Research paper

Following NICE 2008: a practical guide for health professionals on community engagement with local black and minority ethnic (BME) community groups

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What is known on this subject
- Community engagement is expected to play an increasingly important role in service development in health and social care services.
- Community consultation and engagement are often not undertaken adequately.
- The concept of community affiliation is fluid and may be self-defined, as people are members of multiple different communities.

What this paper adds
- It provides a practical guide for health professionals on community engagement with under-represented communities, and builds upon the NICE 2008 guidelines on community engagement.
- It offers a four-stage process model of community consultation and engagement.
- It encourages the representation of marginalised communities in the planning and provision of health and social care services.

ABSTRACT

Community participation and engagement are now meant to be at the heart of health and social care services. In 2008, the National Institute for Health and Clinical Excellence (NICE) developed guidelines entitled *Community Engagement to Improve Health* (National Institute for Health and Clinical Excellence, 2008). However, although these guidelines do recognise that many black and minority ethnic (BME) communities often have specific needs, they do not offer detailed advice on how to consult with these diverse communities. Therefore, while health organisations and providers are increasingly recognising the value of community engagement, health practitioners often lack experience of this process and may not know how to start or progress it. This practical guide to community consultations with BME groups builds on the NICE 2008 guidelines on how to conduct community engagement. The recommendations have evolved as part of an iterative and critical learning process through the authors' experiences of consulting with a range of BME community groups over many years. Although this guide is certainly not definitive, it is hoped that it will encourage the development of positive practice to ensure that the voices of BME community members and other under-represented communities are heard and integrated into the development, planning and delivery of health services, to help to create more inclusive and person-centred services.

Keywords: BME elders, community participation, engagement, NICE guidelines, practice

Introduction: NICE and community engagement

With the rise of the personalisation agenda and the growth of new community consultation processes, such as Local Involvement Networks (LINks) and the Joint Strategic Needs Assessment (JSNA), there is now a growing movement towards offering local communities an opportunity to say how they want their local health and social care services to be planned and delivered. Effective community consultations must give diverse and marginalised communities the opportunity to have their voices heard and also to have their expertise recognised and supported. The role of *community engagement* in the development of services has been recognised by the National Institute for Health and Clinical Excellence, which has developed guidelines on community engagement with the aim of 'supporting those working with and involving communities in decisions on health improvement that affect them.' Within these guidelines, NICE defines community engagement as 'the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities' (Popay, 2006; National Institute for Health and Clinical Excellence, 2008). However, there are some difficulties with this definition, because NICE (2008) has identified *community engagement* and *community development* as two complementary but different terms, suggesting that 'lack of detailed evidence meant it was not possible to make recommendations which distinguish between them.' Therefore, for the purpose of the NICE guidelines, the umbrella term *community engagement* was used, and this term will also be used in this article.

The NICE guidance emphasises the 'importance of identifying and taking into account the needs of those who are under-represented and/or at increased risk of poor health' when implementing the recommendations. This may include people from black and minority ethnic communities, people of a certain age, those with HIV or a disability and those living in rural communities' (National Institute for Health and Clinical Excellence, 2008, p. 12). Although there may be many shared experiences within many under-represented communities in relation to health, and although much of what is stated in this paper could be applied more widely, there are specific issues with regard to the BME community. For example, the role of genetics in specific areas of health (e.g. sickle-cell disorders) and related community engagement programmes have established an impressive history. An example of this is a study by Atkin *et al* (2008), which examined the complexity and interplay between an individual's cultural and religious identity within a context of a range of individual, family and social relationships. It is important to remember that genetic arguments have also been used as a reactionary or reductionist force within health (e.g. in relation to debates over IQ tests).

However, the NICE guidelines do not offer any additional information on how to consult with BME communities, hence the need for some practical guidance on this issue. This paper examines the concept of community engagement, and then proposes a four-step guide for community engagement with BME communities.

Theoretical considerations

Underlying the concept of community engagement are several theoretical assumptions. Primarily, the approach centres on the discourse of *defining a community*. Debates concerning community engagement, democratic processes and community research methodologies have developed. Although the authors do not intend to examine these debates in detail, it may be useful to be aware of some of the interwoven theoretical assumptions that underpin the concept of community engagement.

