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Ways to Improve Uptake of Tier 2 Weight Management Programmes in BAME Communities in Medway: A Qualitative Study

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Abstract

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Ways to improve uptake of tier 2 weight management programmes in BAME communities in Medway: A qualitative study

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Abstract

Overweight and obesity is usually determined by Body Mass Index (BMI). Twelve BAME adults participated in the interviews: six were female, ten were first-generation migrants, three were retirees, none lived with a disability, and all were concerned about their excess weight. There were four themes from the data and eight subthemes obtained. To improve the uptake of the weight management service provided in Medway, the participants recommended the use of strategies such as indigenous food labelling, BAME-led clinics, the use of translated leaflets, the recruitment of local weight management champions, better coordination of services, appropriate communication strategies, and further research. This study investigated a small sample of English-speaking participants, which may not represent all people from BAME backgrounds in Medway and across the United Kingdom (UK). This study investigated the perspectives of residents who are overweight or obese, as well as weight management concerns among ethnically diverse adults. It also investigated how to increase the use of weight management services in Medway, England. In Medway, 69.2% of adults are living with overweight or obesity, which is considerably higher than the national average of 62%. Indigenous food labelling, BAME-led clinics, the use of translated leaflets, the recruitment of local weight management champions, better coordination of services, appropriate communication strategies, and further research are essential ingredients that can be used to improve access to and uptake of weight management programmes in BAME communities.

Ways to improve uptake of tier 2 weight management programmes in BAME communities in Medway: A qualitative study.

Overweight and obesity is usually determined by Body Mass Index (BMI). According to National Institute for Health and Care Excellence (NICE) (2014), a BMI of 18.5 kg/m² to 24.9 kg/m² is classed as a healthy weight, a BMI of 25 kg/m² to 29.9 kg/m² is classed as overweight and a BMI of 30 kg/m² and above is classed as having obesity. However later NICE guidance also stipulates the use of lower cut points for Black Asian and Minority Ethnic (BAME) groups. However, those individuals who have a high BMI should also consider reducing their body mass in order to improve their health.

The burden of obesity and overweight has tripled over the last three decades, affecting every continent [Gupta, 2014; World Health Organisation (WHO), 2020; The Organisation for Economic Co-operation and Development (OECD), 2019; Public Health England (PHE), (2017)]. As a result, obesity is now considered a major public health threat globally (Seidell and Halberstadt, 2015). In the last 33 years, it is noteworthy that no country has effectively reduced the rates of obesity and overweight amongst its populations (Bhurosy and Jeewon, 2014).

In 2016, the World Health Organization (WHO) estimated that approximately 1.9 billion adults were overweight in 2016, of which about 650 million of them had obesity (WHO, 2019). Overweight and obesity have a direct impact on the health, economic and psychosocial wellbeing of a country. Ng *et al.*, (2014) estimated that obesity causes 3.4 million deaths, 3.8% of disability-adjusted life-years, and 3.9% of lost years of life globally. Data obtained from the Global Burden of Disease (GBD) indicates that 4.7 million people died globally in 2017 as a result of obesity, accounting for 8% of all global deaths (Ritchie and Roser, 2020).

The health impact of obesity cannot be overlooked. Obesity is directly linked to stroke, type 2 diabetes, some cancers, musculoskeletal disorders, obstructive sleep apnoea, heart disease, liver disease, and hypertension (PHE 2019; WHO 2016). Noteworthy is the fact that there is a disparity in chronic disease burden with hypertension, stroke, and type 2 diabetes being higher amongst BAME populations when compared to the wider population (HSE 2017; Gallagher *et al.*, 2016; Tsai *et al.*, 2009).

The rate of obesity in the United Kingdom (UK) is the highest in Western Europe with more than 25% of the residents living with obesity in the past five years [Health Survey England (HSE) 2017]. According to the National Statistics (2019), the obesity rate in the UK has doubled (29%) since 1993 while morbid obesity prevalence has quadrupled (4%). In 2017, 64% of the UK adult population was either overweight or had obesity, with 29% of UK adults being classed as having obesity – indicating a rise by 3% from 26% in 2016 (NHS, 2019). Data extracted from hospital admissions in 2016/17 showed that 617,000 individuals had a primary or secondary diagnosis of obesity. This represents an increase of 18% on 2015/16 (National Health Service (NHS) Digital, 2017). It has also been predicted that about half of adult men and a quarter or more adult women in the UK will be living with obesity by 2030 with a projected rise to 50% in 2050 (Gupta, 2014).

To manage with the rising trend of overweight and obesity in the UK, weight management support is critical. The core concept of effective weight management is to prevent further weight gain, attain and maintain healthy weight, and promote long-term behaviour change (NICE, 2014). Equally important are options to reduce the uneven distribution of obesity across different ethnicities in the UK (NICE, 2015).

In the England, NICE recommends a tiered (tier 1 to tier 4) pathway approach to tackling obesity with three overarching sections of prevention, identification, and management. However, this study centres on Tier 2 weight management programmes given

that this tier is underpinned by lifestyle interventions at the level of the community (Mears et al., 2019). The WHO and NICE recommend that community-based weight management programmes for adults who are overweight or who have obesity, should be multi-component behaviour changing programmes aimed at reducing energy intake whilst promoting physically activity. It enables individuals to change their behaviour and work towards achievable goals. These programmes usually consist of 12-weeks of support provided through a course or club offered weekly or fortnightly (Romieu et al.,2017). These programmes are usually provided by the public, voluntary or private sector and are usually based in the community, primary care, workplaces or online (NICE, 2016).

In Medway, South-East of England, 69.2% of adults are living with overweight or obesity, which is considerably higher than the national average of 62% [Public Health Outcome Framework (PHOF), 2019]. Hence, the Public Health Team in Medway Council provides a range of prevention and treatment services to tackle obesity using the tiered approach on obesity and weight management as recommended by NICE guidelines (2014). The team provides a tier 2 weight management service also known as ‘healthy way’, which is a free 12-week multicomponent intervention programme which encourages individuals to adopt healthier lifestyles.

In 2016/2017, only 786 adults accessed the healthy way service (McCullagh and Bayliss, 2019). Through a developed obesity care pathway, the local service recognises the importance of offering consistent advice from health professionals and signposting clients to key services. The Public Health Team has collaborated with a network of, public, private, academic, and voluntary sector partners, to create the Medway Supporting Healthy Weight Network (Moore et al., 2021). This network provides a range of interventions ranging from food growing, healthy eating breastfeeding, healthy setting, marketing, physical activities, and workforce, all in a bid to tackle obesity (McCullagh and Bayliss, 2019). Working in line with the Public Health England (PHE) (2017) key performance indicators (KPIs), the service also aims at ensuring that the number of participants enrolled into the weight management programmes from high-risk groups including BAME is representative of the local population prevalence and that interventions remain fit for purpose.

Given that the BAME populations are at higher risk of developing complications at a lower BMI coupled with the fact that they have low participation rates in weight management intervention programmes (Fruh, 2017), it is recommended that tier 2 weight management services be tailored to engage BAME populations who are: at higher risk of having obesity; at higher risk of obesity-related co-morbidities; and less likely to find weight management services accessible [NICE (NG7) 2015; NHS 2019].

Whilst there is evidence to support the development of inclusive tier 2 weight management services targeting populations at risk, including the BAME populations, there are variations in the implementation for groups more likely to experience health inequalities particularly in relation to what works best in tailoring these services (NHS, 2019). In a publication by PHE (2019) on health inequalities, it was also noted that the validity of some health measures across BAME groups are contestable due to poor data availability both at the local and national levels, making it difficult to determine whether health interventions are equitable across different ethnic groups or not.

Rationale for the study

This study will help in understanding what has already been researched in literature about the subject as well as identifying some knowledge gaps. In addition, literature has shown evidence of low participation in access and uptake of weight management programmes among BAME groups, scarce evidence to inform culturally sensitive

interventions for weight management in BAME groups as well as absence of evidence regarding barriers and facilitators to access and uptake of weight management programmes in BAME individuals who are overweight or obese which may help tailor interventions (Klang et al., 2020). This research is timely within the context of the COVID-19 pandemic where it is observed that BAME populations are disproportionately affected due to a multitude of socio-economic, geographical and underlying medical conditions with obesity being the most frequent co-morbidity associated with the disease with increased mortality rate (Fruh, 2017). The disparity in trends of obesity and consequent health complications would only widen if proper attention were not paid to weight management within BAME populations, hence an understanding of their barriers and facilitators, including their preferences of weight management programmes may help shape policy guidance and implementation for these populations. This research will hopefully provide pointers to the causes of low levels of access and uptake of weight management amongst overweight BAME individuals.

