

Research paper

Developing cultural competence across communities: a coronary heart disease training programme for health advocates and trainers

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What is known on this subject

- In the UK, some minority ethnic communities have higher rates of coronary heart disease (CHD) and diabetes, particularly those of South Asian origin.
- People from these communities often face significant barriers in accessing advice and treatment to prevent and manage heart disease.
- Recent initiatives to help to overcome these barriers include the use of community-based health advocates in statutory health services and voluntary organisations, in addition to the UK Department of Health's health trainer programme.
- These activities have yet to be evaluated, and we know little about the most effective ways of achieving community engagement to improve health outcomes.

What this paper adds

- By offering an evaluation of a series of national training courses, aimed at facilitating greater awareness of ethnicity and CHD among health trainers and advocates, this paper shares the realities of community engagement.
- In sharing these realities, our evaluation reflects on the key ingredients of successful training programmes that are valued by participants, improve their knowledge, and provide them with the necessary skills to engage with local communities and improve health outcomes.
- Building community capacity and cultural competence requires a multi-faceted approach, in which training and engagement initiatives, such as those described in this paper, represent essential building blocks, especially in the light of a poorly developed evidence base, which rarely translates into practice.

ABSTRACT

The health disadvantages faced by ethnic minority communities have prompted a range of local and national initiatives aimed at improving health outcomes. Community-based health promotion and advocacy is one such initiative, which has been further developed in the UK by employing health trainers in voluntary and community organisations as part of a nationally sponsored government programme. These trainers complement the work of health advocates, interpreters and community health workers, bridging the gap between statutory provision and local communities by encouraging healthy lifestyles across different ethnic groups.

Between 2006 and 2008, the British Heart Foundation (BHF) delivered a series of training courses to improve the knowledge of these workers, while at the same time ensuring that this knowledge had meaning within the context of a multi-cultural society. Evaluation of these courses, using a mixed methods approach, from the perspectives of different stakeholders demonstrated the value of planning

proactive engagement with local voluntary and community organisations, ensuring diverse representation among participants, the importance of locating learning in concrete, everyday settings that are relevant to the way in which delegates worked, and relating training to local circumstances.

The long-term impact of such initiatives is difficult to gauge, but successful interventions can be viewed as building blocks towards facilitating community engagement and building capacity. They are also a potential stepping stone in developing a culturally competent workforce. A proactive third-sector organisation that is willing to develop these ideas is equally important for ensuring that the value of such initiatives assumes relevance long after funding has formally ended.

Keywords: coronary heart disease, ethnicity, training and education, voluntary and community provision

Introduction

Advanced industrial societies struggle to provide accessible and appropriate healthcare for culturally and linguistically diverse populations (Healy and McKee, 2004). These are long-standing and familiar problems, but our failure to engage with them contributes to flawed understanding, inappropriate responses and wasted resources (Atkin and Chattoo, 2007). Despite a commitment on behalf of many public organisations in the UK to tackle inequalities and promote diversity, there remains an ongoing disparity between our understanding of the issues and our commitment to act (Taylor, 1994). It is not always clear, for example, what works and why. By reconciling this disparity, we can provide the foundations for more successful interventions, where emerging evidence can engage with and develop existing examples of innovative practice. This represents the starting point of this paper.

Health inequalities and inequities

The problems experienced by people from minority populations can be attributed to both *inequalities* in health status and *inequities* in the way that health services respond to need (Bhopal, 2009). Ethnicity, for

instance, is associated with social disadvantages such as low income, poor housing and low levels of educational attainment, which in turn can be associated with the development of serious chronic health problems, such as diabetes and coronary heart disease (Karlsen and Nazroo, 2009). However, the relationship between ethnicity and health inequalities is complex, and we need a sophisticated approach when conceptualising ethnic differences (Astin and Atkin, 2010). Ethnicity is not always an explanation for a person's disadvantage. Social class, gender and age might be equally important, and many so-called ethnic differences in patterns of disease can be explained by socio-economic disadvantage. Equally, socio-economic disadvantage cannot wholly explain the higher risk of coronary heart disease (CHD) among people of South Asian origin (Nazroo, 2004).

