

Research paper

'We're not fully aware of their cultural needs': tutors' experiences of delivering the Expert Patients Programme to South Asian attendees

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What is known on this subject

- Patient educational self-management courses, including the Expert Patients Programme, help people with long-term health conditions to better manage their daily lives with their condition.
- Few people from South Asian backgrounds attended the pilot phase of the Expert Patients Programme in the UK, raising concerns about exacerbating existing minority ethnic health inequalities.
- While lay tutors' experiences of delivering the Expert Patients Programme to white attendees have been described previously, little is known about tutors' experiences of delivering the Expert Patients Programme to South Asian attendees.

What this paper adds

- Cultural competence training might benefit the Expert Patients Programme tutors.
- The tutors interviewed here believed that culturally tailored Expert Patients Programme courses might better meet the needs of ethnically diverse attendees.
- The highly complex issues around delivering ethnicity-specific versus multi-ethnic Expert Patients Programme courses are highlighted.

ABSTRACT

Deaths from long-term health conditions (LTHCs) are set to escalate rapidly worldwide over the coming decade. Many people from South Asian (SA) backgrounds in the UK face a heightened risk of such conditions, as they already experience severe health inequalities compared with the majority population, including a raised prevalence of many LTHCs. To address these issues, the World Health Organization advocates the use of psycho-educational self-management interventions, to empower people with LTHCs to improve their everyday management of the condition. In England and Wales, pairs of trained volunteer lay tutors deliver one such intervention, the Expert Patients Programme (EPP). However,

few people from SA backgrounds attended the pilot phase of the EPP, raising disturbing concerns about exacerbating existing health inequalities.

This exploratory, descriptive, cross-sectional study aimed to understand white lay tutors' experiences of delivering the EPP to English-speaking SA attendees. Qualitative in-depth semi-structured interviews were conducted, then verbatim transcripts were analysed using interpretative phenomenological analysis, to gain insight into participants' experiences. A divergence of *tutors' training needs* and *South Asian attendees' perceived needs* was identified. Conflicting and sometimes controversial views emerged about the tutors' understanding of the appropriateness of

single-ethnicity versus mixed-ethnicity courses, and the role of interpreters on the EPP, in the themes of *integration versus segregation* and *interpreters*.

This paper concludes that while these tutors have some understanding of SA people's needs in relation to the EPP, they may benefit from cultural competence training. The complexity of implementing

both culturally integrated and ethnicity-specific public health interventions is highlighted, as is the requirement for genuine consultation with SA user groups.

Keywords: cultural competence, self-management, South Asian, volunteering

Introduction

Deaths from long-term health conditions (LTHCs) are predicted to escalate by 17% globally by 2015, with the largest relative increases occurring in high-income countries, including the UK (Strong *et al*, 2005). The World Health Organization (WHO) advocates health education using psychologically based self-management interventions, ambitiously aiming to reduce deaths from LTHCs by 2% annually, by 2015 (WHO, 2005). The Department of Health (DH) supported the national implementation of one such intervention across England and Wales: the Expert Patient Programme (EPP) (DH, 2001). The EPP Community Interest Company was established in 2007 to organise delivery of the EPP, and currently aims to provide 100 000 course places per year by 2012 (DH, 2006). However, the UK also has widening health inequalities (WHO, 2005), with people from South Asian (SA) (see Box 1) backgrounds experiencing substantial disparities compared with other groups (Evandrou, 2000). This, together with low levels of EPP attendance by SA people during its pilot phase (Kennedy *et al*, 2004), has given rise to the alarming possibility that the EPP may actually exacerbate existing health inequalities.

Box 1

South Asia comprises Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka (source: South Asian Development Partnership – www.southasian.org.uk/intro_southasian.html)

Numerous reasons for health inequalities have been proposed. One possible explanation that may be pertinent to the present study is that SA people have low uptake rates of some screening and preventative health-care strategies (Moudgil and Honeybourne, 1998). This may result from distinct cultural attitudes, beliefs and behaviours towards disease and its management, in addition to potential language and communication difficulties (Moudgil and Honeybourne, 1998; Ong *et al*, 2002; Davidhizar and Giger, 2004). However, culturally

appropriate education interventions for SA patients have been shown to improve health (Hawthorne, 2001; Dein, 2004; Greenhalgh *et al*, 2005).

