**BARRIERS TO CARDIOVASCULAR DISEASE AMONGST SURREY's ETHNIC MINORITIES – Jasmine Kapoor**

## EXECUTIVE SUMMARY

Cardiovascular disease is one of the most prevalent chronic diseases amongst the Black and Minority Ethnic Communities. This could be due to genetic factors, high blood pressure, diabetes, unhealthy eating, sedentary lifestyle, smoking, high cholesterol, high alcohol consumption or poverty. Psychological and social effects also play crucial roles in predisposing minority populations to stress that can lead to cardiovascular disease.

Language barriers also pose difficulties in efficient communication and provision of cardiovascular health care. Minority patients with limited or no English language ability may be at a critical disadvantage while seeing Doctors. The interpreters may be family members which can make translation challenging. The Government's Eat Well guide is a definite challenge for poor households. Language barriers are a key cause of miscommunication between medical providers and patients, and negatively affect the quality of healthcare services and patient satisfaction. Hospital medical professionals perceive language barriers to be a source of workplace stress

Poor access to services is another inequality faced by the Minority Ethnic Communities. Irregular buses or unable to drive to the hospital for appointments leads to a high rate of cardiovascular disease as patients miss appointments. Online consultations during covid made it difficult for the communities who were not IT comfortable.

Cultural understanding by the Doctors also play a part in health inequalities. Different cultures entrenched beliefs and their learnt thoughts and interpretation of their health problems can often be very different from those of western ideals and culture. Often patients might misinterpret their diagnosis, their beliefs about health in general, their views and knowledge of the health care system and how their religious beliefs might play a role in their interactions with and access to healthcare.

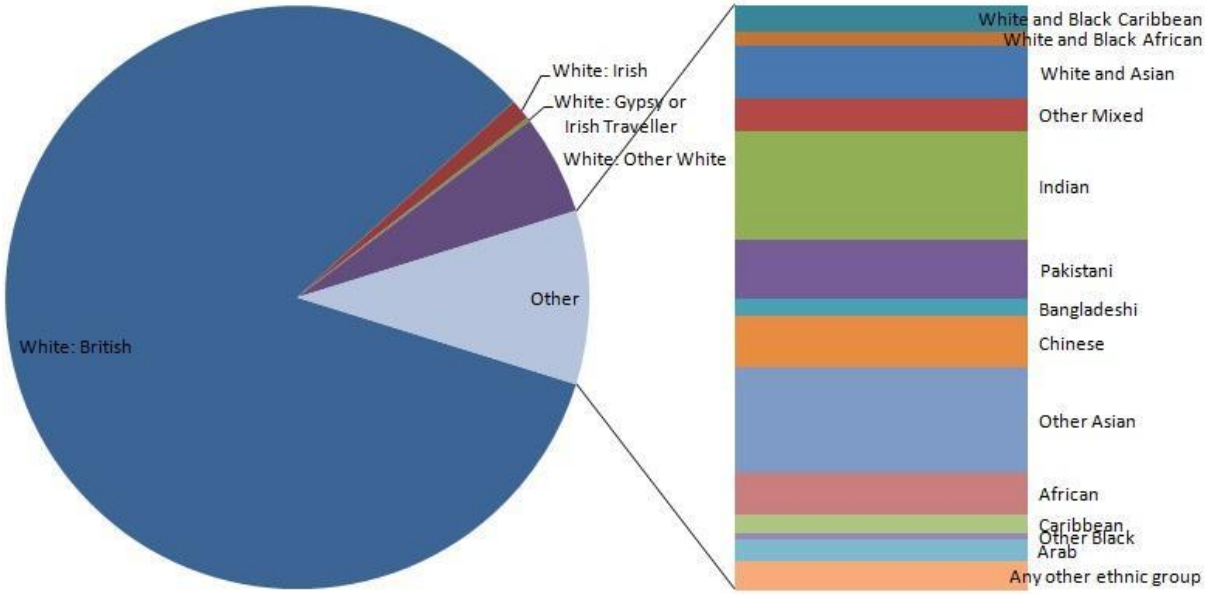
## INTRODUCTION

Cardiovascular disease encompasses diagnosis of coronary heart disease, stroke, sudden cardiac death which could result from risk factors such as

smoking, hypertension, high cholesterol, obesity, excessive alcohol consumption and lack of physical activities.

The county of Surrey in the UK is a diverse society with 17% of the population who are from ethnic minority groups.