People from some ethnic backgrounds might have an inherent susceptibility to these conditions (Gupta *et al*, 2008). Those from the Indian subcontinent who are living in the UK exhibit overall rates of diabetes that are four to five times higher than those of the general population. The rate of premature death from heart disease is 50% higher in South Asian populations compared with the general population (Astin and Atkin, 2010). Inequities in access to appropriate interventions might also explain higher rates of health inequalities. Cardiovascular disease (CVD) mortality for men aged between 20 and 69 years living in England fell by 29% between 1971 and 1991. For men living in

England but born in South Asia, the decline was considerably less (20%). A similar trend was evident for women (Harding *et al*, 2008). Furthermore, less than half of the people who are entitled to cardiac rehabilitation receive it, and the majority of those who participate are white males. This leaves minority ethnic groups, women, older people and those of lower socio-economic status under-represented (British Heart Foundation, 2009).

In exploring this further, heterogeneity within so-called 'South Asian populations' also needs to be acknowledged. Among those aged over 40 years, almost 25% of people of Pakistani origin report that they have CHD, compared with 13% of people of Indian origin, whose risk factors are similar to those of the general population (Nazroo, 2004). People of Bangladeshi origin have high rates of diabetes and stroke but not of hypertension, and although smoking rates are high among Bangladeshi men, they remain low for Bangladeshi women (Alam *et al*, 2008).

Tackling inequalities and inequities

National and local initiatives have grappled with how to reduce health inequalities and inequities among ethnic minority populations in the UK, and in particular how to sustain improvements in knowledge and understanding about chronic conditions, such as CHD. Progress has been slow and patchy, often struggling to engage with the complexity outlined above (Fischbacher *et al*, 2007), with activity falling into two categories. First, there are those initiatives that are aimed at *tackling barriers* to care and support. These might include strategies for dealing with staff assumptions associated with institutional racism, or more specific strategies aimed at tackling poor communication, which results in patients and their families being ill-informed and ill-equipped to manage their illnesses (Hipwell *et al*, 2008). Cultural competence has become increasingly associated with such initiatives, and is often used as an aspirational benchmark to overcoming ignorance, prejudice and stereotyping among health and social care staff (Purnell and Paulanka, 2003; Papadopoulos *et al*, 2004). Secondly, there are those initiatives which are concerned with community engagement and more specifically the *targeting of screening and information in particular communities or localities* as a means of improving health outcomes, health literacy and self-management (Akhtar *et al*, 2001). These initiatives are often delivered through a partnership between third-sector organisations and local health personnel via lay community members who are supported and trained to provide

healthy lifestyle support (Fox, 2004). Numerous examples exist (Farooqi and Bhavsar, 2001; Coe, 2007), and they assume particular significance within the context of this paper, given the low levels of awareness and understanding of CHD among minority ethnic populations (Bhopal, 2007, 2009). These projects, although reporting enthusiastic feedback from participants, remain largely unevaluated, particularly with regard to the extent to which they can achieve long-term health gain (Visram, 2008). Nonetheless, such projects represent a commitment to building competency and capacity within communities through training lay community members to deliver healthy lifestyle messages (Alam *et al*, 2008). They can also empower communities by improving health literacy, thereby enabling people to exercise more control over their lives in ways that are relevant to them (Hemming and Langille, 2006).

The role of health advocates and trainers

Through the idea of health trainers, the UK government acknowledged the importance of such a commitment (Department of Health, 2004). This was partly an endorsement and extension of the bilingual health advocate role employed in the projects outlined above, combined with an emphasis on combining community engagement and culturally competent practice in a way that facilitated self-care among 'at-risk' communities. Following a pilot in 2005, health trainers were introduced nationwide in 2007 to work with a range of at-risk groups, including people with disabilities, prisoners, and minority ethnic communities. Policy envisaged a typical health trainer as a member of their local community, who would provide a bridge between the formal healthcare system and disadvantaged populations, offering individual support and encouraging behavioural change in relation to identified goals such as smoking cessation, weight loss or increased exercise. The idea was described as a move from 'advice on high to support from next door' (Department of Health, 2004, p. 54), and is beginning to assume further policy significance with the announcement by the UK Government of its intention to offer vascular screening and advice to everyone between the ages of 40 and 70 years from 2010. Health trainers are likely to have a key role in facilitating behavioural change as well as reducing potential inequalities that might emerge from such screening (Department of Health, 2008).

By 2008, around 1200 health trainers were in post, and although there seem to be considerable variations in the way that they work, such workers appear to

combine the two roles of advice and advocacy. Support for these workers is fundamental to their success, although local evaluations suggest that policy has seriously underestimated the amount of support they require. Despite emphasising the importance of trainers' local knowledge, their effectiveness has been limited by lack of awareness or commitment from health professionals and a concern about their lack of qualifications and training (Visram, 2008).

