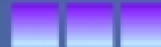
Evaluation of the
Bengali Women's Health Project



September 2003

Dr Liz Brooker
School of Early Childhood & Primary Education
Institute of Education
University of London

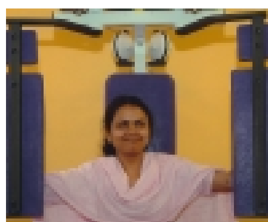
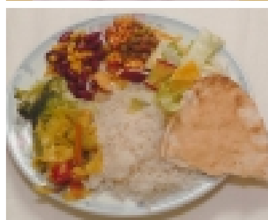
Published and distributed by
The Publications Division
Bangladesh Women's Health Project - UK

© Bangladesh Women's Health Project - 2003
Email: info@bwhp.org, web: www.bwhp.org

Design & Layout by
Sadia Jafreen, www.ecreators.co.uk

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form by any means mechanical, electronic, photocopying or otherwise, without the prior permission of the Publisher.

Contents

1. Introduction 5

2. Data collection for this report 6

3. The Bengali community in Camden 8

4. History, Aims and Objectives of the project 12

5. Running and Management of the project 16

6. Health needs in the community 18

- 6.1 Characteristic health problems
- 6.2 Barriers to healthy living
- 6.3 Provision and limitations of mainstream NHS services
- 6.4 Health needs identified by respondents in this study

7. What the project offers:Ongoing services 25

- 7.1 Doctors Advice sessions
- 7.2 Workshops and discussion groups
- 7.3 Exercise facilities
- 7.4 Sociability and social interaction

8. Specialist provision : research and responses to needs 34

- 8.1 Mental health initiatives
- 8.2 Healthy eating initiatives
- 8.3 Continence research
- 8.4 Herbal medicine project
- 8.5 Other new project

9. Developing a resource base 47

10. How the project is evaluated by participants

- 10.1 Who are the respondents
- 10.2 Use, needs and benefits

11. Strengths of the project 52

- 11.1 Partnership with other providers
- 11.2 Special services
- 11.3 Tackling inequality and social exclusion

12. Recommendations 55

13. References 59

14. Appendix: Questionnaire 60

1.

Introduction

The Bangladeshi community in Camden has its origins in the arrival of small numbers of seamen in London in the 1920s and 1930s. As such it has existed in some form for 70 or 80 years, and now numbers over 12,000 men, women and children. The community continues to grow: the most recent census figures (2001) indicate that, as a proportion of the whole Camden population, the Bangladeshi group has risen to 6.3%, from 3.5% in 1991.

Despite its long-standing presence in the area, the community remains one of the poorest and most socially excluded in a borough which is known for its extremes of wealth and poverty. In recent years, the effects of poverty and social exclusion on all aspects of the life of individuals and groups – on education, health, housing, employment and aspirations – have been well documented, and a number of initiatives at national government level have attempted to lessen these effects. At the same time, the effectiveness of locally-based, community-led ventures has also been demonstrated. The Bengali Women's Health Project is an example of these.

This report describes and evaluates the recent and ongoing work of the Project, in the context of the needs of the local community and the provision of existing mainstream services. It begins by summarising the past history and present circumstances of the Bangladeshi community in Camden, and describing the inauguration of the project as a response to perceived community needs. These needs, as viewed by professionals and users, are described in greater detail, together with the ways the project has responded and continues to respond. The perspectives of a range of service users are presented in order to evaluate the extent to which the project currently meets their needs, and the additional support it might be able to give. By these means the unique strengths of the project as a highly specialised, but community-led, initiative, are identified, and recommendations are made for further development.

2.

Data collection for the report

Data on the project were collected over a two-month period (June and July 2003), and were reviewed and analysed during August 2003. The main sources of information are:

Visits to sessions at the community centres

All six community centres used by the project (Bedford House Community Centre; Chadswell Healthy Living Centre; Coram Parents Centre; Fitzrovia Neighbourhood Centre; Hopscotch Asian Women's Centre; Surma Centre) were visited during June and July. Field notes were made from participant observation in workshop presentations and discussions, questionnaires were administered, and some group and individual interviews were conducted during these visits.

Questionnaires

Questionnaires were completed by a total of 51 participants in health sessions held at five different community centres. Respondents were asked about their personal circumstances and health, about their history of involvement in the project, and about their benefits and continuing needs from the project.

Interviews

Unstructured interviews were held with each of the three project doctors who offer individual face-to-face advice to participants. Discussion focused on the doctors' own history of involvement in the project, and on their views of the changing health needs of the community, and the role of the project in meeting these.

Documentation

Documents supplied and analysed include: referral and record sheets used by GPs and community development workers; administrative documents; review reports produced by the project in 1995 and 2002; plans and evaluations for a number of training programmes; specialist reports; reports from other local health providers; publicity materials and newsletters.

The author gratefully acknowledges the generosity and co-operation of everyone involved in supplying information, including the project co-ordinator, community and family workers, and the participants themselves.

3.

The Bengali community in Camden : Background to the project

History and geography

Bangladeshis have lived and worked in Camden since the 1920s or 30s, when the early arrivals were seamen who settled in London and were able to send relatively large sums from their earnings back home, thus setting a pattern and model for subsequent generations of migrants. In the early phase of migration (before 1945) the pioneer community converged on Bengali restaurants and cafes in Great Windmill Street, and then in Percy Street, where the Basement Café opened by Chanu Miah in 1944 has been seen as the forerunner of contemporary community centres like Surma (Momen, 1991). Early immigrants, like subsequent generations, consisted largely of people from the rural district of Sylhet, although other regions including urban areas have also been represented.

This small community of a few hundred men was succeeded in the post-1945 period by a large wave of migration in response to labour shortages in the UK. Despite the increasingly harsh and punitive immigration controls introduced from the 1960s onwards, many workers were eventually able to bring their families to join them, and the majority of families did arrive during the post-war decades. In these years, most were housed by relatives in over-crowded owner-occupied accommodation. Only in the 1980s and 90s were families re-housed in public sector housing, often after periods of homelessness or bed-and-breakfast residence. The re-housing programme accelerated after the death of a young family in a bed-and-breakfast lodging in 1984, and the occupation of Camden Town Hall by families demanding equal rights to housing. Since the 1990s, the majority of Bangladeshi families in Camden have been offered public sector accommodation, though this is not always of a high standard. The majority of the community is currently clustered into four wards of the borough: Regents's Park, King's Cross, Holborn & Covent Garden, and St Pancras & Somers Town.

Since the 1950s, most male members of the community have worked in low-paid service industries with extremely unsocial hours. While a minority have owned or managed 'Indian' restaurants, the majority have been employed at low levels in the hotel and catering sector, as porters, waiters and cleaners as well as in preparing food. Staff reductions in catering in the 1990s resulted in greater diversity of employment in the area, including employment at the mainline railway stations, minicab driving, and shop work including grocery businesses. The younger generation of Bangladeshis, however, (male and female) have accessed a far wide range of opportunities.

This brief history is of relevance to the situation of Bangladeshis in the area in the 2000s. As Momen (1991: n.p.) wrote,

> Many Bangladeshi families have started their lives in Camden as homeless. The experience of being homeless, particularly in a new cultural and physical environment, has serious implications for their physical and mental health.

The continuing poor levels of health and housing experienced by many families can be viewed as a persistent cause of social exclusion, the process whereby some members of the community are denied the quality of life, and the level of participation, which the majority enjoy (Howarth et al, 1998; Chahal, 2000). Government-sponsored surveys of ethnic minority access to wealth, housing and health (Modood & Berthoud, 1996; Berthoud, 1998) indicate for instance that:

- 80% Bangladeshis in the UK live in households with incomes below half the national average
- 73% Bangladeshi children are living in households below the poverty line, compared with 31% children in all households

- 42% 'economically active' Bangladeshi adults are without work, compared to around 15% white adults

- while some other ethnic minority groups (Indian, African Asian, Chinese) report health levels similar to those of the white population, Bangladeshis (along with Caribbean and Pakistani populations) have lower levels of health.

Present population

The size of the community in Camden is currently estimated at over 12,500, making them the largest ethnic minority group in the borough. The population has an increasingly young profile, with almost 50 per cent under the age of 16, and up to 75 per cent under 25 years of age. Nevertheless a small but significant percentage is over 60.

The community can be envisaged as having a more diverse range of social, health and mental health needs than another community of similar size. The different age groups represented will have widely differing needs because of their hugely disparate social and cultural experiences. Some older members of the community, particularly women, have neither learned English nor been shown how to access the range of health and community services available for families and individuals: their understanding of and participation in local services may be minimal. The middle-aged group, though more likely to have acquired some English, remain rooted in the experiences of their own upbringing in Sylhet, and are bridging the two cultural lives as they bring up their own families. And the younger age groups, born and brought up in the UK, are making their own choices about their cultural and social identity in a world of rapid change and innovation where, in many cases, parental guidance may seem inappropriate and irrelevant. For all ages, the uncertainty of family moves to and from Bangladesh, the extended stays away of one or more family members, and the residual hope of a permanent return to Bangladesh, may be a further obstacle to a settled and stable life, with good physical and mental health.