Ethnic groups, Surrey, 2011



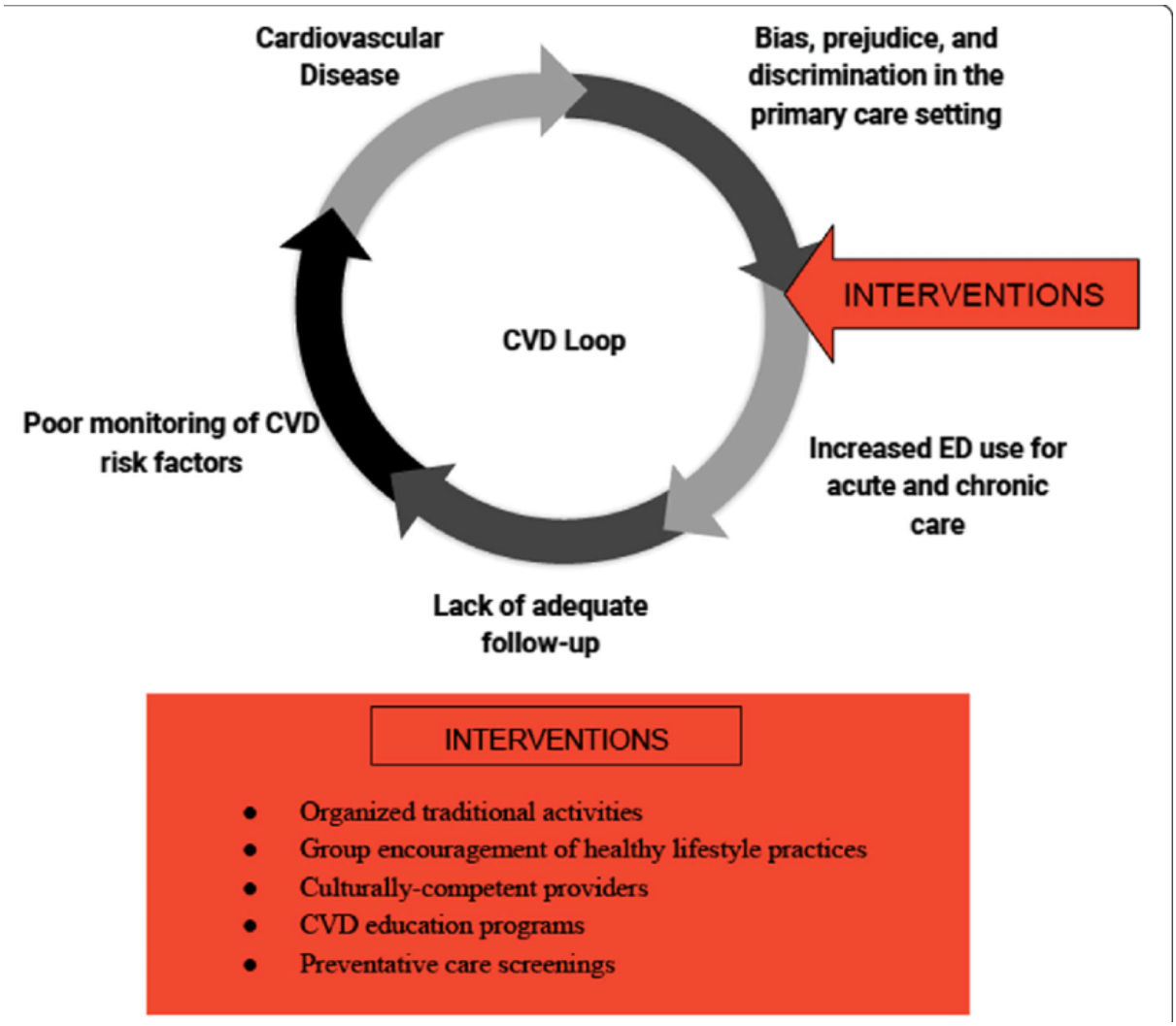

Source: Census – Office for National Statistics

Epidemiology of CVD

Cardiovascular disease (CVD) is the most common and yet one of the most preventable causes of death in the Western World. Economic development in Asia and rapid urbanisation in Africa are associated with rapid changes in lifestyle and environmental exposures, resulting in a high percentage of CVD.1. The two main ethnic groups within the UK, Blacks and South Asians, are at particularly high risk of CVD. The South Asians are prone to Heart attacks while the African and Afro Caribbeans have a high percentage of strokes.2.

Several hypotheses have been proposed to explain how and why racial/ethnicity health gaps exist. Low uptake of services has been correlated with low income, low educational achievement, poorer living conditions and

inability to access primary or secondary care due to language barriers or transport issues.3.




Reference 4.

International research suggests that people living with heart and circulatory (cardiovascular) diseases are at significantly increased risk of severe outcomes (3.9 times higher) and death (2.7) from Covid-19. Coronary heart disease (CHD) is one of the most common pre-existing conditions for deaths involving coronavirus – others include dementia, cerebrovascular disease (stroke), hypertensive heart disease, diabetes, and heart failure. 45 percent of Covid-19 death certificates in England in Spring 2020 mentioned cardiovascular (heart/circulatory) disease. The pandemic has highlighted health inequalities by age, gender and ethnicity and more research is required to understand

these, including how heart and circulatory diseases and their risk factors affect Covid-19 risk and outcomes. A 2020 study of severe Covid-19 cases in hospitals across the UK showed that chronic cardiac disease was the most common comorbidity. Around 9 out of 10 deaths in 2020 in Great Britain that mentioned coronavirus also record a pre-existing health condition such as CVD.5

## METHODOLOGY

A review of published literature was conducted to identify relevant medical, public health, and sociological publications. Retrieval of relevant research was accomplished via searching the electronic databases PubMed, MEDLINE, for the following keywords: racial/ethnic discrimination, race/ethnic minority health, health disparities, cardiovascular disease, and community health. Criteria for inclusion included relevant discussion of cardiovascular and non-cardiovascular health disparities in racial/ethnic minorities.