Aim

To explore the opinions of adult obese BAME groups in Medway, UK, to help determine ways to improve access and uptake of weight management support.

Objectives

1. To synthesise the best available literature of barriers and facilitators of access and uptake of weight management in BAME populations
2. To critically explore knowledge, attitudes and perceptions of weight management amongst BAME groups
3. To critically investigate the challenges and enablers to access and uptake, including motivators amongst BAME groups
4. To critically analyse suggestions on improving access and uptake of weight management among BAME groups in order to implement practises, improve recommendations, and develop policies.

Methods

This qualitative study was conducted in the borough of Medway, Kent, in the South-East of England. It was part of the doctoral research project which explored the opinions of adult obese BAME groups in Medway, UK, helped determine ways to improve access and uptake of weight management support this study. The study used a qualitative approach used and reported using the COnsolidated criteria for REporting Qualitative research (COREQ) checklist which is a 32-item checklist for interviews and focus groups. It also involves research team and reflexivity eight questions in domain 1, study design questions (15) in domain 2 and analysis and findings questions (9) in domain 3. Using face-to-face semi-structured interviews, interviews were audio-recorded, transcribed, coded, and analysed using thematic analysis (Braun and Clarke, 2006). This study used hermeneutic phenomenology as its chosen design because it brings to light and reflects upon the lived meaning of this basic experience (Neubauer, Witkop and Varpio, 2019). Researchers use this design to progress from a human phenomenon to determine themes inherent to this phenomenon by engaging with the lived experiences of people who have encountered it (Neubauer, Witkop and Varpio, 2019). It is thus an interpretive process, and the researcher searches for meaning between competing interpretations.

Sampling and recruitment

Twelve participants (six males and six females) they are of the second generation. Participants from the adult BAME population were more suitable to participate in the study because they had the characteristics the researcher needed to investigate, hence the purposive sampling technique. This sampling method was selected since it allows researchers to specifically choose participants based on the phenomenon of study (Silverman, 2021) so that individuals selected would understand the phenomenon and diverse socio-demographic characteristics to ensure variation in the data collected (Creswell 2013; Patton, 2002). In addition, Walliman (2016) suggested that the deliberate selection of participants ensures optimum information-rich data. The recruitment process began upon receiving ethical approval from Teesside University Research Ethics Committee. Ethical approval clearance number from Teesside University: approval reference number 117/18 approval year 2018. Purposive sampling was used to recruit the participants for this study (Silverman, 2021), with the aim of selecting individuals who understand the study phenomenon representing diverse socio-demographic characteristics (Cohen *et al.*, 2000; Creswell 2013; Patton, 2002).

Participants Selection

Table 1: The inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
Aged 18 and above	Below 18 years old
Of BAME background	White Caucasian or another ethnicity that is not BAME
Resident in the Medway towns	Not resident in the Medway Towns
Concerned about their excess weight by self-assessment	Not concerned about their weight
Able to communicate in English	Unable to communicate in the English Language
Able to give informed consent	Unable to give informed consent

The Director of Studies helped the researcher put up an advertisement on Blackboard (the module platform) regarding potential participants who were interested in participating in the voluntary research study, as well as the researcher's contact details, which included an email address. The researcher received several contacts from potential participants who expressed interest in taking part in the study. Participants who are interested in taking part in the study were sent an initial invitation via email with the participant information sheet (PIS).

Data collection and interview guide

Prior to participation, all eligible participants were informed about the purpose of the study. Participants (n=12) were recruited until data saturation had been reached (Mason, 2010). They were also informed that their participation was completely voluntary and strictly confidential. Written informed consent was obtained from all participants before the interview. All interviews were recorded using a digital voice recorder. The interviews were carried out between September 2018 and December 2018, and each participant was interviewed once in a quiet place chosen by the participant. The interview sessions lasted from 25.34 minutes to 30.2 minutes (average = 27.8 minutes). At the end of the interview, participants were asked if they had anything to add or any comments to make. Each participant was given a pseudonym and study ID number to ensure anonymity and asked to

use the number if they wished to contact the research team. The transcribed copies of the interview were shown to the corresponding participants for verification, before data analysis. The study instruments were an interview guide and a socio-demographic form (Table 2).

Data Analysis

Transcripts of the interviews were thematically analysed using the NVivo-12 software (Braun and Clarke, 2006). In conducting the data analysis, the researcher attempted to bracket off her assumptions while paying attention to her position as an insider researcher. Holmes (2020) posits that the researcher should focus on her subjectivity and remain mindful of considering alternative interpretations. Furthermore, Rivard (2016) postulates that ‘a good way to obtain detailed and comprehensive accounts from interviews is to express ignorance...’ A naïve stance was thus adopted by the researcher to encourage interviewees ‘state the obvious’ thus giving voice to otherwise implicit expectations and assumptions (Rivard, 2016). Most importantly the researcher ensured that the analysis retained information which is truthful to the original nature of the verbal accounts (Braun and Clarke, 2006). The thematic analysis was done based on the six procedural steps recommended by Braun and Clarke (2006). Quotes were presented using in texts, text boxes, and thematic tables, for thematic illustration.

Results

Participants’ Characteristics

Twelve BAME adults (aged 26–65+ years) participated in the interviews: six were females, ten first-generation migrants, three were retirees, none living with a disability, and all were concerned about their excess weight (Table 2).

There were four themes from the data and eight subthemes were identified through thematic analysis of collated data which include: Experience concerning weight management, Knowledge of the local weight management programme in Medway, Attitudes towards the utilisation of the weight management programme in Medway and Participants’ views on improving access to the programme. The process of theme development is demonstrated in summary Table 3.

Table 2. Demographic data of participants

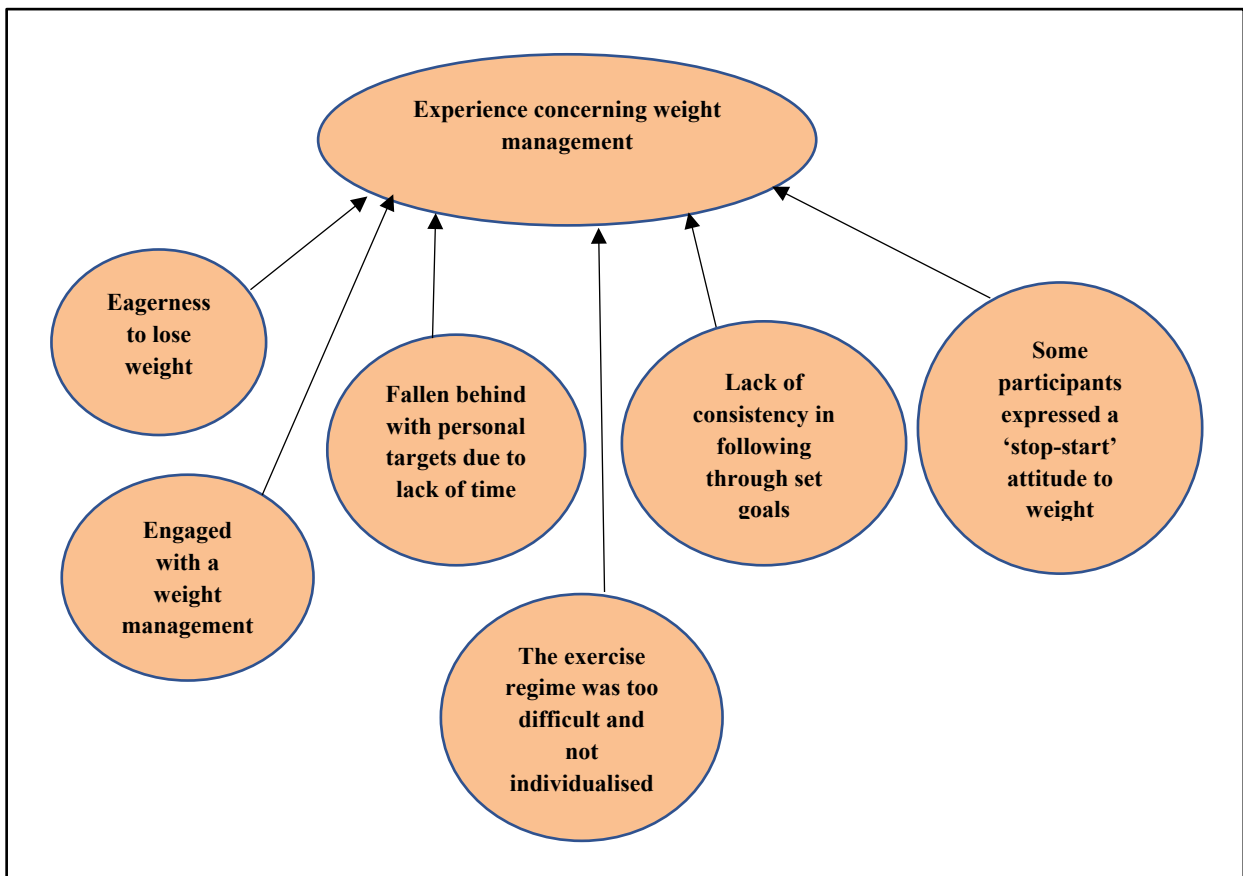
Characteristics (n = 12)	Frequency
Age	
26-35	2
36-45	5
56-65	1
>65	4
Gender	
Male	6
Female	6
Ethnicity	
Black or Black British- African	6
Asian or Asian British- Indian	6
Occupation	
Intermediate Occupation	5
Managerial and Professional Occupation	2
Unpaid Voluntary work	1
Retired	3
Home Carer	1
Disability Status	
Have a known disability	0
Have no known disability	12
Weight Status	
Concerned about their excess weight	12
Not concerned about their excess weight	0
Generation	
First generation migrant	10
Second generation migrant	2