Evaluating the intervention

As a response to these concerns, especially the issue of delivering appropriate training, this paper reports on the evaluation of a programme developed to inform health advocates, interpreters and health trainers working within 'South Asian' and other minority ethnic communities about coronary heart disease. As part of this evaluation, we describe the design, planning and delivery of an educational intervention, as well as reflecting on what was achieved. In making sense of our findings, we were mindful of locating them in broader debates about cultural competence and reducing health inequalities, while also giving a practical assessment of what works and what does not. We are equally aware of the need to understand more about what constitutes good practice and how such practice can be sustained and replicated in other localities. Continually describing the difficulties facing 'South Asian populations' is increasingly unhelpful, and research needs to refocus its attention on understanding how services can best meet the needs of the 'South Asian' population, by exploring how provision is delivered (Atkin and Chattoo, 2007). Learning from previous experience is especially important when developing culturally sensitive care, and understanding the complex ways in which ethnicity becomes expressed when explaining health inequalities (see above).

Programme structure: developing a CHD training programme

As a way of introducing our evaluation, we begin by describing the programme and how it was designed. In 2003, the British Heart Foundation (BHF) recognised that health trainers and advocates, interpreters and others supporting people in 'South Asian' communities would be more effective if they were better informed about managing the risk factors associated with CHD and diabetes. They were also aware that this information needed to have meaning within the

context of multi-cultural communities, rather than being simply based on generic health promotion messages. For instance, encouraging people to follow a healthy diet may have little impact if examples are drawn exclusively from Western experience. Acknowledging diversity is an important starting point in developing interventions, alongside a critical scepticism of why a generic approach might not be appropriate. Broader theoretical reconciliation and clarity about what the training courses are trying to achieve are equally important. Contextualising the intervention in current debates about health inequalities emphasises the need to tackle barriers to care and support alongside a concern to offer screening where it is most needed.

The pilot intervention

Based on a literature review which identified shortfalls in minority community understanding at that time, a two-day pilot course was devised. This was delivered in West Yorkshire by a pharmacist from Bradford University (MP) and local healthcare professionals to 35 health advocates and interpreters recruited from Yorkshire and Greater Manchester. An initial evaluation established the potential of the course by reporting increased knowledge of CHD and improved counselling, networking and signposting skills among delegates (Ali, 2004). This evaluation also suggested that the courses might be too medically focused, with delegates struggling to relate the course content to their everyday practice. Subsequent courses addressed this problem, and reviewing it became an important part of monitoring.

Matched funding from the Department of Health enabled the BHF to plan and deliver a further eight courses on a similar model in five English cities with high minority ethnic populations. The courses would be free to participants, an important consideration when trying to engage third-sector organisations, but one equally relevant to statutory service provision. The two main tutors, a pharmacist (MP) and a GP (PG), led every course to ensure consistency. Both were university teachers of South Asian origin, who devised and delivered the core sessions. Building on the pilot course, these covered ethnicity and health, risk factors in CHD, medications, measuring blood pressure and BMI. Case studies were then used to encourage delegates to apply the information in 'real-life' settings. Local health professionals were engaged on an unpaid sessional basis to deliver presentations on diet, smoking, the organisation of health services and behaviour change. Their input aimed to facilitate networking between formal healthcare agencies and voluntary and community organisations, while also

ensuring that the courses had a local 'feel.' BHF staff taught a practical session on emergency life support (ELS), for which delegates received a certificate, and also facilitated some other sessions, such as a physical activity (walking) at some of the courses. The two-day courses ran between November 2006 and May 2008. Lessons learned from these courses informed the development of a toolkit, which would facilitate training when formal funding ended.

Evaluation methodology

The planning team decided to commission an independent evaluation, to provide a more thorough analysis of the successful and not so successful elements of the training programme. In more practical terms, the evaluative approach was informed by realistic evaluation and a concern with 'what works, for whom, in what circumstances and why' (Pawson and Tilley, 1997). Training cannot be viewed as an end in itself, particularly since practitioners report difficulties in trying to put what they have learned into practice (Atkin *et al*, 2005). The evaluation sought to chart how the courses were devised and delivered, while also considering their potential impact on practice in the future. To this end, the evaluation team were aware of the importance of providing interim feedback following each course, to enable the course organisers, facilitators and BHF staff to fine-tune the material as the courses were delivered. Such information did not alter content *per se*, but offered a constant reminder that

courses had to be made relevant to the current experience of practitioners.