Qualitative research helps us understand the circumstances that shape and perpetuate poor outcomes in health behaviour. Hence, we used personal interviews and focus groups to collect in- depth information. They were conducted in person or on zoom. The respondents were selected by advertisements in the SMEF's E Bulletin, social media, and word of mouth. Each respondent was given a ten-pound supermarket voucher Every interview lasted for 45 minutes to an hour. The Focus Group topic guide is attached in Appendix 1.

Five Health Events were organised in different boroughs of Surrey led by Surrey Minority Ethnic Forum (SMEF) Health and Race Project. They were facilitated by Public Health Specialists and Hospital Consultants. Healthy Eating, High Blood Pressure, Physical Activities and Diabetes were the themes the events focussed on. The events were very well attended as it was an opportunity for the attendees to meet the Consultants in person for the first time in two years.

## DATA ANALYSIS

Thirteen personal interviews and one Focus Group were recorded by the interviewee which were translated into English and transcribed. The thematic

analysis was by using highlighter pens, the colours were according to the themes extracted.

## RESULTS

### PERSONAL INTERVIEWS

| | |
|---|---|
| **BANGLADESHI MEN** | **3** |
| **AFRICAN MEN** | **1** |
| **INDIAN MEN** | **3** |
| **PAKISTANI LADIES** | **2** |
| **INDIAN LADIES** | **2** |
| **NEPALI LADIES** | **1** |
| **BANGLADESHI LADIES** | **1** |

One Focus Group was organised with Bangladeshi Ladies in Dorking. 13 ladies attended the focus group despite having invited only 8 ladies.

### HEALTH EVENTS

5 Health events were organised in Woking, Dorking, Redhill, Guildford, and Camberley attended by 179 participants. They were facilitated by GPs and Hospital Consultants. The objective behind the events was to take the services to the communities giving them the opportunity to discuss health inequalities in a safe and trusted environment.

### ANALYSIS

#### Causes of Heart Disease

The respondents were asked about their knowledge of heart disease. They spoke of lifestyle behaviours and genetics or family history. There were frequent references to the role of diet, not being physically active and lack of education back home.

"Genetic *Factors, Fried Foods, No Exercise"*

*"Eating unhealthy food"*

Psychological and social effects also play crucial roles in predisposing minority populations to stress. Discrimination and bias within racial/ethnic minority communities and within the greater health care system where doctors did not create awareness for prevention but by treatment after the incident.

*"Stress of having to wait so long for appointments and then seeing the doctor for 10 minutes. You come out without understanding your diagnosis."TJ*

*"Long term lifestyle choices such as affluent habits of smoking, alcohol, working in stressful international organisations. Genetic factors only play a small role, it's the unhealthy lifestyle that gives so many people heart attacks. Some of us may sweep our heart health underneath the carpet because we fear what is lying ahead." AK*

*"Our doctors are all about cure and not prevention. The GPs need more awareness on heart health amongst BAME communities before they try and treat us. To them it is popping pills into the patients' mouths."AK*

Smoking was frequently referred to by the Bangladeshi ladies during the focus group.

*" My husband and father in law smoke all day long. I have a small child who often plays with their cigarettes."*

*"I sent my husband to do grocery shopping. He forgets the food I have asked him to buy but he does not forget his cigarettes."*

*"Smoking, Fatty Food, drinking alcohol, it is all unhealthy. Doctors stop people from eating foods which are unhealthy and then find Psychologists to help us deal with stress as they were our comfort foods. The same goes with smoking. When you hear your wife is going to die you are going to reach for a cigarette"."AA*

South Asians originate from a patriarchal society in which the male breadwinner is looked after by the family while his wife with similar health issues would be ignored.

*"Genetic Factors, bad eating habits, no exercise. Neglect of the lady of the house when she is unwell as our culture which is patriarchal gives more importance to the breadwinner's health who is often the man of the house. I have seen it with my mother and I am now guilty of doing it with my wife. Sons receive better healthcare with hot milk and turmeric while daughters are often uncared for."MB*

One of the respondents tried to explain it medically.

*“I think your arteries get blocked with the oil and fat and hence blood cannot pass through it.”*

**LANGUAGE BARRIERS**

Patients with limited English proficiency are less likely to report having a history of cardiovascular disease.6. Health disparities such as unequal treatment related to language barriers are associated with unequal access to healthcare and unequal health outcomes. On asking the participants whether they struggled to speak to their GPs or hospital Consultants, the below quotes highlight the concerns and frustrations faced by the participants who struggled because of limited English.

