Culturally Appropriate Health Communication and Engagement

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Summary

This project responds to the BAME Commission recommendation on health communication and worked with BAME-led organisations and Tower Hamlets residents to develop guidance for culturally appropriate communications and engagement.

Adopting a two phased approach which comprised of a desk top review and semi-structured interviews with 22 Tower Hamlets residents, the project reinforced the importance of community involvement as crucial to the ethos of cultural appropriate health communication and highlights the need for ensuring health messages are co-designed, and accessibility issues considered congruent to the provision of health messaging which is culturally appropriate.

To implant the approach of culturally appropriate health communication and engagement, a checklist was generated to be used as a tool to embed this ethos across the London borough of Tower Hamlets Council.

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1. Introduction

The BAME Commission highlighted the poorer health outcomes associated with ethnicity, linkages to structural racism and the impact of COVID-19 in bringing these inequalities into focus [1]. In response, Tower Hamlets Black, Asian and Minority Ethnic Inequalities Commission Action Plan set out recommendations aimed at addressing these health outcomes[2]. Recommendation 14 of this action plan on Health Communication states that: "*The Health and Wellbeing Board and Tower Hamlets Together partnership commit to working with BAME-led organisations and service users to develop culturally appropriate communications and engagement*".

This project responds to this mandate and is intended to in the first instance develop a resource for culturally appropriate health communication and engagement, and thereafter, embed this resource into the working practice of all council departments. Importantly, this is aligned with all five ambitions in the Tower Hamlets Health and Wellbeing Strategy 2021-2025[3] as embedding culturally appropriate health communication and engagement ensures our approach to partnership working is evidence based and informed by the lived reality of Tower Hamlets residents.

Accordingly, the project aim was to develop and implement guidance for culturally appropriate communications and engagement. Associated objectives were:

- To evidence the importance of cultural appropriate communication and engagement.
- To codesign guidance on culturally appropriate communication and engagement with Tower Hamlets residents.
- To embed guidance on culturally appropriate communication and engagement into the working practice of all council departments through bespoke training.

2. Project methodology

The project adopted a two phased approach triangulating documentary evidence and qualitative data.

2.1. Phase 1

Rapid evidence review of literature: This phase entailed a review of the literature on culturally appropriate health communication and engagement towards generating a checklist/guidance (Appendix 1).

2.2. Sample recruitment

The project team engaged with organisations which work with Tower Hamlets BAME communities towards identifying residents who these organisations felt were best placed to inform the project. This was done by in the first instance sending the project posters to these organisations which they then shared with Tower Hamlets residents on their contact list asking them to contact a member of the project team if interested in contributing to the project. Following this, individuals who established contact were

given detailed information on what participation would entail and if they consented to being interviewed, a date and time of the interview was agreed. Organisations which facilitated the recruitment of residents included: the Young Foundation, Newham African Caribbean Resource Centre, Account3, Somali Senior Citizens Club, Limehouse Project, Tower Hamlets Health Watch, Real and Apasen.

2.3. Phase 2

Semi-structured interviews with Tower Hamlets residents: This phase entailed open-ended interviews with Tower Hamlets residents to review the theoretically generated checklist which emerged from Phase 1 towards generating insights to inform a new iteration of the checklist. The interviews occurred between 7 March 2022 to 31 March 2022. 22 Interviews (13 females and 9 males) were conducted with individuals with 10 different self-described ethnicity whose age ranged from 26 – 75 years. These interviews were thematically analysed.

3. Rapid evidence review

The desk top analysis (Phase 1) on strategies which promote culturally appropriate communication and/or engagement (Appendix1) indicated that the following strategies promote culturally appropriate communication and/or engagement:

- *Use of translation*: Accurate communication increases the likelihood of receiving appropriate care and implies that translation into a range of suitable languages is necessary.
- *Reflect minority group local realities*: Recognising the lived reality of minority groups in approaches to health communication fosters a sense of trust and empowerment.
- *Co-production and use of multiple credible messengers*: Multiple credible sources should be utilised in conveying health information which must be co-produced by local community.
- *Culturally trusted setting*: Health information conveyed in culturally trusted locations are well received by minority groups.
- *Bidirectional communication*: Minority groups value where information sources and key audiences can meaningfully communicate with each other across platforms and language.