Despite recent changes in the employment patterns of the community referred to above, with a slow shift out of restaurant work into a broader range of employment, the Bangladeshi population remains relatively poor. As well as being in low-paid work, many older men in particular are liable to unemployment. The tradition of larger than average family sizes also brings an increasing likelihood of family poverty and child poverty, identified in recent studies as a direct cause of child mortality (Roberts, 2003). Across the UK, Bangladeshi populations have been described as 'easily the poorest groups in the country' (Berthoud, 1998).

Growing up in Camden

The Bangladeshi community has been the focus of national concern for the low educational achievement of its children over many decades (Gillborn & Gipps, 1996; Gillborn & Mirza, 2001). In recent years, supported by greater awareness of their needs from schools and teachers, the community's children have begun to close the gap with other (white and non-white) groups, and the role of parents in this improvement has been identified and fostered. Nevertheless a combination of factors – including poor housing and poor health care, limited English, racism at a local and national level, low expectations from educators and/or families – continues to maintain Bangladeshi achievements at a level below the national average, and below that of many other ethnic minority groups.

The effect of this relatively poor school achievement is to maintain many Bangladeshi young people and adults in low-paid employment with restricted life-chances, and to perpetuate the social exclusion the community has experienced until now. In view of the close association between socio-economic status and health, the continuing low status of the community, and unequal access to services, creates additional health needs.

4.

History, Aims and Objectives of the Project

How the Bengali Women's Health Project developed

The project, a voluntary-sector-led initiative, was set up in 1990. It was formed in response to a growing awareness of the low take-up of available health and social care services by the Bangladeshi community in Camden, and a growing identification of health and mental health issues affecting the community. Such issues have their origins both in the complex history of migration and cultural change indicated above, and in the low socio-economic status, and levels of social exclusion, still present in the community. The initiative for the project came from some research undertaken by Bengali community workers into the accessibility of local GP services for women in the area. This investigation, carried out in the late 1980s, revealed the lack of female and Bengali-speaking GPs in the area, and established that the situation was unlikely to change in the foreseeable future. It recommended the introduction of health advice services, provided by Bengali speaking doctors, in local centres accessed by women.

The project's focus on women reflects an awareness both of the role of women, as wives and mothers, in the care of their families, and also of the particular health and mental health issues which affect women as a result of radical changes in their environment, and their relative social and cultural exclusion. Its original aim was to facilitate the use of existing services by Bengali women, by providing doctor's advisory sessions in local community centres attended by women, and accessible information and advice on health matters generally. The first weekly sessions were held in two centres– Hopscotch Asian Women's Centre and Fitzrovia Neighbourhood Centre – in October 1990.

Funding arrangement

The project has experienced a range of funding arrangements since its inception, but throughout has enjoyed a close collaborative partnership with statutory health providers in the area. Throughout the 1990s the project has expanded its services, and its financial support base.

Early funding from the Health Authority Advocacy Service was supplemented by a three year grant awarded in 1991 from the Joint Consultative Committee, along with some support from the Family Health Service Authority (FHSA). Subsequent changes in policy (towards an increased emphasis on primary and community based health care) enabled the FHSA to take over the costs of the project from 1994, including it in their Primary Care Development Plan. Three years after the launch of the Bengali Women's Health Project, the Family Health Service Authority, which was responsible for primary care services, funded the project's first part-time development worker, who came into post in 1993. The worker at this time was based in Hopscotch Asian Women's Centre, with accommodation costs paid by the Health Authority.

Since its establishment BWHP had been maintaining a close working relationship with the health promotion service and offering support to them in developing health promotion programme in the community as well as in the production of bilingual resource production, and maintained a place on its steering committee for a representative from Health Promotion. The two Bengali speaking health promotion specialists employed by the Camden and Islington Community Health Service NHS Trust had further strengthened this link. However in 1998, due to cuts in the Trust, the female health promotion specialists post in Camden was reduced from full time to part time.

At the same time BWHP steering committee members were facing another challenge. Almost all of the BWHP's steering committee members were themselves community development workers, so that the additional responsibility of managing the worker's duties was an increasingly difficult burden, especially as the project's work was expanding so rapidly into different centres and new initiatives.

At this stage the negotiation between BWHP and Health Promotion Service resulted in the amalgamation of the two half-time posts (one in the BWHP, one in Health Promotion) to create a full-time post. In 1999 this post was filled, so that the collaboration between the Health Promotion, and the BWHP, became permanent and official. The project co-ordinator, as a member of the Health Promotion team, was given an office in the Health Promotion department, and was required to work equally for both services. The first post holder under this new arrangement was appointed in March 1999.

This arrangement brings distinct advantages to all parties. As a result, the management responsibilities of the community workers on the steering committee have been considerably reduced, and they are enabled to devote their time more to initiatives within their own centres. At the same time, the BWHP co-ordinator is strategically placed within the statutory services and works in close contact with representatives from other departments such as Social Services and Mental Health Services, as well as being involved in initiatives like the Health Action Zone.

In its first thirteen years the project has expanded to offer services at six local centres, with the involvement of three Bengali-speaking female doctors (one of whom is a practising GP), and of the family worker / community development worker in each centre. Its focus has broadened from medical (doctor) services to include all aspects of healthy living, including mental health. It also provides a wide range of courses and training, and undertakes numerous health promotion initiatives. All these services are described below (Section 7).

The project is currently making an application for charitable status.

Aims & objectives

The project aims:

- To ensure that Bengali women are able to exercise their right to health and social care services which are accessible, acceptable and appropriate to meet their needs.

- To promote the health and well-being of Bengali women living or working in the borough of Camden.

The objectives include:

- Health sessions for Bangladeshi women facilitated by Bengali women doctors at community centres

- Working with users to enable and empower them to exercise their rights to services

- Providing information and advice to enable women to make informed choices about their health and health care

- Working with statutory health services to ensure that the needs of Bengali women are addressed by providers

- Working with providers to ensure that services are accessible, acceptable and appropriate to the needs of Bengali women

- Working with other organisations to further the aims of the BWHP

Membership is open to all Bengali women living or working in Camden, all organisations working for the Bengali community or for women's health, and all organisations otherwise working towards the aims and objectives of the BWHP.

5.

Running and management of the project

The project's terms of reference declare the principle of accountability to its membership, a principle implemented through the regular review meetings conducted by its steering committee.

The steering committee is made up of representatives from each of the six community centres where project activities are provided, the doctors themselves, and representatives of associated statutory bodies from the health, leisure, carers and social services. Representatives of other organisations working towards similar aims and objectives may also be invited. Current membership include more than 20 individuals, but only those from the voluntary / community sector are able to vote.

The steering committee meets six times a year to review and consult on the progress of the project, and recommend priorities. Because all the community development workers / family link workers are involved, the detailed progress of activities in each of the centres can be monitored and shared at these meetings, and common concerns raised. The presence of statutory sector representatives enables two-way communication, mutual support and shared perspectives to be developed on the health issues which are seen as current concerns, or as an important focus for new initiatives.

The committee also elects an advisory group of four people to serve for two (maximum three) years, which has a more detailed day-to-day involvement with the plans, activities and decisions of the project. Every aspect of the work programme undertaken by the project co-ordinator and the community development workers is regularly reviewed and scrutinised by this group.

The current full-time co-ordinator of the project is employed by the Camden PCT as a health promotion / public health worker, but was formerly employed as a community development worker in one of the local centres, and has long-standing links with the local community. On a practical, week-by-week or even day-by-day level, she is in constant contact with each of the community centre workers: through meetings and phone calls, and where possible through attendance at some of the weekly events and activities held in each centre.

The centre workers maintain their own registers and records of women attending each session, and conduct their own outreach work with families. Women who attend the centres for one-to-one advice sessions with the doctors also have a medical record, maintained at the centre, which parallels their NHS medical record and allows their health progress to be checked and monitored. By 2003, over 500 women's details have been registered at the centres, and each of the community development workers maintains personal contact with 'her' clients. The recruitment of so many women to the project is an indicator of its success in reaching local people, through continuing outreach work and personal contacts.

6.

Health needs in the community

6.1 Characteristic health problems

The health needs of the Bangladeshi community share many of the characteristics of other relatively poor and excluded communities, but have additional features which are characteristic of this particular community at this particular moment of its development. Relatively low levels of income, combined with low levels of education, tend to produce poor health across all ethnic groups including 'white UK' communities.

The causes are many and cumulative, and are well established in research. The poorest groups in society have less access to information on health and nutrition; limited access to health services (because of inflexible working hours, family responsibilities, inaccessible locations, lack of transport, lack of money for fares); limited access to fresh and 'healthy' foods (because of the restricted offer in local shops, their own transport difficulties, insufficient income to buy in bulk, insufficient time and resources for the preparation of fresh foodstuffs); and they experience living and working conditions which are below the standards enjoyed by more affluent groups. The twentieth-century improvements in health and life expectancy which have resulted from better diet, less overcrowding, early diagnosis of disease, and more fresh air and exercise, are not necessarily experienced by poorer groups in society. In consequence, there is a direct relationship between family income and a range of preventable conditions, such as heart disease and some forms of cancer, which continue to reduce life expectancy among the poor. This is arguably the most basic, and far-reaching, form of social inequality.