“*I was given a pen by my GP to check my blood sugar levels as I am diabetic. This was a year ago. She did not explain how to use it as I don’t speak English. I have not used it and often feel very unwell because my blood sugar may be high. I have no way to monitor it*.”

*“I always worry I will die very soon because NHS 111 or 999 do not understand Urdu. How do I make them realise my condition is serious”.*

“ *Our health care is decided by our skin colour.”ME*

Language barriers contribute to reducing both patient and medical provider satisfaction, as well as communication between medical providers and patients which should be at the heart of effective healthcare.

*“Any time I am asked a question by a Doctor I say yes or no. I cannot get into lengthy complicated discussions since I cannot speak the language.”TJ*

*“I avoid the hospitals and GPs because I can't speak English.”*

**CULTURAL AWARENESS**

The respondents often felt they were being judged because of their culture, their poor English, or their clothes leading to missed appointments.

“*My hospital visits give me panic attacks. I feel like I am being judged all the time because my English is poor and I dress differently.”*

*"The receptionist at the GP Practice always makes me feel I am wasting her time. She should understand pain and not judge me for my culture and religion."*

Women respondents preferred being seen in a place where they felt they were at the same footing as the medics. This would help empower them and give them the confidence to discuss their medical problem.

*"I hate my hospital visits. I feel stupid and often a complete idiot because the GPs look at me in such a way. Could we please have health awareness sessions in mosques where each one is just as intelligent or just as stupid as us. In a group with our community women we would feel a lot more empowered."AA*

*"I meet men at the hospital when I am visiting my Gynaecologist. I feel so embarrassed when they see me waiting at the outpatients."*

**HEALTHY EATING**

Participants were asked to identify modifiable causes of cardiovascular disease. The most prominent risk factor was the role of diet and not receiving proper nutrition by eating unhealthy foods.

The evidence below paints a complex and mixed picture of cultural competency. It suggests dietary habits vary by ethnicity, culture, and religion. Lack of halal meals at school was one factor quoted leading to obesity.

*"The culture of Britain promotes unhealthy eating amongst the school children. Students are forced into taking packed lunches because school does not provide Halal food and the vegetarian option is only chips which are so unhealthy or baked potatoes with cheese"*

*"My son has put on so much weight since joining secondary school. The school Dinners are unhealthy. Dinner Ladies encourage you to eat chips rather than fruits".*

*"I am forced to take packed lunch as my school does not serve halal meals. The food turns soggy and cold in the winters despite a thermal lunch bag. The only veg item available are cookies or margarita pizza. Both are unhealthy." ZB*

Cultural clashes in what is considered healthy, taste over healthiness of certain foods, stubbornness to change their eating habits.

*“Our culture is all about carbohydrates, sugar and fatty food. Our spices are rich with aroma, even our small kids find British food bland”.*

*“We are rice eating communities. We have been eating it since we were born. How can you change your diet when for the last 50 years you have eaten rice twice a day everyday”*

*“Culture has an impact on what we eat. If you look at the blue zones which are the five most healthy spots, everyone there is healthy because they eat the right foods. Or Okinova in Japan has a very strong heart health because of very high diet of fish, the omega 3 that they regularly consume.” AK*

*“Our cultures promote unhealthy eating, You are judged in your communities as poor if you don’t eat red meat regularly.”ME*

*“ My grandparents ate the same food as what I eat which was considered healthy. But the same food is now unhealthy.” AA*

One respondent believed in eating what was right for the country he lived in. With temperatures being different the same food can lead to obesity.

*“You need to change according to the country you live in. When in India you can eat ghee and rice and red meat because you would sweat it out. England is different, hence eat salads and fruits rather than biryanis.” MB*

Second generation respondents were aware of healthy eating but struggled to make their families understand. Food culture is closely linked with identity thus making it difficult to bring about the necessary changes.

*“I am second generation in England having been born and brought up in England. I do not eat the traditional meals cooked by my mother as I am more into salads and soups. This causes conflict in our family with my mother as her parents have eaten the same food in India and have lived disease-free lives.”SK*

*“I am unhealthy because of my environment at home. Food in my family is all about carbs. If everyone in my family ate healthy, we could all cook together and eat together, it is so much easier to stay healthy and would benefit all family members. Rather than finding white bread and margarine in the fridge it would make more sense if there were fruits or salad vegetables. My sibling is a lot healthier than myself because he is into sports and has the pressure of staying healthy at university. When he comes home, he is also trapped in the unhealthy lifestyle that exists at home” AK*

*“I eat healthy to stay in shape. I am a second generation Asian in Surrey and I have the knowledge and awareness which the earlier generations lack”.SK*

*I often look in horror when my grandmother cooks Halwa soaking in ghee. This is her tradition she believes in. This is the generation who needs to be talked to by religious leaders. Doctors have no impact.”SK*

Food shopping and cooking can lead to unhealthy eating habits because people have been raised and brought up in a certain style and manner. In addition, taste preference, cost, availability, convenience, and cultural familiarity make up our food trolleys.