Table 3: Summary of process of thematic analysis and themes identified.

Supporting Quotes	Codes	Subthemes	Major Theme
“I have been trying to do it, I walk, brisk walk basically and I still walk now, at times I have been going to the Gym whereby, I did manage to lose some weight, even walking I did manage to lose weight but recently I have put on some weight, obviously due to my diet and obviously I still need to control it”	Eagerness to lose weight	Concerning weight management	Experience concerning weight management
“... I had a personal trainer coming to the house and was training me, that sort of worked, but it is just the consistency of it, and it wasn't like massive weight loss. You have the personal trainer come in; they give you a weight programme in terms of diet programme....”	Engaged with weight management	Taking part in weight management	
“I did know about the service, at one stage when I was doing physiotherapy, I was referred by the Medway Council to a Gym in the Lord's wood centre, I attended the session for about 5 to 6 weeks, that did help me to learn how I can manage my weight. Similarly, I did start exercises at a Gym in Strood about a year ago ..”	Manage my weight. I did start exercises at a gym	Experiences concerning weight management	Knowledge of the local weight management programme in Medway
“I have read that in an advert, but I have not actually gone there or explored that, but it is something that I know exist within the Council”	I have read that in an advert	Awareness of the local, multi-component weight management programmes	
I will call to know, knowledge is power, I will just go to hear more, I would have gained more tricks and more information from them, the motivation would be to learn a little bit more about weight management....”	knowledge is power. Gained more tricks and more information from them.	Had prior knowledge of the service	Attitudes towards the utilisation of the weight management programme in Medway
If I hear good things from most people, I will be encouraged. I need the encouragement, if you are encouraged to... like or you supported to do something like you say exercise or diet or behaviour change at least maybe you join a group..”	I will be encouraged. I need the encouragement	Motivation would be to learn a little bit more about weight management	
“Professionals should be able to move, work across and reach out, it is an outreach team, they need to reach out to the society; go out to local pubs, they need to visit local stores, churches, where ethnic minority people normally come to shop; the	Able to move, work across and reach out	Targeted Outreach	Participants' views on improving access to the programme

reach is endless, they need to visit all nooks and crannies...”			
“... as a person of a black origin. A lot of the programmes would probably give you information on what to look out and what you need to eat.so they can give me portion sizes and they understand that I am an African woman, and this is what I could do. Someone that would not just give me a sort of general Eastern European or sort of European diet regime but that’s not going to sustain me because I am someone of black African origin.	Can give me portion sizes and they understand that I am an African woman	Culturally tailored and sustainable diet programmes	

Theme 1: Experience concerning weight management



From the interviews, most of the participants indicated that they have either tried to lose weight in the past or are currently trying to lose weight. When participants were asked if they are currently trying to lose weight, the responses were varied. A participant noted:

"I have been trying to do it, I walk, brisk walk basically and I still walk now, at times I have been going to the Gym whereby, I did manage to lose some weight, even walking I did manage to lose weight but recently I have put on some weight, obviously due to my diet and obviously I still need to control it" (Participant 9).

Some participants expressed a 'stop-start' attitude to weight management and a lack of consistency in following through set goals. This participant's views acknowledged fluctuating weight gain as a pointer to the individual's non-compliant attitude:

"... I had a personal trainer coming to the house and was training me, that sort of worked, but it is just the consistency of it, and it wasn't like massive weight loss. You have the personal trainer come in, they give you a weight programme in terms of diet programme, and I wasn't seeing that sort of drastic change I wanted. And then, the pain and suffering behind what the personal trainer takes me through, sort of made me give up really" (Participant 10).

Likewise, another participant also highlighted that life events always hinder weight loss:

"I have always been concerned about my weight but then most of the times you try to do the steps to try to lose weight, but something disturbs you and then you stop and then you try again but I haven't really like managed. There was only at one point in time where I really tried to. I actually achieved; I achieved the weight that I wanted to reach" (Participant 1)

Other participants mentioned that they had given up trying to lose weight. A participant summed up this state of affairs:

"Well, I have been trying to lose weight, there was a time I was concerned about my weight. I did not join any weight management school or weight management clinic, but what I did is, I do run, and I also use the gym and I must say I wasn't emm...I didn't go to gym all the time. I am not compliant with it. My money ran out, so I started to run. So yes, that's the only time I worried about my weight. At the moment, I would say yes, I am worried, but I don't think there's anything I can do because I am not compliant with things I do" (Participant 3)

Still, for other respondents, weight management is contingent on a continuous committed attitude of putting in the effort. A participant submitted:

"...weight management is a continuous process, and it kicks in when you look at your weight and see that you have actually gained some weight, then you know it is time to make sure you reduce moving around with cars and do more of trekking. In terms of my weight management, yes, actually, I try to leave my car at home and walk to work every day, and walking to work every day makes you to be very fit, agile and flexible. When I come back from work, I do the normal family routine, I always go to my gym you know, as well, do my cardio, and my weightlifting which is part of my life, you know. If I don't visit the gym, I feel that I am neglecting my body" (Participant 2)

Participants were further asked how long they have been trying to lose weight. It is evident that some participants have been trying to lose weight for a few years. A participant highlighted:

“...I can say since.... It was mainly since 2014 before I was pregnant. That is 2014/2015 I was really and seriously exercising, watching my diet and all those types of things” (Participant 1).

Participant 10 stated:

“I have been doing this for the last year because I had a target of trying to have a fit body and have a good statue and the whole, having the task to get ready for summer 2018 but it hasn't worked” (Participant 10).

