage partnership working across different departments and staff, and even across different agencies. They also allow time to focus on key aspects of work to improve services.

Forums inform health care professionals about the correct engagement tools and techniques to use, about any difficulties that may exist between communities and about how to produce information in the best possible formats. For instance, some languages are better spoken rather than being translated into written materials: an example is Sylheti, a dialect of Bengali, from the Sylhet region of Bangladesh, which has no written form.

Service user groups

The Social Care Institute of Excellence (SCIE) has identified people from black and minority ethnic communities as marginalised and excluded from user groups. They have been described as 'seldom heard' users (Carr, 2004; Begum, 2005). Involving minority ethnic users can be a challenge, and careful consideration needs to be given to the recruitment of users from such excluded groups (Rhodes *et al.*, 2001), as different strategies may be necessary for their recruitment and to facilitate their involvement (Begum, 2006). It is important to ensure that a diversity of views is incorporated within the user group, from both past and present experiences of health care services, as this is crucial for its success (Baxter *et al.*, 2001).

A black and minority ethnic service users' advisory group was established as part of a diabetes service evaluation in Bradford. The group's success was the result of personal contact; continuity of membership; confidence in numbers, which membership of the group gave; and the opportunity to meet and discuss issues away from the main meeting. Wider benefits included the ability to share knowledge with others and gain greater intercultural understanding. It was concluded that facilitators should approach users with a view to shared decision making rather than control (Rhodes *et al.*, 2002).

Real Involvement and LINKs

In 2008 the Department of Health brought out new statutory guidance to help the NHS involve people in health care (DH, 2008). The document, titled *Real Involvement*, states that the NHS must improve engagement with all patients in developing plans and making decisions about local health services. This guidance may particularly help previously excluded groups become more involved with decisions made by the NHS, such as redesigning services or developing a commissioning strategy.

Embedded within the *Real Involvement* guidance is the development of Local Involvement Networks (LINKs). These bring together local people, organisations and groups – including faith and minority ethnic groups – to improve health and social care services in the local area. LINKs promote and support the involvement of people in the commissioning, providing and scrutiny of health care services. For instance in 2008, neighbourhood development officers working at ward level in Birmingham East and North Primary Care Trust identified the key people in the local communities and how to reach them. Engaging with Muslim groups after Friday prayers proved to be a good vehicle for sharing information. It involved good communication, openness and trust in an environment that was comfortable for the communities concerned.

INVOLVE

INVOLVE was established to promote public involvement in research and how it is prioritised, commissioned, undertaken, communicated and used (e.g. see INVOLVE, 2008). This has given previously disadvantaged groups a chance to become involved in the health and social care research process. Active involvement in this way leads to research that is more relevant to people and more likely to be used to improve practice in health and social care.

CLAHRC/NIHR

For instance, a large research programme, the Collaboration for Leadership in Applied Health Research and Care (CLAHRC), in conjunction with the National Institute for Health Research (NIHR), is focusing particularly on patients with vascular disease from black and minority ethnic communities in the Greater Manchester area, and is involving people from these communities in prioritising, designing and implementing the research. This should result in health care services that are more accessible and appropriate for the communities concerned.

Although all methods of engagement mentioned above are applicable to the wider population as a whole, focus groups, patient forums and service user groups can be more effective in engaging with patients from black and minority ethnic communities. The work promoted by LINKs and INVOLVE may also help to engage them more effectively, ensuring earlier access to services and prevention of serious illness.

4 Engagement methods: practical considerations

Consideration should be given to barriers in the physical environment that may hinder user engagement. Practices and contextual factors that facilitate participation include the provision of transport, using interpretation and translation services, allowing adequate time for meetings, culturally sensitive practices and recognising users' complex and multiple needs (Begum, 2006).

The timing of meetings is crucial. Meetings timed on Friday afternoons have been shown to exclude Muslim users who attend formal prayer sessions at a mosque (Rhodes *et al.*, 2002); this particular time should therefore be avoided. In addition, meetings should not be arranged around religious festivals and holidays, as this will affect attendance levels.

Other modes of participation should be offered to those who are not able to attend in person. Consultation should also be allowed via telephone, newsletter, email, internet forum and postal letter. This will enable those who are not able to participate in person, due to ill health or family commitments, to contribute at their own pace (NeLM, 2010).

5 Examples of 'good practice'

Increasing cultural competency via community forums

A forum organised and facilitated by the London Ambulance NHS Trust, as part of the Organisational Development (OD) National Learning Event, focused on engaging black and minority ethnic communities in health services. This sixteen-week project was completed together with the National Centre for Involvement and engaged the Bangladeshi community in Tower Hamlets. This project was used as an example to stimulate discussion and dialogue on how health organisations can better engage with black and minority ethnic communities.