Both quantitative and qualitative methods were used during the evaluation (see Box 1). In keeping with the aims and objectives of the programme, the evaluation was interested in the ethnic and cultural diversity of the audience, appropriate and accessible training and education (which enabled participants to learn and retain knowledge and understanding over time), the quality of the learning experience, and the relevance of the intervention to their own experience and practice. It is these concerns that informed the basis of our evaluation, although here we also draw out themes which others, who need to deliver such programmes, could find useful. Collecting data at several different time points from various stakeholders was another feature of the evaluation. This enabled changes in participants' knowledge to be logged and compared over time, while feedback and suggestions from participants, tutors and organisers could also be collated. Information was also gathered on the longer-term impact of attending the course, and in particular the opportunity for participants to use their new-found knowledge once they were back at work. This was to explore the relevance of what was learned and the potential for its practical application. Improving people's knowledge, for example, although an important outcome, needs to be placed within the context of its potential to improve practice.

Quantitative material gathered from delegates was logged and analysed using SPSS (Statistical Package for the Social Sciences, version 14). Descriptive frequencies were produced together with simple cross-tabulations, exploring possible associations between

Box 1 Course evaluation methods and research instruments

- A structured, multiple choice questionnaire administered to delegates to assess changes in their knowledge of CHD at three time points: just prior to the training (t1), immediately after the course (t2), and three months later (t3).
- A quantitative questionnaire completed by delegates at the end of the course to gain views about the organisation, content and delivery of the courses and how useful the information gained would be for delegates, when they returned to practice. Some qualitative data was also collected through opportunities on the questionnaire to make additional comments about these topics and open suggestions for improving the course.
- Demographic information about most delegates was obtained from their application forms, if available. This enabled us to explore whether the background of delegates explained differences in responses.
- The researcher attended at least one course in each site to observe the processes involved and gather informal feedback from delegates.
- Each of the key stakeholders in the development and delivery of the courses was interviewed during and /or at the end of the courses either in person or by telephone using a topic guide. They were asked to reflect on their perception of different aspects of the courses.
- Two focus groups were held with eight delegates each, one in South Yorkshire and one in London, 3-9 months after participants had attended a course. Each focus group included participants from three different courses. Using a topic guide, these discussions over 90 minutes explored the value and usefulness of the course and what further support and training would be helpful.

variables such as test scores and delegate characteristics or course sites. The qualitative material was analysed using a thematic framework approach (Ritchie and Spencer, 1994), with a focus on identifying good practice and providing suggestions and recommendations which could help those delivering similar community-based training in healthcare. To introduce transparency and a systematic approach to analysis, we engaged in detailed familiarisation with the interview material, identification and indexing of key themes, contextualising these themes in relation to the broader data set and interpreting them, within the context of themes relevant to the interview material and aims of objectives. To ensure confidentiality and anonymity, all delegates and informants were given a code and all questionnaires and other data were stored securely in accordance with the Data Protection Act. Formal ethical approval was discussed with the chair of the host university's governance committee. After consultation, we were informed that our research was audit and did not require formal ethical approval. However, we did follow the procedures established by the Departmental Ethics and Governance Committee. This included adhering to the principles of informed consent and the need to maintain anonymity and confidentiality. We also complied with the ethical standards adopted by the Social Research Association.

Presenting the findings

In practical terms, and although reporting empirical research, we have decided to present our findings in a way that is embedded, rather than separate from the process and outcomes associated with the intervention. This is to give a more nuanced feel for the realities of practice, which as we have seen was an important aim of our evaluation. Specifically in our findings we are interested in describing who attended the courses, participants' experiences of the courses, the extent to which they had increased their knowledge, and their opportunity to put their new-found learning into practice.

Recruitment of course participants

A broad range of participants from a diverse range of ethnic backgrounds was felt to be essential to the success of the course, particularly since many community training courses struggle to recruit participants whose backgrounds reflect the diverse nature of UK society. The original intention was to focus on South

Asian communities, but given the diversity found in most localities, it was considered important to recruit widely. To achieve a diverse audience, a multi-faceted approach was necessary which required considerable community engagement. Methods included local networking, targeting key community organisations and health trainer teams through existing regional networks, and general publicity such as newsletters, emails and local press. Internet searches, for example, identified potentially relevant local community and voluntary organisations, which were then telephoned and encouraged to apply for places.