The EPP is an example of a free health education group intervention. The six weekly structured 2½-hour sessions are usually delivered by lay tutors with an LTHC, to attendees with LTHCs, in a community setting. Core topics include self-defined goal-setting, action planning, problem solving, pain and depression management, nutrition and exercise, decision making, patient–professional partnerships, and resource utilisation (for more details, see www.expertpatients.co.uk/public/default.aspx).

The foundation for the EPP was developed and evaluated at Stanford University, USA, as the Chronic Disease Self-Management Course (CDSMC) by Lorig *et al* (2001). Grounded in social cognitive theory, the interactive courses are designed to enhance self-efficacy – the belief in one's own ability to perform a specific behaviour to achieve a desired outcome (Bandura, 1997). The EPP includes key efficacy-enhancing techniques: mastery experience (trying out health behaviours), persuasion, reinterpretation of physiological state, and role modelling. Regarding the last of these, the use of lay tutors, rather than health professionals, affords useful positive role-modelling and peer-support opportunities, as tutors demonstrate their ability to successfully manage their lives with an LTHC (Barlow *et al*, 2000a). In addition, attendees become role models and provide peer support for each other, when sharing knowledge and successful self-management strategies. Peer support acknowledges experiential social learning (Solomon, 2004), offering a culture of health and ability as opposed to a culture of illness and disability (Mead *et al*, 2001). This encourages a process of social comparison (Bandura, 1999), with attendees evaluating their own performance in relation to the attainments of others on the course (Turner *et al*, 2002; Barlow *et al*, 2008), which in turn enhances motivation to effect positive changes in their lives (e.g. Lawn *et al*, 2007, with mentally ill tutors and attendees).

Tutors are typically volunteers recruited from course attendees. They therefore have an LTHC themselves, and have completed the EPP. Three-day residential

training occurs at accessible venues that provide opportunities for trainees to practise their own self-management skills (e.g. exercise facilities) (Barlow *et al*, 2005a). Tutors are trained and accredited to a rigorous set of quality standards, with training focusing on adherence to protocol, to ensure consistency and quality of both content and delivery. Training is provided by 'master' trainers, and includes programme content, presentation skills, dealing with challenging attendees, and administrative and managerial aspects of tutoring (Barlow *et al*, 2005a). New tutors receive a leader's manual and helpbook. Tutors prepare and deliver courses in their own time, and are paid only for expenses.

International effectiveness data confirm that CDSMC programmes significantly enhance self-efficacy and performance of self-management techniques, including cognitive symptom management, exercise and problem solving (Lorig and Holman, 1993; Taal *et al*, 1993; Barlow *et al*, 2000a,b, 2002; Riemsma *et al*, 2003; Reeves *et al*, 2008). A review of four UK randomised controlled trials (RCTs) examined the effectiveness of the CDSMC and the related Arthritis Self-Management Programme. Significant improvements were found for self-efficacy in all studies, psychological distress in three studies, and generic quality of life in one study, based on intention-to-treat analysis (Griffiths *et al*, 2007). Effect sizes were either small or moderate, while healthcare utilisation was unchanged. The review by Griffiths *et al* (2007) focused on a limited range of outcomes and thus did not report effectiveness for outcomes such as positive affect, energy, exercise, relaxation, cognitive symptom management and communication skills.

The CDSMC also appears to be effective among diverse minority ethnic (ME) groups, for example, when adapted for US Hispanics in Spanish (Lorig *et al*, 2003). Australian research found that concepts around self-management on the course required little modification for Vietnamese, Greek, Chinese and Italian communities (Walker *et al*, 2005). In the UK, an RCT of a culturally adapted CDSMC for Bangladeshis found improvements in self-efficacy and self-management behaviours, and decreased anxiety and depression, although attrition rates were high (Griffiths *et al*, 2005). The EPP is now available in nine languages (Bengali, Chinese, Greek, Gujarati, Hindi, Punjabi, Turkish, Urdu and Urdu-Punjabi) in the UK, although, with the exception of the Bengali course, they have yet to be formally evaluated.