Defining community

The origins of community engagement in health can be traced back to the World Health Organization (1978), in which context it has a long tradition within the development field linked to anti-poverty programmes, development and community capacity building. Within the health field, community engagement is seen as pivotal to service development and delivery, and it is now embedded within a range of policy documents (Rifkin *et al*, 2000; Wallerstein, 2006), as well as in activities that aim to reduce health inequalities (Popay, 2006). Although research suggests that some form of group or community life in itself has a positive impact on individual well-being (Portes, 1998), the definitions of a community vary widely. NICE has defined community as follows:

> A community is defined as a group of people who have common characteristics. Communities can be defined by location, race, ethnicity, age, occupation, a shared interest (such as using the same service) or affinity (such as religion and faith) or other common bonds. A community can also be defined as a group of individuals living within the same geographical location (such as a hostel, a street, a ward, town or region).
>
> (National Institute for Health and Clinical Excellence, 2008, p. 38)

However, the very concept of inclusion and who belongs to a community implicitly suggests that some individuals are excluded. Sometimes people choose their community affiliations, and sometimes these are imposed upon them (Kretzmann and McKnight, 1993). People may choose to become a member of a community, or be ascribed membership by virtue of a social definition such as age, gender, race, ethnicity, sexual orientation, employment, citizenship status or social class. As a result, individuals often belong to multiple communities at the same time. It is worth noting that BME communities, like all community groups, may manifest themselves and change in different ways. Indeed, change of membership may be a feature of the community coming together (e.g. a group learning English, a group supporting asylum seekers who hope to become refugees). It is also worth noting that established communities and emergent communities often have different needs, and this may influence approaches to community engagement. In addition, community groups do not exist in a vacuum, but are subject to internal and external forces resulting in community groups continually evolving and sometimes ending.

Community engagement and democratic processes

There is a growing body of literature relating to democracy and community engagement (e.g. Institute for Public Policy Research, 2004). Some writers have suggested that community engagement can be viewed as a form of pseudo-democracy, where community consultations are seen to offer a remedy for a democratic deficit that exists in representative democracy (see, for example, Harrison and McDonald, 2008). This argument may be particularly pertinent in relation to BME communities, who rarely find their community members represented among the higher echelons of government. Another argument suggests that community participation can be seen as an end in itself, acting as a mechanism for building social cohesion and offering an antidote to social fragmentation (Gyford, 1991).

Qualitative research

The final strand of literature that relates to community engagement is that of qualitative research methods. From early anthropology to modern urban research, qualitative methods have long been used to engage with and understand the beliefs and practices of community members (Charmaz, 2001). Therefore, the use of these methods in community consultations has a long tradition and a rich research literature. In health research, health professionals have traditionally led the consultation (Oakley and Marsden, 1984). A more democratic style, in which communities can also call consultations, where both parties consult and their concerns are listened to, would seem to be vital if we are to ensure that services are appropriate and responsive to the needs of all communities. Certainly the issue of apparent power differentials needs to be addressed openly to ensure a meaningful and valid interaction, rather than a pseudo-consultation (Chamberlin, 2005; Szczepura, 2005). A *community empowerment* or *action research* approach is increasingly used to enable individuals and groups to take greater control over issues that affect their health (Williams and Labonte, 2003). Action research requires engagement with people in collaborative relationships, and draws on different ways of inquiring. In practice, it involves communities in planning and developing their own research (Winter and Munn-Giddings, 2001). This approach has great potential for generating new knowledge, and the process can in itself lead to new practices (Daniel, 2000, 2001; Gustavsen *et al*, 2008). The National Institute for Health and Clinical Excellence (2008) guidelines on community engagement suggest that simply consulting with communities may have only a marginal effect on people's health, although such activities may have an impact on the appropriateness, accessibility and uptake of services, as well as improving people's understanding and use of health information. Helping communities to work as equal partners may lead to more positive health outcomes and improve other aspects of people's lives. The National Institute for Health and Clinical Excellence (2008) also suggests that this approach can give community members an increased sense of control over decisions that affect their lives, and help to build more trust in government bodies by improving accountability and democratic citizenship.