Theme 2; Knowledge of the local weight management programme in Medway

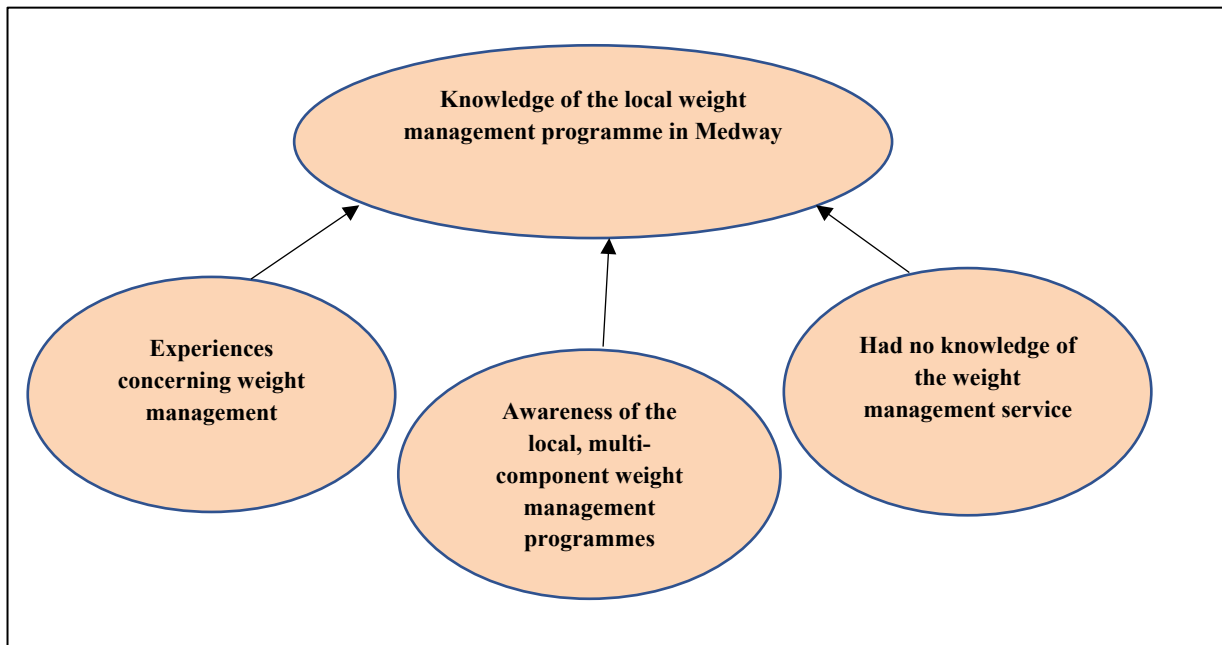


Figure 2: Theme 2; -Knowledge of the local weight management programme in Medway

Aligned to the interview question of understanding their experiences concerning weight management, participants were asked about their awareness of the local, multi-component weight management programmes. A participant who was signposted to the weight management programme indicated:

“I did know about the service, at one stage when I was doing physiotherapy, I was referred by the Medway Council to a Gym in the Lord's wood centre, I attended the session for about 5 to 6 weeks, that did help me to learn how I can manage my weight. Similarly, I did start exercises at a Gym in Strood about a year ago, but recently for a year I have not been following that programme” (Participant 9).

Another participant mentioned they had read the information from an advert but could not remember where the advert was:

“I have read that in an advert, but I have not actually gone there or explored that, but it is something that I know exist within the Council” (Participant 2).

For example, participant 6 did not know about the existence of the local weight management service:

“No. I don’t know. People have problems with heart attack, diabetes and everything and it will be better if they can help us” (Participant 6).

Theme 3: Attitudes towards the utilisation of the weight management programme in Medway

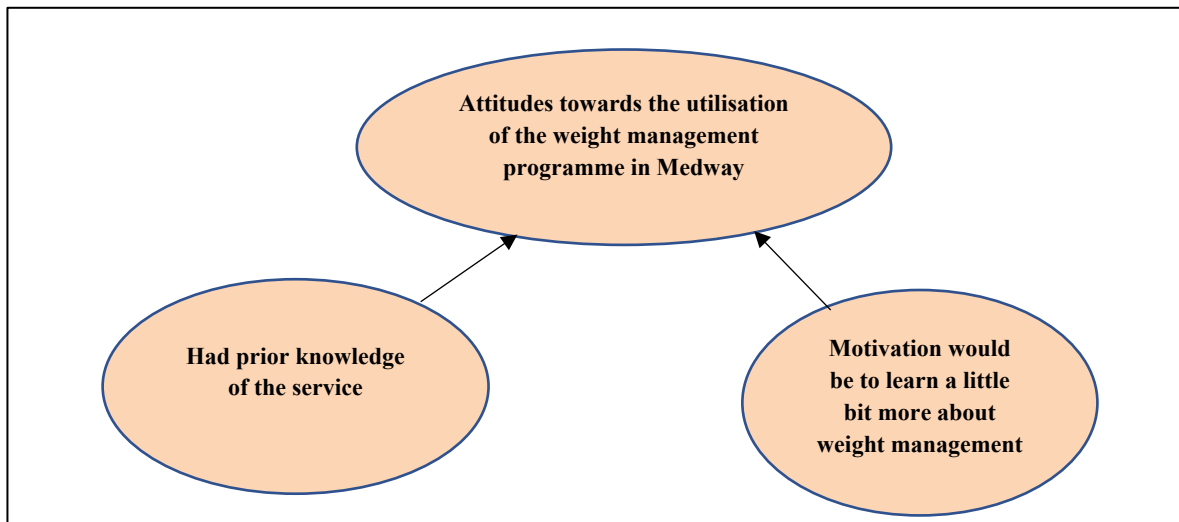


Figure 3- Theme 3-Attitudes towards the utilisation of the weight management programme in Medway

However, when the participants were asked if they would sign up for the programme if they had prior knowledge of the service, their responses were affirmative:

“If I hear good things from most people, I will be encouraged. I need the encouragement, if you are encouraged to... like or you supported to do something like you say exercise or diet or behaviour change at least maybe you join a group What, when I say I have tried diet, I have tried exercise, I have done it all by myself without any support from anybody” (Participant 4).

Another participant indicated:

“I will call to know, knowledge is power, I will just go to hear more, I would have gained more tricks and more information from them, the motivation would be to learn a little bit more about weight management. I know only my own programme, no one has taught me, I will make my own programme, like now I have said I will do 150 days, consecutive days of running and the gym, every day, Monday to Sunday, I will do that, so I shed off weight” (Participant 11).