Among the Bangladeshi community in Camden (where it is estimated that 80% of the community are in households with incomes below the national average) up to 46% of the population suffer from some form of long-term illness. The community demonstrates all the trends identified above as typical of poor communities, as well as having its own specific health issues:

- **Cardiovascular problems :** poor diet and lack of exercise result in growing problems of obesity and a high incidence of hypertension and heart disease; as a result, incidence of coronary heart disease is 40% higher than in the population as a whole

- **Diabetes:** the community is prone to unusually high levels of diabetes: Bangladeshis are five times more likely to have diabetes than the population as a whole

- **Cancers:** breast and cervical cancers, lung cancers and cancers of the mouth and throat are associated with high levels of smoking and paan chewing, as well as with low uptake of screening services; 44% men smoke, and 56% women over the age of 56 chew tobacco

- **Gastric ulcers:** caused by stress as well as by dietary factors, are experienced by women as well as men: the move to a western / urban diet with higher fat content is a contributory factor

- **Chronic ailments:** including back pains aching joints, tiredness and dizziness are experienced by women and may contribute to poor mental health

- **Mental illness:** including depression is commonly experienced but has until recently gone unrecognised or even concealed.

All the above are cited by women using the project, and are addressed by the work of the project.

6.2 Barriers to healthy living

The project has helped to identify and document the reasons for a generally poor take-up of existing, mainstream, health services among Bangladeshi women in the area.

These include:

- **Linguistic barriers:** few women over 35 speak English, and those who do may have great difficulty in communicating; few GPs and hospital doctors speak Bengali or Sylheti; the use of friends and family as interpreters may cause embarrassment and destroy confidentiality, as well as being potentially inaccurate

- **Social barriers:** older women in particular may not be accustomed to travel around freely in London, or to make and keep appointments in public service buildings; they may have little or no experience of travelling alone outside their own immediate neighbourhood

- **Religious and cultural barriers:** extreme reticence and modesty about the body may stem from women's religious beliefs, and may be reinforced by their experience of life in small rural communities, where restrictions on mixed-sex exchanges are strictly enforced

- **Fatalistic attitudes towards health:** there is a perception among some members in the community that ill-health and other misfortunes are the allotted fate of individuals, to submit and suffer without resistance – or even that they are a punishment for their own misdeeds; such community members need a great deal of encouragement to believe that they can or should take charge of their own health

- **Educational barriers:** older Bangladeshis may not be fully literate in any language, and so may be unable to access information on health services; some will have little awareness of symptoms and treatments, or of the range of services available

- **Lifestyle barriers:** recommendations for healthy living (such as exercise classes and swimming, diet and massage) may assume greater social and geographical mobility than many women possess, and do not acknowledge the daily responsibilities of women, or their caring roles in relation to younger and older members of the extended family.

All these factors suggest that new approaches are needed, to embed healthy attitudes and healthy habits in the daily lives of the community's women, especially the older women. The project continues to work to develop new approaches, but has to acknowledge that both socio-economic and cultural barriers have shaped people's beliefs in ways which are hard to change. At the project's 2002 review day, it was remarked that,

> In many cases the concepts of healthy lifestyles are still a far away concept for many people in the Bangladeshi community and make them the disproportionate victim of many fatal diseases.

6.3. Provision and limitations of mainstream NHS services

Camden & Islington Health Authority, and latterly Camden PCT, have funded and encouraged community-based health promotion services for about ten years, and have worked alongside the project, drawing on its specialist knowledge and expertise, throughout this period. Since 1999 the Health Action Zone has had the twin objectives of reducing health inequalities and encouraging community involvement, including meeting national targets on reducing inequalities of life expectancy and infant deaths between richer and poorer communities.

Recent initiatives have focused on several related aspects of these goals, include screening and prevention services for cancers and CVD, sexual health and pregnancy services, and mental health awareness and training. Despite these initiatives, and the close co-operation of the project, members of the Bangladeshi community have continued to use services less frequently than other groups.

Several reasons can be found in addition to those barriers to healthcare identified above:

- **A preference for community-based services:** Evidence from the project suggests that generic services, however good, will not be accessed as widely by community members as those provided specifically by and for the community. Examples might be breast and cervical screening services, which are widely available at mobile locations, and widely publicised, but little used by Bengali women especially older women. In this area the potential effectiveness of the project seems particularly striking (as discussed below).

- **A need for culturally-appropriate services:** The longer-term aims of encouraging healthy life-styles through appropriate eating, sleeping and exercise habits, and positive mental and social attitudes, can not easily be fostered from a western perspective. Information on diet and cookery for instance needs to build on women's prior knowledge and skills, and conform to their cultural and religious requirements.

Advice to participate in exercise needs to be carefully tailored to family and community expectations about women's dress and behaviour. Recommendations for daily routines must take into account women's roles and responsibilities within households, and their sometimes crowded living conditions, as well as their status and relationships within a quite patriarchal community.

- **The importance of a holistic approach:** Reticence and reluctance to engage in specifically 'medical' activities are best overcome by approaches which provide for women's personal and social needs – for spaces to relax and share experiences, eat and drink, and care for small children, as well as for a range of advice and support on non-health matters. The location of project services within community centres staffed by experienced community development workers serves many social functions for participants attending sessions.

6.4. Health needs identified by respondents in this study

The questionnaire distributed at community centres was completed by 51 women attending health sessions. Their responses offer a profile of health and illness which in many ways resembles that reported by wider surveys. The women ranged in age from the early 20s to the over 50s, although almost half the respondents were under 35. More than half answered 'No' to the question, 'Do you view yourself as a healthy person', and gave the following reasons (some naming two or more causes of ill-health): diabetes (7 responses), high blood pressure (6), tiredness (5), gastric ulcer (4), stiff joints and general aches and pain (4), and dizziness (4). Other conditions named include anaemia (2), heart palpitations (2), eye problems (2), high cholesterol, obesity, panic attacks, asthma and incontinence. In discussion, women also talked about mental health problems, especially depression, as their main reason for needing and valuing the project.

Main reasons for 'feeling unhealthy' (from 51 respondents)

Diabetes	7
High blood pressure	6
Tiredness ('I am always tired, all the time')	5
Gastric ulcer or gastric problems	4
Stiff joints, 'pain in my legs', 'aches and pain'	4
Dizziness	4
Anaemia	2
Heart palpitations	2
Eye problems	2

Additional questions referred to women's concerns for their family's health and well-being. Most respondents reported no concerns, but diabetes and obesity were again mentioned, and more information on 'heart problems', 'heart disease', and 'arteries' was felt to be needed. The majority of respondents however seem more concerned to develop a healthy life-style, through exercise and diet, swimming and yoga, than to seek help with major or life-threatening conditions.

7.

What the project offers: Ongoing services

There are two main aspects to the project: a range of core services, which have been provided in a similar way over the project's lifetime, and a variety of single initiatives, many of which have been launched in the last three or four years. Each of these will be discussed, with examples from the researcher's experience of the activities in summer 2003.

7.1 Doctors Advice Sessions

The earliest services provided by the project were advice sessions with Bengali-speaking female doctors, originally provided at two community centres but this year available at five or six. They were offered to counter the perceived problems women had in discussing their health problems with the majority of local GPs, who were neither female nor Bengali-speaking. At present three doctors are contracted to provide this regular service.

The service is available weekly, at a regular time each week in each centre, and may be either formal or informal. Women gather in the community centres for group discussions or workshops, and approach the doctor if they wish for individual advice, which may be offered on the spot if it is non-confidential, or in an adjacent room if requested by the patient. Women frequently ask their questions informally, or sit to have their blood pressure checked, while attending to general social chat. More serious or confidential issues, however, are taken up in private appointments.

All women attending have their full details registered by the community worker who facilitates the sessions, but medical records are maintained by the doctor on specially designed monitoring sheets which record personal details and GP details as well as the main health problem being presented (a checklist headed by heart disease and diabetes is included).

Doctors act in an advisory capacity only: they are not able to prescribe or refer a client to a specialist service, but can offer several other kinds of help: diagnosis of a problem, advice on dealing with the problem, advice on accessing specialist help, and letters to the GP requesting specific help from her/him. In addition they are able to carry out smear tests, blood pressure checks and urine tests, instruct women in breast self-examination, and give new clients a basic health check-up.

A common scenario described by one of the doctors is for a woman to come to her with a health problem and ask to be examined and diagnosed. The doctor may then decide to write to the woman's GP with an account of her symptoms, suggesting that she might need secondary intervention at a hospital or specialist clinic. The GP is thus enabled to make an informed examination of the woman, to help her/his diagnosis and decision about further treatment. Another doctor confirmed that GPs, who were initially somewhat hostile to their 'intervention', now welcome the contribution they make and frequently value their assessments of patients' needs.