While these findings are generally encouraging, the EPP is not without its critics. For example, qualitative studies have revealed that participants find the rigid course format too rushed and lacking in discussion time for subjects that they consider to be important (Barlow *et al*, 2005a; Rogers *et al*, 2006). Using participant observation of one EPP, Wilson *et al*

(2006) argue that while the subjective experiences of living with an LTHC are supported and acknowledged, the EPP reinforced the medical paradigm. Encouragingly, however, Kennedy *et al* (2005) demonstrated that when consultants were trained in patient-centred communication as part of a self-management intervention, the number of outpatient appointments reduced. Furthermore, the small cost reduction associated with attendance shows that self-management education is likely to be cost-effective (Kennedy *et al*, 2007; Richardson *et al*, 2008). Collectively, these findings serve to confirm Rogers and colleagues' (2006) assertion that strategies encouraging self-management must be embedded within the professional practice and organisational arrangements of healthcare systems.

The volunteer lay tutors also benefit. Kennedy *et al* (2004) showed that those with direct patient contact, such as tutors, experienced the EPP as an effective and innovative means of managing LTHCs. This was substantiated by Barlow *et al* (2005b), who found tutors felt that being valued, adding value to others' lives, and making a positive difference to others, were key benefits obtained from tutoring. Barlow and Hainsworth (2001) established that lay tutors gained a sense of purpose that helped to offset losses associated with a decline in health. Tutors derived satisfaction from sharing experiences with course attendees, and felt their contribution to others' welfare was valued by attendees, their peers and society (Barlow *et al*, 2005b). Tutors significantly improved self-efficacy for pain, cognitive symptom management and communication with their physician, and experienced less depressed mood (Hainsworth and Barlow, 2001). However, tutors acknowledged that volunteering has costs, including time, responsibility, invasion of social life, failure, anxiety, and the duration and intensity of training (Barlow and Hainsworth, 2001).

The dominant model of delivery has typically involved white tutors delivering to white and minority ethnic (ME) attendees, which has largely failed to attract SA people on to the course and has led, consequently, to a lack of SA tutors. For example, in one deprived area of a large UK Midlands city with a high ME population (Office for National Statistics, 2001), no one from an SA background attended the EPP pilot (Peapell, 2004; personal communication). Nationally, the UK pilot EPP evaluation identified that recruiting volunteer tutors from within ME groups would ensure equitable access in the future (Kennedy *et al*, 2004). Similarly, the DH (2004, 2005, 2006) wants barriers to equitable access to be identified, with religious, cultural and ethnic needs of individuals addressed through the local development of 'culturally sensitive' services.

When the present study commenced, EPP courses were only available in English, and the low attendance

levels by SA people meant that there was no SA tutor in the multicultural city in which this research was focused. The present exploratory study aimed to understand lay tutors' experiences of delivering EPP to English-speaking SA attendees.

Method

EPP lay tutors were purposively sampled (as is usual for studies using interpretative phenomenological analysis; Willig, 2001; Reid *et al.*, 2005) for their experience of delivering EPP courses that included one or more SA attendees. Qualitative in-depth interviews allowed tutors to give an insider's view of their worlds, by giving meaning to the cultural and social contexts of their experiences (Ong and Richardson, 2006). Relevant ethics committee approval was obtained prior to commencement of the study.

Participants

The city's EPP manager identified SA EPP attendees from self-completed demographic data that are collected routinely from every attendee. Contact details of the tutors who were identified as having delivered the relevant courses were passed to the lead researcher. All five tutors who had delivered the EPP to one or more SA people were telephoned, given a brief overview of the study's aims, and, with their consent, sent an information pack. This contained an outline of the study, an informed consent sheet, and a demographic data-collection form. All five returned their informed consent sheet and demographic details, and were invited by telephone for interview. The tutors (three females, two males) were aged 47–71 years, are all white and English-speaking, and their LTHCs include neurological, autoimmune and musculoskeletal conditions. All extracts from the data were anonymised.