These findings informed a checklist which set out key issues to be addressed in ensuring communication and engagement is culturally appropriate (Table 1):

	Key issue to be addressed	**Yes**	**No**	**NA**	**Comments**
1	Has the message been co-designed with the community?				
2	Has technical language been avoided?				
3	Has language of requirement and mandate been avoided?				

4	Does the message induce fear and/or stigma?				
5	Will compliance with the health message disadvantage target community?				
6	Are multiple trusted credible sources being utilised to disseminate the information?				
7	Are we disseminating in multiple languages?				
8	Are we disseminating using multiple media?				
9	Have we explored the use of a culturally trusted setting?				
10	Have we made provision for questions and clarifications following message delivery?				

Table 1: Key issues in ensuring culturally appropriate communication and engagement (emerged from phase 1)

Subsequently, this checklist was shared with Tower Hamlets residents in advance of interviews to explore their thoughts on using the checklist as a tool to embed good practice in the design and delivery of health communication and engagement which is culturally appropriate.

4. Findings

These findings evidence the thoughts of Tower Hamlets residents on the checklist which emerged from the project first phase.

4.1. The use of technical language

Residents conveyed that it was important that careful thought is given to the language used to construct meaning towards ensuring technical language is avoided when communicating health information:

> *"People like my parents, if you tell them all these technical words, jargon, they will not have even a clue, even if you use this word in their own language" (Bangladeshi Resident).*

> *"The doctors use professional language sometimes and you can't understand the language. This is a problem. I think there's a lot of barriers in that" (English Resident).*

> *"One of the things that stands out is, you know, avoiding technical words and technical languages, because when it comes to BAME communities, they are more in tune with normal languages and normal words, which they seem to understand or kind of get the gist of" (Bangladeshi Resident).*

This thus speaks to the need for ensuring health messages are co-designed and reinforces the importance of community involvement as crucial to the ethos of cultural appropriate health communication:

> *"The technical language is very important. I think the council can sometimes confuse residents by using terminology that is alienating and isolating, just because maybe they haven't thought about things. So, when they co-design that will be fantastic, because people will tell them it doesn't make sense" (British Indian Resident).*

In addition, this approach ensures messaging associated with mandate is appraised by residents in advance of delivery towards ensuring such messages are not misconstrued:

> *"I think any decisions that are made, the public have got to be included in that". (Jewish Resident).*

> *"I'd rather know the strict mandate, for example the COVID rules. As long as you know and the message has come across that, if you don't follow the mandate, there are penalties, then I'm happy with that" (Bangladeshi Resident).*

In doing this however, residents advocated for messaging to be empathetic and not patronising:

> *"It is somebody's life or a risk, you know, health that's being affected, as long as you're honest and abrupt and say it nicely, politely, I think that's how it should be put across by professionals" (Bangladeshi Resident).*

> *"The message need to come out with some sort of compassion, because I know that we are a number for them and they have thousands of cases to go through every day, but I see that sometimes the message does not contain any compassion" (White Other Resident).*

This also speaks to the importance of representation in the look and feel of services which could lead to the development of trust in both message and messengers:

> *"Most important thing, having people from the BAME community themselves, in the services, so people can trust more the services" (Arab Resident).*

> *"You need to probably have a diverse range of people in those groups, in the public health teams, in order for those sorts of messages to be more well rounded, rather than assumptions made. So, I know you have the checklist and I completely understand that the checklist is brilliant, but I think it does need to also work in conjunction with the workforce being very diverse and very inclusive (British Indian Resident).*

4.2. Disseminating cultural appropriate health communication

It was highlighted that the use of culturally trusted settings and multiple credible sources in disseminating health messages were approaches aligned with culturally appropriate heath communication:

> *"Also using multiple credible sources to convey the message and in a cultural trusted setting, those are the main ones I really liked" (Bangladeshi Resident).*

Also, residents highlighted the need for the use of multiple translations in communicating health messages as good practice:

> *"You can have leaflets that have different languages, and especially languages that are mostly used in Tower Hamlets, like Bangladeshi and Somali. So, you have some people that do know how to read but they just don't know how to read in English, and they might just understand Bangladeshi" (Black African Resident).*

> *"I also like the language option, which is something I would have suggested if it had not looked at that. Because not everyone speaks English as a first language, so I like that it's, you know, being disseminated in multiple languages" (Bangladeshi Resident).*