Course organisers found this time-consuming, but emphasised the importance of informal word-of-mouth networking, local knowledge and personal contact with organisations and individuals who applied, to ensure that they turned up on the day (Johnson, 2006). Contact was also made with statutory agencies, and they were asked to help to recruit people who would benefit from the courses. Some primary care trusts asked for their own health trainers to attend the course. Such trusts may have identified the need for such training, but had insufficient resources to organise courses themselves. Having a nationally coordinated training programme involving core elements, adaptable to local circumstances, meant that the training could achieve economies of scale. Quality and consistency could be assured, as well as saving resources.

Over 50% of the delegates said that they had heard about the course through a manager who suggested attendance as part of their induction or ongoing training. Others were recruited via a work colleague or friend (20%), or a newsletter or circular (18%), while 11 delegates (5%), who were perhaps not involved in these networks, had seen the course advertised in the local press. A similar number had been invited directly by a course tutor (see Box 2 and Figure 1).

As well as ensuring equity among those who wished to access the course, a diverse group maximised the potential for networking across different settings, thereby broadening the potential to learn from each other's practice. The multi-cultural nature of the audience also helped to ensure the practical relevance of the course, and facilitated a broader range of experiences from which participants could learn.

Delegates' ratings of the course

Course satisfaction is fundamental to improving knowledge and understanding. There was a high level of satisfaction among the course participants, with most rating it as 'excellent' (76%) or 'good' (18%). When asked to rate each session, many gave all topics and other aspects of the course straight A's or a mixture of A's and B's. Only one delegate said that

Box 2 Delegate profiles

- The eight courses attracted **247 delegates** from a diverse range of professional backgrounds and settings. The demographic characteristics of delegates varying between sites and courses, depending on the profile of the local area and recruitment methods used.
- Twenty three percent classified their **work role** as health trainers; 51% as bi-lingual health advocates, health link workers, smoking cessation advisers or health care assistants or interpreters (or had a mixture of roles); 15% were community volunteers.
- Half of the delegates worked in the statutory health **employment sector**; over a third in the voluntary/third sector and most of the remainder were employed in other statutory organisations, such as local authorities.
- Fifty eight percent of delegates said they had a vocational **qualification**, while more than a quarter said they had a first or higher degree, often in a relevant subject such as education or sports science. One in seven indicated they had no qualifications.
- Delegates were drawn fairly evenly from all **age groups** the largest group aged between 41 and 45 years, with smaller numbers aged over 55.
- In terms of **gender**, nearly three quarters of delegates were women, presumably reflecting the gender composition of staff in health promotion, health advocacy work and volunteering.
- Course participants were also **ethnically diverse** with the largest group indicating that they were of: Indian origin (22%); followed by Pakistani origin (17%); white British origin (16%) Bangladeshi origin (14%); African origin (9%); with a smaller number of delegates saying they were of Caribbean and Chinese origin. The 10% grouped as 'other' were mostly from Eastern Europe, often working with recent immigrant communities.

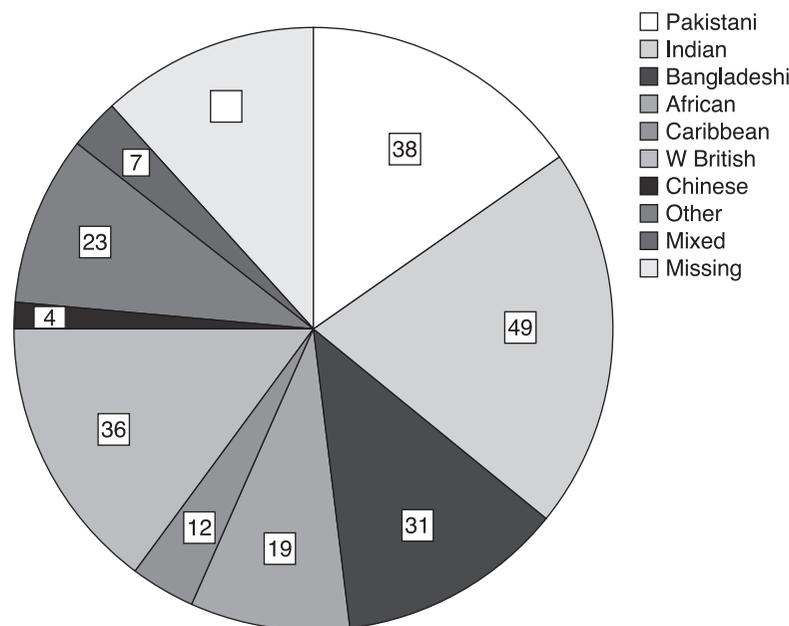


Figure 1 Ethnic diversity of course participants

the course had not met their expectations, but did not elaborate, and seven delegates said that the course had only partly met their expectations, as they would like to have had other topics included, usually more information about diabetes and other allied health conditions. In line with these positive ratings, over 80% of delegates said that their knowledge of CHD had improved 'a great deal' or 'a lot.' Even those whose previous knowledge was good remarked that courses

'acted as a good refresher.' Similarly, 80% anticipated that they would be able to use their increased knowledge 'a great deal' or 'a lot' in their work or volunteering role.