Theme 4: Participants’ views on improving access to the programme

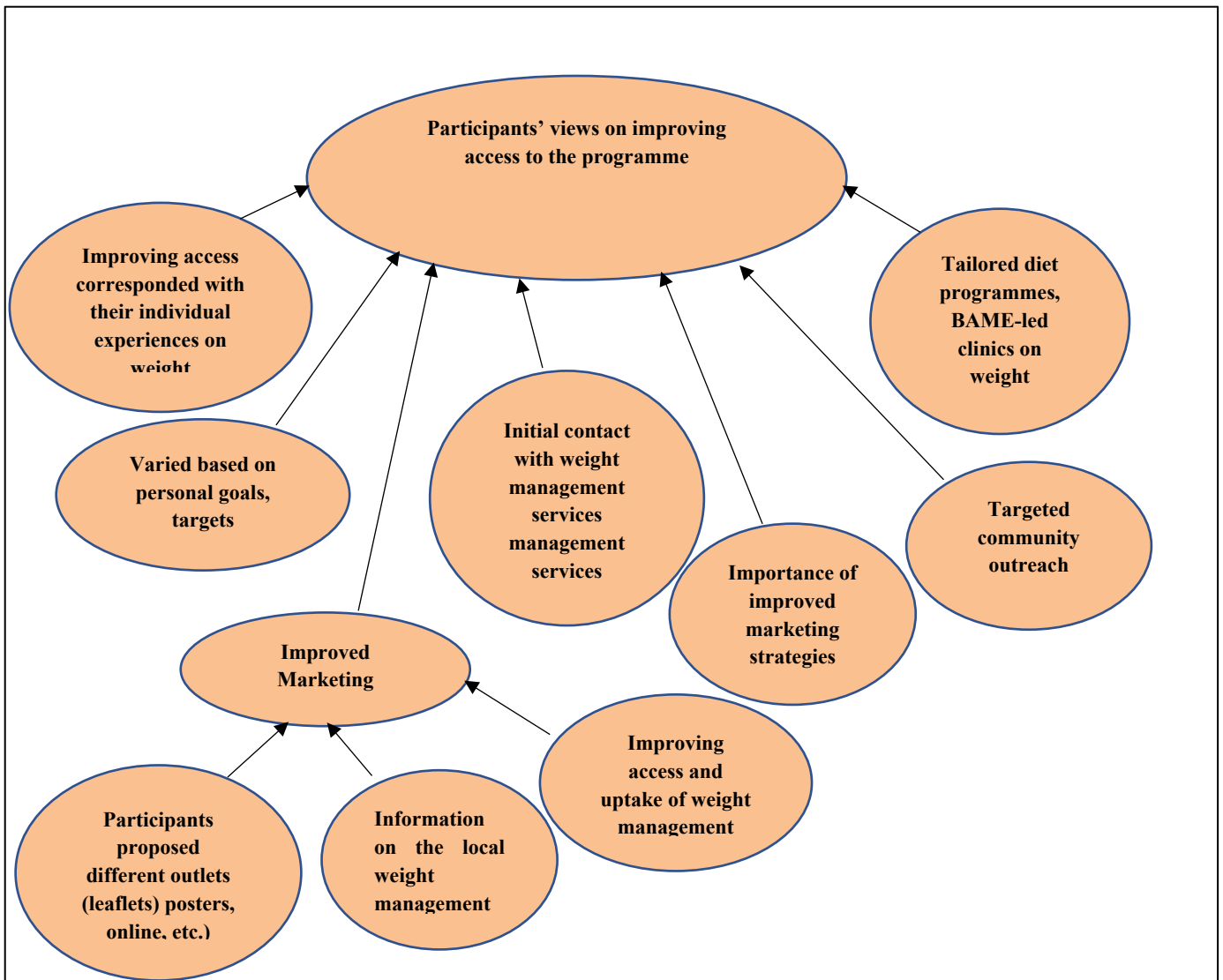


Figure 4: Theme 4- participants’ views on improving access to the programme

Subtheme 1: Improved Marketing

Participants proposed leaflets, posters and online, through which information on the local weight management service can be advertised as a means of improving access and uptake of weight management. Some participants expressed these views:

'I think they need to improve on the way they advertise. I don't know whether to...just to.... I know it might be expensive for the council maybe just to put the leaflets or just some posters at the clinic or anywhere else so at least we get the information. Like me, I didn't know that all those things are there, they are free' (Participant 1).

Another participant noted:

"It means the publicity of the program, it should be advertised, it might be advertised in hospitals, online so people can go online and search for it. It might be more publicity, yeah, we've got our own black African communities where most people meet like churches or weddings, yeah, and maybe it can be advertised in those places" (Participant 4).

Another participant from the Gujarati community emphasised the importance of leaflets and other printed information to be translated into Gujarati and distributed:

"I don't know anything about the service and what it is doing but if you do a paper translated in Gujarati in printing that we are here, we are doing this thing, we have got information about your type of diet, because with Gujarati food, we cook vegetarian diet but if you can print everything on a paper in Gujarati that we can help you this way, then people will read and be interested to come and lose the weight. Then they can come to the community and tell more and more people because people will say go there, they have got a nice service and they have got this one and that one and then more people coming to you" (Participant 5).

Subtheme 2: Targeted Outreach

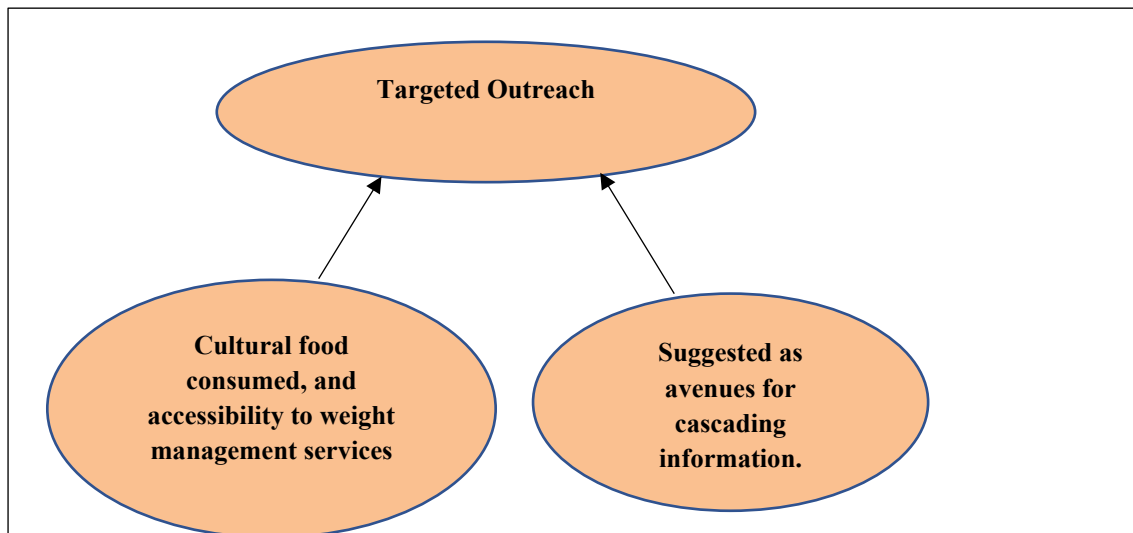


Figure 5: Subtheme 2- targeted Outreach

Targeted community outreach emerged as a major indicator for improving access, particularly for BAME populations that are diverse in terms of location, cultural food consumed, and accessibility to weight management services. Overall, communication was identified by participants as a key indicator of disseminating information:

“Professionals should be able to move, work across and reach out, it is an outreach team, they need to reach out to the society; go out to local pubs, they need to visit local stores, churches, where ethnic minority people normally come to shop; the reach is endless, they need to visit all nooks and crannies, even local banks where people walk in there, they can talk to the bank manager of each branch and say can we leave this (information) here, so people can be reached more” (Participant 2).

Participant 11 stated:

“I have been doing this weight management since 2013, this is the first time that I am hearing about this structured programme. I don’t know how I can help them to communicate it to us; I don’t know how much data they hold about us. They can write us email, send us letters.... They can tailor their services to suit BAME people if they hold information, whatever forms we fill out for the council, they hold information they can use like our emails and addresses they can use them” (Participant 11).

Subtheme 3; Training and sensitisation of healthcare and other relevant professionals

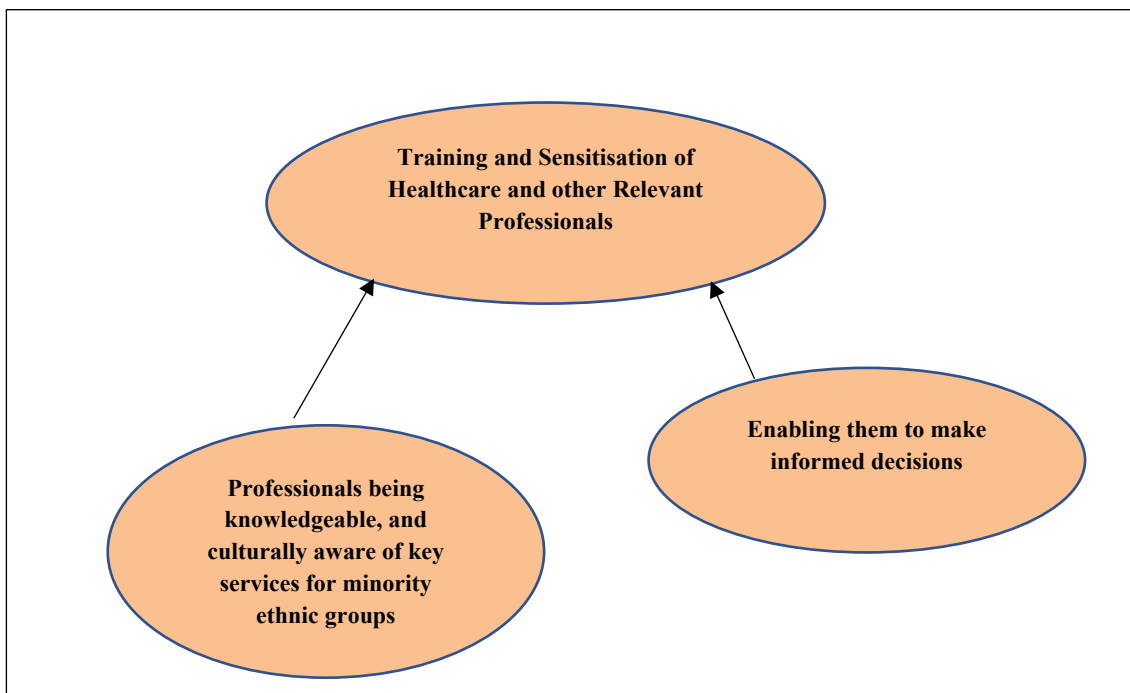


Figure 6: Subtheme 3; Training and sensitisation of healthcare and other relevant professionals