In addition, the importance of disseminating health messages via multiple media was also highlighted:

> *"Maybe also audio message so they can hear the message instead of reading in their own language, so that, that can be accessible for them. That would give them more clarity and assurance and they can see or they can hear themselves what has been advised by the professionals" (Bangladeshi Resident).*

Whilst this approach ensures health messages reach a wider section of the community, it also recognises the realities of residents who are digitally excluded:

> *"Information needs to be accessible rather than me feeding my parents back. So, if that information is available, I mean accessible for everyone, because sometimes digitally, we can exclude many people" (Bangladeshi Resident).*

Importantly, this speak to the need to consider issues of accessibility as congruent to the provision of health messaging which is culturally appropriate:

> *"It is not just different languages, has it been disseminated in different format, for example, in Braille text? What's the availability for people that are deaf or blind to get this information across? What kind of accessibility is available for people with disabilities that can't read or write, or blind or deaf?" (Bangladeshi Resident).*

> *"So, as a blind person from the BAME community, it is advisable that either it should be on phone like you're talking to me, or it should be online, and it should be in accessible format for me to access clearly. Posters won't help me. Your brochures won't help me. Your leaflets won't help me. Your pamphlets will not help me" (British Indian Resident).*

> *"If people have hearing impairment, they need to have sign language adapted to them. So that's something that I would like to add to the checklist" (African Arab Resident)*

In addition, residents maintain that it is important that they are given the opportunity for questions and clarifications following the delivery of a health message:

"Provision of clarification following the message delivery". So yes, that is very important for me. Also maybe make or give an opportunity for them to give you maybe a response by saying yes, they understood or, if they haven't, maybe they can also send the feedback saying they haven't understood" (Bangladeshi Resident).

"So have a number there, a contact name, and an online contact there as well, so people have a range of... so, the resident that's reading the leaflet, they might want to contact someone, so maybe have a question there, prompting them, "Have contact details been included in the leaflet, both for telephone numbers as well as online website details, if people want to get more information?" (Bangladeshi Resident).

"I think no matter if it is a video or poster your design to raise people's awareness, if they want to no more they should have a resource or contact as a way to get to know more" (Chinese Resident).

4.3. Transparency in the use of the checklist

In alignment with trustworthiness and in the interest of transparency, it is important that the section on 'comments' in the checklist is completed with details of the actions taken in response to key issues:

"Sometimes it's going be straightforward, like, "Has it been co-designed with the community?" Yes or no, that's a straightforward thing. But sometimes it could be something which is not applicable, but then you might sometimes need the comment to elaborate" (Bangladeshi Resident).

"The comments is good as well because you can explain it a bit more if you want to, so like give evidence as well, so you know, you can add attachments even, if needed, it doesn't have to be like required, but it can be optional" (British Bangladeshi Resident).

Whilst this makes explicit how issues were addressed, this also concurrently addresses practitioner bias by forcing practitioners to engage with assumptions which may be flawed:

"Maybe we can add something around healthcare provider bias, like has the healthcare provider examined and recognised bias and prejudice before having that message, or no? So, just before like sending a message, have like a stop, wait a minute, is this like coming from a place of a bias or prejudice, or no?" (Arab Resident).

These ensures the decision pathways leading to the provision of health messages are informed by the reality of residents and underpinned by the ethos of situating power with them.

4.4. Embedding the checklist and sustainability

Residents indicated that the issues addressed in the checklist where in alignment with the ethos of cultural appropriate health communication and did not want anything removed from the phase 1 findings checklist:

> *“I think one of the prompts was, "Would you like anything to be removed?", but I feel like, if I was to remove anything from the checklist, it would probably make the checklist less effective” (British Bangladeshi Resident).*
>
> *I don't think I would remove any of them” (White Other Resident).*
>
> *“Yeah, I think the checklist is good. I think, yeah, the more... it makes you think about things a bit more properly” (Black African Resident).*
>
> *“I really like the checklist and absolutely it covers basically everything, in terms of looking at the community that you are targeting, that wants to get the message” (Somali Resident).*
>
> *“I think this is a really good way of bringing them back to the community. Because at the moment, it feels like, you know, there's the public health and there is the local people, so that there is no communication. But having this checklist, I think, for me, it's bringing them back to the community and, you know, to have that conversation with the community” (Somali Resident).*
>
> *“Everything is fine” (Chinese Resident).*