*“Healthy Eating is in the hands of the family member who does food shopping. If you buy red meat once a month you would eat it only once a month which is healthy but if you buy it for 4 times a month then you are heading for a heart attack”ME.*

*“Africans buy food from Asian shops as it is a lot healthier. The problem is not with food we buy but how we cook it. If you bake or grill than fry, the food will taste good and be a lot healthier. We need to change our mind sets.”MP*

Prices of healthy food is much more expensive than food laden with unhealthy levels of fat, sugar, and salt. The price of fruits and vegetables are quite high leading to participants buying junk food which is cheaper and usually on sale. This could be a cause of obesity leading to heart disease.

*“Healthy Food is so expensive to buy. I wish to make smoothies for my young kids. I can’t afford it. I need to buy my children’s school uniform rather than pay for fruits.”*

*“It’s only the junk food that goes on sale. To buy healthy food I need to shop late nights when the supermarkets are trying to get rid of foods that have today’s expiry dates.”*

Healthy Eating classes which have become popular during the pandemic and can be conducted on zoom. Run by hospitals and charities they did not help the respondents. These classes have narrowly focussed on improving healthy eating by improving knowledge and skills about food categories and cooking.

*"We often attend healthy eating classes which are so unsuitable for us Asians. These are run by hospitals. It is more of don't eat this rather than this is what is right for you."*

*Image is important to the younger generation. Social media accounts usually carry pictures of food eaten by the youth at home or restaurants.*

*"You are what you eat. I believe in image because we are in the 21st century. We no longer have the option to look scruffy the way our grand parents did. I eat healthy, not the traditional unhealthy meals you find in ancient Indian families. I am born in the twenty first century and I believe in discipline.."SK*

Motivation to stay healthy comes in after the incident. There are regular follow ups with eating healthy food and regular exercise.

*"I was not careful about physical activities or eating healthy. After my heart attack I felt motivated to do what the doctor had been asking me all along."AA*

*"Oats, no sugar, black tea I am slowly changing my lifestyle as I have been diagnosed with diabetes. Cut down on milk. Milk is Milk, it makes no difference you have all these fancy milk brands like skimmed, semi skimmed or full fat. More water in it higher the price. Just don't drink it and you will remain healthy."MP*

Sugar was bad for your heart but manual labour helped you sweat it out.

*"Our community is involved in high degree of manual labour. Our husbands are always lifting heavy things, Its okay for them to have sugar in their tea or eat the Bangladeshi sweets.They are always sweating."*

**FOOD LABELS**

Nutrition labels help us decide the foods we need to eat. Each package contains a traffic light signal where green is healthy, amber is medium and red is unhealthy. We asked the participants if they were familiar with food labels.

**"***Did not know they existed***.** "SB

"*I have seen them but don't bother much with them. Our life is stressful enough. We do not need to be controlled by what we buy". AA*

*"The best gift from Food Standards Agency to us. I encourage my family to look at them too while food shopping."RP*

Entertaining or giving expensive gifts often result in food that is high in fat.

*“I do usually but not when I am throwing a party.” AK*

*“I like giving expensive biscuits to friends and family. The label there shows red high fat. I must buy them because I cannot give something tacky.” MB*

Common sense is considered more important than food labels. Awareness of healthy and unhealthy food may dictate common sense.

*“You need common sense not food labels to dictate what you eat.” SK*

**EXERCISE**

The World Health Organisation (WHO) reports physical inactivity as one of the leading causes of death amongst South Asians living in the West. To combat this substantial mortality rate, the WHO routinely advocates the promotion of physical activities to manage chronic disease conditions such as cardiovascular disease. 7. Physical Activities prescription by the GPs is a cost-effective intervention that could save the NHS a significant amount of money in prevention of cardiovascular disease. As SMEF had organised physical activities sessions on Zoom which had poor attendance each week, the women tried to defend themselves about not using the facility.

Lack of women only classes was one of the main reasons cited by the Muslims in Surrey. Lack of communication between the leisure centres and the community due to language barriers was the reason quoted by Active Surrey. As promoting active living is one of the Public Health priorities, I asked the participants whether they regularly exercised.

“We *are Muslims and are shy of exercising with men. It is difficult to find women only classes*.”

*“I love swimming and would swim regularly in Bangladesh. I cannot swim in the UK because of mixed classes.”*

*“I love to play football. Our school does not have a girl only team. I am not confident enough to play with boys”. ZB*

Zoom classes were unsuccessful because of lack of privacy in Muslim households.

*“Our communities are multi-generational. We live in small homes. SMEF’s physical activities on Zoom did not suit us. Lack of privacy in the home with father-in-law walking in while I have my leg up will lead to a lot of embarrassment and bad mouthing in our community.”*

In addition a women is expected to do all the housework which left them with no time. Looking after the children was considered enough exercise. Gyms were expensive and lockdowns increased weight issues.