Not all clients come for a diagnosis or referral. Some may wish to have the medicine they have been prescribed (for themselves, their husband or their children) explained more fully, especially if they have not understood the GP's or pharmacists' explanations. Others ask for advice on remedies for headaches or other aches and pains, including chronic backache. One doctor recommends alternatives to the traditional prayer positions for women with back problems who may experience discomfort while praying. Some wish to discuss the depression or other mental health problems of family members, or to have advice on contraception.

The views of users of the doctors' sessions: quotations from group interview :

> Sometimes we have to come here and complain about our GPs, they are rude, they're not nice to us… when my friend went, the doctor said "Don't tell me things, I'm not here to listen to your long story!" They don't want to listen to you…
>
> One time, my neighbour went to the GP after she had an emergency, a diabetic fit, and the GP said "Why have you come? It's not urgent, you shouldn't be here!"
>
> I found out a lot about my diabetes – the GP didn't explain it but here they explain it, and you can talk about what your GP said.

7.2 Workshops and discussion groups

At the same time as the early doctors' advice sessions began, the doctors began to plan and deliver a series of monthly information sessions on topics relevant to the women attending: early sessions were on hygiene, accident prevention, pregnancy, the menopause, or gynaecological problems. As one doctor pointed out, she learned to tailor her materials for different groups in the different centres – young women's topics for groups in their 20s, issues about teenagers for older women with children, and so on. The tradition has continued until now, and has linked up with visiting speakers (some from outside the community and from mainstream NHS or health promotion services) who offer workshops on their area of work.

In 2003, a series of workshops, run in each of the centres, has covered a wide range of topics: in the summer months, these included a series of focus group sessions on access to Breast and Cervical Screening Services; support for breast feeding; and a discussion of drug problems in the community. These sessions are jointly planned by the project co-ordinator, the community workers and the outside agencies who are supplying speakers and publicity materials, so that the session is run in a culturally appropriate manner.

Each session lasts for up to two hours. The speaker is introduced by the centre worker / interpreter, a short interactive presentation is given, eliciting the knowledge the women themselves have as well as extending their knowledge, and then questions and discussion follow. Women are able to participate, or listen, freely; to attend to their children or talk to their friends; and are offered fruit and nuts, or vegetable snacks, and juice or water, after the session. Project workers ensure that as much relevant publicity material (in English or Bengali) as possible is available for women to read or take home.

These sessions offer unique mutual benefits for the participants and the providers [see case study below for an example]. Participants are able to acquire important information in ways that are 'accessible, acceptable and appropriate', and that acknowledge their own cultural modes of interaction. Women are able to come and go according to their other commitments, and to attend to their small children, who are accommodated on laps or sleep in buggies. They may listen in silence, contribute to whole-group discussion or share thoughts with a neighbour: there is no pressure to participate but no apparent hierarchy of age, experience or education. Contributions are respectful but also light-hearted – on matters related to sex, for instance, there is a great deal of laughter, and a great deal of interest in hearing the views of older and younger members of the group. Women from the community are listened to by the 'experts' in ways which they clearly do not experience in their contacts with GPs and receptionists. Providers, in turn, are enabled for the first time to hear the views of the community on the obstacles to, and opportunities for, health promotion and preventative work with this particular group.

The following case study, taken from observation notes, illustrates the two-way benefits of such a session. The session was one of a series of six run in the different centres. Each session was presented by a doctor and a specialist nurse from the breast screening service, and followed the same format, but in each case the outcomes were different, as the women in the group asked their own questions and made their own suggestions.

Case study:

Bedford House, workshop on access to Cervical and Breast Screening services -

By 11.15 the group had gathered: 13 women had come to listen. Seven more women arrived in the course of the next hour, and another 5 women and 5 children came later, after the morning school / nursery session had finished – a total of 25 participants, ranging in age from about 18 to 60 years.

The project co-ordinator introduced the session, and the speaker. There were some giggles and suppressed laughter, but a great many nods – women were aware that they needed to know more on this subject. The co-ordinator asked the older women (who are the target group) what they already knew, and quelled the giggles of some younger girls at the responses. Several of those present have some awareness of the issues, from their GPS or from responding to letters inviting them for a screening; some have grown-up children who read the letter and took them along for the appointment, although this is not always the case. Some women report that their husbands looked at the letter and threw it away. Some have neighbours who were able to explain to them.

A number of questions were discussed:

How could this information be improved? The discussion circled around topics such as the needs of women who can't read Bengali or English; problems with insensitive posters and leaflets, some of them depicting photographs of breasts rather than simply a silhouette or outline; and the importance of this group as a means of disseminating information which was otherwise not getting through to the community. One suggestion from a young woman present was for a leaflet which told an actual case history / life story. There was general assent to this idea. Everyone present seemed to recognise that the message is an important one, and that the breast is 'simply a part of the body', although culturally it is too sensitive to be treated as such, and must be hinted at rather than displayed.

Is there an outlet in Bengali radio / TV / newspapers? A varied response indicated that some women would welcome this while others would switch off at once if there were men or children listening, and would only listen in a women-only group. There were noticeable age differences in people's level of comfort in hearing the issue discussed.

How about a video? Again, women were unanimous that it could only be shown in women-only groups. There was much laughter at the idea of such a video playing in the doctor's waiting-room ("All the old men would go and sit there!").

What is the screening experience like? Women who have attended reported that it was neither painful nor embarrassing, since only female staff are involved, though one reported the view that no-one else should touch a woman's breast. Their main concern was whether the clinic or mobile was close by – if not, it was too difficult to attend. The possibility of allowing women to wear a thin garment for the actual mammogram was considered.

Why are doctors so concerned about Bengali women? Because they have the lowest attendance for screenings, and older women in particular are very hard to access. One elderly lady pointed out that it was all to do with knowledge and understanding: if people knew the consequences, and knew more about breast cancer, they would see that the screening process was relatively painless compared to the consequences of unidentified cancers…

By 12.30, women had brought in drinks (water and fruit juice) and had prepared food (chicken, breads) for everyone to share. The group dispersed – some to take children away, some to chat, and some to an exercise class organised at this centre .

Breast screening is an important issue for both providers and participants, and sessions like this one have been held at all the community centres. Interviews with the doctor and facilitator after one session confirmed how much valuable information they were gaining, from different groups, about the ways that up-take of screening services could be improved. They were able to see that some of their own earlier ideas and efforts for publicity were not viewed as appropriate, and to take away constructive suggestions for bringing women in to the screening units.

These included:

- making arrangements for groups of women, or friends, to have appointments at the same time;
- arranging Bangladeshi-only screening days;
- producing 'life-histories' of women whose cancer had been identified and treated through screening;
- producing statistics on the incidence of breast cancers in different age-groups and ethnic groups; and
- emphasising the preventative effects of breast-feeding, diet etc.

In this way, the sessions are serving two functions: they act as information workshops for the participants, and they form part of an ongoing research project into ways of promoting breast-screening.

In the same period, a number of workshops have also been held on: breast feeding – once a universal practice among Bangladeshi mothers, now dying out fast for a range of reasons; drug use – denied by many community members but recently acknowledged as a problem for the community; healthy eating – to combat the rapid increase in intake of fats from cooking techniques; and herbal medicines – utilising traditional knowledge about medicinal plants. Some of these initiatives are discussed in greater detail below.

7.3 Exercise facilities

The need for dedicated provision of exercise information, equipment and classes for Bangladeshi women is a mark of how far the community has travelled from its roots of a few generations ago. Few women growing up and caring for families in rural Sylhet would have needed to undertake exercise in this deliberate way, because their daily work-load was physically taxing in itself, leaving little time for leisure and few opportunities for weight gain.

In Camden, lack of exercise threatens both the physical and the mental well-being of the community, as many respondents recognise. Both exercise classes and exercise rooms with running and rowing machines are popular. Some of the community centres can provide classes (they have been offered so far in Chadswell, Bedford House Community Centre) but only Chadswell Healthy Living Centre has specialist facilities for exercise machines. Women attending the other centres name this as one of their priorities. Many participants attend classes several times a week. They are keenly aware of the benefits, and suggest that opportunities for swimming and yoga would also be popular.

Women's keen awareness of the benefits of exercise is demonstrated in their questionnaire responses: asked, 'What could make you feel more healthy?', 19 of the 51 respondents cited exercise – 'do more exercise', 'routine exercise classes', 'exercise more', while 12 suggest more exercise opportunities (classes or machines) as a potential improvement to the service.

7.4 Sociability and social interaction

All the sessions attended were marked by the social ease and welcome they offered, and numerous respondents drew attention to this aspect of the BWHP services. One woman, when asked 'what has been the best thing about the project for you?', replied: 'The best thing has been having a project... without this we wouldn't go out, we'd be sitting indoors getting depressed'. Another responded, 'It's health, but also, you come here and have a friend, have a talk; if you feel depressed you can come here, you talk to each other and you feel better'. A third claimed that, 'Coming out and making friends is the main thing: mental health, you learn about mental health, but the best way is to talk to each other'. A fourth added, 'We don't just make friends, we have parties!'