However, residents maintained that there was a need for accountability and monitoring in the use of the checklist:

> *“Once things have been agreed, it should be monitored and audited, at the end of the day, to see if it's actually happening on the ground, rather than just talking about it” (Jewish Resident).*
>
> *“Remind them from time to time around the checklist and have some form of accountability. Once in a while do like an audit thing, like an audit form, try to, for example, take one leaflet or one message that was sent recently, randomly, and then take it and examine it with your team, against this checklist, so you know that your team is complying” (Arab Resident).*
>
> *“It is all about accountability. You need to have a process in place to monitor the use, maybe write an internal policy around accountability” (Black African Resident).*

Suggestions for the operationalising of the checklist included as a digital system which would make completion and monitoring user friendly:

> *“So, I think having like a system, like maybe an online platform, like a survey that is like automated, so you have like tick boxes, you can just tick a box and just easily like say, that has been done. It's easy to like follow, so you just... it's like... you can have like [radio buttons], you know, like yes or no type ones, and then N/A, which is... yeah, how it is now is fine, but just to put it into like a system, so it's easier to track” (British Bangladeshi Resident)*

In addition, residents highlighted the need to share the checklist across local teams and national systems:

> *"I think it's good that this is being considered, but I hope it gets rolled out across the country in other areas as well, not just Tower Hamlets, but like... obviously Tower Hamlets is where I live, so I'm interested in Tower Hamlets, but I mean like maybe some of the findings can be passed on to other boroughs and other areas, so that it can be used not just in Tower Hamlets, because the UK is quite big" (British Bangladeshi Resident).*

> *"So, if we are speaking about communication method, yes, we need probably to reach the [Comms team] or Barts Health NHS Trust, East London Foundation Trust, the GP Care Group, etc., etc., because they are the authority, they put out the messages" (White Other Resident).*

This in the long run ensures the ethos of culturally appropriate health communication is embedded as a norm not only in the London borough of Tower Hamlets, but across regional health systems.

5. Conclusion

This project reinforces the importance of community involvement as crucial to the ethos of cultural appropriate health communication and highlights the need for ensuring health messages are co-designed, and accessibility issues considered congruent to the provision of health messaging which is culturally appropriate. Indeed, the 'manner and way' health information are designed and delivered can unwittingly exclude individuals living with disabilities and thus, informs the need for ensuring health messages actively recognise and address accessibility issues.

Therefore, it is important that emergent checklist evidence accessibility as an issue to be addressed; and multiple media, multiple translations, and culturally trusted settings and messengers are used in disseminating health messages. Doing these, promotes 'Trust' which is closely aligned with culturally appropriate health communication and engagement; and in addition, speaks to the need for Black Asian Minority Ethnic representation in the look and feel of services which could lead to the development of confidence in both message and messengers.

Following the delivery of health messages, the opportunity for questions/clarifications must be provided and in the interest of transparency, it is important that the section on 'comments' in the checklist is completed with details of actions taken in response to key issues. Whilst this makes explicit how issues were addressed, this also concurrently addresses practitioner bias by forcing practitioners to engage with assumptions which may be flawed and evidencing the decision pathway which led to the health message. This thus reinforces the need for accountability and monitoring in the use of the checklist.

Finally, it is important to note that Tower Hamlets residents indicated that the issues addressed in the checklist where in alignment with the ethos of cultural appropriate health communication and did not want anything removed from the phase 1 findings

checklist. However, it was clear that there was a need for the checklist to address issues of accessibility thus informing the need for an iteration which includes this key issue and hence the creation of an updated checklist (Table 2 below):

	Key issue to be addressed	**Yes**	**No**	**NA**	**Comments**
1	Has the message been co-designed with the community?				
2	Has technical language been avoided?				
3	Has language of requirement and mandate been avoided?				
4	Does the message induce fear and/or stigma?				
5	Will compliance with the health message disadvantage target community?				
6	Are multiple trusted credible sources utilised to disseminate the information?				
7	Are we disseminating in multiple languages?				
8	Are we disseminating using multiple media?				
9	Have we explored the use of a culturally trusted setting?				
10	Have we made provision for questions and clarifications following message delivery?				
11	Is the message accessible to people with disabilities?				