Consulting with BME communities

Community engagement with BME community groups has become increasingly important, especially in the field of mental health, where services have often failed BME communities in the past (Department of Health, 2005; Thornicroft and Tansella, 2005). There is a substantial body of research literature which suggests that, by consulting with local BME community organisations, health professionals can start to understand the needs of different communities and begin to work towards making mental health services more inclusive and culturally appropriate (see, for example, Crawford *et al*, 2003; Chamberlin, 2005; McCrone *et al*, 2005; Szczepura, 2005; Duffy *et al*, 2008; Fernando, 2010).

BME community groups can often speak *for* their communities as well as *about* them, and represent a huge pool of expertise that can make a significant contribution to service development and provision (Townend and Braithwaite, 2002; Fernando, 2010). However, although the value of community groups should not be underestimated, it is important not to assume that BME individuals represent the views of everyone in their community. Every community is heterogeneous, incorporating a wide range of cultures, religions and individual views. Community leaders may be asked to speak for the whole community, but this may not be appropriate. For example, many older Bangladeshi women may not speak English. Their experience of accessing health services may be very different from that of older Bangladeshi men who do speak English. It is important that community engagement does not build on the inequalities that are likely to exist within any community. These may include, but are not restricted to, issues of sexism, racism, ageism, class or education, and politics, among other factors. Anyone who is considering any kind of community consultation needs to decide how they will manage these factors in advance of any community engagement, and to plan how they can engage with all sectors of the community in a meaningful way.

The importance of community engagement is being increasingly recognised in a range of health and social care domains. These include the National Institute for Health Research (NIHR), whose commissioning process clearly emphasises the importance of engagement with service users, while the Research for Patient Benefit stream within the UK NHS Service Delivery and Organisation (SDO) programme specifies the gains to be made from incorporating input from users of the NHS into the research process. Although this is a laudable aim, it is not entirely clear how it, in common with many community consultations, will circumvent the danger of inadvertently building on current inequalities, as the more articulate, confident and powerful members of any community are most likely to respond to such a request.

Community groups can also act as a conduit to statutory services. Many BME community organisations act as a bridge or pathway into statutory services, with staff or leaders acting as *cultural brokers* for both community members and health professionals. For example, one of the community leaders in a Somali community group in Sheffield was trying to support a family whose son was experiencing serious mental health problems. The family was reluctant to use Western medicine, but the community leader was able to explain to them the potential value of medication by relating it to the family's health belief system about *Jins* or spirits.

Finally, BME community groups may be service providers, particularly with the inception of personalisation and individual budgets. For example, many BME community groups provide extensive informal and formal mental health support through, for example, shared meals, spiritual and practical advice, networking and social events that help to promote mental health and well-being. Unfortunately, although many BME community groups provide essential services for their community members, their work frequently goes unrecognised and is often under-funded (see, for example, *Beyond We Care Too*, a report by the National Black Carers and Carers Workers Network, which can be found at www.afiya-trust-org.uk).

A four-step practical guide to community engagement with BME community groups

This practical guide to community engagement with BME communities supports the NICE 2008 guidelines, but it also aims to add value by helping practitioners to consider some of the more subtle aspects of working with BME community groups that will result in more positive outcomes for marginalised communities.

The recommendations in this BME practical guide have evolved through the authors' experiences of community engagement and an iterative and critical learning process over many years. Between them the authors have over 30 years' experience of engaging with BME community groups, and although they have different disciplinary backgrounds (one author is a psychologist and the other is a sociologist), their shared experiences of working with BME communities, both nationally and internationally, have enabled them to identify a common approach that is now offered as a guide. This work has been informed by the underlying principles of the *participatory learning and action (PLA)* approach to community consultations (Pain and Francis, 2003; Reason and Bradbury, 2008). This approach uses methods that range from visualisation to interviewing and group work. The common theme is the promotion of interactive learning, shared knowledge, and flexible yet structured analysis. When it is done well, those from outside the community come as learners, conveners, catalysts and facilitators of the community's definition of needs. They then help the community to design a plan of action to meet those needs. Various approaches are used to assist communities in telling their own stories, including techniques such as the mapping of the community area and facilities, focus groups, semi-structured interviews, drawing, drama, diagrams and pictures, time line matrices, and ranking of variables, as well as direct observation. The time frame for carrying out these

activities varies, but the process is most commonly completed within one to three weeks. The case study in Box 1 provides a worked example of the four-step model presented here.