Research has indicated that another significant change in women's lives, consequent on migration, has been the loss of sociable networks. Women report that in Sylhet 'all the doors were open and you talked to everyone', whereas in London doors are closed and the community to some extent lives behind them.

The services and sessions provided by the project are carefully designed to foster healthy and enjoyable social interactions among women who were previously unacquainted. The venues are welcoming, and development workers are always present to greet visitors as they arrive. Community workers get to know each woman attending health sessions, and make introductions. Seating is, if possible, arranged in a circle so that the whole group can interact. The presence of children, passed from lap to lap, and of refreshments, helps to ease shyness. Two respondents, in consequence, report that making friends has been their single most important gain from participating in health sessions, while another describes the project as 'A place where we can come and relax and forget about all our worries'.

8.

Specialist provision: research and responses to needs

8.1 Mental health initiatives

The mental health needs of the Bangladeshi community were identified early in the life of the project. The 1995 BWHP Review Report stated that,

> There is very little awareness in the community as regards the mental health, which often remains as hidden pain

Even at this date, workers were recognising that many women were approaching the doctors with physical complaints – such as tiredness, dizziness, lack of appetite, headaches – which were in reality signs of mental illness or depression. Failing to understand the close links between mental attitudes and physical functioning, they may have been examined by GPs, or referred to hospital clinics, only to learn that there was 'nothing wrong with them', a diagnosis which might lead to further loss of confidence and negative feelings. The project attempted to address this problem through group sessions which demonstrated the close relationship of mental and physical health, and individual treatments which supported the client in identifying the causes of her problem, understanding its impact on physical health, and learning a range of coping strategies.

At the borough level, concerns were first raised in 1999, when it became clear that the community, for a variety of reasons, was not accessing statutory services. The National Service Framework for Mental Health (1999) sets standards requiring local health and social services teams to:

- Promote mental health for all, working with individuals and communities
- Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

In Camden, the strategy for mental health promotion included:

- Strengthening individuals, by teaching coping and management skills
- Strengthening communities, by developing local support networks
- Reducing structural barriers to mental health, by reducing inequality and promoting access and inclusion.

The Health promotion service has worked closely with the project for the last three years to ensure that all these aims are addressed. In 2002 it was reported that one of the most significant achievements of the project to date was 'raising community awareness around mental health issues and work on mental health promotion'. A number of initiatives are noteworthy.

Mental health awareness training courses

These courses have been run regularly since 2000. Initially the courses provided were 8 weeks long and were aimed at the community development workers and health workers, to enable them to acquire knowledge they could share with community members, and encourage them to broaden their understanding. The evaluation of the first training programme held in summer 2000, resulted in the production of a report 'No more small portion of services please...' which highlighted a number of key issues concerning the mental health needs of the Bangladeshi community.

In summer 2002, the training programme has been revised to make it more appropriate for the members of the community. As a result of this, the first 6 weeks mental health awareness training course was organised for the user groups at Coram parents Centre. Currently the course is running on a rolling programme at different community centres in South Camden. In the last 12 months they have been offered at Coram Parents Centre (Summer 2002), Bedford House (Autumn 2002), and the Surma Centre (Spring 2003). They offer Bangladeshi community members and workers the opportunity to raise their awareness and skills in the field of mental health.

The six-week programme includes: definitions of mental health, and discussion of stigma in relation to cultural norms; work on depression, and its relevance to the Bengali community; work on community needs; awareness of self-harm; and information about existing services and the ways they can be accessed by the community.

Evaluations of the courses show that participants have greatly improved their own understanding and awareness of the forms of mental illness in the community, and of appropriate strategies for dealing with them. Many participants have admitted that their own preconceptions may have made them unsympathetic to people with mental health problems; and that they were previously unclear about the relationship of mental illness and depression to physical symptoms. Almost all were shocked to learn the concept as well as the extent of child abuse, and of self-harm and suicide, in the community.

Participants are carefully selected for these courses, which are built into an ongoing training programme for community and health workers.

Mental Health Peer Education project

This pilot project set up with the help of the BWHP has trained six workers in the skills required to set up and facilitate peer support groups on mental health. Groups have now been organised for different types of user (such as single mothers, or newly arrived young men), while three of the former trainees are going on into mental health training.

Bangladeshi Mental Health Forum

The project has been active in setting up this borough-wide forum for mental health issues.

The forum brings together all the groups and agencies who have an interest in mental health promotion in the community (50 members have joined so far), and invites outside speakers to its quarterly meetings. It enables key mental health issues to be discussed, and a multi-agency approach to be developed, as well as providing training and supervision for those working with clients who are emotionally distressed. The forum exists to ensure that the National Service Framework is fully implemented with regard to the Bangladeshi population, and to link communities with statutory and voluntary agencies who are able to provide support.

Bangladeshi Mental Health Action Research Project

This project, intended to identify the mental health needs, and improve access to mental health services, for the Bangladeshi community, was launched as a joint venture of the BWHP, Camden Social Service's Community Mental Health Team, and the Health Promotion service in Camden. The findings of the research project was launched in March 2003; among its findings are that changes have taken place in the community, with respect to understanding an awareness of mental health issues; changes have occurred within GP services, enabling GPs to identify and refer Bangladeshis with mental health problems more accurately; and improved understanding of cultural issues in mental health has enabled the wider mental health community to respond more appropriately.

The project report states that:

> The BWHP … played a key role in the action research project by providing easier access to the Bangladeshi community and obtaining the commitment of the workers in Bengali community projects. (Bisby et al, 2003: 15)

At the start of the joint project a different picture was reported, in which the Bangladeshi community made very little use of statutory mental health services, and the BWHP highlighted: poor access to services; low awareness of mental health issues and services; and the absence of Bangladeshi workers in the mental health sphere.

The action research project identified the familiar antecedents of mental health problems: socio-economic pressures including unemployment; poverty and family stress; gender and generational issues; racism and social exclusion. These well-known factors have been exacerbated in Camden by language problems, cultural misunderstandings, and the lack of ethnic minority workers in mental health services. Another contributory factor found in the research literature is the tendency to somatisation, the process whereby mental and emotional problems are perceived as physical aches and pains. This may be viewed as an inaccurate stereotype, applied to Asian communities by professional health workers for their own convenience; but it may also reflect an actual preference among many individuals and families for citing physical ailments rather than mental states. Many of the physical symptoms reported in the questionnaires for the present report (dizziness, tiredness, heart palpitations, panic attacks, aching bones) may be manifestations of emotional or mental distress.

The Health Promotion Service, reviewing the mental health initiatives undertaken since 2000, states that

> The success of these projects is due to the excellent infrastructure afforded by the BWHP and the unique role of the BWHP / health promotion partnership in galvanising community ownership and mobilising specialist knowledge. (C&I / Health Promotion, 2002: 33)

Views of current research respondents

Women interviewed for the present study demonstrate high levels of awareness of mental health issues, and are keen to treat the subject as a normal part of everyday life, something experienced by everyone at some time, rather than as a source of stigma and secrecy. Many are aware of the causes of depression, and of the ways that women can help themselves and each other in overcoming it.

One group pointed out that in attending the project 'you learn about what mental health is, but at the same time you feel better already because you've talked about it'. Both social opportunities ('talking about your problems', 'getting out of the house', 'making friends') and opportunities for physical exercise were seen as beneficial in tackling depression, as these responses suggest:

- My mind gets fresh after meeting with others. I started joining in the centre's activities after my husband's death and I feel I missed so much (B10)
- I suffer from lots of anxieties and I feel better when I join in health activities (B14)
- [The project helps] by allowing me to talk freely about my feelings with professionals (E2)

As a member of a group interview admitted,

Usually, if you've got a problem, we keep secrets, like "If you know that about me, you will think I'm not good"...here, we can tell each other.

Women who are troubled by anxiety or depression are able to acknowledge their feelings, and are aware of the links with physical well-being, as occasional responses show:

Question : What could make you feel more healthy?

Answer :

- *Be happy [C8],*
- *My mental health will improve if my son gets better [D4]*
- *Peace of mind [D5]*
- *Learn how to remove my worries [E2]*

Nevertheless, four-fifths of respondents expressed a wish to learn more about mental health issues.

8.2 Healthy eating initiatives

A good many of the most common physical and mental ailments in the community, including the most serious and life-threatening, can be attributed to the changes in life-style brought about by migration to the west, and especially to dietary changes. Families who would have eaten a balanced diet of freshly-prepared food in their homes in Bangladesh may be tempted by convenience foods which are high in fat: children in particular are at risk of switching to the worst aspects of western diet.

Several factors seem to contribute to poor diet, including:

- Low incomes: like most poor communities in the UK, Bangladeshis may find that fresh fruits and vegetables, and meat and fish, are too expensive for their family income; in particular, the vegetables they are most accustomed to eat from their home upbringing are among the most expensive types available

- Low availability of healthy food: families on low incomes frequently use small corner shops and local groceries for their shopping, where the quality and freshness of the food is less reliable than in markets and supermarkets

- Changes in life-style: families whose members go to school, college and work at very different times of the day may find it difficult to eat a family meal together as in the past, so that processed and convenience foods become more attractive

- Loss of continuity: young women who would have learned to cook from their mothers and mothers-in-law may now have little understanding of how to provide food for their families.