Table 2: Key issues in ensuring culturally appropriate communication and engagement (Item 11 added to address accessibility following resident interviews)

6. Recommendations

These recommendations are for the Tower Hamlets Together Partnership:

- Recognising the limitations in health literacy and agency to advocate on own behalf congruent with the health reality of individuals from BAME backgrounds, ***opportunity for questions and clarifications must be provided*** following the delivery of health messages and engagement activities.

- Consideration should be given to creating a ***web version of the checklist*** to enable ease of completion.

- The importance of accountability when using the checklist was raised and underpins the need for ***sign off by divisional leads of health messages*** only following completion of the checklist.

- A mechanism to ***monitor and collate the use of the checklist*** across the council public health team should be implemented. This could be via the use of an online portal with a dedicated staff responsible for monitoring and training staff on use where appropriate.

- It is important that the checklist is ***shared across the region*** as an exemplar of good practice and to importantly ensure that the ethos of culturally appropriate health communication is embedded as a norm not only in the London borough of Tower Hamlets, but across regional health systems.

References

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Appendix

Appendix 1: Culturally Appropriate Communications and Engagement Evidence Review – Review Date 06.02.22

Summary

Rapid desk top analysis of materials from key public health databases uncovered the following as strategies which promote culturally appropriate communication and/or engagement:

1. *Use of translation:* Accurate communication increases the likelihood of receiving appropriate care and implies that translation into a range of suitable languages is necessary.

2. *Reflect minority group local realities*: Recognising the lived reality of minority groups in approaches to health communication fosters a sense of trust and empowerment.

3. *Co-production and use of multiple credible messengers*: Multiple credible sources should be utilised in conveying health information which must be co-produced by local community.

4. *Culturally trusted setting*: Health information conveyed in culturally trusted locations are well received by minority groups.

5. *Bidirectional communication:* Minority groups value where information sources and key audiences can meaningfully communicate with each other across platforms and language.

These strategies are inhibited by fear and stigma inducing messaging, the use of vague terms, government distrust and a lack of transparency in messaging.

1. Introduction

BAME communities are less willing to trust government communications on health due to historical issues[1] and contemporary perceptions of institutional racism[2]. In calling for health care that is culturally appropriate, minority groups seek recognition of often racialized constructs of cultural difference as they intervene in health care planning and delivery[3]. Implementing culturally appropriate strategies will help to develop and enhance the ability to practice effective communication in intercultural situations by fostering the ability of individuals and systems to work and respond effectively across cultures in a way that acknowledges and respects the culture of the community[4,5].

This paper set out key tenets and a checklist aligned with the provision of culturally appropriate communication towards supporting our approach to working with BAME communities across London Borough of Tower Hamlets. In doing this, cultural appropriate communication is theoretically constructed as communication that is in alignment with the culture of the community and recognises that health communication that is culturally appropriate promotes health protective behaviour[6,7].

2. Method

Evidence was generated from a non-systematic literature search of EMBASE, MEDLINE and SCOPUS databases using truncation on the following search terms: (culture or cultural* or intercultur* or inter-cultur* or cross-cultur* or transcultural or multicultural) adj2 (appropriat* or respect* or competent or competency or sensitiv* or tailor* or understanding or inclusive) adj3 (communicat* or messag* or engag*).ti.

3. Facilitators of culturally appropriate communication and engagement

These findings reflect the factors which health professionals and individuals from BAME background associate with the provision of culturally appropriate messaging and/or engagement.

3.1. Use of translation

Accurate communication increases the likelihood of receiving appropriate care and implies that translation into a range of suitable languages is necessary, but not sufficient[8,9]. Co-production and pre-testing of health messages with the target community to identify language that retains meaning of the core message and considers the cultural context for the target audience is essential[10]. In doing this, it is important to ensure that where reading skills are limited, the use of audio files and animations to increase knowledge and understanding are adopted[11,12] and importantly aligned with the ethos of accommodating cultural differences in language and nonverbal communication[9,13,14].

3.2. Reflect minority group local realities

Recognising the lived reality of BAME groups in approaches to health communication fosters a sense of trust and empowerment[15,16]. Accordingly, health messages should explicitly consider cultural norms including high risk events (e.g., Eid and weddings)[17], ensure they promote services that are accessible (e.g., multilingual contact tracers)[18] and do not disadvantage the target community (e.g., loss of income due to self-isolation)[10].