Box 1 Case study: working with a Chinese elders community group

- **Background.** The Chinese community has a long history of settlement in the UK, and currently represents the third largest minority in Britain (Cowan, 2001). In common with other BME communities, the social inheritance of health is significant for many Chinese elders (Butt and O'Neil, 2004; Tribe *et al*, 2009). Many Chinese women arrived in the UK unable to speak English, and due to traditional gender politics they often did not have the opportunity to obtain fluency subsequently. Consequently, many Chinese women and some Chinese men of senior years do not speak English. As a result they are often very socially isolated. In addition, many Chinese people have a strong community culture of self-reliance, and mental health problems are often not recognised or are regarded as stigmatising (Chung and Wong, 2004; see also the Chinese Mental Health Association website at www.cmha.org.uk).

- **Step 1: Making sure that everyone is ready for this.** As part of a national Department of Health initiative to promote an understanding of mental health problems for BME elders, funding was made available through the Care Service Improvement Partnership (CSIP 2007–08) to run a one-year national project that aimed to improve the mental health and well-being of BME ethnic elders, and to address the stigma associated with seeking help for depression. As part of this national work, the Bristol and Avon Chinese Women's Group tendered to lead on the development of a mental health resource designed specifically to raise awareness of depression in Chinese elders.

  Success measures agreed by co-production. Key to the success of this project was supporting the BME elder community groups across the UK to develop a culturally appropriate resource for national use. Once the tenders had been awarded, all of the community leaders attended a briefing day in order to meet each other and start to identify community consultation approaches. The briefing also helped to ensure that the resources that were developed were embedded in national community networks and could therefore be accessed by as many people as possible.

  The researchers' role. The role of the authors (together with our colleague Sue Hearsum) was to offer practical and financial support to the communities throughout their consultations, and to help to build community capacity together as required. It was essential that we supported an outcome or resource that the community identified as culturally appropriate.

- **Step 2: The consultation.** We had the privilege of working with a very experienced and trusted community leader. Her approach to community engagement was to start by planning with some other members of the community group to set up a healthy living day workshop, specifically for elders, which was advertised in the local Mah-jong casino and local Chinese food stores to encourage people to attend the workshop. Many of the elders were part of a regular group who were transported by minibus by some of the younger members of the Chinese community, as many elders were not mobile. It was notable that a large number of the Chinese women did not speak English and so felt unable to use public transport.

  During the healthy living day workshop the elders were offered a class in T'ai Chi (a gentle form of Chinese exercise), and a hand massage by student beauticians from a local college. After having shared a relaxing morning and a traditional hot meal, the elders were open to discussing issues concerning depression and isolation. This discussion was conducted in their own language, sharing with other members of their community. This process offered the elders an interesting way to approach a difficult topic that is often viewed as a taboo subject within Chinese culture.

- **Step 3: From talking to action.** The community decided to make an information film, in Cantonese with English subtitles. This format was considered important as many Chinese elders cannot read in any language. The film was developed by Chinese elders for Chinese elders, and provided a very moving account of their experiences of being isolated and depressed, the way they approached this, and how to seek help and support. The film was useful because it offered easy access to information based on the experiences of their own community.

- **Step 4: Feedback and follow-up.** The film was completed and was then launched at a national event with many of the Chinese elders in attendance. It is now used by the local community, and has been made available to other Chinese communities in DVD format through links to the national Chinese community organisations. From the outset, the national community engagement was understood not to be an ongoing consultation. However, at a local level the Bristol and Avon Chinese Women's Group continues to flourish, and it now offers support and social care services for Chinese men and women in Bristol.

Step 1: Making sure that everyone is ready for this

The NICE 2008 guidelines identify an important first step. Both the community and the departments and organisations need to be prepared for community engagement. If they are not, then whatever takes place may become merely a paper exercise, and will not result in change. The engagement must be tailored to the community, not the other way round. It is important to address any constraints facing members of the community who want to be involved (for further details, see www.nice.org.uk/nicemedia/pdf/PH009 Guidance.pdf).

Be sensitive to different health beliefs and practices

Health beliefs, practices and behaviours are influenced directly by elements of our own culture (Spector, 1985; Braithwaite *et al*, 1994). We need to be sensitive to our own cultural beliefs, as well as to the beliefs of others, in trying where possible to understand and work in ways that are consistent with a community's cultural framework (Airhihenbuwa, 1995). Therefore, before starting a community engagement, it is often helpful to develop some understanding of the community's landscapes of ideas and beliefs, as well as its explanatory health beliefs and systems of healing (Kleinman, 1988; Weiss, 1997: Bhui and Bhugra, 2002). This can be done by spending time with the community, through research and by asking questions.