*“We understand we need to exercise to stay disease free. Lack of time because of cooking, looking after children and doing the housework leaves us very tired.”*

*“I have three young kids and a full-time job. That is enough exercise for me. I need no more.”*

*“It is the men in our homes who discourage us from staying healthy. We don’t have the time or the motivation and rather than encouraging us they say oh you look so beautiful with your double or even triple chin” AA*

*“Our cultures back home teach us to learn to cook but not to exercise. Hence Exercise is our lowest priority. The next generation are keener to exercise as compared to us because they know the benefits of exercising.”SB*

*“Women have a reason not to exercise. Our Men do not help out in the homes. They are busy watching football or going out with friends drinking. Women are left at home to cook, clean and wash. Men need to take the initiatives by getting their women folks to walk in groups, have some time off from home worries and be responsible for their women’s health. “ MP*

*“SMEF gave us a funding for badminton sessions for men and women separate sessions. They are extremely popular and stress busters. Our women are ready to walk 45 minutes to reach the badminton courts because it gives them feeling of being healthy. We often get overlooked by the councils. When opportunities do not exist how are we supposed to exercise.”ME*

*“Gyms are very expensive. The Government spends so much money on health care. Why don’t they make Gyms free.”*

*“Cardio exercises (referred to by healthy people) are the best way to prevent us from heart disease. Simple exercises such as running, or walking may help but wont stop you from having a heart attack. AK*

*"Covid has increased the rate of heart disease as we were not allowed to go out for a walk. I missed my 30 minutes daily walk during lockdown. I am now 20 pounds overweight." MB*

While participants who were aware of exercise understood its value.

*"I am a sports professional. I work hard to keep fit, it is a lot harder because my family has obesity genes."SK*

*"GPs should have some indicators which tell the patient their risk of a heart attack. My father ran 2 miles every morning for years but still died of a heart attack. He should have been told what his risk indicators were that would have prevented it."AA*

*"My stress levels reduce when I exercise. I do it for my Mental peace as my work can often be quite stressful."SK*

*"To me exercise isn't difficult. I often run half marathons. It's the will power to eat healthy which is missing" AG*

**ACTIVE SURREY HAVE HELPED US WITH WOMEN ONLY SWIMMING SESSIONS FOR THE DORKING BANGLADESHI WOMEN AS A RESULT OF THE FOCUS GROUP.**

**ACCESS TO HOSPITALS and GP PRACTICES**

The distance to hospitals is often a cause of concern for the ethnic minorities as they need to take a bus if they cannot drive. This often led to mishaps with a lady almost delivering a baby in the bus. As most of the women participants did not drive they were asked how easy was the journey to their local hospital.

*"We have no A&E in Dorking. The nearest hospital is Redhill. If I have a heart attack, I am sure to die"*

*"I cannot drive. I am totally dependent on my husband or the bus. The bus often does not turn up and I miss my appointments. This means being re-referred which can sometimes take a year".*

*"My pregnancy was a nightmare. Having to go to Redhill on the bus from Dorking. My waters broke in the bus and the baby was coming out. What can be more embarrassing than having the Driver wanting to help."*

*"I was horrified when I moved to Dorking there is no hospital. At least the grave is near home".*

*"My hospital is in London and is not easy to get to but it's a worthwhile sacrifice for my health care. The GP Practice is near home, and I can easily bus it. GPs should have online facilities or emails by now. Its very frustrating having to go via the receptionists who are not medically trained but think they know as much as the Doctors." AK*

*"Its easier booking tickets to a premier league football match than seeing a GP"RP*

Long waiting times at the A&E was another cause for concern.

*"My local hospital isn't far. It's the long waiting times at the A&E or waiting for appointments which take a very long time." MB*

Hospitals were also not favoured because of the clash of Indian and Western medicine.

*"Our communities do not go to hospitals. To them hospitals are breeding grounds of diseases. We believe in taking herbal medicine which is a lot more effective than medicines given in hospitals".*

*"I find it hard connecting with my Doctor. She treats us like a stereotypical patient. I do not have blood pressure but my ethnicity does and she insists I have it too."*

*We do not receive the same care as the white population because of our colour.ME*

**LEAFLETS ABOUT CVD**

To create awareness of Cardiovascular disease, there are numerous display posters and leaflets in GP Practices and Hospitals. Our respondents were asked whether they read them. And to list the places where they would be read. GP Practices and hospitals were not necessarily the right places. Neither did they serve the purpose.