3.3. Use of multiple credible messengers

Health messages are more likely to be received by someone known and trusted within BAME communities[19]. These include faith groups, community leaders and lay health educators such as shop workers and taxi drivers[20]. As community insiders, they bring a level of credibility, understanding, and familiarity to interactions with community members[21]. However, it is also crucial to recognize the diversity within racial/ethnic neighbourhoods, understanding that no single “trusted voice” can effectively reach everyone within the community[22]. Therefore, multiple credible sources should be utilised as not all members of BAME communities are responsive to faith leaders for instance[10].

3.4. Community representation in co-production

Identify people that the community trusts and build relationships with them[23]. Involve them in decision-making to ensure communication approach and materials emerge collaboratively, are contextually appropriate and that communication is community-owned[24]. This must be underpinned by tailoring information and communication systems to community needs and involving local stakeholders to guarantee the flow of information across sectors in the community. In achieving this, community representation in co-production must be underpinned by cultural humility[25] and evidenced by keeping an open mind to learn from the community, and as a health system, reflect on biases[26].

3.5. Use of culturally trusted settings

Limited English language proficiency and lack of ethnic match between staff members and patients decrease or delay healthcare-seeking behaviour in traditional healthcare settings[27,28]. This speaks to the need for communicating health information in culturally trusted locations such as religious settings[29] and using professionals who speak the language of the community[30]. This concurrently addresses both the linguistic and cultural barriers for ethnic subgroups who may have limited acculturation to majority norms and behaviours[9] and emphasizes focus on cultural strengths that can facilitate change, as well as reduce cultural barriers[31,32].

3.6. Bidirectional communication

It is important that adopted communication strategies are of a bidirectional nature where information sources and key audiences can meaningfully communicate with each other across platforms and language[33]. This is pragmatically efficient and ensures that there is appropriate space and time for processing and having dialogues that reflects understanding, caring, and creates a safe space for exploring key concerns[22].

4. Inhibitors of culturally appropriate communication and engagement

These findings reflect the factors which health professionals and individuals from BAME background identify as mitigating against culturally appropriate communication and/or engagement.

4.1. Fear inducing messaging

Health modifying communication that neglects to consider psychosocially mediated perceptions are ineffective[34]. Fear inducing messages should be avoided as, even when health messages are adhered to, stressors remain in the physical environment that are not within the control of individuals from minority communities[10]. Moreover, it is important to note that where a health message induces fear, it may result in denial or avoidance as a coping mechanism due to low control over external factors, such as working in frontline roles, which could result in developing fatalistic attitudes[10,35].

4.2. Use of vague terms

It is important that vague terms are rephrased for clarity prior to translating. For instance, words such as shielding and self-isolation do not retain the same meaning when translated into some languages[10]. Literal translations should be checked and cultural context resulting in abstract terms that are unfamiliar which may result in lack of engagement with the health message should be avoided[36]. This thus speaks to the need to co-produce and pre-test health messages with the target community to identify when translated, language that retains meaning of the core message underpinned by the cultural context of the target audience[37].

4.3 Government distrust

Minority communities have low trust in healthcare organisations and research findings due to historical issues of unethical healthcare research[38]. Moreover, whilst minority ethnic groups have historically been under-represented within health research[39], trust in the government is also undermined by structural and institutional racism and discrimination[40]. Accordingly, due to government distrust, messages that emanate from government authorities, that are not evidence based, that appear to be manipulative, and/or that are not transparent, are more likely to be rejected or ignored[22,41,42,43].

4.4. Stigmatisation

Stigma and shame are linked to negative mental health outcomes and create lower likelihood of engagement with health services[40]. This thus speaks to the need for ensuring health messages do not unwittingly label groups and advocates for the need to accommodate varying degrees of cultural identification[8]. Therefore, careful thought must be given to messages which focus on barriers specific to minority communities. Nonetheless, it is important to note here that undue focus on such barriers could breed disinformation e.g., issue of halal/kosher in vaccines[40].

4.5. Transparency

To prevent widening health inequities, health care providers should engage with minority communities by being transparent and honest in declaring conflict of interest[44]. To this end, disclosures must be crafted in a way which ensures that minority community can readily understand and make meaning of the facts conveyed[45]. This thus speaks to the need for presenting information that is easily understood using trusted providers and engaging with communities to deliver evidence-based information.