Addressing misunderstandings about perceptions of small sample sizes, Reitmanova (2008) recently asserted that the socio-cultural *meaning* of health and illness experiences, not simply the *frequency* with which experiences occur, is immensely important in social science research. Conrad (1990) argued that no definitive formula exists to determine an appropriate number of study participants, and sometimes $n = 1$ may suffice. Importantly, Smith (2004) and Smith and Eatough (2007) specifically advocate the use of small samples (<10) and case studies in phenomenological research, such as the present study. This allows for detailed idiographic analysis of participants' richly nuanced accounts of a particular experience, without losing the texture of individuals' experiences. The entire available population of tutors

who had delivered the EPP to SA attendees at the time of recruitment was five, and is therefore considered a satisfactory number of participants with whom to address the present study's aims. Indeed, the seemingly small number of participants further underscores the necessity to investigate this topic.

Procedure

Data were collected in semi-structured, face-to-face, one-to-one interviews. Interviews included questions about tutors' experiences of delivering mixed-ethnicity courses that included SA attendees, their understanding regarding the perceived needs of SA attendees, and their understanding about the appropriateness of culturally specific EPP courses. Interviews were digitally recorded and transcribed verbatim.

Analysis

Interpretative phenomenological analysis (IPA) provides specific insight into individuals' psychological worlds and enhances understanding of particular experiences (Smith *et al.*, 1999; Smith, 2004). Similarly, IPA's aim is the detailed exploration of individuals' personal perspectives on a topic (Smith *et al.*, 1999; Reid *et al.*, 2005). It is especially useful in novel, under-researched, complex or ambiguous areas (Osborn, 2005), allowing deep issues to surface and making unheard voices understood (Larkin *et al.*, 2006). IPA of semi-structured interview data was therefore used in the current exploratory study.

IPA is a flexible approach that permits adaptation to an individual study's requirements, rather than a prescriptive methodology. The approach adopted in the present study used descriptive, interpretative then phenomenological layers of analysis, as follows. Initially, the researcher's first thoughts and ideas describing the participant's experiences were annotated on the transcript. Next, these descriptions and the transcript were examined for alternative explanations and understanding, using more psychological concepts and abstractions. Caution was exercised to ensure that the interpretative nature of this process did not lose sight of participants' own words. Finally, the participants' data and the researchers' interpretations were questioned critically, and deeper phenomenological structures were identified (Eatough and Smith, 2006), and were then collated into themes of related topics.

This cyclical process was repeated for each transcript, with newly emergent themes tested against previous transcripts and current themes. Space limitations preclude detailed reporting of all levels of analysis. An independent audit (Smith, 2003) was performed to ensure the reliability of themes. Two experienced

qualitative researchers independently coded two transcripts, discussed findings, and agreed themes.

Results

Four themes were identified:

- tutors' training needs
- SA attendees' perceived cultural needs
- integration versus segregation
- interpreters.

Themes are not mutually exclusive, but overlap and contain contradictions, reflecting the complexity of the microsituation within its wider socio-cultural context.

Tutors' training needs

Four participants disclosed their need for cultural competence training, in order to avoid inadvertently offending SA attendees:

'I think that we're not fully aware of their cultural needs. I think it would be helpful to be more aware, and not find out when you put your foot in it and have done something you shouldn't ...' (participant 2)

The first sentence suggests that while participant 2 does consider herself to have some awareness of SA EPP attendees' cultural needs, she also recognises a knowledge deficit. Participant 2 understands that improved cultural awareness may assist with tutoring SA attendees. Using the second person, perhaps to deflect personal culpability, this extract infers that participant 2 may already have experienced a negative outcome of an unintentional cultural blunder. Participant 2 also implies that she wishes to avoid such mistakes when dealing with SA attendees.

One participant, based on her positive personal experience of dealing with English-speaking SA attendees, asserted that delivery of EPP in English does not present a barrier 'for anybody':

'And these are people who have an understanding when it comes to language, you know, English, plus a second tongue, I mean it's only people from this country who have only one language! ... And I don't see a lack of understanding when it comes to background language. For anybody.' (participant 3)

Participant 3's perceived success at tutoring bilingual English-speaking SA people is encouraging. However, her somewhat controversial view that people from other cultures are all bilingual might demonstrate an underlying need for cultural competence training. This may further her understanding of broader issues faced by many potential non-English-speaking SA EPP attendees, as they negotiate the healthcare system.