"*No. I have seen them at GP Practices but no I don't read them. They are not in our language. I already know the dos and don't's of keeping healthy. But I don't have the time to follow it."*

*“They need to be at the supermarkets. I visit the supermarket more frequently than my GP Practice. “*

*“I would rather look at it online”.*

*“My children need to become aware as they have to learn to eat healthy. Giving leaflets out at school which the children can bring home will benefit everyone.”*

*“I have seen leaflets at GP Practices but have never read them because I am very young, and they don’t apply to me. And leaflets are very outdated, most young people read everything on social media and only if it affects us or our family members. Yes, we need to be aware but not get too obsessed with it. School health awareness class is very boring and not engaging. It is an opportunity lost to make students aware about heart health. AK”*

*“I have not seen any leaflets as I do not visit my GP Practice for years. The leaflets should be in more visible places such as malls or public libraries or even mosques, places where people visit regularly. You need to read them to stop you from being ill, not when you are ill and then find them while visiting your GP for treatment. It’s like putting the cart before the horse.” MB*

*“I am not interested in leaflets because I am convinced it will never be me who needs to see a cardiologist.”SB*

*“There are leaflets available at Hospitals and GP Practices, even in Pharmacies. I bring them home but before reading them they are recycled. I am blind, they are of no use to me.”MP*

SMEF’s E Bulletin was doing a better job which addresses the health needs of the ethnic minorities in Surrey as quoted by a participant.

*“I work for the NHS and often come across leaflets. SMEF Health E Bulletin is a lot more superior than the leaflets written by the NHS. SMEF E Bulletins are personal, informative and motivates us. ME*

Health awareness should start very young.

*“Leaflets should not be looked at after you have begun to suffer from diseases leading to heart attack. You need to target children when they are young and go to toddler groups. Children should have story books with animations in it telling you what to eat or not to eat. It would help the mothers too.”AA*

**NHS HEALTH CHECKS**

NHS organises free health checks for its patients when they turn 40 years of age. Most of our participants were younger and were not aware of it. When asked if they were invited by their GP, some of the participants did not know about them.

"It *should not be decided by age but by family history*" AK

"*I am 42 and have not heard about NHS Health checks. My GP Practice did not contact me."MB*

*"Not when I was 40. But at 65 when I developed Glaucoma I receive lots of appointments."MP*

NHS Health check diagnosed diabetes in one of our participants.

*"My Health check at 42 years diagnosed my diabetes. I am thankful I attended it."ME*

*"My Doctor is pretty lazy. I cant see her creating more work for herself by sending out letters for a Health check."SK*

**Summary of main findings**

There was a high level of awareness of CVD and the risk factors amongst the participants who were interviewed. Limited English proficiency led to patients answering yes or no to their Doctors to avoid lengthy discussions which resulted in the disease going undiagnosed. This also resulted in poor education of the disease. This could present a major gap in health care as patients may have symptoms indicative of healthcare but have not received a diagnosis. Patients were also not comfortable accessing healthcare because of limited English. Racism was felt by the patients who believed the colour of your skin decided the kind of care you received by the NHS.

Participants expressed a range of cultural factors influencing their attitude towards CVD such as their lifestyle and beliefs about the disease and its treatment, which may act as risk factors or serve to intensify cardiovascular disease. Hospitals and GP Practices were settings which made women participants uncomfortable because they were dressed differently. Mosques and community centres were favoured places to be seen by the Doctors.

There were misconceptions especially concerning diet as the participants believed low fat foods but not saturated fats are inherently protective against CVD. Most of the participants relied on the knowledge obtained from their home nations where total fat was the risk factor. Foods rich in fat were said to lead to heart attacks. There was awareness of sugar being bad for your heart but Bangladeshi ladies believed their husbands physical labour helped them sweat it out. Lack of halal food in schools was blamed for childhood obesity which continued into adulthood as vegetarian options were pizza and french fries. Poor diet was caused by lack of access to healthy foods which were expensive and did not go on sale. This compromised the nutrition and the health of the people. There was confusion about the food that was healthy in their parents' generation is now considered unhealthy. Putting on weight during Ramadan despite fasting all day was a source of concern.

Most participants were unaware of food labels which provide nutritional information that help consumers make healthy choices. The ones who did found life stressful enough without having to be controlled by the Food Standard Agency.

An opinion held by most of the participants was that they had become less and less physically active. Covid and lockdown were blamed. SMEF Physical Activities sessions on Zoom were not popular amongst communities living in multi generational households with limited space and no privacy. Lack of women-only activities outside their homes was another factor leading to lack of physical activities. Women with small children who worked full time considered themselves to be getting the right amount of exercise daily.

NHS leaflets were not as popular despite producing them in different languages. In addition to the GP and Hospital settings, the participants preferred to have them in superstores and town centre public libraries. The young generation preferred reading them on their laptops or their mobile phones while the blind were unable to read them. The weekly Health E Bulletins published by Surrey Minority Ethnic Forum were more popular amongst the participants as the individual needs were focussed on unlike the NHS leaflets which were produced for the general public.

NHS health checks are offered to patients aged 40 to 74 years of age to assess the risk factors. Most of our participants were unaware of them while some of them would have preferred to have it for the BAME population from the age of 25 as they get these conditions earlier. NHS could have helped prevent illness and reduced the

risk of contracting the coronavirus in patients from black, Asian and minority ethnic backgrounds if the age had been lowered.

There was patient dissatisfaction in accessing hospitals amongst women participants who could not drive and had to rely on their husbands or irregular buses. Some hospitals were an hour away on the bus making it difficult to reach the A&E in time during an emergency. A pregnant muslim lady participant who could not make the midwife understand she was in labour had to take the bus to East Surrey Hospital resulting in her water breaking and having to rely on the bus driver for delivery of her baby.