5. Guidance to optimise risk communication with BAME groups

The British Psychological Society developed guidance to optimise policies and risk communication which has been further tailored to BAME communities by considering cultural influences on behaviour[10,46].

Guidance	**Tailored to BAME communities**
Minimise the 'I' and emphasise the 'we'.	Draw on interdependent cultural norms to highlight benefits of protecting family and community.
Deliver messages from a credible source in relatable terms to the target audience.	Identify credible sources from within the community including lay health advisors such as local business owners, shop workers, taxi drivers, and faith and community leaders.
Create worry but not fear.	Threat perception is likely to increase if health messages include real world examples from within the target community. Include evidence of increased risk to specific communities but do not induce fear as there may be stressors outside of the control of BAME communities, such as structural inequalities, which may lead to denial, fatalistic attitudes, and avoidance behaviours.

Identify what influences each preventive behaviour and ensure policies, messaging and interventions target all relevant drivers.	Avoid technical language. Use simple language to make information more accessible for communities with English as a second language. Provide clear advice and instructions on behavioural actions and their related outcomes. Ensure the health message considers localised information to avoid unintended consequences such as having services with no multi-lingual support.
Avoid unintended negative consequences.	There is risk of stigma and stereotyping when policies and health messages target only BAME communities. Reinforce the need for collective action from all communities, BAME and non-BAME, to minimise the risk of hostility towards specific communities. Share positive messages and examples of BAME communities following guidelines, making sacrifices, and continuing to work on the frontline to keep essential services going, to highlight wider factors that contribute to increased risk.
Create clear channels of access for health literacy.	Provide information using different channels including posters in the physical environment, social media particularly for younger generations as they often share health message with older generations with limited English, audio files for BAME groups that have low reading literacy in their first language, and infographics and animations. Health messages should be consistent to avoid confusion.

6. Conclusion

The need for culturally appropriate communication is underpinned by the basic premise that congruency between cultural characteristics and the respective message will increase the communication's effectiveness. Thus, being able to provide information to marginalised communities in culturally and linguistically relevant ways is crucial to successful public health messaging. Those tasked with communicating with BAME communities need to show cultural humility and engage the community by using trusted sources to deliver and offer frequent messages in multiple modes that are locally and personally relevant. Culturally congruent health messages result in positive attitudes and stronger intentions to perform health behaviours. Indeed, when health messages are tailored for specific BAME communities, it is likely that such messages reach the intended community.

Community engagement which involves the community as a partner to promote local buy-in and develop community plans is accordingly key in ensuring culturally appropriate communication and facilitating trust. Credible sources from within target communities should be visible at all levels, including grassroots organisations, healthcare services and policy teams, as authentic representation at each of these

levels increase trust. However, it is important to note that whilst this approach ensures that interventions are collaborative, contextually appropriate and that communication is community-owned, tailoring these messages will not resolve the structural disadvantages and wider inequalities that contribute to poorer health outcomes in BAME communities.

Recognising the risk perception paradox in communicating with BAME communities is thus important and speaks to the need for using tailored health messages as conduits to address health issues of concern whilst concurrently addressing the structural and wider inequalities associated with these communities. Indeed, communicating reasons for health and behavioural change are not enough, we must begin by understanding the lived reality of our communities and consciously situate power with them.

7. Culturally appropriate communications checklist

This non-exhaustive indicative checklist conveys key issues to be addressed in ensuring communication and engagement is culturally appropriate. It is hoped that this serves as a prompt in embedding good practice in the design and delivery of health communication and engagement with minority community.

	Key issue to be addressed	**Yes**	**No**	**NA**	**Comments**
1	Has the message being co-designed with the community?				
2	Has technical language being avoided?				
3	Has language of requirement and mandate being avoided?				
4	Does the message induce fear and/or stigma?				
5	Will compliance with the health message disadvantage target community?				
6	Are multiple trusted credible sources being utilised to disseminate the information?				
7	Are we disseminating in multiple languages?				
8	Are we disseminating using multiple media?				
9	Have we explored the use of a culturally trusted setting?				
10	Have we made provision for questions and clarifications following message delivery?				

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