The delegates' comments suggest that they found the training enjoyable, including aspects such as the venue and catering. Many described the atmosphere of the course as informative, but also informal and welcoming. 'Very friendly, very informative, very

hospitable' and 'friendly staff, interesting information, nice place' were typical comments. The participative style of the training, which included group work, a quiz and practical sessions, was also appreciated, as well as the rapport between the two main facilitators. They and other tutors were perceived as approachable and helpful, while having a good knowledge of the subject. Most of the suggestions for ways of improving the course focused on the timing of sessions and the need to get the right balance between lectures and discussion. The participants wanted more opportunities to explore their knowledge through discussion, and were especially interested in practical advice on how best to achieve behavioural change with their clients. They also felt that networking should be recognised and integrated as a formal aim of the course.

Putting understanding into practice

At three months, the participants were asked whether they had been able to use their increased knowledge in their everyday work. This was seen as an important outcome of the intervention, and ensured that training and education were a means to an end. Nearly all of the delegates said that they had managed to apply this knowledge in their practice, with 56% saying they had done so 'a lot' or 'a great deal.' The two focus groups facilitated with 16 participants allowed further discussion and reflection on the most and least useful aspects of the courses, several months later. These debates highlighted some of the challenges of the health advocate and health trainer role in supporting lifestyle change, such as organisational or role capacity and working among people with limited literacy, a potential problem irrespective of ethnicity, including among white British clients (Papadopoulos and Lay, 2007; Alam *et al*, 2008; Stone *et al*, 2008). In discussing the prototype toolkit, the participants stated that they liked the flexible format and visual materials, particularly for those with limited English skills.

Feedback from both of these sources suggested that the delegates now felt both better informed and more confident in delivering messages about healthy lifestyles and CHD. A few had used their ELS training in an emergency, and others had delivered advice about risk factors and heart health. Activities that were reported included supporting clients in individual or group sessions (such as cookery lessons and group walks), giving talks or informing colleagues, community outreach and awareness raising, and health checks at community venues such as Post Offices and supermarkets, showing DVDs in surgeries and talking to

parents in schools and clients in gyms. There was support for the idea of refresher or more advanced courses, and the courses being delivered in other areas.

Significantly, several delegates mentioned making changes to their own and their family's lifestyles in line with the advice that they were giving to others, although some research suggests there is a possible conflict between the need for them to develop competence in the topic, which they would necessarily relate to their personal and family experience, and the need for them to develop skills in educating others (Stone *et al*, 2008). Those attending the BHF courses generally had vocational training of some kind, so this may not have been such a difficulty for them, and most were eager to develop further skills in communicating healthy heart messages. However, this could be a key issue, especially as information is cascaded into communities and should be monitored, when introducing similar programmes, alongside adequate support for staff who are struggling to promote behaviour change.

Increased knowledge

Fundamental to any educational intervention is the need to improve understanding and knowledge and to ensure that knowledge is retained. It is also useful to have a sense of whether any particular grouping was disadvantaged in achieving improved knowledge and understanding. Before the start of the training, analysis of delegates' scores across all courses testing their knowledge of CHD showed an average value of 60%. Scores improved significantly between the start (t1) and finish (t2) of the course. By t2 in the first six courses, which had a more generic audience, the scores had increased by an average of 20%. Most of the delegates, although usually aware of the main risk factors for CHD, found the courses useful in highlighting how risk factors interact and are relevant to everyone, including themselves. This may have helped their personal and work-related learning.

In the final two courses, which included a higher proportion of health trainers, the scores only improved by 10%. These groups demonstrated a higher baseline knowledge (67%), which did not increase so dramatically, which suggests that there is a possible ceiling with regard to improving people's knowledge, although these participants seemed to gain more by understanding the relevance of applying knowledge in practical settings. As we have seen, this supported a central aim of the courses, which was to personalise the role of risk factors as much as possible, in order to increase their relevance to delegates and their clients, making them an issue for everyone.