Professionals being knowledgeable, and culturally aware of key services for minority ethnic groups, enabling them to make informed decisions, and to pass on such vital information featured prominently in views of participants:

“...number one reason is awareness and talking more about it, I know there are different posters out there, it is one thing for you to have posters, not many people read posters but having health care professionals discuss it like when you go to the GP and they discuss and any concerns about diet and lifestyle, there is nothing like a general lifestyle discussion. When I go to the GP or see a nurse practitioner, there is nothing specifically in terms of weight management and lifestyle except you go specifically for that. You are advised to seek for help out there; but there is no clear signposting that you get and that makes it slightly difficult. So, if health care professionals are imbining it in their culture of raising that awareness, talking about it, having all the information at hand, for me that will be very helpful” (Participant 10).

Subtheme 4: Culturally tailored and sustainable diet programmes

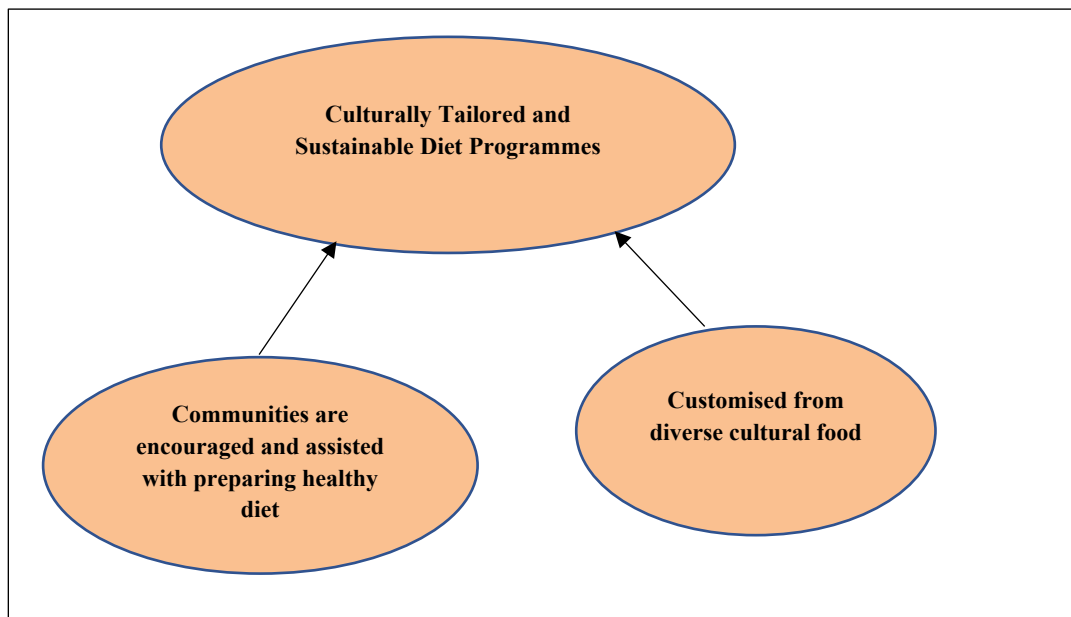


Figure 7: Subtheme -culturally tailored and sustainable diet programmes

Culturally tailored diet programmes which can be sustainable were identified as useful in ensuring communities are encouraged and assisted with preparing healthy diet customised from diverse cultural food. Participants declared:

“I would like programmes that would be directed to people of my origin because I find out much weight programmes, they would not talk more about my diet and what I eat as a person of a black origin. A lot of the programmes would probably give you information on what to look out and what you need to eat. Someone that would not just give me a sort of general Eastern European or sort of European diet regime but that’s not going to sustain me because I am someone of black African origin. I need to know that this person understands what I eat and tells me what is good for me and not good for me” (Participant 10).

Participant 2 noted:

“The council and others should look at multi-ethnicity that exist within the community, they should as well look at what each ethnic group, what is their tradition, what is their custom, and what type of food they eat as well. ... when you go to Bangladesh, these are what they eat, these are the healthy food, when you go to Nigeria, this what they eat, these are the healthy food, these is time they should be eating this, this matters a lot, so all those people from diverse background will enjoy that and take that on board” (Participant 2).

Subtheme 5: Recruitment of Community facilitators and weight management champions

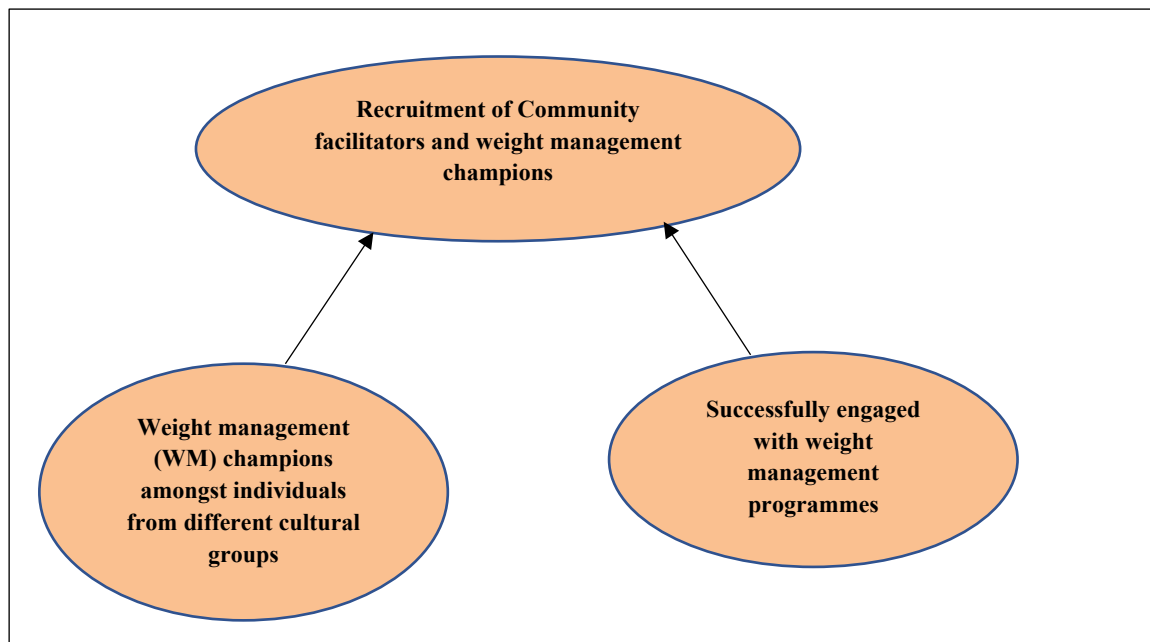


Figure 8: Subtheme 5- recruitment of Community facilitators and weight management champions

Recruitment of community facilitators and weight management (WM) champions amongst individuals from different cultural groups, who have successfully engaged with weight management programmes and services. For example, some participants noted:

“We need facilitators from our communities, it can be people who have been on weight management programmes or been referred to it and have a better feel of what it covers... they will pass on their personal experience of what they have acquired, and how it helped them. In doing so, they will try and recommend in a way that does work, so there is a potential for others to try and do it” (Participant 9).

Another participant highlighted:

“...you know weight management is results-oriented, so, if there will be a sort of a proof to showcase to the community that this was where this person was, and this is where he is now by taking this programme, so it will be a motivating factor” (Participant 2).