## RECOMMENDATIONS

1 Interpreter service which is unbiased and non judgemental should be easily available at GP surgeries and Hospitals. Doctors should ensure the interpreters are reporting the correct information from the participants by asking the same question differently.

2 Schools not serving Halal meat should have a variety of healthy vegetarian options instead of pizzas and french fries.

3 Cook along sessions at Healthy Eating Events would benefit the BAME communities. Importance of food labels should be discussed at these events.

4 Women only exercise sessions such as swimming, walking and badminton have been very popular when organised by SMEF. These sessions should be organised regularly by Active Surrey.

5 NHS leaflets should be displayed in supermarkets and public libraries in addition to hospitals and GP Practices.

6 Healthy Lifestyle should be promoted while children are still young via social media. Pamper sessions which also include healthy eating and exercise would be popular with teenagers.

7 NHS Health Checks for the BAME communities should start from age 25 as they are predisposed to co-morbidities which can lead to heart attack.

8 Equitable access to the BAME communities should include

- having equal access via appropriate information;
- having access to services that are relevant, timely, and sensitive to the person’s needs;
- being able to use the health service with ease, and having confidence that you will be treated with respect.

9  Hospitals and GP Practices should have transport facilities which are easy for patients. Regular buses and low cab fares would result in less missed appointments for patients who are unable to drive.

10 Muslim women because of their culture should be seen by women doctors at Mosques and Community Centres to save them from being embarrassed while visiting maternity services or mental health service.

**Case Studies**

1 JR was invited to attend our health event recently. She is a 75 year old Nepali widow  living in Camberley and speaks no English or Hindi. She can only communicate in Nepali. During the event, the Nepali community leader diagnosed her with mental health symptoms. He is not a Doctor or a Mental Health Professional. The lady seemed in a lot of pain. I approached her and asked her to speak to my Nepali GP friend who was visiting her family in Nepal. After a long discussion with JR, Dr KS diagnosed it as chest pains and should be seen immediately by the GP. The lady was unaware of her GP Practice. She lives with her son but did not have his details either. I volunteered to take her to the A&E but she refused despite trying to explain to her the gravity of her situation. After a lot of asking around I contacted her son who said he was too busy to take her to the Doctor but wanted help from SMEF to get her on benefits. He spoke English fluently but did not offer any help to his Mother.

2 MP was attending our members meeting at our office. Her Mother developed severe chest pains and speaks no English. She called NHS 111 who were unable to help her as they did not have a translator on board. She then called her GP Practice and spoke to the Receptionist who was unable to understand what she was saying and did not put her through to the GP. In sheer frustration the lady took a bus to the hospital A&E and was admitted in the hospital for two weeks.

3 A  retired Doctor who has turned blind had to reach the hospital for his glaucoma appointment. As the weather was bad there were no cabs available and very few buses which were running late. He was unable to organise hospital transport as he had left it too late and missed his appointment.

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Appendix

**Community Participatory Research Training**

**Focus Group and Personal Interviews Topic Guide**

**Thank You for attending today. I am Jasmine Kapoor, Health and Race Officer at Surrey Minority Ethnic Forum. As part of my training being funded by Health Education England, I am working on Cardiovascular Disease Knowledge and Awareness amongst the Black and Minority Ethnic Communities in Surrey. Our conversation is confidential and non-judgemental. There is no right or wrong answer. Hence share your views without any hesitation. Lets speak one at a time. Just so its easy to understand what the other person is saying.**

**On a separate sheet of paper, I will be collecting information about your**

**Age,**

**Gender**

**Topic Guide**

1. **In your own words what are the risk factors in cardiovascular disease?**

**Prompt (if not included)**

**Overweight**

**Blood Pressure**

**Diabetes**

**High cholesterol level**

**Smoking**

**Family History**

**Alcohol**

**Stroke**

1. **What precautions do you take to stay healthy?**

**Prompt (if not included)**

**Physical Activities**

**Eating Healthy**

**Meditation**

**Yoga**

**Gardening**

**Walking**

2. **Have you seen leaflets about cardiovascular disease? Do you read them?**

**Prompt**

**Where?**

**Language barriers?**

**Easy to understand?**

3. **Do you see your GP/ Hospital Doctor regularly for follow up appointments?**

**Prompt**

**Distance**

**Language barriers**

**Long waiting times**

**No appointments**

4. **Cultural/Religious factors shape our lifestyles?**

**Prompt**

**Mixed Exercise sessions**

**Child Care**

**Lack of awareness**

5. **Have you been offered free health checks at your GP Practice?**

6. **Will you in future make any change to your lifestyle?**

7. **Do you think there are any benefits in staying healthy amongst our ethnic minorities?**

8. **Any barriers in staying healthy?**

9. **Would you like to have health awareness sessions by experts?**

**Prompt**

**Mosques**

**Temples**

**Community Centres**

**Libraries**

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