Inferential statistics showed no association with age, ethnicity or different courses and participants'

Box 3 Ingredients of a successful course:

- Trainers who are well informed, experienced and enthusiastic, and connected to the background of the audience
- Proactive engagement with local and community organisations
- An interactive enjoyable atmosphere within the boundaries of the timetable
- Recruitment which uses diverse methods which are persistent and personalised
- Teaching sessions which clarify and repeat key learning points, backed up by handouts to aid recall
- Opportunities to network amongst delegates and exchange practical ideas about putting knowledge into practice
- A comfortable and convenient venue with culturally appropriate refreshments and resources
- A teaching framework which can be adapted to a variety of local conditions and communities
- Working alongside and in partnership with local health promotion initiatives
- A commitment to capacity building and sustainability.

scores. This suggested that the courses were consistent and provided equal opportunities in improving people's knowledge. Again key messages were applicable to everyone, irrespective of background, although some biological processes such as atherosclerosis start earlier in some ethnic groups than in others. Knowledge was also retained three months after the course (t3), although, perhaps not surprisingly, scores did show a slight decrease, but this was not statistically significant. On average, participants' scores still showed a 16% increase between t1 and t3. Those with vocational qualifications showed least loss of knowledge, possibly because they were regularly using what they had learned in their work.

Summary and discussion

Clearly the training programme was successful on several counts, and from our analysis it is possible to identify the generic key ingredients of a successful course, while highlighting components which would also hold for other long-term conditions (see Box 3).

In summary, with considerable networking, often requiring face-to-face contact, a culturally and ethnically diverse group of delegates was recruited for each course, in a way that reflected the multi-cultural composition of the local populations. Local mapping of populations as well as community and voluntary organisations was fundamental in achieving this. The courses improved participants' knowledge, and this improvement was largely sustained after three months. Except for qualification, no other demographic variable appeared significant in predicting an increase in participants' knowledge. This suggested that there was some degree of equity.

There was also evidence that the participants' new-found knowledge was being used in practice. Taking part in the courses seemed to have given participants the confidence and motivation to use this knowledge

at work, and to share their knowledge with colleagues, although not to the extent that they had anticipated at the time of the course. This suggests that their initial enthusiasm was sometimes constrained when they returned to practice, indicating that managers need to consider the implications of sending their employees on training courses, by providing them with more opportunity to use their new-found learning. This seems to be a problem for statutory health and social care agencies, in addition to voluntary and community organisations. Atkin *et al* (2005) have reported how nurses working on acute wards, who had attended training to help them to better support the mental health needs of their older patients, complained that the organisational constraints of the NHS prevented them from putting their new-found knowledge into practice. This is a reminder that developing training to meet a recognised need is not always enough to facilitate change.

The fact that the course was devised and delivered in partnership with tutors who were experienced in training and working with diverse groups meant that many aspects of the course were presented in a culturally appropriate way. For instance, the knowledge questionnaire used examples of typical South Asian foods, and local tutors were requested to make their presentations culturally sensitive. Some local presenters said that they struggled with this, as well as with the challenges of delivering training to a multi-cultural audience. Local trainers, although able to achieve relevance and immediacy, might require support, especially if they are used to working in more mainstream settings. The participative, informal and practical aspects of the course, such as being provided free to participants, made it inclusive and accessible. In addition, refreshments were largely culturally appropriate, diets were catered for, the courses were not held during Ramadan, and delegates were advised about places where they could pray if required.

Despite the importance of these practical considerations, one key question, when evaluating such courses,

is how they helped delegates to work in a culturally competent way when providing information within diverse communities. This is an especially pertinent question given that many participants, whatever their background, work across communities. A multi-cultural audience, for example, helped to support a more considered discussion of cultural competence. In addition, some participants commented on how the course helped them to develop working relationships, which could help to counter a sense of isolation. In one region, delegates from different authorities have been working together to develop further local training assisted by one of the lead tutors. For example, 32 South Asian taxi drivers, a group who are at risk of CHD and may not access appropriate healthcare, were trained by one of the tutors (MP) in conjunction with primary care trust staff to raise awareness about, and promote screening for, cardiovascular disease among their friends, neighbours, fellow taxi drivers and family.