Subtheme 6: Indigenous Food Recipes and Food Labelling

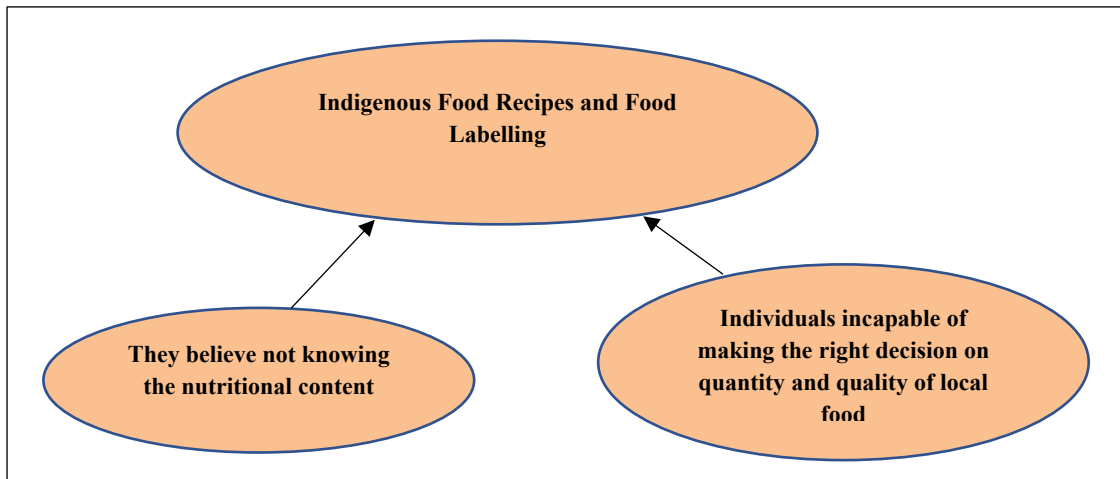


Figure 9- Subtheme 6: Indigenous Food Recipes and Food Labelling

All participants concurred on the importance of labelling for indigenous food. For example, a participant stated:

“...Any programmes on weight management for BAME should be focused on the different people, and their ethnic diet. If the food is for someone of Caucasian origin, not everyone eats certain things or not all what is recommended is incorporated into our diet. People from African areas come from different background, and they eat different things. It is important to have a diet guideline that is tailored to the needs of BAME.....” (Participant 10).

Participant 7 remarked:

“One thing you know is we Indians, our food is different. When you see on the television all different health programmes, everything is in English and it’s on English food. But if they can include Indian food like chapatti and rice, how much we should have, a tablespoon or two tablespoons or the amount we can have, that is very important. Because how many calories they are and all that” (Participant 7).

Subtheme 7: BAME-led Clinics

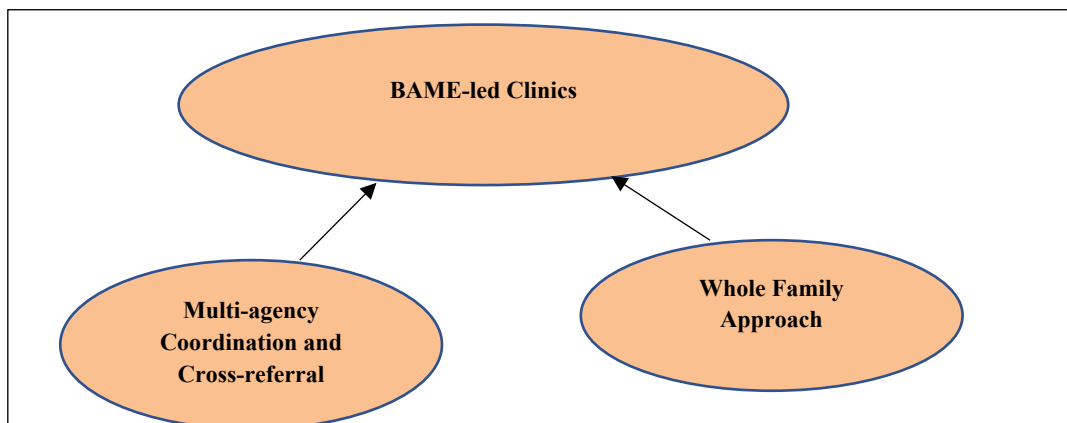


Figure 10: Subtheme 7: BAME-led Clinics

Linked to indigenous food recipe and labelling, the research findings are suggestive of having a BAME-led clinic with staff who understand BAME culture and diet. A second-generation Black African participant summed up:

“Maybe having a BAME-Led Clinic would help...it may be necessary to have someone that is tailored to our needs. We need to have someone that understands us, understands our diet and not make us feel like we need to forego our tradition for someone else’s. It is just being able to sort of tailor our cultural needs but also do it in a healthy way, so we need health care professionals that are more aware of our origin, what we eat is our culture and identity” (Participant 10)

Furthermore, participants believed that having staff of BAME background in weight management services will improve access when trying to encourage family and friends to take up weight management:

“If you say to them that not only will one lose weight but they understand that BAME group and they understand the sort of different cultural diets you have got and different foods you have got and they can help you maintain and obviously ensure that you are not over doing it; and they know what portion sizes and they know how to make it in a more healthy manner and not forget your culture, I do have friends on the large side. A lot of them would simply say if you can get me a weight loss programme that will suit me with my Nigerian food in a healthy way, I will get on it and that’s what we want to see” (Participant 10).

Multi-agency Coordination and Cross-referral

For some participants, multi-agency coordination and integrated joint-up working between different agencies, for follow-up of those referred to weight management programmes. A participant stated:

“One of the other ways I used was, because I have diabetes type 2, I was referred to the diabetic people. Obviously from there, I had some recommendation on how to reduce weight. They did give me dietary information where when I go for shopping from the supermarket, what should I be looking for, like facts, substance, what are the calories, things like that to be checked before I get the products, to use it basically” (Participant 9).

Whole Family Approach

Linked to family unit flagging up concerns is the concept of whole family approach. A participant noted:

“Involve the partners because sometimes in our culture we are scared of the men. If a woman keeps saying I want to lose weight, I want to lose weight, if he (the partner) is not supportive, then it’s not gonna work. He needs to support you... And also, if the man tells a woman, you are too fat (overweight), you need to lose weight; the woman will do all it takes to lose the weight to please the husband which is part of our culture. Our culture is pleasing him” (Participant 3).

Discussion

In Medway, 69.2% of adults are living with overweight or obesity, which is considerably higher than the national average of 62% [Public Health Outcome Framework (PHOF), 2019]. However, the BAME populations are the worst affected population groups with respect to obesity due to existing social inequalities (Wang *et al.*, 2020). In this study, it was observed that most of the interviewed participants, who were all from the BAME background, had no knowledge of the weight management service while only one participant has used the service.

To improve the uptake of the weight management service provided in Medway, the participants recommended the use of strategies such as indigenous food labelling, BAME-led clinics, the use of translated leaflets, the recruitment of local weight management champions, better coordination of services, appropriate communication strategies, and further research.

Food labelling

The participants felt that if the nutritional content of indigenous foods found in local shops were labelled, it may guide individuals to make healthier food choices. Even though previous research recommended the need for indigenous food labelling mostly within African American populations in the US (Kirby *et al.*, 2012), this research has underscored the fact that there is limited research in indigenous food labelling. Research has been carried out by Apekey *et al.*, (2019) to analyse the nutritional content of some popularly consumed West African and Caribbean foods. However, this was limited to cooked food and is yet to be applied to raw produce on the shop shelves. Based on the importance of food labelling, the suggestion of a food traffic system as a template to determine the nutritional component of indigenous food was made by participants. The traffic system is modelled as a form of a signal with green indicating low, amber considered as moderate and red as food with high sugar content (Sacks *et al.*, 2009).

Within the context of this study, the availability of information on the nutritional composition of indigenous food will add to the choice, and influence decision making on purchase and consumption. Research on food labelling traffic light system implemented in high income and some European countries indicates that individuals can spot a healthier substitute among food of same category (Barker *et al.*, 2012; Hodgkins *et al.*, 2015). It is noteworthy that implementing food labelling to suit the needs and choices of ethnic minority groups remains a daunting challenge. Though the option of food labelling remains highly touted, it would require multi-agency collaboration involving joint working with governments, food suppliers, farmers and research organisations to ensure that food labelling is appropriately done and carries the correct calorie information.