Healthy Eating training programme

These six-week programmes started in April 1999, as a joint venture between the BWHP, the community centres, and local further education colleges (Kingsway, Westminster).

The classes combined practical cookery demonstrations and instruction with more theoretical nutritional information. In summer 2003, one of these courses, with an instructor provided by Kingsway College, took place at Hopscotch Asian Women's Centre. Through co-operation between the providers, it was arranged to coincide with the weekly doctor's sessions in the centre, which were held in an adjoining room. This enabled women who attended to participate in both activities and to recognise that the same messages about the importance of diet were being conveyed by all the providers.

At one session that was observed, the messages put across by the cooking teacher - about fats, fresh vegetables, and the role of herbs and spices in health - were reinforced by the doctor in her talks with the women over the meal they had prepared. These joint sessions help to facilitate the inter-generational sharing of knowledge, and opportunities for socialising and for learning, which are typical of the BWHP sessions.

Sewing the Seeds of Health

In another related initiative, the project linked up with the Bengali Women's Sewing and Craft session at Chadswell Healthy Living Centre, to produce a hand-embroidered banner on healthy eating. The aim of this initiative was to raise awareness of the importance of a balanced diet, through mobilising a group of women who were used to meeting regularly to sew – thereby celebrating their traditional skills in embroidery at the same time as reinforcing the message about nutrition. The banner, measuring 1.8 by 2.0 metres, was begun in April 1999 and completed in July 2000 and has now become a prizes asset of the BWHP and are used in a wide variety of contexts. Funding for this project came partly from the BWHP, and partly from the then Camden &Islington community Health Services NHS Trust.

Healthy Life style campaign

A recent initiative has been a campaign, co-funded by the BWHP and Camden PCT, recommending four 'steps to a healthy life style' (diet, exercise, mental health, smoking cessation'. The leaflets produced for this campaign aim to show the links between all aspects of healthy living - all four 'steps' for instance may help avoid coronary heart disease, one of the biggest causes of death in the community.

This holistic and self-help approach offers an alternative to depending on doctors and the health service for one's health, emphasising instead the possibility of taking steps towards becoming healthier oneself.

Views of current research respondents

The questionnaire did not offer any 'prompts' on eating, diet or nutrition, but many respondents named these as important aspects of health. Those who describe themselves as 'healthy' (23 from 51 respondents) cite eating well and exercise as the reasons, while 13 respondents in all name 'fruit and vegetables', 'balanced diet' or 'eating healthily' as the best way to become more healthy. Only six respondents suggest a need for more information (sessions or leaflets) on diet and nutrition: the message is conveyed to them every time they attend the centres, through the provision of fruit and nuts as snacks, or carefully prepared vegetable dishes. In response to a direct question, Do you feel you are well informed on nutrition and diet?, over two-thirds responded 'Yes', although several added that they would like to know more on these subjects.

Encouragingly, healthy eating is not associated in these comments with 'looking thin', although women are conscious of their weight and of the risks from obesity. Instead it is seen as part of an overall healthy life-style:

> I have learned lots, for example, to keep fit. We have to eat healthy food, do exercises, sleep well. (A8)

Despite these positive attitudes towards good nutrition, there is little sign that women are so far transferring their knowledge into their actual practice when shopping and cooking for their families. This makes it all the more important that some women are encouraged to provide food for the whole group at information sessions (as described above at Bedford House), so that low-fat food with plenty of vegetables can be tried and found to be delicious.

Healthy Eating Information Pack

The latest development in this area is the ongoing production of a bilingual information pack which will provide information and advice on developing a balanced eating habit. The pack will present government guidelines on healthy eating in attractive, and culturally appropriate, formats. It uses the image of the 'model plate' containing all five essential food groups as a simple illustration and reminder of the rules for healthy eating. The pack will draw specific attention to the comparison of a 'model plate' diet with a typical Bangladeshi diet, showing what practical steps can be taken to change family diets. It acknowledges that many women will feel reluctant to change from foods they are familiar with to foods which are healthier, but points out:

- The gradualist approach: small changes can be planned and carried out, introducing one new food or cutting out one unhealthy cooking practice, every few weeks, so that both the cook and her family learn to like their new diet

- The life-long benefits for individuals and families which will inevitably follow from making these small changes now.

As part of the development of this new pack, a photography session was held at Chadswell Healthy Living Centre, to develop visual materials on healthy eating, which can be used to get the message across to the community. The photographs of healthy and unhealthy alternatives will enable such messages to be conveyed to the community, and retained in the memory.

8.3 Continence Research

A pilot study into incontinence among Bangladeshi women in the area was carried out earlier this year, as a partnership between the Health Promotion Service, the Advocacy Service, The Bengali Women's Health Project and the Continence and Stoma services. Two previous interventions prompted this piece of research: an attempt made in 1997-8 to provide continence clinics for Bangladeshi women, which was viewed as unsuccessful because the clinics were so poorly attended; and a very successful project run in the Midlands, which has found a variety of means to access and involve women in need of the service. Incontinence had been identified by the project doctors as a particular need of the client group, as early as 1995.

The study was based on two sets of questionnaires, one sent to GP practices and one used with community members in focus groups. Only 10 GPs returned the questionnaire, and their responses indicated that they felt few Bangladeshi women would talk to them about bowel or bladder problems, and that they themselves would have difficulty discussing the issue without an interpreter. Over 120 women took part in community group discussions facilitated by project workers, and indicated a much broader range of attitudes. These include awareness of religious and cultural aspects, feelings of shame and secrecy, and a willingness to become involved with female and Bengali-speaking doctors and nurses to learn more about acquiring control and improving their quality of life. The view previously expressed was that this was a personal problem for which no medical treatment was available, and must be suffered in silence.

The recommendations from the project will enable statutory health providers to develop more culturally appropriate services for women, since incontinence is believed to be a widespread problem, although it is not a well researched area in relation to Bangladeshi populations.

Early feedback on the research report has been overwhelmingly positive. Messages from senior official in the statutory sector have commented on how valuable and thought-provoking the research has been, and have confirmed the need to seek funding for some of its recommendations, particularly as the PCT has a responsibility to demonstrate the equity of its services.

8.4 Herbal medicine project: 'Rediscover your roots'

'Rediscover your roots' is a Bangladeshi Herbal medicine project initiated by Women and Health with funding from the Camden Central Partnership. The aim of the project is to tap in to he rich knowledge that already exists in the community – knowledge about how to treat common ailments with plants and spices, many of which are commonly used in everyday cooking, and can be found in an average kitchen.

The first part of this project focused on the Bangladeshi community in Camden. Bengali Women's Health Project, through the project co-ordinator and community centre workers, facilitated six group sessions in three different community centres during the summer of 2003. A wealth of information on traditional herbal medicine – using bark, berries, seeds, fruits, flowers and leaves – which lies in the minds and experience of many women from the older generation, was discovered during the sessions. Many women brought along samples of ingredients which they use as home remedies; some of these ingredients had been brought back from visits to Bangladesh. The enthusiasm and interest of the women in sharing their traditional knowledge were very encouraging: the positive feelings amongst the participants when they encountered a professional herbalist who was interested in their home remedies (which they generally hesitate to share with others for fear of being disregarded), were particularly evident in these sessions.

The co-ordinator of the herbal remedy project, who is herself a qualified herbalist, is compiling a recipe book to include the remedies that have been shared in these sessions.

8.5 Other new projects

In the recent months the project also assisted the diabetic dieticians to carry out a needs assessment for the provision of dietetic services for Bangladeshi and other South Asian communities in Camden, and organised four group sessions to facilitate this work.

In addition, over the last years, the project organised a series of massage and aromatherapy sessions at a number of community centres mainly for the older women. A professional therapist was contracted to carry out these sessions which aimed at offering the tester alternative health care in maintaining good health.

9.

Developing a resource base / capacity-building in the community

Another ongoing project is the development of a resource base in the community which will enable members to generate their own materials and publicity, and network with each other. The base has acquired a computer with Bengali typefaces, which is available for users at Coram Parents Centre, as well as other production resources. One immediate aim is to produce a wide-ranging bilingual information sheet, written in straightforward language, which can be understood by the local community. Early fact-sheets will address a range of issues including access to services, and key community health issues.

In September 2003 the first issue of a regular bilingual newsletter raising health awareness and reporting local health issues is to be launched, with the intention of developing an ongoing dialogue with he local community. The newsletter is to be called **HEAL** (**H**ealth **E**ducation and **A**ction for **L**ife). Its aim is to inform the wider community (women as well as men, family members as well as BWHP members) of the thinking behind health initiatives such as the project, and to provide information on health issues and local services, as well as health tips.

In time it is intended that the resource base will contribute to capacity-building within the community, providing facilities which can be used by other groups and service providers. Related to such capacity building is an ongoing project (jointly provided by BWHP, Coram Parents Centre and the WEA) to develop a training programme for outreach workers, which will build on the existing knowledge and skills of community members, identified by the development workers as suitable to take on some of the workload which currently falls on them. Potential outreach workers will possess an intimate knowledge of the local community, but may need to develop knowledge and understanding on a range of important issues like confidentiality and impartiality in dealing with families etc, and helping them to access the services they need. This pilot 6 weeks training course 'Outreach in the community' has been taking place at the Coram Parents Centre since mid September 2003. Once trained, the outreach workers may be employed by other service providers.