SA attendees' perceived cultural needs

Tutors' experiences of dealing with EPP attendees from SA backgrounds had given them some insight into the specific areas of EPP where cultural needs may differ between SA and other EPP attendees. However, tutors expressed some uncertainty regarding which issues might require cultural tailoring to be more appropriate; for example:

'The religious background ... Um, types of food that they eat, you know? You know, the things that are acceptable, things that aren't [pause] do they object to sitting next to a lady, or a lady to a man that's not of their own culture?' (participant 2)

Participant 2 understands that EPP attendees from SA backgrounds may have culturally specific needs in the areas of religion, food and gender issues. This indicates that participant 2 is contemplating the cultural appropriateness of the course's content for SA attendees (e.g. the food and nutrition section), based on her tutoring experience. She is also considering the cross-cultural pragmatics and perceptions of an SA person physically attending the course (e.g. gender issues influencing seating arrangements). However, participant 2's question may demonstrate her uncertainty as to the precise circumstances under which these culturally specific issues might arise.

In contrast, some participants considered that SA attendees require neither different treatment, nor cultural modification of the intervention:

'I don't know – I'm just, I can't see how it can differ really. I mean we're all human beings, we've all got health problems, we're all gonna get affected similar ... so I can't see how you can treat them any different, or the course itself should be any different.' (participant 4)

Participant 4 felt that the existential nature of living with an LTHC, complemented by the inclusive course structure, overcame any cultural differences. He did not perceive that EPP attendees from SA backgrounds had particular needs, or that the course required adaptation.

Integration versus segregation

Tutors' understanding about the appropriateness of ethnicity-specific EPP courses for SA attendees attracted diverse views. Participant 1 was concerned about delivering ethnicity-specific courses, feeling that training would not overcome intercultural differences, but rather that tutors should be from the same SA backgrounds as attendees:

'You can't learn their thousands of years of their way of life and their social levels and all the, all the things that are involved in that ... As well as, they've got to give out the

course, because ... it's difficult to read people who are not of the same ethnic group ... their psychological reactions you know?' (participant 1)

This extract reveals the participant's insightfulness into the complexities of SA cultures' long histories and social structures, which he does not believe training could address. Interestingly, participant 1's perception that different nuances in non-verbal cues precluded him from tutoring SA groups led him to advocate ethnicity-specific EPP courses and tutors. His assertion that tutors and attendees should be of the same ethnicity confirmed participant 1's position that cultural differences are intractable, in the EPP context.

Based on her experiences, another tutor felt that ethnicity-specific EPP courses for SA attendees were not needed, but her reasons differed greatly:

'I can't see a need for it at the moment. I'd like to know if there is a need for it? I'd like to know why it's being suggested? Are there more people likely to come to attend these courses if it's purely built around a particular ethnic population? Would that mean a change in language?' (participant 3)

Participant 3 does not initially claim to understand the purpose of delivering specific courses for people from SA backgrounds. However, her series of rhetorical questions belies this perception, demonstrating that she does understand that the language of delivery may be responsible for low levels of EPP recruitment in some SA communities. Her avoidant tone suggests that participant 3 may feel anxious either about acknowledging that cultural differences exist, or of talking openly about them.

Other tutors' perceptions about the appropriateness of ethnicity-specific EPPs differed considerably. Participant 2, after the recording equipment was switched off, said she considered single-ethnicity courses to constitute 'state-sponsored ethnic segregation' (her permission was sought to use this extract). Her emphatic words reflect participant 2's resolute opposition to ethnicity-specific courses, regarding them as highly undesirable. However, one participant acknowledged that single-ethnicity courses might increase attendance among people from SA backgrounds in the short term:

'My own wish would be that ultimately one could run integrated courses, because I do actually think it's enriching for everybody and ... I mean it is a bond isn't it, to have a health issue in common? And I suppose I would just like to feel that the course is, as well as benefiting people with their health, could actually help break down barriers between people as well ... I think one should do anything one can to encourage people and I think that if that means special modules, that would be fine, but I would like to see that as a means to an end rather than an end in itself.' (participant 5)

This extract demonstrates participant 5's understanding that people's collective experiences of living with LTHCs override cultural differences in the EPP setting. There is a tension between the participant's personal ideology and social understanding as she tries to make sense of what ethnicity-specific and generic courses mean to her. Participant 5 clearly views mixed-ethnicity EPPs as having the potential to perform a function beyond health education, in the broader societal context of cultural integration. Her final sentence in this extract concludes by advocating the provision of ethnicity-specific EPP courses to SA groups to boost numbers, considering them to be an unsophisticated interim solution that overlooks the bigger picture in which EPP sits.