Resources 1

The following publications are useful resources regarding health-related policies, inequalities in health for black and minority ethnic communities, cultural competency, communication and methods of engagement. They also highlight practical ways in which service provision for these groups can be improved.

Book

Bhopal, R. (2007) *Ethnicity, Race, and Health in Multicultural Societies: Foundations for better epidemiology, public health, and health care*, Oxford: Oxford University Press.

This book describes the concepts of ethnicity and race in health and defines health and health care needs, ethnic inequalities in health and health care and strategic approaches.

Reports

Betancourt, J.R., Green, A.R. and Carrillo, J.E. (2002) *Cultural Competence in Health Care: Emerging frameworks and practical approaches*, New York: The Commonwealth Fund.

This report describes cultural competence in health care and presents definitions of and barriers and benefits to culturally competent care, and models of culturally competent care in hospitals and the community. It can be accessed at: www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf

Open Societies Institute (OSI) (2009) 'Health care', Chapter 7 in *Muslims in Europe: A report on 11 EU Cities*, New York: Open Societies Institute and Soros Foundations Network.

This chapter focuses on Muslim experiences of health care and access to adequate care using focus groups as an engagement tool. The full report can be accessed at: www.soros.org/initiatives/home/articles_publications/publications/museucities_20080101

The forum identified a clear need for health organisations to explore more fully how to better engage these communities. It suggested further training; discussion groups; focus groups; sharing examples of good practice; written guides; making use of tools and techniques for involvement; and the development of an information pack.

Evaluating health care services using a service users' advisory group

A service users' advisory group comprising members of the Bangladeshi community was established as part of a diabetes service evaluation in Bradford. The aim was to identify barriers to accessing such services. As part of a wider evaluation of diabetes services, this group was set up to gain the views of a specific minority group and problems they may experience.

This service user group engaged users effectively and identified the problems they experienced in order to improve access to diabetes services. Barriers to access identified were cultural insensitivity; similarities with, as well as differences from, other groups in the community; and general weaknesses in service provision.

Strategic engagement using a multifaceted approach

The Leeds Black and Minority Ethnic Strategy Group acts as an advisory body, represents communities in Leeds and engages in key issues with those planning, delivering or commissioning services for these communities. The group hosts various events. For instance, in 2008 a range of health practitioners, community leaders and strategy group members were invited to a focus group to explore the ways in which black and minority ethnic communities engage with the health agenda, the gaps that exist and how to address these. The result of this was a report titled *BME Health (2008)*. This highlights thirteen key messages that NHS Leeds are asked to review and report on. It was sent to all relevant black and minority ethnic groups and agencies. Attendees at the focus group meeting will be asked to reconvene in the summer of 2010 to monitor progress.

Conclusion

Ineffective engagement between health and social care professionals and black and minority ethnic communities results in unequal access to services and care. A health care workforce that has culturally competent staff and involves families in the communication process is a first step to effective and successful engagement. Focus groups, patient forums, service user groups, community involvement using LINKs and INVOLVE are examples of ways in which service providers can engage more effectively with black and minority ethnic service users. Emphasising engagement with these methods is more likely to increase access to services for these communities and improve health.

Resources 2

Journal articles

Rhodes, P., Nocon, A. and Wright, J. (2003) 'Access to diabetes services: the experiences of Bangladeshi people in Bradford, UK', *Ethnicity and Health*, 8, 3, pp. 171–88.

This article describes a service user group from the Bangladeshi community set up to evaluate diabetes services in Bradford.

Scheppers, E., Dongen, E.V., Dekker, J., Geertzen, J. and Dekker, J. (2006) 'Potential barriers to the use of health services among ethnic minorities: a review', *Family Practice*, 23, 3, pp. 325–48.

This paper is a review of articles published between 1990 and 2003 reporting barriers experienced by black and minority ethnic groups when accessing health care services.

Websites

Centre for Evidence in Ethnicity, Health and Diversity
www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/

This website contains information on seminars, events and research publications and projects.

NHS Evidence – Ethnicity and Health
www.library.nhs.uk/ethnicity

The NHS has a specialist library resource on ethnicity and health. It includes the latest news on evidence, consultations and resources on ethnicity, health inequalities, related research, practice and policies.

Transcultural Health Care Practice
www.rcn.org.uk/development/learning/transcultural_health/transcultural

This website is an educational resource for all health care professionals. It includes materials on diversity and transcultural communication.

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