Be clear about what the community engagement is about and with whom it is to take place

Although on one level identifying a community sounds simple enough, as we have suggested above, the very concept of *community* is often open to interpretation. Time needs to be spent in building relationships with community groups and understanding and acknowledging cultural and linguistic diversity within and across communities (Lai, 2008). It is also important to be sensitive to the complex social and political histories of different communities, as well as the huge linguistic, cultural and spiritual variations within and across communities.

Before any new work begins, it is important to make a thorough search to find out whether relevant questions have recently been asked of the community, in order to avoid wasting people's time and asking unnecessary questions. There should be clear statements setting out the aims of the community engagement, why it is being carried out, how the results will be used, and the potential benefits to the community identified. If the latter are uncertain, this needs to be clearly explained.

Be clear about the method that you are using

It is important to identify the framework to be used, who will do the work and approximately how long it will take. Participatory methods may require extra resources. For example, an action research approach in which community members are co-researchers may require more time and funds for capacity building and training than a more traditional grounded theory approach in which the health professional conducts and analyses the investigation.

Ethical concerns

Ethical approval is not often discussed when developing community engagement, but the same rules should apply as when conducting any other research or consultation. It is important to adhere to the ethical guidelines of relevant professional bodies. The concept of informed consent may require detailed consideration to ensure that everyone understands what this means, what they will be expected to do and what will happen to the information that they provide. Adequate time should be set aside for discussing ideas about consent, what this means for community members and how best to formally record individual agreements to participate. Ensure that any information is available in appropriate languages and in a range of formats (e.g. large print). Obviously not all BME members will belong to a community organisation, so it may be necessary to make information available in a wide range of settings (e.g. GPs' surgeries, public libraries, faith centres) and to make announcements on the local language or community radio station.

Depending on the nature of the community engagement, there may be additional ethical issues that require attention before work begins (e.g. how material is to be used, whether it should be anonymised, and who will have access to it). There may also be concerns about how to deal with problems that may arise, such as abuse or neglect, and in what way help may be given.

Contacting local communities

A positive way to start community engagement is to find a leader or champion in a local BME group. Care is necessary here, as community leaders may or may not represent the views of all of their members. Some community members (e.g. some elders, people living with disability, people who are illiterate, gay and lesbian members, some women, and younger people) may be excluded from having a voice in a particular community group. Therefore it is important to identify the most relevant groups for the engagement. This challenge can be overcome by spending a substantial amount of time with the community prior to starting a formal engagement. This allows time to build relationships and to understand some of the complexity and

diversity of the community that will facilitate tailoring of the engagement appropriately and with a range of community members. This is important for ensuring that activities are presented in culturally acceptable ways. For example, in many communities women will not discuss health issues in front of men, discussing mental health openly may not be appropriate, and older Bangladeshi men may not want to talk to a younger woman.

Timing and commitment

It is important to conduct community engagement at the appropriate stage in time of any processes or service development, so that the engagement is meaningful and can have a real impact on decision making and service delivery. This means clarifying whether a short-term consultation or an ongoing commitment is required. Therefore it is important to see how community engagements fit into wider policy or practice processes, rather than just adding them as an afterthought. Tokenistic engagement will not improve community trust in health and social care services (see Box 2).

Box 2 Points that need to be made clear at the outset

- The anticipated benefits of community engagement, and who will be affected by these
- The limitations of the community engagement (e.g. inability to deal with individual cases)
- Reassurance that clashes with times for prayers, festivals and fasting will be avoided
- Acknowledgement that the venues and timing of events will need to be negotiated. Some community groups may prefer to discuss certain health issues away from the rest of the community. In other instances, people may worry about incurring additional costs and the difficulties of using public transport. This is particularly significant in rural locations. Possible solutions may be to provide a minibus to pick up and drop off participants, or to reimburse participants on the day of the consultation

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Booking an interpreter

Interpreters can make the difference between a successful community engagement and an unsuccessful one (see Box 3). Interpreters from within the community can often be helpful because they are known, which may help to build trust. However, this can also be a disadvantage if community members wish to keep

certain information private and do not trust a community interpreter to maintain confidentiality. Decisions about who should interpret will need to be negotiated with the community group. Further details on working with interpreters and mental health have been provided by Tribe and Raval (2003).