Interpreters

The use of interpreters for non-English speakers attending multi-ethnic courses arose during the first interview and was pursued with other tutors in subsequent interviews. Participants used their experiences of tutoring SA attendees to consider what this would mean to them – again revealing disparate and contentious views.

The following excerpts highlight that participant 3 does not consider the use of interpreters necessary, while participant 4 understands that they may help some attendees:

'I think I'd be sorry to feel there was a need for it. Erm, I'd like to know why it's being considered?' (participant 3)

'Well if there is a need because of language, then yes!' (participant 4)

The expression of regret in the first extract demonstrates that participant 3 views interpreters as indicative of some kind of failing. Her somewhat derisory question suggests resistance to the idea, based upon her previous assertion that everyone speaks English. In sharp contrast, participant 4 would be prepared to work with interpreters if attendees' language requirements necessitated it, understanding that it would enable non-English speakers to attend the EPP.

In the following extract, participant 2 clearly articulated the practicalities of working with interpreters in multi-ethnic EPPs. Firstly, she talked about the attributes and training that an interpreter would require, then how it would impact upon her running a group:

'... it would help if the interpreter had a long-term condition ... if you'd got one person who needed an interpreter, then perhaps the interpreter could sit next to them or behind them, so they're there actually talking at the same time ... when you get the feedback sessions, you'd have to give the interpreter time to speak. There's ways of doing it I'm sure!' (participant 2)

This participant is aware that the interpreter would effectively become a 'tutor by proxy' to the non-English speaker, and would therefore have a critical role in the success of the EPP for that individual. This is reflected in her belief that the interpreter would, ideally, have received training about the course and have an LTHC him/herself. Considering the impact that the presence of the interpreter would have on the group, participant 2 understands that additional time may be required to facilitate the translation process, especially in the group feedback sessions.

Discussion

The study aimed to understand tutors' experiences of delivering EPP courses to English-speaking SA attendees. Tutors had experienced no specific or general problems when delivering EPP courses to multi-ethnic groups of attendees, giving an encouraging account of their cross-cultural EPP experiences. This research identified tutors' divergent training needs and their sometimes opposing perceptions of SA EPP attendees' culturally specific needs, and highlights the complexities of delivering both ethnicity-specific and multi-ethnic health interventions, such as the EPP.

A need for cultural competence training for EPP tutors was clearly identified. It should be noted that volunteer tutors are not paid staff. They do not routinely receive such training, are not required to do so, and thus cannot be expected to have cultural expertise. This finding is not, therefore, intended as a criticism of the tutors. Indeed, cultural training is widely advocated elsewhere for health workers, for example for medical students (Godkin and Savageau, 2001), nurses (Wilson, 2004), counselling psychologists (Vera and Speight, 2003) and care workers (Papadopoulos *et al*, 2004). While the process and content of EPP courses are fixed, enhancing tutors' confidence in dealing with multi-ethnic groups through cultural competence training may promote a stronger therapeutic alliance between the tutor and attendees, which has been shown to be beneficial in other group psychological interventions (Yalom, 2005). However, as Papadopoulos *et al* (2004) highlighted, mandatory cultural competence training may lead to ambivalence if participants are made to feel inadequate or guilty. Ideally, involvement of participants in planning the training may be beneficial.