The networks developed through these courses also benefited the BHF. First, workers felt that organising the courses had increased their own sense of cultural competence, making them think about issues in a new way. Secondly, the BHF used understanding and insights gained through organising the courses to develop initiatives when the courses ended. Active engagement, building on established relationships, can help to encourage change and self-sufficiency. The project team were especially keen to ensure that the training programme had a life beyond the time constraints of the project. One of the biggest problems facing those working in voluntary and community organisations is what to do when funding ends.

The *Healthy Hearts Kit*, which was developed by the BHF and is based on the content of the training programme, enables individuals who have been appropriately trained to organise a course adapted to local circumstances and different audiences. The aim is to help people who work or volunteer in primary prevention of CHD to impart key heart health messages in a flexible and interactive way. The kit contains visual aids, key information, activities and handouts. It is being used in a number of settings, including primary care for people identified as high risk, community workers translating the information for mothers at an after-school club, health trainers cascading information to other team members and clients, healthy community collaborative volunteers working towards early identification and management of CVD, and home-based cardiac rehabilitation of patients with their families.

In the long term, it will be interesting to see how such a resource with considerable potential to raise awareness of CHD is used in practice. Unfortunately, our own evaluation is limited with regard to the extent to which we could measure long-term change, although

the delegates' comments on being able to put their training into practice are encouraging. Providing minority communities with the tools to understand their health and how the risk can be modified and managed will hopefully provide them with the confidence to access healthcare, while at the same time challenging existing barriers that prevent them from doing so. This could occur alongside a workforce that is encouraged through these training opportunities to provide information, advice and support in a more culturally sensitive way. Achieving change therefore requires a multi-faceted response, involving at-risk communities as well as those involved in their care. However, achieving behavioural change is likely to remain an ongoing problem, and further work supporting practitioners is perhaps necessary as a counter to inevitable frustrations if long-term outcomes fail to shift significantly.

Maintaining knowledge and translating this into health improvements is a considerable challenge. Appropriately trained health workers, who operate within and understand their local communities, represent an important starting point (Eades *et al*, 2005). Strategies to facilitate this, such as the courses outlined above, assume importance in developing appropriate and equitable care. To this extent, organisers of such programmes need to think beyond the training courses. Getting people together and improving their knowledge can easily be coordinated with activities which get them to network and learn from each other, beyond formal knowledge acquisition. This is what these courses wished to support. The objective was not simply to communicate information on CHD, but to do so in a way which ensured that knowledge had meaning within the context of a multi-cultural society.

As we discussed in the introduction, current policy development emphasises the importance of such approaches. Community-based health promotion and advocacy is one such initiative, as is the employment of health trainers. The goal of these workers remains the encouragement of healthy lifestyles in a sustainable way by bridging the gap between statutory healthcare provision and local communities. Evaluation of courses designed to increase their effectiveness demonstrated the value of ground work in developing the content of the course, proactive engagement with local voluntary and community organisations in ensuring diverse representation among participants, the importance of locating learning in concrete, everyday settings in a way that was relevant to the way delegates worked, relating training to local circumstances, including the use of local presenters, and the need to have access to adequate resources when organising such courses.

The long-term impact of such initiatives is difficult to gauge, but successful interventions can be viewed as building blocks towards facilitating community engagement and building capacity in self-care and prevention

of long-term conditions in ethnically diverse communities. They are also a potential stepping stone in developing a culturally competent workforce at all levels. Support and recognition for those working in health advocacy and a more general willingness within organisations for practitioners to examine their own attitudes and assumptions and learn from each other are also required in order to achieve the goal of health promotion. In addition, a proactive third-sector organisation, willing to develop these ideas, is an important consideration, to ensure that such initiatives have relevance long after they have formally ended.

This is likely to assume added significance as the Department of Health rolls out its Health Check Programme across England (see above). The programme has two aims, namely to reduce the incidence of vascular illness and to reduce health inequalities. However, recent debates have highlighted how ethnically diverse and socially deprived populations may find the offer less acceptable, and have greater difficulty complying with advice (Patel *et al*, 2009). The programme might have the consequence of widening rather than narrowing health inequalities (Capewell and Reissman, 2008). Informed and appropriately trained health advocates and trainers will have an important role in encouraging people to access the checks, while also supporting any behavioural change that they suggest. The training programme described in this paper could not have envisaged such a policy initiative when it was first introduced. Nonetheless, generally improving knowledge and giving workers the confidence to work in multi-cultural settings will reduce the risk of broadening inequalities when more specific policies are implemented.

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CONFLICTS OF INTEREST

None.

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