Culturally tailored and Sustainable diet Programmes

The participants stated that they would engage more in diet programmes for weight loss if it included indigenous recipes and diets. Unfortunately, culturally designed and prepared food along the cultural specifics of minority populations is not factored into weight management programmes in the UK, including Medway. The UK Eatwell guide (PHE, 2019) which is meant to guide individuals to make healthier food choices often used in weight management clinics by dietitians are not tailored to cultural diet and food of minority ethnic populations. In addition, a participant echoed that every ethnic group have their own cultural diets and recipes that are healthy and unhealthy while other participants stated that they have got their own traditional food and would not want to abandon this. Therefore, it is important for dietitians and other professionals to show understanding of these cultural diets so they can

advise appropriately on portion sizes and nutritional value. Furthermore, through organised and culturally tailored cooking sessions and demonstrations where members of the BAME communities assemble, food samples which will serve as a diet template can be prepared to educate them about healthy diet preparations.

Community Outreach

Community outreach as a key strategy for improving access among BAME populations given their diversity in terms of geography, ethnicity, diet and level of access to weight management services. Participants felt that the centre point of community outreach was targeted and coordinated efforts from within the community, outreach teams and multiagency professionals to enable valuable information to get to these groups speedily. Community outreach and coordinated efforts feature prominently in the research literature (Bopp *et al.*, 2012). However, as findings demonstrate, opportunities for local policy interventions can be maximised through targeted forms of communication and creating awareness using leaflets, posters, adverts that speak directly to obesity and weight management needs of BAME populations. Further, linking with these communities through places of interaction such as churches, local banks, and local markets may be utilized as venues for cascading information.

Weight Management Champions

The use of weight management champions from BAME communities was considered essential among the participants. As suggested by South, Stansfield and Fenton (2015), community engagement and empowerment are central in meeting the health needs of diverse communities hence reducing health inequalities. The recruitment of champions to act as facilitators and for raising awareness in their cultural groups on obesity-related issues and weight management services is crucial to disseminating good practice and building the capacity of local communities to take charge of weight management issues.

The idea of champions who hold basic knowledge, and prior experience of engagement with weight management services; serving as role models for the community stands out in this study. The case is made that champions are a linchpin in enabling weight loss messages to get to groups. They can also help boost engagement of participants in weight management, are conversant with the culture and can influence participants' access to services, thus, shaping health outcomes and interventions, for example, funnelling through and updating the content of weight management leaflets.

Communication and Marketing Strategies

Given that lack of knowledge of local weight management services within the area was highlighted as in the findings, communication and marketing strategies emerged as a key suggestion in reaching out to ethnic minority populations at different levels. This should include macro policy, weight management services, and community involvement. Participants suggested the need for television adverts and food-related advertising to be targeted at ethnic minority groups. Leaflets should be translated and distributed in places where they congregate such as churches, mosques, temples, and use of social media hubs and platforms.

At the level of the weight management services, such adverts and leaflets with key information on weight loss can be displayed in posters and information boards in local hospitals and GP Surgeries. At the macro policy level, improved communication, marketing

strategies and other innovative interventions to promote behaviour change in overweight adults has been captured in existing literature (Okorodudu *et al.*, 2015), as a fundamental tool at the hand of governments and other public bodies. Likewise, some studies have highlighted the importance of coordinated approach to communication in enhancing partnerships with local communities for obesity prevention (Hillier *et al.*, 2012; Werder, Holland and Munro, 2020).

Training and Education

The study participants suggested that specialist training on obesity management for healthcare professionals who provide services in the community and primary care settings would help create awareness. This will enable healthcare professionals especially General Practitioners (GPs) to engage in open dialogue and conversations around weight management. Greater involvement of health care professionals in undertaking assessments and reviews at primary care and community level were a major suggestion from participants. The research literature has documented the potential benefits of GPs being the first port of call at primary care level in offering tailored services, and support for individuals from minority populations with obesity-related issues (Bouma *et al.*, 2019; Schutz *et al.*, 2019). As findings show, most participants would desire the involvement of GP practices in weight loss behaviour assessments and other lifestyle interventions, though realistically, the capacity of GP practices to undertake these tasks presents with opportunities and barriers (Schutz *et al.*, 2019).

BAME-led Clinics

BAME-led clinics were suggested by participants as a means of improving engagement in weight management programmes. Participants indicated it will be useful to have professionals who are culturally aware and sensitive to the dietary needs of BAME individuals towards weight management. It is captured in the literature that services that are planned with the involvement of participants from socially deprived areas and ethnic groups tend to be clinically effective in galvanising community members especially women (NICE, 2014). Participants further stated that they can relate more to these professionals as they will have an understanding and greater insights into their culture, diet and other preferences regarding obesity and weight management.

Multi-agency Coordination of Services

In line with the identified finding of fragmented referral services as a barrier to engagement with weight management services, participants indicated that services were delivered in a fragmented way, and agencies were not speaking to each other in a coordinated manner. To this, participants suggested that a better coordination of services could improve engagement. This aligns with literature by Kaplan *et al.*, (2018) and Taylor (2020), who opine that health care professionals struggle with multifactorial issues such as partnership and coordination.

In line with current guidance (NICE, 2014) better coordination of health care services involving health and social care practitioners and other agencies would enhance access and uptake of weight management services (Bouma *et al.*, 2019). Others have argued that improvement of health care training for professionals and systems to deliver obesity and weight management services are crucial (Dietz *et al.*, 2015), while others have advocated for policy support and actions to redress the rates of obesity (Huang *et al.*, 2015). A

multidisciplinary approach remains crucial in managing the complexity of reducing obesity as the referring physician needs the assistance of other specialist professionals and agencies (Westerveld and Yang, 2016) to improve outcomes. Co-creating interventions designed with the collaboration of communities could foster community ownership and increase participation (Kumanyika, 2019).

Whole Family Approach

The whole family approach also conceptualised as a family-based approach recognises the influence of families in effecting change in other family members and themselves (Sallis and Nader, 1988). Some participants in the research indicated that if more men are targeted, it can have a positive influence in a family's weight management journey. Decisions such as diet preparation and other family activities tend to revolve around and predicated on men. Given the situation, it would be beneficial if men are able to encourage and are in tune with weight management activities of other family members, especially their spouse.

Targeting men in weight management programmes as well as kids on healthy eating habits can yield more dividend in terms of family support and keeping an eye on others. This approach resonates with literature on mainstreaming weight management and other lifestyle behaviour change within family settings. It has been suggested by Kumanyika *et al.*, (2019); Powell *et al.*, (2015) and Marquez *et al.*, (2018) that families serve as a catalyst and source of motivation in behaviour change, enabling others to achieve their weight loss objectives through activities like physical exercises, diet programmes, aided by social ties and networks.

Limitations and Strengths

Being a qualitative study, this study investigated a small sample of English-speaking participants, which may not represent all people from BAME background in Medway and further across the UK. Secondly, the issue of response bias may not be completely excluded because the interview sessions were recorded, and the issues discussed were concerning government-provided healthcare services. Hence, some participants' responses might have been influenced by the temptation to provide "safe" answers. Notwithstanding these limitations, this research adds to the very limited body of evidence on how to improve uptake of weight management services in the UK. Secondly, this study is the first known study to investigate how to improve uptake of such services amongst BAME communities in Medway, UK.

Further Research

There is a huge dearth of research literature on weight management amongst UK-based BAME populations (Ige-Elegbede *et al.*, 2019). This is further consolidated by the iterations of the participants in this study. To improve scholarly outputs on weight management amongst UK-based BAME populations, the public health agencies in the UK need to give more funding towards this research area (Mbabazi *et al.*, in press). The participants highlighted that through additional research on this topic area, more knowledge can be obtained on how to improve access and uptake to weight management services in the BAME communities. Additionally, there is a need for more research and the type of research required i.e., more qualitative and evaluative research, in other populations across the UK and internationally, research that is codeveloped with target populations.

Conclusion

This study identified the opinions of residents living with overweight or obesity / weight management concerns from ethnically diverse adults on how to improve the uptake of weight management services in Medway, UK. Importantly, indigenous food labelling, BAME-led clinics, the use of translated leaflets, the recruitment of local weight management champions, better coordination of services, appropriate communication strategies, and further research are essential ingredients that can be used in improving access and uptake of weight management programmes in BAME communities.

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