The tutors' suggestion that any culturally tailored courses should consider religious influences, gender issues and dietary differences was noteworthy, as no tutor had found these factors to be problematic while tutoring SA attendees. This dichotomy between experience and belief may reflect either tutors' cultural stereotypes, or alternatively, that the English-speaking SA attendees they had tutored may be acculturated into Western society. It is also entirely possible that

SA attendees *had* experienced cultural issues, but had simply not voiced them to the tutors, who were unaware of their concerns. An alternative explanation for this finding is that tutors did not want to admit that they *had* experienced culturally related problems with SA attendees, perhaps feeling threatened by admitting this, or afraid of being labelled as racist. A claimed inability to perceive differences, adopting a colour-blind perspective, and the avoidance of discussing issues around ethnicity and cultural diversity can evoke anxiety amongst white people (Wilson, 2004). However, Johnson and Jones (2003) encourage healthcare providers and workers to acknowledge both their own culture and spirituality, and that of their clients, in order to embrace complexity and diversity.

The issue of ethnicity-specific versus multi-ethnic EPP courses is highly complex. One argument that tutors proposed is that ethnicity-specific EPPs, lay-led by trained tutors from the same cultural and linguistic background as the attendees, would encourage more SA people to attend. However, given the recognised difficulty around recruitment and retention of SA attendees and tutors, this raises pragmatic concerns. Same-ethnicity tutors in the study by Griffiths *et al* (2005) did not resolve issues of attrition.

Other tutors were concerned that ethnicity-specific EPPs could exacerbate ethnic divisions, appearing to propose the EPP as a vehicle for achieving small-scale, short-term cultural integration. While this was certainly never a primary concern of self-management educational interventions, this wider social implication is an interesting viewpoint. Improving accessibility to health education for people from ME backgrounds is, however, recognised (DH, 2004, 2005, 2006; WHO, 2005) as potentially contributing to reducing health inequalities, which tutors acknowledged.

Tutors were generally in favour of employing interpreters for non-English speakers in multi-ethnicity English-language courses. They felt that ideally interpreters should themselves be trained SA EPP tutors; recruitment may be problematic given the current low attendance levels by SA people. However, based on her positive experiences, one tutor did not consider ethnicity-specific EPPs or using interpreters on integrated courses necessary, seeming somewhat defensive to these suggestions. This highlights the need to ensure that all tutors are fully trained and informed of the reasoning behind any decision to proceed with ethnicity-specific EPPs or employing interpreters.

Greenhalgh *et al* (2005) proposed that minimal differences exist between SA and white patients in certain respects, and suggested that a patient's health literacy may be more important than 'culture' in explaining health beliefs. These views were strongly supported by some participants in the present study, who believed that the shared illness experiences overcame ethnic or cultural differences.

Ong *et al's* (2002) findings that Western ideals of shared decision making and patient autonomy differ from traditional Asian cultural and religious attitudes are not supported here. This may be because of the small numbers of acculturated SA attendees whom the tutors had encountered. People who self-refer to attend self-management interventions may differ from the general population, for example in terms of autonomy and motivation. Further research with EPP tutors may reveal divergent experiences of delivering to SA people living with LTHCs.

This study has several caveats. The low attendance rates of people from SA backgrounds meant that the white tutors interviewed here had limited experience of working with English-speaking SA attendees. All the SA EPP attendees were, the tutors reported, acculturated ('anglicised' – participant 1; 'westernised' – participant 2). Clearly, this will have influenced tutors' experiences and views expressed. Another potential limitation is that of socially desirable answering. Given the sensitive nature of the topic, it is possible that participants may have given 'politically correct' responses. However, tutors' right to anonymity was stressed prior to and throughout the interviews as necessary, to assure participants that they could speak freely. Given the diversity of answers, response bias does not appear to have compromised the current study.

Finally, it should be noted that the results of this exploratory study cannot be generalised to other white EPP tutors. The next phase of the larger project addresses Punjabi-speaking SA tutors' experiences of delivering the EPP to Punjabi-speaking attendees. The final phase will explore Punjabi-speaking community members' perceptions of health self-management before and after they attend the EPP. Collectively, the different phases of the research will triangulate data to provide a comprehensive insight into how best to organise EPP courses to encourage maximum recruitment and retention of SA attendees. This, in turn, may allow people from SA backgrounds to enjoy the same benefits from EPP as the mainstream population, thus addressing one small element of minority-ethnic health inequalities.

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CONFLICTS OF INTEREST

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