10. How the project is evaluated: the views of users

10.1 Who were the respondents?

Women from five different centres responded to the questionnaire administered in the centres during July 2003 (one centre was no longer running sessions because of the summer holiday, and was not accessed). The 51 respondents were quite evenly distributed by age group, and the majority were married with children, although a majority of those aged over 50 were widowed. None of the over-50s was elderly, but it is likely that some had married men who were considerably older than them.

Age groups and marital status of respondents

Age group	Single	Married	Divorced	Widowed	Total
Under 20	0	0	0	0	0
21-35	1	21	0	0	22
36-50	0	15	1	1	17
Over 50	0	3	1	8	12
All respondents	1	39	2	9	51

All but two of the respondents had children, ranging from one child to seven, and ranging in age from 5 months to 40 years. Older women had noticeably larger families, partly because they had completed their families while younger women had not. Seventeen women in the 21-35 age group had children in the 0-10 age-range only, and may have intended to have more children; one had children aged from 11-21, and four had children from both the younger and the older age groups. More of the 36-50 year olds however had children in the older age groups only (11-21, or over 21) and had presumably completed their families. Women over 50 themselves were more likely to have 6 or 7 children, ranging in age from their 30s to their teens. Between them, we might guess, the 51 respondents had a comprehensive experience of parenting!

Number of children

One child	10
Two children	11
Three children	11
Four children	7
Five children	1
Six, or 'many' children	8
Seven children	1

10.2 Use, needs and benefits

- ***How have they used the project ?***

Respondents were asked how they had come to know about the project, and how they had used it. More than half (33 respondents) report that they had first heard about the project directly from a community worker or project worker; only 6 had been told about it by a friend or neighbour, and only 2 were informed by a doctor or nurse. None was aware of having learned about the project from posters or leaflets, although nine respondents ticked several or all these sources. It seems clear nevertheless that the direct outreach work and publicising by the centre staff and project staff was what brought people to the project (this work continues: centre staff regularly make individual phone calls to women urging them to attend sessions, finding that this is more effective than leaflets or posters).

Many of the respondents have been attending since the early days of the project: over one-third (18 respondents) claim to have attended for 10 years or more, and a few say they were there 'from the beginning', in 1990. Of the remaining 33, about one-third have known the project for less than two years, a third for 3-5 years, and a third from 6-10 years.

Most remarkable is the high levels of use, and the degree of attachment to the project, revealed in the responses. Women who initially attend for one kind of session – a doctor's advice session for instance – seem to end up attending every kind of session on offer – workshops, courses, exercise classes; and having started attending, they keep on coming.

Only three respondents report using only one of the health services, and the majority use 3 or 4 different services. Efforts to code their rates of attendance proved fruitless as so many reported attending 'hundreds of times' 'all the time' or 'so many, I have lost count'. But a conservative analysis of the responses indicates that only seven could be regarded as 'occasional users', who had attended fewer than 25 sessions overall; that a further nine could be described as 'regular users', who attend once a week for months or years; and that at least 23 are 'frequent users', who attend several sessions regularly, and have continued to do so for some years. There is a huge attachment to the project, revealed in these figures as well as in their comments on the project and the workers.

- **Which aspects of the services have been helpful ?**

Eight specific aspects of women's use of the project were named in this section, with clear and perhaps unexpected results. Bearing in mind that the answers given to the question Do you view yourself as a healthy person? were 'No' (28), 'Yes (23), it is reassuring to discover that almost all respondents (50 from 51) report that the project has helped them to 'feel more healthy'. One clue to this may be in the sociable nature of the sessions, described in Section 7.4 above, since an overwhelming number (49 from 51) also report that they have 'made friends from attending the project'.

Other frequently cited aspects are: learning from workshops (47 respondents), joining in healthy activities (42), and having health questions answered by a doctor (41). With reference to the areas where they feel the most need for information, it is interesting to learn that 40 respondents 'would like to know more about mental health', but far fewer have concerns about the health of their husbands (19) and children (28). These emphases are confirmed by a further set of questions, in response to which only 10 respondents express any concerns over parenting, and another 10 (mostly different women) say they are unhappy about their family's fitness. The answers place a strong emphasis on the respondents' concerns about their own health and well-being, as well as their wish to learn about mental health. They are not principally motivated, it seems, by a sense of need and duty on their husbands' and children's behalf and view the project work more relevant for their own benefit.

This may explain the warmth and enthusiasm expressed by the women in the group interview referred to earlier, who come to the sessions because they make friends, discuss problems, share feelings and as a result, feel altogether better, in the sense of more cheerful as well as more healthy, since the two are so closely linked.

- **Personal sense of benefit**

As well as responding to closed and multiple-choice questions and checklists, respondents had the opportunity to add their own comments on the benefits they have felt, and the needs the service could additionally supply. Perhaps because so many 'health topics' were covered in other questions, there are more references in these comments to broader aspects of well-being. A number of comments do refer to learning more about illness, drugs, allergies, and staying fit, but a wider range of comments suggest the social benefits of the project, including:

- Getting to know other young children, to help prepare a young child for school
- Making new friends
- Having a fresh mind
- Broadening our outlook
- Talking to each other (described in different ways)
- Support from each other and from project workers
- Getting through difficult times (being widowed)
- Networking with the community
- Relaxing and forgetting our worries
- Overcoming anxieties

In comparison with these benefits, the 'needs' expressed (for more of the same, more sessions, more exercise, more workshops, more topics) are very minor indeed.

11.

Strengths of the project

On a practical level, the strengths of the project are self-evident and have been described above. Three strands of the project's work can be identified as giving it a particular character. These are: partnership with other providers; building on a specialised knowledge base; and tackling inequalities and social exclusion.

11.1 Partnership with other providers

Throughout this account, it has been clear that a major strength of the BWHP has been the structural links between the project and all other bodies working for the health of the Bangladeshi community in Camden. These include the Health Promotion / Public Health service in which the project is embedded, and the many specialist providers within the NHS (breast screening, diabetes, continence, mental health and so on). Equally importantly, they include the whole range of community providers: the workers in the community centres and other voluntary-sector projects, and local educational services at every level. The links with colleges and the WEA have been mentioned, but equally strong links are made with local schools, where some of the outreach work with parents, co-provided by Coram Parents Centre, takes the form of arts and crafts workshops, or health and beauty sessions, which provide opportunities for women to share their experiences and to learn more about the local facilities available to them.

These links have come about in two ways.

- One is the strategic thinking of the management group and co-ordinators of the project, who have ensured that their own provision is always closely linked with existing statutory and voluntary services. In this way, local women are enabled to access the services which are theirs by right, but which for a variety of reasons they have not been using to meet their needs

- The other is the embeddedness of the project within the community, on a face-to-face level: a huge network of local connections has been created by the community development workers over the last decade, which proves an invaluable resource as each new initiative is set up.

Project users are viewed, not as 'clients' or 'patients', but as individuals with multiple local links and attachments, especially to their schools and community centres. All these attachments are exploited in providing a 'joined-up' service.

11.2 A specialised service

Consequent on this first point is the uniquely specialised body of knowledge the project has brought together in its years of working with the community. Between them, the doctors, the successive co-ordinators and the community development workers have amassed an unrivalled body of information and skills in their field. This expertise enables them to respond appropriately on every kind of issue brought to them by community members – requests for exercise, massage, herbal remedies, support for parenting, depression, cancer care, and so on.

Equally importantly, they are a resource for statutory providers, often unlocking the previously closed doors between the community and the primary care providers, and unblocking apparently insurmountable barriers of communication. The evidence suggests that statutory providers, despite their best intentions, have either (i) failed to provide the health facilities the community needs, and finds culturally appropriate and accessible, or (ii) failed to communicate successfully with women about these facilities. The BWHP, as well as providing its own customised services, has acted as a conduit for two-way communication between community members and other service providers in the statutory and voluntary sector. It does this on the basis of its very specialised expertise in the health needs of its community, an expertise based not simply on 'being there', and listening, but on continuous research and inquiry.

11.3 Tackling inequality and social exclusion

This 'final' point is in fact where the project begins, and runs through all of the project's work. Poor health is a key consequence of every other poor socio-economic indicator – poverty, minority ethnicity, poor housing, low educational outcomes. It is also a key factor in reproducing inequality from generation to generation: the children of the poor and those with low levels of health and well-being, tend themselves to grow up poorly educated and in poor health. The consequence is continuing social exclusion, defined as an inability to share the quality of life enjoyed by others, and to participate in society to the full.

Interventions, in any aspect of people's lives, which break this inter-generational cycle, can have a cumulative effect on all aspects of their life-chances, creating a 'virtuous circle', or spiral, which enables individuals to rise above the low expectations for well-being and success which they have previously held.