Box 3 Interpreting services

These should be engaged at an early stage, with clear information about:

- the objectives of the community engagement
- the activities in which they will be involved
- how the interpretation will proceed
- the language(s) and possible dialects required
- how long each session will last
- consideration of stigmatising concepts such as mental health problems, and how these will be addressed
- the technical terminology to be used
- the arrangements for payment.

Hospitality

In most cultures, the sharing of food is important, and may even encourage people to attend an event. It can offer a more relaxing space in which to discuss issues and socialise. Catering arrangements can be negotiated with the community so long as any arrangements for payment have been clarified beforehand.

Step 2: The consultation

Practical issues

Participants will need to know beforehand what will be required of them and how long each community engagement event will last. Disability access and facilities for those who require a hearing loop will need to be arranged. Gender issues and seating arrangements should also be addressed (see Box 4).

Box 4 Tips for encouraging open expression of views and constructive argument

- Listen to other people's contributions.
- Keep to time.
- Adopt a 'no surprises' policy.
- Aim to fix the problem, not to blame.
- Focus on process rather than just on priorities.
- Avoid the use of jargon or abbreviations.

Frequency

How frequently consultation events are held will depend on the topic, the time and people available, and the approach used. Whenever possible, it is better to increase the number of one-to-one sessions with participants rather than deal only with groups, in order to obtain the views of the wider community. This also prevents domination of the outcome by particular individuals with strong opinions.

Step 3: From talking to action

Reports should acknowledge the full range of views expressed during discussion, and draw attention to areas of agreement and disagreement. Community engagement is not simply a public relations exercise, in that some form of action or response should ensue. Thus agencies and organisations must be prepared to respond, and can only do so if they have been involved before the start of the community engagement and are not simply asked to comment at the end of the process. If a community group is being invited to participate in service development or delivery, they should be offered the opportunity to build on their capacity to deliver (e.g. by offering access to training or practice learning opportunities with partnership organisations). Whatever the outcome, it is important that action is seen to take place following community engagement, although the type of action will depend on the reason for the consultation.

Step 4: Feedback and follow-up

Feedback

The community and participants need to hear about the results of the community engagement quickly, not years later. Ideally, they should be involved in any decisions that are made and the impact of the community engagement on those decisions. The source of the feedback will depend on the extent to which the community has been involved in the design, consultation and collection of materials, or whether the engagement was led by someone external to the group, such as a health professional. Appropriate languages and culturally acceptable formats should be used.

Depending on the nature of the community engagement, it may be useful to develop continuation sessions, as these provide the community with a space in which to voice opinions, as well as offering an opportunity for reflection and for celebration of achievements. If the community feels that it is appropriate, it might be a good idea to invite the local newspaper to the final session, as this helps to promote the contribution of community members

If the community engagement is not ongoing, it is important to acknowledge the contribution of the community in any final policy or service development documentation. It is essential to think about ways in which the community consultation can add to wider policies on inclusion and equal opportunities. It is also appropriate to undertake an evaluation process with the participants, reviewing the different stages of their participation and asking for any feedback or ideas to improve the process.

Conclusion

Community engagement is extremely important if health and social care services are to be appropriate and accessible to all members of the community. The NICE guidelines, set out in *Community Engagement to Improve Health* (National Institute for Health and Clinical Excellence, 2008), have described the importance of this in detail, along with other policy documents, including *Shifting the Balance of Power* (Department of Health, 2002). In addition, it is important to ensure that existing inequalities within communities are considered, and not ignored or replicated in any community engagement, so that the voices of marginalised subgroups are also heard.

This paper has offered a four-step process model for health professionals to use when undertaking community engagements. The authors hope that increasing consultations and dialogue between health or social care providers and BME and other under–represented communities will help to ensure that these groups play a larger role in the development and delivery of health and social care services. They also hope that these consultations will increasingly be initiated by the communities themselves, and that they will meet with a receptive response from health and social care providers. This would go some way towards ensuring that an equal two-way dialogue is established, thereby ensuring that issues of diversity are considered and integrated into service provision as a matter of course.

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CONFLICTS OF INTEREST

None.

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