

Expert testimony

Expert:

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Testimony:

This expert testimony, to be presented to the 'prevention of pre-diabetes' Programme Development Group, is based on the sources cited at the end of this paper.

How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions

The term 'culturally sensitive' is often used to describe interventions adapted for minority ethnic communities. However, understanding of strategies for adapting behavioural interventions for such communities is limited.

The questions addressed in this paper are:

- What are the main strategies for adapting interventions to reduce coronary heart disease (CHD) for minority ethnic communities?
- Why have interventions been adapted in these ways?

A systematic review was carried out to investigate interventions for preventing CHD, including promoting physical activity, smoking cessation, and healthier diets in Pakistani, Chinese and Indian communities in countries where these groups are minorities. International databases and key websites were searched. 23,477 titles and abstracts were initially identified. Seventeen papers met inclusion and quality criteria. The rationale underpinning adaptations is not made explicit in individual studies, limiting the potential for generalisability.

A 'meta-ethnographic' approach to data synthesis was employed to identify underlying principles for adapting interventions.

Five main principles for adapting behavioural interventions for minority ethnic communities were identified:

1. Use community resources to publicise the intervention and increase accessibility
2. Identify and address barriers to access and participation
3. Develop communication strategies which are sensitive to language use and information requirements
4. Work with cultural or religious values that either promote or hinder attitudinal and behavioural change
5. Accommodate varying degrees of cultural identification.

While the principles require further testing and verification, they have been generated through a systematic approach to study identification, quality appraisal and data synthesis. This represents significant progress in advancing understanding of adapted behavioural interventions for minority ethnic communities.

Results

Seventeen behavioural interventions were assessed as being relevant to the review and meeting study quality criteria. The majority of the interventions had been effective in bringing about behavioural changes, with others influencing either health-related attitudes or health status.

Brief description of studies and interventions identified

Sixteen out of seventeen interventions were carried out either in the UK or US. All the UK-based interventions targeted the South Asian population (ethnic groups with origins in Pakistan, India or Bangladesh) while all the US-based interventions targeted Chinese Americans. Sample sizes varied from 13 to 2,950. Intervention designs varied considerably, including organized group activity, individual advice sessions and media campaigns. Only eight studies reported an underpinning theoretical framework.

The research identified recurrent themes and adaptations or 'first order generalisations' involving features of the target community; modifications, presented as 'second order translations,' and five generalisable principles or 'third order interpretations'.

Recurrent themes and adaptations or 'first order generalisations' are summarized in the first column of Table 1. In seeking to determine the relationship between studies in the review to each other, a significant insight was that adaptations to interventions accommodated several distinctive features of the target community, although this was not explicitly stated. This included their minority status, the socio-economic disadvantage of some communities, linguistic diversity and differential access to information, cultural or religious values and heterogeneity.

In order to ensure accessibility and relevance to the target community, interventions were modified in specific ways. Modifications are presented as 'second order translations,' summarised in the second column of Table 1. Finally, five generalisable principles or 'third order interpretations' are presented in the third column of Table 1. Each principle addresses one or more characteristics of the target communities. Since no one study explicitly identified all these aspects of the target communities or adapted interventions on the basis of all these dimensions, our synthesis achieved a conceptual development beyond that attained in the individual studies.

First, second and third order generalisations are presented in table 1, in the appendix.

Conclusions

Our systematic review has contributed to the study of targeted interventions for minority ethnic communities in five ways:

- Firstly, we have found that adapted behavioural interventions for preventing CHD among Pakistani, Chinese and Indian communities are rare in Europe and North America. This indicates that many individuals in these communities may not be taking preventative action, indicating the need for urgent action.
- Secondly, we found that South Asian communities (primarily Pakistani and Indian communities) were the major focus of research in the UK and Chinese communities in the United States.
- Thirdly, the review has synthesized a transatlantic corpus of work. Despite differences in patterns of migration, ethnic composition, settlement and healthcare systems in both continents, many commonalities underpinning adapted interventions have been identified, adding credibility to the strategies employed.
- Fourthly, the review reveals considerable scope for modifying interventions to increase their appropriateness for the target communities by considering the

multiple dimensions of individuals' lived experiences. These include their minority status, socially disadvantaged position, cultural and religious beliefs, and cultural affiliation.

- Fifthly, five principles have been proposed to guide the planning and delivery of future targeted interventions for minority ethnic communities.

A study funded by the Medical Research Council is building on the current work. This will include contact with researchers involved in identified studies and deepen understanding of the applicability of the principles offered above. See: <http://www.hta.ac.uk/1745>.

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Key references

Netto, G, Bhopal, R, Khatoon, J, Lederle, N and Jackson A (2010) 'How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions' *Health Promotion International* daq012v1-daq012.

Noblit, GW, Hare, RD. (1988) *Meta-ethnography: synthesizing qualitative studies* London: Sage

Appendix 1

Table 1: Data synthesis: concepts, second- and third-order interpretations

Concepts/themes derived from primary studies	Second order interpretations	Third-order interpretations
Many interventions used community resources to increase accessibility to the target groups, including community leaders and organisations, networks, ethnic-specific media and events.	The minority status of the target groups required the use of targeted measures to increase accessibility to the intervention.	Use community resources to increase accessibility to the intervention
Many interventions addressed barriers to access related to cost; others addressed barriers to access and participation that were related to gender and age, yet other interventions took account of socio-economic disadvantage experienced by the target population, including low educational levels and long working hours	Interventions need to address disadvantaged socio-economic position and other aspects of identity, in addition to ethnicity, including gender and age.	Identify and address barriers to access and participation.
Many interventions used bilingual facilitators to communicate to participants; other interventions used translated printed material in diverse languages to promote the intervention; yet other interventions took account of varying levels of literacy among participants; some interventions enabled participants to use their native languages to express health-related concerns;	Targeted interventions need to develop communication strategies which address language barriers, literacy levels and differential access to health-related information within the target group. Such strategies should also allow individuals to freely communicate with health professionals.	Develop communication strategies which address language use and differential access to information.

Concepts/themes derived from primary studies	Second order interpretations	Third-order interpretations
one study identified the need for interventions to take account of different sources of health-related information used by diverse language groups		
Some effective interventions used cultural and religious values to encourage participants to make behavioural changes; other interventions incorporated traditional food and physical activities; cultural and religious beliefs which were not consistent with CHD prevention were identified in one study and action recommended to counter such influences	Some interventions identified and incorporated cultural and religious values which were consistent with health promotion messages to motivate participants to make behavioural changes. Cultural or religious beliefs which are not compatible with health promotion messages need to be countered.	Identify and work with cultural or religious values which motivate or hinder behavioural change
Varying degrees of cultural or ethnic identification within the target community were identified in the planning of one intervention and in the assessment of two interventions	Interventions need to accommodate varying degrees of ethnic identification within the target community in the planning and evaluation of interventions	Exercise sensitivity to degrees of ethnic/cultural identification in the planning and evaluation of interventions