The small-scale work with individuals and families which the project has been carrying out may have long-term effects on the aspirations and success of these individuals and their children. Women who attend a session to consult a female doctor, are gradually enabled to assume control of other aspects of their health, and may eventually gain the confidence to run sessions of their own, or to be trained in outreach work themselves. The most striking aspect of group sessions (for one who has worked with Bangladeshi families in schools, and struggled with the apparent reticence and silence of mothers) is the confidence and energy displayed by participants. If such confidence and energy can be transferred outside the project, it will have lasting effects on the families, and especially on the children, of all those who take part.

12 Recommendations

Recommendations from an evaluator seem rather out of place in relation to the BWHP, which is itself the strongest advocate imaginable for the continuous improvement of standards and services. The project is working towards all of these immediate objectives:

- Increased provision of bilingual resources
- Capacity building in the community
- Training of community members in outreach and other areas
- Collaboration with specialist statutory services
- Culturally appropriate publicity
- Identifying gaps in service provision

In particular, the recent initiatives taken by the project in developing culturally appropriate information resources will assist the project in harnessing the long standing community experience of key members of the project (some of whom have been working in the area for over 15/16 years). This will not only benefit the local community but also will increase the effectiveness of service delivery of the local health service providers and health practitioners.

From the results of the survey, the following problems and possible areas for expansion and improvement of service provisions to the community have been proposed.

- **Additional facilities for exercise and swimming**

Some of the requests made by survey respondents are difficult to meet because of the limited physical space available at the community centres. Some of the most common requests were for exercise classes, exercise machines, and swimming. Most of the centres are not able to provide exercise rooms and certainly not specialised exercise equipment or swimming facilities.

Most of the community centres appear to be making the best possible use of quite limited space (for which they must compete with other users).

The way forward can only be to take a further step towards linking the facilities currently accessed by women in the community centres, with 'outside' facilities in the borough, enabling participants to join classes and training at publicly-provided health centres and pools. The project has already undertaken a six-week healthy eating course at Crowndale Health Centre, an extension of its community centre services. Continuing collaboration over fitness facilities can be envisaged in the future using facilities of this kind.

- **Continuing links with statutory providers**

This link needs to be further strengthened so as to develop effective links with the primary care service providers, many of whom have the element of health promotion included in their work profile. This will create an opportunity to develop coherent and comprehensive health promotion programmes, which in turn maximises the impact they have upon the community.

- **Extension of services provided by the project**

BWHP work programme is heavily concentrated in the South of Camden where most of the project's core members are based and where the majority of Bangladeshi community in Camden live. However, the recent census report reveals a sizeable Bangladeshi population in the north of the borough as well. The focus BWHP work programme could be broadened to include areas such as Kentish Town, Gospel Oak etc. This could be done by making effective relationships with the community development projects, in particular with projects which have a local health development remit.

- **Responding to the local health authority's targets**

One of the key strengths of the project is its capacity to identify and respond to local health needs and deliver services directly to the community. However, at the same time, the project could further explore and evaluate opportunities to work towards the priorities and targets identified by the Local Delivery Plan developed by Camden Primary Care Trust.

This will enable the project to make an effective contribution towards the implementation of a number local health strategies developed to tackle key health issues, for example, the Healthy Eating Strategy, Domestic Violence Strategy etc. In addition, to be inclusive within the existing developmental programme, the project could build up further partnership work with the regeneration initiatives such as the Neighbourhood Renewal Strategy and Sure Start programmes as well as Healthy Living Centres etc.

- **Broadening the focus on education**

A strong element of the existing BWHP work is a focus on education: teaching women how to stay healthy, happy and fit, rather than treating their illness. Further aspects of this work are the support given by the project in the running of the parenting initiatives, especially in partnership with Coram Parents Centre, which has helped to facilitate a 'Strengthening Families, Strengthening Communities' course for the Bangladeshi community. Other parenting initiatives are provided through groups meeting in local schools. The work of parenting in a new culture has been identified as a difficult issue for many families, who are uncertain as to their exact role as their try to apply the values of their own culture to the upbringing of their children. Work with parents completes the generational cycle of educational work in matters of health and well-being, and must continue to be integral to the work of the project.

This focus on education by the project could now be broadened in several directions:
The support provided in running the parenting initiatives could be extended to work with the Sure Start programme in identifying and working on the health needs of those under 4 years of age and to work with the schools on health education for children. The project has all the necessary expertise on child development, healthy life styles and self-care. It has a valuable contribution to make in preparing the next generation of young adults for healthy living and inclusion in society.

In many cases, the good habits learned in childhood seem to be lost during adolescence and the teenage years, when a number of serious and even life-threatening problems can arise: diet (from obesity to anorexia), smoking, drug use, unsafe sex and relationship difficulties, teenage pregnancy.

Liaison with secondary schools as well as relevant health services could serve to bridge some of the existing gaps between services for parents and services for young people.

- **Increased links with health charities**

Opportunities for increased liaison with healthy charities may be created through stronger links with national charities working for heart disease, cancer research and care, diabetes, kidney disease, anaemia and other serious illnesses experienced by participants. The poor health and poor quality of life experienced by some older participants suggests the need for work with charities that cater for older people, which already commit resources to help the elderly access benefits of many kinds, including health. A huge amount of promotional material is already produced, some of it already in translation, which may serve to enhance the publications currently being produced by the project.

13 References

References and further reading

Berthoud, R. (1998) Incomes of Ethnic Minorities. Colchester: Institute for Social and Economic Research

Bisby, N, Singam, S, Beattie, A, Ekiko, F & Cliverd, A (2003) The mental health needs of the Bangladeshi community in Camden. London: Camden PCT

BWHP (1995) Bengali Women's Health Project, Review Report. London: Camden & Islington Health Authority.

Camden & Islington Health Promotion Services (2002) Annual Report, 2001-2. London: Camden PCT, Islington PCT.

Chahal, K. (2000) Ethnic Diversity, Neighbourhood and Housing. York: Joseph Rowntree Trust

Gillborn, D & Gipps, C (1996) Recent Research on the Achievement of Ethnic Minority Pupils. London: HMSO

Gillborn, D & Mirza, H (2001) Mapping Inequalities. London: DfES

Howarth, C, Kenway, P, Palmer, G & Street, C (1998) Monitoring Poverty and Social Exclusion: Labour's Inheritance. York: Joseph Rowntree Foundation.

Modood, T & Berthoud, R (1996) Ethnic Minorities in Britain. London: Policy Studies Institute.

Momen, A. (1991) Challenges of adversity – the quest for fulfilment: The Bangladeshi Community in Camden. Camden LEA Conference, London.

Roberts, H (2003) What works in reducing inequalities in child health. York: Joseph Rowntree Foundation / Barnardos.

14 Appendix - Questionnaire

Bengali Women's Health Project

We are currently carrying out a small study to find out how effective we are in promoting health and well-being for the women who use our project and their families. We would be very grateful if you could answer the following questions.

All information given will be anonymous and confidential.

1. Please tick your age group: under 20 ( ) 20-35 ( ) 35-50 ( ) over 50 ( )

2. Are you? unmarried ( ) married ( ) divorced ( ) widowed ( )

3. Do you have children? **YES / NO**

4. If YES, their ages are:

………………………………………………………………………………..…………………..

5. How did you first hear about the project?

- From a friend or neighbour ( )
- From a community worker or project worker ( )
- From a health professional (doctor, health visitor) ( )
- From posters or leaflets ( )

6. When did you first attend any session of the project ?

………………………………………………………………………………..…………………..

7. What types of session have you attended?

- Doctor's surgery ( ) How many times?………………...
- Workshop ( ) How many times?………………...
- Advice session ( ) How many times?………………...
- Exercise session ( ) How many times?………………...

Other……………………………………………………………………………………………..

help?……………………………………………………………………………………………..

8. Do any of these statements apply to you?

- I have had my health questions answered by a doctor ( )
- I have made friends by attending the project ( )
- I have learned interesting topics from workshops ( )
- I have joined in healthy activities at the project ( )
- I have had mental health concerns ( )
- I have worried about my children's health ( )
- I have worried about my husband's health ( )

9. Do you view yourself as a healthy person? YES / NO

- How can you tell?

…………………………………………………………………………………………………..

- What could make you feel MORE healthy?

…………………………………………………………………………………………………..

10. Has the project helped you to feel healthy? YES / NO

- If YES, in what ways?

…………………………………………………………………………………………………..

11. Are there any health problems which frighten you? YES/ NO

- If YES, would you like the project to give information?

…………………………………………………………………………………………………..

12. Are there any parenting problems which worry you? YES / NO

- If YES would you like the project to offer help?

…………………………………………………………………………………………………..

13. Are you happy about your / your family's physical fitness? YES / NO

- If NO could the project help?

………………………………………………………………………………………….………………..

14. Do you feel you are well informed on nutrition and diet? YES / NO

If NO could the project help?

………………………………………………………………………………………….………………..

Please tell us any ways that the project services have benefited you

………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..
………………………………………………………………………………………….………………..

Thank You for your help !

Bengali Women's Health Project

www.bwhp.org